

THE APPLICATION OF MULTIDIMENSIONAL FAMILY THERAPY
WITH TRAUMA EXPOSED ADOLESCENTS

BY

CARMEN N. REYNOLDS

A Practicum Report submitted to
the Faculty of Graduate Studies
In Partial Fulfillment of the Requirements for the Degree of

Master of Social Work

Department of Social Work
University of Manitoba
Winnipeg, Manitoba

© Carmen N. Reynolds, August 2004

THE UNIVERSITY OF MANITOBA
FACULTY OF GRADUATE STUDIES

COPYRIGHT PERMISSION PAGE

**The Application of Multidimensional Family Therapy with
Trauma Exposed Adolescents**

BY

Carmen N. Reynolds

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree
of**

MASTER OF SOCIAL WORK

CARMEN N. REYNOLDS ©2004

Permission has been granted to the Library of The University of Manitoba to lend or sell copies of this thesis/practicum, to the National Library of Canada to microfilm this thesis and to lend or sell copies of the film, and to University Microfilm Inc. to publish an abstract of this thesis/practicum.

The author reserves other publication rights, and neither this thesis/practicum nor extensive extracts from it may be printed or otherwise reproduced without the author's written permission.

ACKNOWLEDGEMENTS

I dedicate this report to my parents. You taught me the value of education, and provided support and encouragement as I fulfilled my dream.

I thank my dear friends Kim, Carmen and Jean-Francois for opening your hearts and homes. Your support and understanding gave me strength to achieve my goal.

I thank my Advisor Dr. Brenda Bacon for her support and guidance over the last four years. You believed in my ability and contributed to my educational success.

I thank Dr. Alex Wright for her feedback on the proposal, and Jay Rodgers for his input on the practicum report and presentation. Jay, your contribution was invaluable to the timely completion of this report.

Finally, I thank my practicum supervisor John Smyth for providing a safe and supportive learning environment. Your commitment to my personal and professional development will be remembered. Thank-you.

ABSTRACT

Multidimensional Family Therapy (MDFT) is a manualized treatment program designed for adolescents and their families. MDFT follows an ecosystems perspective and recommends assessment and intervention with individuals, families, and social systems. This holistic approach is congruent with Social Work practice as treatment occurs in the context of family and social systems. When applied to adolescents exposed to trauma, MDFT shifts treatment from symptom reduction to relational and social development and empowers individual and families to focus on solutions rather than problems.

Multidimensional Family Therapy is a theoretically derived and empirically supported treatment for adolescents who abuse drugs or alcohol. The purpose of the practicum was to apply the theory and concepts of MDFT to adolescents exposed to trauma and to evaluate the effectiveness of the intervention.

TABLE OF CONTENTS

Chapter One	
Introduction	6
Rationale	8
Learning Goals and Objectives	11
Chapter Two	
Literature Review	12
Multidimensional Family Therapy	12
Theoretical Frameworks	12
Core Operating Principles	12
Risk and Protective Factors	15
Developmental Psychopathology	17
Ecological	18
Adolescent Focus	18
Parent/Family Focus	19
Family Interactional Focus	20
Extra-familial Focus	21
Therapeutic Goals	21
Empirical Research	22
Trauma	24
Nature	25
Age and Developmental Level	26
Memories	28
Personality	29
Attachment and Trauma	29
Trauma and the Family	30

Chapter Three	
Description of the Practicum	33
Practicum Format	33
Population and Setting	33
Duration and Intensity	34
Recording	34
Supervision	34
Evaluation	34
Global Assessment of Functioning	35
Family Assessment Measure III	35
Trauma Antecedents Questionnaire	36
Client Satisfaction Questionnaire	36
Client Profiles	36
Client Data	37
Chapter Four	
Case Studies	43
Case Study One	43
Case Study Two	60
Case Study Three	77
Case Study Four	87
Themes	97
Multidimensional Family Therapy in Clinical Practice	101
Chapter Five	
Evaluation	105
Global Assessment of Functioning	105
Family Assessment Measure III	106
Trauma Antecedent Questionnaire	107
Client Satisfaction Questionnaire	108
Social Indicators of Success	109
Learning Goals	109

Conclusion	115
References	116
Appendices	123
Appendix A – Participant Consent Form	123
Appendix B – FAM III – case study one	124
Appendix C – FAM III – case study two	125
Appendix D – FAM III – case study three	126
Appendix E – FAM III – case study four	127
Appendix F – TAQ – case study one	128
Appendix G – TAQ – case study two	129
Appendix H – TAQ – case study three	130
Appendix I – TAQ – case study four	131

CHAPTER ONE

Introduction

Practica provide educational opportunities for students to learn and apply theory in practice settings. This practicum rationale outlines how concepts from the family life cycle, developmental psychology, and attachment theory inform the decision to use Multidimensional Family Therapy (MDFT) to assist adolescents and families in an outpatient mental health setting. In addition, the rationale explores trauma symptomology as it relates to the theory, treatment method, and population. Next, the rationale leads to a discussion of how trauma research and treatment is relevant to Social Work, followed by an outline of the practicum goals and objectives that guide skill development and learning.

The literature review includes a summary of the MDFT model, followed by a discussion of the contributing theoretical frameworks. These theoretical frameworks provide a basis for MDFT's ideological position and contribute to the development of the operating principles that guide clinical orientation, decision-making and intervention. Following are examples of how the operating principles inform practice in each of the four treatment domains: adolescent, parent/family, family interactional, and extra-familial. As well, there is an outline of the therapeutic goals and objectives of MDFT, and a summary of the empirical research to date.

In addition to MDFT, the literature review provides an understanding of child/adolescent trauma. The review looks at how age, personality, and stage of development determine the type and severity of symptomology. It also outlines explanatory theories for post-trauma amnesia, and addresses how trauma damages

attachment relationships. Finally, there is a comparative analysis between trauma family therapy and MDFT.

The next chapter discusses how MDFT was applied with trauma exposed adolescents at St. Boniface General Hospital. The discussion includes a description of the population, program, and setting, along with a review of the intensity and duration of treatment contact. Next, there is an outline of the recording and supervision procedures, followed by the data collection and practice evaluation methods. Finally, the six adolescents recruited for the practicum are profiled with their identified trauma and primary diagnoses.

Of the six adolescents recruited for the practicum, four completed a minimum of ten clinic sessions. These four cases appear in case study format, and follow the MDFT model of assessment and intervention across each of the three domains: individual, family, systems. They also incorporate assessment scores into the individual and family domains, and conclude with data from the client satisfaction questionnaire. Trauma themes from each case study are summarized at the end of the chapter, followed by a review of MDFT's strengths and weaknesses.

The final chapter focuses on evaluation. The evaluation assesses each measure based on availability, ease of use, and the clinical importance of data. It also includes the perceived level of change based on client self-reports and summarizes client satisfaction data. Finally, the evaluation highlights the student's successful completion of practicum goals.

Rationale

The family life cycle is a predictable series of stages that each family goes through (Karpel & Strauss, 1983). Families may differ in how and when they go through each phase, but like other developmental theories, families must sequentially go through each stage before moving on to the next (Karpel & Strauss, 1983). Each stage brings stress and disorganization as families learn to adjust to new demands. Failure to adjust can result in families being stuck in a state of disequilibrium (Becvar & Becvar, 2000).

Adolescence is a particularly difficult stage in the family life cycle as many physical and psychological changes occur with the onset of puberty (Karpel & Strauss, 1983). Developmental theorists suggest the primary tasks of adolescence include redefining the parent-child relationship “regarding issues of autonomy, responsibility, and control, without fundamentally violating their basic trustworthiness” (Karpel & Strauss, 1983, p. 60). Many traditional family therapists focus their energy on autonomy and control issues, while Structural Family Therapists such as Salvador Minuchin reinforce the need for hierarchy and boundaries (Nichols & Schwartz, 2001).

Over the last couple of decades, family therapists such as Howard Liddle made a fundamental shift in how they view the parent-adolescent relationship (2001). Instead of viewing adolescence as a time of separation and emotional detachment, adolescence is considered as a time when the parent/adolescent relationship grows and develops (Liddle & Diamond, 1991). With this in mind, parents need to nurture the emotional relationships they have with their adolescents and take more interest in their adolescents’ activities. This type of parental involvement provides a secure basis for the adolescent to

transition from dependent child to interdependent adolescent, a necessary step in development (Liddle & Diamond, 1991).

Emotional attachment during adolescence is another way of describing the re-alignment of the parent-adolescent relationship (Liddle, 1994). Traditionally, the term attachment was reserved for the relationship between a mother and her infant, but recently the notion of attachment has made its way into discussion of the family life cycle (Ainsworth, 1991). Over the years, many researchers have investigated attachment styles and the effects on parent-child relationships (Grossmann and Grossman, 1991). However, there is still “no direct link between parents’ early attachment experience and their parenting behaviour” (Vanijzendoorn & Bakermans-Kranenburg, 1997, p. 138). According to attachment theory, parents’ early attachment experiences interact with their current attachment experiences, social context, and adolescent characteristics to create the parenting behaviours the adolescent experiences (Vanijzendoorn & Bakermans-Kranenburg, 1997). Therefore, the therapist can use multi-level interventions to emotionally engage and re-align families.

It is particularly important, when working with adolescents and families exposed to trauma, to provide a secure base for clients to form attachment relationships within the family. Many clients who seek treatment for trauma have histories of emotional, physical and/or sexual abuse from childhood. They may also present with problems of attachment, attention, and self-regulation (Van der kolk, 2001). Problems of attachment can significantly impair one’s ability to attain satisfying interpersonal relationships and intimacy due to an array of symptoms. These symptoms include poor boundaries, trust issues, fear of abandonment, impulsive or socially alienating behaviours, difficulties with

self-disclosure, lack of self-care, and anxiety or tension (Van der kolk, 2001; Wilson, Friedman, & Lindy, 2001). In addition to problems of attachment, trauma can also significantly impair one's capacity to self-regulate (Van der kolk, 2001). Such problems include substance abuse, anxiety, depression, poor impulse control, aggression towards self and others, and attentional difficulties such as Attention Deficit and Hyperactivity Disorder (ADHD) (Van der kolk, 2001, Wilson et al., 2001). Therefore, trauma clearly affects individual and family functioning, leading to an increased use of mental health services. For that reason Social Workers must have a theoretical framework to address the interpersonal nature and familial/social context of trauma injury.

Multidimensional Family Therapy is a manualized treatment program designed for adolescents and their families. MDFT follows an ecosystems perspective and recommends assessment and intervention with individuals, families, and social systems. This holistic approach is congruent with Social Work practice as treatment occurs in the context of family and social systems. The shift from symptom reduction to relational and social development empowers individuals and families to focus on solutions rather than problems (Diamond & Siqueland, 1998). Creating solutions is important when working with this population as families often feel blamed for subjecting their child or adolescent to trauma (Havas & Bonnar, 1999). By reducing the blame, Social Workers can create a collaborative agenda for treatment and help families repair the damage caused by trauma exposure.

Learning Goals and Objectives

The student Social Worker created the following goals and objectives to learn MDFT theory, to study trauma research, to develop clinical skills, and to master the use of evaluative tools.

1. Learn and apply the theory and concepts of Multidimensional Family Therapy.
 - Increase knowledge about Developmental theory.
 - Increase knowledge about Ecological theory.
 - Increase knowledge about risk and protective factors associated with adolescent behaviour problems.
 - Increase knowledge and develop skills to engage and align with adolescents and their families.
 - Increase knowledge about diversity issues such as culture and socioeconomic status.
2. Learn about the effects of trauma on attachment and adolescent development.
3. Develop skill and confidence to become a better therapist.
 - Learn how to match the client's emotional tone
 - Develop skills to track and attend to content and process within counselling sessions.
4. Learn how to use clinical supervision.
5. Learn how to evaluate clinical practice and to use measurement.
6. Develop skills for working in a multidisciplinary outpatient setting.

CHAPTER TWO

Literature Review

Multidimensional Family Therapy

Multidimensional Family Therapy (MDFT) is a manualized intervention program. Dr. Howard Liddle created MDFT to treat adolescent drug and alcohol abuse and/or associated behaviours (2002). MDFT is recognized as a comprehensive, multi-component treatment that is theoretically derived and empirically supported in the literature (Liddle, 2002). Although the manual is not yet published, the author graciously provided a copy of the manual for the purpose of this practicum. The following chapter reviews the theoretical frameworks, treatment groups and goals, and empirical research.

Theoretical Frameworks

Multidimensional Family Therapy is a family-based approach to working with adolescents who abuse drugs, alcohol, and/or have significant behaviour difficulties (Liddle, Dakof & Diamond, 1991). Theory guides the development of operating principles, treatment groups and goals, as well as therapeutic techniques. The first theoretical framework incorporates the balance of biological, psychological, and environmental risk and protective factors. The second theoretical domain integrated into MDFT is developmental psychopathology – an adolescent’s ability to cope and manage tasks of development. The third theory influencing MDFT is ecological theory, which outlines the importance of context and social influences on human development (Liddle 1999).

Core Operating Principles. Core operating principles are “grounded rules of therapeutic practice that guide clinical orientation, decision-making and intervention”

(Liddle and Hogue, 2001, p.234). According to Liddle and Hogue (2001), there are ten core operating principles that guide therapy. As adolescent and family problems are multidimensional, the therapist uses developmental and ecological theory to guide intervention and assess adolescent and family symptoms. This assessment provides direction for treatment, thereby creating a sequential pathway for the therapist to follow. During treatment, the therapist builds relationships with the adolescent, family and support systems by exploring themes that are meaningful to them.

This exploration leads to individualized interventions created for each family. These interventions are planned collaboratively, and promote protective factors associated with positive family development while targeting risk factors associated with behavior problems. Challenges are embraced, and the therapist helps families overcome difficulties by evaluating and modifying case plans and interventions as needed. Throughout this process, the therapist recognizes that change occurs with different systems and people at different times. Moreover, individual and family motivation is not assumed: the therapist recognizes that resistance is normal, and not an indicator of therapeutic failure.

Therapist attitude is essential to therapeutic success. The therapist must maintain therapeutic neutrality and remain optimistic about change, thus encouraging client participation and strengthening motivation. The therapist takes responsibility for success or failure by creating a collaborative agenda that enables systematic work within each session or within therapy as a whole. This promotes focus and consistency in sessions and encourages positive behavior change for the individual and family. From this,

multidimensional and multisystemic interventions are created. The success of these interventions is monitored and revised as required.

Core Operating Principles:

1. Adolescent behaviour problems are multidimensional. Therefore, the therapist uses developmental and ecological theory to guide intervention.
2. Adolescent and family symptoms provide valuable information for assessment and opportunities for intervention.
3. Change occurs with different systems, people and processes at different times. Assessment provides an indication of the kind and direction of treatment, thus creating a sequential pathway for the therapist to follow.
4. Adolescent and family motivation is not assumed. Therapists recognize that 'resistance' is normal, and not a negative indicator of therapeutic failure. Therapists embrace the challenge, and help families overcome difficulties that may impair therapeutic success.
5. Treatment is possible through the relationships the therapist makes with the adolescent, the family, and their social systems, and through the exploration of personally meaningful themes.
6. Individualized interventions are created for each family, targeting risk factors associated with behaviour problems, and promoting protective factors associated with positive family development.
7. Case formulation and planning is collaborative with the family, and provides information about the course of therapy. Therapists will evaluate and modify case plans and interventions, as new information becomes available.

8. Therapists are responsible for the success or failure of therapy. Therapists are responsible for:
- Encouraging client participation and strengthening motivation
 - Creating a collaborative agenda
 - Maintaining focus and consistency in session
 - Making multidimensional and multisystemic interventions
 - Encouraging behaviour change
 - Monitoring the success of interventions
 - Revising the interventions as required
9. Therapists conceptualize therapy, reducing therapeutic operations into stages the therapist can work through systematically within each session or within therapy as a whole.
10. Therapist attitude is essential to therapeutic success. Therapists maintain therapeutic neutrality while working with the adolescent and the family, and are optimistic about change (Liddle, 2001).

Risk and Protective Factors. Risk and protection theory states that psychological dysfunction is determined by the interaction between risk and protective factors. Risk factors such as gender, parent functioning and socio-economic status predispose adolescents to the development of disorders (Liddle & Hogue, 2001). Alternately, protective factors such as family cohesion and social supports buffer against the development of disorders. According to the literature, risk and protective factors fall into three main categories: biological, psychological and environmental (Liddle, 2001).

Biological factors refer to traits such as age and gender. According to the research, age and level of development affects how children interpret and store trauma memories (Nader, 2001). However, age and level of development do not affect the rate of Posttraumatic Stress Disorder (PTSD) following trauma exposure (Resick, 2001). In fact, children of different ages respond to similar trauma with similar rates of PTSD (Resick, 2001).

Unlike age, gender affects the type, intensity, and nature of trauma exposure. Males are more likely to experience multiple traumas resulting from accident or injury (Resick, 2001). Females are more likely to experience chronic or acute interpersonal trauma resulting from rape, assault or sexual abuse (Resick, 2001). As such interpersonal trauma produces greater trauma injury, women are more likely to suffer long-term effects of trauma exposure (Van der kolk, 2001).

Environmental factors include socioeconomic status (SES), income and education. A causal relationship between income, education and trauma does not exist. However, the research suggests low income and education are risk factors for they correlate with a higher incidence of trauma (Resick, 2001). Studies find that those with higher SES have greater access to resources that promote recovery than those with lower SES (Resick, 2001). When trauma is unresolved and symptomology persists, there is a greater chance of transmitting psychopathology to offspring.

Psychological risk factors include family environment, parental psychiatric illness, parent/child separation, and/or child abuse (Resick, 2001). Parental psychiatric illness is one of the primary psychological risk factors clinicians need to consider when assessing and intervening with families. Parental psychiatric illness can lead to secondary risk

factors such as early parent/child separation, family instability, and ineffective parenting that may result in child victimization (Resick, 2001). Therefore, parental psychiatric illnesses are indicators for assessment, and secondary risk factors are targets for intervention.

Although there are many risk factors, family health is one of the most important environmental protective factors for adolescents (Liddle & Hogue, 2001). Families that foster positive relationships and communicate well have protective factors that can counter biological, psychological, and environmental risk factors (Liddle, 2002). Consequently, MDFT therapists strive to strengthen families by developing their protective factors to counter-balance risk factors associated with trauma.

Developmental Psychopathology. Developmental psychopathology requires the therapist to assess the adolescent's ability to cope and manage tasks of development (Liddle, 2002). Some of the most relevant developmental issues include adolescents' desire for increased autonomy and peer interaction, as well as their ability to monitor and self-regulate their behavior (Liddle & Hogue, 2001). Although adolescents strive for independence, many do not have the skills to make appropriate choices independently. Therefore, parental support and guidance are crucial for adolescents to learn the skills they need to become competent adults (Diamond, Sessa, Schmidt & Ettinger, 2000). When such support is not available, adolescents seek support and guidance from other sources such as peers. This may lead to less desirable outcomes.

Ecological. Ecological theory stresses the importance of looking at the context of human behavior and the effects that social influences have on adolescent development (Liddle & Hogue, 2001). MDFT uses the ecological theory as a rationale for intervening

with the individual, the family, and the relevant social systems. This systemic approach takes the emphasis off the adolescent and family, provides alternate explanations for the behaviour, and creates avenues for intervention with multiple social systems (Liddle & Hogue, 2001). Ecological targets include income, housing, education and social connection.

Treatment Areas of Focus

After addressing the core operating principles and theoretical perspectives that guide MDFT, the following section will outline the assessment and treatment recommendations in each of the four domains. These domains are adolescent, parent/family, family interactional, and extra-familial.

Adolescent Focus. From the onset of therapy, the therapist will engage the adolescent in individual sessions to develop the therapeutic relationship (Liddle, 1995) and identify personally meaningful goals to increase the adolescent's motivation and commitment to therapy (Little, 2002). During this initial phase, the therapist encourages the adolescent to discuss his/her social network, as well as their ability to meet school demands. The therapist and adolescent also discuss personal successes and failures, and how they make decisions and monitor their own behaviour (Liddle & Hogue, 2001).

Gradually, discussion moves toward the adolescent's drug/alcohol use and behavioural problems, addressing intrapersonal challenges and interpersonal difficulties (Palmer & Liddle, 1995). Although intrapersonal challenges are addressed, the emphasis of MDFT is on the adolescent's interpersonal relationships. Therefore, the therapist assesses familial and extra-familial relationships to determine what is motivating the adolescent to use drugs or alcohol, and/or act out (Liddle & Dakof, 1995). An accurate

assessment during this phase will provide the therapist with information she needs to make therapy personally meaningful for the adolescent.

Parent/Family Focus. MDFT therapists recognize that the relationship between parents and adolescents is the strongest protective factor against behaviour problems (Liddle & Dakof, 1995; Liddle and Hogue, 2001). Therefore, the primary goal of therapy is to strengthen this relationship and foster a sense of hope for the parents. The therapist's initial task includes acknowledging the parent's difficulties and empathizing with their feelings of helplessness. Often, parents of adolescents who use drugs or alcohol and/or have behaviour difficulties have high stress levels. This stress can be exacerbated by poor social supports, low SES, negative feelings about parenting and/or chronic health concerns (Palmer & Liddle, 1995; Dishion, 1998). With this in mind, the therapist spends time alone with the parents at the onset of therapy to address how biological, psychological and environmental factors can affect their parenting, as well as how they can protect their children from the negative effects. Taking an ecological perspective, the therapist assists the parents in accessing resources (Schwartz & Liddle, 2001; Liddle & Dakof, 1995). Such assistance helps families meet their basic needs, thereby freeing up emotional resources needed for therapy.

After parent sessions, the therapist brings the family together and begins to assess the attachment bond between the parents and the adolescent (Liddle & Hogue, 2001). Therapists strive to strengthen the relationship between the adolescent and the parent by fostering the sense of love and commitment they have for their child (Liddle, 2002). The shift from hopelessness to commitment strengthens the relationship by drawing the adolescent closer and making his/her need for connectedness known (Diamond &

Siqueland, 1998). It also strengthens the relationship by increasing the parent's sense of competence and control (Liddle & Hogue, 2001). It is important, however, that the parent and adolescent maintain a balance between autonomy and relatedness (Santrock, 1996), for too much autonomy can lead to emotional disengagement (Schwartz & Liddle, 2001) a risk factor for youth.

