

PRACTICUM

TROUBLED ADOLESCENTS IN THE FAMILY SYSTEM:  
SOLUTIONS IN BRIEF FAMILY THERAPY

BY  
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**TROUBLED ADOLESCENTS IN THE FAMILY SYSTEM:  
SOLUTIONS IN BRIEF FAMILY THERAPY**

**BY**

**JOHN SMYTH**

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

**MASTER OF SOCIAL WORK**

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To my wife, Shelley, for all her love and support.

And in memory of my parents Ruth and Laurence Smyth  
who helped teach me the meaning of family.

## **ABSTRACT**

### **Troubled Adolescents in the Family System:**

#### **Solutions in Brief Family Therapy**

Adolescence is a time in the life cycle which is often associated with conflict in the family system. This practicum involves the application of a Structural/Brief Family Therapy approach with adolescents and their families in an out-patient mental health clinic. Family context including life cycle and developmental stage is viewed as an important area in the understanding of adolescents. The intervention is applied to a range of presenting problems and family forms. The purpose of this practicum was to learn the skills to successfully work with this population and to find out if Minuchin's Structural Family Therapy in combination with de Shazer's Brief Family Therapy was found to be effective. Evaluation instruments included The FAM-III General Scale, a Problem Checklist, a Hopelessness Scale, the Brief FAM, client feedback, a termination summary and various self evaluation methods. The evaluation instruments support the use of this approach with the identified population. Two case examples are presented to illustrate this approach and discuss the results of the evaluation.

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## INTRODUCTION

In my five years experience as a child and family services social worker, a large percentage of families presented with and identified their adolescent as the problem. Through my involvement with these troubled adolescents, it became clear that their families had a significant role in the presenting problem. The number of these families served became so large that I began to wonder if any family did not have problems with its teenager. Preto (1989) and Minuchin (1974) would agree that one of the most common precipitants of problems in families is the transition time of adolescence. It is a time in the family life cycle in which families seek help or are referred by an external system such as courts, schools and physicians (Preto, 1989). It is important to note that although it is common to have problems during the adolescent stage of the family life cycle, only about twenty percent of non-patient adolescents report serious trouble in this period of life. Therefore it is not typical or "normal" for adolescents and families to experience high levels of conflict (Fishman, 1988; Garbarino, 1986; Hall, 1987).

For the purpose of this practicum, troubled adolescents will include all adolescents who are identified as the problem by the family or others when they request or are referred for therapy. All of these adolescents present with various issues which can be viewed on a continuum from internalized symptoms such as being withdrawn, to externalized symptoms such as violent verbal and/or physical outbursts against family members or others.

According to Garbarino (1986), in order to understand adolescence you must understand the contingencies of social context. Understanding troubled adolescents means understanding the mix of circumstances surrounding troubled youth in troubled families. Consistent with this thinking, Carter and McGoldrick (1989) argue that context is important in order to understand individuals and families. "The family is more than the sum of its parts. The individual life cycle takes place within the family life cycle,

which is the primary context of human development" (Carter and McGoldrick, 1989, p. 4). Furthermore, Garbarino's and Carter and McGoldrick's understanding of context fits within systems theory. Systems theory views a problem as a systems problem and not the problem of one individual (Hall, 1987).

Families are systems that operate through patterned sequences of interaction (transactions). These patterns underpin the system and its structure (Minuchin, 1974). The structure provides a framework and influences the development of each individual. You cannot see the structure of a family. It becomes visible to the therapist through the process of interaction of family members. A structural assessment provides a framework that provides a "theoretical link between the symptoms family members present and the observable interaction" (George Enns, unpublished paper, p. 13).

Steve de Shazer's model of Brief Family Therapy is based on systems theory. According to de Shazer et al (1986), most complaints start and are maintained in the context of human interaction. Solutions to complaints are found in changing interactions in the context and constraints of the situation.

De Shazer's model of Brief Family Therapy fits with the structural theoretical framework in the following way. Minuchin's structural framework is a way to view and construct a hypothesis regarding troubled adolescents and their families. It is also a way to teach family therapy interns the skills of assessing a family by looking at transactions, interactions and patterns - the context. Context is the connection to de Shazer's Brief Family Therapy model. Although de Shazer does not openly say he utilizes context in his model it could be argued that he has been influenced by his education, experience and other well known brief therapists such as Haley, Weakland, Fisch, etc. (Bryan Woods, Personal Communication, Sept., 1990). These influences have effected the way he works and utilizes context, only he is so practice and experienced as a therapist that, on the

surface, it looks as if he does not utilize context when it is a fundamental characteristic of his approach.

In short, Minuchin's structural framework fits with the de Shazer model of Brief Family Therapy. Context is an integral part of both paradigms. This is not to say there are not many differences between these two approaches. These differences are not the focus of this practicum.

In summary, although it may appear that most adolescents have difficulty during this stage of the family life cycle, only about twenty percent report serious conflict. Therefore those who do present with troubles, should be taken seriously and not just passed off as a phase associated with a stage of life. Context is an important area in the understanding of adolescence and a key factor in the treatment of troubled adolescents and their families. Salvador Minuchin's structural paradigm provides a framework for assessment as well as an intervention. The combination of the structural paradigm with Steve de Shazer's model of Brief Family Therapy is the treatment of choice because they both look at context. In addition, the Brief Family Therapy Model focuses upon strengths and is solution oriented.

My interest in troubled adolescents in the family system follows from my work experience, my own family of origin issues and my education. Through these various experiences I have come to believe that families have a powerful impact on individuals' emotional health.

### **Objectives of This Practicum**

1. To increase my knowledge of the dynamics of troubled adolescents and their families.
2. To increase my knowledge and skill in the structural (Minuchin) assessment and intervention of troubled adolescents and their families.

3. To increase my knowledge and skill in the application of Steve de Shazer's model of Brief Family Therapy with troubled adolescents and their families.
4. To increase and practice my clinical skills in working with families in a supervised setting.
5. To learn more about the adolescent stage of the family life cycle and how this fits within a structural assessment and brief family therapy intervention.
6. To learn if the combination of Minuchin's Structural Paradigm and de Shazer model of Brief Family Therapy is effective with troubled adolescents and their families.

### **Organization of the Practicum Report**

This report is organized into eight chapters. The report begins with the previous introduction which identifies the client population (adolescents and their families) and the reasons for utilizing the structural/brief approach with this population. The introduction also outlines the practicum objectives. Chapter One provides the literature review on adolescence in a family context, discusses what is normal and abnormal conflict, as well as discusses why a family context is important. Chapter Two provides the literature review on Salvador Minuchin's structural family therapy. Chapter Three discusses the literature review on Steve de Shazer's brief family therapy and provides a summary and synthesis of the two approaches.

Chapter Four, Practicum Methods, Procedures and Evaluation Instruments, reports on the setting, clients, personnel, duration of the practicum, method of evaluation, the instruments and how these are applied, and ends with the educational benefits. Chapter Five, The Application of the Integrated Approach, introduces the nine families involved in the practicum. As well, it includes one case example to illustrate the structural/brief approach and discusses the results of the evaluation, including the results of the measurement instruments. Chapter Six, Further Application of the Integrated Approach, provides a second case example which also illustrates the approach and discusses the evaluation results. This chapter includes a brief summary of what I learned from these two case presentations. Chapter Seven, Common Findings, reports on the commonalities that I found amongst the nine families involved in this practicum and links these findings to the literature review. The final chapter (Chapter Eight) is the conclusion and provides overall statements of the major findings of this report.



## CHAPTER ONE

### LITERATURE REVIEW

#### Overview of the Changing Family Life Cycle

Superimposing the Family Life Cycle Framework on individuals and families is a way to add depth to the clinician's view (Preto, 1989). Symptoms and dysfunctions are viewed in relation to "normal" functioning over the period of time of the family life cycle. Therapy is viewed as aiding the re-establishment of the family's developmental process (Preto, 1989). Problems are framed along a continuum of tasks that the family has moved along in the past, the present, and towards the future.

According to Carter and McGoldrick (1989), family stress is often greatest when the family changes from one developmental stage to another. They believe that symptoms are likely to appear when there is a dislocation or interruption in the course of the family life cycle.

Relationships between family members go through stages as they move along the life cycle. The family as a system has different properties from other systems. You can only become a new member through marriage, adoption or birth and can only leave by death and even that is debatable. With no way to leave the family and no apparent alternative way to function available, pressures can build and in the extreme lead to psychosis (Preto, 1989).

The main value in families is in the relationships, which are irreplaceable. If a parent leaves or dies, another person can be brought in to fill a parenting function, but this person can never replace the parent in his or her personal emotional aspects (Carter and McGoldrick, 1989, p. 6).

In Carter and McGoldrick's (1989) view, family is made up of the emotional system of at least three or more generations. This emotional system is present at any given time and it is not restricted to family members of a given household or one nuclear

family. For example, a nuclear family living in one home is reacting to the emotional subsystem of the past, present, and possible future relationships within the three generational system (Preto, 1989).

People cannot alter whom they are related to in the complex web of family ties over all the generations. Obviously family members frequently act as if this were not so - they cut each other off because of conflicts or because they claim to have "nothing in common" - but when family members act as though family relationships are optional, they do so to the detriment of their own sense of identity and the richness of their emotional and social context (Carter and McGoldrick, 1989, p. 7).

Family process is not linear but it does exist in the linear dimension of time. There is no unifying task from a multi-generational view. For example, three or more generations accommodate life cycle transitions all at the same time. Things that occur in one generation have an effect on relationships at other levels.

There is evidence that stress which occurs around life cycle transitions often creates disruptions in the life cycle which produce dysfunctions and symptoms (Hadley, 1974; Walsh, 1978; Orfanidis, 1977 cited in Preto, 1989). The flow of anxiety in a family is viewed as both vertical and horizontal (Carter, 1978, cited in Carter and McGoldrick, 1989).

The vertical flow in a system includes patterns of relating and functioning that are transmitted down the generations of a family primarily through the mechanism of emotional triangling (Bowen, 1978). It includes all the family attitudes, taboos, expectations, labels, and loaded issues with which we grow up. One could say that these aspects of our lives are like the hand we are dealt: They are the given. What we do with them is the issue for us (Carter and McGoldrick, 1989, p. 8).

The horizontal flow includes the anxiety produced as the family moves through time. It includes the developmental life cycle changes and unpredictable events such as an unexpected death of a family member, illness or the birth of a handicapped child.

Families will appear dysfunctional given enough stress on the horizontal axis. Even if the horizontal stress is minimal but the vertical axis is loaded with stress, the family will experience significant disruption.

In Carter and McGoldrick's view (1989), the degree of stress where the vertical and horizontal axis meet is the key determinant of how well the family will manage the various transitions through life. To a degree, all change is somewhat stressful, but when the developmental stress (horizontal axis) intersects the trans-generational stress (vertical axis), there is a large increase in anxiety in the system.

Families characteristically lack time perspective when they are having problems. They tend generally to magnify the present moment, overwhelmed and immobilized by their immediate feelings; or they become fixed on a moment in the future that they dread or long for. They lose the awareness that life means continual motion from the past and into the future with a continual transformation of familial relationships (Carter and McGoldrick, 1989, p. 10).

Within the past generation, there have been many changes in the patterns of the family life cycle which have changed the meaning of family. For example, child rearing used to consume adults for their entire life span, now it occupies less than half the time. The middle-class American family which Carter and McGoldrick (1989) discuss is more or less mythological. This view of the family is created by existing patterns and by "ideal" standards of the past by which families compare themselves.

As a clinician, it is important to recognize these changes and to assist families to stop comparing their structure and life cycle changes with that of a 1950's family.

### Overview of Adolescence in the Family Life Cycle

Change in the family structure and organization required to deal with the tasks of adolescence is so fundamental that the family itself is changed from a system that protects and nurtures young children to one that prepares adolescents for the responsibilities and commitments of the adult world (Preto, 1989). This family transformation involves profound changes in relationship patterns across generations. These changes may be initiated by the adolescent's physical maturation but often parallel and exist at the same time as other changes in the family, such as parents entering mid-life and grandparents entering old age.

All of these changes take place within the larger social context. In the past the family was the major economic unit. Its main purpose now, in North America, is to provide an emotional support system with external systems taking on the role of teaching, employment and setting limits (Preto, 1989).

Adolescence often demands structural changes and re-negotiation of roles within families, sometimes involving three or more generations (Preto, 1989). Adolescents' demand for more independence and autonomy initiates changes in relationships across the generations. For example, young children may question their position in the family, parents may re-negotiate their marriage and/or redefine their relationship with grandparents. Adolescents' demands are sometimes so strong they serve as catalysts for bringing forward emotional issues and setting triangles in motion (Preto, 1989). In attempting to meet the demands of the adolescent, unresolved conflicts may be brought to the surface between parents, and between parents and grandparents. Triangles may involve the mother, the father, and the adolescent; a parent, a grandparent, and the adolescent; a sibling, a parent, and the adolescent; or the adolescent's peers/friends, a parent, and the adolescent (Preto, 1989).

As conflicts arise at this stage in the family life cycle, efforts to resolve the issues "often repeat earlier patterns of relating in the parents' family of origin.... There appears to be a reciprocal chain reaction of meeting and making demands across the generations that is precipitated by the adolescents of the younger generation" (Preto, 1989, p. 256).

During this same time families are also adjusting to new demands of the other family members who may also be entering new stages of the family life cycle. In many families with adolescents the parents are approaching middle age and may be focusing on mid-life issues such as marriage and careers. The "normal" stress exerted on the family by an adolescent is exacerbated when parents are dissatisfied and feel forced to make changes in themselves (Preto, 1989). At the same time, grandparents may be experiencing retirement, moving, illness and death. These changes in turn call for a change in relationship between the parents and grandparents. Often the stress of these various changes is transmitted both up and down the generations.

### **Tasks of Adolescence**

The origins of this family transformation are the adolescent's developmental tasks that begin with the rapid physical growth and sexual maturation during puberty. As a result of sexual maturation, moves toward solidifying an identity and establishing autonomy from the family (which are really lifelong developmental processes) are accelerated during adolescence .... To establish autonomy they need to become gradually more responsible for their own decision-making and yet feel the security of parental guidance (Preto, 1989, p. 257).

In an attempt to reduce the conflicts during this time, families will often use solutions that worked in earlier stages of the family. Parents may emotionally withdraw to avoid conflict, make even more demands in an attempt to gain control or blindly

accept or reject the adolescent. In turn the adolescent will act in such a way as to try and win their own way.

### Sexuality

Puberty not only involves change in the physical self, but also signals the beginning of the psychological transition from childhood to adulthood (Hopkins, 1983, cited in Preto, 1989). There has been a general trend towards earlier maturation for both males and females called the "secular trend" (Preto, 1989). These physical and sexual changes effect how adolescents see themselves and how they are perceived by others. "Coping with this upsurge in sexual thoughts, feelings, and behaviours is a major task for all family members" (Preto, 1989, p. 258). Parents who are comfortable with their own sexuality appear more able to accept the heightened sexuality in adolescents. If information is openly shared in the home there is greater likelihood of setting realistic limits and tolerating minor violations. This context provides adolescents with an environment in which they can express this new part of their lives (Preto, 1989). If this context is not present and the parents try to deny, reject or ignore the adolescent's growing sexuality, the development of a positive sexual self concept is diminished (Preto, 1989). "The probability of increased feelings of alienation between adolescents and their parents is greater and risks of premature, excessive, or self-endangering sexual activity are increased" (Preto, 1989, p. 259). The parents' own experiences influence the way they set expectations and limits as well as the extent to which they include adolescents in decision making. In general, parents who had a positive experience at home and with peers are more likely to provide a positive experience for their own children versus those parents who were rejected, abused and neglected (Preto, 1989).

Additionally, as the adolescent's sexuality emerges the possibility of an increase in incestuous impulse arises between the adolescent and the opposite sex parent.

Increased conflict could develop due to the energy and unacceptability of these urges (Preto, 1989).

The same sex parent tends to become more competitive with the adolescent. In psychoanalytic theory, they compete for the attention of the opposite sex parent (Freud, 1962; Blos, 1962, cited in Preto, 1989). Another view is that they compete over their different views of appropriate gender roles (Preto, 1989). According to Hopkins (1983, cited in Preto, 1989) adolescents are more stereotypical in their view of sexuality and this sexuality is expressed more than in any other age group. Following this thought further, it makes sense that there would be conflict with the same sex parent and the adolescent, as the parent serves as the primary role model during childhood. "Much of the conflict between parents and adolescents reflects differences in the way each generation interprets the stereotypes and double standard about sexual roles that exist in this society" (Preto, 1989, p. 259-260).

### **Identity**

"Identity refers to a person's private view of those traits and characteristics that best describe him or her" (Preto, 1989, p. 260). Identity undergoes its largest change during adolescence. Our understanding of this process has been based on the work of Freud and Erickson. "Freud focused on sexual drives and on the process of individuation (Blos, 1962), while Erickson (1968) identified adolescence as a period when individuals experience an identity crisis, which when resolved, leads to commitments to sociopolitical conceptualizations and occupation" (Preto, 1989, p. 260).

One area these theories neglect is the role that gender differences play in the way both sexes structure their identities. The few studies that exist in this area report that females generally rely more on relationships and connections they make while males place more emphasis on individuation and separation (Chodorow, 1974; Gilligan, 1982, cited in Preto, 1989). According to Broverman et al. (1970, cited in Preto, 1989), most

developmental theories, based on the studies of men, assume the male pattern is the norm, which creates a double bind for women because traits that characterize the concept of 'ideal women' are different from those that describe the 'ideal adult'. "The 'ideal adult' is seen as having more of the traits that characterize the 'ideal man'. This inconsistency in role expectations makes gender consolidation especially difficult for females during adolescence when this process seems to be accentuated" (Preto, 1989, p. 260).

The changes which occur in adolescent identity formation can be the source of conflict in families. The adolescent's new found ability in intellectual functioning increases his feelings of mastery and creativity (Inhelder & Piaget, 1958, cited in Preto, 1989). These ideas and attitudes act as catalysts for other family members to make changes.

Gender is an important part of identity formation. The same sex parent-child relationship has a powerful effect on this process. Adolescents' views of who they are, are strongly connected to their feelings of being male or female. Relationships with the opposite sex parent are equally important, as they validate adolescents' sexual identities and model to a degree their future relationships with the opposite sex (Preto, 1989). "In their attempt to provide positive role models, parents often teach ideals about sexual roles rather than communicate to their children the value of their own experience" (Preto, 1989, p. 261).

In short, parents tell their children "Do as I say, not as I do". Inevitably, inconsistencies arise which give rise to conflict when the adolescent challenges these differences (Preto, 1989).

### **Autonomy**

Adolescents need to spend time away from their home to learn to become more self-reliant and independent. In this process, relationships with peers become stronger.



Adolescents need acceptance and nurturance to develop separate identities. At the same time they need encouragement and permission to be more responsible for themselves. "Autonomy does not mean disconnecting emotionally from parents, but it does mean that an individual is no longer as psychologically dependent on parents and has more control of making decisions about his or her life" (Preto, 1989, p. 262).

Uncertainty in knowing how to find this balance between nurturance, and encouragement to be more responsible, are common for parents of adolescents (Preto, 1989).

Families who encourage adolescents to participate in decision making, but in which the final decisions are made by the parents, are more likely to move toward autonomy. On the other hand, families which do not encourage participation in decision making and self-responsibility tend to encourage dependency and less self-assurance in the adolescent (Newman & Newman, 1979, cited in Preto, 1989). Interestingly, the same conditions which build independence also build closeness between parents and children (Newman & Newman, 1979, cited in Preto, 1989).

The parents' tolerance for their adolescent's move to autonomy will be compromised if they have not achieved emotional autonomy from their own parents. In addition, if the parents have unresolved conflicts between themselves, they will have more difficulty accepting their adolescent's move towards autonomy.

#### **Attachment, Separation, and Loss**

As adolescents become more involved with peers outside their home, their decreasing involvement at home is often experienced as a loss by other family members. The move from childhood to adolescence is a loss for the family - the loss of the child (Preto, 1989). Parents often feel this change as a void because they are no longer needed the same way by the adolescent and their caretaking relationship needs to change (Preto, 1989).

The task of separation is more difficult when the parents are unable to provide support. In these situations, parents can be overwhelmed and respond by trying to control the adolescent or just giving up control. Attempting to control adolescents and lock them within the family at a time when they should be separating may result in symptomatic behaviour. Families which become overwhelmed may just give up and as a result seek a solution by premature separation. This type of separation may lead to a permanent cut off in the family. For these adolescents there is increased risk for a variety of difficulties including self-inflicted and other inflicted violence (Preto, 1989). The parents and other children in the family are also effected by the expulsion of the adolescent as they try to sort out their own transitions (Preto, 1989).

"All change implies the acceptance of loss" (Preto, 1989, p. 266). Some parents experience depression with the loss of the dependent child. The adolescent must also learn to deal with the changes in themselves and their relationship with their family.

Loss in the parents' history can complicate this stage. Studies have found connections between early loss and development of symptoms later in life (Orfanidis, 1977; Walsh, 1978, cited in Preto, 1989; Aiken, 1985).

Sex, ethnicity, race, social class, place of residence, education, and support network all have a strong influence on the family life cycle (Preto, 1989).

Families handling the tasks of adolescent experience transformations in structure and organizations, which are initially disruptive and create confusion. Most families, however, adjust to the changes without major difficulty and move on in the life cycle, but some, unable to make the transition, become symptomatic. In therapy, unlocking the system to allow movement becomes the goal (Preto, 1989, p. 281).

### **What is Normal and Abnormal Conflict in Adolescence?**

Many professionals who work with adolescents view adolescence as a stage of life which is normally stormy and stressful (Garbarino, 1986). Garbarino (1986) traces the root of this view back to the work of psychologist G. Stanley Hall (1844 - 1924). Hall was influenced by the work of Darwin and biologist, Ernest Haeckel. In Haeckel's view, the biological development of an individual repeated the principal stages of the evolution of the species. Hall utilized this idea and made a comparison between the stages of human development with the stages of human evolution. In Hall's view, adolescence is a time when the adolescent struggles to balance the humane impulses of the civilized person with the more primitive impulses of the savage. The struggle to balance these two impulses results in the normal storm and stress of adolescence (Garbarino, 1986). Hall's theory of adolescence did not gain wide acceptance but it did begin the argument that human behaviour was influenced more by biology (genetics) than by environment - the nature versus nurture argument. Hall's idea that adolescence was normally a time of stress and storm also remained and continued to influence theories of adolescent development.

Sigmund Freud's psychoanalytic view of adolescence is one of the theories influenced by Hall. Freud's theory has had a major influence on how various mental health professionals deal with adolescents. Freud's view is different from Hall's but they shared the common view that adolescence is a stormy and stressful time and that this is based on biological influences.

Anna Freud saw adolescence as a developmental disturbance which is the result of the reawakening of libidinal impulses that involves the movement from latency to puberty (Garbarino, 1986). In her view, teenagers experience conflict as they try to balance what behaviour society dictates as acceptable, with their oedipal impulses. In childhood, defences such as rationalization, projection and repression keep these oedipal

impulses from awareness and therefore the child escapes the turmoil which is felt in adolescence. As the child moves into adolescence, these defences become more inappropriate as they cannot deal with the powerful sexual drives that arise in adolescence. As a result, teenagers must throw out their old systems and build new ones. This whole process results in the ups and downs and rebellion of being a normal adolescent.

This 'period of upheaval' is a healthy, normal expression of development, but during it adolescents will reject their parents (in response to the unacceptable desire to possess the opposite sex parent) and enter into a series of intense but brief romantic involvements with their peers (as they learn to accept and adapt to their new-found sexuality). Parents and other adults will perceive this behaviour as 'rebellion'. This provides a theoretical explanation for the stereotyped view of adolescents as being necessarily 'rebellious' (Garbarino, 1986, p. 8).

According to Anna Freud's psychoanalytic view, the storm and stress of adolescence which comes in the form of conflict with parents is a normal and necessary part of development. In fact, if this upheaval is not present, it is viewed as abnormal (Freud, 1958, cited in Garbarino, 1986). This view in turn removes the support for the idea that acting out behaviours are indicators of family conflict, psychopathology or disrupted development. This in turn may influence our view that the behaviour can be cast off as just a phase, when, in fact, it could represent a 'real' problem.

Having stated all this, research has found that adolescents are not normally rebellious (Garbarino, 1986). Research by Westley and Elkin (1956, cited in Garbarino, 1986) and by Douvan and Adelson (1966, cited in Garbarino, 1986) demonstrates that adolescents do not go through major turmoil and conflict. Garbarino (1986) adds further that psychiatrists and psychologists have a limited view of what the normal adolescent

is like because they normally see only those adolescents who have come to their attention due to some form of distress.

An extensive study on normality in adolescence was done by Daniel Offer and Colleagues (Offer, 1969, Offer and Offer, 1973, 1974, 1975; Offer et al 1981, cited in Garbarino, 1986). Offer identified three main patterns of growth in the adolescents that he studied. Only one of these patterns fits with the stress and storm theorist's view. This pattern only accounted for approximately twenty-one percent of the adolescents in the study with the remainder going through adolescence with little turmoil. The twenty-one percent is large enough to show that there certainly are many troubled adolescents, but there are not enough to claim that the stress and storm is a typical adolescent pattern.

Another study by Rutter et al (1976, cited in Garbarino, 1986) examined a sample group of teenagers in Great Britain. They found only a small difference in psychopathology from childhood to adolescence and a low incidence of parent-teen conflict. They also found approximately the same percentage of adolescents experienced turmoil as in the studies by Offer - twenty-two percent.

In a study of college students they found only twenty-two percent stated they were rebellious as adolescents (Balswick and Macrides, 1975, cited in Garbarino, 1986). In another study, little evidence was found for the normal stress and storm reported by other theorists (Bandura and Walters, 1959, cited in Garbarino, 1986). Studies of other non-clinical populations support the view that conflict and turmoil is not the normal or typical developmental pattern for adolescence (Grinker et al, 1962; Hamburg et al, 1974; Oldham, 1978; Weiner, 1982, cited in Garbarino, 1986).

In summary, the average adolescent does not go through a stage of turmoil as a normal part of growing up. No developmental stage is free from conflict and stress. Adolescents have no monopoly on this aspect of the human experience. The previous

section on the family life cycle does indicate a degree of disruption and confusion which is normal and to be expected as families adjust and adapt to various transitions. However, this is not the same as what Garbarino calls turmoil and, therefore, the degree and intensity of the difficulty should be taken into consideration.

It is helpful to view the adolescent within the family life cycle framework. If the difficulty appears to be the result of the family not adapting to developmental change which persists over a period of time this may indicate that the family is "stuck" and may need therapy to move on in the life cycle. Troubled adolescents are not just in a developmental phase and therefore should be taken seriously.

### **Why a Family Context?**

When a child reaches adolescence, it means the family must adjust its patterns of interaction and authority to include a 'new' individual (Garbarino, 1986). What is new about the adolescent includes a change in cognitive competence, reproductive ability and stature. This new individual does cause disequilibrium in the family for a period of time while they work out and adapt to their new relationships (Hall, 1980, cited in Garbarino, 1986). The adolescent's increase in cognitive ability means that the family will have to accommodate to, and use a different level of reasoning in order to adjust to the teen's new abilities. In this sense, being a parent to an adolescent is different from being a parent to a child.

The changes that occur in the adolescent effect the relationships in the family. For example, the adolescent has more 'power' than as a child. This power includes: physical power to retaliate if treated physically by a parent, power to leave the family, power to hurt themselves or others, power to influence conflict in the home, power to make comparisons between their parents and others, power to embarrass parents and power to help others or themselves. This increased power can be a destructive force

especially when the parents and/or adolescent seem inflexible and unmotivated to negotiate and reach some compromise (Garbarino, 1986).

Another change in the adolescent which effects family relationships is the adolescent's growing contact and relationships with others outside the family. The family must adjust to these other contacts and their influence on the adolescent. This change can cause difficulty for parents who expect a degree of social isolation (Garbarino, 1986).

When the adolescent begins to become more involved with others outside the family, some parents feel rejected (Dreyfus, 1976, cited in Garbarino, 1986). This feeling of rejection may be felt more severely as a result of the parents' own relationship needs and or historical backgrounds (Pelcovitz et al, 1984, cited in Garbarino, 1986). In this situation there may be a rift in the family with regards to power and nurturance. This rift is unfortunate because it comes at a time in the adolescent's life when she needs family/parental support (Garbarino, 1986). On the other hand, if the parents are facing a mid-life crisis, they may feel the need for support from their adolescent (McMorrow, 1977, cited in Garbarino, 1986).

In all, there are many changes which require an adjustment in interaction and relationships. From this perspective, it is easy to see why many parents find the period of adolescence the most difficult (Pasley & Gecas, 1984, cited in Garbarino, 1986). There is no 'right way' in terms of finding a balance between how much freedom parents should allow and how much control is required. According to Baumrind (1979, cited in Garbarino, 1986), it is unwise to give adolescents total freedom, as if they are independent persons when they still are dependent, financially and socially on the parents. This line of thinking follows from the idea that adolescents lack the limits they would have if supporting themselves and, therefore, would develop unrealistic views of their future. This is an example of how the larger social systems influence the family.

It is also an example of how parental behaviour is understood within the context that it occurs in.

The way a family reacts to the adolescent's increased independence depends partly on the family structure (Garbarino, 1986). There is more conflict in families which are authoritarian or permissive than in what Garbarino (1986) calls authoritative homes.

In the authoritarian family, the parents are in charge and there is no room for negotiation. In this type of family there will be more conflict (Edwards and Brauburger, 1973, cited in Garbarino, 1986). In authoritarian homes adolescents are less likely to identify with their parents and will likely be resentful towards them (Flacks, 1971, cited in Garbarino, 1986). Receiving little acceptance from the family the teen may seek this from others outside the home. In their efforts to find attention and acceptance, they may become antisocial or disruptive. Authoritarian parents who are unable to adjust to the adolescents' needs for nurturance and independence, will likely find the period of adolescence full of conflict. This pattern can develop into a cycle where "the teenager's wild behaviour seems to justify the parent's harsh treatment, and vice versa" (Garbarino, 1986, p. 15).

In the permissive home, the adolescent is in charge. Parents that are overly detached, overly indulgent or overly protective all fit within the permissive style of parenting. Children who feel catered to in this way may feel resentful towards their parents when they reach adolescence and begin to have more contact with others outside the home (Garbarino, 1986). Parents who are too close make the adolescent feel smothered and this can also produce conflict when the adolescent starts to have contact with others outside the home. Lack of direction in the permissive home may cause problems, with the adolescent feeling rejected.

In the authoritative family parents negotiate with the children "to a degree appropriate to the child's development and in ways that enhance further development"



(Garbarino, 1986, p. 15). In North America authoritative parents have the best relationship with their children (Balswick and MacRides, 1975; Devereux et al, 1969; Scheck et al, 1973; Baumrind, 1975, cited in Garbarino, 1986).

These families do well because they are more practiced at negotiating. When the child reaches adolescence, the parents are more equipped to deal with the adolescent's increased cognitive abilities, yet at the same time allow the teen some control and autonomy.

Parents that are flexible will likely fair better with adolescents. It is difficult to understand a family as an outsider looking in because "so much of family life is bound up in what special meaning members attach to each other and their behaviour" (Garbarino, 1986, p. 16). Therefore we should be careful about making any conclusion about a family without first having tried to get an insider's view.

As well, it is important to acknowledge the special bond that exists between a parent and child. Children need to know they are loved and loved unconditionally.

It is difficult to say exactly how to parent an adolescent in any specific way. Both parents and adolescents need support.

To increase the probability that adolescents will make a successful transition to adulthood, adolescents need stable, supportive, and protective relationships with their parents .... Parents do not determine what their adolescents will become. The most caring and wise parents do not always succeed in producing competent, caring, and wise offspring (Garbarino, 1986, p. 17).

Having stated this, there is no other social system that has more influence on development than the family (Garbarino, 1986).

In summary, there are many changes in the adolescent which require adjustments in interactions and relationships within the family. Family structure plays an important part in how the family will react to these changes.

## CHAPTER TWO

### SALVADOR MINUCHIN - STRUCTURAL FAMILY THERAPY

Structural Family Therapy is a treatment model based on systems theory (Colapinto, 1982). The model's distinctive features are the emphasis on structural change as the goal of therapy and the therapist's role as an active change agent in this process. The following is a discussion of the basic principles of the model.

#### The Family

"The family is conceptualized as a living open system" (Colapinto, 1982, p. 116). The parts in every system are interdependent in ways that transcend individual functions within the system. The family structure is the set of invisible rules directing interactions within the family system (Minuchin, 1974). Interactions are part of transactions which form patterns over time. As an open system, the family is both influenced and effected by the environment. Therefore, a family's structure is influenced not only by their members, but also by society at large. As a living system, the family is constantly changing and evolving. This living system is regulated by the interplay of change and homeostasis (Colapinto, 1982). "Homeostasis designates the patterns of transactions that assure the stability of the system, the maintenance of its basic characteristics as they can be described at a certain point in time; Homeostatic processes tend to keep the status quo" (Jackson, 1957, 1965 cited in Colapinto, 1982, p. 117). Complementarity is the term used to describe transactions between individuals when the family is in a state of homeostasis.

