BUILDING ON FAMILY STRENGTHS: BRIEF THERAPY OF THE FAMILY DURING THE ADOLESCENT STAGE OF THE FAMILY LIFE CYCLE.

BY

FRANK CANTAFIO

A practicum presented to the
Faculty of Graduate Studies
in partial fulfillment of the requirement
for the degree

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MASTER OF SOCIAL WORK

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ABSTRACT

The purpose of the practicum was to examine the application of an integrated model of brief family therapy during the adolescent stage of the family life cycle. The model, largely based on the work of Steve de Shazer, positively orients the therapist toward family strengths and leads to positively oriented intervention strategies. Therapy represents a process of highlighting and building upon the family's solution oriented behavior and functional patterns of success. The process of therapy was aided by a clear assessment of family functioning based on the structural framework. Comparisons of multiple pre and post-test measurements demonstrated the effectiveness of this model in promoting therapeutic change with a range of families in which an adolescent was the "identified patient", including families with a history of domestic violence.

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INTRODUCTION AND OVERVIEW OF THE CLINICAL PRACTICUM

The field of family therapy has been marked by vast growth and increasing popularity over the past twenty years. This evolution is reflected in the smorgasboard of current family therapy models and the rich array of assessment frameworks, intervention strategies and techniques promoted by the various models. The methods advocated by each of the models are frequently presented as unique to the model in mind. Nevertheless, all family therapy models rest on a "systems perspective" base that integrates elements from a number of separately defined, yet strongly related, family treatment paradigms including: (1) general systems theory; (2) family systems theory; (3) cybernetic theory; and (4) ecological theory. The position adopted in this practicum is that, taken together, all four of these paradigms have merged together to form the systemic perspective base underlying family therapy.

The systemic perspective functions as a "meta-perspective" or a "meta-theory" for all models of family therapy (Hoffman, 1981; Koman and Stechler, 1985). In its simplest form the systemic perspective provides a framework from which to view individuals within the context of their families. In its broadest form, the systemic perspective encompasses ecolgical concepts and provides a framework from which to view individuals in the context of their socio-cultural, political, economic, and physical setting. The systemic perspective emphasizes the relational aspect among "separate entities" and how these entities are organized together as a single, functioning, whole system. In the broadest sense,

the systemic perspective addresses the transactional relationships among the systems of the individual, the family and the larger socio-cultural context (Minuchin, 1974; Hartman and Laird, 1983). Thus, as the family represents part of the larger environment, it at the same time forms an environment for the individual (Hartman and Laird, 1983).

Among the helping professions, social work can uniquely be associated with a systemic perspective. While different language has been used to describe the professional purpose of social work over the years, the language which best describes the social work purpose is systemic in nature. The social work profession has historically laid claim to a person-environment orientation (Germain, 1979; Hartman and Laird, 1983). Social workers have traditionally practiced from the position of viewing individuals in the context of their environment and they have emphasized the impact that transactional forces among systems (individual, group, family, community) have upon the quality of life. The profession of social work has always maintained the primary purpose of improving the transactions between people and systems to enhance the quality of life. Action toward fulfilling this purpose may be directed to the person, the environment or the interaction of the two (Germain, 1979; Hartman and Laird, 1983). In this context, families represent a legitimate point of entry (Germain, 1979).

The social work profession's traditional association with the systemic perspective as its basic practice foundation, and the profession's "history of concern for and association with the family", indicates a natural congruence between social work practice and family therapy (Hartman and Laird, 1983, p.11). Given that family therapy is

theoretically grounded in the systemic perspective, it is founded on theoretical bases which can easily be integrated with social work practice. Within this context, the purpose of this practicum is to outline and demonstrate a clinical model of family-centered social work practice that encompasses an integrated model of brief family therapy. Family-centered practice rests on the systemic perspective in both its simplest and broadest form:

> "The domain of family-centered practice . . . . .is restricted neither to families and their members nor to those larger environment systems which affect the nature of family life. Its concern , its focus, its turf, are those transactions among person, family and environment which affect individuals, families, and though less well understood, even the larger social forces and systems in which families are enmeshed."
> (Hartman and Laird, 1983, p.5).

Area of Focus

This clinical practicum was primarily focused on the application of an integrated model of brief family therapy with families in which an adolescent member was identified as requiring treatment, on an outpatient basis, by the family or a referral source in the community (e.g., school, social services, other therapists). A secondary focus was placed on testing a clinical model of brief family therapy with similarly identified adolescents who had also witnessed some form of family violence.

The focus of this practicum encouraged the acquisition of clinical skills at a number of levels. First, narrowing the clinical population to adolescents and their families provided the opportunity to develop a

high level of semi-specialized clinical skills in conducting family therapy with adolescents. This learning experience was particularly significant given the little attention directed toward the theory and methodology of conducting family therapy with adolescents to date. Second, particularly specialized skills were developed in treating adolescents who have witnessed violence in their family. This was particularly significant as children who witness violence in the home are often over looked as their victimization is often minimized in treatment and society at large. Third, while the focused nature of the practicum fosterd specialized skills, the development of broader, more generalized skills in family therapy was encouraged by virtue of the clinical setting in which the practicum was conducted. Four, there was a very personalized level of learning as the practitioner was afforded the opportunity to trace his own development as a family therapist. The benefits of this personalized process are paramount and will be generalizable to all modalities of social work practice in the future.

Personal Learning Objectives

Primary and secondary learning objectives were specified as this practicum promoted the learning process at a number of levels.

Primary Objectives

1. To acquire the skills and knowledge base necessary to apply an integrated model of brief family therapy with adolescents and their

families.

2. To develop a high level and range of assessment, intervention and evaluation skills in practicing family therapy with adolescents and their families.

3. To develop a model of measuring a family therapy trainee's personal development as a family therapist.

Secondary Objectives

1. To acquire and practice specialized skills in conducting family therapy with adolescents who have witnessed family violence.

2. To test the efficacy of conducting a brief model of family therapy with families where children have witnessed family violence.

PART I: LITERATURE REVIEW: DEVELOPMENTAL THEORY

CHAPTER 1

ADOLESCENT DEVELOPMENT AT THE LEVEL OF THE INDIVIDUAL

Historical Context To Adolescence

While the concept of "adolescence" has largely been worked and reworked within the context of an individually oriented developmental model of psychology, its evolution as a concept can be traced to broader ecological factors associated with the movement toward industrialization and urbanization (Keniston, 1962; Erikson, 1968; Harevan, 1982). Adolescence was not recognized as a distinct stage of development until the the late nineteenth century (Aries, 1962; Bennett, 1986) and was introduced in the literature as a concept by S. Hall (1904). The concept of adolescence was partly invented as a response to the phenomenon whereby "the roles of children and parents became more separate as different economic expectations....created a discontinuity between childhood and adulthood" (Keniston, 1962, cited in Preto and Travis, 1985, p. 22).

Prior to the industrial revolution, the family functioned as a total economic unit in which children shared adult labour tasks and had a crucial economic function. Children made the transition directly from childhood to adulthood as soon as they could assume full work responsibilities. Adolescence, as we now know it, did not yet exist. However, with the move toward industrialization and urbanization the family's role shifted more toward child care and consumption (Harevan,

1962). The child's economic function in the family abated and a prolonged and ambiguous transition from childhood to adulthood developed (Preto & Travis, 1985). Along with technological advances the time between childhood and adulthood increased and as Erikson (1968) notes the stage of adolescence became more clearly defined. In an attempt to cope with this ambiguous time period, young people created a set of rituals and activities which today we refer to as adolescence. The conceptual development of "adolescence" also evolved, then, as an attempt to understand the events, issues and experiences of young people as they made the transition from childhood to adulthood (Preto& Travis, 1985).

Hall's initial formulation of adolescence has been expanded upon from a number of perspectives including cognitive, social, psychoanalytic, developmental and biological orientations. While most of these perspectives focus on the internal, psychological pressures felt by the adolescent, some theorists such as Erikson (1950, 1968) have formulated more integrated models of adolescent development which address the impact of social influences upon psycholgocial development. In Erikson's view of development, "interaction between the person and the environment is a cardinal principle" (Merz, 1988, p.100). Yet, regardless of the orientation brought forward to a discussion of adolescence a review of the literature on this topic uncovers a number of salient issues or themes. Among these themes, a bias toward the social and developmental perspectives is evident since they have been prominent in shaping the views on adolescent development in this century (Elder, 1974, cited in Preto & Travis, 1985). The themes shaping our view of adolescent development will be reviewed and critiqued below. A subsequent analysis

of adolescent development within the context of the family life cycle model will also be provided. The attention that is being directed toward discussing the "basics" of adolescent development at this time, is based on the premise that effective family treatment with adolescents and their families begins with the therapist's thorough understanding of adolescent development at an individual, family, and systemic level.

Recurring Themes on Adolescence

Adolescence is typically described in the literature as a stage of an individual's life development that is predictably stormy, conflictual and confusing, by its very nature. Thus, Erikson (1959, 1968) describes adolescence as a "normative crisis, i.e., a normal phase of increased conflict characterized by a seeming fluctuation in ego strength as well as a high growth potential" (p. 116). The confusing and contrasting nature of the forces which seem to be at work during adolescence are perhaps best symbolized in the cliche that describes adolescence as a period of time in which the individual has one foot in childhood and one foot in adulthood. The adolescent struggles to meet needs which are apparently conflictual, yet reflective of the stages of childhood and adulthood between which she/he is straddled: play vs work; dependence vs autonomy; irresponsibility vs responsibility; intimacy vs distance; family vs peers. The emergence of many new, powerful feelings and needs seem juxtaposed against that with which the adolescent is already familiar and comfortable.

Despite the multitude of theoretical models on adolescence, there is

little variation across the models on two themes in particular. First, all theories correlate the onset of adolescence with the onset of puberty. A great deal of emphasis is placed upon the impact that the vast bio-physical changes, associated with pubescence, have upon the adolescent's social development, inter and intrapersonal functioning, behavior, and interests (Erikson, 1950, 1968; Blos, 1962; Clausen, 1975). Second, all models generally infer that adolescent development involves a series of primary tasks which the adolescent must address and resolve as part of the growth process. Before proceeding to a discussion of these tasks, the impact of pubescence upon adolescent development will be reviewed.

With the vast physical changes associated with puberty the adolescent is forced to contend with a number of new social demands, expectations, and accompanying shifts in relationships. The fact that reproductive maturity proceeds psychological maturity amplifies the potential for the adolescent to experience problems adjusting to pubescence. It is as though the adolescent's physical maturity becomes an objective and obvious sign that other changes are forthcoming. The adolescent's rapid growth and biological development is intertwined with social expectations regarding sex roles and norms for behavior. Suddenly it is less socially appropriate for the physically mature adolescent to participate in child's play. Social and familial demands which emerge place pressure on the adolescent to assume a more responsible role and to begin thinking about an occupational interest.

Although gender identity is beginning to form by age 3, socio-cultural expectations of how a young woman and young man should behave

are overtly evident to the adolescent (Stoller, 1964; Chodorow, 1974). Violations of sex role demands and stereotypes are clearly reacted to in a negative manner by peers and family. Thus, it is less appropriate for adolescent girls to maintain their "tomboyish" characteristics and adolescent boys are ostracized for showing effeminate mannerisms. Sex role identification and occupational identity are strongly interrelated with the socio-cultural environment and very much influence the adolescent's process of identity formation. According to Erikson (1950, 1968), the normative crisis of adolescence entails a reworking of earlier developmental crises. During this period, there is a reevaluation of how well the early skills and lessons acquired by the adolescent fit with the imposing societal demands concerning occupation, sexual identity and responsibility. In the process of this reevaluation the adolescent must come to some sense of an occupational and sexual identity. The emergence of these issues with the adolescent's biological development illustrates that the impact of pubescence cannot be separated from the adolescent's developmental tasks nor from the societal and community expectations and prescriptions he/she faces. Germain (1979) points out: "In our own society, sex, age, colour, and other biological attributes have a profound impact on the sense of identity, arising as it does out of interaction with others and their perceptions and expectations" (p. 12).

Adolescent Developmental Tasks: Identity Formation, Sexuality, Separation

While different terms have been employed to label the developmental issues facing adolescents, the developmental tasks most commonly cited generally have to do with identity formation, sexuality, and separation. These tasks do not emerge, nor are they resolved, in any sequential manner, but rather, are tightly intertwined.

Identity Formation

Identity involves a sense of being all right, of being oneself, and of becoming what other people trust one will become (Erikson, 1950). While the formation of an individual's identity is a life long process, adolescence, as a stage in the developmental process, represents an overt identity crisis (Erikson, 1950,1959,1968). Given this crisis element, adolescence is often mistakenly viewed as a final stage in identity formation as opposed to a transitory stage. The physical and psychological changes which the adolescent undergoes internally and in relation to social - familial pressures, challenge the adolescent's self concept and contribute to the process of identity formation (Preto & Travis, 1985). The adolescent must now define and evaluate her/himself in terms of physical maturation as well as in terms of the accompanying social norms regarding behavior. Social and familial standards around sex role behavior and responsibilities interact with identity formation (Erikson, 1950, 1968; Germain, 1979; Gilligan, 1982).

In particular, the adolescent must begin the process of directing some energy toward determining a future occupation (Erikson, 1950, 1968). While this process moves the adolescent toward more of an orientation to the future it also leads the adolescent to reevaluate the roles and skills acquired in the past. In this regard, the central issue is whether or not the adolescent views the skills and roles acquired in the past to hold much significance and utility in relation to potential available occupations which are of interest. If there is little connection between an occupation which is of interest to the adolescent and the skills and roles at which he/she feels most adept, the adolescent is likely to choose an alternative occupational interest. Ultimately, the adolescent will likely choose an occupational interest he/she will be most competent at based on the skills and roles mastered in earlier developmental stages. The tension that is associated with this process best characterizes adolescence. If the adolescent is unable to settle on an occupational interest, identity confusion is likely to arise (Erikson, 1950). In addition to the internal pressures felt by the adolescent, cultural and familial values, which define particular occupations as gender specific, emerge as strong forces in the process of identity formation.

As part of the process of identity formation, the adolescent begins to "crystallize" her/his own values and beliefs. Paradoxically, while this process is underway the adolescent appears primarily concerned with what he/she appears to be in other peoples' eyes as opposed to what they feel they truely are (Erikson, 1950). Adolescents tend to know more clearly "who they are not". In an effort to figure out "who they are"

adolescents paradoxically overidentify with their peer group. The adolescent's ability to formulate some tentative answers to who they are as an individual is a prerequisite to integrating a sense of identity (Kimmel & Weiner, 1985; Bennett, 1986). In this regard Erikson (1968) maintains that the adolescent must come to terms with crises of earlier years before they can institute a final identity. Identity formation includes significant earlier identifications but also alters these into a coherent whole. This involves integrating various aspects of one's self into a sense of who one has been and who one may become around questions such as: Who am I?; What do I believe?; What do I want to do in life?; (Bloom, 1980; Dreyfus, 1976).

Sexuality

Adolescence is marked by a significant increase in sexual feelings, thoughts and behavior (Preto & Travis, 1985). The emergence of the adolescent's sexuality is intertwined with the other developmental issues of identity and separation and has a major impact upon the adolescent's transactions with peers, family and the community at large. In particular, the interplay of the adolescent's self-concept, identity and sexuality is never so evident as it is during adolescence.

Whereas in earlier stages of development, segregation by the sexes is typical, adolescence provides the individual with her/his first direct experience with the mating process. Adolescents become more interested in forming relationships with those of the opposite sex and begin to date. Erikson (1968) claims that the adolescent's initial

experimentation with "love" often represents the adolescent's projection of their "diffused self" onto another in an effort to arrive at a clearer definition of their self.

The adolescent's initial experimentation with the mating process affords the opportunity to examine personal values around sexual involvement and behavior. Sexual experimentation typically begins for adolescents between the ages of 12 - 15. For some adolescents this will involve masturbation, for others it may involve intercourse. Sexual experiences include intercourse for a majority of adolescents who are between the ages of 16 and 19 (Sorenson, 1973, Katner-Zelnik, 1971, cited in Bernand, 1975; Bloom, 1980). The self-concept plays a critical role in the likelihood of whether or not the adolescent will engage in sexual behavior at an inappropriately young age. The adolescent girl who engages in sexual behavior at an inappropriate age typically has a very poor self-concept and has not likely had the benefit of appropriate nurturance, affection and emotional support. Her early involvement in sexual behavior often represents a misguided attempt to meet needs for acceptance, caring and affection. It is no coincidence that such an adolescent girl becomes "matched" with an adolescent boy who is similarly attempting to compensate for a fragile self-concept by defining himself through inappropriate sexual behavior. The adolescent male's involvement in early sexual behavior often represents an attempt to confirm his sexual identity, and "self", through socially prescribed sex role expectations for him to be masculine, heterosexual, aggressive and in control. Such behavior reflects the socially prescribed means through which males seek and fill needs for nurturance and acceptance. And so a

cycle develops: In an attempt to fulfill her unmet needs for nurturance, caring and acceptance the adolescent girl follows traditionally prescribed sex role channels by turning to the male adolescent who, in turn, follows traditionally defined sex role channels for defining male sexuality by engaging with the girl in sexual behavior at an inappropriately young age.

The question of sexual identity, then, emerges as a critical issue for the adolescent as now, more than ever before, they are faced with socio-cultural expectations regarding heterosexual and same-sex relationships. The male adolescent's sexuality revolves around social demands for aggression, self-control and masculinity. Such demands mask the male's vulnerability and reflect his socially prescribed role of seeking nurturance and affection through active means. The female adolescent's sexuality revolves around social demands for vulnerability, tenderness and sensitivity towards others and reflects the socially prescribed role of seeking nurturance through passive means.

The impact of socio-cultural forces upon sexuality is particularly evident with respect to the socio-cultural pressure toward heterosexual relationships and the pressure against same-sex or homosexual relationships. Feelings of attraction and intimacy toward members of the same gender activate a great deal of emotional confusion, anxiety and psychological dissonance. The intensity of these reactions is most extreme for gay and lesbian youths.

While homosexually oriented youth do not appear to experience differences in general biological and cognitive changes, they must deal with issues different from those of heterosexual youths in the area of

psychological and social development (Hetrick and Martin, 1987). While a full account of the impact of these differences upon the development of homosexual adolescents is beyond the focus of this practicum, some important points can be made.

For the homosexual youth, the process of defining a sense of self and managing social roles, involves the realization that one is a member of a stigmatized group in society (Hetrick and Martin, 1987; Martin, 1982). In this regard the major developmental issues for homosexual adolescents "revolve around their entry into a stigmatized social identity" (Hetrick and Martin, 1987, p.40). This stigmatization creates problems and situations including isolation, family cut-off, violence, emotional stress, shelter, employment, which must be resolved as part of the developmental process. Critical among these issues is the homosexual youth's need to hide a critical aspect of their identity (Martin, 1982). In this isolation the homosexual's sense of "belonging to a primary group, the differentiation between 'we' and 'they', gets lost. To belong, they must condemn and attempt to repress their developing sexuality; to accept their sexuality, they must cease to belong" (Hetrick and Martin, 1987, p.37). In contrast, healthy resolution of the developmental issues facing the homosexual adolescent leads to a fusion of emotionality and sexuality (Martin, 1982; Hetrick and Martin, 1987; Troiden, 1979). Troiden (1979) has developed a four stage developmental model on the process of forming a gay identity.

The absence of references made to the developmental issues facing adolescents who are homosexually oriented represents an area of criticism in the early literature on adolescent development. The bias toward

heterosexual development reflects a similar bias (to be discussed subsequently) evident in the literature that is based on the systematic integration of theoretical concepts which predominately signify the male gender to the exclusion of concepts which signify the female gender. It is critical that recent contributions to the literature, attempting to correct these biases, be integrated into practice so that practice does not reinforce the same biases.

Separation

The adolescent's vacillation between dependence and independence represents the core of the developmental challenge related to the adolescent's separation from family. The adolescent's internal need to become more autonomous and separate from family is associated with corresponding external pressures for the adolescent to begin negotiating areas which require self-reliance and responsibility such as educational and occupational career paths. These demands for increasing self-reliance are usually congruent with the adolescent's desire for autonomy, however, at other times they conflict with the adolescent's desire to retain the sanctity of childhood. The adolescent's ambivalence, in this regard, is usually nestled in feelings of lost childhood years as he/she frequently grieves the safety and insulation that characterized childhood.

The adolescent's move toward full autonomy is gradual and is intimately tied to other related developmental issues. Experiences of failure during the adolescent's early attempts to join the peer group or

experiment in the work world may discourage further risk taking and may heighten the adolescent's reliance on family instead of "self". Germain (1979) supports these assertions and reinforces the interrelatedness of the adolescent's developmental tasks with one another and the environment at large:

> "Identity not only arises out of human relatedness, but influences the nature of relationships. It also rises from experiences of autonomy, and competence and, in turn, affects those attributes. Indeed, identity, competence, autonomy, and human relatedness are interdependent. Issues of autonomy are worked out in the contexts of human relatedness and experiences in the exercise of competence, and in the process of identity formation. Relatedness is the essence of identity, but it also reflects the kind of autonomy that permits one to be either dependent on others or independent as the situation requires" (Germain, 1979; p. 12-13).

Although identity formation, sexuality and separation, as the major developmental tasks of adolescence, were topically discussed in a singular manner, it is evident from the foregoing discussion and Germain's words that these tasks do not arise in a sequential manner nor in isolation from one another. They are constantly at play, in a simultaneous, interactive manner both in terms of the internal psychological pressures felt by the adolescent as well as familial and socio-cultural pressures which come to bear from an external vantage point. While an understanding of adolescent development from the level of the individual is critical, problems and crises which are presented by adolescents and their families in treatment are best understood within the context of the family life cycle model (Haley, 1973; Minuchin, 1974; Okun and Rappaport, 1980; Carter and McGoldrick, 1980; Karpel and

Strauss, 1983). Prior to discussing the life cycle model a critique of the literature on adolescent development is presented.

Critique of Literature

Proceeding to an analysis of the family life cycle model without first critiquing the literature on adolescent development would seem to reinforce the bias that is apparent in the theory construction surrounding adolescent development, and social science theory in general. This bias, although implicit in the literature, is based on the systematic integration of theoretical concepts which predominantly signify the male gender to the exclusion of concepts which signify the female gender (Chodorow, 1974; Gilligan, 1982; Sundal - Hansen, 1987; Merz, 1988). Gilligan (1982) accurately asserts that human development, including adolescent development, has largely been viewed through men's eyes and that theories of human development are based almost solely on the observations of male development. Studies on development are almost exclusively composed of male samples. Consequently, theorists have tended to regard male behavior as the norm for human development. Thus, developmental theorists have projected a masculine image that singularly reflects the male life cycle as opposed to the female life cycle. In short, females are viewed as deviant in this context. Gilligan cites evidence of gender bias in the work of Freud, Erikson, Piaget, Blos, and Kohlberg. The literature on adolescent development is not free of gender bias and, in fact, exemplifies such bias in the emphasis placed on male views regarding developmental tasks such as separation, identity

formation and sexuality.

In tracing the gender bias that is evident in theories of human development, Gilligan (1982) cites the work of Nancy Chodorow (1974). Chodorow indicates that "feminine personality comes to define itself in relation and connection to other people more than masculine personality does" (Chodorow, 1974, p. 43 - 44, cited in Gilligan, 1982). Others support Chodorow's conclusion (Miller, 1984; cited in Sundal-Hansen, 1987; Surrey, 1985, cited in Sundal-Hansen, 1987; Merz, 1988). Miller (1984) and Surrey (1985) suggest that women's self-concepts need to be looked at in a relational context as a woman's view of self is in interaction with other selves from birth on. This "self-in-relation" model emphasizes interdependence instead of independence.

Chodorow attributes male and female personality differences to the fact that women are primarily responsible for child care. As a result, the dynamics of identity formation are different for males and females. For girls, the process of identity formation is fused with attachment since mothers and daughters experience each other as more alike. On the other hand, mothers experience their sons as opposites. Consequently, "boys, in defining themselves as masculine, separate their mothers from themselves" (Gilligan, 1982, p. 8). The process of male identity formation, then, involves individuation and separateness, instead of sameness.

Thus, issues of dependency occur differently for boys and girls. Separation and individuation are critically tied to male gender identity as separation from the mother is a prerequisite for the development of masculinity. In contrast, the development of the female identity is not

tied to separation or individuation but, rather, evolves with attachment. Yet, the literature on adolescent development highlights individuation and separation as milestones in the developmental process. In fact, the literature emphasizes that adolescence, among all stages of development, is a crucial time for separation and identity formation (Blos, 1967; Erikson, 1950, 1968). This emphasis reflects male development and is inappropriate to female development. The shortcoming of such a biased emphasis is labelled by Gilligan (1982):

> "The quality of embeddedness in social interaction and personal relationships that characterizes women's lives in contrast to men's, however, becomes not only a descriptive difference but also a developmental liability when the milestones of childhood and adolescent development in the psychological literature are markers of increasing separation. Women's failure to separate then becomes by definition a failure to develop" (p.9).

The absence of concepts which accurately reflect the development of adolescent females is apparent in Erikson's (1950, 1968) framework. Aside from Erikson's first stage of development, trust vs mistrust, Erikson's overall framework of human development depicts a gradual process of individuation and autonomy. The process of individuation and autonomy are inherent in Erikson's second (autonomy vs shame), third (initiative vs guilt) and fourth (industry vs inferiority) stages of development and are paramount in development as these stages are prerequisites to identity formation (stage 5) and subsequent intimacy (stage 6). Given the perspectives that Gilligan and Chodorow offer, Erikson's framework clearly reflects a bias toward the process involved

in male identity formation and male development in general. According to Erikson, the process of identity formation during adolescence essentially involves: "the celebration of the autonomous, initiating, industrious self through the forging of an identity based on an ideology that can support and justify adult commitments" (Gilligan, 1982, p. 12). Erikson's schema of development is defined through separation. Attachments, and interdependence, which are evidently key to female developmental processes, are viewed as disruptive to the process of identity formation and development.

In conclusion, while the literature on adolescent development contributes to an understanding of the issues which may arise for adolescents, and their families, in treatment it is critical that the therapist appreciate the bias toward males that is evident in the literature. The therapist must sensitize her/himself to distinctions in male and female developmental processes. If such sensitivity is not kept in the foreground the therapist is likely to mistakenly reinforce gender biases in therapy.

A bias toward mislabeling a family's normal transitional difficulties as pathological, may also result if the therapist does not have a thorough appreciation of the developmental processes which occur for every family "as a system" (Minuchin, 1974). In this regard, the problems which adolescents and their families present in treatment are best understood within the context of the family life cycle model (Haley, 1973; Minuchin, 1974; Okun and Rappaport, 1980; Carter and McGoldrick, 1980, 1988; Karpel and Strauss, 1983). Carter and McGoldrick (1988) succinctly address this perspective:

> "The family life cycle views symptoms and dysfunctions in relation to normal functioning over time and views therapy as helping to re-establish the family's developmental momentum. It frames problems within the course the family has moved along in its past, the tasks it is trying to master, and the future toward which it is moving. It is our view that the family is more than the sum of its parts. The individual life cycle takes place within the family life cycle, which is the primary context of human development. We think this perspective is crucial to understanding the emotional problems that people develop as they move together through life" (p.04).

After generally discussing the family life cycle model, particular attention will be focused on the adolescent stage of life cycle development.

CHAPTER 2

THE FAMILY LIFE CYCLE MODEL

Within the family life cycle perspective, the family as a whole is viewed to have its own life cycle with predictable stages or transitions. Each stage of the family life cycle is preceded by a particular life event (e.g. marriage, birth of a child) and is marked by corresponding developmental tasks. The family's transition from one stage to another typically triggers a crisis, of some proportion, for the family as a whole. The pressure and disorganization associated with this crisis prompts the family's need to reorganize itself structurally vis-a-vis the resolution of pertinent developmental tasks (Karpel & Strauss, 1983). Life cycle events are likely to be much more traumatic and crisis engendering if they occur "off-time" from the expected life course (e.g. adolescent pregnancies). The manner in which the family addresses the developmental tasks and responds to the ensuing crisis has a major impact upon the development of individual family members as well as the family's development as a whole. Families which attempt to respond to new circumstances, created by the precipitating life event, by applying old, patterned ways of problem resolution are likely to become "stuck" in the life cycle process. In this regard, poor negotiation of developmental tasks and incomplete resolution of a life cycle stage potentially leads to the family's inability to complete future developmental stages as the effects of poor negotiation shows up in later stages. The inability to completely negotiate tasks from earlier stages frequently shows up during

the adolescent stage of development as this stage requires the greatest degree of flexibility and adaptability

Within the family life cycle model, symptoms which families present in treatment are viewed as signs that the family has become "stuck" in the process of moving from one developmental stage to the next (Haley, 1973; Carter & McGoldrick, 1980; Minuchin, 1974; Karpel and Strauss, 1983; Watzlawick, 1974; Weakland, Fisch, Watzlawick and Bodin, 1974). In this context, Hoffman (1981) contends that: "families that come for treatment with distress in one or more members seem to be having difficulty with evolving - they are or seem non evolved -- stuck..."(p.157). The family therapist's task is to aid the family in becoming unstuck so that it can resolve the pertinent developmental crisis and move on to the next stage of development (Haley, 1974; Hoffman, 1981). From this family life cycle perspective, symptoms are seen as temporary, normal reactions and spin offs of the stress engendered when families are in transition (Minuchin, 1974).

The family life cycle model is particularly helpful as a backdrop for understanding adolescents and their families who come for treatment since the adolescent stage of the family life cycle is characterized by a great deal of stress and calls forth adaptational responses in the family as a whole. A more detailed discussion of the adolescent stage of the family life cycle will be prefaced with a review of the historical development of the life cycle model and its integration with theories of family therapy.

The Historical Development of the Family Life Cycle Model

Once the theoretical underpinnings of the individual life cycle model were laid by Erikson (1950, 1959, 1968), the initial formulations of the family life cycle also evolved as sociologists began to conceptualize the family as a group of individuals who each had their own life cycle (Preto & Travis, 1985; Carter & McGoldrick, 1980). Hill and Duvall (1948), credited with formulating the initial directions toward a family life cycle framework, then made the observation that an interdependence existed between family members as they each attempted to master their individual developmental tasks. Hill and Duvall concluded that the success of each family member in mastering their tasks contributed to the success of other family members as they addressed their developmental tasks (McGoldrick & Carter, 1980; 1988).

These preliminary directions eventually led to the theoretical position that the family as a whole moves through its own developmental life cycle characterized by varying developmental tasks at different stages of development (Duvall, 1977). Based on this position, Duvall developed the first family life cycle model which outlined eight life cycle stages through which each family progresses during development. Since Duvall's pioneering work numerous models of the family life cycle have been developed. Although there is variation among these models, each generally integrates the nodal life events which mark a family's development: marriage; the arrival of children; raising children; adolescence; leaving home; young adulthood; adult years; retirement and death (Haley, 1973; Minuchin, 1974; Karpel and Strauss, 1983; Carter and

McGoldrick, 1980, 1988).

Despite the early formulations of the family life cycle model, its direct affiliation with family therapy was not overtly evident until the 1970's when Haley (1973), Minuchin (1974), and Soloman (1973) made direct reference to integrating the model into clinical practice with families (Carter and McGoldrick, 1980). Haley (1973) integrated a six stage configuration of the family life cycle model with family therapy. In basing his perspective on Milton Erickson's approach to treatment, Haley indicated that symptoms are most likely to manifest in a family member at one of these six life cycle transition points since stress is highest as the family moves from one life cycle stage to the next. Symptoms signal that the family has become stuck in moving from one stage to the next. In this context, family problems are viewed as a temporary derailment from the family life cycle.

Minuchin's earlier perspective on family treatment, is not unlike Haley's in that he adopts the position that many families who come to therapy can be approached as "average families in transition" if they are viewed in the context of the family's developmental cycle. Minuchin relates that many families in therapy reflect the "pain and accommodation that is required to meet new circumstances" which arise through normal developmental processes. From Minuchin's point of view the family life cycle model is a key element to any approach that views the family as a whole system (Minuchin, 1974; Carter and McGoldrick, 1980).

Soloman (1973) compacts Duvall's eight stage model of the family life cycle into five stages and concludes that the model can be used as a framework from which to develop treatment plans with families who are in

therapy.

The initial formulations which integrated the family life cycle model with family therapy generally focused upon the nuclear family and the stress that is engendered as the family moves forward through the life cycle process. Others have since expanded these initial formulations of the family life cycle to a three generational model which broadens the conceptualization of "family" to more clearly include extended family members (Carter & McGoldrick, 1980). Within the three generational model, emphasis is placed upon the patterns of relating and functioning which are transmitted across or down family generations. This orientation highlights the impact that family attitudes, taboos, labels and loyalties, have upon a family's functioning as it moves forward through the life cycle. Carter & McGoldrick (1980) have developed a family life cycle model that incorporates Haley's (and other's) initial formulations with a three generational approach.

Carter and McGoldrick (1980, 1988) suggest that the flow of stress and anxiety that impacts a family's functioning can be viewed along two separate but related axis: "vertical" and "horizontal". The vertical flow of stress encompasses the patterns of relating and functioning that are passed down and across a family's generations and includes elements such as family attitudes, taboos, beliefs, loyalties, and issues that have been passed on intergenerationally. The horizontal flow of stress refers to the stress and anxiety that is triggered as the family system passes through the nodal transition points which are inherently a part of the family life cycle. Unexpected or mistimed life events, such as an early death or pregnancy, are included along the horizontal axis in

addition to the predictable life experiences. Given enough stress along the horizontal axis, any family will appear dysfunctional as it passes through the life cycle. Only a small amount of stress is required along the horizontal axis before dysfunction is evidenced in a family where intense stress has been transmitted intergenerationally along the vertical axis. Carter & McGoldrick's key point is that the combined impact of the stress engendered along the vertical and horizontal axis, at the point where they converge, determines how well a family will function as it moves through life. Thus, Carter & McGoldrick add to Haley's view by emphasizing the impact that intergenerational patterns of resolving life cycle crises have upon the family's movement through the life cycle in present and future generations.

The family life cycle model provides some key principles from which to approach therapy with families. First, as reflected in Milton Erickson's approach to therapy, the family life cycle model highlights the "normal" or "ordinary processes" that occur in families (Haley, 1973, p. 40). In this context, the family life cycle model is based on the notion that all families move through a series of predictable, identifiable stages which involve some degree of stress and crisis for the family. For the most part the stress is temporary in that the family draws upon its own resources to resolve the crisis. The family then proceeds to the next stage of development. According to the family life cycle model, families which seek treatment are those for which the developmental process has become disrupted - - they are "stuck". The symptoms which arise because of this disruption reflect the family's unsuccessful solutions to get past a stage in the life cycle (Haley, 1973

Watzlawick et al, 1974; Fisch et al 1982). The aim of therapy is to assist the family in becoming unstuck by directing the family toward attempting alternative solutions (Watzlawick et al, 1974; Weakland et al, 1974; de Shazer, 1985). Within the context of the family life cycle model, some degree of stress and anxiety is "normalized". Together these points are very congruent with the brief therapy model employed in this practicum which focuses on initiating small changes and punctuating family strengths. This promotes a healthier view of families and has implications for the therapist's approach to family treatment.

Second, the family life cycle model informs the therapist about which issues are most significant to a family during a particular stage of development. Based on this information the therapist is able to more objectively assess whether a particular family pattern is functional or dysfunctional. Depending on the assessment reached, the therapist will employ different approaches with a family according to the family's life cycle stage. For instance, an intense model of parental supervision is functional for a family with infants, but is likely to be dysfunctional for a family with adolescents. The therapist will treat the family with infants much differently than the family with adolescents.

Taken together, the utility of these key principles becomes particularly evident when adolescents and their families present for treatment. Many of the conflicts evident between parents and adolescents can be reframed as part of the normal, predictable developmental process that all ordinary families experience. This reframe serves to alleviate some of the stress and anxiety that family members may feel in relation to one another and free them to more objectively negotiate some of the

accommodations and shifts in power and authority required during the adolescent stage of the family life cycle. Such reframes are particularly important for the family with adolescents as the adolescent stage of family development requires a great deal of flexibility and adjustment on the part of the family as a whole unit. A closer examination of these issues will take place in the following discussion on the adolescent stage of the family life cycle.

The Adolescent Stage of the Family Life Cycle

The adolescent phase of the family life cycle extends from the time the oldest child reaches puberty until the youngest child exits the home. Among all of the expected nodal events in the family's life cycle, adolescence is most likely to test the family's flexibility to accommodate and adapt (Ackerman, 1980). The family's transition into the adolescent stage necessarily involves a structural and organizational transformation for the family (Okun and Rappaport, 1980).

In order to distinguish between predictable developmental crises and dysfunctional family patterns, the family therapist must operate from a base that integrates the systemic foundation of family therapy with the developmental life cycle model (Okun and Rappaport, 1980). In working from such a base the family therapist is able to have a total picture of the family as it transacts with the adolescent's individual development. In this regard Minuchin (1974) states that the family life cycle is a key component of any schema based on viewing the family as a system. Through the integration of the developmental and systemic perspectives, many

families in therapy would be seen as average families reacting to normal developmental processes, circumstances and crises (Minuchin, 1974).

The central challenges which face the family during the adolescent phase of the family life cycle are the renegotiation of the boundary between the family as a unit and the community at large; a renegotiation of the boundary separating the adolescent and his or her parents; and a concomitant renegotiation of the adolescent/parent relationship around issues of autonomy, responsibility, control and sexuality (Carter and McGoldrick, 1980, 1988; Okun and Rappaport, 1980; Karpel and Strauss, 1983). The renegotiation of more flexible family boundaries is a prerequisite to the second order, systemic change in the parent/child relationship (Carter & McGoldrick, 1980).

The adolescent's struggle to master the developmental tasks of identity formation, separation and sexuality necessitate shifts in the parent's role and the family's structure. If the family is to fulfill its primary function of supporting the development of family members then family boundaries must be adapted and accompanying relationship shifts must be permitted. Thus, the diffuse boundary that previously separated child from parent, becomes a more defined boundary, thereby permitting greater separation between the adolescent and her or his parents. A shift in the opposite direction takes place in regard to the boundary that surrounds the family as a whole. This boundary shifts from a closed position to become more diffuse and open. These structural transformations occur in "healthy" families and contribute to a renegotiation of the parent-adolescent relationship. The key to how well the family promotes the adolescent's development, and its own, rests on

the degree to which the family can maintain flexible boundaries in both these areas. Such flexibility is congruent with the adolescent's fluctuating need for parental guidance, support and nurturance, on the one hand, and distance, autonomy on the other. Similarly, while the adolescent becomes much more involved in the community he/she maintains the need to periodically return to the sanctity of the family. The importance of these structural shifts is particularly evident when one considers the interplay of the adolescent's developmental tasks of identity formation, sexuality, and separation, with the family's developmental growth as a system.