The next phase of therapy involves using the parent's renewed sense of competence and control to address parenting concerns such as discipline, monitoring, and limit setting (Liddle & Hogue, 2001). During this phase, therapists help parents develop a supportive emotional atmosphere where parents and adolescents can discuss problem behaviours and work towards more adaptive family functioning (Liddle, 2002).

Family Interactional Focus. The family interactional focus addresses relationships and communication patterns between family members (Liddle, 1995). The goal is to help families develop new skills and ways of interacting that will enhance the bond between parent and adolescent and promote change in adolescent problem behaviour (Liddle & Dakof, 1995). In order to alter interactional processes, MDFT therapists use a structural family therapy technique called enactment (Nichols & Schwartz, 2001). When using enactment, the therapist prompts the family to discuss a topic or issue in order to assess the family's communication patterns, problem solving, and perspective-taking abilities (Liddle, 1999). The MDFT therapist intervenes by shaping the family's responses, thus providing new and more adaptive experiences (Liddle & Hogue, 2001).

Another way MDFT therapists intervene is by teaching and modifying the family's communication patterns. They stress that conversing in a non-defensive, non-

blaming way is fundamental to communication health (Liddle, 1995). Therapists may work individually with different family members or sub-groups to help formulate and practice for a planned conversation. Considerable coaching may take place during these sessions, for the therapist wants the family to create and experience new ways of interacting (Liddle & Hogue, 2001).

Extra familial focus. MDFT therapists use case management skills to connect and collaborate with extra-familial resources (Liddle & Hogue, 2001; Liddle, 1995). The purpose of including the adolescents' formal and informal systems, such as school and recreation, is to help the adolescent re-evaluate and re-process their attitudes and emotional reactions, thus creating new ways of being in different environments (Liddle & Hogue, 2001). Other case management activities include creating educational plans, encouraging pro-social recreational activities, and facilitating relationships with Juvenile Justice and Child Protection Services.

Therapeutic Goals. One goal of Multidimensional Family Therapy is to build the alliance between the therapist and the adolescent. This enables the therapist to align with the adolescent, to monitor his/her engagement in therapy, and to make therapy meaningful for the adolescent. The therapist will then build upon this alliance with the adolescent to help resolve impasses with parents. This leads to an increase in problem solving ability and emotional engagement, and a decrease in negative family interactions.

Multidimensional Family Therapy also aims to change parenting practices for the better by increasing positive skills such as role modeling, limit setting, commitment and positive affect. These changes in the parental subsystem are associated to changes in adolescent behavior, and a decrease in hostility, blaming, and negative affect.

Multidimensional Family Therapy also aims to develop culturally specific interventions and explore culturally specific themes to increase the adolescent's participation in therapy.

Empirical Research. Multidimensional Family Therapy is an empirically supported therapeutic approach for working with adolescents who abuse drugs or alcohol (Liddle, 2002). Participants of the three controlled research studies to date include males and females of various ethnic origins with varying degrees of substance abuse and problem behaviour. In each study, MDFT is compared to traditional treatments used in adolescent outpatient services.

The first study randomly divided 182 marijuana and alcohol-abusing adolescents into three treatment groups, MDFT, group therapy, and multifamily education. Treatments were administered once a week for sixteen to twenty weeks. Researchers assessed for change in client symptoms and pro-social functioning using pre-treatment, post-treatment, and six to twelve month follow-up tests. The results suggest that participants in each treatment group improved, but those who received MDFT showed greater improvement than those in group therapy and multifamily education (Liddle, Dakof, Parker, Diamond, Barrett, & Tejada, 2001).

The second study randomly assigned 224 substance-abusing adolescents into two treatment groups, MDFT and individual Cognitive Behavioural Therapy (CBT). Treatments were administered once a week for twenty to twenty-four weeks. Researchers used pre-treatment and six to twelve month follow-up tests to assess for change in client self reports of drug and alcohol abusing behaviour and internalizing/externalizing symptomology. Examples of internalizing behaviour include depression and social

withdrawal; examples of externalizing behaviour include alcohol and drug use.

Researchers apply statistical tests to look for differences in the rate and effectiveness of the two treatments. The findings suggest that each treatment produced change in alcohol, marijuana, internalizing and externalizing behaviours, but that MDFT produced greater and more lasting change across all three domains (Liddle, Dakof, Turner & Tejada, In press).

The third study randomly assigned 600 participants to one of five interventions: Motivational Enhancement Therapy (MET), Cognitive Behavioural Therapy (CBT), Family Support Network (FSN), Adolescent Community Reinforcement Approach (ACRA), or Multidimensional Family Therapy (MDFT). Treatment delivery occurred at two community-based programs and two medical centres. The purpose of this multi-site, randomized study was to test effectiveness and cost-benefits of five manualized cannabis youth treatments. Participants of this study received different combinations of individual and family counselling, telephone contact and case management consistent with each treatment approach. Researchers used pre-treatment, mid-treatment, post-treatment, and follow-up assessments. They found that MDFT is effective at reducing substance abuse and problem behaviours, and at developing individual and family protective factors (Dennis et.al., In press).

In summary, the clinical research supports MDFT as an effective treatment for adolescent substance abuse and problem behaviour. The research is consistent with theory, for in each clinical trial, adolescent substance abuse and problem behaviour decreased while pro-social and protective factors increased. Such findings support MDFT's integrated approach, where risk and protective factors combine with ecological

and developmental theory, and result in a valuable treatment for adolescents and their families.

Trauma

Trauma research has evolved over the last 20 years with the inclusion of Posttraumatic Stress Disorder (PTSD) in the Diagnostic Statistical Manual (Wilson, Friedman & Lindy, 2001). The diagnosis of PTSD was originally created to classify a group of symptoms seen in Vietnam veterans after the war, and does not include many of the co-morbid conditions clients present following trauma exposure (Van der kolk, 2001). Trauma is a broad term used to classify psychological injury that most often results from our social structure (Freyd & DePrince, 2001). For instance, patriotism, patriarchy, and ethnocentricity can lead to war, abuse, and racial violence. Trauma research increases societal awareness of human cruelty and brutality, thus placing responsibility on the social structure that continues to suppress and marginalize sub-groups of the population. These realities slow research and dampen efforts to understand trauma-related injury and the development of new interventions (Freyd & DePrince, 2001). Although this may be the case, clinicians need the skills to treat trauma. Prevalence studies in the USA suggest that 72% of the population will be exposed to some type of trauma over their lifetime (Freyd & DePrince, 2001).

The study of childhood trauma and treatment has gained a significant amount of attention over the last five to ten years as professionals seek to understand children's responses to different types of trauma (Nader, 2001). Two different types of trauma include acute single episode traumas, such as car accidents or random shootings, and repetitive, long-term exposure to acts of family violence such as emotional, physical and

sexual abuse. Children's responses to trauma differ depending on the nature of the trauma, the characteristics of the child and family, the memories and meanings the child assigns to the traumatic experience, and the child's personality. Clinicians use this information to assess the impact of the traumatic experience and create individualized interventions to meet the needs of the child. Unresolved trauma can lead to a wide range of symptoms that can greatly impair a child throughout his/her life. Therefore, clinicians must use information and resources to understand the nature of the trauma, the PTSD symptoms, the co-morbid conditions, and the secondary long-term effects in order to help clients resolve feelings about the trauma and relieve their symptoms.

Nature

The nature of trauma refers to the type, length and intensity of trauma exposure. The most common type of childhood trauma seen in outpatient treatment settings is chronic emotional, physical, and sexual abuse (Van der kolk, 2001). These types of trauma were evident in the practicum as five of the six families interviewed presented with histories of abuse. Three families reported incidents of sexual abuse, one family reported incidents of physical abuse, and five families reported incidents of emotional abuse. Families that reported physical and sexual abuse reported the co-existence of emotional abuse. Emotional abuse includes the use of harsh coercive parenting, name-calling, lack of parental acceptance, and witnessing acts of family violence. In terms of length and intensity, five families indicated that the abuse occurred consistently for a minimum of two years. The one family that did not report incidents of abuse sought treatment for their daughter who was the driver in a motor vehicle accident.

Age and Developmental Level

Age and developmental level of the child can significantly affect how they calculate threat and attribute meaning to events. For instance, young children rely on their caregivers to protect and nurture them. When they perceive a threat to themselves or their caregivers, the risk of traumatization increases, for the child's sense of safety is diminished (Nader, 2001). In comparison, an adolescent may react to this same threat with feelings of vulnerability and incompetence; in their eyes they should have been able to do something to stop the event from occurring (Nader, 2001). Therefore, the child's age and level of development changes the perceived level of threat and the meaning attached to the trauma.

Precocious development and regression are themes often seen in children exposed to trauma (Nader, 2001). Precocious development is when children pre-maturely develop knowledge, emotion or skill due to abuse or trauma exposure (Nader, 2001). For example, young children may develop sexual knowledge that is inconsistent and inappropriate for their age. Precocious development was evident in the practicum when a thirteen-year-old female displayed sexually provocative behaviour and language that was inconsistent with the behaviour and knowledge of her peers. In comparison, regression is when adolescents show childlike behaviour or regress into concrete thinking as their peers are maturing and developing more abstract thought processes (Nader, 2001). An example of regression occurred with an adolescent male who was physically abused and coerced into adult-like roles. In session, the adolescent repeatedly expressed a desire to be cared for and resisted normal adolescent responsibilities.

Exposure to trauma can also affect moral development in adolescents. There are many different models of moral development, including Gilligan's model of female moral development and Kohlberg's three-stage model of moral development (Nader, 2001). According to Stillwell, Galvin and Kopta's (1991) empirical model of consciousness, there are five stages of moral development. The first stage occurs before the age of six, and suggests that adults have the knowledge and power to protect them. The next stage, beginning at age seven, starts with an introduction to rules and an integration of desire to do what is right and please others. At age twelve, children continue to believe there is a right or wrong, but they start to realize that adults are not always right. They begin to respond to other's emotions and develop the capacity for reciprocal relationships. By age fifteen, adolescence sets in with an overall sense of confusion. Struggles occur between good and bad and between parents and peers, requiring adolescents to sort their experiences to make sense of the world. Finally, by age seventeen, adolescents develop flexible thinking that allows for the co-existence of good and bad and the availability of more than two options. Such thinking creates a renewed sense of control and optimism for the future that reduces the confusion and ambivalence felt in earlier stages (Stillwell, Galvin & Kopta, 1991).

Moral development is important in treatment because children and adolescents exposed to trauma may require extra assistance to develop their moral reasoning, which is a therapeutic goal for many trauma survivors. For instance, a seventeen-year-old female who was sexually assaulted before the age of six continues to struggle with the notion that the perpetrator should have known better. The idea that 'big people know best' continued

to be a theme for this client as memories were stored in the stage of moral development for which they occurred.

Memories

Memories “contribute to an individual’s sense of identity, continuity and predictability in life” by processing and storing information in a personally meaningful way (p., 287, Nader, 2001). Depending on the age of the child, memories of the trauma may be embellished with wishful thinking, or episodes of repeated trauma may blend together into a single script (Nader, 2001). Such encoding allows the child to fit trauma memories into his/her current understanding of the world based on his/her age and level of development. When treating trauma, clinicians must remember that childhood memories are not necessarily factual representations of the past.

Repression and dissociation are two encoding processes that affect the retrieval of coherent verbal narratives and explain why people experience amnesia following trauma exposure (Van der kolk, 2001; Hopper, 2003; Hopper & Osterman, 2001). Repression is a psychological process of forgetting or avoiding trauma memories in attempt to reduce trauma-related stress (Elliott, 1997). In contrast, dissociation is a more complex process whereby associations between behaviour, affect, sensation and knowledge are disengaged (Wakeman, 2002). The psychological process of dissociation allows for smaller packages of information to be stored separately, thereby reducing trauma-related stress upon recall (Wakeman, 2002). Unfortunately, when associations disengage, part of the memory may get lost (Wakeman, 2002). The therapeutic importance of repression and dissociation is that repressed memories may be triggered, retrieved, or recalled during therapy, whereas

dissociative memories can only be recalled in the capacity for which they were stored (Wakeman, 2002).

Personality

Understanding trauma requires an awareness of how people with different personalities interpret trauma, process information, code memories, and cope with the effects. According to Kathleen Nader (2001), research on personality and trauma is in its infancy. Several researchers have used Carl Jung's four mental functions and Myers' sixteen types of personalities to determine how temperament affects trauma and treatment responsiveness (Nader, 2001). Following this investigation, researchers concluded that different personalities may increase one's susceptibility to psychological dysfunction following trauma exposure, but did not suggest direct correlations between specific personality types and discrete trauma responses (Nader, 2001). Differences in personality and trauma response became evident in the practicum when two siblings who were close in age and exposed to similar traumas presented with very different symptoms. One sibling presented with externalizing symptoms such as anger and risk taking behavior. The other sibling presented with internalizing symptoms such as social withdrawal and depression. Observed differences in personality and trauma responsiveness are important to note, but their usefulness in clinical practice is limited due to lack of conclusive research in the area.

Attachment and Trauma

Children exposed to trauma often have pervasive problems with attachment (Van der kolk, 2001). This can significantly impede their ability to develop and maintain personally meaningful relationships, resulting in loss of connection, social isolation,

estrangement and detachment (Wilson, 2001). Therefore, one of the primary goals of trauma treatment includes restoring healthy attachments and relationships by improving the emotional bonds between individual family members (Wilson, 2001; Diamond & Diamond, 2002).

Attachment theory guides therapeutic interventions by promoting the “establishment and reestablishment of a secure relationship base as the foundation for all other interpersonal processes” (Diamond & Diamond, 2002). Using this fundamental principle, the MDFT model suggests interventions that target re-attachment and relationship repair (Liddle, 2002). The first task requires the therapist to develop a therapeutic relationship with the adolescent based on trust and understanding. This enables the therapist to act as a surrogate attachment figure until the parent is ready to assume the role (Liddle, 2002). Secondly, the therapist shifts the affective tone from accusation and blame to disappointment and loss (Liddle, 2002). This softens the tone, allowing parents and adolescents to express past grievances and to hear each other’s apologies. Finally, the therapist uses enactment to help parents and adolescents re-experience each other and communicate more effectively (Liddle, 2002). When working on attachment goals, the adolescent must feel that his/her interpersonal needs can and will be met by his/her parent and/or therapist.

Trauma and the Family

Trauma is a widespread human condition resulting most often from societal and familial discord (Havas & Bonar, 1999). “Whether trauma affects a whole family or a single member, the entire family endures the traumatic aftermath” (Miller, 1999, p. 21). Trauma interferes with child and interpersonal development and disrupts attachment

bonds (Miller, 1999, Nader 2001). Therefore, researchers recommend family therapy for trauma victims and their families (Miller, 1999).

Figley (1988) designed a five-phase family therapy model specifically to treat families affected by trauma. Figley's first three phases of treatment closely resemble the parent/family phase in the MDFT model (Liddle, 2002). For instance, both models suggest building rapport and commitment, developing objectives, and framing the problem. Each model asked family members to express past hurts and grievances to foster forgiveness, acceptance, communication and understanding. With a common understanding and a newly defined story, Liddle (2001) and Figley (1988) reframe the tragedy or problem in the context of the family and improve family cohesion by reducing blame on individual family members. The final phase of trauma family therapy includes developing a healing theory or whole family story (Figley, 1988; Allen & Bloom, 1994). This phase is unique to trauma family therapy, for family members give meaning to their trauma experience before celebrating their success and terminating treatment (Figley, 1988).

Conclusion

The study of childhood trauma and treatment has gained a significant amount of attention in recent years as researchers aim to understand the manifestation of symptoms following trauma exposure (Pelcovitz, Van der kolk, Roth, Kaplan & Resick, 1997). According to the literature, characteristics of the trauma and the child contribute to symptom development. For instance, the type and intensity of the trauma combined with age and level of development determine the perceived level of threat and symptom development. They also influence how trauma memories are stored in order to reduce

intensity and re-traumatization upon recall. Due to the interpersonal nature of trauma injury and its effects on attachment, family therapy is used to repair relationships, reduce blame on the individual, and create healing stories (Liddle, 2002; Figley, 1988).

CHAPTER THREE

Description of the Practicum

From January to June 2003, the writer accrued over 500 practica hours at St. Boniface Hospital. Four adolescents participated in the practicum by engaging in a minimum of ten clinic sessions over six months. Each client/family gave permission for video recording, student charting and two-way mirror observation/supervision. They also completed assessment and evaluation questionnaires. The following chapter will outline procedures and give a brief description of the six adolescents recruited to participate in the practicum. Two of the six adolescents discontinued service after assessment and did not participate in the practicum.

Practicum Format

Population and Setting. Families were recruited from the Adolescent and Child Collaborative Community Intervention Service (ACCCIS) at the St. Boniface General Hospital provides clinical services to adolescents and their families when adolescents experience difficulties across two domains of daily living: home, school, and/or community, following psychological trauma (WRHA, 2001).

Multidimensional Family Therapy is an appropriate treatment for it is a family systems approach that provides intervention suggestions for individuals, families, and social systems. MDFT meets the criteria of the WRHA for its interventions are multidisciplinary and have multi-system involvement (WRHA, 2001). Such criteria are also consistent with the ecosystems perspective that is “universally accepted in contemporary Social Work” (Mattaini, 1997, p. 17).

Duration and Intensity. Each of the six client units participated in an extensive assessment completed by Dr. Hall (Psychiatrist), John Smyth (Senior Social Worker), and the writer. Five of the six adolescents continued to receive services after the assessment, while four of the six had a minimum of ten clinic sessions. Short telephone sessions occurred with four families, and proved most useful when working with parents. Telephone sessions provided opportunities to offer support, discuss parenting, and educate about adolescent development. Case management activities such as home visits and school meetings occurred with three of the four remaining families.

Recording. Five of the six adolescents provided written consent to record sessions on video. Video recordings reduced the need for note taking and allowed careful tracking of the therapeutic process. Video recordings also provided opportunity to review and evaluate each session and to seek supervision as required. The videos were erased following completion of the practicum.

In compliance with hospital procedure, the content and nature of each client contact was recorded in the client's medical chart.

Supervision. John Smyth (MSW), Practicum Supervisor, provided weekly clinical supervision. Supervision activities included live observation, video review, case formulation and treatment planning. Clinical consultation was also obtained from Ellen Gordon (Family Therapist at St. Boniface Hospital) and Dr. Brenda Bacon (Faculty Advisor).

Evaluation. Evaluation is an important component of clinical practice. The measurement package completed with each individual included pre/post tests to assess individual and family functioning, a trauma questionnaire, and a client satisfaction

questionnaire. These evaluations yielded results that support the use of MDFT when treating trauma victims and their families. The following is a brief overview of the evaluation tools used in the practicum.

Global Assessment of Functioning Scale. The Global Assessment of Functioning Scale (GAF) is a multi-axial assessment used to assess psychological, social and occupational functioning (Diagnostic Statistical Manual IV). Clinicians use open-ended interview questions to gather data and assign a GAF code from the DSM IV. Global Assessment functioning Scores can range between 1 and 100. Scores below 50 suggest serious symptomatology with severe impairments in social, occupational and school functioning. Scores between 50 and 80 suggest mild to moderate symptoms with some difficulties in social, occupational and school functioning. Scores above 80 suggest minimal to absent symptomatology with good overall functioning. The GAF is a pre/post measure used to assess adolescent functioning before and after treatment.

Family Assessment Measure III. The Family Assessment Measure III (FAM III) is a standardized, fifty-item scale that evaluates overall family health across seven domains (Skinner, Steinhauer, & Santa-Barbar, 1995). The domains include task accomplishment, role performance, communication, affective expression, involvement, control, and values/norms. The FAM III was an appropriate measure for the practicum, for in addition to measuring treatment outcomes, the FAM III provided diagnostic information about family strengths, weaknesses, and process (Spillane, 1985). The student used the FAM III as a pre/post measure. The pre-test provided assessment information used for case formulation and planning; the post-test provided information to measure treatment outcomes.

Trauma Antecedents Questionnaire. The Trauma Antecedents Questionnaire (TAQ) is a non-standardized, forty-three item scale that gathers information about adolescent risk and protective factors over different stages of development: ages 0-6, 7-12, and 13-18 (Van der kolk, 2001). Protective factors include client resources, competencies, and safety with parents or caregivers. Risk factors include separation from parent or caregiver, witnessing traumatic events and exposure to drugs and alcohol. They also include family secrets, neglect, and physical, emotional and sexual abuse (Van der kolk, 2001). The TAQ is appropriate for the population because it assesses the balance between risk and protective factors, which is one of the main theoretical components of MDFT. The TAQ was administered before treatment to assess the type of trauma exposure and the level of specific protective factors.

Client Satisfaction Questionnaire. The post-intervention, Client Satisfaction Questionnaire (CSQ-8) is a standardized, post-treatment questionnaire used by the ACCCIS Team. The questionnaire assesses overall client satisfaction using eight scaling questions and four open-ended questions. The CSQ-8 was administered to each of the four adolescents and two of the single parents. One participant did not have a parent or guardian to complete the questionnaire, and one parent was unable to complete the questionnaire due to serious mental health concerns at the time of termination.

Client Profiles

Six adolescents were recruited to participate in the practicum. Table one gives an overview of the adolescent's age, family structure, and trauma, and highlights the number of sessions each adolescent/family received. Next is a brief profile of each adolescent and his/her presenting concerns.

