"LOOKING AT THE PICTURE BY STEPPING OUTSIDE": A QUALITATIVE STUDY OF PARENTS' OF ADOLESCENTS EXPERIENCES IN FAMILY THERAPY

By

Maryann Sheridan Walsh

Thesis submitted to the Faculty of the

Virginia Polytechnic Institute and State University

in partial fulfillment of the requirements for the degree of

MASTERS OF SCIENCE

in

Family and Child Development

Approved:

Karen H. Rosen, Ed.D. Committee Chair

Jean I. Coleman, Ed.D

Eric E. McCollum, Ph.D.

Sandra M. Stith, Ph.D.

April 3,1997
Blacksburg, Virginia

Keywords: Parents of Adolescents, Clients' Experience, Qualitative Study

“LOOKING AT THE PICTURE BY STEPPING OUTSIDE’’

A QUALITATIVE STUDY OF PARENTS’ OF ADOLESCENTS EXPERIENCES IN FAMILY THERAPY

By

Maryann Sheridan Walsh

Karen Rosen, Chairman

Family and Child Development

(ABSTRACT)

Parents with adolescents often find themselves caught in the stress and strain that “normally” accompanies this stage of life. It is when parents cannot meet the demands of troubled adolescents that they find themselves seeking family therapy. Most of what continues to be reported about the process of therapy continues to be from the therapist’s or researcher’s perspective. There has been an increased interest in what clients have to say about their experiences. The purpose of this study was to develop a detailed description of how parents of adolescents who attended family therapy in private practice settings viewed their experiences. Fifteen parents who had been to therapy with their adolescent were recruited by their therapist to be interviewed for this study. A multicase qualitative design and constructivist theoretical framework guided the

investigation. The constant comparative analysis was used to develop four core categories that described the subtitles of parents' therapeutic experiences. Five case stories illustrated the categories and parents' quotes were used to further embellish the findings

The findings included parents' expereinces prior to beginning, during therapy as well as reflections in retrospect. The pre-therapy presentation, based on expectations and past experiences in treatment, affected the way parents initially approached therapy. A supportive therapeutic climate was necessary for parents to trust and become open to possibilities and do the hard work required to make changes. The story of their current experience was part of the family therapy process. Parents recognized changes and what they valued about their experiences in family therapy.

ACKNOWLEDGMENTS

There are many people in my life I wish to thank for their encouragement and support while I have been involved in completing this project. First among them are the participants--the parents--who were willing to candidly and openly share their stories with me; and--the therapists-- who believed in this project enough to make time to suggest to clients that they participate, and who supported the continued pursuit of knowledge in the field of Marriage and Family Therapy. Thanks to all of you.

Thank you to my friends and colleagues, and especially Kevin Broderick, the co-creator of this project. I do not know what I would have done without your curiosity and caring ways, and sometimes your knowing just what I needed to continue in this endeavor.

Next, I want to acknowledge my committee, Sandi Stith, Eric McCollum and Jean Coleman. You were inspirational, each in your own way, and shared your enthusiasm and vision of what it is to be an MFT at just the right moments during my journey. I look to each of you as a role model that I will always remember.

And without Karen Rosen, my advisor and committee chair, I might have abandoned this research effort somewhere along the way. Karen's calming presence, sense of humor and expert knowledge guided me through the peaks and valleys of the

qualitative research process. I owe so very much to her.

Thank you to my parents, Abby and Bill Sheridan, my sister, Nancy and late sister, Jean who have given me the chance to know first hand what family is really all about.

I want to thank my husband, Tom, for his encouragement, support and belief in me throughout the years I have been in school, and especially during the last year while I've been working on my thesis. He picked up more than his share of the slack for me to pursue a dream.

Without my daughters, Emily, Julie and Kristen, and step-daughter, Shannon, I would not have had the opportunity to know what it is to parent teenagers. I would not trade many (!!) moments for anything. I want to thank them for allowing me to play the role I do in each of their lives, for sharing the good times and the not so good times with me...and for reaching out, for their kind and caring ways, and for the sacrifices and extra efforts each made to help me through the last year.

For each and everyone, I will "...thank my God each time I remember you."
(Philippians 1:3)

TABLE OF CONTENTS

CHAPTER I

INTRODUCTION

Statement of the Problem

While certainly there are a variety of issues that brings a family to treatment, seeking therapy tends to peak for families with adolescents (Preto, 1989). Whether families reach a point of voluntarily seeking assistance, or whether they are referred or court ordered, many arrive feeling confused, angry, out of control, or at their wits end. Problems presented reflect the stress, strain, and frustration of dealing with the demands families with adolescents "normally" face compounded by the ever increasing complexity of the times in which we live (Lussardi & Miller, 1992; Preto, 1989; Wylie, 1994).

Parents often find themselves on unfamiliar ground as their adolescents introduce new behaviors and ideas into the family system. Dealing with erratic moods and their accompanying behaviors also presents its own set of challenges for parents (Lussardi & Miller, 1992). Many parents find that what were familiar forms of encouragement, displays of affection, and rules of discipline may no longer work. Their challenge is to delicately balance love and respect, connection and openness, with authority and discipline during this phase of family life (Lussardi & Miller, 1992; Preto, 1989; Wylie, 1994).

