Families Serviced by a Community Based Children's Mental Health Agency: A Solution Focused Approach

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FAMILIES SERVICED BY A COMMUNITY BASED CHILDREN'S MENTAL HEALTH AGENCY: A SOLUTION FOCUSED APPROACH

BY

MICHELLE HUDSON

A 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

Abstract

This practicum explores the use of the brief solution focused approach with latency aged children (7 - 12) and their families who had been referred to a community based children's mental health agency. This report reviews the brief solution focused model and compares it to the task-centered approach. The subsequent chapters of this report include a section of methods, a discussion of case examples and the results of the evaluation. The report also includes a summary chapter and a discussion of the perceived strengths and limitations of the brief solution focused model.

The model of practice is evaluated through the use of the FAM III general scale and a Client Satisfaction Questionnaire. The brief solution focused model was deemed successful for five of the six families serviced which supports the utility of this interventive method for the target population. Specifically, for two families, their FAM III post-test scores all fell to within the average range of functioning at termination. The post-test scores for two other families clearly indicated that their presenting complaints were improved and had been reduced to a more tolerable level. In addition, one family reported that their presenting complaint had been eliminated after just one session. All case examples are discussed in detail and the FAM III profile scores and FAM III general scale graphs are provided which depict the specific results for each of the families serviced during this practicum.

Acknowledgements

There are a number of people who were instrumental and whom I would like to thank for their unconditional support and faith in my abilities. Specifically, I would like to thank my parents, Mike and Marjorie and partner, Glen for their constant encouragement and for keeping me on track and focused. Kay David for all her administrative assistance. My advisor Don Fuchs for his guidance and direction. Brenda Bolliger for her clinical supervision and the entire Community Intervention Team for their friendship. Lastly, I am thankful and grateful to the families who participated in this practicum and allowed me into their lives.

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Introduction

Solution Focused Brief Therapy appears to be a viable option and/or adjunct to traditional problem focused long term psychotherapy for families with latency aged children between the ages of 4-12. Fisher (1984) conducted a one year follow-up survey of families who had previously sought help at a child guidance clinic for difficulties with a child 8-12 years old. The results of this study "suggested that very brief treatment of six sessions could be as effective as therapy that was considerably longer" (pp. 102). Furthermore, Fisher (1984) states that "brief treatment can produce more than temporary improvement in a largely unselected, child clinic population" (pp. 104)

This writer was introduced to the solution focused brief therapy model while taking courses required for completion of the MSW program and quickly became excited by its theoretical premises and assumptions in providing service to clients, as well as its applicability in working effectively for a number of different family systems and varying client complaints. This model's theoretical foundations are proactive and highly optimistic in providing clients with hope that change is not only possible, but inevitable (de Shazer et. al., 1986, pp. 216). The major tenets of the solution focused brief therapy model all work from the premise that it is essential to focus on client strengths instead of pathology and that therapy should be a joint endeavor which involves both the therapist and client (s) working together to construct mutually agreed upon goal (s) (de Shazer, 1991). Stated briefly, this writer finds this model's focus on client strengths instead of pathology to be extremely refreshing and furthermore, appreciates the collaborative relationship between therapist and client system which this model promotes.

In addition to these perceived strengths, this writer believes that solution focused brief therapy is advantageous to families who are in crisis and "stuck" as are a large number of clients referred or seeking social work intervention (s) . Moreover, brief solution focused therapy may in fact have inherent capabilities that surpass those found in many traditional forms of long term therapy. Fisher (1984) states that at the one year follow-up mark, self reports on outcome showed no difference between treatment groups who received time limited, and unlimited treatment. He notes that time limits did not decrease the effectiveness or the durability of the outcome. Fisher (1984) concludes that time-limited brief therapy is an effective and durable approach (pp. 105).

Educational goals to the student

The intervention goals of this practicum were to utilize a solution focused approach with latency aged children (7-12) and their families and to then evaluate its efficacy.

This writer received formal training in family therapy with latency aged children (7-12) and their families through the Community Intervention Program (CIP) offered through Peel Children's Center located in Mississauga, Ontario. The educational goals of this practicum were as follows:

1. To observe other family therapists and their techniques. To participate as part of a team in order to benefit from their expertise as well as gain insight and feedback on my own practice techniques.

2. To develop greater experience and skills in working with families in the capacity as a family therapist.
3. To develop and enhance assessment skills from a systemic perspective and strategic framework.
4. To develop interviewing and intervention skills in solution focused therapy.
5. To assess the solution focused brief therapy model and its practical application working with families with latency aged children in crisis and/or seeking social work intervention.
6. To operationalize the solution focused brief therapy model in therapeutic situations.
7. To develop skills and integrate a conceptual model that can serve as a foundation for my future development as a family therapist.

A solution focused interventive strategy was employed which encompassed short term, goal oriented family therapy in order to highlight and enhance behaviors that lead to solutions regarding the client systems presenting problem. The client population consisted of families referred for service to a community based children's mental health agency.

Treatment was offered on the assumption that problems were not an indication of family dysfunction. In addition, other inherent assumptions of this approach were based on the premise that families were seen as "stuck" as opposed to "pathological" and that change was an inevitable product of the therapeutic process.

While the definitional spectrum of mental illness ranges from persons diagnosed and who fit into the current DSM III, the clients serviced during this practicum could best be defined as having issues and/or problems in living. These

problems included such things as a simple lack of access to resources in order to fulfill personal needs; deficits in skill acquisition resulting in interpersonal difficulties; the inability to cope with excessive stress and demands; and/or the result of a families limited world view and problem definition based on past experiences and/or difficulties.

This practicum report is divided into a number of chapters. The literature review consists of two sections. The first will review the assumptions; theoretical premises and therapeutic techniques incorporated by the brief solution focused model. The second section of the literature review will focus on the task-centered approach and will provide an alternate model of brief therapy on which to compare and contrast the brief solution focused model with. The subsequent chapters of this report will present the practicum methods, a discussion of case examples and the results of the evaluation. Finally, the report will close with the conclusions and summary section which will include the observed strengths and limitations of the brief solution focused model when applied with the above noted client population as perceived and noted by this writer.

Chapter 1 - The Brief Solution Focused Model

Introduction

The solution focused brief therapy model has the potential to provide clients with a very different therapeutic experience whereby change is promoted as inevitable and the process is optimistic and proactive in nature (de Shazer et. al., 1986). This model offers both the family and the therapist an efficient and practical means for solving problems. Because the focus is on solutions and what is working, the model promotes cooperation and hope that the presenting problematic situation will get better. This brief literature review will examine the solution focused brief therapy model as developed by de Shazer and his colleagues at the Milwaukee Brief Family Therapy Center (BFTC) which was founded in 1978. Steve de Shazer and Insoo Kim Berg were the two primary founders of the Brief Family Therapy Center (BFTC).

De Shazer and his colleagues at the Brief Family Therapy Center (BFTC) developed their approach based on Milton Erickson's ideas about people's resources. The Solution focused approach evolved from the Milwaukee team's early thinking and experimenting with strategic and systemic approaches such as those of The Mental Research Institute (MRI), Haley and the Milan team (Durrant, 1992 & de Shazer, 1982). Their work led them away from a problem focus to solution construction with clients when they recognized that what clients found helpful often appeared to the therapist to have no direct relationship to the problems presented, but in some way "fitted" with the clients unique experience

(de Shazer, 1985). As a result, the emphasis of treatment shifted from the therapist trying to understand the problem and how to help clients solve it, to asking clients questions and prescribing tasks to help them focus on their own perception of needs and goals and their own existing and potential resources for solutions (Lipchik, 1986; Molnar & de Shazer, 1987). As part of this process, they discovered the notion of exceptions - finding that asking clients about times the problem wasn't a problem (or was less so) seemed more helpful than asking about the times it was a problem (Molnar & de Shazer, 1987, pp. 352).

Brief historical overview

The brief solution focused model falls under the category of strategic family therapy (Fish & Piercy, 1987; Rosenbaum, 1990). Strategic therapy is not a particular approach or therapy (Haley, 1973, 1976, & Madanes, 1980), but rather refers to any therapy in which the therapist is willing to take on the responsibility for influencing people and takes an active role in planning a strategy for promoting change (de Shazer, 1985; Fish et al., 1982; Madanes, 1980; Papp, 1980, & Weakland et al., 1974). The published history of strategic therapy and therefore also that of the solution focused brief therapy approach can be traced back to the work of Milton Erickson and his work in the field of hypnotherapy (de Shazer, 1982)

de Shazer (1982) states that brief family therapy owes a large debt to Milton Erickson' s methods of therapy and the world view that these imply.

> *"Erickson's procedures involve a process of evolving and utilizing a patients own mental processes in ways that are outside his usual range of intentional or voluntary control. Erickson can be seen to accept the persons*

world view and the patterns in which the person is involved; then he helps the person use these patterns in new ways" (de Shazer, 1982, pp. 26).

Furthermore, Erickson was not particularly interested in helping patients consciously understand their predicaments as he thought that insight and interpretation were largely useless. He stated that "the goal of therapy was change, which occurred when patients learned what they already unconsciously knew, though they might never know why they had changed" (Sykes Wylie, 1990, pp. 28). The three primary principles of Erickson's work which have been adopted and assimilated into the theoretical foundations of the Solution Focused Brief Therapy Model are:

"1. Meet the patient where he is at, and gain rapport.
2. Modify the patient's productions and gain control.
3. Use the control that has been established to structure the situation so that change, when it does occur, will occur in a desirable manner and a manner compatible with the patients inner wishes and drives". (de Shazer, 1982, pp. 27).

Solution focused brief therapy

Stated briefly, de Shazer (1982) states that the brief family therapy model is designed to make the principles behind Erickson's methods explicit enough for other therapists without Erickson's particular gifts. The model expands these principles from the field of hypnotherapy to the field of family therapy. Furthermore, de Shazer (1982) states that it was through the Brief Family Therapy Centers efforts to apply Erickson's methods and procedures that their approach was developed (pp. 28).

While brief therapy by its very name denotes "time limited therapy" Weakland (1974) states that he prefers to call his work "efficient therapy" (Weakland et al., 1974) as does Steve de Shazer. Specifically, de Shazer states that "therapy should be as efficient and effective as possible, and brief therapy is built around ways of knowing when therapy is finished" (de Shazer, 1988). " In part, brief therapy is a state of mind of the therapist and of the patient ," write Budman and Gurman (1988). In addition, these authors state that "brevity is a metaphor for clarity about what needs to be changed, an attitude of being task-oriented. In addition, Budman and Gurman (1988) in their book entitled, Theory and Practice of Brief Therapy state that the median length of most psychotherapy is only about five or six sessions, which is fewer than many self defined brief therapists allot for treatment. They further state that people commonly expect to be in therapy for less than three months or six to ten sessions which is also substantiated by de Shazer et al., 1986; Fisher, 1984; and wells & Phelps, 1990.

In the past, brief therapy has also been termed problem solving therapy (Molner & de Shazer, 1987, & Miller, 1992). Simply stated this focus was premised on the notion that problems are assumed to be maintained by repeating interactional patterns. Once identified, a solution can be developed to interrupt the pattern and meet the goal of therapy, which is the reduction or extinction of the problem (Haley, 1987).

Solution focused brief therapy does not accept the assumption that the problem and the underlying causes have to be known in order to find a solution. Rather, it assumes that whatever the cause, the continuation of the problem is related to the context it occurs in, and the expectation that the problem will

continue (de Shazer, 1988). Consequently, the focus is on the situation, rather than on the person:

> *"Given the complexity of complaint construction, it would seem reasonable that solutions would need to match that complexity. However, it is our view that interventions and solutions only need to fit within the constraints of the complaint in much the same way that a skeleton key fits within the constraints of many different locks" (de Shazer et. al., 1986, pp. 212).*

In addition, Miller (1992) states that while solutions, like problems, vary a great deal from individual to individual they are similar enough to allow researchers to construct a description that fits for most (Miller, 1992, pp. 1). Likewise, de Shazer et al. (1986) have described solutions as the behavior and/or perceptual changes that the therapist and client construct to alter (the identified) difficulty, the ineffective way of overcoming the difficulty, and/or the construction of an acceptable, alternative perspective that enables the client to experience the complaint situation differently" (pp. 210).

de Shazer and Berg (1988) suggest that solutions can be developed by amplifying non-problematic patterns without attempting to determine what caused the problem (pp. 42). This is accomplished by the therapist systematically focusing the client on solutions and the future rather than problems and their causes in the past (Molnar & de Shazer, 1987). Stated briefly, the theoretical position of the solution focused brief therapist can be seen as a shift from initiating change to constructing and initiating solutions (Lipchik & de Shazer, 1986).

Problems or complaints requiring therapy are defined as involving a limited and restructured set of behaviors, perceptions, thoughts, expectations, and feelings (de Shazer, 1988). Solutions are seen to exist outside this restricted area,

yet the client system is often unable to perceive the patterns of interaction occurring in these areas.

The role of the brief therapist is to assist clients to discover the solutions outside the complaint. "The solution focus emphasizes exceptions to the rules of the problem rather than the rules of the problem itself" (Molnar & de Shazer, 1987, pp. 350). The solution focused brief therapist engages clients in developing solutions by asking "when does the complaint not occur. Miller (1992) states that by "generating discussion about such exceptions to the complaint, the clinician and client system create the opportunity for solutions to completely emerge "(pp. 3). This model proports that any exception to the complaint is a potential solution since it lies outside the constraint of the problem and the accompanying world view (de Shazer & Berg, 1988). These authors further state that clients can often describe exceptions to the problem, but that these exceptions are not considered significant. "For the clients, these are not differences that make a difference; making these differences make a difference is the heart of the therapists job" (pp.42).

In order to assist the client system in discovering the "difference", the therapist needs to explore the constraints of the complaint (de Shazer et. al., 1986). Stated more specifically:

> *"the task of brief therapy is to help clients do something different by changing their interactive behavior and/or their interpretation of behavior and situations so that a resolution of their complaint can be achieved. In order to construct solutions, it can be useful to find out as much as possible about the constraints of the complaint situation and the interactions involved" (de Shazer et. al., 1986, pp. 288).*

Briefly stated, a solution needs to "fit" within the constraints of the problem in order to allow for the development of a solution (de Shazer, 1985, de Shazer, 1988a). The concept of "fit" deals with the relationship between the therapist and the client (s), and involves feelings of closeness and responsiveness (de Shazer, 1988, Lipchik & de Shazer, 1986). In addition, de Shazer (1988) states that "fit" is a qualitative term that involves the client-therapist relationship, the pathway the interview takes, the goal (s), all of which help to make the present salient to the future and thus, give sense to the therapy situation (pp, 97). Thus, stated briefly, the concept of "fit" pertains to the relationship between the client (s) and therapist as well as intervention techniques and the nature of the presenting complaint/problem.

The solution focused brief therapy model promotes collaboration between therapist and client system (de Shazer, 1984). This model negates the concept of resistance and instead reframes this negative term as the client's way of informing the therapist how to help them, and that the present intervention does not fit (de Shazer, 1988). As a means of promoting and encouraging collaboration de Shazer (1985) states the following:

> *"First we connect the present to the future (ignoring the past), than we compliment the clients on what they are already doing that is useful and/or good for them, and then - once they know we are on their side - we can make a suggestion for something new that they might do which is, or at least might be good for them (pp. 15). "*

de Shazer (1985 & de Shazer et. al., 1986) state that people come to therapy because they want to change their situation, but whatever they have done to attempt change has not worked. Therefore, these authors promote the idea that a small change in one person's behavior can make profound and far reaching differences. Specifically, a change in one part of the system leads to changes in the

system as a whole. de Shazer et. al., (1986) promotes smaller changes as they state that "the bigger the goal or the desired change, the harder it will be to establish a cooperative relationship and the more likely that therapist and client will fail" (pp. 209).

The solution focused brief therapy model suggests that effective therapy can be accomplished even in situations where the problem is so vague that a definition of the presenting complaint or problem cannot be clearly articulated or defined. Because the
focus is on solutions, one only needs to know how the client will know when the problem is solved? (de Shazer et. al., 1986). To further expand this point, de Shazer et. al., (1986) states :

> *"Our view holds that clients already know what to do to solve the complaints they bring to therapy; they just do not know that they know. Our job as brief therapists is to help them construct for themselves a new use for knowledge*
> *they already have" (pp. 220).*

Therefore, a primary task of the intervention is to assist the client system change their method of constructing their experience (s). This view assumes that a change in the way clients construct their experiences, as reflected in how they report it or talk about it, will promote them having a different experience, which, in turn, will prompt different depiction's or reports in subsequent sessions (de Shazer, 1988, pp. 77).

The initial interview process consists of building rapport in order to create a workable and task centered cooperative therapeutic system which involves both the client and therapist (Lipchik & de Shazer, 1986). The establishment of rapport is the process that leads to "fit" between the client (s) and the therapist. Several

studies have shown that the quality of the therapeutic alliance established in the first session functions as a predictor of outcome of contracted, short-term therapy (Marziali, 1984, 1988 ; Moras & Hans Strupp 1982) and furthermore, that alliance factors for clients were significantly associated with a favorable outcome which included a sense of hopefulness about the therapeutic process. Understanding and accepting the clients world view is also considered essential for the development of useful solutions. Moreover, it is optimal to contract the goals of therapy early on in the therapeutic process, preferably during the first interview, as research shows that success in therapy depends upon establishing criteria for change (Thomlison, 1984). Lipchik (1986), states more concretely that "the therapist has to set goals by the end of the first session so that there is a focus for the therapy and some way to evaluate progress" (pp. 94). Also, Fox (1987) states that "the family, in forming goals and in establishing the conditions to be changed, leads the therapy" (pp. 495). He further states that "the setting of goals fosters a truly collaborative effort that offers a paradigm for continuing problem-solving activity outside the therapeutic situation" (pp. 495) In addition, the literature further suggests that the degree of focus on goals is associated with positive change as it is based on the operational principle of starting where the client is (Reid, 1990).

The solution focused model suggests that it is useful to differentiate clients as "visitors, complainants, and customers" (de Shazer, 1988a; Kral, 1990). Kral (1990) states that the client is the person most irritated with the situation and therefore, the person most willing to do something about it (pp. 5). A "visitor" is defined as an individual who is there because he/she has to be. The problem at hand is not a major concern to him/her. In fact, some "visitors" do not even recognize that there may be a problem. A "complainant" is the person who is willing to discuss the problem, but lacks the necessary desire to take any action. Finally, a "customer" relationship exists when a client explicitly identifies the

problem, their goals and is willing to do something about it (Kral, 1990, pp. 5). It is therefore, an essential task for the therapist to identify these differing roles within families and to assist and encourage "visitors" and "complainants" to become customers of service. Identifying the relationships that each family member has to the therapeutic process assists the therapist to fit a response to each member, and to assign initial tasks accordingly.

In addition to the above, the initial interview also begins the search for "exceptions" to the rules or set of problems, in an attempt to formulate with clients possible solutions. It is the search for these exceptions that is the key characteristic of a solution focused interview, as these stated exceptions are the beginnings of solution construction. If exceptions cannot be articulated, then the therapist should continue exploration of the identified problem or complaint and continue to explore and search for exceptions to the problem rules (Lipchik & de Shazer, 1986).

The therapist compliments the search for exceptions with a positive, proactive stance that it is not if change will occur, but rather when it occurs. This positive, futuristic and proactive approach, can also be considered to promote the amplification of non-problematic patterns of behavior within the system (de Shazer, 1984).

In addition to the exploration for exceptions to the problem or complaint rules, the solution focused brief therapy model utilizes what they term the "miracle question" in an attempt to identify solutions. An example of the miracle question is "suppose one night there is a miracle and while you are sleeping the problem is solved: What will you notice different the next morning that will tell you there has been a miracle? what else? (Berg & Gallagher, 1989). By asking the client to pretend as if their complaint had miraculously been resolved, the

clinician and client system create the opportunity for both to see solutions more clearly. In addition, the steps needing to be taken in order to bring about the emergence of the solution become clearer. Miller (1992) states, that "at the Brief Family Therapy Center, clients queried in such a manner have been observed to become more concrete and behaviorally specific as well as become more self-confident, smile and even burst out laughing. Some clients have even been observed to lose touch with the complaint reality entirely" (pp.5).

Likewise scaling questions are used and are reported as being very versatile in their usefulness. They can be used to measure a client's progress before and during therapy, to determine client's investment in change, problems and assess any perceptions of solutions. Scaling questions are simple enough that even children who do not understand number concepts can use them effectively. The absolute number is not as important as the change that was accomplished to get to that point or to the change expected to get to the next level (Brief Family Therapy Center, 1991). An example of a scaling question is "on a scale of 1-10 where 10 is when these problems are solved and 1 is the worst they have ever been, where are you today? A follow-up question might be how did you manage to get to point 3? What would be different if you were at 4? etc.

"de Shazer's theoretical exploration of solution-focused practice was initially developed primarily from an analysis of an intervention known as the "formula first session task" which is given to clients at the end of the first session (Molnar & de Shazer, 1987, pp. 349). The "formula first session task" (FFST) is stated as follows:

> *"Between now and next time, I want you to observe, so that you can tell me what happens is your life (or marriage or family or relationship) that you want to continue" (Molnar & de Shazer, 1987, pp. 349).*

Therapists are presented with a number of challenges early in therapy including the vague or conflicting descriptions of what it is families want to change. The therapist typically attempts to help the family articulate clear and specific goals for therapy in order to develop a treatment plan and to have a criterion against which to judge the effectiveness of the treatment (de Shazer, 1975, 1982; Fisch et al., 1982; Haley, 1963; Watzlawick, Weakland & Fisch, 1974; Weakland, fisch, Watzlawick, & Bodin, 1974; Gurman et al., 1986; Jacobson, 1985). de Shazer (1984, 1985) has formulated an intervention designed to assist both families and therapists in forming a clearer idea of the goals of treatment and in creating a positive context for change. de Shazer (1985) describes this intervention as solution focused rather than problem focused. He maintains that families usually have at their disposal the solutions to their own problems but have not been able to recognize them. The FFST was designed to shift the client's focus from past to present and future events, from problems to strengths, and implicitly to promote expectations of change (Adams et. al., 1991, pp, 278). Clients often expect things to go poorly; the solution focused FFST , according to Molnar and de Shazer (1987) , suggests otherwise. The task is also purported to enable the therapist to "fit" with the clients' goals and their vagueness. de Shazer (1985) believes the FFST intervention, along with a treatment focus which emphasizes family resources and strengths, creates a context in which "change is not only possible but inevitable" (pp. 137). This is a strong but not totally unsupported assertion. Preliminary data appear to indicate that clients report clearer treatment goals following this intervention (de Shazer, 1985). Moreover, clients were judged to be optimistic about the possibility of change, more cooperative in therapy, and often reported improvement in the presenting problem. According to de Shazer (1985), therapists also appeared more optimistic about the possibility of change.

This task is an attempt to define the structure of the clients situation as a framework in which the therapist believes something worthwhile is happening, expects these worthwhile things will continue to happen and expects other worth while things to happen (Molnar & de Shazer, 1987). In order to continue to promote these expectations, and to help shift client's focus toward solutions, the session following the use of the "Formula Task" opens with a question such as "so what happened that you want to continue to have happen more often"?. Thus, this task was designed to shift the focus from the past towards the present and future, while implicitly promoting change (de Shazer, 1985). This again indicates the Solution Focused Brief Therapy's overall commitment and dedication to assisting clients to search for exceptions upon which solutions can be based.

The therapist checks on task completion, and is always mindful that any subsequent tasks that he/she prescribes to the family system, must fit the complaint and the world view of the client system under consideration. The major goal of any intervention is to promote solution behavior. Often this means any behavior that is different, and therefore, the tasks/interventions prescribed by the therapist must assist in the development of clients noticing the differences that make a difference (de Shazer, 1991).

All subsequent sessions build on the initial interview. The therapist will generally check on task completion, and what was noticed. Even if there is no immediate response the therapist's persistence regarding any change can often uncover a small but positive change which again opens the door for possible solutions to emerge.

