# THERAPEUTIC SIMILARITIES, ECONOMIC BIASES, AND SUCCESSFUL THERAPY TREATMENT

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TREATMENT

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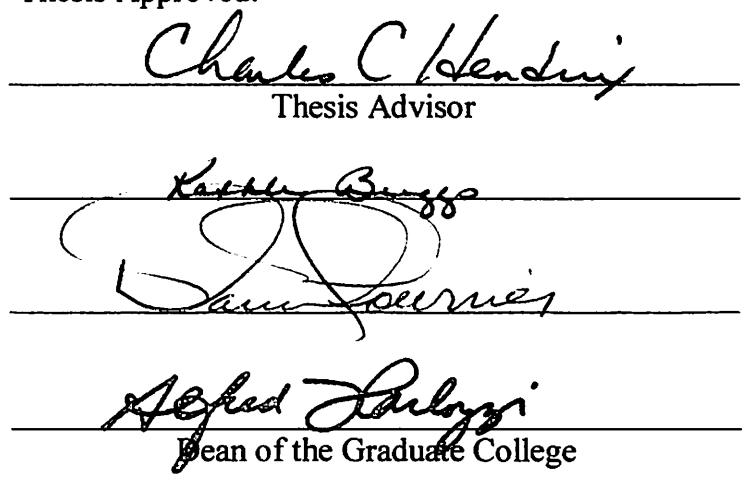

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# CHAPTER 1

## *Problem Statement*

Therapeutic success is an intricately woven tapestry of art and science that blends countless theories and concepts together in order to maximize the overall change in a family. By incorporating the following theories: 1) General Systems Theory, 2) Abraham Maslow's Hierarchy of Needs, 3) Pauline Boss's version of the ABC-X Stress Model, and 4) Martin Seligman's Theory of Learned Helplessness, this paper will assess and review: poverty in today's society, how various economic levels affect the therapeutic outcome, if and why families of various incomes treated differently in the therapeutic process, and if families of a particular economic level benefit from therapy more than families of other statuses.

## *Definition of Terms*

### *Economic status.*

No single indicator can adequately capture all the facets of economic status for the entire population. However for the purpose of this project a median split or average annual income was used to determine lower versus middle economic status. This project measured economic status by characterizing individuals or families earning less than $15,000, annually before taxes as lower economic status, while middle economic status was characterized by individuals or families earning $15,000 or more, annually before taxes. This is congruent with the U.S. Bureau of the Census (1997) which distributes

lower income families as making $14,999 or less while middle income families were classified as making $15,000-$74,999.

*Interactive therapy.*

Interactive therapy will be defined for the purpose of this project as a measurable average of: interventions used, allocated break questions, and homework assigned. Across all sessions, the researcher compiled the number of interventions used, homework, and break questions assigned for each session. From this information, a measurable average per session was obtained. This measured average was termed the relative degree of interactive therapy.

*Successful therapy.*

Therapeutic success for the purpose of this project will be defined called completion of therapy. Completion of therapy will be defined and measured according to the therapist's assessment that the therapeutic goals have been reached.

*Study*

This project compared therapy outcomes and processes between lower economic and middle economic status. This study will be looking for variations in clients' perception of the severity of problem, amount of homework given, amount of break questions assigned, numbers of interventions used per session, number of sessions attended, and if therapy was completed successfully.

This study embodies a developmental nature and will took an in-depth look at 79 therapy cases to see if a person's economic status affects their therapeutic outcome, and attempt to explain why some families benefit more from therapy than others. The research will begin to explore the relationship of successful treatment and how the level

of interactive therapy can affect a successful therapeutic outcome. Therefore, if there is a relationship between success rates and therapeutic procedures, or therapeutic biases towards families in different financial levels, therapists can begin to moderate their practicing behavior to achieve a more successful outcome.

## *Hypotheses*

### *Hypothesis Overview*

Different approaches are likely to work for different reasons, with different kinds of families, and for different individual or family problems (Nichols & Schwartz, 2001). With this information, we are going to be looking for similarities found in the various therapeutic styles that could be keys for a successful treatment outcome. Information was obtained from a training clinic associated with a COAMFTE master's degree program. First, in order to gain a clearer picture of therapeutic styles, the characteristics of the session will be studied. Second, economic status will be compared to therapeutic success. Finally, client's perception of the severity and likelihood of a problem to change will be compared to a client's success rate in the therapeutic process.

*Hypothesis 1.*

The first hypothesis will be reviewing overall key factors in therapeutic success. Later, these findings will be compared to success rates of various economic statuses. This in turn will identify if different therapeutic factors work better as change producing interventions with various economic statuses. Families who receive a greater amount of therapeutic interventions, break questions, and homework, would have an increased success rate, opposed to families who receive fewer therapeutic interventions, break questions, and homework. The dependent variable is the amount of interventions, break

questions, and homework used in a therapist session. The independent variable is therapeutic success rate. For the purpose of this study, a break question is defined as a subject to analyze, examine, or think about while the therapist takes a premeditated brief period of time away from clients in the middle of session. Homework is defined as an assignment to be completed or question to be answered outside the therapy session.

H 1.1: The more interventions used per session, the more likely a client is to succeed in therapy.

H 1.2: The use of a break question will more likely result in a client succeeding in therapy.

H 1.3: Clientele who are consistently assigned homework will be more likely to succeed in therapy opposed to those who are not consistently assigned homework.

H 1.4: Middle economic status people will complete homework more than families of lower economic status.

*Hypothesis 2.*

Economic status affects the therapeutic outcome. The independent variable is family economic status. The mediating variable is amount of interactive therapy and the dependent variable is therapeutic success rate. Interactive therapy for the purposes of this study is defined as the following. Therapeutic sessions classified as high interaction will incorporate above average amounts of interventions, goals, homework, and break questions into each session.

H 2.1: Lower economic status individuals will not be as successful in the therapeutic process as middle economic status families.

H 2.2: Higher interactive therapy will result in increased therapeutic success.

H 2.3: Families from lower economic status will receive lower amounts of interaction in therapy than families from a middle economic status.

H 2.4: Families who receive lower amounts of interaction in therapy will attend fewer sessions than families who receive higher amounts of interactive therapy.

*Hypothesis 3.*

Prior to therapy, families of lower economic status will report the presenting problem as being present longer, more serious, and less likely to change than families of lower economic status. The independent variable is economic status. The dependent variable is reported time length of problems pervasiveness, seriousness, and likelihood of change to occur.

H 3.1: Families from lower economic statuses will report that the problem is more serious than families of middle economic status.

H 3.2: Families from lower economic statuses will report that the problem is less likely to change than families of middle economic status.

H 3.3: Families from lower economic statuses will report that the presenting problem has been a problem longer than families of middle economic status.

*Hypothesis 4.*

At the onset therapy, families of lower economic status will report a higher level of alcohol uses and signs of depression. The independent variable is economic status. The dependent variable is reported use of alcohol, and signs of depression.

H 4.1: Families from lower economic statuses will report more alcohol use more often than families from a middle economic status.

H 4.2: Families from lower economic statuses will report more signs of

depression than families of middle economic status.

Ultimately, the purpose of this study is to see if families from different economic statuses come into therapy with different presenting problems, what interventions were used with families of different statuses, and which families were more likely to continue therapy until completion of therapeutic goals.

# CHAPTER 2

## *Literature Review*

Uncovering key factors directly associated with therapeutic success has been a quest in the realm of marriage and family therapy for many years. Therapeutic failure can create difficulties for therapists through wasted time, vested interests, and injuries to the therapists well being and sense of competence. More importantly, therapeutic failure can be deleterious for clients. Therefore, in order to better understand the impact of poverty on the therapeutic process this paper will review theories such as: 1) General Systems Theory, 2) Abraham Maslow's Hierarchy of Needs, 3) Pauline Boss's version of the ABC-X Stress Model, and 4) Martin Seligman's Theory of Learned Helplessness. This paper will also review poverty statistics in today's society, various economic affects on therapeutic outcome, economic biases in the therapeutic process, and if families of various economic levels benefit from therapy more than families of other economic levels.

### *Poverty Statistics*

Helplessness from victimization, life stressors, crisis, or trauma does not happen only to the weak and frail; helplessness can happen to the best of us. "If the trauma is powerful enough even competent people can become victims as a result of being taught to become helpless through reinforcement" (Boss, 2002, p. 170). Extreme examples could be how brainwashing and torture can change a mastery-orientated person within a

short time into an incoherent shell.

The majority of today's society does not undergo such extreme situations, but there are a plethora of other instances that individuals experience on a daily basis that produce a sense of learned helplessness which is influential in restraining the growth and development of today's society. For example, the number of impoverished men, women, and children in today's society is growing at alarming rates. In 2001, people below the poverty thresholds numbered 32.9 million, a figure 1.3 million higher than the 31.6 million poor in 2000 (U.S. Census Bureau, 2002). The poverty rate in 2001 was 11.7 percent. Those statistics were up from 11.3 percent in 2000 (U.S. Census Bureau, 2002).

When a family's total income is less than the family's threshold, every individual in that family is considered poor and living in poverty. The family's threshold is determined by counting money income before taxes and excludes capital gains and non-cash benefits, such as public housing, Medicaid, and food stamps (U.S. Census Bureau, 2002). Poverty not only affects individuals, but families and children as well, resulting in widespread, cumulative, and long-term negative consequences such as: lower educational achievement, poor nutrition, emotional and behavioral outcomes, teenage out-of-wedlock childbearing. In 2001, 6.8 million families were poor, up from 6.4 million in 2000. The number of poor and the poverty rate of married-couple families increased from 2.6 million and 4.7 percent in 2000 to 2.8 million and 4.9 percent in 2001. That's a staggering increase to 9.2 percent in the poverty rate for families in 2001, which is up from the 26-year low measured in 2000 (8.7 percent) (U.S. Census Bureau, 2002).

Children under six are particularly helpless to poverty. Children are dependent on others; therefore, they enter poverty by virtue of their family's economic circumstances

and cannot alter family conditions by themselves. For example, Brooks-Gunn and Duncan (2002, p. 3) state that "poor families are more likely to be headed by a parent who is single, has low educational attainment, is unemployed, has low earning potential, and is young, thus resulting in poverty." According to the U.S. Census Bureau, there were over 3,400 families characterized as a female householder, with no husband present. The poverty rate for related children under six years of age was 18.2 percent in 2001. U.S Census Bureau 2001 report states that 11.7 million children, or 16.3 percent, were poor, which was higher than the rates for people 18-64 years old and 65 and over (10.1 percent for each). People 18 to 64 years old accounted for most of the net change between 2000 and 2001; both the number of poor and poverty rate increased (17.8 million and 10.1 percent in 2001, up from 16.7 million and 9.6 percent in 2000) (U.S. Census Bureau, 2002).

More alarming are the statistics taken in 2001, that identified the number of "severely poor" people (defined as those with family incomes below one-half their poverty threshold) rising to 13.4 million (4.8 percent), from 12.6 million (4.5 percent) in 2000. The number and percent of "near poor" (people with incomes at or above their threshold but below 125 percent of their threshold) remained consistent at 12.4 million and 4.4 percent, respectively (U.S. Census Bureau, 2002). As these poverty statistics continue to rise, the effects of poverty can been seen in a multitude of dimensions.

*Effects of Poverty*

*Poverty and depression.*

There are obvious material stressors that accompanying poverty which can lead to depression. The daily worries about paying essential bills and being able to afford food

in the face of inflationary pressures and insecure employment could be expected to wear down even the strongest mind, thus resulting in depression.

Depression is characterized by a number of symptoms, in addition to a lowering of mood. These symptoms are loss of interest, poor concentration and forgetfulness, lack of motivation, tiredness, irritability, poor sleep and changes in appetite (American Psychiatric Association, 2002). The symptoms of depression such as poor concentration and lack of motivation impair the ability to carry out everyday tasks. Irritability combined with these can affect the relationships with other family members and fellow workers. The "negative attitude" of depression can impart judgment and reduce problem-solving abilities (Patel, 2001). This latter aspect of depression is especially worrying in relation to socioeconomic inequalities. Depression impairs the ability of poor people to deal with the difficult circumstances they experience. Arguably, for the poorest people in the world, problem-solving abilities are essential in order to deal with their circumstances (Patel, 2001).

Sustained economic hardship is positively related to poorer physical, psychological, and cognitive functioning (Lynch, Kaplan, & Shema, 1997). People living in poverty conditions develop low confidence, suffer from hopelessness, become restless, get involved in inappropriate behavior, and feel depressed from being alienated from health living and a health environment (Kingree, Thompson, & Kaslow, 1999). Lower education, a poor living environment, and often an unhealthy family life make these individuals vulnerable to different forms of abusive behavior (Droomers, Schrijvers, Stronks, Van De Mheer, & Muckenbach, 1999), which in turn adds stress (Hein & Bukszpan, 1999).

Without meaningful, well paying work and the resources and social affirmation that comes with employment, many poor people develop low self-esteem, feelings of worthlessness, depression, or anxiety. Some people attempt to relieve feelings of anxiety and depression associated with poverty through the mind-altering drugs. A common drug among the poor is alcohol, which is legal and affordable (Bureau of Educational and Cultural Affairs, 2001).

*Poverty and alcohol/drug use.*

The ability to deal with new difficulties is harder for those with less money. Poverty means that families have fewer resources for dealing with stress, health problems, and family conflict which can lead to unhealthy and detrimental coping styles such as drugs and alcohol to relieve the depression. Some of those who drink develop alcoholism and become physically and emotionally dependent on drinking. Others use, and become addicted to, more dangerous and often illegal drugs, including heroin, methamphetamines, and cocaine. The view that alcohol helps to deal with stress by screening out intolerable realities and enhancing feelings of adequacy and worth makes common sense and is widely believed, however, there are relatively few studies that address poverty and alcohol abuse directly (Khan, Murray, & Barnes, 2002). Thus, both of these external (being poor) and internal causes (low self-esteem) may have elicited physiological reactions opposite to those engendered by alcohol and thus, may have increased drinking (Khan, Murray, & Barnes, 2002).

Whether an individual will increase alcohol consumption because of poverty or unemployment will depend on moderating factors. However, in a comprehensive review of short- and long-term effects of poverty conducted by Khan, Murray, and Barnes

(2002), all the following conclusions have been supported in various studies: (a) problem drinking, alcohol use and abuse increases with longer periods of unemployment, (b) relatively short-term unemployment reduces alcohol use and, (c) no significant relationship exists between alcohol consumption and unemployment, unemployment does not alter drinking behavior, and (d) some drink more, some less, and some do not change.

Other studies have found an agreement that unemployment increases alcohol use and abuse among heavy drinkers, those who consumed six or more drinks on six or more occasions in the past 30 days (Dooley & Prause, 1997) and that moderate drinkers may decrease alcohol use when unemployed while heavy drinkers may increase drinking (Janlert & Hammarstrom, 1992).

Determining whether alcohol use causes unemployment or is mainly one of the symptoms of unemployment is difficult. Further studies on the relationship between alcohol abuse and income may provide additional insight into the likely direction of causality. The use of drugs and alcohol is only one of the many effects of poverty. Poverty also reaches into the homes of families and impinges on marriages.

*Poverty and marital satisfaction.*

Economic hard times can have severe adverse consequences for families. Economic and work-related stressors comprise the largest body of research on environmental influences on marriage (Bradbury, Fincham, & Beach, 2000). Research reviewing poverty and marital satisfaction has been a topic of interest for researchers for decades. According to research conducted by Liker and Elder (1983) using information from the Great Depression reveals that chronic monetary hardship was more strongly related to marital tension, both concurrently and prospectively. Chronic monetary

hardship is defined as an index composed of individuals who: remained at a low level of income, received public assistance, and were unemployed (Conger, Elder, & Glen, 1990).

More recent research using observational methods, Krokoff, Gottman, and Roy (1988) demonstrated that displays of negative affect, but not reciprocation of negative affect were linked to occupational status in a sample of white- and blue-collar workers. A comprehensive analysis of economic stress and marital functioning conducted by Conger, Rueter, and Elder (1999), found support for a model whereby economic pressure in a sample of predominately rural families at Time 1 predicted individual distress and observed marital conflict at Time 2, which in turn predicted marital distress at Time 3; the effect of economic pressure on emotional distress was greater in marriages poor in observed social support (Bradbury, Fincham, & Beach, 2000, p. 972).