Popular magazines, television programs and personal anecdotes commonly support the notion that adolescence represents a special source of stress to parents,

family members, and the communities in which they reside. The adolescents of today often walk down a dangerous path, and one that is commonly lined with terrifying issues that most middle-class parents rarely heard mentioned when they were teenagers. Among them are divorce, pre-marital sex, AIDS, suicide, drug and alcohol abuse, violence, gang membership as well as the ethical and moral challenges each of these issues raises. Subsequently, the consequences of growing up and experimenting with new behaviors can be potentially devastating for today's adolescents (Lussardi & Miller, 1992; Wylie, 1994).

For some family therapists, treating parents and adolescents who face the complex issues of growing up today is their worst nightmare (Selekman, 1993). Consequently, the "how-to's" of treating parents and their adolescents is frequently the repeated subject of workshops, professional articles, textbooks and research (Todd & Selekman, 1991). The vast majority of what has been published about parents and adolescents in treatment falls into several categories: outcome research documenting the clinical effectiveness of family-based interventions, treatment strategies for specific adolescent behavior problems, and developmental issues of families with adolescents. The focus of much of the family therapy research for parents with adolescents is centered on the adolescent and their particular problems and not the parent (Breunlin, Breunlin, Kearns & Russell, 1988; Mann & Borduin, 1991).

There is a common sense notion among clinicians based on their experience with this population that it is the parents and not the adolescent who present as the consumers of family therapy. Often the family arrives for treatment in the midst of a crisis with the adolescent as the identified patient. Parents' attitudes and participation in the therapeutic process are central to retaining adolescents in therapy, to their compliance with treatment, and in some cases, to the success of therapy overall (Todd & Selekman, 1991). However, parents have had few opportunities to voice their perceptions about the experience of family therapy (Barnard & Kuehl, 1995; Kuehl, Newfield & Joanning, 1990; Shifts & Knapik-Esposito, 1993). Listening to the client's voice is increasingly being recognized as essential to developing a working alliance and to the success of treatment (Barnard & Kuehl, 1995).

The purpose of this study is to describe how parents of adolescents experience participating in family therapy. This study builds a detailed description of parents' experiences and perceptions. Learning more about the parents' experiences provides the opportunity for clinicians to understand parents as consumers, and to better address the issues that bring families with adolescents to treatment from the perspective of the parent. The objective of this research is also to add to the growing body of knowledge within the field that has examined the clients' language and the meaning given to the therapeutic experience. The constructivist theoretical framework guided this qualitative study.

Significance of the Study

Within the field of family therapy, there has been a long standing interest in issues surrounding parents and their adolescent children. Over the decades, the ever growing body of knowledge has contributed to theory development, refinement of clinical practice, and interest in further research on a multitude of themes and issues involving families with adolescents (Breunlin, Breunlin, Kearns & Russell, 1988; Mann & Borduin, 1991; Pinsof & Wynne, 1995).

The stage in the life cycle known as *families with adolescents* (Preto, 1989) challenges the coping and adaptation skills for all members of the family system (Lussardi & Miller, 1992; Preto, 1989). Any number of circumstances may complicate the relationship between parents and their adolescent children. Parents with adolescent children are typically entering mid-life, and are facing the accompanying changes in their own lives. In addition to coping with the demands of adolescence, parents may find themselves dealing with unresolved conflicts with their families of origin, re-evaluating marriage and career choices, and facing the task of becoming the caretakers of their own parents (Preto, 1989). Sometimes because of their personal experiences in their families of origin, parents may differ with each other regarding rule-making and rule-enforcing which may even further complicate this already challenging stage of life (Preto, 1989).

Consequently, parents and adolescents often arrive for family therapy with a variety of issues as presenting problems. Among them are alcohol and drug

experimentation and abuse, depression, suicide, delinquency, school failure, unresolved loss issues, to name a few. Often parents who come to therapy with their adolescents are confused and angry as they relay that their child's behavior does not meet their expectations. Similarly, adolescents are bewildered and upset about their parents' behavior toward them. Parents, in an effort to be in charge during this stage of life, can be controlling and rigid. What were once flexible rules seem to be non-negotiable at times, leaving adolescents with the experience of confusion and uncertainty about their parents.

While it has not been practical or even realistic for family therapists to be experts in all treatment areas, it has been essential for clinicians to have a sense of what is, and what is not, useful when working with this population. Today, family therapists are faced with increasingly complex presenting problems as they attempt to decipher what is meant by power, hierarchy, discipline and authority within the families that present for treatment (Wylie, 1994). Much of the work for today's family therapist seems to be shifting from shoring up and rearranging hierarchies as a means of establishing parental authority (Minuchin, 1974; Preto, 1989) to understanding and supporting parents as they seek to identify norms, values, rules and goals that support the increasingly complex workings of their family system (Wylie, 1994).

Many of the research studies on treatment of families with adolescents reported in the professional literature have focused on the outcome of specific treatment approaches, and/or the treatment of specific adolescent behavior problems. For example, Bruelin,

Bruelin, Kearns & Russell (1988) in their review of the literature on family therapy with adolescents, reported an increase in the application of various family therapy models to specific adolescent problems and situations. Many of the outcome studies included in this review indicated that family therapy with adolescents produces favorable outcomes. Family focused interventions when treating adolescents "is a viable treatment approach, one that in many instances produces results often exceeding those seen when other, more traditional treatments are employed" (p. 328). Similarly, in their review of the literature, Mann and Borduin (1991) concluded that family therapy was effective in decreasing adolescent unacceptable behaviors and problems along with improving family relations, and that positive changes appeared to be maintained over extended follow-up periods.

