# DESCRIPTIONS OF TREATMENT AND OUTCOMES BETWEEN TWO GROUPS OF FAMILY THERAPY CLIENTS

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DESCRIPTIONS OF TREATMENT AND

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TABLE OF CONTENTS

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LIST OF TABLES AND FIGURES

# CHAPTER I

## *Introduction*

### *Background*

Marriage and family therapy has experienced a growth in the data supporting the effectiveness of this treatment since the 1980's (Markus, Lange, & Pettigrew, 1990; Pinsof & Wynne, 1995; Sprenkle, 2003). Due to the increase of quality research, marriage therapies (MT) and family therapies (FT) have now become more evidence-based treatments. Likewise, MT and FT have shown to be helpful in treating a variety of clients with a broad range of presenting problems. Finally, since many MFT's utilize a brief therapy model, MT and FT has also proven to be a cost effective treatment (Pinsof & Wynne, 1995).

Despite the influx of quality, laboratory, and controlled studies a gap still exists between MFT researchers and clinicians (Weisz, Donenberg, Han, & Weiss, 1995). On the whole, "efficacy" research has showed that treatment works under more ideal "research-therapy" field conditions with high validity and reliability (Pinsof & Wynne, 1995). Less research, however, has been conducted under "normal therapy" field conditions called "effectiveness research" (Addison, Sandberg, Corby, Robila, & Platt, 2002). For example, few researchers have yet to describe how MFT's actually "do therapy," or what techniques, interventions,

or which overall approach is most effective for families with a variety of presenting problems (Addison et al., 2002; Nelson & Trepper, 1993). In addition, many therapists are searching both the effectiveness and efficacy literature to discover how to design interventions that promote a more lasting change for their clients.

More specifically, practitioners are trying to evaluate therapy treatments that encourage long lasting change through second order change, defined as "change in the structure and functioning of a system" (Nichols & Schwartz, 2004, p. 444) versus more immediate, but short-term change through first order change, defined as "superficial change in a system that itself stays invariant" (Nichols & Schwartz, 2004, p. 440).

*Purpose and objectives of the study*

Marital therapy and family therapy have proven to be valuable treatments for clients with a variety of presenting problems. However, more efficacy and effectiveness research has been conducted on marital therapies compared to family therapies. In order to close the gap between research and practice in family therapy, clinicians need to know which therapeutic interventions work best for clients presenting with a variety of problems. The overall objective of this exploratory study is to examine what works in family therapy. More specifically, this study explored which interventions were used in cases with families who complete therapy by achieving their goals (Completers), and those clients who continue with more than three therapy sessions but do not achieve their therapy goals (Continuers). In order to conduct this study, an exploratory and descriptive

analysis was conducted of data collected in a clinic associate with a COAMFTE accredited master's degree program. The purpose of this study is to retrospectively explore and evaluate data comparing groups of family therapy clients. Once these groups were identified, themes between presenting problems, therapy goals, interventions, and outcomes were identified.

These themes were categorized by type of targeted change, first order or second order, in order to further examine the differences between groups. Finally, other factors such as demographics, background information, presenting problem, chronicity of problem, pile-up of stressors, length of the problem, and age of the family and members were examined to further explore the themes between the two groups of clients.

*Scope*

This study is directed towards providing information for beginning MFT student-therapists as a way to enhance their training. In addition, the information from this study is also intended to highlight interventions used as a way to close the gap in the effectiveness literature for practitioners. More specifically, this study is designed to offer specific information about targeting types of change to promote completion of therapy goals. Finally, this study is intended to provide practical information to researchers so that effectiveness and efficacy research can be compared and supplemented.

# CHAPTER II

## *Literature Review*

### *The need for effective treatments*

American families face a variety of changes in family structure in the new millennium. Although the national divorce rate stabilized after the 1970's, in 2000 the average national divorce rate was approximately 50% for first marriages and 60% for remarriages (National Center for Health Statistics, 2003), meaning that at least half of American families will experience divorce. In addition, the cohabitation rate (non-married couples living together) quadrupled between the 1970's and 1980's, and in 2000 approximately 3.8 million American couples cohabited.

Today, approximately seven out of ten children live with both parents (US Census Bureau, 2003), with three out of ten children living in some other arrangement. More specifically, in 2000 9.2% of children lived in homes lead by single mothers increasing by approximately 13% since the 1970's. Also, 1.9% of children live in single-father homes continuing the sharp 25% increase of children living with single fathers just since 1995. Another way families are different in the new millennium is that approximately 6% of children under the age of 18 lived with a grandparent instead of a biological parent (Casper & Bryson, 1998;

National Center for Health Statistics, 2003). The number of children living with one or both grandparents increased approximately 27% between the 1970's and early 1990's, and continued to increase in the year 2000 (U.S. Census Bureau, n.d., National Center for Health Statistics, 2003).

In addition to the changing profile of the American family, approximately 22.1% of American adults suffer from a diagnosable mental disorder. In the United States, one in four persons will experience depression in their lifetime (National Center for Health Statistics, 2003). More specifically, women report significantly more symptoms of depression than men, even after controlling for sociodemographic variables, including employment, parental, and marital status (Simon, 2002). In addition, widowed persons, stably never married, and separated or divorced report significantly more depressive symptoms than the stably married (Simon, 2002). Depression is not the only stressor that American families face. Hendy, Weiner, Bakerofskie, Eggen, Gustitus, and McLeod, (2003) found that 16% of men and 26% of women admitted to having inflicted violence on their current romantic partner. As for children and adolescents, 4.1% ages nine to 17 experience Attention Deficit Hyperactivity Disorder, eight percent ages 12-17 used any illegal drug in one month period, and finally the third-leading cause of death for ages 15-24 in 2000 was suicide (National Institutes of Mental Health, 2003). These statistics demonstrate that many Americans are dealing with changes in family structure, violence and/or some type of a diagnosable mental disorder.

*Review of marriage and family therapy efficacy and effectiveness research*

The majority of efficacy research has established that MFT is better than no treatment at all for clients, similar to individual therapy treatments (Baucom, Shoham, Museser, Daiuto, & Stickle, 1998; Hazelrigg, Cooper & Borduin, 1987; Markus, Lange, & Pettigrew, 1990; Pinsof & Wynne, 1995; Shadish, Ragsdale, Glaser, & Montgomery, 1995; Sprenkle, 2003). In a meta-analysis of families with children, the average client who receives family therapy is "better off than 76% of the patients in the various control groups" (Markus et al., 1990, p. 209), with a mean follow-up taking place one-and-a half years after treatment. However, the length of follow-up did influence the treatment effect, with the effect dropping off after 12 months. This drop off effect demonstrates that many clients terminate without making long-lasting changes, perhaps making short-term first order shifts.

MFT has shown to be effective when treating a variety of individual and family disorders including substance abuse, domestic violence, marital problems, relationship enhancement, conduct disorder, juvenile delinquency, anorexia in young adolescent females, childhood autism, aggression and non-compliance in ADHD children, childhood behavioral disorders, depression, dementia, alcohol abuse, affective disorders, severe mental illness, adult schizophrenia, and physical disorders (Edwards & Steinglass,1995;. Pinsof & Wynne, 2000; Sprenkle, 2003). Baucom et al. (1998) found MFT to be most beneficial for those who "seek treatment for relationship problems" (Baucom et al, 1998, p. 87). Moreover, no destructive effects have been found due to MFT meaning that

clients are not in harms way as a result of treatment. Some disorders (schizophrenia, bipolar disorder, addictions, autism, and severe conduct disorder) have been found to need additional treatment, like drug therapies or individual therapy, for the best results (Chambless & Hollon,1998; Pinsof & Wynne, 2000).

*Treatment Models*

MFT models vary and have changed over time; however the fundamental concept in all models is considering how presenting problems may be a product of the relationships surrounding the family members (Nichols & Schwartz, 2004). Some differences between MFT models are what type of change to target and how to provoke change. In this review, a few models have been chosen to explore the differences between the type of change targeted, including Cognitive Behavioral Family Therapy, Jay Haley's Strategic Family Therapy, MRI brief therapy model, Milan Systemic model, and Structural Family Therapy. These models were chosen for either their focus on first or second order change or combination of both types of change.

First order change is described as "a change that does not lead to any essential alteration in the structure of the system itself" (Lyddon, 1990, p. 123). Lyddon (1990) associates first-order change with problem-solving and symptom alleviation. On the other hand, second order change is defined by Lyddon (1990) as a change in the fundamental structure of the system so that the system is permanently redesigned, in addition to problem-solving and symptom reduction. Another description of second order change is reorganization of the family's

process (Bartunek & Reed, 1992). In addition, Hanna and Ritchie (1995) found in their investigation of anecdotal descriptions of second order change that most clients reported some type of new insight that helped them confront a problem by developing a new perspective of the problem, the world and self.

*Examples of models that target first order change*

Cognitive Behavioral Family Therapy (CBT) was developed out of "learning theory to train parents in behavior modification and teach couples communication skills" (Nichols & Schwartz, 2004 p. 252). CBT has shown to be effective with highly motivated clients in changing behavior. For example, the concept of operant conditioning targets positively reinforcing desired behaviors and ignoring negative behavior until extinction (see Table 1). In order to add the piece of cognition to this model, the concept of schema is included. Schema is defined as a "core belief about the world and how it functions" (Nichols & Schwartz, 2004, p. 255). By adding cognition to behaviorism, CBT theorists acknowledged that interpretation of behavior effects how one responds. Some interventions in CBT include contingency contracting (quid pro quo contracts), automatic thought and response journals, time outs, and problem solving training ("I" statements, steps to conflict resolution, etc.)

Another model that focuses on making first order change is Jay Haley and Cloe Madanes' Strategic Family Therapy. Growing out of communications theory and Structural Family Therapy, Strategic Family Therapy focuses on provoking change through paradoxical structural problem solving (Nichols & Schwartz, 2004). Haley and Madanes focused on the functional aspect of problems, and

how to help families achieve clear boundaries and a generational hierarchy. In order to achieve these goals, Haley approached treatment "behaviorally…downplay(ing) the importance of insight" (Nichols & Schwartz, 2004, p. 157). The main interventions in Haley and Madanes work targeted getting clients to do something different. Some interventions included ordeals, or prescribe the symptom so that the price for continuing outweighs giving up the symptom; paradoxical injunction, or forcing the involuntary become voluntary; directives; or targeted suggestions; and finally pretend techniques, where a family is encouraged to have the symptom (Lawson, 1986) (see Table 1).

*Examples of models that target second order change*

Similar to Strategic Family Therapy, the Mental Research Institute (MRI) approach also focuses on provoking a change in the family system. MRI therapists see the family's response to a difficulty as the problem. In other words, a family's attempts to solve the problem are unsuccessful however the family continues to use the same solutions over and over creating a cycle. Therapy is also brief because once the presenting problem is resolved therapy is terminated. MRI therapists state that since families are stuck rather than sick that there is no need to overhaul family structures. The MRI model is "behavioral, both in its goals and its focus on observable patterns of interaction, while scrupulously avoiding speculation about intrapsychic intentions" (Nichols & Schwartz, 2004, p. 157). However, the MRI model's overall focus is to create a bind that forces clients to shift their perspectives about their problems, thus creating a larger, systemic change. Interventions in the MRI approach are most

commonly symptom prescriptions that encourage clients to continue or embellish the behaviors (see Table 1). In addition, MRI therapists often use a restraining technique that tells clients to go slow and adds a caution of worry about relapse. These interventions are designed to cleverly provoke a client to view their symptoms as conquerable.

The Milan systemic model was also developed from the same communication project. However, the Milan approach differs from Haley and Madanes' Strategic therapy in their focus on targeting second order change and how to achieve this change. More specifically, the Milan model assesses past and present relationships to uncover generational power alliances, or the family's "game." All together, Milan therapist design techniques to be "less behavioral and instead…expose games and reframe motives for strange behavior…being less problem focused and more interested in changing a family's awareness or beliefs" (Nichols & Schwartz, 2004, p. 158). Interventions are designed to provoke a larger change in the family structure, for example two primary interventions include positive connotation, or ascribing positive motives to behavior to promote family cohesion, and rituals, which exaggerated or countered family rules and myths (see Table 1). Other interventions in the Milan model include invariant prescription, or parents sneaking away and having a secret from their children, and circular questions, or questions that push for seeing the context from another's perspective.

*Examples of a model that target both first and second order change*

Structural Family Therapy (SFT) developed the title for the model's focus on the processes within family interactions. These processes describe sequences within a family that are maintained by family rules, boundaries, and hierarchy. In order to make changes, the goal of therapy "is to alter family structure so that the family can solve its problems" (Nichols & Schwartz, 2004, p. 186). The main interventions in SFT include joining, or accommodating a family to win their confidence and avoid resistance to change; processing and highlighting interactions, boundary making, enactments, shifting seating, reframing, unbalancing, and challenging unproductive assumptions (Nichols & Schwartz, 2004). SFT's focus on the relationship between client and therapist is key, emphasizing a therapeutic bond than helps a client make changes when being both encouraged and challenged by the therapist (See Table 1). These interventions are designed to offer alternative views and behaviors of their symptoms, and thus enable clients to change both their interactions and overall family structure.