Unemployment is often associated with separation and divorce as well as marital and familial dissatisfaction (Benokraitis, 1993). Unemployed workers report lower levels of communication and harmony and more stressful relations with their spouses. They also argue more frequently with their spouses and experience lower family cohesion. Economic distress due to unemployment also has negative effects on children's physical health, psychological well-being, and behavior (Voydanoff, 1991).

*Poverty, the family, and child problems.*

Poverty has widespread, cumulative, and long-term negative consequences on the family. The uncertain economy, in turn, creates, or intensifies, family problems which demand the expertise of family professionals. In general, the following areas have increased: divorce rates, remarriage rates; numbers of poor, single-parent families; rates of teenage pregnancies; and reports of domestic violence (Tiesel & Olsen, 1992).

Consequently, there appears to be a decline in the quality of marriage, with children being the most vulnerable to the impact of a fluctuating family, cultural environment, and economic stability.

Economic deprivation and limited resources leads to lower achievement among offspring (Benokraitis, 1993). Poor families have less money to invest in children's education activities, which often means children have to drop out of school and find a job to help care for younger siblings (Garfinkel & McLanahan, 1986). Limited resources can also lead to cutbacks in nutritious foods which can also produce lower academic achievement. Undernourished children often do not have energy to learn. As a result, they do not do as well on tests and can be disruptive in school. They are also less resistant to illness and more likely to miss school (Rich, 1991).

Hunger has long-term, wide-spread, negative effects ranging from poor nutrition to physical health. According to the National School Lunch Program (2003), which is a federally assisted meal program that provides low-cost or free lunches, they serve over 26 million children each school day. Eligible family's income for free or reduced-priced meals is set at or below 130 percent to 185 percent of the poverty level (Food & Nutrition Service-U.S.D.A., 2003). In fact, in 1998, Congress expanded the National School Lunch Program to include reimbursement for snacks served to children in after school educational and enrichment programs to include children through 18 years of age because of a growing need to assist this population need (Food & Nutrition Service-U.S.D.A., 2003).

Other factors that occur more in poor children than in non-poor children are: underprivileged nutrition (obesity, heart disease, hypertension), physical health (low birth

weight, growth stunting), cognitive ability (intelligence, verbal ability, and achievement test scores), school achievement (years of schooling, high school completion), and emotional and behavioral outcomes (conduct disorder, teenage pregnancy, alcohol/drug abuse) which can result in family problems. Among adolescents, family economic pressures such as unemployment and underemployment may also lead to conflict with parents.

*Effects of Unemployment & Underemployment*

We certainly have choices in our personal lives, but families "are deeply influenced by broad social and economic forces over which they have little control" (Keniston & Carnegie, 1977, p. 12). The belief that the adequate family is self-sufficient and insulated from outside pressures had deep roots in American history (Benokraitis, 1993). As a result, when something goes wrong, we assume that there is something wrong within the family rather than with political institutions, economic structures, or other outside influences, when really, many families experience economic distress as a result of employment instability, economic deprivation, and economic strain (Voydanoff, 1991).

According to the U.S. Department of Labor, Bureau of Labor Statistics (2001), not-seasonally adjusted employment rate for individuals 16 years and over increased from 4.0% in 2000 to 5.8% in 2002 for a total of 8,378,000 unemployed individuals. This number has since increased drawing the unemployment percentage up to 6.4% as of June 2003 with a recorded 19.8 percent seasonally adjusted average weeks unemployed. As of September 2003 there were approximately 2,102,000 individuals who had been unemployed for 27 weeks and over with 1,108,000 unemployed as a result of job loss due

to layoffs.

Unemployment is an upsetting experience. Unemployment is defined by the U.S. Department of Labor, as people who are jobless, looking for jobs, and available for work. One study found that the process of mourning after losing a job may be even more complex and more difficult to handle than the loss of a loved one because the threat to one's livelihood and self-preservation is more serious (Mattision, 1988). U.S. Department of Labor, Bureau of Labor Statistics reports that as of September 2003, there were 5,014,000 individuals 16 years and over looking for employment because of loss of job or completion of temporary work.

Underemployment is also a distressing experience for many Americans. Underemployment is a situation in which a worker is employed, but not in the desired capacity, whether in terms of compensation, hours, or level of skill and experience. While not technically unemployed, the underemployed are often competing for available jobs or working multiple jobs to survive. In relation to poverty, employment and underemployment, census data reports that people who worked at any time during the year had a lower poverty rate than non-workers (5.6 percent compared with 20.6 percent), but among poor people, many worked either part-time or part-year. Of poor people 16 years of age and older, 38.3 percent worked, but only 11.5 percent worked full-time year-round. In contrast, 69.4 percent of all people 16 year old and over worked, and 46.1 percent worked full-time, year-round. There were 7,620,000 individuals in the United States held multiple jobs in February 2003.

## *Theoretical Perspective*

### *General Systems Theory*

According to General System Theory (GST) is a group of interrelated and interdependent parts which operate within a generally supportive environment. General Systems Theory is used to explain the behavior of a variety of complex, organized systems. As a worldview, GST emphasizes interrelationships between different people and objects. As such, General Systems Theory offers a framework for exploring the dynamics of poverty, economic status, and therapeutic outcome.

Marriage and family therapists often begin their exploration process by working with a systemic perspective in order to better serve the clients' therapeutic needs. Applying a systemic theoretical perspective is valuable in order to assess for differences in the therapeutic processes, content and perspectives of various economic statuses.

In General Systems Theory, the basic concept of cybernetics describes how input can account for the decisions that are made by people from various economic statuses. Ludwig Von Bertalanffy (1986) describes cybernetics as, a theory of control systems based on communications (transfer of information) between systems and environment and within the system, and control (feedback) of the system's function in regard to environment. GST is a process of theory construction focusing on building universal concepts, hypothesis, and principles. According to the concept of cybernetics families take this available construction of information (input) to formulate the most appropriate conclusion available (output). For example, families that come from limited economic backgrounds may not have as many sources of input, which leads to fewer options for coping with economic hardship, output. This restriction in perceived choices may result

in more unhealthy rather than healthy alternatives because the families are limited in how they believe they are capable of dealing with a problem.

The concept of cybernetics in General Systems Theory is a study of systems which can be mapped using loops in network defining the flow of information. These systems of communication patterns are organized into feedback loops which affect goal-setting behavior in the system. A feedback loop is a path of communication in a system (Boss, Doherty, LaRossa,Schumm, & Steinmetz, 1993).

Feedback loops can either be negative (used to maintain stability) or positive (used to promote change). This is based upon the effect feedback has on the system, not the content of feedback. For example, a family may receive the environmental input in the mail that they have a bill that is past due. How this family will respond (output) to that past due bill will be based on their perspective of feasible and available options. Perhaps the family believes that they will be able to pay the bill next month and ignores the debt. They in turn receive another past due bill with interest charges attached. If the family chooses to continue ignoring the bill, they will be engaging in a negative feedback loop, which will result in the same actions, such as more letters from the bill collectors, collection agencies or eventually legal authorities.

Boundaries regulate how input is processed. Individuals, subsystems, families, therapists and clientele are demarcated by interpersonal boundaries, invisible emotional barriers that protect, enhance, and regulate the amount of contact with others (Nichols & Schwartz, 2001). Boundaries protect autonomy by managing proximity. A therapist who assumes that individuals on welfare are lazy has a closed boundary and may not be able or willing to hear the input about the situation that the client has experienced which will

lead to fewer solutions for help, output. For example, a client who believes that the Department of Human Services (DHS) is against them may not heed the input offered in an attempt to help the client.

With many psychological theories, the focus is on the individual and ignores the system. Systems theory is different in that one cannot assign the cause of a problem to a part of the system. This is such that each action within the system affects the others. Therefore, therapeutic success and treatment biases should be recognized as a part of the system. Therapists have a responsibility to own their therapeutic failures. "The outcome of therapy is intertwined between client and therapist. If one succeeds, so does the other. To label a client as difficult, resistant, or impossible is an abrogation of professional duty. "It is ultimately the therapist's responsibility to find the way to success. While we need to trust our clients, they absolutely need to be able to depend on our expertise" (Whiteside & Steinberg, 2001, p.18). Therapists cannot take full responsibility for the final outcome. Professionals should accept a vast amount of influence over the change or lack of change that takes place in session, and be actively aware of how preconceived boundaries, cybernetics, and feedback within the system can affect the therapeutic outcome in order to maximize effective results.

*General systems theory and therapeutic outcomes.*

Compared with the voluminous literature on individual psychotherapy, the research on couples and family therapy is sparse. After all, General Systems Theories emerged some sixty years after the earliest psychoanalytic literature was published (Nichols & Schwartz, 2001). However, an overwhelming number of studies have shown family therapy to be effective, especially in cases of marital problems, adolescent

delinquency, and substance abuse (Nichols & Schwartz, 2001). To a more limited extent, systemic family treatment has shown to be effective for drug abuse (Liddle & Dakof, 1995, Stanton & Shadish, 1997), and children's anorexia and psychosomatic disorders (Campbell & Patterson, 1995).

In review of the outcome literature though mid-1996, Pinsof, Wynne, and Hambrigth (1996) concluded that (a) sufficient data exist supporting the efficacy of family therapy, and (b) there is no evidence indicating that families are harmed when they undergo conjoint treatment. Other comprehensive reviews (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998: Dunn & Schweble, 1995) have also concluded that family therapy treatment groups fare, on average, significantly better than no-treatment controls. A meta-analysis of 163 randomized clinical trials (Shadish, Ragsdale, Glaser, & Montgomery, 1995) indicated that the effect size for couples and family therapy is comparable to those of other psychotherapy modalities. A meta-analysis is a statistical analysis of a group of studies in which each investigation is considered to be one subject. In meta-analysis, the effect size refers to the standard difference between treatment and comparison groups. For the 71 studies in which family therapy was compared with a no-treatment control group, Shadish and colleagues (1995) found an effect size substantially greater than those reported in pharmaceutical, medical, and surgical studies. For the 23 studies in which family therapy was compared with individual therapy, the meta-analytic results showed no substantial differences (Shadish et al., 1995).

With respect to marital therapy, Dunn and Schewebel's (1995) meta-analysis indicated that three approaches were significantly and substantially superior to no treatment. These included behavior therapy, cognitive-behavioral therapy, and insight

orientated therapy (a category that included emotionally focused therapy). At this point, one might question the need to continue to show that family therapy "works." Indeed, a number of reviewers have reached the same conclusion (e.g., Pinsof et al., 1996), and studies are beginning to accumulate in which one form of conjoint therapy is tested against another. At present, however, there are few comparative family therapy studies. The evidence to date suggests that, like the comparative studies of individual therapy, no one approach is better that the others (Shadish et al., 1995), particularly if we only consider well-designed investigations (Pinsof et al., 1996). Nevertheless, because of methodological limitations, one is unwise to assume that different family therapy approaches will not produce differing success rates (Pinsof et al., 1996). To the contrary, various approaches may prove effective for diverse reasons, ranging from different kinds of families to different presenting problems.

In the context of this study, a general systems perspective is used to investigate the spreading network of influence which includes the larger systems such as poverty statistics, pressures, causes and affects associated with poverty in today's society. In order to better understand this network a therapist should be aware of the existential pressures and needs associated with poverty in today's society.

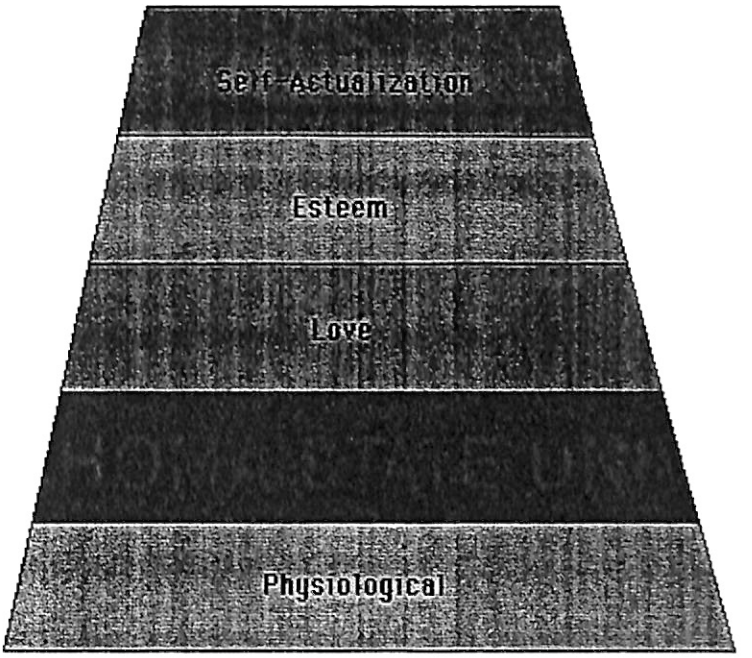
*Maslow's Hierarchy of Needs/ Pressures with Poverty*

The development of poverty is ubiquitous. In order for a therapist to be able to effectively serve this component of society, analysts must understand the impending and often overlooked pressures associated with living in lower socioeconomic statuses. For example, within the confines of poverty individuals struggle with stressors that families of middle and upper socioeconomic statuses do not worry about on a daily basis such as:

unemployment, permanent and safe housing, food, adequate transportation, self-care, medical or mobility limitations. Therefore, therapists working with families struggling with financial problems, unemployment, underemployment or poverty must often spotlight basic needs such as food, clothing, and shelter first before they can explicitly concentrate on marital satisfaction, positive interaction cycles, or becoming good parental role models. According to Maslow's Hierarchy of Needs (Gwynne, 1997), there are general types of needs or levels that motivate humans: physiological, safety, love, esteem, and ultimately self-actualization (see figure 1).

Figure 1:

**Maslow's Hierarchy of Needs**






According to Maslow, these driving forces motivate action and movement from all mankind, however, the lowest level of needs must be satisfied before the higher needs can be fulfilled. For instance, the second level on the hierarchy of needs is safety, which

entails establishing stability, consistency, and security. Therefore, if a family is in distress over a member's loss of employment, which is a direct threat to their safe and secure place to live, that family would not be able to move towards a higher level without first stabilizing and securing their safety needs.

Spotlighting basic needs instead of emotional/personal potential improvement is not the only roadblock a therapist must maneuver around to produce effective therapy while working with families of lower economic status. Studies link the effects of poverty to increased mental instability such as depression, increased drug and alcohol use, as well as, decreased marital satisfaction, and problematic child behaviors.

Pressures associated with poverty tend to perpetuate more poverty. Whether the family and their family members either propagate or preclude poverty, this process is influenced by their internal and external contexts which is described in detail in Pauline Boss's ABC-X Stress Model.

*ABC-X Stress Model and Poverty*

An individual's internal and external contexts will influence whether a person impoverished will either succumb or overcome their financial limitations. External context is composed of dimensions over which the family has little or no control. Culture, history, economy, developmental stages of life, and heredity/genetics are all examples of external context. Whether a family is impoverished due to job layoffs from a poor economic period or unable to work due to poor physical health for example, will affect how a family perceives input and how they incorporate that input into either positive or negative feedback to either maintain or change their system. The external context cannot be ignored when processing the effects of poverty and therapeutic

outcome. These factors are outside the control of the system and will influence how the individual perceives events, situations, problems, and manage in the best possible way, whatever stress is produced (Boss, 2002).

Internal context is composed of dimensions in which the family has a greater influence or control over. Internal contexts can be seen in forms such as structural (family form, function, boundaries, roles, and rules), psychological, (family's perception, appraisal, or definition of assessment), and philosophical (values and beliefs) (Boss, 2002). Assessing and understanding an individual's internal context provides therapists with an accessible window of change, because the internal context is flexible and under the individuals control.

In Boss's version, the A, B, & C are the foundation of the stress model (see Figure 2). "A" represents the provoking event or stressor which results in change within the system. How a stressful event is defined is highly influenced by the family's external context. A sudden loss of income may be perceived as highly stressful and cast an individual into crisis mode where the family is immobilized and stops functioning. Whereas other individuals might view the loss of a job/income as motivation to move up and find better employment. Or individuals may refuse to acknowledge the event at all, and continue their prior spending behaviors making no adjustment in their lifestyles to accommodate the change.