Change is the re-accommodation of the system to a change in developmental need or in environmental circumstances. Birth, onset of adolescence, moving away from home, and marriage are examples of changes in development in the family life cycle. An unexpected death, illness, loss of a job or a promotion are events which call for changes in patterns.

Boundaries are the rules which define who participates and how (Minuchin, 1974). Boundaries serve to protect the differentiation of the system. "Every family subsystem has specific functions and makes specific demands on its members; and the development of interpersonal skills achieved in these subsystems is predicated on the subsystem's freedom from interference by other subsystems" (Minuchin, 1974, p. 53-54). In order for the family system to function properly, the boundaries must be clear so subsystem members can perform their functions without too much interference yet be flexible enough to allow contact between various members of subsystems and others (Minuchin, 1974).

According to Colapinto (1982), homeostasis and change are a matter of perspective. If you view the family process over a brief period of time, you would likely see the homeostatic mechanism operating and the system in equilibrium. If you view the process of the family over a longer period of time, you will see the evolution of change as different system patterns become apparent. Taking an even larger view covering the entire family life cycle of a system you would likely find homeostasis again in the various transitions and sudden re-accommodations as the system adjusts to these changes and tries to maintain or recover equilibrium.

The paradox of family evolution is their attempt to remain the same but in order to do this, they must accommodate which moves them into something different (Colapinto, 1982). This process stops when the family does not change to developmental or environmental demands. Thus the family does not make new rules for transactions and becomes stuck in its old patterns of interaction.

When families get stuck in their development, their patterns of transactions become stereotypical (Colapinto, 1982). The homeostatic mechanisms described earlier exacerbate the system as the system tries to rigidly follow the same pattern. When there is any movement away from this stereotypical pattern, the family quickly moves to keep

the status quo. Various dysfunctional patterns develop as a result of rigidly following this pattern such as triangulation, where a child is used within a parental relationship difficulty or intergenerational coalitions that overthrow various natural hierarchies (Colapinto, 1982). These dysfunctional patterns serve the purpose of avoiding open conflict. This avoidance contributes to a level of equilibrium, but at the cost of preventing differentiation and growth.

Enmeshed families are families in which there is a high level of conflict avoidance. These are families whose members become very close and boundaries become unclear. The strong ties within these families reduce the possibility of conflict. This kind of system can become overloaded and lack the resources to accommodate and change. At the other end of the continuum is the disengaged family system which develops overly rigid boundaries. Distance between members becomes excessive and as a result communication is difficult with the protective function of the family also being reduced (Minuchin, 1974). The rigidified pervasive style of the enmeshed and disengaged family is dysfunctional. Enmeshment and disengagement are largely determined by the context. For example, it is appropriate for a parent and an infant to be more enmeshed. Families that become stuck have a narrower view of themselves as individuals and as a family (Colapinto, 1982). This narrow construction of their reality leaves large portions of their potential resources unused and unavailable because they cannot see the resources that they have. Most families fall somewhere in the larger "normal" range between enmeshed and disengaged (Minuchin, 1974).

This fits with the family life cycle view and Garbarino's view, that the majority of adolescents and their families are able to adapt to the various developmental transitions and move on in the family life cycle without serious difficulty. It further adds to the belief that context is helpful in understanding. As well, Minuchin's structural paradigm is helpful in understanding patterns of transactions (structure) and therefore provides a

framework for understanding adolescents who do have difficulty. In addition, Minuchin's view that families who do become stuck have narrower views of their potential resources is similar to de Shazer's beliefs about families and points to congruence between these two models. This congruence is important because this practicum involves the application of an integrated structural/brief approach.

### **The Presenting Problem**

The problem is conceptualized as part of the family structure of transactions. Therefore the problem needs to be put into perspective by looking at the family context (Colapinto, 1982). The therapist tries to find the function and position of the problem behaviour by looking at the system as it supports the symptom (Colapinto, 1982). The therapist also interprets the structure of the family's perceptions in relation to the presenting problem. One of the principles of structural family therapy is that there are resources in the individuals and the family but these resources are not apparent to the individual or family. In addition, there is systemic support for this "blindness".

The "real" presenting problem for the structural family therapist is the interactions around the identified concern. One of the main elements of this view is the systemic support of the problem. The model's emphasis is on what maintains the problem and not what causes the problem. There is no claim of a causal path between the system and the problem (Colapinto, 1982). "Thus, instead of a simplistic, one-way causal connection the model postulates an ongoing process of mutual accommodation between the system's rules and the individual's predispositions and vulnerabilities" (Colapinto, 1982, p. 120).

The structural family therapist is focused on the current systemic support of the problem. "The model shares with other systemic approaches the radical idea that knowledge of the origins of a problem is largely irrelevant for the process of therapeutic change" (Minuchin & Fishman, 1979, cited in Colapinto, 1982, p. 120). In addition, elaboration and discussion of the history of the problem may hinder the process of

therapy by increasing the family's focus on the problem and therefore increasing and strengthening their view of what appears unchangeable.

This view is congruent with de Shazer's view that change can occur without knowing the person's past (Literature Review, p. 31). De Shazer's beliefs about expectations of change (Literature Review, p. 35) is also congruent with Minuchin's belief that elaboration and discussion of history may hinder the process of therapy because it reinforces the client's expectations that things will not work out. Both these ideas fit with this practicum's focus on an integrated structural/brief approach which is oriented towards the expectation of change (solutions) and is focused on the present and the future.

### **The Process of Therapeutic Change**

The structural family therapy model looks for solutions by altering the structure of the family which fits with the model's basic axiom that problems are the result of dysfunctions in the family structure. Change is therefore the process of assisting the family to alter its stereotypical patterns. The presenting problem is a part of these patterns.

This process takes place within the context of the therapeutic system which offers a chance to challenge the family's rules (structure).

The privileged position of the therapist allows him to require from the family members different behaviours and to invite different perceptions, thus altering their interaction and perspective. The family then has an opportunity to experience transactional patterns that have not been allowed under its prevailing homeostatic rules. The system's limits are probed and pushed, its narrow self-definitions are questioned; in the process, the family's capacity to tolerate and handle stress or conflict increases, and its perceived reality becomes richer, more complex (Colapinto, 1983, p. 121).

The main source used to expand the family's reality is the family itself. As discussed earlier, the structural family model believes that the family system blocks its own view of potential resources within its own system. The restructuring initiated by the therapist alters the system so these resources can be released. At the same time the therapist uses these new resources so the system can change (Colapinto, 1982). "The model is not just a cluster of techniques with specific indications, but rather a consistent way of thinking and operating, derived from the basic tenet that human problems can only be understood and treated in context" (Colapinto, 1982, p. 121). To make this point more clear, Colapinto (1983) states that the model's tenets provide direction in the solution of a problem that otherwise may seem incapable of justification which goes far beyond the practical application of techniques. It requires a change in attitude and perception. For example:

If the therapist finds the client to be disgusting ("undermining", "a bitch", "disqualifying") chances are that he will not join that person --- regardless of the techniques used. In order to join (or to challenge, for that matter) the therapist needs to actually see the best of his client, rather than pretend that he has seen it. The structural paradigm represents the glasses that facilitate such a perception (Colapinto, 1983, p. 12-13).

This approach is congruent with the brief approach which builds on the client's strengths. As well, the brief approach views the therapist's attitude and the way he sees the family and their situation as important because this influences the family's expectations of change, cooperation and the impact of the therapist.

### **The Therapist's Role**

The therapist's role is paradoxical in the sense that she must be supportive of the individuals and families while against the transactions that have brought the family into therapy in the first place. The therapist must develop a working relationship which

requires a degree of accommodation but only to a point that the therapist still maintains an element of power. This balance of accommodation and challenge is achieved through a process of probing, advancing and withdrawing.

According to Colapinto (1982) the therapist meets with the family having first constructed an initial hypothesis built from minimal intake information. Starting in the first session, as the therapist is joining the family, the hypothesis is tested, expanded and corrected. The therapist's attention is focused at information at the process level and away from content. People can convey information through process, which is often more accurate than verbal information. The therapist pays attention to what is said mostly as a way of learning the language of the family which will later be used to construct metaphors that will fit with the family and help enlist their cooperation. As the interview proceeds a map or description of the family begins to emerge in the therapist which depicts alliances, hierarchies and patterns.

This initial role of the therapist is consistent with the structural/brief approach utilized in this practicum.

The therapist is looking at how the system maintains homeostasis so that he can disrupt this pattern and push the family into equilibrium at a broader higher level. The therapist is also looking for strengths that will provide a direction for their questions and challenges.

Structural family therapy has mostly grown out of, and has been practice in the context of the family, where one of the children is identified as the problem (Colapinto, 1982). As the client population of this practicum is families who identify their adolescent as the problem, this particular model is appropriate.



### **Goals and Function of Therapy**

According to Colapinto (1982) the main goal of structural family therapy is the restructuring of the family's transactional rules. This restructuring enables the family to mobilize some of its own previously underutilized resources which improves their ability to cope. From the point of view of homeostasis, once the constricting set of transactional rules is outgrown, dysfunctional behaviours, including the presenting problem, lose their support in the system and become unnecessary. Therapy ends, once the family can maintain these changes without the challenging support of the therapist.

There is no ultimate cure in structural family therapy, as the model emphasizes changes and constant growth as fundamental features of the family system. According to Colapinto (1982), structural family therapists limit their involvement with the family to the minimum required to set in motion the family's own resources. This is congruent with the brief approach (Literature Review, p. 41).

In summary, Minuchin's structural family therapy places emphasis on the structural assessment of the family by looking at interactions, transactions and patterns (the context). This assessment is critical when developing tasks that fit the family and move it in the desired direction. The brief family therapy approach provides a means with which to utilize this information to promote positive change.

### CHAPTER THREE

#### STEVE DE SHAZER - BRIEF FAMILY THERAPY

Brief therapy should not be viewed in terms of time frames or number of sessions but as an approach which is focused on solutions for human problems (de Shazer, Kim Berg, Lipchik, Nunnally, Molnar, Gingerich, Weiner-Davis, 1986). According to de Shazer et al (1986), most complaints start and are maintained in the context of human interactions. Solutions to complaints are found in changing interactions in the context and constraints of the situation. "The task of Brief Therapy is to help clients do something different, by changing their interactive behaviour and/or their interpretation of behaviour and situations so that a solution (a resolution of their complaint) can be achieved" (de Shazer et al, 1986, p. 208). An intervention only needs to open the way to a solution which according to de Shazer et al (1985) can be done without knowing what is maintaining the complaint or without knowing the person's past. All that is required is that the client do something different.

Brief therapy may be more appropriately called efficient therapy as "Therapy should be as efficient and effective as possible, and brief therapy is built around ways of knowing when therapy is finished" (De Shazer cited in Sykes Wylie, 1990, p. 29). Solution oriented does not just mean finding the answer or way to solve a problem, it is an indirect approach which creates a context for change that focuses on the clients' strengths and resources and builds on these to initiate new behaviour and solve problems.

According to de Shazer the key to brief therapy is "Utilizing what the client brings with him to meet his needs in such a way that the client can make a satisfactory life for himself" (de Shazer, 1985, p. 6). Knowing what life would be like without the problem is viewed as more important than knowing details of the problem or complaint.

## **Principles of Brief Therapy**

### **Complaints**

De Shazer (1985) makes some assumptions about the construction of complaints. These assumptions help the therapist construct solutions. One of these assumptions is that "Complaints involve behaviour brought about by the client's worldview" (de Shazer, 1985, p. 23). People behave in a certain way because of their beliefs (worldview). For whatever reason they feel they are making the right (best, logical, or only) choice. When people do this, everything outside these beliefs or worldview is lumped together and excluded. It is like a horse wearing blinders. They have a limited view of the choices available to them.

The second assumption is based on the idea that people will continue to follow the same behaviour over and over because they have excluded other possibilities based on their worldview or belief system. As a result of their worldviews, people can respond to a given complaint in habitual ways; they do not remake the decision because they see the complaint as the same and therefore respond in the same old way. In this way an unhelpful pattern develops.

The therapist constructs the complaint and potential solution out of the same information as the client but with a focus on solution. This difference in emphasis causes the therapist to construct a therapeutic problem different from the complaint. This difference leads to solution. The therapist is able to do this because of the difference in emphasis. Once the therapist recognizes the pattern, any behaviour which is outside the person's worldview might make enough difference by moving the person out of rigidly following a certain choice to provide a solution.

### **Construction of Solutions**

Another assumption de Shazer (1985) makes is that the client will generate further changes once the therapist starts a minimal change towards solving the complaint. De

Shazer (1985) calls this change in the system the ripple effect. This ripple effect means that only a small change is required to produce differences in behaviour which can lead to inordinately large differences in the system. Asking the client about what life would be like without the complaint is a way for the therapist and the client to gain ideas about what to change. Just the suggestion of a different or new view may be enough to provide a solution.

### **Wholism**

The concept of wholism is an important part of brief therapy. This concept is based on systems theory as applied to people and their problems. In systems theory a family is not just a group of individuals. "A human system is more than the sum of its parts. It is not only the individuals included in the description but also the relationships between and among the individuals" (de Shazer, 1985, p. 105).

The concept of wholism allows the therapist to minimize and on the other hand utilize the complexity of the system so solutions can be constructed. A change in one part of the system will lead to changes in the system as a whole. For a solution to work, only a fit is needed, otherwise the solution would need to be as complicated as the human system and the problem system. Following this line of thought, solving the client's complaint does not necessarily mean seeing the whole family. As de Shazer (1985) states, the person who has the most pressing complaint is the one who most wants to work towards having something different happen. The interactional view suggests that "interaction between members of a social system is seen as the primary shaper and determinant of ongoing behaviour" (Weakland, 1983, cited in de Shazer, 1985, p. 107). Therefore a change in any one member of a family will lead to changes in behaviour of the other members in the system.

### Maps

Conceptual maps explain how to construct problems and solutions. These conceptual maps are descriptions of what is going on in therapy. Having more than one description or map as Bateson (1979) suggests "leads to a bonus of some sort: an idea which is of a different class than the class of descriptions (maps) used" (de Shazer, 1985, p. 50). The therapist makes two maps or more if working with a team behind a one way mirror. One map is of the clients' interpretation of their complaint. The second map is of how the therapist sees the client's interpretation. The difference between the two descriptions or maps provides the therapist with information which may lead to a solution and provides the framework for designing the intervention.

### The Concept of Fit

"It is the fit between the therapist's description of the complaint pattern and form and the map of the intervention which seems central to the process of initiating therapeutic change" (de Shazer, 1985, p. 60). If the intervention does not fit, then it is likely that the therapist will not initiate new or different behaviour and the client will remain stuck in her complaint. The intervention can be constructed in the same description or map used to describe the interaction between the various parts of the system. As well, it takes into consideration the context of the complaint which helps give the therapist an understanding of what the behaviour means. The concept of fit is that the intervention is based on the same interactional and contextual description or map of the complaint as interpreted by the therapist with the exception that the therapist's map has constructed a problem with a solution in mind. The therapist should look for the simplest explanation that fits without taking into consideration the complexity of the problem.

In this approach the actual complaint or problem is the client not the family or individuals. This approach allows the therapist to minimize what can be very complex

situations. If a therapist tries to match the complexity of the problem when thinking about the problem this can lead to further confusion instead of solution.

A therapeutic intervention only needs to fit the constructed problem in such a way that a solution develops. In this sense other interventions can also fit the constructed problem and also reach a solution but this approach does not tell you anything of these other interventions or how they fit. In this way this approach is general and not specific.

### **Cooperating**

In therapy, change is an interactional process involving both therapist and client. It is not something done to clients, it is something done with clients. De Shazer (1985) views therapy as a cooperative endeavour that involves the therapist and client jointly constructing a problem which can be solved.

### **Resistance**

If the therapist decides that the client's behaviour is resistant then they are unlikely to see any cooperative behaviour. Likewise if the therapist sees the client's behaviour as cooperative then they are unlikely to see any resistant behaviour. Brief therapy assumes cooperating instead of resistance. De Shazer (1990) views resistance as only a concept and that the concept of cooperating is much smoother and faster in therapy and therefore more efficient. What cooperation means for a particular situation or how it will fit depends on the client's response in that particular context.

### **Expectations of Change**

"Expectations states theory" (Berger et al, 1974, cited in de Shazer, 1985) is a theory of how interactional situations start and maintain patterns as well as about how these patterns change. For a situation to fit within this theory it must meet two conditions. One, the situation has to have a task or goal and two, those involved need to be working together to reach this task or goal. De Shazer's model involves a cooperative relationship between client and therapist working towards solving a

complaint. In this sense the model fits expectation states theory. Brief therapy is both collectively oriented and task oriented. Having a goal means the client has some expectation that there will be a positive change. When clients attend therapy they may have tried to solve the problem several times without success. Each failed attempt to solve the complaint maintains their expectation that things will not work out. They feel stuck. In this way their behaviour reinforces what they see happening.

Change in these expectations will happen when there is a change in the situation. This change in the situation alone does not promote change as the process as described above generates maintaining the same old expectations of attempts and failures. A therapist can intervene and promote change in behaviour with different outcomes which develop new and more successful expectations in the client. These new expectations are also self maintaining and the client has a better chance of developing a more satisfactory pattern.

There are ways a client could behave in the future without the complaint. Predicting just how the client would behave is difficult if not impossible to do. Rather than aiming for a specific way of behaving without the complaint, expectations can be made out of any successful or satisfactory change. Any change has the potential of starting the ripple effect which will lead to expectations of more success and so on. The therapist reacts to any change as an indicator that things are going in the right direction for the client. The type of change does not seem to matter even if it is not related to the complaint. Any change may be enough of a change to make a difference and be part of the solution. This is how the therapist uses change to create a new set of expectations that will be part of a successful solution.

At the start of therapy a resolution of a specific complaint may be the explicitly stated goal. Applying this approach to solving problems means that not only would that stated goal be the focus but so would other behaviours in that same class of behaviour.

As a result, a specific change is difficult to predict. The therapist's goal is a change in the context which will achieve what the client expects to change as a result of reaching the stated goal.

### **Future Made Salient to the Present**

Change is viewed as not something that might happen but as inevitable (de Shazer, 1985). Cooperation and the expectation of change can be promoted by connecting the future to the present. When the future is linked to the present and a positively constructed goal is established, behaviour in the present can be reconstructed and used as part of attaining the goal. The past, particularly past failures, are not helpful while past successes can be used to construct solutions.

### **Constructing Solutions**

One way to project the client into the future is to ask what would life be like for them and others when the problem is not present. In this way the client constructs their own solution. This information is used to guide the course of the therapy. Clients are able to make descriptions of what their life would be like. Once they have this picture they can do something different so their idea of the future without the complaint can become a reality (de Shazer, 1985). The more versions explored of what the future would be like the more clues and chances of success. De Shazer (1985) refers to this as the crystal ball technique.

### **Constructing Problems and Goals**

When a client attends therapy the nature of the problem and the possible solutions are subject to redefinition (de Shazer, 1985). For this reason in solution focused therapy, goals are very important. Without goals there is no end to therapy and the therapist and client could end up following the same unsuccessful pattern that the client has followed. Often clients have difficulty stating specific goals. When this occurs it is the therapist's role to define the problem in a way that a goal or vision of the future emerges which



does not include the complaint. The crystal ball technique is a way to create this vision. "What one expects to happen colors or 'determines' what is happening and what is going to happen" (de Shazer, 1985, p. 93). According to expectations states theory, expectations help determine what will happen in the future, therefore altering what one expects will change behaviour. When a goal is made the client expects that things will change and improve. This expectation affects their present behaviour. This makes the future salient to the present. Setting the goal and achieving the goal effects what happens. Having the client describe what the future will be like without the problem is important to the solution and success. The concept of "fit" can easily be achieved when the client rather than the therapist constructs his image of the future. Part of the therapist's task therefore is to help construct and clarify the client's expectations since these expectations are not created when the complaint is generating itself.

### **Application of the Model**

The first interview starts with a brief introduction and an explanation of what will happen in the session. The therapist then asks about the complaint with the intention of gaining as clear a description of what happens as possible. The more details about the pattern of the complaint, the more potential interventions and goals (de Shazer, 1985).

This leads to the next stage of the interview which is the exploration of the exceptions to the rule, that is, when and why the complaint does not happen. This stage often overlaps with the exploration of the complaint. If the client mentions an exception it should be explored shortly after it is mentioned. Exploring exceptions helps create the expectation that things can be different and helps lead the therapist and family into a discussion of goal setting. Specific goals are an important part of this approach.

After the goals have been established, the therapist focuses on what life would be like without the problem (solutions). In this way there is a focus on discussion of potential solutions throughout the interview. This helps the clients distance themselves

from the problem and look at their own and others' behaviour. This solution talk also helps the therapist decide what tasks should be assigned.

### **Intermission Consultation Break**

At this point there is a brief break in the session. The break is used by the therapist to design a therapeutic message (the intervention) (de Shazer, 1985). The intervention should take into consideration the type of relationship between the therapist and client. De Shazer (1988) divides the general term, client into three labels, "visitor", "complainants", and "customers" as a way to assist the therapist in deciding what type of intervention or task to assign.

Visitors are clients who seem to have no complaint and have attended therapy because someone told them to attend. If there is no complaint, therapy cannot begin and it would be unhelpful for the therapist to intervene, no matter how obvious the problem may appear. Any intervention that is assigned would likely be rejected and sets up a resistant relationship. In this type of client, therapist relationship, the therapist should give the visitor compliments but no task in the hope that the client will find the session a positive experience and return in a future session with a complaint.

Complainants are clients who attend therapy with a complaint and expect some type of solution as a result of attending. The distinction between this type of client and a visitor is that the complainant can be assigned a task with which they will cooperate. In this type of client, therapist relationship an observational or thinking task can be assigned.

Customers are clients who not only identify a complaint but also indicate they want and are willing to try something different about the complaint. In this type of client, therapist relationship an observational and behavioral task can be assigned with a degree of confidence that the client will do the task.

When a therapist is seeing a family, various members may be described as visitors, complainants or customers. The tasks assigned for each person needs to take into account the different types of client/therapist relationships. This view of the client/therapist relationship is all in an attempt to find tasks that fit with the client and assists in building a cooperative working relationship with the family.

If the therapist is working with a team behind a one way mirror the break is used to consult the team to design this therapeutic message. The advantage of working with a team is that the therapist will hear many interpretations or maps which can be used to construct solutions. The break builds an attentiveness which heightens the client's receptiveness to the therapist's direction (de Shazer, 1985). The message the therapist constructs is made up of two main parts: compliments and clues (therapeutic tasks/suggestions).

### Compliments

After the break the therapist starts by delivering the compliments. The compliments are based on what the therapist sees in the client that the client is already doing which is useful or helpful to the client. Compliments are not necessarily connected to the complaint and are provided with the intent of assisting the client to view her situation in a more flexible way. This is a cooperative move which lets the client know the therapist clearly understands the client's problem and agrees with her. This is a more focused continuation of a solution orientation which has been initiated and followed throughout the session and helps the client move into a frame of mind which allows her to consider trying something different - the task or suggestion.

### Clues

Clues are tasks or suggestions that the client can do that may lead towards a solution. These tasks or suggestions need to "fit" in such a way that a solution will evolve. De Shazer (1985) has created a number of what he calls formula first session

tasks that "fit" for a variety of complaints. The therapist may use these if appropriate or construct their own tasks based on the situation in an attempt to find a fit. Once the therapist returns to the session and presents the message to the family, the session is ended.

### **Second and Subsequent Sessions**

As the complaint has already been discussed in the first session, little or no discussion of the complaint is promoted in the second or subsequent sessions. The therapist's first task is to focus on what the client has done that is useful or helpful to the client. This question can be asked in many ways. Asking if things are better, the same or worse is one way to get this information. If the client says better the therapist explores what is better. The therapist then shifts from the client's possible view of seeing these differences as just happening, to implying that the client made them happen. This is done by asking how the client was able to get these changes to occur. When the client reports things are better, then the first session task "fits". The therapist's goal is then focused on preventing a relapse and the continuation of these changes. This will promote the ripple effect and lead in the direction of a solution. If the client reports things are worse or the same, then the first session task did not "fit" and no change which will lead to a solution occurred. The therapist's goal then continues from the first session to search for exceptions or differences that may lead to solutions.

When things are reported as better, the time interval between sessions is increased. This is an indirect way of telling the client that, since things are better he does not need to attend as often. Until the client reports things as better the length of time between sessions remains uniform. When the therapist believes things have changed enough to continue a solution pattern, therapy is usually terminated.

De Shazer's (1985) model defines therapy as cooperative, oriented towards the expectation of change (solutions) and is focused on the present and the future. This

approach utilizes the creativity and resources clients had before they came to therapy. De Shazer (1986) believes clients already know what to do to solve their problems, they just do not know they know. The therapist's job is to assist the client to create a new use for knowledge they already have.

### **Summary and Synthesis**

In summary, the average adolescent does not go through a stage of turmoil as a normal part of growing up. Troubled adolescents are not just in a developmental phase and should be taken seriously.

Context is a common theme throughout the literature. It is a key factor in understanding human problems. As Garbarino (1986) states, although the family is not all determining, there is no other social system that has as much influence on development. This is a major reason for a focus upon the family as well as a family assessment and intervention.

The family life cycle adds depth to the view of the therapist. Problems are framed along a continuum of a constantly changing family system just as the structural and brief model view the family. The family emotional system is made up of at least three generations and is reacting to all three at the same time (Carter and McGoldrick, 1989). The relationships within the family are seen as irreplaceable. Symptoms and dysfunctions are viewed in comparison to "normal" functioning over the period of time of the family life cycle. Problems occur when there is an interruption or dislocation in development.

The main purpose of the family in North America is to provide an emotional support system. Emotional support is an integral part of the balance of control and support provided by parents during the stage of adolescence in the family life cycle. There are many changes for adolescents, such as changes in the development of their sexuality, identity, autonomy as well as attachment, separation and loss issues. As a

result of these changes, there are changes in the structure and organization of the family which are at minimum disruptive to the family's equilibrium. Most families are able to adapt and move on in the life cycle but some are unable to make the various transitions and develop troubles. This points to family context as important to understanding troubled adolescents and their families. Further, it points to family therapy as the treatment of choice for the identified population of this practicum.

There are many similarities between Minuchin's structural model of family therapy and de Shazer's brief family therapy model. Both are based on systems theory, both look at strengths and build on them, both do not require a history of the problem, both are brief models in the sense that they are solution oriented, both see clients as having the resources to solve their complaints, but not utilizing these resources, and both see context as a key factor. The problems start and are maintained in the context of interactions. The structural and brief model both see the attitude and perception of the therapist as very important. These are not just techniques. They are a way of thinking about problems. For example, you need to truly believe in the strengths you see in the family and its members or these intervention models will not work. In both models there is no ultimate cure; they see the family system as constantly changing and evolving. As well, in both models, therapy ends once the therapist believes the family can continue a solution pattern without the support of the therapist.

The solutions are found in changing interactions that help the client do something different in behaviour and/or their interpretation of behaviour. The main difference is one of emphasis. The Minuchin structural model looks at what maintains a problem and promotes conflict. The resolution of this conflict is seen as growth producing. Avoiding conflict produces a level of equilibrium but at the cost of preventing differentiation and growth. The brief model states that change can occur without knowing what maintains the complaint and it does not promote conflict. It seeks strengths and exceptions to the

rule and builds on these to promote change. In this practicum the focus is on the application of the combination of the two models with the emphasis on seeking and building on strengths.

The structural family therapy model as applied in this practicum was used primarily as a framework to understand a given family by doing a structural assessment. The brief family therapy model was utilized as the method of promoting change. The two approaches are congruent and compliment each other to enable the therapist to understand or make sense of the problem in such a way as to allow for effective interventions with individuals and families.

## CHAPTER FOUR

### PRACTICUM METHODS, PROCEDURES AND EVALUATION INSTRUMENTS

#### A Clinical Internship in Family Therapy

As discussed in the introduction, the focus of this practicum is on three main areas: (1) adolescents, (2) skill development, and (3) the effectiveness of the structural/brief family therapy approach. To this end, an evaluation package was designed which included a family assessment measure, a problem checklist, a hopelessness scale, a brief family measure, a client feedback form and a termination summary. As well, a number of procedures were employed to assist in the assessment of the therapist's skill development.

#### Setting

The setting was the MacNeill Clinic in Saskatoon, Saskatchewan. My interest in this setting has to do with its attempt to meet the emotional needs of children and youth within a family context. For many years, the setting has had a family therapy internship program which has a reputation for quality supervision. The training is systemic, primarily involving a structural/brief family therapy approach.

The MacNeill Clinic is a multi-disciplinary, out-patient, mental health setting. It is divided into four teams: Early Childhood (age 0 - 5), Mid-Childhood (age 6 - 12), Youth and family (age 13 - 18), and a Young Offender Team. Each team specializes in the various developmental needs of the age range covered by the team. The Young Offender Team is mostly involved in court ordered assessments and runs groups for adolescent sex offenders. The MacNeill Clinic's mission is to assist children up to the age of eighteen with a variety of problems related to social, emotional and behavioral issues, as well as to assess and treat problems of cognitive growth and development. There is no fee for service, and clients attend on a voluntary basis.



This practicum involved being a family therapy intern on the Youth and Family Team.

### **Clients**

The client population of this practicum was composed of adolescents who were identified as the problem by their family or others when they requested or were referred for therapy. All of the adolescents presented with a range of troubles which included elements of parent-adolescent conflict, adolescent "negative" behaviour involving violent verbal and/or physical outbursts, drug and alcohol abuse, self-destructive behaviour, defiance, delinquencies, running away, truancy, poor academic functioning, suicidal thoughts, weight gain, sleep disturbances, personality changes, incest, depression, self-imposed social isolation, and uncommunicativeness. In all cases, family therapy was the treatment of choice for the adolescent and their family. A total of nine families were seen. All of the families were assigned at weekly youth and family team meetings.

### **Personnel**

During the internship the majority of the clinical supervision was split between George Enns and Bryan Woods. George Enns is the director of the family therapy internship program and director of the youth and family team. Bryan Woods is a member of the youth and family team.

Overall, the practicum experience was supervised by my advisor, Ruth Rachlis of the Faculty of Social Work and the other members of the practicum committee, Don Fuchs of the Faculty of Social Work and Bryan Woods as the external member from MacNeill Clinic.

### **Duration**

This practicum ran on a full time basis from September to December 1990.

## **Evaluation**

### **Post Intervention Assessment**

The first instrument utilized was the FAM-III (Family Assessment Measure) as developed by Skinner, Steinhauer and Santa-Barbara (1983). As the FAM-III is protected under copyright laws, permission was obtained to use this instrument (see Appendix A for letter of permission). The second instrument was the adapted version of the Morrison Centre Problem Checklist (Trute, Campbell & Hussey, 1988). As this checklist is not covered by copyright laws, permission was not requested for its use. The third instrument was an adapted version of the Hopelessness Scale for Children (Corcoren & Fisher, 1987) called the Hopelessness Scale for Adolescents - HSA. Permission was obtained to use this instrument from the author Alan E. Kazden (see Appendix B for letter of permission). The fourth instrument was the Brief FAM as developed by Skinner, Steinhauer & Santa-Barbara (1983). The fifth and sixth instruments were the adapted version of the Children's Home of Winnipeg Client Feedback Form and a Termination Summary, both initially developed for the Children's Home of Winnipeg study completed by Trute, Campbell & Hussey (1988). This measurement package and feedback from the families was designed to provide supportive evidence of change occurring as a result of the intervention.

### **Evaluation Procedures**

The FAM-III, the adapted version of the Morrison Centre Problem Checklist and the Hopelessness scale for adolescents were administered just prior to the first session. Of the nine families involved, four completed these same instruments at the end of the last session. Another four families were mailed the post measures and these were returned within two months of the last contact with the family. One family which I only saw on two occasions declined to complete the post measures. Administration of these instruments allowed me to make pre and post intervention comparisons. As well, after

the first session, these instruments were used to compliment my assessment of each family.

Each family was informed in the last session that someone other than the therapist would be contacting them by telephone to obtain feedback about the service they received. In each case the mother was contacted. Trute, Campbell & Hussey (1988) recommended that someone other than the therapist should collect the data in order to try and reduce bias. They also stated that telephone surveys have a higher response rate than mail and is less reactive than in-person interviews. According to Skinner, Steinhauer and Santa-Barbara (1983) mothers provided the most accurate information in the families that they studied in the process of developing the Family Assessment Measures. Within a two month time span all of the families were contacted by telephone by a person other than the therapist or clinic staff to complete the Brief FAM and the adapted version of the Children's Home of Winnipeg Client Feedback Form.

