CONSTRUCTING A SUCCESSFUL THERAPEUTIC EXPERIENCE WITH ADOLESCENT CLIENTS: A QUALITATIVE STUDY OF ADOLESCENT EXPERIENCES IN FAMILY THERAPY

by

Kevin Dee Broderick

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APPROVED:

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E.E. McCollum, Chair

_____ _____

K.H. Rosen S.M. Stith

_____

J.U. Coleman

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Kevin Dee Broderick

Committee Chair: Eric McCollum

Marriage and Family Therapy

(ABSTRACT)

Traditionally, therapists and researchers have not asked adolescents about their family therapy experience. This qualitative study was designed to solicit in-depth feedback from adolescents who have recently participated in family therapy to broaden our understanding of their experiences in counseling. Interviews were conducted with 10 adolescents, between the ages of 14 and 20, to discover what helps teenagers have a successful family therapy experience. From the interviews, five main categories emerged; (1) client/therapist relationship, (2) talking and being heard in both individual and family sessions, (3) gaining insight during therapy, (4) taking personal responsibility for making therapy work, and (5) seeing positive results. Feedback from the adolescents is used to suggest ways family therapists

might enhance their effectiveness with adolescent clients and a model for treatment success is presented.

CHAPTER ONE - INTRODUCTION

CONSTRUCTING A SUCCESSFUL THERAPEUTIC EXPERIENCE WITH ADOLESCENT CLIENTS: A QUALITATIVE STUDY OF ADOLESCENT EXPERIENCES IN FAMILY THERAPY

As an undergraduate, I thought I wanted to be a high school teacher. I took a course where I learned some basic teaching skills and then I was given the opportunity to teach a class of high school freshmen for a one week period. I'm still recovering from that experience. I found it extremely challenging to effectively communicate with the youth. Some were disruptive, some were sleeping, some would give "smart" answers, and others would give no answer. Gladly, there were a few who respectfully listened and learned --I think I survived the experience because of them.

After my "baptism by fire" experience, each class member was given the opportunity to anonymously evaluate their student teacher. Suddenly, prior communication barriers were cleared and the students evaluated my performance with direct and clear honesty. Similar to my brief student teaching experience, I have encountered both difficult and cooperative adolescents in family therapy. As a student therapist, I have had the opportunity to meet with only a few families with teenagers. With some adolescents, I felt

more like a student dentist. Soliciting useful information from these clients seemed comparable to pulling teeth. But again with others, I felt their trust and I enjoyed their willingness to grow.

As a student teacher I learned from my students what they thought I did well and what they thought I needed to improve. The feedback was useful. I learned about some of their concerns and insights that would enable me to more effectively instruct a class of high school freshmen.

Student feedback helps an instructor to mold, change, or amplify his or her skills to increase effectiveness in teaching. Client feedback has the potential of increasing the effectiveness of Mental Health services as well.

RATIONALE OF THE STUDY

Historically, researchers and writers have documented the therapeutic experience based upon the counselor's, rather than the client's perspective (Garfield, 1978; Gurman, 1977; Kantor & Andreozzi, 1985; Kruger, 1985). More recently, investigators have sought in-depth, client-based experiences in counseling to augment our understanding of "consumer" opinions concerning therapy (Kuehl, Newfield, & Joanning, 1990; Kuehl, 1986; Mabrey, 1995; Metcalf & Thomas, 1994;

Metcalf, Thomas, Miller, Hubble, & Duncan, in press; Newfield, Kuehl, Joanning, & Quinn, 1990; Quinn, 1996; Sells, Smith & Moon, 1996; Stith, Rosen, McCollum, Coleman, & Herman, 1996; Swint, 1995).

Post-modern therapists assume that social reality is coconstructed and so the clients' experiences play a significant role in research and therapy.

> Since clients influence the course of treatment and the overall value of family therapy, it is essential to explore what it is that they believe is occurring in treatment and what they perceive themselves to be learning or changing that improves their lives (Quinn, 1996, p. 91).

Thus, in the midst of unveiling the client's experiences in therapy, researchers are discovering that consumer views give counselors invaluable feedback (Mabrey, 1995). Though adult client voices are emerging through qualitative inquiries, few researchers have taken the time to ask adolescents what they think about their family therapy experience.

Why Adolescents?

My wife and I have three young children ages five and under. Taking care of their physical and emotional needs is challenging and at times it seems overwhelming.

Despite our concerns, the most common words of sympathy echoed from more experienced parents around us are, "You think it's hard now, just wait until they're teenagers."

Lussardi and Miller (1992) documented a few reasons why teenagers have such a reputation among some parents:

> Adolescence is a time of great change for both the adolescent and his or her family. It can be a stage filled with confusion and ambiguity regarding what behaviors are appropriate and/or acceptable. Former rules and expectations are questioned when both new behaviors and new ideas are introduced into the family system and the parents and the adolescent begin to adjust to these changes (p. 227).

As adolescents and their parents adjust to their new roles, disruptive family interactions are likely to arise. Preto (1989), noted that family therapy referrals are prone to peak with families who have adolescent children in the home. According to Preto (1989), parents who do seek therapy for their adolescents tend to feel, "confused, angry, and out of control, and present problems that reflect the family's inability to deal with the tasks of adolescence" (p. 271).

Teenagers find themselves in a challenging and crucial stage of life. They are in the midst of a developmental sprint that is bound to create friction, and possible casualties, along their cognitive, sexual, physical, and social developmental courses. In their quest for autonomy, adolescents tend to test their own ideas and values against those of their families. "Teenagers may reject parental values,...may test limits,...and often feel the need to make independent decisions despite poor judgment and impulsivity" (Rubenstein, 1991, p. 221).

With the developmental stressors that adolescents experience, it seems fair to assume that they can be a challenging population to work with in the context of family therapy. Treadway (1989), an experienced adolescent substance abuse and family counselor, confessed his anxiety in working with adolescent participants in family therapy,

> For me the hardest part of working with adolescents is that, when it comes to a confrontation over control, many kids are willing to die in order to win. Adolescents are able to intimidate adults because they will go to such extremes in order to resist being controlled. Kids always have the power

> to hurt themselves.... Parents do not really have much power, and neither do therapists. Work with out-of-control adolescents can feel like driving a huge tractor trailer that has lost its brakes and is careening down the mountainside. You can't stop the truck. Somehow you have to either run into a snow bank or steer it all the way down to safety. It's really a matter of hanging on for dear life (pp. 135-136).

Engaging adolescents in family therapy and establishing a collaborative relationship with them can be an extremely challenging endeavor. Selekman (1993), a noted expert who works with teenagers and their families, has found that some difficult adolescents exert their power to the point of refusing to participate in any type of family therapy all together. Those adolescents "...are 'window-shoppers' for therapy and will refuse to attend one session with their parents" (Selekman, 1993, p. 161).

As adolescent voices emerge in family therapy research, we may begin to gain a better understanding of their experiences in therapy which can help us mold a more client-based approach to increase our effectiveness in working with the adolescent population. In the

limited qualitative research that has been conducted concerning teenager's experiences in family therapy, we have learned little about what they believe therapists can do to improve the process of family counseling for adolescents.

PURPOSE OF THE STUDY

The purpose of this study was to solicit feedback from adolescents who have recently completed family therapy, or who are currently participating in family therapy in non-academic, private practice settings. This study was designed to learn from the consumer's viewpoint and experiences so that practitioners can better understand how to more effectively provide services to adolescents in family counseling.

The findings of this study cover ground that was initially investigated by Kuehl, et al. (1990), and Newfield, et al. (1990). These researchers interviewed adolescents and their families about their participation in family therapy in a training and research setting. All families in their study, "...presented for therapy with the problem of adolescent drug abuse" (Kuehl, et al., 1990, p. 311).

The present study extends the work of Kuehl et al. (1990) and Newfield et al. (1990), by interviewing adolescents who, (a) participated in family therapy with

practitioners who were not in training, (b) experienced family therapy in a non-training environment (i.e. without cameras, one-way-mirrors, etc.), and (c) came to therapy with a variety of presenting problems. Thus, this qualitative study serves to deepen the insights and understanding of how teenagers experience the process of family therapy.

RESEARCH QUESTION

Congruent with the purpose of this study, the principal research question that guided this inquiry was, "What helps adolescents to have a successful family therapy experience?" I was interested in discovering what therapists can do to increase the likelihood of providing a successful therapy experience to their adolescent clients according to the consumer's perspective.

THEORETICAL FRAMEWORK

This multiple case qualitative study was conducted by looking through the lens of a post-modern, constructivist framework. According to post-modern, constructivist reasoning, individuals produce their own realities by assigning subjective meanings to events, experiences, and interactions they encounter within their social context. In therapy, the therapist, client(s), supervisor(s) and/or collaborating

colleagues, are all involved in a complex interaction of unique meaning systems (Newfield, et al., 1990).

Throughout the process of the complex therapeutic interaction, all involved subsystems co-create a therapeutic approach for change (Newfield, et al., 1990). Based in this paradigm, many marriage and family counselors are taking a more collaborative approach to therapy where ideas and insights from clients and therapists come together to mold outcome (Duncan, Solovey, & Rusk, 1992). Typically, however, the client members of the therapeutic system have not been asked to provide in-depth feedback concerning their experience of therapy, and so their unique construct of the therapeutic experience has not been heard and essential participants in the therapeutic system have been silent (Conran & Love, 1993).

The feedback from the client subsystem to the therapeutic system concerning the process of therapy is fundamental and necessary to effectively manage a client-based, collaborative, therapeutic approach. Hearing client voices evokes, "...a sense of collaborative relationship between therapists and clients in which both are understood as fully involved participants in therapy process and outcome" (Conran & Love, 1993, p. 15). Thus, a qualitative investigation

into the client's experience and perceptions of therapy, provokes readers to think differently about theory and the way a therapist typically conceives and implements, interventions (See Conran & Love, 1993; Newfield, et al., 1990).

SUMMARY

Teachers solicit and receive feedback from their students in order to refine teacher/student interactions and to improve the process of class instruction. As teachers learn from their students, therapists can learn from their clients. Traditionally, the therapeutic consumers have been silent concerning the process of therapy. With the post-modern/constructivist movement toward a more collaborative approach to therapy, the feedback from the client subsystem has become essential. This study builds on qualitative inquiries of other researchers and provides practitioners a new look at what works for adolescents in therapy. It also offers suggestions from therapeutic consumers for treating teenagers in family therapy.

CHAPTER TWO - LITERATURE REVIEW

The professional field of Marriage and Family Therapy (MFT) is quite young compared to other social science disciplines and thus the research base of MFT needs to be strengthened. Recognizing this deficiency, researchers have focused some attention to analyzing the role and success of marriage and family therapists in providing mental health services to a broad range of problems. Below is a brief review of some recent empirical outcome research that provides valuable insight into the general effectiveness of trained marriage and family therapists. Also, as an MFT student and aspiring professional I am interested in discovering the process of what happens in therapy that leads to positive outcomes. For that purpose I have sought a deeper understanding of the successful process of therapy from the consumers perspective, to enrich my knowledge of what can be done to positively influence outcome and client's experiences in therapy. Thus, several qualitative studies of client experiences are also reviewed and useful client feedback is summarized.

MFT OUTCOME RESEARCH

To date, the most extensive and thorough meta-analysis of MFT outcome research was recorded by Shadish, Montgomery, Wilson, Wilson, Bright, and Okwumabua, (1993). Based on the 1993 analysis of 163 published and unpublished studies of marital and family therapy, Shadish, Ragsdale, Glasser, and Montgomery, (1995) decisively concluded that "marital and family therapy works" and that "the literature supporting this conclusion is at least as strong as it is for other forms of psychotherapy" (1995, P. 345).

A special October 1995 edition of the Journal of Marital and Family Therapy (JMFT) compiled the most up-to-date information on the efficacy of marriage and family therapy. In that special edition, several steps were taken to ensure the accuracy of the reports and the editor's suspected that the positive outcome results may have erred on the side of conservatism (Sprenkle & Bailey, 1995).

Guest Editors, Pinsof and Wynne (1995), thoroughly reviewed the research in that special edition and concluded:

> There is a convincing body of scientific evidence supporting the efficacy of MFT. There is also a growing body of evidence to support the superiority of MFT in the treatment of various adult, adolescent, and child disorders. MFT in its purest, standard format appears to be more effective for moderately severe disorders and problems, particularly when these disorders involve relational moderating variables like marital or family distress. MFT appears to be applicable to very severe disorders when it is combined with other biological, psychological, and social intervention components. Involving families seems to potentiate most other intervention components for most disorders. Additionally, MFT appears to have few if any negative effects (p. 610).

There are other studies that seem to authenticate the conclusions of the research found in the October JMFT special report. The results of a nation wide survey, for example, were recently published over the

inter-net by Dr. Ronald Jay Werner-Wilson (1996), Assistant Professor and Marriage and Family Therapy Program Clinic Director at Colorado State University. Surveys were administered to marriage and family therapists and their clients to inquire about treatment outcomes and client satisfaction with treatment. It was learned that 83.10% of clients surveyed felt as if their therapy goals were achieved, 91.90% reported that their emotional health was improved, and 89.40% documented that their partner relationships had improved.

Notably, the positive reported outcomes influenced clients' satisfaction with therapy and their therapists. Over 90% of those surveyed reported feeling satisfied with their marriage and family therapy experience and over 96% would return to the same therapist in the future.

Outcome research concerning adolescents in family therapy indicates that family therapy is generally helpful for troubled teenagers. In a thorough review of the literature on family therapy with adolescents, Breunlin, Breunlin, Kearns, and Russell (1988) concluded,

> In the 1979 article, we took the position that family therapy offered "new and exciting directions" for the treatment of adolescent disturbances. We still think this is true. Family therapy in its various forms, has proven to be a well established approach to the treatment of adolescent problems (p. 328).

As the research mounts, it is becoming more and more evident that professionally trained marriage and family therapists are doing productive work in strengthening marriages, families, and individuals.

Outcome research provides useful results but it does not reveal the in-depth process of what works and what doesn't work in therapy. Moon, Dillon, and Sprenkle (1990), wrote, "Qualitative methods provide contextual data that can enrich the interpretation of quantitative outcome studies" (p. 356).

A QUALITATIVE REVIEW OF CLIENT EXPERIENCES IN THERAPY

Early pioneers of MFT did not base their theories and work on a mass of empirical evidence, rather they developed their work through more qualitative measures

of analysis. Batson, Haley, Minuchin, Bowen, Watzlawick, and others generated insights through interviews and close observation of families. Their methods were rarely systemic and largely undocumented (See Atkinson, Heath, & Chenail, 1991). Of late, several researchers have continued a more qualitative method of research by asking the consumers of therapy, through ethnographic interviews, to describe their counseling experience. The client's candid responses have added depth to my investigation of what works in therapy. The following is a review of helpful information for counselors provided by clients in regard to client/therapist relationship, interactions that help to produce change, the influence of the therapeutic environment, and other beneficial feed back. These topics were chosen because they were topics of emphasis in several of the ethnographic studies concerning client's experiences in family therapy that I reviewed.

Client/Therapist Relationship

Throughout my review of the literature, it became evident that the client/therapist relationship was noted by the consumers of therapy as an essential component to

a successful counseling experience. A foundation of trust appears to set the stage for progress. Kuehl et al. (1990) concluded, after interviewing 12 families who participated in family therapy, that clients who viewed their counselor as caring, personable, and competent were likely to be satisfied with their therapeutic experience. Mabrey (1995) interviewed couples and families who reported having positive experiences in therapy. She found that most of the participants interviewed described having a comfortable relationship with their therapist and felt as if there was an "open door" to return should the need arise (Mabrey, 1995). Swint (1995) interviewed six individuals and three families and found that most of those she interviewed reported feeling comfortable with their therapist. Parents and young children who participated in family therapy also assigned a similar importance to the therapist/client relationship,

> A final, consistent theme throughout the interviews with parents, and echoed by some of the children, was that the personality and behavior of the therapist is an essential

> ingredient in therapy. A number of parents, when asked what they thought their child liked about coming to the clinic, first mentioned qualities of the therapist (Stith, et al., 1996, p. 80).