Several reviews of research published in the October, 1995 issue of the *Journal of Marital and Family Therapy* focused on outcome of family therapy for the treatment of selected disorders of adolescents including conduct disorder, delinquency, autism, attention deficit/hyperactivity disorder, and drug abuse combined with specific approaches aimed at both parents and adolescents (Chamberlain & Rosicky, 1995; Estrada & Pinsof, 1995). In their concluding summary, Pinsof and Wynn (1995) state that with few exceptions "there is a convincing body of scientific evidence supporting the efficacy" and in some cases "the superiority of marriage and family therapy" (p. 610) in the treatment of adolescents.

Traditionally, most family therapy research with this population has reported on the outcome of treatment under controlled condition, using quantitative designs that tested hypotheses by measuring change with reductionistic techniques and discrete variables measured with standard assessment instruments (Mahrer, 1988). While this research has contributed significantly to the field of family therapy, applying statistical data reduction techniques can obscure meaningful distinctions of clinical phenomena. Quantitative designs may also mask the richness and the insight into the complexities of the therapeutic process as it is experienced by the client. More recently, family therapy research has expanded to include qualitative discovery-oriented psychotherapy research for evaluating the therapeutic experience (Mahrer, 1988; Moon, Dillon & Sprenkle, 1990). This study uses a qualitative design and methods to analyze interviews conducted with parents of adolescents to obtain a description of their experiences in family therapy. It is aimed at identifying general themes which highlight parents' experiences of family therapy prior to, during and after therapy by providing the opportunity for them to "step outside" of the therapeutic process and reflect on what happened-- by taking a "look at the picture."

With few exceptions, much of what is reported about the process of therapy is based on the therapist's and not the client's experience (Garfield, 1994; Kantor & Andreozzi, 1985). The understanding of clients' experiences of family therapy is based on the perceptions of the clinician, the researcher or the theoretician rather than the

individuals who participate in the treatment. Accounts of clients and their experiences in family therapy have only recently begun to be reported in the literature (Kuehl, Newfield & Joanning, 1990). An initial study conducted by Kuehl (1987) described experiences in therapy of substance abusing adolescents and their family members focused on the counselor's contributions to the counseling experience as perceived by the clients.

In a subsequent study, Newfield, Joanning, Kuehl and Quinn (1991) were primarily interested in constructing a mini-ethnographic account of family members' discussion of treatment issues. Several of the domains of inquiry included expectations of counseling, types of "psychos and shrinks" (p. 277), the setting and characteristics of the counselor. These researchers concluded that "there is little consistency regarding the way clients and family therapists conceptualize expectations of counseling, ... the value placed on family therapy, ... and characteristics of the counselor" (p. 301).

Several other studies followed similar patterns. While family members' experiences have been included in several studies, there has not been a study that specifically addresses the perceptions of parents' of adolescents in family therapy. It should also be noted that most of the reported studies published have been conducted in clinical training settings. This research project begins to fill this gap by examining the therapeutic experiences of parents of adolescents who were seen in private clinical practices. With the effectiveness of family interventions having been well documented

with this population, it is important to gain new insights from parents' of adolescents because they play a vital role in the treatment process of adolescents.

This investigation has several implications for clinical practice. The purpose of this study is to develop rich descriptions of how parents of adolescents experience family therapy, and in doing so, add to the growing body of knowledge regarding clients' views of treatment. With the focus on examining the experiences of parents of adolescents in family therapy, this study can help therapists develop specific ways to enhance their effectiveness with this population. Clinicians are provided with additional insights and increased understanding of the therapeutic process leading to more effective interactions with parents and their adolescent children and more effective means to deal with the issues they bring to treatment. This will facilitate the process of developing a more consumer friendly therapy for parents of adolescents (Shifts & Knapik-Esposito, 1993).

Theoretical Framework

The current study examines parents' experiences of family therapy from a constructivist theoretical framework. Constructivist theory suggests that the concept of "reality" is created through personal ideas, experiences or constructs about the world in which one lives (von Glasserfeld, 1984). Gergen (1985) describes "reality" as invented not discovered, and "reality" as evident only through constructed meanings that shape and organize an individual's experiences. Meaning is continually constructed during ongoing interaction between an individual--as observer/describer--and the social

environment. Constructed meanings of reality thus serve as a way for one to organize perceptions and experiences into patterns and beliefs, and as a means to describe, direct and predict the experience of life. As Gergen (1985) summarized:

> The terms in which the world is understood are social artifacts, products of historically situated interchanges among people. From the constructivist position the process of understanding is not automatically driven by the forces of nature, but is the result of an active, cooperative enterprise of persons in relationship. (p. 267)

In the last decade, there have been many developments in the field of family therapy based on the theory of constructivism (Anderson & Goolishian, 1988; deShazer, 1991; Efran, Lukens & Lukens, 1988; Kantor & Andreozzi, 1985; McNamee & Gergen, 1992; Sprenkle & Piercy, 1992). Constructivist theory also provides a means for developing alternative methods of conducting psychological inquiry (Gergen, 1985). Constructivist thinking elevates the client's view of reality, and when applied to the therapeutic process, elevates the meaning clients give to problems and solutions. The constructivist therapist considers therapy to be collaboratively based and client driven to the extent that the clients' view of reality and goals guide the therapy (Anderson & Goolishian, 1988; Duncan, Solovey & Rusk, 1992; Sprenkle & Piercy, 1992).