It is important to solicit feedback from clients because it acknowledges their view as they are the ones experiencing the service. It also provides their unique perspectives of the services. Measures of satisfaction are subject to "response biases such as acquiescence, social desirability, or cognitive dissonance resulting in distortion of reports" (Trute, Campbell & Hussey, 1988, p. 49). Despite these response biases, client feedback is still valuable in showing the acceptability and adequacy of the service (Lebow, 1982, cited in Trute, Campbell, Hussey, 1988).

After all the previous information was gathered the therapist completed the Termination Summary.

### **Instruments**

#### **FAM-III (The Family Assessment Measure)**

The FAM-III is an instrument used in clinical evaluation which has three scales: the General scale which examines the level of health/pathology from a systems

perspective; the Dyadic Relations scale which focuses on relationships between specific pairs; and the Self-Rating scale which focuses on the individual's perception of his/her functioning in the family. The general scale (see Appendix C) was the instrument utilized in this practicum.

The general scale is composed of fifty items which can be divided into nine subscales. The first seven subscales measure the following variables: 1) **TASK ACCOMPLISHMENT**: refers to the family's ability to organize itself to achieve basic, developmental, and crisis tasks; 2) **ROLE PERFORMANCE**: refers to the allocation, agreement and carrying out of various roles within the family; 3) **COMMUNICATION**: the means of accomplishing adequate exchange of information which leads to understanding necessary for task accomplishment; 4) **AFFECTIVE EXPRESSION**: the ability to communicate feelings appropriately and effectively; 5) **AFFECTIVE INVOLVEMENT**: the degree and quality of family members' interest in one another; 6) **CONTROL**: the process by which family members influence each other in order to maintain family functioning and adapt to change; and 7) **VALUES AND NORMS**: the influence on the family of the broader culture and family context (Skinner, Steinauer and Santa-Barbara, 1983). In addition to the above seven subscales, there are two response-style subscales which measure social desirability and denial (see Appendix D for the FAM Interpretation Guide).

The FAM-III scale was an appropriate instrument for this practicum for the following reasons: it looks at family context, assists the therapist by providing an "insiders" view of the family, distinguishes between healthy and pathological families, and can be used with individuals twelve years and older. As the FAM-III distinguishes between strengths and weaknesses, it could be a useful tool in formulating the intervention tasks which focus on solutions and strengths. As well, the Family

Assessment Measure is based on Canadian norms for both clinical and non-clinical populations (Trute, 1985). The FAM-III:

provides an important compliment to a clinical assessment by giving a comprehensive overview of family functioning, by providing an objective and independent verification of the clinical assessment, by identifying areas of potential difficulty that warrant further assessment, and by providing quantitative indices of family health/pathology that may be used as a baseline for evaluating the course of the therapy (Skinner et al, 1983, pp. 103-104).

The FAM-III general scale has a reliability coefficient of 0.93 for adults and 0.94 for children. The reliability scores of the subscale for adults range from 0.65 to 0.87 and for children 0.60 to 0.87.

A disadvantage of the FAM-III general scale is that it was not designed to measure a specific approach to therapy such as the structural/brief approach. As well, although the FAM-III general scale does measure the overall level of health of a family, it is not designed to measure a specific therapeutic goal.

### **The Problem Checklist**

The Problem Checklist (see Appendix E) was designed for the Morrison Centre for Youth and Family Services in Portland, Oregon. It is a list of family concerns and is used to record different levels of satisfaction in family members that may be useful clinically (Trute, 1985). The checklist is helpful in the assessment of therapeutic impact. A problem checklist is also useful on intake to help identify family concerns that may need immediate attention that might normally not be identified by family members at the start of therapy. Problem checklists also provide an index of goal attainment on a pre/post or time series basis (Trute, 1985). The main weakness of the Problem Checklist is its generalizability and empirical strength (Trute, 1985). Checklists provide a measure of specific areas of concern and according to Trute (1985) have been identified as having

merit in evaluating short term interventions. Thus, the Morrison Problem Checklist fits with the Brief Therapy model of intervention.

### **The Hopelessness Scale For Adolescents - HSA**

The Hopelessness Scale for Children (Corcoran & Fisher, 1987) was designed by Alan E. Kazdin. It is a seventeen item instrument created to measure hopelessness, which is defined as negative expectations about oneself and the future. An adapted version of the instrument called the Hopelessness Scale for Adolescents (see Appendix F) was included in my package of measures because I believed the context of the families I would be seeing partially creates a situation where the adolescent feels he has no control and therefore has a level of hopelessness. As well, there is empirical evidence for a relationship between family dysfunction and increased risk for suicide in adolescents (Spirito, Brown, Overholser and Fritz, 1989). The instrument only takes a few minutes to complete and was originally designed for children aged seven or older.

When the instrument is scored, it provides you with a number from one out of seventeen. The higher the score the higher the level of hopelessness. Norms in the original scale were based on a relatively small clinical population of American children age five to thirteen. The mean score they obtained was 5.2 with a standard deviation of 3.2. I altered the way the scale was administered, and I made a number of changes in the wording of the questions in the scale so it would be more appropriate for the age range of the client population in this practicum (12 - 18 years). As a result, I cannot report anything other than the face validity of the instrument.

The Hopelessness Scale is appropriate for this practicum because of the client population, it is easy to administer and, as with the problem checklist, will provide an index of goal attainment on a pre/post or time series basis.

One of the disadvantages of the scale is that it does not point to a specific problem other than a general indication of a level of hopelessness which can be associated to higher risk levels for attempted suicide or other self-destructive behaviour.

### **The Brief FAM**

The brief scale of the Family Assessment Measure is a shorter version of the general scale (Skinner, Steinhauer and Santa-Barbara, 1983). It only has fourteen items (see Appendix G) as compared to the general scale which has fifty items (see Appendix C). The brief FAM is not broken down into various subscales as in the general scale (see Literature Review, p. 49). When the brief FAM is scored it provides you with a general indicator of family functioning. As with the general scale, the brief FAM has a mean of fifty and a standard deviation of ten. Scores of forty to sixty indicate that the family is within the normal or average range. Scores of forty or less indicate a degree of family strength, while scores of sixty or above indicate problems in family functioning.

The brief FAM is appropriate for this practicum, because of the client population, it is easy to administer, only takes a short time to complete, and will be useful as a follow up measure of the therapist's impact on the family.

The main disadvantage of the brief FAM is that it only provides a general indicator of family functioning and therefore does not indicate specific areas of strength or weakness.

### **The Client Feedback Form**

The Client Feedback Form (see Appendix H) is an altered version of the Client Feedback Form used in the Children's Home of Winnipeg study completed by Trute, Campbell and Hussey (1988). It has nine questions. The first six have four possible answers to choose from. The last three are open ended; they ask what the therapist did

that worked, what the therapist did that did not help, and if they have any other comments or suggestions.

### **The Termination Summary**

The Termination Summary (see Appendix I) is completed by the therapist. It asks: (1) What were the key interventions tied to the change in the child or family? (2) Were there any important life circumstances that could have positively or negatively affected the outcome? (3) Were there any circumstances tied to the agency's setting or its procedures which could have affected the progress of the case? (4) How would the therapist assess change as a result of her clinical intervention on the seven subscales of the FAM-III general scale? (5) Would the therapist assess the major presenting problems as better, unchanged, or worse as a result of the therapy (Trute, Campbell & Hussey, 1988)?

### **Educational Benefits**

Supervision and evaluation was primarily provided through weekly individual meetings with each of my supervisors at MacNeill Clinic. This included live supervision of sessions and review of video tapes of sessions on my own and with the supervisors. With the exception of one home visit, virtually every session with each family was videotaped. A midterm and a final evaluation were provided in meetings with both supervisors.

In addition, I participated in a family therapy seminar once a week. This involved various therapists conducting first session family assessments in front of the team. Prior to the interview the case was presented to the team and a hypothesis developed. After the family was gone, the team and therapist who conducted the interview met to discuss the case and provide feedback to the therapist on how they conducted each phase of the interview as well as the therapist's effectiveness at assessing and intervening with the family (see Appendix J for Therapist Feedback Outline). As



an intern, I completed two assessments in front of the team. This process allowed me to learn how various therapists work in addition to the two separate styles of my supervisors.

As well I kept a daily journal of my experience which included issues, connections and questions related to my development as a therapist. I returned to Winnipeg every two or three weeks to discuss the contents of this journal, and review my progress and videotapes of sessions with Ruth Rachlis.

## CHAPTER FIVE

### The Application of the Integrated Approach

#### Introduction

During the internship I worked with a total of nine families. Four of these families were intact families, two were blended families, one was a recently separated family and two were single parent families. The number of children living at home in each family ranged from one to four. The age of the identified patient ranged from twelve to seventeen. Five of the identified patients were male, and four were female. All of the families were referred by the mother except one, which was referred by a school social worker. The families came from a range in socio-economic background. The number of sessions per family ranged from a low of two to a high of eleven. All of the sessions took place at the clinic, except one in which the stepfather was terminally ill and could not leave home due to his illness.

The table on page fifty-six provides a brief summary of client information for all nine of the families seen during this practicum. It includes family form, number of children living at home, onset of problem, age and gender of the identified patient, length on the waiting list, number of sessions as well as the assessed outcome of therapy.

The following is a list of the presenting problems as initially described by the referral source with the numbers corresponding with the families listed in Table I (p. 56); (1) unhappy, moody, volatile and concerns regarding suicidal thoughts, (2) conflict over household chores and theft, (3) unhappy, overly sensitive and beginning to abuse alcohol, (4) personality change, withdrawn, suicidal thoughts, (5) recently diagnosed as epileptic, school performance dropping, difficulty sleeping, (6) behaviour problems worse since stepfather diagnosed with life threatening cancer, (7) exceptionally bright but chronic underachiever at school, (8) mother concerned over recent separation and effect on her children, and (9) unhappy, uncommunicative, withdrawn, skipping school.

**TABLE 1**  
**SUMMARY OF CLIENT INFORMATION**

Family #	Family Form	No. of Children Living at Home	Onset of Problem	Age of I.P.	Gender of I.P.	Length on Waiting List	No. of Sess.	Outcome	Termination or Transfer
1	Single Parent	2	7 years ago	17	F	2 weeks	6	Positive	Termination
2	Single Parent	3	Initially Reported as starting 5 months ago	13	F	2 months	11	Positive	Transfer
3	Intact	4	7 or 8 years ago	14	F	4 months	4	Positive	Termination
4	Blended Family	4	Always a difficulty worse last 2 years	16	M	1 1/2 months	5	Positive	Transfer
5	Intact	3	1 year ago	17	M	5 months	3	Positive	Termination
6	Blended Family	3	2 years ago	16	M	3 1/2 Months	4	Unknown	Termination
7	Intact	1	Appr. 7 years ago	13	M	2 1/2 Months	5	Positive	Transfer
8	Recently Separated	2	Appr. 10 years ago	13	F	2 months	2	No Change	Transfer
9	Intact	3	Appr. 1 1/2 years ago	12	M	1 month	4	Positive	Transfer

Of the nine families involved in this practicum two case examples were selected to illustrate the structural/brief approach and discuss the results of the evaluation. The presentation of Family One is included in this chapter, while the presentation of Family Two follows in Chapter Six.

Details of the seven other families are included in appendices K through Q. Each of these appendices includes a description of the family constellation, a description of the presenting problem, and what I learned from the family rather than the details of the case. In addition, each appendix, with the exception of Family Eight, includes the pre and post FAM-III profiles, a table of the outcome results of the Family Problem Checklist and a table of the outcome results of the Hopelessness Scale for Adolescents. Family Eight declined to complete the post measures.

In all nine families the names of the family members have been changed to preserve confidentiality.

### **Case Presentations**

Prior to the first session with a family, I would review the intake information and construct a genogram. As well, I would hypothesize what I thought was going on in the family by attempting to answer a list of questions (see Appendix R - Problem Formation).

The first contact with a family was by telephone to make an initial appointment and explain what to expect, including pre measures, videotaping, use of the team, time involved, etc. All of the family members were requested to attend when possible, with the exception of very young children.

The first session was used to complete the assessment by testing out possible hypotheses of what may be going on in a particular family, looking for strengths and possible solutions. Each of the first sessions followed the first interview format which was previously discussed in the Literature Review, p. 38-41.

This format included starting the interview with a brief introduction, and an explanation of what was to happen in the session. This introduction was followed by a social or engagement phase and was an important step in beginning the joining process which continued throughout the process of therapy. A clear description of the problem was then obtained from each family member. Questions were then asked which were aimed at understanding the family's logic by discussing how they understood why the problem exists. Further questions were asked in order to obtain a process description of the behaviour pattern in the family with regard to the problem. These questions explored the family's structure, its attempted solutions, "stuckness" and its approach to problem solving. The next stage of the interview was aimed at gaining a clear behavioral description of when and what people are doing when the problem does not happen (the exceptions to the rule). At any time during the interview, when an exception was mentioned, it was explored before continuing on with this first interview format. The last set of questions were called the "miracle" questions. These were aimed at gaining a clear description of how people would behave differently if the problem did not exist.

The last two sets of questions helped people step back from the problem and look at their own and others' behaviour. The answers to these questions helped the therapist to determine what tasks to assign that would "fit" with the client's description of the interaction between various members of the system and would build on the family's strengths. Clients' motivation levels were then checked by asking on a scale of one to ten how willing would they would be to follow some suggestions that I might make, and, on the same scale, how important it would be that they see the problem resolved. This helped in determining what cooperation might mean for each of the individuals in the family and was helpful information when designing the tasks.

At this point there was a brief break in the session which was used by the therapist to consult the team or, if working alone, to think about the family with the

goals of outlining the family's strengths which were to be delivered as compliments, and designing the tasks.

After the break the therapist delivered the compliments to each family member. The compliments were based on what the therapist saw the client as already doing which was useful or helpful to the client. As well, the therapist often described the family's definition of the problem and its attempted solution before suggesting a number of tasks which would build on the family's strengths and direct the family towards trying something different. Once these therapeutic messages were delivered the session ended.

The initial contract was usually made for five or fewer sessions, with the understanding that further sessions could be contracted at the end of that time.

Second and subsequent sessions were used to build on the information gained in the assessment and strengths found in the first session. The focus changed from exploring the problem to exploring what the client had done that was useful or helpful, highlighting the family's strengths and developing potential solutions. At the point of termination, the family was invited to return to the clinic at any time in the future. Families that were to continue on in therapy were made aware, prior to the final session, that they would be transferred to another therapist and were briefly introduced to this therapist in the final session.

Family One was selected for presentation because I had a partial record of many of the comments from my supervisor and thought this record would help demonstrate the learning process of developing knowledge and skills in family therapy and illustrate what I had learned and how. This case example also demonstrates the process of therapy and the critical variables to change problems. This family was the first one that I saw during the practicum experience.

**Family One: Starting Where the Client Is At**

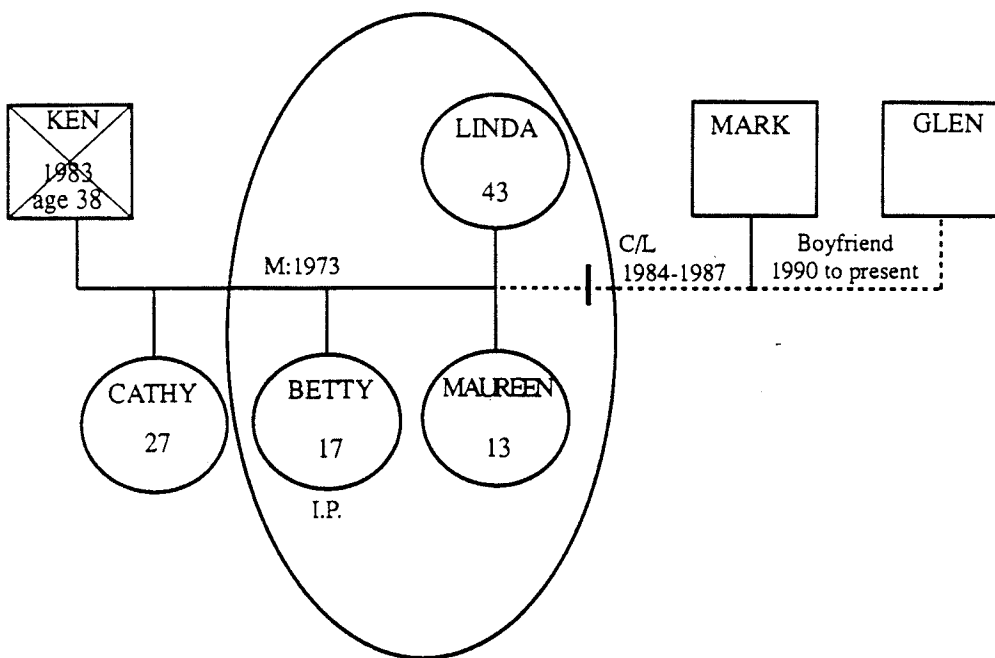


Figure I: Genogram: Family One

**The Problem**

This was a self-referral by the natural mother, Linda. She was concerned about her seventeen year old daughter, Betty, who was unhappy, moody and volatile at home. She was physically aggressive with her younger sister, Maureen, and oppositional with her mother. Linda was also requesting help for her whole family stating they needed to improve their communication skills and learn new ways to resolve problems. The previous year Betty had difficulty in school, was often physically ill and gained twenty to thirty pounds in weight. She did not feel good about herself. She spent all of her time watching television and had no close friends. The mother was worried about her daughter having suicidal thoughts.

This was a natural single parent family consisting of the mother, Linda, age 43, who was currently in her second year of full time university. Linda had three children:

Cathy, age 27 was married and resided away from her mother, Betty, age 17, was in grade twelve and Maureen, age 13, was in grade seven.

### First Session

For the first interview I met with Linda and Betty to complete the evaluation instruments and do an initial assessment. Due to a misunderstanding, the youngest daughter was not present for this interview.

Linda described her husband Ken as easy going and well liked by everyone. They supported their family by operating a farm. In 1983, at age 38, Ken died suddenly from a heart attack.

I asked how they coped when Ken died. Linda stated that after all the years the tears still came, although she believes not as much as for her children. Linda believed that some of Betty's difficulties were the result of the death of her husband and Linda becoming preoccupied with running the farm. Betty agreed that this was when the problem started. Betty was age nine when her father died. She became tearful when she told me that she could not remember anything about him. She remembered keeping busy with school, gymnastics and skating.

In January 1984, Linda began living common law with Mark, a close friend of hers and her deceased husband's. Betty openly objected to this man attempting to take charge and discipline her, and was quite angry at her younger sister for accepting her mother's partner "as if he were their father". This relationship ended approximately three years later. She described feeling like she needed "building up" after this experience and attended counselling.

In the fall of 1987, Linda returned to high school to complete grades eleven and twelve. Some time during this same year Betty met her first boyfriend. He was killed in a car accident approximately four months after they started to date.



In 1989, the family moved to the city so they could all attend school. Linda began first year university. At this time the problems with Betty became more severe. She did not like the school in the city and did not think she "fit in". Around the middle of the school year, Betty went back to the farm community where they previously resided to complete her grade eleven. She resided with extended family. Over the course of the year she missed a lot of school and did poorly academically.

Over the summer Betty decided she wanted to return to the city and try attending a different high school. She had met a few girlfriends and appeared to have been doing much better at school. They attributed this change to her new school having fewer cliques and a more transient population.

At times the mother felt overwhelmed. She believed that Betty had not dealt with the death of her father or boyfriend. In the not too distant past, Linda started seriously dating Glen and believes this may be the cause of some of their problems. She continued to worry about the amount of time Betty watched television, her unhappiness, and the conflict between her two youngest daughters.

### Assessment

The pattern in this family involves a hierarchal role reversal with Linda abdicating her role as parent and Betty filling this position. The generational boundary between the mother and daughter appeared to be diffuse. The mother's belief system or world view included seeing herself as a follower and nurturer. In her marriage she was the nurturer while her husband was the disciplinarian. Linda was uncomfortable with tension and conflict and made her decisions based on whether her children would agree or disagree with her. The mother had tears in her eyes when she stated that she did not like being yelled at. She stated that fights made her feel defeated. She dealt with issues by getting "preoccupied" as a way of avoiding.

Betty had good social skills and was able to assert herself. She was self conscious of her appearance which was appropriate for her age and developmental stage. Her world view included seeing herself as incompetent, withdrawn and a loner. She saw her mother as not taking charge and being taken advantage of by others. As a result Betty felt obligated to take charge and fill the parenting role.

Betty was stuck in this pattern with her mother and this trapped her at home. It kept her from going through the age appropriate developmental process of separating from her family. Being trapped at home and therefore unable to separate made her angry and upset. It also made her feel isolated and lonely. She tried to hide these feelings by watching television and avoiding life. She was the disciplinarian and did not believe her mother would take charge. "My mother won't take charge, she just won't".

The information from the first interview all pointed to unresolved grief on the part of the mother, and her seventeen year old daughter. I initially assumed this was the reason for Betty's unhappiness. These issues needed to be further assessed.

When they were asked what was different when things were going better, the mother said that Betty was out more often with others, that she watched less television, and that they talked more. Betty stated that she was more active when things were going better, that she was more involved with social activities at school, and that her mother went out more often and had more fun.

We set a five session treatment contract with the goals of encouraging the mother to take more of a leadership position within the family and to encourage Betty to be more involved with peers and activities away from home.

I told them that I saw two people who appeared to have a very inaccurate image of themselves. The mother was a capable, bright, determined individual who had many personal strengths which helped her cope with the events in her life, yet she saw herself as a follower and nurturer. She presented as soft spoken and sensitive. Betty had

exceptional social skills and was able to assert herself, yet her world view (Literature Review, p. 32) included seeing herself as incompetent, withdrawn and a loner.

Linda was assigned the task of voicing her opinions and thoughts about things with her family, especially with Betty, so that Betty could see her mother as the competent mother that she was. As well, Linda was asked to tackle some of the things which she had avoided. She was to let me know what she discovered in the process of doing this task.

Betty was told that by sitting and waiting for a job we were worried that she would not see how skilful she was at interacting with others. I suggested that she apply for part time employment as this was something both she and her mother had discussed. Betty was also asked to try a couple of different things each day so she could see how socially competent she really was.

### **The FAM-III Pretest**

The results of the Family Assessment Measure pretest (Figure II, p. 65) confirmed the assessment that this was a dysfunctional family and that Betty and her mother were having difficulties. Betty scored high in the family problem area for task accomplishment, role performance and communication. These scores pointed to her difficulty in organizing herself to achieve basic developmental and crisis tasks. It also pointed to lack of agreement regarding family roles and an inability to adapt to new roles in the evolution of the family life cycle. Her scores for affective expression and involvement were also high, indicating an inadequate range of affect and lack of autonomy. Her score on the communication subscale showed a lack of understanding.

### FAM GENERAL SCALE

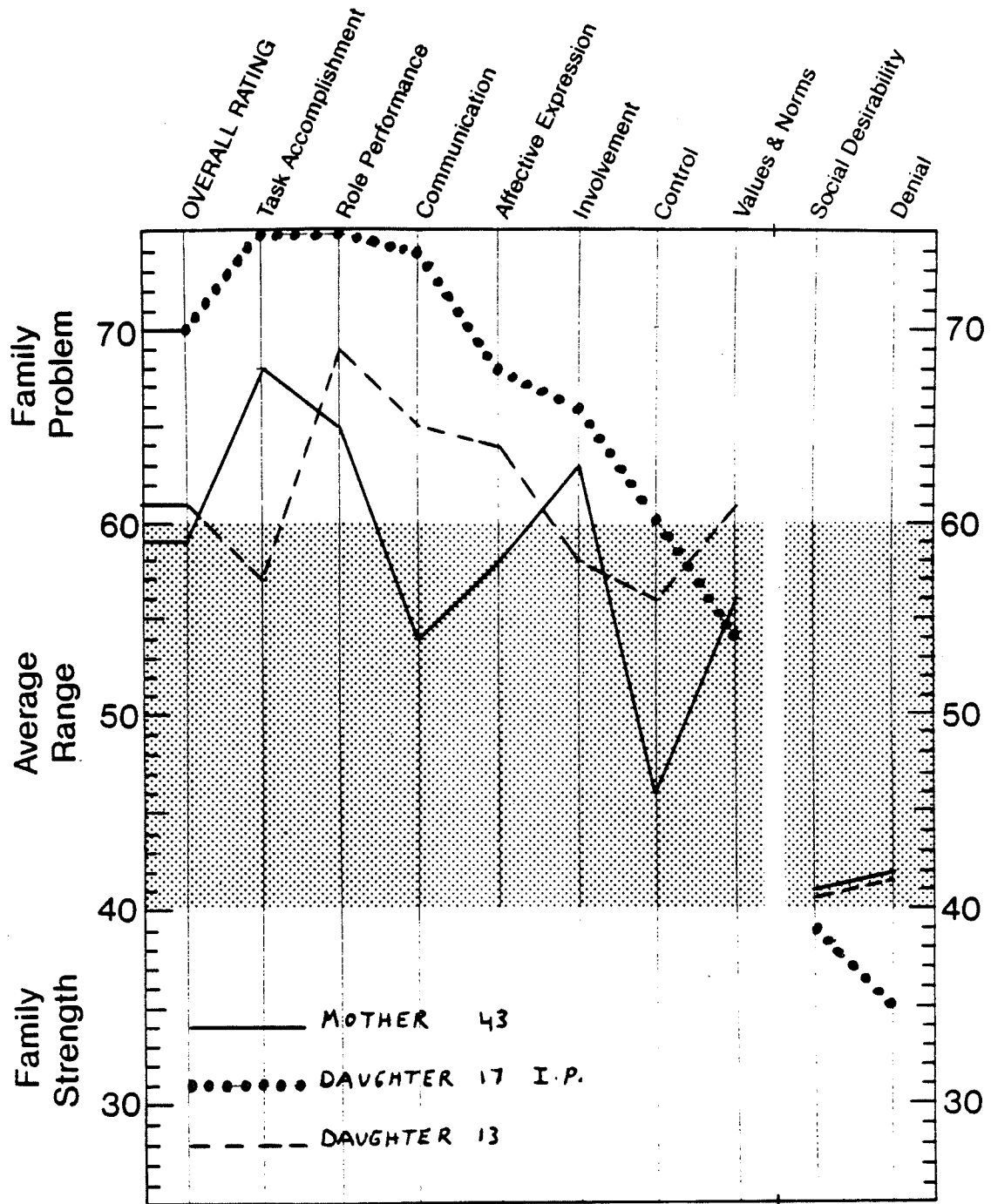


FIGURE II

PRE TEST FAM-III PROFILE FAMILY ONE

The mother also scored high in task accomplishment and role performance, indicating that she had the same difficulties as Betty in these areas. Her scores for affective expression and involvement reflected her ability to have a range of affect but not demonstrating this affect with her children. At the outset of my contact with this family I thought the mother simply did not demonstrate this affect with her children because she was busy with university, running a farm and being a single parent. I later learned that this was part of her pattern of keeping busy as a way of avoiding conflict.

The youngest daughter also scored high for role performance, communication and affective expression. These scores indicated that she too had difficulty adapting to the new roles in the evolution of the family. Linda and Maureen's scores were close together, indicating an aligned relationship, while Betty's scores were much higher, suggesting a disengaged relationship with her mother.

#### **The Family Problem Checklist Pretest**

The response on the Family Problem Checklist indicated that the mother's overall satisfaction with her family was "dissatisfied", while she checked "in between" as the way she felt about herself. The majority of the responses were in the "dissatisfied" to "in between" range.

Betty was "dissatisfied" with her overall satisfaction with her family and how she felt about herself. Again, the majority of the responses were in the "very dissatisfied" to "in between" range.

The youngest daughter reported herself as "in between" with her overall satisfaction with her family, while she checked "satisfied" with feeling good about herself. They all checked sharing of responsibilities as "dissatisfied" or "very dissatisfied".

### The Hopelessness Scale for Adolescents Pretest

Betty scored eight out of seventeen and Maureen scored six out of seventeen on the hopelessness scale. Betty's score indicated she had a fairly high level of hopelessness. This score fit with what I saw in the first interview. Higher levels of hopelessness are connected to higher levels of risk for self harm.

### Supervision

In supervision I was told I joined and formed a strong alliance with both family members; they trusted me and openly spoke of their issues. It was pointed out that my strengths were being gentle, supportive and engaging the family with little difficulty.

Prior to the first session I "poured" over the intake information and constructed several hypotheses of what may be happening in this family. Some of these included: the mother likely had not worked through the grief over her husband's death as she moved into a common law relationship within a year of his death. If the mother did not deal with these grief issues then her younger children's ability to grieve would also have been compromised. The mother identified that the problems with Betty started shortly after her husband passed away.

I further hypothesized that Linda's first child was born when she was age fifteen, and this led me to wonder about the relationship Linda had with her own parents. Was this a way for her to leave home early because of tensions there? My guess was that Linda deals with conflict and pain by withdrawing and leaving. This fits with the unresolved grief and the manner in which she left home.

In addition, the mother allowed Betty to go back to the farm community by herself, to complete her previous school year. This situation suggested a disengaged relationship. Betty was described as angry at her sister Maureen. I hypothesized that Maureen and her mother were aligned and this was the reason for Betty's anger at her younger sister. If the problems could be resolved, the mother would be reinstated to her

executive position in the family as the parent in charge. The personal and generational boundaries would be clarified and strengthened, allowing for clear direct communication with a greater likelihood of establishing functional problem solving patterns. The children would be freed from their preoccupations, and with clear consistent limits and structure, they could put their energy into developing age appropriate competencies.

I felt I did very poorly with this first interview. It was disjointed. I had thought a lot about the family before the interview and ended up using the interview to carefully go through the many hypotheses that I had constructed. Near the end of the session, the daughter clearly demonstrated their pattern by showing how she felt obligated to take on the parenting role. The diffuse generational boundary became apparent.

I learned that the hypothesis only gives the therapist a sense of direction even if it is wrong. It is better to have some direction than flying by the seat of your pants and guessing as you go. Having a hypothesis and therefore direction helps build confidence in the family's view of you as therapist.

I learned that once you have an idea of what is going on in the family, then you should move towards the therapeutic goal. The goal is set by what is happening and your assessment of the family.

In this case I thought the mother and daughter had unresolved grief issues. As well, I thought the 17 year old daughter felt obligated to take on the parenting role. The goal should be to place the mother back in the executive position and to deal with the grief issue. In this case, this involved both the mother and daughter feeling the pain involved in mourning, which they had tried to avoid.

The balance of our supervision time was used to explore different ways to work towards the stated goals, as well as possible tasks that could be assigned to move the family in the direction of these goals.

## Second Session

In the second session I met with Linda and Maureen. I had Maureen complete the measurement instruments before starting the session. The mother explained that Betty had an exam at the end of the day and, therefore, would not likely attend today's session. In review of the previous session's tasks, the mother reported that she had put her foot down with Betty and did not drive her to school one morning simply because Betty was slow in the morning and would be late without a ride. This had been an ongoing issue. The mother was congratulated for this decision. As well, she had considered her options in regards to a large ailing pet dog that they owned. She was again complimented for taking on a difficult decision and for not avoiding painful things.

After a discussion of her deceased husband I assigned the task of the mother sitting down and doing specific activities which would recall images of her husband with her daughters. Suggestions included looking through old photo albums, talking with her daughters about their father while listening to some of his favourite songs, recalling a special event such as a birthday or Christmas gathering or a visit to the grave site. The mother was to decide the topic. She was made aware that this task could bring forth powerful emotions and that she should talk with her daughters to see how they would prefer to be comforted and supported.

Maureen was complimented for being a sensitive caring person as she attempted to comfort her mother by making her laugh whenever her mother spoke of a sensitive issue. This was an example of a role reversal and added to our assessment that the mother was not in charge. Maureen appeared to have been more able to grieve the loss of her father. She was assigned the task of keeping track of things she would like to see more of in their family.



### Supervision

In supervision and review of the video tape of the second session, I was told that I am very respectful of families and do not want to tell them what to do, but I still influence them and lead them to a point where they make a decision anyway. My supervisor suggested that I offer more direction and be more decisive with this family. These things would help clarify my professional boundaries with the family and obtain the same results more quickly and effectively.

Prior to the second session I had decided that I would focus in on the emotional aspects of this case partly because the mother had a range of affect but did not demonstrate this affect with Betty. For example, in the first session the mother did not comfort Betty when Betty began to cry about the loss of her father. I thought the mother's lack of demonstrating her affect was somehow connected to the unresolved grief which appeared to be effecting her ability to be close and more supportive of Betty. As well, in the first session I had been drawn into the family system and missed exploring why the mother avoided the more emotionally laden issues.

When I assigned the mother and youngest daughter the task in the second session I tried to be clearer as to why emotions are important, while explaining this likely would be difficult and painful. The mother was somewhat apprehensive of the task. At the time I thought she was being apprehensive because she would be focusing on something I thought she had avoided and because she was busy and only she would know how much energy and time she had available. In retrospect, it was not that she was busy. She was apprehensive because this task did not fit or make sense with what she wanted to gain from therapy.