The adolescent's move toward identity formation calls for a stronger, more defined boundary between the adolescent and his/her parents. The formation of a more clearly defined boundary affords adolescents the added emotional and psychological space they need to begin defining their own values, beliefs and orientations toward life. At the same time the adolescent's moves away from the parents call for a more open diffuse boundary between the family as a whole and the community at large. Such an adjustment provides adolescents with the freedom they need to access their peers and the community. With the adolescent's move outward, there will be an infiltration of new values and beliefs into the family's life. In this sense, the adolescent acts as a bridge or a communicae between the family and larger external systems. The new values, ideas and beliefs which adolescents access vis-a-vis peers and the community, help to facilitate their identity formation. As adolescents move outward and bring back new information parents may face threats to parts of their own identity (Karpel & Strauss, 1983). In response to the infiltration of

new values, ideas and outsiders, the family may respond by tightening its own boundary in an effort to protect this identity. This may trigger issues of family loyalty between the adolescent and other family members. As adolescents struggle to form their own identity and the family responds by maintaining its identity, conflict frequently ensues. If the parents respond to this conflict by maintaining an inflexible boundary around the family they will block the adolescent's access to the community. The adolescent may, in turn, become "entrenched" with the parents and individual and family developmental processes may become derailed. The major challenge faced by parents is to provide an optimal blend of protection and flexibility to permit the adolescent's individuation.

Intertwined with the family's struggle to facilitate the adolescent's identity formation is the family's struggle to promote the adolescent's process of separation. The clash of values and attitudes that is inherent in the adolescent's move toward identity formation functions to distance the adolescent from his or her parents thereby promoting separation. Again the structural shifts in boundaries are essential. The diffuse boundary enclosing the family permits the adolescent's access outside of the family in order to broaden his/her support network beyond parents and family. With a more clearly defined boundary separating the adolescent and his/her parents, the adolescent becomes more responsible and independent.

The adolescent's rising independence necessitates a renegotiation of the adolescent/parent relationship around expectations, demands, control and authority. A healthy adaptational response by the family involves

shifting ultimate authority from the parents to the adolescent over a number of years. If the parents maintain an overinvolved position in relation to the adolescent, the adolescent will respond by becoming overly dependent on the parents or by rebelling. Such functioning reflects the family's inability to adapt to changing circumstances. Whatever the case, the process of renegotiating power and control generally leads to some conflict between adolescents and parents. Such conflict can be framed as a necessary antecedent to the adolescent's separation and the family's overall growth (Preto and Travis, 1985). This conflict is often a healthy reflection that expectations and demands require further negotiation. If parents respond to the adolescent's emerging issues of control and authority by employing past solutions which were successful in earlier stages of their child's development, a standoff is likely to ensue. These solutions will escalate conflict between the parents and the adolescent as they reflect earlier stages of family development in which the parents held unitary authority and the process of decision making was autocratic.

The parent's loss of control and authority over the adolescent represents but one of the loss issues which surfaces in relation to the adolescent's separation. The adolescent's process of separating represents a concrete signal to parents that their child's stay in the family is not a permanent one. This realization often forces parents to look toward the future and to begin refocusing on elements of their own relationship which have become lost during the process of raising children. This may trigger old feelings of loss and the struggle of letting go from earlier experiences may be rekindled and relived.

Separation, and the accompanying independence, often symbolizes the loss of childhood for the adolescent. Feelings of loss are reflected in the strong ambivalence that adolescent's feel between wanting greater autonomy, yet, needing the sanctity of their parents' protection. Due to this ambivalence parents are often very confused about how much protection versus how much autonomy they should provide their adolescents.

Sexuality represents the third major area of adolescent development that is interwoven with the developmental processes of the family. Sexual thoughts, feelings and behavior which emerge during adolescence influence the same kind of structural changes in the family system that are evidenced in relation to the developmental issues of identity and separation (Preto & Travis, 1985). The adolescent's increased distancing from his/her parents and the development of a stronger boundary between the two generations is associated with the adolescent's sexual maturity. As the adolescent matures physically, they are perceived and responded to differently by others (Erikson, 1950, 1959, 1968; Preto and Travis, 1985). Parents are less comfortable in providing physical nurturance and adolescents demand more privacy and distance in this respect. Through their increased contact with peers and the community adolescents access a broader range of values concerning sexuality than they may have been exposed to in their families. Their experience of what has been conveyed to them as "normal sexuality" becomes challenged. The adolescent may, in turn, challenge his/her own family's existing values and beliefs around sexual behavior and gender roles.

The adolescent's emerging sexuality squarely confronts parents with

unresolved issues from their own past sexual development. This often influences the climate in which sexuality is addressed in the family (Gordon, 1983). The manner in which sexuality is discussed in the family has a critical impact on the development of the adolescent's sexuality. The adolescent's exposure to a new set of values outside the family is likely to be more threatening to a family in which the parents have provided little, if any, information about sexuality and in which the adolescent's emerging sexuality has been denied (Preto & Travis, 1985). Such families maintain an overly rigid boundary between family members and the community and this can lead to the adolescent's dependence or rebellion. Families that maintain an openness toward discussing values and questions about sexuality promote positive sexual self-concepts in their members (Preto and Travis, 1985; Gordon, 1983). Parents who experienced excessive sexual permissiveness during their adolescence may try to protect their children from premature sexual involvement by setting overly restricted limits around their adolescent's sexuality. Often, of course, this becomes a self-fulfilling prophecy because adolescents, in their rebellion toward such restrictions, often engage in premature sexual relationships. If they do not rebel toward this kind of restriction, the adolescent may develop sexual inhibitions (Preto and Travis, 1985).

The emergence of the adolescent's sexuality, then, represents the third major area of adolescent development that is interwoven with the family's developmental processes. The key variable in all these areas is the degree to which the parents can develop a blend of protection and flexibility that is congruent with the adolescent's need to individuate,

yet, return to the security offered by dependence on his/her parents. In order to achieve such a blend, the family must undergo some structural changes involving the development of a stronger boundary between the parents and the adolescent and a clearer boundary between the family as a system, and the community at large. Such structural shifts permit a renegotiation of the adolescent/parent relationship (Carter and McGoldrick, 1980). The conflict and tension that emerges through the renegotiation process is viewed as predictable and as a necessary antecedent to the growth of the adolescent and the family.

However, in some instances, the psycho-social development of individual family members and the life cycle development of the family as a system, can be seriously disrupted by severe aberrations in family process and functioning, such as that evidenced in family contexts which are characterized by violence. The traumatizing effects upon development, for victims of family violence, has become well documented in the literature over the past fifteen years (Balicki, 1987; Berliner and Steven, 1982; Brekke, 1987; Cohen, 1984; Crumbley, 1985; Elbow, 1982; Hilberman and Munson, 1978; Hughes and Barod, 1983; Jaffe, Wolfe, Wilson and Zak, 1986; Miller, 1984; Pizzey, 1974; Rush, 1980; Sgroi, 1982; Stacey and Shupe, 1983; Walker, 1984;). This practicum report touches on one area of family violence that is frequently overlooked, involving cases where children have witnessed violence in the family. Before moving to a discussion about child witnesses, a few summary points can be reiterated with respect to the literature that integrates individual development into the life cycle approach.

The criticisms levied toward the literature on adolescent

development, earlier in this report, with respect to the systematic bias toward theoretical concepts signifying the male gender and excluding the female gender, apply to much of the literature concerning the family life cycle model and family therapy in general. Only recently has the literature begun to reflect the differential roles played by males and females in the family life cycle. This slight shift is reflected in the proliferation of feminist approaches to family therapy and the more direct attention being paid toward this issue in recent texts and articles. In their second major contribution to the family therapy literature on the family life cycle Carter and McGoldrick (1988), focus on this issue in their introductory remarks:

> "In the short span of years since the first edition of this book appeared there have been a great many changes in the family therapy field with regard to this topic, and in life cycle patterns themselves. First of all there is a burgeoning literature discussing families in relation to their developmental phase. . . . Second there has been a small revolution in awareness of differences in male and female development (Gilligan, 1982; Miller, 1976; etc) and in their implications for the family life cycle. The conservative, or even reactionary, stance that the family therapy field has taken regarding the role of women has come under strong criticism (Goldner, 1986; Taggert, 1986; Libaw, 1984; Hare-Mustin, 1978, 1980, 1987; The Womens Project in Family Therapy, in press; McGoldrick, Anderson and Walsh, in press, etc) and requires a careful rethinking of our assumptions about "normality", the notion of "family" and who is responsible for its maintenance, and the role of the therapist in responding to changing norms and sociopolictical realities" (p.3).

However, much of the literature still reflects the biased notion that healthy family functioning promotes the achievement of individuation and separation for both male and female members despite observations that these tasks reflect the male developmental process and that female

developmental processes are more centered on attachement, interdependence and a sense of "self in relation" to others (Chodorow, 1974; Miller, 1984; Gilligan, 1982; Sundal-Hansen, 1987; Merz, 1988). Evidence of a potential bias, such as this, is reflected in the structural approach to families which labels increased emotional involvement in relationships (more characteristic of same-sex relationships involving females) as potentially dysfunctional. In fact, such relationships are potentially adaptational and functional given the developmental process for females observed by Chodorow (1974), Gilligan (1982), Sundal-Hansen (1987) and Merz (1988).

Admittedly, the criticisms levied here are sketchy, nevertheless, they point to the potentially detrimental impact that these kinds of biases can have in treatment if the therapist is unaware of broader systemic issues when conducting therapy. The potential impact of such biases is particularly relevant in the area of family violence where it is vitally important for the therapist to maintain an awareness of the differential roles prescribed, played, and reinforced, for men and women in the family and the broader socio-cultural context.

CHAPTER 3

FORGOTTEN VICTIMS: CHILDREN WHO WITNESS FAMILY VIOLENCE

In recent years the area of family violence has become a major focus among social workers and other helping professionals. To a large degree this focus has been forced by a substantial increase in the reporting of various forms of family violence particularly in the sub areas of child sexual abuse and wife abuse. While it is generally concluded that the true incidence of wife abuse and child sexual abuse have not changed substantially, those practising in the field have become aware of the exponential increase in the reporting of these forms of violence on the part of victimized children, adolescents and women. The social services system's increased sensitivity to the violence in families has both contributed to and resulted from the substantial increase in reported cases of violence. As the number of reported cases of family violence rises, the demand for an increased understanding of the etiology, effects and specific treatment strategies for the various forms of family violence becomes more urgent. Yet, the area of family violence is a very complex one and the literature on the topic reflects many gaps. Family violence occurs in many forms - - physical, sexual and emotional abuse toward children, adolescents, women and the elderly - - and each seems to call for specific and unique treatment strategies. While there has been a proliferation of treatment approaches in each of the sub areas, treatment models are often constructed in general terms and seldom

offer specific intervention strategies. One of the largest gaps is reflected in the fact that little attention is directed toward the identification and treatment of those who witness violence in the home:

> "There are none of the bruises, blood and broken bones sometimes found in child abuse cases involving beatings and sexual molestation that scream so often these days from newspaper headlines. Rarely does child abuse that scars only the mind make the news. The most severe cases occasionally attract attention of the authorities. But the vast majority go quietly unnoticed; except by the victims" (Oldenburg, 1987).

The lack of attention directed toward children who witness family violence has evolved out of three main factors. First, children's treatment services in the area of family violence have largely been grounded in the child protective services movement. The child protection movement has historically been concerned with protection issues related to cases where children are the direct victims of abuse or neglect. Until recently, then, child welfare workers were not mandated to provide protective services to children who witnessed violence or abuse in their home. The child welfare acts of Newfoundland, Prince Edward Island and New Brunswick now state that children who witness abuse in their family are in need of protection (CASW, 1982 cited in Balicki, 1987).

Second, with the drastic increase in the number of reported cases of family violence, the number of trained professionals capable of providing specialized treatment services have not been able to keep up with the demand for service. This situation has contributed to a process whereby the most clearly defined victims of violence receive service. Child victims who witness violence are easily overlooked in this process as

they are less likely to be identified by professionals as true "victims".

A closely related third factor has to do with the professional community's "collective reluctance" to view children who witness family violence as victims. This denial, of sorts, reflects the degree to which violence is accepted and legitimized in our socio-cultural environment. Professionals, then, have downplayed the impact that violence has upon children who witness it and in the process they have overlooked the need these children have for treatment. In Western culture violence is legitimized as a primary method of resolving conflict. Thus, in a culture where direct, hard-core violence is sanctioned, it is hard to view those who witness violence as victims.

In many respects children who witness violence are "forgotten victims" (Elbow, 1982). Treatment services are almost exclusively focused toward those children who are the direct victims of violence despite a proliferation of articles which suggest that detrimental effects result for children who witness family violence (Hiberman and Munson, 1978; Elbow, 1982; Cohen, 1984; Jaffe et al, 1986; Balicki, 1987; Oldenburg, 1987; Schuman, 1980). The lack of a coordinated service delivery system for children who have witnessed violence relates to the collective reluctance of professionals to acknowledge these effects, as well as the polarization in practice and theory that characterizes the field. This polarization centers around the ongoing debate over whether treatment should be provided from an individual based focus or from a systemic perspective (Larson and Maddock, 1986; Shapiro, 1986; Coyne, 1986).

Individually focused models of practice conceptualize the problem of

violence in terms of "victims and victimizers" (Shapiro, 1986). Emphasis is placed on victim advocacy and external control of the family and/or perpetrator (Larson and Maddock, 1986). Little attempt is made to view the victim or perpetrator in the context of the family or the broader socio-cultural context. In contrast, those who work from a systemic perspective view violence as a symptom of dysfunctional family process and forces in the socio-cultural context which promote violence.

The systemic perspective is frequently criticized on the grounds that it exonerates the perpetrator of responsibility and places the victim in a vulnerable position of potential retribution. However, the first of these criticisms confuses the notion of neutrality, vital to family practice, with the issue of responsibility. The intent of the systemic practitioner is never to relieve the perpetrator of responsibility nor to condone the violence. The second criticism simply reflects an issue of poor practice and, as such, should be appropriately directed to practice.

The systemic perspective can be a particularly effective framework from which to treat family violence since in its simplest and broadest forms, it allows for a range of interventions which take into account the individual, the family and the socio-cultural context. The systemic therapist always has these levels of context in mind. Depending on the exact circumstances of the case, treatment might be targeted for the individual or the family, however, it is the transitions between these two units of attention, as well as the socio-cultural setting, that provides the basis to a systemic therapist's practice. In designing interventions, the systemic therapist always has the broader implications and forces in mind yet he/she is able to narrow the focus to the

individual. A systemic perspective on family violence intertwines all of these levels. Children who witness family violence often experience disruptions in their psycho-social development since the family in which they are raised is unable to fulfill its purpose of providing emotional support and belonging or a sense of autonomy, and separateness.

Frequently, as in many other problem areas, the effects of the violence do not become directly apparent until the child becomes an adolescent and the family reaches the corresponding life cycle stage. As violent families tend to be rigid systems, they do not provide the family members, particularly adolescents, with the autonomy to negotiate appropriate developmental tasks. The closed nature of the system frequently reinforces the presence of patterns and solutions which contribute to the violence. The therapist's awareness of these elements and the broader socio-cultural context provide insight into the factors which promote violence in the family and the manner in which children cope with the effects. The following discussion will address all three of these levels before addressing the appropriateness of applying the integrated model of brief therapy, used in this practicum, to families in which the children have witnessed violence.

Family Violence Defined

Family violence involves a range of acts imposed by one family member onto another, at a physical, psychological or emotional level, for the purpose of controlling the other's behavior either through direct attack or through creating a sense of fear and intimidation in the other. This

range of acts includes verbal abuse, uttering physical threats creating an aura of potential violence, inflicting direct physical attacks (including shoving, slapping, burning and beating) sexual assault (ranging from threats of a sexual nature to forced sexual intercourse), forcing an individual to perform an act out of fear or intimidation, threatening or hurting a family member's pets, and forcing or leaving another in the position of having to observe any of the above noted acts. Within this definition the intent or perceived intent to hurt a family member through the commission of any of the above noted acts constitutes family violence (Brekke, 1987). Those who witness family violence are considered to be victims of family violence. What children see or hear can be as damaging as what has happened to them (Fredrickson, 1982, 1985, 1986).

Socio-Cultural Elements In Working With Children Who Witness Family Violence

Effective intervention in the identification and treatment of children who are exposed to violence in the home depends upon an understanding of the socio-cultural context in which family violence takes place. An understanding of this context permits insight into the factors which block service delivery to these children and provides cues to the therapist about how these children are likely to respond to the violence. Socio cultural prescriptions for behavior, according to gender, influence the manner in which these children cope with the effects of witnessing violence.

The current socio-cultural climate that condones violence is rooted in a long history of legitimized violence. Historically, men have assumed the role of perpetrator and women and children have been ascribed the role of victim. In their ascribed role as victim, children have been historically viewed both as property and as "small adults". In tracing the ownership of children back over several hundred years Rush (1980) outlined the process whereby young boys were shared among ancient Greek men and forced to perform sexual acts. Young boys were raped as an initiation into the Greek military. Rush indicates that the victimization and ownership of children went underground during the nineteenth century as children were bought and sold in brothels.

In addition to being treated as property, children have also been historically regarded as small adults. Prior to the Industrial Revolution, the family functioned as a total economic unit in which children shared in adult labour tasks and fulfilled a critical economic function. Children were transitioned directly into adulthood as soon as they could assume full work responsibilities (Preto & Travis, 1985). "Adolescence", as we now know it, did not exist (Aries, 1962; Keniston, 1962; Harevan, 1982). The perception of children as young adults continued through the period of the Industrial Revolution when children were misused as a cheap source of labour (Garbarino, 1982).

The perception of children as "property" is still a prevalent theme in contemporary society and is strongly linked to a philosophy that regards the family unit as sacred in our culture. It is taboo for people to infringe on the sanctity of the home despite the possibility that a child may have been victimized. People are unlikely to intervene in

situations where there is evidence to suggest that a child is suffering from maltreatment or misuse at the hand of his parents and family. The sanctity of the family has partly contributed toward maintaining the power differential that has historically existed between adults and children, and between men and women in that it has insulated the family from outside intervention that is aimed at breaking the cycle of violence. This power differential leaves women and children more vulnerable to violence. Families which are characterized by violence are particularly well insulated from the social environment. The violent family is "relatively closed, undifferientated and rigid in both structure and function" (Larson and Maddock, 1986). Given these features, aggressive attempts to intervene often reinforce the rigidity of the system.

The historical and contemporary patterns of family violence cannot be viewed separately from the culturally defined sex role prescriptions that have evolved along side these patterns. An analysis of these prescriptions provides a clearer awareness of how the cycle of violence is maintained and how children witnessing this cycle respond. The male role that is prescribed in our culture revolves around social demands for aggression, self-reliance, independence, strength, sexual aggression, and masculinity. Male vulnerability is not prescribed. The culturally prescribed female role revolves around social demands for vulnerability, tenderness, passivity and sensitivity toward others, particularly men. Within these prescribed roles men are socialized to release trauma, anger and aggression outward. Women, on the other hand, are socialized to internalize their anger and trauma. These sex role variations promote a

cycle whereby men occupy the position of perpetrator and women are ascribed the position of victim. Women have been unable to move out of this position due to a legacy of political, economic, cultural, and religious conditions which have served to discriminate against them and perpetuate injustice against women.

These variations along gender also influence how male and female children respond to violence in the home. Generally speaking, there are some differences between male and female children of the same age who are exposed to violence in their home. These differences reflect socially prescribed sex role channels for coping. Hiberman & Munson (1978) observed that latency aged boys who had witnessed family violence were more aggressive than girls of the same age and experience. Others have observed that there is a relationship between gender and aggression among children who witness family violence that is consistent with socio-cultural sex role stereotypes (Hiberman & Munson, 1978; Pizzey, 1977; Stacey & Shupe, 1983; Walker 1984; Hughes & Barad, 1983).

The impact of merging elements associated with historical patterns of violence, gender, and the modeling influence of parents, cannot be minimized in cases where children have witnessed violence. Gelles and Steinmetz conclude that "each generation learns to be violent by being a participant in a violent family" (in Jaffe et al, 1986, p.142). Boys in particular, exhibit behavior problems and symptoms related to emotional disturbance and social adjustment (Jaffe et al, 1986). In this regard Schuman points out that "parents who are violent toward one another tend to have children who use violence on siblings, school mates, and, later on, their own spouses" (1980, p.183). Later, in the same article,

Schuman quotes from John H. Meier: "Parents are children's primary models - - the most important people in their lives. Much of what children learn about dealing with stress and conflict is patterned on their parents' behavior" (p.183).

Children Who Witness Family Violence: Effects And Responses

Children who witness violence in their family are potentially exposed to several forms of violence. The most common exposure is to violence between the child's parents, typically physical or sexual abuse perpetrated by the father upon the mother. Walker (1984) relates that 87% of the 400 battered women she interviewed indicated that their children were aware of the violence inflicted upon them. Violence directed toward a child's sibling represents a second form of violence that children witness. A major gap exists in the provision of treatment for children who witness such violence. Cases of intrafamilial sexual abuse most often involve the victimization of a child's brother or sister on the part of the father or father figure. In cases of physical abuse there seems to be a 50-50 split between male and female perpetrators (Gil, 1967; Zalba, 1987 cited in Crumbley, 1985). Although these sub-areas of violence are presented separately here, they often occur simultaneously in the child's home. Herman and Hirschman (1981, cited in Crumbely, 1985) reported that in 50% of reported child abuse cases the mother was also abused by the father. Straus and Hotaling (1980) claim that child abuse is 30 times more likely to occur in homes where the

mother is being assaulted then in homes where the mother is not. Children who witness violence directed toward others in their family are often also the victims of direct violence themselves (Brekke, 1987). In Walker's (1984) study of 400 battered women, 53% of the men who abused their partners also abused their children.

For a child, the experience of witnessing violence in the home can be conceptualized as an abnormal event that interrupts the normal developmental process (Berliner & Stevens, 1982). The child's preoccupation with the violence disrupts age appropriate tasks. The child's inability to assimilate or encompass the experience of violence is frequently reflected during adolescence. If the child is a witness to wife battering, the mother is often unavailable to the child at an affective or instrumental level as she herself is preoccupied with her own survival. The child's dependency and nurturance needs often go unmet. The deficits in the child's psycho-social development, resulting from these unmet needs, often expose the child prematurely to adult tasks (Larson and Maddock, 1986). The child is often pressed into meeting the needs of other family members, particularly the mother. In such instances, a role reversal may evolve in which the child moves to support and excuse the mother. While some of this behavior is adaptional, over the long term it leads to a distorted belief in the child that he/she can meet any and all emotional needs. This frequently sets the stage for female children to later select a partner who will repeat the cycle of violence (Larson and Maddock, 1986).

Thus, the child who witnesses violence does not receive the nurturance, emotional support and the availability of parents that is

necessary to promote healthy development. Children who witness family violence, then, show disturbances in their development. If outside intervention does not take place the effects of early disruptions in the child's development will manifest as symptoms in later stages of development, particularly adolescence. This is particularly the case during adolescence as the victim's predominant developmental tasks relate to issues of sexuality, identity, and separation which typically involve issues of power and control. The closed, rigid nature of the violent family system often precipitates adolescent rebellion as it is unable to adapt to changing circumstances associated with the child's adolescence. While these symptoms typically cluster together they can, for the sake of clarity, be viewed along an emotional - psychological axis and a socio-behavioral axis. Many of these symptoms are consistent with the trauma that is experienced by children who have violence directly inflicted upon them (Jaffe et al, 1986).

Emotional - Psychological Effects

Adolescents who have witnessed violence in their family typically show difficulty in making attachments and forming intimate relationships with adults. This is largely based on their experience with parents who have been unavailable to meet their affective and instrumental needs with any consistency. In the face of this inconsistency, these children have typically had to rely upon themselves. Such self-reliance often represents the child's attempt to instill some level of control into an uncontrollable situation. They have found it easiest to avoid conflict,

and survive, by not expressing any personal needs (Schuman, 1980). The child witness is not willing to relinquish this control in relationships as such relinquishment signals the possibility of further rejection by and failure with adults. The child's belief that she/he does not occupy a significant place in his/her parents' lives, leaves him/her with a very low level of self-esteem and a sense of conditional acceptance in most relationships.

Children who witness family violence hold distorted beliefs about the violence. In an effort to explain the violence, the victim "personalizes" by assuming responsibility for the violence. Miller (1984) suggests that "since children want to love their parents, and want to believe that the world they were raised in made sense, children decide at some level that their humiliations are necessary: their parents must be right and they must be wrong" (Van Gelder, 1987, p. 40). The child's process of personalization leads to feelings of guilt and self-blame. In the case of wife battering, child witnesses may hold the distorted belief that the father beats the mother because they are a bad child. In families where a sibling is victimized child witnesses may believe they are responsible for the abuse because they did not prevent or stop the abuse from occurring.

An additional effect of the violence is the feeling of loss that the victim experiences in a number of areas. Primary among these areas is the sense of loss that the victim feels in relation to their childhood. The child's need to become self-reliant at a very early age results in a short-lived childhood, if any is experienced at all. This loss may be more pronounced according to the birth order of the child as older

children may have had to assume a parental role in relation to younger siblings due to the parents' unavailability. This unavailability creates an additional loss of the parent-child relationship for the victim. As part of the parents' inconsistency, the victim also experiences a loss of trust and security. The explosive and unpredictable nature of the violence leaves the child with a felt loss of control and powerlessness. This is particularly significant for child witnesses to violence as they lack even the control over when and where the violence will occur that victims of direct violence occasionally grasp onto as a survival instinct. Adolescent witnesses frequently compensate for this powerlessness by attempting to assert control in other areas. Finally, children who witness wife battering may also have to cope with the issue of loss if their parents separate.

All of the above noted disturbances are compounded by the child's impaired ability to identify and express feelings. The witness to violence demonstrates a poor modulation of emotions: most feelings are reduced to anger. Attempts to express other emotions are ignored, denied or punished. The victim has not had the benefit of parents who themselves could role model a healthy process of expressing emotions. Consequently, the witness often reacts impulsively or allows tension to mount until there is a crisis and explosion. This deficit obviously compounds the difficulties experienced by the witness along the socio-behavioral axis of functioning.

Socio-behavioral Effects

Regressive behavior manifests as one of the primary symptoms in the socio-behavioral functioning of children who witness family violence. Regressive behaviors, such as bedwetting or nightmares, frequently reflect that significant trauma was experienced by the witness during an earlier stage of development. Regressive behavior, of a less extreme form, will be reflected in immaturity, primitive social functioning and impulsive behavior. The child's attempt to compensate for earlier losses of control and powerlessness, becomes very evident in the socio-behavioral area. The child will often "cut his own territory" among peers by acting out in destructive, pronounced ways including drug and alcohol abuse, truancy, running away, sexual promiscuity and physical aggression. There is a strong relationship between a child's destructive behavior outside the family and violence in the family (Walker, 1984).

Children who witness violence in the home have a poor repertoire of problem solving skills as violence is the most frequent method of conflict resolution modelled in the home. Due to this, children, particularly adolescents who witness violence are likely to utilize aggression and intimidation whenever conflicts arise with peers. If such tactics place the victim in a position of power among peers the reinforcing aspect of this may lead them to rely on violence as their primary coping skill. Predictably, children who witness family violence often have peer relationships which are superficial, conflictual and short-lived. Although in adolescence the witness' move toward the peer

group is developmentally appropriate the process is often undermined by the family's closed nature. In an effort to meet their own dependency needs wife batterers or perpetrators of child abuse may block the adolescent's move outside the family. This may escalate the witness' destructive behavior to a more pronounced level which in turn can trigger violence upon the witness. The victim may also feel guilty for "deserting" family members who are the direct victims of the violence. The witness may also be led to feel he/she is deserting the family by the victims themselves. These processes impede the witness' move toward independence and separation during adolescence.

The interrelationship of socially prescribed sex role behavior and the manner in which male and female children cope differently with the trauma of witnessing family violence is particularly evident in the victim's socio-behavioral functioning during adolescence. As indicated, females are socialized to internalize their feelings of anger and aggression and cope with trauma in a passive way. Women have historically been forced to be passive due to political, economic and discriminatory constraints (Cohen, 1984). The outward expression of trauma, by women, is not culturally supported unless such expression occurs from a vulnerable position - - which promotes further victimization. Males, in contrast, are socialized to externalize trauma through the outward expression of anger and aggression. Men typically attempt to compensate for the vulnerable position their victimization leaves them in by recapitulating the victimization onto others.

Based on their experience of violence in the home, adolescent girls may confuse violence with love. The primary love relationship they have

experienced, between their mother and father, is characterized by violence. The female is the victim. In a misguided attempt to meet her unmet needs for acceptance, nurturance, affection and love, the adolescent girl may enter relationships which involve violence (as this is love) and sexual behavior at an inappropriately young age. It is no coincidence that such an adolescent girl becomes "matched" with an adolescent boy who is similarly attempting to compensate for deficits in the same areas which arose through the same experience. The primary love relationship that the adolescent male has experienced, also between his mother and father, is characterized by violence. The male is the perpetrator. A cycle develops: In an attempt to fulfill her unmet needs, the adolescent girl follows traditionally prescribed sex role channels by turning to the adolescent male who, in turn, follows traditionally defined sex role channels for resolving his trauma by perpetuating the cycle of violence through sexually and physically victimizing the adolescent girl. This process is culturally reinforced and is strengthened by the impact that same sex relationships have upon learning and the process of socialization.

Female children who have witnessed violence in the home may find themselves in relationships characterized by violence for other reasons. The patterns of functioning which emerge in future violent relationships represent the patterns of functioning which are most consistent and predictable for those who have witnessed violence as a child. Children who are raised in the midst of violence develop a familiarity with violent relationships. This is the context in which they have learned to function in relationships. Stepping outside of this context represents a

different, unpredictable reality, one which child victims are unsure they can function within. So, in a distorted way, child victims operate out of a "devil you know is better than the devil you don't know" reality that promotes continued involvement in violent relationships. This reality is fueled by the victims' interpretation that their victimization was necessary and deserved (Miller, 1984). Feelings of worthlessness, associated with this interpretation, support a belief in victims that they do not deserve any thing better than violent relationships in the future.

An additional explanation is found in Alice Miller's (1984) thesis which centers on the notion that adults often seek out relationships in which they unconsciously repeat their childhood. In a case study of the childhood of novelist Franz Kafka, Miller remarks: "A person who was as lonely as Franz Kafka as a child is unable, as an adult, to find a friend or a woman to understand him, since he often seeks unconsciously to repeat his childhood . ." (in Van Gelder, 1987, p. 42). Children from violent homes, then, may find themselves in violent relationships through a process of projection or an unconscious attempt to work through the trauma of past parent-child relationships or victimization.

It is clear that the presence of violence in the family is as detrimental to the psycho-social development of the individual child who witnesses violence as it is to the child who is "directly" victimized. For the child witness, the developmental process is seriously disrupted and, in some instances, arrested. Given this disruption, the child witness is unable to acquire the social skills which are developed through a healthy and normal developmental process. The child's deficits

often show up during adolescence which is predictably stormy under normal circumstances. Consequently, the child witness is often unable to meet the developmental demands associated with adolescence. The tasks of identity formation, separation and sexuality are poorly negotiated as the child witness may still be working through earlier stages of development. Thus, it is no coincidence that adolescence is frequently the period of development in which behavior disturbances and parent-adolescent conflict arise. As a result, families frequently present for treatment during this period.

As the primary context of human development the family plays a critical role in the development of its members. Families which are characterized by violence are unable to consistently support the developmental needs of its members. Violent families are typically closed, rigid systems which usually short circuit adaptational responses to new circumstances, arising from changes in the developmental stage of individual family members, or from external influences in the environment at large. The life cycle development of these families is always derailed and is frequently arrested. This disruption in development is promoted by "severe boundary disturbances" which insulates the family from critical feedback in the larger social environment, that could influence the violent behavior (Larson and Maddock, 1986). The closed nature of the family system means that "family members can draw only upon each other for emotional support, self-esteem maintenance and reality testing" since outsiders are regarded as intruders (Larson and Maddock, 1986, p. 28). Aggressive means to intervene therapeutically can often reinforce this rigid structure.

Violent families are also characterized by disturbance in the generational boundary that separates parents from their children. Children who witness violence frequently occupy adult roles and are pressed into adult functions. Role reversals in which the child supports the victimized parent, typically the mother, are not uncommon. If children are not forced into a "direct" victim role they may assume the role of "perpetrator" or "rescuer". These roles reflect learned patterns of response (Larson and Maddock, 1986) and often reflect differences according to gender in which males typically assume a perpetrator role and females assume a rescuer role. As children move to either of these roles they further forsake their own development. It is usually this process that leads to the development of symptoms.

From a systemic perspective, the development of symptoms signals that the symptom bearer's need for autonomy and differentiation are being sacrificed to maintain dysfunctional family relationships (Larson, 1986). Symptoms commonly arise during adolescence as autonomy and separation became vital issues in the adolescent's developmental process. A systemic approach to treating family violence focuses on interactional processes between family members. Though many therapists advocate approaches to treatment which are long term and insight oriented, the integrated model of brief therapy applied in this practicum is particularly well suited to the area of family violence for two reasons. First the integration of the structural approach provides a framework from which to view family organization, structure and adaptation. Structural concepts provides a very clear organizational framework from which to interpret the therapist's observations and assess the family's

adaptational processes according to boundary and subsystem functioning. This is particularly useful to the therapist as violent families are typically characterized by severe boundary disturbances.

Second, the brief therapy principles which underline this family therapy model, promote a therapeutic context that empowers and validates family members. This is particularly relevant as one of the contributing factors, and effects, of family violence is a sense of powerlessness that is felt among family members. Therapy must be built upon empowering victims in an effort to mobilize them in future relationships. Therapy must also empower the perpetrator, at some level, along more legitimate means in order to stop the violent behavior.

Now that a conceptual overview to developmental theory has been completed both at an individual level as well as the family life cycle level, Part II of the Literature Review will focus upon the principles underlying the clinical model of practice in this practicum. The foregoing discussion on the family life cycle is particularly relevant and congruent with the structural framework and brief therapy as each of these approaches view symptoms in relation to normal family processes associated with life cycle transitions.

PART II: CLINICAL ASSESSMENT AND INTERVENTION

Introduction

Clinical intervention reflects, in part, an epistemological issue. Epistemology can be conceptualized as the philosophical base of paradigms and therapy (de Shazer, 1982). While the language of epistemology may seem somewhat distant from actual clinical intervention it, in effect, speaks to issues which are central to the clinician's choice of strategies and tactics. Epistemology, according to de Shazer (1982), "is concerned with how we know, think and decide" (p. 71). In this context, the beliefs, views, expectations and assumptions which the therapist holds form the therapist's epistemology and influence the course and direction of therapy.

The early epistemology of family therapy rests heavily on family systems theory and the concept of homeostasis. Family systems theory began to crystallize along with the initial attempts at viewing individuals in context. From the systems perspective, the development of symptomatic behavior in an individual reflects the presence of dysfunctional family patterns. Family systems theory has been, and still is, instrumental in organizing our observations of the family as a system. As family systems theory has developed, the concept of homeostasis has been relied upon to interpret a family's stability in the midst of circumstances which keep the identified patient "sick". The concept of homeostasis has been pivotal in explaining the development and maintenance of family interaction patterns which promote and reinforce symptomatic behavior in a family member. The family's stability is ensured through homeostatic mechanisms which restore the family's status

quo.

Homeostasis has been a helpful concept for understanding the "family as a system", but it has not been helpful in understanding "family therapy" (de Shazer, 1982, 1984). It is ironic that the early epistemology underlying family therapy historically drew from a concept which conveyed "no change" when the primary aim of therapy was "change". It is paradoxical to build a model of therapeutic, change, upon a concept of stability (de Shazer, 1982). In effect, the concept of homeostasis has provided the therapist with a frame of reference to study why families do not change. The emphasis upon homeostasis has made a significant contribution to developing the concept of "resistance" and directing the therapist's focus toward the processes in a family which impede change. This is why, for years, family therapists have spent energy identifying and tracking redundant patterns and determining the function served through symptomatic behavior. The relevance of the above-noted statements to family therapy becomes clear in consideration of a couple of additional points.

In the context of family therapy, which is a context of change, a central issue relates to how the individual therapist views the construction of problems and the nature of solutions (de Shazer, 1985). What the therapist believes, the therapist sees. If, for example, the therapist believes that "resistance" is an inevitable part of therapy, then patterns of resistance are likely to be present, perhaps highlighted. Believing in resistance generates resistance (Fisch, Weakland, and Segal, 1983; de Shazer, 1985). If, on the other hand, the therapist believes that cooperation is an inevitable part of therapy,

then patterns of cooperation are likely to be present, perhaps highlighted (de Shazer, 1982, 1985, 1988). How the therapist chooses to orient him/herself around these concepts, determines whether a pattern of resistance or a pattern of cooperation will emerge in therapy. Either of these orientations can have an extraordinary impact upon the course of therapy. The crux of the matter becomes: Given the early (and present) tendency to focus on the processes which maintain a family's stability, therapists have punctuated patterns of family dysfunction and entrenchment, and neglected to highlight and build upon the success oriented patterns, the resources and strengths which family's have at their disposal. Thus, in the process of therapy the "negative" (processes impeding change) always looms much larger than the "positive" (processes of change). This emphasis seems illogical for a discipline that holds change as its primary aim.

Given that change is the primary aim of family therapy, it seems logical that there be a shift in emphasis toward punctuating the mechanisms and patterns which are proven to create and promote change instead of those which deter change. The clinical model applied in this practicum illustrates the impact of interventions which highlight and build upon a family's success oriented patterns, resources and strengths. The success of such intervention is not contingent upon a detailed understanding of the presenting complaint nor of the patterns maintaining the complaint (de Shazer, 1985).

The model of family therapy applied in this practicum represents the integration of the brief therapy approach to families developed by de Shazer (1975a, 1975b, 1977, 1980, 1982a, 1982b, 1985, 1988) and the

structural approach to families (Minuchin, 1974, 1981, 1984; Colapinto, 1982), within a broader context of the family life cycle model (Haley, 1973; Carter and McGoldrick, 1980; Minuchin, 1974; Karpel and Strauss, 1983; Watzlawick, 1974; Weakland et al, 1974; Carter and McGoldrick, 1988). There is a natural congruency and "fit" between brief therapy and the structural framework as each of these models is well grounded in developmental theory. As such, they also fit well within the broader framework of the family life cycle model. The grounding of brief therapy in developmental theory is well documented in Haley's (1973) treatise of Milton Erickson's approach to therapy and in the literature at large (Weakland et al, 1974; Watzlawick, Weakland, Fisch, 1974; Fisch, Weakland, Segal, 1982).

Within the context of brief therapy, human problems are viewed to be an outcome of difficulties experienced in everyday living which are typically linked to the transitional steps which form a part of every family's life cycle. Mismanagement of these transitions lead to the development of symptoms in a family member. Although de Shazer does not explicate the developmental theory upon which his model is based, he clearly establishes the origins of his clinical model in the brief therapy tradition (de Shazer, 1985). The structural framework evolved as an attempt to describe the transitions which families make as they adapt to changing circumstances arising internally through changes in the developmental stages of family members, and externally through the pressure of broader systems in the socio-cultural environment. Thus, Minuchin (1974) remarks that the family life cycle is a key element of any framework based on viewing the family as a system. As such, the

structural framework, like brief therapy, very much represents a developmental approach to family functioning. Together, these models provide a particularly relevent context for therapy targeted for adolescents as the adolescent stage of the life cycle presents the greatest challenge, to a family's ability to adapt, among all of the expected nodal events in a family's life cycle (Ackerman, 1980). Transition into the adolescent stage of development necessitates structural and organizational changes in the family (Oken and Rappaport, 1980).