Evaluation of the solution focused brief therapy model

Evaluation and empirical studies are becoming a widely expected and essential component of clinical practice. de Shazer et al., (1986) state that "because therapy needs to be evaluated, we are taking a position somewhere between research findings and clinical impressions. We suggest that an evaluation can be based on a comparison between what a therapy proposes to do and its observable results" (pp. 219). After conducting research in this area which included contacting the Brief Family Therapy Center (BFTC), this writer states confidently that there is relatively few empirical studies confirming the longevity and overall effectiveness of this model. However, the center and other proponents of this model do ascribe to and rely on follow-up client self-reports (de Shazer et al., 1986). Specifically, between 1978 and 1983, therapists from the Brief Family Therapy Center saw 1600 cases for an average of 6 sessions per case (de Shazer et al., 1986). These same authors state that in their follow-up phone calls to a representative sample of 25% (done by someone who had no connection with the case) indicated that 72% either met their goals for therapy or felt that significant improvement had been made so that further therapy was not necessary (pp. 219) This apparent success is further substantiated by Weakland et al., (1974) who reported similar success rates within an average of 7 sessions per case.

In 1988, the BFTC conducted what is probably the most ambitious, comprehensive, and long-term follow-up study ever done of therapy designed to be brief (Sykes Wylie,1990). Family therapist David J. Kiser as part of his residency at the BFTC tracked the progress of 164 BFTC clients for 6, 12, and 18 months after therapy, using a questionnaire similar to one employed by the Mental Research Institutes (MRI) brief therapy center in 1974. The earlier study had reported that 40 percent of the clients had achieved "complete relief" of the

complaint, and 32 percent, "clear and considerable", but not complete relief (Weakland et. al., 1974).

Kiser's study showed even better results. Of 69 cases receiving 4 to 10 sessions, 64 clients , or nearly 93 percent, felt they had met or made progress on their treatment goal (about 77 percent of the 64 met the goal, and more than 14 percent made progress). At the 18 month follow-up, of all the 164 clients (94% percent of whom had 10 or fewer sessions), about 51 percent reported the presenting problem was still resolved, while about 34 percent said it was not as bad as when they had initiated therapy. In other words, about 85 percent of the clients reported full or partial success (Kiser, 1988). While these types of results are incredible and unparalleled there are inherent methodological criticisms as they were founded on descriptive survey methods; lacked experimental controls; failed to take into account chance improvements; and are based on subjective responses (Sykes Wylie, 1990). In conclusion , not withstanding the empirical scrutiny subjected by some other theoretical methods and their respective research studies, the BFTC does have a basis of efficacy . While this is not founded on an empirical base, the BFTC concurs with Fishers findings (1984) which indicate that things do continue to get better rather than deteriorate after brief therapy (de Shazer et al., 1986).

Summary and Comments

In summary, the solution focused brief therapy model is an innovative form of therapy which encompasses the ethical guidelines for social work practice. Specifically, it has respect and values clients' right to self determination. This model proports that the resources for problem resolution lie within individuals in the form of solutions. The goals of therapy are dependent on what is important to the client system. Therapy is designed to build on successes. It serves to replace

past ineffective patterns of behavior and problem resolution with new meanings which help to construct new effective prosocial patterns of interaction and problem resolution.

The solution focused brief therapy model helps clients to focus on their own strengths and serves to develop their own solutions to their complaints/problems. Therefore, it helps to build confidence and provides individuals with a sense of success. In addition and most importantly, it empowers clients to feel a sense of mastery over their problems and assists individuals to feel a sense of success which enables them to establish a repertoire of coping strategies for future use. Stated briefly, this therapeutic model is premised on the notion that it is easier and more beneficial to build on successes than to eradicate unfavorable behaviors.

The solution focused approach offers the therapist and client system an alternative to focusing on problematic interactions. It also provides clients who have received previous, unsuccessful counseling services an innovative and different approach to problem resolution, and as de Shazer and Berg (1988) state "it is the difference that makes a difference".

The solution focused approach is an orientation a therapist follows to promote change. There are specific guidelines and interventions used which have briefly been discussed. The therapist is responsible for the relationship and must understand the clients' world view, search for exceptions, and project the client into the future. This approach values client individuality and therefore, focuses on what fits for the client, not what fits for the approach. This model is premised on a positive focus away from a problem saturated world view as it encourages clients to identify effective solutions to their problems. It is a model that encourages and promotes health and competence. Lastly, the brief solution

focused model is a suitable and compatible fit within this writers clinical practicum site which will be outlined and discussed in detail further on in this report.

However, before discussing the clinical relevancy of the brief solution focused model as applied within this writers practicum site, an alternate form of brief therapy will be highlighted and summarized. Specifically, the task-centered approach was chosen as an alternative model of brief therapy on which to compare and contrast the brief solution focused model with, given both models use of tasks and their similar theoretical foundations and premises.

Chapter 2 - Task Centered Approach

Introduction

The task-centered approach grew out of a psycho dynamic short-term model of clinical social work developed in the early 1960's (Reid, 1990). This model, which provided eight weekly sessions, was compared in a randomized experiment with long-term, open-ended treatment within the same theoretical orientation, with results that actually favored the shorter service even when the findings of a six month follow-up were taken into account (Reid & Shyne, 1969). Using the psycho dynamic model as a base, William Reid in collaboration with Laura Epstein developed a more systemic, effective brief treatment design, one with its' own theoretical framework but still open to concepts and methods from other approaches (Reid & Epstein, 1972). In constructing this model, emphasis was placed on specific, client-perceived problems and actions or tasks clients could carry out to alleviate these problems (Reid & Epstein, 1972). The model was appropriately called "Task-Centered" in as much as helping clients plan and achieve these tasks became the main focus of treatment.

Brief historical overview of the task-centered approach

While the use of tasks is not new or solely applicable to the task-centered approach, this model, unlike others places primary emphasis on task development and implementation. Its main thrust is to help people resolve a limited number of specific, explicit problems that practitioners and clients agree will be the focus of work (Reid & Epstein, 1972; Epstein, 1980). Reid (1990) states that "in general, ideas are drawn from various approaches that use tasks including, cognitive (Beck, 1976; Sherman, 1984; Werner, 1982) and strategic (de

Shazer, 1982; fish, Weakland & Segal, 1982; Haley, 1976; Madanes, 1981; Werner, 1982). In addition to these sources, Reid (1990) further states that tasks are also drawn from specialized literature on homework and the like. This borrowed technology is not simply transferred, but rather is converted to fit the principles of the model (Reid, 1990).

As stated above the main thrust of the task- centered model is to help the client system resolve a limited number of specific problems that both the practitioner and client(s) agree to focus on (Reid, 1990). Reid (1990) further states that "although the definition of these problems may change as the case proceeds, care is taken to keep focus on explicit client-acknowledged problems rather than on what the practitioner may see as the 'real' problem underlying them (pp. 57). In addition, this model proports that although emergencies are dealt with as they arise, there is no expectation that therapy can accommodate all the clients concerns (Epstein, 1980).

Task-centered approach

The task-centered model like other forms of brief therapy begins by helping clients identify problems and goals in order to initiate problem resolution. In general, this model consists of assessment of the clients presenting problem and a problem-reduction program of action (Epstein, 1980). The problem-reduction program consists of asking clients to rank their problems in terms of the order that they would like to see them solved. Up to three problems are the solicited, explored, specified in detail and become the focus of the short-term intervention (Reid, 1990; Epstein, 1980). A contract is then designed which organizes the problem-solving work and outlines tasks which state specifically what the client and practitioner are to do to bring about problem resolution. In addition, the number of sessions is decided upon and contracted from the outset,

with the understanding that extensions are possible given individual needs and where deemed appropriate and necessary by both the practitioner and client.

The client's progress on problems and tasks are routinely reviewed at the beginning of each subsequent session. The review covers developments in the problem and what the clients have or have not accomplished in tasks to resolve them. What the practitioner does next depends on the results of the review. If the task has been substantially accomplished or completed, the practitioner may formulate another task with clients on the same problem or different problem. If the task has not been carried out or only partially achieved, the practitioner and client may take up obstacles, devise a different plan for carrying out the task, or apply other task implementation activities. The task may be revised or replaced by another, or the problem itself may be reformulated (Epstein, 1980).

Similarities between the two brief therapy approaches

The task-centered approach provides a viable model on which to compare and contrast the brief solution focused model with, given their respective assumptions and theoretical suppositions . Both models adhere to planned brevity which is supported by a large amount of research evidence that suggests the following: 1. recipients of brief, time-limited treatment show at least as much durable improvement as recipients of long-term, open-ended treatment (Koss and Butcher, 1986; Reid & Shyne, 1969; Fisher, 1984); 2. most of the improvement associated with treatment tends to occur quickly - within the first few months (Howard et. al., 1986); and 3. regardless of their intended length, most courses of voluntary treatment turn out to be relatively brief - the great majority probably last no longer than a dozen sessions - a generalization that suggests that most people exhaust the benefits of treatment rather quickly (Garfield, 1986).

There are a number of other characteristics which both of these models share. Specifically, the task-centered approach and brief solution focused model both have a systemic orientation and therefore, an inherent feature of both models is the assumption that change in one part of the system effects and creates changes in other parts of the system. Moreover, both approaches are premised on the understanding that problems occur in a context of individual, family, and environmental systems that may block or facilitate their resolution. Likewise, change in the problem may bring about, or require, contextual change that may have benefits for clients beyond resolution of the identified problem(s). Therefore, while both models primary purpose and focus is to help clients resolve specified problems, they also aim to strengthen and expand the client's repertoire of problem-solving capacities and skills on which they can benefit and draw on in the future.

In addition to the above, both of these models are committed and dedicated to building collaborative relationships between social worker and client system whereby the therapy is not self imposed or dictated by the social worker onto the client, but rather the two systems interconnect and together decide upon the direction that therapy is to take. Furthermore, both models view human beings optimistically and believe that they possess inherent capacities for resolving problems or at least reducing them to a tolerable level. The client systems own construction of the complaint/problem and his/her world view is paramount to both approaches and likewise the social worker avoids imposing his/her definitions of the presenting difficulties. However, both approaches do assist clients in formulating clear goals on which to base solutions and/or problem resolution.

In addition, both the brief solution focused model and the task-centered approach avoid a full-blown exploration and theoretical explanation of the clients presenting problem(s) but rather channel their energies on identifying possible explanatory factors that may be amenable to change. Therefore, a commonsense approach is taken with both models as they rely and are guided by the client's own ideas of what is wrong and why, and accordingly, believe that this provides the basis for problem definition and initial task assignment. Both of these models aim to stimulate, guide, and strengthen the client's problem solving efforts and based on this premise, the task-centered approach and the brief solution focused model require that identified complaints/problems be alleviated through the client's own actions, which both refer to as tasks.

Tasks are activities and/or actions that are formulated via the information that the client(s) provide to the social worker and are to be carried out by the client system in-between sessions. Both models spell out the task with whatever degree of detail is appropriate to the problem, situation, and the client's problem solving style. In some cases, a very explicit detailed plan is called for (who does what, when, how, etc.); in others, the task plan is best left open and flexible. Regardless of degree of structure, it is important to both models that the client(s) understands the nature of the plan and that he/she expresses a commitment to carry it out. In addition, all subsequent sessions for both of these approaches begins by assessing and discussing the clients progress of assigned tasks.

This review of tasks covers developments in the problem and what the client(s) has and has not accomplished in tasks to resolve it. When devising tasks, social workers are mindful in either, and/or both approaches to develop tasks that fit the clients world view. Furthermore, both models attempt to develop tasks which are not anxiety provoking for clients, however, they often

include behaviors, and/or changes in thoughts and/or perceptions which are outside the client(s) "normal" functioning in an attempt to stimulate client problem solving behavior and problem resolution. The use of tasks is an inherent theoretical technique used by both models, however, it is important to distinguish each approach as unique and as having its own respective ideology and historical background as discussed previously. While both the brief solution focused model and the task-centered approach have similarities (as discussed above), there are also a number of distinct differences. These differences are largely due to their distinct theoretical frameworks and underpinnings which will now be discussed.

Differences between the two brief therapy approaches

While the theoretical premises of both of these models are very similar and the positive and proactive stance towards clients strengths implicit, there are also a number of differences. Some of these differences are subtle and/or lie in the language of each respective model. Others are based on the degree of emphasis placed on key elements, and still others are due to the individuality of each respective model. It is these differences that clearly separate the brief solution focused model from the task-centered approach.

Language and its use are paramount to the practice of social work as it is our primary tool on which to base our interactions and interventions with our client systems. Therefore, while subtle differences in language may at the outset appear trivial, it is in fact meaningful given its overt and/or covert impact on the individuals, families, and groups that we as social workers work with. While both the brief solution focused model and the task-centered approach appear to be very mindful and cognizant of the impact of language as demonstrated through the use of proactive language as opposed to the use of language which implies

sickness and/or pathology, there is one significant difference which distinguishes them. Specifically, the brief solution focused model refers to the acting social worker as a "therapist", while the task-centered approach uses the word "practitioner". This subtle difference may at first appear irrelevant, however, on closer inspection it is in fact meaningful. The dictionary defines a "therapist" as a person who "treats bodily or mental disorders or maladjustment", which to this writer implies pathology and a connection to the medical model. This is significantly important as the definition and inherent meaning of the term go against the very core principles and assumptions made by this model. Specifically, this model makes a firm commitment and is dedicated on promoting healthy, non-pathological practice which is contradictory to a word which is defined by the words mental disorders and maladjustment. Conversely, the task-centered approach uses the word "practitioner" which is defined in the dictionary as "one that practices a profession". It is clear to see that this term is much less value laden and more importantly does not indicate any negativity or undermine the very core principles that the task-centered approach is based one.

Another difference between these approaches lies in their respective theoretical underpinnings in respect to the use of tasks. Specifically, the brief solution focused model implements and uses tasks as an interventive strategy with clients, but is not focused solely on task assignment(s) and its instrumentality. Stated more concretely, each model places different emphasis on the use of tasks as the brief solution focused model uses tasks as a means of highlighting and strengthening exceptions to clients presenting problems/complaints whereas the task-centered approach is premised solely on task assignment and implementation. Based on the sole importance of tasks which the task-centered approach adheres to, in addition to home tasks assigned by both models, the task-centered approach also incorporates in session tasks.

Specifically, two or more family members work together face-to-face on a target problem within the session. The implementation of session tasks and home tasks formed the basis of the Family Problem Solving Sequence (FPSS) and Reid (1987) states is "an intervention that addresses both immediate problems and contextual factors impinging on these problems" (Reid, 1987 a, b). In addition, as stated previously task assignments implemented using the solution focused model are not necessarily directly associated with the presenting problem/complaint but rather are designed to highlight further exceptions and/or address the confines of the complaint. Conversely, task development and implementation used in the task-centered approach are often more tangible and are problem specific.

Furthermore, there is also a difference in the context in which the work between social worker and client system takes place. The task-centered approach places very clear boundaries around setting durational limits in terms of sessions within a time period and also clearly contracts specific roles for both the client system and practitioner. In addition, this model also makes use of oral and/or written contracts which serves to organize the problem-solving work to be done. Therefore, goals, problems, and tasks are set firmly, but in a way that reserves flexibility. While the brief solution focused model is premised on brevity, therapists operating out of the BFTC do not define brevity by placing any restrictions of the number of sessions to be provided to clients , and also unlike the practitioners working from a task-centered approach they do not make use of formal written contracts.

Furthermore, a more obviously inherent difference between these two models is based on the emphasis on client problem(s) identification and time spent addressing them. The brief solution focused model spends relatively little time discussing clients presenting problems/complaints and in fact these are not

addressed directly past the initial session, as all subsequent sessions focus on task completion, noted exceptions to the problem, and building on already existing client strengths. In addition, the brief solution focused model does not dictate the need for clearly defined problems but is content with a statement(s) from the client system in terms of how they will know when the indefinable problem is alleviated or made more tolerable. This is substantially different from the task-centered approach where clear problem definition is deemed necessary as it is viewed as the corner stone of problem resolution.

Moreover, the model practices what its name implies as it is solely interested and focused on solutions and not on problems. This is a key difference, as the task-centered approach is problem focused as is illustrated throughout the stated basic concepts and principles of this model. Specifically, as stated above, the main thrust of the model is to help people resolve a limited number of specific, explicit problems that practitioners and clients agree will be the focus of work. Therefore, assessment is problem centered, and once the initial "problem survey" has been completed, the client system is then asked to rank the problems in terms of the order that they would like to see them solved. All subsequent sessions then focus on the client's progress on problems and tasks. Stated briefly, the brief solution focused model is solution focused, while the task-centered approach is problem focused.

Summary and comments

The task-centered approach values and is based on the inherent assumption that clients have the ability to solve their own problems. The purpose of treatment is to cultivate and promote effective problem solving skills. The relationship between client and practitioner is collaborative in nature and therefore, the practitioners intervention(s) into the clients life is sanctioned by

explicit agreements with clients on target problems to be dealt with as well as the nature of service to be delivered. Based on the premise of collaboration inherent in this model, it has been proven effective even when working with both non voluntary and/or mandated clients (Epstein, 1988).

From the initial phase through to termination, the model proceeds in a series of well defined steps (Epstein, 1980). This structure enables practitioners to move ahead systematically and to retrace steps as a means of pinpointing short falls. The task-centered model works with clients and assists them in making the necessary changes in order to alleviate problematic issues and to enhance the goal of problem resolution.

While there are inherent similarities between the brief solution focused model and the task-centered approach, it is the differences that makes each model unique. However, it is also important to note that neither interventive strategy was developed in a vacuum. Both of these models were derived from other approaches and their theoretical bases.

Chapter - 3 - Organizational Context, Methods and Evaluation Procedures

Setting

This practicum was completed at the Peel Children's Centre located in Mississauga, Ontario. The mission statement of the agency is to provide services for children, youth, and families who are experiencing, or may experience, serious emotional difficulties by strengthening the competencies of the individual, family and the community. The agency services children/youth who, in the judgment of Centre staff, are experiencing symptoms and characteristics that place the child at risk (actual or potential) of an irretrievable loss of ability for normal developmental progression. To determine the level of risk, Centre staff investigate the areas of individual , family, school, and social functioning of the referred client, with input from the referral source, child, youth, and family. Particular attention is given to determining the intensity, severity, frequency, duration and multiplicity of the presenting problems. The staff of the Centre is multidesciplinary, and consists of social workers, psychologists, psychiatrists, speech and language pathologists, child care workers and nursing professionals.

The Centre provides a number of services to children/youths and their families which includes; counseling, day treatment programs, residential treatment programs, court clinic assessments, prevention work and consultation to other agencies or practitioners to assist in service delivery. The Community Intervention Program (CIP) is one of the programs offered through the Peel Children's Center and is relatively new as it has only been in existence since September, 1990. This is the specific program where this writer completed her practicum.

The Community Intervention Program (CIP) is designed to deliver rapid response short-term (12 sessions) children's mental health services to latency aged children (4-12 years) and their families with, or at risk for developing serious mental health problems. The target client group is children between the ages of 4-12 and their families who reside in the region of Peel and who might not engage successfully in treatment offered in a more traditional manner.

Several community agencies each have a pre-set number of spaces available per month. They refer children and their families where they have observed that the families are overwhelmed by a multitude of stressors which have led to diminished coping and problem solving ability resulting is distress and feelings of hopelessness. The needs of the clients have exceeded the mandate of the referral source. In the referral source's judgment the family is unlikely to respond to the requirements of traditional services in the context of their current distress. Family members appear to have withdrawn from their community and each other and thus potential sources of support and assistance.

Identified families serviced by the Community Intervention Program (CIP)

The Peel Children's Center has identified the following three family "types" as deemed appropriate referrals to the Community Intervention Program (CIP):

1. **Ready Now Families** which are defined as single problem families; families in situation crisis; families in transition and; families in crisis that are requesting service, where crisis is not part of their "normal pattern of functioning".

2. **System Shy Families** which are defined as families who do not know how to or who are unable to access or utilize mental health services i.e. : cultural norms, belief systems regarding helping services; isolated families with limited access to transportation services or own resources due to multiple

demands on their time; families whose previous negative experience regarding seeking help prevent them from reassessing services.

3. The third and final family "type" is termed the **Crisis/Multi Problem Families** and are defined as multi problem; no single precipitant identified, chronic crisis pattern of interacting; trust and engagement issues; depressed, withdrawn or abusive caretakers with behaviorally acting out in children; family history of alcohol and drug abuse; familial sexual abuse and family violence; involvement with social services, Low Income Housing, CAS - high prevalence of protection issues; ambivalent about treatment services; powerless, presence of inverted parenting hierarchies; multi system issues and engagement difficulties with these systems; high ambivalence regarding usefulness of treatment services; family functions on an instrumental level limited effectual connectedness; isolated families regarding internal and external resources and; a high need for nurturance and parenting.

While this last family "type" represents the majority of the Community Intervention Programs (CIP) referrals, they are also the most difficult to service. The objective with these families is to reduce isolation and experience(s) of helplessness, to provide a positive therapeutic connection that may assist in their ability to utilize future resources, to define one or two workable problem areas to focus on and assist families in achieving some success related to these areas, to collaborate with other service providers and to assist families to connect with alternate more long term service providers. The brief solution focused model's assumptions and practice techniques are a good fit with these identified family problematic situations. As stated previously, this therapeutic model is proactive and provides clients with the necessary hope that change is not only possible, but inevitable. Furthermore, this model has the advantage of providing clients with a very different type of therapeutic experience which focuses on solutions for the future and does not stagnate on the past or identified pathologies.

The therapists currently providing service through the Community Intervention Program (CIP) are providing brief therapy (12 sessions) based on systemic and strategic approaches. These therapists are also proactive, task centered, and believe that it is the difference and search for differences in behaviors, relationships, and events which makes the difference. Many of these therapists adhere to a solution focused approach and/or use some of the inherent techniques of this approach.

Methods

The client group for this practicum consisted of families with latency aged children between the ages of 7-12 who had been referred by community resources and presented with problems identified and consistent with one of the three different classifications of appropriate referrals previously discussed. This writer was the primary therapist for four family cases and worked conjointly on an additional two cases with a colleague who is a full time therapist with the Community Intervention Program (CIP). The majority of the six families that this writer worked with fell into the third classification, namely the Crisis/Multiple Problem Families, which is consistent with the majority of cases serviced by the team as a whole.

All families serviced by this writer during the practicum were selected and assigned by the clinical supervisor of the Community Intervention Program (CIP). In all cases, a systemic based solution focused approach was employed. This was achieved according to techniques prescribed by the model which includes:

a. Identification of the type of client-therapist relationships.

b. Develop rapport or "fit" with the client system; and as he therapist take responsibility to promote fit throughout treatment.

c. Redefining the client's problem/complaint by searching for exceptions to the problem/complaint, using positive feedback, and promoting strengths in order to move the client system towards realistic solutions, thus, problem resolution.

d. Negotiating goals with the client system and use techniques of task setting to help the client system accomplish these goals.

e. Assist clients to reach a level of functioning that they feel or is deemed to be satisfactory.

Given the outreach component of the Community Intervention Program (CIP) interviews occurred primarily in the families home but on occasion families attended sessions in the office. It should be noted that family D attended all 12 sessions in the office of the Peel Children's Centre. Interviews on average were approximately one to one and one half hours in duration. Interviews generally occurred biweekly except family D who attended weekly sessions. The two week interval adopted by most families served the primary logistical purpose of providing families with a reasonable time for task accomplishment and also occurred as a matter of chance due to families request for bi-weekly sessions and/or due to canceled appointments.

Personnel

This writer was the primary therapist in cases A through D and worked conjointly with a full time therapist from the Community Intervention Program (CIP) on cases E and F. Clinical supervision was provided by Brenda Bolliger, MSW, CSW, the clinical supervisor of the Community Intervention Program (CIP). Clinical supervision was held weekly for a approximately one and one half

hours and on an as requested basis. Supervision included; discussion, case planning, audiotape reviews and feedback, and live supervision via the one way mirror. This writer also attended the weekly team meetings and provided assistance and consultation to two of her colleagues via viewing several of their sessions from behind the one way mirror. External supervision of the practicum was provided by Don Fuchs who reviewed audio tapes.

Duration

The practicum consisted of a three month placement at Peel Children's Centre within the Community Intervention Program (CIP). The placement commenced on June 1, 1993 and was completed on September 1, 1993. The practicum involved full time study and practice five days a week over the full three month period.

Recording

Recording followed the procedures and format set out by the Peel Children's Center. An initial assessment recording was completed after the second or third session with each family. The initial assessment included relevant historical background, identified problems as perceived by each family member, assessment of family functioning, and proposed treatment plan. A brief summary recording was also required after the eighth session with families and finally a closing recording was completed once services were terminated. In addition, progress notes were recorded at the end of each session with families as well as any additional contact or collateral contacts.