Table 1

*Treatment Models and Examples of Interventions Used*

| MFT Models | Examples of 1st Order Change Interventions | Examples of 2nd Order Change Interventions |
|---|---|---|
| Cognitive/Behavioral | Operant conditioning, reinforcing, ignoring, extinction, quid quo pro contracts, thought and response journals, time outs, & problem solving training | |
| Strategic | Ordeals, symptom prescription, paradoxical injunctions, directives, pretend techniques | |
| MRI | | Symptom prescriptions, embellishment, restraint |
| Milan | | uncover power alliances, positive connotation, rituals, invariant prescription, circular questions |
| Structural | Enactments, assigned seating, process interactions, challenging assumptions | Joining, reframe, unbalancing boundary making, challenging assumptions |

*Treatment models and interventions in research*

Many literature reviews have been conducted that identify the effectiveness of specific treatment models for both marital therapy and family therapy. However, more research has examined the differences between models in marital therapies. Dunn and Schwebel (1995) conducted a meta-

analysis to assess the efficacy of three treatments for couples: behavioral marital therapy (BMT), cognitive-behavioral marital therapy (CBMT), and insight-oriented marital therapy (IOMT). Similar to other meta-analyses, all three treatment models were found to be more effective than no treatment for changing behaviors and each spouse's general assessment of the relationship. Specifically, IOMT was more effective than BMT or CBMT for changing each spouse's general assessment of the relationship, and CBMT significantly changed a spouse's relationship cognitions after therapy.

Based on this review, IOMT was able to create a larger change in perception, or a second order change in the functioning of the family system. Also, CBMT and BMT were able to create change in behaviors and CBMT in cognitions. All together, these three treatment models were able to create the type of change in which they targeted, perhaps offering evidence that a targeted change is the type of change achieved in marital therapy. The next section reviews the *family therapy* literature to examine interventions that are used to create types of change, first versus second order change.

*Examples of first order change programs and interventions*

Similar to marital programs that focus on introducing new behaviors (Butler & Wampler, 1999), Parent Effectiveness Training (PET) focuses on teaching skills to change behaviors (Gordon, 1970). These tasks include Time Outs, reinforcing positive behaviors with praise, and ignoring negative behaviors. PET was found to have effects on parents' knowledge, attitudes, and behavior and on children's self-esteem (Cedar & Levant, 1990). In this meta-analysis, the

authors found that better designed studies had significantly greater effect sizes. Collectively, PET had an overall effect size of 0.33. This effect size was significantly greater than the effect size of a group representing alternative treatments at termination of services, however no reports were available about follow-ups.

Two clinical treatment programs have developed treatment manuals used with a realistic client population in order to treat adolescent behavior disorders using family-based interventions: functional family therapy (FFT) (Alexander & Parsons, 1973) and multisystemic family therapy (MST) (Borduin, Henggeler, Blaske, & Stein, 1990). Both of these treatment interventions target adolescent disruptive disorders and the problems of delinquency, drug abuse and family conflict (Alexander & Sexton, 2002). Reviews of MST found decreased drug use, reductions in long-term recidivism (25-70%), improved school attendance, lower rates of institutionalization, and improved family relations and functioning. In addition, clients of a variety of ethnicities were found to have similar success in MST.

FFT also measures the outcomes from this program in similar ways. FFT is "probably the longest term, most systematic, and independently replicated" treatment for adolescent behavior disorders (Alexander & Sexton, 2002, p. 245). FFT was found to reduce recidivism between 26-73% and remain stable at follow-up even five years later. Also, FFT found younger siblings of "delinquent adolescents treated with FFT to have significantly fewer offenses" (Alexander & Sexton, 2002, p. 245), reductions in drug use among the Hispanic delinquents

and their caregivers, and found that of the FFT treated delinquents who do break the law, their offenses were less severe. Both MST and FFT have established significant successful outcomes that last at follow-up. However, Alexander and Sexton (2002) caution, “it is the nature of behavioral orientations to identify target outcomes in such a way that the effect sizes may be enhanced” (p. 246). Since these successes are measured in behavioral outcomes, clinicians are unclear how or if larger structural changes or perspective shifts in the adolescents and families took place.

*Examples of second order change programs and interventions*

The research also describes models and interventions that target change at a structural level. Pinsof and Wynne (1995) stated that the following models and programs designed interventions to target second order change: “social learning family therapy (SLFT), …structural family therapy (SFT), …a multitarget ecological treatment (MET), …and a new multimodal treatment” (p. 561). All of these models were described as targeting in a variety of combinations reinforcement, boundaries, cognitions and peer processes.

In Structural Family Therapy, the main interventions included shifting boundaries to create a connected and yet flexible relationship between family members that met developmental needs. This was achieved by using enactments and reframes to shift family member’s perspectives about relationships and rules. Social Learning Family Therapy targeted identifying family and peer processes that lead to specific behaviors and reinforcement patterns within a family. Finally, multitarget ecological treatments and multimodal

treatments focused on individual, family, school, community and larger societal contexts and cognitions that exist between the contexts. These treatments identified how information from these contexts become part of the family's pattern and then become reinforced by beliefs and support (Pinsof & Wynne, 1995).

This review by Pinsof and Wynne (1995) indicated that when compared to individual therapy or no therapy, that family therapy was able to reduce conduct problems and delinquency for all treatments. As a treatment specifically for adolescent conduct disorders, the overall finding upon examining 18 studies on conduct disorder was a significant effect size of .53. Collectively, these treatments were able to create a second order shift in a family's structure and patterns, and able to reduce conduct disorder problems.

Another program or treatment model that focuses on second order change is multidimensional family therapy (MDFT). MDFT is a manualized treatment that focuses on changing core behavior symptoms related to adolescent substance abuse, similar to many behavior-oriented treatment approaches (Liddle & Hogue, 2001). However, MDFT targets family interactions directly in sessions by including caregivers, peers, and other community members. MDFT also conducts individual sessions dispersed between family sessions to focus on personal attitudes and behaviors of the adolescents. MDFT reported outcomes of reduced marijuana use and fewer externalizing and internalizing symptoms, with superior gains and maintenance of the gains after therapy than a first order change targeted Cognitive-Behavioral therapy (Liddle & Hogue, 2001). The longer maintenance of gains could indicate a larger, more lasting shift in the

family system, thus providing evidence for the superiority of second order change treatments.

Many programs, both those that target first and second order change, focus on outcome targets and measures to evaluate success. Sexton and Alexander (2002) reviewed the literature on family-based empirically supported interventions and found that many studies "focus on well-defined and pragmatic outcome categories" (p. 251). For example, clinical trials on adolescent behavior disorders typically use recidivism as a measure of outcome. Although recidivism involves a variety of behaviors, the common link is involvement with the legal system. Therefore, outcome can be clearly measured using this one behavior indicator. However, the clinical studies that use recidivism as their measure of outcome do not provide information on the process of change.

*Process research in family therapy*

Process research can offer valuable information about in-session interventions and family therapy outcomes (Pinsof & Wynne, 2000). Specific treatment models use these interventions as part of their treatment manuals (if manuals are used) or treatment protocol. Within specific treatment models, "mediating variables are more than common factors and instead represent important model-specific change mechanisms that are hypothesized to guide therapeutic interventions" (Alexander & Sexton, 2002, p. 249). Process research provides clinicians with links between family-based interventions and mechanism of change in four main areas: therapeutic alliance, within-family negativity, family

interaction and communication patterns, and the relationship between program adherence and treatment fidelity on therapeutic outcome.

Therapeutic alliance is the most consistent process linked to outcome for both individual and family counseling (Sexton & Whiston, 1994). Bischoff and Sprenkle (1993) found high rates of joining to significantly lessen client dropout. This alliance is found to not only lessen dropout, but also retain, connect, and engage clients in therapy sessions (Alexander & Sexton, 2002). On the other hand, negative family interactions increase the likelihood of dropout and are associated with poorer therapy outcomes. A higher ratio of negative to positive statements and interactions was found among dropouts than completers, and for adolescents this means a higher rate of recidivism. More specifically, a greater frequency of interventions like reframes, positive directives, and supportiveness that balanced structure with support were linked to more involvement in therapy, and therefore more successful outcomes (Alexander & Sexton, 2002).

Family interaction and communication change is the third area of the process literature. In session, parent and adolescent communications that were modified to be more positive was linked to a reduction in recidivism. In addition, improvement in family interactions in sessions between conduct-disorder adolescents and their parents was associated with more positive outcomes. Some of these interventions included making positive statements about others, discussing successes, and making statements that attribute positive intentions to behaviors.

The final area in the process literature is treatment adherence. In MST, high adherence predicted more positive outcomes and low adherence predicted poorer outcomes. However, Alexander and Sexton (2002) stated, “treatment adherence is becoming a particularly important, albeit unstudied, process issue” (p. 250). The question is to what degree a practitioner must adhere to a program in order to replicate successful outcomes, and if adherence is necessary or practical if a treatment manual has not been developed. Despite these questions, treatment adherence points out the importance of using empirically supported interventions that have been linked to positive outcomes for clients.

The four areas of process research have described ways a therapist can increase the likelihood of achieving therapy success with their clients. However, Alexander and Sexton (2002) call for measuring client problems and outcomes from multiple perspectives, like the family members as well as therapist, supervisor, and independent observers. Measuring outcomes should also include identifying specific behaviors targeted by the family, as well as the overall perspectives about presenting problems and change based on observations and interactions of the therapist and supervisor or other observers.

*Gaps in the research*

Despite much research conducted on specific treatment programs for both couples and families, in a meta-analysis of 71 studies of MFT Shadish et al. (1995) did not find one orientation superior to another. In particular, all MT and FT orientations were found to be more effective than no treatment at all after conducting regression analyses. More specifically, “if all treatments were equally

designed, implemented, measured, and reported, significant differences among orientation might not be found" (Shadish, 1995, p. 350). However, many authors have found different results when they compare treatments in research conditions (efficacy) versus clinical conditions (effectiveness). Specifically, Weisz et al. (1995) found in a meta-analysis that nine studies of therapy in a clinic showed markedly poorer outcomes than research therapy studies.

These differences between the efficacy and effectiveness research has left many gaps to discover what works in family therapy. Shadish, Ragsdale, Glaser, and Montgomery (1995) state that the best way to rate efficacy and effectiveness would be to examine global satisfaction and specific target behavior measures. Also, these outcomes should be evaluated by the client, their interpretation of others, and by the therapist's evaluation of the client's affect and cognition. Finally, Shadish et al (1995) state that reviewers of family therapy literature should identify the differences between behavior and nonbehavior therapy so that differences or similarities in outcomes can be measured. Despite these recommendations, few studies have been conducted that adhere to these suggestions.

*Promotion of achievement of therapy goals in family therapy*

Reviewing the literature has shown that models of therapy can be effective when targeting either type of change, first order or second order. In addition, that these therapy models have a variety of interventions in order to achieve the type of change desired. However, a question still remains as to *what*aspects of treatments or interventions promote clients in achieving their therapy goals. One

aspect of treatment could be the number of sessions attended by clients. Shadish, Navarro, Matt, and Phillips (2000) found that an increased “dose” of family therapy typically is associated with a better outcome; however, these benefits seem to level off after approximately one year. While these authors stated that “the more such therapy is provided, the better the outcomes” (Shadish et al, 2000, p. 520), a clear declaration of how many sessions is considered enough of a “dose” is not stated, only that clients attend a flexible number of sessions.

The original Milan group had a different philosophy on the number of sessions required in order to be effective. Instead, the Milan group limited the number of sessions to ten, and if necessary would start an additional but final cycle of ten more sessions. This decision was “determined by our conviction that with these families we would have to provoke change rapidly or miss the opportunity for change entirely” (Palazzoli, Boscolo, Cecchin, & Prata, 1978, p. 15). The Milan group also stated that the brief number of sessions empowers families to become responsible for their own change. These two different views on the number of sessions required to achieve therapy goals indicate that change can happen in both a many and a few number of sessions.

Since the amount of sessions is not a clear indication of therapeutic success, the next logical step is examining what goes on in these sessions that promote achievement of therapy goals. Shadish et al. (2000) supports the concept of clinical representativeness as way to promote effectiveness. Clinical representativeness is described as or being treatment in which the therapy take

place in a non-university settings; be conduced by a typical, non-specifically trained, experienced professional who did not use a treatment manual but was free to use a variety of treatments; treat a heterogeneous population of clients with heterogeneous presenting problems. By using the concept of clinical representativeness, treatment can be specified and designed to fit individual client needs (specific therapy goals, a variety of type and frequency of interventions used) and yet be part of general practice for family therapy practitioners in typical treatment settings (treatment follows a protocol, i.e. therapy goals by session three, a treatment plan by session seven, etc.).