Both the brief therapy and structural approaches bring some important aspects to the integrated model in this practicum. The structural approach provides the framework for observing the family as system, and for assessing the family's organization and level of functioning. In the absence of a conceptual framework, such as this, the therapist is much more likely to be pulled blindly into the family system and, in the process, neutralize the effectiveness of applied interventions. The brief therapy portion, largely based on the model developed by de Shazer (1975a, 1975b, 1977, 1980, 1982a, 1982b, 1985, 1988), positively orients the therapist toward family strengths and leads to positively oriented intervention strategies. The process of therapy becomes a process of highlighting and building upon solution oriented behavior and patterns of success which family's have at their disposal. Through the punctuation of solution patterns, family members are able to achieve some distance from their problems. This distance provides family members with greater freedom to identify more of the same success oriented patterns. A pattern of cooperation, between clients and therapist, emerges as opposed

to a pattern of resistance. In essence, many of the elements borrowed from de Shazer's approach, reflect the philosophy of change inherent in the brief therapy tradition (Haley, 1973; Watzlawick, Weakland and Fisch, 1974; Weakland, Fisch, Watzlawick and Bodin, 1974; Fisch, Weakland, and Segal, 1982). Given this, an explication of the model will begin with a review of the principles which underlie brief therapy and its evolution. This review will be followed by a synopsis of the structural framework, the conceptual framework used for assessing families in this practicum, and the brief therapy interventions which shift the orientation of therapy toward family strengths.

CHAPTER 4

BRIEF THERAPY OF THE FAMILY

Brief Therapy Defined

The term "brief therapy" strongly connotes a concept of "time" which frequently leads to misconceptions about what "brief therapy" actually means. By focusing on this time connotation, individuals mistakenly assume that brief therapy is merely a short term model of therapy or a briefer version of conventional therapy. Distinguishing brief therapy from other models of therapy solely on the basis of a time constraint is misguided, at best, and reflects a superficial understanding of the epistemology underlying this model of therapy. In fact, such time factors vary according to the particular model of brief therapy in mind and range from less than ten sessions (Weakland et al, 1974; de Shazer, 1982, 1985), ten to twenty-five sessions (Castelnuovo - Tedesco, 1975) and as many as forty to fifty sessions (Malan, 1976).

Overemphasizing time constraint as a defining characteristic of brief therapy leads to additional distortions about brief therapy. In this regard, brief therapy is often confused with shorter versions of conventional treatment which evolve in response to the pressures of client needs or other situational limitations (e.g., money, time, availability, poor client capacity for self insight). Such models of intervention reflect the same basic assumptions of conventional therapy forms which are adapted, or compacted, into a shorter version (Weakland

et al, 1974). Thus, brief therapy is often misconstrued as an alternative therapeutic mode when a "treatment of choice" is not available or is not feasible. In this way brief therapy is misconceptualized as a stop-gap or temporary remedy that provides temporary relief but does not lead to fundamental change in the client's complaint or situation. These distortions reflect misguided definitions of brief therapy based on time constraints.

In conceptualizing brief therapy one must distinguish between brief therapy as defined by time constraints and brief therapy defined as a way of understanding and solving problems. The latter emphasis reflects the core of what brief therapy is all about. While it may seem paradoxical, in the context of brief therapy, "brevity" in itself is not a goal. Any such emphasis upon brevity evolves from the belief that setting time limits on the treatment process has a positive influence on the client and the therapist. "Brevity", as well as other aspects of brief therapy, essentially arises as a consequence of the premises about the nature and approach to human problems and solutions upon which brief therapy is based. These premises can be exemplified by tracing the evolution of brief therapy and the assumptions upon which it is based.

Evolution of Brief Therapy

The conceptual origins of brief therapy can be traced to the innovative techniques of brief hypnotherapy employed by Milton Erickson (1954). Erickson's work was based on two primary constructs which today remain as essential elements in brief therapy. Erickson is credited with

influencing the development of brief therapy on the basis of two points in particular. First, Erickson placed great emphasis upon _accepting_ what the client offered, or brought to therapy, and _utilized_ this to promote positive change. Even if what the client presented might be labelled as "resistance", Erickson transformed this into positive use in therapy. The notions of _acceptance_ and _utilization_ are central to conducting brief therapy and they have been identified as "key" elements in brief therapy (Weakland et al, 1974; de Shazer, 1985). Second, although Erickson was concerned with altering overt, observable behavior and the effects of this behavior on the client, his methods to alter such behavior were based on implicit or indirect means of influence. Thus, no attempt is made to correct underlying causes or disorders. Rather, energy is directed toward altering "problematic behaviors" by redefining and transforming them into positive usage.

Despite the initial formulations of brief therapy within the context of the hypnotherapy field, subsequent developments in the evolution of brief therapy occurred in conjunction with the development of family therapy during the 1960's and 1970's. Under the umbrella of the Mental Research Institute, Weakland et al established the Brief Therapy Centre in 1966. In an attempt to conceptualize their approach Weakland, Fisch, Watzlawick and Bodin published a paper in 1974 entitled: "Brief Therapy: Focused Problem Resolution". In this paper Weakland et al outlined a view of human problems, and how problems are resolved, based on six years of brief therapy with families. Weakland and his co-authors reported significant success related to the client's main complaint in approximately 75% of their cases within an average number of seven

sessions of therapy. Each case was limited to a maximum of ten family sessions regardless of the nature or degree of the complaint reported by the family. Weakland and his co-authors specified: "the nature of our therapy, including its brevity, is primarily a consequence of our premises about the nature and handling of psychiatric problems" (p. 144).

As a fundamental premise, Weakland, Fisch, Watzlawick and Bodin indicated that the problems which people present in treatment persist only if they are maintained by the client's ongoing current behavior and by others with whom she/he interacts - - regardless of the basic origin of the problem. In respect to "solutions", they hypothesized that problem resolution is achieved when the problem maintaining behavior is altered or eliminated. In conjunction with Erickson's constructs, mentioned above, brief therapy rests on these two basic premises about problems and problem resolution.

Although the MRI model of brief therapy developed in conjunction with the growing popularity in family therapy, the MRI group departed from other family therapists on a central premise. Most family therapists, at the time, believed that the dysfunction evidenced in the family was an essential aspect of the system's organization and equilibrium. Thus, these family therapists adopted the approach that fundamental changes needed to take place in the family system in order to alleviate the family of its dysfunctional aspects. The MRI group, on the other hand, postulated that relatively minor changes in behavior, or the definition of that behavior, were sufficient to initiate ongoing, progressive changes. In other words, only a small change was believed necessary to dislodge a family from its redundant position in the family

life cycle. Frequently, such change is initiated by prompting family members to "do something different" than they have previously attempted to do in an effort to resolve their problem. This position is reflected in the basic principles which underline brief therapy.

In addition to the evolution of the MRI model of brief therapy, developments in brief therapy were also evolving independently in other areas. In 1969 Steve de Shazer began to independently develop a model of brief therapy culminating in a paper entitled "Brief Therapy: Two's Company" (1975). In this paper de Shazer utilized language which today is still explicitly a part of brief therapy ("relabelling", "change-initiating intervention", "family spontaneously behaves differently"). de Shazer followed his initial paper with several subsequent publications, all of which explicate his model of brief family therapy (see, for instance, de Shazer, 1975, 1977, 1980, 1982, 1984, 1985, 1988).

A third significant paper, entitled "The Treatment of Children Through Brief Therapy of Their Parents" was published by the Milan Group, which consisted of Selvini-Palazzoli, Boscolo, Cecchin and Prata (1974). The Milan therapists reported successful resolution of the behavior problems of encopresis and anorexia in two children through the brief therapy of the children's parents. The employed interventions, based on systems theory and the cybernetic model, were designed specifically to create rapid change in family interaction. Palazzoli et al's approach was built on the theoretical models proposed by Haley (1973) and the Brief Therapy Centre of the Mental Research Institute (Watzlawick, Weakland and Fisch, 1974). The Milan Group identified the "positive connotation" as a therapeutic intervention of prime importance in

fostering change in the family system. Their description of this intervention reflected some of the basic constructs of Erickson's approach which helped to form the basis of brief therapy: "It consists of approving all observed behaviors that are traditionally considered pathological" (p. 440).

The papers published by Weakland et al, de Shazer, and Palazzoli et al were matched by the publication of two books most significant to the development of brief therapy. "Uncommon Therapy" authored by Haley, in 1973, outlined Milton Erickson's approaches to therapy in the context of the family life cycle model. Haley's interpretation of Erickson's work was instrumental in the development of an approach to human problems that is based on the view that symptoms arise when families become "stuck" in the process of moving through the normal transitional steps in family living (Weakland et al, 1974; Haley, 1973; Minuchin, 1974; McGoldrick and Carter, 1980; Karpel and Strauss, 1983). Within Haley's context of work, the therapist's role is to help the family get unstuck, through indirect influences, by initiating apparently minor changes.

A second significant book, entitled, "Change: Principles of Problem Formation and Problem Resolution", authored by Watzlawick, Weakland and Fisch (1974), represented the outgrowth of the authors' work at the Brief Therapy Centre. Watzlawick et al outlined the Brief Therapy Centre's views "on how problems arise and how they are perpetuated in some instances and resolved in others" (p. xiii). In outlining their view Watzlawick et al postulated that the solutions people choose in an attempt to resolve their problems very often represent the problem. In other words chosen solutions very often contribute to the problem. When

the problem continues, "more of the same" solution is attempted, leading to a further persistence in the problem, and so on. In particular, Watzlawick and his co-authors examined how "common sense" and "logical" behavior often fails to resolve problems while "illogical" or "unreasonable" actions very often lead to solutions. Watzlawick et al suggest that "simply trying something different" often is enough to initiate desired change and prompt movement through the life cycle.

According to de Shazer (1985), all of these "originating" publications focus on "problems and how to solve them" as opposed to "problems and how they are maintained". Each of these models, then, is grounded in a particular orientation toward problem construction and problem resolution that distinguishes it from other conventional models of therapy. The tactics and strategies of clinical intervention which represent the substance of these models rest on a number of principles which reflect this basic orientation.

Principles Underlying Brief Therapy

The principles to be discussed are adapted from the literature on brief therapy including Erickson (1954); Haley (1973); Weakland, Fisch, Watzlawick, Bodin (1974); Watzlawick, Weakland, Fisch (1974); de Shazer (1975a, 1975b, 1977, 1980, 1982, 1985); and, Fisch, Weakland, Segal (1982). The context for this discussion can be established by drawing upon the words of Fisch, Weakland and Segal (1982):

> "Given this conceptualization of problems and
> their resolution, the therapist must be an active

> agent of change. Not only must he get a clear view of the problem behavior and of the behaviors which function to maintain it; he must also consider what the most strategic change in the "solutions" might be and take steps to instigate these changes - in the face of the clients' considerable commitments to continuing them. This is the job of the therapist as we see it" (p. 19).

These words convey that the principles which underline brief therapy essentially evolve from a "meta-view" (Fisch, Weakland and Segal, 1982) about how problems are constructed, how problems persist, and how problems are resolved. Thus, as emphasized earlier in this report, the ideas, beliefs, assumptions which the therapist holds concerning problems and problem resolution will influence the data she/he collects; the interventions she/he utilizes; and her/his evaluation of intervention and progress in treatment. Given this meta-perspective, the principles of brief therapy may be examined according to how problems are conceptualized, how change is conceptualized and how intervention is conceptualized.

In the context of brief therapy, human problems are viewed to be primarily an outcome of the ordinary difficulties experienced in everyday living (principle I). These difficulties are typically associated with the normal transitional steps which form a part of every family's life cycle. While these transitions are most often adequately managed they frequently are mishandled and lead to the development of symptoms in a family member (Haley, 1973; Minuchin, 1974; Carter and McGoldrick, 1980; Karpel and Strauss, 1983). Frequently, the family is unable to adjust to new circumstances arising out of change in the developmental stages of family members or the family at large. According to brief therapy,

ordinary difficulties are likely to develop into problems if they are overemphasized or underemphasized. That is, symptoms or problems will develop if people treat an everyday difficulty as a "problem" or as "no problem at all" (principle #2) (Weakland, Fisch, Watzlawick, Bodin, 1974). The amount of emphasis placed on a particular difficulty is frequently interrelated with socio-cultural norms and expectations regarding human functioning. Thus, the meaning or implications attributed to a particular behavior, situation or difficulty can itself have a powerful effect on an individual's attitudes, responses and relationships (principle #3). Simply put, some labels provoke further difficulties, other labels provoke adjustment (Weakland, Fisch, Watzlawick, Bodin, 1974).

Problems, which arise through these processes, are viewed by brief therapists to be situational and interactional in nature (principle #4). That is, problems evolve and are maintained by the individual's own current behavior or by other's with whom the individual interacts. Thus, once a difficulty is mishandled and begins to be seen as a "problem" the individual is prompted toward solution behavior. Brief therapists maintain, however, that chosen solutions frequently intensify and exacerbate the initial difficulty thereby leading to a greater problem (principle #5). When the solution fails to resolve the problem the apparently "logical" nature of the solution prompts the individual to apply "more of the same" solution, leading to a vicious negative cycle of solution, problem exacerbation, solution, problem exacerbation. The proverbial illustration of this cycle is the individual's mistaken attempt to engage her/his withdrawing partner by nagging, leading to

further withdrawal, thereby, leading to further nagging, subsequent further withdrawal and so on in a spiraling fashion.

Once the original difficulty is labelled as a problem requiring resolution it is often exacerbated and maintained by a positive feedback loop that centers around the solution behavior chosen and performed by the individual or family in order to resolve the difficulty (principle #6). Watzlawick, Weakland and Fisch (1974) suggest:

> "In real life, although some human problems may continue at a steady level of severity, many difficulties do not stay the same for long, but tend to increase and escalate if no solution (under emphasis) or a wrong solution is applied. When this happens, the situation may remain structurally similar or identical, but the intensity of the difficulty and of the suffering entailed increases" (parenthesis mine; p. 32).

This vicious circle explains how problems persist even when people convey they want to change. This interpretation of problem persistence is distinguished from other orientations which suggest that problems persist as a function of mental illness, irrationality, personal inadequacy (psychodynamic interpretations) or of maintaining homeostasis, functional roles (traditional family therapy interpretations). Given this context, longstanding problems or symptoms are viewed as the persistence of a repetitively poorly handled difficulty (Weakland, Fisch, Watzlawick, Bodin, 1974) as opposed to a chronic defect or inadequacy in the client (principle #7). "Chronic problems" simply reflect that people have been struggling to find appropriate solutions for a longer time. In brief therapy, problems are considered to be undesirable behaviors which

are repeatedly performed. A single event does not constitute a problem.

How the therapist chooses to orient him/herself toward viewing how problems persist is intimately related to the orientation they adopt in respect to how change occurs. Fisch, Weakland and Segal (1982) indicate: "Our view of treatment and problem resolution is a counterpart of this view of the nature and persistence of problems" (p. 18). Thus, if solution behavior, chosen to resolve a problem, serves to maintain and exacerbate that problem through a positive feedback cycle, then it stands to reason that alteration of such behavior will alter the cycle and lead to problem resolution. Within brief therapy, substitution or removal of the behavior which provokes the problem within the interactional cycle interrupts the positive feedback cycle and leads to problem resolution (principle #8). Thus, "less of the solution leads to less of the problem" (Fisch, Weakland and Segal, 1982). Sometimes "simply" redefining the meaning of the behavior that provokes difficulty can lead to positive shifts in attitudes, behavior and relationships.

Given the premise that human problems are interactional in nature, only a small shift in the client's behavior is necessary to initiate a reversal to a beneficent feedback cycle in which positive change leads to "more of the same" self induced positive change and so on (principle #9). In this way, a small change in person #1's behavior can lead to profound change in persons #2 and 3, which in turn leads to more of the same positive change in person #1. This principle reflects a major departure from treatment orientations which postulate that a total restructuring of the entire family system in question is a prerequisite to change.

The brief therapy focus on "thinking small" has implications for whom

intervention is targeted, the nature of the interventive goals and the selection of intervention strategies. Since problems are conceptualized in terms of an interactional system and only a small change in that system is necessary to initiate further change, the number of people involved in creating solutions is irrelevant. In this respect the systemic concept of "wholism" is primary in brief therapy (principle #10). In the brief therapy context, change in one part of the system leads to change in all other areas of the system. It takes one individual to change an entire system (Weakland, Fisch, Watzlawick, Bodin, 1974; de Shazer, 1985). Thus, intervention strategies may be directed toward a particular family member who is most accessible to influence, as targeting intervention in this way may lead to change in the quickest manner. This principle, essentially systemic in nature, suggests that family therapists need not conduct therapy sessions with all members of a family in order to create change.

In terms of intervention, brief therapy is clearly symptom oriented (principle #11). Intervention is focused on clearly defined symptoms and specific, limited treatment goals. The therapist's initial agenda is to gain a concrete behavioral picture of the presenting problem. The presenting problem provides a frame of reference for what the family is prepared to work on. It also provides a concrete measure of the progress made in treatment. Given the principle of initiating apparently minor change, only a reasonable goal is necessary as accomplishment of this goal will lead to progressively greater change. Once a specific, concrete goal is established the context for change evolves and self-induced solutions may spontaneously arise (de Shazer, 1985, 1988). In

intervening, the therapist's aim is to produce apparently minor behavior change which in turn will lead to subsequent self-induced behavior changes on the part of the "identified patient" and his/her system. No attempt is made to assist the family in achieving "insight" into their problems or to rework their history as a system. The process of intervention involves transforming the symptom complaint into positive usage in therapy by accepting and utilizing what the client brings to therapy (principle #12). Symptoms are accepted at "face value" and transformed, through indirect influences, into part of the solution. Thus, while the emphasis is upon creating overt observable behavior changes, indirect influence represents the primary strategy through which change is initiated in brief therapy (principle #13). Clients frequently require assistance through indirect means as they are usually convinced about the apparent "logical" nature of the solutions they have been attempting on a "more of the same" basis. Such solutions are often culturally prescribed in a "common sense" way.

Brief therapists frequently employ means of promoting change which appear illogical: the emphasis is on "what works" to create beneficent cycles of change (principle #14). As such, brief therapy represents a very pragmatic approach to human problems and problem resolution.

In summary, brief therapy is grounded in a developmental or life cycle orientation. Human problems are viewed to be an outcome of ordinary difficulties associated with the transitions arising in every family's life cycle development. These difficulties are compounded by the family's inability to adapt to changing circumstances, arising out of such transitions, as well as the family's mistaken solutions. Mistaken

solutions, chosen to irradicate the complaint, frequently intensify the initial difficulty and contribute to a greater problem by virtue of a positive feedback loop. The substitution or removal of the mistaken solution or behavior promoting the problem can, through the same interactional principles, initiate eventual problem resolution.

Given the interactional nature of human problems, the brief therapist seeks to initiate a small change with the intent, that through a "ripple effect" (de Shazer, 1985), this small change will snowball to eventual solution. The therapist, then, aims to assist the family in becoming "unstuck" by directing the family to attempt alternative solutions aimed at creating a small change and shift in the pattern surrounding the complaint. Such a process is frequently initiated by prompting family members to "do something different" from the mistaken solutions they have applied to the problem in an effort to achieve resolution. Change of any kind is desirable.

However, within the context of the integrated model under study in this practicum, before the therapist can initiate <u>change that is beneficial</u> the therapist must have a clear goal indicating the direction in which therapeutic change will occur. In an effort to achieve such clarity it is helpful for the therapist to maintain a theoretical frame of reference, such as the structural framework, upon which he/she can rely to organize observations, assess family functioning, and determine the direction of therapeutic change. The structural model provides such a framework and is particularly congruent with brief therapy given its developmental basis. The structural model is also particularly congruent given its emphasis on present and future functioning. As in brief

therapy, no attempt is made to produce insight or understanding based on past history. An overview of the structural model, adapted from Minuchin (1974, 1981, 1984) and Colapinto (1982), will be followed by the brief therapy model developed by (de Shazer 1975a, 1975b, 1977, 1980, 1982a, 1982b, 1985, 1988). The blend of these two approaches into an integrated model of brief family therapy will be illustrated through subsequent case examples and analysis.

CHAPTER 5

THE STRUCTURAL FRAMEWORK

The structural framework evolved as an attempt to describe the organizational transitions which families and their subsystems make over a period of time. As such, the structural framework very much represents a developmental approach to normal family functioning and shows particular congruency with the family life cycle model. It is from this developmental foundation that the methology of change in structural family therapy evolved (Minuchin, 1984). The structural framework views the individual in "context". An individual's growth and development depends upon the social systems with which the individual interacts. The most critical of all social systems is the family system as it represents the primary context in which an individual grows and develops.

The family's existence as a system depends upon its flexibility to adapt to new circumstances arising internally, through changes in the developmental stage of family members and subsystems, or externally through the pressure of broader systems in the socio-cultural environment. Thus, the family is described as "an open system in transformation" as "it constantly receives and sends inputs to and from the extrafamilial, and it adapts to the different demands of the developmental stages it faces" (Minuchin, 1974, p.50). Adaptation to new circumstances necessitates a shift in the family organization and structure (established ways of interacting). The process of adaptation involves a degree of stress and tension for all families. Given this

tension, the mere absence or presence of problems is not an adequate indicator of normal and abnormal families or of effective and ineffective family functioning. However, since the family provides the primary context for each family member's growth and development, the family must adapt its structure in a manner that does not destroy the continuity of the family as this provides a foundation for promoting each individual's continued growth. Effective family functioning is evident when family members are able to utilize new ways of interacting, without sacrificing the continuity of the family, instead of relying upon established patterns of interaction based on old circumstances.

Thus, besides emphasizing the family's move through developmental phases, the structural model emphasizes two additional key components: family structure and adaptation. Together, these three components provide a conceptual framework upon which the assessment of family functioning is based in this practicum. As the family life cycle has already been discussed in detail, attention will now be directed toward the components of family structure and adaptation.

Family Structure

The set of rules which regulate and organize the interactions among members of a family constitute a family's structure (Colapinto, 1982). Such rules determine the way in which relationships are organized in a family. All families establish invisible rules, demands and nuances around decision making, contact within and beyond the family, and the activities of daily living. These functional demands underpin the family

as a system. Repeated activity, along these functional lines creates transactional patterns. Such transactional patterns organize family operations and regulate how, when, and to whom one should relate. Thus, a father advises his son that he must complete his chores; the son, occupying a lower hierarchical position, complies (Minuchin, 1974). Transactional patterns set a context for how family members see themself and this, in turn, helps define the identity of individual family members.

Transactional patterns are maintained by both generic and idiosyncratic systems of constraint (Minuchin, 1974; Colapinto, 1982). The generic system of constraint includes the set of rules which universally govern family organization. Thus, in all families there must be mechanisms to ensure that instrumental needs (e.g., food, clothing, finances) as well as affective needs (e.g., nurturance, expression of feelings) are met. There must also be complementarity between husband and wife with respect to how these needs are met. Idiosyncratic constraint mechanisms refer to the mutual expectations that family members hold in relation to one another. The origin and history of these expectations is frequently forgotten and family members are frequently unaware of their role in maintaining them. In effect, then, the emerging pattern of constraint takes on a life of its own and the system maintains itself.

The merging of universal and idiosyncratic constraints is evident when we observe a husband, overfunctioning in the instrumental area through his career, occupy a distant position in relation to his wife (and child) who, in turn, occupies an overinvolved position with the

child, and overfunctions in the affective area. Here we see the complementarity of functions between husband and wife which reflects both idiosyncratic constraints (mother's closeness to child - father's distance; the unwritten expectation that wife watches child - husband brings home "bread") and universal constraints (both instrumental and affective needs must be attended to; there must be a complementarity of functions between husband and wife). Such complementarity serves a homeostatic purpose for the family system. The husband's initiative in the instrumental area allows the wife to assume a more passive role in the instrumental area, in turn, allowing her initiative in the affective area and the husband's passivity in the affective area . This is the sort of patterning evident in the traditional nuclear family which reflects the regulating effects of a culture that encourages a mother's closeness to children and a father's distance (Colapinto, 1982).

Very often, patterns such as these take on a life of their own. The family comes to rely upon these patterns as preferred and accustomed ways of organizing itself. The family resists alteration of these patterns and attempts to maintain them despite the availability of alternative patterns. Shifts in these patterns lead to instability and tension in the family. When shifts create stress that is beyond a tolerable level, mechanisms are triggered to re-establish the preferred patterns of functioning. However, the family is an open system that is constantly transforming (Minuchin, 1974; Colapinto, 1982). It is prone to shifting circumstances created through internal changes in the family (e.g., developmental milestones) as well as external changes in the broader culture. For example, the cultural forces associated with the

traditional nuclear family are no longer as relevant. The complementarity of functions between husband and wife is not as strongly regulated by a culture that restricts the husband to the instrumental areas and the wife to affective areas.

Associated idiosyncratic changes in either the wife's or the husband's position creates a new set of circumstances for the family and calls forth alternative patterns, or a shift in family structure. Families which fall within the broad range of effective functioning possess the flexibility to adapt their structure in order to meet the demands posed by new circumstances in a way that does not trigger instability beyond a tolerable level. Such changes and adaptation of the family structure frequently increase the complexity of the family system. In order to manage this complexity and ensure differentiation, the family structure is organized around subsystems and boundaries.

Subsystems

Given its complexity, the family system carries out its functions through subsystems. Subsystems can be composed of a single family member, a dyad (husband-wife or spouse subsystem) or numerous family members (sibling subsystem). Subsystems can be formed according to age, generation, interest, function, and sex. Individuals have membership in a number of different subsystems at any one time and benefit from varying degrees of authority and influence according to the particular subsystem in mind. For instance, a male child may at once, be a son, in which he must accede authority to his parents, yet be the oldest in a sibling

subsystem wielding greatest authority. Membership in different subsystems provides the milieux in which individual family members develop competence in both differentiating and relating interpersonally (Minuchin, 1974). Three key subsystems which compose part of the family structure are the spouse subsystem, the parental subsystem and the sibling subsystem. Changes or shifts which arise in any of the subsystems leads to shifts in the others.

The Spouse Subsystem

The spouse subsystem is composed of a husband and wife, or two partners (eg. commonlaw union) who join for the purpose of forming a family. As such, the spouse subsystem has a boundary of its own and does not include children. Effective functioning in this subsystem is vital to ensure the healthy development of children and the overall functioning of the family. Ineffective functioning in the spouse subsystem may spill over to the child so that the child becomes the battleground for spouse conflict. The child might be drawn into alliances with either partner, or be scapegoated as the cause of family problems. Such triangulation blocks the child's development and leads to symptomatic behavior in the child.

Children learn the business of intimate relationships by observing their parents negotiate differences, support one another, express intimacy, and reinforce and accept each others strengths or weaknesses. A couple's ability to mutually accommodate to one another and develop complementary patterns of functioning is crucial to the maintenance of

effective functioning in this subsystem. Each partner must support the others' functions. As each partner grows, as an individual, the rules governing the relationship must be renegotiated and changed. If partners are unable to continue developing as individuals, and as a couple, the child is likely to become a symptom bearer. To promote effective negotiation the spouse subsystem must develop a boundary that protects the couple from the inappropriate intrusion of others (eg. parents, children) yet allows the access of others in order to prevent isolation.

The Parental Subsystem

The parental subsystem evolves with the arrival of the family's first child. This developmental milestone transforms the family structure. The spouse subsystem must now adapt in order to meet the needs of the child without undermining the support and accommodation that is necessary for effective functioning in the spouse subsystem. New rules need to be negotiated to define who participates with whom and in what fashion. The complementarity between partners must now extend to complementary functions in the parental arena. If marital and parental functions become mixed, the child's freedom to differentiate and develop will be hampered. Thus, the parental subsystem boundary should permit a child's access to both parents, yet exclude the child from spouse functions. Children, for instance, should not participate in a couple's arguments.

The parental subsystem is cross generational in nature and is characterized by transactional patterns involving the typical child rearing functions. However, effective family functioning is predicated

upon a clear hierarchy in which the parents occupy an executive position (Minuchin, 1974). Changes in the child's developmental needs call for shifts in parenting and the manner in which parents operationalize their hierarchical position. It is through this process that a child's sense of trust, security, control, independence, develop. During the earlier years the child's need for nurturance, protection and control seem clear cut and challenges to parental authority are dealt with more definitely. However, as the child moves toward adolescence, parental authority becomes blurred by the adolescent's need for autonomy and independence. The adolescent makes different demands upon the parent which necessitate alternative patterns of functioning and accommodation. This adaptational process is never smooth. The conflict that ensues is a necessary part of the changes that take place in the parental subsystem and the child's progression toward differentiation, competency and self-control.

The Sibling Subsystem

The sibling subsystem obviously constitutes the grouping of children within a particular family. To the extent that there are families with only a single child, the sibling subsystem does not always form a part of the family structure. The sibling subsystem frequently represents the first peer group for many children. In this respect, this subsystem provides children with their first experiences at competing, cooperating, negotiating, scapegoating, asserting and submitting (Minuchin, 1974). The child's experience in the sibling subsystem provides him/her with the initial tools, or context, from which to interact with extrafamilial

peers. Depending upon the idiosycracies of the child's family, the tools and skills which the child has acquired through the sibling subsystem may or may not be relevant. A highly idiosyncratic family may respond to a child's differences by rigidifying the boundary to the external world, and in turn reinforce the idiosyncratic ways of functioning which have made it difficult for the child to enter other social systems (Minuchin, 1974).

The sibling subsystem provides children with a context for belonging and a context for separateness and individuation from the rest of the family system (Minuchin, 1974). As a child experiences the processes of negotiation, asserting and submitting, he/she adopts positions which exercise a sense of inclusion or belonging, and those which exercise a sense of independence. For this to take place it is important that the subsystem boundary prevent undue interference from parents and other adults. Children should be left to problem solve, assert their needs and establish their position amongst one another without the overinvolvement of parents.

In summary, then, subsystems represent one component of a family's structure. Subsystems ensure the differentiation of the family system and ensure that family functions are fulfilled. Each family member is included in some family subsystems and excluded from others, at any one time. This interchanging membership provides "valuable training in the process of maintaining a differentiated 'I am', while exercising interpersonal skills at different levels and sustaining a sense of attachment and belonging" (Minuchin and Minuchin, Unpublished paper: A Child in Context: A Systems Approach to Growth and Development, p.6).

However, in order for family members to benefit from this interchangeable membership their subsystem must be protected from the inappropriate intrusion of other family members. It is essential that the boundary surrounding each subsystem prevent such intrusions, otherwise the members of a subsystem cannot carry out their functions. Subsystems which are not protected in this manner do not promote growth and development in family members. At the same time, members of a subsystem must have access to one another, and other subsystems. In essence, subsystems and subsystem boundaries must promote the process of differentiation. They should ensure that each individual family member's need for involvement is met without sacrificing each individual family member's need for separateness. In this regard, the boundary of a subsystem is an important attribute of the family structure.

Boundaries

All subsystems, and the family at large, are marked by boundaries which function to protect the differentiation of the system (Minuchin, 1974). Boundaries regulate the amount and the nature of contact between family members. Boundaries are the rules which determine who participates with whom, in what context, and in what manner. The nature of the boundaries surrounding a family's subsystems is a critical variable in determining the family's level of functioning. Effective functioning is predicated on the degree to which a family's boundaries are defined and clear, thereby providing protection against the interference of other subsystems, yet, permitting interaction between the

members of a subsystem and others. Boundaries must be pronounced enough to ensure that subsystem functions are carried out freely as these functions are vital to the development of individual family members and the family as a whole. For example, a couple must be free to carry out their complementary functions as husband and wife, and as parents, without the interference of inlaws. Poorly defined boundaries, or diffuse boundaries, permit inappropriate intrusion and the overinvolvement of others into the subsystem in a manner that impedes family members from carrying out their functions. Overly defined boundaries, or rigid boundaries, prevent interaction between the members of different subsystems.

Families or subsystems which tend toward overinvolvement and intrusion develop a high degree of concern and energy among members. Family members maintain close proximity to one another and distance between family members is decreased. Boundaries are blurred and diffuse leading, in turn, to greater intrusion and overinvolvement. The close proximity between family members leads to the dissipation of a high level of energy and resources among family members. This frequently leaves the family unable to adapt to new circumstances triggered through developmental process or the pressures of external social systems. Families which exhibit this pattern of boundary functioning are "enmeshed". In other families and subsystems, interaction and involvement among family members is restricted. The proximity between family members is distant and the expression of concern is narrow. Overly rigid boundaries develop in such families and lead to a reinforcement of this style of interaction. Families which exhibit this

style of boundary functioning are "disengaged".

Enmeshment and disengagement refer to preferred styles of interaction, or boundary functioning and are not meant to convey "qualitative differences between functional and dysfunctional" (Minuchin, 1974, p.55). However, extreme repetitive transactions at the extreme of either of these contexts may indicate family dysfunction. In this regard, it is helpful to conceptualize boundaries along a continuum in which rigid boundaries (disengaged functioning) and diffuse boundaries (enmeshed functioning) occupy the extreme ends, while clear boundaries occupy the wide normal range of effective functioning. Most families include both enmeshed and disengaged subsystems at different points in their developmental life cycle, yet manage to fall within the normal range of family functioning. For instance, the arrival of a newborn is frequently associated with an "enmeshed relationship" between the mother and the child, and a somewhat more disengaged relationship between father and child. In earlier years the boundary separating parent and child is diffuse and the functioning tends toward enmeshment. Given the family's life cycle stage this style of interaction is functional. A clearer boundary is gradually drawn as the child develops and the parent child relationship becomes more distant, in turn, supporting the child's need for autonomy and independence.

Families which persistently function in the extremes of disengagement or enmeshment do not promote differentiation, growth and development. In highly enmeshed systems, the loyalty demanded of family members necessitates that family members relinquish their autonomy. In practical terms this means that individuals are not free to explore, and tackle

problems independently. Differences which children acquire through their limited experience outside the family are not openly received or tolerated. Such differences are usually neutralized by the family's pressure to accommodate or remain consistent with the system. In this respect, "enmeshed families respond to variations from the accustomed with excessive speed and intensity" (Minuchin, 1974, p.55). Only a small amount of stress is required to activate the system. Families which function in the extreme end of disengagement tolerate wide variations. Family members are free to function autonomously and show differences, however, feelings of belonging and loyalty are sacrificed. Members of these families often develop a distorted sense of independence. The support systems in disengaged families are not as easily activated and a high level of stress is required before adaptational resources are mobilized. Within the structural framework, a family's adaptational mechanisms constitutes a third major component in assessing family functioning.

Adaptation

As an open system, the family system is vulnerable to disequilibrium from a variety of internal and external sources. Internally, the family remains vulnerable to the evolving developmental needs of its members, particularly children. The intrusive, authoritative position held by the parents in relation to their child as an infant is not functional in relation to that same child as an adolescent. Both the parents and the child must shift their positions in relation to one another. Externally,

the family is subject to the shifting forces exerted by various social institutions. The pressures upon the family system, whether internal or external, challenge the family with a new set of circumstances. Meeting the demands associated with these circumstances necessitates the repositioning of family members and a change in the organizational structure of the family. Thus, the parents of an adolescent might move to a position of greater distance and choose to act as the adolescent's "consultant" so that the adolescent exercises his/her autonomy. However, such changes are not always smooth.

As a system, the family has a natural desire for homeostasis and it tends to rely upon accustomed transactional patterns. Shifting patterns lead to instability and unsettledness. In healthy family systems this instability is transitional and serves as a stimulus to demonstrate flexibility and enact alternative patterns. Moving beyond this instability leads to a new level of stability and a higher level of functioning. However, if in the face of such stress the family rigidly adheres to previously established patterns and boundaries, the continuity of the family as a system will be lost. In such cases, rather than adapting, the family repeatedly enacts rigid dysfunctional patterns which serve to block the continued growth and development of family members. The family fails to respond to a new demand from within its own development or from the environment at large. The family neglects to "substitute new rules of transactions for the ones that have been patterning its functioning" (Colapinto, 1982, p.118). Transactional patterns become redundant and the family stagnates in its development. When the family structure becomes stereotyped and homeostasis is

amplified to this degree the family's functioning is pathological.

In functional families the instability associated with new circumstances is only a transitory period of disequilibrium that is representative of all change processes. Functional families respond to the instability by restructuring. The family exercises its flexibility to activate hidden resources and operationalize new roles, positions and styles of interacting (Minuchin, 1974).

In summary, the concept of family adaptation represents one of three major facets in the structural framework and its emphasis upon viewing the family as an open system in transformation. First, the family developmentally transforms itself as it moves through life cycle transitions. Such transitions require the family's adaptation and restructuring. Second, all families have a set of rules, or a structure, which regulates interaction among family members. Over time, preferred transactional patterns, subsystems, subsystem boundaries emerge. The health of the family system is predicated on the family's capacity to enact alternative transactional patterns when developmental or external processes create demands upon the family to restructure. Finally, the family adapts to new circumstances by drawing upon transactional patterns in order to preserve its continuity as a system. Families which are unable to reorganize their structure, and maintain continuity, typically present themselves for therapy.

Thus, the recurring theme in the structural framework relates to the family's capacity to restructure. Consistent with the theme of restructuring, is the tenet that symptoms observed in therapy ultimately reflect dysfunction of the family structure (Colapinto, 1982). This

tenet provides the foundation for the philosophy of therapeutic change upon which structural family therapy is based.

The Change Process of Structural Family Therapy

The structural framework maintains, first, that human problems can only be understood in context and, second, that human problems must be treated in context. Human problems which are presented in therapy are viewed as reflections of dysfunction in the family structure. The identified problem is a metaphor for the overall structural organization of the family and it is seen as complementary to the system's dysfunction. Given this basis to understanding human problems, "change" rests on the transformation and modification of the context - - the family structure - - so that the pathways to growth are reopened for all family members. The primary goal of structural family therapy, then, is to restructure the family system. Change essentially represents a process of supportively challenging the family to relinquish old, stereotyped patterns of functioning, of which the presenting complaint is a part, and adapt new alternative patterns which warrant the homeostatic aspect of the complaint inoperable. Alteration of the family structure involves changes in the position of family members, relative to one another, and corresponding changes in the demands which family members make of one another (Minuchin, 1974). Freeing a daughter from triangulation may necessitate closer proximity between husband and wife and greater distance between father and daughter.

Interventions, aimed at orchestrating change, challenge the relative

positions of family members and the system of rules both which govern transactions among family members. These challenges promote structural shifts which lead to increased flexibility in the entire family system at large. Family members are relinquished from past roles and have greater freedom to experiment and develop new ways of behaving and interacting with one another. As a system, the family finds increased freedom to uncover and utilize hidden resources in order to meet the stressful challenges of developmental pressures. As the family puts these resources to work the family reality transforms. Alternative transactional patterns, earlier rebuked in favour of the demand for homeostasis, are perceived as more manageable. As the family structure is transformed dysfunctional patterns and behaviors, including the complaint, are no longer supported. The complaint no longer serves a homeostatic function as the system of rules, to which the complaint was complementary, is outgrown. The family forges to a higher, more complex level of homeostasis and functioning.

Within the structural model, change is achieved through the process of restructuring the family as a system. Restructuring warrants the homeostatic function of the presenting complaint inoperable. This conceptualization of change implies that the therapist must first achieve an understanding of the family's structure and how this structure maintains or is maintained by the presenting complaint. This requires detailed information about the complaint and how the family is organized around the complaint. In order to achieve this, the therapist must join the family, assess its structure and develop interventions based on this assessment. The therapist "observes the system, making deductions that

enable him to transform his experience into a family map, from which she/he derives therapeutic goals. To understand and know a family in this intimate, experiential way is a vital component of family therapy" (Minuchin, 1974, p.124). Understanding the problem is seen as a vital step in the process of determining a solution and promoting change. This approach to therapy emphasizes problems and how they are maintained. The more complicated the problem, the more complicated the solution. In fact, Minuchin (1974) writes:

> "In average families, the therapist relies on the motivation of family resources as a pathway to transformation. In pathological families, the therapist needs to become an actor in the family drama, entering into transitional coalitions in order to skew the system and develop a different level of homeostasis" (p.60).