So what is it about therapists that facilitates a trusting relationship with their clients? According to the consumers that Swint (1995) interviewed, it was because the therapist was friendly. Five out of nine informants described talking with their therapist as "talking with a friend". "Well, it would be like talking with a friend. Someone who knew you even though you didn't socialize with them outside. You felt like they were a friend" (Swint, 1995, p. 4). Other reported counselor attributes that help clients to build trust and rapport with their therapist include, displaying a noncondescending attitude, being nonjudgmental, showing interest and concern, being sincere and genuine, maintaining a relaxed, casual, and informal presence, having a sense of humor, being playful, enthusiastic, and patient, and being a loving person who shows warmth and empathy (Quinn, 1996; Sells, et al., 1996; Stith et

al., 1996; Swint, 1995). One respondent suggested, "I think if I were a therapist, and I wanted to know a tip, they're gonna have to love these people....If there's not love in their heart, they won't get anywhere" (Quinn, 1996, p. 78). When clients perceived that their therapist exhibited the above attributes, they felt more at ease or comfortable about the counseling process (Sells, et al., 1996).

What can counselors do that will help them to build a trusting, comfortable relationship with their clients? According to the Kuehl et al. (1990), therapists need to ask questions and give suggestions that show that he or she really understands what his or her clients are truly thinking and feeling. When therapists are able to do so, they are viewed as not just, "doing their job" but that they really care about those they are serving (Kuehl et al., 1990). Other clients reported feeling more comfortable with their therapist once they shared some personal information about their own life, "...just little brief thing, little something that will draw me into her life a little bit" (Quinn, 1996, p. 77). One respondent reported feeling comfortable with the

therapist because he or she listened without being opinionated and without cutting the client off in the middle of a sentence (Quinn, 1996). For parents and young children, Stith et al. (1996) found that including young children in therapy, instead of making them stay in the waiting room, and communicating with them through their own media--activity and play, helped them to better join with the therapist.

When clients reported feeling more comfortable with their therapist, they considered themselves more likely to follow the suggestions they offered (Kuehl et al., 1990; Swint, 1995).

Therapist's Suggestions Help Produce Change

Therapists have the option of being directive in the therapeutic process by giving specific assignments, or to be non-directive by not giving any explicit counsel or simply offering suggestions. Certainly, many therapists use some combination of the three approaches. A few clients have reported that a directive approach is useful. In Mabrey's (1995) interviews with couples and families that participated in Strategic Therapy, she found that the clients appreciated the directives of

their therapist. "We got advice. And it really made a difference having us rebuild our relationship together. There were actual tasks to do which were very, very helpful" (Mabrey, 1995, p. 10). Sells, et al. (1996), discovered that the clients they interviewed perceived the homework tasks as useful and helpful. Six out of 14 client systems (i.e. individuals, couples, or families) interviewed recommended that counselors offer concrete and specific advice in solving a particular problem (Sells et al., 1996).

Others have reported that a therapist's suggestions are more helpful than specific assignments. Kuehl et al. (1990) found that "...most of the informants preferred a therapist who they perceived was offering 'suggestions' and 'alternatives' rather than 'trying to tell us what to do'" (Kuehl et al., 1990, p. 315). In Swint's interviews, she discovered that all the clients perceived his or her therapist as making nondirective suggestions by using words such as "might", "may", and "maybe". Six out of thirteen of those interviewed directly attributed change to utilizing suggestions (Swint, 1995).

Newfield et al. (1990), interviewed a mother of a troubled adolescent who expressed her frustration with a therapist who did not offer suggestions;

> What we found was people as yourself to field the questions and throw them right back at us, and possibly put a new wrinkle to them and make us think about it and not have ever given us any kind of an answer. This was a cop-out for us because we were at our wits end as far as frustration and as far as what we thought we should or should not, or could or could not do, and we were frightened of whatever the future may be (Newfield et al., 1990, pp. 65-66).

In another study, one angry husband reported,

> I've talked with a lot of counselors, and they always come up with this thing in a soft voice and it's like, "Well, what's been going on with your life?" and "How do you feel?" It's bullshit. I want some one to come straight to the point and give me their impressions of what to do. I don't want to be talked down to

like I am a kid. I'm a professional, so talk to me like one (Sells et al., 1996, p. 334).

Contrary to the frustrations of the above respondents, the client/informants in Quinn's (1996) study rarely emphasized advice giving or instruction in their accounts of significant treatment events. Another mother in the Newfield et al. (1990) study reported that it was helpful to have a counselor who did not offer suggestions but who asked just the right thing that made "...the light bulb go off" (Newfield et al., 1990, p. 66).

Knowing that some clients appreciate suggestions and directives where others don't, how is a therapist to know how to approach each situation? Quinn (1996) suggested, "If what clients believe should be going on in treatment is in fact happening, then they believe it to be useful" (Quinn, 1996 p. 87). Similarly, Newfield, et al. (1990) suggested that when a client's expectations of therapy do not mesh with the therapist's, their differences in opinion may be a characteristic of unsuccessful results in therapy. Perhaps then in our collaborative efforts with clients,

we should inquire about their expectations of therapy early on and continue to do so throughout the therapeutic process.

Insight and Self-Understanding Help Produce Change

Though Haley (1963, 1990), the father of Strategic Therapy, rejects the assumption that insight and self-understanding are primary factors in producing change, Mabrey (1995), found that insight and self-awareness were valued by consumers of Strategic Therapy. One wife reported, for example, "It helped us to learn some of the reasons why we fight, and sometimes we would get in some of the same arguments like over and over; like we would push each other's buttons" (Mabrey, 1995, p. 11). Sells, Smith and Moon (1996), found that several of the consumers they interviewed reported that insights into the reasons for the presenting problem improved the outcome of treatment. One of Quinn's (1996) respondents stated,

> I can't say exactly what it was or how it happened but I do feel like I've been able to see things from (spouse's) point of view a

> little more than before. I mean (the therapist) didn't interject a whole lot but I was able to see things from a different perspective (Quinn, 1996, p. 80).

What can therapists do to help clients increase their insights and change their perspectives? Clients have reported that asking questions that really make them stop and think helped them to see things differently (Swint, 1995; Quinn, 1996). Another client reported that it helped her when the therapist gave her three ways to look at things differently, like multiple choice (Quinn, 1996).

The Therapeutic Setting

Newfield et al. (1990), interviewed twelve families who had participated in family therapy at a university based clinic. According to the respondents, the therapeutic environment affected their counseling experience. The team, for example, was viewed as a panel of expert consultants, a jury, a group of learning students, and teachers grading the counselor. When the team interrupted a session, one father reported that it felt like, "...being called into the principal's office"

(Newfield et al., 1990, p. 69). For others, especially adolescents, the use of a camera disrupted their therapeutic experience. Adolescent respondents reported feeling sensitive to the camera's presence throughout therapy. Newfield, et al. (1990), found that some adolescents felt strongly that the use of technology (e.g. camera) was demeaning and overly intrusive. "There is a stigma that there is someone always eavesdropping, if the camera is there, which it always was..." (Newfield, et al., 1990, p.70). In another study, one half of the adolescents who commented on their family therapy experience objected to the video taping of their session (Stuart-Smith, 1994). One adolescent stated, "I didn't like other people being able to look at us without being able to look at them" (Stuart-Smith, 1994, p.485).

Stith, et al. (1996) interviewed children and their parents who participated in family therapy at a university-based training center. They found that the children interviewed didn't worry as much as the teenagers reportedly did, yet there were some children who felt uncomfortable about the one-way mirrors,

cameras, team members behind the mirror, and call-ins. One nine-year-old boy reported, "It's also kind of scary because... somebody's watching you every single second and you don't even, sometimes you just forget that they're watching you. Then you suddenly go, 'Somebody's watching me, I think.' And you get frightened from it" (Stith et al., 1996, p. 75).

Interestingly, in Sells, Smith, and Moon's (1996) qualitative study at a university-based training clinic, there was no report concerning the technical therapeutic environment. They did note that 5 of 14 client systems interviewed specifically reported that they viewed the clinic as a safe place where they could openly talk about their problems and feelings. No other references to the therapeutic environment was documented in their study.

For the children, it was discovered that talking with them openly about the physical set-up of the clinic and the reasons for the technology and call-ins helped to ease their acceptance of those aspects of therapy (Stith, et al. 1996). For the adolescents, there weren't any suggestions offered that would help them

better deal with the technology side of treatment. Many reported feeling sensitive to the use of technology and would "dress up" for the camera or would situate themselves in a position where their back was to the camera or where it was more difficult to see them on the camera throughout the therapy process (Newfield et al., 1990). It was suggested, however that perhaps too many intrusions by the team behind the mirror can lead to an unfavorable opinion of the therapeutic experience (Newfield et al., 1990).

Goals and Direction

At least one study reported that maintaining specific goals and staying focused during treatment was very important to consumers of therapy. Four of the 14 clients interviewed in Sells et al. (1996) study reported that unclear goals and having no clear direction was not useful in therapy. "At the point we're at right now, I'm unclear where we are going. Basically, I'm told it's going to take time, but I don't know what we're going to be doing in the meantime and I'm frustrated" (Sells et al., 1996, p. 333). Another respondent advised,

> From one session to the next you need to come back with knowing, "This is the path, this is where we need to go." This is the most important thing to establish because without it, he (therapist) is not going to get you anywhere (Sells et al., 1996, p. 333).

By asking the consumers of therapy to share their experiences, researchers and therapists are able to gather first-hand information directly from essential stakeholder's in therapy instead of basing their work and research on the tainted assumptions of the clinical "experts". Thus, clients become the experts of their own stories and provide post-modern therapists with valuable feedback that will help them to mold their therapeutic approach to treatment and enhance their understanding of the population they serve.

VOICES OF ADOLESCENTS

Adolescents who have had the opportunity to provide feedback through ethnographic interviews have given us new ways to view their experience. By asking teenage clients to evaluate their therapeutic experience, researchers have begun to better understand

the therapy process from the adolescent's perspective. The work of Kuehl et al. (1990) and Newfield et al. (1990), are the primary sources of our knowledge concerning adolescents' experiences in family therapy.

In a qualitative study both Kuehl, et al. (1990), and Newfield et al. (1990), interviewed 8 adolescents who reported on their experience in family therapy in a doctoral-level program accredited by the American Association for Marriage and Family Therapy. Each family presented for therapy because of a substance abusing adolescent.

In the Newfield et al. (1990) analysis, researchers found that four domains of meaning emerged from the adolescent interviews: (a) expectations of therapy, (b) types of psychos and shrinks, (c) the setting, and (d) individual versus family therapy. Many of the teenagers interviewed created their own expectations of therapy and "psychos and shrinks" through the influence of the media. Some expected to lay on a couch while others expected people to shout at them. One thought their therapist would be like Bob Newhart, but not as funny. Many of the informants, including adolescents,

expected individual sessions with the drug abusing teenager. When their expectations of treatment did not mesh with the therapist's approach, or the opinions of other family members involved in treatment, it was less likely that they would report having a successful therapeutic experience because "...therapy was creating more problems than it was solving" (Newfield et al., 1990, p. 73).

As noted above in the qualitative review, adolescents reported not feeling comfortable in a technology based training setting with cameras, and team interruptions. They also expressed interest in individual counseling versus a family therapy approach (Newfield et al., 1990).

As far as the process of therapy was concerned, Kuehl et al. (1990), reported that in the initial phases of therapy, adolescents reported feeling scared and saying "as little as possible" to anyone, or saying "only what the therapist and parents want to hear" (Kuehl, et al., 1990, p. 314). As the therapeutic process progressed, the adolescents reported misleading or "bull shitting" their parents and counselors in an

effort to sabotage therapy. They tried to talk their parents out of following through on suggestions, tell their parents that therapy was not working, and they tried to instill doubt in their parent's minds concerning the helpfulness of therapy (Kuehl et al., 1990).

According to those same adolescents, if counselors would have initiated some individual meetings along with the family meetings they would have been more honest and willing to make therapy work. They also suggested that if the counselors had some personal drug experience and if they were not so easy to "bullshit", that they would have been more impressed with their therapist and his/her skills (Kuehl et al., 1990).

The information provided by Newfield, et al., (1990) and Kuehl, et al., (1990) is insightful. It gives us quality feedback from a difficult therapeutic population. Though the research clearly describes adolescent experiences in family therapy from the teenagers perspective, it gives therapists little information as to what they can do to improve the therapeutic process for adolescents. For that purpose,

the current study ties together positive and negative experiences in family therapy with the processes, and approaches, that lead to such outcomes, as described by adolescent stakeholders. In addition, interviewing adolescents who participated in counseling with experienced family therapists, in non-training clinical environments, and who presented in therapy with a variety of problems are unique aspects of this study. Thus the information provided herein is more applicable to an expanded audience of experienced practitioners who provide family counseling to adolescents in non-training environments.

This study also serves to add to the accumulating qualitative reports of adolescents' experiences in family therapy. As the research mounts and more and more adolescent experiences are shared, it is assumed that the qualitative insights, while not being statistically generalizable, will become more universally applicable as common domains and themes emerge across different cultures and samples.

SUMMARY

Though MFT is young as a mental health discipline, the positive results of its labors seem to denote that it is a successful and helpful field of treatment. Unquestionably the positive outcomes for qualified marriage and family therapists are helpful in determining what works in therapy, yet we have not acquired sufficient insight as to the client's perspectives concerning treatment. Qualitative research from the consumers perspective, is giving us additional and essential information that is helping us to discover what works in therapy and what doesn't work. Their experiences and insights should be used to strengthen our work with individuals and families in similar circumstances.

CHAPTER THREE - METHODS

PROCEDURES

Two researchers, myself and M. Walsh, jointly conducted the data collection phase of this research project. We are masters' candidates in the MFT Program at the Northern Virginia Graduate Center of Virginia Tech. We worked together by interviewing both parents and adolescents. Because the study involved human subjects, it was initially approved by the Institutional Review Board at Virginia Tech to ensure appropriate concern for the participants. I interviewed 6 adolescents and 4 parents and M. Walsh interviewed 6 parents and 4 adolescents. We each transcribed the interviews that we conducted, and each of us shared access to all the data from all interviews to use in our individual projects. M. Walsh focused her attention on the parents' experiences in therapy while I studied the adolescents' experiences. Thus the unit of analysis for my portion of the research was adolescent participants in family therapy.

Once the data were collected, we worked independently on coding the data although on several

occasions we discussed our individual analyses as the project proceeded. Each of us completed our own final report based on independent analysis and interpretation of the data.

Sample Selection

Throughout the creation of this project, we made several contacts with family therapists who practiced in non-training facilities to see if they would be willing to present our project to their clients and ask permission for us to contact the family about participating in the study. If a therapist was unable or unwilling to participate, we would ask for the names of other therapists to contact. Each therapist who expressed interest in the study was given a brief written summary of the purpose and procedures of the study, and an informal meeting was held with those therapists. During the meeting, we reviewed the therapists' roles and responsibilities in the study, including the possible risks and benefits to their participation. Time was given to the therapists during the meeting to express any concerns and to ask any questions about their participation in the proposed

study. Each family therapist who agreed to participate was asked to sign a therapist informed consent (Appendix A) describing the study's basic purpose, its design, confidentiality, and their right to withdraw from the study at any time. At this time we also requested general demographic information from the therapist (Appendix B).

Participating therapists were asked to review their client populations for parents and adolescents who (a) had attended 4 or more therapy sessions, (b) had participated in counseling sessions where the adolescent was a focus of concern, and (c) were currently in therapy or who had terminated therapy within the last six months. Therapists were also asked to contact those families to request that the parent(s) speak to the researchers concerning the study.