The type of change targeted could also effect achievement of therapy goals, as discussed previously. The literature found that treatments that target both first order change and second order change are effective. However, in a meta- analysis by Markus, Lange, and Pettigrew (1990), these authors found a slight advantage in effectiveness for non-behavioral (second order) treatments compared to behavioral (first order) therapies at termination, three and six month follow-ups. However, for all therapies the effects dropped off after 12 months follow-up. This study supports targeting second order change in order to create a (somewhat) more lasting change. Palazzoli et al. (1970) stated that for therapists “to obtain maximum amount of change…must realize that…we must allow ourselves enough time to provoke illuminating feedbacks”(p. 48), or create a structural change in the family.

Despite examining what goes on in therapy sessions as a link to achievement of therapy goals, other factors could also affect outcome.

Demographics and resources of clients could also play an important role in a client's ability to achieve therapy goals (Leon, Kopta, Howard, & Lutz,1999). Shadish et al (2000) acknowledges demographics as important in his definition of clinical representativeness by describing clients as being heterogeneous as a population and in presenting problems. Part of the variety of populations and problems include socioeconomic status (SES). Bischoff and Sprenkle (1993) found an inverse relationship between SES and the drop out rate in family therapy. However, Gilbert, Fine, and Haley, (1994) found no difference between SES, sex, intelligence, and current living arrangements between those who completed therapy and those who did not complete treatment. These authors did find that those who dropped out of treatment were more likely to have a history of substance abuse and be at least one grade behind in school, lending support to the more severe or pile-up of problems, the more difficult success can be in family therapy. These reviews point out that demographic factors and severity of presenting problem can play a part in therapy outcomes.

Finally, the perceptions of success could also vary from therapist to client. In a national sample of MFT's, Doherty and Simmons (1996) found that therapists consistently reported lower levels of positive outcomes than clients. The authors concluded that therapist ratings could either be considered conservative estimates of therapy results, or could be viewed as having pessimistic perceptions about client's progress and therefore not good barometers of client change. Therefore, these authors encourage using client's ratings to gage effectiveness.

*Theoretical Framework*

In order to gain a greater understanding of issues and to increase the likelihood of useable results, General Systems Theory (GST) is used as a conceptual foundation of the current research. GST stresses the connection between interrelated and interdependent parts in complex systems as a way to explain behavior. Therefore, GST provides a framework to connect interventions and therapy outcomes through examining the content, perspective and process of each client.

One General Systems Theory concept that stands out as being helpful when conceptualizing this research is holism, or the idea that the whole is greater than the sum of its individual parts (Becvar & Becvar, 1982). In therapy, this means that since a family acts like a system, a change in one part of the family will lead to a ripple effect causing a change in the larger family system. Since one change can affect many members, a therapist can tailor interventions to fit for not only the whole family but also an individual and still create whole change that moves a family toward accomplishing their therapy goals. In this study, the concept of holism is applicable since individual interventions are identified and success is measured by whole family goals, so small targeted changes can make changes in the larger family system.

Two additional concepts from General Systems Theory that apply to the study of interventions and techniques that work for families in therapy are equifinality and multifinality. Equifinality is defined as different causes or routes may produce similar results, and oppositely multifinality is defined as similar

conditions may lead to different ends (Becvar & Becvar, 1982). For a therapist, this means that using one technique or intervention with two different families can lead to very different outcomes, and using different techniques or interventions can lead to similar client results. In the case of reviewing client outcomes, this means that emerging themes may vary from case to case and therapist to therapist, and yet still hold validity as effective techniques or interventions.

In order to achieve any type of results, a system must find a way to balance change and stability. The concepts of morphostasis (stability) and morphogenesis (change) anchor a continuum of change in which a healthy family is placed at neither extreme (Speer, 1970; Becvar & Becvar, 1982). When identifying interventions used for clients, these interventions can be identified as falling on the stability versus change continuum. Most importantly for this research study is identifying which interventions pushed clients towards achieving their goals, or pushed for morphogenesis while not asking the system to become so unstable that the clients fought for morphostasis and were not able to accomplish their therapy goals.

Building upon the concepts of equifinality/ multifinality and morphostasis/morphogenesis, is the idea of feedback. Becvar & Becvar (1982) discuss feedback as information contained within the system and which is transmitted throughout the system. There are two types of feedback, positive and negative. Positive feedback is information that suggests or actually makes changes in the system, and negative feedback is self-correcting keeping system activity the same (Becvar & Becvar, 1982). In this research, the type of feedback

could be different for clients who achieve their therapy goals and those who do not.

Even after a system has been able to accept positive feedback and make changes, change can happen at different levels. First order change is defined in GST terms as a "pattern change at a structural level that allows the system as a whole to maintain stability", for example an individual changes their behavior but the whole family system is not changed (Montgomery & Fewer, 1988, p. 183). Second order change is defined in GST terms as an "organizational change of such magnitude that the former system ceases to exist and a new system with a different membership and different patterns replaces it" (Montgomery & Fewer, 1988, p. 187). An example of second order change is the birth of child because the whole family must establish new rules, structure and organization in order to meet the needs of the child and family members. A therapist's goal is to help clients make changes at an organizational level since these changes can be more long lasting.

Data for this research study is also examined using concepts from the OSU Model. This model embodies GST assumptions using the concepts of perspective, process and context (see Figure 1).

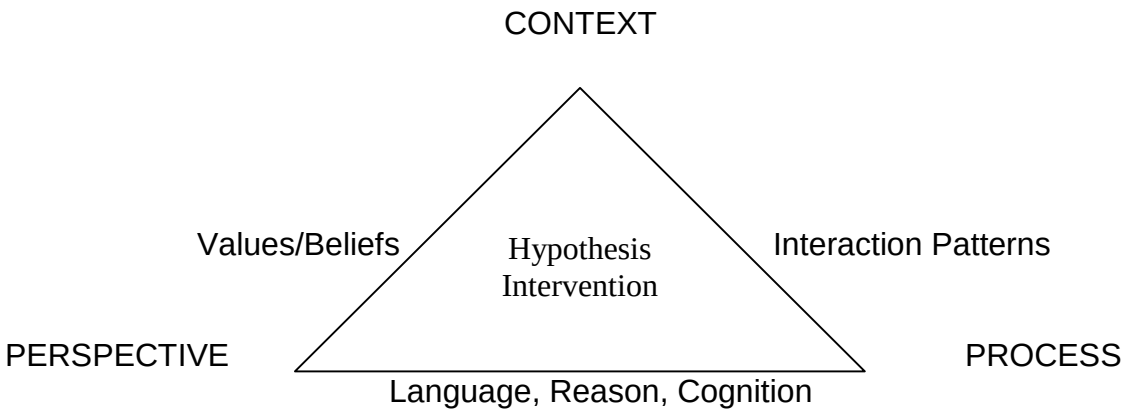


Figure 1. The OSU INSIGHT model demonstrates the links between the three dimensions, as well as how these dimensions are expressed by clients, and where a clinician can find ways to intervene.

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The OSU INSIGHT Model focuses on individual experiences (perspective), relational interactions (process), and resources and limitations (context) (Hendrix, Briggs, & Fournier, 1999, October). This model enhances all aspects that a family can bring to therapy, as well as where a therapist can intervene to help a family achieve their therapy goals. More specifically, this model identifies ways a therapist can treat a presenting problem within the family's context, such as connect families with social support systems like parenting groups, within each family member's perspectives, such as gaining new understanding of the problem or family member's intentions, and within the process of a family, such as creating new patterns to change interactions to be supportive (Hendrix et al., 1999, October).

In this research, interventions that aim at all three areas in the model can help clients not only achieve their therapy goals but maintain these changes over time. Overall, all of these theoretical concepts can aid the researcher in

delineating between what interventions helped the clients achieve their desired changes, and how these interventions were helpful.

*Research Questions*

The literature and GST have influenced the research questions for this project. Since this study is designed to explore and describe, no hypotheses were explored. Instead, research questions were developed to guide the research and yet leave the researcher open enough to discover themes as they emerged. The large question explored in this study is what interventions are the most effective in helping clients achieve their goals? More specifically, this study examines aspects of treatment that stand out for clients who complete their goals and those who continue therapy but do not meet their goals. In addition, this research explores themes between continuers and completers in regards to type of change targeted in interventions used in therapy.

Finally, other factors (demographics, chronicity of and length of presenting problem(s), pile-up of stressors, and supra systems involved in the case) are compared between continuers and completers to further study differences between the two groups due to treatment versus background factors. In order to uncover and analyze the best answers to these questions, four main documents were examined: the Intake form, Background form, Session Summary form, Diagnosis form, and Termination Report form. These forms will provide the client's perspective of the problem as well as the therapist' perspective of the treatment and progress towards therapy goals. In addition, these sheets provide numerical and narrative descriptions about the therapy process.

# CHAPTER III

## *Methodology*

### *Research Design*

This study uses a variety of design features to accomplish stated goals. By using elements of descriptive and exploratory design, this study takes advantage of the strengths of each method by providing a detailed analysis of treatment. Using a mixed design of qualitative and quantitative features, this study is able to describe and investigate the type of clients that attended sessions and treatment using narrative depictions as well as means, standard deviations, and percentages. These design features were chosen to provide a combination of descriptions so as to best create a picture of similarities and differences between the two groups.

Specifically, the data for this study was gathered from a student-run MFT clinic's database and examined retrospectively, or after the therapy sessions have already taken place between the families and therapy intern. The purpose of this study is to explore the types of interventions used by therapy interns in cases with families since many studies have neglected to identify what therapists actually "do" in therapy. In addition, another goal of this study to describe the type of interventions associated with the type of outcomes the clients achieve so

the purpose of this research study is both exploratory and descriptive. The unit of analysis in this study is the family with children, and since the population of this data will be examined as therapy goals and treatment develops, this study also uses a developmental design.

*Sampling*

The sampling frame for this study came from a list of clients treated at a family services clinic using primarily graduate student interns in the time frame of 2002-2004. In order to be included in the sample, at least one parent or guardian and one child must have attended more than half of the total sessions together, with the other part of the sessions attended by either an individual or couple. The dates of eligibility were chosen because interns began using a detailed case note form that provided the necessary data. The age range of the children is 0-18 years of age in order to have enough families in the sample. The elements and sampling unit in this study are the family with children who attended therapy at the clinic.

The sample was drawn by searching the clinic files for cases that were coded on the termination form as attending a majority of family sessions by the therapy intern. Since many clients attended a combination of family, couple, and individual sessions, the clients who attended primarily family sessions were included. Families that were put on the research list had to include at least one adult and one child or adolescent (either the custodial parent or guardian). Following the identification of family cases, these cases were placed in two categories: continuers (those who attended more than three sessions but did not

achieve their goals) and completers (those who completed their goals). The placement in either category was based on the MFT intern's coding on the "reason for termination" category on the termination form, as well as the narrative description of the presenting problem following treatment on the same form. After this analysis, 20 cases were found to fit the study criteria, with eight cases fitting under the completer category and 12 cases fitting under the continuer category. The clients included in the sample are also a clinical sample since they are being drawn from a clinical database, and the sampling method is a convenience method. Finally, since the purpose of this research is to gather information that will help novice therapists learn about the therapy process and effectiveness, the sampling method is also purposive.

This study is representative of clients that are families with children who attend therapy sessions at a Master's level, MFT, student-run clinic in the mid-West. Since part of the goal is to help graduate students at similar school-run clinics gather some new information about the therapy process, the sample could be representative of clients at other student-run facilities. However, this sample is not representative of all families with children of a variety of ages who seek therapy services around the country. In addition, the local community is aware that services at the student-run clinic are discounted so many clients are low to middle income families, which could potentially bias the sample not representing all income levels. Due to this evidence, this study is not completely applicable to all MFT practioners.

## *Research Methods*

### *Procedure*

As mentioned above, the research began by examining documents that are part of the student-run MFT clinic database to collect descriptive data, with some quantitative data to provide description. More specifically, an analysis of data was conducted that used information gathered from five main documents: the telephone *Intake form*, the client *Background Information form*, the *Session Summary forms*, the *Diagnosis form*, and the *Termination form* (see appendices). These forms were chosen to provide a description of the course of therapy. The Intake and Background forms provide information about the client's perspective of the problem and likelihood of the problem to change before the therapy sessions have begun. The Session Summary and Diagnosis forms provide the therapist's perspective of progress towards therapy goals and overall treatment throughout the course of therapy. Finally, the Termination Report form provides the therapist's perspective about therapy achievement after therapy sessions have been competed. All these forms supply information about the flow of treatment from the beginning to termination with both the clients and therapist's perspective, with an emphasis on the therapist's perspective about achievement.

A receptionist or intern fills out the telephone Intake form when a client calls to initiate services. This form provides the presenting problem, as well as the client's income. Clients (adults and children over the age of 12) fill out the client Background Information form once before the first therapy session. The information identified from the client Background form is the client's age, date of

birth, income level, ethnicity, perception of seriousness of problem, and likelihood of the problem to change. The information to be gathered from the Session Summary form is data filled out by the therapist following the completion of every session In other words, if a case runs ten sessions than there should be ten Session summary forms in the client's file. These summary forms are filled out, signed by the therapist, checked and signed by a supervisor. For this sample, 177 summary summaries were included.