Client Data

Client	Age	Family Composition	Trauma	Parenting	# of Clinic Session	# of Community Visits	# of Phone Sessions
1	13	Blended	Peer Assault	Parent/Child Conflict	16	4	6
2	15	Shared custody ½ time Blended ½ time Single Parent	Physical Emotional Abuse Death	Parent/Child Conflict	12	2	4
3	16	Single Parent	Intra-personal Conflict	Interpersonal Challenges	10	0	4
4	17	Independent Living	Sexual Abuse	N/A	10	3	3
5*	15	Two Parent	Car Accident	Disengaged	4	0	0
6*	13 & 14	Single Parent	Sexual Abuse	Parent/Child Conflict	2	0	1

* Dropped-out

Client One

Emily, a 13-year-old adolescent female, was referred to ACCCIS after five girls physically attacked her in a school parking lot. Following the incident, Emily felt anxious and nervous much of the time. She experienced nausea, light-headedness, increased heart rate, shakiness, flashbacks and nightmares - symptoms of Posttraumatic Stress Disorder.

In addition to the identified trauma, Emily struggled with adjustment issues related to her family's move to Canada. Since the family's move several years earlier, Emily had not made friends, was not involved with community activities, and did not do well in school. She relied heavily on her family for entertainment, social interaction, and emotional support.

The blended family struggled socially, emotionally and economically. Her mother and step-father held low-paying jobs, had mental health concerns, and few social supports. Family stress often led to marital discord and Parent-Child Relational Problems (Axis IV). Using the MDFT model, Emily received eight individual counseling sessions, eight family counseling sessions, and community support.

Client Two

Mark, a 15-½ year old adolescent, referred himself for counseling after he had a violent outburst at his High School. While having a dispute with his girlfriend, Mark lost his temper and put his palm through a window. Mark received a one-week suspension for his violent behavior and the damage he caused to school property. After one week, Mark was expelled from school with the condition he see a psychiatrist before his return. To meet the school's request Mark called Centralized Intake and referred himself for counseling.

Centralized Intake referred Mark to ACCCIS, for his anger seemed secondary to trauma exposure. In middle to late childhood Mark was physically and emotionally abused by his stepfather. In addition, his sister died suddenly several years earlier. Mark received trauma treatment from the school guidance counselor following the death of his sister, but he continued to have conflict with his stepfather and mother. Mark's mother was his primary support, for his biological father had mental health concerns and had attempted suicide several times. Mark had biological and environmental risk factors that predisposed him to a multitude of lifelong difficulties. Therefore, Mark received 12 individual counseling sessions focusing on family and systemic change. Telephone sessions with parents further supported Mark's efforts to resolve the Parent-Child Relational Problems (Axis IV).

Client Three

Laura, a 15-year-old adolescent female, requested counseling following the partial remission of a 3-year depression. Laura received pharmacological treatment for depression, but continued to struggle with Social Anxiety Disorder. Although Laura felt hyper-aroused in social situations, she continued to participate in activities such as choir, kickboxing, and soccer in attempt to 'find her identity'. Laura had ambivalent feelings about her sexuality and often wondered if she was bisexual. Laura disclosed that most of her social anxiety and depression revolved around gender identity issues. The primary treatment goal was to help Laura understand and come to terms with her sexuality. In doing so, MDFT was offered to help resolve Family Relational Problems (Axis IV). Laura received seven individual counseling sessions, three family counseling sessions, and four telephone sessions.

Client Four

Barb, a 17-year-old adolescent female was a permanent ward of Child and Family Services. Since the age of three, Barb had lived in eight different foster homes and numerous hotels before entering the Independent Living Program in the fall of 2002. Barb requested counseling services because she had been sexually and emotionally abused while in foster care. Barb met the diagnostic criteria for Depression, PTSD, Substance Abuse, and Sexual Abuse of a Child.

At the time of intake, Barb had no contact with her biological parents or siblings. She relied on Child and Family Service (CFS) for financial assistance and on friends for emotional support. Barb was not an ideal candidate for MDFT. However, her urgent need for service and lack of available resources created a therapeutic match. Barb benefited from 10 individual counseling sessions that primarily focused on resolving past issues of abuse and development of attachment relationships.

Client Five

Rachelle, a 15-year-old adolescent female, lost control of a motor vehicle and hit a hydro pole. Rachelle did not have a driver's license or driving experience when she was permitted to drive by family relative who was the passenger in the vehicle. The passenger fractured a limb in the accident, while Rachelle escaped with no physical injuries. Both girls were responsible for the accident, yet Rachelle's relative sought compensation.

Rachelle reported an overall sense of guilt, anger, and hopelessness. She seemed overwhelmed and burdened by ruminating thoughts of restitution. She reported weight gain, headaches, middle insomnia, poor concentration and lack of motivation. Rachelle's symptoms were consistent with a diagnosis of Adjustment Disorder. She did not meet the

criteria for PTSD or Depression. Multidimensional Family Therapy was offered to Rachelle and her family. Rachelle attended four counseling sessions: one accompanied by her mother, one accompanied by her sister, and two alone. The family dropped out of counseling due to time and transportation concerns.

Client Six

Veronica (age 12), Mandy (age 14), and Samantha (age 15) resided full-time with their biological mother. Veronica and Mandy disclosed sexual abuse by their two brothers (biological and step). Child and Family Services investigated the abuse, while the family sought counseling at St. Boniface Hospital.

Veronica presented with internalizing symptoms of depression, while Mandy appeared to have precocious development (Nader, 2001). Both girls met the criteria for Atypical Posttraumatic Stress Disorder, Sexual Abuse of a Child, and Parent-Child Relational Problems. The family was extremely disorganized, had poor boundaries, and lacked parental control. The mother was separated from her second husband, had five children from three different men, and had moved 20 times in 15 years. The children did not identify with a community or school and often fended for themselves. There was a positive family history of suicide, depression, child abuse, and alcohol abuse. The ACCCIS Team offered MDFT, but the family did not follow through. After numerous calls and missed appointments, the files were closed.

Conclusion

Each of the six clients engaged in an extensive assessment and completed the FAM III, and the TAQ. Patterns noted in the initial diagnoses included three cases of Sexual Abuse of a Child, two cases of Atypical PTSD, and one case of PTSD. Consistent

with the trauma research, the cases of PTSD and Sexual Abuse were in young women and were caused by interpersonal trauma (Van der kolk, 2001).

From a family systems perspective, five of the six clients met the criteria for Parent-Child Relational Problems (Axis IV). The client that did not meet criteria did not have contact with her family of origin. Understanding and treating the co-occurring disorders from a Multidimensional Family Systems perspective reduced the symptomology and chances of re-occurrence by increasing adolescent and family protective factors (Liddle, 2002).

The next chapter will provide comprehensive case reviews of the four clients that completed a minimum of ten clinic sessions. The case reviews will follow the multidimensional model of assessment and treatment across three domains: individual, family, and community.

CHAPTER FOUR

Case Studies

Case Study One

Introduction

The Anderson family consisted of a 13-year-old adolescent (Emily), her 50-year-old mother (Bev) and her 34-year-old stepfather (Tom). Emily had two brothers (ages 23 and 26) from her mother's first marriage. Both her brothers and her biological father resided in the United States.

Emily's parents were married in 1973 and divorced in 1998. Bev described the marital relationship as unhealthy and indicated her husband emotionally and physically abused her. According to Bev, her first husband had diabetes and was on permanent disability. Consequently, Bev provided most of the financial earnings for the family.

Bev met her second husband (Tom) over the Internet in 1998. After a six-month email courtship, Tom moved from Winnipeg to a large city in the United States to live with Bev, Emily and John (Emily's brother). During this time, Bev provided financial support to Tom and the family, as Tom was unable to work without a Green Card. Shortly after Tom's arrival in the United States, Bev and Tom were married. This relationship provided Emily with a new father figure. According to Emily, she and Tom became close, although she continued to have a distant relationship with her biological father.

In 2000, Bev, Tom, Emily and John moved to Winnipeg with hopes of building a better life for themselves. Upon arrival, the family lived with Tom's parents until they could locate housing and secure employment. This took longer than expected, and

created animosity between Bev and Tom. As time went on, the family's dreams of building a better life in Canada were destroyed. Bev started to resent Tom, his family, and Canada.

Emily's personal transition was difficult. She found herself alone, without friends, feeling very out of place. During this time, Emily and John became very close. They relied on each other for emotional support when Bev and Tom disagreed about money, housing, employment, and family. They often engaged in computer games and discussion and isolated themselves from their environment. Emily would go to school and come home. She did not have a life outside of the family.

The precipitating event that led to the referral was an incident at school. Five girls attacked Emily physically. This resulted in a mild concussion and bruising to her head and ribs. Her mother made the referral and indicated that Emily suffered from anxiety as result of the incident. Although Emily presented with few symptoms of anxiety upon intake, there was a discussion of the family's current situation and of John's deportation. From the intake assessment, Emily's symptoms seemed related to family conflict and change. Consequently, the ACCCIS team offered individual and family counseling to Emily and her family.

Individual Assessment. With the MDFT model, assessment occurs at three levels: individual, family and systems (Liddle, 2002). The individual assessment with Emily began with an assessment of individual functioning across six domains: drugs and alcohol, adolescent identity and autonomy, peer and peer influence, race and culture, health and sexuality, and bonding to pro-social activities.

At the time of intake, Emily denied drug and alcohol use. She relied solely on her family for emotional support and social interaction, and she did not engage in pro-social activities. Emily's over-reliance on family resulted in part from the relocation to Canada, a common occurrence when families emigrate from a foreign country (Santisteban, Muir-Malcolm, Mitrani, & Szapocznik, 2002).

In terms of health, Emily led a sedentary lifestyle and had a poor diet. Her mother, stepfather and brother were significantly overweight, suggesting a genetic or environmental predisposition to obesity. In addition, Emily had just entered puberty, had a growth spurt, experienced her first menstrual cycle, and began to explore her sexuality. Emily used fashion from pop culture to create an identity separate from her parents. She also expressed a need for more independence and autonomy.

According to information gathered at intake, Emily was entering the early stages of adolescence. She was going through puberty and striving for independence, but her current family situation prevented her from achieving these normal tasks of development. Emily's social isolation and enmeshed family structure created an unhealthy environment where boundaries were blurred. Emily was over involved in parent decision making and was often a mediator between her mother and stepfather. Along with a lack of external social support and pro-social activity, Emily developed internalizing symptoms of depression and anxiety, and was at risk of developing externalizing symptoms such as drug or alcohol use.

Individual Assessment Measure. According to the DSM IV, Emily's GAF score was 55. This suggested moderate difficulties in social, occupational and school functioning (DSM IV, 1994). Emily's scores on the TAQ suggested moderate degrees of

safety and competence (protective factors) with low exposure to trauma and neglect (Van der kolk, 2001).

Individual Treatment Goals

1. To build a strong therapeutic alliance and collaborative agenda for therapy.
2. To help Emily externalize problems and develop alternate coping strategies.
3. To facilitate individuation.

Individual Intervention. The primary individual treatment goal was to develop a strong therapeutic relationship with Emily, thus providing her with a safe, supportive environment where she could talk about her concerns. This goal was consistent with the MDFT model because the therapeutic relationship is the primary agent used to promote change (Liddle, 2002). Techniques used to develop the therapeutic relationship included one-to-one sessions with the adolescent, unconditional acceptance, and empathy. One-to-one sessions allow adolescents to share personal stories, past hurts, and current grievances (Liddle, 2002). With the use of narrative, Emily described of her move to Canada, her process of acculturation, and the deportation of her brother. She expressed difficulties at school and openly talked about the peer assault. She also noted the challenges of living with her mother and stepfather. Her parents had a volatile relationship, and were inconsistent and incongruent in their parenting practices.

Active listening and empathy were used to help Emily feel valued in the therapy session. Emily learned that her feelings and opinions mattered, and realized she had something to gain by engaging in treatment. Through the one to one sessions, therapy became personally meaningful for Emily, thus increasing her interest and commitment to

the process. Armed with support and an agreed upon agenda, Emily was prepared for family therapy.

The second individual goal was to help Emily externalize problems and develop alternate coping strategies. Using techniques from Cognitive Behavioral Therapy (CBT), Emily began to connect her thoughts and feelings. With gentle guidance, Emily identified antecedent, behavior and consequence sequences that contributed to symptoms of depression and anxiety. Emily also learned how to challenge her thoughts and beliefs and to look for evidence that supports or negates her thought perceptions and/or realities. Although CBT concepts were incorporated into treatment to reduce internalizing symptoms and provide alternate ways of coping, Emily had little success with generalization. Consequently, she required continued support and guidance. Mini-telephone sessions were used to support Emily as she developed skills to cope independently in the community.

The final individual goal for Emily was to facilitate individuation. As a normal task of development, adolescents seek more independence and autonomy. The first task of individuation was to help Emily externalize personal and family problems. Emily's job in the family was to monitor the emotional tone and to keep the peace. She felt highly responsible for family conflict, and often intervened to prevent arguments. Emily was triangulated with her parents. Psycho-education was used to teach Emily about family interpersonal processes and ways of removing herself from family problems.

Parent/Family Assessment. Family assessment in MDFT includes assessing attachment and the developmental appropriateness of parent/child interactions. Such assessments also focus on parenting styles and practices, parental motivation, emotional

commitment, and parental functioning. In terms of assessing attachment, the literature states there are two main types: secure and insecure (Rutter, 1997). Infants with secure attachment have their emotional needs met in a prompt, predictable, and positive manner (McKinsey Crittenden, 1997). In contrast, infants with insecure attachment do not have their emotional needs met in a predictable or positive fashion. When such unpredictability exists, infants develop avoidant, ambivalent or avoidant/ambivalent insecure attachment (McKinsey Crittenden, 1997).

Emily presented for treatment with combined avoidant/ambivalent insecure attachment. Emily's emotional needs were inconsistently met, creating ambivalence between affective and cognitive responses. Emily learned how to "prevent unwanted rejection and punishment, but not how to elicit desired caregiving" (McKinsey Crittenden, 1997, p. 54).

Assessing developmental appropriateness of parent/child interactions requires an understanding of child development and interpersonal communication. According to Erik Erikson's stages of development, Emily was transitioning into the 'identity versus identity confusion' stage of development (Santrock, 1996). Emily changed her clothing and hairstyle to create a unique identity separate from her parents. She also had an increased interest in developing and discovering her sense of self and her place in the world. Throughout this transition, Emily required her parent's support and understanding. She needed freedom to explore and guidance to make good decisions. Throughout the assessment process, Bev demonstrated an understanding of Emily's developmental needs. Consequently, she was able to alter her interactional style from directive to inquisitive to help Emily understand the consequences of her exploratory behavior. Rather than

disallowing Emily to dye her hair purple, Bev talked with Emily about societal perceptions and allowed Emily to make an informed decision. In addition, Bev and Emily negotiated curfews, social outings, and expectations around school attendance. Consequently, Emily and Bev's interactions were appropriate for Emily's level of development.

Although Bev was quite appropriate with Emily, Tom was not. Tom was over-protective of Emily and had little understanding of adolescent development. Throughout the assessment, Tom spoke of 'his little girl' and referred to Emily as a child. Tom restricted Emily's access to friends, community, and cyber-space, and often projected that 'bad things' would happen. The dichotomy between Bev and Tom created many parenting and interpersonal challenges for the whole family.

It is a common challenge for many parents to find a balance between permissive and authoritarian parenting. Parents must work together to implement a consistent set of rules. Quite often, the parental sub-systems split when one parent becomes too permissive or authoritarian. Such was the case with the Anderson family. Tom had a very authoritarian parenting style, while Bev was more permissive. As the parental sub-system split, Tom and Bev became less consistent and less effective.

Understanding parental motivation and emotional commitment is a complex task of assessment. Throughout the assessment process, Bev demonstrated parental motivation by referring Emily for treatment, by engaging in the therapeutic process, and by following through with treatment recommendations. Clearly, Bev was emotionally committed to the health and welfare of her daughter. She understood her personal limitations as a parent and actively sought therapeutic services to help her daughter.

Unlike Bev, Tom's motivation and emotional commitment to Emily seemed self-serving. Initially, Tom refused to participate in treatment and suggested disbelief in counseling. Tom engaged in treatment and telephone sessions only when he saw opportunity to promote his personal agenda. Although Tom identified his need for therapy to address his own issues, he was not emotionally committed to making personal change for the benefit of the family.

Assessing parental psychological and psychosocial functioning is the final task of family assessment in MDFT. Psychological functioning refers to any psychological or psychiatric disorder that may impair one's ability to parent. The family assessment with Psychiatrist Dr. A. Hall, revealed parental diagnoses. Bev had Depression and Anxiety Disorder. Bev sought individual counseling for her depression and managed her anxiety with medication. Tom had Depression with narcissistic tendencies, but did not receive pharmacological or psychological treatment. According to the research, children raised in families with psychiatrically disordered parents are genetically and environmentally wired to develop psychiatric disorders themselves (Schwartz and Liddle, 2001). Therefore, assessing for such risk is an important component of psychiatric assessment and treatment.

Family Assessment Measure-III. Emily, Bev and Tom each completed the FAM-III upon intake. Emily's overall score fell within the normal range at 47. Bev's overall score also fell within the normal range at 56, while Tom's overall score fell within the 'family problem' range at 72. The family's scores were consistent with the interview assessment of parenting styles, communication, control and psychological functioning.

Parent/Family Intervention Goals

1. To strengthen the parent-child relationship.
2. To re-align and strengthen the parental subsystem.
3. To teach adolescent development and age-appropriate parenting.

Parent/Family Intervention. Multidimensional Family Therapy uses attachment theory to guide assessment and intervention. As noted in the assessment, Emily presented with ambivalent/avoidant insecure attachment. This attachment style suggested that Emily's attachment figures had been unreliable and unpredictable at meeting her emotional needs. In one-to-one sessions with Emily, the goal was to develop the therapeutic relationship to create an environment where Emily's emotional needs could be met. Howard Liddle calls this intervention 'surrogate parenting' (2002). By providing new experiences, Emily learned how to trust another person with her emotional needs.

The second step of surrogate parenting is to develop the parents' ability to meet the adolescent's emotional needs. Using emotionally focused sessions, the parents' emotional needs were addressed and experiential learning occurred. The therapist used modeling to facilitate relationship development between Emily and her parents. During family sessions, teachable moments were used to model empathetic communication. For instance, Emily stated, "My anxiety goes up when I hear yelling. I don't like yelling. I hear yelling every day. Sometimes I think my parents aren't meant to be together". The therapist responded with empathy by stating "it sounds like you're worried your parents might separate". This empathetic response validated Emily's experience and addressed her fear of abandonment.

Finally, enactment strategies were used to provide opportunities for the family to re-experience situations, thus creating new ways of interacting. The following dialogue occurred between Bev and Tom in the fifth family session.

Tom – I control to protect.

Bev – Yeah, he's a control freak and he's got to stop it. He can't tell me what to say, when to say, or how to say it.

Therapist – What is it like for you to be in that situation?

Bev – Shitty, I'm depressed. I fear physical abuse and emotional putdowns. It destroys the dignity I have left.

Therapist – What was it like for you to be told you can't speak when you want to?

Bev – I was scared and humiliated. I felt like a prisoner.

Therapist – Is that how you're feeling now?

Bev – Yes. I feel like my voice is not being heard. I feel like I don't matter. I have lots of hurt and anger.

Therapist – How do you express your hurt?

Bev – I get angry and throw cheap shots.

Therapist – Tom, what's it like to hear Bev talk like that?

Tom – It bugs me. It pulls at my heartstrings. The pain she feels, I feel eventually too.

Enactment allowed emotional content from the past to be reprocessed in present day treatment. This example started with anger and hostility, but ended with the expression of pain and sadness.

The second goal of therapy was to re-align and strengthen the parental sub-system. Using genograms, Bev and Tom learned how past experiences influence current behavior. This non-threatening introductory intervention engaged Bev and Tom in the therapeutic process, while creating an environment for more in-depth family work.

Psycho-education was also used to strengthen the parental subsystem. By sharing assessment information, Bev and Tom learned the pitfalls of bilateral parenting. They identified areas of weakness and discussed ways of overcoming their differences. Unfortunately, Bev and Tom could not implement the necessary changes to re-align as a couple. Tom and Bev had polar positions and were not prepared to change unilaterally. Consequently, much of the work focused on strengthening the parent/child relationship between Emily and Bev, a protective factor against adolescent psychopathology.

Bev and Tom were not able to re-align as a united parental sub-system. Therefore, teaching adolescent development and age-appropriate parenting became a much more difficult task. Through psycho-education, the parents learned about normal adolescent processes, needs and desires. They learned to listen to Emily's requests and accept her challenges as part of normal adolescent development. With encouragement and support, Bev and Tom identified the bottom line on issues such as curfew, school attendance, and substance use. Tom often took a harder line than Bev, yet they came to understand each other's parenting strategies and techniques without coming to a collective agreement on situation specific interventions.

Ecological Assessment. The ecological assessment requires an understanding of the family's social, economic and environmental conditions. Social conditions include extended family and friends. Economic conditions include the family's access to

financial resources, and environmental conditions include the family's community and school. By completing an ecological assessment, one can determine external supports and stressors that contribute to the family's current situation.

Social support for the Anderson family was primarily comprised of Tom's family of origin. The Anderson's lived with Tom's family when they first moved to Winnipeg. Tom's family offered housing and financial support for the first year. According to Bev and Emily, the situation was less than ideal. Emily and Bev described having strict rules and little emotional support, leaving them to feel indebted to Tom's family.

Emily and Bev's family resided in the United States of America. Since moving to Canada, the family had little contact with Emily's maternal grandmother, brother, or biological father. One of Emily's brothers moved to Canada with the family, but was deported. Subsequent to the deportation, Bev and Emily had ill feelings toward the Canadian government, and wished to return to the United States as soon as possible. The Anderson's were socially isolated for they are not connected with peers, co-workers or neighbors.

Financially, the Anderson family lived below the poverty line. Bev left a well paying administrative support position to move to Canada and had little success finding meaningful, full-time employment. Tom worked full-time evenings in a building maintenance position. Although Tom had regular employment, his wage was low and he had no health benefits. Tom and Bev's combined income limited access to affordable housing, reliable transportation, prescription medication, food and clothing. The Anderson family lived from paycheck to paycheck.