My supervisor pointed out that the main issue in this case was not unresolved grief. The issue was that Betty was stuck and saw herself in a very inaccurate way. She thought she was incompetent, a loner, and withdrawn. In addition, the mother was not

helping Betty by not taking charge of the family. The goal should be to get Betty involved with peers and activities away from home. If Betty had been out working and more involved with peers, the mother would likely have seen the problem as fixed and not have come to therapy in the first place. If I assisted the mother to take a firm stand, it would help Betty get unstuck. The assigned task was supposed to keep the mother in charge and have the mother and daughter begin to experience the pain of mourning. In supervision it was suggested this task may set up a battle between the mother and her daughter because this issue is a sensitive one for both of them. If that battle occurred it would not further the family along towards the stated goals.

It became clear to me that this family's pattern was what had brought them to therapy. This was significant to me because, although I had heard the phrase "start where the client is at" many times in the past, no one had ever shown me exactly what that meant. If the main issues were resolved, and the family wanted to deal with the unresolved grief issues, then this would be an appropriate time to work on these problems. In other words, if you ask yourself what the family wants when they come for therapy, do a careful assessment, and do not make any assumptions, you will be on your way to starting where the client is at.

My supervisor added that I need to deliver the task more powerfully and succinctly at the end of my sessions. He suggested that I write out what I have to say, say it clearly to the family, ask if they have questions, then just leave. A suggestion was made that would help me be clear and more able to give direction. I am to ask myself: what do these people want when they come for therapy? What information do I need to know and what sequence of events led to their present situation? I realized that I could move much faster with this family, but I did not know how to do this.

Linda called to reschedule the third appointment, at which time she commented that she had been having difficulty with Betty, especially since the weekend. Glen,

Linda's boyfriend, was over and Betty and Maureen did not like him commenting on how they treated their mother. Linda was uncomfortable with the tension in the house, although she felt her boyfriend was right.

The focus of our involvement should be to encourage the mother to be more firmly in the executive position within the family and to have Betty be more involved with peers and activities away from home. From the mother's telephone call I knew that she was continuing to not take charge, so others felt they had to, including her boyfriend.

### Third Session

For the third session I met with Linda, Betty and Maureen. In review of the first sessions tasks with Betty, I found that she had applied to nine or ten places for part time work. She had also made a resume. In addition, Betty had made a few friends at her school. She was complimented for all her efforts.

I spoke with the mother separately from the children. She had unsuccessfully made some attempts at the previous session's tasks. In this session, she agreed that, although unresolved grief was an issue, she would like to focus on Betty's present behaviour. Linda demonstrated that she was starting to take steps at being more in charge. She was assigned the task of pushing herself to take a stand, lay down rules, and give direction. She was complimented on her abilities to make good decisions. She was to "fire" her daughter and take charge.

I told Linda that, in the past, her deceased husband had taken care of the discipline while she had done the nurturing; now she must do both. She was told that her children were worried that her boyfriend was taking over and that this scared them. This is what had happened in the past with her previous common-law relationship. The children had become worried and would not let this man take over the discipline. It was suggested to Linda that she tell her boyfriend that it would be most helpful if she were to take charge.

At the end of our session I met separately with Betty. She confirmed that her mother did not take charge and that she has filled this role for a long time. She viewed her mother more as a friend and quite different from her friend's mothers. Betty was unsure if she was willing to step down and let her mother take charge. I suggested to Betty that she should "keep at the wheel until her mother can show she can take charge otherwise it will be too dangerous too let go".

### **Supervision**

In reviewing the video tape of session three, it was evident to me that I did not meet my objective of being more direct and taking a firmer leadership position. In supervision it was suggested I build a strategy prior to session four so that I would be clearer about what direction to take. In the interview I ended up pushing the mother to take charge instead of exploring why she was having difficulty taking charge. If I explored her position I would likely learn more information which might be helpful in building a solution. As well, exploring would create less resistance than pushing.

### **Fourth Session**

As previously arranged, in the fourth session I met with the mother separate from her children. In review of the previous session's tasks, the mother related that her children did not like her laying down the rules. She stated that there had been lots of battles in the last few weeks. The children believed Linda's boyfriend had put her up to these changes even though Linda had told them it was her own idea. She also stated she was busy with midterm exams so had not worked at being firmer. Linda described getting discouraged and complained about the children's behaviour and their not doing a host of household duties. In this way she was attempting to avoid her duties as a parent.

Linda was uncomfortable with taking charge. She explained that she was the eldest child in her family of origin and grew up on a farm. She described her father as

easy going while her mother was more rigid. She did not feel she had anyone in her family of origin that she could confide in and talk with. Her mother was described as preaching or nagging to Linda.

At age fifteen, Linda became pregnant with Cathy and, at age sixteen, married the father of her child, Ken. Shortly after she married, Linda returned home to live for several months and look after her younger siblings and help with her parent's farm. Her mother ended up in the hospital and was seriously ill. Linda felt that, within a short period of time, she had to move from having to make few decisions to attempting to take charge. She felt overwhelmed.

Linda's discomfort with taking charge stems from these experiences. She takes her stance from the position of protecting her children by not controlling.

I explained to Linda that firmness offers protection, is supportive and is freeing (Literature Review, p. 14). I suggested that the more she takes charge and shows she is serious, the better. In the long run this will improve her relationship with her children. In addition, I assigned the following tasks. As explained in session three, she was to tell her boyfriend that she will take charge of the discipline because if he does it for her, it is not helpful. In addition, she was to institute a two hour limit as the maximum amount of time the children could watch television. If they did not follow this request Linda was to tell her children she would remove the television altogether for a length of time, such as three or five days. Several other suggestions were made as to what Linda could do to take charge as we addressed the various concerns which she raised throughout this session. All of these would clearly demonstrate that she was taking charge.

### **Supervision**

Prior to session four I had made a strategy, was prepared and was clear on what I needed to do. I came across as gentle but directive and therefore presented myself as

more confident. I was pleased with the interview for this reason and because the family was moving along in the right direction.

My supervisor suggested that in the next session I might find it helpful to tie in the father's death to the present behaviours within the family. The father was the disciplinarian, the mother the nurturer. When the father died, the disciplinarian role was not fulfilled. The mother became involved in another relationship. This man tried to take on the disciplinarian role but Betty would not let him, so it did not work. Betty over identified with her father so she would not let her mother take over. The disciplinarian role still remained empty. The mother needed to fill this role. It was suggested I address this issue in private with the mother, then see Betty individually to first comment that she was taking on a grandmother's role by parenting her mother, and then ask why she would want to do this.

In this case, if the family reached the stated goals, Betty could get on with her life. The mother would be more in charge, and achieve more satisfaction at being a mother.

In this session the mother spoke of possibly reducing her work load by dropping a university course. My supervisor suggested that I not make this decision. He suggested saying that it is good to look at priorities and what is important. The mother was to make the decision. This would keep her in control and in charge.

### **Fifth Session**

For the fifth session I met with Linda, Betty and Maureen. I spoke with the mother separately from the children. Linda was very pleased with herself. She had instituted a list of chores and rules and her children were cooperating with her. She felt good about the progress she had been making. The mother was complimented for her success and encouraged to continue in her current direction.

I met with Betty and Maureen separately from their mother. Betty was unhappy because her role as her mother's caretaker was changing. Maureen was actually asking for more consequences. These changes were signs that the mother was taking charge.

The two daughters were quite concerned about their mother's relationship with her boyfriend and what her plans were in terms of their farm, should their mother get married again. They explained their mother had told them nothing of her plans. We did not set another appointment as the mother was entering into her exam period at university.

### **Supervision**

After the interview I thought that this case was not going as well as I expected. At the time I could see progress but I wasn't sure what I thought should be happening. I realized in supervision that I was misunderstanding Betty's sadness as a step backwards instead of a sign that her role was truly being displaced and that the mother was beginning to take charge. The brief approach states that the therapist should consider any change as an indicator that things are going in the right direction (Literature Review, p. 36). My supervisor suggested that I see the family one more time to build on the mother taking charge and to terminate our contract as Linda was feeling more confident.

### **Sixth Session**

For the sixth and final session I met with Linda, Betty and Maureen. On the way into the interview room the mother told me Betty did not wish to attend today. When she had picked the children up at school, she had gone down to the office and had Betty paged. Linda also told me she was taking her landlord to court. This was an issue we had discussed several times. Both of these activities demonstrated that the mother was taking charge.

I met with them as a group for a brief time. They all agreed there were more good days than there were bad days. Some days were still very difficult. Betty was socializing more often with two girlfriends and had looked for employment on a few occasions.

I then met with the mother separately from the children. She was complimented on how well she was doing and encouraged to continue. I added another justification for the mother to continue working at taking charge. She was in a career field which involved business, the more she learned to be in charge now, the better. I suggested that she could even think of taking charge at home as training which would also help her later in her new career.

We spoke of some areas in her life which she should think about separately from her children and then inform them of her decisions. This included what her plans were with her boyfriend and her farm. This would keep her in charge and ease the children's feelings because they were worried about what the future holds for them.

Linda commented that, although Betty was not liking the changes which were occurring, she was not fighting these changes very hard. I pointed out that Betty's sadness may also be the result of over identifying with her father and that whenever Betty gives up her role of mother's caretaker, she is unconsciously mourning the loss of her father, as well as the loss of his role of disciplinarian. When asked what the mother would like Betty to do, she responded with watch less television. I said good, take charge, and make it happen.

Linda commented that her boyfriend found it very hard to sit and take the way the children treat her. As discussed in sessions three, four, and five, we again spoke of how it would be most helpful if she were to take charge of her family. I explained that if she takes charge now, history will not repeat itself, and they will have a much better chance of success.



When I had arranged this interview the mother was informed that it would be our last session. I suggested that if she felt the need to continue she could contact my supervisor who was aware of her family and, therefore, if she were to contact him, she would not have to start from the beginning. She was a little hesitant to stop attending but then decided it was okay and had no further questions. All of the family members completed the post measures. The session was ended by my telling them they had a very nice family and that they will do well.

I think they have a promising future.

### **Results of the Evaluation Instruments**

#### **FAM-III Profiles**

The results of the Family Assessment Measure post test (Figure III, p. 79) show some minimal improvement in family functioning. The largest change in Betty's score was in the role performance subscale indicating improvement in adapting to new roles required in the evolution of the family life cycle. Her score also improved slightly on the affective involvement subscale, pointing to an increase in her sense of autonomy. These were two key areas in this case and were a good indicator that the intervention was on target.

Overall, both Linda and Betty's scores indicated a continued problem with task accomplishment and role performance. Overall, there was a larger improvement from the family problem area to the average range for the youngest daughter.

I attributed these scores for the mother and Betty partly to the structural/brief approach which suggests that the therapists limit their involvement to the minimum required to set in motion the family's own resources (Literature Review, p. 30) and continue a solution pattern (Literature Review, p. 41). "The Brief Therapy approach does not look globally. It is more like looking at one rung on a ladder, repairing it, and

### FAM GENERAL SCALE

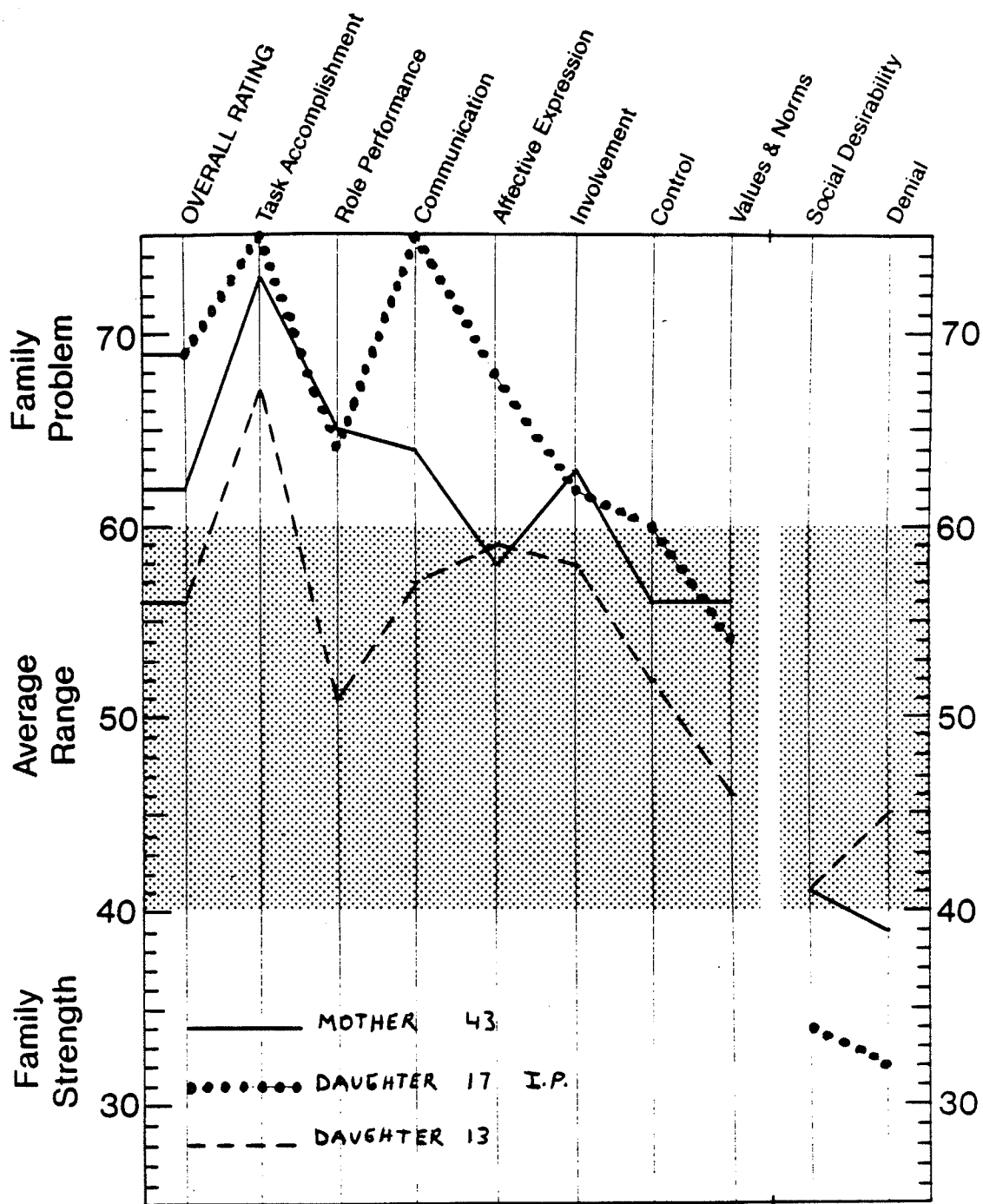


FIGURE III

POST TEST FAM-III FAMILY ONE

hoping the family will move to the next rung" (George Enns, personal communication, December 1990). As well, the FAM-III is designed to pick up on overall family functioning. It is not designed to pick up on a specific goal, such as changing a hierarchal role reversal.

Although the family assessment measure does not show it, the mother and daughter made significant changes. The mother had followed her world view since she was an adolescent and for her to move from seeing herself as follower to being in charge is a significant change. As well, Betty was beginning to respond to her mother's new role within the family. This was the start of this family becoming "unstuck". As stated in the Literature Review, the intervention only needs to open the way to solution (Literature Review, p. 31). A change in any one member of the family will lead to changes in behaviour in the other members of the system (Literature Review, p. 33). It is a situation where the pattern which created and reinforced the problem no longer exists. To some extent Betty's behaviour still remained a concern but it was hoped that the changes which were initiated in therapy would generate further changes (Literature Review, p. 33, re: ripple effect) so that Betty could move on and begin to follow more age appropriate developmental tasks.

### **The Family Problem Checklist**

The response on the Family Problem Checklist post-test showed that the mother's overall satisfaction with her family moved from "dissatisfied" to "in between", while she moved from "in between" to "satisfied" about feeling good about herself. The majority of responses were in the "in between" to "satisfied" categories.

Betty's overall satisfaction with her family moved from "dissatisfied" to "in between" while she remained feeling "dissatisfied" about herself.

The youngest daughter's overall satisfaction with her family moved from "in between" to "satisfied". She remained feeling "satisfied" about feeling good about

herself. The majority of her responses moved to the "in between" to "satisfied" categories. For an overall review of the outcome results of the family problem checklist, see Table II, below.

### The Hopelessness Scale for Adolescents

On the hopelessness scale, Betty's score improved from eight out of seventeen to four out of seventeen. Likewise, her younger sister's score also improved from six out of seventeen to three out of seventeen (see Table III below).

**TABLE II**

#### FAMILY ONE

##### Outcome Results of the Family Problem Checklist

Outcome	Mother	Daughter Age 17	Daughter Age 13
Positive Change	11	8	10
No Change	7	6	9
Negative Change	3	7	2

Note Question fourteen, relationship between parents, did not apply in this case, as Family One was a single parent family.

**TABLE III**

#### FAMILY ONE

##### Outcome Results of the Hopelessness Scale for Adolescents

Family Member	Pre Test	Post Test
Daughter - Age 17	8	4
Daughter - Age 13	6	3

### **The Brief FAM and the Client Feedback Form**

Approximately two months after my last contact with this family I had a colleague contact the mother for feedback. On the brief Family Assessment Measure, her score was sixty-three, indicating that there were still some problems in this family's functioning. This score was approximately the same as the score on her post-test on the Family Assessment Measure general scale, which was sixty-two. As the Family Assessment Measure general scale did not pick up on the improvements in this case, the brief FAM was not helpful in showing that the changes which had occurred remained with the family. However, it did suggest that the family is close to the normal or average range (forty to sixty), and therefore they are functioning in a healthy way.

On the Client Feedback form the mother reported that there had been improvement in their family situation as a result of their contact with me and that things had improved for her personally. When asked what the therapist did that worked for her family, she stated that "the biggest thing he gave me was the push to do the things I had to do". She said I made her feel like she wasn't a bad mother, that I gave them direction, and that they got along better. Linda liked the service and was glad she attended. While the mother gave me a positive report, she indicated that Betty was still not feeling good about herself and that she may need a little more help.

### **The Termination Summary**

The key interventions in this case were all aimed at placing the mother in the executive position within the family as the parent in charge, and encouraging Betty to develop more age appropriate competencies.

As a result of these interventions, the mother had moved more firmly into the executive position and taken charge of the family. She consistently made efforts towards this goal and was well on her way. This leadership behaviour was generalized to other aspects of her life, including how she dealt with some difficulties with her landlord. As

stated in the Literature Review (p. 36), applying this approach to solving problems means that not only would the stated goal be the focus, but so would other behaviours in the same class of behaviour. Betty had become more involved with two of her peers and had made substantial efforts at being more involved in activities away from home. She also began an exercise program. At the point of termination she was still feeling a little displaced and unhappy.

When I consider the family as a whole, I would assess that things had improved in each of the FAM-III subscales as a result of the clinical interventions. As well, the two major presenting problems in this case, the role reversal, and Betty's withdrawal into herself and her social isolation, had much improved.

Family One taught me the importance of having hypotheses when working with families and the importance of uncovering the pattern. They increased my understanding and demonstrated a fundamental principal of therapy, "start where the client is at". I also learned how to be more economical and efficient by focusing on attitudes and beliefs versus individual incidents (putting out fires). I found supervision to be a very helpful experience which greatly increased my skill development as a therapist. In this case, I learned, like the mother, that I can be more directive and take leadership. These skills will make me much more functional as a therapist.

## CHAPTER SIX

### FURTHER APPLICATION OF THE INTEGRATED APPROACH

Family Two was selected because there was a fairly dramatic change in the pre and post measurement instruments pointing to a significant change as a result of the intervention. It is a good example of building on the family's strengths and resources to assist the family in finding a solution for a complex problem - incest. The format of this case presentation was selected to illustrate how I learned and utilized the skill of reading process to assist in promoting change when working with families. As well, my intent in this practicum was to apply the structural/brief approach to a range of presenting problems and, therefore, chose a very different case situation from that presented in Family One.

#### Family Two: The Demystification of Process

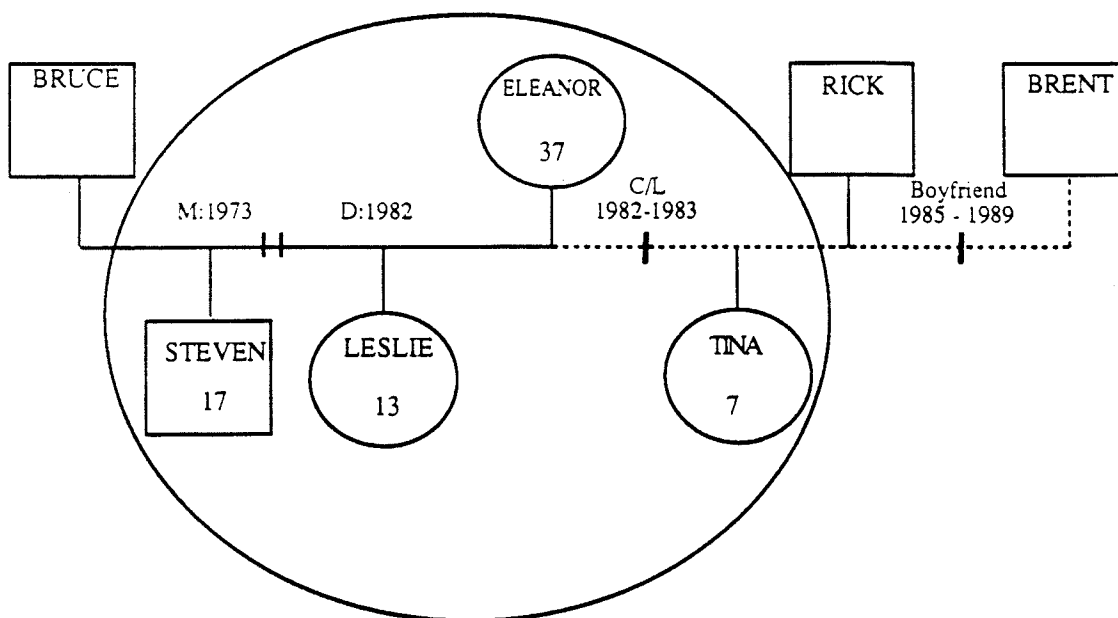


Figure IV: Genogram: Family Two

### The Problem

This family was a self referral by the natural mother, Eleanor. She called to refer her oldest daughter, Leslie, who had been caught stealing from their neighbour's house, where she had been hired to babysit. The police were not involved, and no charges had been laid. Leslie believed she had more responsibility than her older brother, Steven, especially in terms of daily chores. This was the source of conflict between Leslie and her mother who had been fighting quite frequently over the past two years. The mother was experiencing a lot of stress, including financial stress, raising her three children as a single parent, looking after their home and working full time. She felt she could not cope with one more problem and found herself yelling all the time. Leslie was reported as eager to attend counselling.

### First Session

For the first interview I met with Eleanor, Steven, Leslie and Tina to do an initial assessment and to complete the evaluation instruments. All of the family members completed the evaluation instruments except Tina, who was too young.

This was a single parent family which included the natural mother, Eleanor, age 37. Eleanor married her first husband, Bruce, in 1973 and had two children by him, Steven, age 17 and Leslie, age 13. They separated after a stormy relationship. Bruce was described as having an alcohol problem, staying out late, lying and stealing. The marriage ended after Bruce was caught and jailed for theft from his employer. In the same year, 1982, the mother separated from her husband and entered into a common-law relationship with Rick. The mother had one child from this union, Tina, age 7. This relationship ended in 1983. In 1985 the mother entered into a common-law relationship with Brent. They lived together for approximately one month, separated, but continued to have contact with each other until 1989. There were no children from this relationship. The mother's last two partners were described as not very reliable,



immature, and more trouble than they were helpful. The mother stated she would like to have a man around but views men as more trouble than they are worth. Bruce only visited the children a few times a year, until about six months earlier, when Steven was able to get part-time employment on weekends with his father. Rick and Brent had no contact with this family. The mother had one close girlfriend with whom she had regular contact.

The mother stated that over the past six or seven years she had held many jobs to try and support her family. Some of these jobs involved working shifts and weekends. Approximately six years ago the mother was able to secure and buy a home where they continued to live. The mother did not drive but was able to commute back and forth to her job through a car pool. The children attended school in a nearby community.

The mother felt good about having her own home, as prior to this time, the family moved often, partly due to their financial circumstances and partly to secure employment. Although the mother felt good about having her own home, she found it difficult to keep up with house repairs and daily chores.

The concern over Leslie's stealing became known when the family who hired Leslie to do babysitting began to notice things missing. The family asked Leslie and other sitters about the missing items and they all denied being involved. At one point this family told Leslie they would call the police and take finger prints. This is when Leslie confessed. This in turn upset the mother enough that she called a crisis line which referred her for family counselling at MacNeill Clinic. Eleanor was upset because Leslie took approximately two hundred dollars worth of belongings when the mother was struggling to make ends meet. Eleanor felt pressure and shame at her child's behaviour because the home that Leslie took the items from was right next door. The mother stated that she "cannot stand liars and stealers", which is also how she described her first husband. In response to this incident the mother grounded Leslie for six or seven

months, restricted her from friends, and arranged for her to do housework to pay off the value of the belongings. In the past, Eleanor believed she had given in to the children, and this time she had decided she was not going to do this. She wanted to teach Leslie a lesson. In addition to this concern the mother was worried about Steven, whom she described as always out with friends.

After the previous information was gathered, a short break was taken so I could review what I thought were the strengths in this family. I was unclear what they wanted from therapy, as the two issues they raised were finances and feeling disorganized.

Following the break, they were all told that I saw them as a very caring family, with the ability to communicate with each other. Each family member was complemented for what I perceived were their strengths. The mother was complemented for being a very competent person at arranging and getting things done with little support. Steven was complimented for his ability to communicate and his willingness to speak up, even when he knew some of what he had to say would likely upset his mother. Leslie was complimented for doing a lot of work at home to help her mother and for trying to do the right things. Tina was complimented for being very well behaved and not at all disruptive.

Because I saw the mother as very organized and capable, she was assigned the task of building in a break for herself at the end of each day to collect her thoughts. As well, she was to work out what she felt the children should do in terms of household chores and set aside a set period of time for them to complete these chores. They were unable to describe what life would be like when the problem did not exist. As a result they were all assigned the task of ranking each day in the morning, using a scale of one to ten, with one being a bad day, and ten being a good day. At the end of the day they were to match up how they felt the day had gone. The days with scores five or less were

to be disregarded as just bad days. On days ranked five or better they were to keep track of what had gone well.

We set a second appointment to complete the assessment.

### Second Session

Only Eleanor, Leslie and Tina attended the second session. At the start of this session the mother burst into tears, stating that the evening before Steven had been charged and detained for sexually abusing Tina. Eleanor did not feel like attending today, but came because a social worker from the child protection agency suggested it might be a good idea.

Through my questioning, the mother described in detail what had occurred and her reaction. Apparently when Eleanor had spoken with the child protection social worker, Eleanor had said she would "kill" Steven when she saw him. This was explained to me more as a statement expressing her anger than actually following through with any intent to harm her son. This statement was relayed to the RCMP, so that when Eleanor arrived home the police were present and would not allow her to have contact with Steven. Eleanor described being unable to tell anyone at work what happened, and not being able to leave work because she had no way of getting home. As time passed, Eleanor became increasingly frantic, so that when she was finally able to get someone to drive her home, around mid afternoon, she would likely have been unable to contain her fear, concern, and anger. Steven was held in jail overnight and was ordered to have no contact with Tina. He was then placed with his paternal grandparents, Flo and Eddie, who resided on an acreage just outside the community where Eleanor's home was situated.

Eleanor was very distraught and vacillated between being agitated and tearful. She did not know what to do and spoke of selling their home, quitting her job and fleeing. As the mother deteriorated I stopped the session and requested the children

return to the waiting room while I spoke with their mother in private. I wanted to place the mother in charge and control and did not think it was appropriate for the children to hear some of what needed to be said. The mother was given concrete clear tasks to place her in charge and control. She was complimented on the way she contacted the various professionals and organized herself and her family around this crisis. She was informed of what to expect regarding the police, court, social services, and the medical examination for Tina. As well, it was suggested that she inform her boss, who was a lawyer and could be viewed as a possible source of support. We spoke of the importance of Eleanor keeping in contact with her son, even though she was very angry with him. I explained that her anger was valid and to be expected, but that she should let him know that she is angry. I further explained that Steven was still her son and that he would feel she had abandoned him if she did not call. I suggested that seeing him in person would be better. Once the mother was clear on what to do and what she could expect, we called the children back into the session. The children were prepared so they would know what to say if friends or neighbours asked about Steven. The mother left considerably calmer and more in charge than when she had arrived.

The following day, Flo called our intake services to request counselling for Steven. She was told that I would be seeing Steven, but that I would have to confirm this with his mother. This position was taken to again place the mother in charge.

### **Third Session**

For the third session I met with Flo briefly before seeing Steven. She reported that the family was doing as well as could be expected under the circumstances. Steven was attending school, visiting his friends and continued to work on weekends with his father. Flo stated that she was looking after Steven because he did not have any other place to go. Steven's father was remarried, and his current wife was described as not liking children. Flo was willing to have Steven live with her and her husband as long

as he wanted to stay. She described Steven as not a problem and quiet. She told me that he had wet his bed twice since being in their home and that this had been a problem for many years. She also said that Eleanor had told her that Steven would have "night terrors" and scream out in the middle of the night.

I then met with Steven separately from his grandmother. This session was used to discuss what happened in detail as well as to suggest what Steven could do about this situation. According to Steven, the sexual abuse involving his half sister, Tina, had begun a little over one year ago. The abuse had occurred on a total of four occasions. All of these had occurred within a two or three week time span. The abuse had consisted of fondling, simulating intercourse and having Tina perform fellatio on Steven.

Steven denied penetrating or attempting to penetrate Tina. He said that he convinced Tina to do it. The first time she said "no" but he continued. The other time she was unhappy but did not tell him to stop. When asked about what effect this might have had on Tina he said "she is young, but she is handling it good".

Steven stopped this behaviour because, at one point, his mother talked to him after they saw a television show that depicted a sexual assault. Steven said his mother had difficulty watching the program. He thought his mother suspected something was not right. After this talk his mother never left him alone with Tina.

Steven denied ever being involved with Leslie in an inappropriate or sexual way. Steven stated he never wanted this to happen again. He said he felt "bad" but his affect was flat. He wanted this whole matter to be over as soon as possible.

Steven stated he had never been abused. He did not know why he had night terrors and screamed out at night. He said he did not like horror movies and thought perhaps this was the reason for his night terrors. He said he had no idea why he assaulted Tina.

Steven was worried and anxious about court. I explained the court process and suggested that he could be placed in jail, put on probation, be ordered to pay a fine or do volunteer community service. I suggested that a way he could help himself would be to attend a therapy group at the Clinic (Literature Review, p. 37-38), Constructing Problems and Goals). I suggested this would help him resolve the sexual abuse incidents, give him knowledge to protect himself, and help him feel better about himself. I suggested that sometimes people who engage in this kind of behaviour continue to sexually assault many others over the course of their life time. If Steven attended the therapy group he would learn about sex, sexuality and relationships. He was told this was important information for everyone to know and that he could learn ways to increase self control to prevent further offending behaviour. He could gain support from the leaders who would eventually be able to corroborate his understanding of his behaviour.

Steven was informed that the only way he could gain entrance into the group run by the clinic was if he was convicted or if he admitted his guilt and was charged. As a result, he would be required to attend. This was partially explained as a way to support offenders to get help, because some offenders are unwilling to follow through with treatment. Steven looked like he might consider this option but was uncomfortable with the group idea. The balance of the session was used to again administer the Family Problem Checklist and the Hopelessness Scale for Adolescents.

While he filled out the checklist and scale I met with the grandmother separately and relayed the same information about the therapy group to her. I wanted to gain her support for this suggestion and I hoped that she too would suggest that Steven attend the group. The mother was also informed in the next session. This manoeuvring was a way to place pressure on Steven to attend the group. Prior to Steven leaving the interview room, he was complimented for being open and talking about this sensitive subject. Flo and Eddie were told in Steven's presence that he had done very well in this session.

### Assessment

This was an enmeshed family system. They were all sensitive individuals. The boundaries were poorly defined. The mother was not in the executive position. No one was in charge. This lack of leadership vacillated between the mother moving in and taking an overly rigid command and then letting everything go and following a more laissez-faire stance. This cycle only added chaos and confusion to their lives. This pattern of being inconsistent and then over reacting may have been how she handled her relationships with previous partners. This pattern points to lack of communication and poor problem solving skills.

Eleanor presented as an anxious, well-spoken, depressed individual. She appeared to be a very emotionally needy woman who had tremendous personal strength to be able to function and raise her three children mostly on her own. She was trying to be sensitive to her children's needs and provide for all of them.