When applied to qualitative research, a constructivist position de-emphasizes the importance of the search for "truth" as well as the role of the researcher as the source of "truth." Constructivism allows the researcher to take a collaborative stance with participants during the research process. The researcher's role is to respectfully create

the conditions for exploration and explanation, not necessarily looking only for the answers. There is also a de-emphasis on the researcher's control of the process since the meaning is embedded in the interaction. Thus, research becomes a process that seeks to allow mutual collaboration in defining and revising the research conversation.

Constructivist theory informs the study by providing the means of challenging the context-bound meanings ascribed to the experiences of therapy as viewed by the researcher or clinician. The parents' views of reality and their meaning system become important as they relate to the experience of the therapeutic process. Thus, the researcher was called upon to respect the parents' presentation and to consider the uniqueness of each therapeutic encounter. The parents' presentation contributed to determining the direction and content of the research conversation. These shared conceptualizations of reality described by parents can be used by therapists, researchers, or others involved in similar experiences in the future (Kuehl, 1987).

In summary, a constructivist theoretical framework guided the development and focus of this study. To capture the constructed meaning of the therapeutic encounter as experienced by parents of adolescents, the researcher began by posing questions which enabled participants to describe how they experienced family therapy.

Research Topics

The research questions that guided the inquiry into the experiences of family therapy for parents with adolescents from a constructivist theoretical frame included the following:

1. What are parents' expectations of family therapy? What contributed to parents' expectations prior to beginning family therapy?

2. What are parents' actual experiences and reactions to therapy? This question seeks descriptions of parents' initial experiences and the factors that contributed to their experiences.

3. What has participating in family therapy over time been like for them as parents? What do parents think family therapy has been like for their adolescent? This line of questioning focuses on what has been helpful, and not helpful, and what they experienced as helpful or not for their adolescent. What contributes to their perception of helpfulness?

4. What changes did the parents experience for themselves during the course of family therapy? What factors do they feel contributed to these changes?

5. What were the characteristics, techniques and interventions of the therapist that left an impression? What suggestions might parents make that could be useful for a therapist to consider when working with a family of similar circumstance?

6. What if anything about the experience of a session do parents reflect on between visits? This question aims at seeking a description impact of therapy outside of the session. How do parents use the experiences of therapy outside of treatment?

CHAPTER II

LITERATURE REVIEW

Introduction

This study examines how parents of adolescents experienced family therapy. Family therapists have sought to understand the complexities of therapeutic process and its outcomes based on the ever growing body of research conducted over the decades. Traditionally research has been quantitative in design and reported from the perspective of the clinician, researcher or observer. Recently, there has been an interest in understanding the therapeutic encounter from the client's viewpoint. This literature review examines the pertinent research on clients' experiences from several vantage points. First, it includes examples from the field of clinical psychology literature focusing on clients' experiences. This is followed by a more comprehensive review of qualitative research on clients' experiences in family therapy.

Clients' Experiences of Psychotherapy

Within the field of clinical psychology much of the research on the process of therapy has been conducted by researcher/observer using objective measures within specific theoretical frameworks. Subjective data for the most part had been excluded allowing for a limited view of the intricacies of the therapeutic encounter. The limitations of hypothesis-testing research to the exclusion of everything else has been challenged by a few researchers within the psychotherapy field (Maher, 1988).

In an article appearing in *American Psychologist,* Maher (1988) offered a critique of hypothesis-testing psychotherapy research along with several discovery-oriented alternative methods of research for the field to consider. Citing "a small but vigorous interest in what is coming to be known as discovery-oriented research" (p. 694), Maher suggested that researchers study psychotherapy by asking questions "whose answers provide something one wants to know but might not have expected, predicted or hypothesized" (p.697).

One of the many subjects investigated by those who stepped outside of the boundaries of traditional hypothesis-testing research and into the arena of the discovery-oriented approach was that of clients' self-reported experiences of therapy. It was suggested that in order to understand and appreciate the therapeutic process, the personal experiences of the client participants should be considered along with the traditionally reported experiences of the therapist, researcher and/or observer (Elliott & Shapiro, 1992; Lietaer, 1992; Llewelyn, 1989; Rennie, 1990). Considering the clients' perspectives was also thought to be essential in understanding the process of change (Elliott & Shapiro, 1992; Lietaer, 1992; Llewelyn, 1989).

Clients' experiences of psychotherapy were studied from various perspectives using a variety of qualitative methods. Several studies looked at what clients considered to be the significant events of therapy (Rennie, 1990), whether these events were experienced as helpful or hindering in therapy, and how they impacted the process of

change (Elliott & Shapiro, 1992; Lietaer, 1992; Llewelyn, 1989). Some studies also considered the therapist's perceptions of the same event in an effort to understand the relationship between the two views, and if the differences and similarities were significant and related to the outcome of therapy (Elliott & Shapiro, 1992; Lietaer, 1992; Llewelyn, 1989; Regan & Hill, 1992).