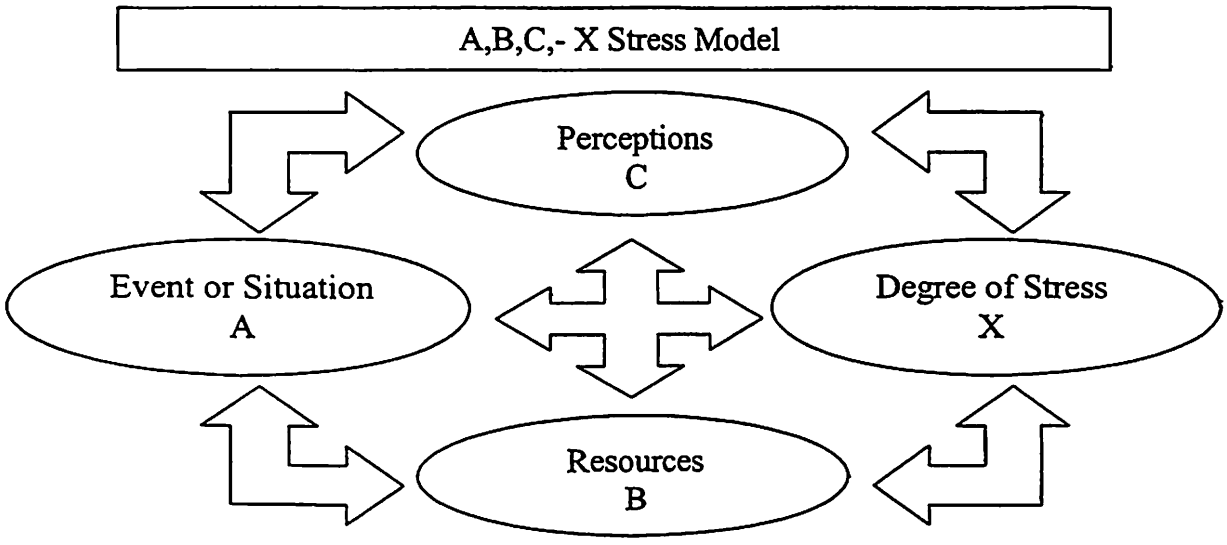
"B" symbolizes the family's resources or strengths at the time of the event. Being cognitively aware of a family's existing resources available to them to adequately cope with a stressor even can be a determining factor as to whether the stress will be high or low. For example friends, family, support groups, church affiliations, neighbors, co-

workers, government agencies, federal programs, volunteer groups, and community programs are resources that could be utilized if an individual was aware of their availability in order to alleviate the strain of loosing a job. Although the loss of a job/income will no doubt alter the family system, the severity of the stressor can be lessened by the availability of perceived functional resources.

"C" characterizes the meaning attached to the event by the family (individually and collectively). How a particular family views the loss of a job/income will determine how that individual will cope or what alternatives (if any) they see for resolving the problem. Perhaps the only job an individual has ever known is factory assembly line work. Therefore, when they are unemployed because the local factory plant closes down, they feel hopeless, unqualified or inadequately educated for other work and cease looking for employment. Consequently, how an individual perceives the stressful event such as job loss will ultimately determine "X," which is the resulting degree, either high or low, of stress.

"X" signifies the degree of stress experienced. Family stress means change-an interrupted equilibrium in the family's system (Boss, 2002). Stress levels can vary from high to low. High stress can be so severe that families can no longer function at optimal physical or psychological functioning, and roles, tasks, and boundaries become blocked. Lower stress levels results may take the form of dissatisfaction within the family due to a lower performance in the family's usual routines and tasks. Ultimately, the resulting degree of stress can be seen in the appearance of harmful or constructive effects in the family which is determined by the family's perception and assessment of the circumstances.

Figure 2:




Insomuch, the A,B,C, and X are intricately woven together and important when assessing the magnitude, meaning and motivation in a stressful situation such as poverty, unemployed, or underemployed. Despite an individual's efforts poverty, unemployment or underemployment may affect their lives at one time or another. How the individual perceives this situation could result in feelings of helplessness.

*Learned Helplessness, Poverty & Employment*

Helplessness is a feeling of 'little or no control' that can result in feelings of victimization. Victimization is defined as the overpowering of a person or family with physical or psychological trauma that results in feelings of helplessness, distrust of the world, and humiliation, such as loosing a job or not being able to provide for your family (Boss, 2002). Underemployed workers who have part-time jobs but would rather be working full time, individuals who accept jobs below their levels of job experience and educational credentials, or the many discouraged part time workers who have given up on finding full-time jobs (Ball, 1990) may experience feelings of victimization resulting in helplessness.

Learned helplessness is a concept that was first described empirically with studies of animal learning (Overmier & Seligman, 1967; Peterson & Seligman, 1983). They conducted experiments in which dogs were put in a cage and exposed to unavoidable and inescapable electric shocks. The dogs ran around the cages trying to avoid the shock and, within 24 hours, they showed symptoms of helplessness. A series of positive and then negative reinforcement called intermittent reinforcement, can lead to confusion among individuals seeking help.

Reinforcements are consequences that affect the rate of behavior, either accelerating or decelerating behavior (Nichols & Schwartz, 2001). Negative reinforcements result in aversive consequences which terminate a particular response, whereas positive reinforcements are positive or rewarding consequences increasing a response. Positive reinforcements could include material or social actions that an individual is willing to work for such as: food, money, medals, smiles, praise, approval or status. Negative reinforcements decreasing behaviors could include nagging, ridicule, exclusion, shock, pain, pressure, or punishment. Repeated negative reinforcements for positive efforts can result in feelings of hopeless, helplessness and victimization. For example, how the underemployed and unemployed go in and out of poverty is an example of how helplessness and feelings of victimization can be learned. This form of intermittent reinforcement can result in families viewing poverty as a chronic condition instead of one that can be overcome.

In the initial experiments, the researchers made avoidance possible and the dogs felt relief, but then arranged the electric shocks so the dogs could not avoid them. Three changes occurred in these experiments.

The first behavioral change detected was a motivational deficit. Such passivity in the face of danger happens to men and women as well, especially when the situation seems illogical and escape seems hopeless, such as overwhelming debt, poverty, or long term illnesses (Boss, 2002).

Second, a cognitive deficit set in; due to the incongruence in reinforcement. When a person has been wounded enough, he or she will just lie down and take the negative response, even if escape is possible. Behaviors produced by victimization are passivity, isolation, feelings of helplessness, and distrust of the world (Boss, 2002). This type of victimization can be looked upon as the overpowering of a person or family with physical or psychological trauma that results in feelings of helplessness, distrust of the world, and humiliation (Boss, 2002). These things could include loosing a job or not being able to provide for your family.

Third, emotional deficit was experienced. Emotional deficit can be seen as individuals express flat affect, listlessness, or inattention. For example, effort to obtain employment may seem futile and individuals seeking pay may give up trying. These individuals develop self-defeating strategies which eventually leads to the very failures that they are attempting to avoid. They may strive for unattainable goals, procrastinate, or accomplish only tasks that require little effort, thus perpetuating their own disappointment.

## *Therapeutic Biases*

### *Therapeutic Biases and Poverty*

A therapist must not only decipher which techniques and therapeutic forms they will practice to best suit their strengths and abilities, they must also be aware of personal

and client biases and prejudices that could hinder effective and efficient therapy. "Despite decreasing fees due to managed care, most therapists are able to maintain reasonably comfortable middle-class lifestyles" (Nichols & Schwartz, 2001, p. 326). However, they have little appreciation of the obstacles their poor clients face and the devastating psychological impact of those conditions. When poor clients no-show or do not comply with directives, therapists may be quick to see them as much of rest of the culture does as apathetic and irresponsible (Nichols & Schwartz, 2001). In many cases, this is also the way people of lower economic status come to see themselves-and that negative self-image/learned helplessness can become the biggest obstacle of all. Empowering not only the client but the therapist to take on a different perspective can aid in altering these perceived negative images.

How can we counter this tendency to think that families of lower economic status simply are not as adept as individuals of upper or middle economic status? The answer may be more difficult than one thinks. For instance, when a therapist directs a poor working mother to spend more time with her children, she may feel misunderstood and insulted, and not return. If on the other hand, that therapist listened empathically to her story of how much she would like to spend more time with her kids but cannot, and helped her not blame herself for her predicament by explaining the sociopolitical reasons for her constraints, she might lighten up on herself and feel a compassionate connection in her world (Nichols & Schwartz, 2001).

The fact is, this is not a land of equal opportunity. Narrative therapist Jodie Kliman (1998) believes that:

Collaboratively exploring class relationships, in and out of therapy, challenges the psychic constraints of class....Families denied mortgages or college loans can locate their

difficulties in the economic system, noting their own failings. Detailed questions about the ingenuity and work needed to keep a poor household going can focus on strengths and survival skills, not self-blame or helplessness...Understanding their class situation helps families to develop self-respecting family narratives and to draw on family and community resources in new ways. This counters the experiences of isolation, shame, and immobilization that blame-the-victim ideologies engender (p 58-59).

In a large-scale marital outcome study (Cline, Mejia, Coles, Klein, & Cline, 1984), effective therapist behavior differed on the basis of family economic status (SES). For middle economic status couples, movement towards less directiveness predicted increases in clients' emotional expressiveness and positive behaviors like acceptance, agreement, understanding, approval, and admitting responsibility. The opposite pattern was observed for lower economic status couples, who seemed to fare better when the therapist was increasingly directive. Therefore, less directive methods of interventions such as circular questioning, metaphors, reframes, and strategic questions which are often found in marriage and family therapy may be less effective while working with lower economic status families.

Family therapy alone can often feel powerless when working with the many constraints poor families face. Median family income has declined in the past two decades to the point where young families cannot hope to do as well as their parents, even with the two incomes needed to support a very modest standard of living (Rubin, 1994). That is why therapists need to educate themselves to the social and political realties of being poor in the United States in an effort to think more systemically, while combating biases and discriminations that could lead to inappropriate and ineffective therapy, which will result in empowering clients towards change.

*Empowerment*

Poverty can be explained by amount of education, skill, experience, intelligence,

health, handicaps, age, work orientation, time horizon, culture of poverty, discrimination, bad timing, economic recession, together with race, sex, etc. (Bureau of Education and Cultural Affairs, 2001). The hopeful side of such victimization is that if helplessness can be learned, then it can also be unlearned. Boss's version of the ABC-X model outlines that empowerment comes from (a) regaining self-esteem in family members and pride in the family as a team; (b) regaining control over what happens to the family, individually and as a group (this depends on if they see the situation as being in their control); (c) making some sense out of what happened by finding some meaning in the stressor; and (d) sharing with others while actively working to prevent a similar event from happening again (Boss, 2002). Often families who made the desired therapeutic changes in the shortest period of time viewed themselves as more competent at the outset of therapy (Hampson & Beavers, 1996). The concept of perceived personal power and control can be a contributor to therapeutic success or improvement.

In a larger study of successful and unsuccessful cases, Munton and Antaki (1988) reported that, relative to families with poor outcomes, those with good outcomes viewed their problems as less fixed as therapy progressed. Therefore, individuals that have been immersed in despair and seemingly helpless can often seem stuck for movement in life and the therapeutic process, first need to feel empowered. Empowerment is defined as recovery from victimization (Boss, 2002).

For example, while working with individuals in poverty as a family therapist, Ramon Rojano, developed a model called the community family therapy model. Rojano now heads the Department of Human Services in Hartford, Connecticut and oversees a $20 million annual budget and uses this model to network with all individual and

community systems. For Rojano, the greatest obstacles poor people face are the sense of powerlessness that comes with being controlled by a multitude of dehumanizing bureaucracies and the hopelessness of having no vision for achieving the American dream of a good job and nice home (Nichols & Schwartz, 2001). Looking at the individual's strengths that they have forgotten is what Rojano does to try and empower individuals. For example: behaviors of recovery and empowerment could be seen when individuals are able to find and develop options, make choices, get information, find peer support groups, or develop a future.

Rojano will encourage clients in their state of hopelessness and disconnections to dream of things they never even considered like: owning a home, going to college, starting a business, or running for office (Nichols & Schwartz, 2001). Rojano tries to encourage behaviors of recovery (empowerment) such as: finding and developing options, making choices, getting information, finding peer support groups, and developing a future (Boss, 2002). However, community empowerment by alone is not enough. Without ongoing family therapy, daily stressors and every day pressures would begin to erode an individual's empowered state, and their dreams of owning a home, going to college, or starting a business would begin to evaporate because of renewed conflicts.

There are blocks to empowerment process that must be made aware. For example, inequality of gender, classes, and race. Racial minority families have fewer resources and opportunities to share their own destinies. Also, in almost all cultures and subcultures throughout the world, females are still socialized to be more passive and submissive than are males. They are more likely to be victimized if passivity is perceived

as their role. Finally, the poor have fewer resources and choices with which to recover from their victimization. Empowerment is difficult, if not impossible, while such discriminatory barriers remain (Boss, 2002).

# CHAPTER 3

## *Design and Methodology*

Ultimately, the purpose of this quantative study is to see if families from different economic statuses come into therapy with different presenting problems, what interventions were used with families of different statuses, and which families were more likely to continue therapy until completion of therapeutic goals. Therefore, the method of this research is descriptive, comparative, and correlative looking for patterns and ideas that could possibly lead to a better understanding concerning the make-up of an effective therapeutic session and develop an explanation for what key elements produce better therapeutic results.

### *Research Design*

Using an ex post facto design, the archival data were used in a developmental nature. Therefore, the data used in this project already existed and could not be changed. The unit of analysis consisted of the cases used. The unit of observation was the family, individual, or couple. The information used in this study was collected from the cases, and then coded by the therapist.

The time dimension for the study was a longitudinal cohort study, looking at data that were collected over time on a category of people (lower and middle class) who share a similar life experience (need for therapy) in a specific period of time December 2001 to December 2003. This project used a form of standardized assessment. The information

that was collected from the families and reported by the therapists was the same for every unit observed in the study.

*Sampling/Conceptualization*

The target population consists of all clients who have attended, and all therapists and interns who provided mental health services during the time frame. The sampling frame consists of clients treated at a medium-sized south-central state university marriage and family therapy clinic. Clientele who met the requirements for middle and lower economic status were selected for this study.

A total of 128 subjects were involved in the study who completed all the initial paperwork and one session. The unit of analysis was cases. The total number of cases was 79. Only new and complete cases were used in the study. Premarital Prepare therapy and reopened cases were excluded from the sample. The sampling unit will be the individual client, the client system, and the therapists. The sampling procedure will be purposive, yet also convenience as every client that sought therapy, attended at least one session, and fit the criteria for lower and middle economic status during the specified time was included.

The elements are families of lower economic status and families of middle economic status seeking therapeutic services. The study population is lower class income and middle class income clients who sought services at a medium-sized south-central state university marriage and family therapy clinic between December 2001 to December 2003.

The limitations to this study are that attempting to generalize findings beyond the limited sampling frame could mislead some clinical sites. In order to better represent the

population at whole, future studies should consider excluding families whose income was primarily based on student loans or who listed student as their primary occupation.

*Research Instruments*

The researcher used a combination of the following procedures to collect the original data. Instruments included: telephone intake interview, clientele's background information, and face-to-face interviews, which determined the therapist's personal observations and perceptions while completing session summaries, diagnosis and treatment plans, and termination reports (see Table 1).