Eleanor had very high expectations of herself and of others and, as a result, she was constantly "let down" because she could never meet her expectations and neither could anyone else. As a result, Eleanor ended up feeling disappointed. The pattern of frustration, anger, catharsis and feeling disappointed was a common theme in this woman's life. An example of the mother's high standards and unrealistic expectations was her rigid response to the presenting problem with Leslie. These parental reactions increase the likelihood of parent-teen conflict and non-cooperation, with the possibility of dishonest or deceitful behaviour on the part of the adolescent.

The mother expects failure and personalizes or blames herself for unsuccessful outcomes. She then feels guilty, and engages in behaviour that sets up another failure. This is a dysfunctional cyclical pattern that is influenced and perpetuated by her world view.

In the second session, I had become preoccupied with the sexual abuse crisis and initially thought the mother's upset was related to this disclosure. In reviewing the session I realized from the mother's reaction that she may have been a victim of sexual abuse. This needed to be further assessed in future sessions.

The mother and Leslie were too closely aligned. Leslie tried to help her mother by doing all the right things, working hard at school, behaving well and doing household chores, but she could never meet her mother's expectations or emotional needs. Eleanor suspected something sexually inappropriate may have occurred between Steven and Tina and as a result of this suspicion never allowed Steven to be alone with Tina. This left Leslie with more of the child care responsibilities. Leslie was unaware of her mother's concern and did not understand why her mother made her babysit but not Steven. Leslie's stealing behaviour and conflict with her mother over having more responsibility than her older brother were a reaction to this increased responsibility and the stress of attempting to meet her mother's expectations and emotional needs. This was all occurring at a developmental period which should have been the start of the process of individuation for Leslie.

There was a strong alliance between the mother and Tina. Tina sensed her mother's feelings and tried to comfort her when Eleanor was feeling down. The mother was emotionally needy and, as a result, allowed the child to comfort her. In this way the pattern was reinforced.

I would estimate Steven's intelligence to be slightly below average. He was a quiet spoken lethargic individual. His behaviour fit more closely to a younger adolescent. Steven, as with the other children in this family, was sensitive towards his mother's emotional state. He was not as involved at home as his sisters, but when he was home he felt the tension, so he stayed away as much as possible to avoid confrontations with his mother. He tended to meet his needs through his peers. This in



turn angered his mother because she felt he should be home helping more with household tasks.

The family members agreed to be involved with our service to work on the sexual abuse crisis. In addition, other treatment goals included: placing the mother in charge of meeting the children's needs and parenting in a more functional way; working towards a clear decision with all of the players regarding whether reunification of this family was possible; engaging the mother in the process of reducing her depression so she could be more emotionally available to her children; clarifying and strengthening the personal generational boundaries to assist family members' differentiation; and engaging this family in the resolution of the presenting problem involving Leslie. A set number of sessions was not made. Given the situation and the nature of the problems, this family would likely be a long standing therapy case.

#### **The FAM-III Pretest**

The results of the Family Assessment Measure pretest (Figure V, p. 96) confirmed the assessment that this family was having a lot of difficulties with problems in many areas of their functioning. Generally, the scores confirmed the observed impressions that communication, emotional expression, emotional involvement and control were weak areas for the children. Task accomplishment was a weakness for Steven as he was not as involved with the family. Both children scored well into the average range for values and norms, indicating that both children's values were in harmony with each other. These scores were in large contrast to the mother, whose score showed there was a large discrepancy between her values and those of her children. The mother scored high on task accomplishment, as she was overwhelmed and stressed with attempting to deal with all of the tasks of being a single parent and working full time. She also scored at the start of the family problem area for role performance, which pointed to her difficulty adjusting to the new roles required in the evolution of the

family life cycle. In addition, the scores, when graphed, were all fairly close, indicating that this was an enmeshed family system.

#### **The Family Problem Checklist Pretest**

The Family Problem Check-list showed that, overall, the mother was "dissatisfied" with her family and did not feel good about herself. Leslie's response indicated that she was "in between" in both these areas. Steven was also "in between" with his satisfaction with the family, but checked off feeling "very satisfied" about feeling good about himself.

#### **The Hopelessness Scale for Adolescents Pretest**

Leslie scored five out of seventeen and Steven scored three out of seventeen on the hopelessness scale. These scores are within the average range. These results are consistent with what was observed in the first interview as Leslie was feeling more dissatisfaction with her family than Steven.

After the sexual abuse disclosure by Tina, I again administered the problem checklist and the hopelessness scale to Steven. I should have administered all of the measurement instruments to the other family members but chose not to because they were in crisis. In general, I have found the measurement instruments to be quite sensitive and believe they would have picked up a large shift into the problem area. For Steven there was a number of improvements in the majority of responses on the problem check list which I attribute to his move to his paternal grandparents' home. There was, however, a change in his report of feeling good about himself, going from "very satisfied" in the first interview to "in between" after the disclosure. In addition, Steven's score on the hopelessness scale doubled from three out of seventeen to six out of seventeen. This score is still in the average range but indicates an increase in hopelessness which fits with Steven's circumstances.

### FAM GENERAL SCALE

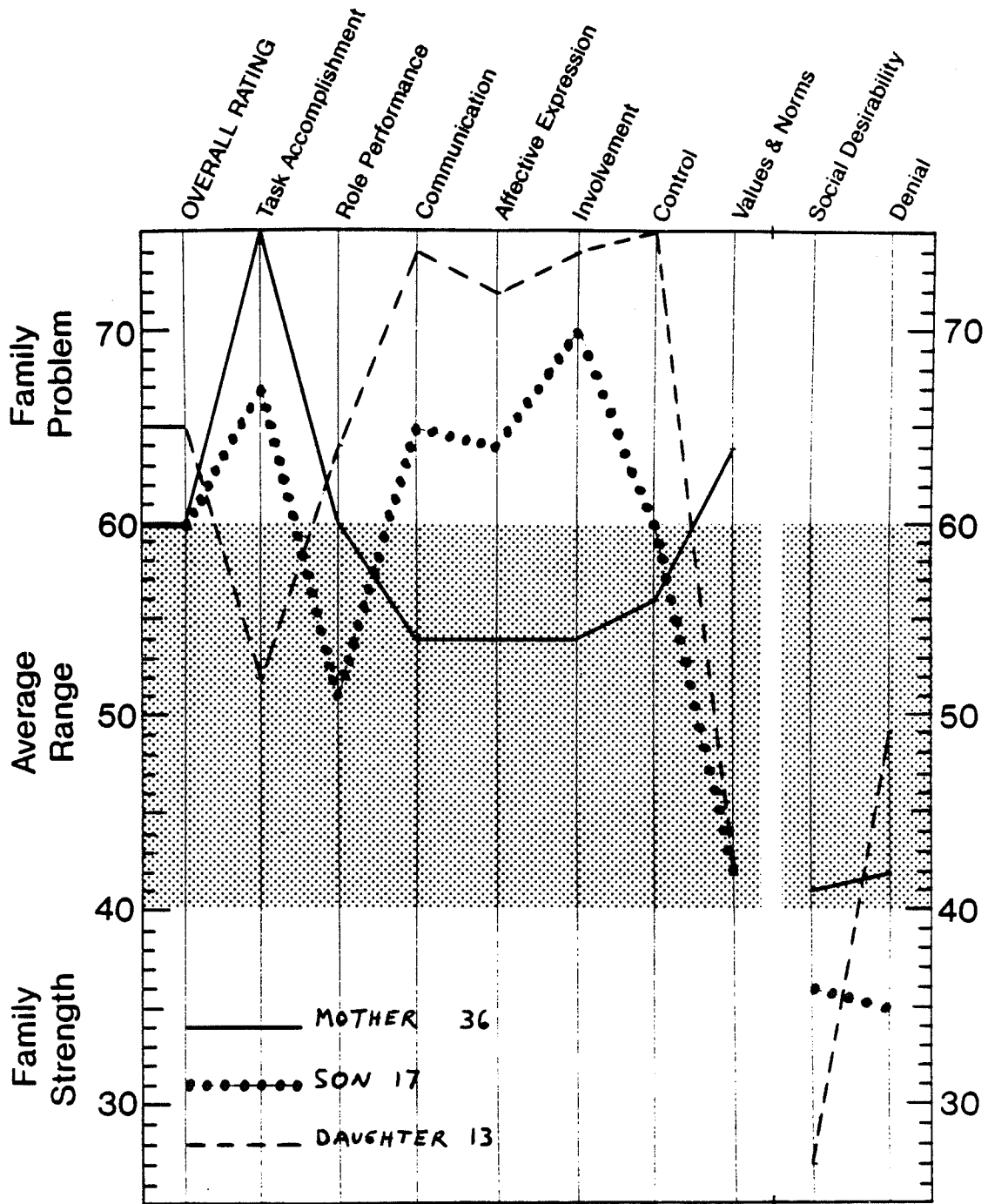


FIGURE V

PRE TEST FAM-III PROFILE FAMILY TWO

#### Fourth Session

In the fourth session I met with Eleanor, Leslie and Tina. This session was started with what became a standard question for each of the following sessions. Each person was asked if things were better, the same, or worse (Literature Review, p. 41). By asking this question I was introducing the expectation that change would occur. The previous session's tasks were then explored. When they did anything which placed them in the desired direction it was explored to emphasize what they did that was useful. As well, the mother was complimented for being capable, in charge and in control. I then met with the mother separately from her children.

The mother was upset that Tina did not tell her about the abuse. This was a nice lead into the question about whether she had been abused as a child. I learned from this session that the mother had been sexually assaulted as an adolescent. She was very uncomfortable and ashamed with this topic. She initially responded by saying "sort of". In further discussion she talked about her own victimization. It was apparent, at the emotional and cognitive level, that she had not worked through her own assault.

We spoke about the mother's guilt about not being there to protect Tina. She thought she should have stayed home until the children were old enough to protect themselves. When I asked how old this would be, she smiled and acknowledged that there was no age at which she, as the mother, could always be available to protect her children. I checked to see if the mother had met with Steven and talked with him on the telephone. She reported she could not force herself to see him because she was angry, but she did talk with him several times by phone. She reported that he seemed to crave their time on the phone. She also explained part of the difficulty in seeing him would be seeing her mother-in-law, whom she did not get along with, and having no place in private to talk. I suggested they could go for a walk without the mother-in-law.

We then met with Leslie and Tina, and I had the mother tell Tina she was sorry she had not been there to protect her from Steven, that Steven was wrong, and that what happened was not Tina's fault. We spoke of how Steven is older and knows that he should not have assaulted her. In this interview I could see the pattern of Tina supporting her mother when the mother felt upset. This needed to be addressed in future sessions so the mother could be in charge and provide support to the child.

The next part of the session was used to see if the mother believed she had high expectations of herself and others and if, as a result, she was constantly let down because she could never meet her expectations and neither could anyone else. We spoke of her own mother, her previous partners, her children, her expectations of herself, even her expectations of herself when she attended school. They all fit the pattern.

This discussion led to a discussion of Leslie's grounding and how this, too, was part of Eleanor's high expectations and a set up for failure. I initially started this conversation by asking the mother how she was able to enforce the grounding, expecting her to say that she herself felt grounded because she would have to watch Leslie all the time. She reported that she was having no difficulty enforcing the grounding. I attributed this success to Leslie desperately trying to please her mother.

I had a chance to speak with Leslie in private. We spoke of her grounding, and she disclosed that she had already begun to sneak phone calls and visit with friends. Through discussion, Eleanor was able to see that her high expectations really were setting her up for disappointment. As well, we spoke of how children at Leslie's age should be involved with their peers, as this is partly how adolescents learn about the world and themselves (Literature Review, p. 13-14). I suggested that it was very appropriate to ground Leslie and be angry with her for stealing their neighbour's belongings. However, seeing how Leslie had already served approximately two to three months of her grounding, it may be more helpful if the grounding was ended. I told the mother that

I did not wish to make this decision for her and, therefore, she should think about what is best for her and Leslie. It was clear she would drop the grounding. Leslie was all smiles.

Just after the fourth interview, I spoke with the child protection worker who explained that Tina had told a friend that "I sucked on Steven's privates". This conversation occurred while Tina was riding the bus to school. The conversation came about when the other child was talking about kissing. The friend told the bus driver, who told the school principal, leading to the referral to the child protection agency. Tina then proceeded to say "I made it all up" which then changed to "I can't remember, it stopped so long ago". Tina did not make a disclosure to any adult outside the family. Steven was charged because he admitted to assaulting Tina.

#### **Fifth Session**

In the fifth session I met with Steven. I used this session to continue to assess exactly what happened between Steven and his half sister, Tina. He basically related the same story with a little more detail. I again encouraged him to request from his lawyer and the court that he be ordered to attend the therapy group at the Clinic. I explored why he sexually assaulted Tina. He had no idea. I asked him if, when his mother was living with his father or her common-laws, they had left the bedroom door open and if he had seen them in a sexual act or if he ever seen pornographic magazines or movies. He responded "no" to all the questions. He had no idea where he got the idea to be involved with Tina, in the particular manner in which he was involved.

When asked, Steven said he would be willing to meet his mother at the clinic. He told me she had called but they had not met in person. Steven was quite apprehensive of having a meeting with his mother. I suggested that he knew that she would be angry and that she should be angry. I suggested he might as well get this over

with sooner, than later. We spoke about what he could say to her. Steven was cooperative and verbal about his situation.

### Sixth Session

In the sixth session I met with Eleanor, Leslie and Tina. The mother reported when asked if things were better, the same, or worse, that things were worse. Eleanor was feeling a higher level of stress than she normally experienced due to the sexual abuse disclosure and the events and people involved with her family. I reviewed with all of them the pattern I saw last session in which Tina was attempting to meet her mother's emotional needs. Eleanor noticed that her own moods were up and down. She was confused by Tina's behaviour because when she felt down, Tina tried to nurture her by dancing, making faces and generally attempting to cheer her up. On the days Eleanor felt fine, Tina was feeling down. I reframed this behaviour as the child realizing that her mother felt alright, and did not need to be cheered up. Therefore, Tina could experience and express her own emotions.

Since the second interview with the mother and daughters (Session Four) Tina had been having fits of anger. She was yelling, screaming, and then running into her mother's bedroom and pounding on the bed. Eleanor did not understand this behaviour and ended up hitting Tina out of frustration. Eleanor was made aware that hitting was not appropriate and that Tina's behaviour was reframed as excellent and to be encouraged as a way for Tina to release her anger. Eleanor was then clearer that she must "fire" Tina from her role of trying to 'mother her own mother' by attempting to meet her mother's emotional needs and that she should encourage Tina to express her own feelings of anger. I suggested to the mother how she could support Tina and give her permission to talk and express her feelings about the abuse. The mother was instructed to allow Tina to pound her bed and then lay with her and talk about what she was so upset about.

We set a date to review the "Feeling Yes/Feeling No" videos with the children and the mother.

For the remainder of the session I met with Eleanor alone. She was willing to meet with Steven at the clinic. She had been unable to see him, on her own, for fear of what she may say or do. The purpose of the meeting with Steven would be for Eleanor to confront Steven over his behaviour and find out exactly what had happened, as well as to ask him what he planned to do about this whole issue. This was a way of introducing the mother to problem solving.

Eleanor was encouraged to attend court with Steven to show she had not given up on her son. She was unsure if she could ever allow Steven to return home to live. She was told Steven himself has said he would like to continue staying with Flo for the next few years until he completed his high school.

Eleanor could not understand why Tina did not tell her when she was being abused. This was my lead into a discussion which involved a detailed description of Eleanor's own assault and how she was unwilling to tell anyone, including her own mother.

Eleanor's sexual assault occurred not long after her parents separated when she was employed as a live in babysitter. The father of the children sexually assaulted Eleanor and led to her being fired. As a result, Eleanor felt blamed. She did not tell anyone until four years later. She told her mother just prior to her marriage to Bruce but could not remember why she told her mother, only that it was blurted out in anger. Eleanor explained that, in her family, they never talked about sex or sexuality. This discussion was then used to demonstrate why Tina did not tell Eleanor and to ask the mother what she thought should have happened now that she looks back as a more knowledgeable adult. This question was another way to introduce problem solving to the mother and to educate her about how she could deal with the current situation.



The discussion of the mother's own assault was a way for me to check on the process level information which my supervisor had pointed out several sessions earlier. That is, the mother's world view included the belief that things will not work out and in addition that she will be blamed when things do not work out.

Eleanor's mother and father separated when she was a teenager. She never saw her father after the separation. She described him as very strict. Eleanor grew up quickly and was always around adults. Her mother always openly stated that she was a "man hater" and constantly told Eleanor that men were "no good". According to Eleanor, her mother gave birth to a child as the result of a sexual assault when her mother was an adolescent. Eleanor's mother suffered from depression for most of her life. During my involvement with this family, Eleanor's mother resided within driving distance, and they were in contact approximately once a week. Eleanor was clearly not well differentiated from her own mother. She easily "exploded" with anger and frustration in her presence. She often expected more of her mother than her mother could offer as her mother was constantly moving in and out of a depressed and confused state. Eleanor ended up feeling disappointed. This disappointment was another confirmation of the pattern described in the assessment.

When asked, Eleanor reported that she was most upset because she felt that all these years she has had to care for Steven and the other children basically on her own and now (in tears) when things are down and going poorly she is made out as the "bad guy", while Bruce and his mother Flo, are made out as the "good guys", helping Steven. This situation was very unfair to her. We talked about what was really happening and about how she had held in there, no matter how tough things got, and that this current situation was not going to change all of the things she did do to try and help her children. She was feeling guilty, stating she brought her children up to be better than

this. When asked if she thought Steven could have been abused in the past she was unsure, but said it was possible because they had many sitters.

We spoke of several things Eleanor could do for herself to reduce the anxiety she was feeling, including arranging time for a hot bath, making time to visit her friend whom she had stopped seeing when Tina disclosed that she was being abused and forcing herself to go for walks no matter how tired she was and continuing to work and not quit her job. Eleanor was continually shown to be in charge with the mind set that it will work out, that she will take charge and make it work out.

### Seventh Session

In the seventh session I met with Steven to prepare him for his first meeting with his mother. I prepared him for this visit by going over the questions I believed his mother would ask and by having him go over his responses. These questions included: Why did he do it? What happened in full detail? How does he feel now? How does he think Tina feels now? After some probing, he raised the idea that he should apologize to his mother. I asked him exactly what he would say in this apology? What does he plan to do now?

Steven felt isolated at his grandparents. He had nothing to do so he had started to place some effort at his school work and had brought his average up to seventy-three percent. He was complimented for working hard at school. He was now requesting to attend the sexual offender group at the clinic.

We spoke for a brief time about Steven's dreams and night terrors. He did not remember ever having these night terrors or screaming out at night. He said he could not remember his dreams. He was only aware that he had these night terrors because his mother told him that he had them. I assigned him the task of writing the word "dream" in large letters across a piece of paper and placing it beside his bed, to remind

him to think about what he had been dreaming about each morning. He was aware that we would be talking further about these dreams in future sessions.

### Eighth Session

For the eighth session I met with Eleanor, Leslie and Tina. The first hour we viewed Part One of the "Feeling Yes/Feeling No" video tape series. The focus of this video tape is the importance of expressing your feelings, both good and bad, and is aimed in particular at children. Expression of feelings is an important skill that would be helpful in this family because the mother tried to hold her emotions in and eventually exploded, usually in anger. As well, the video tape teaches children the ability to say "no" in the context of sexual abuse. This ability is an important self protection skill.

For the second hour, I met with Eleanor separately from the children to see if she followed through on some of our previous suggestions. Eleanor stated that, after our last session, Tina went home feeling she had permission to hit Leslie and to tell her mother "no". Eleanor allowed this behaviour to continue for one week feeling that it was allowing Tina to vent and express her anger. Eleanor finally became angry and said "enough". I complimented Eleanor for allowing Tina to vent her anger but suggested it might be better to tell Tina that hitting is not allowed, but that pounding the bed is alright. We again spoke of Eleanor being in charge and firing Tina from taking on the job of trying to meet her mother's emotional needs.

Eleanor did attend Steven's court hearing but arrived a bit late and was in a fluster because it was over before she knew it. Flo and her son, Bruce, were also present and they were going to leave without talking to Eleanor. Eleanor described having a blow up with Flo and realized this blow-up was more the result of her feeling anxious than anything else. She was angry at Flo because she had not informed her of Steven's various appointments. She told them that she was still Steven's legal guardian and mother, and that she wanted to know what was going on. Eleanor was praised for

asserting herself as in charge. We spoke of alternate ways to get the same results without her feeling upset.

Eleanor did a number of things to attempt to reduce her anxiety level as suggested in our last session. She visited her friend seven times, managed at least one hot bath and "thought" about going for walks.

Eleanor's biggest concern was our future session with Steven. She did not know what had happened between Steven and Tina and had been thinking about this constantly. This behaviour fit with her pattern. We reviewed what questions she should ask and what was acceptable behaviour. Eleanor was concerned that she might lose control, explaining that I had never seen her really angry. I again told her that I expected her to be angry and that she should be angry with Steven. I suggested that she really give him "a piece of her mind".

### Ninth Session

In the ninth session I met with Eleanor and Steven. This session was the first time the mother had actually sat and talked with her son since the disclosure, which was approximately one and one-half months earlier. The mother was able to remain in control and, with assistance, confronted Steven. Steven broke down and cried. He let his mother know that he was suffering as a result of the sexual abuse disclosure and was finding the whole thing very traumatic. Like his mother, Steven stated that he has difficulty talking about his feelings. He did very well in this session and told his mother exactly what had happened. Efforts were made by both parties to talk about what should happen with Steven. They agreed to meet again.

We also spoke about Steven's night terrors and Eleanor reported that Steven has had them for approximately nine years. Steven did make attempts to recall his dreams as part of a previously assigned task without success.

The next scheduled session, which was to involve the mother and her two daughters, was cancelled because Eleanor was feeling ill.

### Tenth Session

For the tenth session I met with Steven. Eleanor was to attend but misunderstood and thought our session was the following day. I introduced the therapist who was taking over the case. Steven was quite worried about his upcoming court appearance. I did not try to reduce his apprehension but again reaffirmed that what would be most helpful for him was to request to be ordered to attend the sexual offenders group at MacNeill Clinic. He understood that if this was not addressed in court, he should make sure that his lawyer and the judge were aware of his request.

Steven felt his living arrangement was working out satisfactorily. He was playing hockey and had started attending a youth group once a week. He also said that he now had a fifteen year old girlfriend. His only concern about living with his grandparents were the rules which he felt he must obey because of his involvement with the court. One of the rules involved the biological father telling Flo that Steven could not attend a local indoor skate board park because of the possible exposure to drug abuse. Steven had been attending the same skate board park for years. As well, Steven did not like the idea of not being allowed to have his girlfriend over unless his grandparents were home. I had Steven raise both these issues with the grandmother before he left. I also ensured that the grandmother was in charge and not taking direction from her son, Bruce, as she was caring for Steven in her own home. As this was my final session with Steven, I had him complete all of the post measurement instruments.

### Eleventh Session

For the eleventh and final session I met with Eleanor and Leslie. Tina did not attend because she was tired and feeling cranky. I introduced the therapist who was taking over the case. I suggested to Eleanor that she encourage Tina to talk about what

had happened between her and Steven. If Eleanor became frustrated with Tina she was to tell Tina she was frustrated, but that it was still alright to talk about what had happened. Eleanor was to give Tina a clear message that she was not at fault. To date, Tina had not talked about the abuse, and Eleanor was not sure how to encourage Tina to talk.

I asked Leslie what she understood was the reason she had had to babysit most of the time in the past, while Steven had not. The mother had told Leslie that Steven could not babysit because of what they had seen on television, meaning the show which depicted a sexual assault. I learned that this had not been a movie, but actually a news report of a sexual assault. Leslie had not clearly understood what her mother was saying but had not questioned what was being implied. Now Leslie was clear that her mother was only trying to protect Tina.

We spoke of how they could arrange Christmas visits with the least amount of difficulty. In keeping with the court order, Steven was not to have any contact with Tina.

Eleanor felt that things were much improved and had a few good days. I complimented Eleanor on her work and her family. As well, I strongly encouraged them to continue in therapy, stating that I felt they could gain from continued involvement with the clinic. Both Eleanor and Leslie completed the post measures.

### **Results of the Evaluation Instruments**

The results of the Family Assessment Measure, the Family Problem Checklist and the Hopelessness Scale for Adolescents show that therapy had been effective in bringing most of the scores down from the family problem area into the average range.

### **FAM-III Profiles**

The results of the Family Assessment Measure Post Test (Figure VI, p. 109) confirm the assessment that there were significant improvements in the family's functioning. There was a large change in the mother's score in task accomplishment, showing that she was much more able to organize and achieve basic developmental and crisis tasks. The mother and the children were much closer in their scores for values and norms, indicating a greater harmony among family members. Steven still scored in the family problem area for affective expression and involvement. This score likely has to do with the family's pattern, the nature of the issues, his living circumstances and his increase in anxiety as a result of his upcoming trial.

As previously stated, the FAM-III is designed to pick up on overall family functioning. I attribute the large swing into the average range on the FAM-III scale due to the many targets of the intervention.

### **The Family Problem Checklist**

The Family Problem Checklist also showed improvement. The mother's responses all moved to "in between", "satisfied" or "very satisfied". Her overall satisfaction with her family and feeling good about herself moved from "dissatisfied" to "satisfied". Steven's responses remained mostly in the "in between" category reflecting how unsure he was of his position in the family and what would happen after court. Leslie's responses all moved into the "satisfied" or "very satisfied" area. Her overall satisfaction with her family and feeling good about herself moved from "in between" to "satisfied". For an overall review of the outcome results of the Family Problem Checklist, see table IV, p. 110.

### FAM GENERAL SCALE

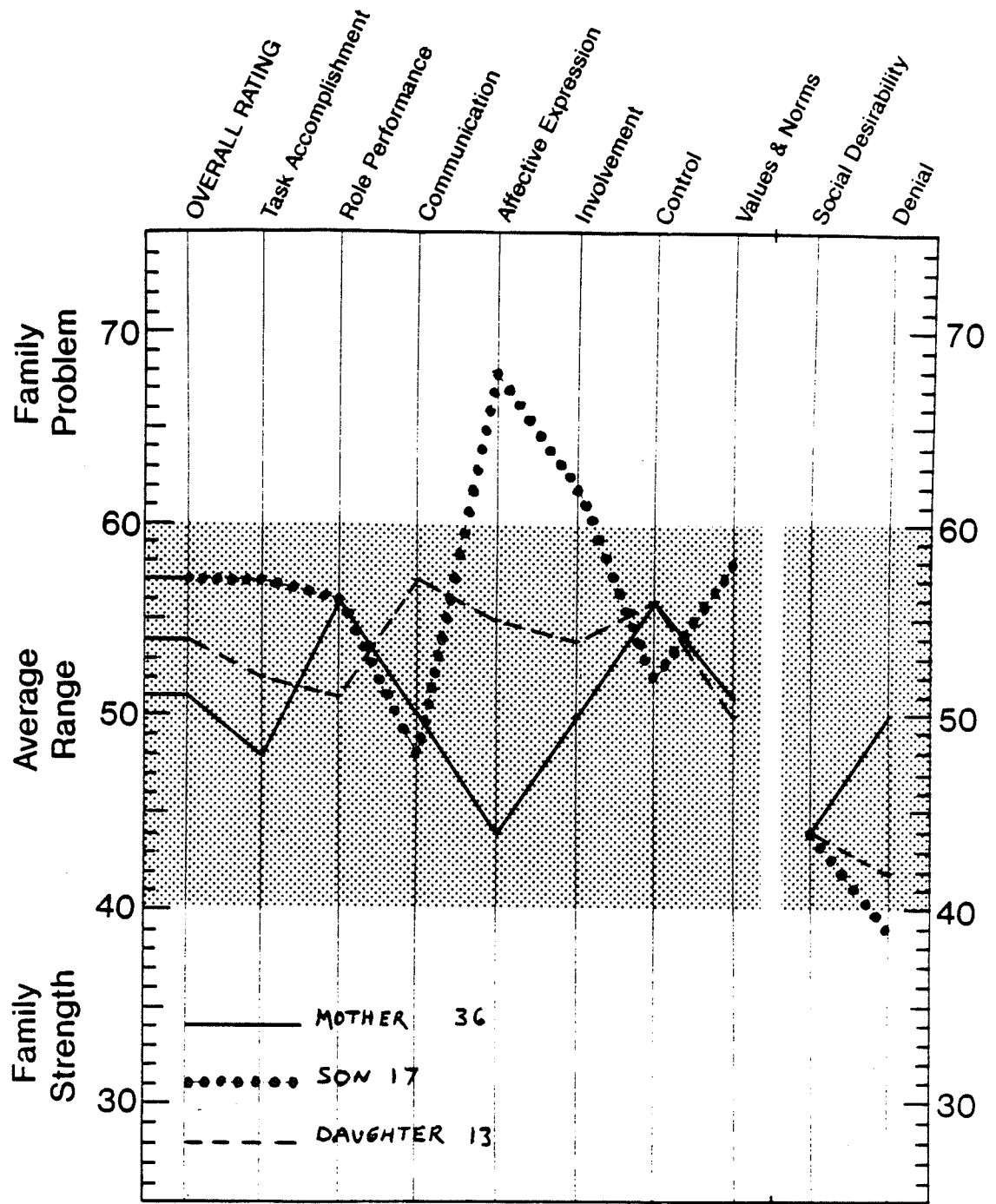


FIGURE VI

POST TEST FAM-III PROFILE FAMILY TWO



**TABLE IV****FAMILY TWO**Outcome Results of the Family Problem Checklist

Outcome	Mother	Son Age 17	Daughter Age 13
Positive Change	14	9	16
No Change	7	9	5
Negative Change	1	3	0

**TABLE V****FAMILY TWO**Outcome Results of the Hopelessness Scale for Adolescents

Family Member	Pre Test	3rd Session	Post Test
Son - Age 17	3	6	6
Daughter - Age 13	5	N/A	5

**The Hopelessness Scale for Adolescents**

The scores on the Hopelessness Scale for Steven remained unchanged from the third to final session, at six out of seventeen. Leslie's scores also remained unchanged, at five out of seventeen. The post test scores for Family Two were within the median range and, therefore, indicate that hopelessness was not a critical concern in this case.

**The Brief FAM and the Client Feedback Form**

A few days after my final contact with this family I had a colleague contact the mother for some feedback. On the Brief Family Assessment Measure her score was fifty-three indicating that this family was functioning in a healthy way. This score is approximately the same as her score on her post-test in the Family Assessment Measure,

general scale, which was fifty-one. The brief FAM was a way to check on the mother's FAM-III post-test score and indicated that her score is accurate.

On the Client Feedback Form, the mother stated that there had been a great deal of change in her family situation and that there had been some improvement in their family situation as a result of their contact with me. As well, she stated that things had improved a fair amount for her personally. She reported that she was not very good with words but that she had been very pleased with the service and very satisfied with her therapist. When asked what the therapist had done that worked for her family, she said, "Despite being male he used a calm quiet approach which was very helpful".

### **The Termination Summary**

As a result of the interventions there was a progression toward attaining all of the stated treatment goals, with the exception of working toward a clear decision with all the players regarding whether reunification of this family was possible. In my opinion, this family was able to deal with the initial abuse crisis, and the mother was progressively placed more in charge with meeting her children's needs and parenting in a more functional way. As well, we worked toward the mother meeting some of her own emotional needs and reducing her depression.

Steven was assisted in making a clear disclosure of the abuse to Tina with his mother. Eleanor and Steven were both engaged in a confrontation session so that they could begin to work towards some type of resolution. Efforts were made to have Steven openly take ownership and responsibility for the sexual abuse. He was convicted of sexually assaulting Tina and ordered to attend the sexual abuse group at the clinic. He was open and cooperative. This cooperation is less common for someone his age and, therefore, a good sign he would follow through with therapy. I was not able to learn anything further about Steven's night terrors but I suspect that this behaviour, in combination with sexual offending, is a strong indicator that he has been abused. It may

also be just a sign of emotional abandonment by a mother who had been told all her life that all men were bad.

The mother had attempted to support Tina throughout our contact. Some attempts were made to lead the mother through a discussion of her guilt about not being there to protect Tina. Tina had not yet talked about the assault, and the mother needed to be supported and assisted in learning how to get Tina to express her anger and to talk about the abuse. These efforts would assist Tina in working through her own victimization.

The "Feeling Yes/Feeling No" video tapes were reviewed with the mother and her two daughters. The process of beginning to assist Eleanor in learning how to discuss sex and sexuality was started in order to help her be more able to educate and protect her children.

The mother also began setting more reasonable expectations for Leslie. Leslie was going out more often and was having more contact with age appropriate peers.

Overall, the family was functioning in a more healthy way. In our final session I spoke with the mother about continuing in therapy for her children and herself. She felt better about how things were going and was willing to continue with the new therapist. Some mention was made of her attending a sexual abuse group for herself.

When I consider the family as a whole, I would assess that there was improvement in each of the FAM-III subscales as a result of the clinical interventions. As well, the major presenting problems in this case, the conflict between the mother and Leslie over chores, the stealing, and the sexual abuse crisis, were much improved.