In contrast, brief therapist's challenge the notion that "complicated problems" require "complicated solutions". From the brief therapist's point of view all that is frequently required to prompt a solution in a difficult situation is that the individual(s) in the situation "do something different". This calls into question whether understanding a particular problem has anything at all to do with change. In essence, the brief therapist is less concerned with how problems are maintained than they are with how problems are solved. These points of emphasis, along with several others, form the basis for the brief therapy interventions applied in this practicum. The interventions reflect a model of brief therapy that extends the solution "mind set" of brief therapists from '"problems and how to solve them to solutions and how they work"' (de Shazer, 1985, p.45).

CHAPTER 6

BUILDING ON FAMILY STRENGTHS

Since the training of most family therapists focuses upon problems, and how they are maintained, a shift in emphasis toward solutions does not come easy. The passion for problems has led many family therapists to follow beliefs such as: understanding the problem (for both client and therapist) will lead to change; complex problems require complex solutions; resistance is an expected element of change. Naturally, in working from this frame of reference, therapists have inadvertently highlighted dysfunctional family patterns, collected data to support the presence of such patterns, and introduced interventions which challenge the family to alter such patterns, in effect creating the expected resistance. This approach to therapy tends to highlight family inadequacy at the expense of family strength. At a process level, the family is invalidated and disempowered.

The brief therapy model applied in this practicum, which emphasizes solutions, illustrates that the connection between understanding a particular problem and creating change is often very loose:

> "For an intervention to successfully fit, it is not necessary to have detailed knowledge of the complaint. It is not necessary even to be able to construct with any rigor how the trouble is maintained in order to prompt solution . . All that is necessary is that the person involved in a troublesome situation does something different, even if that behavior is seemingly irrational, certainly irrelevant, obviously bizarre, or humourous" (de Shazer, 1985, p.7).

Approaching therapy in this manner seems counterintuitive given the early training of most family therapists. Nevertheless, de Shazer's points provide the context for a model of brief therapy that focuses upon solutions and emphasizes family strength. Therapy becomes a process of validation. This brief therapy model is built upon several points of emphasis which concurrently shift the therapist's and the family's orientation toward solutions. These focal points, as adapted from de Shazer (1975a, 1975b, 1980, 1982a, 1982b, 1985, 1988), are as follows:

1. Understanding the exact nature of the complaint is not necessary to effectively generate solutions. In fact, skeleton or formula "interventions can initiate change without the therapist's first understanding, in detail, what has been going on" (de Shazer, 1985, p.119). Interventions need only prompt some new behavior patterns.

2. Only minimal changes are required to initiate solving problems. Once change has been initiated, additional changes will be created by the family through a "ripple effect" (Spiedel and Linn, 1969, in de Shazer, 1985).

3. A therapeutic reality can be generated in which change is believed by the therapist and the family to be "not only possible but inevitable" (Haley, 1967, p.535 in de Shazer, 1985, p.78).

4. Ideas about what and how to change evolve from the family's perception of what the family's future reality will be like in the absence of the complaint and connecting this future reality to the present. In this regard, change is promoted by making the future salient to the present (de Shazer, 1985).

5. New behavior based on a change in the definition or meaning (frame) attached to the problem can promote the family's resolution of the problem. Simply suggesting a "reframe" may be sufficient to initiate new behavior (de Shazer, 1985).

6. All families show unique ways of attempting to cooperate, based on their desire to change, which can be utilized by the therapist to establish a cooperating mode of therapy and promote change (de Shazer, 1985).

7. Change is built upon highlighting and punctuating what the family is doing that is good for them. This emphasis, along with a vision of an improved future, helps to build cooperation and an expectation of change (de Shazer, 1985).

A detailed discussion of each of these points will produce a clearer picture of how the brief therapy model applied in this practicum works.

1. Understanding the exact nature of the complaint is not

necessary to effectively generate solutions. In fact, skeleton or formula "interventions can initiate change without the therapist's first understanding, in any detail, what has been going on" (de Shazer, 1985, p.119). Intervention need only prompt some new behavior patterns.

Given the "apparent complexity" of the complaints which families frequently bring to therapy, it has been reasonable to assume that the therapist must have an equally complex understanding of the complaint. Similarly, planned interventions were believed to have to match the complaint in complexity. Therapy based on these assumptions is long term and re-educative in nature.

In contrast, brief therapists maintain that solutions can be built upon minimal interventions aimed at initiating new behavior patterns. Small changes in a pattern open up new pathways and doors for the family. Thus, effective interventions need not match the problem in complexity, they merely need to "fit" the constructed problem, and the family's logic, in a way that promotes a solution. Any real change in behavior, however small, can prompt solution. All that is necessary for an intervention to be successful is that it create a situation which leads the client or family to do something different: "The exact nature of the trouble does not seem important to effectively generating solutions, because the intervention needs only to fit" (de Shazer, 1985 p.119).

"Doing something different" involves prompting the family to try some new behavior that is different enough from what they were doing before, to try and resolve the complaint, that did not work. The introduction of

some random new behavior shifts the sequence of behaviors and patterns which have contributed to the problems which the family brings to therapy (de Shazer, 1985). Anything the client does that is different "fits" for them as they are the ones performing the behaviors. Frequently, it is a small change, that results from doing something different that leads to more of the same and an eventual solution to the complaint.

2. Only minimal changes are required to initiate solving problems. Once change has been initiated, additional changes will be created by the family through a "ripple effect" (de Shazer, 1985; Spiegel and Linn, 1969).

An everyday difficulty is frequently tranformed into a major human problem by applying more of the same unsuccessful attempts at resolving the difficulty because the family believes that what they are doing is the only right and logical thing to do. In such developments the problem usually becomes the rule, not the exception, and, so, more of the same is called for. Since human problems are interactional in nature, only a small change in behavior is needed to initiate a cycle in which positive change leads to "more of the same":

> "Once a system is kicked in a right direction and with sufficient initial push, the deviation - amplifying mutual positive feedbacks take over the process, and the resulting development will be disproportionally large as compared with the initial kick" (Maruyama, 1963, as quoted in de Shazer, 1982, p.03).

Thus, brief therapists seek to initiate small changes. They are

concerned with small differences. Regardless of how complicated or long standing a situation is, minimal change in one individual's behavior can lead to dramatic changes for that person and all others involved in the situation (de Shazer, 1985). A small shift in behavior or a pattern opens pathways which frequently promote spontaneous solution oriented behavior on the part of family members. Milton Erickson succinctly addresses this point of view:

> "And then you need to do SOMETHING that induces a change in the patient . . . . . any little change, because that patient wants a change, however small, and he will accept that AS a change. He won't stop to measure the EXTENT of that change. He will accept that as a change and then he will follow that change and the change will develop in accord with his own needs . . . . . It's much like rolling a snowball down a mountainside. It starts out a small snowball, but as it rolls down it gets larger and larger . . . . . and it becomes an avalanche that fits the shape of the mountain" (in de Shazer, 1985, p.67).

Each successive change promotes and reinforces the expectation of further changes, pushing the treatment process into a direction in which solutions are achieved.

Within this model, any change in behavior or response, has the potential for initiating a ripple effect. Thus, this model focuses attention on identifying "exceptions to the rule" in which the patterns normally supporting the problem are less active or are not present. Exceptions to the rule operate in even the most complicated, longstanding cases, however, "these exceptions frequently slip by unnoticed because these differences are not seen as differences that make any difference: The difference is too small or too slow" (de Shazer, 1985, p.34). A case

in point would be one in which a married couple attends therapy as a last effort to save their relationship. From the wife's point of view, her husband is insensitive to her needs and her attempts to discuss this with him only leave her frustrated and bitter as the husband responds defensively. From the husband's point of view, his wife seldom expresses her needs and expects him to be a mind reader; she withdraws and maintains distance until she blows up and attacks the husband for being insensitive. Both the wife and husband feel that their attempts at problem solving and intimacy _always_ end up in explosive battles and eventual withdrawal from one another until the next round of conflict.

However, even if the prevalent pattern is conflictual, there are exceptions to the rule in which the husband is more sensitive to the wife and the wife is more communicative about her needs. Realistically, nothing _always_ happens. Thus, an intimacy pattern does operate for this couple at exceptional intervals. It is precisely this kind of pattern or, "exception to the rule", that the therapist needs to focus on and gather information about. In particular, the therapist needs to identify and highlight what the differences are between the conflict pattern and the intimacy pattern. Awareness of these differences can form the basis for designing interventions which create a change and solve the problem. Frequently this can be accomplished by asking the client/family to identify a time recently in which the identified problem was absent and describe what people were doing differently during that time. Once this is known the therapist can initiate change in an appropriately beneficial direction.

At a process level, this conveys to both the therapist and the family

that solution patterns do exist and that they form part of the family's reality. Focusing on "exceptions to the rule" promotes a cooperative relationship between the therapist and the family and initiates changes upon which further change is generated through the ripple effect.

3. A therapeutic reality can be generated in which change is believed by the therapist and the family to be "not only possible, but inevitable" (Haley, 1967, p.535 in de Shazer, 1985, p.78).

Families that come for therapy frequently have lived a "reality" where things only go from bad to worse. Each unsuccessful attempt at resolving their difficulty has reinforced this reality and established an expectation of continued failure. The expectation of continued failure builds much like the snowball rolling down a mountainside. What you expect influences what you do, and so the family goes about performing expectation - maintaining behaviors (de Shazer, 1985). However, this process can be reversed through the introduction of new information or a different focus. Because people's expectations influence so much of what they do, it is the therapist's job to create a different reality in which the client comes to believe that things are going to be different. This starts with the therapist's own expectation of change. Haley's description of Milton Erickson best exemplifies this:

> "Erickson appears to approach each patient with an expectation that change is not only possible but inevitable. There is a sureness which exudes from him,

> although he can be unsure if he wishes, and an attitude of confidence as if it would surprise him if change did not occur (Haley, 1967, in de Shazer, 1985, p.78).

Establishing "exceptions to the rule" represent the first of many processes which formulate a context that things are going to be different. Exceptions to the rule refocuses the family onto the solution oriented patterns which are already a part of their reality. This emphasis helps develop an expectation of a "difference". The expectation of a difference, initiated by establishing exceptions to the rule, can be heightened by assigning a formula task during the first family session. The task is illustrated in the following example:

> Between now and our next session, at the end of every day, I would like each of you to individually rate the day on a scale from one to ten (where ten is the highest and one is the lowest) according to how well you think the day has gone for your family. Pay particular attention to the things that are different (or, what people are doing differently, or, what is happening that is different) on the days which you rate five and above. Disregard all other days.

This task promotes an expectation of change, and a difference, at a number of levels. First, by directing family members to pay particular attention to the days they rate high, the task focuses the attention of family members onto patterns which are functional and different from those which surround the complaint. Second, the message implies that the family is already doing something that is good for them and orients the family toward this. Third, completion of the task establishes a context in which the family relates a "change" or a "difference" to therapy, thus promoting the expectation of further change. In reporting their results,

family members frequently identify what has happened as new or different despite the fact that they are observing events which were present prior to therapy (de Shazer, 1985). Variations of this task can be applied throughout the course of therapy, across a wide range of problems regardless of their complexity, without changing the basic thinking behind the task.

Once a context of change has begun to evolve, solutions can be achieved by formulating a picture of what the family's future will be like in the absence of the complaint. Connecting the future to the present, in this way, reinforces the notion that change is not only possible but inevitable.

4. Ideas about what and how to change evolve from the family's perception of what the family's future reality will be like in the absence of the complaint and connecting this future reality to the present. In this regard, change is promoted by making the future salient to the present (de Shazer, 1985).

A key to generating solutions in this model rests on the process of joining with the family in formulating a picture of a more satisfactory future, in which the complaint is absent, and making this future salient to the present (de Shazer, 1985). This process is most easily initiated by posing a "miracle question" to each family member, a form of intervention that closely resembles Erickson's (1954) and de Shazer's (1985) "crystal ball technique". Like the crystal ball technique, the miracle question is used to "project the client into a future that is

successful: The complaint is gone" (de Shazer, 1985, p.81). The miracle question orients family members to a successful future and prompts them to describe what they expect to be different once the problem is solved. The reorientation to a successful future creates an expectation of change. People's expectations influence their behavior and the expectation of change, alone, can frequently lead to different behavior and spontaneous solution. The miracle question is usually put forward in the following (or some closely related) way :

> If you could have a miracle, and you could have your family anyway you like, when the problem is gone, what will your family look like, and what will people be doing (or, what will be happening) that is different.

The miracle question "enables clients to know what their world might look like when the problem is solved" (de Shazer, 1985, p.93). Once family members know where it is possible to go, it is easier to get there. The vision of an alternative future enables clients to join the therapist in solution behavior. Through responding to the miracle question, each family member constructs a set of solutions which they, and others, can potentially adopt. As each family member responds they, in effect, advise other family members of the course they can follow in order to create a more satisfactory future. Each family member is provided with a script for solution oriented behavior. This script emerges in a non-blaming, nonjudgmental manner and leaves family members freer to act.

Once the vision of a more beneficial future is established, changes can occur in the present. The future is made salient to the present.

The thinking behind this approach to change can be summarized through several of de Shazer's comments:

> "Once the therapist has created (or helped to create) expectations that things are going to be different, next in importance is what the client expects to be different after the complaint is gone. That is, what you expect to happen influences what you do; . . . . .
>
> Recent work has pushed our understanding of solutions and how they work even further. . . . . What seems crucial here is that solutions develop when the therapist and client are able to construct the expectation of a useful and satisfactory change. The expectation of change or the making of a different future salient to the present (Berger, Cohen, Zelditch, 1966; de Shazer, 1978a) seems to be a skeleton key to opening the door to solution. This is not, of course, some sort of magic. It makes sense that if you know where you want to go, then getting there is easier. What does not seem so commonsensical is the idea that just expecting to get somewhere different, somewhere more satisfactory, makes it easier to get there, and just being somewhere different may be satisfactory in itself." (de Shazer, 1985, p.45-46).

Through the miracle question, the client is forced to step back from the problem and the patterns supporting the problem. "Something different" becomes the focus instead of "more of the same". As de Shazer puts it, the principles behind a technique such as the miracle question, provide the foundation for therapy based on solutions instead of problems (1985).

5. New behavior based on a change in the definition or meaning (frame) attached to the problem can promote the family's resolution of the problem. Simply suggesting a "reframe" may be sufficient to initiate new behavior (de Shazer, 1985).

> "To reframe, then, means to change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby change its entire meaning. . . . . What turns out to be changed as a result of reframing is the meaning attributed to the situation, and therefore its consequences, ..." (Watzlawick, Weakland and Fisch, 1974, p.95).

Brief therapists believe that human problems and the meaning that people attach to their problems define, and interact with, each other in a cyclical manner. The meaning or definition attributed to a problem has a significant effect on an individual's behaviors, attitudes and relationships. The meaning or label that people attach to their difficulty frequently provokes further difficulty and more of the same (Weakland, Fisch, Watzlawick, Bodin, 1974; Watzlawick, Weakland, and Fisch, 1974; de Shazer, 1985).

By the time clients come to a therapist for assistance they have constructed a world view that is based on the problem and the patterns supporting the problem. As part of this world view family members attribute some definition and meaning - a frame - to the problem. Once a particular frame begins to develop, other frames, by nature are excluded and the developing frame comes to be seen as the only right and logical way to see things. Unfortunately the frame is typically one which reinforces the problem and the patterns supporting the problem. If it did not, the family would not be seeking therapy. Solutions, based on this frame, predicatably reinforce and provoke the problem leading to the belief that more of the same is necessary as their is no other logical way of seeing the world. When something is, without doubt, seen as

logical and good, then "twice as much" seems in order (the only logical and right thing to do) (Watzlawick, 1988). "Without doubt", the family becomes locked into a symptom frame which promotes the problem instead of resolution.

If some doubt can be introduced into the family's frame then alternative behavior becomes possible for family members (de Shazer, 1985). Thus, in working from the model in this practicum, the therapist endeavours to create some doubt about the frame through which family members see the problem and introduce a new frame through which alternative solution behavior can be considered. A reframe can be initiated by: inducing some doubt into the way family members perceive the problem; by prompting family members to behave differently; or by creating a scenario where family members see a difference, which in turn, creates doubts about their initial framing. The development of a new frame is an important aspect of the first session and it is built upon in each successive session in order to provide the basis for a consistent theme throughout therapy.

In order for a reframe to be accepted and utilized it must fit with the family's style of logic and motivation. The therapist works toward promoting the family's acceptance and utilization of the frame in several ways. First, the therapist familiarizes him/herself with the family's system of logic. The therapist asks questions which briefly explore the family's understanding of the problem and the things they have attempted in order to resolve their problem. The therapist asks questions, and leads the therapy in a way which forces family members back from the problem. In this regard the family is frequently asked: "What sense do

you make out of this (or that)?" This sort of question forces family members to step back from the problem and allows family members enough distance to view the problem from a different angle. This prompts family members to reveal their way of thinking. Throughout this process the therapist pays keen attention to the manner in which family members describe sequences, the tone, words, and pace they use. These observations provide valuable information about how to construct and present the reframe.

Second, exceptions to the rule are explored. Exceptions to the rule represent success patterns and frequently lead family members to "see a difference" or to spontaneously behave differently. This can frequently shift the family's view of the problem.

Third, the therapist may assign a research task which asks family members to observe what is different in their family when the problem is less evident. Again, this sort of task orients family members to anything that is different and, thus, induces some doubt into the family's frame.

Fourth, the introduction of the message carrying a new frame can be preceded by a set of compliments for each family member and/or the family as a whole. Complimenting the family is validating and creates a "yes set". The yes set" promotes the family's receptiveness to the frame. The introduction of the compliments and the reframe usually comes after the therapist has taken a short break, (often to consult with the team or supervisor) during which time the actual frame is constructed. Taking a break often serves a hypnotic purpose and promotes a "response attentiveness" on the part of the family members (de Shazer, 1982, 1985).

According to de Shazer, "this is the moment to introduce a therapeutic suggestion or a reframing (1985, p.91).

Once a reframe begins to develop a new context is formulated for the family. Within any given context there are a number of different options. When one of these options doesn't work people frequently try another and another until they have "tried absolutely everything". Frequently, all that has happened is that more of the same has been tried, and tried unsuccessfully. Each of these options represent the same context and, so, are of the same logical type: the difference isn't different enough to make a difference that matters. Change resulting from this sort of difference is referred to as "first order change" (change of no real difference). Certain contexts are not helpful for solving problems. Thus, the options available within a certain context have no benefit of a difference. What is called for is a new context.

A new context promotes a difference that makes a difference. Change resulting from this sort of difference is referred to as "second order change" (change of a real difference). Simply creating a new frame helps the family begin to see the problem situation differently and, through this, new pathways emerge and are followed:

> "Therapy, through reframing, provides a type of mirror which can help people to see situations differently and thus behave differently. Although two (or more) labels can be applied to the same situation, all labels can be applied to the same situation, all labels are not equal. Some promote detrimental behaviors while others seem to promote more beneficial behaviors" (de Shazer, 1985, p.43).

6. All families show unique ways of attempting to cooperate, based

on their desire to change, which can be utilized by the therapist to establish a cooperating mode of therapy and promote change (de Shazer, 1982, 1985).

Therapy which focuses on solutions starts with the premise that clients want to change. As such, an emphasis upon the concept of "resistance" is not satisfactory. "Resistance" is a concept that therapists have misused to describe situations in which family members have lost their way through a difficult situation. It is the therapist's job to help family's find their way. An expectation of change promotes a cooperative mindset in the therapist. The therapist who works from a model of therapy that is based on solutions establishes a cooperative mode between him/herself and the family. In this regard, the concept of "resistance" is replaced, in the therapist's mind, by the concept of "cooperation" (de Shazer, 1982, 1985).

The therapy model in this practicum orients the therapist to a cooperative position. Throughout the course of therapy, the therapist creates a therapeutic milieu that encourages and punctuates cooperation between him/herself and the family. This emphasis begins with the first session in which the therapist (and occasionally the team) pays particular attention to the preferred patterns which the family shows such as: the pattern each member describes around the complaint; the meaning each member attaches to the complaint; to whom the complaint is most distressing; vocabulary' preferred phrases and adjectives'; visual, auditory, kinesthetic preferences; activity among family members. These patterns, along with other processes, provide valuable clues for designing interventions which "fit" for the family, and thus, promote

cooperation. For instance, communication can be enhanced between the therapist and the family if the therapist incorporates the family's preferred phrases and words into messages (de Shazer, 1982). Interventions which fit in this way reflect the therapist's understanding of the family and encourage cooperation.

A cooperative mode is concurrently promoted through a number of additional processes, several of which have been touched on, including: highlighting exceptions to the rule; creating an expectation of change; formulating a vision of a successful future and making this vision salient to the present; complimenting and validating family members for what they are already doing that is good for them; highlighting and punctuating any changes which family members make. These processes merge together and build a cooperative mode between the therapist and the family. Establishing exceptions to the rule, vision of successful future, and an expectation of change, provide a positive orientation toward patterns of solutions which form a part of the family's existing reality. Once an expectation and vision of a beneficial change becomes salient in the family's world view, and the therapist and the family have constructed this together, then cooperation is a natural bonus. Once a cooperative mode has been initiated the therapist, following the principles behind the ripple effect, continues to focus and punctuate patterns of cooperation:

> "If a therapist chooses to see the client's behavior as resistance, then their attempts to cooperate cannot be seen, since each view precludes the other; if a therapist is looking for cooperative behavior, then he will be unable to see resistance. That is, both concepts

> or levels of description can address different aspects of the same behaviors" (de Shazer, 1985, p.73).

The context of cooperation that the therapist builds within this model is perhaps most evident in the process followed when introducing an intervention to a family. The introduction of a task or homework assignment is generally preceded by a consultation break and a series of compliments delivered to each family member and the family as a whole. Once the therapist has gathered adequate information and accomplished the goal he/she had in mind for the session, the family is informed by the therapist that he/she will be taking a short break to consider what they have discussed together, or in some cases to consult with the team. The therapist generally uses this time to build a "frame" that promotes an adequate fit between the task and the family, and to create a set of compliments for the family, based on what they are already doing that is good and useful.

The consulting break promotes a "responsive attentiveness" and focuses attention upon the therapist, and what they have to say upon returning to the interview room (de Shazer, 1982, 1985). This break strengthens the impact of the therapist's compliments by heightening expectancy. Upon returning the therapist begins by providing a brief summary of the family's situation (this promotes the family's perception that they are being heard) and then introduces a series of compliments to each family member and/or the family as a whole. The compliments are usually constructed in a certain way to punctuate particular words, phrases or pauses, and the therapist usually delivers the compliments in a manner which punctuates a particular tone or pace, depending on the

family's preferences. Compliments might also be delivered along with the task in a "to the point manner" without any preamble if this is more isomorphic to the family's preferred patterns.

When the therapist returns to the interview room, particularly during the first session, family members frequently make comments which reflect an "expectation of no change" or "more of the same", such as: "Now, the bad news"; It's hopeless, isn't it?" de Shazer writes:

> "When the conductor returns to the room after the consulting break, the family is probably expecting a profound series of insights and interpretations about its psychological make up. (As one client remarked: "Well, when do I hear the bad stuff?") The family might even be prepared to fight off these kinds of "negative statements" (like an opponent). Instead, the team develops complimentary statements based on the reframing section of the map and details of the family's description" (1982, p.44).

Family members often respond to the compliments by smiling, nodding their head or shifting their body, all of which suggest a shift in context and, thus, in thinking.

Once the compliments have been shared the therapist proceeds to deliver the task. The compliments form part of the therapy process in order to create a "yes set" and shift the context toward a cooperative, validating mode. They create an atmosphere of cooperation which facilitates the family's acceptance of the task or intervention. The compliments represent something different and initiate a shift in the family's way of thinking. In combination with other conditions (eg., exceptions to the rule, vision of a successful future) they frequently prompt family members to do something different which in turn can lead to

spontaneous change between sessions. Any change in behavior has the potential to initiate a ripple effect which can eventually build to problem resolution and a satisfactory future (de Shazer, 1985). Thus, once change is initiated, the process of therapy involves highlighting and punctuating what the family is doing that is good for them. The process of highlighting and punctuating healthy patterns, in and of itself, can prompt change.

7. Change is built upon highlighting and punctuating what the family is doing that is good for them. This emphasis, along with a vision of an improved future, helps to build cooperation and an expectation of change (de Shazer, 1985).

This model of therapy establishes and builds upon a family's success patterns in order to prompt and reinforce change. This reflects a departure from most therapeutic approaches which tend to focus on dysfunctional patterns. Once exceptions to the rule have been identified and change is initiated in an appropriately beneficial direction, the process of therapy involves focusing on the things that the family is already doing that are good and useful. This emphasis is logically more suited to promoting beneficial change then focusing on what is going wrong. The former approach to therapy validates and empowers families while the latter colludes with their despair.

Cooperation between the therapist and family is assured when the family's success becomes the therapist's focus (de Shazer, 1988). This has some relevence for conducting therapy with families labelled as

"involuntary" or "resistant". When the focus is placed on the involuntary aspect of the relationship between client and therapist further resistance is generated. Families are usually involuntary and resistant due to feelings of powerlessness and invalidation. Since the focus of this model empowers families and validates them for what they are doing that works, the involuntary aspects of the relationship becomes less of an issue and cooperation is generated instead of resistance. Since the therapist focuses on what the family is _already doing_ that works, cooperation is developed (de Shazer, 1988). Interventions which build on this "fit" as all that is being asked is that the family continue doing something they are already doing, although the family does not recognize it as a solution:

> "This process of solution development can be summed up as helping an unrecognized difference become a difference that makes a difference" (de Shazer, 1988, p.10).

If something doesn't work, "do something different", however, once you know what works, do more of it (de Shazer, 1985, 1988).

PART III: THE PRACTICUM

CHAPTER 7

THE ORGANIZATIONAL ASPECTS OF CLINICAL PRACTICE

Setting

This practicum was completed at the MacNeill Clinic in Saskatoon, Saskatchewan. The MacNeill Clinic offers individual, group and family therapy services to clients referred to the clinic by self or by community referral sources (e.g., social service agencies, doctors, helping professionals) for outpatient treatment services. Treatment services are provided in the context of a multidisciplinary team milieu of helping professionals including social workers, psychiatrists, psychologists, and family therapists. The development of this practicum was organized to permit the student's completion of the Family Therapy Internship Program offered at MacNeill. Thus, the student actually conducted the clinical work for this practicum as a family therapy intern in the Youth and Family Program at the clinic. The internship was completed under the supervision of Mr. George Enns, Director of both the Youth and Family Program and the Family Therapy Internship Program at MacNeill.

Clients

The client group representing the primary focus of clinical intervention in this practicum was composed of adolescent family members who were identified as requiring treatment by their family or by community referral sources (e.g. social services, doctors, other therapists, school). The client group encompassed cases which included elements of parent-adolescent conflict and adolescent behavior "disturbances" involving truancy, defiance, running away, aggression, physical violence, delinquencies, withdrawal, and poor school functioning. Within this broader target group, a secondary focus of clinical intervention was with adolescents who had witnessed violence in their family. In such cases the family violence often represented a key factor contributing to the kinds of behavior listed above. Finally, in addition, the student also worked with two families in which the identified patients were of 7 and 8 years of age. In all cases, family therapy was the treatment of choice for the adolescent and their family. A total of eleven families were seen, involving a total of fifty-nine family therapy sessions. All families were assigned to the student by Mr. George Enns, at the Youth and Family Team's weekly team meeting.

Duration

The practicum was of four months duration extending from January, 1988 to April, 1988 inclusive. In conjunction with the internship program, the practicum involved full time study and practice from Monday

to Friday of each week over the entire four month period.

Clinical Supervision

The student benefited from a variety of clinical supervision modalities on an ongoing, weekly basis throughout the practicum. Primary supervision was provided on sight at the MacNeill Clinic by Mr. George Enns, Director of the Family Therapy Internship Program and Director of the Youth and Family Program. The clinical supervision provided by George Enns was complemented by clinical supervision provided by two additional family therapists on the Youth and Family Team. Each supervisor met separately with the intern each week for 90 minutes of individualized supervision of video taped family sessions or live supervision. The ongoing availability of three different clinical supervisors provided the opportunity to receive a range of orientations (styles) toward family therapy.

The student also benefited from live supervision of himself or other team members vis-a-vis a one way mirror on a weekly basis. In team supervision situations where the student was not conducting the actual therapy, he participated with the team behind the mirror in drawing assessment conclusions and forming intervention strategies. Supervision was also provided through ongoing case consultations and strategizing with supervisors and colleagues. There was also the expectation that the intern participate in a process of personal supervision and learning through the completion of reading assignments and ongoing preparation and review of video taped sessions of the intern's own clinical practice as

well as the clinical practice of other therapists at the clinic. Finally, in addition to the clinical supervision received on site at the MacNeill Clinic, external supervision was provided by the intern's graduate advisor, Ruth Rachlis, and committee member, George Buranyi.

Clinical Evaluation

In theory, the social work profession has long been concerned with evalutating the outcome of treatment services provided to clients seeking assistance. Evaluation is, in part, an ethical issue in that it addresses the question of how to provide the most effective service through the least intrusive means, in the most cost-efficient manner. Despite the significance of such a question, clinical practitioners are not always readily motivated to integrate formal evaluative components with the treatment services they provide clients. Lack of enthusiasm is, in part, a spin-off of the limited applicability that some evaluation instruments have in clinical settings. Trute (1985), for instance, points out that the use of comprehensive measuring instruments is not always time effective within clinical settings in that they frequently demand too great a time commitment given the perceived limited benefit to the therapist and client. Enthusiasm about using formal measuring devices is also dampened by practitioners who believe evaluation is obtrusive in the context of therapy. Such a belief frequently reflects the therapist's unfamiliarity with formal evaluation or a sense of inadequacy in utilizing evaluation instruments. Therapists are also reluctant to utilize evaluation devices as they frequently perceive

outcome evaluation as an evaluation of their clinical skill and competence. Such beliefs are somewhat short sighted as, in fact, most clinicians are quite familiar with evaluative processes as the process of therapy itself always involves questions of evaluation: How is the problem defined? Which treatment strategies are most appropriate? How is the client responding to the direction in which treatment is moving?

Trute (1985) points out that the evaluation of family therapy practice represents a far more complicated process than the evaluation of individually focused practice simply because, in family therapy, the clinical focus is upon more than one person. Evaluation of family therapy must address the transactions between people. Consequently, when evaluating family therapy practice "one must consider multiple levels of communication encompassing both verbal comments and non-verbal behavior" (Trute, 1985 p.103). Thus, attempts to evaluate family practice must utilize multiple measures instead of just a single measuring instrument or approach.

The system of evaluation to be applied in this practicum will include multiple measurements at two basic levels of family therapy practice:

(1) Outcome level: measuring family change;

(2) Process level: measuring the intern's skill development as a family therapist trainee (adapted from Trute, 1985).

Outcome Level: Measuring Family Change

The system of measuring outcome in this practicum was based on a pre-test post-test design component as well as a single system time

series design involving the application of the Family Assessment Measure (FAM III) and the Morrison Centre problem checklist respectively.

Pre-test, Post-test Measurement: FAM III (APPENDIX A,B,C)

All families seen in this practicum were required to complete the Family Assessment Measure. The FAM was administered on a pre-test basis immediately before the first assessment interview and on a post-test basis immediately following the therapist's last session with the family.

The FAM is based on Canadian norms for both clinical and non-clinical populations (Trute, 1985). It is comprised of three scales, each of which have a number of subscales. The General Scale, composed of 50 items, assesses family functioning along 7 subscales including: task accomplishment; role performance; communication; affective expression; involvement; control; and, values and norms. Measures of social desirability and defensiveness are also included. The General Scale measures the family's overall functioning as a whole system.

The Dyadic Relationship Scale, comprised of 42 items and 7 subscales, examines relationships between specific pairs of family members. The Self Rating Scale, also composed of 42 items and 7 subscales, measures an individual family member's perception of his/her functioning in the family. The evaluation of outcome was operationalized by utilizing the General Scale.

The reliability co-efficients for the FAM Scale range from .86 (for children on the Self Rating Scale) to .95 (for adults on the Dyadic Relationship Scale). The use of the FAM Scale was particularly relevant

for this practicum given the target population and the model of intervention to be employed. First, the General Scale has demonstrated reliability and validity in distinguishing between "problem" and "non-problem" families. This aspect is particularly congruent with the context in which treatment was offered, namely: Family dysfunction is a matter of degree and reflects temporary "derailment" from normal life cycle processes. The symptoms which families present in treatment reflect situational difficulties experienced by most ordinary families. Second, the Family Assessment Measure highlights family strengths as well as family problems. This also is congruent with the model of intervention employed which focused on strengths. Third, the FAM can also be utilized to test hypotheses formulated in the initial stages of treatment. Finally, the FAM provided a comprehensive analysis of family functioning in a relatively unobtrusive manner. Completion of the instrument took approximately twenty minutes.

Not withstanding these points, the FAM inventory is probably most appropriately used in situations of longer term therapy where efforts are directed at altering the overall organizational structure of the family system. To cover this bias a problem checklist, similarly aimed at measuring family change, was employed where possible, on a single system time series basis. Problem checklists provide a sound measurement of specific behavioral changes or goal attainment and have been identified as having merit in evaluating short term intervention (Trute, 1985). As such, problem checklists are particularly relevant for the brief therapy focus on initiating specific behavioral change as the goal of therapy.

Time Series Measurement: Problem Checklist (APPENDIX D)

All families in the practicum were required to complete a problem checklist developed at the Morrison Centre for Youth and Family Service (see appendixes, the Morrison checklist is not copyrighted and is reproduced without written consent). Although the intent was to administer the problem checklist on a time series basis, this was not always possible given the small number of sessions with some families. In all cases the checklist was administered on at least a pre-test and post-test basis, immediately before the first assessment interview and immediately following the therapist's last session with the family.

While problem checklists are weak in their generalizability and empirical strength, they provide a sound method of evaluating progress in respect to the accomplishment of treatment goals which are focused on specific target behaviors (Trute, 1985). This utility is particularly relevant to brief therapy.

Process Level: Measuring Skill Development as a Family Therapist

The measurement of family change or therapeutic outcome, per se, does not necessarily tell the clinician about whether or not the family has received skillful therapeutic services (Trute, 1985). Consequently, an additional level of evaluation is required to measure the quality of therapeutic services provided. In this respect, the evaluative segment of this practicum integrated three different components aimed at measuring the writer's progress in developing effective skills in

conducting family therapy: (1) formal supervision and evaluation with clinical supervisors; (2) personal journal writing; and, (3) the Client Feedback Scale. The Client Feedback Scale was developed by the therapist solely for this practicum and is untested.

In conducting process evaluations there is a need to utilize a number of varying measurements as certain instrument features may not be relevant to the model of intervention employed in therapy. This need arises out of the fact that there is no "one approach" to family therapy. Different models of therapy advocate different approaches to treatment. Across these approaches, there is little uniformity concerning the skills, techniques and strategies which are highlighted and emphasized. Particular aspects of some evaluation instruments, then, may be more congruent with different models of intervention and less so with others. This possibility is particularly crucial in respect to measurements which rate skill development. Depending on the context of therapy, particular skills to be measured in the rating scale may not be applicable or desirable given the model of therapy employed. This must be kept in mind throughout the evaluation process.

Formal Supervision and Evaluation

The process of formal supervision and evaluation provided on site during the practicum represented a major means of evaluating progress and development as a family therapist. Clinical supervision was provided on a weekly basis by three different individuals. The perspective of the different supervisors enriched the learning and supervision process.

Formal evaluation of the therapist's development was conducted with the therapist's supervisors at mid-point in the internship and at the completion of the internship.

Personal Journal

A personal journal was kept throughout practicum with the exception of the last three weeks. Entries were made to the journal on a daily basis. The journal was used to record issues and questions related to the therapist's development that arose over the course of the internship. The journal was meant to be a self reflective document aimed at tracing the writer's personal process of development.

Client Feedback Scale (APPENDIX E)

All families seen during the practicum were asked to complete a short questionnaire aimed at measuring their satisfaction with the therapy provided. The Client Feedback Scale was administered to each family member immediately following the therapist's last session with the family.

PART IV: CASE ILLUSTRATIONS

Introduction

A total of eleven families were seen over the course of the four month practicum, involving a total of fifty-nine family therapy sessions. Four family therapy sessions were conducted in front of the team. There was a wide sampling of economic and occupational backgrounds in the families seen in therapy - ranging from those on social assistance to those in upper income groups. A sampling of occupations among the eleven families includes a bank manager, student, housewife, teacher, cook, nurses and a university professor.

Of the eleven families, six were single parent families parented by women, four were intact families and one was a blended family composed of a father and his commonlaw wife. In three of the families there was a history of family violence in which the mother was repeatedly victimized over a period of years by the father or father figure (i.e., live in boyfriend). In all of these cases the perpetrator was out of the home at the time of therapy. In each of these cases, the adolescent, identified as the problem, witnessed violence in the home. In two of these cases, where the adolescent was male, violence and aggression was still a major theme in the home and often represented the adolescent's primary method of problem resolution. Violence and aggression represented the primary problem in two other cases, however, this aggression was directed outside the family. In these cases no disclosure of domestic violence was received.

All families were seen for an assessment interview (or two) before a contract for therapy was offered. No more than five sessions were

offered in the initial therapy contract. If services were still required at the completion of the initial contract then additional sessions were contracted for with the family. All family members were seen together for the assessment interview(s). Attendance at later sessions was altered according to the particular needs of the family. Subsequent sessions involved the family unit as a whole, a parent, the adolescent, and, with one family, the I.P.'s grandparents. In one case, therapy involving the adolescent was completed and the focus shifted to couples therapy.

All but one of the eleven families seen for an assessment interview entered into a therapy contract. The one family that did not, dropped out after the first assessment interview. Of the ten families entering into contracts, two remained in treatment at the completion of the practicum and were transferred to other therapists. Services were completed in the remaining eight cases. The average number of sessions for these eight families was six.

In order to provide a thorough analysis of the brief therapy model in practice, the number of case illustrations chosen for presentation is restricted to two. Each of these case illustrations provide a synopsis of the therapeutic process and integrates the salient issues which arose in the therapist's own development with respect to the case.

One of the two case illustrations demonstrates brief therapy of a family in which the adolescent I.P. had witnessed domestic violence. The names of family members, and other identifying information, has been changed in order to preserve confidentiality.

CHAPTER 8

CASE EXAMPLE: COMPLEX PROBLEMS DON'T ALWAYS REQUIRE COMPLEX SOLUTIONS

Circumstances Surrounding Referral

Mrs. L. contacted the clinic, on the recommendation of a government youth service, in order to receive therapy for her and her son, Jay. Mrs. L.'s initial request for service was based on the following reasons:

- Jay was angry at everything. Although he followed rules, he was disrespectful and rude;

- When Jay became disrespectful, Mrs. L. resorted to slapping him, which in turn led to shoving (retaliation) on Jay's part, and further hitting, on Mrs. L.'s part, so that the physical confrontation escalated to outright violent confrontations;

- Mrs. L. was seeking help in order to find more appropriate means for her and Jay to express their anger.