Rennie (1990) used the technique of *interpersonal process recall* to study clients experiences of the psychotherapy. During the research interview, clients were asked to review tapes of recent sessions, identify what they considered to be meaningful moments, and describe their recalled experiences at the time. Qualitative analysis of the clients' interviews yielded the core category of *clients' reflexivity*, "turning back on one's self" (p.159). Four main categories of experience were also specified: the client's relationship with personal meaning, the perception of the relationship with the therapist, the client's experience of therapist's operations, and the client's awareness of outcomes.

According to Rennie (1990), the clients' experiences of psychotherapy, in part, were based on developing new self-awareness. In focusing on this awareness, clients reflected on what they were thinking and feeling, reflected on their behavioral response, and constructed personal narratives regarding their reflections. Based on whether experiences of therapy and perceptions of the relationship with the therapist were positive or negative, the client either addressed these personal reflections (positive), or focused on managing the relationship (negative) rather than on self.

Elliott and Shapiro (1992) examined clients' and therapists' analysis of significant events in therapy. Significant events were defined by the researchers as the instances clients experienced as helpful or important, and were viewed as "windows into the process of change" (p. 164). Applying the qualitative method of comprehensive process analysis, Elliott and Shapiro described the context, the important features and the impacts of significant events. Using the technique of brief structured recall, clients and therapists expanded upon what they considered to be their personal significant events as they reviewed tapes of a therapy session. Clients and therapists described similarities and differences ranging from virtually identical to moderately inconsistent. However, most often the same events were identified as significant and described similarly.

Their study illustrates the need for therapists to be able to recognize discrepancies between theirs and their clients' experience and to use the differences in a way that builds an alliance with the client. Rigorous adherence to a model of treatment may at times prevent the therapist from realizing the client's concerns or lead to setting inappropriate goals for treatment.

Llewelyn (1989) investigated clients' and therapists' views of helpful and unhelpful events that occurred during therapy sessions. The study used the Helpful Aspects of Therapy (Bloch, Reibstein, Crouch, Holroyd, & Themen, 1979, cited in Llewelyn, 1989) questionnaire after each session and again six months after termination. The Helpful Aspects of Therapy (HAT) questionaire asked open-ended questions that

required participants to describe their session experiences in their own words. Forty therapist-client pairs provided feedback about 399 sessions yielding 1069 events that were analyzed using the Therapeutic Impact Content Analysis System (TICAS). The TICAS consisted of thirteen categories of events--eight helpful and five unhelpful. There was a difference in perspective between clients and therapists. While they were active participants in therapy, clients found the reassurance and relief that therapy provided was most helpful. In retrospect, they valued the problem-solving aspects therapy offered them. In contrast both during and after therapy, the therapists identified the cognitive and affective insights they assumed their clients had developed as most helpful. Regardless, the results suggested three major therapeutic ingredients in psychotherapy: insight, reassurance/relief, and problem solving. The results also suggest the need to keep these in balance. Therapists need to create a supportive and reassuring context for their clients, and at the same time challenge their existing cognitions and behaviors as the way to stimulate change.

Similarly, Lietaer (1992) explored the extent to which the theory of change coincided with the actual experiences that therapists and clients described as impactful. A sample of 41 clients and 25 therapists participated in this exploratory and descriptive study by answering opened questions regarding the helpful and hindering experiences in therapy. The content analysis was based on 325 interviews and 1053 response segments and yielded three categories: aspects of relational climate describing attitudes and

characteristics of the therapist--such as acceptance, empathy and genuineness; specific therapist interventions--including encouraging self exploration, here-and-now feedback, giving advice; and aspect of process concerning client--insight, exploring experiences, experiencing progress.

Both clients and therapists identified self-exploration and insight as helpful components of therapy. Clients thought having a safe relationship with an accepting and empathetic therapist was essential for self-exploration and facing, accepting and integrating previously denied aspects of their experiences. Clients were left feeling more powerful and in control and knowing possibilities for change existed. Therapists' interventions identified by clients as contributing to the their experiences included asking exploratory questions, confronting, interpreting, and giving feed-back. Clients also found it helpful when therapists revealed personal aspects of themselves within sessions.

In Lietaer's (1992) study, clients and therapists offered few comments regarding hindering processes of therapy, and described them as "a short episode in an otherwise positive session" (p. 150). Both clients and therapists tended to attribute non-helping aspects of therapy to themselves and not to each other. Also noteworthy was that some clients saw therapists as not helpful when they were either too passive or too active, too confronting or not confronting enough, too interpretive or insufficiently interpretive.

Regan & Hill (1992) take a different approach to the study of client experience of therapy. They looked at what did not occur and how that impacted the process of

therapy. Their study was based upon the fact that self disclosure is an important aspect for both clients and therapists. When clients conceal significant aspects or leave negative statements unsaid, they may be less involved and less likely to benefit from the experience. The result for the therapist is a misperception of the client's process and misdirections in addressing the problems that need addressing.