The family's low income limited their residential options. The Anderson's were renting a two bedroom, 900 square foot home. The house was poorly maintained with many health hazards. Water leakage from the shower led to mould and mildew growth and animal dander soiled the carpet. The neighborhood, traditionally known for its crime rate and gang-related activity, contributed to the family's poor sense of security. Emily did not feel safe walking in the community or commuting to school after five girls physically assaulted her in September of 2002.

Ecological Goals

1. To coordinate income and health benefits through Employment and Income Assistance.
2. To explore affordable housing options.
3. To connect Emily with pro-social extra-curricular activities.

Ecological Intervention. Coordinating income and health benefits through Employment and Income Assistance (EI) required an understanding of the family's income-related needs. Upon first assessment, the family's income seemed to preclude them from benefits. However, a new provision in EI Policy qualified the family for health benefits without financial support. Such benefits opened access to pharmacological treatments such as Bev's anti-anxiety medication, but did not assist with the family's financial situation. Through the therapeutic process, Bev gained support to continue her search for more equitable employment while coping with feelings from her current employment status.

Finding adequate, affordable housing is a major issue for many low-income families. Fortunately, the Anderson's application for Habitat for Humanity was

approved, granting subsidy for the purchase of a new home. As part of the agreement, Habitat for Humanity requires each family to contribute 500 hours of 'sweat' equity. Over the course of therapy, the Anderson's worked at the construction site and volunteered at the Habitat for Humanity fundraising booth. As a family, they worked together towards the goal of a new home. The family moved to their new home before the treatment contract commenced.

Although the family's physical home improved considerably, the location did not. The new home was located in an area, which had many of the same concerns as the previous neighbourhood. Social Work involvement with the family ended shortly after the move. Therefore, follow-up on the family's living conditions did not occur.

Connecting Emily to pro-social extracurricular activities was a goal directed at increasing protective factors. Due to Emily's social isolation, poor community access, and high-risk neighborhood, she was at risk of developing poor coping strategies and inappropriate peer relations. Part of treatment involved identifying interests and researching community programs such Army Cadets, the Boys and Girls Club, and swimming. Using the Internet, Emily assessed the pros and cons of each activity. She also identified the nearest location and costs involved. Following the research, Emily initiated trips to the pool with peers, but waited until September of 2003 to register for Cadets.

Client Satisfaction Questionnaire. Emily and Bev each completed the Client Satisfaction Questionnaire upon termination of service. On each of the eight questions, they were mostly or completely satisfied with the quality of service they received. On the qualitative questions, Emily found "talking about what was wrong and solving issues"

most helpful. Bev found that helping her daughter “understand she has a right to speak and be herself” was the most helpful part of treatment. Emily did not identify the least helpful service and did not suggest areas for improvement. Bev noted the least helpful service was couples’ work, but did not identify areas for improvement.

Conclusion

Throughout therapy, the parent-child relationship between Emily and Bev evolved. Emily learned she could rely on her mother for support and positive parenting, even when difficulties arose in the parental sub-system. Overall, the individual interventions were successful. Emily’s self-esteem and sense of hope increased as she learned to trust and express her feelings in therapy. Finally, by challenging her thoughts and beliefs, Emily learned she was not the cause of her family’s problems. Emily’s GAF score increased by five points, but she continued to experience moderate symptoms with difficulties in school and social functioning.

Although small successes occurred for mother and daughter, Bev continued to suffer from depression and anxiety. Her symptomology worsened towards the end of treatment as stress and conflict increased in the parental sub-system. Throughout therapy, Bev came to realize her marriage was ending. She began to emotionally separate from Tom and prepare for single parenthood. During this time, the goal of parent reunification was aborted as more emphasis was placed on strengthening the mother/daughter relationship. Scores on the FAM III depicted the increase in family/parental stress. Bev’s score increased by twenty points, while Emily’s score increased by eight points. Tom did not complete the FAM-III at termination for he prematurely withdrew from treatment.

Ecologically, the family made a few gains. They accessed the pharmacological subsidy from Employment and Income Assistance, moved to their new home built by Habitat for Humanity, and encouraged Emily to develop peer relations and participate in pro-social activities. Throughout this process, the Anderson's showed considerable strength and determination, defying societal, economic and cultural barriers.

Personal Reflection

Several challenges arose when working with Emily and her family. Initially, the family sought trauma treatment for Emily, as she was the victim of a peer assault. The intake assessment revealed complex family dynamics related to the immigration, the newly formed parental relationship, and the introduction of extended family supports. Given the family history, the treatment team recommended a combination of individual and family therapy.

In this case, the identified patient presented for treatment with symptoms related to family, social, and cultural difficulties. Therefore, the goal was to engage the family and develop a treatment contract to meet their needs. Strategies used to engage Emily included one-to-one sessions, home visits, and community involvement. One-to-one sessions allowed Emily to gain individual attention and to articulate a treatment agenda separate from her parents. The home visits provided an opportunity for Emily to share her home and personal life experiences, and the community involvement gave Emily renewed hope as she gained support in her academic pursuits. These engagement strategies were used to connect with Emily and to demonstrate my commitment to the work. Consequently, they were the key to therapeutic success.

Contrary to initial belief, parental engagement was more difficult to attain than adolescent engagement. Emily's mother was willing to attend family sessions. However, her stepfather was not willing to attend. Strategies used to engage Emily's stepfather included telephone calls, a letter, and a face-to-face introduction. After meeting face-to-face, Emily's stepfather finally agreed to attend one session. During that session, time was spent talking about his individual needs and the benefits of family therapy. The empathy and understanding shown towards Emily's stepfather facilitated the engagement process.

Time spent on engagement increased client commitment and created 'customers'. Customers are willing to attend sessions, are open to treatment recommendations, and trust the therapist. The family became customers by the second month of treatment.

Another challenge when working with this family was their inability to agree upon a unified treatment contract. Family members had incongruent agendas and limited agreement about treatment goals. In addition, the family had many challenges and often presented with a 'crisis of the day'. As a new therapist, I struggled to relate these crises to treatment goals and identify themes amongst crises. Individual themes for Emily were invisibility and not having a voice. In session, Emily was encouraged to share her stories while her parents listened. Emily gained strength from a strategic alliance with the therapist and the support she received in one-to-one sessions.

Many challenges arose while working with this multi-problem family. From a systems perspective, I realized the benefits of working on systemic goals. This family struggled to meet their instrumental needs and required assistance and support to coordinate service. The MDFT model provided a theoretical framework to work

systemically. As a Social Worker, I valued the opportunity to work holistically and realized the therapeutic benefits of doing home and community visits. Without this involvement, adolescent and parental engagement may have suffered.

Case Study Two

Introduction

Mark was a 15-year-old adolescent male. Mark resided half time with his 46-year-old biological father (Bob) and half time with his 34-year-old biological mother (Jen), 50-year-old stepfather (Joe), and six-year-old half sister (Megan). Mark's father was an unemployed mechanic, his mother was an accountant, and his stepfather was a machinist. Mark's biological parents lived common law from 1985 to 1993. Upon separation, Mark lived with his mother - no custody hearing took place. Shortly after the separation, Jen became involved with her current husband, Joe. In 1996, Jen and Joe gave birth to their first daughter, Megan, followed by their second daughter Mary two years later. Mary passed away in her sleep three days after her second birthday. Mark described Mary's death as a particularly difficult time in his life and indicated he received therapeutic support from his school counselor to help him understand and cope with the situation.

While living full-time with his mother and stepfather, Mark was physically and emotionally abused by his stepfather. Mark made the disclosure four years ago. Child and Family Services investigated the allegations and awarded Mark's biological father full custody.

Over the last four years, Mark's home environment changed significantly. He went from living with his mother, to living with his father, to living half time with each.

Mark expressed having very different experiences and expectations at each of his parent's homes. Mark's father was more permissive and supported his independence. Mark's mother was more authoritarian, but was instrumental in taking care of his basic needs. Mark avoided his stepfather, but he was not physically fearful.

In the summer of 2002, Mark experienced a traumatic incident while staying with his father. One night, following a disagreement, Bob disappeared without warning. For two nights and three days, Mark was unaware his father was admitted to hospital to receive treatment for depression. Bob continued outpatient treatment for his depression, but attempted suicide for the third time in the spring of 2003.

Over the last ten years, Mark had a tenuous home life with multiple traumas. He was physically abused by his stepfather between the ages of 9 and 12, and his little sister died suddenly in the family home when Mark was 12 years old. Mark lost his family when custody changed at age 12 and he endured the aftermath of his father's depression and suicide attempt. Although Mark experienced many traumas, a violent outburst at his High School led to Mark's referral for service. According to Mark, he had a dispute with his girlfriend, lost his temper, and put his palm through a door window. Mark denied the school's allegation that he intentionally punched the window. Rather, when Mark pushed the door with excessive force, the window broke. Mark received 12 stitches on his right forearm, which left a three-inch scar. Mark was the only person physically injured in the incident, yet he received a one week suspension for his violent behavior and the damage he caused to school property. After a week, Mark's suspension turned to expulsion with the condition that he saw a psychiatrist before his return to school. To meet the school's

request, Mark called Centralized Intake and referred himself for counseling. Mark requested counseling to help him with anger management and relationship difficulties.

Upon intake, Mark disclosed a long history of family relational problems combined with multiple traumas. Consequently, the ACCCIS team offered individual and family counseling to Mark and his family.\

Individual Assessment. Using the Multidimensional Family Therapy model of assessment, Mark was assessed across six domains: drugs and alcohol, adolescent identity and autonomy, peer and peer influence, race and culture, health and sexuality, and bonding to pro-social activities. This initiated the development of individual treatment goals and the application of specific interventions.

Drug and alcohol use is prominent across youth in Canada. Adolescents often experiment without looking at the long-term consequences. Mark reported drinking alcohol at parties, trying marijuana twice, and taking ecstasy once. Mark was concerned about addiction, for his father had a long history of alcohol and prescription drug abuse. In Mark's current stage of development, he struggled with identity issues. Mark worried he had an underlying mental illness or would develop a serious addiction problem like his father. Consequently, he limited his drug and alcohol use as a preventative measure.

In school, Mark learned that abuse victims often become abusers. Mark's violent episode at school was a warning sign for Mark, his family and his teachers. Although Mark realized he was in the wrong, he minimized the incident, and suggested the school overreacted. Overall, Mark was a good student. He was never in trouble, he had good grades and he had regular attendance.

Mark relied heavily on school for the structure, support and continuity it brought to his life. At school, Mark was accepted by his peers and was safe from the abuse he endured at home. Therefore, his expulsion was a threat to his personal safety. Mark lost his connection to pro-social activity and age-appropriate peers. He lost his opportunity to complete school, to go to college, and to create a life separate from his parents. Mark needed school, and was motivated to seek and attend counseling for re-admittance.

Although Mark took the necessary steps to get back into school, he did not want to wait. Rather, he independently gained admission to the neighboring school by agreeing to play on the senior football team. Mark was 6'2" 230lbs, and was an asset to any high school football team. Mark attended all training camps even though he was not interested in the sport. Though Mark did not like football, his actions demonstrated his need for structure, continuity and connection.

Mark's need for connection is a learned response from his family of origin. Mark learned from an early age that his parents were emotionally unavailable. Therefore, Mark sought acceptance and support from peers, teachers, and guidance counselors. Mark learned to suppress his feelings and hide his emotions. By putting on a brave front, Mark separated his feelings from his actions to cope with everyday stressors. Mark's anger was a presentation of feelings, emotions, and hurts buried deep down inside. Consequently, this anger was an externalizing symptom or warning sign of emotional difficulties.

According to research, anger is most often directed towards the person or people the aggressor is closest to (Johnson & Ferrar, 2000). Mark's relationship with his girlfriend was one of his primary lifelines. Mark developed his first sexual and emotional relationship and found the unconditional love and acceptance he so desired. The couple

professed their love for one another, creating a false sense of permanence. When the relationship was threatened, Mark expressed his hurt and sadness through anger as his stepfather had done so many times before. When the anger failed to relieve his sadness, Mark's depressive thoughts led to suicidal ideation. Though Mark considered his options for suicide, he did not have a concrete plan. Therefore, Mark's risk of suicide was low.

Mark was raised as a middle-class, Caucasian male. Mark believed that boys should be tough, self-reliant, and independent. Mark internalized these cultural beliefs, but was conflicted when he desired nurturance, affiliation, and connectedness. Mark desired more family involvement and peer connection, but had difficulty expressing his need. Like many, Mark was embarrassed about seeking help. He saw it as a sign of weakness, which challenged his sense of manhood. Mark also resisted family and societal pressure to become an independent, autonomous young man. Mark repeatedly stated 'I am only 15' when challenged to take more responsibility. Mark clearly was not ready for the responsibility or independence of adulthood.

Individual Assessment Measures. According to the DSM IV, Mark's GAF score was 65. This suggested mild difficulties in social, occupational or school functioning (DSM, 1994). Mark's scores on the TAQ suggested a high degree of safety and competence (protective factors) with mild exposure to trauma and moderate degrees of neglect.

Individual Goals

1. To build a strong therapeutic alliance and develop a collaborative agenda for therapy.
2. To understand the cycle of violence and de-escalate anger.

3. To connect anger to sadness, hurt and disappointment.
4. To explore Mark's history of abuse.

Individual Intervention. The primary individual intervention goal for adolescents in the MDFT model is to develop the therapeutic relationship (Liddle, 2002). The therapeutic relationship provides a safe and supportive environment where adolescents can express their feelings and become aware of internal emotional states. Techniques used to develop the therapeutic relationship with Mark included one-to-one sessions demonstrating emotional availability and permanence, as well as unconditional acceptance. One-to-one sessions enabled the sharing of personal stories, past hurts and current grievances. With the use of narrative, Mark shared his experiences of abuse and the devastating loss of his sister. He noted the challenges of the 50/50 custody arrangement and stated he felt displaced, unloved, and unwanted. Mark minimized and justified his parent's actions and blamed himself for the abuse and family conflict. In one-to-one sessions, Mark told his personal stories and gave meaning to the events that shaped his world.

The first step towards understanding an individual's reality is to recognize the meaning they attribute to life events. Mark created a coherent story by organizing his thoughts, beliefs and experiences into personal schema. With active listening and empathic responses, themes were extracted from Mark's stories. The primary themes Mark identified were that no one was there for him, and that he was not ready to grow up. Using these themes, treatment interventions were developed to provide Mark opportunities to experience emotional connection and voice concerns about becoming an

adult. Such an intervention is called 'surrogate parenting' in the MDFT model (Liddle, 2002).

When using the surrogate parenting intervention, the therapist becomes a predictable and dependable emotional figure in the adolescent's life (Liddle, 2002). Demonstrating emotional commitment requires consistent availability, genuine caring, and unconditional acceptance. When the adolescent feels emotional connection, their commitment to therapeutic process increases significantly (Liddle, 2002). Such was the case with Mark. Mark attended weekly therapy sessions with little support from his parents. By attending to Mark's emotional needs, therapy became personally meaningful, thus increasing Mark's interest and commitment to the process.

Upon attaining Mark's commitment, a collaborative agenda for treatment was identified. Mark indicated that anger management was his primary reason for seeking treatment. The second goal was to educate Mark about the cycle of violence and to teach de-escalation techniques. Using the cycle of violence, Mark learned about the calm, the build-up, and the explosive stages of anger development (Johnson & Ferraro, 2000). With examples from the past, Mark identified behavioral warning signs such as body tensing and fist clenching that preceded an explosion. He also practiced relaxation techniques to contain or prevent an explosion. Finally, he identified safe ways to release the energy such as hitting a pillow or punching bag. Though Mark quickly learned the cycle of violence and how to use the interventions, this did not address the root of the problem.

Understanding anger requires an understanding of emotional development. According to Johnson and Ferraro, anger is a secondary emotion (2000). Secondary

emotions are an expression of primary emotions such as sadness. Therefore, the final goal was for Mark to connect his primary emotions with his secondary emotions.

Multidimensional Family Therapy suggests using events from the past to enter the present or future (Liddle, 2002). The technique involves analyzing the emotional tone of past situations in present oriented therapy sessions. With guidance and support, Mark replayed the high school incident, exploring his emotions along the way. Mark soon realized by doing these exercises that his anger was an expression of hurt or sadness. Therefore, our new goal was to use emotionally based interventions to explore core issues related to abandonment, abuse, and neglect.

Using the strong therapeutic relationship as a foundation for emotionally focused treatment, Mark began to explore his history of abuse. Using guided imagery, Mark replayed experiences from his childhood. Mark explained how he cleaned toilets and mopped floors at age 7, and how he moved furniture and cleaned warehouses at age 10. He was put to work by his stepfather and physically punished if he did not complete tasks. Mark remembered going straight from school to work with little time for play or friends. Mark felt robbed of his childhood.

From a trauma perspective, the theme of not wanting to grow up may have come from the lack of nurturance Mark received as a child. Mark may have been stuck in the stage of emotional development until his emotional needs were met. Although Mark began to explore his history of abuse, current issues took precedence over past issues. With continued support from the ACCCIS team, Mark will likely come to terms with his abuse. Mark's therapeutic experiences increased his ability to trust others with his

emotional needs. Such experiences will enhance Mark's ability to continue his therapeutic journey and engage in meaningful relationships.

Parent/Family Assessment. Comprehensive parent/family assessments require the participation of all family members. When all members are unable or unwilling to become involved, family assessment is completed with anecdotal information from participating family members. In Mark's situation, his biological father completed the FAM and TAQ. Otherwise, he was uninvolved in treatment. Bob had mental health concerns and was emotionally unavailable to participate in family therapy. Jen, on the other hand, was unsupportive of Mark's therapy. With repeated attempts on the part of the student, Jen engaged in telephone conversations and eventually came for one individual session towards the end of treatment.

Using MDFT with a single adolescent presented many challenges. Treatment goals and interventions were based on assessment theory and assumption, with an emphasis on secondary change. Mark was supported and coached to promote change in the family system through change in his own behavior.

The first task of parent/family assessment includes assessing the attachment relationship between Mark and his parents. Mark presented with insecure avoidant attachment. From an early age, Mark's parents were unavailable. His father suffered from depression and his mother was emotionally disengaged. Mark could not rely on his parents to meet his emotional needs. In attempts to cope, Mark convinced himself he did not need emotional connection with his parents, while he inadvertently sought extra-familial relationships to fill the void.

The second task of parent/family assessment is determining the developmental appropriateness of parent/child interactions. According to Eric Erickson, Mark's primary task was to develop intimate relationships to prevent feelings of isolation (Santrock, 1996). During this stage, intimacy and companionship from peers takes precedence over family relationships. However, parents must continue to support and guide their adolescent, even when the adolescent is resistant or ungrateful.

Mark experienced two different types of parenting. His father was permissive and his mother provided structure and guidance. Mark's parents were not able to balance his need for social connection and family. His father allowed Mark to be autonomous with little or no parental guidance. Mark liked the freedom, but often felt isolated and alone. Consequently, he spent much of his time with friends away from his father's home. Bob overestimated Mark's need for independence. In contrast, Mark's interactions with his mother were more developmentally appropriate. Jen set limits regarding curfew and peer relations and maintained parental responsibilities. Although Mark pushed the limits with his mother, he expressed greater satisfaction with less responsibility. Mark responded well to the rules, guidance, and care his mother provided.

Although Mark received very different messages from his mother and father, he learned how to cope in his changing environment. One of the primary challenges was learning how to co-exist with his stepfather, who physically abused him as a child. Mark's desire for family and connection led to an unusual living arrangement. Mark agreed to avoid contact with his stepfather if permitted to live with his mother 50% of the time. Mark was not pleased with the restrictions of the arrangement, but was motivated to make it work.

Assessing parental functioning, motivation, and emotional commitment are the final tasks of family assessment. As noted earlier, Bob suffered from Major Depressive Disorder. He lacked the motivation to parent or care for Mark, yet seemed concerned for Mark's emotional well being. Bob could not provide the support Mark required, but he assisted Mark in his efforts to seek counseling. Bob did what he could, given the severity of his depression.

Based on limited contact with the student, Jen seemed more functional than Bob. Jen had symptoms of PTSD, which limited her emotional availability. Jen had been on autopilot since the death of her daughter three years earlier. She was not able to grieve and did not receive professional support following the incident. Rather, she continued to work and complete family functions in an effort to move on. Jen was a functional provider and caregiver. She completed the necessary tasks to maintain her career, home and family. However, she was not emotionally or socially available for Mark.

Family Assessment Measure-III. Mark and Bob each completed the FAM-III upon intake. Mark's score fell within the normal range at 54, while Bob's score fell within 'family problem' range at 61. The family's scores are consistent with the interview assessment of parenting styles, communication, control and psychological functioning.

Parent/Family Intervention Goals

1. To assist Mark to express his feelings and articulate his needs.

Parent/Family Intervention. Multidimensional Family Therapy provides a framework for intervening with families. The model suggests working with the adolescent, parents, and family as a whole. Mark's parents and family were unavailable for intervention. Therefore, we created family interventions for Mark to practice in

session and try at home. The primary techniques used to help Mark express himself were role-plays and enactment. Role-plays provided opportunities for Mark to express himself in a safe environment. With gentle encouragement, Mark articulated his thoughts and feelings. Mark practiced telling his mother how he felt hurt and abandoned when she threatened to kick him out of the house. Mark practiced using 'I' statements to reduce defensiveness and explored possible outcomes of sharing his thoughts and feelings with his family. By role-playing each side of the conversation, Mark experienced sending and receiving 'I' messages and became more comfortable incorporating the skill in session.

The next task was to generalize Mark's new skill in the home. Ideally, MDFT therapists prepare parents to hear messages. Without parent access and preparation, outcomes are unpredictable. Mark prepared emotionally for a variety of responses and evaluated the usefulness of the exercise. With support and encouragement, Mark expressed his feelings about the 50/50 custody arrangement to his mother. He also expressed concerns about the suicide attempt of his father, and his desire for reconciliation, with his stepfather. Mark followed through with the practiced discussions for he desired change in his current living arrangements. He wanted to live full-time with his mother, stepfather and sister. Mark expressed his feelings, needs, and wants as he strived to change the family system. The intervention increased Mark's confidence to communicate with his parents, but did not change his living arrangements.