Summary of Assessment Interview

Mrs. L. and Jay were both present for the assessment interview and for all other sessions. Mrs. L. (50) was a registered nurse and was employed as a Departmental Assistant at the local university. She lectured third and fourth year students. Jay (16) attended high school and was enrolled in a Grade 10 program. Jay was the youngest of three male children in the family. Mrs. L.'s two other children, Warren (26), and Matt (25), were both in the Armed Forces and were stationed elsewhere in Canada. Jay's father, Mr. L. (49), resided in the United States.

In 1978, Mrs. L. and the children returned to Canada from the United States where they were residing with Mr. L. Mrs. L. separated from Jay's father two years earlier, in 1976. Mr. L. was physically violent toward Mrs. L. and toward Jay's older brothers. Mrs. L. decided to leave the relationship when her husband began to physically abuse the older boys. Jay indicated that he did not witness much of the violence that his father directed toward his mother or brothers. Jay did indicate, however, that he witnessed numerous episodes where Mrs. L. directed violence toward his brothers. Jay also witnessed episodes of violence between his brothers.

Jay had a total of four visits with his father since his parents separated. Mr. L. was an alcoholic dating back to years when the family was together. He has since remarried while Mrs. L. remained single.

In defining and exploring the problem, Mrs. L. took responsibility for her behavior. From Mrs. L.'s point of view, Jay did not appreciate

her, or how difficult it was for her as a single parent. When Jay became rude, Mrs. L. became extremely angry, struck out and continued to do so until Jay fled. Mrs. L. recognized that her behavior was unacceptable and she was embarrassed and remorseful about it, particularly given her experience as a victim of violence herself. Mrs. L. speculated that Jay's disrespect was related to her tendency to "smother" him as she constantly reminded him and worried about him. She also wondered whether Jay was angry at her for leaving Mr. L.

Jay denied the latter explanation but agreed that he felt smothered and that this contributed to his verbal disrespect. From Jay's point of view his mother did not treat him as a 16 year old. This "put him in a fighting mode", and once a fight began his mother wouldn't back down.

Throughout the interview both Jay and his mother presented as very verbal and quite open. Jay assumed a protective role in relation to his mother by assuming the larger portion of responsibility for the presenting problem despite his mother's clear statement that she was partially responsible for the conflict. During the interview Mrs. L. made frequent physical contact with Jay, patting his knee, as though to reassure him. Mrs. L. watched Jay intently as he spoke and occasionally "moved in" to answer for him. She frequently asked his opinion when responding to a question.

This family had many strengths. For instance, Mrs. L. had already identified some of the patterns which were contributing to their difficulty (e.g., her tendency to smother Jay) and both Ms. L. and Jay indicated a clear desire to change.

Structural Assessment of the Family

This family was characterized by a diffuse generational boundary. The mother occupied an overinvolved position in relation to her son and the son complemented this by assuming a protective role by worrying about his mother, and assumed an inappropriate degree of responsibility for the problem. This structure was supported by a dysfunctional pattern of interaction in which the mother persistently pursued the son by reminding him about chores, daily activities and, in the process, communicated distrust and invalidation of her son's ability. The son would become irritated with this overinvolvement and, in an attempt to establish distance, verbally abused the mother, in turn refuting her primary goal of receiving respect and appreciation. The mother, in turn, resorted to her primary means of defence and problem resolution over the years and physically lashed out at the son, leading to his attempts to establish more distance by pushing and shoving the mother away, leading in turn to more of the same response by the mother. These periods of conflict were followed by guilt and embarrassment, on the part of Jay and Mrs. L., and led to reconcilliation and fusion, reinforcing the cycle of built-up worry and overinvolvement.

Thus, Jay's behavior represented an attempt to establish greater distance between his mother and himself, but the resulting guilt drew Jay and Mrs. L. into greater proximity. This rigid pattern prevented Jay from negotiating appropriate development tasks and left him in a vulnerable position to face the developmental task of separation from a position of confidence.

Treatment Goals

- To establish a clearer generational boundary and greater distance between Mrs. L. and Jay so that Jay was free to confidently negotiate appropriate developmental tasks and Ms. L. was able to function on a daily basis without anxiety and worry in relation to Jay.

- To alter the interaction pattern between Jay and Mrs. L. so that Mrs. L. communicated in a less intrusive manner and Jay communicated in a more mature, respectful manner.

- To establish involvement between Jay and Mrs. L. that supported clear personal boundaries and neutralized the pattern of guilt - fusion - anger - distancing.

Therapy Contract

The therapist and the family agreed to meet in two weeks time from the assessment interview at which time the need for ongoing sessions was to be evaluated.

Intervention Process

There was a total of three sessions, including the assessment

interview, with this family. The first two sessions were conducted in front of the team. There was also one planned follow-up telephone call, approximately one week after the last session.

After the therapist completed the assessment portion of the first interview he took a break and then returned to deliver the following intervention message consisting of compliments, a reframe and tasks:

Therapist	I've talked with my colleagues about the things we've discussed today, and, in talking with them, it is clear that we are all very impressed with the two of you and we would like to compliment you on somethings.
(Compliments)	Mrs. L., you know, it's clear that you have a lot to offer the situation and it's obvious, from what we've talked about, that in many ways you already have some solutions in mind. (Ms. L. smiles and begins to laugh in relief.) I'm really struck and impressed with your openness. To be able to come in and discuss things as openly as you have today is really exceptional.
	And, Jay too, I'm really impressed with you. Teenagers often find these situations difficult and you were able to participate and be open throughout. And, also, you are _very_, _very_ perceptive. I'm really struck with how perceptive you are. A good example of this is how _you know how important it is to you_ to go to school, to do your homework. You recognize how important it is to you, to do it _for you_; That's very perceptive on your part. (Jay smiles.)
(Reframe)	What strikes me and my colleagues is that in many ways, the anger really isn't the problem (mother looks slightly surprised).
	What the problem really is, is that you both worry very much and feel guilty very much (mother nods and says m m hum). This worry and guilt builds up and builds up until the two of you end up getting angry; but, in many respects the anger is only secondary.

The guilt and worry is the crux.

Mother	So, we need to find some way to get through that part.
Therapist	What occurs to us is, you've already thought of some solutions and, the two of you are already saying you want, something different; that, it's time to do something different;
(Task)	And, I'd like to ask you if you would be interested in doing an experiment over the next two weeks (Ms. L. and Jay nod approval).

Over the next two weeks I'd like you to experiment with this.

Ms. L., I'd like you to pay particular attention to what you can do, to what works, that helps Jay feel like an adult. Pay attention to the kinds of things you do which reinforces Jay feeling like a man, moving into adulthood. You know, it could be that, you're going to stop nagging him about the day; stop getting him up in the morning.

So, pay particular attention to the things that work.

And, Jay, we feel it's important that you take advantage of the opportunity this will present you with to, show how independent and how much of a man you can be.

Pay attention to and do somethings to, demonstrate to your mom and show your mom that you can be responsible like an adult. This might involve showing that you appreciate your mom. So, you might decide to make your own supper, or supper for you and your mom without telling her or asking her; you know, do things on your own . . . . ., things, that show you appreciate her. Like, you might just give your mother a hug.

I would like you to, put into action, the things that show you are responsible and you appreciate your mom.

Second Session

Both Ms. L. and Jay completed their tasks and reported dramatic changes during the two weeks between the first and second sessions. Mrs. L. reported that she was able to separate herself from an issue Jay had at school so that he handled it on his own; extend Jay's weekend curfews; not nag him about the day; not run his bath water, and allow Jay to go "cruising" with his friends. Jay managed his increased autonomy in a responsible manner, complimented his mother and even gave her a hug. Jay related that he felt his mother was trusting him more and treating him like an adult. Given these shifts, Mrs. L. and Jay did not have any verbal or physical outbursts.

The reports provided by Mrs. L. and Jay clearly confirmed that Jay's verbal and physical aggression represented an attempt to create greater distance between Mrs. L. and himself. As Mrs. L. moved to a less intrusive position, Jay behaved more responsibly and showed appreciation for his mother. There were no incidents of violence between Mrs. L. and Jay. This, in turn, reinforced Mrs. L.'s move to a less involved position and neutralized the pattern of guilt - fusion - anger - distancing. On occasion Mrs. L. alluded to how difficult it was to resist becoming involved with Jay. This was taken as an opportunity to further validate Mrs. L:

> "You love your son and want to ensure he is cared for. At the same time, you recognize he will have to leave the nest some day. In spite of how difficult it was for you to resist doing things for him, you managed to stay out. That reflects how much you truly love your son and how strong you are as a parent".

The process of the second session, then, highlighted and built upon the solution oriented patterns which Mrs. L. and Jay were reporting. To ensure such an emphasis the following kinds of questions and comments were delivered by the therapist:

- "You have had wonderful success over the past two weeks! What sense do you make out of this success?"

- "With you pulling back, Mrs. L., what changes have you noticed in Jay's behavior? What sense do you make out of all of these changes?"

- "What, Jay, have you noticed your mom doing that helps you behave like an adult? How do you interpret your mom's changes?"

- "Well, Jay, it's clear that you have had plenty of opportunity to demonstrate how mature you are. I'm interested in what kinds of things you have done."

- "How did you resist being pulled over to Jay?"

- "What, Mrs. L., were you and Jay doing that was different, when things were going well?"

- "When things were going well, what were you and your mother doing different?"

- "How has this change affected your relationship?"

- "On the whole, what do you attribute your success to?"

- "What's your sense of what you need to do to keep going in this direction?"

- "If this success continues, what will things look like, what will you, Jay, and you, Mrs. L. be doing?"

These kinds of questions oriented both Mrs. L. and Jay to their success patterns, and in the process reinforced a continued expectation of beneficial change. The latter questions resemble the "miracle question" as they direct Mrs. L. and Jay to a future in which their problems are absent.

Based on Mrs. L.'s and Jay's task performance, and the preferred patterns which emerged for each of them during the first two sessions, it was evident that a cooperative mode could be promoted by providing clear tasks which encouraged Jay's independence. However, this would have to be done in a way that did not invalidate Mrs. L.'s need for respect and recognition. In providing the tasks, consideration also had to be given to the emotional pulls which Mrs. L. was still feeling toward Jay and the protective position Jay often assumed in relation to this. Given these factors the tasks were aimed at providing Mrs. L. with a focus other than Jay that was validating of her, and "normal" given this family's life cycle stage. After complimenting both Mrs. L. and Jay for the changes they had made between sessions, the therapist delivered the following message and tasks:

Therapist — "As you, Mrs. L. and you, Jay, <u>continue in the direction that you are presently moving</u>, your time together will be less, but <u>it will be more enjoyable</u>. Naturally, each of you will have more free time on your hands. To occupy your free time I would like

(Task) — you to consider trying some things. Mrs. L., to occupy your free time the team would like you to consider the following:

- One team member thinks that if Jay is out late at night <u>you should stay out and come home later than him</u>;

- Another team member feels that you are still a very attractive and interesting woman and, after all, like all teenagers <u>Jay will have to eventually leave the nest</u>. He <u>thinks you should consider getting remarried</u>.

- Another team member feels that if Jay forgets to take the garbage out, you should dump it in his bedroom.

These are just some ideas to consider. I believe <u>in all likelihood</u>, Ms. L., <u>you will come up with your own ideas and solutions</u> about what you can do with your free time, and these are likely to be best.

(Task) Jay, to <u>avoid the temptation of falling back into your old ways</u> I would like you to consider the following:

- <u>You, wake your mom up</u> in the morning before she can wake you up;

- <u>Make decisions on your own</u>, before talking to your mother, and then tell her about the decisions you've reached.

In closing, the therapist delivered the following message:

It also occurs to me that <u>you have had extraordinary success</u>. To <u>avoid the disappointment of having a sense of failure</u>, that is imminent after such success, and to avoid forgetting where you have come from, I would like you to pick one day every week and revert back to what you were doing in the past. On that day I would like you, Ms. L., to nag Jay; and, Jay, I would like you to act irresponsible.

Prescribing the symptom in this manner set the stage for the third, and final session, with this family three weeks later.

Session 3

In the third session Ms. L. and Jay reported that they had "backslid", by arguing with one another, however, there were no incidents of physical aggression or violence. When this was explored ("Did this happen more in the first, second, or third week?") it became evident that the arguing did not take place until the last, of the three, weeks between sessions. Mrs. L. related that she had been "down" and that she took it out on Jay. She resorted to nagging and he, in turn, argued with her. This meant that the family had enjoyed success for four consecutive weeks and five in which violence was not at all evident. This information was crucial to the process of the interview and therapy as it provided a key success pattern to build upon.

In following up on the tasks, Ms. L. related that she didn't really have much free time. She looked in the "companions wanted" section of the newspaper and found two men who were of interest to her, however, she was too nervous to follow up on the ads. Jay found it impossible to wake his mother up as she simply got up early. However, he did make some decisions, regarding school, on his own. Mrs. L. was validated for having the courage to even look in the "companions wanted" section and was advised that in most cases the anxiety of trying something as different as this, would have immobilized most people. Jay was complimented for making decisions, that were good for him, on his own.

Despite continued success during the first two weeks, and the fact that there had not been any violent outbursts at all, both Mrs. L. and Jay came to the session focused on the arguing that had taken place

between the two of them. Maintaining this focus through the session would only have reinforced the patterns supporting the arguments. It was important, then, for the therapist to reorient the family to what they were already doing that was solution oriented and successful. Once you know what works do more of it (de Shazer, 1988). The therapist punctuated the fact that there were not any episodes of violence and that for four consecutive weeks Mrs. L. and Jay had not even had one argument. The "slippage" that took place was reframed as part of the typical road to change: two steps forward and one step back. Jay's behavior was reframed as a protective move to distract his mother from whatever was getting her down and she was complimented for raising such a sensitive son. The arguing was also normalized as something that happens in all families, particularly when teenagers and parents attempt to adjust to each other's changing needs. The process of the interview then punctuated and highlighted the patterns in which Mrs. L. and Jay were doing things which were good and useful in reaching solutions. This meant focusing on the time periods in which the complaint (arguing) was not evident (exceptions to the rule):

> "During the two weeks when things were going well you must have been going about your business. Ms. L. I'm curious to know what was different then?"

> "In total you've had four consecutive weeks without any arguing. During that four weeks what have you found your mom doing that has particularly helped you be responsible?"

> "What's your sense, Mrs. L., of what has helped you to resist being pulled over to Jay, during

> the four weeks when things were going well?"
>
> "What are you doing with your new found energy, Ms. L., when things are going well?"

This emphasis helped move the family to a greater sense of competency and solution oriented behavior. Both Mrs. L. and Jay began to share their fears and ambivalence about Jay eventually leaving home. These fears were normalized within the context of the family life cycle. Mrs. L. and Jay were then directed toward potential solutions:

> "What's your sense of what would help the two of you make this transition?"
>
> "What's your sense, Jay, of what your mom can do to help you with preparing for the world?"

Jay was then able to share that he needed his mom's support, but it would be most helpful if she could provide advice when he asked for it. This process helped to create distance between Jay and Mrs. L. and helped to establish a clearer boundary between the two of them.

Given the success that Mrs. L. and Jay had, the need for further sessions was reviewed. Mrs. L. felt that they were headed in the "right direction" and that further sessions were not needed. Jay agreed that they were headed in the right direction but he was worried that "they would blend back afterwards". Given Jay's ambivalence it was agreed that Mrs. L. and Jay would take a week to decide whether they needed to come back. Mrs. L. related: "We can't keep coming back forever. There comes a time when you gotta take it and go with it . . . . . especially if

you've been shown the tools". In closing the session both Ms. L. and Jay were complimented for their openness and desire to have a healthy relationship. They were then given the following tasks:

Therapist (Task)

- Mrs. L. I would like you to pay particular attention to what helps you to resist nagging Jay. If you become frustrated with something he hasn't done, then sing a song or go for a walk. Ms. L., do whatever it takes, that is different, to resist being pulled over to Jay's side.

- If, Jay, you require help or advice then ask your mother, otherwise, she will simply play the role of consultant.

- I would like you, Mrs. L., and you, Jay, to think further on whether you need to come for further sessions.

When contacted one week later, by phone, Mrs. L. advised that she and Jay had talked it over and decided that they didn't need to come back for further sessions at that time. Mrs. L. expressed pleasure with how Jay was doing. From her point of view, Jay was acting more mature. He had also received his highest marks yet in two courses at school. Mrs. L. related that she and Jay were "headed in the right direction and they just needed to keep doing so". She indicated that if in the future they needed a "check in" she would contact the clinic. The therapist validated Mrs. L. for her and Jay's success. The therapist prescribed that there will likely be some difficulties in the future, but indicated that some set backs are normal.

Evaluation

Outcome Level: Measuring Family Change

The FAM(III) General Scale and the Morrison Centre problem checklist were administered to the L. family on a pre-test basis, immediately preceding the first interview, and on a post-test basis, immediately following the final interview.

The pre-test profiles (Time 1) on the FAMs (APPENDIX F) completed by this family support the conclusions drawn in the therapist's own assessment. There is congruence between Mrs. L.'s and Jay's high scores on the Involvement and Control subscales suggesting a shared perception of how they function in these areas. Both Mrs. L.'s and Jay's profiles show elevated scores in these areas supporting the notion that this is an agreed upon problem area in which there is intense involvement, broken by chaotic periods in which Mrs. L. and Jay engage in covert power struggles escalating to violence. The elevated scores along the Involvement subscale supports the presence of an enmeshed, overinvolved relationship between Mrs. L. and Jay. High scores along this subscale reflect the involvement to an extreme degree, between Mrs. L. and Jay and the lack of autonomy that they both exhibit. The elevated scores along the Control subscale support the presence of shame-based attempts at control which are chaotic and characterized by covert power struggles. The periods of emotional distance triggered by the violence between Mrs. L. and Jay, are followed by shame and guilt which eventually reinforces continued fusion until the build up of frustration and worry, resulting from this, leads

to another explosive episode.

Outside the congruence that is evident in scores along the Involvement and Control subscales, Mrs. L. and Jay show considerable discrepancy in the areas of Role Performance, Communication and Affective Expression. Jay's scores on these subscales cluster together in the average range of functioning (Role Performance - 51; Communication - 52; and Affective Involvement - 47), while Mrs. L.'s scores are highly elevated (Role Performance - 83; Communication - 68; and Affective Expression - 63). This discrepancy possibly reflects that Mrs. L. was in a highly anxious state at the commencement of therapy. If accurate, this may have contributed to her motivation to change. Mrs. L.'s extremely high score on the Role Performance subscale reflects the difficulty and stress she was experiencing in adapting to her family's life cycle stage. Certainly, this adaptation was highlighted during the process of therapy.

The post-test scores (Time 2) on Mrs. L.'s and Jay's FAM profiles (APPENDIX F) reflect dramatic improvement in most subscale areas, particularly with respect to the problem areas of Involvement and Control. Both Mrs. L. and Jay scored these subscales within an average range of functioning. They again showed relative congruence suggesting a shared perception of improved functioning in these areas. The lower scores in the subscales of Involvement and Control can be attributed to the increase in emotional distance between Mrs. L. and Jay and the associated autonomy. This was, of course, interrelated with the absence of any violence, thereby neutralizing the shame based control patterns. While Mrs. L.'s score on Role Performance dropped significantly (from 83 to 70) it was still elevated to a level which reflects problematic

functioning. This attests to Mrs. L.'s struggle to adapt along with the life cycle transition she and Jay were in at the termination of therapy. Certainly, this transition was in full bloom during the last session. However, such tension can be framed as normal and situational.

The behavior checklist was administered on a pre-test (Time 1) and post-test (Time 2) basis given that there were only three sessions with the family. Again, there are some discrepancies between Mrs. L.'s profiles and Jay's profiles (APPENDIX G). Mrs. L.'s pre-test profile reflects a more negative assessment of her family's functioning than does Jay's pre-test profile. A comparison of the pre-test and post-test profiles indicates that significant change was perceived by both Mrs. L. and Jay in most of the twenty-four areas of family concern. An analysis of Mrs. L.'s pre-test/post-test comparison reveals that she perceived improved change in twenty-one out of twenty-four areas. There was no change in the remaining three areas, each of which was rated as "In between" before and after therapy. Of the four areas with which Mrs. L. was dissatisfied prior to therapy, three were rated as "Satisfied" at the end of therapy and the fourth was rated "In between". Of the eight areas with which she was "Very dissatisfied" prior to therapy, six were rated as "In between", one was rated as "Satisfied", and one was rated as "Very satisfied" at the end of therapy. A comparison of Jay's pre and post test profiles indicates that he perceived positive changes in fourteen out of twenty-four areas; seven areas remained the same (rated "In Between" "Satisfied" or "Very Satisfied" before and after therapy); and, negative change was perceived in three areas (Being patient and calm with others - from Satisfied to In between. Being consistent with discipline

- from Satisfied to In between; Making contacts with friend, relatives, etc. - from Satisfied to Dissatisfied). Jay's rating of "In between" in two of these areas may have reflected his ambivalence in terminating therapy as well as the "slippage" he perceived in the week preceding the final session. Jay's rating of Dissatisfied with respect to "contacts with friends etc" might be related to the possibility that he was more directly faced with this area of functioning by virtue of his increased distance from Mrs. L.

Process Level: Measuring Skill Development as a Family Therapist

Three components aimed at measuring the therapist's skill development, and the quality of service provided, were utilized in relation to this case. These components were: (1) the client feedback scale; (2) personal journal writing; and, (3) formal supervision and evaluation with the therapist's clinical supervisor and colleagues including feedback based on two interviews before the team.

The Client Feedback Scale was completed by Mrs. L. and Jay immediately following the final therapy session. Both forms reflect satisfaction with the quality of service provided (APPENDIX H).

Excerpts from the therapist's personal journal provide some insight into the issues which arose for the therapist in relation to this case. The excerpts also present a still shot of the supervision process with respect to this case. There were, in total, four formal supervision

sessions on this case. Three of these sessions centered on reviewing the video tape of interviews with the clinical supervisor. The other session was a preplanning session in which pertinent case issues were reviewed and an initial hypothesis was drawn. The therapist also had the benefit of working before the team for the first two interviews with the L. family. Each of these interviews was followed by a feedback session in which the therapist received concrete information from each team member about the strengths and weaknesses observed during the session (APPENDIX I). Highlights of this feedback are also reflected in journal excerpts:

March 9, 1988 - Day No. 39

> I saw one family the L. family before the team on March 9, 1988. This was a 16 year old boy who was physically aggressive toward his mother. Largely, the cycle goes from the boy yelling at the mom (disrespect), the mom physically slaps the boy (her goal is to receive respect) and he tries to gain some distance by pushing her away which leads to further physical hitting on mother's part. This family has a history of family violence. The mother was abused over a period of years as were her two older sons. The I.P. witnessed violence in the home. This mother and son are enmeshed. The boy tries to establish distance by being disrespectful as mother is so intrusive. She starts to remind him of things from first thing in the morning. Mother refuses to "take" any disrespect so she resorts to the mechanism she best knows to defend herself - violence. This keeps the cycle going as they feel remorseful afterward and fuse leading to greater resentment, worry etc., then anger.
>
> In this case the model really is clear. I deal with the presenting problem and symptom and try to break the pattern. At this point we have agreed to a second assessment interview. As the mother puts it: "If things are going well over the next two weeks there is no reason that we can't continue it on our own".

Thus, even if one regards the past violence as something that needs to be resolved - - there is no contract to deal with it.

This was interesting in the sense that I thought I had a very good interview. I thought that I had tracked fairly well and explored certain areas that I needed to explore (e.g., separation, grandparents, role in the pattern, father's role in the pattern). The feedback from the team was that I did a nice job at the beginning of the interview (defining problem, joining) and in complimenting and task assignment. G. and M. felt that I could have tracked "deeper" instead of staying at the same level. Also, I tended to move away from the interaction between the mother and son when I explored the other areas. One team member disagreed slightly and thought I needed to explore these areas. So, I thought this is a wonderful chance for learning as I can review this tape with M. We did so on Friday, 11th. It was very helpful to receive feedback from her on how to go deeper, etc. What's helpful is having a sense you did something, then having to learn more in order to push the learning process deeper. This is never ending at the clinic and in the internship. As you learn and move ahead you are pushed to learn more. Also interesting was that during the break when we plan tasks and compliments, it seems that M. was pushing me more to come up with some of my own compliments and tasks instead of relying on the team.

Wednesday, March 23, 1988 - Day No. 46

Today was a busy day. It started with a regular team meeting, case assignments, then I did the interview in front of the team. Following this I had an interview with the P. family and then one with the L. family.

My interview in front of the team was interview No. 2 with the L. family. This was the first time I did a follow-up interview in front of the team. I had a clear agenda of what I wanted to follow. This was a very hard interview for me. It seemed that on one level everything was clear, yet on another level everything was unclear. It seemed like the mother and son had given me everything in the first fifteen minutes and then I simply seemed to be asking the same questions. I was trying to track deeper but it seemed like everything was staying at the same level. I came

out of the interview with a headache - - thereby really confirming the extreme enmeshment in this family. At one point the mother mentioned that one of the changes was that she was no longer running the bath water for her son!! I discussed this interview with G. He indicated that what was happening was that at a process level the family was pulling on me very hard to "join" their family. My resistance to this creates tension, intensity and keeps the therapist stuck. The therapist needs to break the intensity somehow by perhaps cracking a joke, making a comment. When this happens the pattern is broken, but then, the therapist needs to have a goal in mind so he can lead the family, otherwise, the pattern will start up again. G.'s information was helpful.

Friday, March 25, 1988 - Day No. 48

Today was low key. I had supervision with Margo and reviewed my interview with the L. family. She thought it wasn't a bad interview, that I had covered everything I set out to. But I could have taken it further. So, what else is new?? It seems like it can always be taken further.

CHAPTER 9

CASE EXAMPLE: THREE'S A CROWD

Circumstances Surrounding Referral

Mrs. Brock contacted the clinic to request therapy for her son, Paul, and herself. Mrs. Brock's initial request for service was based on the following reasons:

- Continuous conflict between Paul and Mrs. Brock centering on Paul's irresponsibility;

- Paul's irresponsible behavior including lying, truancy, late hours, losing his driver's licence;

- Suspected use of drugs and alcohol.

Summary of Assessment Interview

The assessment interview was attended by natural mother, Marcie Brock (38), and Paul (17). Ms. Brock was a registered nurse and had a history of employment in various health care settings. Ms. Brock had received earlier therapy at the clinic, off and on over a period of three years, in relation to the breakup of her second marriage. Paul attended high school, in Grade 12 and held down two part-time jobs. Ms. Brock and Paul had been seen at the clinic for one session of family therapy, three years earlier, and then dropped out.

In addition to Paul's "irresponsible behavior", Ms. Brock also expressed concern about the stress she was feeling at work and in connection to the relationship with her boyfriend, Fred. Ms. Brock showed some ambivalence in viewing Paul's behavior as totally irresponsible and acknowledged his responsibility in holding two part-time jobs. Paul defined himself as the problem, stating that he doesn't "do his part", and is unable to contribute anything at home.

With the exception of her mother's frequent involvement, Ms. Brock largely raised Paul on her own. Ms. Brock separated from Paul's father during her pregnancy with Paul. Ms. Brock indicated that she and Paul's father were too immature to maintain the relationship. Paul's father lived in the same city but, Paul had not seen his father since he was 8 years of age. Ms. Brock recently made a contact with the father on Paul's behalf, however, the father was not willing to see Paul. Ms. Brock's second marriage ended in divorce, after four years.

Ms. Brock's second husband did not assume a parental role with Paul. According to Ms. Brock, the relationship ended because she and her second husband were not compatible. At the time of the assessment interview Ms. Brock was in a relationship which she characterized as "stressful at times".

In raising Paul, Ms. Brock frequently turned to her mother for support. At one point, Paul lived with his maternal grandmother for six months when he was 14 years of age. Ms. Brock described a pattern whereby her mother would respond to Ms. Brock's requests for support by criticizing her, taking over the parent role and aligning with Paul. Ms. Brock also described a pattern whereby she would discipline Paul, as

a child, and then not follow through because she would feel guilty. Ms. Brock would also do things for Paul because it was easier than putting her foot down. Ms. Brock speculated that this pattern, along with emotional problems she has had over the years, and the absence of a father for Paul have all contributed to the current situation. Paul downplayed the latter two explanations.

Throughout most of the interview, Ms. Brock presented as anxious and tentative. She tended to define herself as powerless in the face of life's stresses. Rather than taking a clear position of validation in relation to Paul, she more clearly focused on the very few areas that he was irresponsible, thereby invalidating his independence and responsibility.

Paul presented as subdued and distant. He adopted a protective position in relation to his mother by defining himself and his behavior as the problem. Paul frequently looked toward his mother when responding to questions as though to ensure he did not deviate from his protective role.

Structural Assessment of the Family

The primary dysfunctional interaction pattern in this family supported the existence of a diffuse generational boundary between Ms. Brock and Paul. Ms. Brock historically assumed an overly responsible position in relation to Paul, thereby blocking him from acquiring the confidence and freedom to address appropriate developmental tasks of adolescence such as identity, independence and autonomy. Paul's

dependencies were reinforced by a dysfunctional interaction pattern in which Ms. Brock focused on that part of Paul's behavior that was irresponsible, thereby invalidating his current responsible behaviors. Paul's misbehavior, in turn, served a protective function in that it provided a focus other than the issue of separation associated with the family's life cycle stage of adolescence. Paul's behavior also provided Ms. Brock with a focus other than her own pain, loneliness, and the decisions she had to make in connection to her relationship with Fred.

Treatment Goals:

- To establish a clearer generational boundary between Paul and Ms. Brock, thereby freeing Paul to address appropriate developmental tasks related to adolescence and freeing Ms. Brock to directly negotiate other concerns in her life including her relationship with Fred.

- To strengthen Paul's confidence in addressing developmental tasks by shifting the interaction pattern in this family so there was a greater focus upon the responsible behavior Paul was demonstrating.

- To empower Ms. Brock so that she was stronger to address conflict and relationship issues directly instead of avoiding and deflecting them through her triangulation of Paul.

Therapy Contract

The therapist and the family contracted for an additional assessment interview from which a contract for five sessions of family therapy was agreed upon.

Intervention Process

There were a total of seven sessions, including two assessment interviews, with this family. Of the seven sessions, four were with Ms. Brock and Paul; two were with Ms. Brock and her partner Fred; and, one was with Ms. Brock alone.

Based on the first interview it was evident that Ms. Brock and Paul were facing a developmental crisis related to the adolescent life cycle stage and that other stresses, associated with Ms. Brock's relationship with Fred, were impinging upon this transition. In this context, Ms. Brock remarked: "I'm terrified for when he leaves". It was clear that, as part of completing this transition Ms. Brock would have to squarely face the issues in her relationship with Fred. Paul was caught in a triangle with Ms. Brock and her partner and was fulfilling a protective function by allowing his mother to deflect the anxiety and ambivalence from her relationship with Fred, onto himself.

However, the "miracle question" revealed that Ms. Brock envisioned a successful future in which Paul was demonstrating that he could "be an adult", "someone who can be responsible for himself". Paul's miracle included a vision in which he could take his share in instrumental

functions such as housework, contributing financially. This was different than assuming responsibility for affective functions, yet, it represented a good "fit" for the mom's vision that Paul be responsible. This provided a clue as to what and how change needed to occur.

At the completion of the first session Ms. Brock and Paul were complimented and then asked to complete the following research task during the two weeks between sessions:

Therapist (Task)	Between now and our next session, at the end of every day, I would like each of you to individually rate the day on a scale from one to ten (where ten is the highest and one is the lowest) according to how well you think things have gone between the two of you. Pay particular attention to what you are both doing differently and what is happening that is different, on the days which you rate five and above. Disregard all other days.

The purpose of this task was to orient Ms. Brock and Paul to the things they were already doing which were solution directed and which could lead to spontaneous change through the ripple effect. The research task also provided information about solution patterns which could form the basis of the next session (and future sessions) along with an emphasis upon broadening the problem definition to include Fred.

Second Session

The purpose of the second assessment interview was threefold: first, to build upon and punctuate the success patterns which emerged through Ms. Brock's and Paul's report on the research task; second, to more clearly define Fred's involvement in the family; third, to

establish a clear contract for therapy.

In following up on the research task, both Paul and Ms. Brock reported that twelve out of fourteen days were good (an average of "7" and above). As Paul verbalized: "There is a different cycle". This "different cycle" is much like the snowball rolling down the mountainside and demonstrates the power of the "ripple effect". Paul had taken initiative in completing chores around the house and Ms. Brock was pleased about this. Ms. Brock, in turn, did not nag Paul and they had some good conversations. Paul related that he felt much better about himself and wasn't as worried about the future. Thus, the process of the interview punctuated these patterns:

> "To what do you attribute your success, Ms. Brock?"
>
> "On successful days, what were you and Paul doing differently?"
>
> "What's your sense of how Paul has taken more initiative?"
>
> "What sense, Paul, do you make out of the presence of this different cycle?"
>
> "What can your mom and you do to keep going in this direction?"
>
> "What has your mom done to help you worry less about the future?"

Through this process solution patterns and a positive context emerge. This creates the expectation of further change. The validating nature of this process created a climate in which Ms. Brock and Paul could begin to address pertinent developmental issues. They talked about "growing pains", independence, "mid life crisis".

The freedom was also created to begin tracking Fred's involvement in

the family:

> "When Paul is taking on more responsibility, and you're not having to nag him anymore, what are you doing with your extra energy?"

Ms. Brock reported that she was not as stressed about her relationship with Fred and that she was making a firm commitment to him. Ms. Brock related that she and Fred were looking for a house and that they would be moving in together shortly.

Toward the end of the session Ms. Brock and Paul were complimented on the success they had achieved in the two weeks between sessions. The "issues" they were facing were framed as normal and an expected part of the life cycle transition in which they were in the midst. Paul was then dismissed for a few minutes so that the therapist could deliver the following intervention:

Therapist: I'm <u>really impressed with the success you've had</u> over the past two weeks. What I'm really impressed with, is how you've managed to not nag Paul, you've <u>let him be responsible</u>. That's wonderful because that leaves him to wrestle with his own conscience, his own guilt. That's one of the best ways to help him prepare for the adult world.

Ms. Brock: What do you mean?

Therapist: Well, it's natural for parents to nag their kids because they worry about them, especially at Paul's age. The thing is, when parents nag their kids, especially teenagers, the child never has to feel their own guilt about not doing things they should do. All their energy goes into blaming their parents, and rebelling, because of the nagging.

Ms. Brock: Nods and acknowledges the logic behind this.

Therapist: What I'd like to suggest is that you just <u>keep</u>

> doing what you're doing. Try not to nag Paul. If he doesn't do his chores, or is irresponsible, try not to nag. Let him wrestle with his own guilt. You might even want to compliment him on the things he does well over the next three weeks. That will help build his confidence.

Ms. Brock agreed to the task and then sent Paul in alone to talk with the therapist. Paul was complimented on his responsible behavior over the past two weeks and was asked to:

1) continue doing his chores and behaving responsibly on his own initiative;

2) keep track of what he appreciated about his mother and complimented her on this.

The family and the therapist contracted for five sessions of family therapy. The following session was scheduled for three weeks later.

Session Three

The process of the third interview was critical in that it began to free Paul from his triangulated position. Ms. Brock and Paul reported that things were not as positive as they were between the first and second session, however, things were still much better then before the start of therapy. Paul continued to take on responsibility at home, although to a lesser degree. Paul was also able to compliment his mother on several occasions. Ms. Brock was unable to totally refrain from nagging, however, both she and Paul thought that the nagging was still noticeably less. In fact, Paul and Ms. Brock had only one "fight" over the course of the three weeks between sessions and it became clear that

this was strongly related to stress in Ms. Brock's relationship with Fred. The therapist attempted to challenge the pattern of triangulation yet punctuate the success that Ms. Brock and Paul did have:

Therapist: What sense do you make out of this change?

Ms. Brock: I attribute it to the move and to my relationship with Fred.

Therapist: How did you see it Paul?

Paul: Well, that was when she lost her cool.

Ms. Brock: I was waiting for Paul to come home and wanted to cry on his shoulder. When he came home, I just blew up at him.

Therapist: So, he was your trigger valve that night?

Ms. Brock: I have to have someone to yell at and he's the only one who comes so. . . .

Therapist: So, is that the only fight you have had in three weeks?

Ms. Brock: Yes

Therapist: Well, that's marvelous. In spite of how stressful things have been with the move and Fred, you've only nagged Paul once.

Paul: (to his mother) Well you can't just stop doing every thing; you wouldn't be a good mother.

Therapist: You've done a wonderful job with your son. He's very sensitive, very protective of you.

Ms. Brock: Sometimes I think too much. Lots of times he wants to take half the blame and he isn't to blame.

Ms. Brock acknowledged that her tension in relation to Fred had spilled onto Paul and she took responsibility for managing her tension with Fred in this manner. The process of the interview, then, helped

Paul and Ms. Brock to see that the issues between Ms. Brock and Fred were "their issues" and not Paul's.

After taking a short break, toward the end of the session, Ms. Brock and Paul were complimented on how well they had done considering the recent stress associated with the upcoming move and their discouragement with having slipped slightly. Their slippage was normalized as part of the change process. Paul was then dismissed and the following intervention was delivered to Ms. Brock alone:

Therapist: Basically, I think that <u>you're on the right road</u> and heading in the right direction. In spite of the one disagreement you and Paul had which we talked about, you've really done an excellent job at not nagging and leaving him to be responsible. What's exceptional about all this, is how open and willing you are to <u>take your share of the responsibility for things</u>. You recognize that <u>your problems with Fred spill over onto Paul</u>. Because of that, <u>you're a lot further ahead</u> than a lot of others. I really think that you need to <u>keep doing what you've been doing, you're on the right track</u>. If you can think of yourself as Paul's consultant, it might help.

Ms. Brock: Consultant?

Therapist: Yeah, what I mean is <u>try and take a consultant role</u>. If you need to set limits with Paul like curfews or chores, tell him that you prefer he do certain things, but, leave the decision to him. That will help him take responsibility for things.

The therapist then spent a few minutes alone with Paul and delivered the following message and tasks:

Therapist: I really want to compliment you on how well you've been doing. I'm also impressed with how sensitive and protective you are of your mother. I think that one of the best ways you can help your mother,

> is to <u>not worry about her</u>, because she worries about you worrying.
>
> So, I'd like you to keep doing what you've been doing to show your responsibility. This will help her worry less. I'd also like you to pay attention to what helps you not to worry about your mother.

The next appointment was scheduled for one month later, thereby reinforcing the notion that Ms. Brock and Paul were on the road to a solution.

Session 4

Ms. Brock and Paul followed through on their tasks from the last session. On the few occasions that Ms. Brock was able to take a consultant role with Paul, it worked positively. Paul indicated that there was no need to worry. Both Paul and Ms. Brock reported that things were going well between the two of them. However, Ms. Brock indicated that she was quite unhappy with her relationship with Fred. Between sessions they had completed the move together and Ms. Brock was particularly unhappy about having to look after Fred's son and the lack of support Fred was displaying overall. Ms. Brock did not talk with Fred about these issues and her resentment had built up.

Paul reported that he was unaware of his mother's unhappiness and that she had not been nagging him. Ms. Brock agreed that her stress had not spilled over onto Paul. This change suggested greater distance between Ms. Brock and the presence of a clearer generational boundary. This "exception to the rule" was punctuated and highlighted through a number of sequences:

Therapist: Well last time we talked you mentioned that when things aren't going well with Fred, this spilled over onto Paul. How has this gone?