The three parts of the Session Summary form focused upon are the sections *Therapy Goals, Interventions Used*, and *Progress Toward Therapy Goals.* These three sections provided specific therapy goals for each case, the interventions used for each case in each session, as well as a monitor of achievement of therapy goals on a one to five scale. This form provides the *therapist's* perception of achievement. The Diagnosis form is also completed by the therapist following the third session, and is again completed after every twelfth session. This form addresses Axis I through Axis IV diagnoses, as well as a Global Assessment of Functioning score. This form is also signed and checked by a supervisor. This form will provide a GAF score at session three, every twelfth session, and the final termination session, which can be a monitor for achievement in therapy.

The final data source is the Termination form. This form provides the number of sessions attended, the type of session attended (i.e. family, individual, and couple sessions), reason for termination, and the therapist's perception of the problem at termination. The information provided by this final section gave a

description of the family's progress, or lack thereof after therapy was completed. This section provided the most information about how the family had changed, and the type of changes the family had made.

*Analysis*

The researcher began the process of collecting the four above forms by examining the 20 case files that met the study criteria. In order to increase objectivity, protect client confidentiality, and decrease bias, each case was assigned either a number or letter. The completers were assigned a letter (A – H), and continuers a number (1-12) in order to keep the two groups separate. The assignment of the number or letter was done at random in each group so that analysis was not biased by recognition of the case number by the researcher. In addition, an unbiased therapy intern provided the demographic data in a separate file so that again any identifying information was not provided and the researcher analyzed the data with less recognition of the case. Each file was pulled and notes were gathered from each document mentioned above and put into a Microsoft Office Word 2003 document. The information included the following categories: the client's narrative description of the problem, a description of the family members, therapy goals, interventions used, progress towards therapy goals on a one to five scale, diagnosis information on Axis I-V, and a narrative description of the problem at termination.

From there, all Microsoft word documents were imputed and then coded using QSR NVivo Version 1.2142d, a software program designed to analyze qualitative data. These documents were each viewed in the program, and then

organized to compare themes between groups. The NVivo program was able to highlight key words within each section in the Word documents (i.e., the key words of *increase time together* and *connection* in the therapy goals and termination description sections*)* as well as view the documents together by section. This program provided an organization of data and aided the reporting process for the researcher because this program helped the researcher think through key ideas between the completer and continuer group found in the narrative data.

Throughout the narrative coding process, themes were identified within the therapy goals, interventions, and termination report data sections. These themes were explored based on types of change described and targeted in each section in order to dissect any differences between a first or second order change focus in each group. This analysis was conducted by creating lists and tallies for both completers and continuers that had the following headings: Therapy goals – First order change focused, Therapy goals – Second order; Interventions – First order, Interventions – Second order; Termination data – First order, Termination data – Second order. Next, each individual intervention was tallied to describe the most and least frequently used interventions (see Appendices E and F). These lists were a way to visualize and inspect the type of treatment experienced for both completers and continuers.

Finally, the Termination report was analyzed by creating another list and tally for each group with the following headings: First order process change, Second order process change; First order perspective change, Second order

perspective change; First order context change, and Second order context change (see Appendix G). This final list and tally provided a way to break down and describe the type of change made for each group. All of these lists were created using both Microsoft Word documents and NVivo analysis as a way to organize and analyze the narrative descriptions of treatment for both completers and continuers.

After the narrative descriptors were analyzed, the researcher used SPSS to further describe the sample. All of the information from all the clinic's forms are put into an SPSS database and given a numerical code by the clinic staff. For this project, first the researcher and another therapy intern went through the clinic database and found the 20 case files in this project, and put all of them into a separate file titled for this research. Then, the researcher and intern cleaned the data to check for mistakes in the numerical codes. The SPSS data checked included the Intake, Background, Diagnosis, and Termination Report forms. Using SPSS, the researcher conducted frequency analysis including mean, median, mode, and standard deviation for the whole sample. Next, the files were separated into the eight completer and 12 continuer cases and again analyzed using the same statistical measures.

The data was analyzed as a whole and between the two groups in order to describe the sample and evaluate the similarities and differences between the completers and continuers. The quantitative data provided information about the client's age, gender, socioeconomic status, family members, location, view of

seriousness of the problem, likelihood of the problem to change, diagnosis on Axis I –V, Global Assessment of Functioning score, and reason for termination.

By analyzing the narrative descriptions of the presenting problem, interventions used, and problem upon the close of therapy, a rich and detailed description of treatment throughout the course of therapy is revealed. In addition, analyzing demographic and numerical information using SPSS provided a quantitative measure of the similarities and differences in treatment and background data for completers and continuers. The combination of analyses paints a more complete descriptive picture of the types of resources and problems brought into therapy as well as therapy goals, interventions used, and outcomes in both groups.

# CHAPTER IV

## *Results*

Many themes emerged as contributing to the differences between and within both completers and continuers. In order to identify these themes, the results will be broken down into four areas based on the four main documents examined in this study: Background information, Intake information, Diagnosis information, and Termination information. This data was organized by using the NVivo program to identify themes and key words of all the text in the before mentioned forms. Then, in order to develop frequencies and percentages to compare within and between groups, tables were developed using SPSS. The results first describe the whole sample and then specifics comparing completers and continuers for each form.

### *Background Information*

First, the overall sample included a variety of family members that attended therapy sessions in the years 2002-2004. Majority of the sample identified the local town as being their home zip code (75%, n=15), with the other 25% living within one hour of the town. A total of 71 clients were included in at least one of the therapy sessions. The age range of clients was from one year to 63 years old. Nine children (n=22) were school aged children (ages 6-12), eight were five years and younger, and five were teenagers (from 13-17). Overall, 23

mothers were included, seven fathers, four stepfathers, three maternal grandmothers, one maternal aunt, and one adult male who was described as "grandmother's boyfriend." As for the children, 15 were described as the oldest daughter, four as the second oldest daughter, 13 as the oldest son, one the second oldest son, two as the third oldest daughter, one as the fourth oldest daughter, and one described as a grandson. Forty one adults and adolescents completed a background form, however the other 30 clients were too young to complete a form. Of those who completed the background form, 42% (n=29) identified themselves as mother, 20% as father, and 8% as daughter number one (see Table 1). Also, of the clients who filled out background forms 65% identified themselves as White/Caucasian while the other clients did not fill out this part of the form (34%) (see Table 2).

Table 2

*Descriptions of Family Members and Ethnicity of Sample*

| Family Codes | Frequency | Percent | Ethnicity | Frequency | Percent |
|---|---|---|---|---|---|
| Wife | 1 | 2.4 | White/Caucasian | 27 | 65.9 |
| Male Partner | 1 | 2.4 | Other | -- | -- |
| Female Partner | 1 | 2.4 | Total | 41 | 100 |
| Father | 8 | 19.5 | | | |
| Mother | 17 | 41.5 | | | |
| Son 1 | 2 | 4.9 | | | |
| Daughter 1 | 3 | 7.3 | | | |
| Daughter 2 | 2 | 4.9 | | | |
| Step Father | 2 | 4.9 | | | |
| Female's mother | 2 | 4.9 | | | |
| Female's sister 11 | | 2.4 | | | |
| Mother male friend | 1 | 2.4 | | | |
| Total | 41 | 100 | | | |

Other demographic characteristics of the whole sample based on information from the background form include religious preference, occupation, education, marital status, and length of marriage. Most clients identified themselves as Baptist (20%, n=8), then Christian (17%, n=7), and finally other Protestant (10%, n=4). As for occupation, the clients provide a range of occupations including 17% (n=7) identified as students, 15% (n=6) left this question blank, and 12% (n=5) identified as other professionals and homemakers (see Table 2). Education was somewhat less diverse, with 34% (n=14) of clients having completed high school, 20% (n=8) having completed some college, and

15% (n=6) leaving this question blank (see Table 2). Twenty clients identified themselves as married (49%), with the length of marriage ranging from less than one year (7%) to more than 40 years (2%). Most of the married clients had been married less than one year and five years (see Table 3).

Table 3

*Occupation, Education, and Number of Years Married of Sample*

| | Frequency | Percent |
|---|---|---|
| **Job description** | | |
| Professionals | 3 | 7.3 |
| Other professionals | 5 | 12.2 |
| Skilled and building trades, farmer | 3 | 7.3 |
| Sales, technicians, clerical | 4 | 9.8 |
| Laborer, waitress | 4 | 9.8 |
| General service employee | 1 | 2.4 |
| Homemaker | 5 | 12.2 |
| Student | 7 | 17.1 |
| Employment total | 35 | 85.4 |
| Missing | 6 | 14.6 |
| Total | 41 | 100 |
| **Education level** | | |
| Graduate School | 5 | 12.2 |
| Four year college | 3 | 7.3 |
| Some college | 8 | 19.5 |
| High school | 14 | 34.1 |
| Some high school | 3 | 7.3 |
| Elementary | 2 | 4.9 |
| Education level total | 35 | 85.4 |
| Missing | 6 | 14.6 |
| Total | 100 | 100 |

| | Frequency | Percent |
|---|---|---|
| Number of years married | | |
| 0 | 3 | 7.3 |
| 2 | 2 | 4.9 |
| 4 | 1 | 2.4 |
| 5 | 3 | 7.3 |
| 6 | 2 | 4.9 |
| 10 | 2 | 4.9 |
| 14 | 1 | 2.4 |
| 15 | 1 | 2.4 |
| 23 | 2 | 4.9 |
| 24 | 2 | 4.9 |
| 27 | 2 | 4.9 |
| 40 | 1 | 2.4 |
| Total | 22 | 53.7 |
| Missing | 19 | 46.3 |
| Total | 100 | 100 |
| | Mean | Standard Deviation |
| | 12.4 | 11.3 |

*Intake information*

Therapy sessions were initiated primarily by the mother (70%, n=14), and then by father (15%). As for the presenting problem, 65% (n=13) of the time the one who initiated services stated that multiple people were involved in the

problem. Twenty percent (n=4) of cases were assigned in months of February and October with most treatment beginning in the years 2003 and 2004.

*Diagnosis information*

One aspect of treatment was diagnosis using the Diagnostic and Statistical Manual of Mental Disorders IV. Of the 52 clients who were identified in the paper work, 29 (56%) of the mothers were diagnosed with either an Axis I or Axis II diagnosis. The second most diagnosed family member was son number one (15%, n=8). As for the clinical disorder diagnosed, 62% of the time the family member was described by the diagnosis of V61.20 Parent Child Relational Problem as the primary Axis I diagnosis. As a secondary diagnosis, no code stood out more than another. As for an Axis II diagnosis, the most frequent diagnosis was V71.09, or No Diagnosis. In addition, 68% of those diagnosed did not have a medical condition, and 31% had one problem marked on Axis IV.

*Background information for the Completers versus for Continuers*

A variety of similarities and differences were found between the two groups when examining the background forms. Despite having a different number of clients in each group (completers had a total of 29 and continuers 42), many of the demographic characteristics were similar for both groups. Both the completers and continuers identified themselves as White/Caucasian (55%, n=11 & 65%, n=11), Baptist (20%, n= 4 & 22%, n=8), students (15%, n=3 & 19%, n=7), and as having completed high school (30%, n=6 & 35%, n=13) or some college (20%, n=4 &22%, n=8). As far as marital status, the completers had nine percent married clients (n=9), and the continuers had 18 percent married clients (n=18).

The length of marriage was most often less than one year for completers (15%, n=3), then five years (10%), and finally five clients had been married for 23 years or more. As for continuers, eight percent had been married for five years (n=3), and then the percentages were spread out between less than one year (5%) to 40 years (3%). For clients in both groups, majority had not been married before (60% n=12 & 54% n=20), with one client having been married three times before in both the completer and continuer group, and one client having been married four times before in the continuer group (see Table 4).

Table 4

*Completers and Continuers Background Information*

| Ethnicity | Religious preference | Occupation | Education | Marital status | Length of marriage |
|---|---|---|---|---|---|
| | | Completers | | | |
| White/ Caucasian | Baptist | Students | High School | Married | Less than 1 year |
| 55% (n=11) | 20% (n=4) | 15% (n=3) | 30% (n=6) | 45% (n=9) | 15% (n=3) |
| | | Continuers | | | |
| White/ Caucasian | Baptist | Students | High School | Married | Five years |
| 65% (n=11) | 22% (n=8) | 19% (n=7) | 35% (n=13) | 49% (n=18) | 8% (n=3) |

A few reported differences between the two groups included the client's perception of the seriousness of the presenting problem and perception of the likelihood of the problem to change (see Table 5). The continuers group reported that their presenting problem was more serious with a mean of 3.1 and standard

deviation of 0.8, but more frequently rated their problem as likely to change (M=3.25, SD=0.72). The completers group reported a more middle rating of the seriousness of the presenting problem (M=2.6, SD=0.88), and was even in their ranking of the likelihood of the problem to change across all levels (M= 2.5, SD= 1.2).