Table 1:

Variable Coding Table

| Source | Variable | Coding |
|---|---|---|
| Intake Report | How long has this been a problem? | 1=0-6 month,<br>2=7-12 months,<br>3=13-18 months,<br>4=19-24 months, etc |
| Intake Report | Any financial considerations? | 1=yes,<br>0=no |
| Intake Report | Yearly income before taxes. | 1=$999 or below<br>2=$1,000 to $1,999<br>3=$2,000 to $2,999, etc |
| Background Questionnaire | Please check if you have experienced the following symptoms during the past six months: | 1=yes,<br>0=no |
| Background Questionnaire | Do you drink? | 1=yes,<br>0=no |
| Background Questionnaire | If yes, how much? | 0=Never/do not use,<br>1=On occasion,<br>2=1-3 times weekly,<br>3=4+ times weekly |
| Background Questionnaire | Do you think you drink too much? | 1=Yes,<br>0=No |
| Background Questionnaire | How serious would you say this problem is right now? | 1=Not at All Serious,<br>2=Slightly Serious,<br>3=Moderately Serious,<br>4=Very Serious |

| | | |
|---|---|---|
| Background Questionnaire | How likely do you think the problem is to change? | 1=Not at All Likely,<br>2=Slightly Likely,<br>3=Moderately likely,<br>4=Very Likely |
| Background Questionnaire | Gender | 1=Male<br>2=Female |
| Background Questionnaire | Highest level of education completed. | 1=Less than 9th grade<br>2=Less than 12th grade<br>3=High school graduate<br>4=G.E.D.<br>5=Some college attended<br>6=College graduate |
| Background Questionnaire | Number of times married before. | 0=Never married<br>1=Married one time<br>2=Married two times<br>3=Married three times, etc |
| Session Summary | Break question/activity | 1=Yes, a break question/activity was given,<br>2=No break question/activity was given |
| Session Summary | Interventions used | 1=One recorded intervention,<br>2=Two recorded interventions,<br>3= Three recorded interventions, etc |
| Session Summary | Interactive therapy | 1=Yes, on average, sessions engaged in interactive therapy,<br>2= No, on average, sessions did not engage in interactive therapy |
| Session Summary | Homework given | 1=Yes, homework was assigned,<br>2=No homework was assigned |
| Diagnosis and Treatment Plan | Axis IV: Psychosocial and Environmental Problems | 1=Yes,<br>0=No |
| Termination Report | Type of therapy and number of sessions | 1=Those who complete twelve or more therapeutic sessions,<br>2=Those who attend therapy three to eleven therapy sessions,<br>3=Those who attend one or two therapeutic sessions |
| Termination Report | Reasons for termination | 1=Those who end therapy with the designation of completion of therapy,<br>2=Those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy,<br>3=Those who choose to discontinue before the third session with some reason other than therapy completion |

For analysis, the researcher used prerecorded information from documents/materials that were collected from completed sessions. No additional instruments were administered. The information used was based upon the client's self reports and therapist's perspectives. Researchers used this information in order to assess and categorize economic status. Studying the association between these variables, interactive therapy, and interventions administered will provide information for understanding therapeutic outcomes in various economic statuses.

*Intake report.*

A telephone intake report sheet was reviewed. The intake report is composed of 17 variables. For the purpose of this project three of the 17 variables were used. Information such as: how long has this been a problem, financial considerations, and yearly income before taxes was obtained upon the client calling to arrange a session date and time (see Appendix A).

The telephone intake takes approximately 10-20 minutes to be completed. The intake person asks a series of questions writing down the answers given by the individual who made the call. Once a telephone intake has been completed the clinical supervisor assigns a therapist to the case. The therapist then contacts the client and establishes a date and time for their first session. A telephone intake form must be completed before the client can be seen by a therapist.

*Background questionnaire.*

The background questionnaire is composed of 134 variables. For the purpose of this project six of the 134 variables were utilized. The background questionnaire includes information concerning alcohol use, health symptoms, gender, highest level of education,

seriousness of the problem, and client's perspective on likelihood that the problem will change will also be reviewed. Questions such as alcohol use and health problems will be reviewed looking at the differences between various socioeconomic statuses.

Prior to their first session, all clients were instructed to arrive 15 to 30 minutes early. At that time they were then greeted by their assigned therapist(s) who dispensed a background questionnaire to be completed (see Appendix B). All background forms were completed before the first session of therapy commenced. As with the intake form, there are no previously reported measures of reliability. However, the background form's face validity was also established by the collaboration of the three faculty supervisors who direct the clinic.

*Session summary sheet.*

The session summary sheet is composed of 29 variables. For the purpose of this project four of the 29 variables were employed. Session summary records typed by the therapist were documented within 24 hours of each session and included information such as: whether or not a break question was assigned, how many interventions were used, whether or not homework was assigned, and finally whether or not previously assigned homework was completed (see Appendix C).

*Diagnosis and treatment plan.*

The diagnosis and treatment plan is composed of 33 variables. For the purpose of this project nine of the 33 variables were drawn upon. The fourth axis of the DSM-IV is listed on the treatment plan (see Appendix D) and includes a section listing nine possible categories of psychosocial and environmental stressors (American Psychiatric Association, 2000). The list of possible psychosocial stressors includes: problems with

primary support group, problems related to the social environment, educational problems, occupational problems, economic problems, housing problems, problems with access to health care services, problems related to interaction with the legal system/crime, and other psychosocial and environmental problems. In addition to providing information that should be considered when determining a treatment plan, these psychosocial problems often provide information about the development and maintenance of a mental disorder, as well as information about possible outcome of the mental disorder.

On the treatment plan used in this study, the therapist checks the box for all current psychosocial stressors the client has reported that the therapist judges to be relevant. After checking the box for each relevant item, the therapist fills out a description of the problem under the categories he/she has marked. This study will use the assumption that greater number of psychosocial stressors will interfere with the client's ability to be successful in the therapeutic process.

*Termination report.*

The termination report is composed of 33 variables. For the purpose of this project three of the 33 variables were used. The termination report is filled out by the therapist upon closure of the case. This report contains information concerning number of sessions, the type of sessions (family, couple, individual, group), and the reason for leaving therapy (see Appendix E). A classification success in the therapeutic process will be determined from data on the sections, "number of sessions" and "reasons for termination" listed on the termination report. As for the validity of the form being used, the content and face validity of the item questions being used seems readily apparent and again, face validity of this form as established by the collaboration of the three faculty

supervisors who direct the clinic.

*Conceptual Definitions*

*Socioeconomic status.*

The intake form was used to determine low and middle socioeconomic status values. The question on the intake form regarding financial considerations specifically states, "Any financial considerations?" Therapeutic fees were based upon the clients reported yearly income before taxes. Fees were based upon a sliding scale fee, ranging from $5-$50 per hour. Assigned fees were negotiable.

Low and middle socioeconomic status was determined by doing a median split of the family's gross income before taxes. Clients whose gross income before taxes was lower than $15,000 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more were classified as higher economic status. Clients whose gross income before taxes was not recorded were placed into economic brackets according to fees assigned per therapeutic session. A median split was also used to determine the breaking point for fees assigned per therapeutic session. Clients who paid less than $20 per session were identified as lower economic status. Clients who paid $20 or more per session were identified as higher economic status. The total number of lower economic cases was 39. The total number of higher economic cases was 40.

*Interactive therapy.*

Using the session summary sheet, the researcher measured the amount of interactions using the average number of times a therapist used interventions, homework, and break questions in a therapeutic session. Across all sessions, the researcher compiled the number of interventions used, homework, and break questions assigned for each

session. From this information, a measurable average per session was obtained. This measuring average was termed interactive therapy. The measuring average included: assigning a break question, homework, and using 3.3 or more interventions per session.

Interactive therapy was then divided into four measured categories: low interaction, low medium interaction, high medium interaction, and high interaction. Clients who did not receive the average number of interventions, homework, and break questions assigned for each session were classified as receiving low interaction in the therapeutic process. Clients who received below the average number of interventions, homework, and break questions assigned in two areas were classified as receiving low medium interaction. Clients who received above the average number of interventions, homework, and break questions assigned in two areas were classified as receiving high medium interaction in therapy. Finally, clients who received above the average number of interventions, homework, and break questions assigned in all three areas were classified as receiving high interaction.

*Successful therapy.*

The termination report was used to determine whether or not therapy is labeled successful or unsuccessful. On the termination report, the therapist checks one of four responses: 1) completion of therapy, 2) client request, 3) no shows/cancellations, or 4) other, please explain. From this information, three classifications of termination will be determined.

First, therapeutic dropout will be those who choose to discontinue before the third session with some reason other than completion of therapy. The second classification of continuers will be those who discontinue therapy after three or more sessions, but for

some reason other than completion of therapy. The last classification will be labeled as therapeutic completers and end therapy with the designation of completion of therapy.

Completion of therapy will be defined and measured according to the following criteria: any client that 1) successfully completes therapy, and 2) mutually agree with the therapist that the therapeutic goals have been reached.

*Effective therapy.*

For the purpose of this research design, effective therapy will be defined and measured by success rate. Any client who 1) successfully completes therapy, and 2) mutually agrees with the therapist that their therapeutic goals have been reached is termed for this study, a therapeutic success. Therefore, therapeutic clients that have completed all of the above criteria will be categorized as having received "effective therapy." Clients that do not complete the above criteria or drop out of therapy will be seen as having received "less effective therapy."

*Research Method Hypothesis Implementation*

*Hypothesis 1.1: the more interventions used per session, the more likely a client is to succeed in therapy.*

The researcher used session summary sheets as testing procedures for the hypothesis 1.1. The session summary sheet contained areas specifically designated for the therapist to record "Interventions Used." (see Appendix C). The coding for "Interventions Used" is 1=one recorded intervention, 2=two recorded interventions, 3= three recorded interventions, etc.

The researcher used the termination report to determine therapeutic success. Coding for therapeutic success will be 1= those who end therapy with the designation of

completion of therapy, 2= those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy, and 3= those who choose to discontinue before the third session with some reason other than completion of therapy.

*Hypothesis 1.2: the use of a break question will more likely result in a client succeeding in therapy.*

The researcher used session summary sheets as testing procedures for the hypothesis 1.2. The session summary sheet contained areas specifically designated for the therapist to record "Break Question/Activity." The coding for "Break Question/Activity" will be coded 1=yes, a break question/activity was given, and 0=no break question/activity was given.

Researcher used termination report for coding therapeutic outcome. Coding for therapeutic outcome will be 1= those who end therapy with the designation of completion of therapy, 2= those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy, and 3= those who choose to discontinue before the third session with some reason other than completion of therapy.

*Hypothesis 1.3: clientele who are consistently assigned homework will be more likely to succeed in therapy opposed to those who are not consistently assigned homework.*

The researcher used session summary sheets as testing procedures for testing measuring homework assigned in hypothesis 1.3. The session summary sheet contained areas specifically designated for the therapist to record "Homework Given." (see Appendix C). Coding for homework assigned will be 1=yes, homework was assigned, and 0=no homework was assigned.

The researcher used the termination report to determine success rates among clientele. Coding for therapeutic success will be 1= those who end therapy with the designation of completion of therapy, 2= those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy, and 3= those who choose to discontinue before the third session with some reason other than completion of therapy.

*Hypothesis 2.1: lower economic status individuals will not be as successful in the therapeutic process as middle economic status families.*

The termination report will be used to determine therapeutic success in hypothesis 2.1. Coding for therapeutic success will be 1= those who end therapy with the designation of completion of therapy, 2= those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy, and 3= those who choose to discontinue before the third session with some reason other than completion of therapy.

Economic status will be determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more were classified as middle economic status.

*Hypothesis 2.2: higher interactive therapy will result in increased therapeutic success.*

The session summary sheet was used to test hypothesis 2.2. Therapy sessions that perform the average and above average numbers of interventions, homework and break questions in all three areas was labeled "high interaction" therapeutic session. Therapy

sessions that perform the average and above average numbers of interventions, homework and break questions in two areas was labeled "high medium interaction" therapeutic session. Therapy sessions that meet only one of the average number of interventions, goals, homework, and break questions will be labeled a "low medium interaction" therapeutic session. Therapy sessions that do not meet none of the average number of interventions, goals, homework, and break questions will be labeled a "low interaction" therapeutic session. Coding for interactive therapy will be 1=low interaction, 2=low medium interaction, 3= high medium interaction, and 4-high interaction.

The termination report will be used to test therapeutic success rate in hypothesis 2.2. Coding for therapeutic success will be 1= those who end therapy with the designation of completion of therapy, 2= those who discontinue therapy after three or more sessions, but for some reason other than completion of therapy, and 3= those who choose to discontinue before the third session with some reason other than completion of therapy.

*Hypothesis 2.3: families from lower economic status will receive lower amounts of interaction in therapy than families from a middle economic status.*

The session summary sheet was used to test hypothesis 2.3 by using the measuring average for "interactive" therapy according to this research project. Therapy sessions that perform the average and above average numbers of interventions, homework and break questions in all three areas was labeled "high interaction" therapeutic session. Therapy sessions that perform the average and above average numbers of interventions, homework and break questions in two areas was labeled "high medium interaction" therapeutic session. Therapy sessions that meet only one of the

average number of interventions, goals, homework, and break questions will be labeled a "low medium interaction" therapeutic session. Therapy sessions that do not meet none of the average number of interventions, goals, homework, and break questions will be labeled a "low interaction" therapeutic session. Coding for interactive therapy will be 1=low interaction, 2=low medium interaction, 3= high medium interaction, and 4-high interaction.

Economic status will be determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 or whose feel was less than $20 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more or whose fee was more than $20 were classified as higher economic status.

*Hypothesis 2.4: families who receive lower amounts of interaction in therapy will attend fewer sessions than families who receive a greater amount of interactive therapy.*

The session summary sheet and termination report was used to test hypothesis 2.4. The session summary sheet was used to determine clients who received active therapy, and those who received less interactive therapy. Therapy sessions that perform the average and above average numbers of interventions, homework and break questions in all three areas was labeled "high interaction" therapeutic session. Therapy sessions that perform the average and above average numbers of interventions, homework and break questions in two areas was labeled "high medium interaction" therapeutic session. Therapy sessions that meet only one of the average number of interventions, goals, homework, and break questions will be labeled a "low medium interaction" therapeutic

session. Therapy sessions that do not meet none of the average number of interventions, goals, homework, and break questions will be labeled a "low interaction" therapeutic session. Coding for interactive therapy will be 1=low interaction, 2=low medium interaction, 3= high medium interaction, and 4-high interaction.

The termination report was used to test the number of sessions attended in hypothesis 2.4. The termination report contains information concerning "number of sessions." The coding for "Number of Sessions" is 1=one session, 2=two sessions, through 26=twenty-six sessions.

*Hypothesis 3.1: lower economic status individuals will perceive the problem (very serious vs. not at all serious) as more serious than individuals of a middle economic status.*

The background questionnaire will investigate hypothesis 3.1. The question on the background questionnaire covering client attitude toward problem severity states, "How serious would you say this problem is right now?" The subject is asked to respond by circling one of the four possible answers: 1=Not at All Serious, 2=Slightly Serious, 3=Moderately Serious, 4=Very Serious. The seriousness of the problem will be coded according to the scale above for individual clients. Cases where multiple individuals were seeking therapy together, the first two coded family members answers were averaged together to tabulate the final perception of seriousness on a possible scale from 1 to 4.

Economic status will be determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 were classified as lower economic status. Clients whose gross income

before taxes was $15,000 or more were classified as higher economic status.

*Hypothesis 3.2: families from lower economic statuses will report that the problem is less likely to change than families of middle economic status.*

Considering literature that reviews lower economic status families experiencing learned helplessness, the background questionnaire will test hypothesis 3.2. Attitude toward the likelihood that the problem will change is measured with the question, "How likely do you think the problem is to change?" The subject is asked to respond by circling one of the four possible answers: 1=Not at All Likely, 2=Slightly Likely, 3=Moderately likely, 4=Very Likely. The likelihood of change will be coded according to the scale above for individual clients. Cases were multiple individuals were seeking therapy together, the first two coded family members answers were averaged together to tabulate the final perception of likelihood of change on a possible scale from 1 to 4.

Economic status will be determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more were classified as higher economic status.

*Hypothesis 3.3: families from lower economic status will report that the presenting problem has been a problem longer than families of middle economic status.*

The intake form was used to test hypothesis 3.3. The intake form specifically asks, "How long has it been a problem?" The answer is numerically coded by the therapist according to months, for example, 1=one month, 2=2 months, 3=3 months.

Economic status was determined according to the client's report of gross income

before taxes on the intake report. Clients who reported income that was lower than $15,000 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more were classified as higher economic status.