Criteria for Evaluation

Pressure from consumers and funding sources increasingly requires program planners and clinicians to demonstrate empirically effective and efficient service to clients. Slonim-Nevo and Vosler (1991) state that "examples of empirical practice that demonstrate the feasibility of integrating an evaluative component into the assessment and intervention process, particularly for behavioral and cognitive models of practice, are appearing in the social work literature. However, in order to enable clinicians whose theoretical orientation is not behavioral or cognitive to effectively utilize single-system evaluation, successful use of these techniques with a variety of other practice theories and models needs to be demonstrated (pp. 38). These authors further state that evaluating the effectiveness of brief problem-solving therapy by means of single-system design is particularly feasible since they both have several common requirements. First, both require the specification of the problem in concrete terms. Second, both recommend specifying the desired change in concrete terms before intervention begins. And third, both emphasize the need to plan and define the intervention (pp. 40).

The value of using single-system designs in evaluating the effectiveness of clinical practice has been discussed in detail (Bloom and Fischer, 1982; and Ivanoff et al., 1987). Additionally, secondary benefits have been noted. These include clarifying and prioritizing the client's problems, enabling the client to be part of the treatment plan by providing her or him with a clear and documented report on progress, and offering agency administrators a profile of the agency's clients, practitioners' interventions, and treatment effectiveness (Bloom and Fischer, 1982; Reid, 1979). In broad terms, the methodology provides procedures for empirically evaluating the treatment of an individual, family, or group. It requires a clear definition of the problem/treatment goal, a clear definition of the

intervention, and repeated measures of the problem/goal before during and/or after the therapy process (Bloom and Fischer, 1982). Weakland et al.(1974)further emphasize the importance of practice evaluation by stating "if psychotherapy is to be taken seriously as treatment, not just an interesting exploratory or expressive experience, its effectiveness must by reliably evaluated".

However, it is also important to note that sophisticated single-system designs are hard to implement in real-life because they require additional investment of time and energy on the part of practitioner and their clients (Slonim-Nevo and Vosler, 1991). Therefore, the simple A-B design is often recommended (Bloom and Fischer, 1982). In this design, the "A" symbolizes the baseline, the period prior to the intervention, and the "B" symbolizes the period during which intervention is provided.

All families were requested to complete and participate in the evaluative procedures employed in this practicum. This included the completion of both a pre and post-test measure (FAM III) . In addition, a debriefing component was incorporated into the termination session in order to provide families with the opportunity to discuss their experience. Clients were also provided with a post-test Client Satisfaction Questionnaire (CSQ) which is a standard practice of the Centre and were requested to submit these directly to this writer or mail them into the Centre.

Evaluation Procedure

The outcome of the treatment process was evaluated through the use of a single system design that was used with each family. The measurement package included pre-test, post-tests using the Family Assessment Measure III (FAM III) as well as a Client Satisfaction Questionnaire (CSQ) which was administered post-

test. Both of these evaluation tools have been enclosed in the appendices of this report. While an additional measure was initially going to be used (Family Well-Being Assessment) this writer in discussion with her clinical supervisor, Brenda Bolliger decided against its use given the Centre's general findings that clients were often anxious about such measures and felt them to be intrusive. The FAM III was chosen as the primary measure in accordance with information provided by Bloom and Fisher (1982). Specifically, Bloom and Fisher (1982) suggest that the practitioner should first select a primary measure that is the closest to or the most direct expression of the problem. It should also be the one in which one would most expect change to appear, and has the highest priority for change.

Evaluation Instruments

1. Family Assessment Measure III (FAM III)

The FAM III (Skinner, Steinhauer, and Santa-Barbara, 1983) is a four point Likert style questionnaire composed of three separate rating scales, all of which assess various dimensions of family strengths and weaknesses. The specific rating scale which this writer chose was the General Scale which is comprised of 50 items, and assesses overall family functioning, with respect to seven specific areas of family functioning; task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. The self rating scale was chosen because of its ability to tap family member's individual perceptions of their family's strengths and weaknesses. The FAM III General Scale was administered to each family member where applicable, as this measure is only suitable for children approximately 10 years of age or older. These raw scores were then translated into standard scores using either Table 1 (adults) or 2 (adolescents aged 10-18) which are both located in the

appendices of this report. The FAM III is based on Canadian norms for both clinical and non-clinical populations (Skinner et. al., 1983), and is based on a process model of family functioning that integrates different approaches to family therapy (Touliatos et. al., 1990). These authors further state that the instrument may be used as a clinical diagnostic tool, as a measure of therapy outcome, or as an instrument for basic research on family processes (pp. 536). FAM III has excellent psychometric properties (Trute, et. al., 1988). FAM III has an overall alpha score of 0.93 demonstrating strong internal consistency and reliability between scales (Skinner, et. al., 1983).

2. Client Satisfaction Questionnaire

The second evaluation tool that was implemented was a Client Satisfaction Questionnaire (CSQ) as it fits with the solution focused approach and has an inherent value and respect for client self-determination. This was administered to all family members (again where applicable) at the end of the intervention in order to evaluate their level of satisfaction and success which they attributed to the social work intervention and their specific experience with this form of therapy. The client satisfaction questionnaire which was utilized is located in appendix B of this report.

This writer believes that both of these evaluation tools encourage and promote health and competence. Furthermore, the FAM III, as stated previously, targets the primary client complaint/problem identified and shared by all three types of family referrals to the Community Intervention Program (CIP). The FAM III provided a clear indication as to client changes (improvement, deterioration or no change) from pre-test to post-test and enabled this writer to effectively evaluate her own ability to produce improved client functioning

utilizing a brief solution focused approach. While Client Satisfaction Questionnaires are subjective in nature, they did provide this writer with some general feedback from clients about their personal experiences and thoughts regarding the application of this particular form of therapy.

Chapter - 4- Families of the Practicum

Introduction

This section of the report will examine the results of the practicum and discuss in detail the evaluative application of the FAM III and Client Satisfaction Questionnaire in respect to the families which this writer worked with during the three month practicum. First, a general overview of the results will be presented which will include a summary of the results obtained as well as the conclusions regarding the utility of the evaluation instruments. The case studies will attempt to illustrate how the interventive strategy was utilized through descriptions of the therapeutic process. All case discussions will include the clinical observations in addition to the results of the FAM III General Scale and findings of the Client Satisfaction Questionnaires. An attempt will be made to demonstrate how the evaluation instruments complemented and supported both this writer's and the family's perception of the changes which occurred.

During the three month practicum (June 1, 1993 - September 1, 1993), therapy was provided to a total of six families. Of the six families, only one family dropped out of therapy during the course of the practicum (family B) and only one family (family B) declined to complete the evaluation instruments. Therefore, this practicum generated data for a total of five families. It is important to note that the majority of the practicum cases can be categorized under the heading of crisis/multi problem families which is representative of the majority of families serviced by the Community Intervention Program (CIP) as outlined in chapter three of this report. Table 1 provides a description of the families who participated in therapy during this practicum and includes both the four families where this writer was the primary therapist and the two worked on conjointly. It is important to note that client names referred to in the case discussions have been changed to ensure client confidentiality.

Table 1

Summary of Family Type, Presenting Problems and Number of Sessions provided

Family	Type	Presenting Problems	# of Sessions
A	intact	child's defiance and refusal to follow parental directives. Number of family losses.	5
B	step family	incident of physical abuse. Child is defiant and family requesting assistance if improving communication and relationship building.	1
C	single parent	child is negative towards mother and places blame for parental separation. Child is defiant and manipulative.	3
D	single parent	child's low self esteem, poor peer relations and aggravating behaviors	12
E	single parent	child's defiance and aggressive behaviors, excessive family conflict.	8
F	mom-C/L partner	parent/child conflict, child's behavior and aggression, poor academic performance.	7

Profile of the Families Serviced

This writer was the primary therapist for four of the six families serviced during this practicum. The first family to be discussed (family A) was an intact family which was comprised of the two natural parents, their son aged 7 and their daughter who was 9 years old. Family B was also a two parent family who had a daughter aged 8 and an infant son. This writer only had one session with this family and while they neglected to complete any of the evaluation instruments, they did advise during a brief telephone conversation that their presenting problem had dissipated after just one session. They further advised that their brief exposure to therapy had been a worthwhile experience and had benefited them greatly. The second family to be discussed (family C) was a single parent family. This family was comprised of a mother and her two children, aged 13 and 10. Family D was also a single parent family. This family was comprised of a mother and her two adolescent children, aged 12 and fourteen. This writer also worked conjointly with a colleague from the Community Intervention Team (CIP) with an additional two families. Family E was a single parent family and was comprised of a mother, her two sons aged 12 and 3 and her daughter who was 7 years old. The last family which will be presented is family F. This family was comprised of the natural mother, her common-law partner and her natural son who was 12 years old.

Each families presenting problem/complaint was different and served to highlight different facets of the solution focused approach as well as its wide range of applicability. Specifically, Family A illustrates the use of the miracle question and scaling questions as two means of narrowing and focusing in on the "true" problem/complaint experienced. Also, of significance is the fact that this approach enabled the family to realize and then process their true source of aggravation and frustration which had been previously mislabeled and

misunderstood by them. Family C illustrates the search for "exceptions" to the family's stated problem/complaint as a means of attempting to highlight a solution orientation. While this case was chosen to illustrate the use of the solution focused model with a highly stressed family, it also exemplifies possible limitations of the model and/or the family's possible discomfort with it. Family D illustrates the search for "exceptions" and the use of tasks which highlighted and promoted these "exceptions" as solutions to the family's stated problem/complaint. While families E and F also utilized a combination of the above techniques, they also supported the use of a solution focused approach within a co-therapy context.

In each of the practicum cases, a solution oriented approach was implemented. During the initial session with each family the following process was adhered to: Individual perceptions of the presenting problem/complaint were solicited, a verbal contract regarding the goals of therapy were discussed, the use of the miracle question and scaling questions, compliments, the search for "exceptions" to the problem/complaint were initiated; and lastly, a task was assigned such as the "formula first session task" (FFST) and/or tasks based on session content. Throughout the course of therapy, this writer continued to build and maintain rapport with each family. In addition, she was cognizant of each persons world view as well as the strengths and abilities inherent to each individual and family.

All families that participated in therapy appeared to readily accept the FAM III evaluation tool and appeared to appreciate its use and applicability. In addition, they valued the opportunity to provide feedback on the therapeutic experience via the Client Satisfaction Questionnaire (CSQ). Due to the fact that all families serviced by the Community Intervention Program (CIP are referred via a third party as previously outlined in chapter three of this report, the pre-test

component of the FAM III scale was administered after the first session and was returned by the families to this writer prior to the second session of therapy. While this is not optimal and may scew the final results obtained, there were no other alternatives given the stated boundaries and service mandate of this program.

Case Example 1 - Family A

Bobby (age 7) and his family were referred to the Community Intervention Program (CIP) via the Roman catholic School Boards guidance counselor due to his low self-esteem, emotional difficulties dealing with the recent (August, 1992) death of his maternal grandmother and his parents stated concerns regarding his defiance and increasing behavioral problems.

The guidance counselor initially recommended family therapy in October, 1993. While the family attended one office session with the out-client program operating out of Peel Children's Center, they declined further service and did not attend any subsequent sessions at that time. These problematic concerns intensified to the point that a second referral was made to the agency. More specifically, due to the parents increasing concerns regarding their sons acting out behaviors and defiance, a second referral was made to the Community Intervention Program (CIP) in May, 1993. The disposition summary written by the previous worker advised that the family was resistant to counseling and unwilling to engage.

Family Biography

This family was comprised of Ben (37), and Mary (34) who have been married for ten years, Eve (9) and Bobby (7). This family is interracial as Ben is Jamaican/Canadian and Mary is Anglo Canadian. Mary works full time for Bell Canada and Ben has been unemployed for almost a year due to a back injury. However, he conducted some sporadic car repair work from his garage. Therefore, this family is not traditional in the sense that Mary works outside of the home and is the primary income earner and Ben remains at home.

Presenting Concerns

Both Ben and Mary identified Bobby as a major source of anger and frustration given his verbal defiance, and increasing aggression. While they had some similar concerns regarding Eve, they were not to the same degree or intensity. Eve advised that she felt that her parents were frequently upset and yelled a lot which she found upsetting. Bobby remained very quiet and appeared withdrawn and uncomfortable by this writers presence despite any attempts at demystifying any falsehoods that he may have had regarding therapy and/or therapists. Bobby's discomfort was perceived by this writer as being quite natural given the fact that his parents told him that they were in therapy because of him and his behaviors. This was discussed further and

this writer advised Bobby that lots of families have difficulties and/or problems and that he was not the problem, but rather that it was the family as a whole that was experiencing some difficulties. This was done in an attempt to "normalize" therapy and remove any personal blame that he probably had, given his parents explanation as to who this writer was and why she was there. However, despite numerous attempts by this writer, Bobby remained relatively quiet throughout therapy and only engaged in non-threatening discussions such as favorite activities and superficial discussions which were unrelated to any stated family issues

All sessions with this family occurred within the family's home in accordance with the outreach component of the Community Intervention Program (CIP), therefore, direct observations by Brenda Bolliger were not possible. In an attempt to have some feedback and clinical direction based on session content, this writer did explore the possibility of audio taping the sessions, however, this was not possible given the families stated discomfort exhibited by their refusal to sign the necessary consent forms.

Description of the intervention

During the first session individual perceptions regarding the problem/complaint which encouraged this family to seek therapy were explored. Ben and Mary concurred that Bobby had been a "difficult" child since approximately age four and that both children's behaviors had

significantly deteriorated over the last two years which corresponded with the maternal grandmothers death. Specifically, they advised that both children were frequently defiant and did not follow simple parental instructions or directives, but Ben clearly articulated Bobby as their "biggest problem" as he was becoming increasingly aggressive and easily became frustrated and aggravated. In addition, Ben further advised that he was concerned regarding Bobby's lack of interest in school and inferior marks when compared to his sister. These concerns were not validated by Bobby's teacher or school personnel, who advised that while he did exhibit some difficulties with his reading, he was improving. As stated previously, Bobby remained relatively quiet throughout this session and became aloof when discussing personal issues which were problematic to his parents. Therefore, he was not able to provide any input regarding his perceptions as to why the family was seeking therapy at this time and did not make any comments or display any reaction to his parents stated concerns. Bobby undoubtedly felt austersized given his parents, specifically, his father's statements that he was the primary and central cause of his anger and frustration. Eve advised that she and Bobby had a "bad attitude" and were at times bad which made her parents very mad and upset.

Both children were quiet and presented as being shy and uncomfortable by this writer's presence. It quickly became obvious that there was a clear division in parenting responsibilities and styles as both children maintained close proximity with their mom and frequently hugged and kissed her or hid behind her as a means of avoiding a question asked by this writer which they did not want to answer or possibly didn't know how

to answer. In addition, before choosing to answer a question they would look towards their father for approval and/or permission to continue. Mary was quite soft spoken and spoke openly about her feelings and emotions while Ben presented as a very logical and pragmatic person who spoke about facts and realties which appeared to be very troublesome to Mary and the children. Specifically, Mary advised that she felt that Bobby's problematic behaviors could possibly be attributed to the loss of his grandmother who had passed away two years prior in the families home. On the other hand Ben felt that these behaviors were based purely on his inability and/or unwillingness to follow simple rules and could also be attributed to his laziness. While Mary felt that Bobby and Eve required love, support and guidance, Ben was punitive and felt that reprimanding the children was the only way to rectify the situation. In addition, Ben frequently cut Mary and the children off when they were speaking and often finished their statements or comments with little consideration regarding their thoughts or what they were going to say. This obviously infuriated Mary as she would say "Ben, your not listening now just like you never listen" or she removed herself from the table waving her arm and laughing to herself, as though saying "here he goes again".

Each family member was asked the "miracle question" which consists of the following : "If a miracle happened tonight while each of you was sleeping, what would you notice the next morning that was different and that would let you know that a miracle had occurred". This was a little confusing for both Bobby and Eve but they appeared interested and intrigued by such a question. Therefore, the question was restated as such: "if you had a magic wand and could wave it to make a wish so that something about

your family would be different, what would your wish be". Mary spoke first and advised that she would like to get along better. When she was asked "what would it take to get along better", she advised that she would like the families communication to improve so that they felt better about each other, and for her husband to listen to her and understand her feelings more. Ben agreed with Mary and also advised that he would like his wife to yell less at the children and for them to listen more and do as they were told. Eve advised that she too would like less conflict within the home. In addition, she would like her parents not to yell at each other or at them as often and wished that everyone would be happier. Bobby remained quiet and advised that he did not know. In exploring the "exceptions", all three family members (Mary, Ben and Eve) advised that there is less conflict when the family does things together.

There appeared to be a lot of conflict between Mary and Ben and a sense of hopelessness which was expressed both verbally as mentioned above and also non-verbally via their eye contact or lack of it and sighs indicating their discomfort and/or difference of opinion regarding their perceptions of difficulties and responses to the "miracle question". Given the children's increasing irritability, this writer asked if the children could be excused so that we could spend some time alone for the duration of the session.

This writer shared her observations regarding the level of marital conflict with Ben and Mary. This feedback served to open up a Pandora's box of unspoken feelings and thoughts regarding their relationship which appeared to be the primary cause of the families conflict. The two engaged in a heated discussion regarding their unmet emotional needs. Mary became

quite emotional and reactive to Ben interrupting her and to his oppositional demeanor and Ben appeared confused and upset by the exchange that had taken place. Both looked towards this writer and appeared embarrassed by her presence. This type of conflict was further processed in terms of the "exceptions" and the times that they had been able to share their differences of opinions, feelings and thoughts without such a heated conflictual exchange. Their different emotional needs and expectations were also discussed further and a new sense of awareness and understanding emerged.

This writer then proceeded to ask a series of scaling questions. Specifically, the following three questions were asked: 1. On a scale of 1-10 where 10 is the highest, where would you rate your sense of family satisfaction. Ben answered first, although, was a little hesitant as he stated a 6, Mary advised that she would rate it a 4. Again, in an attempt to search for "exceptions" this writer asked both Mary and Ben what it would take to move them one number up the scale (from a 6 to a 7, and from a 4 to a 5 respectively), both advised that they would like to argue less, understand each other better and enjoy each other more without feeling as though they were always stepping on egg shells, and to spend more positive time with the children instead of "always" yelling and disciplining them.

The use of the above scaling questions moved the parents past their pseudo difficulties which were initially identified as their children's behaviors and towards the true causes of their dissatisfaction which was their marital relationship. In addition, these scaling questions served the purpose of channeling the therapy towards this primary problem and to the formulation of the contracted goal of therapy. The second and third scaling

questions were also based on a ten point likert scale and the two questions were in terms of their personal motivation regarding therapy and feelings of optimism that therapy would be worthwhile and beneficial. Mary assigned a rating of 9 regarding her personal motivation and rated her sense of optimism at a 7. Ben was less motivated and optimistic as he assigned a 5 to both of these scaling questions. According to de Shazer (1988 a); and Kral, (1990) Mary appeared to be the "customer" of service as she presented as the person most irritated with the situation and therefore, probably the person most willing to do something about it (Kral, 1990, pp.) and Ben could be termed a "complainant" of service as he was willing to discuss the problem, but was not as motivated to do anything about it

Given the couple's answers to the first scaling question and in respect to what would need to occur for things to improve; the marital conflict impacting this couple and also negatively impacting their relationship with their children; their inability to satisfactorily discuss and process conflict and inability to satisfactorily discuss feelings, thoughts and differences of opinion; Mary's projection of anger onto the children; Ben's presentation of indifference and projection of sole blame for the families difficulties onto Bobby, and lastly, the children's young age and inability and/or unwillingness to participate in sessions, Mary and Ben with this writer's assistance contracted the following goal of therapy: To process and attempt to improve marital communication in order to decrease marital conflict, thereby decreasing family conflict. Therefore, all subsequent sessions were spent with Mary and Ben. The children did not participate in any more sessions but would frequently ask if they could talk about school activities and different certificates that they had earned, as well as exciting family and peer activities

that had taken place or were being planned. We did this for approximately 5-10 minutes at the end of each session which both Eve and Bobby appeared to enjoy.

The remainder of the session was spent delivering compliments and acknowledging strengths which this writer had noted and written down during the session. Lastly, two tasks were discussed and assigned. The first was the "formula first session task (FFST) which is stated as follows:

> *Between now and next time, I want to you observe, so that you can tell me what happens in your life family and/or relationship that you want to continue" (Milnar, de Shazer, pp. 340).*

This was assigned to shift Mary's and Ben's focus from past to present and future events, from problems to strengths, and implicitly to promote expectations of change. Secondly, they were asked to "do something different" every time they felt the urge to argue and to do this as soon as they sensed that any conflict or tension was raising. They were both very receptive to these tasks, however, the second task needed further clarification as initially they did not understand the concept, but after further explanation they both felt that it made sense. In addition, Mary and Ben came to the conclusion that since family outings and "togetherness" time was enjoyable for the whole family and appeared to decrease their conflict, they would make a concerted effort to do more of this.

Mary and Ben both advised that they felt comfortable working together with this writer on the contracted goal and agreed that Eve and Bobby did not need to be involved in subsequent sessions. They both advised that they

were committed to working on their relationship and on improving their communication and conflict resolution skills which did not require their children's participation. A second session was scheduled to take place in two weeks time which was felt to be appropriate given the tasks assigned and the time needed to work on these.

During the three month practicum, this writer attended this families home for a total of five sessions which for the most part occurred weekly or bi-weekly with the exception of a two week hiatus when the family took their planned family vacation.

By the third session, both Mary and Ben agreed that they had a better appreciation of each other and were able to come up with some interesting and unique ways of implementing the "Do Something Different" task. Both agreed that they enjoyed spending time together without the children as it served to decrease their feelings of animosity and conflictual exchanges and increased their ability to understand one another. Furthermore, Mary advised that since she and her husband had been spending more quality time together, she felt more supported and therefore, better equipped to deal with her children's behaviors and more adequately meet their needs without yelling.

As Mary and Ben continued to direct increased energy and time to their marital relationship, the conflict between the two decreased and while they continued to have disputes and differences of opinions, they both felt better understood and were able on occasion to "agree to disagree" without any unspoken or repressed feelings of remorse. As communication became more

direct and open within the marital sub-system, there was also acknowledgment on the parents part, that communication had also improved between themselves and their children and that there was a noted decrease in the amount of yelling and duration of conflictual feelings within the family. Both Mary and Ben advised that they were enjoying their children more and did not feel as antagonistic towards them for insignificant negative behaviors and occasional disrespect and/or defiance.

From one session to the next, there was also an observable increase in positive communication and affect between Ben and the children. Ben was not as ill-tempered when talking to the children or asking them to do something and he was more affectionate with them in giving hugs and allowing Bobby to sit on his lap. This observation was shared with the parents as it was such a sharp contrast to our first session.

Given this writer's time constraints dictated by the three month practicum and the fact that only five of the twelve allotted sessions could take place, Mary and Ben were advised prior to our termination session that Brenda Bolliger would be pleased to continue on with them and provide an additional seven sessions. At this point both parents felt that they had achieved their goal of improved marital communication and decreased marital conflict which had also been successful in positively impacting the degree of family conflict. They understood how the high level of marital conflict had affected not only their relationship but also their ability to adequately and effectively deal with their children's needs in a calmer and more nurturing manner. Also, the positive impact that their improved communication had had on their relationship with their children as it had

served to decrease their children's negativity and increase the families sense of cohesion.

During the termination session (session number 5), Mary and Ben reported a more open and direct communication pattern which consisted of decreased conflict and an increased sense of mutual understanding. Mary also reported less frustration with her husband which had also served to improve her communication with her children and heightened the families feelings of connectedness and cohesion. The improved marital relationship was discussed and the positive domino effect that this had had on their relationships with their children.

During the initial session, the parents were able to highlight the "exceptions" to their complaint/problem as being increased family "togetherness" and quality time. By the termination session they had implemented activities to make these exceptions occur more frequently whereby, they became more the rules of family functioning instead of the sporadic exceptions. Specifically, throughout the course of therapy the family allocated more time and energy in discussing and planning family activities which created increased family communication and positive time spent together.