Each therapist was given a packet including a letter introducing the study (Appendix C), and a parents' and adolescents' release form (Appendix D) to provide to those families who expressed an interest in participating. Once the therapist received a signed release from the clients, a copy was sent to the

researchers. One or the other researcher would then contact the family by phone to introduce ourselves, to begin to establish rapport, to clarify the purpose of the study, and to solicit participation. The first eight families who met the criteria stated above, and who volunteered to participate, were selected for the study. In addition, two other teenagers who attended family therapy with their sibling(s) but who were not the focus of concern, and who participated in three family therapy sessions, agreed to be interviewed for the study. These two adolescents were selected to increase the number of respondents, and to acquire a different adolescent point of view--that of a participant in family therapy who was not seen as "the problem." Thus, a total of 10 adolescents participated in the study.

For those families who agreed to participate, appointments for the first interview were scheduled at a mutually agreeable time and location for parents, their adolescent children, and the researcher. All of the first interviews, with the exception of one, occurred in the homes of the participants. The other interview was

completed at the therapist's office where the adolescent was being seen in therapy.

The Interviews

The parent/parent couples and their adolescents were interviewed twice. For the first interview, one researcher met individually with the parent(s) and their adolescent(s) and conducted a face-to-face interview in which the informants were asked to describe their experiences in family therapy. Adolescents and the parent(s) were interviewed separately. Each adolescent interview lasted between 20-30 minutes and each parent interview lasted between 40-90 minutes. A second interview with a majority of the participants was conducted over the phone to ascertain the accuracy of our interpretations of the first interview by reviewing a summary of their responses. The second interview also gave the participant a chance to share any additional insights and/or concerns. Each follow-up adolescent interview lasted between 3-6 minutes while follow-up parent interviews lasted between 8-30 minutes.

At the onset of the first interview, each participant was asked to read and sign the appropriate

informed consent (Appendix E, F, or F1) describing the study's basic purpose, design, confidentiality, and their right to withdraw from the study at any time. During the initial phase of the first interview, we took time to answer questions and to build a stronger rapport by talking about non-therapy topics that were of interest to the participant. We worked to build a sense of collaboration with the participants by telling them that we were interested in hearing their point of view and by letting them know that we believed that they were the best ones to tell us about their therapeutic experience (see Marshall & Rossman, 1989). During this time, basic family background and demographic information (Appendix G or H) was collected from each participant.

The remainder of the interview followed a semi-structured design, guided by pre-determined questions and topics (Appendix I or J). For the adolescents, the topics of focus were; (a) the adolescents' experience in therapy, (b) the interaction between the therapist and the adolescent, and (c) suggestions for family therapists to improve their work with adolescents.

Specific questions asked included: (a) What was your family therapy experience like for you? (b) What has your therapist done that has been helpful (or not helpful)? (c) How do you feel the therapist relates to you personally? (d) What advice would you offer a therapist so he/she can improve family therapy for kids your age? After each question was asked, we would use the answer to formulate additional questions in order to maximize freedom of description from the participant's point of view. The aim of the research questions and topics was to create a conversation with a purpose (Gilgun, Daly & Handel, 1992), thus allowing for data collection and discovery through the free exchange of descriptions, language, and narratives.

After the first interview was transcribed and a preliminary analysis of the data was completed, we mailed each participant a summary of their feedback derived from the first interview (see appendix K for a sample). Once the participants received the summary, the researcher who initially interviewed the participants contacted at least one of the parents and the adolescent for a follow-up interview by phone.

Eight of the 10 adolescent respondents participated in the second interview. One adolescent refused to speak with the researcher over the phone and another had run away from home and was unable to be contacted. All of the adolescents who participated in the phone interview were asked: (a) What did you think about our first interview? (b) Is there anything about my interpretation of what you said that is inaccurate or confusing? And (c) What would you add? One or two specific additional questions were also asked to individual adolescents to clarify ideas, thoughts, or statements left unclear in the first interview. For example, "You said that therapy helped you to be more open with your feelings, how did that happen?" Though the second interview helped to clarify some of their responses and to amplify the data, the main purpose of the second interview was to ascertain the trustworthiness of the our interpretation of the participants' views (Yin, 1989) and see if the participant had any further thoughts he/she wished to contribute.

After the completion of both the first and second

interviews, we contacted a few of the participating therapists by phone to solicit their general impressions of the differences between the group of families who initially agreed to be contacted by the researchers and those who did not give their consent. Obtaining the therapist's opinions concerning the families who did not agree to be contacted shed light and understanding as to why some families chose not to participate in the study. The therapist's perceptions are documented in this chapter after the description of the sample.

Data Collection

All interviews, including the phone interview, were audio taped and transcribed verbatim by myself, my wife, or M. Walsh. To assure the accuracy of the typed manuscripts I listened to portions of the audio tapes and read from the documents to verify the correctness of the transcriptions. In addition, the summaries that were sent to the adolescent participants contained a great deal of their exact language and wording which served to affirm that the transcriptions were reliably transcribed.

In the transcripts, pseudonyms were used for

therapists and client participants to protect their privacy.

Analysis

As much as possible, data collection, transcription, and analysis occurred concurrently throughout the research project. The constant comparative method was used in analyzing these data to extract patterns and themes leading to the development of categories (Glasser & Strauss, 1967). After each initial interview, the researcher would briefly document his or her impressions concerning the interview. These notes included the documentation of the informants' attitude, some general themes that emerged throughout the interview, and the interviewers' thoughts about the process of the discussion. This was done to enrich the analysis of the findings (Strauss & Corbin, 1990). After the transcription of the interview, I carefully read the content of each transcript and documented my impressions about various themes and theoretical notes on the transcript itself. As I did so, various patterns and general themes began to emerge. Each transcript was then re-read for the purpose of developing a

comprehensive summary to give to the adolescent participants for their review (see appendix K for a sample summary).

The summaries were composed of adolescent responses and consolidated into general categories. From the summaries, memos, and notes, an initial set of categories was developed. Throughout the analysis, I consulted with my faculty advisor and research partner which helped to broaden my perceptions of the general themes and which helped in identifying and consolidating specific categories. I then began to combine the categories into a visual model which lead to further consolidation and categorization of the patterns and themes. Once the categories were mostly identified, I assigned each category a specific color and I color-coded the transcripts of the first interviews as well as the transcripts of the second interviews. The color-coded transcripts served as the basis for the write-up of chapter four of this document. There you will find a final consolidation of the data into a beginning model of what works in therapy according to the views of my adolescent informants.

SAMPLE

The sample in this study was composed of marriage and family therapists and their adolescent clients. The parents of the adolescents also participated in the study, however their experiences were reviewed and documented by M. Walsh's independent analysis and report.

Family Therapists

Several family therapists located in the greater Washington D.C. and Richmond Virginia areas, who work in non-training clinics, were conveniently recruited for this study. Family therapists were defined as a person who had graduated from an AAMFT-accredited program, or who had experienced intensive post-graduate training in the field of marriage and family therapy, and who had practiced family therapy for at least three years. Throughout the project, over 35 family therapists were contacted. Over 20 therapists were formally introduced to the study through presentations and information packets, and 9 of those 20 expressed interest in participating. Ultimately, five therapists participated in the study.

Each of the five therapists reported that they

practiced marriage and family therapy and had some significant background and training in marriage and family therapy.

BRAD*

Brad attained a master's degree in social work and became a licensed social worker. Later, Brad took a job where he was supervised in counseling by a director who had a Ph.D. in Marriage and Family Therapy. Brad worked under his supervision and tutelage for two years. During that time, Brad also attended several Marriage and Family seminars and training meetings. Currently, Brad is the director of a non-profit social services agency. He reported that he mostly uses a Solution-Oriented Brief Therapy approach to counseling. Brad was the counselor to 3 of the 10 adolescents interviewed for this study.

JED

Jed completed a masters degree in education and worked as a mental health and school counselor for 10 years. He currently is a Licensed Professional Counselor and has been in private practice for 3 years. He is an associate member of AAMFT and has had three years of post-master's clinical training in marriage and

family therapy. Jed reported working mostly from a systems and structural approach. Four of the 10 adolescents interviewed for this study worked with Jed in family counseling.

DEBBIE

Debbie is a Licensed Professional Counselor in the state of Virginia. She is also an AAMFT Approved Supervisor. She worked in county substance abuse programs and mental health services for three years and for three additional years she has worked full time in private practice. Debbie reported working from a variety of systemic models with particular use of collaborative conversation and solution-oriented techniques. She was the counselor to 1 of the 10 adolescents interviewed.

JIM

Jim attained many graduate degrees, one of them being a masters degree in an accredited Marriage and Family Therapy program. He is a clinical member of AAMFT and he currently works with a therapy group who provide clinical services to a large metropolitan population. He reported working from a Solution-Oriented brief therapy model and he engages in some

Narrative therapy as well. Jim worked with 1 of the 10 adolescents interviewed for this study.

JILL

Jill earned a post-graduate certificate in Marriage and Family Therapy and is a clinical member of AAMFT. For the past three years she has worked in private practice and reported approaching therapy with Solution-Focused, Cognitive, and Behavioral, system-based techniques. Of the 10 adolescents interviewed, she provided counsel to one.

All the participating therapist were white Anglo-Saxon Americans. Each reported that they had practiced family therapy for at least three years. Four of the five counselors approached therapy from a post-modern perspective using Solution-Oriented, Narrative, and Collaborative models of treatment. All of the counselors reported working from a general systems-based approach.

Adolescents

The adolescent participants in this study attended family therapy in a non-academic private practice or agency setting. Eight of the 10 participants interviewed were the focus of concern for 4 or more

therapy sessions. The two additional adolescents attended family therapy because their sibling(s) was experiencing problems that effected the family system. Both of those participants attended therapy three times.

Nine of the 10 participants were adolescent males. Seven were caucasian-American, two were African-American, and one was Asian-American. The ages of the adolescents' ranged from 14 to 20 with the average age being 16-years-old. Their families income ranged from $35,616 to $110,000 yearly-- the mean being $83,000 per year. It should be noted that 5 of the 8 families earned $90,000 or more per year while 2 other families grossed $70,000 or more annually. Thus, the majority of the sample come from economically stable middle- class families.

The following is a detailed review of each adolescent participant.

AMY*

Amy is a 20-year-old white female. She is an only child and she and her parents attended family therapy approximately 50 times over a two year period. Amy wrote that she attended family therapy because of her, "Intense yearning to make things better." Her mother

wrote that Amy was depressed and suicidal and that was the reason for treatment.

JASON

Jason is a 16-year-old white male. He is the middle child of three. Jason attended family therapy with his parents and reported participating 11 times to learn how to be able to live a good life and to better understand his parents. His parents wrote that the purpose of therapy was to help him with his Attention Deficit Disorder and to help themselves to deal with issues that Jason raised.

STEVE

Steve is a 14-year-old white male who attended therapy approximately 48 times. He is the oldest of three children. Steve, his mother and his father all attended family therapy. Steve wrote that they were in therapy because he and his dad had conflicts and that he was depressed. His parents noted that Steve was suicidal.

DERRICK

Derrick is a 17-year-old white male and only child. He and his parents all attended family therapy for at least 6 sessions. Derrick wrote that he attended family

therapy to be supportive of his mother, while his parents reported that they were trying to improve family relationships and communication skills with one another.

GARY

Gary is a 17-year-old African-American male who attended therapy 3 times because his siblings were having problems. He is the second youngest of 10 children. Gary, his mom, little brother and older sister all participated in therapy. Gary wrote that he went to therapy so that he and his family could share their opinions in an organized setting with someone to arbitrate the discussion. Gary's mother wrote that they initiated therapy because of the death of her husband and the children's father. She reported that they were all grieving his death in different ways resulting in family difficulties.

TREVOR

Trevor is Gary's little brother. He is a 15-year-old African-American male who attended therapy more than 10 times. He wrote that the purpose of family therapy was because they had some family problems. He particularly had a hard time getting along with his older sister.

BRENT

Brent is a 15-year-old Asian-American male. He is the youngest of three children. Brent, his mother and his father all attended family therapy on 12 occasions. Brent reported that the purpose of therapy was because of, "Problems". His mother stated that Brent was court involved and that he and his parents did not get along.

JARED

Jared is a 16-year-old white male who participated in approximately 10 therapy sessions. On occasion he met with his mom and dad in session. Jared is the oldest of 7 children. He wrote that he attended therapy because he took, "Indecent liberties with two of his sisters". His mother noted that Jared had to overcome problems of a personal nature.

BEN

Ben is a 17-year-old white male who attended family therapy on 10 occasions. He is the oldest of 2 children and he, his mother, and his younger brother have all participated in therapy. Ben wrote that his family did not get along well and so "therapy was necessary". His mother wrote that they were in family therapy because Ben was an underachiever and angry.

BILL

Bill, Ben's little brother, participated in therapy 3 times. He is a 14-year-old white male who went to therapy because he, "Was asked to."

All of the adolescents reported attending both family and individual sessions with their family therapist. Some participated in more family sessions throughout the course of therapy while others participated in more individual sessions over all.

At the onset of this study, it was assumed that the volunteer adolescent participants would be teenagers who were generally cooperative in counseling. This assumption appears to be accurate because most of the adolescents interviewed were very cooperative and reported taking personal responsibility for successful outcomes in treatment. One adolescent, however, initially refused to be interviewed, yet ultimately decided to give us feedback concerning his experiences in family therapy after eavesdropping on his parent's interview. However, upon the request of a second phone interview, that same adolescent refused to talk with the researcher and told his parent that he did not read the summary that was sent to him.

Similarly, some parents and adolescents who were approached by their counselor refused to talk with a researcher. A few therapists reported that families did not want to let another person into their confidential therapeutic world. One counselor speculated that some of the families felt shame for their problems and thus were not willing to talk with anyone outside of therapy. Other client participants reportedly felt that they had overcome their problems and that an interview with a researcher would require them to rehash the issues. One adolescent wanted some monetary compensation in order to participate and others refused outright without giving an explanation as to why they wouldn't talk with a researcher.

Overall, despite the vast differences in age, culture, socioeconomic factors, presenting problems, and family composition, the adolescents in this study provided significant feedback that can help therapists enhance their skills of working with teenagers.

Confidentiality

Pseudonyms were assigned to each therapist and family participant before the analysis of data in this study. All identifying information (e.g. consent forms,

demographic information, etc.) were kept separate from the data and all transcripts and audio tapes were identified only by the participant's pseudonym. The researchers and their advisors were the only persons with access to the raw data which were destroyed when analysis was completed.

SUMMARY

The methods and procedures of the study were carefully designed to protect the participants and to acquire quality feedback that will be useful to counselors who work with teenagers and their families. The process of collecting and analyzing the data has been a time consuming challenge that has produced rich results. Chapter four of this document provides a detailed account of our findings.

CHAPTER FOUR - RESULTS

After my student teaching experience with a class of high school freshman, I sat down with my professor to review the student feedback. In preparation for the event, my professor cautioned me that students tend to say what they think and "tell it like it is". Accordingly, I was surprised at how articulate the students became when asked to evaluate their student teacher. Analogous to that experience, I found that the adolescent respondents in this study were quite frank with their feedback and appeared anxious to share their point of view. While I expected the adolescents to want to share their opinions concerning therapy, I was surprised at how cooperative they were from the out set. I expected that it would be more difficult to initially gain their cooperation than it actually was.

SETTING THE STAGE

Eight of the ten adolescents participated in the second interview because one adolescent had run away from home and could not be contacted. Another refused to speak with the researcher over the phone. All eight adolescents who did participate in the second interview reported that they had read the summary of their first

interview and each stated that the summaries were accurate representations of their experiences and feedback concerning family therapy. Quotes from the follow-up interviews illustrate the adolescents' judgements of the accuracy of our interpretations. (Please note that quotes from all ten of the adolescent participants are well represented throughout this chapter. Pseudonyms were not used so that counselors, parents, and other involved individuals could not identify the adolescent and track his or her responses. Three asterisks denote a shift from one adolescent respondent to another. A= Adolescent; I= Interviewer).

I: Did you have a chance to review the things that I wrote up about what you said?

A: Yes, actually I did. They are right in front of me....