Ms. Brock: I find myself getting defensive with Fred.

Therapist: But, it hasn't come out in nagging?

Ms. Brock: No.

Therapist: Wonderful!

Therapist: Paul, I know that you're a sensitive person, have you picked this up from your mother?

Paul: Not really.

Therapist: So, you've been able to go about your business without worrying about your mother.

Paul: Yeah.

Therapist: This is wonderful. What sense do you make out of this? What has been different?

In line with the emphasis in this model, the process of the interview punctuated and highlighted the ways in which Ms. Brock resisted nagging Paul and the manner in which Paul was able to go about his business.

During this session Ms. Brock clearly acknowledged the pattern of how her tension with Fred spilled over onto Paul and she was able to acknowledge how this pattern of triangulating Paul impeded his development. Ms. Brock eventually indicated that she wanted specific help with her relationship with Fred. This was eventually built to, through a number of sequences in the interview:

Therapist: When your thermometer was rising did you say anything to him?

Ms. Brock: No.

Therapist: What's your sense of what would happen if you did?

Ms. Brock: He would get angry and defensive.

Therapist: Well very quickly you've become like a wife and a mother. That's a hell of a load. This is very unhelpful for you. If you continue to keep these things inside you might end up with headaches, depression; your resentment might spill over onto Paul . . . . .

Therapist: Well if I asked you to tell Paul what his job is in life right now what would you say Ms. Brock?

Ms. Brock: To be responsible for you. That's the main thing.

Therapist: You see, Paul, if you worry about your mom - you won't be able to do what your mother wants you to do.

Paul: I always thought I could do both.

Therapist: These are the things that catch Paul in a dilemma and make it difficult for him to leave the nest. (The therapist then compliments Ms. Brock for not nagging Paul even when under stress.)

Ms. Brock: It would be very hard for me to do the nagging, like before, again.

Ms. Brock: (Talking about her relationship with Fred.) I don't know if through this whole thing I was just kidding myself. I don't know if this would overwhelm anyone. I feel wound up, unclear and cloudy.

Therapist: From here, it seems clear. Feelings don't go away. They might stay inside; they might give you a

> headache; lead to depression or spill over onto Paul. When things are unresolved resentment builds up. I am prepared to meet with yourself and Fred to coach the two of you on this. This would be a beautiful gift to your son. Some day he will be married and one of the nicest gifts would be to show him how to problem solve in an intimate relationship.

Ms. Brock indicated that she would ask Fred to attend some sessions with her in order to try and resolve some of their differences. The contract was re-evaluated to include two sessions with Ms. Brock and her partner Fred and one session to review and evaluate the need for continued sessions with another therapist as the internship was coming to a close. The decision about whether or not Paul should be included in any of these sessions was left to the family to decide.

Before ending the session separate time was spent with Ms. Brock and Paul. Ms. Brock related that her attempts at playing the consultant role had worked well. Ms. Brock was encouraged to continue taking a consultative role with Paul in order to continue promoting his independence and responsibility. The following message and task was also delivered:

Therapist: <u>You've done a wonderful job with your son</u>. He is so sensitive, especially to your needs. My only concern is that he is so sensitive that he might sacrifice his own development.

Ms. Brock: I don't want that at all.

Therapist: The more that you can do to convey to Paul that <u>you can work it out</u>, that <u>it's your issue</u>, that <u>he's not responsible</u>; the less responsible he will feel and the less he will worry. So, I'd like you to

keep doing what you're doing as a consultant. I'd also like you to do whatever you can to convey to Paul that you and Fred can resolve your own problems. You're already on the road.

Individual time was then spent with Paul:

Therapist: Did you have a chance to think about what helps you not to worry?

Paul: Yes. I realize that she's been through it and can handle it. She's an adult. There's also you. She has people to relate to.

Therapist: Well, I really want to compliment you for how well you've handled this whole thing, especially for being able to go about your business. I would just like you to continue what you have been doing that's worked. When you start worrying about your mom do something to distract yourself; watch television, listen to the radio or go for a walk. If it gets unbearable just ask her if there is anything you can do.

It was clear that Ms. Brock's issues with Fred were not being addressed and that the stress of this relationship had been spilling over onto Paul, creating a diffuse generational boundary between Paul and his mother. This dysfunctional pattern of triangulation blocked Paul's development and Ms. Brock's resolution of issues. Once a frame had been established to promote greater distance between Ms. Brock and Paul, through the ripple effect, this pattern was exposed and a clearer generational boundary was drawn. This freed Paul from the triangulation and empowered Ms. Brock to begin squarely addressing the issues in her relationship with Fred.

Sessions Five and Six

Two sessions of couples therapy were conducted with Ms. Brock and Fred before the case was transferred to another therapist. It was clear from these sessions that Ms. Brock's attempts to negotiate with Fred were blocked by Fred's defensiveness. Fred interpreted Ms. Brock's challenges to negotiate as "overly charged". Rather than following through on the negotiation, to break through the defensiveness, Ms. Brock withdrew, leaving issues unresolved. This withdrawal, in turn, led to a build-up of more frustration and resentment before it spilled over onto Paul or was discharged in a subsequent "overly charged" confrontation between Ms. Brock and Fred. This led to more defensiveness on Fred's part and a continuation of the pattern.

The first of these two sessions was much like an assessment session. Effort was made to identify "exceptions to the rule" in which Ms. Brock and Fred were able to negotiate successfully. During the second session effort was made to highlight and normalize much of their current stress as transitional and "to be expected" given the fact that they had just moved in together and, in this sense, were blending families. Greater emphasis was placed on the exceptions during the past week in which the couple was able to negotiate and achieve compromise. It was evident that Ms. Brock was more ambivalent about the relationship then Fred. They were both validated for their efforts to make the relationship go.

After the second session it was agreed that the next session would be a review session to determine whether a case transfer should take place. Ms. Brock and Fred were given the assigned task:

Therapist: Each night Ms. Brock and Fred I would like you to do the following:

> Go somewhere private. Each take five minute turns sharing the concerns that you have about something that the other has done that day, and what that person can do to resolve the concern. After each has taken a turn, you are each to take another turn at sharing what you were particularly pleased about in respect to your relationship. Alternate who starts from day to day.

By doing this task Ms. Brock and Fred were "doing something different" in the area of the complaint. The latter part of the task also focused each of them toward something positive in their relationship and directed them to share this. Finally, the task was built on an exception pattern in that both Fred and Ms. Brock described scenarios in which most of their successful negotiations took place when they were alone and away from the kids.

Session Seven

Ms. Brock attended this session alone and reported that she and Fred had four very good days after the last session. She indicated that they did not have to do the assigned task. Instead Ms. Brock had made a list of pros and cons concerning her relationship with Fred and she reviewed this with Fred. She felt that Fred had really "heard her out" and that this had contributed to the four good days. Ms. Brock indicated that she wanted to work things out in the relationship instead of quitting. Ms. Brock also indicated that she did not feel the need to continue sessions in relation to Paul but she requested that sessions continue for Fred. The remainder of the session highlighted the achieved solutions.

Evaluation

Outcome Level: Measuring Family Change.

The FAM (III) General Scale was administered to both Ms. Brock and Paul on a pre-test basis, immediately preceding the first interview, and on a post-test basis, only with Ms. Brock as Paul was not present at the final interview. The Morrison Centre problem checklist was also administered: to Ms. Brock before the first interview, after three sessions, and after six sessions; to Paul only before the first interview and after three sessions.

The shape of the pre-test profiles (Time 1) on the FAMs completed by Ms. Brock and Paul (APPENDIX J) are generally congruent, however, Ms. Brock's scores are extremely elevated in comparison to Paul's. This perhaps reflects that Ms. Brock was the "client". In this regard Paul's willingness to come for therapy is consistent with the protective position he adopted in relation to Ms. Brock. Certainly, Ms. Brock's scores, ranging from sixty-four to eighty-three across all subscales with the exception of Communication, reflects a high level of distress.

Comparison of the two profiles reveals that Ms. Brock and Paul similarly perceive the problem in functioning to lie in the areas of Task Accomplishment, Affective Expression, Involvement and Control. These are the four areas in which Paul's profile shows scores elevated into the problem range, along with Ms. Brock's profile. Interpretations of the scores along these four subscales supports the therapist's assessment that Ms. Brock and Paul were having a difficult time responding to life

cycle changes, and changing life events. There is evidence of insecurity and a lack of autonomy among family members (Involvement) supported by the presence of shaming attempts to control often characterized by overly intense emotions (Affective Expression) and involvement. Ms. Brock's extreme scores on the subscales of Task Accomplishment (83) and Role Performance (83) clearly reflect an inability to adapt to the change in roles and circumstances involved in the evolution of the family life cycle, in particular the stages of adolescence and launching children.

The post-test scores (Time 2) on Ms. Brock's FAM (APPENDIX J)reflect significant improvement in all subscale areas except Values and norms and Communication. The score on Values and norms remained the same and the score on Communication actually rose. The most dramatic change in scores was evidenced along the subscales of Task Accomplishment (from 83 to 63), Role Performance (from 83 to 51) and Affective Expression (from 82 to 62). The improvement along the former scales suggests an increased ability to adapt to the life cycle changes impinging on Ms. Brock. Along with the subscale of Role Performance Ms. Brock's profile also suggests improvement into the average range of functioning in the areas of Involvement and Control. Improved scores on these subscales support the presence of a clearer generational boundary between Ms. Brock and Paul, implying greater emotional distance and autonomy.

Comparison of the completed behavior checklists reveals some discrepancy between Ms. Brock's profile and Paul's profile that is consistent with the discrepancy observed in their FAM profiles (APPENDIX K). Ms. Brock's Time 1 profile reflects a much more negative assessment of family functioning than does Paul's profile. This is consistent with

the extreme scores on her FAM pre-test profile. Nevertheless beneficial change was perceived to have occurred by both Ms. Brock and Paul. A comparison of the Time 1 and Time 2 profiles completed by Ms. Brock reveals that she perceived beneficial change in 22 out of 24 areas of family concern. In the two remaining areas (Participation in family fun and recreation; Feeling good about myself) no change was perceived and each was rated as In-between at both time measurements. A comparison of Ms. Brock's Time 1 (prior to therapy) and Time 3 (at the completion of therapy - seven sessions); profiles reveals that beneficial change was perceived in nineteen out of twenty-four areas of concern; no change was perceived in four areas (Being positive, saying nice things about others; Making sensible rules; Being able to discuss what is right and wrong; Feeling good about myself, were all rated as In-between at both measurements); and negative change was perceived in one area (Participation in family fun and recreation, went from In-between to Dissatisfied). While a comparison of these profiles clearly reflects a perception of change, one must note that seventeen of the areas were rated as "In-between" by Ms. Brock. This suggests a great deal of ambivalence on Ms. Brock's part at the time of the third measurement.

An analysis of Paul's Time 1 and Time 2 profiles indicates that beneficial change was perceived in fourteen out of twenty-four areas of concern; no change was perceived in seven areas; and negative change was perceived in one area (Dealing with matters concerning sex went from Satisfied to In-between).

In summary, the profiles do indicate that both Ms. Brock and Paul perceived significant change to have occurred. This is particularly true

when one compares the measurements taken at Time 1 (before therapy) and at Time 2 (after three sessions) since the Time 2 measurement was taken at a time when both Ms. Brock and Paul felt they had slipped slightly. For a closer examination of the behavior checklist profiles, the reader is referred to the actual checklist.

Process Level: Measuring Skill Development as a Family Therapist

The components used to measure the therapist's skill development, and quality of service, in this case were: (1) the Client Feedback Scale, (Cantafio, 1988); (2) personal journal writing; and, (3) formal supervision and evaluation with the therapist's clinical supervisor.

The Client Feedback Scale was completed by Ms. Brock upon completion of the final session. Paul did not complete the scale, as he was not present for this session. The feedback provided by Ms. Brock reflects satisfaction with the quality of service provided (APPENDIX L).

Excerpts from the therapist's personal journal highlight issues which arose for the therapist in the context of his own personal examination as well as those which emerged in the supervision process:

<u>January 26, 1988 - Day No. 12</u>

> This day turned out to be a long day in terms of hours. I started with supervision with J.T. J.T. took a more directive approach, structuring how I could approach the family I was going to see that she is supervising me on. We went through the interview model together. Some of this was helpful; some not, as I have conducted several interviews so far. This session of supervision accents the differences in each supervisor. I

think I will learn different things from each person.

I finished the end of the day with an assessment -- a 17 year old boy and his mother. Presenting problem relates to the boy's irresponsibility and associated conflict. My hypothesis is that this boy's behavior reflects a difficulty in negotiating the separation and launching that is forth coming. Mother has assumed a very involved role with her son and he feels ill-equipped to address responsibilities. This was a good interview as I was able to engage both. I was also more aware of my tone and their's. They (mom) presented as very defeated. I thought it was different to utilize myself to alter this tone. This interview now completes six full assessment interviews. I feel that I am now into it. But, is this totally it?

Tuesday, February 9, 1988 - Day No. 22

Today started with supervision with J.T. It was very helpful. We finished viewing my tape of the B. family and then strategized as I am seeing them later today. From supervision and feedback I've picked up that I need to take things further in detail: tracking, miracle questions, etc., so that the family is always being moved in the direction of the therapeutic goals.
I met with the B. family for first follow-up. Both the boy and the mother reported twelve out of fourteen days went well. The boy attributes this to simply doing more around the house, thus his mom nags less, he feels better. She reports that she is feeling less stressed out. Clearly, this is an example of where the de Shazer, brief model, particularly doing something different, from the family's point of view has had a major impact. The next appointment with this family is scheduled for three weeks down the road. This boy's and woman's affect were much more alive today then two weeks ago. This reflects their much more positive orientation.

Tuesday, February 16, 1988 - Day No. 27

I had two supervision sessions today. The first, with J.T., involved a review of an assessment report, hypothesizing and strategizing re: The B. family. J.T. is really good at helping me think more systemically, particularly in respect to

complementarity of relationships. We also looked at part of the second session with the B. family. I could have used my "self" more in this interview; i.e., tone, and excitement at the family's progress.

Tuesday, March 1, 1988 - Day No. 34

The other session was with the B. family. This was their third session. The mother and the 17 year old boy reported that things were not as positive as the time between the first and second session, but things were still better overall, then before they came in. This family will be back in one month's time. We may follow this up with one additional session before I leave.
In both these sessions I tried to focus on having a strong position in the system. I tried to track more and maintain a clearer focus.

Tuesday, March 29, 1988 - Day No. 50

I started the day with having supervision with J.T. first thing in the morning. We reviewed the last interview with the B. family. I thought, on the whole, that this was a good interview. I found some of this supervision time frustrating in the sense that I did not feel that I got to show some of the good sequences of the interview. Anyway the advice J.T. gave was absolutely excellent and I used it in the interview I had with B. mother and her son, Paul in the afternoon. I was clearly able to establish and clarify the dysfunctional pattern in the family. Mother triangulated the boy by falling on him for support, nagging him, whenever she has conflict with her boyfriend. It was a nice interview. I eventually worked it so that the mother is coming in with her boyfriend for a few sessions before I leave.

This case provided an excellent vehicle for the therapist's learning process as it challenged the therapist to a greater awareness and sensitivity to the systemic principle of complementary pairings; triangulation, whole patterns; and the generalizability of systemic principles. At the onset of therapy with this family the therapist

tended to focus on only one half of the complementary pairing between Ms. Brock and Paul. In other words, the emphasis was upon Ms. Brock's overinvolvement and intrusion with Paul. However, "with work" the therapist's thinking did shift to observe the complementarity of Ms. Brock's and Paul's functioning: As much as Ms. Brock seemed to be the overinvolved mother, it became evident that Paul enabled this through his protective positioning. Paul's protectiveness was as much a factor in blocking the developmental process as was Ms. Brock's overinvolvement.

The therapist's understanding of triangulation deepened as he became more aware of the need to view patterns in their entirety. In the therapist's initial thinking he placed emphasis on Ms. Brock and Paul, and neglected the impact that Fred had on the family. The therapist's thinking gradually shifted to include Ms. Brock's partner. Once the therapist began to think of the pattern more fully he was able to direct therapy in a way that exposed the pattern of triangulation and shifted the focus onto Ms. Brock and Fred. Finally the generalizability of systemic principles crystallized for the therapist when the principles behind his thinking remained unchanged although the focus in sessions moved from the mother and son to the wife and husband.

PART V: DISCUSSION AND CONCLUSIONS

Introduction

The organization of this practicum has encompassed two major components. The first of these components, and perhaps the most articulated, is the application of an integrated model of brief therapy with families lodged in the adolescent stage of the family life cycle. As an adjunct, some attempt has been made to test the efficacy of brief therapy with more complex cases in which children have witnessed family violence. The application of this clinical model has involved the acquisition of assessment, intervention skills needed to practice family therapy and so the second of these themes relates to the process of tracing the writer's skill acquisition and personal development as a family therapist. Discussion and a number of conclusions can be reached with respect to each of these components.

Personal Development as a Family Therapist

An examination of the therapist's experience in the internship reveals that there are several "psuedo-stages" involved in the process of developing as a family therapist. The stages to be discussed reflect the therapist's self-analysis based on his experience as a family therapist intern. After an initial "joining" phase in which the intern is quickly introduced to his colleagues and the mechanics of the internship (supervision times, evaluation dates, scheduling sessions, meetings), the intern slips into a stage which is experienced pretty much as a regression in skills, knowledge and competency in conducting

therapy. It is as though the intern has left all of his skills, his tricks, his knowledge in a bag at the front door. "Stripped" of his/her skills, the intern is ripe for learning. This stage of development is best described as "not knowing what you don't know".

What becomes apparent, sometime later, is how much of the therapist's earlier practice was based on intuition and instinct. Given this intuitive base to practice, part of the learning process involves supplanting the therapist's intuition with increased knowledge relating to family therapy practice. This involves a process of deepening the therapist's understanding of concepts (e.g., boundaries, complementary pairings, punctuation) and skills (e.g., tracking, reframing, validating) and how these fit together. This process introduces more sophisticated interpretations of practice and leads to increasing confusion and losses in clarity. An excerpt from the therapist's journal illustrates this experiences:

> "I felt myself moving from clarity to more and more muddiness. This, I think is the learning process - - - from confusion comes gradual clarity. I'm wondering how muddy this will get. I have found this - - - that, whereas I was feeling clearer earlier - - - I am now becoming unclear and muddy. It leads one to question confidence, competence."

The confusion that characterizes this stage of development points to and substantiates the importance of having a theoretical framework, such as the structural model, from which to work. In the absence of such a framework the therapist is much more likely to be pulled blindly into the family system. While the structural framework does not eliminate the family's emotional pulls upon the therapist, it helps the therapist

respond more effectively to such pulls. de Shazer's model of intervention, in and of itself, can be criticized on the grounds that it does not provide the therapist with a framework for understanding the family. In practicing the integrated model of brief therapy in this practicum (which includes de Shazer's brief therapy model of intervention), the therapist relied heavily on the structural framework to organize observations. The structural framework provided the therapist with a backdrop upon which to rely in the confusion of working with some of the families. With such confusion the therapist came to rely more on the framework and, in the process, achieved a beginning clarity in how to use the framework to advantage in practice. By this stage of development the therapist has advanced to the stage of "knowing what he doesn't know". Once at this stage the therapist has a clearer sense of the process of therapy, his strengths, and weaknesses in conducting therapy, however, the therapist's ability to transfer his increasing knowledge, awareness, and clarity into practice is more inconsistent, then consistent. Two excerpts from the therapist's personal journal reflect this:

<u>Monday, February 29, 1988 - Day No. 33</u>

> Today I started the morning by preparing for my mid-term evaluation which is tomorrow. For the most part, I was clear on what I thought my areas of weakness and strength are. It's curious to note that in some respects "I have learned what I don't know" - - this is the flip of "not knowing what you don't know". It's an interesting way to conceptualize learning. As I have been gradually coming to understand some of the concepts more fully I become more aware of the little I have known about some of these concepts. So, in some respects, the first stage of learning is recognizing that I don't know a great many things (that

perhaps I thought I knew) then learning about them in a fuller, more accurate way.

Tuesday, March 1, 1988 - Day No. 34

> Today was a relatively productive day. I had my mid-term evaluation with C., M. and J. Basically, what I was seeing in myself was confirmed by others. G.'s emphasis was for me to concentrate on "my position in the system". I need to be more definite and assume more of an expert position. This will encourage my interventions to have greater impact. M. thought I was "right where I want to be". I need to concentrate on taking more leadership and keep forging ahead. J.'s sense was that I had a nice set of skills; my work is free of personal issues. At this point I feel my learning process has started, partially, with "discovering how much and what I don't know". I am stronger in terms of the framework, but there is a definite gap in putting it into practice.

The next stage of development involves moving to an increased feeling of confidence and consistency in being able to practice therapy in an organized fashion based on the particular clinical model in mind. This stage of development is described as "knowing what you know". This stage of development is characterized by an increasing clarity and understanding with respect to systemic principles and the points of emphasis which underline the clinical model of choice. The therapist is more often clear then unclear. When the therapist is unable to actualize and manipulate these principles in practice the therapist is most often aware then unaware. At this level of practice the therapist generally has a sound appreciation of how change is enacted through his clinical model and a solid foundation for continued developmental growth has been laid.

The therapist's level of development along these stages was clearly reflected in the comparison of his practice at the beginning of the

internship and at the end. During the beginning stages of the internship when the therapist was learning the brief therapy model, he found it more difficult to assume a leadership position with families and maintain a focus during sessions on a consistent basis. Interventions tended to be "soft" as the therapist was not conducting therapy from a position of confidence. As the therapist became clearer about systemic principles and how the clinical model worked, there was a significant change in his practice. With greater clarity achieved, the therapist was able to assume a stronger position in the therapeutic system. This was reflected in an increased ability to take leadership during sessions, maintain a focus, specify clearer goals, expose patterns, and direct the process of sessions and therapy toward change. This developmental process is captured in a journal entry:

Friday, April 8, 1988 - Day No. 57

> Today I had my second interview with R. family. M. supervised me live but I didn't use the bug. I thought this interview went very well for a number of reasons. I was clear; I took leadership, and I did a nice job of tracking. The other thing is that both the son and mother reported improvement and success over the past week. This means that the tasks I had assigned last time around were appropriate and instigated some change. I think this interview generally reflects my increased clarity, and sureness as compared to where I was at earlier in the internship. I've also worked harder at establishing a stronger position with families and I think this has happened some. I still need to work on this however.

A number of different components were encompassed in the process of tracing the intern's development as a family therapist. Included among these components were: formal clinical supervision meetings and

evaluation with clinical supervisors; live clinical supervision; self-examination, review and evaluation of therapist's personal video tapes; observation and analysis of live and videotaped interviews conducted by other therapist (team members, supervisors); personal journal writing and reflection; and, analysis of the Client Feedback Scale.

The components which aided the therapist's development most, were those which directly examined the therapist's own work and the work of others and did not require a second interpretive process. Among all components, the process of clinical supervision presented the therapist with the greatest opportunity to learn and develop. By this, is meant the series of steps involved in preparing for supervision meetings (self-analysis of taped interviews), the actual meeting itself (review of tape with supervisor, feedback and discussion, strategizing for next session with family), and trying out what was made salient in the process. While live supervision was occasionally advantageous, in that it allowed the supervisor to view an entire session, it did not play as significant a role in the intern's development as ongoing supervision meetings. In fact, some disadvantages were observed. Practically speaking, it is simply not possible to provide live supervision with enough frequency. Secondly, because of the time factor, it does not allow for a cross-section of the intern's work over a number of different cases. It is noteworthy to mention, however, that live supervision is particularly helpful in situations where the therapist becomes stuck with a family and needs immediate direction in an interview to become unstuck.

The process of observing other therapists conduct interviews, either live or on videotape, represents the second most significant aid to

developing family therapy skills. Such observation promotes learning in two ways. First, it allows the developing therapist to observe the process of therapy (e.g., engaging, tracking, leadership, focus, reading process) and the execution of interventions (e.g., task assignment, delivering messages, marking boundaries, reframing) performed by more advanced therapists. This provides a modelling function. Second, it allows the developing therapist to learn from the mistakes that others make. This is particularly the case in observing live interviews, where the developing therapist is able to assume the position of therapist from the other side of the mirror. The power of this learning is illustrated in the following excerpt:

<u>Wednesday, March 16, 1988 - Day No. 44</u>

> Today started with our regular team meeting and then team interview. This was a good learning experience for me in that I was able to view the therapist make several errors, ones that I have made, and see it in living colour in someone else. The therapist continued to cut people off, and was, or seemed, unaware of this. Then when G. had her direct the father to talk to the daughter she continued to intervene when they (father and daughter) were doing a nice job. This was helpful for me to observe as this is exactly what I had done in an earlier interview, with the M. family. This type of learning was quite powerful as I was able to detect the problem on the other side of the mirror. It also demonstrated the strength and power of being in the room with the family and how the therapist can get caught into their own goals, and hypothesis, agenda, and lose touch with the family.

What this, and the suggested value in clinical supervision points to, is the important role that modelling and "trial and error" play in the

process of becoming a family therapist.

The benefit or utility of the remaining components in developing skills and competency as a family therapist was somewhat limited. The personal journal was used on a daily basis to document and reflect upon pertinent issues which arose in the internship in relation to cases, supervision, self-examination. Over the course of the internship the journal actually served little purpose in the process of development. In fact, the therapist stopped making entries into the journal with three weeks left in the internship. However, the journal has served a useful purpose as a retrospective document in that it does highlight particular themes and provides a cross-section of the issues which did arise in development.

Finally, an analysis of the Client Feedback Scales, completed by family members, did not reveal any patterns with respect to the therapist's skill development. Overall, feedback was positive regardless of the time completed, the number of sessions, or the complexity of the case (APPENDIX M).

In summary, the process of clinical supervision and observing the work of other therapists represent the most salient components in promoting the intern's development as a family therapist. This speaks to the importance of modelling, practicing, and learning from one's own and other's mistakes in conducting therapy.

Conclusions About The Brief Therapy Model of Practice

The brief therapy approach and the structural framework, which

constitute the basis for the integrated model of brief therapy in this practicum, each brought important aspects to the process of conducting family therapy. The structural approach has provided a framework for observing the family as a system, assessing the family's organization and level of functioning. Together, with other principles of brief therapy, the structural framework has defined the direction for therapeutic change. The brief therapy principles underlying the model, largely taken from de Shazer (1975a, 1975b, 1980, 1982a, 1982b, 1985, 1988) has oriented the therapist toward establishing a cooperative mode of therapy that is built upon validating families for what they are doing that is good; highlighting and punctuating a family's success patterns; helping families to create a vision of a satisfactory future in which the complaint is absent; and, establishing a context for unavoidable change that is beneficial.

In accordance with the philosophy of brief therapy, much of the emphasis in therapy was placed upon creating a small change, with the intent that through the "ripple effect" this change would snowball to eventual solution. Frequently, this involved prompting family members to do something different from what they were doing that was contributing to their complaint. This approach to therapy is consistent with principles of brief therapy which emphasize that only a small change is required to initiate a series of additional changes leading to solution. In fact, de Shazer advocates that all that is required is that the troubled person or family member(s) do something different in order to alleviate their troublesome situation (1985).

The therapist's observation of family change while working from this

model, throughout the practicum, certainly indicates the validity of these principles. Time and time again the therapist observed evidence of the ripple effect, based on an initial small change or a "change of difference". Not withstanding these observations, a critical point is to be made: Any of the therapist's interventions aimed at creating a small change or a change of a difference, which were of any success, were always preceded by a thorough, accurate assessment and understanding of the family's organization, structure and functioning based on the structural framework. Such an assessment, along with "exceptions to the rule" and the client's vision of a satisfactory future, pointed to the desired direction of change and helped establish a "frame" to move the family in the desired direction. For example, the desired direction of change in the L. family was to create greater distance between Mrs. L. and Jay based on the structural assessment that Mrs. L. and Jay maintained a fused, over-involved relationship. Thus, a reframe was developed to create distance, not proximity. Brief therapists maintain that such a structural assessment is not necessary. Their belief is that the solutions which people apply to their problems exacerbate the problem so that the solutions become the problem. The concern of the brief therapist is with creating a "second order change" by intervening to change the client's attempted solutions and not the problem itself. Thus, de Shazer speaks of prompting the family members to "do something different" from what they normally do in response to the problem.

de Shazer claims that "it is not necessary even to be able to construct with any rigor how the trouble is maintained in order to prompt solution . ." (1985, p. 7). The details of the complaint are

important only in how they are different from how family members behave when the problem is not present or less evident - - - during "exceptions to the rule". From de Shazer's point of view, "exceptions to the rule" represent the crux of promoting change as exception patterns describe what is different when the problem is not evident. Thus, patterns of exceptions indicate the direction of change and provide clues about how family members can behave differently (do something different). After the therapist elicits these exceptions, the key to promoting change rests on helping the family do "more of the same", more of what already works, as outlined by exceptions to the rule.

If exceptions to the rule can be generated a detailed assessment is not essential, as exception patterns provide the information necessary to plan interventions and promote change in a beneficial direction. In fact, exceptions generated by the family will describe situations of "distance" or "involvement" depending on whether family relationships are characterized by "enmeshment" or "disengagement" respectively. Thus, in responding to the exception question, Mrs. L. and Jay described a situation in which there was greater distance between the two of them. Both described a situation in which they went on an outing together. The important differences outlined by Mrs. L. and Jay revolved around their observations and conclusions that they were able to relate to one another as adults, on an equal level. From Mrs. L.'s point of view, Jay behaved maturely, and treated her with respect. Consequently, she did not have to nag Jay. From Jay's point of view, his mother did not impose herself or nag him. She treated him like a 16 year old . This helped Jay to feel more mature. Not surprisingly, the outing Mrs. L. and Jay described

involved going to a movie - - a situation in which they could be together, yet not be overly involved with one another.

The miracle question is complementary to exceptions to the rule as it further expounds upon the direction of change. The miracle question elicits notions of what family members will be doing differently when the reported complaint is solved. In effect, these notions further outline the direction of change and provide measurable goals to evaluate success. In the L. family, Mrs. L. described a "miracle" in which she would not be nagging Jay. Jay would be responsible and be able to look after himself. Mrs. L. described a future in which Jay would be functioning as separate and independent. Jay described a miracle in which his mother allowed him more freedom, one in which he and his mother were not arguing and fighting, and one in which his mother was able to go about her own business. Thus, both Mrs. L.'s and Jay's responses to the exception question and miracle question described situations of greater emotional distance. These responses are consistent with what one would prescribe as the direction of change based on a structural assessment. Given this, one might argue that "exceptions to the rule" and the "miracle question", in effect, due represent an assessment as they provide information upon which the therapist bases intervention.

de Shazer maintains that information based on "exceptions to the rule" and the "miracle question" is all that is necessary in order to plan interventions and promote change. However, in the practicum, in at least one case in which an accurate assessment had not been achieved, in conjunction with "exception information", and "miracle information", the frames and interventions utilized did not fit. No evidence of a ripple

effect was observed and change was superficial. Asking the family to "do something different" created little impact in altering patterns because what family members were asked to do missed the mark.

The family history in this case was characterized by years of family violence directed at the mother as well as her children. The mother's primary concern centered on the effects of the violence upon her children. The mother was unable to "control" her adolescent daughter's behavior. The daughter was displaying noncompliant behavior, a very poor self-image and had begun to run away with increasing regularity. Both the mother and the daughter were able to articulate responses to the exception question and the miracle question, however, interventions based on these responses were repeatedly ineffective. As therapy progressed it became apparent that the mother's parents (daughter's grandparents) assumed a very overinvolved position in relation to their granddaughter and the family's functioning in general. It became clear that the initial assessment of this family's organization and functioning was incomplete as it did not take into account the diffuse generational boundary and the intergenerational alliance that existed between the adolescent girl and her grandparents. Any attempt made by the mother to "do something different", based on the initial exception and miracle questions, were invalidated by the grandparents, leaving the mother in a powerless position relative to her daughter. Once a more accurate assessment of the family's organization was achieved, the therapist was able to promote some change by drawing a clearer generational boundary and positioning the mother in an appropriate executive position in relation to her daughter. In effect, interventions based on "exceptions

to the rule" and the "miracle question" were of minimal influence in promoting change because the family structure was misread. Certainly, if more attention would have been focused on <u>what was maintaining</u> the problem(s) (i.e. the grandparent's overinvolvement), intervention would have been much more successful earlier in therapy. This case illustrates the importance of completing a thorough assessment in developing effective intervention strategies. Such an assessment is vital at least as an adjunct to "exceptions to the rule" and the "miracle question" despite de Shazer's assumptions to the contrary.

The conclusion that a thorough assessment is essential represents a direct challenge and criticism to de Shazer's assumption, one which underlines this model, that "it is not necessary even to be able to construct with any rigor how the trouble is maintained in order to prompt solution" (1985, p.7). But what, then, is going on when de Shazer makes this assumption? First, de Shazer talks about "without any rigor" which implies that some assessment is possible but it is not required in any detail. de Shazer's assertion is a <u>point of emphasis</u> much like the other points of emphasis which underline the model in this practicum. Secondly, de Shazer is making this assertion based on fifteen years (now more) of doing therapy. His understanding of families and family organization is second nature. de Shazer need not complete a "formal" assessment: "he just knows", without any rigor or detail, what is happening in a family. In fact, de Shazer alludes to assessment processes:

> "However, the therapist does not simply receive this information as a videotape does. He interprets the

client's interpretation of what is going on and constructs this interpretation on a general, goal-directed foundation: 'What will a solution look like?' That is, the therapist maps his perception of the client's interpretation and then maps his perception of his own interpretation. The differences between these two maps point in the direction of the potential solutions and provide the framework for intervention design" (1985, p.62).

Are these maps different than structural maps? A similar level of practice was observed in more advanced therapists at the clinic who often would introduce frames and interventions to other team members without first explicating their assessment in detail.

The conclusion reached in this practicum is that an accurate and thorough assessment of the family, its structure, and the pattern surrounding the complaint is a necessary part of formulating effective interventions. Interventions can be aimed at initiating small changes but effectiveness is frequently influenced by an accurate assessment and understanding of the complaint pattern. What is clear from this model, however, is that the emphasis in therapy is not on the patterns which maintain the problem, but instead, on the success oriented patterns the family portrays. The power and effectiveness of the model lies in this emphasis.

Implicit in the discussion above is the notion that the therapist's structural assessment helps indicate the direction of therapeutic change. The model's integration of structural concepts in this manner qualifies the brief therapy notion that change, of any kind, is desirable and qualifies other related principles. While de Shazer and other brief therapists are clear in their emphasis upon the desirability of creating change, however small, they do not clearly address the issue of

"direction". According to brief therapists a small change in behavior, or shift in a pattern can, through the ripple effect, lead to eventual solution. However, the interactive principles which amplify a positive cycle are also the same principles which amplify a negative cycle, if change is initiated in the wrong direction. In fact, it is this sort of thing that has gotten families into trouble in the first place.

What de Shazer and other brief therapists are referring to when they say "do something different" is a class of behavior or change in a pattern that is beneficial to the family. In order for the change to be of benefit it must move the family in a direction that is opposite to the direction in which the family is moving. de Shazer talks of this when he refers to "changes of a difference", "beneficial changes" or "differences that make a difference". However, these references to therapeutic change are not at all clear. Based on these points one can conclude that change in and of itself may not produce therapeutic benefits unless it is change initiated in a particular or "right" direction. Change that is not initiated in the right direction, at best, may have a neutral effect. At worse, it may kick the family into a negative cycle, through the ripple effect. This speaks to the value of working from a theoretical framework that serves as a backdrop to organize observations and pinpoint the direction of change.

The integration of structural concepts into the practiced model implies that change in a specific direction is therapeutic dependent upon the therapist's assessment of the family's structure. For instance, the direction of therapeutic change in an enmeshed relationship is "distance"; the direction of change in a disengaged relationship is

"involvement". In cases of the former "exceptions to the rule" would convey situations where there is greater distance in the relationship; in cases of the latter "exceptions to the rule" would convey situations where there is greater involvement in the relationship. Once the appropriate direction of change is established in the therapist's mind, "exceptions to the rule" and responses to the "miracle question" can be utilized to create a therapeutic "frame", develop a set of compliments and design interventions which initiate change, however small. Once change in the right direction is initiated the principles behind the "ripple effect" and the process of highlighting and punctuating success patterns becomes the rule. The important aspect of this model is that any change in the right direction is highlighted and built upon throughout the process of therapy so that change generates further change, leading to eventual solution.

It is clear that the most powerful and effective aspect of this model is the emphasis it places upon validating families through complimenting them; focusing on what they are already doing that is good; highlighting and punctuating success patterns; and establishing a context, throughout therapy, in which the "positive" looms much larger than the "negative". The process of therapy is "empowering" rather than "defeating". Repeatedly, the therapist observed family members come to therapy feeling hopeless, frustrated and powerless over their dilemma, with the expectation that therapy would definitely confirm what they were doing wrong. The therapist's conscious emphasis upon complimenting family members and punctuating that which they were doing well, was observed to have a dramatic impact on the change process. This was particularly

evident after the first session in that family members frequently demonstrated signs of increased confidence, hope and energy toward the problem. This was evidenced in their verbal expressions ("It's good to hear not all is lost"; "I was expecting to hear a lot worse"; "There is hope"; "What a relief, I was feeling that I was a terrible parent") and non-verbal expressions (smiling, laughter, relaxed face and body, expressions of relief).

This shift in context seemed to provide a renewed reality with respect to the complaint and was often followed by dramatic changes. Family members often connected these changes to "feeling better about the situation", to discussion in the previous session that focused on something positive, or to doing something they used to do when things were going well. These "spontaneous" changes can be attributed to the positive, cooperative context in therapy. The renewed hope and energy generated through this context, in and of itself, seemed to be a pathway to beneficial change.

The "spontaneous" changes attributed to the positive, cooperative context in therapy were not limited to any particular kind of case. A beneficial impact resulting from the emphasis upon the positive was observed in "simple" problems as well as those of a long standing, apparently complex nature such as those cases involving family violence. This observation is particularly significant in that it points to the potential effectiveness of this aspect of the model with families who have a history of previous therapy or with "resistant families". In some respects the model's emphasis upon cooperation allow the therapist (and family) to bypass the "tug-of-war" that characterizes the process with

resistant clients. Families are often "resistant" because they feel powerless and invalidated. The process of therapy in this model, which actively validates and empowers the family, neutralizes potential resistance without having to address the resistance directly. This observation holds particular relevance for areas of social work practice, such as child welfare, in which families are often "involuntary" and "resistant".

Though this model was effective with a range of cases, including very complex ones, in two out of the three cases in this practicum in which children had witnessed violence in the home, the effectiveness of brief therapy interventions was inconclusive. In one of the two cases only superficial change was observed. It was clear in this case that simply "doing something different" was not enough and what was called for was "being different". The therapist was never able to create an adequate enough frame to assist the mother to genuinely assume a firm, clear position with her son with respect to his violent behavior and irresponsible lifestyle. While the mother was able to do something different with her son she was never able to emotionally distance herself and "be different" with her son. One might interpret the mother's change as being of the "first order variety" (change of no real difference) instead of the "second order variety" (change of a real difference). Thus, while the mother was able to take a firm position by asking her son to leave the home (in the face of his threat of violence), she continued to emotionally pursue her son and absolve him of his irresponsible lifestyle outside the home. In this case it was evident that the mother's change was limited to the home context and was not

generalized beyond the home. Certainly, at a structural level there was little change as the mother continued to pursue the son outside the home. Thus, change was superficial and of the "first order variety". This points to the conclusion that "doing something different" isn't always enough if the "difference" isn't dramatic enough or across different contexts (e.g. at home and outside home).