When Mary and Ben were asked what had been the most helpful aspect of the therapeutic process, both stated that re-focusing the therapy from family to marital sessions and helping them to identify the true source of their frustration and aggression was the most beneficial aspect. They advised that it helped them to open up blocked communication and release

past hurts which were not directly because of anything the children did or did not do. Both Mary and Ben stated that they were dedicated to maintaining a more open and direct communication pattern given the noted benefits and that they were committed to not allowing this to become a problem again. In addition, through this personal and dyadic introspection, they both advised that they were not so quick to challenge their children on minor behavioral issues. Moreover, they felt that they were ready to assess and implement alternative parenting strategies other than the punitive means that they had been relying on.

Outcome and Comments

In this case the evaluation instruments supported both the family's reports of change, and this writer's clinical observations. In the pre-test, Mary and Ben scored 59 and 60 respectively on the overall rating scale. Areas identified as family problems via the couples completion of the FAM III and noted by this writer included task accomplishment (63 and 63 respectively), communication (64 and 59 respectively), affective expression (54 and 63 respectively), and control (61 and 66 respectively). These family problems were further substantiated in reading the FAM III interpretation guide provided in table three of the Family Assessment Measure developed by Skinner et al., (1983). Specifically, this interpretation guide states that high scores (60 and above) in the task accomplishment scale are indicative of a families failure of some basic tasks; inability to respond appropriately to changes in the family life cycle; problems in task identification, in generation of potential solutions, and in implementation of change; problem solving

generally ineffective; and lastly, minor stresses may precipitate a crisis, which is liable to become chronic.

Similarly, high scores (60 and above) in respect to the communication scale are indicative of the following: Communications are insufficient, displaced or masked; necessary information is frequently not exchanged effectively; lack of mutual understanding among family members; and lastly, inability to seek clarification in cases of confusion. Skinner et. al., (1983) also state that scores above 60 in the affective expression scale are indicative of inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotional discharge, often at times not appropriate to the situation. In addition these researchers state that high scores in the control scale (60 and above) indicate family problems with the following: Patterns of influence do not allow family to master the daily routines of ongoing family life; failure to perceive and adjust to changing life demands; may be extremely predictable (rigid and lacking spontaneity) or chaotic; control attempts are destructive or shaming and/or ineffectual; style of control may be too rigid or extremely laissez-faire; characterized by overt or covert power struggles: "who's right" or "who wins" usually more important than solving the problem ("what fits"); and lastly, oppositionality and possessive with aggressiveness being common. Mary and Ben's ratings in these four scales are note worthy as they clearly depict the major problems identified during the initial session and further substantiate the stated goal of the therapeutic process. A full listing of the pre and post test scores can be found in table 2.

Table 2

Pre and Post Test Results for Family A Using the FAM III

Scale	Mother		Father	
	Pre	Post	Pre	Post
Overall Rating	59	53	60	52
Task Accomplishment	63	60	63	60
Role Performance	60	51	60	47
Communication	64	54	59	59
Affective Expression	54	49	63	54
Involvement	56	46	50	42
Control	61	56	66	56
Values and Norms	56	56	60	51
Social Desirability	47	54	47	50
Defensiveness	46	46	50	42

Figures one and two provide the pre and post-test scores which were obtained approximately eight weeks apart.

figure 1

Pre Test Profile For Family A Using the Family Assessment Measure (FAM III)

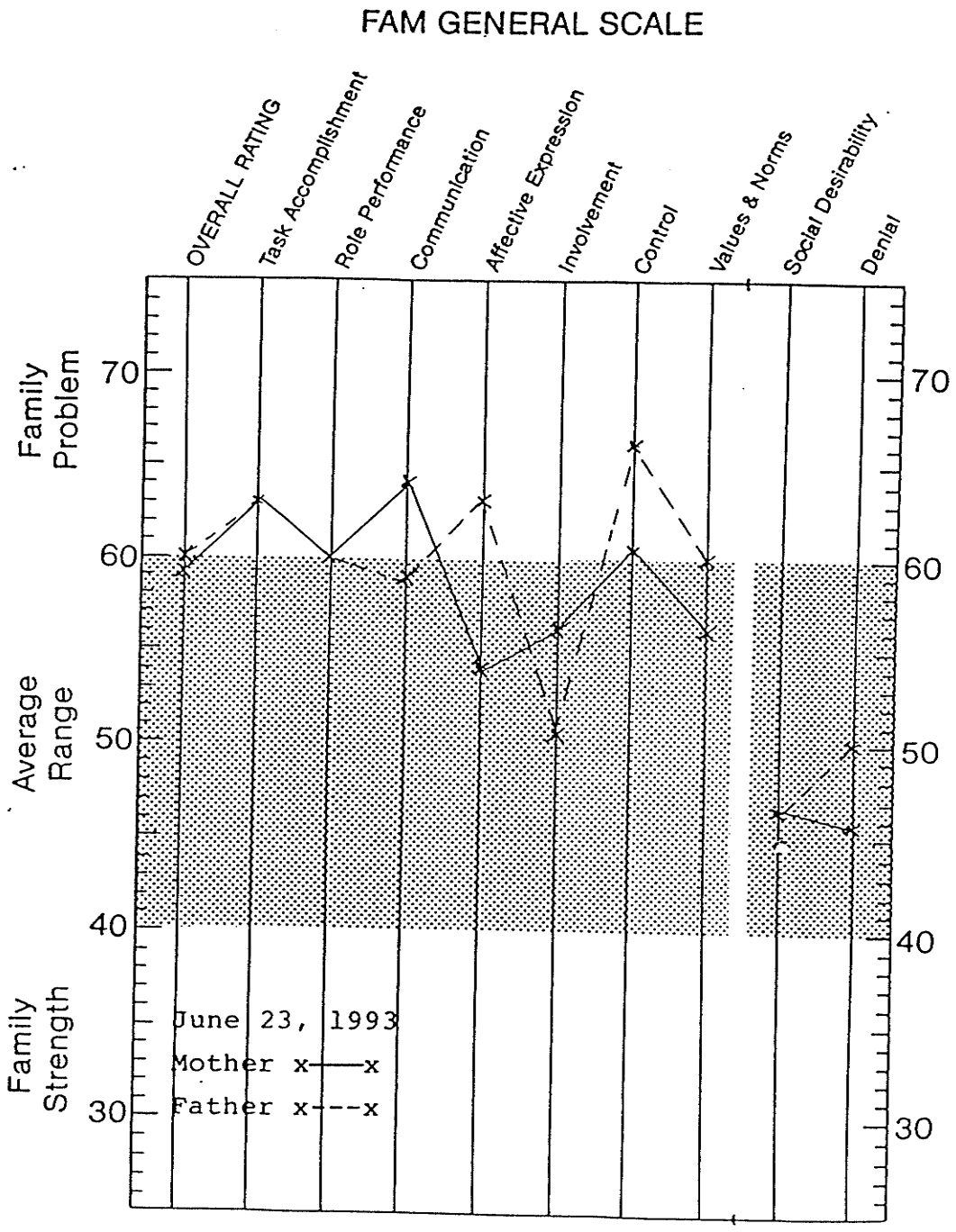
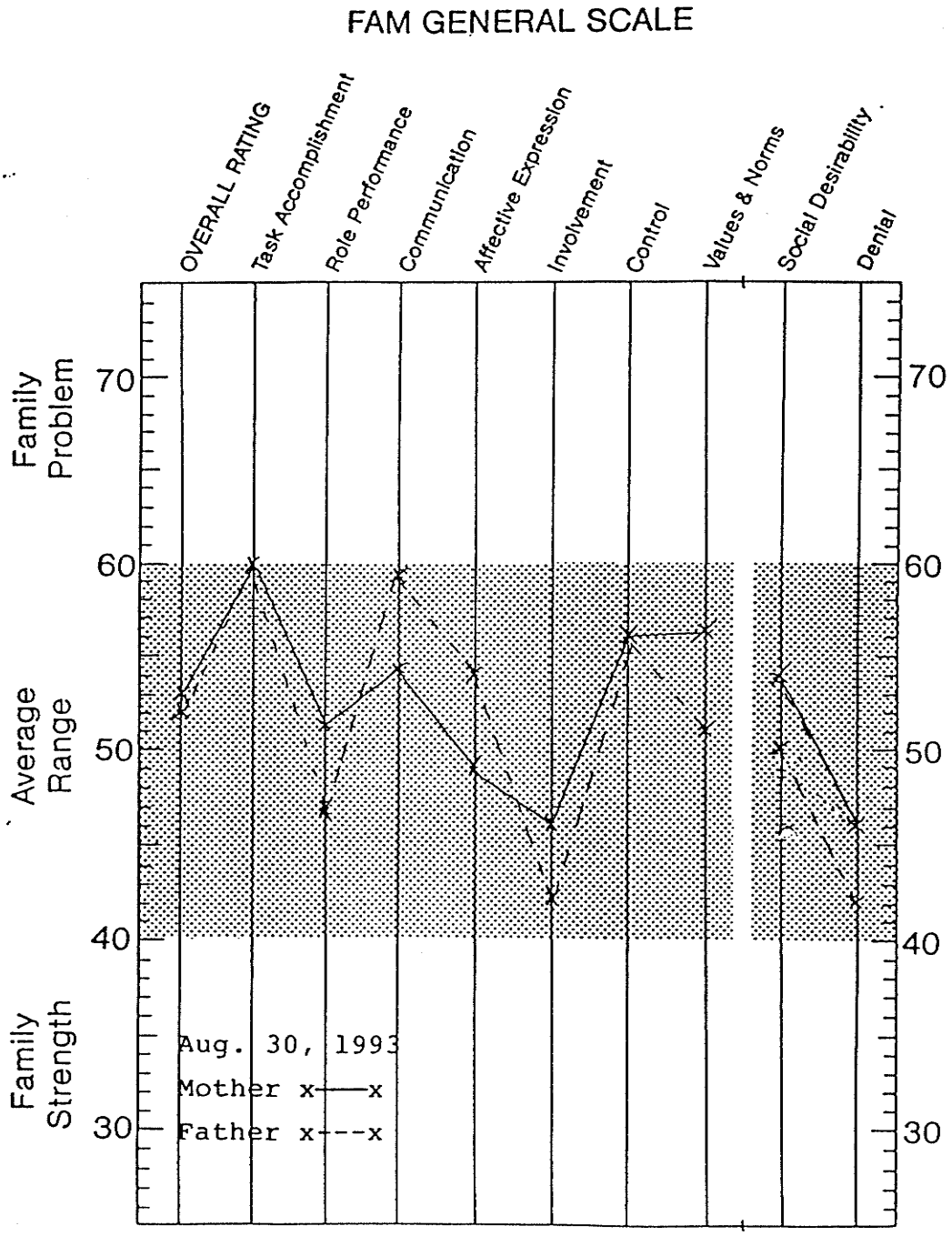


figure 2

Post Test Profile for Family A Using the Family Assessment Measure (FAM III)



At the time of termination all scores fell to within the average range, as illustrated in table two, except for task accomplishment which remained at 60 and therefore, within the family problem area. More specifically, for the most part, both Mary and Ben fell in the middle of the average range with noted improvements in all of the scales except social desirability and denial. These two scores did raise slightly, and continued to support the validity of the scores obtained.

The four primary identified family problems observed by this writer and supported in the pre-test component of the FAM III fell quite significantly in their post-test profiles, thus, supporting the utility of the solution focused approach. The pre-test scores for task accomplishment were 63 for both Mary and Ben and fell to 60 for both in their post-tests. While Skinner et. al., 1983 state that scores 60 and above still indicates a weakness, there was positive movement as their post-test scores bordered on the average range of family functioning as opposed to the pre-test scores which clearly indicated a family problem. Their pre-test scores for communication were 64 and 59 respectively, and fell to 54 and 59 respectively. The scores for affective expression fell from 54 and 63 respectively to 49 and 54, and lastly, their scores for the control scale dropped from 61 and 66 respectively to 56 for both. Thus, indicating that this couple made significant improvements at the termination of therapy.

This family was highly motivated throughout the therapeutic process and eagerly engaged in assigned tasks. They were able to redefine their

problems and implement a solution orientation which served to improve their marital relationship. This in turn created a positive ripple effect that enhanced the entire family's well-being and sense of happiness as indicated via the post-test FAM III scores. These improvements were further supported when the couple articulated verbally and via their completed Client Satisfaction Questionnaires (CSQ) that they were very pleased with the service that they had received and were happy that they had given therapy a second try. Specifically, they assigned a rating of 1 to all of the questions on the CSQ indicating that they totally agreed with the statements being asked. Moreover they emphatically thanked this writer for her assistance during our last session together and appeared genuine in their appreciation.

In conclusion, this case illustrated the use of the miracle question and scaling questions as two means of narrowing and focusing in on the true problem/complaint experienced. Also, of significance is the fact that the referral source was incorrect in their assessment of the families problematic issues as the parents themselves had initially mislabeled and misunderstood their true source of aggravation and frustration. This case also depicted the use of identifying an exception and utilizing the exception in order to promote the development of a solution. Subsequent sessions served to reinforce and amplify the changes which were already occurring and other strengths and positives derived from such changes.

Case Example 2- Family C

Family Biography

Laurie B is a single mother of two children. She had initially referred herself, Tony and Kathy to the out-client unit for therapy, however, due to their long wait list and the decrease in referrals to the Community Intervention Program (CIP), the family was offered immediate service via its twelve session model which they were receptive to.

Laurie (43) works for a department of the Federal Government. She works as needed on a contract basis and therefore, her work schedule is quite sporadic. Laurie separated from her husband in April, 1991 due to his emotionally abusive behavior and since that time he has maintained infrequent contact with the children. Both Tony (13) and Kathy (10) are enrolled in a mainstream school and are in grades eight and five respectively.

Presenting Concerns

Laurie contacted the Peel Children's Centre to refer herself and her two children, Tony (13) and Kathy (10) for therapy. The referral information stated that Laurie was very concerned regarding the chronic conflict and anger within the family, specifically, between the children towards herself. She advised that this had been fairly constant since the marital separation in April, 1991 which she felt her children blamed her for since their father

continually advised them that he did not want the separation. Tony and Kathy have had infrequent and sporadic contact with their father since the marital separation which he apparently blames on his illness. This illness has been diagnosed as a very rare muscle enzyme deficiency which is mild and non progressive in nature but which Laurie advised he constantly uses to avoid his parental and work responsibilities. Laurie stated that her children felt that she left their father due to his illness, however, it was due in part to his history of drug abuse and mental health issues (past suicide attempt) of which the children were not aware of. In addition, Laurie stated that her ex-husband was verbally abusive and extremely controlling to the point that she was not allowed to leave the house without his permission and he would time her activities to ensure that she was doing exactly what she was supposed to be doing. Another primary concern indicated by Laurie on the referral form was Kathy's recent school phobia for which she had received short term psychiatric attention. This appeared to be of assistance in minimizing this concern as Kathy began attending school more frequently towards the end of the last school year, however, Laurie was concerned that this could become problematic again in the future.

Description of the Intervention

All sessions with the B family occurred within the Peel Children's Centre at the request of the family. While Brenda Bolliger was not able to view any of the sessions, they were audio taped. Therefore, this writer was able to gain feedback and clinical direction through consultations based on session content which was provided via verbal and written feedback.

At the beginning of the first session with this family, pre-session changes were explored. Specifically, the following question was asked "what have you noticed that has been better since the time you initially contacted the agency for family therapy up until today's first session". This was asked in order to highlight the changes that this writer already knew about (Kathy's eliminated school phobia) and to explore any other changes which could be built on as exceptions and solutions to the families problem/complaint. This difference was further discussed and processed. Kathy's attendance and participation in her academic studies began to improve when she became more socially active and had joined the Girl Guides. This was identified as a solution. Tony who appeared angry at having to attend the session and whose presentation was one of forced omnipotence towards this writer and his family, advised that he had not stolen anything for the last month. This was also processed further and Tony was complimented on his improved behavior. Laurie was also provided with some positive feedback for creating an "exception" to this stated problem. Specifically, due to the clear boundaries that she had placed around Tony's behavior and the clear message that this behavior would not be tolerated and that she would no longer "bail him out", Tony's shop lifting had ceased for a month which was a significant improvement. This writer commended the family on their abilities to develop effective solutions to their stated concerns. Specifically, this writer advised that while it appears important for this family to protect each other and feel safe, it also appears that their mom is respecting their independence. Due to the fact that she realizes that they are no longer small children, she is encouraging them to make positive life decisions by way of accepting personal responsibility and ownership for those decisions. This writer proceeded to explore other pre-session changes by asking "what else is

different". The family remained quiet for a few moments and advised that nothing else was positive and Laurie began identifying a myriad of identified problems. The pre-session changes and exceptions were highlighted once again and the family was commended for their obvious problem solving skills before individual perceptions regarding the problem/complaint (s) were explored.

This writer asked the family "what would you identify as the problem(s)/complaint(s) that precipitated your family's desire to pursue family therapy at this time". Laurie advised that the children, specifically Tony was disrespectful and defiant towards her; frequently swore; refused to follow any parental directives; both children refused to get out of bed in the morning without her constantly yelling at them; Tony's negative peer group and frequent fighting; and both children's insistence on placing sole blame for the marital separation on her without knowing all the facts. Laurie presented as being very calm and in control throughout the session. Even when discussing emotionally charged subjects such as her children's distancing from her and their intense anger at her breaking up the family, she maintained a very cool disposition and continually intellectualized all subject matter discussed.

Tony advised that he felt as though he got blamed for everything that went wrong in the house and that people always assumed that he was lying about everything. He stated that this had been even worse of late as they had recently moved in with his two maternal aunts and maternal grandmother and therefore, he felt as though he had four mothers. In addition, Tony stated that nobody ever listened to him whenever he spoke. He advised that

he hated being at home and made sure that he was out with his friends as often as possible. Kathy had remained relatively quiet up to this point and had her eyes riveted on the floor for most of the session. When asked why she felt that her family was seeking family therapy she advised that she really was not sure. She stated that there was always a lot of yelling in the house; that she and her brother missed their dad and that it made her upset when she heard her parents arguing on the phone which they did frequently.

It became clearly evident that while Tony externalized his feelings of anger and loss via his delinquency, yelling and fighting, Kathy internalized her feelings and appeared to emulate her mothers lack of outward expression. It appeared as though each family member was not feeling valued or understood and there was a sense that the children were possibly projecting their feelings of hurt, sadness and rejection that they felt towards their father onto their mother. This projection acted as a defense mechanism that likely felt safer to adopt rather than risk the possibility of losing their father altogether if they confronted him with their true feelings of sadness and anger, or their ambivalence regarding why he refused to see them on a more regular and consistent basis.

Each family member was then asked the "miracle question". Tony spoke first which surprised this writer given his outward presentation of indifference which appeared indicative of his slouched position in the chair, tone of voice and visual expression of frustration at having to be present for the session. He stated that he would like his mom to start listening to him when he spoke and to not always assume that he was lying and he would also appreciate it if his aunts would stop telling his what to do all the time. In

addition, he advised that he would like his parents to get along better and for his mom to be nicer to his dad instead of always insulting him and putting him down. Laurie spoke second and advised that she would like for the three of them to get on with their lives and to stop arguing with her over every little thing. She advised that she could not help it if their father visited them so infrequently and despite his persistence she did not want to reconcile with him despite what he may think or say. When asked what the first thing she would notice that would let her know that a miracle had occurred, she advised that both children would get up in the morning without having to he told a million times and that they would have breakfast without any conflict. Kathy asked what the question was again and when repeated, she advised that her family would be the way it used to be with her dad living with them and that her brother and mom would not fight as much and that everyone would be happier and smile more often.

Attempts were made to identify exceptions to the conflict that had been mentioned by all three family members. Kathy and Tony both advised that things used to be much better when their dad lived with them and that everyone seemed to get along much better. Laurie concurred that while there was much less conflict between herself and the children when she was married, she was not happy and stated that perhaps unbeknownst to the children, she and their father fought frequently.

Due to the fact that there was not going to be a marital reconciliation, attempts were made to identify other exceptions that could have attributed to the differences (less conflict) that were present prior to April, 1991 before the marital separation and that were more amenable to a solution

orientation. Both Tony and Kathy advised that their mother's style of parenting and personality characteristics were the same and stated that "mom is just the way she has always been". Tony advised that everything would have continued to be o.k. had their mother not left their father and that it was very unfair of her given the fact that he was ill and did not have very much money. While attempts were made to process this comment further, Laurie provided no input and Tony refused to discuss this further, as did Kathy.

It became clear to this writer that communication was a central issue for this family. Specifically, individuals did not feel heard or understood, their primary communication was in the form of yelling at each other or giving each other the silent treatment. In addition, there were family secrets regarding what could be discussed and what could not be discussed with little permission given to ask questions or gain any clarification. The children did not know why their parents had separated and felt that their mother had left their father due to his illness and at his time of need. Their father was perpetuating further confusion and hurt in encouraging the children to believe that it was just a matter of time before their mother "came around" and reconciled with him. Due to these family secrets, the communication in this family appeared to be very complex and was further exacerbated by the reality that individuals were encouraged to co-exist in a superficial manner, maintaining the status quo without asking questions or discussing and expressing their true feelings. This also served to make the therapeutic process very difficult as this writer had been inducted into the family secret held by Laurie and therefore, felt as though she were promoting it. Furthermore, it served to make the therapy session feel very superficial as there were clear boundaries around issues that could not be discussed. This

writer believed that this Pandora's box needed to be opened in order to deal with the family's repressed feelings which were negatively impacting their abilities to effectively communicate.

A series of scaling questions were then asked of the family. Laurie, Tony and Kathy assigned a value of 5, 3, and 7 respectively to the following question: "on a scale of 1-10 where 10 is the highest, where would you rate your sense of family satisfaction. Once again each member was asked "what would it take to move you one notch up the scale, from a 5 to a 6, a 3 to a 4, and a 7 to an 8 respectively". While both Laurie and Kathy rated their motivation relatively high (8 and 8 respectively), Tony rated this scaling question a 4 and advised that he really was not very interested in pursuing therapy any further. When the third scaling question was asked in terms of the level of optimism that each family member had regarding the positive outcome of therapy, both Laurie and Tony assigned a rating of 4 and Kathy assigned a value of 7. Thus, indicating that two of the three family members were not very optimistic that therapy would be beneficial. While Kathy assigned relatively high ratings to the three scaling questions, she appeared to be eager to please and quite compliant which was further substantiated in her FAM III profile where she minimized and/or denied the existence of any family problems. It was therefore, very difficult in this first session to assess who the true customer of service was as on some degree all three family members presented as either visitors of service or complainants of service. Furthermore, given the blanket of secrecy and ambiguity that appeared to surround the children's relationship with their mother and vice versa, this writer felt that more information was needed before a clear assessment could be made or goal(s) of therapy contracted.

While this had already been a lengthy session, an additional five minutes was taken to deliver compliments to the family and acknowledge their strengths. Specifically, Laurie was complimented on her desire to protect her children from pain, while also recognizing the need to support them in their pursuit towards increased independence as they grow older. Tony was advised that this writer appreciated his input to the session and admired his ability to clearly articulate his concerns as well as the commitment that he had towards his family as demonstrated by his attendance at this session. Kathy was complimented on her sincerity and ability to share her feelings despite the fact that it is sometimes difficult to do.

Just prior to the family leaving the session, we discussed a task for them to work on. Specifically, the "do something different" task was assigned for the family to implement when arguments and/or conflicts began. This writer also assigned the Formula First Session Task (FFST) in order to assist the family in identifying some exceptions to their identified problems and to implicitly promote the expectation of change. Due to the family secrets which Laurie held, this writer believed that it would be most advantageous to have an individual session with her before continuing with family sessions. Given Laurie's sporadic work schedule, she advised that she would like to schedule a subsequent session in two weeks time which was agreed upon.

Both Tony and Kathy were eager to complete the FAM III scales and Laurie advised that she would drop them off at the agency upon completion

which she and the children agreed would be before the next scheduled session.

The second session with Laurie served to discuss in detail the family secrets regarding her stated "dysfunctional" marriage to her children's father and lack of fulfillment due to his abusive and controlling nature; her need to cover up the truth regarding his suicidal ideation's and two brief hospitalizations and drug use (prescriptions); the positives and negatives of harboring such secrets from her children and for how long she intended or thought she could do so given the double bind messages that the children were receiving from their father; and reality that while parents withhold information from their children in order to protect them, sometimes partial truths and lies can be even more damaging and destructive. We discussed possible goals of therapy and Laurie advised that she would like to have the contracted goal of therapy focused towards bettering the families communication patterns and agreed that the family secrets would need to be exposed in order to facilitate this goal. While Laurie interacted in this session, she appeared threatened by this exchange, however, did not admit to this discomfort when asked about it. At the end of this session, Laurie advised that she felt comfortable spending time at the next family session giving the children permission to ask any questions that they may have about the marital separation. However, having said this, she further advised that she would give some serious thought as to the impact of the partial truths and lies that she had told the children about their father and the separation and what information she felt was now in her children's best interest to know if any. A third family session was scheduled for one weeks time at Laurie's request.