*Hypothesis 4.1: families from lower economic statuses will report more alcohol use more often than families from a middle economic status.*

The background questionnaire tests hypothesis 4.1. The first question on the form regarding alcohol use specifically states, "Do you drink alcohol? If yes, how much?" The coding for the answer is first 1=yes, and 0=no. If the client drinks alcohol the amount is coded according to the scale of: 0=Never/do not use, 1=On occasion, 2=1-3 times weekly, 3=4+ times weekly, or 4= Multiple times a day. The client's perception of alcohol consumption will be coded according to the scale above for individual clients. Cases were multiple individuals were seeking therapy together, the first two coded family members answers were averaged together to tabulate the final perception of alcohol consumption on a possible scale from 0 to 4.

Economic status was determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 or whose fee was less than $20 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or whose fee was more than $20 more were classified as higher economic status.

*Hypothesis 4.2: families from lower economic status will report more signs of depression than families of middle economic status.*

In being consistent with associated literature on economic status and depression, the health symptoms checklist was used to test hypothesis 4.2. The checklist contains 12

possible items that the client may have experienced in the past six months. The checklist included selections such as "eating problems," "trouble sleeping," or "unexplained worry or fearfulness." The respondent was asked to check the listed symptoms they had experienced in the past six months: 1=yes and 0=no. This question will provide a measure of the health symptoms experienced prior to therapy. Several of the listed health symptoms are indications that a client may be experiencing depression or anxiety.

Economic status was determined according to the client's report of gross income before taxes on the intake report. Clients who reported income that was lower than $15,000 were classified as lower economic status. Clients whose gross income before taxes was $15,000 or more were classified as higher economic status.

*Statistical Procedures*

Hypotheses were tested using a one-way analysis of variance (ANOVA). An analysis is the separation of a whole into its parts so as to study the elements in their relationship. Specifically the variance is the mean of the sum of the squared deviations from the mean score divided by the number of scores (Vogt, 1999). A one-way ANOVA is an analysis of variance with only one independent variable or factor being measured at a time.

*Ethical Considerations*

Deception and physical harm was not a part of the research conducted. All information used was previously collected and processed data and was not an ethical consideration. Individuals sought services at the center at their own voluntary discretion and were able to discontinue services at any time they deemed necessary. Individuals were not solicited for the purpose of this study.

Before services were ever rendered, clients signed an informed consent form which reviews the client's privacy rights (see Appendix F and G). With this form, the families a part of the study have voluntary consented to receiving treatment, knowing that the information recorded in session could be used as research materials, and signed a written informed consent form that has enclosed the protection of their privacy, guaranteeing complete confidentiality.

To prevent any possible harm to subjects due to disclosure of information, preserving subject confidentiality was a priority. No one but research personnel, Marriage and Family Therapy staff, second, and third year interns have access to information that could be used to link the respondents to their responses which is kept in a locked office in a locked filing cabinet. Only numbers were used to identify respondents on their questionnaires and the names that correspond to these numbers are kept in a safe, private, and separate location unavailable to staff and others who might otherwise come across them.

*Evaluation of Design*

This design has much strength, for example, data were prerecorded without bias to this particular study. Therefore, the therapists who recorded this information were blind to the study's objectives. The data collectively covered both the therapists' perspective and things that the therapist has control over, such as assigned break questions, homework, and interventions used per sessions. Data also covered the client's perspective over things the client has control over, such as: perception of the problems severity, likelihood of change, alcohol consumption, and number of sessions attended.

# CHAPTER 4

## *Results*

The current study yielded a sample of 79 cases in which all participants completed the initial paperwork and at least one session. The primary means of analysis used to evaluate the results were chi-square test, one-way ANOVA statistics, and post hoc comparisons.

### *Clients*

The total number of cases was 79. The total number of subjects was 128. The number of cases consisted of the following: 39 couples, 16 families, and 24 individuals. Of the 128 subjects who participated in this study clients were classified into 11 groups. Of theses groups, there were: 25 husbands, 26 wives, 13 male partners, 12 female partners, nine male individuals, 13 female individuals, one father, 14 mothers, three sons, seven daughters, and one identified step-father. Ages range from 12 to 59 years of age (mean=29.27, median=29, mode=22). From the total number subjects chosen, 52 (40.6%) were males, 72 (56.7%) were females, and four (3.1%) were missing this identifying information. Married participants comprised 51.6% percent of the subjects, 44.5% were not married and 3.9 % were missing this information. Caucasian participants comprised 62.5% of the sample, 10.2% were American Indian/Alaska Native, 1.6% were Hispanic/Latino, 1.6% were mixed ethnic background, 0.8% were African American/black, 0.8% were Asian/Pacific Islander, and 22.7% participants were missing

this identifying information. Client education ranged from some elementary to graduate school, with the majority of clients having finished high school (34.4%) and some college or more education (41.4%). The total number of lower economic cases was 39. The total number of higher economic cases was 40 (see Table 2).

Table 2:

Client Demographic Overview

| | | | |
|---|---|---|---|
| Gender | Male | 52 | (40.6%) |
| | Female | 72 | (56.7%) |
| | | | |
| Cases | Couples | 39 | (30.4%) |
| | Families | 16 | (49.4%) |
| | Individuals | 24 | (20.3%) |
| | | | |
| Economic Status | Lower | 39 | (49.4%) |
| | Middle | 40 | (50.6%) |
| | | | |
| Mean Income | $23,000 | | |

*Hypothesis Testing*

The primary means of analysis used to evaluate the results were chi-square test, one-way ANOVA statistics, and post hoc comparisons. Chi-square tests were used as a test statistic for categorical data testing for independence as well as goodness of fit. One-way ANOVA were used to test the statistical significance of the differences among the mean scores of two or more groups on one or more variable or factors (Vogt, 1999). Post hoc comparisons were used to test the significant differences between group means after having done a one-way analysis of variance (Vogt, 1999).

*Hypothesis Testing Results*

*Hypothesis 1.1.*

Hypothesis 1.1 states that the more interventions used per session, the more likely a client is to succeed in therapy. The number of interventions per session ranged from 1 to 7.6, with a mean of 3.3 (sd=1.1), and a mode of 2. A one-way ANOVA revealed significant differences between groups ($F(2,76)=4.21$, $p<.025$) (see Table 3).

Table 3:

Relationship Between Number of Interventions Used and Therapeutic Success

**ANOVA**

Average # of Interventions Used per Session

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 9.644 | 2 | 4.822 | 4.214 | .018 |
| Within Groups | 86.967 | 76 | 1.144 | | |
| Total | 96.611 | 78 | | | |

| | N | Mean | Std. Deviation |
|---|---|---|---|
| Dropout | 29 | 2.88 | 1.04 |
| Continuer | 38 | 3.65 | 1.17 |
| Completer | 12 | 3.32 | .76 |
| Total | 79 | 3.32 | 1.11 |

A post hoc test, using Tukey's HSD, assessed the statistical significance of differences between groups and revealed mixed results. Findings indicated that there was a significant difference in the number of interventions used between two groups, dropouts and continuers ($p<.05$), and no significant difference between client groups of dropouts and completers or continuers and completers ($p>.05$). Despite the lack of significance between the average number of interventions used in cases where therapeutic clients dropped out and completed therapy, there appeared to be a moderate trend towards

therapists using more than the average number of interventions in cases where therapy was successfully complete (see Table 4).

Table 4:

Post Hoc Test for Multiple Comparisons Between Average Number of Interventions Used per Session and Therapeutic Outcome

**Multiple Comparisons**

Dependent Variable: Average # of Interventions Used per Session
Tukey HSD

| (I) OUTCOME | (J) OUTCOME | Mean Difference (I-J) | Std. Error | Sig. | 95% Confidence Interval | |
|---|---|---|---|---|---|---|
| | | | | | Lower Bound | Upper Bound |
| dropout | continuer | -.7657* | .26377 | .013 | -1.3963 | -.1352 |
| | completer | -.4364 | .36718 | .464 | -1.3141 | .4413 |
| continuer | dropout | .7657* | .26377 | .013 | .1352 | 1.3963 |
| | completer | .3293 | .35422 | .623 | -.5174 | 1.1761 |
| completer | dropout | .4364 | .36718 | .464 | -.4413 | 1.3141 |
| | continuer | -.3293 | .35422 | .623 | -1.1761 | .5174 |

*. The mean difference is significant at the .05 level.

| | N | Mean | Std. Deviation |
|---|---|---|---|
| Dropout | 29 | 2.88 | 1.04 |
| Continuer | 38 | 3.65 | 1.17 |
| Completer | 12 | 3.32 | .76 |
| Total | 79 | 3.33 | 1.11 |

*Hypothesis 1.2.*

Hypothesis 1.2 states that the use of a break question will more likely result in a successful therapeutic outcome. A one-way ANOVA showed no significant difference ($F(2,76)=1.75$, n.s.) (see Table 5).

Table 5:

Relationship Between Break Questions Assigned and Therapeutic Success

**ANOVA**

% break question assigned

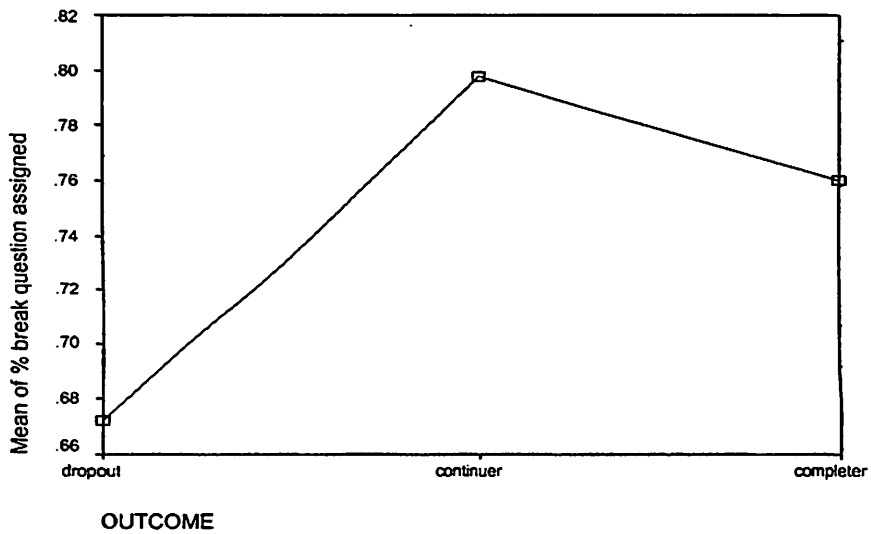
| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | .261 | 2 | .130 | 1.175 | .314 |
| Within Groups | 8.423 | 76 | .111 | | |
| Total | 8.684 | 78 | | | |

| | N | Mean | Std. Deviation |
|---|---|---|---|
| Dropout | 29 | .67 | .43 |
| Continuer | 38 | .80 | .24 |
| Completer | 12 | .76 | .33 |
| Total | 79 | .75 | .33 |

Although there was no significance between the use of a break question among therapeutic dropouts, continuers, and completers, there appeared to be a moderate trend towards therapists using break questions more often for clients who either continued therapy or completed (see Graph 1).

Graph 1:

Use of a Break Question and Therapeutic Success



*Hypothesis 1.3.*

Hypothesis 1.3 prognosticated that clients who are consistently assigned homework will have an increased success rate opposed to those who are not consistently assigned homework. Hypothesis 1.3 was tested using one-way ANOVA and was not supported ($F(2,76)=.470$, n.s.) (see Table 6).

Table 6:

Relationship Between Homework Assigned and Therapeutic Success

**ANOVA**

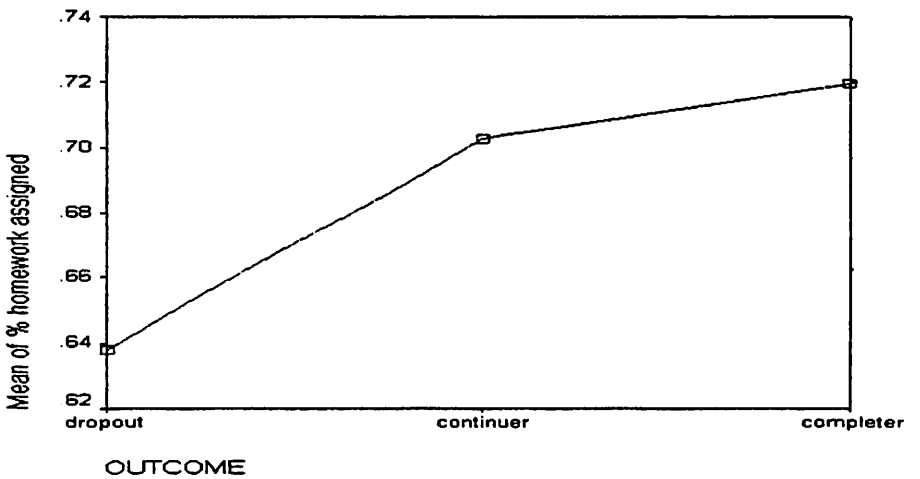
% homework assigned

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | .090 | 2 | .045 | .470 | .627 |
| Within Groups | 7.252 | 76 | .095 | | |
| Total | 7.341 | 78 | | | |

Although there was no significance between homework assigned among therapeutic dropouts, continuers, and completers, there appeared to be a moderate trend towards therapists who assigned homework more often for clients who either continued therapy or completed (see Graph 2).

Graph 2:

Homework Assigned and Therapeutic Success



*Hypothesis 2.1.*

Hypothesis 2.1 states that lower economic status individuals will not be as successful in the therapeutic process as middle economic status families. A chi-square analysis was used as a test statistic for categorical data. Results demonstrate that economic status is not significantly related to success in the therapeutic process ($X^2$=.022, df=2, n.s.) (see Table 7).

Table 7:

Economic Status and Therapeutic Success Rate

**SES * OUTCOME Crosstabulation**

| | | | OUTCOME | | | |
|---|---|---|---|---|---|---|
| | | | dropout | continuer | completer | Total |
| SES | low income | Count | 14 | 19 | 6 | 39 |
| | | % within SES | 35.9% | 48.7% | 15.4% | 100.0% |
| | | % within OUTCOME | 48.3% | 50.0% | 50.0% | 49.4% |
| | | % of Total | 17.7% | 24.1% | 7.6% | 49.4% |
| | high income | Count | 15 | 19 | 6 | 40 |
| | | % within SES | 37.5% | 47.5% | 15.0% | 100.0% |
| | | % within OUTCOME | 51.7% | 50.0% | 50.0% | 50.6% |
| | | % of Total | 19.0% | 24.1% | 7.6% | 50.6% |
| Total | | Count | 29 | 38 | 12 | 79 |
| | | % within SES | 36.7% | 48.1% | 15.2% | 100.0% |
| | | % within OUTCOME | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 36.7% | 48.1% | 15.2% | 100.0% |

*Hypothesis 2.2.*

Hypothesis 2.2 which predicted that interactive therapy will result in increased therapeutic success rates was not supported resulting in no significant difference, ($X^2$=6.77, df=6, n.s.). Table 8 shows the results and general trends.

Table 8:

Use of Interactive Therapy and Therapeutic Success Rate

**INTERAC * OUTCOME Crosstabulation**

| | | | OUTCOME | | | |
|---|---|---|---|---|---|---|
| | | | dropout | continuer | completer | Total |
| INTERAC | Low Interaction | Count | 6 | 6 | 4 | 16 |
| | | % within INTERAC | 37.5% | 37.5% | 25.0% | 100.0% |
| | | % within OUTCOME | 20.7% | 15.8% | 33.3% | 20.3% |
| | | % of Total | 7.6% | 7.6% | 5.1% | 20.3% |
| | Low Medium Interaction | Count | 10 | 14 | | 24 |
| | | % within INTERAC | 41.7% | 58.3% | | 100.0% |
| | | % within OUTCOME | 34.5% | 36.8% | | 30.4% |
| | | % of Total | 12.7% | 17.7% | | 30.4% |
| | High Medium Interaction | Count | 8 | 10 | 5 | 23 |
| | | % within INTERAC | 34.8% | 43.5% | 21.7% | 100.0% |
| | | % within OUTCOME | 27.6% | 26.3% | 41.7% | 29.1% |
| | | % of Total | 10.1% | 12.7% | 6.3% | 29.1% |
| | High Interaction | Count | 5 | 8 | 3 | 16 |
| | | % within INTERAC | 31.3% | 50.0% | 18.8% | 100.0% |
| | | % within OUTCOME | 17.2% | 21.1% | 25.0% | 20.3% |
| | | % of Total | 6.3% | 10.1% | 3.8% | 20.3% |
| Total | | Count | 29 | 38 | 12 | 79 |
| | | % within INTERAC | 36.7% | 48.1% | 15.2% | 100.0% |
| | | % within OUTCOME | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 36.7% | 48.1% | 15.2% | 100.0% |

*Hypothesis 2.3.*

Hypothesis 2.3 states that families from lower economic status will receive less interactive therapy than families from a middle economic status. A chi-square analysis indicated that there was no significant difference between the groups ($X^2$=2.13, df=3, n.s.) (see Table 9).