Table 5

*Rating of seriousness of problem and likelihood of problem to change for both groups from 1-4*

| Seriousness of problem | | | | M | SD | Likelihood to change | | | | M | SD |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | | | 1 | 2 | 3 | 4 | | |
| Completers | | | | | | | | | | | |
| 2 | 4 | 8 | 2 | 2.6 | 0.88 | 4 | 4 | 4 | 4 | 2.5 | 1.2 |
| Continuers | | | | | | | | | | | |
| 1 | 3 | 12 | 7 | 3.1 | 0.8 | 0 | 3 | 9 | 8 | 3.3 | 0.72 |

*Intake information for completers and continuers*

Some of the characteristics that stood out between the two groups included the family member who sought services. While the mother was the most frequent person to seek services for completers (63%, n=5) and continuers (75%, n=9), in the completer's group fathers sought services twice, and the female partner once. However, in the continuers group the father sought services only once, and multiple persons sought services twice. Also, the continuers group was more likely to have families made up of a wider range of number of members (ranging from two family members to eight, compared to

three members to seven in the completers group). Similarly, continuers were more likely to identify more people involved in the problem, identifying multiple people 67% (n=8) of the time, and then husband (n=1), father (n=1), and ex husband (n=1) totaling the other 32% of the time. Completers identified multiple people as being involved in the problem 63% (n=5) of the time, the mother 13%, and the other 24% of the information was missing.

Another small difference between the two groups was involvement of an institution or other people. Completers had two cases involved with the Department of Human Services (DHS), and two with School/Teacher, however 50% (n=4) of the time there was no involvement. As for continuers, three cases were involved with DHS, one with School/Teacher, one with the police, and 58% (n=7) of the cases were not involved with an institution or other party. Overall, most clients were not involved with any third party or referral source in both groups.

A more distinct difference between the two groups is length of the presenting problem. The clients in the completers group stated that the problem had been going on from one month, three months, 12 months, 36 months, and to 96 months. For completers the most frequently stated length of problem included one month (25%, n=2) and 12 months (25%, n=2), with a mean of 23 and standard deviation of 34. The continuers group stated that the problem had been going on from two months to 168 months. The most frequently marked length of the problem was 12 months (17%, n=2), with a mean of 48 and a standard deviation of 51. Another part of the presenting problem was involvement with

alcohol. Thirty three percent of the continuers stated that alcohol was a problem (n=4), while 25% of the completers stated alcohol was a problem (n=2). Also, of those who identified alcohol as a problem, the completers identified only one person and the continuers identified both one (25%) and two (8%) persons as having a problem with alcohol.

Completers were also more likely to state that the whole family would attend therapy (63%, n=5), while continuers stated the whole family (33%, n=4) or partial family would attend 33% (n=4) of the time. The continuers also stated the couple would attend in three cases, however the completers did not state just the couple would attend. As for financial concerns, 33% (n=4) of continuers stated there were no concerns while 13% (n=1) of completers stated no money problems. Completers were more likely to be taking medications (63%, n=5), ranging from cancer medications to antidepressants, compared to 58% (n=7) of continuers. Continuers were more likely to be receiving mental health services somewhere else (33%, n=4 for continuers and 25%, n=2 for completers), however completers were more likely to be referred by someone (75%, n=6 versus 42%, n=5 for continuers). For both completers and continuers, 25% (n=2 and n=3) had received prior services at the mental health clinic.

A final difference indicated on the intake is yearly income. Completers had a much wider range of incomes, ranging from 0- $90,000 (M=$28,250, SD=3.12). The income range for continuers was $10,000- 45,000 (M=$15,333, SD=1.55) with three cases earning $12,000 per year. Similarly, 38% of

completers were quoted $50 per session while only 18% of continuers were quoted $50 per session.

*Diagnosis for completers versus continuers*

Diagnosis forms were examined for the all cases in both groups. Some information was similar, for example both completers (44%, n=7) and continuers (47%, n=14) were most diagnosed frequently in session three which is typical since the clinic requires a diagnosis at session three. In addition, mother was the family member most often diagnosed, 69% (n=11) of the time for completers and 53% (n=16) of the time for continuers. The most frequently used Axis I diagnosis for both groups was V61.20 Parent Child Relational Problem, occurring 50% (n=8) of the time for completers and 73% (n=22) for continuers. The next two most frequent Axis I diagnoses for the completers included 300.4 Dysthymic Disorder and 309.24 Adjustment Disorder with Anxiety. For continuers, the next most frequent diagnoses were 303.90 Alcohol Dependence, 295.70 Schizoaffective Disorder, and V62.89 Phase of Life Problem. As for Axis II, 88% (n=14) of completers and 83% (n=25) of continuers were given the code V71.09 No Diagnosis. For two completers, the diagnosis of 301.20 Schizoid Personality Disorder was used, and for continuers twice both 295.70 Schizoaffective Disorder and V62.89 Phase of Life Problem was used. Most completer (75%, n=12) and continuer (63%, n=19) clients did not have a general medical condition, and most completers had two problems listed on Axis IV Psychosocial and Environmental Problems (31%, n=5) while continuers were more likely to have one problem listed (40%, n=12).

Global Assessment of Functioning (GAF) scores varied between the two groups. The mean GAF score at session three was 66 for completers and 65 for continuers. At termination, the mean score was 73 for completers and 63 for continuers. In addition, seven of the eight completer cases had an increase in their GAF score (mean increase of 8 points) and only one case received the same GAF score at session three and termination. For continuers, five clients had increases in GAF score (mean increase of 10 points); one case received the same score; and seven cases that had a decrease in the GAF score (mean decrease of 12 points). One continuer case had a GAF score of 75 at session three and then a 41 at termination session number 18.

*Termination information for completers versus continuers*

Most cases began and ended in the years 2003 and 2004 due to the expanded paperwork becoming protocol in the clinic in 2002. In addition, the number of sessions attended by clients varied between groups. For completers, 25% (n=2) of cases attended four sessions, nine sessions, and 12 sessions. Thirteen percent (n=1) of clients attended eight sessions and 19 sessions. The mean total number of sessions for completers was 9.6 with a standard deviation of 4.9. As for the continuers, the mean total number of sessions attended was 8.2, (SD=5.9). Also, 33% (n=4) of continuers attended four sessions, 17% attended seven and eight sessions, and nine percent attended five, nine, 18, and 20 sessions. The total number of therapists who worked on the case was one for both completers (88%, n=7) and continuers (67%, n=8). However, 33% (n=4) of continuers had two therapists compared to 12% (n=1) for completers.

Other differences between the two groups are found in the type and number of therapy sessions attended. For completers, ten individual sessions were conducted, zero couple sessions, and 67 sessions were family sessions. Individual sessions were attended only a few times, however, family cases were attended much more frequently with modes being four and twelve family sessions. Continuers attended eight individual sessions total, evenly spread out between three cases attending one, two and five sessions. Also, continuers attended nine couple sessions, with one case attending three couple sessions and another case attending six couple sessions. As for family sessions, continuers attended a total of 81 sessions with four family sessions attended the most frequently (33%, n=4) (see Table 6).

Table 6

*Number of Sessions and Type Attended by Both Groups*

| Group | Total number of sessions | Individual sessions | Couple sessions | Family sessions |
|---|---|---|---|---|
| Completers | 4 (n=2) | 0 (n=4) | 0 (n=8) | 4 (n=2) |
| | 8 (n=1) | 1 (n=1) | | 5 (n=1) |
| | 9 (n=2) | 2 (n=1) | | 7 (n=1) |
| | 12 (n=2) | 3 (n=1) | | 8 (n=1) |
| | 19 (n=1) | 4 (n=1) | | 12 (n=2) |
| | -- | -- | | 15 (n=1) |
| Continuers | 4 (n=4) | 0 (n=9) | 0 (n=10) | 4 (n=4) |
| | 5 (n=1) | 1 (n=1) | 3 (n=1) | 5 (n=3) |
| | 7 (n=2) | 2 (n=1) | 6 (n=1) | 7 (n=2) |
| | 8 (n=2) | 5 (n=1) | -- | 9 (n=1) |
| | 9 (n=1) | -- | -- | 12 (n=1) |
| | 18 (n=1) | -- | -- | 15 (n=1) |
| | 20 (n=1) | -- | -- | -- |

The reason for termination was obviously different between the two groups. The two groups were decided based upon the reason for termination and the description of the problem on the termination report. For completers, 63% (n=5) of clients terminated because therapy was completed, and 37% because of client request. The continuers terminated therapy 58% (n=7) of the time because of No shows or cancellations, 33% of the time because of client request, and 8% because of an undefined other reason.

*Treatment descriptors*

Treatment themes are identified by therapy goals, interventions, and descriptive termination reports by therapist. These reports provide information about the type of changes the therapy targeted. One aspect of treatment that was similar in both groups was the type of change targeted by therapy goals. Goals for both groups were more often first order goals than second order goals. More specifically, most cases had either two or three overall therapy goals (both 40%). These goals were usually targeted at specific changes that are more behaviorally focused. Some goals had both first and second order descriptions. Goals were determined to be first or second order based upon the definitions described by Lyddon (1990). First order change is described as a change that does not alter the structure of the system itself (i.e. problem-solving and symptom alleviation), and second order change is detailed as a change in the essential structure of the family system so that the system is permanently reorganized (i.e. new family patterns, insights into perceptions, in addition to problem-solving and symptom reduction).

However, for both groups most cases had at least one goal that was focused on first order change (30%, n=4), and then two first order focused goals (25%, n=3). Forty five percent of cases had at least one goal that was second order change focused. A list of goals is provided in Table Seven for completers and continuers taken directly from Session Summary reports. This table provides the goals focused on first and second order change for both groups.

Table 7

*Types of Change Targeted in Therapy Goals for both Groups*

Completers

First order therapy goals

1. Better communication
2. Figure out what's going on with son that is causing problems at school
3. Set more structure during son's time away from mother
4. Keep a journal of the meals served to the children
5. Create a safer home by installing safety locks on cabinets and keeping children involved in completing chores
6. Provide appropriate discipline for the children
7. Provide the children with choices when appropriate
8. Increase communication
9. Gain coping skills to handle stress of visitations with father
10. Learn to communicate so others will listen and listen so others will communicate
11. Improve problem solving skills
12. Increase the quality and amount of time together

Second order therapy goals

1. To negotiate rights and responsibilities of daughter as she becomes more independent
2. To help daughter be happy by being successful in school and get along well with family and friends
3. Clients want to ensure daughter is coping appropriately with the family's cancer influence
4. Clients want to alter daughter's challenging attitude towards mother
5. Help mother to reduce overall stress levels by setting priorities
6. Model appropriate behaviors and responsibilities for the children
7. The family would like more unity so they understand each other better
8. More trust and respect within the system
9. Learn to accept father's limitations as a parent

Continuers

First order therapy goals

1. Increase closeness as shown by more quality time together
2. Increase expressions of respect and consideration for self and others
3. Enable the family to learn how to deal with the daughter effectively when the mother has and episode of feeling down or depressed
4. Increase amount o time in activities spend together as a family
5. Build teamwork and increase shared responsibilities in household chores
6. To help mother and son manage anger
7. Work on communication issues through stating clear messages and building trust with one another
8. Learn alternative parenting methods including ways to deal with son' anger
9. Recognize positive actions made by family members
10. Demonstrate more respect for family members through attitude and language
11. Improve communication and cohesion in family relationship
12. To educate mother with age appropriate parenting skills
13. Reduce son's aggressive behaviors such as kicking, biting and screaming
14. Increase positive behaviors and connection
15. Increase number of pleasant conversations between family
16. Increase the level of connection
17. Increase the effectiveness of the mother's parenting skills so that she is able to treat her children similarly at home in public
18. To learn better teamwork when playing
19. Improve communication between mother and son around difficult
20. Learn and practice new discipline techniques to increase the effectiveness of the couple's parenting skills

Continuers

Second order therapy goals

1. Increase honesty demonstrated between family members

2. Increase the level of stability in the family, allowing the child to feel more secure, through gaining a greater understanding of each family member's perspective

3. To increase the level of trust and emotional security within the family

4. Create a safe, consistent atmosphere to enable the children to express emotions related to their recent stressors

5. Create a united front for the parents to increase the effectiveness of parenting skills

6. Increase the level of closeness between family members

7. To learn how to better trust one another

8. To make our family our number one priority

9. Assist mother and friend in identifying and creating appropriate expectations for children – 2

10. Improve the relationship between mom's friend and son by increasing understanding and the level of respect

The similarities continue for treatment of both groups. First, the total number of interventions used over the course of therapy varied depending upon the number of sessions attended. The range of interventions used for completers ranged from six to 75, and for continuers from ten to 80. The mean of interventions used in each session in both groups was four (SD=3.14, range= 2 - 8). The analysis comparing the percentage of first order to second order interventions used found a similar percentage for both groups. For both groups, second order interventions were used more often than first order interventions.