In the second inconclusive case, dramatic change was observed in the family's organization, however, this change was initiated more through structural interventions than interventions based on traditional brief therapy principles. The family in this case was characterized by a chronic history of family violence and of family dysfunction over generations. The organizational structure of this family was characterized by a cross-generational alliance between the identified adolescent patient and her grandparents which left the mother in a position of powerlessness to affect any change with respect to the relationship between her and her daughter. At termination the mother had been repositioned to an executive position with her daughter, however, brief therapy interventions played little role in this process. Thus, of the three cases in which children had witnessed violence, brief therapy was an extremely effective method of intervention in one case; was minimally effective in the second, and was not effective at all in the third.

In cases where family members were not able to establish a clear statement of "exceptions to the rule" or a clear vision of a satisfactory future, based on the "miracle question", an emphasis upon structural concepts and interventions seemed to be more effective in initiating

change than an emphasis upon brief therapy principles, at least in the beginning of therapy. One such case involved a family of four in which the identified patient was a 13 year old adolescent boy. The request for therapy was based on the boy's behavior. The father reported that the boy would throw temper tantrums whenever he didn't get his way, show socially inappropriate behavior with peers and adults (e.g. he would persistently invade others' social space and hug them), and refuse to participate in "normal activities" for his age. The family had suffered the loss of the boy's birth mother, after a lengthy battle with cancer, two years prior to the commencement of therapy. The father had since developed a relationship with a woman, fourteen years younger than himself, who had been living with the family for four months. It was evident that the partner had been drawn into the family to fill a parenting function.

This family was characterized by an unclear generational boundary. The father maintained a disengaged position in relation to his son and his partner. This position was supported by a dysfunctional interaction pattern in which the father communicated in a very unclear, inconsistent fashion as he would often send contradictory and confusing messages to both his partner and his son. For instance, the father would make a statement and then minimize or alter the statement whenever his partner attempted to negotiate with him around the statement. He would also avoid direct communication with his son and was reluctant to discipline him. Efforts to negotiate around relationship struggles were often blocked or detoured by the father, leaving family members very confused about their position in relation to him and in the family in general.

For instance, the father's partner quickly found herself functioning as a parent, by default, yet she did not feel she had a "license" to set limits with the children as her efforts were always undermined or minimized by the father. When she attempted to negotiate with the father around this issue, he minimized the inconsistency in their approaches, yet, continued to undermine his partner's efforts. In simplest terms, the father was a "conflict avoider" and tended to maintain emotional distance at all costs. Attempts to engage the father in providing clear, concrete messages were usually blocked.

Given the father's pattern of avoidance with others, it was very difficult to gain a clear response from him to the exception question and the miracle question. This negated the therapist's ability to develop a clear "frame" and set of interventions that would "fit" for the entire family. During the initial stages of therapy, then, the therapist relied on structural interventions aimed at repositioning the father to a greater degree of involvement in relation to both his partner and his son. This was accomplished by tracking and amplifying sequences in order to expose the dysfunctional pattern and structure; directing family members to negotiate around specific relationship issues and marking boundaries in order to block detouring and triangulation processes. These interventions helped to join the father with both his partner and his son. Once there was a corresponding improvement in the son's behavior the focus of therapy was then placed on punctuating and highlighting what the family was already doing that was good for them. This helped to engage the father in a cooperative manner and promoted a ripple effect in the process of change. At the end of therapy, the

father was communicating much more clearly with family members, assuming a major role in parenting the children and spending much more time with his son. The father's partner was reporting more of a "united front" in the parenting arena, and was expressing much less anxiety with respect to her role in the family. In this case, once change was initiated through structural interventions, a return to the principles behind the ripple effect, and the process of punctuating success patterns, greatly assisted the process of change. In other words, once the therapist and the family "know what works - - - keep doing it". However, if the family and the therapist "don't know what works", due to vague responses to the exception and miracle question, it is difficult to build on some of de Shazer's brief therapy principles. In cases of the latter it may be more fruitful to utilize structural interventions, particularly at the onset of therapy.

de Shazer (1988b) acknowledges that his approach is not foolproof. The approach may break down when the therapist is unable to help the family see the significance of the exceptions, when the therapist and family have different goals, or when the therapist is unable to help the family do more of what it is already doing that works (de Shazer, 1988b). Certainly, in the above-noted case one might argue that the father's goal was to avoid conflict. Thus, his "resistance" to any process of direct negotiation around issues. Clients might be so focused on the complaint that they do not recognize the exceptions or they may interpret the exceptions as "fluke". While the therapist may not need to understand the origins of a problem, family members often believe they need to, otherwise they haven't "truly" resolved their problem. One additional

interpretation, that has to do with "knowing, then doing" can be offered to explain why some family members may not provide a clear statement of "exceptions to the rule" or a clear response to the miracle question. Once family members clearly respond to the exception question and the miracle question, they in essence provide one another with a script of what they can do to promote change. Once family members know what they can do, the next step is doing it. "Doing it" might represent a difficult or painful process for some people if it involves being honest with one's self, directly facing issues in a relationship or acknowledging stressful or uncomfortable feelings. Thus, in some cases, family members may have an investment in not clearly responding to the exception and miracle questions. In such instances the therapist may need to rely on other strategies such as those based on the structural framework.

In addition to those cases in which clear responses to the exception and miracle question were not achieved, structural interventions were also observed to be more effective in cases where families "short circuited" the opportunity for a positive focus by only partially completing tasks. In such instances, an emphasis upon structural interventions, such as "tracking", at least exposed the family's way of interacting and, at some level, shifted the family's organization or perceptions. Any observed shift was framed by the therapist as a sign of positive change and was built upon and highlighted as a success pattern or potential solution pattern.

Thus, practice in this model always reflects a return to the emphasis upon processes of change (not homeostasis), success patterns, solution

behavior, and the things that family members are doing that are good for them. This <u>process</u> is the key element in providing family therapy that is humane, empowering and effective.

As the writer sees it, the social work profession needs to move toward greater consciousness in empowering clients by adopting models of practice which validate clients and ensure a process that emphasizes the things which clients do that are good, highlights a client's successes, punctuates a client's solution patterns, - - such as the process of therapy demonstrated in this practicum. In line with this, the social work profession needs to move away from individually focused models, which place the source of dysfunction in the individuals, and refocus its energy toward the profession's original orientation of viewing individuals and their families in their context, their systems, and their ecology.

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APPENDIX A: FAM (111) Questionnaire

Family Assessment Measure

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

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Please do not write on this page.
Circle your response on the answer sheet.

1. We spend too much time arguing about what our problems are.
2. Family duties are fairly shared.
3. When I ask someone to explain what they mean, I get a straight answer.
4. When someone in our family is upset, we don't know if they are angry, sad, scared or what.
5. We are as well adjusted as any family could possibly be.
6. You don't get a chance to be an individual in our family.
7. When I ask why we have certain rules, I don't get a good answer.
8. We have the same views on what is right and wrong.
9. I don't see how any family could get along better than ours.
10. Some days we are more easily annoyed than on others.
11. When problems come up, we try different ways of solving them.
12. My family expects me to do more than my share.
13. We argue about who said what in our family.
14. We tell each other about things that bother us.
15. My family could be happier than it is.
16. We feel loved in our family.
17. When you do something wrong in our family, you don't know what to expect.
18. It's hard to tell what the rules are in our family.
19. I don't think any family could possibly be happier than mine.
20. Sometimes we are unfair to each other.
21. We never let things pile up until they are more than we can handle.
22. We agree about who should do what in our family.
23. I never know what's going on in our family.
24. I can let my family know what is bothering me.
25. We never get angry in our family.

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
35. Sometimes we avoid each other.
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
42. One family member always tries to be the centre of attention.
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

APPENDIX B: FAM (111) Interpretation Guide

TABLE 3

FAM Interpretation Guide

1. TASK ACCOMPLISHMENT

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– basic tasks consistently met – flexibility and adaptability to change in developmental tasks – functional patterns of task accomplishment are maintained even under stress – task identification shared by family members, alternative solutions are explored and attempted	– failure of some basic tasks – inability to respond appropriately to changes in the family life cycle – problems in task identification, generation of potential solutions, and implementation of change – minor stresses may precipitate a crisis

2. ROLE PERFORMANCE

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– roles are well integrated: family members understand what is expected, agree to do their share and get things done – members adapt to new roles required in the development of the family – no idiosyncratic roles	– insufficient role integration, lack of agreement regarding role definitions – inability to adapt to new roles required in evolution of the family life cycle – idiosyncratic roles

3. COMMUNICATION

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– communications are characterized by sufficiency of information – messages are direct and clear – receiver is available and open to messages sent – mutual understanding exists among family members	– communications are insufficient, displaced or masked – lack of mutual understanding among family members – inability to seek clarification in case of confusion

4. AFFECTIVE EXPRESSION

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity	– inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation

5. AFFECTIVE INVOLVEMENT

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– emphatic involvement – family members' concern for each other leads to fulfillment of emotional needs (security) and promotes autonomous functioning – quality of involvement is nurturant and supportive	– absence of involvement among family members, or merely interest devoid of feelings – involvement may be narcissistic, or to an extreme degree, symbiotic – family members may exhibit insecurity and lack of autonomy

6. CONTROL

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– patterns of influence permit family life to proceed in a consistent and generally acceptable manner – able to shift habitual patterns of functioning in order to adapt to changing demands – control style is predictable yet flexible enough to allow for some spontaneity – control attempts are constructive, educational and nurturant	– patterns of influence do not allow family to master the routines of ongoing family life – failure to perceive and adjust to changing life demands – may be extremely predictable (no spontaneity) or chaotic – control attempts are destructive or shaming – style of control may be too rigid or laissez-faire – characterized by overt or covert power struggles

7. VALUES AND NORMS

LOW SCORES (40 and below) STRENGTH	HIGH SCORES (60 and above) WEAKNESS
– consonance between various components of the family's value system – family's values are consistent with their subgroup and the larger culture to which the family belongs – explicit and implicit rules are consistent – family members function comfortably within the existing latitude	– components of the family's value system are dissonent resulting in confusion and tension – conflict between the family's values and those of the culture as a whole – explicitly stated rules are subverted by implicit rules – degree of latitude is inappropriate

APPENDIX C: Authorization to copy FAM (111), Dr. Harvey Skinner

Alcoholism and Drug
Addiction Research Foundation
Fondation de la recherche sur la toxicomanie

Central Office
33 Russell Street
Toronto, Ontario
Canada M5S 2S1
(416) 595-6000

January 21, 1988

Mr. Frank Cantafio
214-811 Wollaston Crescent
Saskatchewan, Saskatoon
S7J 4J4

Dear Mr. Cantafio:

I am responding to your recent letter regarding the Family Assessment Measure. You have my permission to use FAM III in your clinical practicum, and you may reproduce a copy of FAM in the report from your work. Obviously, I would be quite interested in learning of your findings.

I have enclosed a sheet which describes how you may obtain copies of the test booklet and answer sheets. Best wishes for the new year.

Lisa tells me you have already order FAMS.

Sincerely,

[signature]

Harvey A. Skinner, Ph.D.
Senior Scientist

HAS/rs

Encls.

APPENDIX D: Problem Checklist - Morrison Centre

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8. Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right and wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistant with discipline					
18. Participation in family fun and recreation					
19. Making individual decisions					
20. Making family decisions					
21. Making contact with friends, relatives, church, etc.					
22. Dealing with stress					
23. Feeling good about our family					
Make the last rating for yourself:					
24. Feeling good about myself					

APPENDIX E: Client Feedback Scale

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

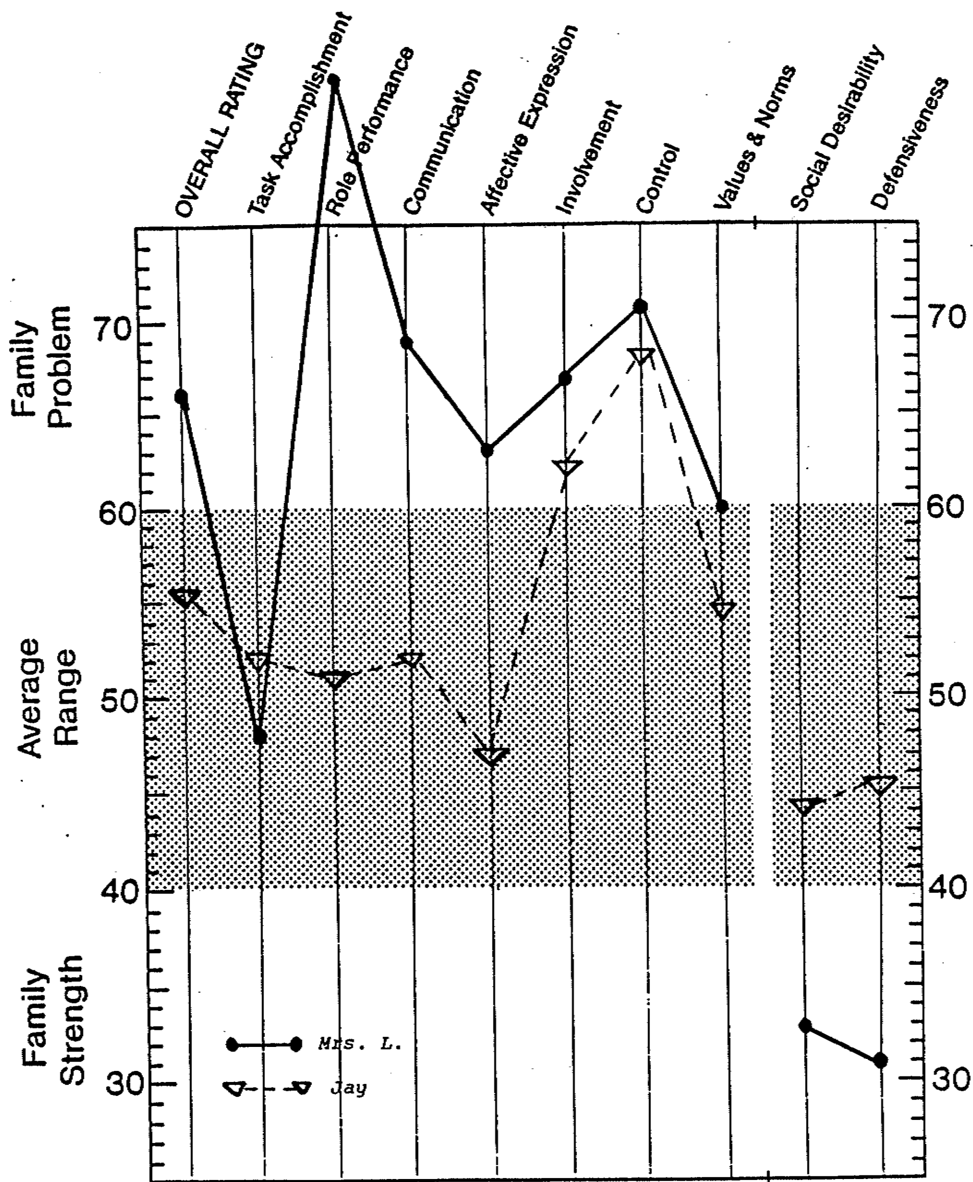
	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					
Communicates clearly					
Demonstrates an under-standing of our family					
Demonstrates acceptance					
Provides suggestions that are helpful					
Demonstrates a sense of humor					
Provides a relaxed atmosphere					
Helps family to find own solutions					
Provides information in a way that is not imposing					
Demonstrates warmth					
Helps family to see things differently or in a new way					
Overall quality of service					

Any Additional Comments

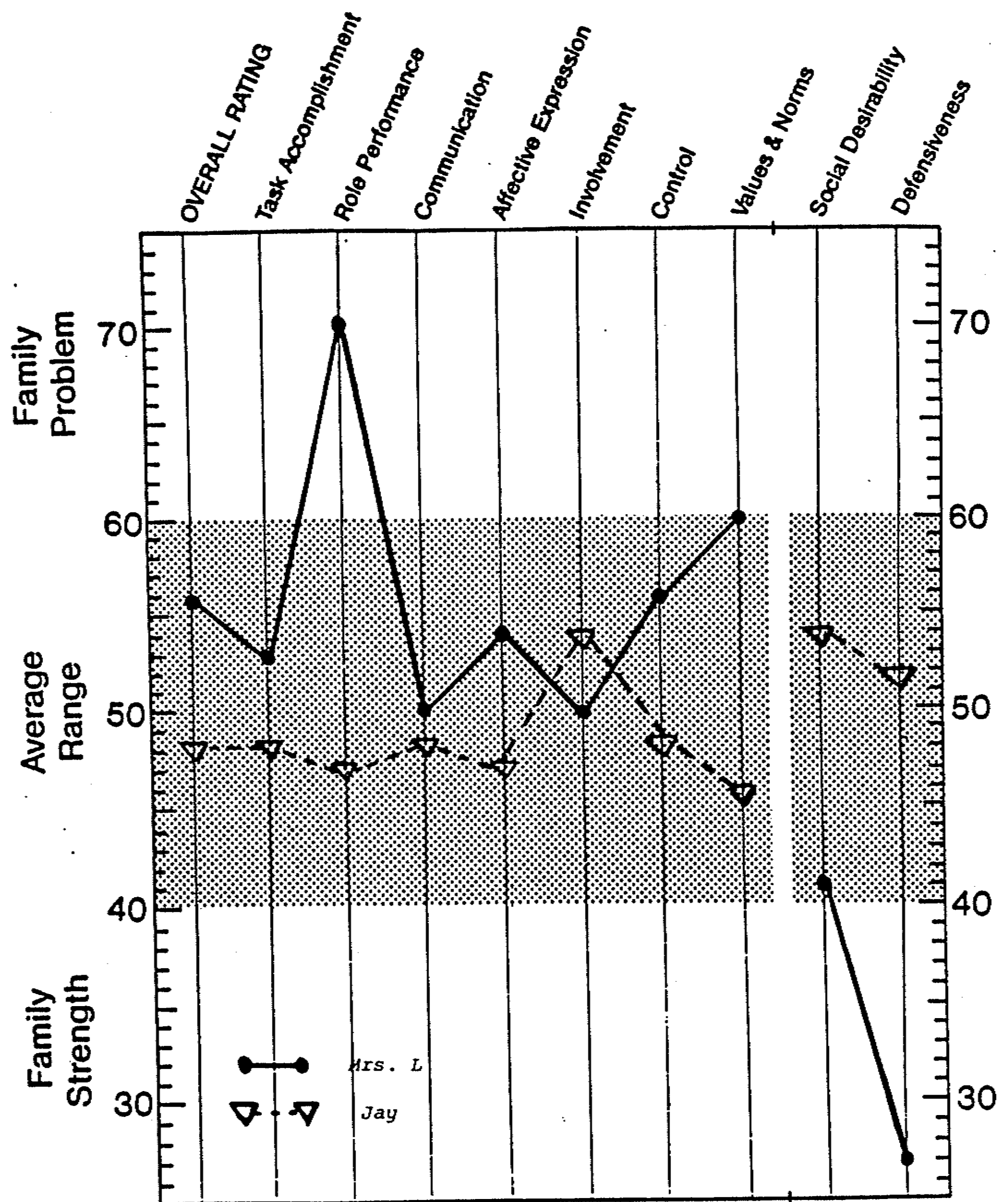
Cantafio, 1988

APPENDIX F: L. Family FAM Profiles

FAM GENERAL SCALE



TIME 1



FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
Mrs. L
Jay
TIME 2

APPENDIX G: L. Family Behavior Checklist Profiles

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied.	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			X		
2. Sharing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family			X		
4. Listening and understanding		X			
5. Being patient or calm with others	X				
6. Showing care and concern	X				
7. Being positive, saying nice things about others	X				
8. Knowing what behavior to expect at different ages			X		
9. Dealing with matters concerning sex			X		
10. Making sensible rules	X				
11. Being able to discuss what is right and wrong			X		
12. Taking on responsibilities	X				
13. Encouraging others to take on responsibilities	X				
14. Use of self-control	X				
15. Proper use of alcohol, drugs			X		
16. Deciding, agreeing upon discipline	X				
17. Being consistent with discipline		X			
18. Participation in family fun and recreation			X		
19. Making individual decisions			X		
20. Making family decisions			X		
21. Making contact with friends, relatives, church, etc.				X	
22. Dealing with stress		X			
23. Feeling good about our family			X		
Make the last rating for yourself:					
24. Feeling good about myself			X		

Mrs. L.
TIME 1

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing <u>now</u> in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family			X		
4. Listening and understanding				X	
5. Being patient or calm with others			X		
6. Showing care and concern			X		
7. Being positive, saying nice things about others			X		
8. Knowing what behavior to expect at different ages				X	
9. Dealing with matters concerning sex			X		
10. Making sensible rules				X	
11. Being able to discuss what is right and wrong				X	
12. Taking on responsibilities			X		
13. Encouraging others to take on responsibilities			X		
14. Use of self-control			X		
15. Proper use of alcohol, drugs				~~X~~	X
16. Deciding, agreeing upon discipline					X
17. Being consistent with discipline				X	
18. Participation in family fun and recreation					X
19. Making individual decisions				X	
20. Making family decisions				X	
21. Making contact with friends, relatives, church, etc.				X	
22. Dealing with stress			X		
23. Feeling good about our family				X	
Make the last rating for yourself:					
24. Feeling good about myself			X		

Mrs. L
TIME 2

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing <u>now</u> in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					X
2. Sharing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family			X		
4. Listening and understanding				X	
5. Being patient or calm with others				X	
6. Showing care and concern				X	
7. Being positive, saying nice things about others				X	
8. Knowing what behavior to expect at different ages			X		
9. Dealing with matters concerning sex				X	
10. Making sensible rules			X		
11. Being able to discuss what is right and wrong				X	
12. Taking on responsibilities				X	
13. Encouraging others to take on responsibilities			X		
14. Use of self-control				X	
15. Proper use of alcohol, drugs				X	
16. Deciding, agreeing upon discipline			X		
17. Being consistent with discipline				X	
18. Participation in family fun and recreation			X		
19. Making individual decisions				X	
20. Making family decisions				X	
21. Making contact with friends, relatives, church, etc.				X	
22. Dealing with stress				X	
23. Feeling good about our family					X
Make the last rating for yourself:					
24. Feeling good about myself				X	

Jay
TIME 1

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing **now** in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					X
2. Sharing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family					X
4. Listening and understanding					X
5. Being patient or calm with others			X		
6. Showing care and concern					X
7. Being positive, saying nice things about others					X
8. Knowing what behavior to expect at different ages					X
9. Dealing with matters concerning sex				X	
10. Making sensible rules					X
11. Being able to discuss what is right and wrong					X
12. Taking on responsibilities				X	
13. Encouraging others to take on responsibilities			X		
14. Use of self-control				X	
15. Proper use of alcohol, drugs					X
16. Deciding, agreeing upon discipline				X	
17. Being consistent with discipline			X		
18. Participation in family fun and recreation				X	
19. Making individual decisions				X	
20. Making family decisions					X
21. Making contact with friends, relatives, church, etc.		X			
22. Dealing with stress					X
23. Feeling good about our family					X
Make the last rating for yourself:					
24. Feeling good about myself					X

Jay
TIME 2

APPENDIX H: L. Family Client Feedback Scale

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an under-standing of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor					X
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing					X
Demonstrates warmth					X
Helps family to see things differently or in a new way					X
Overall quality of service					X

Any Additional Comments

I feel the counsellor was excellent, sorry to see him leaving here. Also feel better about family than I have in a long time (also better about self)

THANK YOU !!

Mrs. L.
CLIENT FEEDBACK

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments				X	
Communicates clearly					X
Demonstrates an understanding of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful.					X
Demonstrates a sense of humor					X
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing				X	
Demonstrates warmth					X
Helps family to see things differently or in a new way					X
Overall quality of service					X

Any Additional Comments

Jay
CLIENT FEEDBACK

APPENDIX I: Therapist Feedback Form

THERAPIST FEEDBACK FORM

Clear and Concrete as possible

1. PREPARATION

2. JOINING - TUNING IN TO FAMILY MEMBERS

3. MAINTAINING FOCUS, TRACKING:

   - CLEAR DEFINITION OF PROBLEM FROM EACH MEMBER'S PERSPECTIVE

   - EACH MEMBER'S UNDERSTANDING OF THE PROBLEM

   - CLEAR DESCRIPTION OF INTERACTIONAL PATTERN AROUND SYMPTOMATIC BEHAVIOR

   - EXCEPTIONS TO SYMPTOM

   - BEHAVIORAL CHANGES OF FAMILY MEMBERS IF MIRACLE OCCURRED

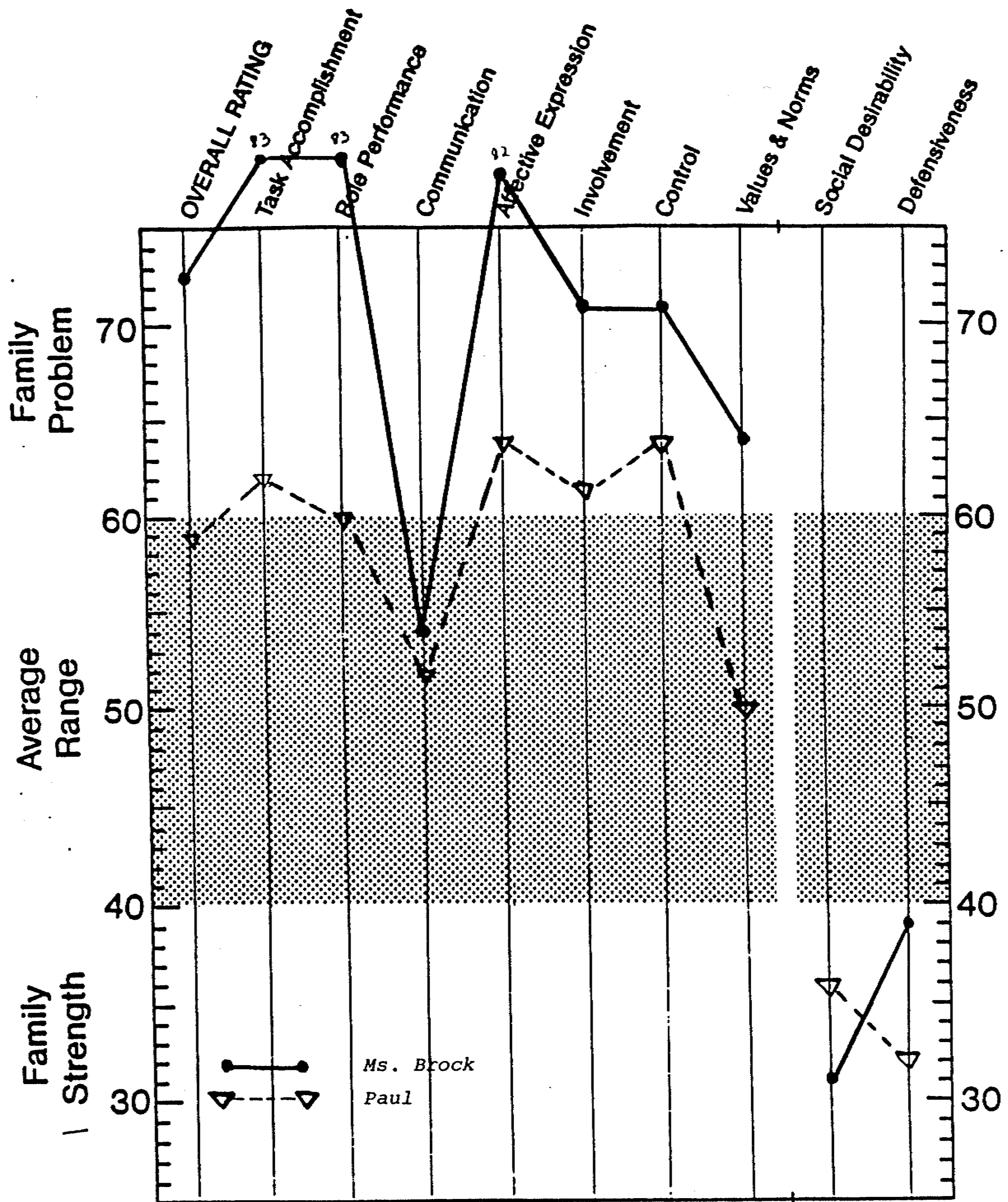
   - MAINTAINING A POSITIVE, VALIDATING POSITION

4. DELIVERY OF COMPLIMENTS

5. DELIVERY OF TASK(S)

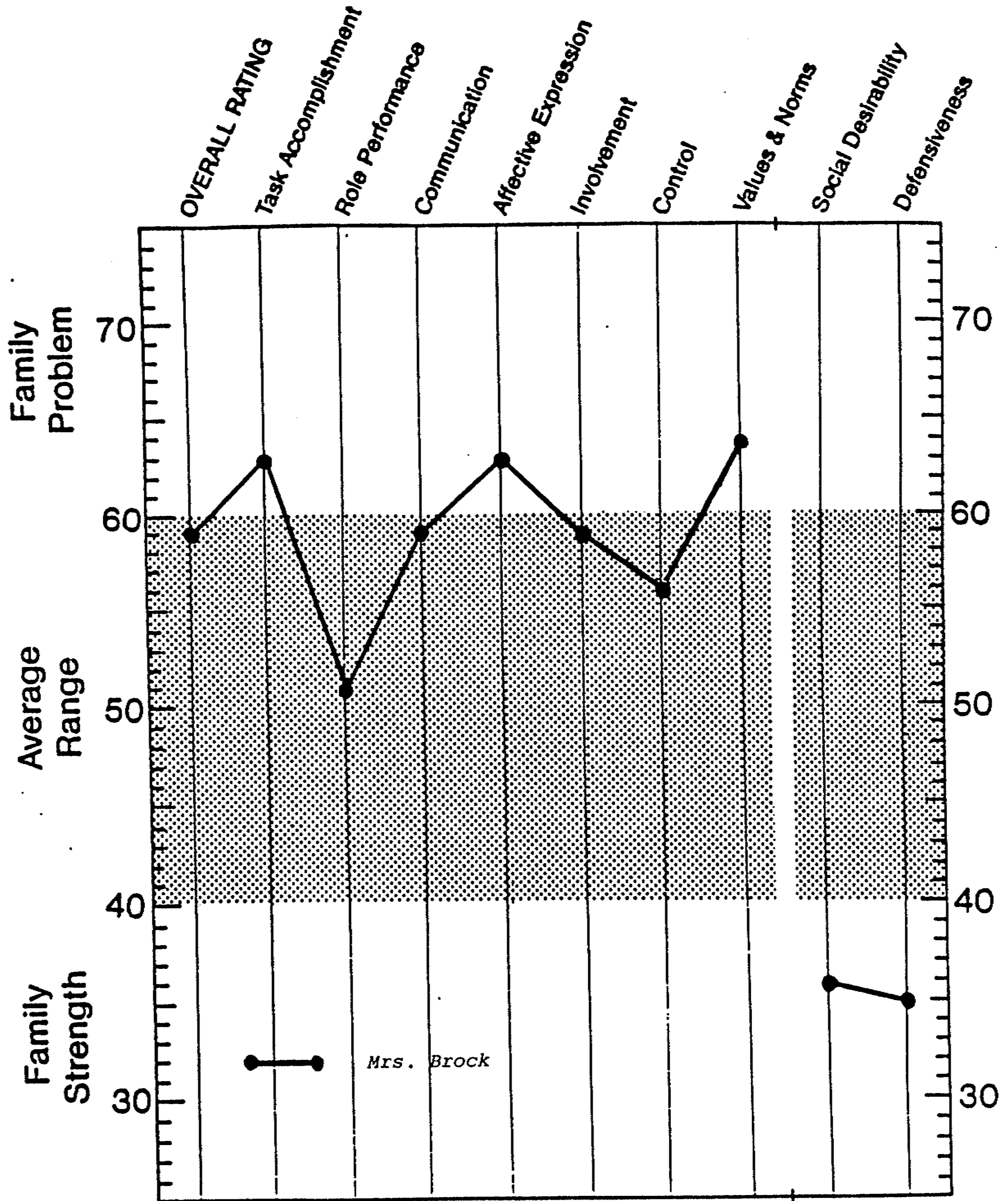
APPENDIX J: Brock Family FAM Profiles

FAM GENERAL SCALE



TIME 1

FAM GENERAL SCALE



TIME 2

APPENDIX K: Brock Family Behavior Checklist Profiles

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing <u>now</u> in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)	X				
2. Sharing feelings like anger, sadness, hurt, etc.	X				
3. Sharing problems with the family	X				
4. Listening and understanding		X			
5. Being patient or calm with others	X				
6. Showing care and concern			X		
7. Being positive, saying nice things about others			X		
8. Knowing what behavior to expect at different ages		X			
9. Dealing with matters concerning sex		X			
10. Making sensible rules			X		
11. Being able to discuss what is right and wrong			X		
12. Taking on responsibilities	X				
13. Encouraging others to take on responsibilities	X				
14. Use of self-control	X				
15. Proper use of alcohol, drugs		X			
16. Deciding, agreeing upon discipline	X				
17. Being consistent with discipline	X				
18. Participation in family fun and recreation			X		
19. Making individual decisions		X			
20. Making family decisions		X			
21. Making contact with friends, relatives, church, etc.			X		
22. Dealing with stress	X				
23. Feeling good about our family	X				
Make the last rating for yourself:					
24. Feeling good about myself			X		

Ms. Brock
TIME 1

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied.	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family			X		
4. Listening and understanding				X	
5. Being patient or calm with others					X
6. Showing care and concern				X	
7. Being positive, saying nice things about others				X	
8. Knowing what behavior to expect at different ages			X		
9. Dealing with matters concerning sex			X		
10. Making sensible rules				X	
11. Being able to discuss what is right and wrong				X	
12. Taking on responsibilities				X	
13. Encouraging others to take on responsibilities			X		
14. Use of self-control				X	
15. Proper use of alcohol, drugs			X		
16. Deciding, agreeing upon discipline				X	
17. Being consistent with discipline			X		
18. Participation in family fun and recreation			X		
19. Making individual decisions				X	
20. Making family decisions				X	
21. Making contact with friends, relatives, church, etc.				X	
22. Dealing with stress			X		
23. Feeling good about our family				X	
Make the last rating for yourself:					
24. Feeling good about myself			X		

Ms. Brock

TIME 2

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				✓	
2. Sharing feelings like anger, sadness, hurt, etc.			✓		
3. Sharing problems with the family			✓		
4. Listening and understanding			✓		
5. Being patient or calm with others			✓		
6. Showing care and concern				✓	
7. Being positive, saying nice things about others			✓		
8. Knowing what behavior to expect at different ages			✓		
9. Dealing with matters concerning sex			✓		
10. Making sensible rules			✓		
11. Being able to discuss what is right and wrong			✓		
12. Taking on responsibilities				✓	
13. Encouraging others to take on responsibilities			✓		
14. Use of self-control			✓		
15. Proper use of alcohol, drugs			✓		
16. Deciding, agreeing upon discipline				✓	
17. Being consistent with discipline			✓		
18. Participation in family fun and recreation		✓			
19. Making individual decisions			✓		
20. Making family decisions			✓		
21. Making contact with friends, relatives, church, etc.				✓	
22. Dealing with stress		✓			
23. Feeling good about our family			✓		
Make the last rating for yourself:					
24. Feeling good about myself			✓		

Ms. Brock

TIME 3

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied.	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			X		
2. Sharing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family				X	
4. Listening and understanding			X		
5. Being patient or calm with others		X			
6. Showing care and concern			X		
7. Being positive, saying nice things about others				X	
8. Knowing what behavior to expect at different ages			X		
9. Dealing with matters concerning sex				X	
10. Making sensible rules				X	
11. Being able to discuss what is right and wrong			X		
12. Taking on responsibilities		X			
13. Encouraging others to take on responsibilities					
14. Use of self-control			X		
15. Proper use of alcohol, drugs			X		
16. Deciding, agreeing upon discipline			X		
17. Being consistent with discipline				X	
18. Participation in family fun and recreation			X		
19. Making individual decisions		X			
20. Making family decisions			X		
21. Making contact with friends, relatives, church, etc.			X		
22. Dealing with stress		X			
23. Feeling good about our family			X		
Make the last rating for yourself:					
24. Feeling good about myself		X			

Paul

TIME 1

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing <u>now</u> in each area. Put a check (x) in the box that shows your feeling about each area.

	Very Dis-Satisfied	Dis-satisfied	In between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family				X	
4. Listening and understanding			X		
5. Being patient or calm with others					X
6. Showing care and concern				X	
7. Being positive, saying nice things about others				X	
8. Knowing what behavior to expect at different ages			X		
9. Dealing with matters concerning sex			X		
10. Making sensible rules				X	
11. Being able to discuss what is right and wrong			X		
12. Taking on responsibilities			X		
13. Encouraging others to take on responsibilities					
14. Use of self-control				X	
15. Proper use of alcohol, drugs				X	
16. Deciding, agreeing upon discipline				X	
17. Being consistent with discipline				X	
18. Participation in family fun and recreation					
19. Making individual decisions			X		
20. Making family decisions				X	
21. Making contact with friends, relatives, church, etc.					X
22. Dealing with stress				X	
23. Feeling good about our family				X	
Make the last rating for yourself:					
24. Feeling good about myself			X		

Paul

TIME 2

APPENDIX L: Brock Family Client Feedback Scale

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					✓
Communicates clearly					✓
Demonstrates an under-standing of our family					✓
Demonstrates acceptance					✓
Provides suggestions that are helpful					✓
Demonstrates a sense of humor					✓
Provides a relaxed atmosphere					✓
Helps family to find own solutions					✓
Provides information in a way that is not imposing					✓
Demonstrates warmth					✓
Helps family to see things differently or in a new way					✓
Overall quality of service					✓

Any Additional Comments

Frank was very easy to relate to, very helpful in relation to court problems & I hate to see Winnipeg get him.

Ms. Brock
CLIENT FEEDBACK

APPENDIX M: Client Feedback Scales, Other Families

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an understanding of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor					X
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing					X
Demonstrates warmth					X
Helps family to see things differently or in a new way					X
Overall quality of service					X

Any Additional Comments

Thanks Frank for everything!!

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an under-standing of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor					X
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing					X
Demonstrates warmth					X
Helps family to see things differently or in a new way					X
Overall quality of service					X

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an understanding of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor				X	
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing					X
Demonstrates warmth					X
Helps family to see things differently or in a new way				X	
Overall quality of service					X

Any Additional Comments

Frank has been very helpful to me & my son James. His understanding of our problems has helped me find solutions myself. I am very satisfied and am glad I came to McNeill Clinic.