Table 9:

Use of Interactive Therapy as Compared to Economic Status

**SES * INTERAC Crosstabulation**

| | | | INTERAC | | | | |
|---|---|---|---|---|---|---|---|
| | | | Low Interaction | Low Medium Interaction | High Medium Interaction | High Interaction | Total |
| SES | low income | Count | 8 | 9 | 13 | 9 | 39 |
| | | % within SES | 20.5% | 23.1% | 33.3% | 23.1% | 100.0% |
| | | % within INTERAC | 50.0% | 37.5% | 56.5% | 56.3% | 49.4% |
| | | % of Total | 10.1% | 11.4% | 16.5% | 11.4% | 49.4% |
| | high income | Count | 8 | 15 | 10 | 7 | 40 |
| | | % within SES | 20.0% | 37.5% | 25.0% | 17.5% | 100.0% |
| | | % within INTERAC | 50.0% | 62.5% | 43.5% | 43.8% | 50.6% |
| | | % of Total | 10.1% | 19.0% | 12.7% | 8.9% | 50.6% |
| Total | | Count | 16 | 24 | 23 | 16 | 79 |
| | | % within SES | 20.3% | 30.4% | 29.1% | 20.3% | 100.0% |
| | | % within INTERAC | 100.0% | 100.0% | 100.0% | 100.0% | 100.0% |
| | | % of Total | 20.3% | 30.4% | 29.1% | 20.3% | 100.0% |

*Hypothesis 2.4.*

Hypothesis 2.4 projects that families who receive less interactive therapy will attend fewer sessions than families who receive a greater amount of interactive therapy. An examination of the one-way ANOVA results show no significant difference between the total number of sessions completed and the amount of interactive therapy ($F(3,75)=2.4$, $p<.10$) (see Table 10).

Table 10:

Relationship Between Interactive Therapy as Compared to Number of Sessions Attended

**ANOVA**

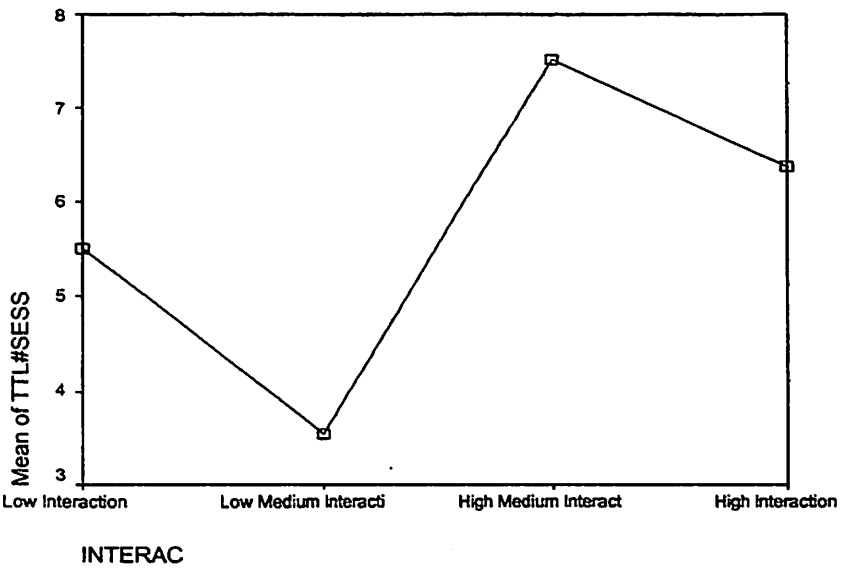
TTL#SESS

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 195.996 | 3 | 65.332 | 2.403 | .074 |
| Within Groups | 2039.447 | 75 | 27.193 | | |
| Total | 2235.443 | 78 | | | |

Although there was no significance between interactive therapy as compared to number of sessions attended, there appeared to be a moderate trend towards high medium interaction and high interaction being used in more sessions (see Graph 3).

Graph 3:

Number of Sessions Completed and the Level of Interactive Therapy Employed




*Hypothesis 3.1.*

Hypothesis 3.1 states that lower economic status individuals will perceive the problem (very serious vs. not at all serious) as more serious than individuals of a middle economic status approached significance ($F(1,73)=3.94$, $p<.10$) (see Table 11).

Table 11:

Relationship Between Perceptions about the Presenting Problem as Compared to Economic Status

ANOVA

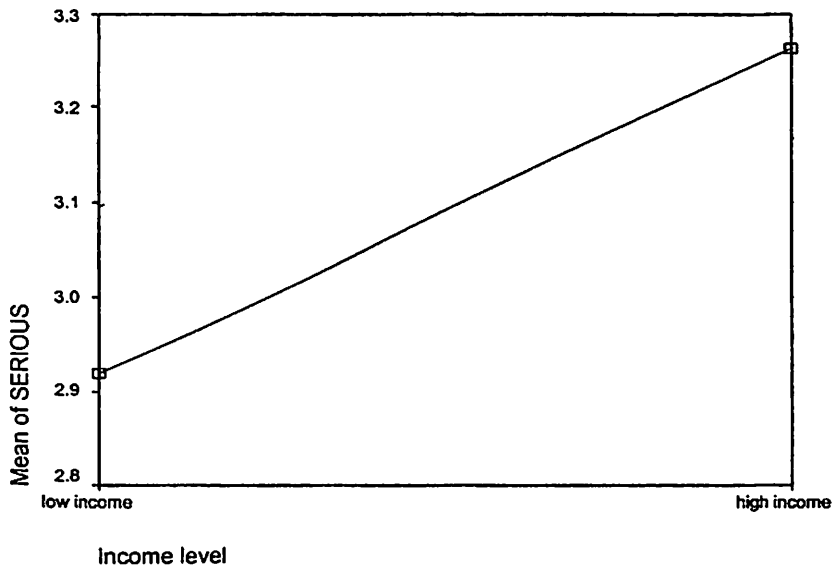
SERIOUS

| | | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|---|
| Between Groups | (Combined) | | 2.221 | 1 | 2.221 | 3.943 | .051 |
| | Linear Term | Unweighted | 2.221 | 1 | 2.221 | 3.943 | .051 |
| | | Weighted | 2.221 | 1 | 2.221 | 3.943 | .051 |
| Within Groups | | | 41.125 | 73 | .563 | | |
| Total | | | 43.347 | 74 | | | |

Although, notably hypothesis 3.1 approached significance in the opposite direction of that predicted, thus projecting that higher economic status clients perceived the problem as more serious than individuals of a lower economic status (see Graph 4).

Graph 4:

Perceptions about the Presenting Problem as Compared to Economic Status




*Hypothesis 3.2.*

Hypothesis 3.2 which states that families from lower economic statuses will report that the problem is less likely to change than families of middle economic status was not supported ($F(1,70)=.945$, n.s.) (see Table 12). The likelihood of change ranged from 1 (not at all likely) to 4 (very likely), with a mean of 3.1 (sd=.77), and a mode of 4.

Table 12:

Relationship Between Client's Perception about Likelihood of Change as Compared to Economic Status

**ANOVA**

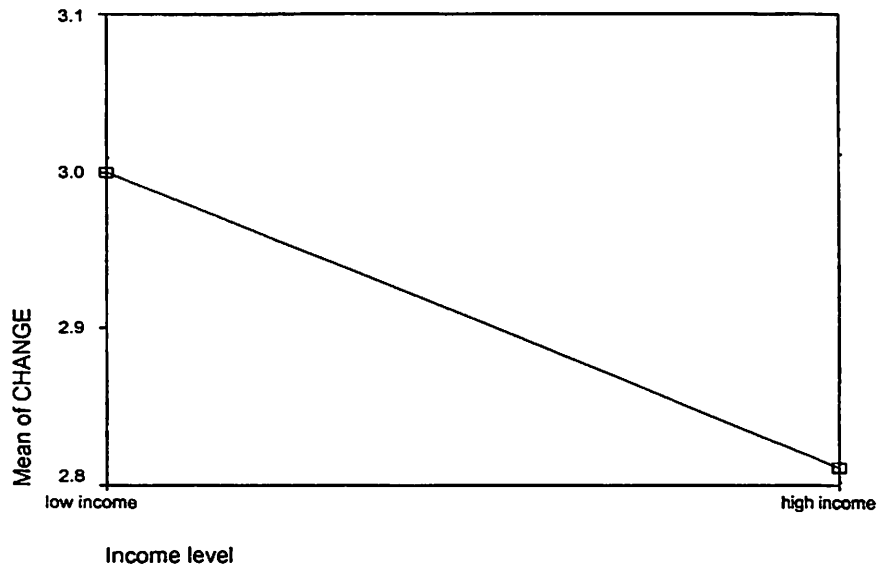
CHANGE

| | | | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|---|---|
| Between Groups | (Combined) | | .644 | 1 | .644 | .945 | .334 |
| | Linear Term | Unweighted | .644 | 1 | .644 | .945 | .334 |
| | | Weighted | .644 | 1 | .644 | .945 | .334 |
| Within Groups | | | 47.676 | 70 | .681 | | |
| Total | | | 48.319 | 71 | | | |

While there was no significance between lower and higher economic status on clients' perception concerning the likelihood of change, there appeared to be a moderate trend towards supporting the reverse of this hypothesis. These tendencies suggest that lower economic status clients perceive the problem as more likely to change (see Graph 5).

Graph 5:

Client's Perception about Likelihood of Change by Economic Status



*Hypothesis 3.3.*

Hypothesis 3.3 stating that families from lower economic status will report that the presenting problem has been a problem longer than families of middle economic status was significant ($F(1,72)=5.97$, $p<.05$) (see Table 13).

Table 13:

Relationship Between Client's Perspective on Prior Problem Duration and Economic Status

**ANOVA**

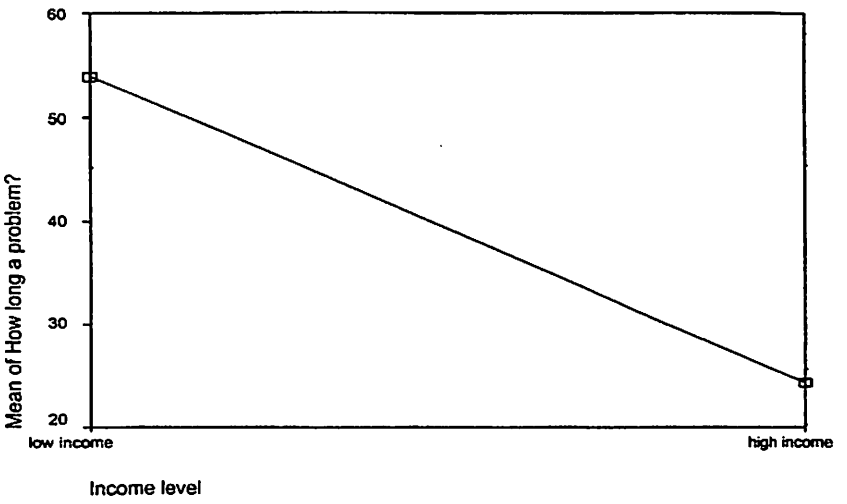
How long a problem?

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | 16172.489 | 1 | 16172.489 | 5.966 | .017 |
| Within Groups | 195172.1 | 72 | 2710.723 | | |
| Total | 211344.5 | 73 | | | |

A clear and easy view of the results of significant hypothesis 3.3 can be seen in Graph 6.

Graph 6:

Client's Perspective on Prior Problem Duration and Economic Status




*Hypothesis 4.1.*

Hypothesis 4.1 states that families from lower economic statuses will report more alcohol use more often than families from a middle economic status. Results show that

economic status is not significantly related to more reported alcohol use ($F(1,38)=.817$, n.s.) (see Table 14).

Table 14:

Relationship Between Alcohol Use and Economic Status

**ANOVA**

How much do you drink?

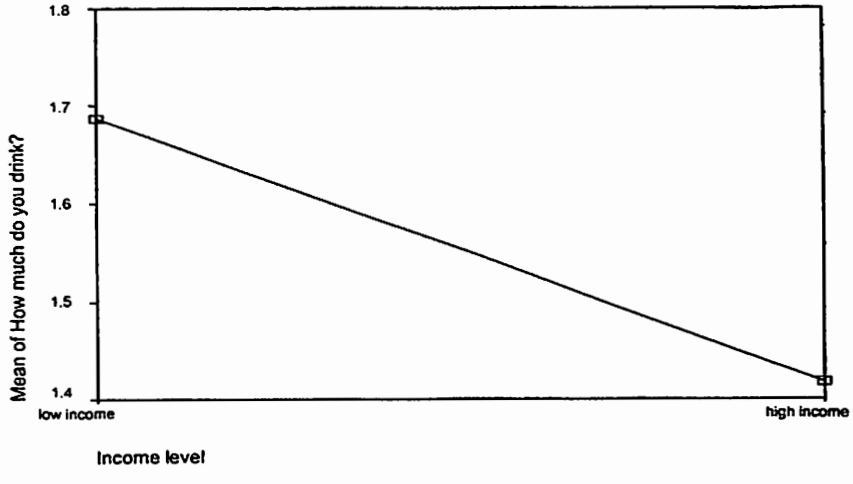
| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | .704 | 1 | .704 | .817 | .372 |
| Within Groups | 32.771 | 38 | .862 | | |
| Total | 33.475 | 39 | | | |

| | N | Mean | Std. Deviation |
|---|---|---|---|
| Low income | 16 | 1.69 | 1.12 |
| High income | 24 | 1.42 | .78 |
| Total | 40 | 1.52 | .93 |

Graph 7 shows the visual trends of the results for hypothesis 4.1.

Graph 7:

Client's Perspective on Alcohol Use and Economic Status



*Hypothesis 4.2.*

Hypothesis 4.2 which states that families from lower economic status will report more signs of depression than families of middle economic status, a one-way ANOVA showed no significant results. ($F(1,73)=1.71$, n.s.) (see Table 15).

Table 15:

Relationship Between Depressive Symptoms and Economic Status

**ANOVA**

depression symptoms

| | Sum of Squares | df | Mean Square | F | Sig. |
|---|---|---|---|---|---|
| Between Groups | .106 | 1 | .106 | 1.710 | .195 |
| Within Groups | 4.519 | 73 | .062 | | |
| Total | 4.625 | 74 | | | |

After using a sample of 79 cases in which all participants completed the initial paperwork and at least one session, this experiment used a combination of chi-square test, one-way ANOVA statistics, and post hoc comparisons to evaluate the significance of twelve hypotheses. Of the twelve hypotheses reviewed, two yielded significant results, while ten produced no significant difference. Of the ten hypothesis that were not significant, four of these hypothesizes generated non-significant results with a moderate trend supporting the significance of the hypothesis and one supported the opposite of the initially proposed hypothesis.

# CHAPTER 5

## *Discussion*

This study took on a preliminary format assessing quantative variables, such as income, treatment, and success in therapy. The next step would be to take these preliminary studies and break them down into qualitative studies. This would begin the movement necessary to uncover categories, concepts, differences, or similarities that begin to emerge or fail to develop in each hypothesis grouping.

### *Hypothesis Testing Discussion*

#### *Hypothesis 1.1.*

Hypothesis 1.1 stating that the more interventions used per session, the more likely a client is to succeed in therapy showed a significant difference in the number of interventions used between two groups, dropouts and continuers, and no significant difference between client groups of dropouts and completers or continuers and completers. The differences indicated that more types of interventions were used with those clients who continued treatment past the second session and fewest with those who dropped out before the third session.