I: Did we get it right? Is that what you wanted to tell us?

A: Yeah, I would say that ninety nine percent of the stuff was very accurate, that most of it was right on the money. I think that you did a very good job considering what I gave you.

***

A: Well I looked over it and everything looks just like I told you. So it all looks fine.

***

I: Did you get a chance to read over the summary?

A: Oh yeah.

I: Well what did you think?

A: Well that's basically what I said, you just condensed it in a more sufficient, efficient way.

I: Is there anything that you think I misinterpreted or got wrong?

A: No, I don't think so. I think everything's pretty good.

***

I: Was there anything that was inaccurate or that you would like more emphasis placed on?

A: Nope. You pretty much read me like a book.

Based on the second interviews, it is assumed that the results of this study accurately represent the participants' experiences, suggestions, and insights into the process of family therapy.

Of the 10 adolescents interviewed, 6 viewed family therapy as a helpful and/or a positive experience.

I: What was family therapy like for you?

A: Well actually I kind of liked it because I was hesitant to go, because like you're going to a shrink, but then I

went and it was cool because I really like (therapist) and it actually helped....

***

A: I think it was very helpful.

***

A: ...I've had a good experience here....

***

A: It was very helpful for me. I definitely don't think I'd be here if we hadn't gone through therapy.

***

I: On a scale of 1 to 10 with 10 meaning it was an awesome (therapy) experience, couldn't have been any better, and 1 meaning that it really stinks, how would you rate your experience?

A: Nine. Just because sometimes I didn't want to go because I wanted to do something else....

Interestingly, 3 of the 6 adolescents who reported having good experiences in family therapy also reported that they didn't always feel like going to therapy.

A: ...One night I had a lot of homework and I wasn't like, ok so let's all go to therapy, but after I got there it was good. I was glad that I went.

***

A: ...When the time comes it might be a little annoying driving up here or

> something like that. I mean I can't go do something with my friends or something like that.

Despite their difficulties in generating an enthusiastic attitude for <u>each</u> therapy visit, these 3 respondents reported that they were generally glad that they attended family therapy.

Three adolescents were somewhat indifferent about their experience. They reported that therapy was both helpful and not helpful.

> A: Well, it helped me in a couple of isolated situations. (Therapist) gave me good suggestions which I put to use and it worked. But overall, in my lifestyle and my motivation...no therapist has been able to help me there. That's the only drawback that I've had.

***

> A: Sometimes I feel it is not helpful. I mean I guess later on in life I'd probably realize that it was.

One of the 10 reported that there was no reason to go to family therapy and that the worst part of family therapy was, "Just having to go."

> A: I guess that I just don't see that I need to be there... I don't see any reason to go.

Most of the respondents participated in a combination of individual and family sessions with their therapist. As the study progressed and I was finishing the interviews, I became interested in finding out if the respondents liked family sessions, individual sessions, or a mixture of the two. Thus, only 3 adolescents were asked which approach they preferred.

A: Well a combination of the two because meeting alone you got to say what may be your particular problem you were having, but meeting together you actually found out why it was happening.

I: So do you think it was important to actually have the opportunity to meet with him alone?

A: Yeah because then if nothing else that gave us a period to get to know each other.

I: If you were to go back to therapy again for any reason, would you choose to go back as a group, as a family, or as an individual or both?

A: Well it would depend on the problem. If I was having a lot of trouble with myself I would want to go by myself, but if I was having complications with others I would maybe want to go as a group.

***

A: They were both beneficial in different ways.

I: ...So if you were to continue or go in for different problems...would you

want to go in with your family or as an individual...?

A: Probably a combination of both again depending on what the problem was.

***

A: Family sessions were helpful but I preferred individual because I got more out and I was able to get into the session more.

According to the adolescents I spoke with, both family and individual sessions were beneficial, but in different ways. The teenagers viewed family therapy as helpful with family or relational problems while individual sessions were more helpful for working through personal problems.

One half of the participants had previous therapy experiences with other counselors. Some of those adolescents talked about how their most recent family therapy experience differed from their previous experiences. The following results are mostly based on their most recent family therapy experience, however, feedback from previous experiences was integrated into the results to provide some contrast to their most recent experience in family counseling.

FINDINGS

In careful analysis of the data, five main categories emerged that describe successful therapy experiences for adolescent clients. Primarily, the client/therapist relationship served as a solid foundation upon which all other categories were built. Embodied in the relationship foundation was being able to relate to the teenager, maintaining a broad focus, maintaining a balanced structure, respect and trust for the adolescent, and respect and trust for the therapist. These sub-categories have the potential of strengthening or weakening the very foundation of therapeutic success with adolescents.

A solid relationship was necessary but not sufficient for successful therapy in the informants' eyes. Built on the relationship foundation was a frame of three activities that led to progress. First, adolescents found it helpful to be able to talk about their problems with someone who actually listened. Being heard in an individual setting and in a family setting, with the therapist acting as a mediator, was important to these participants.

Second, gaining insight through conversations with the therapist lead to change. Both personal and family-relational insights were reported to be helpful.

Third, the respondents reported that therapy will not work if they are not willing to take personal responsibility for its success. They had to do their part to make it work. Thus categories two, three, and four, served as a frame of activities which lead to progression and change in therapy.

Finally, assuming that the relationship foundation and the frame for progress and change were in place, the crowning factor to a successful therapeutic experience for these adolescents respondents was that they had to be able to see the results of their efforts. Recognizing positive therapeutic outcomes was essential to their perceived success in therapy (see appendix L).

RELATIONSHIP FOUNDATION

Throughout the interviews, it became increasingly clear that a successful therapeutic experience for these adolescents rested on the establishment of a positive relationship with their therapist. When asked about their therapeutic experience, 6 of the 10 respondents began by talking about their therapist and referred to

the quality of the relationship. All 10 respondents talked about the importance of the therapeutic relationship throughout the course of the interview and a few teenagers clearly articulated the significance of a relationship foundation.

> A: I have to like the person, the therapist, otherwise I didn't get anywhere.... The person has to be liked well enough so that you want to talk.
>
> ***
>
> A: ...Try and befriend the teenager and build a definite trust between them before trying to go anywhere else. That probably should and was the first step in any adolescent therapist relationship.... Yeah, a strong relationship like with (therapist), I feel that I can go there and tell him what's wrong and why I think this.
>
> ***
>
> A: Now I have established a relationship with him and I can tell him anything and I go by myself and I can start a conversation and talk to him and he helps me a lot. But at first, it was difficult and kind of intimidating speaking to an adult that you don't know, about your problems.

According to the respondents, therapists can construct and/or strengthen a relationship foundation by relating to the youth, maintaining a broad focus,

maintaining a balanced structure, and respecting and trusting the adolescent.

Relating to Teenagers

Nine of the 10 adolescents spoke about how important it was to feel that the therapist related to their particular needs and circumstances.

A: Through our talks...I think that he's gotten to know me a lot better and hmm...I feel like my therapist like really can relate to what I'm going through. ...I feel like he's able to relate to what I'm saying as if he were somebody my age.

***

A: I thought (therapist) was real down to earth and able to relate to us as teenagers.

***

A: ...He (therapist) knew where I was coming from and he could talk to me about it.

***

I: So what kind of advice can you give to a therapist? What do they really need to know to be good with teenagers...today's teenagers?

A: ...Kind of just go out and see things through a teenager's eyes like, I don't know, and understand what they do.... If they could see it our way, they would understand a lot more and be more helpful.

Some of the respondents offered insight and suggestions as to how a counselor can better relate to adolescent clients.

A: He's really good at putting himself like pulling himself back to when he was my age and he is able to recognize and remember what I'm going through and what he had to go through.

***

A: Well, he (therapist) always told us stories about him when he was a teenager.... He also relates a lot of personal experiences to what he says.

***

A: The way (therapist) related to me is by asking questions about how things are going at home.

***

I: What sort of things did he (therapist) do or say that helped you to feel that he related to you, that he understood you?

A: He just kind of expressed some of the things that he liked that we liked, like he likes football and things like that and he just seemed like he liked some of the things we liked and it just kind of worked.

***

A: Try to understand.... Tell them (therapists) to go to high school for one day and hang out with people for one day and just see what it is like.

Describing previous counselors, two adolescents warned that trying too hard to relate doesn't work.

I: What about it (therapy) made it boring?

A: She (therapist) told these stories that went on forever about herself--so what does that have to do with me?

I: How did the therapist relate to you?

A: Relate to me? She tried to do it through the stories but that didn't hmm, work. She didn't really relate.

***

A: Don't try like being all extremely friendly. Don't go to any extreme with a teenager.

I: Why didn't you like her (therapist)?

A: She seemed kind of fake.

Being genuine and being able to relate to the youth without trying too hard was noted as an important element in the relationship foundation.

Maintaining a Broad Focus

Seven of the adolescent respondents reported that being the focus of concern during therapy was not helpful. They reported feeling more comfortable with therapists who maintained a broader focus.

A: At the first it (therapy) was really uncomfortable. I didn't like it. It

> depends a lot on the therapist and how much focus he puts on you. ...Sometimes the focus would be on me and in the beginning I didn't like it being on me at all. Let it be on someone else.
>
> ***
>
> A: If you ever like get backed into a corner, that's what the first person did, she'd back me into a corner sometimes, and I just, "Can I leave now?!"
>
> ***
>
> A: One of these times I just want to be like--they're going to ask me how I feel and, "No! How do <u>you</u> feel?" (to the therapist). "Let's talk about <u>you</u> today!"
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> ***
>
> A: They (therapists) are trying to talk to me like they are my friend, but they are trying to figure out what's going on in my head. That's the worst feeling in the world. ...It doesn't take one person in the family to screw things up. My parents have problems too.

Four of those same respondents reported that focusing on problems was not helpful in therapy and it also led to feelings of discomfort with the therapist. Speaking about his relationship with his dad, one adolescent reported that talking about problems didn't help.

> A: I don't think that family therapy helps

it along that much. We just kind of go and talk about the problem.

Other adolescents reported:

A: ...it just is--had a lot of people telling my parent what was wrong with me and what they needed to fix, and how they needed to fix it and it's just not what it is about at all.

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I: Was there anything about the first therapy that was helpful that you can remember?

A: No. It just brought up a lot of problems between my dad and I, and it really didn't work.

Some of the respondents told us what their therapist did to help broaden the focus in therapy.

A: He didn't like try to analyze my brain like the first ten minutes I was there. He was getting to know you, "What do you like," "Hey that's cool," just relating to you on more of an adolescent basis.

***

A: He does his job. He tries to find out what's wrong but he doesn't sit there and brow beat me about it either. So there's a nice balance between it.

Reportedly, some therapists creatively applied certain activities to broaden the focus in therapy.

A: When I come (to therapy), sometimes it's been in just a room but sometimes we go

> for walks outside and it's, I guess a variety helps. And just taking a walk out in nature with a breeze blowing and everything, I guess for me I'm kind of a nature person, but it helps a little bit to have a little variety. I think it helps my mind to think and everything and just sitting in a room it helps to get out.

Another adolescent reported that the therapist used pie charts, writing, sculpting, and drawing as ways to metaphorically discuss what was going on.

> A: She liked using different objects and using the Play Dough almost like a metaphor for some things.

Broadening the therapeutic focus by discussing solutions rather than being problem-centered also helped teenagers feel more comfortable with their therapist.

> A: ...it's not just like he's (therapist) telling me to do something, he's helping me to solve my problems.

According to these adolescents, maintaining a broad focus by not putting them on the spot, and by focusing on more than just their individual problems, helped them to feel comfortable with their therapist and thus strengthened the relationship foundation.

Maintaining a Balance in Structure

According to the adolescent's feedback, it appears that therapists need to find an appropriate balance between providing structure and flexibility in therapy. According to 8 of the 10 adolescents, their relationships were stronger with therapists who were successful in finding and establishing an appropriate balance. In the following example, the interviewer restated the adolescents response to the question, "What helps you to like the therapist?"

I: So like someone who will just sit down and talk to you like a friend?

A: Kind of like that, but not so relaxed. Someone who's just, you do anything like a friend, that didn't work for me at all.

I: And why didn't that work?

A: Because they never got anything done. It was too relaxed. ...There has to be some structure. It's a compromise between structure and what you like doing.

Other teenagers advised:

A: I think actually as a therapist that you would maybe just want to have a certain plan of action and then not stick to it word for word and just like have what you want to get done and then apply it differently for each person.

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I: Do you have other suggestions that you would give to therapists working with teenagers?

A: I think that if they felt more comfortable in talking to the person, just a relaxed environment not a real formal situation that they would be more open, open themselves up to let you know how they really feel.

Another respondent reported on how frustrating it was to meet with therapists who worked from a non-structured therapeutic approach.

A: A lot of times when I'd go to counselors they'd make me come in and expect me to sit there and talk, and I was not there because I wanted to be there! I was not there because, hmm... 'cause I wanted to talk to them. It would make me so angry!! In fact it still does!! ...For me going in there and having that counselor/therapist...say, "What do you want to talk about today?"... The gall of somebody to do that and after they had talked to my parent and knew that I didn't want to be there!

Conversely, an approach that is too structured and too directive doesn't work well either.

A: Being too forceful doesn't work. It just makes you go away, I don't want to talk. You know, that's a big thing--yeah, that's the main thing that makes me not want to talk to someone, trying to force themselves in.

According to the adolescent feedback, some therapists were able to establish and maintain a balanced structure in therapy.

> A: She (therapist) was not overpowering me with, "You have to do it my way and that's it!" But we'd do what she wanted to do like we'd talk about something, then she'd ask me what I wanted to do or talk about type of thing.
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> I: And was your other experience a contrast to that in some ways?
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> A: A dictatorship.
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> A: He (therapist) hasn't said, "I want you to go do this." He hasn't said, "This is what you need to do," but he'll suggest things.... He's never forceful about it or anything like that but he will sometimes he will give suggestions.
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> A: He'll (therapist) try to start to guess and ask the initial questions and from there I keep on talking until I'm finished with all of my complaints and then he helps me out with them.

Finding and maintaining a balanced structure by not being too directive or forceful and by not being too relaxed or flexible was viewed as an important ingredient in the relationship foundation. Adolescents reported liking a therapist who was relaxed and

flexible, but to go too far in that direction and not provide some therapeutic structure was counterproductive.

Respect and Trust for the Adolescent

All 10 of the adolescent participants spoke about the importance of feeling respected and trusted by their therapist. For therapists who treated the adolescents with respect and established a collaborative and equal partnership with them, the relationship foundation was greatly strengthened.

> A: He (therapist) talks to me as an equal.... He talks to me as somebody who's worth talking to and it's not like I come in here and he's preaching to me trying to bend me or shape me in the way he wants me to go. It's more like I come in and he takes what I tell him, he takes what he knows, and tries to merge them together to help me make decisions in my life, not try and force me to do what he want's me to do.
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> I: So what helps you to like the therapist?
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> A: Their attitude. The way they were if they are friendly or if they seem like they are someone whose trying to investigate you like a friend or a person...not someone who is a professional or above you.

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A: You'll never get an answer from him, "Because I said so" or "Because I told you too."

I: It sounds like he treats you with respect.

A: Incredible respect. I like that because no matter if I'm being the biggest shmuck in the world or trying to help out, he's still going to treat me with the same amount of respect.

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I: Why do you think he's easy to talk to?

A: Because it's like, it's like I'm talking to one of my peers. It's not like when I sit down with my counselor at school and talk to her because she's a nice lady but it's like talking to a brick wall, but I'll sit there and try to figure out what's going on and you know he'll tell me if I'm full of crap or something and he'll tell me if he agrees with me. So I enjoy talking with him.

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A: He (therapist) made it about me whereas my life was always about other people. He'd just ask me questions and wanted to get to know me and said, "I'm not here to take sides" and "I'm not here to fix you, I'm here as someone to talk to." A lot of times counselors go through that, and you know, after a time you realize its not like that.

I: So (therapist) said and stuck to it then. What he said he was going to do he really did?