These interventions were classified as first or second order based on the *intent* of the interventions. Examples of the descriptions of interventions and

their intent taken directly from case information are illustrated below in Table Eight  A frequency is also provided that shows how many times the interventions were used in all cases.  Specifically, first order interventions were used 48% of the time for completers and 46% of the time for continuers.  As for second order interventions, they were used overall 52% in completer cases and 54% for continuers.  In addition, Table Nine provides a tally of the frequency of majority of interventions so as to provide a picture of the differences and similarities of treatment between the two groups. This tally is not the whole picture (i.e. no means, standard deviations or percentages) of how many times a specific intervention was used because many times one listed intervention had two or more intents.  This tally is just to describe how many times an intervention addressed the following areas within the types of change.

Table 8

*Description, Total Number, and Percentages of Type of Change Targeted in Interventions for both Groups*

Completers

First order interventions

1. Linear questions to gain context
2. Reframe to clarify intention
3. Brainstorming to expand descriptors
4. Probing for information
5. Scaling questions to measure goals
6. Summarize to demonstrate listening
7. Drawing activity to illustrate differences in the family between happy and sad mom
8. Use of clay to define depression
9. Write a letter to depression to externalize and think of solutions
10. Normalizing the clients feelings
11. Discussion of emotional response
12. Circumplex model to develop therapy goals
13. Playing a children's game to discuss emotions
14. Use of balloons as a metaphor to discuss internalization of emotions
15. Scaling questions to asses level of closeness
16. Open-ended questions to gather information
17. Scaling questions to identify levels of communication
18. Human sculpture to operationalize anger
19. Summarizing to clarify and join
20. Invention questions to identify areas in need of improvement
21. Circumplex to assess levels of flexibility and cohesion
22. Goal setting to direct future sessions
23. Diagnostic questions to assess areas of concern

Completers

First order interventions

24. Talking to partner about what keeps them from being open to their partner
25. Validate client's feelings to convey understanding
26. 26.Circumplex review family of origin
27. Enactment to model engaging in an activity with son
28. Identified responsibilities, consequences, and privileges
29. Probing questions to gain information about consequences from the executive subsystem
30. Brainstorming to identify alternative behaviors and responsibilities
31. Assess positive and negative changes
32. Draw pictures to demonstrate current feelings
33. Modeling positive discipline techniques to increase effective parenting skills
34. Squiggly wiggly game to use art to draw and tell a story
35. Reinforce positive disciple techniques to increase effective parenting skills
36. Promote discussion of feelings
37. Encourage mom and son to discuss son's emotion
38. Coaching mom on how to reflect an understanding of son's emotions
39. Strategic questions to determine challenges experience in play
40. Teach parents alternative discipline techniques
41. Enable parent to practice and utilize new skills
42. Identify rules for the children to set structure

Completers

Second order interventions

1. Circular questions to expand perspectives
2. Family map to clarify interactional style
3. Attending to show acceptance of child by therapist
4. Reflexive questions to explore priorities
5. Reframe to offer fresh interpretation

Completers

Second order interventions

6. FACES to assess family's level of cohesion and adaptability
7. Draw memories to focus on positive
8. Normalize to instill hope
9. Circumplex model to assess level of cohesion and adaptability
10. Miracle question to understand desired changes in the family
11. Write a letter to depression to externalize and think of solutions
12. Reading a story to externalize discussion of emotions
13. Summarizing to show understanding from emotions
14. Joining to build a therapeutic relationship
15. Movement in seating to create one family
16. Reading aloud the best things about each member to alter focus from negative to positive
17. Reframing to broaden perspective and instill hope
18. Reflexive questions to create a vision for the family
19. Normalizing children's behavioral reactions
20. Creation of art project of X-Rays to explore children's emotions
21. Reflecting children and mother's emotions to facilitate expression of emotion
22. Use play techniques of sand tray and puppets to externalize emotions
23. Open-ended questions to gather information
24. Reframing to challenge negative connotations Externalize anger to normalize emotion
25. Validate both viewpoints to join
26. Slowing down the pace of therapy to put the responsibility of change on the clients
27. Process emotions related to past abuse
28. Sand tray to allow children to play out what they are feeling
29. Drawing pictures of recurring dreams or nightmares to uncover feelings about events
30. Metaphor to facilitate understanding
31. Circumplex model to assist in setting goals

Completers

Second order interventions

32. Set therapy goals to determine a vision for therapy
33. Sculpting placements to visualize family structure
34. Role play to push for perspective
35. Predicting sabotage to place a family in a paradox
36. Cycle to explain patterns of interaction
37. DVD clip to compare and contrast interactions
38. Reframing to recognize family strengths
39. Reframing to alter and address fears
40. Reframing to acknowledge son's desire for connection
41. Normalize issues that might get in the way of change
42. Logical questions to stimulate thoughts of alternative behaviors
43. Metaphor to illustrate process in family
44. Role play to demonstrate interactions between all members
45. Skit to enact a vision of their perfect family
46. Animals to describe members and broaden perspective
47. Played game "Feelings Freeway" to explore feelings within family
48. Identify positive characteristics of each member to shift focus from negative to positive
49. Imaginary time machine to build family unity
50. Reinforce positive disciple techniques to empower mother
51. Encourage discussion between mom and son to assess ability to interact
52. Validating mom's parenting practices Utilized video to externalize mom's behavior
53. Therapy letter to deliver final messages
54. Circular questions to assess client's perception of DHS requirements

## Continuers

### First order interventions

1. Probe for information
2. Probe to explore differences
3. Invention prescription to involve children in goal setting
4. Ranking questions to determine priorities
5. Scaling questions to measure goals
6. Tracking to establish a pattern
7. Brainstorming for potential solutions
8. Affirmations of strength to encourage teamwork
9. Summarizing to encourage
10. Open-ended questions to assess moods
11. Summarizing to direct therapy
12. Invention discussion to assess
13. Linear questions to gather information
14. Summarizing to covey listening
15. Make a note of progress
16. Diagnostic questioning
17. Discussion of food pyramid to educate about nutritional requirements
18. Handout of food pyramid to educate about nutritional requirements
19. Food toys to explore concepts of healthy nutrition
20. Discussion on parenting styles
21. Handout on parenting styles
22. Discussion on child development and milestones in cognitive, social, emotional, and physical development
23. Handouts on child development Discussion about roles related to co-parenting
24. Parent-child interaction techniques (PCIT) to model behaviors for parents
25. Activity to engage family in an activity to coach and reflect PCIT techniques

Continuers

First order interventions

26. Reflecting actions and feelings during PCIT play of both children and adults
27. Praising the recognition of actions and feelings during PCIT play of adults
28. Scaling questions to assess progress
29. Explained therapy process for the child and adult to understand the process and build relationship
30. Game to encourage discussion of emotions
31. Body outline tracing to discuss feelings
32. Brainstorming to stimulate thoughts of coping strategies
33. Reading a book to identify feelings

Second order interventions

1. Reflexive questions to determine ownership of issues
2. Reflexive questions to expand perspective
3. Reflexive questions to determine differences
4. Summary to demonstrate the value of ideas
5. Highlight interactions to increase awareness
6. Reframe to normalize adjustment to divorce and co-parenting
7. Reframe to link problems to therapy goals
8. Reframe to give a different view of interactions
9. Circular questions to expand perspectives
10. Circular questions to point out recurrent pattern
11. Exception questions to look for solutions
12. Review progress
13. Open-ended questions to assess perspectives
14. Game to enact family interaction patterns
15. Attending to family's effort to change
16. Joining to build therapeutic relationship and trust
17. Summarizing to join and clarify information

Continuers

Second order interventions

18. Normalizing to broaden perspectives and security
19. Reframing to encourage
20. Encouragement to support strengths
21. Circular questions to assess emotions
22. Open-ended questions to address emotional coping
23. Cycle development to address coalition
24. Reframing to build strengths in perspectives
25. Open-ended questions to find out about interaction prescriptions
26. Solution focused questions to identify strengths
27. Family sculpting to use energy and assess perspectives on structure
28. Hug tags, or supportive words to use energy, build connection, and test boundaries
29. Alternative hypothesis testing to change perspectives
30. Enactment to test boundaries
31. Enactment to assess and strengthen changes
32. Enactment to assess interactions
33. Circular questions to assess goals
34. Assessment homework to identify progress
35. Reflexive questions to identify progress
36. Circumplex to increase understanding
37. Circumplex model and family structure discussion to evaluate where the family is today and how mom envisions the future
38. FACES to assess communication and satisfaction
39. Normalizing to offer hope and let clients know they were heard
40. Miracle question to assess desired changes
41. Goal setting to direct future therapy
42. Play techniques to assess interactions

43. Reflexive question to explore future possibilities
44. Games and books to explore concepts related to views of the family
45. Game to engage all family members to assess interaction
46. Assessment of interaction between adults and children to establish a baseline for PCIT techniques
47. Process emotions about son's absence
48. Empathic listening to join with client
49. Reframes to draw client into the therapy process
50. Circular questions to process transitions for family changes
51. Encouraging family to write a letter describing therapy completion
52. Goal achievement questions to process experience in therapy
53. Reflective listening to increase understanding
54. Strengths to provide encouragement about parenting skills
55. Empathetic listening to facilitate joining
56. Family drama to gain understanding of visits with father
57. Balloon metaphor to externalize fear
58. Miracle question to help family think of new possibilities
59. Emphasizing on family strengths to give client new experience of skills

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Table 9

*Description of the Frequency of Types of Interventions for both Groups*

Completers

| Frequency of first order interventions | | Frequency of second order interventions | |
|---|---|---|---|
| Linear Ques. | 27 | Circular Questions | 42 |
| Teach Skills and/or Educate | 13 | Normalize | 42 |
| Process Interactions | 10 | Joining | 22 |
| Brainstorm | 6 | Reframes | 21 |
| Use discussions | 5 | Process interactions | 18 |
| Joining | 3 | Reflexive questions | 16 |
| Summarize | 3 | Focus on strengths | 10 |
| Draw/Art | 3 | Address emotions | 10 |
| Assess progress | 2 | | |
| Goal Setting | 1 | Attending | 9 |
| Explore differences | 1 | FACES/Circumplex | 8 |
| Attending | 1 | Assess progress | 5 |
| Open ended questions | 1 | Explore differences | 4 |
| | | Draw/Art | 3 |
| | | Open ended questions | 3 |
| | | Solution focused/Exceptions | 4 |
| | | Promote discussions | 3 |
| | | Role play | 3 |
| | | Summarize | 2 |
| | | Hope | 2 |
| | | Goal setting | 2 |
| | | Slow down/Relapse | 2 |
| | | Externalize | 1 |
| | | Linear questions | 1 |

Continuers

| Frequency of first order interventions | | Frequency of second order interventions | |
|---|---|---|---|
| Linear Ques | 30 | Circular questions | 56 |
| Teach Skills and/or Educate | 38 | Normalize | 30 |
| Process Interactions | 5 | Joining | 8 |
| Brainstorm | 8 | Reframes | 27 |
| Use discussions | 1 | Process interactions | 18 |
| Joining | 5 | Reflexive questions | 24 |
| Summarize | 29 | Focus on strengths | 8 |
| Draw/Art | 12 | Address emotions | 3 |
| Assess progress | 0 | Attending | 4 |
| Goal Setting | 4 | FACES/ Circumplex | 4 |
| Explore differences | 1 | Assess progress | 4 |
| Attending | 0 | Explore differences | 1 |
| Open ended questions | 1 | Draw/Art | 4 |
| Normalize | 8 | Open ended questions | 2 |
| Focus on strengths | 1 | Solution focused/Exceptions | 2 |
| Reframes | 1 | Promote discussions | 2 |
| FACES/ Circumplex | 8 | Role play | 4 |
| Reflexive questions | 1 | Summarize | 2 |
| Metaphor | 1 | Hope | 3 |

Continuers

| Frequency of first order interventions | | Frequency of second order interventions | |
|---|---|---|---|
| Emotions | 1 | Goal setting | 3 |
| Externalize | 1 | Externalize | 1 |
| Role play | 1 | Linear questions | 0 |
| | | Metaphor | 7 |
| | | Assess progress | 4 |
| | | Teach skills/ Educate | 4 |
| | | Slow down/Relapse | 2 |
| | | Create paradox | 1 |
| | | Brainstorm | 1 |

Outcome was also described in ways other than the numerical Global Assessment of Functioning (GAF) score described above. Another way outcome was measured was using the progress towards achievement scale of one (low) to five (high). The completers earned a higher score, more often earning a "four" or "five" on the scale than the continuers, who mostly earned "ones" and "twos" (see Table 10).

Table 10

*Rating of Progress Toward Therapy Goals for both Groups (1-5)*

| Completers (N=21) | | | | | Continuers (N=32) | | | | |
|---|---|---|---|---|---|---|---|---|---|
| Progress towards therapy goals | | | | | | | | | |
| 1 | 2 | 3 | 4 | 5 | 1 | 2 | 3 | 4 | 5 |
| 0 | 2 | 4 | 11 | 4 | 9 | 9 | 7 | 6 | 1 |
| | Mean | | | 4.2 | | Mean | | | 6.4 |
| | Standard Deviation | | | 4.15 | | Standard Deviation | | | 3.29 |

Finally, outcome was described in the therapist's perception of change in the termination report. This report described the changes, or lack thereof, for

each case in terms of a perspective, process, or contextual change. This change was also broken down into a first or second order change. The theme that stands out the most from this measure is the likelihood to change. The completers were much more likely to have changed overall than the continuers in all aspects, including perspective, process and context. More specifically, seven times a case was described by the therapist to have achieved a second order change in perspective, six times as having made two or three first order process changes, four times as having made a second order process outcome, and three times as having made a first order context outcome.