Ecological Assessment. Ecological assessment requires an understanding of the family's social, economic and environmental supports. Mark had two independent family situations. Mark's father lived alone in a two-bedroom apartment with few social or family supports. He lost his job with the onset of the depression one-year ago and has

since lived on Disability Benefits. Mark described his father's living arrangement as poor for they struggled to pay for food and rent. Mark was not comfortable with the state or location of their apartment. He lied to his friends about where he lived and would not invite people over.

Mark's mother, stepfather, and sister were economically well off. They temporarily lived in an apartment close to schools and transit, but were in the process of building a larger home. Mark received his clothing allowance and spending money from his mother. Jen seemed to indulge Mark with clothes and gifts, thus compensating for emotional hardships. This was a closed family system with few social/emotional supports.

Unlike his family, Mark had many social supports. He relied on friends, school and extra-curricular activities to meet his social/emotional needs. At intake, Mark's primary support was his girlfriend and her family. Mark called his girlfriend's guardian 'Grandma' and viewed her as a surrogate parent. She invited him to family dinners and paid his community basketball fees. 'Grandma' adopted Mark as her son. When the relationship with his girlfriend ended, Mark lost his primary social support.

In addition to friends, Mark relied heavily on community basketball and school football to meet his needs. Mark played each sport three times a week. These pro-social activities gave Mark a place to go after school and on the weekends when he could not be at home. They limited his involvement in street culture and curbed his drug and alcohol use. Although Mark was only 15, he had many opportunities to engage in illegal drug activity. Mark stayed clean because he did not want to be like his father. He recognized his vulnerability and chose to stay away.

Ecological Goals

1. To encourage and support pro-social, extra-curricular activities.
2. To facilitate Mark's goal to live full-time with his mother.
3. To support Mark's re-entry into school.

Ecological Interventions. Mark's involvement in community basketball and school football provided social, emotional, and physical benefits. Through sport, Mark made new friends, developed his sense of belonging, enhanced his self-esteem, and appropriately released energy build-up. Therefore, encouraging and supporting Mark to continue with sports became a therapeutic goal. The first task was attaining funding for Mark to continue in community basketball. Due to a fall out with his girl friend, his 'Grandma' stopped paying league fees. Mark had one week to come up with \$230 for the winter season. Through consultation with the Recreational Therapist at the hospital, we found a sports subsidy program. We downloaded the application, attained the appropriate signatures, and prepared to submit. With a day to spare, Mark's mother paid the application fees contrary to her original decision not to pay. Mark continued with community basketball as planned.

The second ecological goal was to support Mark in his efforts to live full-time with his mother. Given the information in the parent/family and ecological assessments, Mark's protective factors are greater at his mother's home. Although both parents had mental health issues, his mother was higher functioning. She provided Mark with his instrumental needs including a safe home and warm meals. Mark knew he could rely on his mother to care and protect. Unfortunately, the relationship between Mark and his stepfather was tentative at best. With role-plays and enactments, Mark tried to make

amends with his stepfather and prove to his mother they could co-exist. Unfortunately, Mark's stepfather was not prepared to make concessions. Telephone sessions with Jen were used to support Mark's efforts and to reinforce Mark's need for a stable home environment. Although Jen seemed to understand, she was a mediator between Mark and his stepfather. She indicated that Mark would have to continue the 50/50 arrangement until they moved into their new home.

The final ecological goal was to support Mark's re-entry to school. Mark's school re-entry was contingent on him seeking counseling and addressing anger management issues. After Mark's re-admittance to school, the Social Work student monitored Mark's academic and social progress with bimonthly telephone calls to the guidance counselor. For the remainder of the year, Mark maintained good attendance, achieved a B/B+ average, and stayed out of trouble. There were no reports of physical or emotional aggression.

Client Satisfaction Questionnaire. Upon termination of service, Mark completed the Client Satisfaction Questionnaire. Mark's CSQ-8 suggested complete satisfaction with the services he received. On the qualitative answers, Mark said the most helpful part of treatment was the "advice he received", whereas the least helpful part of treatment was the "paperwork". Mark did not make recommendations for improvement. Overall, the treatment interventions helped Mark build an emotional connection, gain insight, and learn new skills. Mark achieved most of his treatment goals in the time provided.

Conclusion

Over the course of treatment, Mark worked towards individual, family, and ecological goals. Mark learned to trust the therapeutic relationship as he gained

emotional support, guidance, and unconditional acceptance. With therapeutic rapport, Mark processed emotions from past experiences and gave himself permission to let go of the hurt. In doing so, Mark's anger subsided. Using psycho-education, Mark learned about the cycle of violence, triggers, and de-escalation techniques. The combined treatment approach addressed core issues related to anger development, while providing anger management tools for daily use. Mark achieved three of the four individual treatment goals. However, the ACCCIS team will continue to provide ongoing therapeutic support to further address abuse-related issues. Mark's GAF remained unchanged over the course of treatment due to limitations in familial and social functioning.

Achieving the parent/family goal required Mark to participate in role-plays and enactments that paralleled interpersonal challenges in the home. With preparation and skill development, Mark successfully expressed his feelings and familial needs to his mother, father and stepfather. The therapeutic goal was to work with Mark to promote secondary change in the family system. The intervention proved unsuccessful in creating change due to lack of parental involvement. However, Mark experienced an increase in positive communication with his mother as result of the exercise.

Over the course of treatment, Mark's overall score on the FAM-III increased from 54 to 56. Although higher scores depicted greater family pathology, Mark's scores for Affective Expression, Control, and Role Performance decreased, showed improvement on each sub-scale. Such improvements are consistent with the interventions that focused on emotional expression, anger management, and family role-plays. Areas requiring continued support include, Task Accomplishment and Values/Norms. Mark's scores

increased in the latter two sub-scales secondary to parent/family crisis. These scores reflected Mark's inability to respond and understand his father's suicide attempts in the context of family and societal norms.

Ecologically, Mark achieved two of his three goals. He maintained involvement in community sports and completed grade ten at a community school. Mark's third goal was to live full-time with his mother. The request was initially declined. With therapeutic support, Mark's mother came to understand his need for familial support and agreed to address custody issues within three to six months. Overall, the ecological interventions were successful.

Personal Reflection

Engagement, gender, and counter-transference were three of the primary concerns when working with Mark. Mark presented as a mature adolescent male with anger management concerns. Although he seemed like an unlikely candidate for emotionally based treatment, I worked to develop the therapeutic relationship. Engagement strategies used with Mark included one-to-one sessions and discussion about common interests. Mark easily engaged in discussions about basketball, football, and cars, and willingly shared his expertise. These initial discussions provided an opportunity for Mark to engage in a safe and supportive environment, and enabled him to talk more openly about individual and family concerns.

The initial assessment highlighted potential gender issues. As a young female therapist, I acknowledged the potential for client attraction and became increasingly aware of body language, dress, and professional boundaries. I also took increased safety precautions such as notifying reception of session times, limiting one-to-one community

involvement, and restricting transportation. This pro-active approach defined professional boundaries and preserved the integrity of the therapeutic relationship.

Counter-transference was the final area of concern. Many aspects of Mark's family resembled my family of origin. With the help of supervision, I acknowledged the similarities and remained neutral throughout the treatment process.

The primary themes for Mark included his need for parental support and his developmental readiness to grow up. He repeatedly expressed his desire for more parental involvement and less responsibility. These themes evolved from his parentified role and abuse he endured as a child. Therapy gave Mark an opportunity to express his grievances and to gain support, while contact with his parents increased their understanding of his developmental needs.

Case Study Three

Introduction

The Madison family consisted of a 15-year-old adolescent female Laura and her 49-year-old biological mother Denise. Laura was born in British Columbia, but moved to Winnipeg with her mother when her parents divorced in 1989. Laura visited her father, who lived in BC. Laura's mother was employed full-time doing kitchen preparation, and her father worked as a laborer.

Individual Assessment. Laura attended grade 10 classes at a Winnipeg High School. Laura did well academically, and participated in the advanced placement program. Over the last three years, Laura noted a decline in her concentration and motivation with the onset of depression. Laura socially withdrew from her family and

friends, slept excessively, and had a poor appetite. Laura tried three different antidepressant medications. Prozac was the most successful at reducing the depression.

Laura was diagnosed with Social Anxiety Disorder. She experienced hyperarousal in social situations, leading to a fight or flight response. When Laura attended school, she was defensive and reactive towards peers. She had a strong sense of social justice and would not back away from confrontational situations. Laura presented as a confident and driven young person who worked hard to cover her social anxiety and fear.

Upon intake, Laura disclosed she was bisexual. She suffered internalizing symptoms of depression and anxiety related to identity issues. Laura endured parental and social pressure to conform. This directly affected peer relations and bonding to pro-social activities. Laura actively sought similar peers at school, kickboxing, choir, and aerobics, but was unsuccessful in her attempts. She identified with the male gender role and could not find her place in adolescent culture.

Laura was the youngest child in her family of origin, and the only child from her mother's second marriage. Due to marital breakdown, Laura lived with her mother most of her life. Laura had a close emotional relationship with her mother and was eager to please. As an adolescent, Laura tried to differentiate from her family of origin. She strived for independence, but longed for support and understanding. She wanted to be open and honest, but feared disappointment and lack of understanding. Laura felt hopeless and helpless in her attempts to gain support.

Throughout the intake and assessment sessions, Laura showed insight into the problem. She identified the onset of the problem and progression of the symptoms. Laura demonstrated good judgment in her attempts to seek help and abstain from drugs

and alcohol. With pharmacological intervention, Laura's depression and anxiety subsided, enabling her to participate in therapeutic interventions.

Individual Assessment Measures. According to the DSM IV, Laura's GAF score was 65. This suggested mild difficulties in social, occupational or school functioning (DSM, 1994). Laura's scores on the TAQ suggested a high degree of safety and competence (protective factors) with low exposure to trauma and neglect.

Individual Treatment Goals

1. To build a strong therapeutic alliance and collaborative agenda for therapy.
2. To address identity issues and facilitate differentiation.
3. To externalize problems and develop alternate coping strategies.

Individual Intervention. The first therapeutic goal was to build a strong therapeutic alliance and collaborative agenda for therapy. The therapeutic alliance was developed using one-to-one sessions, empathy and acceptance. In the first one-to-one session, Laura identified herself as bisexual, thus attributing the depression and anxiety to an inability to understand and cope with her feelings. As Laura made the disclosure, she quickly assessed the therapist's values and beliefs and evaluated the sincerity of the response. At that moment, Laura made the decision to continue therapy for she felt safe to explore her thoughts and feelings. She trusted the therapeutic relationship and was prepared to work on the contracted issues. Laura agreed to explore identity issues, address coping mechanisms and challenge her social anxiety.

The second therapeutic goal was to address identity issues and facilitate differentiation. Laura described her thoughts and feelings from early childhood to present day and identified markers in her growth and development that contribute to gender role

and sexual identity. Laura used labels and stereotypes to identify high school groups (valley girls, jocks and punks) and noted their similarities and differences. Laura cognitively understood her sexual identity and social standing, but was emotionally isolated in her attempts to develop outside of social and family norms.

Emotional isolation contributed to Laura's sense of hopelessness and helplessness. She developed internalizing symptoms of depression and anxiety and was unable to differentiate from her family of origin. Using techniques from emotionally focused therapy, Laura was assisted to identify and express her feelings. Laura spoke of sadness, loss, and fear as she uncovered the root of her depression. She mourned the loss of heterosexuality as she explored the possibility of bisexuality. This confusing juncture created an internal dialogue that compounded the symptoms of depression and anxiety. Consequently, Laura learned cognitive behavioral techniques to evaluate the accuracy of her internal dialogue and monitor her mood. As Laura learned new skills, she gained self-awareness and renewed self-esteem. Laura's affect became bright, she maintained eye contact, and began to assert herself. After ten sessions, Laura's internal emotions and external presentation became more congruent, as she became more comfortable with her gender identity.

Parent/Family Assessment. The first task of parent/family assessment includes the assessment of parent/child attachment (Liddle, 2002). Laura presented for treatment with avoidant insecure attachment (McKinsey Crittenden, 1997). Avoidant insecure attachment results when primary caregivers inconsistently respond to infant affect (McKinsey Crittenden, 1997). Laura's Grandmother often provided care while her mother and father worked and she developed avoidant insecure attachment possibly due

to inconsistent childcare in infancy. Signs of Laura's attachment style included her self-determination and self-sufficiency (West & Sheldon-Keller, 1994), as well as her mother's over-protective nature (McKinsey Crittden, 1997).

The next task of parent/family assessment is to assess the developmental appropriateness of parent/child interaction. According to Erik Erikson's stages of development, Laura was struggling with 'identity versus identity confusion' and 'intimacy versus isolation' (Santrock, 1996). Laura assimilated the information about bisexuality, but had difficulty accommodating (Santrock, 1996). She required her mother's support and understanding, but she received resistance and lack of acceptance. Laura's mother stated she understood and accepted her daughter, but made statements such as 'she'll grow out of it' and 'maybe it's just a phase'. Laura felt stigmatized and alone. She had the capacity to think in abstract and logical terms, but felt stunted by her mother's narrow-mindedness. Laura's cognitive, emotional, and moral development was superior for her age. Even when Laura disagreed with her mother, she respected her mother's experiences, values and beliefs. Laura tolerated her mother's over-protectiveness and lack of acceptance in order to keep the peace. Such behaviors likely contributed to Laura's internalizing symptoms of depression and anxiety.

Assessing parenting styles and practices requires an in-depth understanding of family and home functioning. Due to the nature of the identified problem, parenting was not a focus of assessment or treatment. However, parental motivation, emotional commitment and functioning were relevant to the treatment process. Laura and her mother had a strong emotional connection that bordered on enmeshment. They responded to each other's emotional states and often felt responsible for each other's

moods. Consequently, Laura's mother was motivated to help Laura resolve her depression. Mrs. Madison supported Laura's efforts to attend counseling and participated in sessions as required.

In terms of parental functioning, Laura's mother maintained full-time employment and provided an average standard of living for the family. She acknowledged her emotional and academic limitations and sought help for Laura whenever necessary. Mrs. Madison did not seem to suffer from emotional or physical ailments. However, she noted a history of child abuse and alcoholism in her family of origin. Such factors may have contributed to the intergenerational transmission of insecure/avoidant attachment.

Family Assessment Measure-III. Laura and Denise each completed the Family Assessment Measure III (FAM-III) upon intake. Their scores had a 12-point spread, but fell within the normal range at 46 and 58 respectively. Denise's score of 58 was consistent with the high degree of parental control and involvement noted in the interview assessment.

Parent/Family Intervention Goals

1. Assist Laura in efforts to differentiate from the family of origin.
2. Evaluate family values and beliefs
3. Educate, normalize, and validate feelings.

Parent/Family Intervention. Differentiation is a stage of adolescent development that captures adolescent need for autonomy and individual thought. Based on the assessment, there was a high degree of parental control, traditional values, and emotional attachment. In supportive one-to-one sessions, Laura expressed that she felt trapped, devalued, and stigmatized. The enmeshed nature of the parent/child relationship held

Laura emotionally captive. She felt her mother's pain, and was unable to grow and develop outside of the family norms. Laura used exploratory questions to identify parental and personal expectations, values and beliefs, and patterns of relating. She gained validation and support as her concerns were normalized in the context of development and attachment theory. According to MDFT, therapeutic support that is not available in the family context is labeled as surrogate parenting (Liddle, 2002). Surrogate parenting provides adolescents with new experiences and ways of interacting that can be generalized to other environments.

Generalizing skills and transferring trust from the therapist to the parent requires strategic and planned intervention. Laura prepared and rehearsed how to talk to her mother about her bisexuality. Laura anticipated possible outcomes and prepared emotional responses in role-plays. She trusted the therapeutic relationship and felt safe to participate in the family intervention.

The next step toward successful family intervention is to prepare the parent. Parent preparation required careful analysis of values and beliefs. In one-to-one sessions, Mrs. Madison talked about the generation gap, family teachings, and belief system development. Mrs. Madison echoed statements and began to acknowledge her biases and evaluate her language. Probes and questions provided opportunity for Mrs. Madison to reflect on the messages she gave her daughter. Such intervention provided renewed insight into problem development and maintenance, thus creating an emotional base to proceed with the family intervention.

Completion of the family intervention, known as enactment, required a family session in order to discuss the presenting problem. Laura followed guided discussion to

review her identity development from early childhood to present day. By cognitively and rationally expressing the facts, Laura demystified her mother's belief that Laura was in a phase of adolescent development. The second task required Mrs. Madison to respond emotionally to her daughter's comments. By doing this, Laura gained validation and support from her mother. Before accepting her mother's renewed commitment, Laura challenged past comments to test sincerity. Laura was leery of her mother's acceptance, and looked to the therapist for approval. By the end of the session, Laura and her mother were crying. Each expressed sorrow and remorse as they embraced. Together, they agreed to communicate more effectively in the future.

Ecological Assessment. Ecological assessment includes an understanding of the family's social, economic and environmental conditions. Due to the nature of the identified problem and the time-limited treatment, ecological factors were not a focus of treatment. Laura was involved in choir, kickboxing and school activities. She understood her social needs and limitations and actively sought social activities to meet those needs. Mrs. Madison supported Laura's efforts by providing transportation and moral support. Economically, the family was able to meet all their basic needs. Mrs. Madison worked full-time and provided adequate housing, transportation, food, clothing, and recreation for her and Laura. Economic and environmental needs were not a concern when applying the MDFT model the Madison family. Consequently, ecological goals and interventions were not completed.

Client Satisfaction Questionnaire. Upon termination of service, Laura and her mother each completed the CSQ-8. According to the questionnaires, they were completely satisfied with the services they received. Laura stated that "talking and

getting advice” was the most helpful part of treatment, while Denise noted, “all the services were wonderful”. No services were qualitatively marked as least helpful, and no recommendations were made for improvement.

Conclusion

Over the course of treatment, Laura made considerable progress in her overall functioning and symptom management. Her GAF score increased 10 points to 75, suggesting transient symptoms with slight social impairments. Laura achieved her individual goals for she addressed identity issues, started to differentiate from her mother, and learned to externalize her problems. Although Laura made significant gains, Cognitive Behavioral Therapy for depression and anxiety may further enhance her functioning in the future. Laura chose not to continue with ACCCIS after completing the student treatment contract.

Family often plays a role in adolescent dysfunction. Insecure attachment and parent/child enmeshment contributed to Laura’s inability to differentiate. With enactment strategies, the family practiced interpersonal communication. Laura expressed a need for emotional connection and autonomy, while her mother listened and responded appropriately. The family learned how past experiences shape belief systems and parenting styles while increasing awareness and understanding.

Scores on the FAM III depict change in the family system. There was a 12-point spread on the pre-tests, and a 5-point spread on the post-tests. Laura’s overall score increased from 46 to 48 due to increases in communication, affective expression, involvement and control. Her mother’s overall score decreased from 58 to 53 as she reduced involvement and parental control. Such scores are consistent with Laura’s goal

to externalize her problems and differentiate from her mother. Using MDFT, the family maintained homeostasis and shifted involvement and control from parent to child.

Personal Reflection

Laura saw three different therapists before seeking service at St. Boniface Hospital. Previous therapeutic attempts were unsuccessful, as Laura was unable to open up. Given these past experiences, I spent several sessions talking with Laura about adolescent culture and listening to the social constructs she used to understand her environment. As Laura described her experiences she engaged in the therapeutic process and learned to trust the therapeutic relationship.

The therapeutic relationship provided a foundation for emotionally based treatment. Connecting with Laura on an emotional level was a practicum goal and personal challenge. Laura and I had similar ways of communicating and were comfortable working in the cognitive realm. Supervision provided an opportunity to mirror affective expression and practice emotional engagement. With increased comfort, I used empathy to set the emotional tone and to reflect my observations and experiences back to the client. Laura responded to these interventions as she gained insight into her emotions.

As Laura gained awareness and personal strength, family interventions were used to develop the adolescent/parent relationship. The MDFT model provided theoretical frameworks for adolescent development and attachment, along with specific interventions to foster parental commitment. As a new Social Worker, I valued the opportunity to strengthen family systems. Such interventions enhance individual and family functioning and reduce the need for long term support. The individual and family interventions

addressed Laura's social and familial isolation, reduced her depressive symptoms, and increased her mother's understanding. Therefore, the primary themes were addressed with the tools and techniques of MDFT.

Case Study Four

Introduction

Barb was a 17-year-old female who lived independently and was a permanent ward of Child and Family Services. Barb had two siblings, Dana, aged 19, and Neil, aged 15. Although Barb maintained minimal telephone contact with her mother, she had not seen her parents since she was 13 years old. At the time of intake, Barb's siblings and mother lived outside of the Winnipeg area. However, each family member independently moved back to Winnipeg over the course of treatment.

Barb had a long history with Child and Family Services (CFS). Since the age of three, she lived in eight different foster homes and numerous hotels before entering the Independent Living Program in the fall of 2002. Barb requested counseling services as she was emotionally and sexually abused while in foster care.

The first incident of abuse took place when Barb was between the ages of 4 and 8. Their foster parent's son sexually abused Barb and her siblings. After the disclosure, the perpetrator confessed to the crime and was sentenced to two years in jail. Barb did not testify at the hearing. Following the disclosure, Barb and her siblings were placed in two, short-term foster homes before a long-term placement was found. According to Barb, the latter placement lasted five years, but dissolved when the foster mother's mental health deteriorated. Barb maintained contact with her foster mother, who was a stable person in Barb's chaotic and disorganized life.

Following the stable, five-year placement, CFS placed Barb and her siblings in separate foster homes. At 13 years of age, Barb lost her connection to family. Barb's placement lasted approximately a year, during which Barb had minimal access to her former foster parents or siblings.

Barb's next placement was with a couple and their child. While in care, Barb's foster parents socially isolated her from the family, repeatedly comparing her to their biological daughter and unfairly reprimanding her for her behavior. Barb described several accounts when her foster mother threatened to strangle and kill her. After numerous complaints, CFS removed Barb from the foster home and re-united her with her sister. Child and Family Services placed the sisters in their final foster home just before Barb's 15th birthday. Again, the sisters endured emotional abuse. Barb described how she and her sister were 'kicked out' of the house and had nowhere to go. The foster home placements ended just before Barb's 17th birthday. Child and Family Services provided hotel accommodations while Barb prepared for the Independent Living Program.