The purposes of their study were to investigate the differences between clients and therapists in terms of frequency, content and nature of things left unsaid, to explore the relationship between these three, and to investigate whether therapists were aware of what clients left unsaid. Twenty-four therapists and 24 clients completed the Things Left Unsaid Inventory by answering open-ended questions aimed at eliciting information about what was experienced but not stated overtly during a session. Responses were then coded into categories in terms of content (behaviors, cognitions, emotional reactions and clinical conjecture), and valence (affective tone) using a five-point Likert-type scale ranging from very negative to very positive. Most of the things left unsaid by clients and therapists were negative emotions, behaviors or thoughts that occurred to them during session. For clients, there was a positive correlation between the things left unsaid, and a negative correlation between things of behavioral/cognitive content and satisfaction and change. Counselors were aware of only 17% of things clients left unsaid. When counselors guessed what clients left unsaid, they rated those sessions as more difficult, and clients said they were less satisfied with treatment.

In conclusion, studying clients' experiences in therapy has been, and continues to be the subject of research in the psychotherapy field. With few exceptions, clients' perceptions offer new insights into the subtleties of the therapeutic process. In the day-to-day practice of psychotherapy, therapists have the opportunity to use this information to better select and evaluate the ways in which they interact with their clients.

Qualitative Studies of Clients' Experiences in Family Therapy

Over the last decade within the field of family therapy, there has been an ever-growing curiosity about how clients' experience the process of therapy. This interest has grown to where clients' experiences in therapy have been addressed at professional conferences and in professional journals. As recently as the January/February 1997 issue, *The Family Therapy Networker* called for articles addressing "client perspectives." Two trends in the field of family therapy have supported documenting what clients have to say about their experiences. One trend has been the growing interest in qualitative, ethnographic and interpretive research designs (Moon, Dillon & Sprenkle, 1990). In response to this interest, a number of qualitative researchers have emphasized the relevance of clients' dialogue, descriptions and opinions of therapy. The other trend is related to the shift in theoretical models and its influence on the practice of family therapy. Clinicians who draw from theories based on constructivism, collaboration,

narratives, and solution focus describe therapy as "the inventions and elaboration of new ideas and behaviors through clients' active participation in the therapeutic conversation" (Conran & Love, 1993, p. 8). They view their role as therapist as one who provides a context for consultation that allows clients to explore and revise uncomfortable or undesired thoughts, behaviors, feelings and communication styles.

A growing number of researchers and clinicians have attempted to understand what clients think about their experiences in therapy, what has proven to be helpful and what has not, and what influences the therapist-client relationship. Client experiences have been studied from various perspectives using a variety of qualitative methods and techniques. Several studies considered clients' description of the therapeutic process and relationships and effectiveness in supporting desired change (Beer, 1992; Bischoff & McBride, 1996; Fine & Turner, 1996; Kuehl, 1987; Kuehl, Newfield & Joanning, 1990; Mabrey, 1995; McCollum & Beer, 1995; Newfield, Kuehl, Joanning & Quinn, 1990, 1991; Sells, Smith, & Moon, 1996; Swint, 1995; Wark, 1994). Several researchers focused on a particular population and/or presenting problem and clients' experiences in therapy (Broderick, 1996; Conran & Love, 1993; Shilts & Knapick-Esposito, 1993; Stith, Rosen, McCollum, Coleman & Herman, 1996). Several researchers studied the effects of specific models of marriage and family therapy or intervention techniques and how clients experienced them (Metcalf, Thomas, Duncan, Miller & Hubble, 1996; Sells, Smith, Coe,

Yoshioka & Robbins, 1994; Sells, Smith, Pereira, Todahl & Papagiannis, 1995; Smith, Yoshioka & Winton, 1993; Thomas, 1994).

Experiences of Therapeutic Process and Relationships

Newfield, Kuehl, Joanning and Quinn (1986, cited in Kuehl, 1987) were among the first in the field to conduct a mini-ethnographic investigation focused on clients' experiences in family therapy. Ethnographic research methods aim at describing individual cultures or aspects of cultures in a non-interpretive manner. These researchers used the data collected from an ongoing outcome study investigating the effectiveness of different approaches for working with substance abusing adolescents to focus on the family systems component of treatment. They reported their findings in four separate reports.

Kuehl (1987) has been cited as the first researcher in the field of marriage and family therapy to focus on clients' descriptions of the therapeutic experience. The 39 clients from 12 families who participated in the project were interviewed between 1 and 6 times for a total of 27 interviews that provided 76 hours of interview data. Each of the families attended an average of 10 therapy sessions. In Kuehl's study, participants were asked to discuss a broad range of domains relevant to the therapy experience. The domains which emerged during the discussions included themes related to clients' expectations of counseling, the stages of counseling including the physical setting, the different types of counselors who helped them, what it was like to be the parent,

adolescent or sibling in counseling, what happens between meetings, and clients' suggestions for counselors. The findings suggested a wide-range of implications for counselors. Most noted were the client's ambiguity toward the process which often goes unnoticed, how client's perceptions of the counselor affects the counseling process, and the counselor's use of theory.

Peterson (1980, cited in Kuehl, 1987) defines ambiguity as "the lack of structure or the presence of incompleteness or vagueness in a stimulus situation, so that the situation does not elicit or demand the same response from all persons" (p. 175). Clients' ambiguity increases their anxiety to the point where their cooperation becomes inhibited and the effect is detrimental to the therapeutic process. Kuehl's (1987) study suggested that a great deal of ambiguity was experienced in family therapy by clients and was unrecognized and unused by counselors. When ambiguity lingered it contributed to clients feeling uncertain, misunderstood, manipulated or invalidated, and to prematurely terminating counseling.