As for continuers, thirteen times a first order process change was described, four times a second order perspective change, and three times a first order perspective change was described. In addition, continuers were more likely to experience no change or for problems to get worse. Only one time in the completer group did a case report no change in problems, while eleven times a continuer reported no change and eight times problems were described as worsening. Examples of the change reported in the termination report are as follows:

> 1. The family was able to develop problem-solving skill, and hold each other accountable for behavior. Family was also able to increase quality time together. Family members became more supportive of each other, and were able to change their interactions so that positive interactions were rewarded and negative behaviors were less necessary. –Report of a Completer family, including Father, 42, Son 13, Daughter, 12.
>
> 2. Clients report being able to use more appropriate coping mechanisms, expressions of anger, and the role of confidence. Mother reported awareness of her need to be a role model for appropriate emotional coping. However, mother reported still feeling depressed and scheduled

> many individual sessions that were not kept. –Report of a Continuer family, including Mom, 35, & Son, 11

One theme that emerged is in the category of process change. Completers were more likely to have a change in overall process, and specifically more likely to have a change in second order process than the continuers. In addition, completers never reported problems worsening upon therapy termination, while three families reported problems getting worse in the continuers group. These differences are found in the following excerpts:

> 1. Parents were able to establish solid boundaries surrounding their subsystem and work together to lead the family. They were also able to establish a flexible structure. Family stated that their goal is to continue to strengthen and solidify changes in their interactions. Mother reported fewer severe depressive symptoms, and less reactivity in her interactions. –Report of a Completer family, including Mom, 44, Dad, 47, and daughter, 8.

> 2. Couple was able to gain some trust in one another by recognizing the steps the other has taken to improve their relationship. However, the mother left the father again and took the children two days after the final family session. The father stated that he worries about his children, and fears that his children no longer feel safe and secure in the family.– Report of a Continuer family, including Dad, 42, Mom, 29, Son, 9 and Daughter, 7.

Overall, there were some differences between the completer and continuer group found in all forms as well as treatment. However, many of these findings were small and therefore difficult to discern complete divergences between the two groups. The differences between the two groups that do stand out includes range of income, fee per session, length of presenting problem, the involvement of alcohol in the problem, who was perceived to be able to attend sessions pre-treatment, referral of services, total number of therapists on the

case, type of sessions, Global Assessment of Functioning scores, and finally reason for termination.

Despite these differences, the finding that stands out the most is found in the treatment. Specifically, that the percentage of interventions used for both groups was very similar. This indicates that treatment was focused on making both second and first order changes for a family, with a more heavy focus on second order change for both groups. Upon analyzing the specific interventions used for the two groups, one of the largest differences between the two groups is a focus on family interactions in session. The completers received a variety of first and second order interventions that discussed or enacted interactions to focus on a family's process compared to the continuers. Another specific intervention that stands out between the two groups is joining; for both groups this intervention was used quite frequently however it was used more often for completers than continuers. Despite these difference, the analysis of interventions used reveals that questioning, reframing, normalizing and summarizing were some of the most frequently used interventions for both groups, and that most interventions were used in both groups.

In addition, another finding for all cases is the measurement of achievement in therapy. For both completers and continuers, treatment flowed well from presenting problem to therapy goals that are specific for each case. Next, interventions are linked to the presenting problem and goals, focusing again on personalized treatment. Finally, therapy success is determined by reflection upon achievement of therapy goals. Since both a numerical score and

a narrative description of the problem upon termination of therapy are provided, the researcher is provided with a way to compare a rank of achievement with a more targeted description of the family's success or shortcomings. In conclusion these results reflect both differences and similarities in resources brought to therapy between the two groups, similar and different treatment for a variety of problems, but most important this analysis displays personalized treatment for each case based on their needs.

# CHAPTER V

## *Discussion*

The results indicate that there are many similarities and differences between the completers and continuers; the differences include some demographic factors, length of presenting problem, perception of the seriousness of the problem, the type of sessions attended, specific interventions used, and the type and amount of change produced for each group. The similarities include some demographic factors, involvement of other institutions in the problem, the diagnosis of the mother majority of the time, the actual diagnosis, first order focused therapy goals, and the percentage of first versus second order interventions in treatment. An overall finding in this research is that in both groups there was some benefit reported, supporting the research that Family Therapy can treat a variety of family disorders and severity of disorders (Pinsof & Wynne, 2000; Sprenkle, 2003).

The similar demographic factors show that at this clinic, the ethnicities and religious preference of clients was similar in both groups meaning that the groups were similar in their backgrounds and beliefs. Also, since majority of clients in both groups were not involved with another institution this could indicate that the presenting problem for clients in both groups had similar levels of severity. In

addition, all of the families in the sample lived together so again treatment was focused on improving relationships in the home for both groups. However, the differences between the two groups are also important.

One difference shows that completers had more financial resources than continuers (median income for completers was $28,250 and continuers was $15, 333), which is supported in other research (Bischoff & Sprenkle, 1993). In addition, continuers reported more problems with substance abuse, and specifically more people in the family involved with substance abuse. This could be a coexisting problem to the presenting problem indicating a similar level of severity, showing that the problems were more severe for continuers, which again is similar to other findings in the literature (Gilbert et al, 1994). Likewise, clients in the continuers group were more likely to rate their perception of the problem as highly serious than the completers. Finally, the presenting problem was also reported to have been a problem for a longer duration for continuers than completers. These last two findings indicate that continuers could come to therapy feeling more worn out and less hopeful that the problem could change.

As for the type of change reported, therapy goals were most often stated in first order change terms for both groups. In addition, many of the interventions targeted first order shifts. For example, parent training, behavior modification, communication skill building and problem solving were all mentioned in goals and interventions for both groups, reflecting interventions found in Cognitive Behavioral Therapy (CBT) treatments (Nichols & Schwartz, 2004). However, no therapy goals and only one intervention was found that was linked to Haley and

Madanes' Strategic Family Therapy model (Nichols & Schwartz, 2004). This intervention was found in one continuer case that focused on creating a paradox for a family with a 16-year-old daughter who was not "getting along" with her mother. This shows that an overwhelming majority of the first order focused therapy goals and interventions were influenced by the CBT model.

As for second order change, this type of change was more diversely influenced by a variety of models in the therapy goals and treatment. For example, the idea of telling a family to "go slow", and predicting setbacks/relapse was found in both groups. These interventions are focused on creating a new way of seeing problems and achievement, and are influenced by the Mental Research Institute (MRI) model of Family Therapy (Nichols & Schwartz, 2004).

The Milan Model of Family Therapy influenced some of the most frequently used interventions and some therapy goals. Often, in therapy goals clients stated a desire to be closer to or connect with family members. Many interventions were also focused on ascribing positive motives to behavior (i.e. reframing) in order to foster family cohesion. Finally, circular questions were found frequently in both continuers and completers, indicating the therapist's push for a perspective shift as a way to create change.

One result that stands out is how both first and second order change were targeted in both therapy goals and interventions. Many of these goals and interventions seem to be influenced by Structural Family Therapy (SFT). Joining was used often in both groups as interventions; often the description of this intervention was of creating an alliance to prevent resisting change, or the

definition of joining in SFT (Nichols & Schwartz, 2004). Another SFT technique included processing and highlighting interactions, which was found much more often in the completers group than the continuers group. The greater emphasis on assessing interactions indicates a greater focus on achieving second order process change, which was the greatest difference in the type of change between the groups.

Reframing was also used frequently for both groups, and this intervention had an emphasis on shifting perspectives about the presenting problem or family member's intentions. Shifting boundaries was also used in both groups, but found more often in completers than continuers. This technique was described as a way to challenge unproductive assumptions. A final SFT intervention that was used was enactments. Enactments were described either as enactments, or as role play/skits. These enactments were used to process perspective of the presenting problem, family roles, and family rules. The overall analysis of SFT interventions used shows that the completers were more likely to use SFT interventions than continuers, indicating the most distinct difference in the type of treatment for the two groups. This difference demonstrates that focusing on interactions as well as joining clients in the process of therapy is important and can lead to more positive outcomes, which is similar to other research findings (Sprenkle, 1995).

The influence of other models on treatment was also found. For example, therapy goals and interventions were found that addressed the larger family and social context (the influence of the correctional system on a family, the influence

of school policy on a family, the influence of human services requirements on a family). The influence of the contextual dimension is similar to multitarget ecological and multimodal treatments. Therapists in this research did not directly try to change a family's context (no case management or arrangement of further services was mentioned), however therapists used the contextual dimension to look for patterns that are supported by beliefs in order to make changes in a variety of dimensions.

Success or achievement in each group was based on the type or manner of termination (Client request, Completion of therapy, or No shows/Cancellations). In addition, the therapist provided a numerical rating of success for each therapy goals (from one to five, with one being low and five being high) so success could be compared over the course of therapy. Finally, a narrative description of the problem at the beginning of therapy and at termination provided a depiction of the type of changes made, or lack thereof. All of these measures demonstrate the flow of treatment from the problem, to therapy goals that address the needs, to interventions that move clients towards these goals, and finally a description of change that measures specific goals as well as provides a description of the type of change. This evaluation of success is similar to other evaluations in the literature in which specific measures or outcomes were focused upon to evaluate success (Sexton & Alexander, 2002). However, this evaluation is also different in that a narrative is also provided giving additional and supplemental information about therapy outcomes.

Therapy success was also measured in this research by a clients Global Assessment of Functioning score (GAF). This score was given at session three (protocol at the therapy clinic), then session seven, every seventh session following, and finally at termination. This GAF score and continuous scoring provides a progression of change throughout therapy. Since many continuers had decreases in their GAF scores as therapy came to an end, this indicates that many clients begin to make changes but these changes are not sustained. The combination of evaluating specific target behavior measures and a global score provides information that was identified as a gap by Shadish et al. (1995).

Other findings in this study were similar to information found in process and effectiveness research. Specifically, therapeutic alliance was stated in research as the most consistent factor linked to outcomes for individual and family therapy (Sexton & Whiston, 1994). Therapeutic alliance was described in the literature as being important because this connects clients to the therapy process and begins to create positive statements and interactions (Bischoff & Sprenkle, 1993; Alexander & Sexton, 2002). In this study, joining was used frequently in both groups but more so in the completers than continuers. Also, many reframes and positive statements were found in both groups but more so in the completers group. These findings support the strong association between a therapeutic alliance with a client and a more positive therapy outcome.

Another process area that is linked to outcomes is family interaction and communication (Alexander & Sexton, 2002). Many therapy goals and interventions were focused on improving communication and having more

positive interactions within the family for both groups. Similar to the finding above, completers were treated with more interventions that focused on family interactions than continuers. This finding again supports the literature on the importance of addressing interactions and creating positive communication as a way to achieve a positive therapy outcome.

A final part of the process research linked to more successful outcomes is treatment adherence (Alexander & Sexton, 2002). Although a treatment manual is not protocol at the therapy clinic, treatment was found to be based upon empirically supported interventions and therapy models. As described above, most of the interventions and the intent of the interventions were linked to a variety of family therapy models. In addition, therapy was found to flow from the presenting problem, therapy goals, interventions, and finally termination indicating that treatment follows an order that can be somewhat replicated.

The number of sessions attended is one area disputed in the literature. While Shadish et al (2000) found that an increased dose of therapy is typically associated with better outcomes, this is a very different philosophy compared to the Milan group's approach to treatment. This group found success in fewer sessions, in fact stating that a briefer approach empowers families to become accountable for their own successes. In this study, completers attended an average of more sessions (approximately one and a half more sessions) however this difference was not significantly large. Since no follow-up information is available, the researchers are not able to discern if more sessions could have been more helpful for either group. This finding does add evidence to

the Milan philosophy of provoking change rapidly since neither group attended an average of many sessions.

The number of interventions used for each case is also linked to a Milan influenced approach to treatment. In this study, the average number of interventions per session used in each case for both groups was four. However, this number does not indicate how many *times* one of the four interventions was used per session, so the activity level of the therapist is unclear. Instead, this finding supports that the most important aspect of interventions is the type of change targeted and dimension targeted (process, perspective, and context). Specifically, completers were more likely to have second order process and perspective level interventions than continuers indicting the importance of changing a family's structure and interactions on a second order level. This supports Milan goal of "provok(ing) illuminating feedbacks" (Palazzoli et al., 1970, p. 48).

Looking at the findings of this study, many General Systems Theory (GST) concepts stand out. Firstly, holism (the whole is greater than the sum of its parts) is found in the specific interventions that were designed for individual family members but were able to lead to a change in the whole family system. For example, drawing or art projects were used often for the children and adolescents in treatment however these interventions were designed to help the family accomplish their goals. The two concepts from GST that stand out the most when analyzing these findings are equifinality and multifinality. One example of multifinality is the two groups had very similar percentages of first and

second order interventions and yet the outcome being different for each group. Also, since the clients within each group brought a variety of resources, perceptions and patterns to therapy and had similar results equifinality is also evident. These concepts from GST help to explain the differences and similarities in the therapy outcomes for both groups.