This could be attributed to the client's immanent desire to change. More interventions could be perceived as help being received during the beginning phases of therapy which draws clients back for more sessions. Whereas, once a relationship has been established between the therapist and client and measurable results are obtained, the

quantity of interventions becomes less important. Future studies may want to look at types of interventions used in the beginning of therapy verses at completion. The therapist might try a multitude of interventions in an attempt to uncover what appears to be most effective for clients. Therefore, while cases that have engaged in more sessions may be receiving less therapeutic interventions, these interventions may be more specified to fit the needs and personalities of the clients involved in therapy.

*Hypothesis 1.2.*

Hypothesis 1.2 stating that the use of a break question will more likely result in a client succeeding in therapy was not significant between any combination of dropouts, continuers, and completers. Although there was no significance between the use of a break question among therapeutic dropouts, continuers, and completers, there appeared to be a moderate trend towards therapists using break questions more often for clients who either continued therapy or completed. Because the sample was small, more meaningful results may have been found in a study conducted with a larger sample size.

*Hypothesis 1.3.*

Hypothesis 1.3 stated that clients who are consistently assigned homework will have an increased success rate opposed to those who are not consistently assigned homework was not significant. Although there was no significance between homework assigned among therapeutic dropouts, continuers, and completers, there appeared to be a moderate trend towards therapists who assigned homework more often for clients who either continued therapy or completed. Due to the small sample size, more meaningful result may have been found in a study conducted with a larger sample size.

Hypothesis 1.2 and 1.3 both looked at quantitative measures reviewing whether or not break questions or homework were assigned and no significant differences were found. Future studies may want to take a more qualitative look at the content and applied use of the break questions and assigned homework. For example, whether the break questions/homework was thought or action orientated may be an important distinction to assess, especially for clients from lower incomes where action oriented assignments might be more effective. Other divisions to evaluate could include: if or how the break questions/homework were directly related to the therapeutic goals or content currently being discussed, if and how the break questions/homework were pertinent and did they have some immediate effect on the remaining outcome of the therapeutic session, what kinds of break questions/homework's were most and least successful, when did break questions/homework have the most and least effectiveness.

If no trends are uncovered it could be hypothesized that break questions and homework assignments in this study are automatically given out. This would indicate that the idea of a break questions/homework assignment in and of itself does not prove beneficial in therapy. This would point towards future investigations to look less at the quantity of questions/homework but the quality and application of break questions/homework and their effect on the therapeutic outcome.

*Hypothesis 2.1.*

Hypothesis 2.1 predicted that lower economic status individuals will not be as successful in the therapeutic process as middle economic status families. Results demonstrate that economic status is not significantly related to success in the therapeutic process.

Future studies may want to look at other socioeconomic characteristics such as education level, number of individuals living in the home on allotted income, prediction of future economic status (i.e. is their current economic bracket indicative of where they expect they will be living financially in five more years), and desired therapeutic goals.

*Hypothesis 2.2.*

Hypothesis 2.2 which stated that interactive therapy will result in increased therapeutic success rates was not supported resulting in no significant difference,

*Hypothesis 2.3.*

Hypothesis 2.3 stated that families from lower economic status will receive less interactive therapy than families from a middle economic status showed no significant difference between the groups.

*Hypothesis 2.4.*

Hypothesis 2.4 projected that families who receive less interactive therapy will attend fewer sessions than families who receive a greater amount of interactive therapy showed no significant difference between the total number of sessions completed and the amount of interactive therapy. Although there was no significance between levels of interactive therapy by number of sessions attended, there appeared to be a moderate trend towards high medium interaction and high interaction being used in more sessions. Replicating the same kind of study with a larger sample size could yield more meaningful results.

Hypothesis 2.1, 2.2, 2.3, and 2.4 assessed various economic statuses, the use of a break questions, homework assigned, and the number of interventions employed in each session, showing no significant differences.

Future studies may want to take a more qualitative look at the content and applied use of the break questions, assigned homework, and types of interventions applied. For example, whether the break questions/homework was thought or action orientated may be an important distinction to assess. Also, determining the effectiveness of interventions that utilize more first order change or second order change may prove to be a significant division to review. Other divisions to evaluate could include: if or how the break questions/homework were directly related to the therapeutic goals or content currently being discussed, if and how the break questions/homework was pertinent and did they have some immediate effect on the remaining outcome of the therapeutic session, what kinds of intervention were most and least successful, when did interventions have the most and least effectiveness.

Future studies may also want to establish a stricter regimen for establishing economic status, in addition to reviewing a sample at various locations which may be more systematic in representing the population at whole. For example, the selected center is affiliated with a medium-sized south-central state university, and often serves low-income families who are working towards higher education, which could skew the results, ending in data that is not representative of all families seeking family therapy. Obtaining findings from various testing sites would increase the generalizability of the findings. In addition, the current sample used a median split of average annual income to determine lower verses middle economic statuses in order to have more evenly distributed economic groups. This classification form of economic status does not take into consideration any socioeconomic factors such as education level, marital status, number of family members living on the income, or prospects for future earning

potential. Using these and possibly other factors to determine a split between economic statuses may better represent the population in future studies.

*Hypothesis 3.1.*

Hypothesis 3.1 states that lower economic status individuals will perceive the problem (very serious vs. not at all serious) as more serious than individuals of a middle economic status approached significance. Notably, hypothesis 3.1 approached significance in the opposite direction of that predicted, thus indicating that higher economic status clients perceived the problem as more serious than individuals of a lower economic status. Combining these finding with the results of hypothesis 3.1 and 3.3 indicates that families of higher economic statuses perceive their problems as more serious and seek help sooner than families of lower economic statuses. Where as families of lower economic statuses perceive their problems as less serious, thus seeking help later.

These results can be warranted according to Maslow's Hierarchy of Needs, where basic needs must be addressed before attending to higher needs. Families where their basic needs are currently being met may view issues brought into therapy such as; self-esteem, communication problems, marital satisfaction, positive interaction cycles, or becoming good parental role models as serious issues to address. Whereas lower economic individuals may perceive other issues, not commonly addressed in therapy, such as: unemployment, permanent and safe housing, food, adequate transportation, self-care, and medical or mobility limitations as more serious.

Future studies may want to evaluate the presenting problems from a more qualitative stance upon entering therapy. For instance, are the presenting problems

similar in nature, are various presenting problems identified as more resilient to change universally across all economic statuses, does the degree of severity vary from economic status with the same problem. Perhaps families from higher economic statuses grow to be accustomed to having more, and eventually become apt to demand more from their partner, spouse, or family. Looking at relational expectations and therapeutic goals could help determine if the demands, expectations or outlooks are similar across economic statuses. Taking a more detailed look at these questions could prove to be a significant division to expose.

*Hypothesis 3.2.*

Hypothesis 3.2 which anticipated that families from lower economic statuses will report that the problem is less likely to change than families of middle economic status was not supported.

These findings should be looked at more closely in union with General Systems Theory which looks at each action within the system and how that action affects others. Perhaps families of lower economic status have experienced more ups and downs in life and believe change will always happen. Future studies may want to look at available family support or stigmas associated with asking for help. Lower economic statuses may be more comfortable utilizing outside help and admitting problems. Therefore as a result are able to more likely see change as a possible outcome of the current situation. GST offers a framework for exploring the dynamics of presented problems and likelihood of change in prospective studies.

Future studies may want to utilize a stricter regimen for establishing economic status, in addition to reviewing a sample at various locations which may be more

systematic in representing the generalized population at whole. Future studies may also want to evaluate the presenting problems upon entering therapy or established therapeutic goals. Whether the presenting problems brought to therapy by various economic status clients are similar in nature might be an important factor to ascertain. This qualitative look would then begin to determine what kinds of problems are being brought to a therapeutic session. Researchers could then assess for variations in the problems brought to therapy according to economic status. If the presenting problems are similar, then perhaps certain problems are viewed as more resilient to change. Researchers might then be able to help family's combat difficult problems with various therapeutic techniques which are better suited for certain situations.

*Hypothesis 3.3.*

Hypothesis 3.3 stating that families from lower economic status will report that the presenting problem has been a problem longer than families of middle economic status was significant.

These results can be examined in conjunction with Pauline Boss's ABC-X Stress Model. Perhaps families of lower economic status are used to larger levels of internal and external contextual stressors in their lives. Therefore, viewing larger levels of internal and external stressors as a common occurrence, lower economic status individuals wait longer to address a problem; opposed to someone who is not used to experiencing chaos in their life and therefore seeks help more quickly.

Future studies might want to restructure this question to address more qualitative issues such as; what brought you into therapy now or what has stopped you from coming into therapy before. Being able to determine what kinds of factors contribute to a clients

delay in seeking therapy could benefit therapists by knowing certain hesitations. Other issues that future studies may want to address is the content of the presenting problems brought to therapy by various economic status clients. If these problems are similar in nature investigating what keeps families from lower economic status families from seeking help sooner could be valuable information to identify with. This qualitative look would then begin to determine what kinds of problems are being brought to a therapeutic session, from what economic bracket, and what motivated the clients to seek help when they did.

*Hypothesis 4.1.*

Hypothesis 4.1 stated that families from lower economic statuses will report more alcohol use more often than families from a middle economic status. Results show that economic status is not significantly related to more reported alcohol use.

*Hypothesis 4.2.*

Hypothesis 4.2 which stated that families from lower economic status will report more signs of depression than families of middle economic status, showed no significant results.

Hypothesis 4.1 and 4.2 assessing alcohol use and signs of depression between lower and middle economic statuses resulted in no significant differences, which were contradictory in regards to much of the research reviewed earlier which did not hold similar findings. Perhaps findings differed from prior research because of the small sample size, which was unable to utilize a full range of clients to produce liberal variation. In addition, variations in geographic areas, religion, or socioeconomic factors

could play a part in the overall influences and outcomes of this study which may want to be addressed in future studies.

*Limitations and Implications*

Potentially beneficial implications for future research are reviewed within the limitations of this current study. Interpretations of the meaning and possible explanation of non-significant results are also discussed in the following section.

*Sample generalizability.*

There are some limitations to this study. For instance, sample generalizability is a potential threat to the study. The selected center is affiliated with a medium-sized south-central state university, and often serves low-income families who are working towards higher education, which could skew the results, ending in data that is not representative of all families seeking family therapy. Therefore, a large portion of the population being served by this facility will either be higher economic status professors/ teachers, and lower socioeconomic status individuals going to school for some form of higher education, which is not representative of the population as a whole. In so much as the findings accumulated from replications with different people and different settings would provide a more ideal and solid basis for generalization.

Therefore, in future studies to better represent the population at whole, families whose income was primarily based on student loans should be considered before placing families in economic groups. Although this study did not formally assess for socioeconomic status, clients seen in this facility may not truly represent lower and higher economic clients. This could be due to the fact that although students are

financially limited in the arena of means, their current economic status is not indicative of future potential earnings.

*Sample size.*

One of the possible reasons that the data identified possible trends without significant results between therapeutic dropouts, continuers, and completers when paired with an average number of interventions, the use of break questions, homework assigned, and higher interactions in therapy resulting in more sessions attended, could be due to the small sample size. Results may have been different from the current study had there been a larger sample with which to compare results. In the future, to have a larger sample would better represent the population at whole. Due to the small sample size and lack of variation between dropouts, continuers, and completers, vigilance needs to be taken when generalizing the findings of the current study.

*Therapist Experience.*

One implication from this study could be that data was collected and recorded by marriage and family therapy interns. Although the interns were each supervised by a clinical faculty supervisor, the less experienced therapists may have had an effect on quality of therapy received by clients who dropout, continue, or complete therapy, and the information the therapists chose to include on session summaries. Therefore, the intern's experience could be a limiting factor when assessing the therapeutic outcome. Future studies may want to look at the therapist's experience level compared to clients who dropout, continue, or complete therapy to look for a relationship between therapeutic experience and positive outcomes in therapy.

*Internal validity.*

The major threat to the internal validity of this study is treatment misidentification, such as the expectancies of the experimental staff. The change among experimental subjects may be due to the positive expectancies of the therapy staff who are delivering the treatment rather than due to the treatment. Recording therapists may also be biased in favor of the program for which they work and eager to believe that their work is helping clients.

## *Suggestions for Future Research*

*Sample size.*

This study would probably obtain more variation and significant results if the sample size was larger. Because of the small sample size, the full range was not utilized enough to produce ample variation. Researchers may wish to consider collecting data for longer periods of time to obtain more clients so that more opportunity would be generated for client participation in therapy. The results may produce more variation and thus more meaningful implications for clinicians and researchers.

*Sample generalizability.*

In addition to including more therapy cases, researchers may want to contemplate conducting a replication of this study, or a portion of this study, in a variety of clinical populations. Community mental health centers or specialized agencies, such as local domestic violence centers or youth and family services, may offer a more randomized example of participants and better represent the various economic statuses.

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# APPENDIX A

*Intake Report*

Intake Person: _____
Packet Sent on: _____

# Telephone Intake

Date: _____

Time: _____

Name: _____

Address: _____

_____

Telephone number: _____ Best time to be contacted within 24 hours:_____

Who made the call? _____

Presenting Problem?

Who is in the family? (2-3 generation genogram)

Who else is involved in the problem?

How long has it been a problem? _____

Is there any alcohol or drug use? _____ If yes, who and how much?

Who will be able to attend sessions?

Intake Person: _____
Packet Sent on: _____

Times/days available for sessions?

Is any one in the family on any kind of medications? If yes, who and what?

Is anyone in the family receiving mental health services anywhere else? If yes, who, where, and for what?

How did you hear about us? Who referred you?

_____ Telephone Book

_____ Referred by _____

_____ Received services before

_____ Other (Explain below)

Any financial considerations?

_____ No

_____ Yes. If yes, explain below

Yearly income before taxes _____

Fee _____

Therapist(s) assigned _____

Date _____

Case # _____

*Center for Family Services, 103 Human Environmental Sciences West, Stillwater, Ok 74078, (405) 744-5058*

# APPENDIX B

*Background Questionnaire*

*CENTER FOR FAMILY SERVICES*
*104 HUMAN ENVIRONMENTAL SCIENCES WEST*
*STILLWATER, OKLAHOMA 74078*

# BACKGROUND FORM

(This information is part of your *confidential* file and will be available to CFS staff for reference/research purposes)

NAME: _____ AGE (YEARS): _____ GENDER: MALE FEMALE
CIRCLE ONE

ADDRESS: _____ ETHNICITY: _____

HOME TELEPHONE: _____ WORK TELEPHONE: _____

SOCIAL SECURITY NUMBER: _____ RELIGIOUS PREFERENCE: _____

PRIMARY OCCUPATION: _____ HIGHEST LEVEL OF EDUCATION COMPLETED: _____

ARE YOU MARRIED: YES NO IF YES, HOW LONG: _____ TIMES MARRIED BEFORE? _____
CIRCLE ONE

ARE YOU A MILITARY VETERAN? YES NO YEARS OF SERVICE: _____
CIRCLE ONE

FOR IMMEDIATE FAMILY MEMBERS (SPOUSE, CHILDREN, AND STEP-CHILDREN). PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP TO YOU, AND CURRENT RESIDENCE (SAME AS YOU OR DIFFERENT).

| NAME | GENDER CIRCLE ONE | AGE | RELATIONSHIP TO YOU | RESIDENCE CIRCLE ONE | CITY/STATE IF DIFFERENT |
|---|---|---|---|---|---|
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |
| _____ | M F | _____ | _____ | SAME DIFFERENT | _____ |

NOTES:

OFFICE USE

| | | | |
|---|---|---|---|
| 01=HUSBAND/FATHER | 02=WIFE/MOTHER | 03=SON1 | 03=DAUGHTER1 |
| 05=STEP MOTHER | 08=FIANCÉ-FEMALE | 09=FIANCÉ-MALE | 13=SON2 |
| 23=SON3 | 33=SON4 | 23=DAUGHTER2 | 24=DAUGHTER3 |
| 34=DAUGHTER4 | 98=INDIVIDUAL FEMALE | 99=INDIVIDUAL MALE | 71=STEP SON |
| 72=STEP SON2 | 73=STEP SON3 | 74=STEP DAUGH1 | 75=STEP DAUGH2 |

FOR RELATIVES FROM THE FAMILY IN WHICH YOU GREW UP, PLEASE LIST NAME, GENDER, AGE, RELATIONSHIP, CURRENT RESIDENCE, AND MARITAL STATUS OF ALL WHO ARE STILL LIVING (PARENT, BROTHERS, SISTERS, STEP-BROTHERS, AND STEP-SISTERS).