The beginning of the third session was used to process the positives that they had noticed and observed via the assigned tasks. Specifically, Laurie advised that Kathy had been using her alarm clock regularly and had been getting herself up at a reasonable hour without her having to yell as often, which she really appreciated. Kathy was provided with some positive praise and advised that it was a really good way of exerting her independence and a definite sign of her maturity. Tony advised that he had noticed that his aunts did not interfere as much or tell him what to do as often which he assumed was a result of his mom talking to them. He stated that it made him feel good and advised that maybe the last session was not a complete waste of time as he had originally thought. He added that he was surprised because it indicated to him that his mom had listened to him and understood his frustration with having "four mothers "in his life. While Kathy did not volunteer any input, when asked she advised that there had been a little less yelling and screaming in the home which she would like to continue and have happen more frequently. All three family members were complimented on their hard work and encouraged to keep on doing what they were doing as it apparently produced some positive results.

Each family members desired goal of therapy was discussed and it was agreed upon by all three family members that the contracted goal of therapy should be focused towards bettering the family's communication patterns. This goal was articulated as follows: To increase the amount of time that family members spent talking, listening and understanding each other while simultaneously decreasing the amount of yelling that occurred between its members.

Given the lack of family interaction observed by this writer during this session and the initial family session, the following task was assigned for the family to work on during the interim before the next session: "Between now and the next time we meet, have a family discussion based on anything that you would like to discuss or that you share in common. All three family members agreed to this and a fourth family session was scheduled for one weeks time.

It was clear to this writer that this family merely co-existed together with very little interaction or intimacy. This writer hoped that this task would be a small step forwards in assisting them to exert some time and energy in their family instead of avoiding each other or merely exchanging monosyllabic responses.

Laurie telephoned this writer shortly before the scheduled fourth session and advised that she needed to cancel due to illness. It was agreed that she would call back to reschedule which she did not do. This writer attempted to re-engage the family by telephoning and leaving three telephone messages, however, to no avail. A letter was subsequently sent to the family advising that if they did not contact this writer within a two week time frame their file would be closed and counseling sessions terminated.

Laurie did respond to this letter and did telephone to advise that the family "problems" had decreased and she did not feel that further sessions were necessary. This writer advised that should the family wish to pursue counseling at a further date they could contact the agency again to be serviced

by the out-client unit where they had originally self-referred themselves to. Before saying our good-byes, Laurie advised that she and the children would be pleased to complete the post-test component of the FAM III which they did and mailed back to this writer. While there was no termination session scheduled with this family given Laurie's refusal to commit to one, and therefore no opportunity to process what had been most helpful, Laurie did advise that they would be pleased to complete the Client Satisfaction Questionnaire (CSQ) which she did, however, Tony and Kathy neglected to do. Laurie assigned a value of 1 to each of the questions on the questionnaire (refer to appendix B of this report) and provided some additional positive feedback on the back of the form.

Outcome and Comments

The pre-test component of the FAM III supported this writer's assessment and observations regarding the intensity of the family's difficulties (refer to table 3). Family members scored between 46 and 71 on the overall rating scale. As predicted, Tony's score was the highest indicating his high level of frustration and intense feelings of negativity that he felt towards the family and their current living situation. Kathy's passivity and intense need to please was also indicated by her very low score of 46 despite her apparent level of confusion and sadness regarding the level of family conflict and conflict between her parents which she expressed within the therapy sessions.

Kathy's presentation of passivity is further substantiated as being a possible facade given her low scores in social desirability and

defensiveness (below 40) as were Tony's and Laurie's. Skinner et. al., (1983) state that Social desirability and defensiveness scales below 40 do not guarantee the validity of the scales, as there may be other distortions that are not being measured (i.e. projection). Therefore, this family's scores could be a more accurate depiction of their feelings of projection given the presence of this defense mechanism, rather than the areas measured by the FAM III and therefore, this family's FAM III scores need to be reviewed and assessed with caution.

Of particular interest are the communication, affective expression and involvement scores which range from 52 - 74, 51 - 68, and 50 - 70 respectively. These specific scales and their related high scores appear to be indicative of the personality characteristics of the members and are congruent with the individual perceptions of the severity of problems experienced. Skinner et. al., (1983) state that scores 60 and above in communication indicates that communications are insufficient, displaced or masked; necessary information is frequently not exchanged effectively; there is lack of mutual understanding among family members and; there is an inability to seek clarification in cases of confusion. Likewise, they advise that high scores in the affective expression scale (60 and above) are indicative of inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotional discharge, often at times not appropriate to the situation. Similarly, scores 60 and above in the involvement scale indicates that there is an absence of involvement among family members, or merely interest devoid of feelings; the involvement may be narcissistic, or to an extreme degree, seen as excessive or intrusive; and lastly; family members may exhibit insecurities and lack autonomy. These explanations serve to

highlight the observed family problems as observed by this writer. In addition, Tony's scores appear to be indicative of his intense feelings of negativity and Kathy's low scores representative of her passivity and internalization of family problems. Similarly while Laurie had a high role performance score (74) which Skinner et. al., (1983) indicate that among other things is an "inability to adapt to new roles required in evolution of the family life cycle", she provides relatively neutral scores to all the other scales, which appears to be in line with her current need to keep the family secrets and patterns of behavior status quo. A full listing of the pre and post test scores can found in table 3.

Table 3

Pre and Post-Test Results for Family C Using the FAM III

Scale	Mother		Son		Daughter	
	Pre	Post	Pre	Post	Pre	Post
Overall Rating	63	60	71	67	46	44
Task Accomplishment	63	63	76	76	38	44
Role Performance	74	65	51	50	51	43
Communication	59	59	74	70	52	43
Affective Expression	58	49	68	68	51	39
Involvement	59	63	70	66	50	50
Control	61	56	80	70	44	42
Values and Norms	60	69	76	73	39	44
Social Desirability	28	39	49	49	36	38
Defensiveness	39	46	25	32	32	32

Figures three and four provide the pre and post-test FAM III profiles, which were obtained approximately five weeks apart.

figure 3

Pre Test Profile For Family C Using the Family Assessment Measure (FAM III)

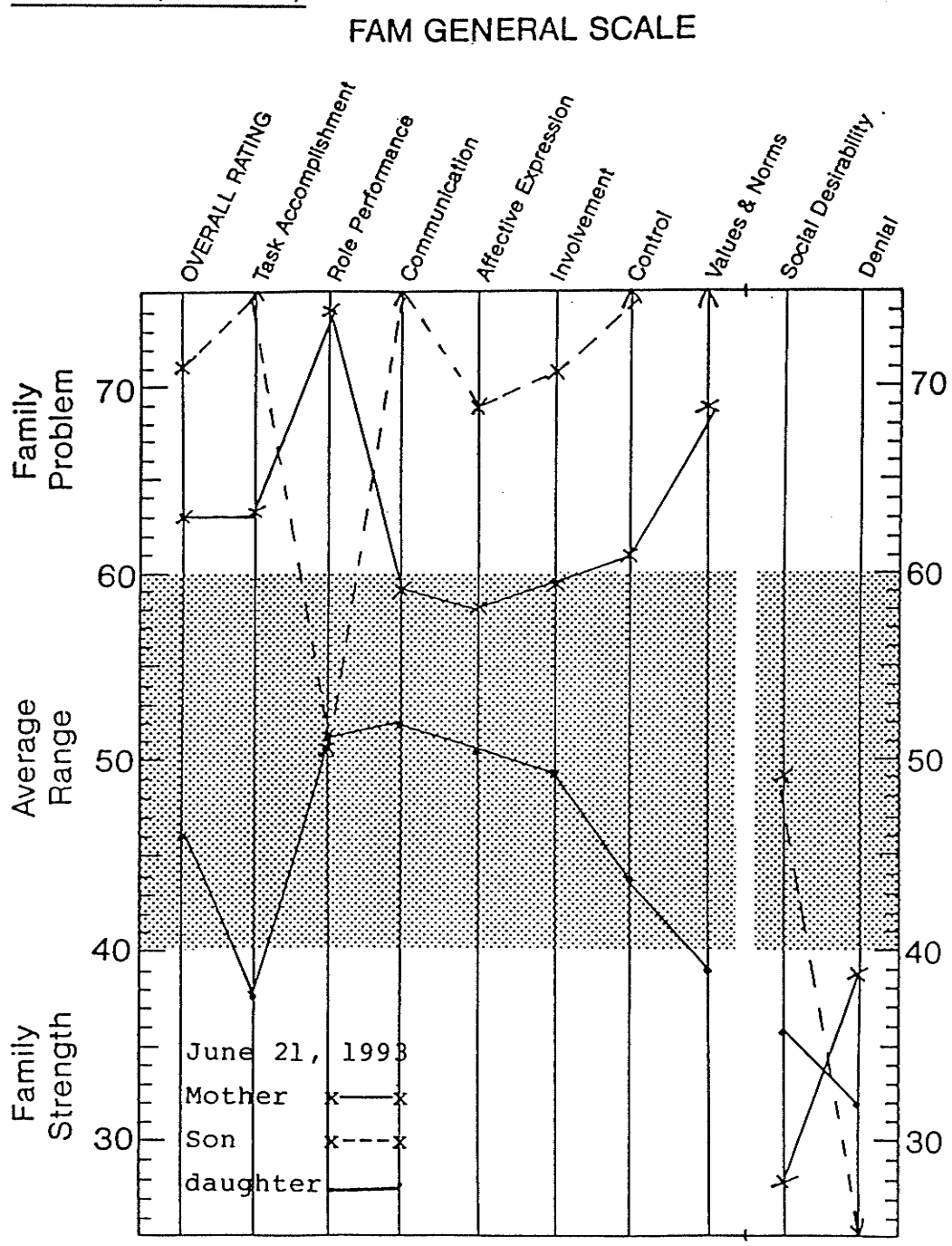
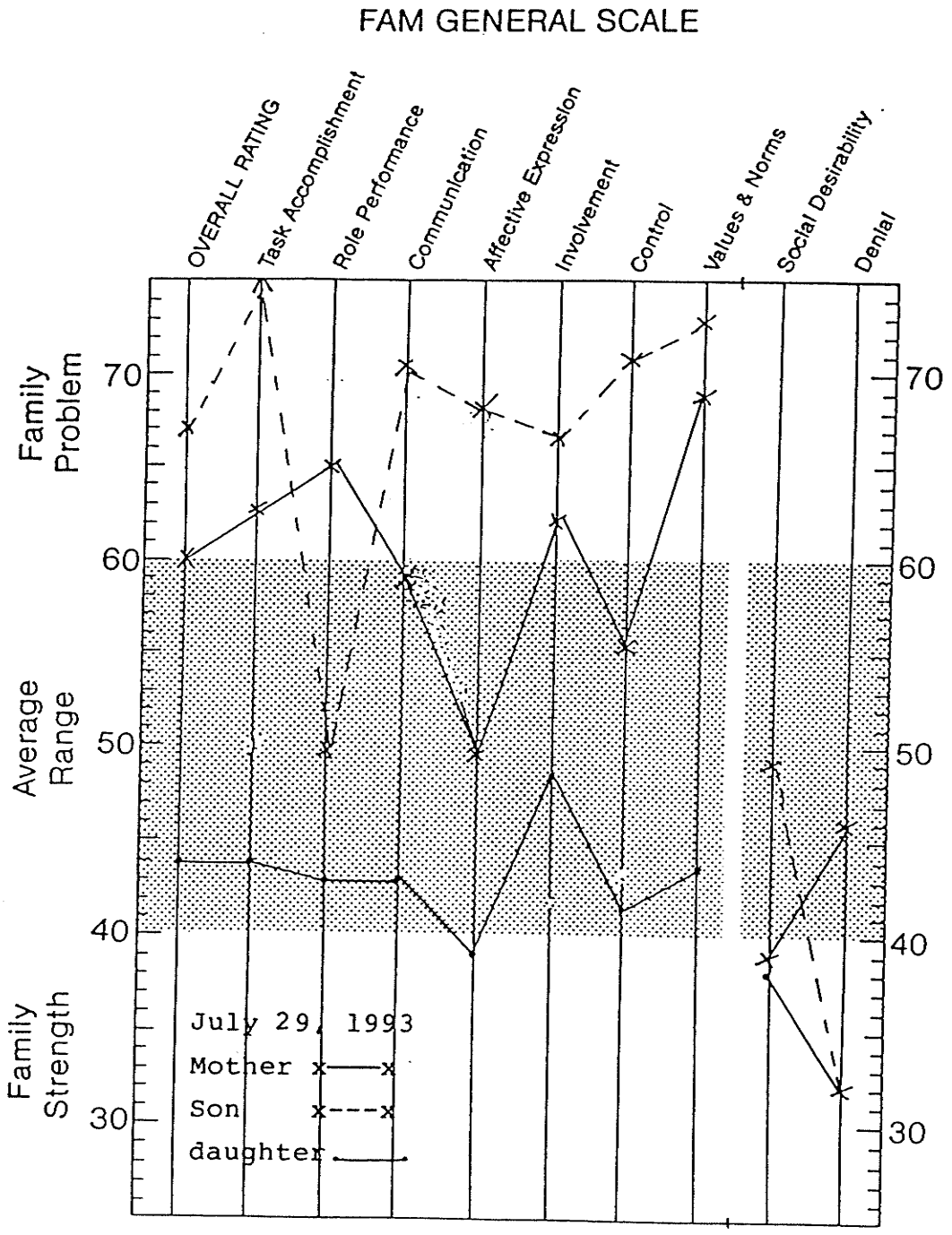


figure 4

Post Test Profile For Family C Using the Family Assessment Measure (FAM III)



While most scores either remained the same or decreased slightly, the family problem areas were still significant in their post-test FAM III profiles as illustrated in the above table. It is interesting to note that Laurie's scores in the involvement scale and the values and norms scale increased quite significantly from pre to post-test. Specifically, her score rose from 59 to 63 for the involvement scale and from 60 to 69 in the values and norms scale. It is possible that the therapeutic process served to raise her anxieties and enabled some repressed feelings to surface. This process may have served the positive function of highlighting a necessary problem so that hopefully she will chose to do something about it in the future and provide her children with some necessary truths.

High scores in the involvement scale have been outlined above, however, it is interesting to read what Skinner et. al., (1983) say about high scores in the values and norms scale. Specifically, high scores (60 and above) in this scale indicate that components of the family's value system are dissonant resulting in confusion and tension; there is conflict between the family's values and those of the culture as a whole; explicitly stated rules are subverted by implicit rules; and lastly; the degree of latitude is inappropriate. These statements provided by Skinner et. al., (1983) clearly articulate the realities that this family is faced with.

In conclusion, while this writer attempted to identify, highlight and amplify the exceptions to the families stated concerns which centered around the general issue of problematic communication patterns, there appeared to be an overwhelming feeling of oppression. All three family members

appeared to constantly be walking on egg shells and devoted a lot of energy on maintaining the secrecy and clearly defined boundaries around issues that were allright to discuss and those that were sacrosanct and taboo which appeared to inhibit their ability to communicate effectively. The family appeared to be stuck in a cyclical negative pattern of communication and the family secrets served to perpetuate this cycle. Laurie appeared to be very fearful and anxious regarding the children knowing about their father's emotional instability. She appeared to provide him with additional ammunition with which he used to manipulate the children's feelings and create increased and ongoing conflict between herself and the children. This appeared to serve the additional negative impact of eliminating and/or severely hindering Laurie's ability to parent her children as they received verbal and/or non- verbal messages from their dad that he was better than their mom was and that she was to blame for everyone not being together or being happy. It is this writer's assessment that it was apparently easier for their father to slander their mom than to draw undesired attention to his own inability and/or unwillingness to provide consistent time with his children or provide a paternal role for them (it should be noted that this assessment is based on observations and information provided from the family, and not derived from any direct contact with their father). The family as a whole appeared to be dedicated to preserving the family secrets and maintaining the families status quo which was respected by this writer throughout the three therapy sessions.

While Laurie advised this writer via our telephone conversation that the family conflict had decreased, and that the situation in the home was less

problematic, which she felt eradicated the need for further therapy, this was not confirmed by Tony and Kathy and not supported by their FAM III profiles. This families problematic issues were very complex and multifaceted and it is possible that with an increased skill level and expertise in utilizing the solution focused model to its full potential, this family may have felt less anxious and/or threatened with the therapeutic process. They may have also continued in therapy until significant positive changes were achieved, which does not appear to be the case given their FAM III profiles. It is also possible that although the conflict in the family was significant, the family was not yet ready to risk confronting the truth in order to free themselves from a history based on lies and half truths. In other words they were comfortable in their assumed roles of "visitors" and/or "complainants" of service and not yet ready to become "customers" of service. They were only ready to do a little piece of the work at this time and may at a later date engage in a similar therapeutic process again. At any rate, it is hoped that the families brief exposure to therapy and particularly to the solution focused model has been successful in providing them with increased skills and a larger repertoire with which to draw on in the future so that they can view their situations differently and enhance their own possibilities for change.

Case Example 3 - Family D

George who is 12 years of age and his family were referred for service to the Community Intervention Program (CIP) via a women's shelter where the family resided for a short period of time after the parental separation which occurred in May, 1993. The referral source identified the following

problems impacting this family as follows: Pain and stress associated with the emotional and physical abuse that the family endured; issues of family loss and grief; George's low self-esteem; The mother's feelings of inadequacy regarding parenting and her use of inappropriate language (name calling) and frequent yelling at the children, specifically George.

Family Biography

This family unit is of Anglo Canadian ethnic background and consists of Hannah (34) who is the single mother of George aged 12 and his sister Josie who is 14 years old. Hannah is employed outside of the home as a consumer representative for a large transportation company and George and Josie were completing grades 7 and 8 respectively. The family has moved very frequently since both children were small and in total has resided in fourteen different homes within southern Ontario. Their last move had taken place half way through the school year which required both children to change schools. While this did not pose a problem to Josie as she quickly re-established a peer group, it was another major adjustment for George. He had lost his peer group and was experiencing difficulties making friends at his new school which was exacerbated given the up coming summer holidays. In addition, it was causing a lot of conflict between the children as George wanted to spend time with Josie and her friends given their proximity in age which caused great distress to Josie and thus, great strife between the siblings.

Both George and Josie have maintained sporadic contact with their natural father whom they have not resided with for the majority of their lives as their parents separated and later divorced when they were very

young. Specifically, the children had no contact with him until approximately a year and a half ago when he initiated contact. The referral information reported that George had more of a bond with his natural father than did Josie and that her contact with him was almost exclusively via the occasional telephone call as opposed to George who would see his father as often as possible. They have two half siblings aged 3 and 1 who have continued to live with their step-father since the marital separation and whom they have contact with via bi-weekly weekend visits. Both children have had no contact with their step father since the marital separation in May, 1993 when Hannah, George and Josie left the family home due to emotional and physical abuse and moved into the women's shelter. Specifically, the step-father was described as being a very controlling man and emotionally abusive to both females calling them names and telling them that they were useless. While George also endured the emotional abuse, he also suffered physically as his step-father would frequently hit him across the head, pin him against walls and pull hard on his ear, among other abusive acts as means of discipline.

All sessions with this family occurred within the agency's office and took place weekly which accumulated to twelve sessions in total. The large majority of these sessions were either audio taped and/or observed by Brenda Bolliger via the one way mirror which provided ongoing clinical consultation and supervision throughout the phases of the therapeutic process. In addition, it afforded this writer the benefit of Brenda's expertise and clinical observations as the interviewing room was also equipped with a telephone, whereby Brenda would occasionally call to provide in-session feedback and direction. During the sessions observed by Brenda Bolliger, a

consultation break was taken after a 45-60 minute session with the family. This served the added advantage of us developing compliments together and devising consultation messages which were delivered to the family and which acted as a bridge in the formulation of assigned tasks.

At the beginning of the session, Hannah presented as being very eager to charge ahead and talk about everything which she found problematic, apparently in the hopes of getting a quick fix to her identified problems. When attempts were made to engage the children in the therapeutic process, Hannah would frequently rephrase and/ or interpret what she felt her children meant and would then again attempt to monopolize the conversation. This issue needed to be addressed and was done so in a very non-threatening way by advising the family that everybody was equally as important as were everybodies thoughts and feelings, therefore, we contracted that everybody have equal time to talk within the sessions. This was initially somewhat helpful in assisting Hannah to slow down so that she could listen and understand her children's view points and feelings, but continued to be an ongoing issue throughout therapy which on occasion required reiteration of the above statement.

While pre-session changes were briefly explored, all agreed and remained adamant that there were no positives worth reporting or that could be thought of. Hannah advised that the fact that the family had all agreed to attend therapy was perhaps positive because it indicated that as a whole they agreed that their problems were significant and warranted therapeutic intervention. This writer complimented the family on its commitment to each other.

Presenting Concerns

Individual perceptions regarding the problem/complaint which precipitated therapy were discussed and processed during the initial therapy session. When this question was posed to the family, Hannah was the first to speak. She advised that she always felt angry and was constantly yelling at the children. This frequently included swearing at them and calling them names which were often very demeaning. In addition, she advised that she was "sick and tired" of the sibling rivalry which was continual and tired of doing everything around the house while they, specifically George did nothing due to his laziness and irresponsibility. Josie spoke second and also advised that there was a lot of conflict in the house specifically between herself and her brother. Half laughingly she said that she wished he could do things alone as she really didn't like him. George advised that there was always yelling and screaming in the house and he felt miserable all the time. He was then asked to discuss a time when he didn't feel miserable. He advised that that was when he lived in Oshawa and was always busy with friends doing things and when he and his sister used to hang out together.

Other themes discussed during this initial session included the separation and loss of their family which included their step father and half siblings who they felt very close to and missed; new family system which had drastically altered the families communication patterns (this was also processed further in terms of the noted differences and therefore, as being another exception); Hannah's feelings and concerns that the children had withdrawn and had emotionally distanced themselves from her; The

different expectations of family members and how to compromise on task completion around the house; Peer issues for George; The intense sibling rivalry and Hannah's issues around parenting and desire to implement some alternative strategies.

Description of the Intervention

When the "miracle question" was explored, Hannah again spoke first and advised that she and the children would get up in the morning and sit at the kitchen table to eat breakfast in peace and harmony without any arguing. Again in order to search for exceptions, this writer asked Hannah to speak of the last time when this had happened which she quickly advised was just a few days ago when she and Josie had breakfast alone as George was still sleeping. This was further processed to include the last time that the three of them had breakfast without conflict which had occurred some weeks before when the family had gone on a family picnic with an association which Hannah was involved with (Parents without Partners). The differences were discussed in detail and highlighted as being an exception and solution to the family conflict which the family was encouraged to do more of (i.e. individual members thinking of something they are looking forward to and focusing on that thing/event instead of thinking of negatives or conflictual issues). George advised that his miracle would consist of he and Josie getting up in the morning and being busy all day long doing different things such as sports, swimming and exploring their new neighborhood. Josie needed some prompting to this question and advised that George would entertain himself, she would sleep until noon and then hang out with her friend watching television or lying in the sun. Each individuals response to the

miracle question was explored in terms of what parts of the miracle were already occurring. This did not prove to be very beneficial in identifying other exceptions as Josie and Hannah began to side against George in advising him that he needed to be more assertive and responsible for planning his own fun instead of being so heavily dependent on others. This information and strong mother/daughter alliance confirmed this writer's original observations and thoughts that this family was very much divided and George appeared to be alienated and austersized from it. There appeared to be very fused boundaries between Hannah and Josie and a reversed hierarchy of family structure whereby Hannah and Josie occupied the parental sub system and George the position of only child.