Individual Assessment. Barb requested counseling services to address long-standing issues of abandonment and abuse. Barb suffered from Posttraumatic Stress Disorder, with co-occurring symptoms of Depression and Substance Abuse. Barb was prematurely separated from her mother at age 3, then from her foster mother at age 8. Consequently, she lacked the ability to trust and emotionally connect to an adult caregiver. Barb relied on two friends for emotional support, and on CFS for financial aid. She enrolled in grade nine at an alternative high school, but rarely attended as symptomatology and drug use impaired her ability to think and concentrate. Barb

previously engaged in self-harm behaviour, and reported sleep disturbance related to fear, paranoia and nightmares. Barb's feelings of hopelessness and helplessness contributed to suicidal ideation. However, cultural beliefs prevented her from taking her life. Barb believed her spirit would wander in the presence of death.

Individual Assessment Measures. According to the DSM IV, Barb's GAF score was 31. This suggests major impairment in areas such as work, school, family relations, judgment, thinking and mood (DSM, 1994). Barb's scores on the TAQ suggested a low degree of safety and competence (protective factors), with mild/moderate exposure to trauma and neglect. The assessment scores are consistent with Barb's life experiences and primary diagnoses, as abandonment and abuse lower protective factors and increased symptomatology.

Individual Goals

1. Develop therapeutic rapport.
2. "Develop insight into how my feelings work".
3. Explore thoughts and feelings from past experiences.

Individual Intervention. The most important task of treatment was to develop therapeutic rapport. Barb learned from an early age not to trust helping professionals. Child and Family Service workers repeatedly placed Barb at risk. Teachers were not culturally or emotionally sensitive, and counselors were ineffectual in their efforts to help. To avoid similar errors, Barb identified treatment preferences such as the therapist's age and gender. She also asked that teaching tools such as video and mirrors not be used in treatment.

Cultural sensitivity was another consideration when building therapeutic rapport. Throughout treatment, Barb identified cultural values and beliefs that contributed to her health and wellness. She outlined beliefs about suicide and the rules and norms of sweatshops. Barb abstained from drugs before going to sweats. Therefore, she was encouraged to participate in cultural events as an intervention towards harm reduction. Barb accepted and responded well to culturally based treatment goals. With guidance, Barb developed a culturally based safe place using her visual, auditory and olfactory senses. At the end of each session, Barb returned to her imaginary safe place to reduce the emotional and mental images discussed in treatment. Grounding therapy in cultural themes enhanced the therapeutic relationship as Barb learned to trust the relationship and the process.

The second individual goal was to help Barb develop insight into how her feelings work. Barb articulated the treatment goal for she could not explain her anger. Using guided imagery, Barb revisited memories from her childhood. She described her apprehension by CFS, as well as specific incidents of abuse. In doing so, anger surfaced. Barb expressed anger towards her mother for not "being a mother" and towards the perpetrator who "was older and knew better". Through the use of emotionally focused treatment, Barb evaluated her anger and uncovered the deep sadness and loneliness she felt every day. Barb began to understand her feelings by drawing connections between her sadness and her anger.

The third individual goal was to explore thoughts and feelings from past experiences. Due to Barb's horrific past, she learned to cope by avoiding and suppressing memories. Unfortunately, the unresolved issues were flooding her unconscious mind. Barb's

symptoms of depression, sleep disturbance, and anger were indicators of Post Traumatic Stress Disorder. Barb believed that symptoms would worsen if she talked about the trauma. To evaluate the belief, Barb was encouraged to score her symptomology on a scale of 1-10 between each session. Barb quickly learned that her symptoms decreased or remained the same if she talked about the trauma during sessions.

Symbolism was another technique used to contain thoughts and feelings discussed in sessions. As sessions became intense, Barb wrote down thoughts and feelings to place in an envelope. Symbolically, Barb sealed the envelope and left the worries behind. Upon introduction of the exercise, Barb asked for a written copy of a statement made in session – “the less you carry around, the happier you will be”. Barb carried and referred to the statement until the end of treatment.

Barb presented for treatment with symptoms of PTSD and Depression. Throughout treatment, Barb gained positive experiences of helping professionals and began to address long-standing issues of abandonment and abuse. Although Barb had 10 sessions over four months, she required long-term treatment. Therefore, Barb was referred to a female counselor to continue her journey of healing.

Parent/Family Assessment. Parent/family assessment in MDFT evaluates the parent/child attachment and relationship. Barb presented for treatment with avoidant/insecure attachment (McKinsey Crittenden, 1997) and reported experiences of neglect and abuse from her parents in early childhood. Barb’s parents abused alcohol and were ineffectual caregivers. Based on assessment information and physical presentation, Barb’s parents either did not respond or responded negatively to cries of distress. Consequently, Barb learned to control her affect to avoid punishment and negative

reinforcement. (McKinsey Crittenden, 1997). Insecure attachment developed in the absence of tender, loving, responsive relationships in infancy (West & Sheldon-Keller, 1994). Barb's early experiences contributed to her lack of trust and her inability to relate to others in an authentic and emotional capacity (West & Sheldon-Keller, 1994). The result, when combined with early experiences of abuse, was that Barb became emotionally detached from life.

The final tasks of the parent/family assessment are to assess the parent/child relationship, parental motivation, and parent emotional commitment. Due to the lack of communication and contact, the parent/family assessment was not completed.

Family Assessment Measure. Barb's score on the FAM III was in the normal range at 56. Barb used historical information and past family contact to complete the questionnaire. Therefore, the score is not consistent with interview assessment data, and is not a valid measure for the identified client.

Parent/Family Goals

1. Provide opportunity for emotional connection.
2. Support the expression of authentic and congruent feelings.

Parent/Family Intervention. According to MDFT, the primary intervention used to counter the effects of avoidant/insecure attachment is 'surrogate parenting' (Liddle, 2002). Surrogate parenting is a therapeutic technique used to offer unconditional support in efforts to build trust and rapport. This goal was achieved by developing therapeutic rapport (individual goal) and by demonstrating reliability and trustworthiness. Barb attended 10 of 26 scheduled sessions. Missed sessions were followed by telephone calls, letters and home visits. Barb learned to trust the sincerity of the therapeutic relationship,

giving her a new experience of helping professionals. With increased involvement, Barb attended more regularly and/or telephoned to cancel in advance. Without perseverance, Barb's poor attendance may have become a self-fulfilling prophecy and may have led to the demise of the therapeutic relationship.

The 'surrogate parenting' technique remained incomplete as Barb's mother was emotionally and physically unavailable to participate in treatment. However, similar techniques were used to transfer Barb to another therapist following the student's term. Barb's work and commitment continued as she generalized her skills and learned to trust other helping professionals.

The second parent/family intervention supports the expression of congruent thoughts and feelings. Barb's avoidant/insecure attachment contributed to flattened affect and an inability to regulate emotions. Barb identified that she felt emotionless and faked happiness. Through the use of emotionally focused therapy, Barb identified layers of feelings associated with loss and trauma. Barb allowed herself to cry and feel the pain from the past. By releasing some of the emotion, Barb expressed feeling lighter. She often arrived with her head down, shoulders slumped, and eyes to the floor. By the end of the session, Barb's affect changed considerably. She sat up in her chair, made eye contact, and smiled spontaneously. Barb learned to be more 'present' and authentic in therapy. Unfortunately, she needed much more practice to generalize these skills to her day-to-day life.

Ecological Assessment. The completion of an ecological assessment led to an understanding of Barb's financial status, environmental living conditions, social relationships and educational/vocational needs. Barb received financial assistance,

transportation, and medical from CFS. She completed the Independent Living Program and had a one-bedroom apartment on the outskirts of downtown. Barb reported an ability to meet her basic living needs, but stated she felt lonely and isolated much of the time. She learned to budget, pay rent, buy groceries, and live independently. Barb had two close friends and spent much of her time away from home. Barb enrolled full-time at an alternative Aboriginal school and was repeating grade 9 for the third time. She had difficulty with motivation and concentration, secondary to PTSD. Barb had the cognitive ability to complete school, but her ability to follow through seemed limited by the circumstances of her life.

Ecological Goals

1. Explore alternative school/vocational programs.

Ecological Interventions. Adolescents involved in the outpatient hospital program at St. Boniface Hospital can attend a low enrolment, continuous progress school program. After consultation with Barb and the school coordinator, a pre-intake appointment was scheduled to evaluate Barb's academic needs. To avoid cancellation, we arranged transportation and placed written reminders in Barb's mailbox. Unfortunately, Barb did not attend. The meeting was rescheduled. Again, Barb did not attend. After further discussion, Barb suggested she was not ready to engage in academic programming. Consequently, we explored summer vocational programs. Barb inquired about a program at New Directions and attained an application form. However, she did not complete or submit the form. Barb suggested her symptomology was interfering with her ability to complete academic and vocational goals. Therefore, ecological goals became secondary to individual and family goals.

Client Satisfaction Questionnaire. Upon termination of service, Barb completed the CSQ-8. According to the questionnaire, Barb was generally satisfied with the services she received. She thought the quality of the service was good, but was mildly dissatisfied with the quantity of help she received. Barb indicated she would seek services from the ACCCIS program again, and would recommend the service to family or friends. Such information is clinically important because Barb did not trust helping professionals upon intake. Barb's renewed trust will increase her therapeutic opportunities in the future. Qualitatively, Barb noted the most helpful aspect of treatment was that of meeting with a "counselor regularly for talking sessions". Barb did not indicate the least helpful service and did not make recommendations for improvement.

Conclusion

Over the course of treatment, Barb made few gains in her overall functioning and symptom management. Her GAF score increased 10 points to 41, suggesting serious symptoms with significant social and school impairments. Although Barb began to have increased trust in the therapeutic relationship, she required ongoing support to address thoughts and feelings from past childhood experiences.

Barb presented for treatment with avoidant/insecure attachment. She had difficulty connecting with caregivers and expressing emotion to those she loved. Throughout treatment, Barb started to relate in an emotional capacity. She allowed herself to cry and became more authentic in her emotional expression. Barb's score on the FAM III decreased from 56 to 50 over the course of treatment. Although she experienced a decrease in role performance and control, her scores have no assessment or evaluative validity as Barb had minimal contact with her family of origin.

Personal Reflection

Barb presented for treatment with symptoms of Depression and Posttraumatic Stress Disorder. Her overall functioning was significantly impaired and her affect was blunted. Barb sought treatment to cope with the effects of Child Sexual Abuse. However, themes of abandonment and attachment became the focus of therapeutic intervention.

Relationship development was one of the primary tasks of treatment. At the initial assessment, Barb answered questions with one-word answers and did not make eye contact. She did not trust Psychiatry, medication or male clinicians and did not approve of two-way mirror supervision or video recording. Barb appeared leery and guarded. As a new Social Worker, I questioned my ability to connect and support Barb in a therapeutic capacity.

In attempts to connect and address attachment issues, I accepted the treatment conditions and acknowledged Barb's strength and courage. These actions fostered trust and demonstrated respect, two primary components of the therapeutic relationship. Of the four clients, Barb suffered the most severe psychological trauma and was in the greatest need of service. Therefore, the pace and intensity of treatment was monitored to avoid premature termination of service.

In efforts to connect, I softened the tone, avoided direct language, and reduced the intensity. The fear of re-victimization discussed in the trauma literature limited my ability to address Barb's trauma directly. With supervision, I gained a better understanding of trauma therapy and implemented therapeutic safe guards to ground treatment in the present, to monitor symptom development, and to reduce the intensity at

the end of each session. These interventions allowed for increased therapeutic depth and greater success. They also relieved personal fears and enhanced the quality of service Barb received.

Indicators of success were Barb's willingness to engage in treatment and to continue therapy with another therapist upon completion of the six-month practicum contract. Over the course of treatment, Barb started to trust the therapeutic relationship, as she gained support and understanding from the staff and students at St. Boniface Hospital. Barb's renewed sense of safety and trust enabled her therapeutic journey to continue beyond the scope of the practicum.

Themes

Introduction

Working with trauma-exposed adolescents in a mental health capacity requires knowledge of trauma research, including knowledge of personal and family risk factors that can increase the likelihood of trauma exposure. The following trauma themes evolved as the case studies came to conclusion. The first common theme was the adolescents' diagnoses and symptomology, followed by insecure attachment, loss, and stage of development. The final two themes related to family composition and parent functioning.

Diagnoses and Symptomology. Three of the four families reported chronic emotional, physical, or sexual abuse, the most common types of childhood trauma and symptomology (Van der Kolk, 2001). As well, each family reported parent-child relational difficulties, which is an Axis IV diagnoses in the DSM IV (1994). In terms of gender based symptomology, the three adolescent females presented with internalizing

symptoms of depression and anxiety secondary to trauma and parent-child relational problems. On the other hand, adolescent males presented with externalizing symptoms of aggression. Such findings are consistent with trauma research for symptomology often falls along gender lines (Van der Kolk, 2001)

Attachment and Trauma. Each of the four adolescents who participated in the practicum had insecure attachment. Three of the adolescents had avoidant insecure attachment and one had avoidant/ambivalent insecure attachment. Insecure attachment can significantly impair one's ability to develop and maintain personally meaningful relationships. It can also lead to social isolation and detachment (Van der Kolk, 2001). Therefore, attachment became a target for intervention. Multidimensional Family Therapy provided tools to assess parent/child attachment and intervention strategies to develop attachment relationships.

Loss. Loss was one of the primary themes that evolved from the practicum. Each of the adolescents lived through their parents' divorce and the loss of one or both parents. They lost contact with siblings or extended family due to relocation, life circumstances or death. The sense of loss felt by each adolescent contributed to his or her overall functioning and symptom presentation.

Developmental Stage. According to Erik Erikson, adolescence is a time when young people develop their identities and separate from their family of origin (Santrock, 1996). Erikson calls these stages identity vs. identity confusion and intimacy vs. isolation. Each of the adolescents involved in treatment fluctuated between these two stages. Emily and Laura struggled with their sexual and social identity. They constantly changed their styles and challenged their beliefs. In terms of intimacy vs. isolation, Emily

received primary social/emotional support from family. In contrast, Laura began to look outside the family for emotional support.

Mark's identity crisis was family based. Mark did not identify with his male role models for his biological father had severe depression and his stepfather was abusive. Given the genetic and environmental influences, Mark worried about his future and often felt isolated from his family. Like Mark, Barb did not have good role models. She identified with a former foster parent who provided her with cultural teachings and encouraged her to pursue her dreams. Although Barb aspired to more, she identified herself as a victim. She socially isolated herself out of fear, and was reluctant to pursue personal or intimate relationships.

Each adolescent worked through the stages of development. They carved out unique identities based on personal values, familial experiences and peer influences. In pursuit of the ideal image or identity, they realized the limits of their efforts. Societal beliefs around socio-economic status, culture, child abuse, and sexual orientation played into their personal identity structure, thereby contributing to identity confusion (Santrock, 1996). Consequently, each client worked to incorporate their experiences and attributes in efforts to define their identity.

Adolescents use their unique identities and experiment socially as they look for relationships to counter social isolation. Adolescents who do not resolve identity confusion have difficulty moving to the next developmental stage. Developmentally, Emily and Barb were in the middle phase of identity development, whereas Laura and Mark were in the latter phase of identity development. With this said, Laura and Mark were more capable of moving into the next stage of development, intimacy vs. isolation.

Family Composition. Family composition in childhood affects stability and permanence of adult caregivers. Of the four families involved in the study, all of the parents were divorced. Three of the four mothers gained custody of their children following divorce, whereas one client was apprehended by CFS. The adolescents who remained in their mother's care were less traumatized, had more protective factors, and had higher GAF scores than the adolescent who went into care.

All four sets of parents divorced after years of marital discord, and three sets of parents abused alcohol. Family violence and alcohol abuse are correlated in the literature. Both conditions are inter-generationally transmitted due to environmental factors and genetic predisposition (Johnson & Ferraro, 2000). Therefore, intervening with adolescents and their families becomes increasingly important when there is a family history of violence and/or alcohol abuse. Such interventions increase adolescent protective factors and contribute to overall functioning.

Parent Functioning. Another common factor among the families was the presence of psychiatric disorders among the parents. Three of the four sets of parents suffered from Axis I diagnoses including Depression, Anxiety Disorder and Posttraumatic Stress Disorder. It is clinically important to assess for psychiatric illness in children raised in families with parents who have psychiatric disorders as these children are genetically and environmentally predisposed to develop psychiatric disorders themselves (Schwartz and Liddle, 2001). The clinical sample attained for the practicum revealed similar patterns of psychiatric illness in families. Each adolescent had an Axis I diagnosis similar to his or her parent.

Conclusion

Themes that came out of the four case studies highlight the importance of developing protective factors to counter personal and familial risk factors. With each additional risk factor, the potential for harm multiplies exponentially (Van der Kolk, 2001). Therefore, the adolescents involved in this practicum were at increased risk of further trauma injury. The role of the therapist provides one of the most important protective factors by engaging adolescents and their families in treatment. Trauma research states that adolescents will have a greater chance of avoiding trauma injury if they have one solid attachment figure (Liddle, 2002). Consequently, MDFT therapists strive to reconnect adolescents with their primary attachment figure or act as a surrogate attachment figure when parents are unavailable. The aforementioned themes solidify how the MDFT theory of risk and protective factors addresses treatment recommendations for adolescents exposed to trauma.

Multidimensional Family Therapy in Clinical Practice

Multidimensional Family Therapy provided a comprehensive framework for assessment and intervention. Howard Liddle used developmental and ecological theories to design a program to enhance individual, family and ecological protective factors (2002). This intensive, time limited approach to treatment targets intrapersonal and interpersonal difficulties, and systemic challenges. When used with the intended population, adolescents exposed to drugs and alcohol, the treatment is more effective than traditional therapies such as Cognitive Behavioural Therapy, Group Therapy, Family Support, and Multi-family Interventions (Liddle, 2002).

Multidimensional Family Therapy provided assessment and intervention recommendations across each of the three domains: individual, family and ecological.

The individual assessment guide provided in the MDFT manual was a comprehensive tool that collected a breadth of information and required the therapist to evaluate the adolescent's overall functioning at home, in the community, and at school. In addition, the DSM was used to screen adolescents for psychiatric disorders, substance abuse, and child abuse (1994). This combined assessment approach used the clinical interview to gather data before intervention occurred.

Like the individual assessment, the family assessment provided a breadth of information. The most useful information collected in the family assessment was based on attachment styles, parenting styles and parent psychiatric illness. The family interview provided an opportunity to evaluate communication styles and interpersonal processes. The limitation with the family assessment was parent availability. Two families were actively involved, one family was minimally involved, and one family was not involved in treatment. When families are not available, assessment comes from adolescent reports and perception. This type of data is not necessarily accurate, but is still valuable to the assessment process.

Finally, the ecological assessment evaluated the family's social networks, systems involvement and environmental conditions. The ecological assessment incorporated in the MDFT manual encouraged therapists to consider the context of individual and family problems. Ecological assessments, which are the foundation of Social Work practice, provided valuable information to the practicum for three of the families lived in poverty with few social supports. According to Maslow's hierarchy of needs, primary needs such as food and shelter must be addressed before individuals or families can engage in

therapy (Longest, 1996). Individuals and families were more able to work on intrapersonal and interpersonal goals after addressing basic needs.

Goals were created from information gathered in the multidimensional assessment. According to the MDFT manual, the therapeutic relationship is the most important treatment goal (Liddle, 2002). Therefore, the first individual intervention was to join with the adolescents. As stated in the first stage of therapeutic engagement, one-on-one sessions were used to successfully join with each of the four participants. Indicators of effective joining included the adolescents' willingness to return to treatment and their optimism about future sessions.

After joining with each adolescent, the goal was to develop the therapeutic relationship and create a collaborative agenda for treatment (Liddle, 2002). Like many therapeutic treatments, MDFT attempts to make therapy personally meaningful for each participant, thereby increasing commitment and trust. With therapeutic rapport, the adolescents worked on intrapersonal treatment goals with the assistance of cognitive behavioural strategies, narrative techniques, emotionally focused sessions, and guided imagery. Multidimensional Family Therapy does not provide specific intrapersonal interventions. Therefore, therapists have the flexibility to incorporate intervention strategies from a variety of sources. The weakness of integrated treatment is that clients do not receive the full benefit of a specific approach. The strength is that they receive components of treatments to best meet their individual needs.

Multidimensional Family Therapy uses three primary family interventions: enactment, role-plays, and surrogate parenting. Enactment is a structural therapy technique that brings emotional content from the past into present day therapy. This

technique brought harbored feelings of hurt and resentment into treatment, gave adolescents a voice, and allowed families to re-process emotionally laden situations. To increase enactment success, surrogate parenting strategies were used to prepare adolescents and their families, to model active listening and to demonstrate delivery of emotional responses. The goal was for parents to hear their adolescent's cry for help without becoming defensive. Overall, the family interventions were successful for the strategies outlined in the MDFT manual were relatively easy to follow and implement.

The weakness of MDFT was the absence of parent/couple interventions. There are no intervention strategies designed to re-align the parental sub-system, to address couple functioning, or to treat parent psychiatric illnesses. The manual recommends parents address mental health concerns before family intervention occurs. However, lack of parental commitment and immediacy of adolescent concerns prevented this from occurring. Two parents received individual therapy separate from the family therapy offered at St. Boniface Hospital. The intensity of one parent's treatment and the severity of his illness precluded him from engaging in MDFT.

Ecological interventions included case management activities. Over the course of the practicum, there were multiple home visits, referrals to outside resources, and contact with Counselors, Teachers, and Social Workers. Multidimensional Family Therapy is a superior model of treatment for disadvantaged and multi-problem families. By incorporating ecological goals into a manualized treatment program, MDFT acknowledges social, cultural, and economic barriers. This is consistent with Social Work practice, as people are treated as individuals and problems are placed in an environmental context. By considering the individual and their environment, Social

Workers find alternate explanations for problem development and use systemic interventions to reduce or alleviate the symptoms.