Kuehl (1987) also reported that the counselor's use of theory contributed to the clients' perceptions of whether they were responsive to the family and their concerns. When counselors were wedded to "unmitigated application of theory" (p.196), clients perceived them as unreceptive to family members' concerns and goals, and as using sessions to discuss topics that seemed unrelated and irrelevant to solving the family's problems. Based on his investigation, Kuehl suggested that a counselor's strict adherence

to a theoretical orientation was problematic in many instances, and perhaps the result of the counselor's inexperience or the strict research context in which the counseling took place.

Newfield, Kuehl, Joanning and Quinn (1990) focused on clients' descriptions and opinions of family therapy and treatment conditions for adolescents. Four domains emerged from their analysis: expectations of counseling, types of "psychos and shrinks" (p. 277), the setting and individual versus family therapy. The researchers found there were a number of areas where clients' opinions of how therapy should be conducted did not fit well with their actual experiences. The results indicated that the lack of shared meaning in the ways clients and therapists conceptualized their experiences led to an "ambiguous experience" (p.72) of therapy. Newfield, et al. (1990) concluded that therapists should ask themselves what clients are saying, and how clients are viewing what is occurring. They suggested that therapists should ask clients directly rather than rely on their own perceptions.

Kuehl, Newfield and Joanning (1990) constructed a client-based description of family therapy. Clients identified and described the phases of treatment beginning with the introductory meeting followed by assessment, sharing successes with the counselor, trouble-shouting and follow-up. Clients' responses also reaffirmed the importance of therapist's characteristics. When clients felt their therapist was personable, caring and competent, they were often satisfied with their experience. In considering the perspective

of dissatisfied clients, the researchers suggested that the therapists rather than clients show up as resistant, and that therapists should be cautious when trying to convince clients of the usefulness of an approach that the client does not accept.

In their fourth report, Newfield, Kuehl, Joanning and Quinn (1991) presented additional domains derived from interviews with participants that included characteristics of the counselor and how counseling progressed. According to clients, the behaviors of counselors ranged from "congenial and sympathetic to provoking and hurtful" (p.294). Several of the characteristics frequently mentioned included "asking many questions and having no answers, making clients figure things out for themselves, becoming a friend, and getting something in his head and not wanting to change it" (p.294). Newfield, et al. (1991) expanded on the Kuehl, Newfield and Joanning (1990) report of clients' descriptions of the therapy process. They added several to the earlier study and noted clients' descriptions closely matched those of the best known family theorists: assessment, getting down to basics, putting suggestions into practice, sharing successes with the counselor, and trouble shooting and follow-up.

In a single case study, Beer (1992) examined the therapeutic process from the client's, therapist's and researcher's perspectives. Single-case inquiry allowed the researcher "to investigate the complex and recursive interactions that systems theory suggests occur in family therapy" (p. 17). Beer conducted a pre-therapy interview with the participants independently to obtain their perspectives regarding assumptions,

attitudes and beliefs about therapy before they met as clients and therapist. Then, Beer intensively examined the first ten sessions of therapy by observing through a one-way mirror, and conducting videotaped post-session interviews with both clients and therapist. Selected segments of the videotaped session were replayed to facilitate the discussion. Beer then reviewed the videotapes of the sessions and interviews to generate inquiry and compare his interpretations with those of the participants. For the last 11 sessions, the researcher reviewed the videotaped sessions, but did not conduct post-session interviews.

The findings of the project comprehensively captured the experiences of therapy and research for all participants. Beer (1993) concluded with many thought provoking ideas. One of these ideas is that research is therapeutic. The notion that "research somehow enhanced the effectiveness of therapy" (p. 230) was reported in some fashion by all of the participants. Beer suggested that therapists routinely talk with clients about therapy using "research talk" in addition to "therapy talk" and research-type questions during the therapeutic process as a means for therapists to improve their understanding of clients and vice versa. Beer also suggested that clients have untapped expert knowledge resulting from their unique vantage point in therapy, and that exploring clients' expertise allows clients to become competent contributors to the therapist-client relationship. The clients in the study reported that meeting with the researcher before the first session and hearing something about the therapist made the initial session more comfortable. Beer

suggested pre-therapy consultation meetings between therapist and prospective clients could be useful to clarify expectations about the process, and to discuss how the therapist and client might best work together. Beer concluded that participants, each in their own ways, shared the uniqueness and intensity of the experience of getting together and talking about therapy, and were each left with an impression that may last as long as a lifetime.

In an issue of *The Family Therapy Networker,* McCollum and Beer (1995) discussed their reactions to participating in the Beer (1992) study. Midway through the project, the researcher interviewed the therapist and couple together and asked how they felt about the work they had done together. For the therapist, it was a new experience to talk with clients about the therapy process, to come fact-to-face with what his clients thought of being in therapy with him, and to find out what clients really wanted from him as their therapist. The therapist learned what it really means to collaborate with clients and that his standards of what constitutes "good therapy" were not always shared by his clients. The authors challenged therapists to listen to clients' voices as "the way not to change *them* but to change *us*, to reshape our ideas of what therapy is, how it can help, what place it should occupy in society" (p. 62).