This writer then proceeded to ask a series of scaling questions. Specifically, the following three questions were asked. The first question was as follows: On a scale of 1-10 where 10 is the highest, where would you rate your sense of family satisfaction. George spoke first and assigned a value of a 6. Again in an attempt to search for exceptions, this writer asked what is going to need to happen in order to move you from a 6 to a 7. George advised that if the family could get along a little better and not argue as much that it would make things better. In order to refine this further, George was asked "how many arguments per day were deemed acceptable to him". He found this question odd at first but after this writer "normalized" arguing as a natural and healthy part of family functioning, he advised that two or three arguments would be much more satisfactory to him than the current level of constant conflict. Hannah advised that she would rate the current family situation at a 4 and stated that the children would need to get along a little better with less yelling and that she would need not to swear at the children

or call them names in order for her perception of their problems to increase one notch, from a 4 to a 5. Josie advised that she was not sure where she would rate the family situation but that she didn't think that it was that good. With some prompting she too assigned a value of 6 and advised that there would need to be less arguing in the house and that people would get along better in order for her assigned value to increase to a 7. Josie was asked to further articulate what she meant by "people getting along better" and she advised that everyone would talk more instead of yelling and would enjoy each others company more.

When looking for common themes indicative of the family's responses to the "miracle question" and above scaling question, the issue of family conflict and frequency of arguing held true for all three as being an area that they would like to be better and different than it currently was, which was articulated and contracted as being the primary goal of therapy. Other goals of therapy articulated by the family included assisting them to operate and function as a family given the recent change in constellation and past issues of abuse, and; Providing Hannah with some alternative parenting strategies and anger management techniques.

The second and third scaling questions centered on individual perceptions of personal levels of motivation and optimism. Hannah advised that she rated her level of motivation a 10 as she was prepared to do anything and everything to make things better for herself and her family. She rated a value of 7 to her feelings of optimism as to the positive outcome of therapy and stated that she thought that it would be very positive as long as everybody worked equally hard and was dedicated to attending sessions.

George said that he also rated his motivation high (9) and stated that he was equally as optimistic regarding the positive outcome of therapy. Again Josie needed some prompting and looked a little uncomfortable by this question. This writer advised that her honest feelings were all that was important and that this writer would not be at all offended by her response. Josie assigned a value of 5 to her personal level of motivation and a 6 to her feelings of optimism and was thanked for her honesty. Therefore, it appeared clear that while both Hannah and George were "customers" of service, Josie would likely remain a "complainant" of service throughout the therapeutic process.

The remainder of the session was spent delivering compliments and acknowledging strengths which this writer had noted and written down during the session. Specifically, Hannah was complimented on her personal insight and courage to articulate her own negative flaws. George was advised that this writer appreciated and admired his ability to discuss his feelings as it was sometimes difficult for people to do. Josie's attendance was recognized as being important and she was complimented on her ability to express herself honestly and openly. Lastly, all three family members were complimented on their concern and commitment to each other and were commended for recognizing the importance for the family to communicate more openly and effectively in order to reduce the level of conflict and solve their present problems.

After the above messages were delivered, this writer shared some thoughts and observations as a means of bridging the session content with the assigned task. Specifically, this writer advised the family that they appeared to be a relatively active family and enjoyed planning and doing

activities together (i.e. the family picnic), however, it was also clear that the level and frequency of conflict was really getting in the way of them enjoying each other's company as often as they would like to. Therefore, the following paradoxical task was assigned: The family was to pick a day during the week and make a concerted effort to avoid conflict, and then between 8-10 p.m. (a time deemed most appropriate by the family) revert to "normal" conflictual interactional patterns and report what they noticed during our next session.

The following sessions were marked with highs and lows whereby the family would vacillate between making considerable gains in meeting their desired goals as outlined above, to being very negative. Specifically, this negativity centered on George and frequently consisted of Hannah making demeaning statements to him. This negativity would be dealt with during sessions and this writer attempted vehemently to reframe Hannah's hostility and deal with its source, as she appeared to project a lot of aggression onto George. The intensity and level of hostility appeared to be related to Hannah's negative and chaotic family background which had been briefly discussed. Specifically, she had a very antagonistic relationship with her father and had had a number of male companions, as well as two "failed marriages" all of which had ended in emotional torment for her and undoubtedly her children as well.

Given the limited number of sessions left and the model's primary focus on the "here and now" and "future", as opposed to historical events and causal effects, this writer was quite perplexed regarding what to do next. Clinical direction and supervision were relied on and very much appreciated

with this case given its complexity, and the multitude and magnitude of the problematic issues. In order to utilize the remaining two sessions (11 and 12) most effectively with this family, it was determined necessary to formulate some additional thoughts and hypotheses regarding the family's situation and how best to proceed clinically.

This writer hypothesized, based on the information that Hannah had provided that she had had a number of emotionally unfulfilling relationships with men. Due to these negative relationships, it appeared that Hannah was projecting a lot of negativity and hostility onto George and had emotionally isolated him from the family of three that currently existed. This emotional isolation and projection was further exacerbated due to the close bond and nurturance that Hannah provided to Josie. Therefore, it appeared likely that George felt on the outside of this family and in an attempt to feel loved and accepted was searching for a more stable and emotionally fulfilling relationship with his natural father.

During the course of therapy, George began seeing his dad on a more consistent basis and began to have regular and frequent telephone contact with him, all with the stated consent of his mom, however, stated displeasure of his sister. This contact precipitated a family crises when George announced that he wanted to live with his natural father. Specifically, during the tenth session George advised his family for the first time that he wanted to live with his dad. He sounded very confident and assertive as he advised his mom and his sister that he had thought a lot about it and felt that it would be the best thing for everyone. This news did not appear to surprise anyone or be a great revelation, as initially nobody

responded which provided George with the opportunity to further articulate his decision and reasons for making it.

Hannah presented as being extremely hostile towards George during this session. However, this presentation was viewed as a facade as it appeared to mask her true feelings of sadness at losing yet another child to a man who was no longer a part of her life. In addition, this presentation of anger could possibly have been due in part to her own feelings of inadequacy which were heightened due to George's desire to leave her home and move in with his natural father and his new family. Unfortunately, Hannah's history of emotionally inadequate relationships with men compounded her limited expressions of emotional closeness with her adolescent son and impeded her ability to provide for his emotional needs.

During the eleventh session, Hannah attended alone. George had already moved to his fathers home in Woodstock, Ontario the previous weekend (the move had been finalized very quickly) and Hannah felt that it was not in Josie's best interest to attend, given her own emotional instability. Hannah was much less defended during this session. She allowed herself to express her sadness and was much better able to examine her own feelings of anger and to discuss her projection of negativity onto George. In addition, Hannah expressed a lot of insight as demonstrated in her ability to express how her own past unresolved family of origin issues surrounding her past relationships with men negatively impacted her relationship with her son. Furthermore, Hannah appeared very self aware of her need to resolve these issues in order to ensure her own emotional well being and develop a

positive relationship with her son, and was therefore, very receptive to receiving further individual therapy.

However, Hannah continued to express her anger and resentment towards George for leaving and vacillated on this issue throughout the session. Given George's need to continue to have a relationship with his mom, Hannah agreed to concentrate and make a concerted effort to list ways of connecting with George which she felt she would be able to operationalize short term while she pursued her own need for individual treatment (referral information was provided to Hannah by this writer).

The termination (12th session) session was held with only Hannah and Josie as George was unable to attend given the distance between Woodstock and Mississauga and related transportation difficulties. The first half of the session was used to further process George's move and impact on the family which both Hannah and Josie reported as being very positive in significantly reducing the level of family conflict. The additional differences (besides George's move) and exceptions were highlighted and amplified as being solutions and means for the family to rely on should the conflict become a problem again in the future (i.e. continuing to focus on positives and plan for joint activities; talking more and Hannah taking time outs when she felt herself getting angry instead of yelling and being derogatory towards the children). In addition, this session was used to assist Hannah and Josie in identifying the cues that tended to precipitate the conflict and means of acknowledging these cues without engaging in such conflict.

The second half of the session focused on what had been the most helpful aspect of the therapy process. Hannah advised that she never felt threatened to express herself honestly as she knew that this writer was not judging her. Both Hannah and Josie felt that they had been heard and that this writer appreciated the family's struggle and distress. Josie also advised that she appreciated that this writer did not tell them what to do but respected their thoughts and decisions regarding their stated problems and encouraged them to utilize their own skills in solving their problems. This writer telephoned George to provide him with some closure to our last ten weeks of work together. He advised that he felt settled at his dad's and was glad to be there. He was also very eager to find out how his mom and sister were doing as he had not spoken to them since his move, however, did state that he would call in the near future.

While it is not possible to say what the future holds for this family, all three family members appeared to be satisfied and content with the events that had transpired and significant family changes that had occurred. While the means were very drastic, the family conflict had decreased, and in addition, all three members reported feeling happier and more content at the end of the therapeutic process. Due to the fact that George moved to his dad's home in Woodstock prior to the termination of therapy, he only completed the pre-test portion of the FAM III scale and therefore, full data regarding the FAM III profile for this family is only available for Hannah and Josie.

Outcome and comments

The pre-test component of the FAM III was fairly consistent and for the most part mirrored this writers observations. Specifically, as predicted the overall rating scale for all three family members was relatively high, bordering on the family problem area (members scored between 57 and 61). Areas indicated as severe family problems and ones also observed and noted by this writer were the communication and affective expression scores which ranged from 61 -74, and 68 -77 respectively. Both these scores illustrate the families discomfort and insufficient and inadequate communication patterns. Of additional interest to this writer was that the involvement scores for this family were not as high as originally predicted. The scores for this scale only ranged from 50 - 63 indicating that this was not viewed as a problem for two of the three family members. Also of particular interest was Hannah's score of 60 in the values and norms scale which Skinner et. al., (1983) state is an area of weakness (scores of 60 and above). High scores in this scale (60 and above) indicate that components of the family's value system are dissonant resulting in confusion and tension; Conflict between the family's values and those of the culture as a whole; Explicitly stated rules are subverted by implicit rules and; The degree of latitude is inappropriate. Again this appeared indicative of Hannah's issues with the family and particularly with her son and the conflict and confusion which plagued family. Furthermore, George's scores overall do not appear to illustrate the degree of discomfort and the severity of emotional distress that he was enduring. A full listing of the pre and post-test scores can be found in table 4.

Table 4

Pre and Post-Test Results for Family D Using the FAM III

Scale	Mother		Son		Daughter	
	Pre	Post	Pre	Post	Pre	Post
Overall Rating	61	50	59	-	57	45
Task Accomplishment	53	43	62	-	57	48
Role Performance	56	42	51	-	56	38
Communication	69	50	74	-	61	44
Affective Expression	68	58	77	-	72	51
Involvement	63	54	50	-	54	54
Control	61	46	56	-	56	48
Values and Norms	60	51	46	-	46	35
Social Desirability	41	52	42	-	40	54
Defensiveness	42	54	40	-	42	56

Figures 5 and 6 provide the pre and post-test FAM III profiles and were obtained approximately 10 weeks apart.

figure 5

Pre Test Profile for Family D Using the Family Assessement Measure (FAM III)

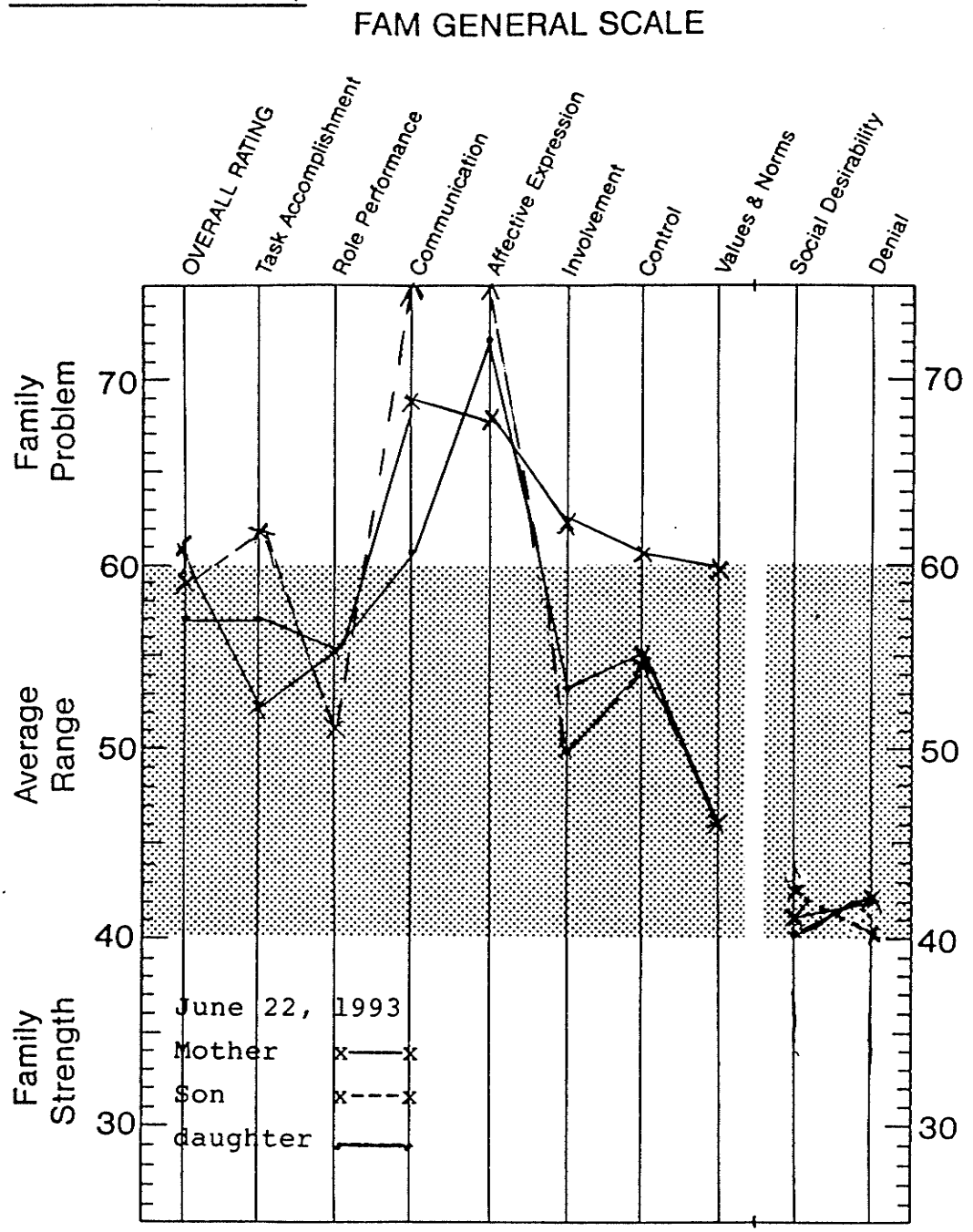
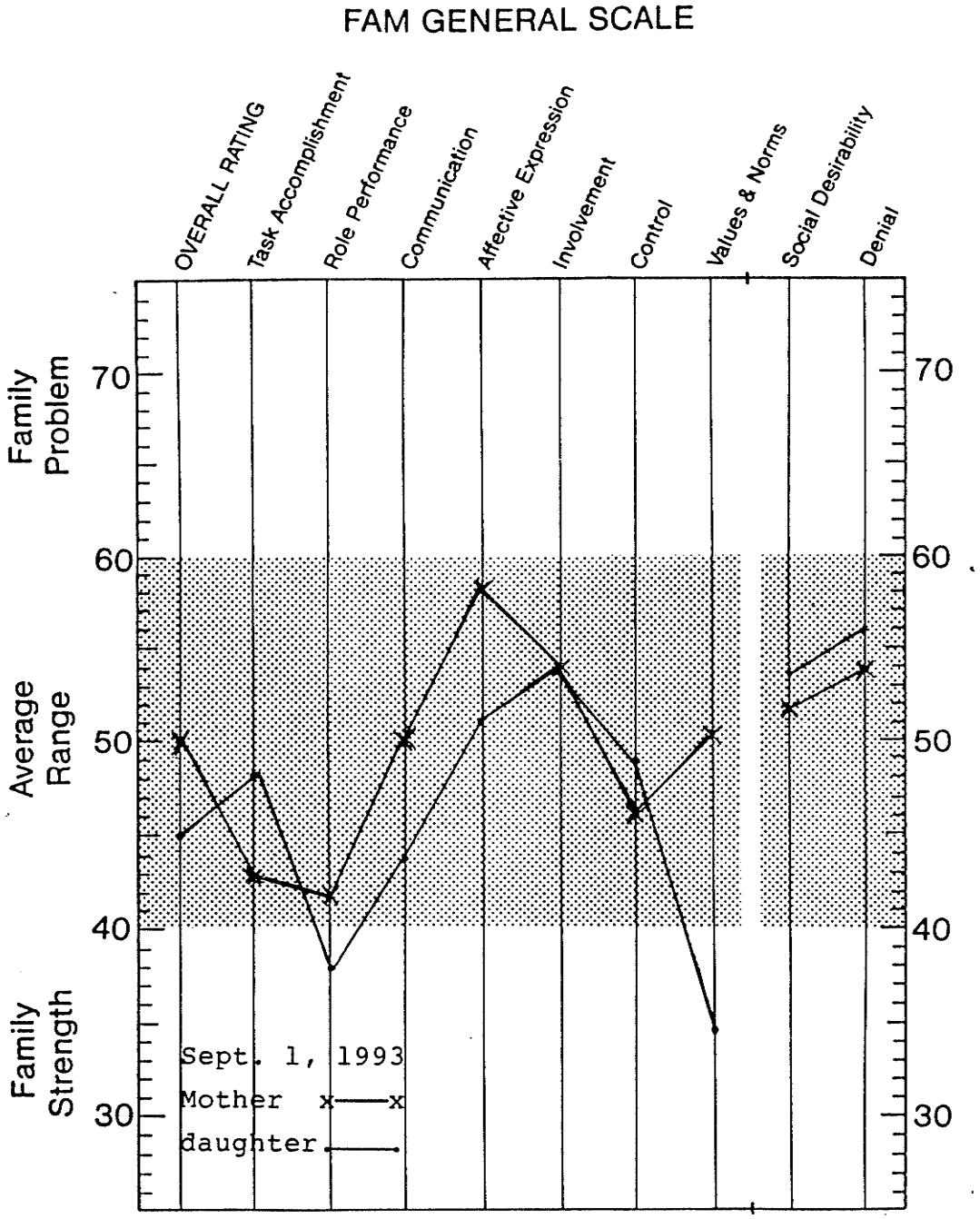


figure 6

Post Test Profile for Family D Using the Family Assessment Measure (FAM III)



At the time of termination all scores for Hannah and Josie fell within the average to family strength range, as indicated in table 4. While there were significant positive changes in all areas, the largest improvement can be seen in the communication and affective expression scales for these two members. It is suspected that if it had been feasible for George to have completed the post-test component of the FAM III profile, his scores would also have been much improved given the healthier and increased emotional stability which he was now receiving.

Hannah and Josie both competed the Client Satisfaction Questionnaire and provided favourable responses. They each assigned a rating of 1 to each of the questions and each provided additional positive feedback which they included on the back of the questionnaire.

In conclusion, while the family structure of this family was drastically altered by George moving to his natural father's home which could be perceived as a significant failure in the therapeutic process, it was viewed as being a very positive occurrence. Specifically, therapy appeared to assist George in freeing himself and afforded him the ability to seek emotional security instead of sacrificing his own needs. While this event occurred towards the end of the therapeutic process and therefore, it is not known what the long term ramifications of this separation are, it certainly appeared to be a contributing factor to Hannah and Josie's improved post-test scores and George's increased happiness and contented state as reported via our brief telephone conversation.

While this case was quite complex and took an unexpected turn towards the final sessions, it served to illustrate the use of identifying exceptions and utilizing the exceptions in order to promote the development of a solution. Initially it was difficult for the family to discern the exception(s) to their stated problem/complaint, however, slowly but surely throughout the therapeutic process they were able to articulate them and for the most part completed assigned tasks aimed at the promotion of these exceptions as solutions.

However, given the chaotic and highly conflictual relationships in this family whereby Hannah was projecting her own issues onto George which was supported on a more subtle level by Josie, the family separation appeared to serve the greatest positive impact for the family as a whole. It is not known at this time whether this solution is a short term or long term one, but it did appear to serve the positive function of reducing the intensity of family conflict and making the family's situation much more satisfactory for everyone. Furthermore, while there undoubtedly remains relationship problems within this family which may require further therapeutic intervention at a later time, the information received by this writer (verbal feedback from Hannah, George and Josie and the two completed FAM III profiles, and completed Client Satisfaction Questionnaires completed by Hannah and Josie) supports the immediate success of this case.

While the above case examples describe in detail the presenting problems and a more indepth description of the interventions and outcomes of therapy, it is also important to briefly discuss the two cases where this

writer acted as co-therapist and worked conjointly with a colleague from the Community Intervention Team.

Synopses of Families E and F

Family E was referred for service via the school board due to Sean's increasing aggression and verbal defiance witnessed both at school and at home. In addition, Sharon advised during our first session that Sean was becoming increasingly volatile towards his siblings and was constantly seeking negative attention. Sharon was also able to articulate her son's strengths which included his love of animals and at times his willingness to help others. This family unit is comprised of Sharon (34), and her three children, Sean (12), Amanda (7), and Patrick (3).

The pre-test scores of the FAM III clearly depicted Sharon's high level of stress and her perceptions of the family's multifaceted problems as illustrated in her overall score of 66. Surprisingly, although Sean appeared to be distressed and very angry, his overall score of 56 was not indicative of our observations and assessments which were garnered during the first session. This issue was discussed when reviewing Sean's pre-test score sheet as it appeared that he had filled it in haphazardly without taking the time to read and understand the questions. This was later confirmed by both Sean and his mother. Therefore, Sean's FAM III profile needs to be assessed with extreme caution as parts of it are not a true depiction of his views and personal experiences.

The pre-test component of the FAM III supported our assessment and observations regarding the intensity of the family's difficulties. It is important to note that all of Sharon's scores were either depicted as severe family problems or bordered on being family problems as indicative of her scores which ranged from a minimum of 54 (communication) to a maximum of 88 (role performance). Of particular interest and relevancy for this family are task accomplishment, role performance, communication and control which ranged from 83 - 57, 88 - 69, 59 - 61 and 66 - 56 for Sharon and Sean respectively.

Specific interventions were aimed at opening up the family's blocked and confrontational communication style. In addition much time and emphasis was placed on assisting Sharon in implementing different parenting techniques. This included incentives aimed at encouraging Sean to display more socially acceptable behaviors and ways in which Sharon could provide her son with increased positive praise and feedback.

The post-test component of the FAM III was administered at the end of the eighth session which is when this writer's practicum was over. Therefore, the scores obtained cannot be interpreted as conclusive but are a good indicator as to the progress which this family had made. By the end of the eighth session the FAM III profiles for both Sharon and Sean were much improved indicating that the therapeutic process and interventions outlined above were beneficial. Specifically, the majority of scores for the individual scales had decreased indicating that the family situation was much more tolerable. However, it is also important to note that some scores remained within the problem area such as role performance (74 and 64 respectively),

and communication (64 and 61 respectively). Sharon advised that Sean's behavior had improved slightly and that she felt better equipped to deal with his behaviors. She advised that the specific interventions had been helpful and that she was very appreciative of the support and encouragement that she had received throughout the therapeutic process to date.

While Sean did not complete the Client Satisfaction Questionnaire, Sharon did so willingly. Sharon assigned a rating of 1 to questions 1-9 except for question 8 which she assigned a value of 4 indicating her desire for further therapeutic intervention (refer to appendix B). Sharon provided some additional feedback on the back of her questionnaire and stated that she enjoyed working with this writer and wished her well.

A full listing of the pre and post-test scores can be found in table 5.