CHAPTER FIVE

Evaluation

Introduction

Evaluation was an important component of clinical practice. The measurement package provided tools to assess individual and family change over the course of treatment and to evaluate the effectiveness of the intervention. The measurement package included the Global Assessment of Functioning Scale (GAF), the Family Assessment Measure III (FAM-III), the Trauma Antecedent Questionnaire (TAQ), and the Client Satisfaction Questionnaire (CSQ-8). To conclude, the student reviewed and evaluated her practicum goals.

Global Assessment of Functioning. The Global Assessment of Functioning scale was a multi-axial, pre/post assessment of psychological, social and occupational functioning (DSM IV, 1994). The GAF used interview data to detect symptomatology and level of overall functioning before and after treatment. The GAF was easy to administer; there were no costs attached, and no questionnaires to score. However, it was a subjective measure based on clinician perception. Therefore, inter-observer reliability was used to reduce favorable outcomes. The student and her supervisor independently scored each adolescent before they collaborated and came to a consensus on each score. Three of the four adolescents involved in the practicum showed improved overall functioning using the GAF.

GAF Scores

Name	GAF pre-treatment	GAF post-treatment
Emily	55	60
Mark	65	65
Laura	65	75
Barb	31	41

Family Assessment Measure III. The Family Assessment Measure III was a standardized, fifty-item scale used to evaluate family functioning. The FAM-III was a useful measure with two of the four families. The FAM III detected familial change across all domains when used as a pre/post measure with the adolescent and parent. The FAM-III was easy to administer and score, but was difficult to acquire. Regulations on the FAM-III prevented students from purchasing the scale without supervisor assistance.

For this particular practicum, the FAM-III confirmed assessment data but did not provide additional clinical information. The FAM-III detected improvement with one family and deterioration with another. Pre-treatment scores suggested Laura was under-functioning and her mother was over-functioning; post-treatment scores demonstrated a more equitable mother/daughter relationship (Appendix E). The FAM-III scores for Emily and her mother increased as conflict intensified in the parental sub-system (Appendix C). The FAM-III was a reliable and valid measure for these two families.

The final two families did not complete the FAM-III under optimal conditions. Mark and his father each completed the pre-test, but his father did not complete the post-test. Mark's pre-test scores were in the normal range; his father's were in the family problem range. These results were congruent with the interview assessment as Mark's father had mental health concerns, was uninvolved in family life, and lacked effective

communication. Mark's score increased two points from pre-test to post-test as a result of family change and stress at the time of termination (Appendix D).

Barb was estranged from her family of origin. However, she completed the FAM-III as a practicum participant. Barb's scores showed less variability and decreased six points from the pre-test to the post-test (Appendix F). The FAM-III was not a valid measure for Barb, as it was not designed for individual assessment.

The FAM-III quantified assessment data and provided evidence of treatment efficacy. When used with empirically supported treatment such as MDFT, the FAM-III provided valuable information that guided clinical assessment and decision-making. The FAM-III increased the student's confidence and ability to administer and score standardized measures in clinical practice.

Trauma Antecedent Questionnaire. The Trauma Antecedent Questionnaire (TAQ) was a non-standardized, forty-three item scale used to gather information about risk and protective factors over different stages of development: ages 0-6, 7-12, 13-18, and adulthood (Van der Kolk, 2001). The TAQ detected risk factors such as separation from parents or caregivers, exposure to drugs or alcohol, and degree of family secrets. The TAQ also assessed for specific trauma such as abuse and neglect and protective factors such as resources, competencies, and safety with parents or caregiver. The TAQ was a lengthy questionnaire that was difficult and time-consuming to score. The scoring guide provided a data collection sheet to translate and reverse numbers, and required a calculator to add each category. The TAQ was not a user-friendly assessment for trauma exposure.

In terms of assessment data, adolescent and adult scores were not comparable. Scores in each age category range from 0-3: 0 is the least amount of exposure, and 3 is the greatest amount of exposure. The total category is the sum of all other categories. Therefore, adolescents have one less score in the total than adults.

Finally, self-reports were not accurate representations of trauma exposure. Each of the forty-three questions required an answer for each age category. An inability to remember was marked as a star and tallied into the total. Bessel Van der Kolk accounted for repressed or dissociated memories, but clients did not (2001). Some marked an inability to remember as a zero and some marked it as a star. The degree of exposure was also self-reported using a Likert scale. Therefore, the clients' perceptions were scored, rather than rates of trauma exposure. Though the TAQ covered a broad range of trauma questions and provided insight into the types of trauma exposure, it did not accurately measure trauma intensity. The safety scores were somewhat useful for they quantified client perception of protective factors, which became a baseline for developing treatment goals.

Client Satisfaction Questionnaire. The Client Satisfaction Questionnaire (CSQ-8) was a standardized evaluation tool used by the ACCCIS program at St. Boniface Hospital. The CSQ-8 had eight Likert scaling questions and four open-ended qualitative questions. Four adolescents and two parents completed the CSQ-8 upon termination of service. Of the six questionnaires completed, all of the clients were completely or mostly satisfied with the quality and quantity of service they received. The program met most of their needs and helped them deal more effectively with their problems. Although clients

expressed overall satisfaction, the Likert scaling questions provided minimal feedback for clinical improvement, and qualitative questions had a low completion rate.

Social Indicators of Therapeutic Success. Observable treatment outcomes provided additional information for evaluation. Several indicators of success were Mark's re-admittance to school, Laura's increased school attendance, and Emily's increased community involvement. These observable outcomes correlated with the ecological goals and were social indicators of therapeutic success.

Evaluation of Learning Goals. The primary goal for the practicum was to learn and apply the theory and concepts of Multidimensional Family Therapy (MDFT). MDFT is a complex model that takes a systems perspective and draws on development, ecological, behavioural, and emotion based theories. This integrated treatment approach provides great flexibility in terms of treatment options. Specifically, the theory guides the practice, which benefits from identifying and developing protective factors and considering the environment when providing intervention. Consequently, MDFT enables practitioners to see the big picture and make decisions in the best interest of their clients.

In addition to theory, the practicum provided opportunity to learn and practice engagement strategies and to develop an awareness of cultural and diversity issues. According to MDFT, engagement is the first step to development of the therapeutic relationship. During this stage, the therapist monitors the alliance, reflects the emotional tone, validates the adolescent's experiences, and creates a collaborative agenda for treatment (Liddle, 2002). Such tasks demonstrate the therapist's willingness to listen and ability to help. Evidence of engagement was seen in Mark's openness and commitment to treatment. Mark voluntarily attended and actively engaged in each session.

Cultural awareness and sensitivity is another way of showing respect and fostering adolescent commitment. Culturally appropriate interventions were used to foster the therapeutic relationship and increase engagement with one client. These interventions were created collaboratively as the client shared her values and beliefs in session. For example, Barb created an emotional safe place where she envisioned herself as an elder living in a log cabin. At the end of each session, Barb returned to her emotional safe place where she felt safe and secure. This culturally appropriate intervention decreased emotional intensity as Barb prepared to leave the session.

The second goal was to learn about the effects of trauma on attachment and adolescent development. Trauma, specifically abuse, is inter-generational, and is prevalent among families with poor attachment (Van der Kolk, 2001). This was evident with Emily and her mother, Bev. Bev's TAQ suggested high degrees of trauma and low degrees of competence and safety. These risk factors, combined with Depression and Anxiety, likely contributed to Emily's insecure attachment. Therefore, building attachment relations was one of the primary treatment goals for the practicum.

Attachment, in terms of adolescent development, is an important component of trauma treatment and MDFT. Adolescence is a time when young people become more autonomous and identify more readily with their peers. For adolescents exposed to trauma, this normal developmental process often occurs prematurely as young people seek to have their emotional needs met outside the family. Mark's connection to peers, school and pro-social activity was an example of how adolescents seek emotional connection. Practitioners use the MDFT model in attempt to slow or reverse the

separation process by therapeutically connecting with the adolescent and fostering attachment relationships between the client and his/her parent.

The third goal was to develop the therapeutic skills and confidence to become a better therapist. Feedback and guidance were readily available from other therapists who provided supervision and consultation. Opportunities were provided for personal growth and for connecting emotionally with individual clients. Videotaping was utilized to learn how to mirror emotional tone and identify when and how to slow the therapeutic process. Finally, I experienced what it is like to track process instead of content, and to use themes to guide treatment. For example, Barb requested counselling to address issues related to childhood sexual abuse, yet sessions often led to feelings of abandonment and isolation. Exploration of abandonment brought forth primary relational/attachment needs, which were then addressed in treatment.

The fourth goal was to learn how to use supervision. Multidimensional Family Therapy was a comprehensive, multi-component treatment. The model recommended assessment with individuals, families and social systems, and suggested an integrated treatment approach with behavioural, cognitive, and emotional interventions (Liddle, 2001). Given the complexity of the model, therapists require education, experience, and supervision to apply and evaluate MDFT in clinical practice.

According to the MDFT manual, therapists require a Master or Doctoral degree and a Family Therapy background (Liddle, 2001). Therapists also require experience working with delinquent adolescents and the ability to work in the cognitive, affective and behavioural realms. As a graduate student with Family Therapy and Family Systems

education, I minimally met the criteria outlined in the MDFT manual. Therefore, clinical supervision became vitally important to the success of the intervention.

Supervision for the practicum included case formulation, videotape review, clinical analysis by a supervisor, feedback from other clinicians, and an independent review of the work. Each method provided opportunity for reflection and learning. Together, they accounted for 50% of the practicum hours.

Case formulation was a way to conceptualized treatment using the MDFT manual and clinical research. The first phase of case formulation was to draw parallels between the research and treatment cases. The research provided direction for assessment and intervention, and prepared the clinician for anticipated outcomes. Case formulation was a useful way to conceptualize the therapeutic goals and prepare for treatment.

Videotape review was another way to gain supervision. Three of the four clients allowed sessions to be videotaped. Each videotape was transcribed and analysed, as themes were extracted. The videotapes provided an opportunity to evaluate the emotional tone and the therapeutic techniques. They also provided a way to monitor the therapeutic relationship and the authenticity of the interactions. Videotapes were reviewed by the clinical supervisor, as he looked for evidence of connectedness, depth, and use of self in therapy.

In addition to the videotape review, the supervisor provided live supervision behind the two way mirror and acted as a co-therapist for teaching purposes. These supervision methods allowed for immediate guidance and feedback as required. Other methods of supervision included role plays and experiential learning strategies. These

methods encouraged the use direct language and provided an opportunity to experience therapy from a client perspective.

Feedback from other clinicians was another way to gain supervision. Throughout the practicum, a senior Social Worker reviewed videotapes, as she evaluated engagement and emotional tone, and addressed gender and culture issues. She also reviewed case formulation and treatment goals for three of the four clients.

The final supervision task was to complete an independent review of the work. The independent review helped identify personal characteristics and potential barriers to treatment. As a new clinician, I had a tendency to be self-hypercritical, over protective, and to identify with clients. Hypercritical tendencies towards slow progress and therapeutic ability led to periods of self-doubt. Clinical supervision provided an opportunity to gain support and encouragement, and to highlight therapeutic success. Such activities increased my confidence and motivation to continue therapy with clients.

The second tendency was to over protect clients, to soften the emotional tone, and to release the therapeutic tension. Supervision helped increase my tolerance for emotional intensity and reduced my need to protect individual clients. Finally, the independent review helped acknowledge my tendency to identify with client communication and personality traits. This tendency increased my comfort level and ability to empathize. However, it limited my ability to move beyond cognitive and behavioural interventions. Supervision helped acknowledge the similarities and address counter-transference issues.

Counter-transference occurs when therapists identify with characteristics of the client. The practicum provided opportunity to experience counter-transference and

supervision to understand and address the personal experience. For instance, two clients lived in blended families similar to my family of origin. Supervision provided opportunity to explore these similarities and to discuss the implications for service delivery.

Evaluation of values and beliefs was the last component of the independent review. As a pro-feminist, my values and beliefs influence my work. Although I believe in equality and woman's rights, I recognized that some women subscribe to patriarchal values and traditional distribution of labour. Recognition of these differences is a foundation of Social Work practice. Throughout the practicum, I became increasingly aware of how my values and beliefs influence my work with diverse populations.

The fifth goal was to learn evaluation techniques and how to use standardized measures. This goal was achieved by reading the manuals and literature on each scale and by using them in clinical practice. Although the goal was achieved, the usefulness of the scales was limited; they supplemented the assessment and provided minimal post-treatment evaluative information.

The final goal was to develop skills to work in a multidisciplinary outpatient setting. When working in a multidisciplinary team, one collaborates with team members to provide the best possible service. MDFT suggests that one therapist administer individual and family therapy and serve as the primary case manager. This way of working is inconsistent with the philosophy of the ACCCIS Team, as separate members of the multidisciplinary team generally complete each function. Throughout the placement, I was the primary therapist for four adolescents and their families. However, I consulted with nursing, psychiatry, education, and recreation as required. Such consults

allow families to benefit from the expertise of the multidisciplinary ACCCIS Team while receiving service from their primary therapist.

Conclusion

Overall, Multidimensional Family Therapy was an effective treatment for adolescents exposed to trauma. The multi-modal assessment provided a comprehensive view of individuals, families and ecological systems, while the multidimensional interventions produced individual and family change marked by scores on the GAF, FAM-III and CSQ-8. In addition to clinical evaluation, researching, applying and evaluating the MDFT model, as a member of a multidisciplinary adolescent treatment team helped the student to achieve practicum goals.

REFERENCES

- Allen, S.N. & Bloom, S.L. (1994). Group and family treatment of post-traumatic stress disorder. *Psychiatric Clinics of North America*, 17, 425-437.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- Becvar, D. & Becvar, R. (2000). *Family therapy: A systemic integration*, (4th ed.). Boston: Allyn & Bacon.
- Bloom, M., Fischer, J., & Orme, J.G. (1999). *Evaluating practice: guidelines for the accountable professional* (3rd ed.). Toronto, ON: Allyn and Bacon.
- Dennis, M.L., Godley, S.H., Diamond, G., Tims, F., Donaldson, J., Liddle, H., et.al. (In press). Main findings of the cannabis youth treatment (CYT) randomized field experiment. *Journal of Substance Abuse Treatment* (submitted September 11, 2002).
- Diamond, G.S., & Diamond, G.M. (2002). Studying a matrix of change mechanisms: an agenda for family-based process research. In H. Liddle, D.A. Santisteban, R.F. Levant, & J.H. Bray (Eds.), *Family Psychology: Science-based Interventions*, (pp. 41-66). Washington, DC: American Psychological Association.
- Diamond, G.M., & Liddle, H.A. (1991). Adolescent substance abusers in family therapy: the critical initial phase of treatment. *Family Dynamics of Addiction Quarterly*, 1 (1), 55-68.
- Diamond, G.M., Sessa, F.M., Schmidt, S., & Ettinger, D. (2000). Toward a developmental family therapy: the clinical utility of research on adolescence. *Journal of Marital and Family Therapy*, 26 (4), 485-500.

- Diamond, G.M., & Siqueland, L. (1998). Emotions, attachment, and the relational reframe: the first session. *Journal of Systemic Therapies, 17* (2), 36-51.
- Dishion, T.J. (1998). Advances in family-based interventions to prevent adolescent drug abuse. In National conference on drug abuse prevention research: Presentations, papers, and recommendations (pp. 87-100). [United States Department of Health and Human Services]. Rockville, MD.
- Elliott, D.M. (1997). Traumatic events: prevalence and delayed recall in the general population. *Journal of Consulting and Clinical Psychology, 65*, 811-820.
- Figley, C.R. (1988). Post-traumatic family therapy. In F.M. Ochber (Ed.), *Post-Traumatic therapy and victims of violence*, (pp. 83-109). New York: Brunner/Mazel.
- Freyd, J.J., & DePrince, A.P. (2001). In J.J. Freyd, & A.P. DePrince (Eds.), *Trauma and cognitive science: a meeting of minds, science and human experience*, (pp. 1-8). New York: The Haworth Press, Inc.
- Grossman, K.E., & Grossman, K. (1991). Attachment quality as an organizer of emotional and behavioral responses in a longitudinal perspective. In C.M. Parkes, J. Stevenson-Hinde, E & P. Marris (Eds.), *Attachment across the life cycle*, (pp. 93-114). New York: Tavistock/Routledge.
- Havas, E. & Bonnar, D. (1999). Therapy with adolescent and families: The limits of parenting. *American Journal of Family Therapy, 27*, 121-136.
- Hopper, J. (2003). *Recovered memories of sexual abuse: scientific research and scholarly resources* (pp. 1-10). Retrieved May 16, 2003, from www.jimhopper.com/memory/.

- Johnson, M.P., & Ferraro, K.J. (2000). Research on domestic violence in the 1990s: Making distinctions. *Journal of Marriage and the Family*, 62, 948-963.
- Karpel, M.A., & Strauss, E.S. (1983). *Family Evaluation*. Toronto, ON: Allyn and Bacon.
- Liddle, H.A., & Hogue, A. (2001). Multidimensional family therapy for adolescent substance abuse. *Social Science*, 1, 227-259.
- Liddle, H.A. (1994). The anatomy of emotions in family therapy with adolescents. *Journal of adolescent research*, 9 (1), 120-157.
- Liddle, H.A. (1995). Conceptual and clinical dimensions of a multidimensional, multisystems engagement strategy in family-based adolescent treatment. *Psychotherapy*, 32 (1), 39- 58.
- Liddle, H.A. (1999). Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology*, 28 (4).
- Liddle, H.A. (2002). Multidimensional family therapy treatment manual. *Center for Treatment Research on Adolescent Drug Abuse – Department of Epidemiology and Public Health*. University of Miami School of Medicine: Miami, Florida.
- Liddle, H.A., & Dakof, G.A. (1995). Family-based treatment for adolescent drug use: state of the science. In E. Rahdert & D. Czechowicz (Eds.), *Adolescent drug abuse: Clinical assessment and therapeutic interventions* (pp. 218-254). [NIDA Research Monograph 156, NIH Publication No. 95-3908}. Rockville, MD: National Institute on Drug Abuse.

- Liddle, H.A., Dakof, G.A., & Diamond, G.M. (1991). Adolescent substance abuse: multidimensional family therapy in action. In E. Kaufman & P. Kaufmann (Eds.), *Family therapy approaches with drug and alcohol problems* (2nd ed., pp. 120-171). Boston: Allyn & Bacon.
- Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejada, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a controlled clinical trial. *American Journal of Drug and Alcohol Abuse*, 27 (4), 651-687.
- Liddle, H.A., Dakof, G.A., Turner, R.M., & Tejada, M. (In press). Treating adolescent substance abuse: A comparison of individual and family therapy interventions. *NIDA Monograph on the 2001 CPDD Conference* (paper presented at Adolescent Drug Abuse Treatment Research Symposium [A. Morral & M. Dennis, Chairs], CPDD, June, 2001).
- Longest, B.B. (1996). *Health professional in management*. Toronto, ON: Prentice Hall Canada, Inc.
- Mattaini, M.A. (1997). *Clinical practice with individuals*. Washington, DC: NASW Press.
- McKinsey Crittenden, P (1997). Patterns of attachment and sexual behaviour: Risk of dysfunction versus opportunity for creative integration. In Atkinson, L., & Zucker, K.J. (Eds), *Attachment and Psychopathology* (pp. 47-93). New York, NY: The Guilford Press.
- Miller, L. (1999). Treating posttraumatic stress disorder in children and families: Basic principles and clinical. *American Journal of Family Therapy*, 27, 21-34.

- Nader, K (2001). Treatment methods for childhood trauma. In J.P. Wilson, J.Friedman, & D. Lindy (Eds), *Treating psychological trauma and PTSD* (pp. 278-234).
- Nichols, M. P., & Schwartz, R. C. (2001). *Family therapy: concepts and methods* (5th ed.). Toronto, ON: Allyn and Bacon.
- Palmer, R. B., & Liddle, H.A. (1995). Adolescent drug abuse: contemporary perspectives on etiology and treatment. In G. Blau & T. Gullotta (Eds.), *Adolescent dysfunctional behavior* (pp. 114-138). Thousand Oaks, CA: SAGE Publications.
- Pelcovitz, D., Van der kolk, B., Roth, S., Mandal, F., Kaplan, S., & Resick, P. (1997). Development of a criteria set and a structured interview for disorders of extreme stress (SIDES). *Journal of Traumatic Stress, 10* (1), 3-16.
- Santrock, J.W. (1996). *Child development* (7th ed.). Toronto, ON: Brown & Benchmark Publishers.
- Salter Ainsworth, M.D. (1991). Attachments and other affectional bonds across the life cycle. In C.M. Parkes, J. Stevenson-Hinde, & P. Marris (Eds.), *Attachment across the life cycle* (pp. 33-51).
- Schwartz, S.J., & Liddle, H.A. (2001). The transmission of psychopathology from parents to offspring: development and treatment in context. *Family Relations, 50* (4).
- Spillane, S. (1985). Review of the Family Assessment Measure version III. *American Educational Research Association, American Psychological Association, and National Council on Measurement in Education*. Retrieved November 7, 2002, from Mental Measurements Yearbook database.