A: Yeah! And he said I don't really expect you to believe me when I say that right now, you know, are you willing to give me a shot? Because if you're not only you can decide that.

One way therapists were able to demonstrate respect and trust for the adolescent was by giving them the power to make important therapeutic decisions.

A: She (therapist) was really into what the person wanted to do. ...She kept asking me after every session, "When do you want to bring your dad in? Maybe next time." And she wanted to bring my dad in when I was comfortable. ...She asked me if I was comfortable with that or if I wanted her to talk to him.

***

A: My therapist usually gave me the option. If I don't want to come to therapy any more, it's my choice....

One participant reported that sometimes he didn't feel like talking about things and his therapist respected that feeling and allowed him to talk about it when he wanted.

A: He'll respect my belief, like this is new or this is something that I would like to deal with before I bring it to you.

Some counselors were able to demonstrate respect and trust by keeping confidences. One adolescent reported the following about her previous therapy

experience:

A: And right after I'd say something to her that I didn't want her to repeat, she'd go and tell them (parents) anyway.

I: She would tell them anyway? So what did that do to you? How did you feel?

A: There was no trust there.

I: So you didn't trust this therapist?

A: No. That's why we went to a different one.

I: What about your last experience with family therapy?

A: She (therapist) was just really good because if she wanted to tell my mom something, she'd ask me first. And hmm...if I didn't want her to know she wouldn't tell her, and she actually would not tell her.

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A: Don't feel like oh, he's going to make fun of me or he's going to tell my parents or something because he's not. He respects your confidence.

A few of the adolescent respondents clearly articulated the need they have to feel respected by their therapist and to feel that an equal relationship has been established.

I: Any other advice you'd give to a therapist to make it a better experience for kids like you?

A: Be more of a friend type figure than authoritative. ...Treat them like adults.

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A: Don't use complicated words.

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A: Get them to feel like you are on their side.

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A: Talk to them like they're people. Like they're not kids like they're a person, like you were talking with your friends. That's very effective for me and I imagine it is for other as well. ...Talk to them like they are human beings. That would be very effective.

Inevitably, when the adolescent client felt respected and trusted, they felt better about their therapeutic relationship and they had a stronger tendency to respect and trust their therapist in return.

Respect and Trust for Therapist

Once the therapist had applied the above elements to the relationship foundation, a final and solidifying element remained in the hands of the adolescents. If the adolescent chose to respect the therapist as a person, and also for his or her counseling skills, the relationship foundation become a strong fortress upon which continued therapeutic progress could be built.

All six of the adolescents who reported having a successful experience also reported respecting their therapist and his or her skills. Two of the respondents who were indifferent about the helpfulness of therapy also spoke of the importance of respecting and trusting the therapist. Thus, 8 of the 10 respondents acknowledged that respect and trust for the therapist was an important factor in the relationship foundation.

> A: I think he (therapist) just knows a lot about the field. ...Every answer he gives to any question always has some logic behind it. He's just more stable than most of the adults I know....
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> A: ...He was a genius.... I think he's a genius when it comes to people. ...He can just pinpoint exactly what was going on inside your head.
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> ***
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> A: I guess I consider him (therapist) an honest person who will--who respects me and I respect him too. ...He still has the wisdom and everything of an adult and he's been through it all. ...I feel like he's there for me. ...He always remembers what we talked about last time and everything and he's like up-to-date on what's going on.
>
> ***
>
> A: He (therapist) knows his stuff. He knows what he's talking about. He knows

> what's going on. I think he has experience and he's been through school and so he knows a lot about people like me. So he knows what he's talking about and he knows what to say. Which is very good. It's nice to hear someone who knows their stuff.

In summary, adolescents have the power to weaken or strengthen the relationship foundation by choosing whether or not they will respect and trust the therapist. A therapist can work to construct a strong foundation by relating to clients, maintaining a broad focus, a balanced structure, and respecting and trusting the adolescent client. One adolescent eloquently summarized:

> A: I would tell them (therapists) to try not to be so intimidating or so caught up in their profession or doing things the textbook way. To relax and have an informal meeting, kind of casual, and to get to know the person to build a relationship of trust with the patient or the client and this will help. You may not solve the problem on the first visit or even talk about their problem in the first visit but as long as you maintain kind of a friendship and hmm..., it helps a lot because the person will be more willing to discuss with you the feelings because a lot of people just don't walk into an office and just let it all out and you tell them what to do and go home. It's a long process but it's worth it and it's very beneficial to everyone including the therapist.

Constructing a strong relationship foundation lead the way to progress and change. Though the respondents found it difficult to explain what exactly lead to change, they were able to give some ideas as to what helps in building upon the relationship foundation. Just being able to talk and being heard in both an individual and family setting, helped in framing progress and change. Both personal and relational insight were reported factors that facilitated change as well. And finally, taking personal responsibility for making therapy work for themselves added essential support to the frame of progress and change.

TALKING AND BEING HEARD

When asked what was helpful about therapy, 9 of the 10 adolescents reported that just being able to talk and being heard was an essential factor. The only adolescent who did not make mention of the helpfulness of talk, was the teenager who reported that family therapy was not useful.

> A: ...It (therapy) kind of gave me an opportunity to talk and like spill the beans on stuff in my life. It wasn't a bad experience. It was a nice opportunity for me to talk and kind of lay out my side of things. It was a pretty good experience. ...I feel like

being able to talk and to have somebody there listening to you who actually cares and will listen to your side of the story is really important and it helps a lot.

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A: You pretty much get to go in there and talk about anything that's bothering you. ...A lot of times that's what you really need to do is go and vent to a person that you can actually say what you actually think without getting grounded or what have you. So that's actually a very important thing.

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A: That's one thing that has kind of helped me to go there just kind of release all of my pressures and everything that I'm worried about rather than keep it inside.

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I: So you've had some good experiences in therapy?

A: Ah huh. I didn't always like them, but there was some good.

I: Like what was good about it?

A: We got feelings out and sometimes they were emotional and sometimes they weren't.

When referring to a previous negative experience in therapy one adolescent stated:

A: Just that half the time I didn't even talk to her.

Conversely, when referring to the most recent positive therapy experience the same adolescent reported that feeling free to talk with the therapist and to tell the truth was helpful.

A: It just gets the problems off your chest.

Another adolescent reported that talking helped him and his therapist develop solutions to problems.

A: But I just go and talk to him and he talks to me and at the end he kind of gives me solutions to my problems.

I: Do you feel like you come up with solutions together or that he comes up with all the solutions?

A: I think we come up with them together.... We just sit there and talk and we'd come up together with solutions that would just start me out, not the solutions to all my problems, and then when I go home and I'm confronted with these situation I find that I come up with them on my own.

Therapist as a Mediator

Six of the 10 respondents reported that having a mediator during family sessions allowed them to talk about their feelings in a non-threatening environment which lead to positive therapeutic outcomes.

I: In general, I would like to know what your family therapy experience has been like as a teenager?

A: Yeah, I think it was very helpful. I think that we needed someone to kind of arbitrate the discussion between not only ourselves but ourselves and our parents or parent whatever the situation is. Let your voice be heard in a not really a formal setting but an organized setting. ...So it was not like someone was forcing you to listen but kind of assured you that everyone else was listening to what you were saying. I guess that was kind of comforting to me.

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A: Ohm, I guess...(therapist) helped to be a mediator between my parents and me. Both sides would always leave feeling that things worked out to their benefit.

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A: With the family problems the whole family was involved in and we would meet with the family and they were helpful because we got to talk with each other and he was going to be the mediator.

One adolescent who reported feeling closer to parents as a result of therapy offered some insight as to how that happened.

I: What do you think contributed to that (feeling closer to parents)?

A: Just understanding and discussing things.

I: So did family therapy give you the place to make some of that happen?

A: It's a safe zone, I guess. That's were I told my dad I got a ticket....

I: It was easier to do it there?

A: There's someone there to give their opinion of what could happen without taking sides.

Another adolescent spoke about taking sensitive family issues into therapy.

A: ...Bringing that in front of (therapist) and so that (therapist) could be the mediator in the process was helpful. ...You would get a chance to voice your opinion without worrying about any one else getting their feelings hurt or getting in trouble for what you're saying and then you get a chance to find out what the problem's really about and find out how to solve it.

An adolescent who went to therapy with his father reported:

A: Sometimes we both sat in there. Sometimes I just wanted her (therapist) to tell my dad stuff, and they'd talk about it. My dad and I would never talk about it again, but it would be fixed. ...(Therapist) was the middle person in it.

I: She was the middle person in it?

A: The person passing the note in study hall....

Talking, and being heard in both individual and family settings, with the therapist taking the role of mediator, helped these adolescents in the construction of a frame of progress and change.

GAINING INSIGHT

Personal and relational insight was reported to be helpful by the adolescents. According to the respondents, it was useful in initiating individual and systemic changes. Nine of the 10 participants acknowledged that insight was an important factor in therapy.

Personal Insight

Most of the adolescent respondents reported that personal insight gained through therapy was helpful.

> A: He (therapist) helped me to realize that I had to change myself because I couldn't change everyone and so it was a lot of self-discipline involved in my situation with changing myself.
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> A: I feel like it's been helpful to move forward. I think one of the things that's helped me a lot is like thinking and analyzing myself and being able to like change myself and... and find things in myself that can be changed and can be helped.
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> I: Has therapy helped you in some way to be different?
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> A: I guess it makes me understand things more. ...It makes me think about things before I do them which is something I haven't done in the past 16 years.

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A: ...Because I've come to him with a conflict saying, "you know, I'm having a conflict with this person because they're doing this." And he's found something that I might have been doing to implement it and usually I would brush it off saying, "No, no it's them, it's them." But actually he pointed out that most of the time I'm always able to stop some sort of conflict that I'm in. So that's been very helpful because that's one of the reasons I think it has been a working experience.

***

A: They (therapists) have to make you look at yourself and make you realize certain things like what you like about it, what you like, what you didn't like, finding yourself....

Relational Insight

Three of the 9 adolescents told us that gaining family relational insight was helpful as well. Two of the three were the siblings of the troubled adolescents who were not the focus of concern, and the third was the adolescent who reported that family therapy was not helpful. The only "somewhat helpful" thing about family therapy for that adolescent was gaining insight into relational patterns.

A: I would do something that I didn't perceive as a problem, and he'd flip out about it. Then I would flip out about

it. Then I would flip out about him. It's like we fed into each other. I've learned about why that happens.

***

A: He (therapist) showed us that we are actually a lot the same and we both attack each other....

I: So (therapist) helped you to figure out kind of the process that was going on that hurt perhaps?

A: And realize what we were doing so that the next time we had a confrontation we wouldn't like automatically resort to our defense mechanisms.

(later in the interview)

I: What's it like going to family therapy and not really being the main problem?

A: Well then you get to see what everyone else's maybe problems or stipulations are and then you can see why they were having a problem and then you can adjust your own personal attributes to maybe suit that or maybe help them to find a conclusion to that.

Another sibling participant gained insight into individual family roles that help him to change his behavior.

A: I think what it was him (therapist) stressing the point that there were too many chiefs and not enough indians and I think that you know that aspect if you take care of yourself and please yourself then there will be less contention and things will run a little smoother and that's pretty much what I was shooting for.

Some of the adolescents talked of personal therapeutic experience and gave some suggestions that may help therapists stimulate personal and relational insights for their adolescent clients.

> A: I think by asking them questions, making them part of the interview, having them answer things and think about things. Like once teenagers start thinking about it and having to answer questions and stuff then they start to take a little bit more responsibility because they start to realize how things actually are.

***

> A: They (therapists) need to be, I was going to say not accusing, but it helps some times when you are accused of something like you know you implemented this. I guess they shouldn't be afraid to turn it back on the patient, which I guess most of them do. Not in a mean way, but turn it back on them, make them look at what they've done in the situation. That's been effective for me.

Two respondents reported that talking about real life scenarios in therapy helped.

> A: I'd tell them (therapists) that they ask questions and give you situations about what can happen. Like if it's an action... what can happen bad or what can happen good...what you should have done...and then you realize what's going on. Then that makes you think about doing that.

***

A: He (therapist) gave me hypothetical situations that showed me how to react in a certain way if a certain situation came up. And that helped me a lot because a lot of the situations did come up.

Another adolescent reported that working creatively in therapy by writing, drawing and sculpting helped to promote insight.

A: It just gave me a different understanding of it, kind of like a different perspective.

According to the adolescent participants in this study, personal and relational insight helps in constructing a solid frame for progress and change.

PERSONAL RESPONSIBILITY

As it is in a solid relationship foundation, so it is in the frame of therapeutic progress, teenage clients have to do their part to construct a successful therapy experience. Eight of the 10 teenagers interviewed spoke of the importance of taking personal responsibility for change.

A: The therapist doesn't really do a lot of the work. I think the person has to do a lot of the work themselves. I think the therapist is there to guide you . They are not there to pull your teeth or force answers out of you.

***

A: ...If you're not open and honest then the session is really not doing what it's supposed to because you're not getting whatever you're supposed to.

When the adolescents were asked the following question, many of them responded by giving their "friend" advise as to how to make therapy work.

I: If a friend about your same age came up to you and said, "I have to go with my family for counseling. Will you tell me what it is going to be like?" What would you say?

A: I'd tell him that it's not just something that you go there and they solve your problems for you but you have to solve them yourself. So don't expect them to just tell you what you should be doing or not, they just help you change and there is a lot of work involved on your part and you'll always be working at it. You do get better in time, but you still have to work no matter how far you've come.

***

A: ...I mean you have to put some effort into it. I mean you have to listen to what the other family members are saying and try to incorporate that into how you were acting and try to change that to how you act after. So I guess you just kind of have to put into action what you hear. ...You have to want to change.

***

A: Be open. ...I'd recommend being open about everything and if you feel like maybe you want to say something about something then say it.

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A: I guess I'd tell him you get out of it what you put into it. You go there with a shitty attitude nothing is going to get accomplished and you don't understand and don't want to go, and put up this whole rebellion thing, it's not going to work. And if you go in there and lie and say, "I don't have a problem, and I'm doing this or that.." everything will stay the same.

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A: I would say, you know, do your best to go in with sort of an open mind and try to listen to what he's going to tell you.

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A: Oh, just the main thing is to go in there and tell the truth.

Interestingly, one of the adolescents who found therapy to be helpful in some ways and not helpful in others, said that he was not willing to take enough personal responsibility to make therapy work.

A: Well it helped me in a couple of isolated situations. He gave me good suggestions which I put to use and it worked but overall in my lifestyle and my motivation, whatever, it hasn't. No therapist has been able to help me there. That's the only drawback that I've had.

(later in the interview)

I: Since it wasn't all that effective for

you, what would have made it more effective?

A: Again, what I said, I don't think that it was anything that the therapist in general did, it's the fact that I was not very open to it because it was forced upon me, and therefore I went in with a closed mind. Therefore, the therapy has not been working. I don't know if I'm to the point yet where I'm ready to apply it but I think that as soon as I am, it probably will be much more helpful.

Some of the respondents offered advice as to what a therapist can do to assist a teenage client in taking personal responsibility in therapy.

A: He (therapist) can just show you that if you were having some sort of problem that you weren't treating yourself right. He could tell you why that was and show you your best route about changing that.

***

A: Well, they can kind of tell them that they are going to have to do some work. The therapist can't do it all, they can use your ideas but the teenagers would have to go there and be willing to change whatever's the problem.

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A: Well, they have to be frank with that in the very beginning and say that in order for this therapy to work I can't just sit here and talk to you. You have to apply what I'm saying and digest what I'm saying. You can't just sit there and be an inanimate object and have this stuff

bounce off you head, or it is not going to work for you.

***

A: Let the kid handle it.

I: Let the kid handle it in what way?

A: For the most part, I don't know, I think it's more of a maturity thing or I'll do it when I'm ready type thing.