Table 5

Pre and Post-Test Results for Family E Using the FAM III

Scale	Mother		Son	
	Pre	Post	Pre	Post
Overall Rating	66	58	56	56
Task Accomplishment	83	58	57	57
Role Performance	88	74	69	64
Communication	59	64	61	61
Affective Expression	54	44	55	51
Involvement	59	59	58	58
Control	66	51	56	52
Values and Norms	56	56	46	46
Social Desirability	46	39	39	41
Defensiveness	40	38	40	42

Figures 7 and 8 provide the pre and post-test FAM III profiles and were obtained approximately 8 weeks apart.

figure 7

Pre Test Profile for Family E Using the Family Assessment Measure (FAM III

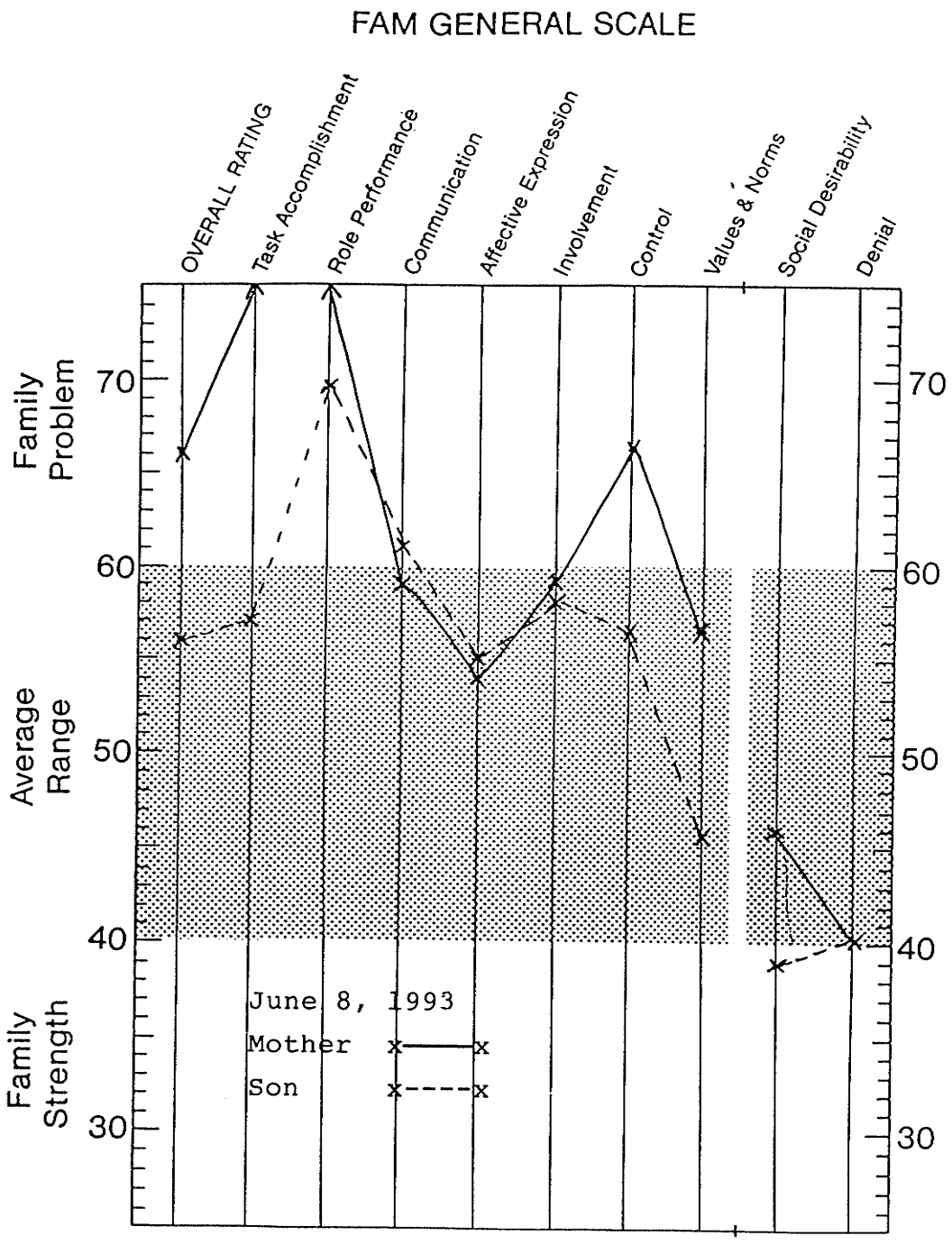
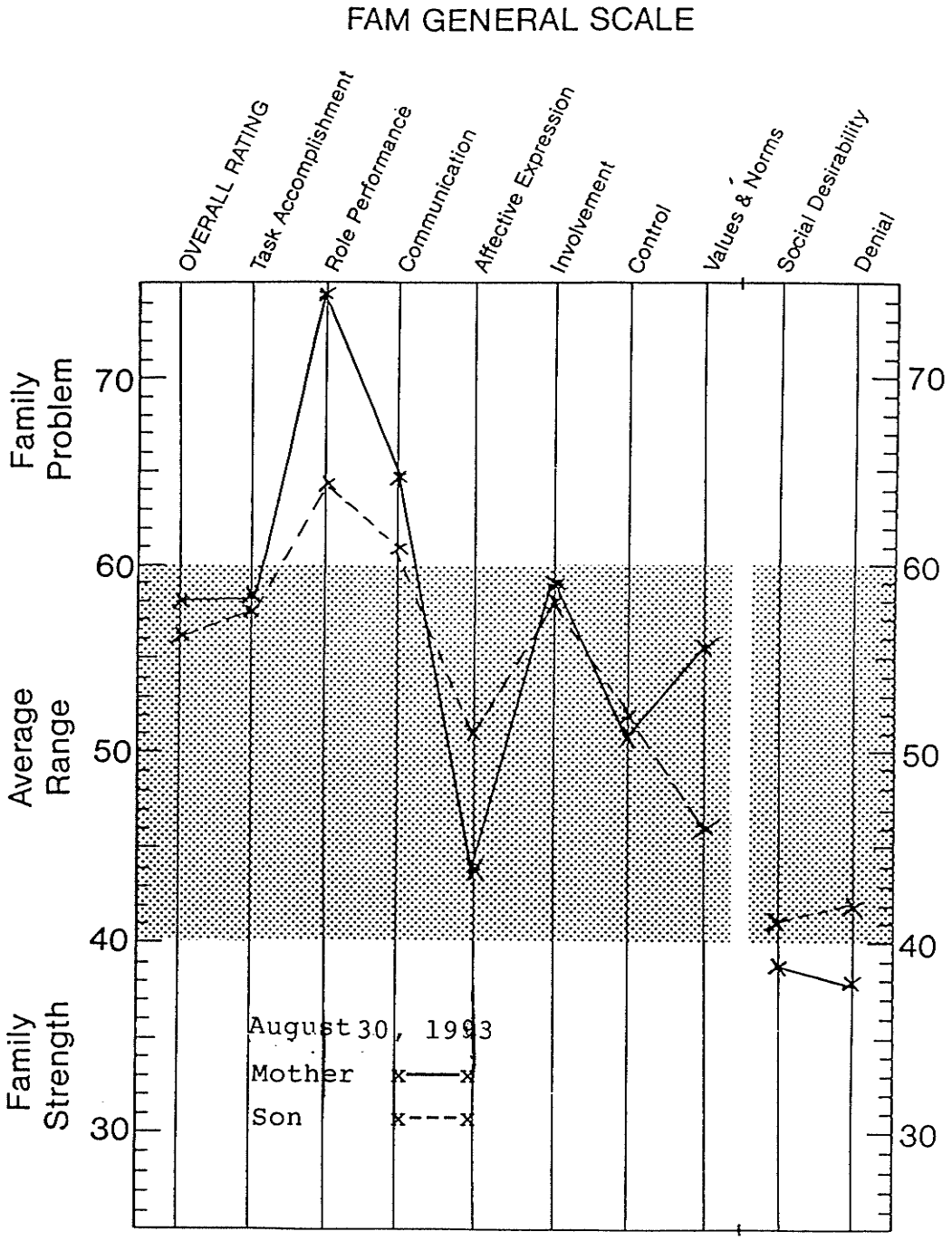


figure 8

Post Test Profile for Family E Using the Family Assessment Measure (FAM III)



Family F

This family was referred for service via the Children's Aid Society due to the child's disruptive behaviors and his parent's unwillingness to provide care to him if these behaviors did not dissipate. This family unit is comprised of the natural mother, Lee (32), her common-law partner, Al (29), and Lee's son Michael (12). This family presented as very chaotic and as being multi-stressed. While Michael's defiance, physical and verbal aggression, and poor academic performance were identified as being the primary issues, the family was also under considerable financial strain and the parental and mother/son relationships were viewed as being very tenuous and erratic.

These observations were further substantiated via the family's pre-test FAM III scores. Specifically, family members scored between 68 - 75 on the overall rating scale. In addition, there was at least one family member, if not full consensus that all other scales were perceived as family problems. Of particular interest are the role performance, communication, involvement and control scores which range from 73 - 79, 48 - 83, 74 - 87, and 66 - 82 respectively, thus, indicating the high level of stress and difficulty which this family was faced with. Given the high level of conflict between Michael and his mom and Al, his score of 48 in the communication scale does not appear indicative of the degree of discomfort and the severity of the problems he was facing.

Due to Michael's irritability and unwillingness to attend family sessions, it was contracted that future sessions would consist of dyad sessions

with Lee and Al and individual sessions with Michael. Specific interventions included the search for "exceptions" which uncovered past effective patterns of behavior and interactions, the "do something different" task was very effective in assisting the family to expand their problem solving skills, and specific attention was devoted to praising the family for their ability to cope given the adversities which they faced.

This family completed the post-test component of the FAM III after the seventh session. While their post-test scores were still relatively high, there was a marked decrease which indicated that there was improvement. The most significant progress can be seen in Michael's and Al's profiles which include some scores within the average range such as communication (52 - 54 respectively), and affective expression (55 - 59 respectively). As stated previously, this family was plagued with a number of environmental and relational issues, and hopefully benefited further from their remaining five sessions.

All three family members completed the Client Satisfaction Questionnaire. Their responses were very favourable and for the most part all three assigned a rating of 1 to the questions, again except for question 8 where both Lee and Al advised that they would like additional therapy. There were no additional comments or feedback provided.

A full listing of the pre and post-test scores can be found in table 6.

Table 6

Scale	Mother		Son		C/L Partner	
	Pre	Post	Pre	Post	Pre	Post
Overall Rating	68	67	67	60	75	61
Task Accomplishment	73	68	71	67	68	38
Role Performance	74	88	73	73	79	74
Communication	64	64	48	52	83	54
Affective Expression	54	49	72	55	68	59
Involvement	87	87	74	74	75	46
Control	66	46	80	72	82	82
Values and Norms	64	56	80	50	73	64
Social Desirability	46	42	45	42	41	41
Defensiveness	27	23	39	39	27	50

Figures 9 and 10 provide the pre and post-test FAM III profiles and were obtained approximately 9 weeks apart.

figure 9

Pre Test Profile for Family F Using the Family Assessment Measure (FAM III)

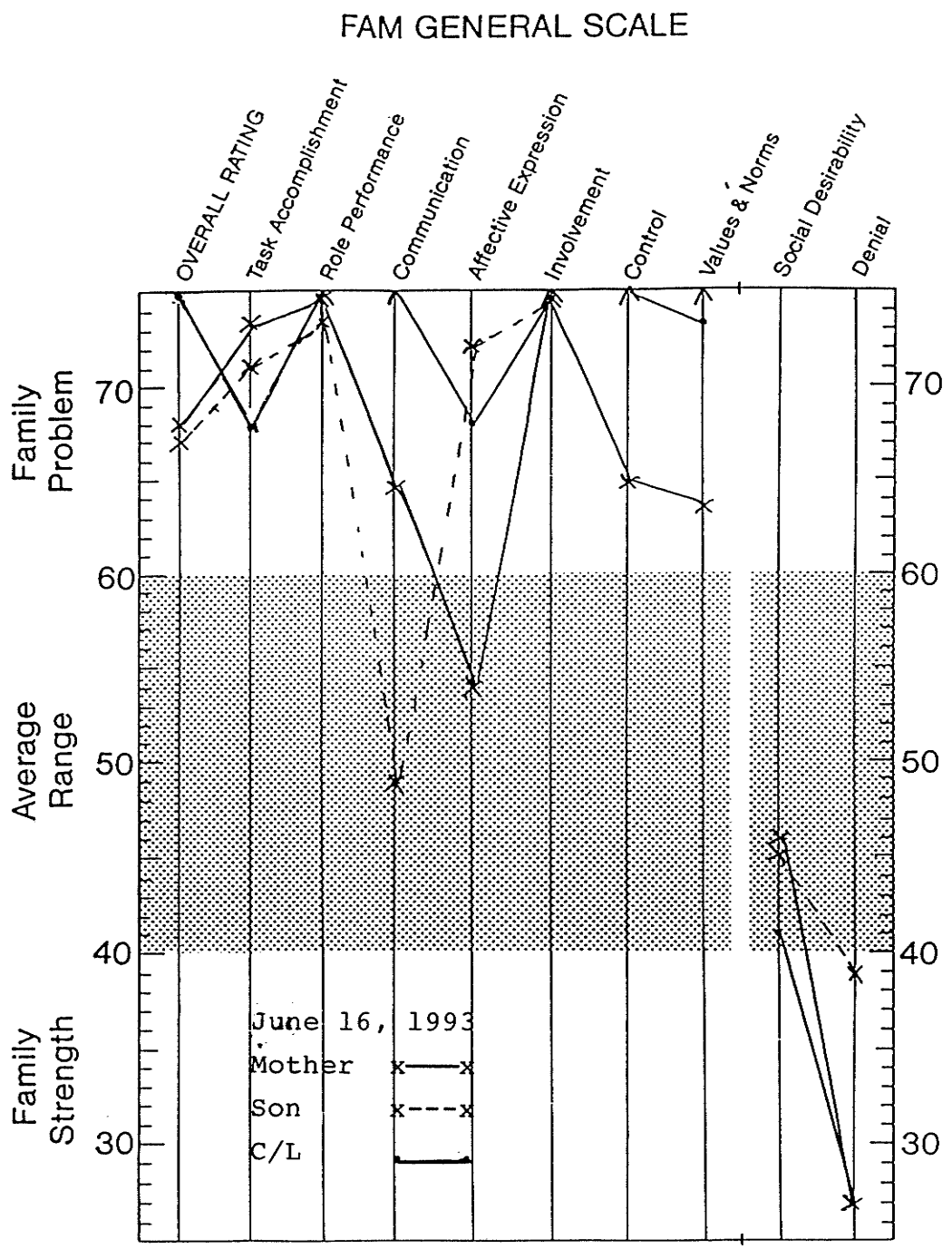
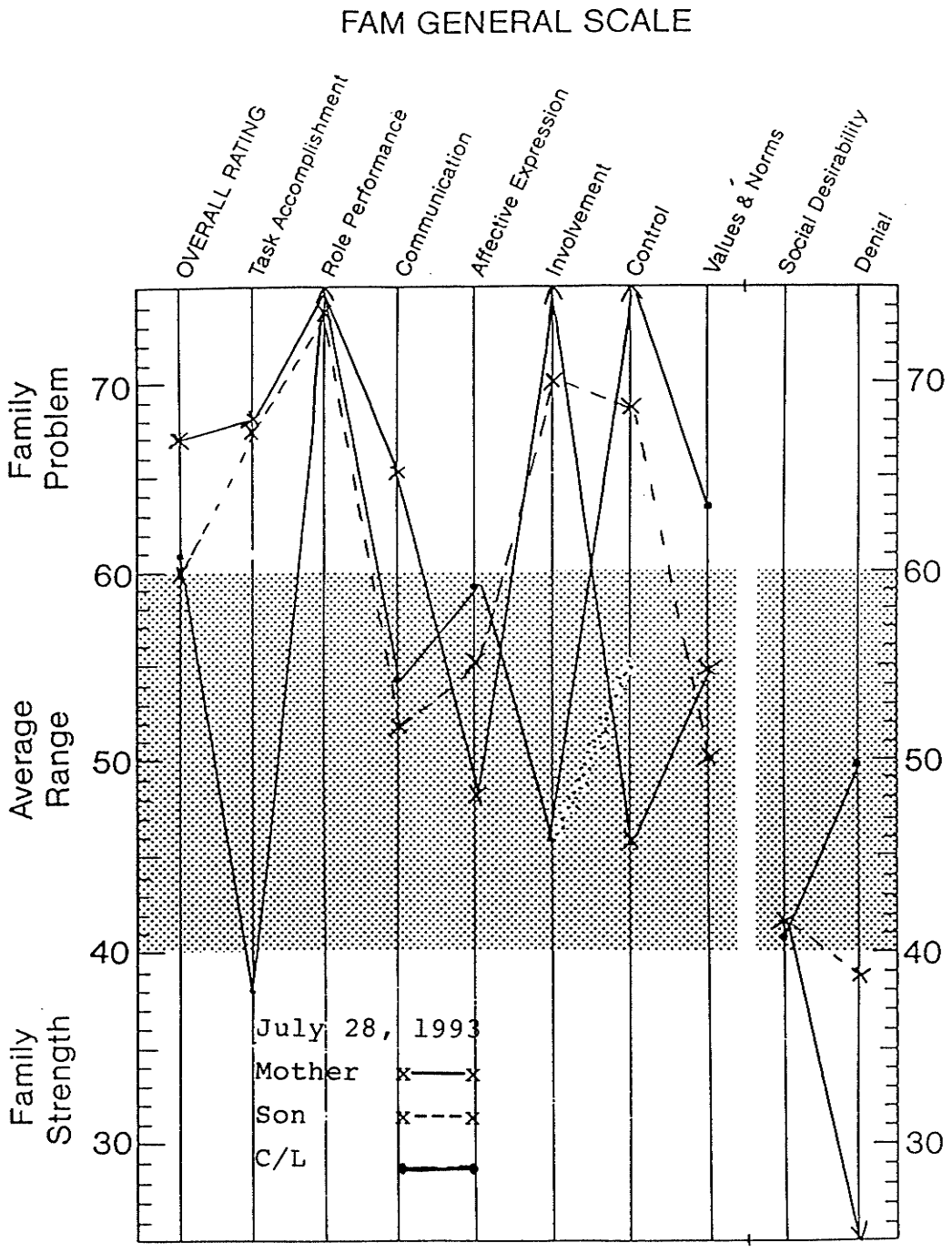


figure 10

Post Test Profile for Family F Using the Family Assessment Measure (FAM III)



Personal Evaluation and General Findings of the FAM III

Generally speaking, it was noted that the person identified by the referral source as experiencing the difficulties had the highest overall rating in the pre-test component of the FAM III measure. In addition, for the most part, the FAM III profiles presented a view of the family which was congruent with clinical observations. In the majority of the cases it was interesting to this writer that family members identified certain areas defined in the FAM III measure with similar intensity which depicted that for the most part, family members viewed their problematic areas in much the same way and experienced similar realities. Skinner et. al., (1983) state "the more congruence there is among the profiles of the various family members, the greater the likelihood that the scores are valid and that family members share a common perception of their family (pp. 8). However, it should also be noted that Skinner et. al., (1983) state that "social desirability and defensiveness scales below 40 do not guarantee the validity of the scales, as there may be other distortions that are not being measured (i.e. projection). Therefore, this needs to be taken into consideration for families C and F as their noted scores for desirability and defensiveness did fall slightly below 40. In accordance with this information, the validity of these families scales needs to be assessed with caution.

The FAM III evaluation instrument was found to be extremely sensitive and accurately depicted the various problematic concerns identified by families during the initial session. The pre-test scores generally provided a confirmation of clinical impressions, and the degree of difficulty that each

family was experiencing. The post-test scores provided results reasonably consistent with the perceived treatment outcome, however, for family D the post-test scores far surpassed this writers assessment given the magnitude of the stated concerns and chaotic, unstable history that this family had endured. Appendix C provides the results from each family member that attended the sessions and completed the pre and post-test FAM III instrument.

Personal Evaluation and General Findings of the CSQ Measure

The Client Satisfaction Questionnaire (CSQ) incorporated in this practicum while not adapted exclusively for the Community Intervention Program (CIP) is one that is utilized by the Peel Children's Centre. This evaluation tool was administered at termination and/or at the end of this writer's practicum and also provided useful feedback regarding the therapy process. Clients were requested to complete the questionnaire and either give it back to this writer or mail it in directly to the agency. The specific Client Satisfaction Questionnaire (CSQ) utilized in this practicum can be located in Appendix B of this report.

All six of the families serviced were satisfied with the service that they received. They stated that they felt they had been understood, that the therapist was empathic and genuinely interested in their problems, and most advised that if they were to seek assistance again in the future, they would return to the agency. While each family member was provided with a Client Satisfaction Questionnaire, not everyone completed it. Each family, however, did provide at least one completed form and several provided additional comments on the back of the forms. No family reported any adverse affects of

the therapy process and no negativity was expressed. The most interesting results were obtained from question number three which stated "I was encouraged to express my views about what might be helpful for me/my family". All families assigned a rating of 1 to this question which indicated that they totally agreed. Therefore, the solution focused approach was successful in validating the families stated concerns and provided the basis for contracting client goals. In addition, it also supports the notion that families felt supported and encouraged in the knowledge that they had within them the ability to solve their own stated problematic issues.

Clients were encouraged to make additional comments on the back of the questionnaire. This writer asked that they write both positive and negative comments and left it up to each individual to write as much or as little as they felt comfortable doing. While few individuals made any additional comments, some made the following: Mary (family A) stated that she and her husband felt that this writer had taken the time to hear and understand them, and that she was thankful for this writer's assistance. In addition, she wrote that they had initially thought that things were worse than they really were, and that they now had a better outlook on their family and appreciated their children more. Laurie (family C) wrote that she had a better appreciation of the difficulties that her children were facing and said "thank-you". Hannah (family D) advised that she was very nervous before meeting this writer and after the first session she felt very comfortable. On the back of her questionnaire she wrote that family therapy felt O.K. and that she was made to feel comfortable. She further advised that she appreciated not being blamed for the problems which the family faced. In addition, Josie (family D) stated that she had enjoyed attending sessions.

Summary

While each of these case examples are different and each family system very unique, the above case synopses clearly demonstrates the applicability of the solution focused approach and its techniques. Although, a general solution focused framework was adhered to throughout the practicum, specific solution focused techniques and tasks were custom made and therefore, case specific to meet each family's unique needs. While the solution focused approach was not deemed successful in all cases, this writer states confidently that this approach was viewed positively with each and every family serviced during this practicum. This approach served the purpose of providing or starting to provide each family with a different perception of their presenting problems. Furthermore, each family's problem resolution skills based on their own inherent strengths were enhanced which gave them the knowledge and/or confidence that they had the ability to effectively solve their own problems. Moreover, this therapeutic process enhanced each family's repertoire of problem solving skills which would assist them in dealing with problematic issues should they arise in the future.

Chapter - 5 - Family Feedback and Personal Evaluation of the Practicum

Of the four families where this writer was the primary therapist, the FAM III profiles depicted that therapy was successful in two of the cases (albeit in one case - family D, the solution may be short term in duration). While Family B neglected to complete any of the evaluation tools, they advised via a telephone conversation that their original stated concern/problem had been eliminated after just one session. Although, Family C cannot be termed a successful case as depicted by their post-test FAM III scores, it is important to note that this family was able to engage in the therapeutic process but were not yet ready to become "customers" of service. For the two families (E and F) where this writer worked conjointly with a colleague from the Community Intervention Program, the post-test component of the FAM III which was administered at the end of the practicum clearly indicated that after 8 and 7 sessions respectively, these families had made significant gains. This was depicted both in their FAM III profiles and as articulated by the family members during this writer's final session with them and via their completed Client Satisfaction Questionnaires. The duration of sessions ranged from 1 (family B) to 12 (family D). In the two cases (E and F) where therapy was not completed at the end of this writer's placement, the primary therapist for these cases continued to provide service to the maximum 12 session limit.

Overall, the practicum was a positive experience for both this writer and the families that were serviced. The brief solution focused model was effective in five of the six family situations encountered, as it reduced the intensity of the families problems to within the average range of functioning or to a level that was more tolerable. While no evaluative measures were completed for family B and therefore, this positive outcome cannot be definitively substantiated, they did

advise this writer verbally that their presenting issues were eliminated after just one session.

In order to illustrate the overall effectiveness of this therapeutic model, the average pre and post-test results were computed for the parents of the five families who completed the evaluative instruments, and then these scores were aggregated. The children's FAM III profiles were not taken into account as not all of the children participated in the evaluation process. After completing the necessary mathematical computations, the aggregate pre-test score was 72.1 and the aggregate post-test score had dropped to 65. Thus, the brief solution focused model was effective in reducing clients complaints/problems, and improving their level of functioning. While the aggregate post-test score was still within the family problem area, there was still a significant overall improvement from pre-test to post-test. It is important to note that the aggregate post-test score would have been lower had it not been for families E and F who were both still actively engaged in therapy and had not yet completed the therapeutic process. However, of equal importance is the fact that these two families had made considerable improvements as indicated via their post-test scores which were obtained after the eighth and seventh session respectively.