- Stillwell, B.M., Galvin, M., & Kopta, S.M. (1991). Conceptualization of conscience in normal children and adolescents, ages 5-17. *Journal of the American Academy of Child and Adolescent Psychiatry*, 30(1), 16-21.
- Van der kolk, B.A. (2001). The assessment and treatment of complex PTSD. In R. Yehuda (Ed.), *Traumatic stress* (pp. 2-29). American Psychiatric Press.
- Van der kolk, B.A., Hopper, J.W., & Osterman, J.E. (2001). Exploring the nature of traumatic memory: combining clinical knowledge with laboratory methods. In J.J. Freyd, & A.P. DePrince (Eds.), *Trauma and cognitive science: a meeting of minds, science and human experience* (pp. 9-32). New York: The Haworth Press, Inc.
- Vanijendoorn, M.H., & Bakermans-Kranenburg, M.J. (1997). Intergenerational transmission of attachment: A move to the contextual level. In L. Atkinson, & K.J. Zucker (Eds.), *Attachment and Psychopathology* (pp. 135-170). New York: The Guilford Press.
- Wakeman, S. (2002). Working with the centre: psychiatric rehabilitation with people who dissociate. *Psychiatric Rehabilitation Journal*, 26(2), 115-122.
- Wilson, J.P., Friedman, M.J., & Lindy, J.D. (2001). Treatment goals for PTSD. In J.P. Wilson, M.J. Friedmam, & J.D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 1-27). New York: The Guilford Press.
- Wilson, J.P., Friedman, M.J., & Lindy, J.D. (2001). A holistic, organismic approach to healing trauma and PTSD. In J.P. Wilson, M.J. Friedmam, & J.D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 28-58). New York: The Guilford Press.

- Wilson, J.P. (2001). An overview of clinical considerations and principles in the treatment of PTSD. In J.P. Wilson, M.J. Friedmam, & J.D. Lindy (Eds.), *Treating psychological trauma and PTSD* (pp. 59-93). New York: The Guilford Press.
- Winnipeg Regional Health Authority (2001, June). *Child and adolescent mental health program: Rebalancing project*. St. Boniface General Hospital.

APPENDIX A

Participant Consent Form

I am a Master of Social Work student from the Faculty of Social Work at the University of Manitoba. As part of my training, I am completing a practicum in Family Therapy with the Child and Adolescent Mental Health Program at the St. Boniface General Hospital. By signing this consent, you are agreeing to participate in family therapy and acknowledging that I have explained the practicum to you.

Participation in this practicum is voluntary and you may withdraw or refuse to participate at any time without consequences or penalty. Should you refuse or withdraw from participation, you will not be refused further service from the St. Boniface General Hospital.

Information gathered during this practicum may be published or presented in a public forum. However, no identifying information will be included, nor will sufficient detail be used that people could easily identify you.

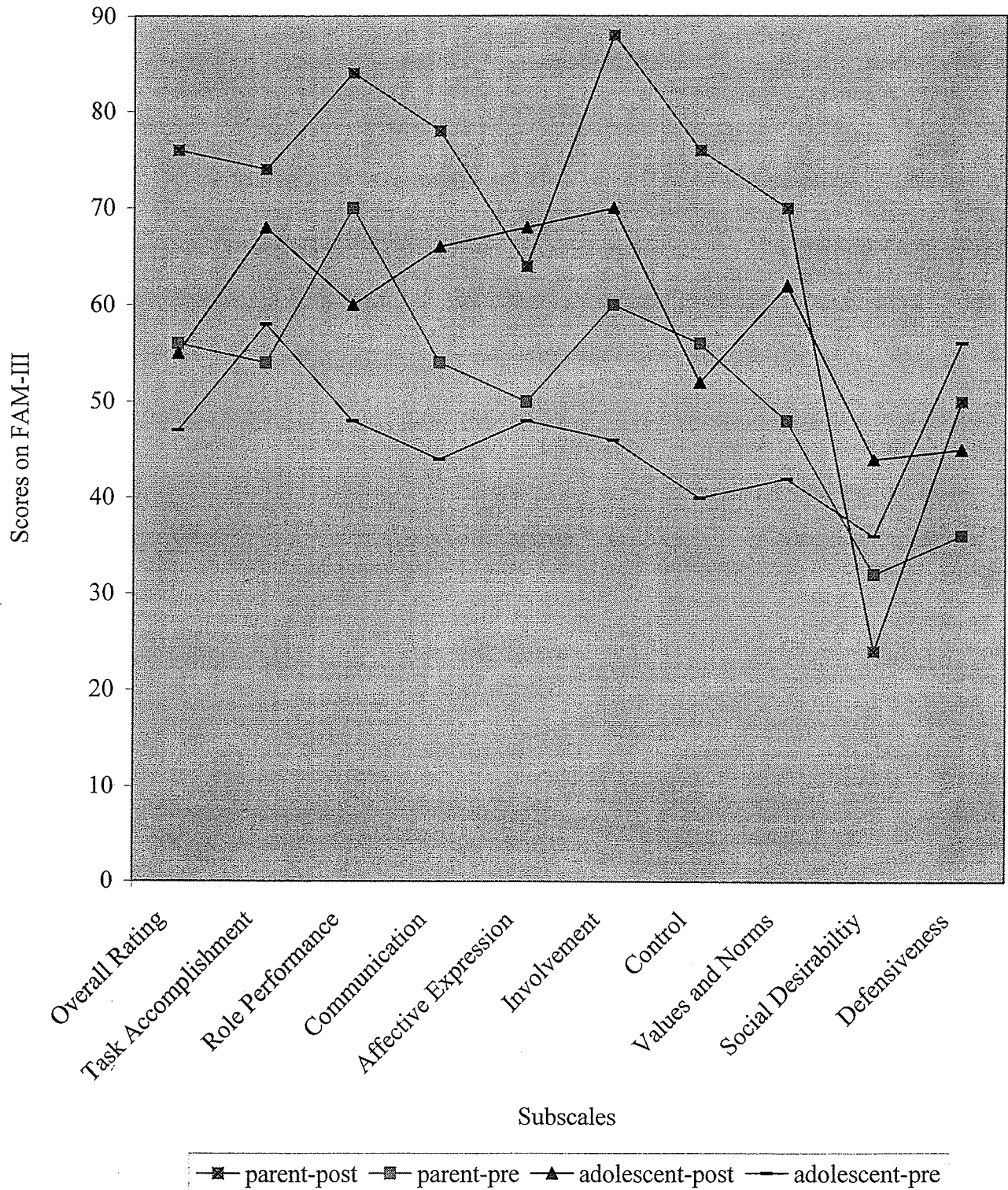
As part of my education/training, I will be supervised by John Smyth and Dr. Brenda Bacon.

Any questions or concerns regarding this practicum may be directed to Carmen Reynolds (TBA). Any complaints regarding these procedures may be reported to Dr. Brenda Bacon (474-XXXX), or John Smyth (237-XXXX).

_____ Name of Participant	_____ Signature of Participant	_____ Date
_____ Name of Participant	_____ Signature of Participant	_____ Date
_____ Name of Participant	_____ Signature of Participant	_____ Date
_____ Name of Participant	_____ Signature of Participant	_____ Date

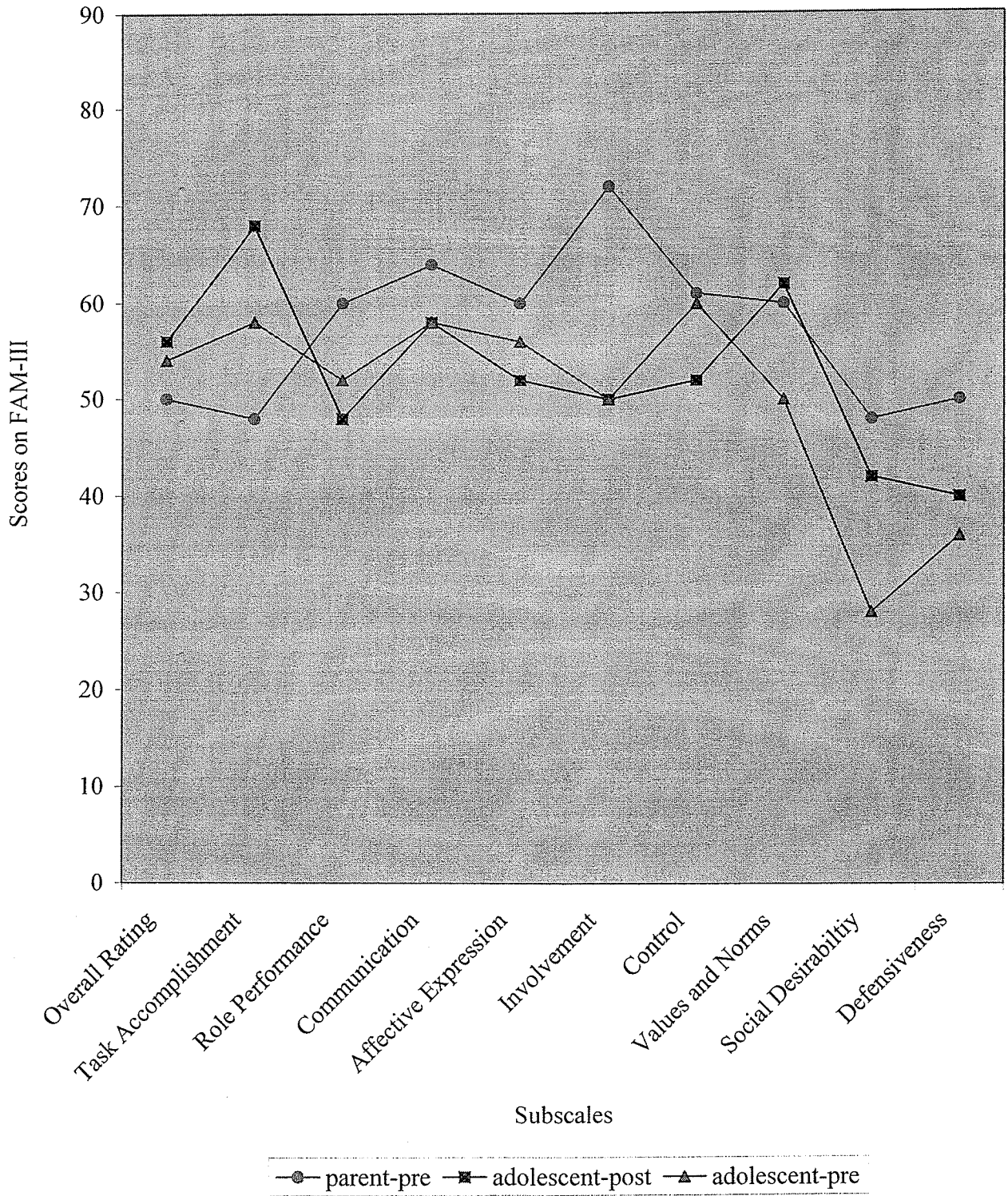
APPENDIX B

FAM-III Emily



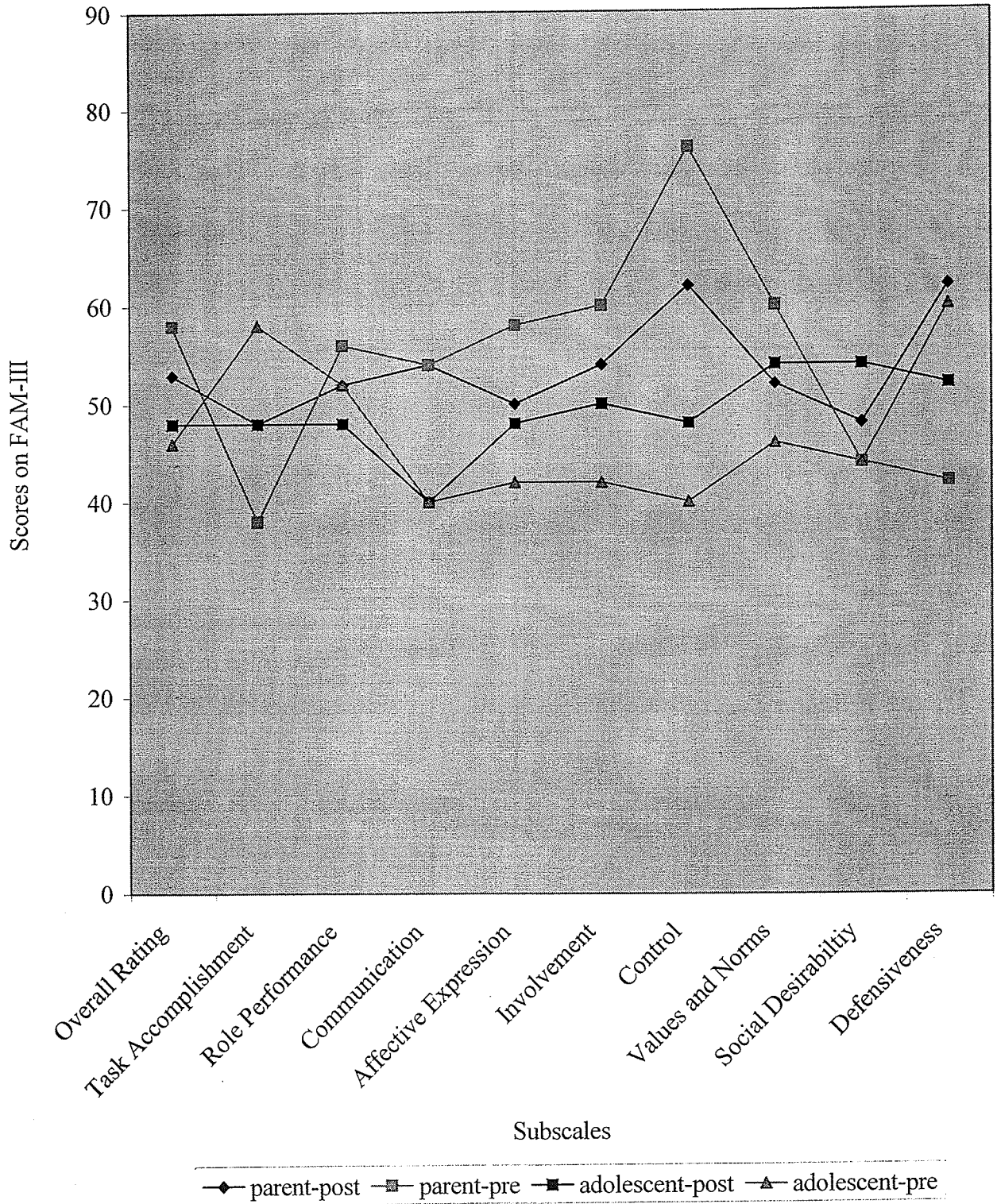
APPENDIX C

FAM III - Mark



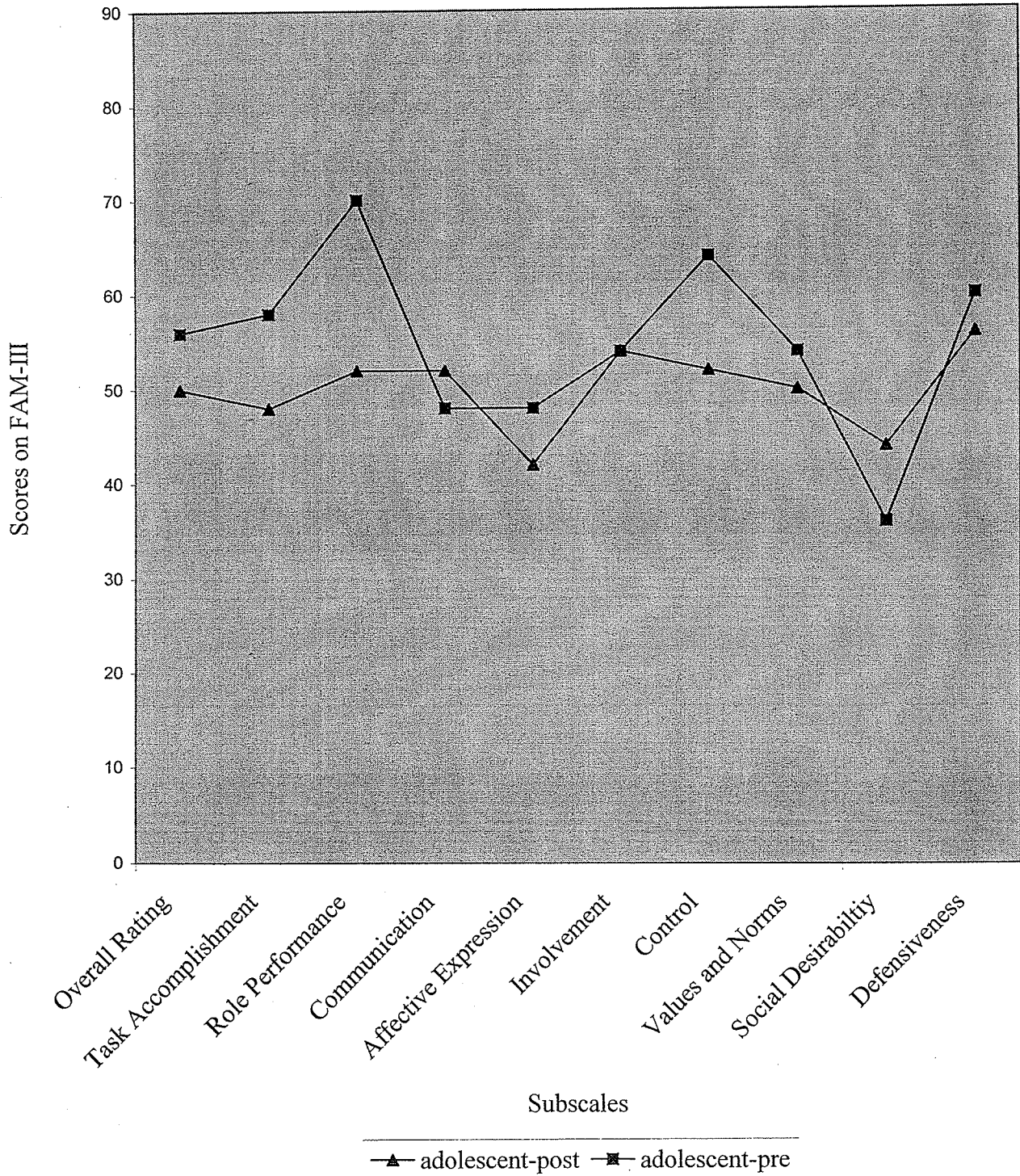
APPENDIX D

FAM III-Laura



APPENDIX E

FAM III - Barb



APPENDIX F

Trauma Antecedents Questionnaire

Emily					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	3	2.5	1.5		7
Safety	2	2	2.67		6.67*
TRAUMA AND NEGLECT					
Neglect	0	0	0.6*		0.6
Separation	0	1	1		2.0
Secrets	0	0	0		0
Emotional Abuse	0	0	0		0
Physical Abuse	0	0	1		1
Sexual Abuse	0	0	0		0
Witnessing	0*	0	0		0
Other Traumas	0	0	0		0
Alcohol and Drugs	0	0	0		0

Emily's Mother					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	0	0	2	1.5	3.5
Safety	0.67	0	0.3	1	1.97
TRAUMA AND NEGLECT					
Neglect	0.6	1.6	1.6	2.67	6.47
Separation	0	0	0	2	2
Secrets	1.5	1.5	1	2.5	6.5
Emotional Abuse	2.2	2.2	1.8	1.2	7.4
Physical Abuse	0	1	1	0	2
Sexual Abuse	0	0	0	0	0
Witnessing	0.83	0.5	0.5	0	1.83
Other Traumas	0	1	1	0.5	2.5
Alcohol and Drugs	1.5	1.5	3.0	0	6

APPENDIX G

Trauma Antecedent Questionnaire

Mark					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	3	3	2.5		8.5
Safety	3*	3	2.6		8.6*
TRAUMA AND NEGLECT					
Neglect	0*	0.4	0		0.4*
Separation	1.5*	2	2		5.5*
Secrets	*	1	2		3*
Emotional Abuse	*	0	0.8		0.8*
Physical Abuse	0	0	0.6		0.6
Sexual Abuse	0	0	0		0
Witnessing	*	0.4	0		0.4
Other Traumas	0	0	0		0
Alcohol and Drugs	0	1.5	1.5		3.0

Mark's Father					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	2.5	2.5	2.5	2.5	10.0
Safety	1.33	1.33	2	2.33	6.99
TRAUMA AND NEGLECT					
Neglect	0.5	1	1.75	2.5	5.75
Separation	0	0	0	0	0
Secrets	1	1	2.0	2	6.0
Emotional Abuse	0.66	1.33	2.0	2.66	6.65
Physical Abuse	0	0	0	0	0
Sexual Abuse	0	0	0	0	0
Witnessing	0	0	0	0	0
Other Traumas	0	0	0.33	0.5	0.83
Alcohol and Drugs	1	1	3	3	8.0

APPENDIX H

Trauma Antecedent Questionnaire

Laura					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	1.5	2.5	3.0		7
Safety	3	3	3		9
TRAUMA AND NEGLECT					
Neglect	*	0	0		0*
Separation	*	0.5	1.6		2.1*
Secrets	*	0	3		3*
Emotional Abuse	*	0	0		0*
Physical Abuse	0	0	1.33		1.33
Sexual Abuse	0	0	0		0
Witnessing	0.4	0	0		0.4
Other Traumas	0.5	0	0.33		0.83
Alcohol and Drugs	1.5	0	0		1.5

Laura's Mother					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	0	0	1.5	3	4.5
Safety	0	1	1	2	4.0
TRAUMA AND NEGLECT					
Neglect	0	0	1.25	1.25	2.5
Separation	0	1.5	1.5	2.25	5.25
Secrets	1.5	1.5	2.5	2.5	8.0
Emotional Abuse	0	0	0*	1*	1*
Physical Abuse	0	0	0	0	0
Sexual Abuse	0	0	0	0.75	0.75
Witnessing	0	0	1.16	0.8	1.96
Other Traumas	0	0	0	0.5	0.5
Alcohol and Drugs	0	0	1.5	3	4.5

APPENDIX I

Trauma Antecedent Questionnaire

Barb					
AGE	0-6	7-12	13-18	ADULT	TOTAL
RESOURCES					
Competence	0	2	1.5		4.0
Safety	1	2.6	2		5.6
TRAUMA AND NEGLECT					
Neglect	1.5	0.5	1.5		3.5
Separation	1.5	1.5	1.5		4.5
Secrets	0	2	2		4
Emotional Abuse	.75	0	.5		1.25
Physical Abuse	0	0	0		0
Sexual Abuse	1.25	1.25	0.75		3.25
Witnessing	1.33	0.66	0		1.99
Other Traumas	0.6	0.4	0		1.0
Alcohol and Drugs	1.5	0	2		3.5