NAME GENDER AGE RELATIONSHIP TO YOU RESIDENCE (CITY/STATE) MARITAL STATUS

IF ANY MEMBER(S) OF YOUR FAMILY (SPOUSE, CHILDREN, PARENTS, BROTHERS, SISTERS, IS/ARE DECEASED, PLEASE LIST BELOW:

NAME GENDER AGE RELATIONSHIP TO YOU RESIDENCE (CITY/STATE) MARITAL STATUS

FAMILY PHYSICIAN: NAME _____

ADDRESS _____

CIRCLE YOU PRESENT STATE OF HEALTH:

EXCELLENT GOOD FAIR POOR

PLEASE CHECK IF YOU HAVE EXPERIENCED THE FOLLOWING DURING THE PAST SIX MONTHS:

_____ SEVERE HEADACHES
_____ SEVER BACKACHES
_____ STOMACH PROBLMES
_____ EATING PROBLEMS
_____ SEIZURES
_____ UNEXPLAINED WORRY OR FEAREFULNESS
_____ FREQUENT TIREDNESS
_____ FREQUENT TROUBLE SLEEPING
_____ DIZZINESS OR FAINTING
_____ LARGE WEIGHT LOSS OR GAIN
_____ ASTHMA OR OTHER RESPIRATORY PROBLEMS
_____ OTHER PROBLEMS (PLEASE SPECIFY)
_____

HAS ANY MEMBER OF YOUR IMMEDIATE FAMILY EXPERIENCED ANY OF THE BEFORE MENTIONED SYMPTOMS IN THE LAST SIX MONTHS? _____ IF YES, PLEASE EXPLAIN.

HAVE YOU EVER HAD A SERIOUS MEDICAL ILLNESS? _____ IF YES, PLEASE EXPLAIN.

HAVE YOU EVER HAD A SERIOUS MEDICAL ILLNESS? _____ IF YES, PLEASE EXPLAIN.

HAVE ANY OF YOUR CHILDREN OR SPOUSE EVER HAD A SERIOUS MEDICAL ILLNESS? _____
IF YES, PLEASE EXPLAIN.

LIST ALL MEDICATIONS AND/OR DRUGS WITHIN THE LAST 6 MONTH, BOTH PRESCRIPTION AND NON-PRESCRIPTION:

| NAME OF MEDICATION/DRUG | REASON TAKEN | CHECK IF TAKING NOW |
|---|---|---|

DO YOU SMOKE? _____ IF YES, HOW MUCH?

DO YOU THINK YOU SMOKE TOO MUCH?

DO YOU DRINK? _____ IF YES, HOW MUCH?

DO YOU THINK ANOTHER FAMILY MEMBER SMOKES OR DRINKS TOO MUCH? _____
IF YES, PLEASE EXPLAIN.

HAVE YOU EVER ATTEMPTED SUICIDE? _____ IF YES, GIVE DATE(S) AND DETAILS.

HAS ANYONE IN YOUR FAMILY EVER ATTEMPTED SUICIDE? _____ IF YES, GIVE NAME(S), RELATIONSHIP TO YOU, AND DETAILS.

ARE YOU CURRENTLY RECEIVING SERVICES FROM ANOTHER THERAPIST/COUNSELOR? _____
IF YES, WHO AND FOR WHAT?

HAVE YOU EVER BEEN TREATED BY ANOTHER THERAPIST/COUNSELOR? _____ IF YES, WHEN, WHERE, AND FOR WHAT?

FROM THE FOLLOWING LIST, PLEASE CHECK THE REASONS THAT YOU ARE SEEKING SERVICE AT THIS TIME.

_____ PERSONAL ENRICHMENT
_____ RELATIONSHIP ENRICHMENT
_____ MARITAL ENRICHMENT
_____ FAMILY ENRICHMENT
_____ MARITAL CONFLICT
_____ FAMILY CONFLICT
_____ SEXUAL PROBLEMS
_____ PHYSICAL ABUSE
_____ SEXUAL ABUSE
_____ DIVORCE ADJUSTMENT
_____ ADJUSTMENT TO LOSS
_____ SINGLE PARENTING
_____ PARENTING-TWO PARENT FAMILY
_____ STEP-PARENTING
_____ CHILD BEHAVIOR PROBLEMS
_____ ADOLESCENT BEHAVIOR PROBLEM
_____ ALCOHOL ABUSE-CHILD/ADOLESCENT
_____ DRUG ABUSE-CHILD/ADOLESCENT
_____ ALCOHOL ABUSE-ADULT
_____ DRUG ABUSE-ADULT
_____ FAMILY STRESS
_____ OTHER (SPECIFY) _____

PLEASE DESCRIBE IN YOUR OWN WORDS THE MAJOR REASON FOR SEEKING OUR SERVICES AT THIS TIME.

HOW SERIOUS WOULD YOU SAY THIS PROBLEM IS RIGHT NOW? (CIRCLE ONE)

| NOT AT ALL SERIOUS | SLIGHTLY SERIOUS | MODERATELY SERIOUS | VERY SERIOUS |
|---|---|---|---|

HOW LIKELY DO YOU THINK THE PROBLEM IS TO CHANGE? (CIRCLE ONE)

| NOT ALL ALL LIKELY | SLIGHTLY LIKELY | MODERATELY LIKELY | VERY LIKELY |
|---|---|---|---|

WHAT DO YOU HOPE TO GAIN FROM OUR SERVICES?

WHO REFERRED YOU TO OUR SERVICES? IF SELF-REFERRED, HOW DID YOU FIND OUT ABOUT OUR SERVICE?

# APPENDIX C

*Session Summary Sheet*

Case # _____ **Session Summary** Date: _____

Therapist(s): Session # _____

**Pre-Session:**

Therapy Goals:

TG1.
TG2.
TG3.

Session Goals:

SG1.
SG2.
SG3.

**OSU Model**

| Context: | Perspective | Process |
|---|---|---|
| | | |

Hypotheses:

H1.
H2.
H3.

Interactional Cycle:

Issues of Concern: Minimal *Significant*

| | | | | | |
|---|---|---|---|---|---|
| C1. | 1 | 2 | 3 | 4 | 5 |

Homework from Prior Session:

H1.

**Post-session:** LvOb ___ TAPE ___ TEAM ___

Clients Present:

Homework: Completed Not Completed

Break Question/Activity:

Summary of Session Content: Not taped

Supervisor Phone Messages:

Interventions Used:

| Progress Toward Session Goals | Minimal | | | | Significant | Met(Y/N) |
|---|---|---|---|---|---|---|
| G1. | 1 | 2 | 3 | 4 | 5 | |
| G2. | 1 | 2 | 3 | 4 | 5 | |
| G3. | 1 | 2 | 3 | 4 | 5 | |

Homework Given:

| Progress Toward Therapy Goals: | *Minimal* | | | | Significant | Met(Y/N) |
|---|---|---|---|---|---|---|
| G1. | 1 | 2 | 3 | 4 | 5 | |
| G2. | 1 | 2 | 3 | 4 | 5 | |
| G3. | 1 | 2 | 3 | 4 | 5 | |

New Information from Session:

| Context | Perspective | Process |
|---|---|---|
| | | |

Changes to Hypotheses:

H1.
H2
H3.

Next Appointment: *Date:* *Time:*

Therapist:

Therapist: Supervisor/Date:

# APPENDIX D

*Diagnosis and Treatment Plan*

Case #_____

***DIAGNOSIS AND TREATMENT PLAN***

Date of First Session: Diagnosis for Session:

Family's Definition of the Problem

| |
|---|
| |

Diagnosis: Family Member Diagnosed:

*Axis I: Clinical Disorders or Other Conditions That May Be a Focus of Clinical Attention*

*Axis II: Personality Disorders or Mental Retardation*

*Axis III: General Medical Conditions*

*Axis IV: Psychosocial and Environmental Problems*

[ ] Problems with primary support group: _____
[ ] Problems related to the social environment: _____
[ ] Educational problems: _____
[ ] Occupational problems: _____
[ ] Economic problems: _____
[ ] Housing problems: _____
[ ] Problems with access to health care services: _____
[ ] Problems related to interaction with the legal system/crime: _____
[ ] Other psychosocial and environmental problems: _____

*Axis V: Global Assessment of Functioning* GAF = GARF =

| Proposed Treatment: |
|---|
| |

_____
Therapist

_____ _____ _____
Therapist Supervisor Date

*Center for Family Services, 103 Human Environmental Sciences West, Stillwater, OK 74078, (405) 744-5058.*

# APPENDIX E

*Termination Report*

Family ID#:_____

**CENTER FOR FAMILY SERVICES**
**103 Human Environmental Sciences West**
**Stillwater, Oklahoma 74078**
**(405)744-5058**

## Termination Report

Date of Intake:_____

Number of Sessions:_____

Date of First Session:_____
Date of Last Session:_____
Official Termination Date:_____

Therapist(s):_____
_____

Type(s) of Therapy and Number of Sessions:

_____ Individual Therapy

_____ Couple/Marital Therapy

_____ Family Therapy

_____ Group Therapy

Reasons for Termination:

_____ Completion of Therapy

_____ Client Request

_____ No Shows/Cancellations (letter sent by therapist)

_____ Other, Please explain:

Were the clients referred to another agency/professional?

_____ Yes - Where? _____

_____ No

_____
Therapist

_____
Therapist

_____
Supervisor

_____
Date

Give a brief description of the presenting problem at the beginning of therapy and a description of the problem upon closure of therapy on the back of this report.

# APPENDIX F

*Counseling Agreement/Client Rights*

**CENTER FOR FAMILY SERVICES**
123 Human Environmental Sciences West
Stillwater, OK 74078
(405) 744-5058

**Counseling Agreement**

The Oklahoma State University Center for Family Services is dedicated to the treatment of families and the training of skilled family therapists. In an effort to offer clients the best therapy possible, the Center's family-oriented approach includes observation by fellow therapists-in-training, video-taping and diagnostic evaluation, if deemed appropriate.

I, the undersigned, do consent to the observation and video-taping of my therapy sessions. I understand that I may request the tape be turned off or erased at any time either during my session(s) or any time thereafter. I understand that any video-tapes will be used to assist the therapist(s) in working with me to improve the quality of therapy that I receive. I understand that I will not be video-taped without my verbal consent, at the time of taping, and that all video-tapes of sessions are erased immediately following viewing by my therapist(s). I acknowledge the importance of research in increasing the effectiveness of therapy and in training high quality therapists. I do consent to any research that may be completed through the clinic on my case. I understand that names are never used in research and that the Center for Family Services guarantees the confidentiality of my records.

Since OSU is an educational institution, I recognize that any counseling, testing, taping, or diagnostic work may be seen by other therapist interns, the clinical supervisor, and may be used for training purposes. No information about me may be given to any person outside the Center without my written consent unless mandated by law; including, but not limited to a court order and child abuse or neglect. However, if I am dangerous to myself or others, I am aware that mental health professionals have the responsibility to report information to appropriate persons with or without my permission.

I agree to notify the Center for Family Services at least 24 hour in advance should I need to cancel an appointment. If not, a fee for services will still be charged. Payment for services is due when services are rendered. I understand this fee to be $_____per session. When I decide to discontinue therapy, I agree to discuss this with the therapist(s) at a regular therapy session, not by phone.

I understand that should I attend a therapy session impaired by alcohol or drug use that the session will be terminated and another session scheduled for a future time. This event will be treated as a missed session and charged at full fee.

I am aware that Oklahoma State University Center for Family Services is not an emergency service, and, that in an emergency situation if I cannot reach my therapist, I have been advised to contact local community mental health center or another crisis counseling center.

My rights and responsibilities as a client for the Center for Family Services, the procedures, and treatment modalities used have been explained to me and I understand and agree to them.

| | |
|---|---|
| (Name) | (Name) |
| (Name) | (Name) |
| (Witness) | (Date) |

**CENTER FOR FAMILY SERVICES**
123 Human Environmental Sciences West
Stillwater, OK 74078
(405) 744-5058

YOUR RIGHTS AS A CLIENT OF THE
OSU CENTER FOR FAMILY SERVICES

**TO LEAVE** the premises at any time. You are not to be detained against your wishes unless you are a danger to yourself or others.

**TO BE ADVISED** in writing of all the services offered by CFS.

**TO REFUSE** any service which you do not want and to discontinue any services you have already started. However, if you choose to discontinue treatment against professional advice, a notation to that effect will be placed in your records. In the event of court-ordered clients, the terms of the court may supersede this right.

**TO CONFIDENTIALITY** of records. Information in your records may not be given to any other person without your written consent or if mandated by law, including but not limited to a court order. However, if you are dangerous to yourself or others, mental health professionals have the responsibility to report information to appropriate persons with or without your permission. Another exception to confidentiality is in the case of child abuse, where Oklahoma law requires professionals to report such instances to the Oklahoma Department of Human Services.

Under no other circumstances may the therapist communicate information about you outside the CFS.

However, mental health professionals do have the right, when they deem necessary, to consult with other members of the supervisory and clinical team regarding treatment.

If you request that your records be sent to another professional or agency, your wishes will be fulfilled with promptness upon receipt of your written request for information and provided there is no outstanding balance on your CFS account.

The scope of the clinical services offered by the Center for Family Services is limited to:

- Premarital counseling
- Martial therapy, including problems of communication, marital discord, domestic violence and sexual adjustment.
- Family therapy, including discipline problems with children, school adjustment problems, adolescent rebellion, problems precipitated by loss of family members through death, desertion, occupational service, imprisonment, problems precipitated by the addition of family members through birth, adoption, foster care, or new living arrangements.
- Divorce counseling, including mourning the loss of the former marriage, acceptance of a new lifestyle and identity.
- Single parent counseling including any of the issues listed above plus the stresses of parenting as a single person.
- Remarriage counseling, including any of the issues listed above plus the complexities of combining two family groups.
- Counseling with single adults around issues related to the family in which they grew up as a child.

- CFS offers marriage and family therapy from a systems perspective of the family that integrates research based models of therapy including emotionally focused, strategic, solution-focused, and structural therapy into a brief therapeutic approach.

Services of the Center for Family Services *do not* include:

- Personality, ability, or vocational interest testing or evaluations.
- Custody evaluations
- Prescription of medications or treatment of problems for which medication or hospitalization may be the treatment of choice, such as major depression, suicidal intention, hallucinations, delusions, etc.

At least one parent must consent to the therapy of any minor children.

I have read, understand and accept the above statements concerning my rights as a clients of CFS and the scope of clinical services available.

_____

(Client) (Client)

_____

(Client) (Client)

_____

(Date) (Therapist)

VITA (1)

Holly Reed Sheueckuk

Candidate for the Degree of

Master of Science

Thesis: THERAPEUTIC SIMILARITIES, ECONOMIC BIASES, AND SUCCESSFUL THERAPY TREATMENT

Major Field: Marriage and Family Therapy

Biographical:

Personal Data: Born in Oklahoma City, Oklahoma, February 10, 1977, the daughter of Gary Sheueckuk, Harlene and Howard Reeves.

Education: Graduated from Putnam City North High School, Oklahoma City, Oklahoma in May of 1995; received Bachelor of Arts degree in Psychology from Oklahoma State University, Stillwater, Oklahoma in May of 1999. Completed the requirements for the Masters of Science degree with a major in Marriage and Family Therapy at Oklahoma State University, Stillwater, Oklahoma in May of 2004.

Experience: Oklahoma State University Center for Family Services marriage and family therapy intern, Stillwater, Oklahoma, 2001 to 2003; Stillwater Domestic Violence Inc. therapy intern, Stillwater, Oklahoma, 2002 to 2003; employed by Oklahoma State University, Department of Human Development and Family Science graduate research assistant, Stillwater, Oklahoma, 2002 to 2004; employed by Payne County Youth Services, Child home based services case manager, Stillwater, Oklahoma, 2004 to present.

Professional Memberships: American Association of Marriage and Family Therapy, Oklahoma Association for Marriage and Family Therapy, Kappa Omicron Nu.