For therapists to be able to effectively construct a frame of progress and change, they must enlist the adolescent's help in the process. According to the participants, therapy does not work if clients do not take personal responsibility to make it work. If they choose to be responsible, if they acquire personal and relational insight, and if they are able to talk and be heard in both individual and family settings, a strong frame of progress and change will be constructed and it then becomes more likely that they will see positive results in therapy.

SEEING RESULTS

Crowning the frame of progress and change which sits atop the relationship foundation, is the adolescents' ability to see positive results for their efforts in therapy. All 10 of the adolescents spoke of its importance.

A: I keep feeling like we keep moving forward and that we're not floating back all the time.

***

A: It took me a while to realize that I never left his office unhappy, I could be bawling in there the first fifteen minutes, and when the hour was over, I was fine always! And it was amazing. And I don't know when I finally realized that. And when I talked to my parents they felt the same way.

***

A: Well, I mean when my brother and I went there and we were going through some turmoil pretty much as a direct result of that (therapy), we found out how to deal with each other without physically harming each other and since that my relationship with my brother has been almost flawless.

***

I: What changes have you seen in your parents since you've been going to see (therapist)?

A: When I get in trouble every once in a while, they don't explode as bad. They just try to understand why I did it. ...I seem to be closer to my parents.

***

A: I think it kind of got everybody in a better mood. Just going up there, before you even got to therapy or after therapy everybody kind of seemed to get along because if you got something to say you knew that you were going to have a chance to say it or to get that point across.

It just seemed like things kind of were better going to and from, before and after.

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A: Every time I go I get something out of it or something helps me....

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A: ...If you actually see that he's (therapist) helping you then your more willing to talk. And if he's helping you and you like it then that's good.

One therapist, using a more structured approach, reportedly used a pie chart to help track results.

I: Is that something that worked for you in some way?

A: Yeah, and we'd go back to it and work on the smallest one first and when the smallest ones were done, we'd cross it out. When we got to the biggest one we did it last. So gradually once you got over those, it was like building you up for something bigger.

I: I see. You would get over the little pieces of the pie, you would put them behind you?

A: Yeah, solve them and um... after you did that successfully you felt good about it and you were ready to go for the next one. ...And we always at the end of session go over the progress we made....

One of the participants who was indifferent about the helpfulness of family therapy reported:

> A: When I talk to him (therapist) you know it sounds like a good idea, maybe I'll try and implement that,...It sounds like a great idea but when you go home and try and work it out it seldom worked for me.

The one adolescent who reported that family therapy was not useful stated:

> A: It seems like when we go nothing really comes out of it. It doesn't get any better or any worse.

Adolescents who found family therapy helpful in one way or another, were able to recognize and articulate the positive results of their therapeutic experience. Seeing positive results topped off a sound edifice of successful therapy experiences with the adolescent participants.

SUMMARY

Family therapy was reported to be helpful for most of the participants. It strengthened them personally as well as enhanced their family relationships. All of the participants spoke about the importance of first establishing a relationship foundation. Once the foundation was laid by both the therapist and the adolescent, a frame of progress and change was co-constructed through talk, insight, and taking personal responsibility in therapy. Topping both the frame and

foundation was the adolescents ability to see positive results for their efforts in attending and participating in family therapy.

CHAPTER FIVE - IMPLICATIONS AND DISCUSSION

After having received the student feedback concerning my student teaching experience, I had to make some choices as to what I wanted to do with the information. I had to decide how to best utilize my students' feedback in my life and how it could be used to enhance my skills as a high school educator. Similarly, each reader will need to decide how the above information will best serve them in their respective career and field of study. The following discussion will serve to generate some thought on the application and implications of this research.

Though the findings in this study are hardly generalizable to a large population, they do offer a "thick" description of adolescent experiences in family therapy. It is assumed that as this in-depth feedback is compared to other client experiences in family therapy, the congruencies and commonalities across samples will begin to emerge and become more and more generalizable to a larger population. Certainly, the field is in its infancy as far as ethnographic studies are concerned, and there needs to be many more independent studies before we can begin to assume that the commonalities in feedback are widely generalizable.

Nevertheless, the congruencies across qualitative studies of client's experiences in family therapy should not be ignored. Rather they should be viewed as laying a general ground work for understanding what leads to therapeutic success according to one of the primary stakeholder's perspectives.

The five core categories (client/therapist relationship, talk, insight, personal responsibility, and seeing results) and the five sub-categories (relating to teenagers, maintaining a broad focus, maintaining a balanced structure, respect and trust for adolescent, and respect and trust for therapist), that emerged from the client's feedback in this study provide a useful framework for therapists to consider when working with adolescents in family therapy. In the following discussion, each component of the framework is reviewed and compared to existing literature.

RELATIONSHIP FOUNDATION

In their book, Changing the Rules: A Client-Directed Approach to Therapy, Duncan, Solovey, and Rusk (1992), reported that client/therapist relationship factors play an essential role in the influence of successful outcomes in psychotherapy (see also, Luborsky, Critis-Christoph, Mintz, & Auerbach, 1988;

Pinsof & Catherall, 1986; Strupp & Hadley, 1979). Congruent with their quantitative findings, qualitative researchers have also documented the importance of the therapeutic relationship in producing successful client experiences in family therapy (Kuehl, et al., 1990; Mabrey, 1995; Quinn, 1996; Sells, et al., 1996; Stith, et al., 1996; Swint, 1995). Indeed the findings in this study show that the adolescent's relationship with the therapist is of paramount importance in the process of successful therapy.

As it was for many of the respondents in this study, Kuehl, et al. (1990) found that adolescents initially felt scared, awkward, and/or intimidated in therapy. Thus, taking the time to establish rapport in the very beginning phases of therapy can lay a foundation for therapeutic success (see Quinn, 1996, for similar feedback from adult clients).

Relating to Clients

For the participants in this study a portion of the relationship foundation was built on the therapist's ability to relate to the client as a teenager. Similarly, Kuehl et al., (1990) found that when a therapist asked questions and gave suggestions that indicated that he or she really understood the client,

the therapist was viewed as caring and the client/therapist relationship was strengthened. Quinn (1996), found through his interviews, "Clients want to know that therapists live in the same world they do" (p. 76). Therefore, Laing's (1960) notion of how a therapist needs to posture him/herself rings true, "In these cases, one has to be able to orient oneself as a person in the other's scheme of things rather than only to see the other as an object in one's own world" (p. 26).

According to the participants in Quinn's (1996) study and the respondents in this inquiry, one way that therapists have been able to relate to their clients is through self-disclosure. Sharing personal experiences and building on common interests seem to help clients to feel like a therapist can relate to them in their individual circumstances (Quinn, 1996). Also, the respondents in this study suggested that therapists can show they relate by pulling themselves back--trying to remember what it was like when they were teenagers, and by asking question that help the therapist learn how it is for today's teenagers.

The findings from this study indicate that therapists should be careful not to try too hard to

relate to their adolescent client. To self-disclose too much or to act as if you relate when you really don't seems to be counterproductive in building a strong relationship. Adolescents are good at detecting counterfeit attempts at relating and react rather negatively when they view a therapist as "fake." Being genuine is helpful.

Maintaining a Broad Focus

Maintaining a broad focus in therapy appears to give the adolescent some needed space to strengthen his or her relationship with the therapist. Stith et al., (1996) interviewed children between the ages of 5-13 who participated in family therapy. Similar to the adolescents in this study, the children Stith and her colleagues interviewed did not like to be the focus of attention during therapy.

Interestingly, many family therapy models encourage therapists to be tenacious with their clients. For example, Minuchin and Fishman (1981), suggested that clients are selective in what they choose to hear in therapy and thus, "The therapist must make the family 'hear,' and this requires that his message go above the family threshold of deafness" (pp. 116-117). Similarly, Madanes (1981) suggested, "The therapist should repeat his requests time and time again until he succeeds. A

great many of the therapist's tactics within this approach involve repetitiousness and tenacity" (p. 143). The results of this study and Kuehl's et al. (1990), study suggest that therapists should proceed cautiously when working tenaciously with adolescent clients so as to not "brow beat" them and put too much focus on the teenage client.

This raises an interesting question, how does a therapist provide treatment to a troubled adolescent without making them the focus of concern? According to some of the adolescents in this study, focusing more on solutions rather than being problem focused was helpful. This would make sense assuming that with a problem-centered approach the focus naturally becomes more narrow as core problems are identified, whereas with a solution-oriented approach the focus becomes broader as you evaluate options in search of solutions. By focusing on solutions, the adolescents didn't feel as if they needed to be "fixed" and it helped them to participate in therapy without feeling as if they were the focus of concern.

Based on this feedback, perhaps a solution-oriented approach to treatment with adolescents would help to

moderate the focus by offering what Selekman (1993) called, "a wellness perspective on adolescent problems" (p. 139). A systems approach that embraces the idea of circular causality may also be helpful in that the therapeutic focus is more on the inter-relational patterns rather than individual problems.

A creative treatment approach that was reported to be helpful by one adolescent in this study was the use of objects, diagrams, and charts to assist in the externalization of the problems and in taking the direct focus off of the adolescent. A pie chart, for example, was used to visually list the biggest stressors down to the smallest stressors. The concerns were framed as "stressors" and not as "problems." Once the stressors were listed, the focus of both therapist and client was centered on the pie chart with a goal of resolving the smallest stressors first and crossing them out as therapeutic progress was made. This seemed to help take the direct focus off the teenager. It allowed them to externalize the stressors and focus the treatment towards finding solutions. Perhaps by employing a more creative approach in therapy by using activities in the treatment of adolescents, teenage clients will feel more

comfortable with their therapist and not feel as if they are, "Backed into a corner" or "put on the spot", thus strengthening the relationship foundation.

Maintaining an Appropriate Balance

Maintaining an appropriate balance between a structured approach and an unstructured or extremely flexible approach was reported to be helpful in building and maintaining a positive relationship with the therapist. Some of the respondents in this study reported distancing themselves from the therapist who, "took charge" and who choose a directive approach to treatment. According to Kuehl, et al. (1990), clients who believed that the counselor was on too strict a program were dissatisfied with their experience. The author also found that informants preferred a therapist who offered suggestions, rather than, "telling us what to do" (p. 315). Most of the respondents in this study felt the same way.

Conversely, to go too far from a structured approach and become too flexible and unstructured in therapy appears to frustrate adolescents and damage the therapeutic relationship according to our participants. Similarly, Sells, et al. (1996), found that clients did

not appreciate a therapist who did not have a specific goal of focus and who would meander from topic to topic.

Therapists have the challenging task of appropriately assessing the adolescent's cognitive and emotional progress and then finding a proper balance in structure with each individual client. While laboring to establish a balance in structure, counselors may find it useful to consider taking a collaborative approach in therapy with teenagers. Working collaboratively means taking ideas from both clients and therapists in order to shape outcome (Duncan et al., 1992). Therefore, therapists can provide some feedback and structure in therapy and at the same time integrate the client's opinions and expertise into the therapeutic process according to the teenager's developmental capabilities. In the qualitative interviews conducted by Sells, et al. (1996), both therapists and clients expressed satisfaction in collaboration, "Clients said that 'they felt an active part of treatment,' and therapist stated that treatment was often better because 'both clients and therapists provided input into the treatment process'" (p. 338).

Other suggestions to help therapists establish and maintain an appropriate balance in structure include, (a) give suggestions but don't "tell them what to do", and (b) go into each session with a treatment plan but be flexible.

Respect and Trust for the Client

The results of this study indicate that the therapist's respect and trust for the adolescent is an important element in the relationship foundation. Adolescents reported that they felt better about the therapist when he or she treated them with respect by talking to them like a friend, by trusting and respecting their judgement and insights, and by keeping confidences.

Adolescent respondents did not appreciate a hierarchal structure in therapy. They wanted to be treated on more of an equal level. They wanted to be treated like a friend. Quinn (1996), reported that clients who expected a partnership with their therapist yet who ended up being treated more like a patient in a doctor's office, felt shortchanged and misunderstood. Most of the clients Swint (1995), interviewed who reported having good experiences in therapy felt that

therapy was like talking with a friend, talking with someone who was trustworthy and who was nonjudgemental.

A few of the clients in Quinn's (1996) study reported that they expected more of a hierarchical structure in therapy. Conversely, the adolescents in this study emphasized the importance of an equal relationship with their therapist. Being "treated as an adult" was important to them. Thus it seems that adolescents feel much more comfortable in an equal relationship of mutual respect and trust.

Therapists can show respect and trust in their adolescent clients by keeping confidences, respecting their moods (i.e. if they've had a bad day and they don't feel like talking about their problems--that could be respected), trusting the adolescent to make important decisions in the therapeutic process (e.g. "When would you like to invite your mom into these sessions?"), and by working to create an equal, collaborative relationship as appropriate. One researcher concluded that by soliciting and utilizing opinions and suggestions of clients, practitioners are better able to establish and maintain an equalitarian and

noncondescending relationship early on in the therapy process (Swint, 1995).

According to the adolescents in this study, if a therapist was successful in relating, maintaining a broad focus and a balanced structure, and showing respect and trust for the adolescent, these elements served to facilitate a feeling of respect and trust for the therapist and his or her skills.

Respect and Trust for Therapist

In other studies it was reported that when clients felt comfortable with their therapist, they were more likely to follow the suggestions and counsel they offered (Kuehl, et al., 1990; Swint, 1995). The adolescents' in this study, who felt comfortable with their counselor, likewise indicated that they respected and trusted their therapist. Thus one important element to solidifying a strong relationship foundation is left to the adolescent client. They have to choose whether or not they will respect and trust the therapist. This infers that the relationship foundation is not simply constructed by the therapist alone but co-constructed by both the therapist and the client together.

Interestingly, one thing that may help an

adolescent to respect and trust the therapist is the counselors ability to not be deceived and to appropriately confront the teenage client when necessary. Adolescents interviewed in Kuehl's, et al. (1990) study indicated that they did not respect a therapist who was easy to "bullshit". Similarly, one adolescent in this study suggested that therapists should not, "take any crap from a teenager." Thus it appears that therapists who are perceptive and appropriately confrontive are more likely to gain the respect and trust of the adolescent client.

The findings of this study indicate that a strong relationship foundation is an essential precursor to framing progress and change. Congruently, Swint (1995) found that "feeling comfortable" was significantly related to the informant's perceptions of how change occurred.

A FRAME OF PROGRESS AND CHANGE

For the adolescent respondents in this study, identifying exactly how change occurred was difficult. Swint (1995), found that the respondents in her study struggled similarly. Nonetheless, the adolescents

offered some insight as to what helped to frame progress and change.

Talking and Being Heard

Being a young therapist, I probably underestimate the power of talk therapy. I sometimes feel that unless I come up with creative answers and/or solutions, that therapy is not effective. Surprisingly, many of the adolescents in this study spoke of the importance of just being able to talk to someone about their problems, someone who would listen in a caring and non-judgmental manner. I was left with the impression that some of these adolescents really didn't have anyone to talk to about their intimate problems and that being able to talk with a therapist and being heard was helpful in framing progress and change.

Five of the informants that Sells, et al. (1996), interviewed reported that,

> Counseling was a "safe place where one could talk openly about their feelings and problems." Clients reported that they did not talk about feelings or problems outside counseling sessions. Somehow, the act of going to a counselor gave clients permission

to talk about their feelings and/or problems (p. 331).

An important part of talking and being heard for many of the participants in this study was that they had the opportunity to be heard in both individual and family sessions. In Kuehl, et al.'s (1990) study, parents and adolescents reported that therapy would have been more productive had the adolescent experienced some individual sessions along with family sessions. Adolescents in this study valued a combination of both. If they were going to talk about personal problems, they would prefer to do so in an individual setting. If they were to talk about family issues they preferred to do so in a family session with the therapist acting as a mediator so that all could speak and be heard.

Interestingly, the adolescent siblings who were not the focus of concern in Kuehl's et al. (1990) study reported that therapy was "boring" and felt as if they should not have to go. Conversely, the nonproblematic siblings in this study reported that being included in therapy was very beneficial. The difference between the two samples are that the sibling adolescents in our study only participated in three family therapy sessions on a, "as needed" basis whereas the adolescent siblings

in the Kuehl et al. (1990) study participated in each family therapy session regardless of the therapeutic focus. This implies that nonproblematic adolescent siblings may feel better about attending therapy only when the focus of the session deals with their particular role in the family process.