Family Two was a very gratifying case to work with. I have had several years experience working with sexual abuse cases as a social worker employed by Child and Family Services, but I was never before able to form such a strong connection and gain such positive results in such a short period of time. I attribute this success to the

cooperative nature of the structural/brief approach and to learning how to read process and utilize this information in therapy.

Supervision and the act of writing about this family taught me about the importance of process as well as content (Literature Review, p. 29). I have begun to learn this valuable skill in working with families. This skill enables the therapist to assess and work with a family with increased speed, accuracy and, most importantly, understanding. At my beginning level, when watching experienced therapists, I found myself attributing to the therapist an aura of "magical" insight, clarity and understanding in what seemed like minutes, even in first sessions with families. I now know that what I was really witnessing was the therapist's skill at reading process, which was developed from hard work and years of experience.

In this case, the mother and her children never really told me anything about the major areas in the assessment. As the mother stated in the client feedback section, she was not very good with words. This statement also applies to her children. The majority of my understanding was gained through process level information. My understanding of process was gained through skilful supervision, by watching video tapes of sessions and, finally, by checking directly with the family. In this way I learned about the family, and so did they. This increased understanding for all of us and helped them find a solution by using the strengths and resources they already had (Literature Review, p. 31). These strengths and resources were highlighted in the very first session, even before the family and I were able to set concrete goals. These strengths and resources were then built upon in each session to assist the family to find a solution.

Due to the presenting circumstances and the nature of the problem, I did not follow the approach as closely as I did in the first family example. This will be more fully discussed in the following section.

### Summary

Family One gives a good description of the therapy process. It demonstrates that, although the structural/brief approach is a systems based approach, it does not look globally at the larger ecological systemic view. Once a change has occurred, and the family looks like it can maintain this new direction on their own, the therapist's role is completed. As previously stated in the discussion of Family One, "it is more like looking at one rung on a ladder, repairing it and hoping the family will move to the next rung" (George Enns, personal communication, December, 1990).

In Family Two there was more emphasis on the structural family therapy approach as the directiveness of this model lends itself to issues like sexual abuse. The brief therapy approach is not as appropriate, particularly in the early stages of sexual abuse cases, because it is less directive and places more responsibility on the client for the problem and solution. Some aspects of the brief, solution focused approach were applied in this case and contributed to the overall effectiveness of the therapy. For example, the structural/brief approach as presented here was helpful in promoting change by using the strengths and resources the family already had and building upon these to reach a solution (Literature Review, p. 31). As well, I successfully connected the future to the present (Literature Review, p. 37) particularly in the session where I talked with the teenage boy about how he could do things differently in order to prevent himself from becoming reinvolved in sexual offending behaviour. This same approach was used with the mother in order to assist her to protect her children and help herself out of a pattern which helped make her feel depressed and overwhelmed.

In this case there were also some major departures from the approach. For example, de Shazer states that an intervention only needs to open the way to a solution which can be done without knowing what is maintaining the problem or without knowing the person's past. He asserts all that is required is that the client do something different.

In sexual abuse cases it is very helpful to review history. Discussing the exact details of the abuse exposes the secret which previously helped perpetuate the problem and often keeps individuals and families from seeking and obtaining help. As well, discussing the details of the assault is a way to have the offenders acknowledge what they have done and is the start of the process of solving the problem. Sexual offenders often do not seek or attend therapy.

The mother's past unresolved sexual abuse was influencing the whole family's lack of appropriate boundaries, lack of communication, poor problem solving skills and lack of dealing with crisis issues. These issues require, in my opinion, dealing with the past in relation to how they effect the present family functioning and how they may effect the family's functioning in the future.

As well, de Shazer states that according to the concept of wholism (Literature Review, p. 33) solving the client's complaint does not necessarily mean seeing the whole family, as a change in one part of the system leads to change in the system as a whole. Further, de Shazer states that a change in any one member of a family will lead to changes in behaviour of the other members in the system. In Family Two I could not see the whole family together because the court did not allow contact between the victim and the offender. However, I still saw the teenage boy individually and later on in therapy with his mother. Just seeing the mother and her daughters would not have been very helpful because it would have meant not dealing with the offender or how the various members of the family were part of the problem and the solution. This approach supports the belief that family therapy is an important part of the treatment of sexual abuse.

Both case examples illustrate how the structural/brief approach is a way to look at and understand problems, therefore allowing options and alternatives to work with individuals within the context of their family.

## CHAPTER SEVEN

### COMMON FINDINGS

In this chapter I will comment on the commonalities that I found amongst the nine families that were a part of this practicum. This chapter includes discussion of the family life cycle, adolescence, the structural/brief approach, the evaluation instruments and the clinic's evaluation of my progress.

#### The Family Life Cycle

In all nine families, I found that viewing symptoms and dysfunctions in relation to "normal" functioning, over the period of time of the family life cycle, was helpful. It increased my understanding of the problem and provided me with direction because I had a clearer understanding of what should be happening with families in that stage of the life cycle.

All of the families' difficulties began in the transitional period, most commonly from childhood to adolescence. This fact supports Carter and McGoldrick's view that family stress is often greatest when the family changes from one stage to another. (Literature Review, p. 6) In Family Six, the most stressful family that I saw, when the developmental stress met the transgenerational stress, a lot of anxiety surfaced in the system which is congruent with the family life cycle theory (literature review, p.8)

All the families lacked time perspective when dealing with problems. The families often used methods of dealing with issues which, although successful in the past, proved unhelpful in a new and different developmental phase. Family One was a good example of this problem.

In families Four, Seven and Nine, where the problems appeared more acute and ingrained, the adolescents were in triangles with parents who were themselves having serious relationship difficulties. These triangles appeared to place the adolescents in

positions in which they had no power, felt frustrated and engaged in behaviour unhelpful to them. Other types of triangles existed in the other families, but none as powerful as the ones in these three cases.

### Adolescence

In all nine of the families, I found that having some understanding of the tasks of adolescence helped increase my understanding of the presenting problem. Like the family life cycle, this understanding gave me direction and, therefore, a clearer understanding of what should be happening.

In eight of the families, the parents had difficulty balancing nurturance with encouragement that the identified patients needed to become more responsible for themselves, a difficulty connected to the task of autonomy in adolescence. This task of autonomy was an issue easily discernible in each case. In the families where the adolescent was older, Families One, Four, Five and Six, the issues around autonomy were more acute.

In all nine families, the parenting styles fit into what Garbarino (1986) calls the authoritarian or permissive style of parenting (Literature Review, p. 21). According to Garbarino (1986), there is more conflict in these types of homes, which is congruent with the conflict in the families seen for this practicum.

I found that, as I worked with the families and encouraged them to move in the direction of taking on more functional roles, they developed more of what Garbarino (1986) called an authoritative style of parenting. This development paradoxically improved the relationships between the parent and child. This finding fits with Garbarino's belief that, in North America, authoritative parents have the best relationships with their children. (Literature Review, p. 22).

I also found that, in every case, the family had a significant role in the presenting problem. None of the families could be said to have difficulties based simply on the



developmental stage of adolescence. As well, all of the families' difficulties had been in existence for a considerable length of time. Only Family Two stated that the onset of the problem was less than one year. On more careful examination, I found that difficulties in this family had clearly existed for years.

All of the above findings support a systemic family approach when working with troubled adolescents and their families.

### **The Structural/Brief Approach**

The brief approach is solution focused and builds on strengths. The more traditional approach to therapy is problem and dysfunction focused. Minuchin's structural approach works at changing the system. It uses power and control and is more of an oppositional process. De Shazer's brief approach asks the question; Has there been a time when it worked? - the exploration of the exceptions to the rule. As well, this approach builds on the client's strengths and works toward the client trying something different. This method is a less oppositional and a more persuasive one. In this way the brief approach is nothing magical at all.

For all nine of the families I found that it was critical to have a good assessment and a clear understanding of the problem and dysfunctional pattern before any intervention was assigned. Without a good assessment, it was difficult to assign tasks that fit. De Shazer's concept of fit is central to the process of initiating change. If the intervention does not fit with the client's complaint, it is unlikely new or different behaviour will be initiated (Literature Review, p. 34). This was particularly evident in Family Three where I did not have an accurate assessment and, as a result, assigned tasks that placed the family in the wrong direction, increased their resistance and nearly caused the family to withdraw from therapy. The need for an assessment is in contrast to de Shazer's brief family therapy model, which does not articulate a theoretical model for assessing families. De Shazer states an intervention only needs to open the way to

a solution which can be done without knowing what is maintaining the complaint or without knowing the person's past. All that is required is that the client do something different (Literature Review, p. 31).

De Shazer states that the therapist makes two maps when designing interventions. One map is of the client's interpretation of the complaint. The second map is of how the therapist sees the client's interpretation. The difference between the two descriptions or maps provides the therapist with information which may lead to a solution and provide the framework for designing the interventions (Literature Review, p. 34). These maps imply that de Shazer does make an assessment and that the intervention is based on this assessment. It could be argued that, although de Shazer does not articulate a theoretical model for assessing families, he has been influenced by his education, experience and other well known therapists. These influences have effected the way he works and assesses a family, only he is so practical and experienced that his assessment is done quickly and intuitively.

De Shazer also states that any change has the potential of starting the "ripple effect" which will lead to expectations of more success and so on (Literature Review, p. 32-33). From my experience with the nine families, particularly Family Three, I found that not just any change may be enough to be a part of a solution. It has to be change in the right direction. Without an accurate assessment, the therapist might initiate change that leads in a negative direction and, instead of creating expectations of more success, the therapist could contribute to building on a downward cycle in which the client's expectations generate further expectations of failure, and therefore do not lead to a solution. Again, this points to the importance of having an accurate assessment as well as knowing what direction to move toward in therapy.

In contrast to the brief approach, the structural framework clearly articulates an assessment by looking at the dysfunctional pattern and context. The therapist can use this

information to help guide him in the appropriate direction and therefore assign tasks that fit. For example, Family Three was an enmeshed family system in which the identified patient was being smothered by the family. Once the therapist has an assessment of the family and understands that the family is an enmeshed system he can suggest tasks which will move the family in the opposite direction, and therefore increase distance between family members.

An accurate assessment of the family and its dysfunctional pattern is an important part of constructing effective interventions that point the family in the desired direction. In this way the two approaches compliment each other. The structural model provides a way to assess a family and therefore provides direction. The brief model provides a way to utilize this information and promote change.

The name "brief therapy" is a bit misleading. As stated in the Literature Review (p. 31), brief therapy is not about time frames, it is about an approach which is focused on solutions. To successfully work through the issues brought to therapy by each of the families could take a considerable amount of time. For example, Family Two was a very successful case, but it is important to note that eleven sessions did not solve generations of unresolved sexual abuse and depression. It is quite possible that this particular family could be in therapy for several years before they reach a point where they would have a much better chance of living in a more healthy functional manner.

I found that, in terms of time, many aspects of the structural/brief approach proved to be efficient and effective in my work with all nine families. The following are some components, qualities and characteristics of this approach which support this view.

Approximately half way through the internship I realized that setting clear goals (contracting) with the family as well as having clear objectives of how to attain these goals were very helpful. These things provided both myself and the clients with clarity and focus, which in turn gave both the clients and myself a sense of direction, something

against which to measure change. All of these things were very critical. As stated by de Shazer in the literature review (p. 37), without setting goals therapy can be a never ending, confusing process.

I found that, for the majority of the families I saw, the structural/brief approach was supportive and validating. It provided mutual respect between client and therapist. The families felt heard and understood. Overall, it was a very positive way to work with families.

When families came to therapy they seemed to expect the worst. They expected to be told negatives about themselves. When I complimented them by telling them the things I felt they have done well, it had impact and built a quick working relationship. The compliments were a nice way to acknowledge the positive things the family had done. It gave them a boost and helped ensure their return.

Compliments can be viewed as interventions in their own right. I found that, in the majority of cases, when a family was complimented on one of its strengths, the family increased its efforts in that direction and, therefore, the compliments could be used to work toward a solution.

Tasks or suggestions, when they fit with both the problem and the compliments, supported the family into carrying out what was assigned. As a result, the family believed I had an understanding, and they were more willing to try something different.

Both the solution focus and the problem focus may provide the therapist with the same information. The solution focus, however, is much more of a positive experience for the family and more helpful in the sense that it is more likely to promote change.

In the majority of families the structural/brief approach was helpful in keeping clearer boundaries between myself and the families. There was less chance of becoming entangled within the system because I was not focused on exploring the problem. The responsibility for the problem and the solution was left with the client. As well, there

was less responsibility on myself for the frames and intervention. These characteristics of the approach helped keep me from being emotionally drawn into the system resulting in the symptom being supported and the problem continuing.

The structural/brief approach from the start of the first session built on the families' cooperation. This cooperation helped make therapy in the majority of families a positive experience. As stated in the literature review (p. 35) de Shazer views resistance as only a concept and that the concept of cooperating is much smoother and faster in therapy and therefore more efficient. I found this aspect of the approach to be very significant in terms of this approach being efficient and effective. For example, the success of Family Two was strongly connected to building on cooperation. Family Three and Family Six were more resistant families. Applying this approach assisted in building cooperation to achieve success at promoting positive change with these families, although I would have previously labelled them as difficult, uncooperative, and resistant.

I found that in the majority of families part of building a supportive context for change was connected to the choice of words and language used by the therapist. This skill was particularly evident when watching other therapists who often used the words "try something different" and "solution" as a natural part of their interviews. These words are part of what de Shazer calls "solution talk". Reviewing my sessions on videotape and supervision also demonstrated how important choice of words and language are when working with people.

Choice of words was of particular importance when designing tasks which fit with the complaint. As de Shazer says the intervention is based on the same interactional and contextual description of the complaint as interpreted by the therapist, with the exception that the therapists' description has constructed the client's problem with a solution in mind (Literature Review, p. 34). This skill was all part of creating the context for change and was important to the process of therapy.

Overall, I found the structural/brief approach not just to be a cluster of techniques, but rather a way of thinking, understanding and intervening with adolescents and their families. The attitude of the therapist and the way he sees his clients and their situations influence their involvement and impact. This was consistent with the theory on the structural/brief approach (Literature Review, p. 28 and p. 43). For example, in Family Six the approach changed the way I viewed the identified patient which contributed to building on the client's cooperation and the effectiveness of the therapy.

### **Does the Integrated Approach Work?**

In this practicum the approach was applied to a range of presenting problems and family forms and was helpful in promoting change in the majority of cases. Having stated this, I think that a pure application of this approach was not always helpful in promoting change in all situations. For example, Family Two illustrated some of the strengths and weaknesses of the approach and was the one family problem (incest) that I worked with during the internship which demonstrated a departure from the theory. I found that overall, it may be more helpful in promoting change when working with a range of family forms and presenting problems to integrate some of the history and what is maintaining the problem with the structural/brief approach.

### **Evaluation Instruments**

The use of measurement instruments in my work as a therapist was new to me. Even though I had taken some course work on clinical evaluation I did not truly believe they would be helpful. What I found was that the instruments were exciting, useful ways to add to my work with the families. They added in terms of assessment, evaluating outcome, and in one case, helped to focus and engage people within a given session.

The FAM-III in particular was an accurate sensitive instrument for assessment in every case. As previously stated the FAM-III is designed to pick up on overall family functioning and therefore does not pick up on specific goals. For example, in Family

One it did not show a significant change which involved a hierarchal role reversal. In this case, the FAM-III was not as helpful in making pre and post test comparisons. In contrast there were many targets of the intervention in Family Two which promoted change in several areas of the family's functioning. These changes clearly showed up in the FAM-III post test profile.

In addition, although the FAM-III did distinguish between strengths and weaknesses, it took time to score and interpret the results. In this way I did not have immediate access to the strengths which showed up on the scale and therefore could not use this information in the first session which was the foundation of my involvement with the family. In this sense the problem checklist was much more of a useful and appropriate instrument when applying the structural/brief approach.

The problem checklist was completed quickly by the families and was helpful in showing change on a pre and post test basis. As well it often showed difficulties which family members did not raise in first sessions.

The Hopelessness Scale for Adolescents was useful in providing pre and post comparisons. It appeared accurate in the sense that those adolescents whom I assessed as higher risk for self harm scored higher on the scale, which is what should happen. For example, the identified patient in Family Three had the highest score of all the adolescents I saw and from my initial assessment was the most hopeless about their situation.

I found myself anxiously awaiting the results of the client feedback form. In each case, the comments were reassuring in that they fit with my assessment of how I did.

Overall, I have learned that measurement instruments are helpful and will try to incorporate them into my future work with families.

### The Clinic's Evaluation of My Progress

My supervisors at MacNeill Clinic pointed out that what seems to drive me to do this work and organizes my learning is my desire to be competent and attain what I feel is the best I can do.

My strengths are: my sensitivity, the flexibility to "back off", good personal boundaries, my ability to engage with families easily and well, the ability to keep focused, the flexibility to be supportive, the flexibility to explore sensitive issues, and a strong desire to learn. I became more aware of patterns, became more competent, became more aware of the emotional pull a family has on me, and learned how not to allow this emotional pull to control the interview. I learned ways to maintain engagement with difficult families who did not wish to return. There was a change in my view. My child welfare experience told me parents do not have control and could not gain control. This is false. Parents can gain control and when they do not, boundaries become confused and there is no structure provided.



## CHAPTER EIGHT

### Conclusion

In conclusion, applying the structural/brief approach to a variety of presenting problems and family forms exposed me to a variety of family contexts which increased my understanding and knowledge of the dynamics of troubled adolescents and their families. The structural/brief approach was found to be an effective combination. The structural assessment provided me with a framework to understand what was happening in a given family. This understanding helped provide me with direction, focus and, therefore, clarity. The brief approach provided me with the "tools" to achieve my goals and a framework for understanding how change works.

My skill development as a therapist was primarily guided and assessed through supervision, seminars, review of video tapes of sessions, both on my own and in supervision, as well as watching live interviews. I became more competent and skillful. As well, I learned what to watch out for and was given suggestions to follow so that I may continue to develop and grow as a therapist.

I increased my understanding of troubled adolescents by examining the context of the various families, including the developmental and family life cycle stage. Viewing symptoms and dysfunction over the period of time of the family life cycle, and understanding the developmental tasks of adolescence, provided a theoretical base for understanding adolescents and provided direction by increasing my understanding of what should be happening in this stage of the life cycle. This information was utilized when assessing families, when making compliments, and when designing tasks which fit with the interactional and contextual constraints of the situation.

I found the structural/brief approach to be an effective way to work with troubled adolescents and their families based on the following factors: it is solution focused and builds on the client's strengths; it is a less oppositional and a more persuasive method

compared to a more traditional problem focused approach to therapy; it is supportive, validating and provides mutual respect between client and therapist; it helps the client feel heard and understood; it is helpful in keeping the boundary between the therapist and family clearer. In addition, the cooperative nature of the approach is significant and contributes to the approach being efficient and effective.

Overall, the structural/brief approach was a very positive, effective way to empower clients and promote change. The approach promoted change in the majority of cases in this practicum. I found that, overall, when working with a range of family forms and presenting problems, it may be more helpful in promoting change to integrate some of the history and what is maintaining the problem with the structural/brief approach.

The evaluation instruments were useful in corroborating the assessments; measuring change in families; and indicating the effectiveness of therapy using the structural/brief approach.

Near the end of the internship, I worried that I might not remember or be able to use all that I had gained. I found that it takes time to fit all the pieces together so they make sense, and to integrate what you have learned. The writing of this practicum report and my current practice show me that I have met all of my objectives and that I have not forgotten. This information will stay with me and effect the way I work as a therapist.

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**APPENDIX A**

**The Letter of Permission For the Family Assessment Measure**



October 15, 1990.

Addiction  
Research  
Foundation

Fondation  
de la recherche  
sur la toxicomanie

Central Office  
Siège social:

33 Russell St.  
Toronto, Ontario  
Canada M5S 2S1

33, rue Russell  
Toronto, Ontario  
Canada M5S 2S1

Tel: (416) 596-8000  
Fax: (416) 596-8017

Mr. John Smyth

Dear Mr. Smyth,

I am responding to your request regarding the Family Assessment Measure. You have my permission to use the FAM-III in your study of therapeutic outcome with adolescents and their families.

Please respect our copyright and do not make copies of the instrument available to others or reproduce it without my permission.

Obviously, I would be quite interested in your findings. All the best with your work and please let me know if I can provide you with further information.

Sincerely,

Dr. Harvey A. Skinner  
Professor and Chairman  
Department of Behavioural  
Science  
Faculty of Medicine  
University of Toronto  
and  
Senior Scientist  
Addiction Research Foundation

**APPENDIX B**

**The Letter of Permission For the Hopelessness Scale**

Yale University

Department of Psychology  
P.O. Box 11A Yale Station  
New Haven, Connecticut 06520-7447

Campus address:  
2 Hillhouse Avenue

January 4, 1990

Dr. John R. Smyth  
MacNeill Clinic  
912 Idylwyld Drive North  
SASKATOON, Canada  
S7L 0Z6

Dear Dr. Smyth:

I am writing to respond to your letter that was recently forward to me from my prior address in Pennsylvania. You mentioned your use of the Hopelessness Scale with adolescents and changes in the scale that you have made.

At the outset, please feel free to use the scale. I cannot comment on your changes in an informed way. On the one hand, items in a relatively new scale perhaps should not be viewed as immutable or more useful or valid than an altered version. On the other hand, altering items commensurately affects the conclusions about validity and the relations between studies of the scale.

If you are interested in further work on the scale, articles in the last few years have appeared in the Journal of Abnormal Child Psychology and the Journal of the American Academy of Child and Adolescent Psychiatry. These are not papers in which I have been involved and hence cannot send reprints.

Good luck with your work.

Best Wishes,

Alan E. Kazdin, Ph.D.  
Professor of Psychology

AEK/js

**APPENDIX C**

**The Family Assessment Measure**

# F A M e a s u r e

## GENERAL SCALE

### Directions

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

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

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

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

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

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

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

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



**APPENDIX D**

**The FAM Interpretation Guide**

TABLE 3

## FAM Interpretation Guide

## 1. TASK ACCOMPLISHMENT

## LOW SCORES (40 and below)

## STRENGTH

- basic tasks consistently met
- flexibility and adaptability to change in developmental tasks
- functional patterns of task accomplishment are maintained even under stress
- task identification shared by family members, alternative solutions are explored and attempted

## HIGH SCORES (60 and above)

## WEAKNESS

- failure of some basic tasks
- inability to respond appropriately to changes in the family life cycle
- problems in task identification, generation of potential solutions, and implementation of change
- minor stresses may precipitate a crisis

## 2. ROLE PERFORMANCE

## LOW SCORES (40 and below)

## STRENGTH

- roles are well integrated: family members understand what is expected, agree to do their share and get things done
- members adapt to new roles required in the development of the family
- no idiosyncratic roles

## HIGH SCORES (60 and above)

## WEAKNESS

- insufficient role integration, lack of agreement regarding role definitions
- inability to adapt to new roles required in evolution of the family life cycle
- idiosyncratic roles

## 3. COMMUNICATION

## LOW SCORES (40 and below)

## STRENGTH

- communications are characterized by sufficiency of information
- messages are direct and clear
- receiver is available and open to messages sent
- mutual understanding exists among family members

## HIGH SCORES (60 and above)

## WEAKNESS

- communications are insufficient, displaced or masked
- lack of mutual understanding among family members
- inability to seek clarification in case of confusion

## 4. AFFECTIVE EXPRESSION

## LOW SCORES (40 and below)

## STRENGTH

- affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity

## HIGH SCORES (60 and above)

## WEAKNESS

- inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a situation

## 5. AFFECTIVE INVOLVEMENT

### LOW SCORES (40 and below)

#### STRENGTH

- empathic involvement
- family members' concern for each other leads to fulfilment 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, symbiotic
- family members may exhibit insecurity and lack of autonomy

## 6. CONTROL

### LOW SCORES (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 in order to adapt to changing demands
- control style is predictable yet flexible enough to allow for some spontaneity
- control attempts are constructive, educational and nurturant

### HIGH SCORES (60 and above)

#### WEAKNESS

- patterns of influence do not allow family to master the routines of ongoing family life
- failure to perceive and adjust to changing life demands
- may be extremely predictable (no spontaneity) or chaotic
- control attempts are destructive or shaming
- style of control may be too rigid or laissez-faire
- characterized by overt or covert power struggles

## 7. VALUES AND NORMS

### LOW SCORES (40 and below)

#### STRENGTH

- 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 E**

**The Family Problem Checklist**

### FAMILY PROBLEM CHECKLIST

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

	Very Dis- satisfied	Dis- satisfied	In Between	Sat- isfied	Very Sat- isfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Making sensible rules					
5. Being able to discuss what is right and wrong					
6. Sharing of responsibilities					
7. Handling anger and frustration					
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline					
11. Use of physical force					
12. The amount of independence you have in the family					
13. Making contact with friends, relatives, church, etc.					
14. Relationship between parents					
15. Relationship between children					
16. Relationship between parents and children					
17. Time family members spend together					
18. Situation at work or school					
19. Family finances					
20. Housing situation					
21. Overall satisfaction with my family					
Make the last rating for yourself:					
22. Feeling good about myself					

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**APPENDIX F**

**The Hopelessness Scale for Adolescents**

HSA

The following statements are about how some young adults feel about their lives. Your answers let us know about how young adults feel about things.

I'd like you to tell me if the sentence is true for you or false for you. If the sentence is how you feel, you would say it is like you or true. If the sentence is not how you think you feel, you would say it is not like you or false.

There are no right or wrong answers. Please circle the "T" (true) or the "F" (false) if the sentence is like you or not like you ... "True or False".

- T F 1. I want to be an adult because I think things will be better.
- T F 2. I might as well give up because I can't make things better for myself.
- T F 3. When things are going badly, I know that they won't be bad all of the time.
- T F 4. I can imagine what my life will be like when I'm an adult.
- T F 5. I have enough time to finish the things I really want to do.
- T F 6. Some day, I will be good at doing the things that I really care about.
- T F 7. I will get more of the good things in life than most other young adults.
- T F 8. I don't have good luck and there's no reason to think I will, when I am an adult.
- T F 9. All I can see ahead of me are bad things, not good things.
- T F 10. I don't think I will get what I really want.
- T F 11. When I become an adult, I think I will be happier than I am now.
- T F 12. Things just don't work out the way I want them to.
- T F 13. I never get what I want, so it's dumb to want anything.
- T F 14. I don't think I will have any real fun when I am an adult.
- T F 15. Tomorrow seems unclear and confusing to me.
- T F 16. I will have more good times than bad times.
- T F 17. There's no use in really trying to get something I want because I probably won't get it.

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NAME

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DATE

**APPENDIX G**

**The Brief FAM**



**THE BRIEF FAM**

THERAPIST: \_\_\_\_\_

FAMILY: \_\_\_\_\_

In this part of the questionnaire we would like to know how you see your family **NOW**. The following is a list of statements about family life. Think about your family as I read each statement and tell me if you strongly disagree, disagree, agree or strongly agree.

	STRONGLY DISAGREE	DISAGREE	AGREE	STRONGLY AGREE
1. Family duties are fairly shared in my family.	1	2	3	4
2. My family expects me to do more than my share.	1	2	3	4
3. We feel loved in our family.	1	2	3	4
4. When things aren't going well, it takes too long to work them out.	1	2	3	4
5. I never know what is going on in our family.	1	2	3	4
6. We deal with our problems even when they are serious.	1	2	3	4
7. When you do something wrong in our family, you don't know what to expect.	1	2	3	4
8. We tell each other about things that bother us.	1	2	3	4
9. It is hard to tell what the rules are in our family.	1	2	3	4
10. My family tries to run my life.	1	2	3	4
11. We take time to listen to each other.	1	2	3	4
12. Punishments are fair in our family.	1	2	3	4

	<b>STRONGLY DISAGREE</b>	<b>DISAGREE</b>	<b>AGREE</b>	<b>STRONGLY AGREE</b>
13. When someone in our family is upset, we don't know if they are angry, scared or what.	1	2	3	4
14. We are free to say what we think in our family.	1	2	3	4

**APPENDIX H**  
**The Client Feedback Form**

THERAPIST: \_\_\_\_\_

FAMILY: \_\_\_\_\_

I am interested in your honest opinions of the service you received from your therapist. This information will be helpful to the therapist in future work with other families. Please respond to the answer which fits closest to your feelings.

1. To what extent did the therapist meet the needs of your family?

ALMOST ALL OF OUR NEEDS WERE MET	MOST OF OUR NEEDS WERE MET	ONLY A FEW OF OUR NEEDS WERE MET	NONE OF OUR NEEDS WERE MET
--	----------------------------------	--	----------------------------------

2. To what extent were you satisfied with your therapist?

VERY DISSATISFIED	DISSATISFIED	SATISFIED	VERY SATISFIED
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3. To what extent did your family situation change?

A GREAT DEAL	A FAIR AMOUNT	VERY LITTLE	NO CHANGE
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4. Did your family situation improve?

MUCH IMPROVEMENT	SOME IMPROVEMENT	NO IMPROVEMENT	MORE OF A PROBLEM
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5. Did things get better for you personally?

NOT AT ALL	VERY LITTLE	A FAIR AMOUNT	A GREAT DEAL
------------	-------------	---------------	--------------

6. If you were to seek help again, would you use the same therapist?

DEFINITELY NO	I DON'T THINK SO	I THINK SO	DEFINITELY YES
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7. What did the therapist do that worked for your family?

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8. What did the therapist do that didn't help?

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9. Do you have any other comments or suggestions that you would like to make?

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**APPENDIX I**  
**The Termination Summary**

TERMINATION SUMMARY

WORKER: \_\_\_\_\_

FAMILY: \_\_\_\_\_

What would you identify as the key interventions that were tied to change in the child and/or family system?

During the course of therapy, were there any important life circumstances that could have negatively or positively affected the family system? (That is, in the home, workplace/school, or community setting.)

Were there any circumstances tied to this agency setting or its procedures that you believe could have affected the progress of this case?

When you consider the family as a whole, how would you assess change that was the result of your clinical intervention, within these domains?

Task Accomplishment	better ___	unchanged ___	worse ___
Role Performance	better ___	unchanged ___	worse ___
Communication	better ___	unchanged ___	worse ___
Control	better ___	unchanged ___	worse ___
Affective Expression	better ___	unchanged ___	worse ___
Involvement	better ___	unchanged ___	worse ___
Values and Norms	better ___	unchanged ___	worse ___

What were the major presenting problems that were addressed in this case:

As a result of the therapy, were they

	better	unchanged	worse
(1) _____	_____	_____	_____
(2) _____	_____	_____	_____
(3) _____	_____	_____	_____
(4) _____	_____	_____	_____

Other comments:

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**APPENDIX J**

**The Therapist Feedback Outline**

**WEDNESDAY MORNING SEMINAR****Therapist Feedback Outline**

1. Please comment on how well the therapist performed the following tasks:
  - a) Therapist's engagement of the family:
  - b) Clear problem definition:
  - c) Exploration of family's logic:
  - d) Exploration of family's structure and approach to problem solving:
  - e) Is there an exception - was it explored?
  - f) Miracle question - was it appropriate?  
- were solutions clearly and concretely defined?
  - g) Delivery of compliments and task:

**APPENDIX K**

**Family Three**

### FAMILY THREE

Family Three was an intact family comprised of Roy, age 46; Krysta, age 43; Karen, age 16; and fraternal twins Barbara and Debbie, both age 14. A fifth daughter, Sandy, age 24 was married and resided away from home.

Krysta had contacted the clinic at their family physician's suggestion, when she discovered Debbie began to smoke and abuse alcohol to build her self-esteem. Debbie was described as very unhappy, was overly sensitive to comments from family and peers, had escalating anger and hostility towards her sisters and friends, as well as very sensitive at being a little overweight. Many of these concerns had existed for seven or eight years. This family was seen for a total of four sessions.

The father in this family took more than twice as long as the other family members to complete the Family Assessment Measure pre test and this initially made me wonder about his comprehension and reading ability. After I scored the Family Assessment Measure the results indicated that he was attempting to answer the questions the way he felt I would like to hear instead of how he truly saw his family. The mother's and father's score normally would indicate a healthy functional family. This was not what I saw in our first session. I found it helpful to interpret the results of the Family Assessment Measure with the family as it helped enlist their cooperation and brought the family back into therapy.

This case taught me how to work with and keep involved with a resistant family which was made more resistant because of my own misunderstanding.