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an under-standing of our family					X
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor					X
Provides a relaxed atmosphere					X
Helps family to find own solutions					X
Provides information in a way that is not imposing				X	
Demonstrates warmth					X
Helps family to see things differently or in a new way				X	
Overall quality of service					X

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					X
Communicates clearly					X
Demonstrates an understanding of our family				X	
Demonstrates acceptance					X
Provides suggestions that are helpful					X
Demonstrates a sense of humor				X	
Provides a relaxed atmosphere				X	
Helps family to find own solutions				X	
Provides information in a way that is not imposing					X
Demonstrates warmth				X	
Helps family to see things differently or in a new way					X
Overall quality of service					X

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					✓
Communicates clearly				✓	
Demonstrates an under-standing of our family				✓	
Demonstrates acceptance					✓
Provides suggestions that are helpful				✓	
Demonstrates a sense of humor				✓	
Provides a relaxed atmosphere				✓	
Helps family to find own solutions				✓	
Provides information in a way that is not imposing				✓	
Demonstrates warmth					✓
Helps family to see things differently or in a new way				✓	
Overall quality of service				✓	

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments				X	
Communicates clearly				X	
Demonstrates an under-standing of our family				X	
Demonstrates acceptance				X	
Provides suggestions that are helpful				X	
Demonstrates a sense of humor				X	
Provides a relaxed atmosphere				X	
Helps family to find own solutions				X	
Provides information in a way that is not imposing				X	
Demonstrates warmth				X	
Helps family to see things differently or in a new way				X	
Overall quality of service					√

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments				X	
Communicates clearly				X	
Demonstrates an understanding of our family				X	
Demonstrates acceptance				X	
Provides suggestions that are helpful					X
Demonstrates a sense of humor				X	
Provides a relaxed atmosphere				X	
Helps family to find own solutions				X	
Provides information in a way that is not imposing				X	
Demonstrates warmth				X	
Helps family to see things differently or in a new way					X
Overall quality of service				X	

Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments				✓	
Communicates clearly			✓		
Demonstrates an under-standing of our family					✓
Demonstrates acceptance			✓		
Provides suggestions that are helpful				✓	
Demonstrates a sense of humor			✓		
Provides a relaxed atmosphere				✓	
Helps family to find own solutions			✓		
Provides information in a way that is not imposing					✓
Demonstrates warmth					✓
Helps family to see things differently or in a new way			✓		
Overall quality of service				✓	

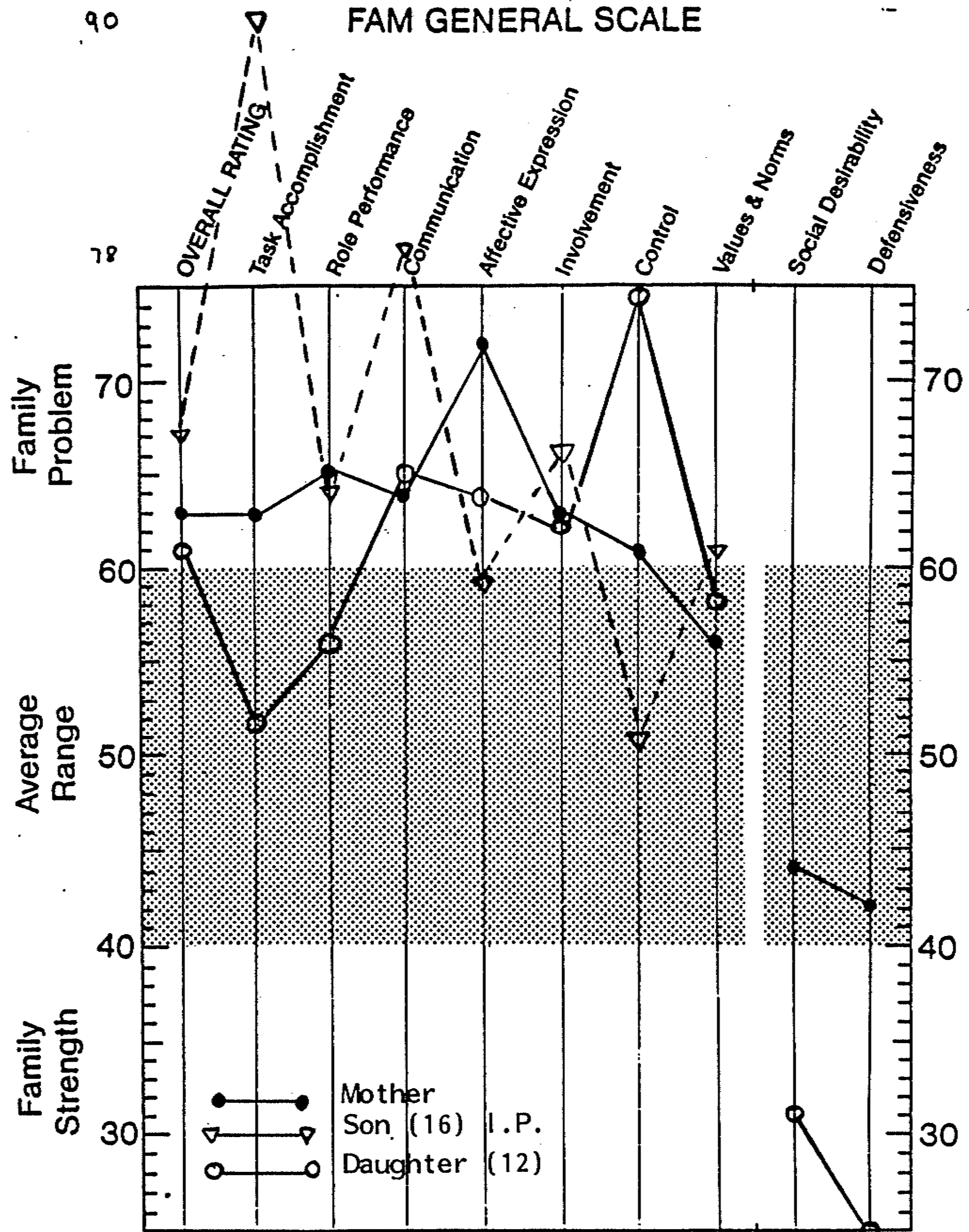
Any Additional Comments

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful. Such information assists in providing quality services to families. Put a (x) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dis-satisfied	Dis-satisfied	In between	satisfied	Very satisfied
Keeps to appointments and time commitments					✓
Communicates clearly				✓	
Demonstrates an under-standing of our family				✓	
Demonstrates acceptance					✓
Provides suggestions that are helpful					✓
Demonstrates a sense of humor				✓	
Provides a relaxed atmosphere				✓	
Helps family to find own solutions				✓	
Provides information in a way that is not imposing					✓
Demonstrates warmth					✓
Helps family to see things differently or in a new way				✓	
Overall quality of service					✓

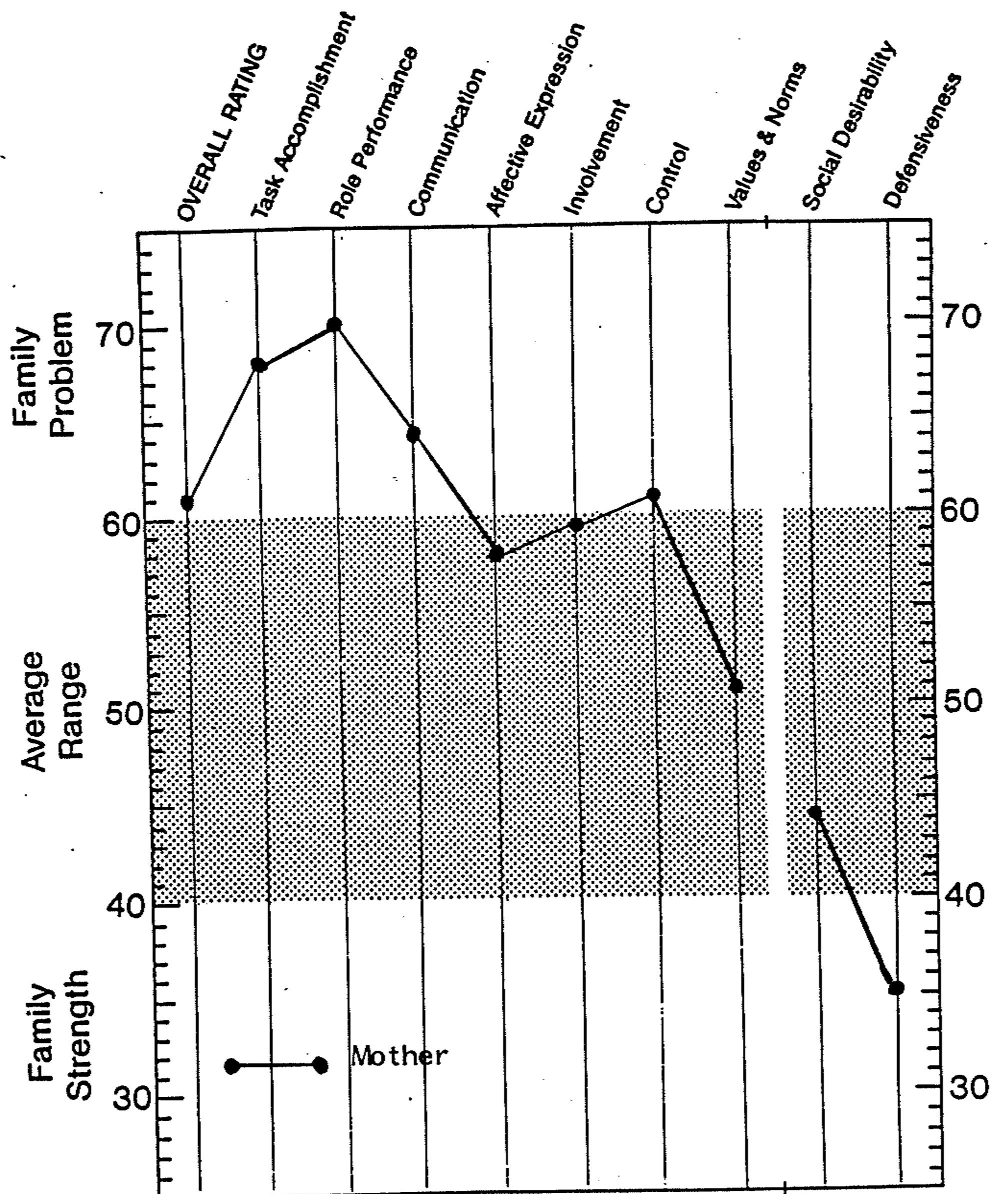
Any Additional Comments

APPENDIX N: FAM Profiles For Five Other Families For Which Pre and Post-Test Scores Were Achieved



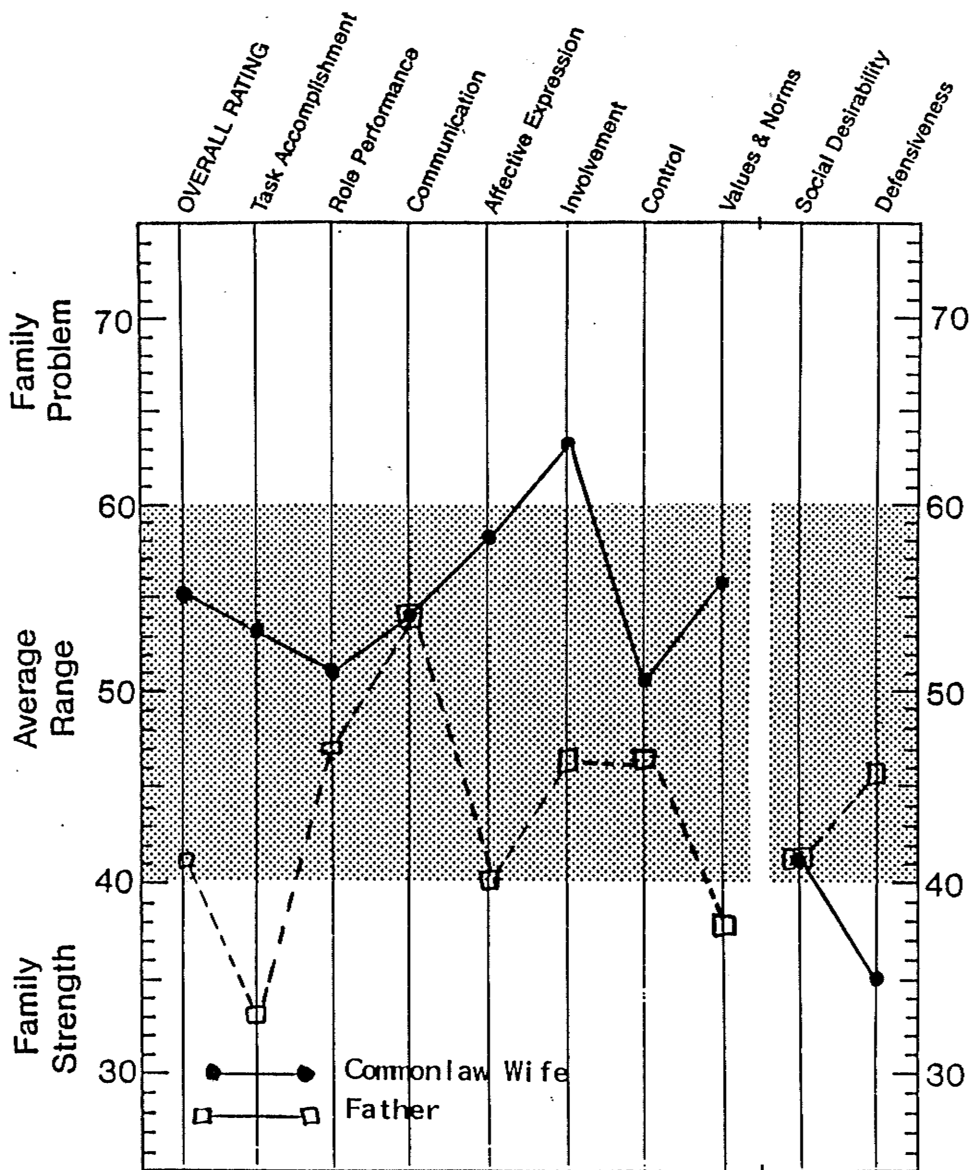
Family 1

Time 1



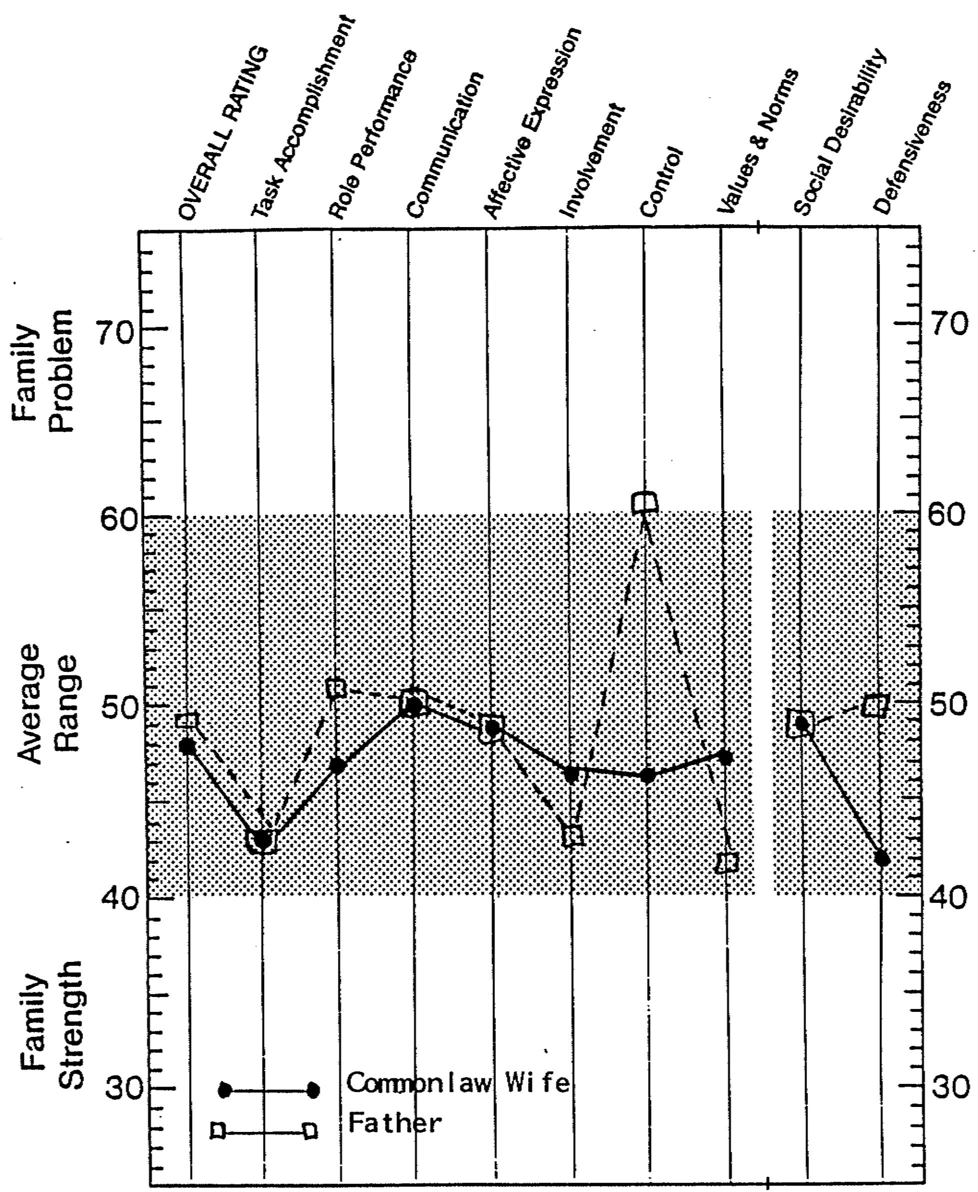
Family 1

Time 2



Family 2

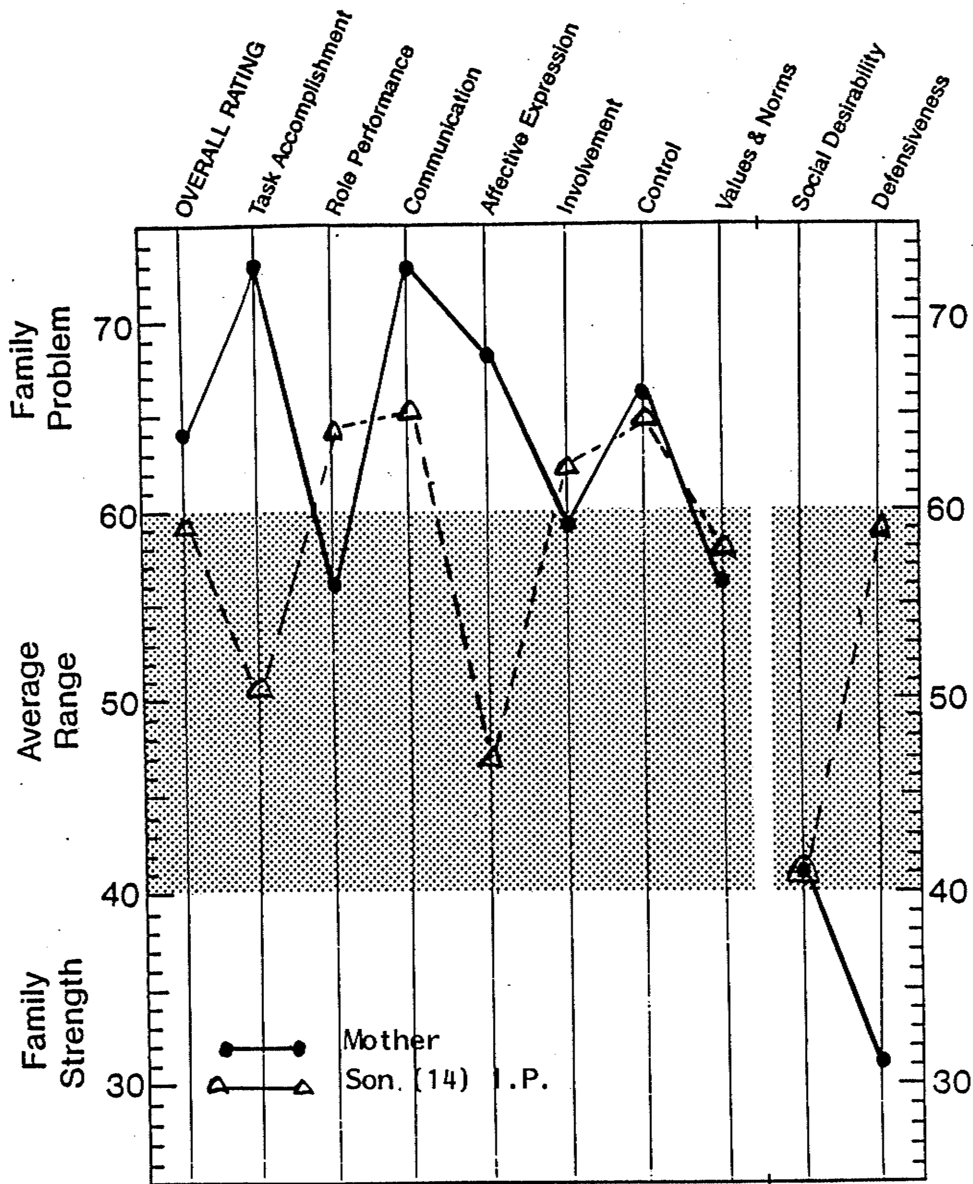
Time 1



Family 2

Time 2

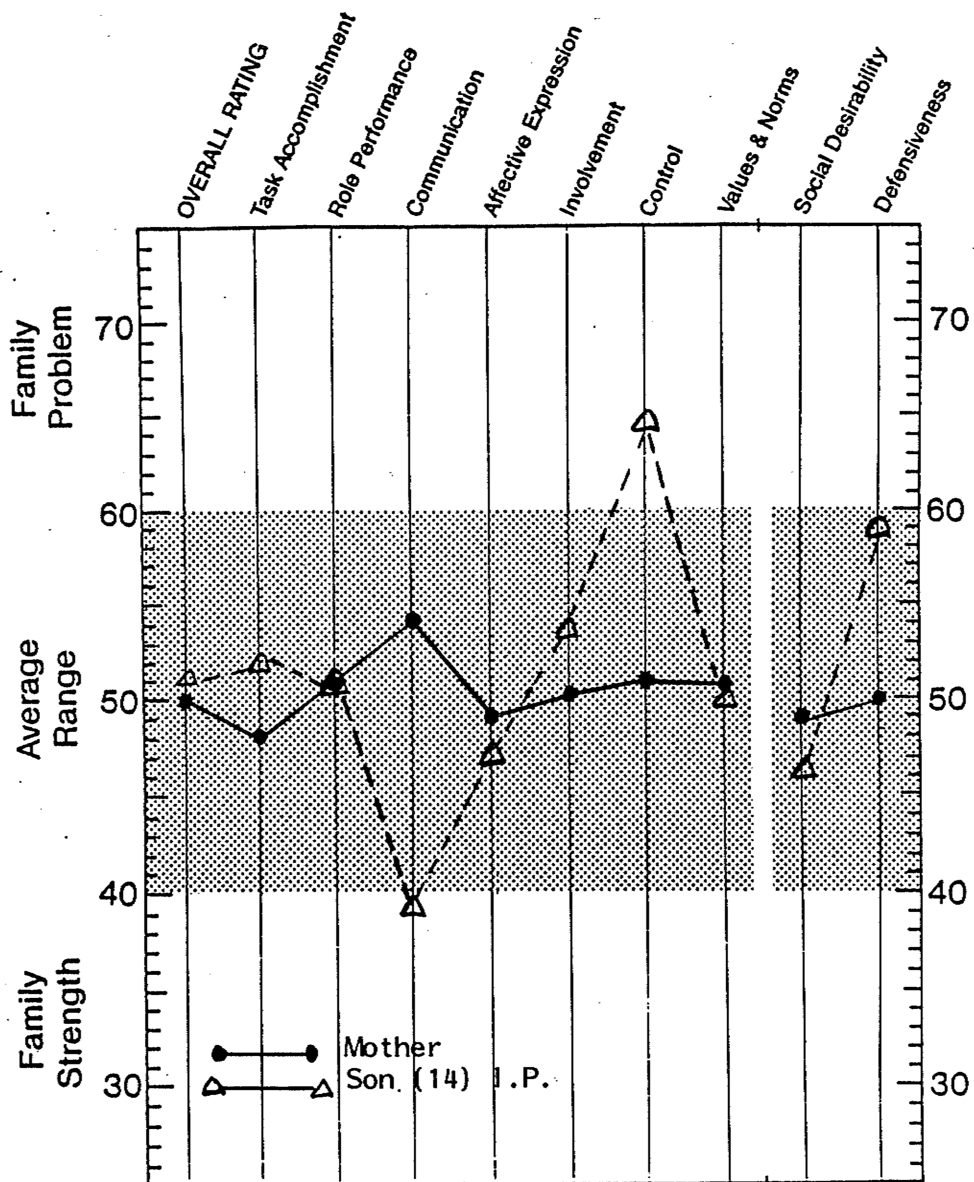
FAM GENERAL SCALE



Family 3

Time 1

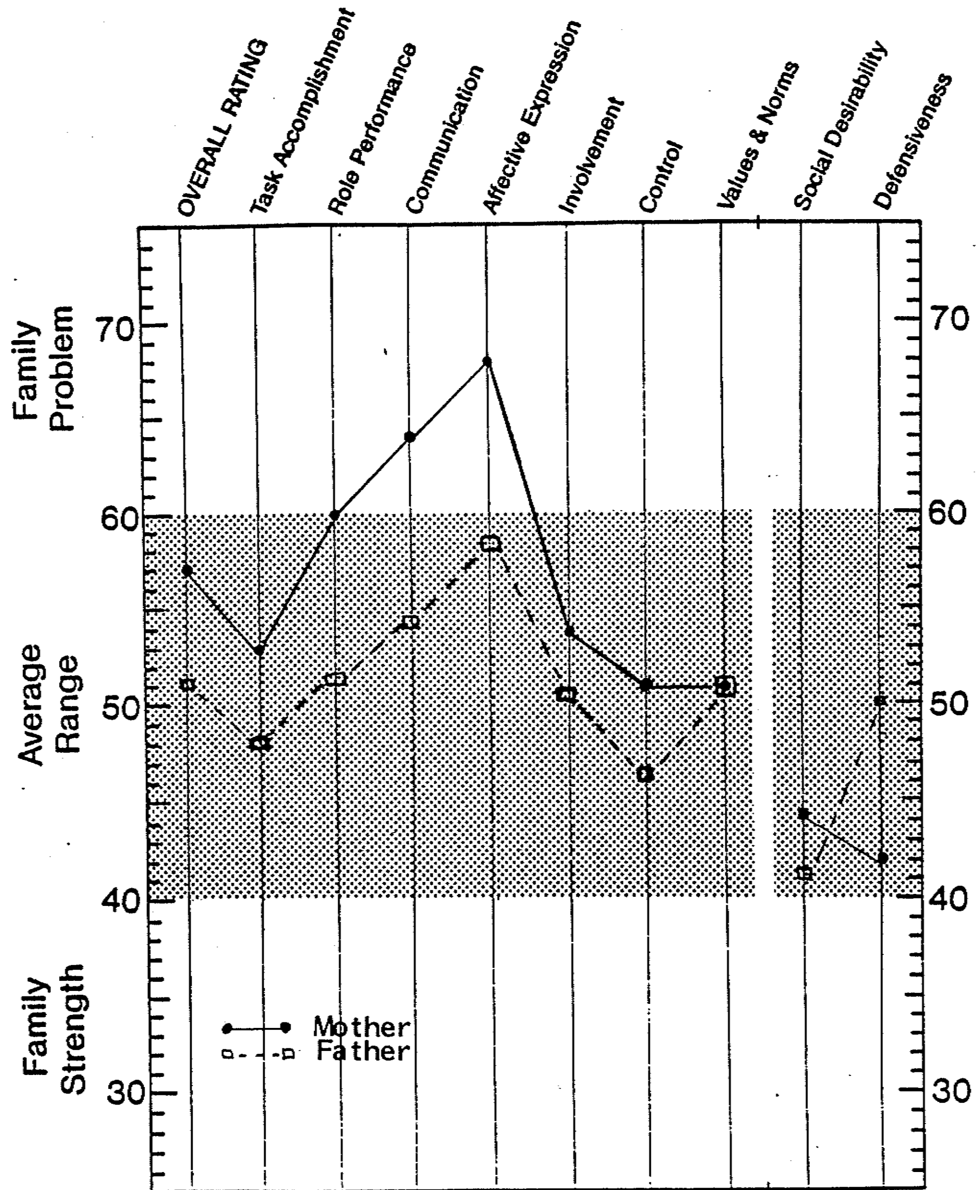
FAM GENERAL SCALE



Family 3

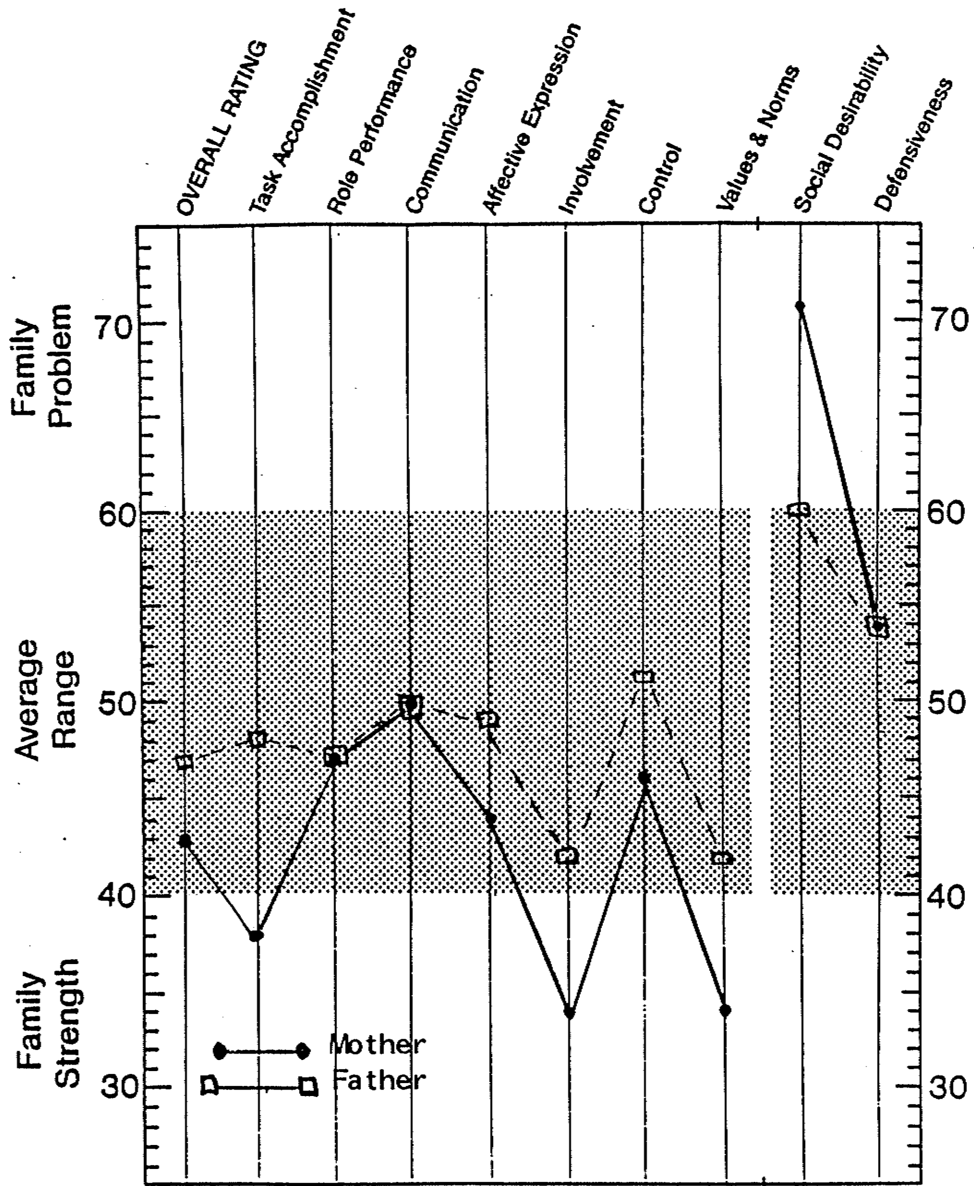
Time 2

FAM GENERAL SCALE



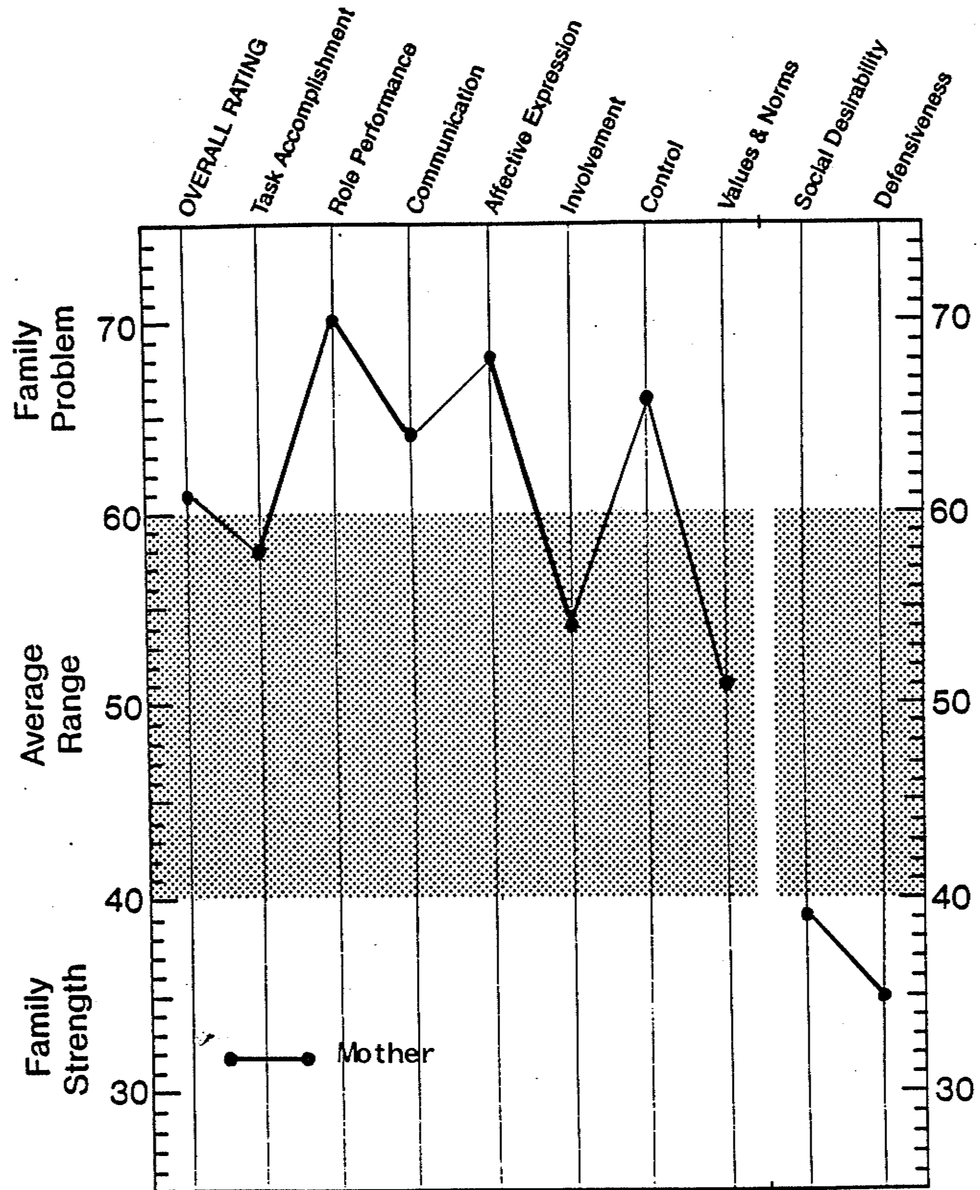
Family 4

Time 1



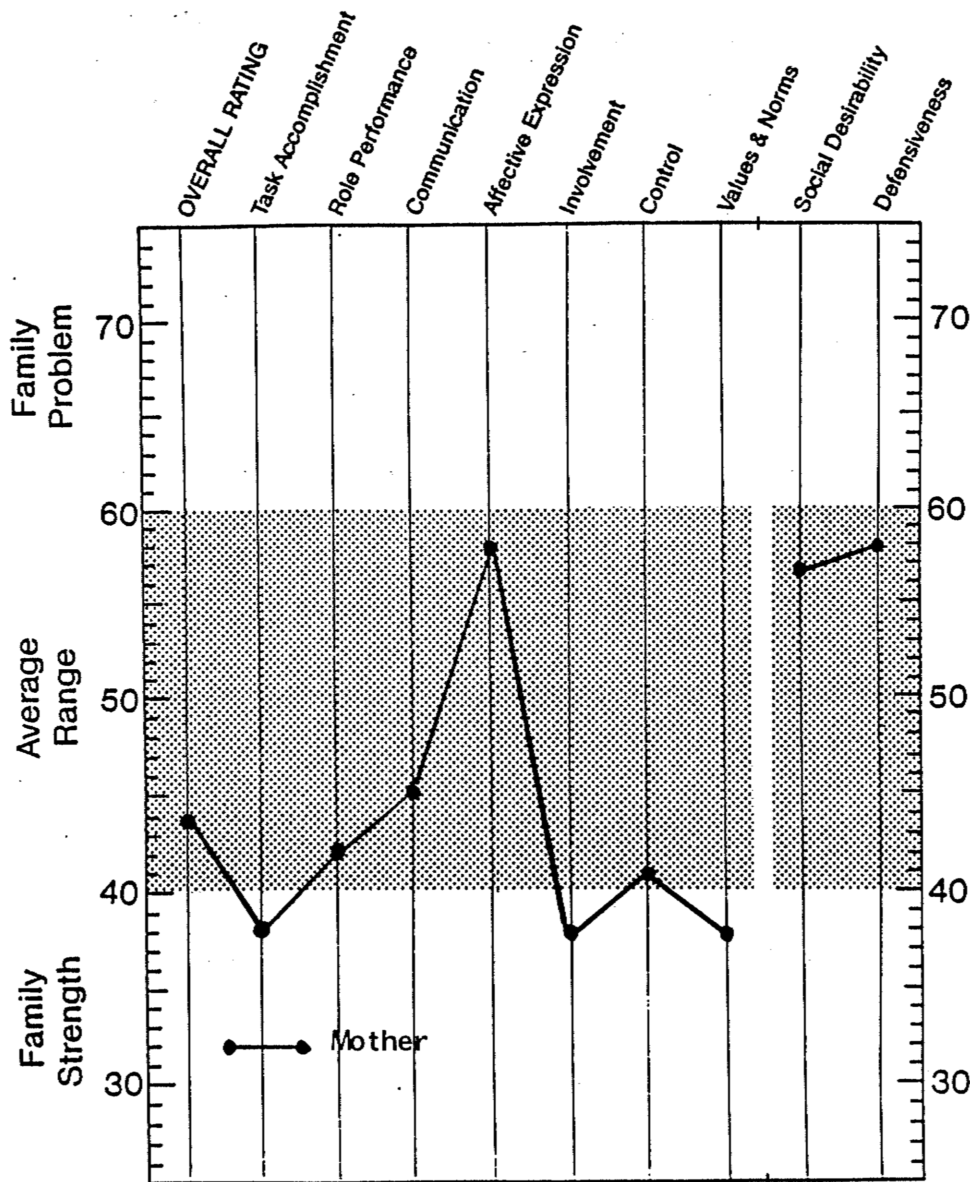
Family 4

Time 2



Family 5

Time 1



Family 5

Time 2