The solution focused model afforded both the families serviced and this writer an efficient and practical means of solving problems. For the most part it created dramatic changes and initiated the inherent probability that the initial changes would continue to be expressed and that new growth could continue to emerge. This model of therapy is a useful and effective one given that it often promotes rapid change. Clients frequently found the sessions to be enjoyable and refreshing and frequently said thank-you at the end of sessions and on occasion, advised that they looked forward to attending the following session.

Conceptually, a solution focus seems to hold a good deal of promise. One example of the kind of conceptual difference that the solution focus made was that it defined therapy as a process during which this writer in collaboration with the families constructed something (a solution) rather than fixed something (a dysfunction). Clinically, a primary value of a solution focus is that, in general, therapeutic tasks were built on thoughts, feelings and behaviors that were already used by the families. This served to enhance the rapport between therapist and client(s) as well as augment the level of cooperation because this writer did not demand that clients think, feel or behave in ways that were foreign to them. The core principle held by this model and one which was promoted throughout this practicum is that clients already know what to do to solve the complaints they bring to therapy; they just do not know, that they know. Consequently, this writer's job as a brief therapist was to help them construct for themselves a new use for knowledge they already had. Therefore, clearly stated, the solution focus is a very respectful and validating method of therapy. Clients responded positively to a solution focused approach as illustrated by the positive feedback received via the Client Satisfaction Questionnaire (CSQ), and as noted throughout the therapeutic process with them.

It would appear that there are some cases that cannot be concluded within as brief a period as others and/or ones that are not as emendable to the solution focused approach given its structural limitations. Specifically, for those cases in which there is a long history of emotional and /or physical trauma and/or generational issues, a longer period of time and a more intensive analysis may be required in order for the survivors to recover and heal from their pain. While this may have been a contributing factor with family C, it is believed that the outcome of this case may also have been a result of this writer's limited skill

level as well as the family members assumed roles of "visitors/complainants" of service. However, this writer still maintains that this family will undoubtedly benefit from the futuristic orientation inherent within this model. Specifically, the solution focused approach initiated the process of encouraging this family to discover, amplify, and build exceptions. This will undoubtedly enable them to begin to view their situations differently and open up and expand their possibilities for change.

Evaluation of Personal Skill Development

The theoretical and clinical skills learned throughout this practicum and the benefits gained via the reflective process of reviewing this report are significant. While evaluating one's own skill acquisition is a subjective process as it is enhanced by personal perceptions, previous professional experiences, education and training, there are a number of areas which clearly developed as a result of this practicum at the Peel Children's Centre. Perhaps the most notable change has been the acceptance of a healthy, functional view of clients presenting complaints as opposed to a problem saturated stance. In addition, a new perception of the role of the family "therapist" emerged. Specifically, it is very reassuring to know that the role of the family therapist is not to be an expert on each families presenting complaint(s) as previously thought. Moreover, this writer has learned that this assumption was not only extremely onerous, but also irresponsible. This model and the experiential application of it served to highlight that the role of the family therapist is to "punctuate the differences between the complaint pattern and the pattern of the exception (change) thereby making explicit the naturally occurring variations which are in the direction of the desired solution (Kral & Kowalski, 1989)

The theoretical foundations and techniques inherent in this model, coupled with the utilization of it has consolidated past learning and professional experiences at a new and more intensive level of understanding. There is a sense of having built a solid foundation of professional practice. The solution focus is by nature an open, expansive and evolutionary model which has been adopted and utilized in this writer's current position as a family therapist.

Strengths and Limitations

The solution focused model is deemed to be very effective, however, like all others is not immune to problems and/or limitations. The following strengths and limitations were noted by this writer throughout the practicum and have been intensified after reflecting on this experience and on the previous case synopses.

The perceived strengths of this model include the following:

1. The use of proactive and optimistic language (i.e. when the problem is solved) and systematically focusing the client system on solutions and the future rather than on problems and their causes in the past, enabled this writer to engage with the families quickly and easily during the first session. In so doing, this writer was able to build good rapport and collaborative relationships developed which enhanced the therapist/client relationship and set a solid base on which to draw on in subsequent sessions.
2. A solution focus introduced genuine collaboration into the helping process. It madepossible individualized and family work and mobilized ingenuity and energy to perform tasks.
3. It was very helpful and beneficial to differentiate clients as "visitors" "complainants", and "customers" of service. This provided an overview of who

was most concerned and willing to do something about the presenting problem/complaint. In addition, it assisted this writer in fitting appropriate responses to individual members as well as the assigning of tasks.

4. The exploration of exceptions to presenting client complaints has also been extremely beneficial as it assisted in the formulation(s) of goals and related tasks. The use of this strategy was central to all cases and highlighted throughout the entire therapy process with all families. This technique became clearly evident with family B as they were unaware of the changes that they had made which had resulted in solutions and ultimately to the resolution of their presenting complaint. These were discussed and identified as solutions within the first and only session with this family and highlighted as such, which provided clarity for them and encouraged them to continue to search for such exceptions in the future.

5. Lastly, by breaking down vague global problems presented by families into small, workable and identifiable goals, this writer was able to give her clients the hope and the knowledge that change was not only possible but inevitable. This provided all families with a more empowered approach to the solutions of their presenting problems/complainants.

Limitations

The primary perceived limitation of this model is one of practice logistics. While the solution focused language and the underlying premise that clients have the ability to solve their own problems is imperative to effective social work practice, this model does not address the formulation of working hypotheses. Specifically, this model guards against therapists thinking in "causal" terms in respect to clients presenting problems/complaints and/or taking into account their histories. In the cases outlined and detailed in the previous section

of this report, this focus appeared to be a little simplistic for some cases as their histories were so intertwined and enmeshed with their presenting issues. Therefore, this writer on occasion needed to look beyond this models structure in order to formulate necessary working hypotheses. Specifically, many of the families presented with very chaotic histories and multifaceted issues (families C, D, E and F) which this writer felt to some degree impacted their presenting problems. For these families, it was necessary at times to look beyond the information which was presented, and with the assistance of Brenda Bolliger formulate working hypothesis which guided and supported the therapeutic process. This is not to negate the strengths of this model as this writer strongly believes that the inherent proactive stance of the therapist; solution focused language, and; respect and trust in client's abilities to solve their own problems should be maintained throughout the entire therapeutic process.

In addition, the theoretical premises inherent in the solution focused model are a good fit with this writer's practice techniques and beliefs. Specifically, this writer adheres to the model's theoretical foundations which are proactive and highly optimistic in providing clients with the hope that change is not only possible, but inevitable (de Shazer et. al., 1986). Furthermore, this writer also adheres to the concept that it is essential to focus on client strengths instead of pathology and that therapy should be a joint endeavor which involves both the therapist and client system working together to construct mutually agreed upon goals (de Shazer, 1991).

This writer states confidently that this model offers both the family and the therapist an efficient and practical means for solving problems. The role of the therapist is seen as a shift from initiating change to constructing and initiating solutions (Lipchik & de Shazer, 1986). "The solution focus emphasizes exceptions

to the rules of the problem rather than the rules of the problem itself" (Molnar & de Shazer, 1987, pp. 350). Miller (1992) states that by generating discussion about such exceptions to the complaint, the therapist and client system create the opportunity for solutions to completely emerge. This model proports that any exception to the complaint is a potential solution since it lies outside the constraint of the problem and the accompanying world view (de Shazer & Berg, 1988). Theses authors further state that clients can often describe exceptions to the problem, but that these exceptions are not considered significant. "For clients, these are not viewed as differences that make a difference and therefore, making these differences make a difference is at the heart of the therapists Job" (pp. 42). The solution focused model is an innovative form of therapy which encompasses the ethical guidelines for social work practice and one which this writer believes encourages and promotes health and competence.

Chapter - 6 - Conclusions and Summary

In summary, the intrinsic benefits of this model are multifaceted as it is both palatable to clients and successful in nature. Logistically, it makes sense that in order for brief therapy to be satisfactory and successful, the present needs to be relevant to the future. Otherwise, there is no sense in the client system doing something different or in seeing something differently. When the future, expressed in terms of goals, is drawn in specifics, i.e., in behavioral terms, and the goals are ones established by the client system, then doing something now (in the present) to attain those goals makes sense. This writer learned that goals need to be described in minimal terms, they need to be achievable and they need to be perceived by the client system as difficult enough to demand effort.

Once exceptions (and/or hypothetical solutions) are seen by the client system to make a difference and are seen as associated with the goal, then the present is clearly salient to the client's future and the client's task becomes the arduous one of making the exception into the rule. Without the expectation that things can get better, therapy makes no sense. Therefore, it is very important that the solutions to client's problems fit within their worldview. de Shazer (1988) discusses how people often view their problems and the possible solutions within an either/or framework. He notes how this conceptualization is exclusive as it limits perceptions and solution development, while keeping people stuck in their problems. de Shazer (1988) proposes that many solutions can be found and fit within a "both/and" conceptualization which allows for the inclusion of a greater amount of

information. The expansiveness of this orientation promotes the development of an expanded worldview and of subsequent solutions. de Shazer (1988), proposes that one does not need to really know what the problem is. Identifying exceptions and what the solution will look like is sufficient.

The operational principle of starting where the family is at, is imperative. This approach demonstrates to the family the relationship between family interaction and the problem. It improves the means of interaction; and examines, then establishes and reinforces, appropriate vehicles for family development, growth, and stability. This process allows the client system to observe its own process(es), to establish new and better modes of communication and support, and ultimately, to the reduction or elimination of the presenting complaint and the reinstatement of a more satisfactory way of life.

Clients usually come to therapy totally blinded to positive possibilities by the negative emotions evoked by their problems. For example, for all the families serviced during this practicum, most initially presented as hopeless. They were so overwhelmed by their sense of grief and sadness that their inherent abilities and strengths appeared to be non-existent and the possibility of solutions appeared almost inconceivable. Specifically, the parents (Mary and Ben) in Family A, mother (Hannah) in Family C, and the parents in Families E and F were so consumed by their need to vent their anger and frustration that this writer's attention and emphasis on positive family attributes and successes was likely obscure to them. While eliciting such negative information and details about the complaint is important, it is

only useful for the purpose of distinguishing client's future expectations and to allow them to feel heard and understood.

The building blocks for solution construction are a focus on clearly defined goals, recognizable steps toward their achievement, and the bits of positive information elicited during the interview. Various direct and indirect techniques are selected by the therapist to maintain a cooperative climate, including compliments for existing efforts and strengths, task assignments, and reframing. Brevity is not a goal but a natural byproduct of the guiding principles about cooperation versus resistance, the systemic ripple effect and an inductive methodology.

While the literature on the solution focused approach is abundant, there is a need for increased research in the overall effectiveness of this therapeutic model. There needs to be evaluative procedures that substantiate the specific interventions and their impact on family functioning, as well as what types of family problems and in what situations, a solution focused approach is beneficial as well as when and why it should and should not be used. Therefore, therapists need to be comfortable and competent in using evaluative methodologies to substantiate the utility of the solution focused approach as well as other modes of therapy. While research on the solution focused approach is currently very limited, the literature on this therapeutic model is expanding in density and popularity at a fast pace. Therefore, it is likely that in time, more time and energy will be devoted to research in this area so that this approach will have a more definitive empirical base.

This writer believes that the advantages for the therapist practicing brief solution therapy are twofold. First, it is much less stressful to work in a climate of cooperation with the client system than to be confrontive, trying to break down their so called "resistance". When the therapist maintains the mind set of cooperating with clients (Berg, 1992; de Shazer, 1985, 1988, 1991) and respecting their way of solving problems, these families will offer many opportunities for therapists to learn from them. Adaptation to the way the client system sees their lives is not only a respectful thing to do but also a prudent move that promotes cooperation in therapy. It is the therapists responsibility to be sensitive to the client systems world view and try to fit with this view as closely as possible. Second, the ultimate responsibility for change rests on the client. Too many therapists struggle for years with clients who will not change according to the therapeutic treatment goals they have set. In solution-focused work, the therapist must use every strategy possible to help the client help her/himself. Even if therapy in not deemed successful, it is possible and even likely that clients will begin to take some responsibility for their own solution or leave and return at a later date when they are more ready to do so. Such maybe the case for family C.

Given the theory learned in University and the related practice techniques which this writer adhered to working in the field, she believed that the problem(s) that the client system brought to the therapeutic process was of primary importance if the problem(s) was to be solved. However, the theoretical knowledge gained and clinical application of a solution focused approach has served to significantly change this theoretical foundation. Doing solution oriented therapy has changed this writer's

practice beliefs. She now has a deeper respect for people's inherent abilities to resolve their difficulties. The more this writer observed people making significant changes easily, the more she believed it is possible, even with difficult cases. The more this writer believed that people can change their lives, the more this belief was reflected towards her clients. Learning to be a brief therapist has stretched this writer's thinking. With increased practice utilizing the solution focused approach in her current position, this writer regularly sees individuals and families making enduring changes in their lives. It is highly probable that solutions to problems were frequently missed because they often looked like mere preliminaries. The theoretical foundation now adopted and adhered to, is that the solution(s) in and of itself, is its own best explanation.

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Appendices

Appendix A

Multi-Health Systems, Inc.

Publishers of Professional Assessment and Practice Materials.

Michelle Hudson

August 24, 1993

Dear Ms. Hudson:

Multi-Health Systems, Inc. and the Psychology Department are granting you permission to include the Family Assessment Measure III (FAM III) in your practicum report for your Masters of Social Work degree.

Congratulations and good luck in your future endeavors.

Sincerely,

Debra Green
Psychology Department

65 Overlea Blvd., Suite 210, Toronto, Ontario, M4H 1P1
908 Niagara Falls Blvd., North Tonawanda, NY 14120-2060
Tel: (416) 424-1700 Fax: (416) 424-1736

Table 1a

GENERAL SCALE: ADULTS-NORMAL FAMILIES

STANDARD SCORE CONVERSION										
RAW SCORE	TA	RP	COM	AE	INV	C	V-N	SD	DEF	RAW SCORE
0	23	24	26	26	34	26	29	23	12	0
1	28	28	31	30	38	31	34	25	16	1
2	33	33	35	35	42	36	38	28	19	2
3	38	37	40	40	46	41	42	31	23	3
4	43	42	45	44	50	46	47	33	27	4
5	48	47	50	49	54	51	51	36	31	5
6	53	51	54	54	59	56	56	39	35	6
7	58	56	59	58	63	61	60	41	39	7
8	63	60	64	63	67	66	64	44	42	8
9	68	65	69	68	71	71	69	47	46	9
10	73	70	73	72	75	76	73	49	50	10
11	78	74	78	77	79	82	78	52	54	11
12	83	79	83	82	83	87	82	55	58	12
13	88	83	88	87	87	92	86	57	62	13
14	93	88	92	91	91	97	91	60	65	14
15	98	93	97	96	95	102	95	63	69	15
								65	73	16
								68	77	17
								71	81	18
								73	85	19
								76	88	20
								79	92	21
									96	22
									100	23
									104	24

Standard Score: mean = 50, standard deviation = 10

OVERALL RATING = average of the 7 clinical scales

(exclude SD and DEF) in standard scores

Table 2a

GENERAL SCALE: ADOLESCENTS-NORMAL FAMILIES

STANDARD SCORE CONVERSION

RAW SCORE	TA	RP	COM	AE	INV	C	V-N	SD	DEF	RAW SCORE
0	24	25	26	25	34	27	27	24	18	0
1	29	30	31	30	38	31	31	27	21	1
2	33	34	35	34	42	36	35	29	25	2
3	38	38	39	38	46	40	39	31	28	3
4	43	43	44	42	50	44	42	34	32	4
5	48	47	48	47	54	48	46	36	35	5
6	52	51	52	51	58	52	50	39	39	6
7	57	56	57	55	62	56	54	41	42	7
8	62	60	61	59	66	60	58	44	45	8
9	67	64	65	64	70	64	61	46	49	9
10	71	69	70	68	74	68	65	49	52	10
11	76	73	74	72	78	72	69	51	56	11
12	81	77	78	77	83	76	73	54	59	12
13	85	82	83	81	87	80	76	56	62	13
14	90	86	87	85	91	85	80	58	66	14
15	95	90	91	89	95	89	84	61	69	15
								63	73	16
								66	76	17
								68	80	18
								71	83	19
								73	86	20
								76	90	21
									93	22
									97	23
									100	24

Standard Score: mean = 50, standard deviation = 10

OVERALL RATING = average of the 7 clinical scales (exclude SD and DEF) in standard scores

Table 3

FAM INTERPRETATION GUIDE

1. TASK ACCOMPLISHMENT

LOW SCORE (40 AND BELOW) STRENGTH	HIGH SCORES (60 AND ABOVE) WEAKNESS
- basic tasks consistently achieved	- failure of some basic tasks
- able to respond appropriately to changes in the family life cycle	- inability to respond appropriately to changes in the family life cycle
- functional patterns to task accomplishment are maintained even under stress	- problems in task identification, in generation of potential solutions, and in implementation of change
- task identification shared by family members, alternative solutions are explored and attempted	- problem solving generally ineffective
- effective problem solving	- minor stresses may precipitate a crisis, which is liable to become chronic
- relatively resistant to crisis; those that do occur are short-lived	

2. ROLE PERFORMANCE

LOW SCORES (40 AND ABOVE) STRENGTH	HIGH SCORES (60 AND ABOVE) WEAKNESS
- roles are well integrated; family members understand what is expected, agree to do their share and get things done; little role conflict	- insufficient role integration, lack of agreement regarding role definitions; considerable role tension and conflict
- members adapt to new roles required in the development of the family	- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles not prominent	- idiosyncratic roles prominent

3. COMMUNICATION

LOW SCORES (40 AND BELOW) STRENGTH

- necessary information is successfully exchanged
- messages are direct and clear
- receivers are available and open to messages sent
- mutual understanding usually exists among family members

HIGH SCORES (60 AND ABOVE) WEAKNESS

- communications are insufficient, displaces or masked
- necessary information is frequently not exchanged effectively
- lack of mutual understanding among family members
- inability to seek clarification in case of confusion

4. AFFECTIVE EXPRESSION

LOW SCORES (40 AND BELOW) STRENGTH

- affective communication characterized by expression of a full range of affects, at an appropriate time and with correct intensity

HIGH SCORES (60 AND ABOVE) WEAKNESS

- inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotional discharge, often at times not appropriate to the situation

5. AFFECTIVE INVOLVEMENT

LOW SCORES (40 AND BELOW) STRENGTH

- empathic involvement
- family members' concern for each other leads to fulfillment of emotional needs (security) and promotes autonomous functioning
- quality of involvement is nurturant and supportive

HIGH SCORES (60 AND ABOVE) WEAKNESS

- absence of involvement among family members, or merely interest devoid of feelings
- involvement may be narcissistic, or to an extreme degree, seen as excessive or intrusive
- family members may exhibit insecurity and lack autonomy
- enmeshment seen clinically will score high in affective involvement only if the rater recognizes that the fusion is pathological

6. CONTROL

LOW SCORE (40 AND BELOW) STRENGTH

- patterns of influence permit family life to proceed in a consistent and generally acceptable manner
- able to shift habitual patterns of functioning when necessary to adapt to changing demands
- control style is predictable yet flexible enough to allow for some spontaneity
- control attempts are more likely to be constructive, educational and nurturant than excessively shaming or blaming
- few power struggles, with those there are usually solved on the basis of "what fits" rather than "who's right" or "who wins"
- oppositionality and passive aggressiveness usually infrequent

HIGH SCORES (60 AND ABOVE) WEAKNESS

- patterns of influence do not allow family to master the daily routines of ongoing family life
- failure to perceive and adjust to changing life demands
- may be extremely predictable (rigid and lacking spontaneity) or chaotic
- control attempts are destructive or shaming and/or ineffectual
- style of control may be too rigid or extremely laissez-faire
- characterized by overt or covert power struggles: "who's right" or "who wins" usually more important than solving the problem ("what fits")
- oppositionality and possessive -aggressiveness common

7. VALUES AND NORMS

LOW SCORES (40 AND BELOW) STRENGTH

- consonance between various components of the family's value system
- family's values are consistent with their subgroup and the larger culture to which the family belongs
- explicit and implicit rules are consistent
- family members function comfortably within the existing latitude

HIGH SCORES (60 AND ABOVE) WEAKNESS

- components of the family's value system are dissonant resulting in confusion and tension
- conflict between the family's values and those of the culture as a whole
- explicitly stated rules are subverted by implicit rules
- degree of latitude is inappropriate

Appendix B

Peel Children's Centre

Form sent out on: __/__/__
Form received back on: __/__/__
Data entered on: __/__/__
Copy to Director/clinician on: __/__/__
yy mm dd

CLIENT QUESTIONNAIRE for: _____

To help Peel Children's Centre to provide quality services in the community, we would appreciate your feedback on this questionnaire.

Please start by telling us if we can share your comments with your workers. (check off your choice (✓) below).
YES, YOU CAN SHOW THIS FORM TO MY WORKERS:(___)

PLEASE DO NOT SHOW THIS FORM TO MY WORKERS:(___)

OR **I DO NOT WISH TO COMPLETE THIS FORM (please do not send me a reminder letter): (___)**

Now, please circle the number to the right of each comment which most closely represents your view:

KEY:

1	2	3	4	5
Totally Agree	Mostly Agree	Not Sure	Mostly Disagree	Totally Disagree

	COMMENT	YOUR VIEW
1.	I understood why I was referred to P.C.C.	1 2 3 4 5
2.	The worker/team listened carefully and considered my view of the concerns seriously.	1 2 3 4 5
3.	I was encouraged to express my views about what might be helpful for me/ my family.	1 2 3 4 5
4.	I provided the worker/team with relevant information to assist them in understanding my concerns.	1 2 3 4 5
5.	The worker/team and I arrived at a common understanding of the concerns and services to be offered.	1 2 3 4 5
6.	The service was helpful.	1 2 3 4 5
7.	Services were provided within a reasonable period of time following the referral.	1 2 3 4 5
8.	I received enough service.	1 2 3 4 5
9.	If I were to seek help in the future I would return to P.C.C.	1 2 3 4 5

PLEASE WRITE ANY ADDITIONAL COMMENTS YOU MAY HAVE ON THE BACK OF THIS FORM

Thank you for your help!

qaclnt10.adm

Appendix C - Overall Pre/Post Test Results Using the FAM III General Scale

The following table represents the Pre-Test and Post-Test scores for all five families that completed this evaluative instrument. As stated previously, there is no data for family B as they did not complete the FAM III. The first number under each scale is the Pre-Test standard score and the second number represents the Post-Test standard score. For families A, C, and D this writer was the primary therapist and for families E and F, this writer worked conjointly with a colleague from the Community Intervention Program (CIP) who also employed a solution focused approach.

Family - A	Overall		TA		RP		COM		AE		INV		C		V-N		S.D.		DEF	
Mother	59	53	63	60	60	51	64	54	54	49	56	46	56	56	56	56	47	54	46	46
Father	60	52	63	60	60	47	59	59	63	54	50	42	66	56	60	51	47	50	50	42

Family - C	Overall		TA		RP		COM		AE		INV		C		V-N		S.D.		DEF	
Mother	63	60	63	63	74	65	59	59	58	49	59	63	61	63	69	69	28	39	39	46
Son	71	67	76	76	51	50	74	70	68	68	70	66	80	70	76	73	49	49	25	32
Daughter	46	44	38	44	51	43	52	43	51	39	50	50	44	42	39	44	36	38	32	32

Family - D	Overall		TA		RP		COM		AE		INV		C		V-N		S.D.		DEF	
Mother	61	50	53	43	56	42	69	50	68	58	63	54	61	46	60	51	41	52	42	54
Son	59	-	62	-	51	-	74	-	77	-	50	-	56	-	46	-	42	-	40	-
Daughter	57	45	57	48	56	38	61	44	72	51	54	54	56	48	46	35	43	54	42	56

Family - E	Overall		TA		RP		COM		AE		INV		C		V-N		S.D.		DEF	
Mother	66	58	83	58	88	74	59	64	54	44	59	59	66	51	56	56	46	39	40	38
Son	56	56	57	57	69	64	61	61	55	51	58	58	56	52	46	46	39	41	40	42

Family - F	Overall		TA		RP		COM		AE		INV		C		V-N		S.D.		DEF	
Mother	68	67	73	68	74	88	64	64	54	49	87	87	66	46	64	56	46	42	27	23
Son	67	60	71	67	73	73	48	52	72	55	74	74	80	72	80	50	45	42	39	39
C/L	75	61	68	38	79	74	83	54	68	59	75	46	82	82	73	64	41	41	27	50