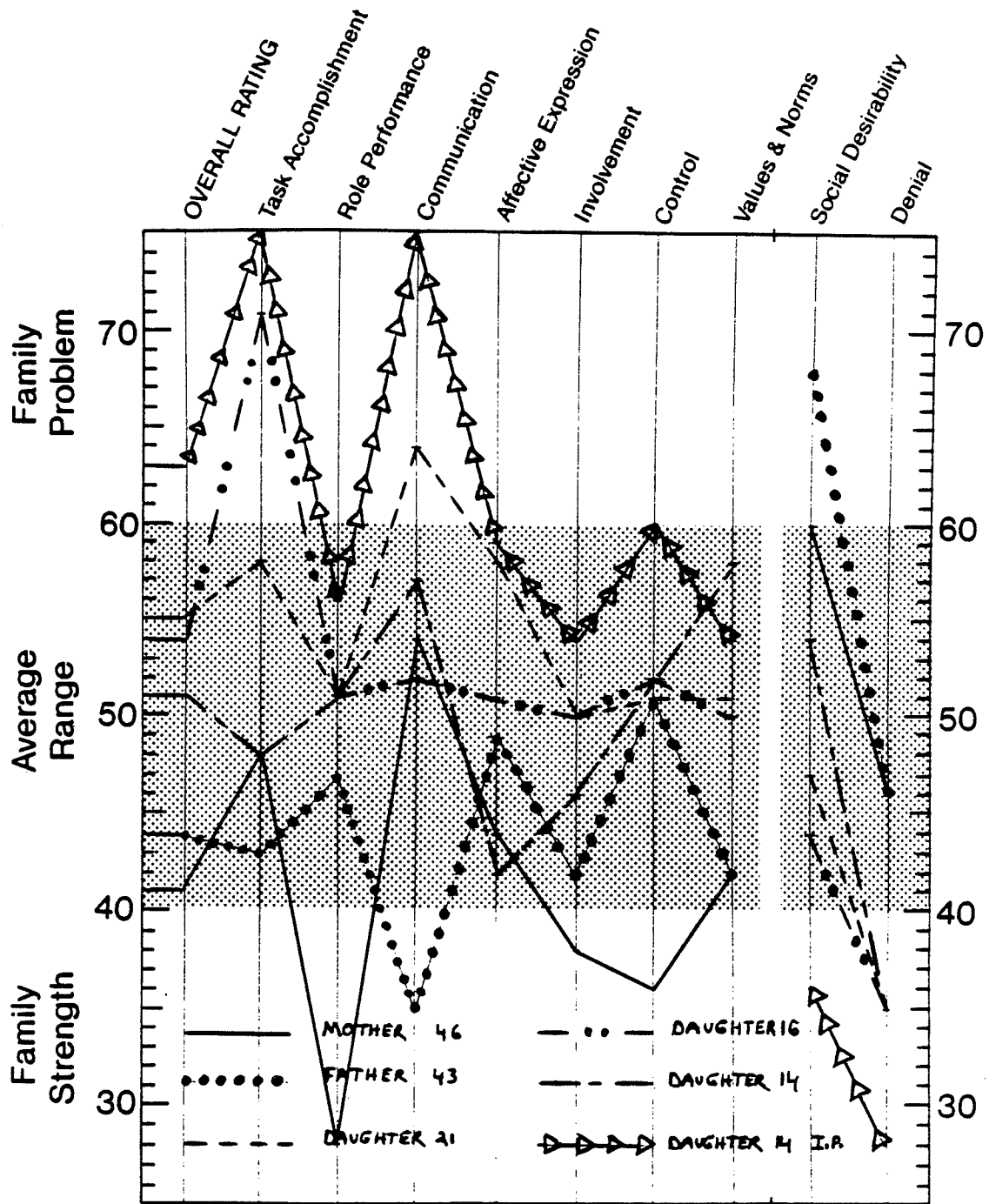
I learned that the first session is very important because it sets the stage for therapy and, therefore, is helpful in assessing the family accurately and assigning tasks that "fit" (Literature Review, p. 34-35).

As well, this family was an example of how a teen can be smothered by an enmeshed family system which, in this case, increased the adolescent's risk for self harm. Debbie scored ten out of seventeen on the pre test of the Hopelessness Scale for Adolescents. Out of the nine families, the identified patient in this family scored the highest on the Hopelessness Scale for Adolescents, confirming my concern for the risk of self harm.

After my involvement with this family was over I initially thought there had been little or no change as a result of the intervention and would have said the identified problems remained the same. After a more careful examination, I believe that there were several improvements as a result of our contact, including an increased level of understanding, improved communication and a more functional hierarchy. Our contact brought attention to the whole family. This attention minimally took the pressure off the identified patient who appeared much happier and less depressed. Her self esteem and self-image also improved.

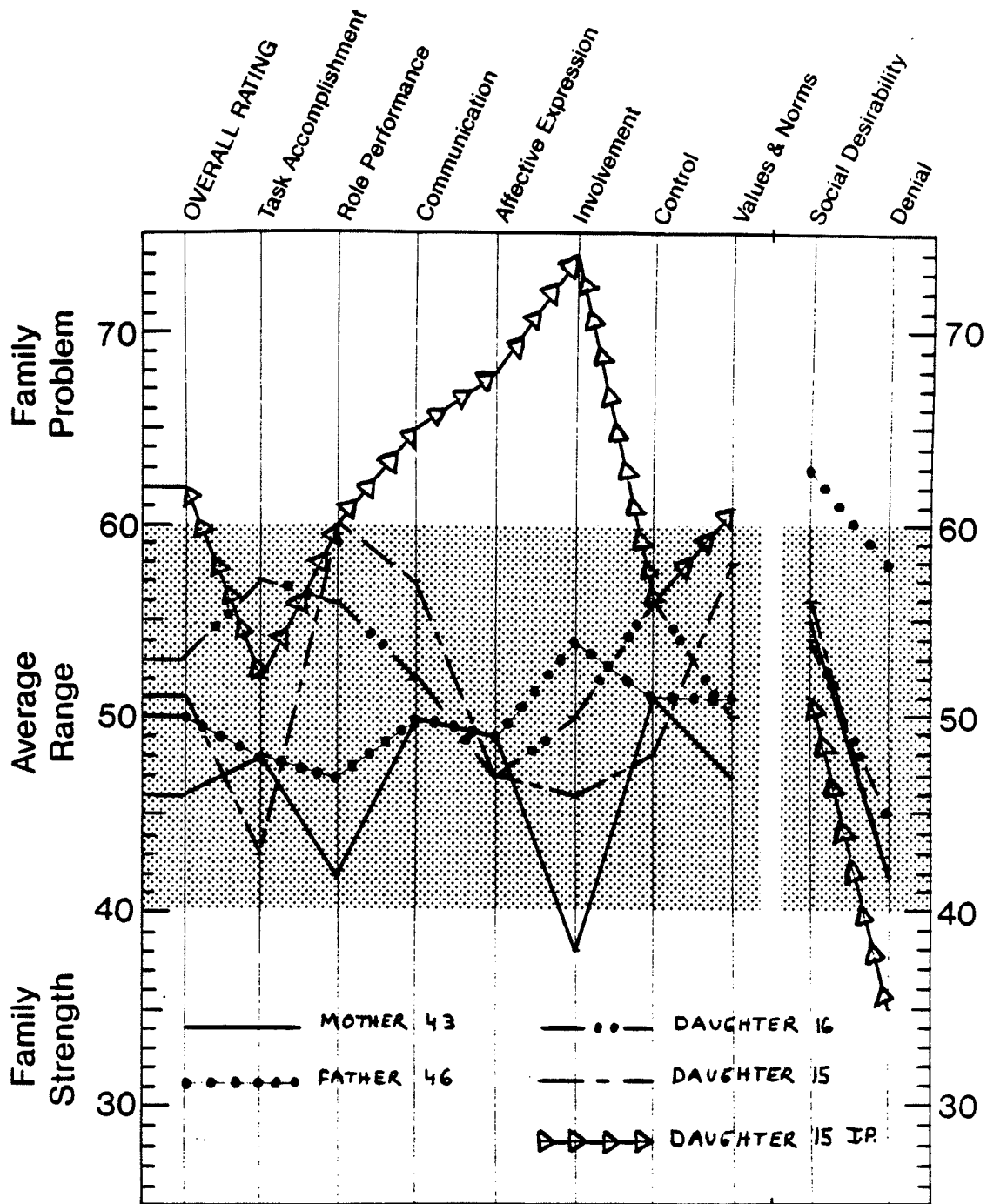
This family's score on the Family Assessment Measure Post Test, included with this appendix, suggested that they wanted to present themselves as more functional than they actually were (even more so than on the pre test) and may have tried something different in working toward a solution simply because they wanted to show me things were better. As well, almost all the responses improved on the Family Problem Checklist and the Hopelessness Scale, with the identified patient's score going from ten out of seventeen to two out of seventeen. This improvement suggested that the identified patient felt much less hopeless and there was much less risk of self harm.

### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY THREE

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY THREE

FAMILY THREEOUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Father	Daughter Age 17	Daughter Age 15	Daughter Age 15 (I.P.)
Positive Change	15	4	11	9	13
No Change	6	15	10	11	8
Negative Change	1	2	1	2	1

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Daughter - Age 17	1	0
Daughter - Age 15	4	3
Daughter - Age 15 (I.P.)	10	2



**APPENDIX L**

**Family Four**

### FAMILY FOUR

Family four was a two parent step-family consisting of the natural mother Michelle, age 32 and her husband Paul, age 35. Michelle and Paul had been together for thirteen years. Michelle was previously married to David, age 35. She had two children from this union, Neil, age 16 and Annie, age 14. Both children resided with their mother and stepfather. Paul had previously lived common-law and had one child by that union. Paul's previous common-law partner and child resided in another province. Michelle and Paul's relationship bore two children; Ben, age 9 and Alexis age, 2.

This case was a self referral by the natural mother. She was concerned about her oldest son, Neil. Since the birth of Alexis, age 2, Neil's personality had changed. He had taken on a rebellious appearance and was withdrawn from the family. He spent all his time alone in his room or watching television. The school had reported aggressive behavior on the school grounds. He had been involved with some stealing at home, and the mother suspected he might have been involved in drug abuse. She was worried that Neil had suicidal thoughts as he often said "I'll be gone from here soon". I saw this family for a total of five sessions.

Family Four was a struggle for me. I found myself attempting to rescue the mother by doing the work she needed to do. The parents were not united, and the identified patient was falling through the gaps. I took responsibility for getting the husband involved. This was not nearly as helpful as if I had worked at getting the mother to get her husband involved. My approach enlisted the mother's cooperation, but did little to resolve the problem. Near the end of my contact with the family I realized through supervision what was happening and was able to have a more helpful interview in our final session. My supervisor pointed out that I can be vulnerable to taking responsibility for others; I let them "hire" me instead of letting them struggle. It was

suggested to me that it is alright for them to feel some pain and discomfort, in order to maintain motivation to solve problems.

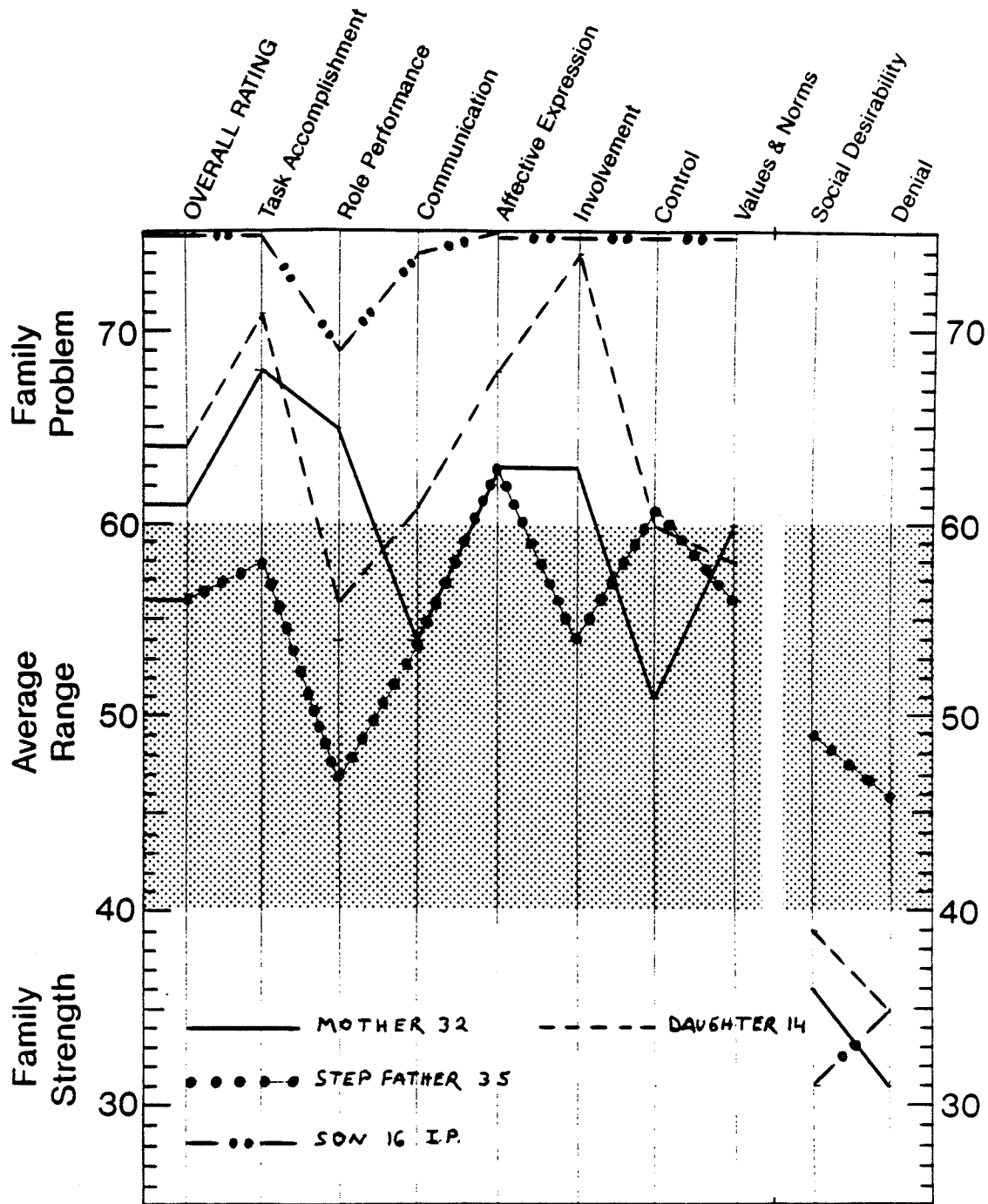
There were a number of improvements as a result of our contact. Neil felt better about himself. His statement "I'll be gone from here soon" was more an indication of how uncomfortable he was at home than his intent to harm himself. Overall, there was an improved level of communication in this family. The parents made attempts at developing a more equal share in their parenting roles especially in regards to discipline for the older children. This minimally increased the father's understanding of how his wife was feeling. The parents began to more openly acknowledge they were having some relationship difficulties. They began to have a minimal understanding of how they triangulate Neil into their relationship difficulties and how this was unhelpful to them and to Neil.

The Post Test FAM-III profile included with this appendix confirmed the assessment that there was improvement in the identified patient's functioning. All of his scores on the subscales improved, except in two areas which remained unchanged. The most significant change was in the control subscale. This score points to a change in the patterns of influence in this family which would allow family members to be more able to master the routines of ongoing family life, as well as allow more flexibility to change and adapt to demands. It indicates a control style which would be more predictable, constructive, educational and nurturant. There was also a significant change in affective expression for the identified patient and both his parents. This change indicates an increase in affective communication. Improvements in these areas are a good sign that the intervention was on target. Overall, the family's scores indicate continued problems in many areas of their functioning.

As the parents began to focus more on their relationship difficulties this appropriately increased the level of tension and conflict within the marital system where

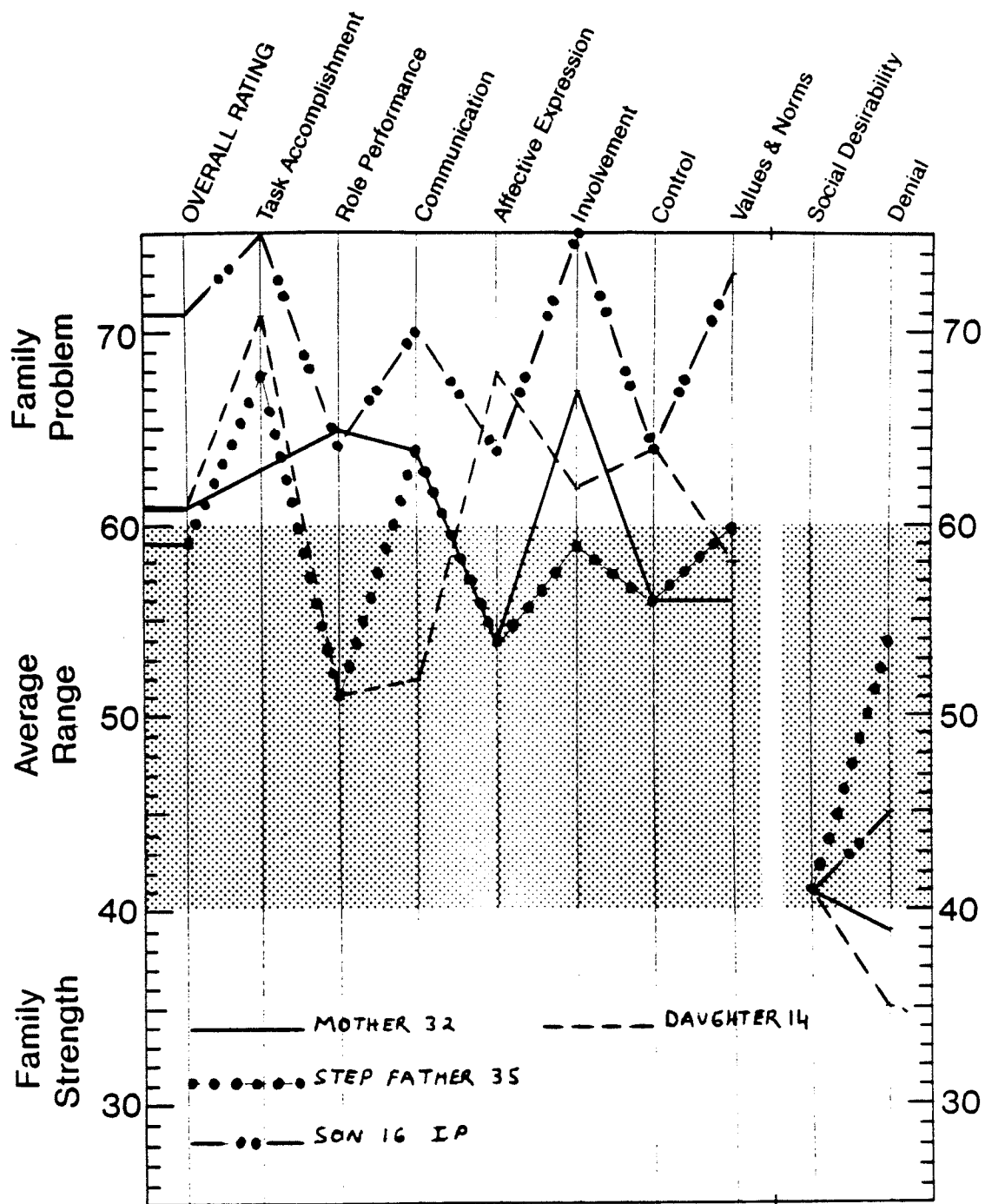
many of the issues belonged. This was likely the reason for the negative changes indicated by the family problem checklist and the continued problems indicated on the Post Test of the family assessment measure.

### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY FOUR

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY FOUR

FAMILY FOUROUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Father	Son Age 16	Daughter Age 14
Positive Change	4	1	12	14
No Change	12	12	8	7
Negative Change	6	9	2	1

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Son - Age 16	9	5
Daughter - Age 14	1	1

**APPENDIX M**

**Family Five**



### FAMILY FIVE

Family Five was an intact family comprised of Henry, age 41; Helen, age 38; Shawn, age 17; Claire, age 15, and Quentin, age 13. This family was closely involved with the children's paternal grandparents Harold, age 77 and Ann, age 74.

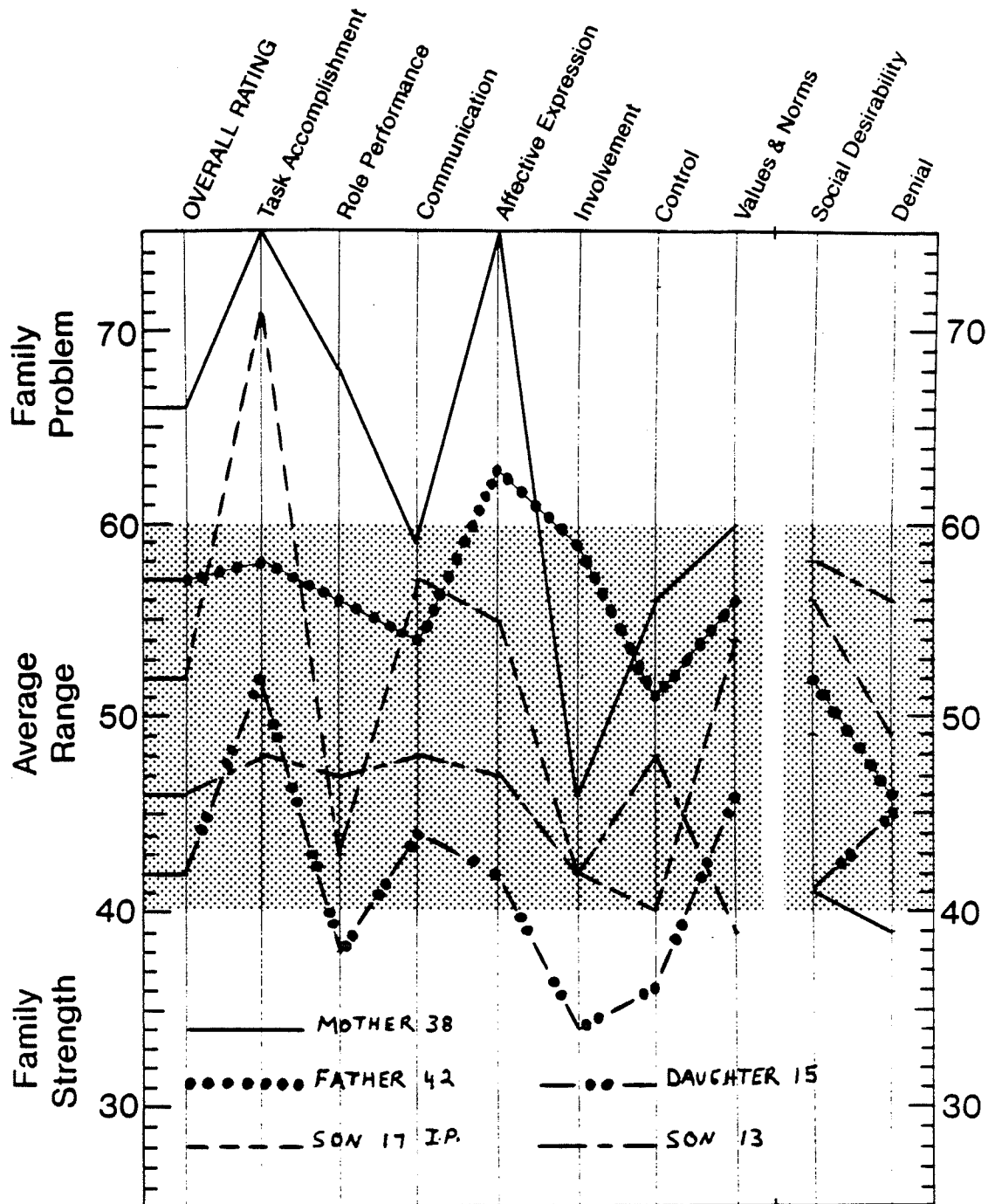
This case was a self-referral by the natural mother. She was concerned about her seventeen year old son who was diagnosed as epileptic and had two Grand Mal seizures approximately one year prior to their first contact with the clinic. Around the same time the seizures began, his school marks dropped from above average to failing or just passing. Shawn became upset when he could not get his driver's licence due to his seizures and began feeling ill over his school performance. The mother stated that Shawn felt tired and wanted to sleep, but couldn't sleep at night. She believed her son was so scared of failing that, at times, he would become physically sick. I saw this family for a total of three sessions.

Family Five was a good example of problems that can develop when the boundaries around a family are not strong enough and extended family become intrusive in the family. In this case the issues that forced the family to seek counselling were resolved while they were on the clinic's waiting list.

Therapy was terminated because the reason they came to therapy was resolved, although the pattern which helped create the initial presenting problem continued. Therefore, it was likely that this family would continue to develop problems. A situation like this one can be frustrating for therapists because training and experience tells them the family will likely return in the future. Unless they are willing to recontract and set new goals you have nothing with which to work with.

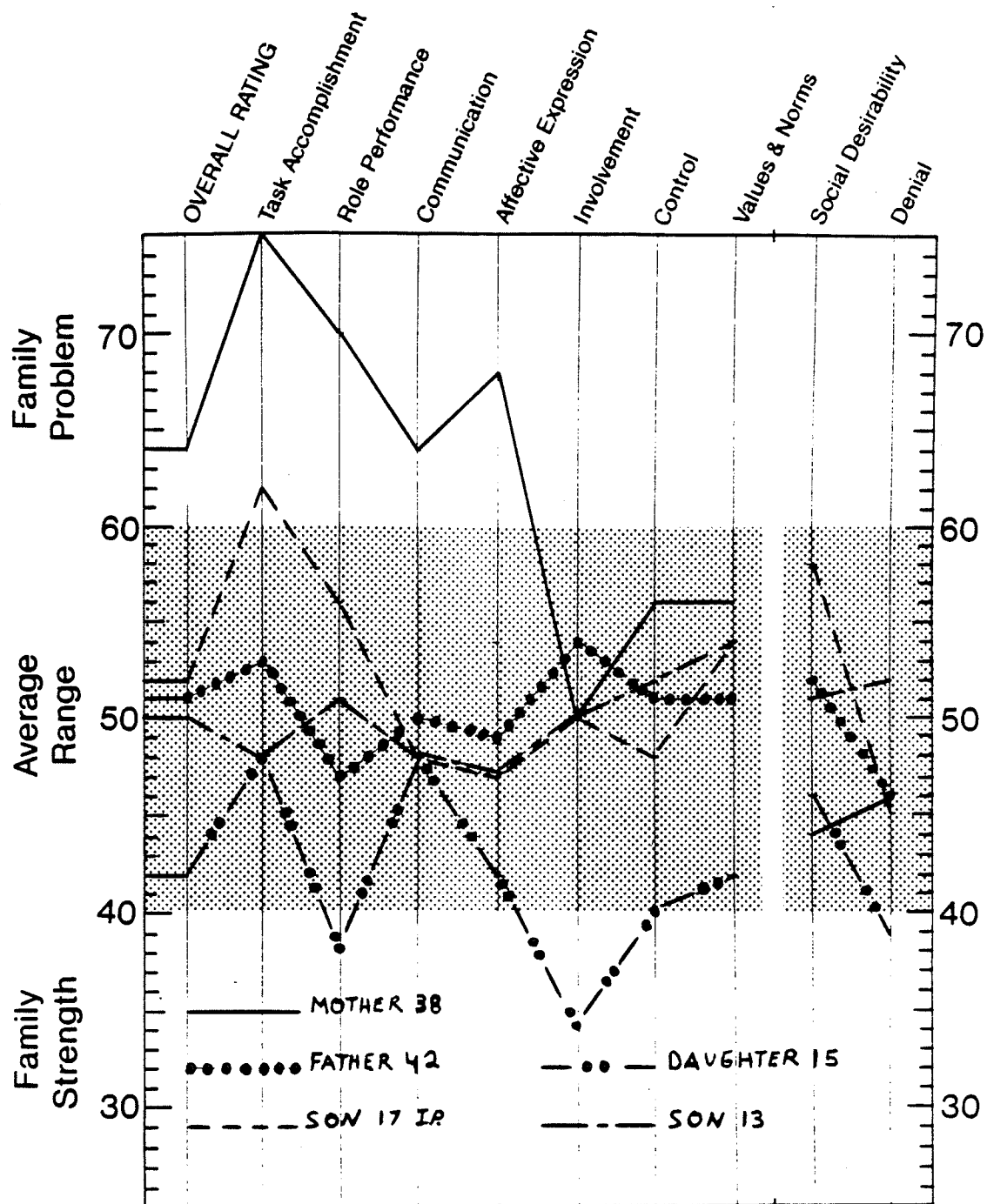
The outcome results of the measurement instruments are included with this appendix.

### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY FIVE

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY FIVE

FAMILY FIVEOUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Father	Son Age 17	Daughter Age 16	Son Age 13
Positive Change	5	4	4	5	5
No Change	14	18	15	15	10
Negative Change	3	0	3	2	7

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Son - Age 17	2	2
Daughter - Age 16	2	3
Son - Age 13	1	2

**APPENDIX N**

**Family Six**

### FAMILY SIX

Family Six was a two parent blended family consisting of the natural mother, Heather, age 32 and her husband Gary, age 32. Heather gave birth to her first son Gordon, age (16) when she was in high school. The birth father was not involved with this family and Gordon resided with his mother and stepfather. Gary and Heather had been together since Gordon was an infant. Heather and Gary's relationship bore two children, Grant, age 4 and Andrew, age 2.

This case was a self-referral by the natural mother. She telephoned to request counselling for Gordon. He had been "acting out" for approximately two years with his behavior progressively getting worse since her husband had been diagnosed with life threatening cancer. The mother had been aware of her husband's diagnosis for approximately six months prior to her first contact with the clinic. This family was seen for a total of four sessions.

I learned from this family that I have very good personal boundaries. As a therapist I was drawn into the family system and within the same interview able to remove myself from the system and place the mother and son in their appropriate roles. I was told this is a sign of a very skillful therapist as once you are drawn into a family system it is very difficult to get out. It was suggested to me that at times people "hire" me to do their work. I need to be more sensitive to this and not get trapped.

I learned something about working with the older adolescent. Prior to this internship, I had many years of experience working with adolescents who at times were non-voluntary clients. These teens were often difficult, manipulative and uncooperative. I developed a belief that change would be difficult if not impossible with these individuals. I discovered that I might not have truly listened to what they had to say. I discovered that just labelling them difficult or manipulative was a barrier to my hearing

what they had to say. I did not build on cooperation because I did not see any. As well, I did not pick up on their strengths because I focused on their problems.

I had some very successful interviews with the adolescent in this family and found that the solution focus, as well as de Shazer's ideas about cooperation and resistance, were helpful. In this case I was able to help a stubborn adolescent make some decisions for himself by making sure he understood as well as knowing how he could follow through. Rather than seeing him as resistant, I kept these two positive thoughts in my mind. As a result, I was able to build a more cooperative working relationship.

Family Six taught me that parents can have the power to be in control of their teens. Prior to this internship my work experience had taught me incorrectly that teens are often out of control, and that their parents have no control. I had been influenced by parents who felt they had tried everything and had become hopeless about their situation. In a sense these statements were true, but I did not acknowledge that parents can gain control and be in charge and that the therapist can also be very influential in this process. This was a change in my belief system.

I learned through supervision that when someone disagrees with me I end up explaining my position. It would be more helpful if I explored their position first, because this is more neutral, then introduced a reframe. This way I would be more helpful because I would learn more from the family and not alienate them as much.

I also learned that when I provide an explanation for the client, it might be more helpful to be less direct and more gentle. For example, instead of saying "you will feel such and such", it would be better to say "you might feel this way" or "in my experience others in this kind of situation feel this way". Because I really do not know how they will feel or what the outcome may be, I can only give an educated guess. These may be small differences, but they will likely make my approach smoother and more skillful, and build more cooperation.