Personal and Relational Insight

Congruent with other qualitative investigations concerning client's experiences in family therapy, the findings of this study indicate that gaining personal and relational insight strengthens the frame of progress and change (See also Sells, et al., 1996; Swint, 1995; Mabrey, 1995; Quinn, 1996). For some of the adolescent participants in this study, gaining insight into their personal and family problems led the way to making changes and to interrupting dysfunctional behaviors and patterns. They gained insight by responding to thinking questions, being challenged, in a nice way, and by discussing and/or practicing real life scenarios with their therapist.

Personal Responsibility

Another important factor in constructing a frame of progress and change is that the adolescent client takes

responsibility to do his or her part in making therapy work. Therapists have some responsibility in framing progress and change yet therapeutic success also rests on the shoulders of the adolescent client who has to decide whether or not he or she is willing to do his or her part in therapy.

Some of the adolescents suggested ways that therapists can help a teenage clients to take personal responsibility in therapy. One adolescent suggested that if teenagers are not taking responsibility for change then they are not treating themselves right. So a therapist can show them how to treat themselves right and they will then take more responsibility. Other adolescents said that therapists should tell the teenage client in the beginning that therapy will not work without their cooperation. Another adolescent said, "let the kid handle it." Perhaps that is not bad advise, therapists should allow the adolescent to be in charge of his or her own healing as appropriate according to the adolescent's developmental capabilities.

From this study, it appears that laying a strong foundation and framing an environment of conversation

and insight will facilitate, but not mandate, the participation of the adolescent in therapeutic success. Thus, both the foundation and the frame have to be co-constructed with both the therapist and the client doing their part.

TOPPING THE FRAMEWORK

Once a solid foundation and frame had been co-constructed, being able to see positive results topped off a successful therapeutic experience for the adolescents in this study. Similar to our findings, Kuehl, et al. (1990) found that if positive results were not seen quickly enough, family members would become impatient with the therapy process and in some cases drug use would increase. For those families who did see and discuss positive results with their therapist, the adolescents reported feeling less inimical toward the therapist and therapy and their drug use was either greatly reduced or discontinued altogether. These findings suggest that therapists who work with adolescents may benefit by amplifying strengths and progress, praising and noticing differences, asking questions to help clients recognize what has worked in therapy, and documenting and tracking progress (see also

Metcalf, et al., in press). Other interesting factors that were illuminated through this study were that (a) the therapeutic environment (with out cameras, one-way mirrors, etc.) was not noted as an important factor in the adolescent's therapy experience and (b) teenagers who reported having good experiences in therapy did not always feel like attending. Because our study was conducted with adolescents who participated family therapy in a non-training setting (e.g. with out camera's, one-way-mirrors, phones, etc.) the therapeutic environment was not noted as a significant factor in their experience. Conversely, Kuehl, et al. (1990), found that the technical equipment used with the adolescents in their study significantly influenced their therapeutic experience. Also, adolescents in this study who had good therapy experiences did not always feel like attending. Similarly, Stith, et al. (1996) found that the young children they interviewed did not want to come to therapy at first. The authors suggested, "that therapists and parents not be put off by children's initial resistance to attending sessions and give the process some time to develop" (p. 84). The results in this study with adolescents indicate that

parents and therapists would benefit by following the same advice.

LIMITATIONS

The clinical implications of this study must be interpreted modestly because of the small sample size, the lack of probalistic sampling, and the generic qualitative features inherent therein (Sprenkle, 1994). Also, the demographic characteristics of this sample limit the application of our findings in that nine of the ten respondents were male adolescents and all of the adolescent respondents came from economically middle-class families who may have more confidence in professional help than others.

This research was based on the responses of voluntary adolescent participants. Most of the adolescents who volunteered appeared to be cooperative in therapy and thus the feedback of less cooperative adolescents was not well represented herein. Also, most of the adolescents in this study liked their therapists and felt that family therapy had been helpful.

IMPLICATIONS FOR FUTURE STUDY

This study serves to build on other qualitative studies of client experiences in family therapy. It

adds some depth and validation to the work of Kuehl, et al. (1990), who were the first to interview adolescent participants in family counseling. It also breaks new ground in that these adolescents participated in family therapy in non-training facilities with professional practitioners who were not in training. It is suggested that we continue to instigate future qualitative inquiries to amplify our understanding of client experiences in therapy. Focusing in on a particular population, such as adolescents, parents of adolescents, children, etc., appears to be particularly helpful to gain more specific insight into the treatment of that population. Also, most family therapy consumers see private practice and/or agency practitioners in a non-training setting and thus it is recommended that more studies be conducted with clients receiving services in non-training environments.

In this study, there is some evidence that may suggest that the therapists related better to adolescent clients of their same sex. Thus, it is also recommended that future studies with adolescent clients examine gender issues and how they may influence the development of a strong relationship between teenager and therapist.

CONCLUSION

After receiving the student feedback from my student teaching experience, I carefully evaluated my options and thought about how to best implement their feedback into my life. Since that time I have chosen a different career and I have not placed a foot into any high school classroom. Truthfully, the feedback wasn't all that bad, but I found that I was more interested in working with families than teaching high school students.

Hopefully, the feedback and insights gained through this study will benefit the reader by offering new ways to view the therapeutic experience with adolescents. In addition, it is hoped that the information contained herein will offer new ideas and elicit different ways of thinking when choosing approaches and treatment interventions while working with adolescent clients. Finally, it is suggested that therapists take the time to more fully consider the client's perspective by studying the qualitative, consumers-eye-view literature and by openly maintaining an ongoing evaluation with current clients to further enhance understanding and insight into the stakeholder's experiences in family

therapy (see Barnard & Kuehl, 1995). Atkinson, et al. (1991), insightfully noted that "...the legitimization of knowledge requires the judgment of an entire community of observers and is most appropriately a democratic process in which all stakeholders have equal input" (p. 162). Traditionally clients have not had much of a voice in the therapeutic process and there has not been "equal input." That is beginning to change.

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* All therapists and adolescents were assigned pseudonyms to protect their anonymity.

Appendix A

Participating Therapist's Informed Consent

Title of the Study:
Parents' and Adolescents' Experiences in Family Therapy: A Qualitative Study

Investigators:
This study is being conducted by Maryann S. Walsh and Kevin D. Broderick, candidates for masters degrees in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Faculty advisors are Dr. Karen Rosen and Dr. Eric McCollum. Maryann Walsh can be reached at 703-631-4985; Kevin Broderick can be reached at 703-698-6033.

I. Study Purpose
The purpose of this study is to examine parents' and adolescents' descriptions of their experiences of family therapy. We are interested in learning about what parents and their adolescent children find useful and not useful about their experiences in family therapy. The focus will not be on the issues that brought the families to therapy nor on evaluating your performance as their therapist.

II. Procedures
Participation in this study will consist of reviewing your client population and then selecting and contacting families who meet the study's criteria to request that they speak with the researcher concerning the project. For those families willing to be contacted by the researcher, we will provide you with an information packet which includes a letter introducing the study, release form allowing the researcher to speak with the family, and a self-addressed, stamped mail-back envelope. Our interest is to interview families who may have not terminated under the best circumstances, as well as those who did well in therapy. It is expected that the process of soliciting clients will take time beyond your normal schedule. Please keep in mind that the researchers anticipate completing the selection process between April and June, 1996, and the interviews with participants by June of this year.

Appendix A (cont'd)

The researchers will not be asking you to share information about the details of therapy, nor will specifics of what your client participants disclose about therapy be shared with you. It is also the intention of the researchers to solicit information regarding the participants' experiences in family therapy and not to evaluate you as their therapist.

III. Benefits of this project

Your participation in this project will provide the researchers with parents and adolescents to interview who have experienced family therapy in non-academic or agency settings. The researchers will provide all participating therapists with a summary of the findings upon completion of the project. Therapists who have participated in similar qualitative research projects have found this type of research experience provides valuable feedback.

IV. Extent of Anonymity and Confidentiality

The information you provide for this study will be treated as completely confidential. Your name will be removed from the Therapists' Demographic Questionnaire and be replaced with a participant pseudonym for use during analysis and in the final written report. Only the researchers and their advisors will have access to the audiotapes of the interviews and other raw data. The expected completion of this research project is September, 1996. At the time of completion, all raw data pertaining to this study will be destroyed. Specific information received from your clients will not be made available to you at any time during or after the study.

V. Risks

For participating therapists, the risks are minimal. Some of their clients may offer evaluations of their work. The final report, however, will focus more on the client's experience in family therapy and will not be used in any way to evaluate the participating therapists.

Appendix A (cont'd)

VI. Compensation

Upon completion of this project, participating therapists will be provided with summaries of the studies' findings. The final reports in their entirety will be made available at Virginia Tech for those of you who are interested.

VII. Freedom to Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

VIII. Approval of Research

This research project has been approved, as required, for projects involving human subjects at by the Institutional Review Board Of Virginia Polytechnic Institute and State University and by the Department of Family and Child Development.

IX. Participant's Responsibilities

I agree to participate in this study, and realize that my responsibility lies in providing researchers with potential parent and adolescent participants between the months of April and June, 1996. I have read and had my questions answered. I hereby give my consent for participation in this project.

_____ _____

Participant's Signature Date

Appendix A (cont'd)

X. Participant's Permission

I have read and understand the informed consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. I agree to abide by the guidelines of this project. I realize I have the right to withdraw at any time. Should I have any questions about this research I will contact:

Maryann S. Walsh	Karen Rosen
(703) 631-4985	(703) 698-6027
Researcher	Faculty Advisor
Kevin D. Broderick	Eric McCollum
(703) 698-6033	(703) 698-6018
Researcher	Faculty Advisor

Ernest R. Stout
(540) 231-9359
Chair, IRB Research Division

Appendix B

Therapist Demographic Information

Name_____ **M F**
Race_____

Address of Practice_____

_____

_____

Please list your years of family therapy experience and clinical credentials:_____
_____
_____
_____
_____
_____
_____

Therapeutic model(s) or approach(es) most used with clients_____
_____
_____
_____

Approximate number of eligible clients_____

Appendix C

Letter of Introduction

Dear

Thank you for your interest in participating in our study. Our purpose for conducting this study is to find out what parents and their teenagers think about family therapy. Because you have recently completed, or you are currently attending family therapy, we feel that you and your teenage son/daughter are the best people to ask about your family therapy experience.

The information that you share with us will be confidential and will not be used to evaluate your therapist's work. Your personal responses will be combined with the experiences of several other parents and teenagers, and used to inform therapists about how parents and their teenage children experience family therapy. Your therapist will not be told how you personally responded to our study. A general summary of our findings, void of any identifying information, will be given to all the families and therapists who participate in the study so that you may know how your responses informed our investigation and how some of your experiences compare to other families who have participated in family therapy.

Attached is a release form that will allow us to contact you by phone. Please complete, sign, and return the form in the enclosed self-addressed stamped envelope. By signing and returning the form, you are not required to participate in our study. The researchers will contact you by phone to answer any questions that you may have regarding the study and to schedule a convenient time and place for an interview with you and your teenager if you decide to participate.

Appendix C (cont'd)

If you have any questions before you sign and return the attached release form, please feel free to call one of us at any time. If we are not immediately available, we will return your call as soon as possible.

Thank you again for your time and interest.

Maryann Walsh
Co-Principal Investigator
703-631-4985

Kevin Broderick
Co-Principal Investigator
703-698-6033

Appendix D

Parents' and Adolescents' Experiences in Family Therapy

Release Form

Researchers at Virginia Tech are conducting a study to see what parents and adolescents think of family therapy. They are currently recruiting families who have at least one adolescent between ages of 12 and 19, who have been seen for at least four sessions or who have completed treatment. They are looking for parents and their adolescents who are willing to talk to researchers about their experiences in family therapy. The researchers are family therapy interns in the Marriage and Family Therapy Program at Virginia Tech and are not the therapist who worked with your family. The interviews will be arranged at a mutually acceptable time and location.

If you would be willing for me to give your name and telephone number to the researcher so that he or she could give you more information about the proposed study, please sign below. Participation in the study is not a requirement for continued family therapy or future therapeutic treatment.

I am willing to have you give my telephone number to the researcher. I understand that I have not yet agreed to participate in the study and only agree to talk to the researcher more about the study.

_____ _____
Parent(s) Signature Date

_____
Parent(s)' Name Printed

_____ _____
Adolescent's Signature Date

_____
Adolescent's Name Printed

Daytime Phone No._____ Evening Phone No._____

Appendix D (cont'd)

Best time to call_____

Location of Practice_____
_____

_____
Therapist’s Signature

_____
Therapist’s Name Printed

Appendix E

Parent Participation Informed Consent

Title of the Study:
Parents' and Adolescents' Experiences in Family Therapy: A Qualitative Study

Investigators:
This study is being conducted by Maryann S. Walsh and Kevin D. Broderick, candidates for masters degrees in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Faculty advisors are Dr. Karen Rosen and Dr. Eric McCollum. Maryann Walsh can be reached at 703-631-4985; Kevin Broderick can be reached at 703-698-6033.

I. Study Purpose
The purpose of this study is to examine parents' and adolescents' descriptions of their experiences of family therapy. We are interested in learning about what you as parents find useful
and not useful about your experiences in family therapy. The focus will not be on the issues that brought you to therapy. The results of the study will not be used to evaluate your therapist's performance.

II. Procedures
Participation in this study will consist of two interviews. The first will be conducted in person lasting sixty to ninety minutes, and the second will be conducted via the phone for fifteen to thirty minutes. All the interviews will be audiotaped and transcribed for analysis. A potential risk of participating may be discussing uncomfortable issues during the interview although you will not be asked to discuss the content of therapy unless you want to. If you should become uneasy during this process and wish to withdraw, you need only to inform the researcher.
The researchers will focus their questions around your experiences of family therapy. They will not be sharing your specific responses with your therapist. Only the researchers and their faculty advisors will have access to the information you share.

Appendix E (cont'd)

III. Benefits of the Project

Your participation in this project will provide the researchers and therapists who work with parents and adolescents the opportunity to learn how parents experience family therapy and to learn how to be more helpful to families similar to yours. The researchers will provide participating families with a summary of their findings upon completion of the project.

IV. Extent of Anonymity and Confidentiality

The information you provide for this study will be treated as completely confidential. Your name will be removed from the Family Background Questionnaire and be replaced with participant pseudonyms for use during analysis and in the final written report. Only the researchers and their advisors will have access to the audiotapes of the interviews and other raw data. The expected completion of this research project is September, 1996. At the time of completion, all raw data pertaining to this study will be destroyed. Specific information you share will not be made available to your therapist at any time during or after the study.

However, if it is learned that you are in danger to yourself or to someone else, or if there is suspicion of child abuse, the researcher has the responsibility to report this information to the appropriate persons and will do so.

V. Risks

As a participant, you may on occasion find it uncomfortable to discuss certain aspects of your experiences in therapy. You will not be asked to discuss the issues that caused you to seek therapy unless you wish to do so. It is the expectation that by doing this, the potential for discomfort will be minimized.

VI. Compensation

Upon completion of this project, participants will be provided with a summary of the studies' findings.

Appendix E (cont'd)

VII. Freedom to Withdraw

If at any time you change your mind about participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

VIII. Approval of Research

This research project has been approved, as required, for projects involving human subjects by the Institutional Review Board Of Virginia Polytechnic Institute and State University and by the Department of Family and Child Development.

IX. Participant's Responsibilities

I agree to participate in this study. I have read and had my questions answered. I hereby give my consent for participation in this project.