An additional way to see the differences between the two groups is by looking at them using the OSU model. The model allows for each domain to impact and influence the first and second order changes in each group. For the process domain, this domain was where both groups made the most changes. This finding indicates that these changes target altering feedback loops to be positive, or change the family's organizational pattern. Both groups made more first order process level changes than second order, however, completers made more process changes in both levels than the continuers. The difference between first and second order process level changes indicates that some clients had begun to do some things differently, and some (more likely completers) had truly changed roles and tasks, creating a second order process level change. The overall process level finding demonstrates a key and distinct part of family therapy compared to psychological and/or individual model treatments.

The perspective domain again shows a Milan influence in treatment that promotes thinking or perceiving things differently. Often, therapy targeted creating new beliefs or views about a family member's intentions to reinforce new patterns (a second order change). Second order perspective level changes were more frequent than first order in both groups, demonstrating that creating new

perception patterns was targeted similarly for all clients. Since both groups were targeted equally, a difference between the two groups is unclear.

Finally, contextual changes took place when a client reached out and accessed another resource (i.e. school, extended family members, the justice system). First order contextual changes were much more frequent than second order for both groups (i.e. they shifted schedules and were able to spend more time with members; child was able to turn in more school work), with only one second order contextual change overall (completer was able to collaborate and share information with son's teacher, leading to better attendance and grades). These changes were more frequent in the continuer group so two hypotheses emerge. First, continuers had a greater need to access help in larger contexts, or secondly that changes in just one dimension of the OSU model does not lead to therapy success. Also, since the changes were mostly firsts order a lasting psychological (perspective) change did not take place, lessening the impact of these changes. For example, one completer case was able to talk to her son's teacher about his family problems and so her son's problems at school were fewer. However, the mother did not report feeling any more supported with this change.

In conclusion, the overlap of dimensions in the OSU model shows that a change in one dimension or concept can have positive effects. However, a change in many dimensions can lead to more positive outcomes. This finding overlaps with the GST concepts of holism and positive feedback loops,

demonstrating that a change in one can lead to a change in many and thus become self-reinforcing.

*Limitations*

The overall limitation of this study is generalizability from this small clinical population to other clients in therapy clinics. This limitation is further supported since the sample was very small (only 20 families) and since all no families were excluded from the sample. However, this study does provide some insight and understanding of families who come to therapy with a variety of presenting problems and the type of treatment they receive at a training therapy clinic. This could provide some clues for beginning therapists when they are designing interventions so as to individualize treatment to increase effectiveness.

Another limitation of this study is the lack of follow up information to assess outcomes. Since therapy outcome was based upon information provided in the last session attended, this research is unable to provide any clues about if the changes were or were not maintained, or any additional improvements. Therefore, information about a drop off effect is not available so as to compare with the reviewed literature on effectiveness and drop off after treatment.

A final limitation is the perspective by which this information is described. The treating therapist(s) completed three of the four documents examined, with only the Background form providing the client's perspectives of the problem and desired treatment. In addition, since the therapists in this study are novice therapists many of these therapists could not be able to accurately assess interventions (an evaluation of self) and outcomes (assessment of client's

achievement). With only the therapists' perspective of a treatment and outcome, a complete description of effectiveness is unclear.

*Implications*

Although additional research needs to be conducted, these findings support Marriage and Family Therapy theories and overall philosophy of creating different types and dimensions of change in order to achieve goals. First, this research revealed that making both first and second order changes can lead to overall therapy success. Also, that focusing on achieving process and perspective level changes is important in order to complete therapy goals. Therefore, beginning (and any practicing) therapist should be reminded of the importance of not just linking services but also creating new patterns and beliefs for clients as the most effective way to achieve success.

This study also found that focusing on creating a therapeutic relationship and processing family interactions leads to the most successful outcomes. Neither of these findings are new, instead they further support the literature and point out that a therapist needs to find ways to create a therapeutic connection with clients as a way to promote connection between family members. In addition, this research points out how important assessing, processing, modeling, and prescribing interactions is to achieving second order change, in both the process and perspective dimension. This finding not only supports GST and the OSU model of treatment, but also the whole philosophy of marriage and family therapy.

Once again, treating a whole family is a unique opportunity that sets apart MFT from other professions. The focus upon interactions in therapy goals, interventions and outcomes not only makes the MFT discipline distinct, but also was found to be one of the most defining characteristics between those families who did and did not achieve their goals. Perhaps this finding will add energy to therapists even when clients present with serious problems.

In the future, follow up research with both groups could provide supplemental information about how a particular goal or interventions moved them toward their desired goals. A focus on rich descriptions about how the change took place and what each person was thinking, feeling and doing in order to create this change could add details to this data. In particular, spotlighting on client's perceptions about the quality of the therapeutic relationship, focus on family interactions, and how this contributed to achievement of therapy goals. This information can widen the therapists' perspective about how change takes place for a client and how to foster this type of a therapy environment.

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# APPENDIX A

# INTAKE FORM

## CFS TELEPHONE INTAKE

Intake Person _____ Date _____

Time _____

_____ _____

Name Telephone Number(s)

_____ _____

Street City, State Zip Best time to contact in 24 hrs.

_____

Who made the call?

Presenting problem?

| |
|---|
| |

Who is in the family? (2-3 generations 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 attending the session?

Days and Times available for sessions:

Is anyone in the family on any kind of medication? If yes, who and what?

How do you hear about us? Who referred you?
_____ Telephone Book
_____ Referred by _____
_____ Received services before
_____ Other (explain below)

Any financial considerations?
____ No
____ Yes (Explain below)

Yearly income before taxes _____
Fee _____
Therapist assigned
_____
Date _____
Case # _____

Additional Information

# APPENDIX B

# BACKGROUND FORM

**Family ID#:_____**
**Family Member_____**
**Today's Date_____**

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

Background Form
(This information will be part of your confidential file and will be available to staff for 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 0 1 2 3 4 5
(Circle One)
Are you a military veteran: Yes No Years of Service _____ to _____
(Circle One)

For immediate family members, please list name, gender, age, relationship to you, and current residence (same as you or different).

| Name | Gender | Age | Relationship | Residence |
|---|---|---|---|---|
| _____ | M F | _____ | _____ | Same Different _____ |
| _____ | M F | _____ | _____ | Same Different _____ |
| _____ | M F | _____ | _____ | Same Different _____ |
| _____ | M F | _____ | _____ | Same Different _____ |

For relatives from the family in which you grew up, please list name, gender, age, relationship, current residence, and marital status of all those who are still living

| Name | Gender | Age | Relationship | Residence | Marital Status |
|---|---|---|---|---|---|
| _____ | M F | _____ | _____ | Same Different | _____ |
| _____ | M F | _____ | _____ | Same Different | _____ |
| _____ | M F | _____ | _____ | Same Different | _____ |

Please list any deceased family members below:

| Name | Relationship | Age at death | Date at death | Cause of death |
|---|---|---|---|---|

Family Physician: Name _____

Address _____

Circle your present state of health:

Excellent Good Fair Poor

Please check if you have experienced the following during the past six months:

__ Severe headaches __ Seizures

__ Severe backaches __ Frequent tiredness

__ Stomach problems __ Trouble sleeping

__ Large amounts of weight gain or loss __ Unexplained worry

Has any of your family members experienced any of the before mentioned symptoms in the last six months? _____ If yes, explain.

Have you ever had a serious medical condition ____ If yes, explain.

Have your children or spouse ever had a serious medical condition ____ If yes, explain.

List all medications or drugs taken within the last six months, both prescription and non prescription:

Do you smoke? _____ If yes, how much?

Do you smoke too much?

Do you drink? _____ If yes, how much?

Do you drink too much?

Do you think another family member smokes or drinks too much? ____ If yes, please explain.

Have you ever attempted suicide? If yes, explain.

Has anyone in your family ever attempted suicide? If yes, explain.

Are you currently receiving services from another therapist? If yes, whom and for what?

Please describe in your own words the major reason for seeking services at this time.

How serious would you say the problem is right now?

Not at all serious Slightly serious Moderately serious Very serious

How likely do you think the problem is to change?

Not at all likely Slightly likely Moderately likely Very likely

What do you hope to gain from out services?

Who referred you to our services?

# APPENDIX C

# SESSION SUMMARY FORM

Case # **Session Summary** Date

Therapist(s) Session #

**Pre-Session:**

Therapy Goals:

| TG1. |
|---|

Session Goals:

| SG1. |
|---|

**OSU Model**

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

Hypotheses:

| H1. |
|---|

Interactional Cycle:

| |
|---|

Issues of Concern:

| Significant: | Minimal |
|---|---|
| C1. | 1 2 3 4 5 |

Homework from Prior Session:

| |
|---|

**Post Session:**

Clients present:

| Homework: | Completed | Not Completed |
|---|---|---|
| | | |

Break Question/Activity:

| |
|---|

Summary of Session Content:

| |
|---|

| Supervisor Messages: Break | Phone |
|---|---|
| | |

Interventions Used

| |
|---|

| Progress towards Session Goals | Minimal | Significant | Met (Y/N) |
|---|---|---|---|
| SG1. | 1 2 3 4 5 | | |

Homework Given:

| |
|---|

| Progress towards Therapy Goals | Minimal | Significant | Met (Y/N) |
|---|---|---|---|
| TG1. | 1 2 3 4 5 | | |

New Information from Session:

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

Change to Hypotheses

| |
|---|

Next appointment: Date: Time:

Therapist Signature _____ Supervisor/Date: _____

# APPENDIX D

# DIAGNOSIS AND TREATMENT PLAN FORM

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 Condition:*

*Axis IV: Psychosocial and Environmental Problems:*
___ Problems with primary support group
___ Problems related to social environment
___ Educational problems
___ Occupational problems
___ Economic problems
___ Housing problems
___ Problems with access to health care
___ Problems related to interaction with legal/crime system
___ Other psychosocial and environmental problems

Axis IV: Global Assessment of Functioning GAF = GARF =

Proposed Treatment:

| |
|---|
| |

_____
Therapist

_____ _____ _____
Therapist Supervisor Date

# APPENDIX E

# TERMINATION REPORT FORM

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

**Termination Report**

Date of Intake: _____ Date of First Session: _____

Date of Last Session: _____

Number of Sessions: _____ 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

_____ 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 beginning and closure of therapy on back of this report.

# APPENDIX F

# INSTRUMENTS

*List and total of goals, interventions, and termination data for both groups*

*Completers*

Therapy goals – First order change focused
Total:
Therapy goals – Second order
Total:
Interventions – First order
Total:
Interventions – Second order
Total:
Termination data – First order
Total:
Termination data – Second order
Total:

*Continuers*

Therapy goals – Firstorder change focused
Total:
Therapy goals – Second order
Total:
Interventions – First order
Total:
Interventions – Second order
Total:
Termination data – First order
Total:
Termination data – Second order
Total:

*List of individual interventions used in each group*

*Completers*

Individual interventions – First order

Individual interventions – Second order

*Continuers*

Individual interventions – First order

Individual interventions – Second order

*List of Termination report types of changes made for both group*

*Completers*

First order process change
Total:
Second order process change
Total:
First order perspective change
Total:
Second order perspective change
Total:
First order context change
Total:
Second order context change
Total:

*Continuers*

First order process change
Total:
Second order process change
Total:
First order perspective change
Total:
Second order perspective change
Total:
First order context change
Total:
Second order context change
Total:

Caroline Smitherman Kyger

Candidate for the Degree of

Master of Science

Thesis: DESCRIPTIONS OF TREATMENT AND OUTCOMES BETWEEN TWO GROUPS OF FAMILY THERAPY CLIENTS

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Name: Caroline S. Kyger Date of Degree: May, 2005

Institution: Oklahoma State University Location: Stillwater, Oklahoma

Title of study: DESCRIPTIONS OF TREATMENT AND OUTCOMES BETWEEN TWO GROUPS OF FAMILY THERAPY CLIENTS

Pages in study: 108 Candidate for the Degree of Master of Science

Major Field: Human Development and Family Science

Scope and Method of Study: This exploratory and descriptive study examines the differences between two groups of family therapy clients: those who terminated after completing therapy goals (completers), and those who terminated therapy after three sessions but did not complete therapy goals (continuers). A main focus of this research was type of change targeted, first order change versus second order change.

Findings and Conclusions: The researcher examined and compared therapy goals, interventions, diagnosis information, a numerical rating of each therapy goal and a text description of therapy achievement. This study found that for both groups, most therapy goals were specific to each case and first order change focused. Overall interventions used were mostly second order for both groups, with similar percentages of first versus second order interventions between groups. The differences included financial resources (more for completers), and the specific interventions used (interventions for completers targeted the family's interactions and therapeutic relationship). These findings support the research that stresses joining and focusing on process throughout treatment.