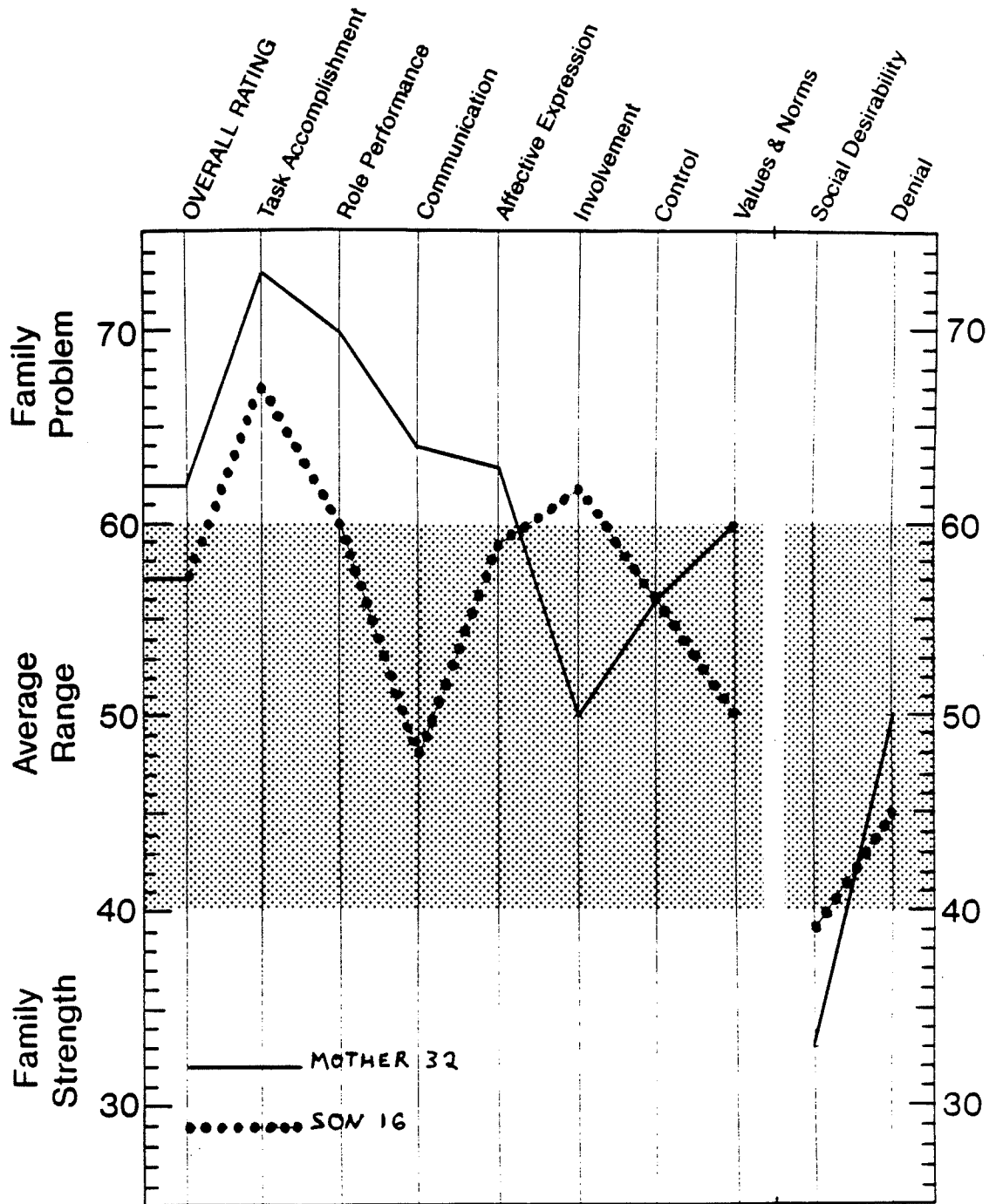
I learned through supervision that when you brainstorm with a family and they come up with nothing, it is better to leave them hanging and tell them they should think on it. This way you leave the responsibility with them to come up with something, which is far more helpful than providing them with your own ideas of a solution.

The results of my efforts with this family were reported by me as unknown. A lot of information was provided to them, but they were in such a stressful situation it was difficult to say what effect I had. It would be interesting to see what this family is like in a year's time.

The results of the Family Assessment Measure Post Test showed a significant improvement for both the mother and identified patient in some areas of their functioning. The outcome results are included with this appendix.

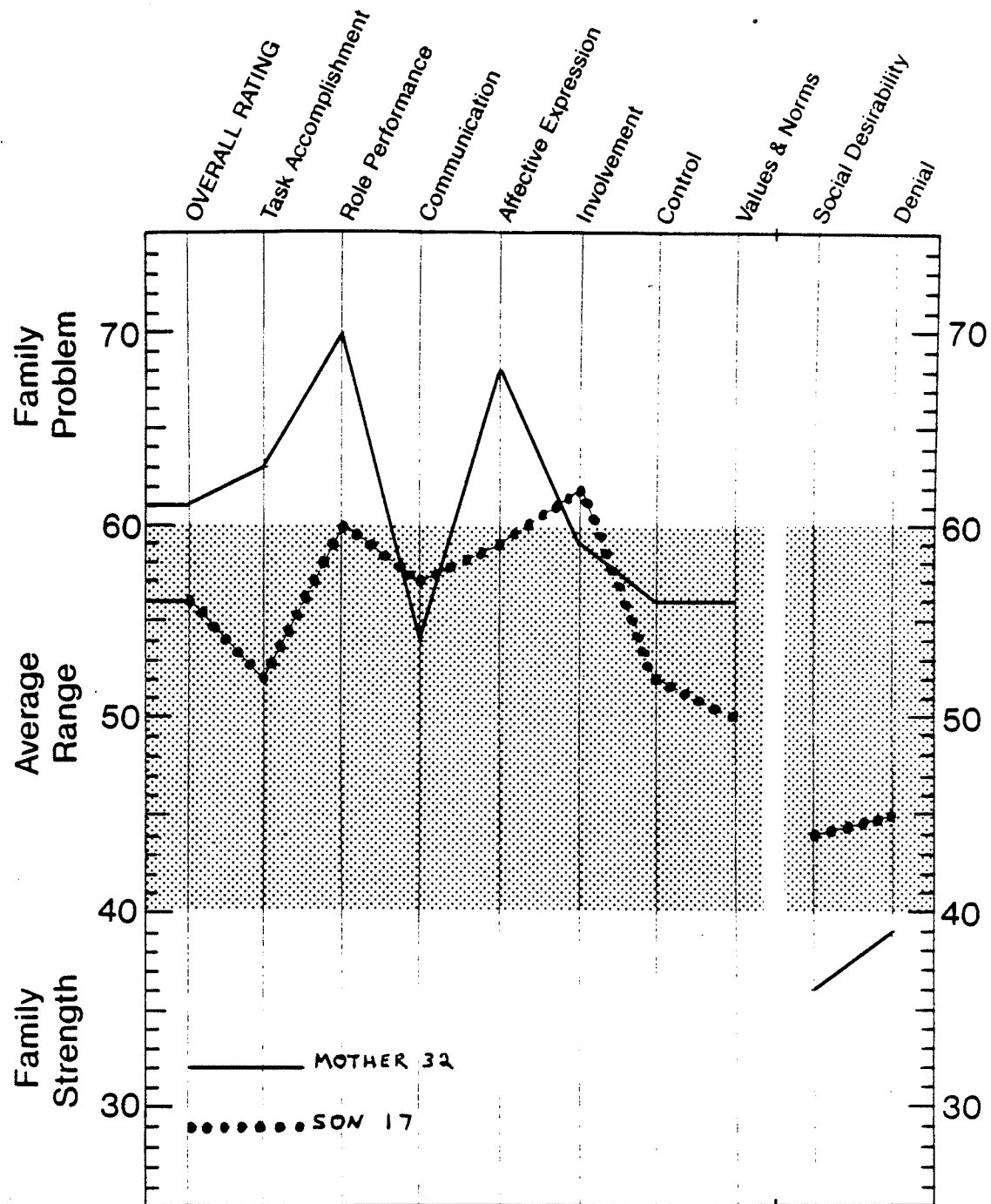


FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY SIX

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY SIX

FAMILY SIXOUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Son Age - 16
Positive Change	5	5
No Change	8	13
Negative Change	7	4

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Son - Age 16	3	3

**APPENDIX O**

**Family Seven**

### FAMILY SEVEN

Family Seven was an intact family consisting of Donna, age 37; Joe, age 44 and their son, Kevin, age 13.

This case was a self-referral by the natural mother. She was concerned that her son was bright but a chronic underachiever in school. Kevin had been tested by the local university's department of education and no learning disabilities were found. The university's education department recommended that Kevin attend counselling as he was described as passive resistant towards learning. This family was seen for a total of five sessions.

Like Family One, Family Seven helped operationalize the phrase "start where the client is at". All the intake information focused on their only child who was reported to be very bright, but having difficulty in school. In the first session I learned that the father had a serious long term alcohol problem, and that the mother wanted to separate from her husband. The parents clearly identified that they only wanted to work on their son's school problems.

In the past I likely would have seen these other issues as far more influential in this family's functioning [which they were] and attempted to address these issues first. In this case, under supervision, I did not follow my old path but remained focused on the presenting problem of their son's school difficulties. The parents had triangulated their son into their marital problems. The father told me of a time when they were able to get their son to follow through. The mother was quite successful in the business world and therefore demonstrated her abilities to make good decisions. Following the solution focus, I built upon her good decision making abilities and explored the exception which the father introduced. These strengths were used to get the parents to take charge of their son and perform their executive tasks. In a sense the parents needed space to gain

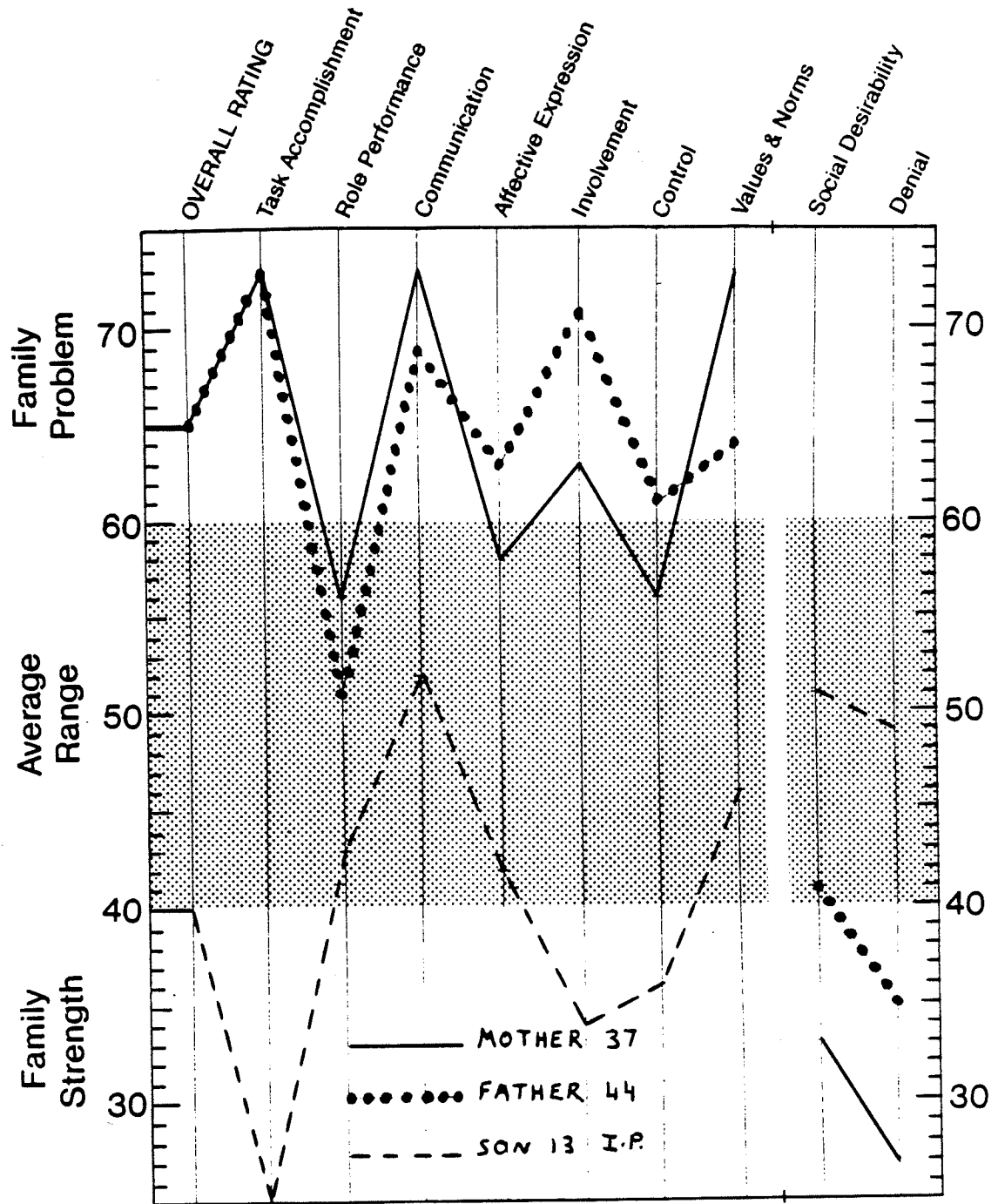
perspective. Paradoxically, my approach gave the parents tasks which forced them to spend more time together. This approach helped them to look at themselves and their relationship.

This approach also helped the mother realize she would have to take charge of her personal life, which might lead to the parents' separation. If the mother takes charge of her personal life the identified patient would no longer be triangulated into the parents' marital problems and she would be able to provide the necessary structure so that her son could achieve at school.

In the first session with this family my presentation of the tasks did not go well. This was an interview observed by the Team, who came up with tasks which were long and involved. Although I felt I understood the tasks, I could not deliver them with the clarity and conviction that was required. For this approach to be successful you must truly believe in the strengths you see in the family (Literature Review, p. 28, 43). My supervisor ended up delivering the tasks in a very convincing manner. He pointed out that using one's own thinking and wording for a task enables the therapist to deliver the task in a more convincing way. Being observed by a team means you can use the various team member's maps of the situation to come up with what Bateson calls the bonus or the difference that makes a difference (Literature Review, p. 34). This is one of the advantages of working with a team. The disadvantage for me was it meant I was not the sole author of the tasks and, therefore, in this case unable to deliver the tasks in a convincing manner. It was suggested to me that, in the future, when working with a team that I not present the task until I believe it will work and it makes sense to me.

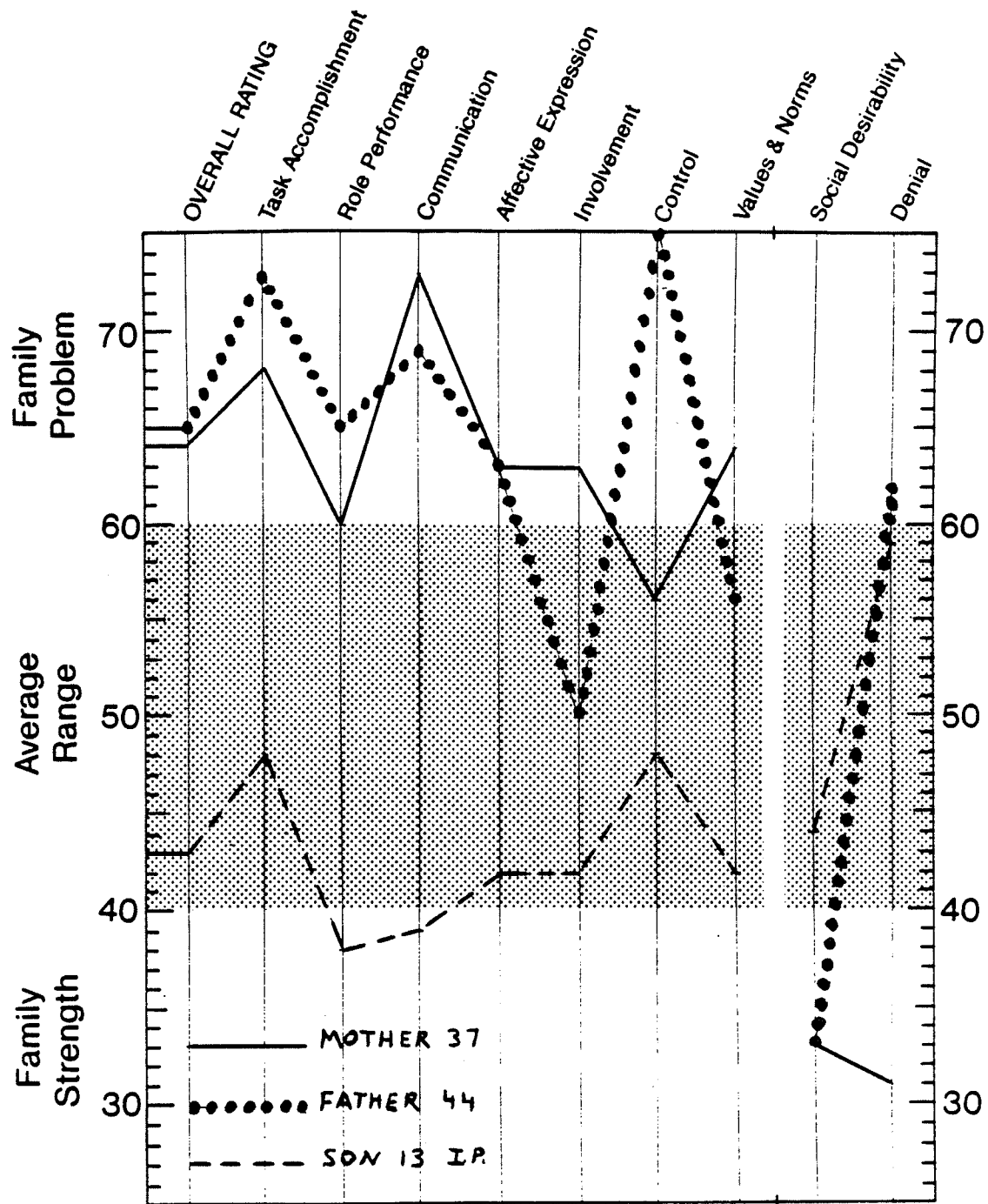
The outcome results, included in this appendix, indicated that there continues to be problems in this family. On the Family Assessment Measure Post Test, the father and son's denial, subscale scores increased significantly, indicating that they were becoming aware that the mother would likely leave the relationship.

### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY SEVEN

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY SEVEN



FAMILY SEVENOUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Father	Son Age 13
Positive Change	2	3	4
No Change	14	7	8
Negative Change	3	10	8

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Son - Age 13	2	1

**APPENDIX P**

**Family Eight**

### FAMILY EIGHT

Family Eight was a recently separated family consisting of the natural mother Nancy, age 37. She separated from her husband Peter, age 39, approximately one month prior to her first contact with the clinic. Peter and Nancy had been married approximately seventeen years. They had two natural children Oliver, age 11 and Kelly, age 13. The children resided "half time" with each parent (three or four days each week with each parent).

This case was a self referral by the natural mother. She was concerned that their recent separation might have a negative effect on their children. In particular the mother was concerned about Kelly whose behavior had been a problem since she was age four or five. Kelly's behavior was described as more problematic since the separation and included increased anger, lack of communication, irresponsibility and being untrustworthy.

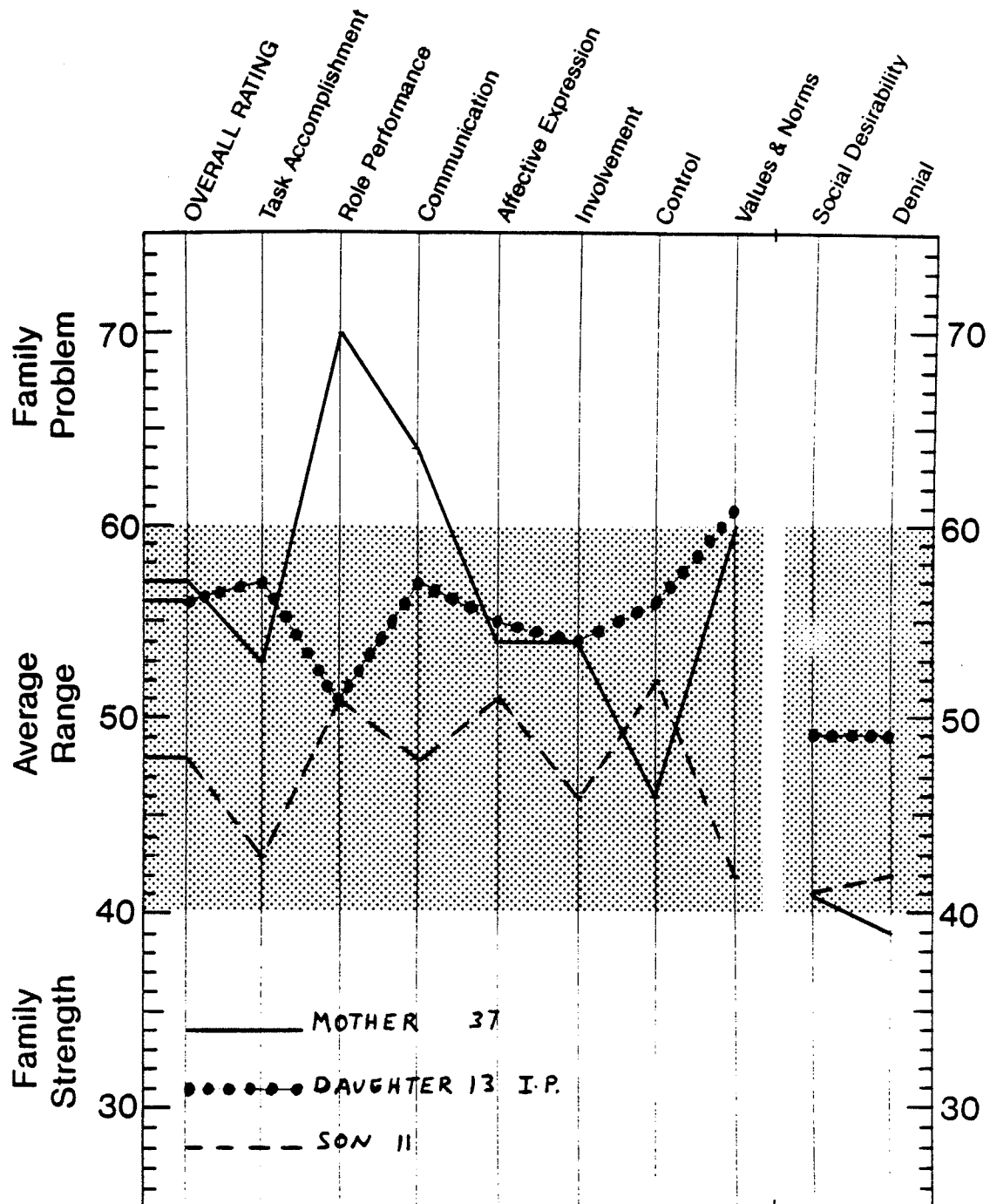
This family moved to their present location approximately two years earlier and both children were having trouble making friends and "fitting in". Kelly was tested and had a slight learning disability. The mother believed there was some controversy over this testing and tended to believe that Kelly's difficulties in school were more the result of negative family dynamics. I saw this family on two occasions and was able to make a good assessment.

I learned that this case was an extreme example of how people will often behave in certain ways out of the sensitivity and the desire to protect significant others (Literature Review, re: world view/belief system, p. 32). In this situation the mother had waited to separate from her husband for nearly ten or eleven years. She sacrificed herself in order to protect her husband and her children from the pain of separating. When she finally did separate she was confused and felt guilty about her decision.

Through all the years and the act of separating, she never told her husband or her children that she was unhappy or why she was unhappy. The children rarely saw their parents fight and did not know why they had separated. This behaviour was very confusing for the children and their father. At termination, the mother held strong to her belief of protecting others much to the detriment of her and her children's well being.

As this family declined to complete the post test measurement instruments, only the pre test of the FAM-III profile is included in this appendix.

### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY EIGHT

**APPENDIX Q**

**Family Nine**

### FAMILY NINE

Family Nine was an intact family consisting of Howard, age 49; Kathy, age 42, and their three natural children, Todd, age 15; Brian, age 12, and Lisa, age 10.

This family was referred to the clinic by a school social worker. All of the children were reported as displaying rebellious behaviors, in both passive and aggressive ways. The parents belonged to a fundamentalist church and believed that part of the cause of their difficulties with their children was the result of their children being physically and emotionally abused by the minister and his wife.

The parents had focused on their son Brian as their main concern. They described him as unhappy and withdrawn and, therefore, found it difficult to understand what was bothering him. Brian had no close friends and although he was described as bright, he had no special interests. He was skipping school, had been caught smoking at school and was ignoring his responsibilities at home. When the parents attempted to talk with Brian, he would either refuse to speak or run out of the house and not return for hours. Brian had stomach pains for a length of time, but the family physician could not find any physical reason for these pains. I saw this family for a total of four sessions.

In supervision and review of the tape of the first interview, I could see that the family was keeping a secret or secrets. There was no clarity for me or for the family because some issues were not being discussed. These issues needed to be brought out on the table. I could sense there was something more but did not know how to ask and was not sure how intrusive the questions might be.

It was suggested to me that information is important. How you ask is just as important, but you must ask. By asking you give the family permission to talk which is what they want. In the second session I followed these suggestions. In supervision

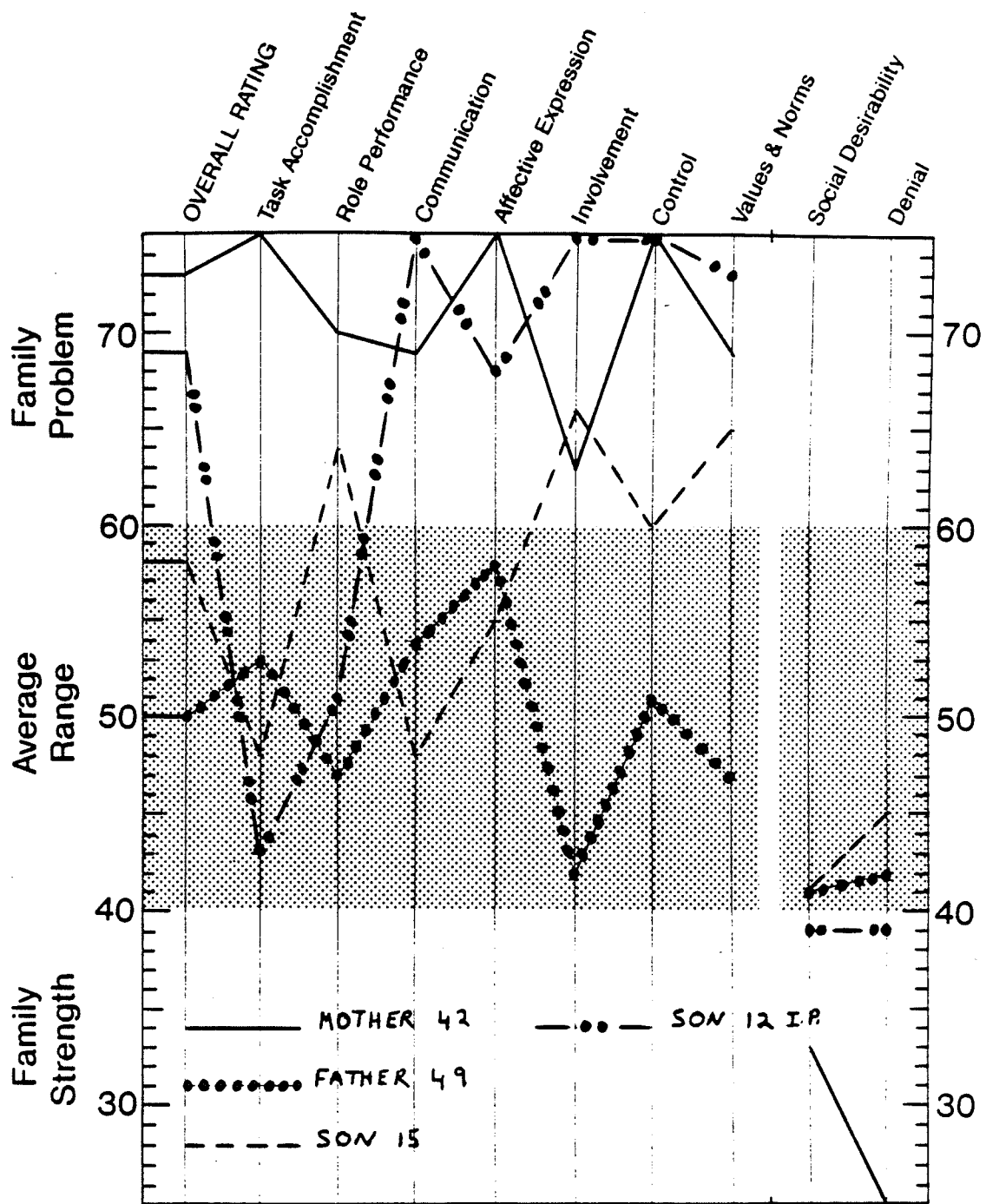
I was told my gentle persistent manner was very helpful in having this family openly talk about a long term secret - the parents' marital problems and depression. This opened up the family to solution.

This was the last family I saw at the clinic, and it was transferred to my supervisor after the internship ended.

The outcome results of the measurement instruments are included with this appendix. They show significant improvement for the identified patient indicating that the intervention was on target.

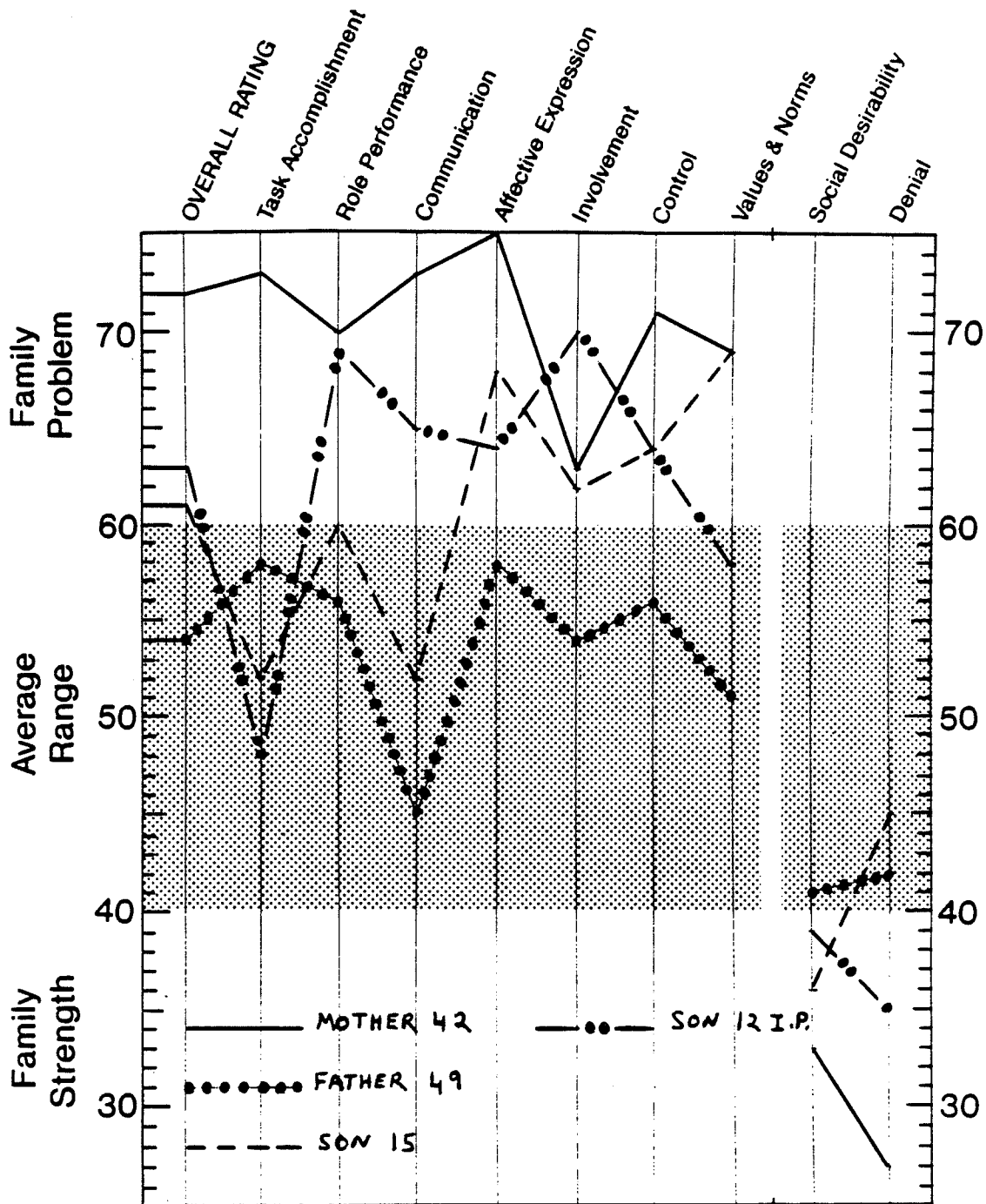


### FAM GENERAL SCALE



PRE TEST FAM-III PROFILE FAMILY NINE

### FAM GENERAL SCALE



POST TEST FAM-III PROFILE FAMILY NINE

FAMILY NINEOUTCOME RESULTS OF THE FAMILY PROBLEM CHECKLIST

Outcome	Mother	Father	Son Age 15	Son Age 12
Positive Change	3	2	4	14
No Change	11	16	14	4
Negative Change	8	4	4	2

OUTCOME RESULTS OF THE HOPELESSNESS SCALE  
FOR ADOLESCENTS

Family Member	Pre Test	Post Test
Son - Age 15	1	0
Son - Age 12	8	8

**APPENDIX R**  
**Problem Formation Questions**

**PROBLEM FORMATION**

1. What is the structure of the family?
2. What is the dysfunctional pattern?
3. What is the purpose of the symptom?
4. How does each person's behavior maintain the system?
5. If the problem is a metaphor for another behavior, for what does it stand?
6. Who else in the family has a similar problem?
7.
  - (a) What interaction is not possible because the present interaction is taking place?
  - (b) Where does this lead?
8. Discuss what effect the family's pattern has on each individual in the family?
9. What would happen if the family got unstuck?