_____ _____
Participant's Signature Date

_____ _____
Participant's Signature Date

X. Participant's Permission

I have read and understand the informed consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. I agree to abide by the guidelines of this project. I realize I have the right to withdraw at any time. Should I have any questions about this research I will contact:

Maryann S. Walsh (703) 631-4985 Karen Rosen (703) 698-6027
Researcher Faculty Advisor

Kevin D. Broderick (703) 698-6033 Eric McCollum 703) 698-6018
Researcher Faculty Advisor

Ernest R. Stout (540) 231-9359
Chair, IRB
Research Division

Appendix F

Parent Consent for Adolescent Participation

Title of the Study:

Parents' and Adolescents' Experiences in Family Therapy: A Qualitative Study

Investigators:

This study is being conducted by Maryann S. Walsh and Kevin D. Broderick, candidates for masters degrees in Marriage and Family Therapy at the Virginia Polytechnic Institute and State University. Faculty advisors are Dr. Karen Rosen and Dr. Eric McCollum. Maryann Walsh can be reached at 703-631-4985; Kevin Broderick can be reached at 703-698-6033.

I. Study Purpose

The purpose of this study is to examine parents' and adolescents' descriptions of their experiences of family therapy. We are interested in learning about what your adolescent son/daughter finds useful and not useful about his/her experiences in family therapy. The focus will not be on the issues that brought you to therapy. The results of the study will not be used to evaluate your therapist's performance.

II. Procedures

Participation in this study will consist of two interviews. The first with your adolescent will be a thirty to sixty minute face-to-face interview and the second will be conducted via the phone for fifteen to thirty minutes. All the interviews will be audiotaped and transcribed for analysis. A potential risk of participating may be discussing uncomfortable issues during the interview although they will not be asked to discuss the content of therapy unless they want to. If your adolescent should become uneasy during this process and wish to withdraw, he/she needs only to inform the researcher.

The researchers will focus their questions around your son/daughter's experiences of family therapy. They will not be sharing their specific responses with your therapist. Only the researchers and their faculty advisors will have access to the information they share.

Appendix F (cont'd)

III. Benefits of the Project

Participation in this project will provide the researchers and therapists who work with parents and adolescents the opportunity to learn what adolescents think about the experience of family therapy and to learn how to be more helpful to families similar to yours. The researchers will provide participating families with a summary of their findings upon completion of the project.

IV. Extent of Anonymity and Confidentiality

The information your adolescent provides for this study will be treated as completely confidential. Their name will be removed from the Adolescent Background Questionnaire and be replaced with a participant pseudonym for use during analysis, and in the final written report. Only the researchers and their advisors will have access to the audiotapes of the interviews and other raw data. The expected completion of this research project is September, 1996. At that time, all raw data pertaining to this study will be destroyed. Specific information you share will not be made available to your therapist at any time during or after the study.

However, if it is learned that your son/daughter is a danger to him/herself or to someone else, or if there is suspicion of child abuse, the researcher has the responsibility to report this information to the appropriate persons and will do so.

V. Risks

As your child participates, he/she may on occasion find it uncomfortable to discuss certain aspects of your experiences in therapy. Your child will not be asked to discuss the issues that caused your family to seek therapy unless he/she wishes to do so. It is the expectation that by doing this, the potential for discomfort will be minimized.

VI. Compensation

Upon completion of this project, client participants will be provided with a summary of the studies' findings.

VII. Freedom to Withdraw

If at any time you change your mind about your adolescent's participating in the study, you are encouraged to withdraw your consent and to cancel your participation.

Appendix F (cont'd)

VIII. Approval of Research

This research project has been approved, as required, for projects involving human subjects by the Institutional Review Board Of Virginia Polytechnic Institute and State University and by the Department of Family and Child Development.

IX. Participant's Responsibilities

I agree to allow my adolescent to participate in this study. I have read and had my questions answered. I hereby give my consent for my son/daughter to participate in this project.

_____ _____
Parent's Signature Date

_____
Name of Participating Adolescent

X. Participant's Permission

I have read and understand the informed consent and conditions of this project. I have had all my questions answered. I hereby acknowledge the above and give my voluntary consent for participation in this project. I agree to abide by the guidelines of this project. I realize I have the right to withdraw at any time. Should I have any questions about this research I will contact:

Maryann S. Walsh (703) 631-4985
Researcher

Karen Rosen (703) 698-6027
Faculty Advisor

Kevin D. Broderick (703) 698-6033
Researcher

Eric McCollum (703) 698-6018
Faculty Advisor

Ernest R. Stout (540) 231-9359
Chair, IRB
Research Division

Appendix F1

Adolescent Assent

Title of the Study:

Parents' and Adolescents' Experiences in Family Therapy: A Qualitative Study

Why do we want to talk to you?

The purpose of this study is to develop a better understanding of what teenagers like you think about family therapy. We are interested in learning about what you like and don't like. We also want your ideas about how we can make therapy more useful for other teenagers.

What do we want you to do?

We want to talk to you one time in person to get your experiences, ideas, and suggestions for family therapists. Because we are interested in what you have to say about therapy, and in your suggestions for family therapists, the interview will last between thirty and sixty minutes. A few days after our interview, we will want to contact you by phone to assure that we accurately understood what you told us and to see if you have any further questions or comments.

Who is going to talk to me?

The person who will talk to you is a family therapist intern from Virginia Tech's Marriage and Family Therapy Program. He or she will not be your family's therapist.

What are the Risks?

As a participant, you may on occasion find it uncomfortable to discuss certain aspects of your experiences in therapy. You will not be asked to discuss the issues that caused you to seek therapy unless you wish to do so. It is the expectation that by doing this, the potential for discomfort will be minimized.

What if I change my mind?

If at any time you do not want to answer any questions, or are not comfortable, you should tell the person who is talking to you that you want to stop. Though the interview will focus more on your experiences in therapy

Appendix F1 (cont'd)

than the issues that brought you to therapy, it is possible that you may be discussing uncomfortable issues during the interview however you will not be asked to discuss the content of therapy unless you want to. If this happens, please inform your interviewer. This study should be interesting for you. If it is not, you have the right at any time to say you have changed your mind and do not want to participate in the study anymore.

Who will know what I said?

We will be tape recording the answers to your questions, but no one who knows you will get to listen to your answers. They will be private. We will not tell your therapist or your parents what you said. The information you share will be combined with the responses form other teenagers. However, if the person who talks to you learns something that makes him/her think that you are in any danger, he/she will let someone know who can help you. When the researchers share the information they learned from you in a research report, they will share responses from many teenagers so that no one will know what you said. Your real name will not be connected in any way with what you said.

Will you give your permission?

I have read and understand this consent form. I have had all my questions answered. I know that I do not have to participate in this study if I do not want to, and I know that I can change my mind if I want to. I agree to participate in this project and to share my ideas about family therapy whether they be good, bad, or indifferent.

_____ _____

Participant's Signature Date

_____

Printed Name

Appendix F1 (cont'd)

Participant's Permission

Should I have any questions about this research I will contact:

Maryann S. Walsh (703) 631-4985
Researcher

Karen Rosen (703) 698-6027
Faculty Advisor

Kevin D. Broderick (703) 698-6033
Researcher

Eric McCollum (703) 698-6018
Faculty Advisor

Ernest R. Stout (540) 231-9359
Chair, IRB
Research Division

Appendix G

Parent Background Questionnaire

Name_____Male / Female

Address_____
_____

Family Income_____

Family Members
_____Age_____ Male / Female
_____Age_____ Male / Female
_____Age_____ Male / Female
_____Age_____ Male / Female
_____Age_____ Male / Female

Who attended family therapy?_____
_____

How many sessions did you attend?_____ Completed: No__ Yes__ If yes when?_____

In your own words, describe why you attended family therapy_____
_____
_____
_____
_____
_____

Appendix H

Adolescent Background Questionnaire

Name_____
Age_____ **M or F**

Family name (if different)_____

Number of family therapy sessions in which you participated_____

In your own words, why did you attend therapy with your family?_____
_____
_____
_____
_____
_____

Appendix I

Guiding Interview Questions for Parents

This interview schedule will serve as a guide during the actual interview. The researcher will begin with a brief introduction stating the purpose of the study.

First Interview

1. I am interested in knowing more about your experience of family therapy as a parent of a teenager. What can you tell me?

2. What did you as parents expect to have happen in the sessions?

3. How did that compare to your initial experiences of family therapy? What factors do you feel contributed to your experiences?

4. Tell me what participating in family therapy has been like for you as a parent. What do you think of your teenager's experience in family therapy?

5. How did your experience of therapy change as treatment progressed? What brought about that change?

6. Tell me about the experiences in therapy that were particularly helpful to you as the parent. Be as specific as you can. What about it was helpful for you? for your teenager?

7. How do you think the therapist relates to your teenager?

8. What did you find not helpful about family therapy? What did you find not useful about therapy for you? for your teenager?

9. What suggestions can you make for a therapist to consider when working with a family similar to yours?

10. Tell me about the experiences of a session that you found yourself reflecting on between visits. What did you notice that was different about your family as a result of family therapy? How does your teenager talk about

Appendix I (cont'd)

therapy between sessions?

11. On a scale of 1 to 10 with 10 meaning family therapy has been very helpful for your teenager, and 1 meaning it has not at all been helpful, how would you rate your experience in therapy? What could the therapist do that would increase your rating?

12. If a friend with a troubled adolescent was considering treatment, and asked you about the overall experience of family therapy, what would you say to them? How would you describe the therapy process?

13. Some people find out as they look back that they see things differently. In what ways have your thoughts and feelings about therapy changed since you have completed the experience?

14. What changes do you continue to experience because of what you learned in family therapy? What do you feel contributes to maintaining those changes?

15. In your own words, tell me about what led you to initiate coming to family therapy.

Second Interview

Share the summary of the first interview and ask for thoughts and impressions about the researcher's interpretations as well as the parents' own thoughts of the first interview.

1. What else have you thought of since our first interview that you would like to share about the experience of family therapy for yourself?

2. What questions haven't I asked that you think are important?

Appendix J

Guiding Interview Questions for Adolescents

This interview schedule will serve as a guide during the actual interview. The researcher will begin will a brief introduction stating the purpose of the study:

First Interview

"I am interested in what family therapy is like for teenagers and what ideas or suggestions you have for family therapists. Since you have been to therapy, I believe that you are the best person to help me understand this. The information you provide will also help therapists improve how they help teenagers. Do you have any questions?"

The areas of focus are the adolescent's experience in therapy, the interaction between the therapist and the adolescent, and suggestions for the family therapist.

1. Tell me about your family therapy experience. What was it like for you?

2. How do you feel that the therapist relates to you personally?

3. What has your therapist done that has been helpful to you in therapy?

4. What has your therapist done that has not been helpful for you in therapy?

5. If a friend about your same age came up to you and said, 'I have to go with my family for counseling. Will you tell me what it is going to be like?' what would you say?

6. On a scale of 1 to 10 with 10 meaning that family therapy is really awesome and 1 meaning that family therapy really stinks, how would you rate your experience in therapy? What could the therapist do that would increase your rating of family therapy?

7. What advice would you offer a therapist so he/she can improve family therapy for kids your age?

Appendix J (cont'd)

8. What questions did we forget to ask that we should ask the next teenager we interview?

Second Interview

Share the summary of the first interview and ask for thoughts and impressions about the researcher's interpretations as well as the adolescent's own thoughts of the first interview.

1- What did you think about our first interview?
2- Is there anything about my interpretation of what you said that is inaccurate or confusing?
3- What would you add?

Appendix K

Sample Summary of First Interview

The first interview was for me to learn about your perceptions and experiences in family therapy. You offered me a glimpse of what you liked and didn't like about therapy. In an attempt to read between the lines, I offer you the following brief summary of my interpretations of your experience of family therapy.

Therapy was a positive experience for you because...
It gave you the opportunity to talk about problems in your life.

You got to explain your side of things.
Therapy was a conversation and not an interrogation.
You had the feeling that you were progressing and moving forward.
Thinking about your problems and analyzing yourself helped you to find things that were wrong in your life and then to change yourself.
Both you and your therapist developed solutions together by sharing insights.

You liked your therapist because...
He was nice and easy to get along with.
He was easy to talk to.
He was able to relate to you by trying to remember what life was like for him when he was your age.
He didn't compare you to himself but tried to see things from your perspective.
He helped you to visualize things that gave you self-insight that helped you to
make things better in your life.
He gave you suggestions but did not tell you what to do.

Your therapist really cared about you and showed it by...
Listening to you.
Taking time to get to know you personally.
Being there for you.
Remembering what you had talked about from one session to the next.
Staying up-to-date on everything that was going on.
Helping you to feel that you were worth talking to.

You respected your therapist because...
You saw him as wise.

Appendix K (cont'd)

You viewed him as an honest person and who kept his word.
He was insightful.
He didn't force you to do the things he wanted you to do.

Your therapist showed respect for you because...
He spoke to you in a way that you could understand.
He gave you the power to decided what he was going to share with your parents and what he would not share with your parents.
He maintained confidentiality.
He talked to you as an equal.
He didn't "preach" to you.
He allowed you to decide when you wanted to see him again.

Teenagers are responsible to make therapy a good experience by...
Being open.
Not being afraid to talk about personal things.
Saying what they really want to say.

Just being able to talk to someone who will listen, relate and care about you is very helpful.

The therapist asked good questions that made you think about certain things that helped you to see things from a different perspective. Those questions helped you during therapy.

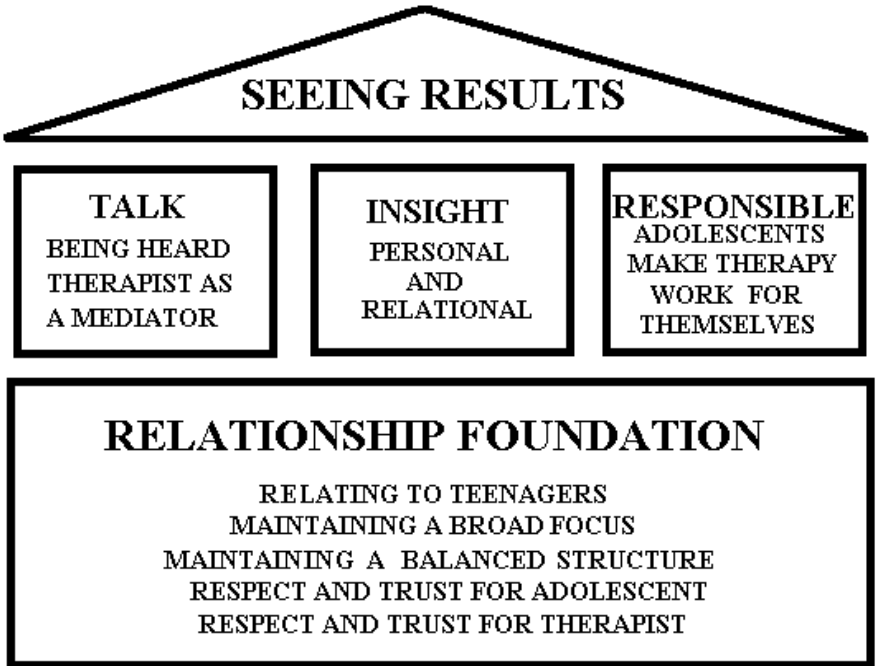
Even though therapy was a positive experience for you, there were still times when you didn't feel like going.

Thanks for you help! You gave us great feedback!

Appendix L

Figure 1:

CONSTRUCTING A SUCCESSFUL THERAPEUTIC EXPERIENCE WITH ADOLESCENT CLIENTS



VITA

Kevin Broderick was born in Provo, Utah on October 10, 1967. He was the fifth child in a family of six children.

From 1987 to 1989, Kevin severed a mission for the Church of Jesus Christ of Latter-Day Saints in South America. After his mission Kevin returned to Brigham Young University, located in Provo, Utah, where he graduated with a Bachelors Degree in Family Science in 1991. In 1993, Kevin began his graduate studies in Marriage and Family Therapy at Virginia Polytechnic Institute and State University.

Currently, Kevin is a full-time employee for LDS Social Services in Richmond, Virginia and resides there with his wife Shauna and their three children.