Bischoff and McBride (1996) examined clients' experiences of the therapy process, including what was helpful and not helpful about the treatment they received. The researchers analyzed videotaped interviews of 18 client systems who had attended family therapy at a university-based clinic. The 28 interviews took place at different

points during the course of ongoing therapy, anywhere from the sixth to twentieth session. Applying the constant comparative method of analysis yielded three categories: the hierarchy within the therapist-client relationship, therapist empathy and other ingredients of good therapy, and family therapy techniques. In contrast to several other studies, clients reported experiencing a power differential between themselves and their therapists, and often deferred to them to set the direction of therapy. The researchers found some clients were comfortable working with someone who is an expert at resolving problems,and for some a collaborative approach was not helpful or desired. The researchers also found that for the client to trust and respect the therapist-as-expert, the foundation of the relationship had to be based on empathy, understanding, and mutuality. In addition, clients found experiential in-session activities with multiple family members helpful, especially when children were involved. Parents reported they gained new insights about their children and relationships. The findings of this research suggested the need for therapists to question clients, and to consider their expectations, experiences and what they find helpful as part of ongoing treatment planning.

Sells, Smith and Moon (1996) explored both the clients' and therapists' perceptions of family therapy effectiveness throughout the treatment process by considering what occurred on a session-to-session basis. Fourteen clients and their four therapists from a university-based marriage and family therapy clinic participated in post-session interviews at different points during the course of therapy. During the first

phase of the project, the therapists interviewed their own clients; during the second, an outside researcher interviewed the same therapists and different clients. Using ethnographic research methods and domain analysis, the following six core categories describing clients' and therapists' perceptions of therapy effectiveness emerged: changes associated with counseling, important practitioner qualities, effective interventions and techniques, ineffective interventions and techniques, and recommendations for future sessions. The sixth core category described the strengths and limitations of ethnographic practice evaluation.

Both clients and therapists identified specific areas that improved as a result of counseling. Clients named improved parenting skills, better communication and understanding of their problems. Both clients and therapists thought specific personality traits (e.g., being down to earth instead of stiff or overly professional, having a sense of humor, or being understanding and impartial) played an important role in fostering a good therapeutic relationship. Therapists believed adjusting tactics between sessions contributed to positive changes for their clients. Clients thought it was helpful to gain perspective about problems and to have a safe place to talk. However, they thought it was not helpful when therapists misunderstood them or failed to directly address their problems. Both clients and therapists believed it was not helpful when treatment goals were unclear. Clients recommended that therapists focus on specific problems, establish

clear goals, and make specific suggestions. Therapists thought that it would be helpful to periodically review goals and progress with clients.

Several findings emerged regarding the benefits and limitations of ethnographic practice evaluation. Both clients and therapists felt that their participation in research contributed to their feeling that the therapeutic process was based on collaboration. Clients, in particular, felt as if they were part of the process and that their opinions mattered. However, when interviews were conducted too early in the course of treatment, clients felt they did not know their therapist well enough to comment or insufficient change had occurred in therapy. Clients also preferred to be interviewed by someone other than their own therapist. The most interesting and unexpected finding was "how the process of completing this research changed how therapists viewed their existing practice and philosophy of treatment" (Sells, Smith & Moon, 1996, p.335). That is, therapists learned that collaborating with clients and considering their evaluations of therapy were essential to the therapy process.

Wark (1994) used qualitative methods to study what was meaningful and helpful to therapeutic change according to couples and their therapists. In-depth interviews were conducted with five groups of participants comprised of a client couple, a therapist, and a supervisor who did live supervision. Each of the groups participated in six post-session interviews and one interview after completing therapy. Nine categories relating to change in therapy emerged from the therapists' data, and 11 categories from the clients' data. The

findings indicated that therapists and clients considered different aspects of therapy as important for therapeutic change. Therapists thought relating well to clients, challenging clients, providing the environment for change, pointing out patterns of relating, and using interventions in and out of sessions contributed to therapeutic change. In contrast, clients' reported contributions to change that involved both the therapist and themselves such as: the therapist relating to clients and sharing perspectives about self and couple, both partners having equal time in therapy, therapist validating progress and enhancing positives, and clients gaining awareness and insight about problems and solutions. Therapists thought that therapeutic change was hindered by their lack of follow through and mistakes. Clients felt change was hindered when sessions lacked resolution, and when the therapist did not understand their situation. Since these findings indicated that clients' views were often not obvious to therapists, Wark suggested that clarifying clients' perspectives contributes to "reducing the distance between therapists' thinking and clients' lived experiences" (p.34).

Swint's (1995) study focused on how clients experienced the therapy process and how they perceived and reported change. The six individuals and three families who participated in the study all reported experiencing change. All were clients in a clinic setting where a collaborative approach to treatment was the norm. The researcher conducted a long, focused interview which was videotaped and transcribed verbatim. Most clients described therapy as a casual conversation that involved balanced interaction

between themselves and their therapist. The majority of participants reported talking with their therapist was like that talking to a friend who was trusting, non-judgmental, and who maintained confidences. The majority also considered therapy to be "very comfortable." Clients reported that the level of comfort contributed significantly to establishing a good relationship with their therapist and their perceptions of how change occurred. Clients thought that the role of the therapist was to encourage clients to "think" about different perspectives by asking questions and using activities and tasks to make a point. Giving suggestions was the most often reported therapist action. Clients generally perceived their therapists giving suggestions in a non-directive manner using language such as "might," "may" or "maybe". Almost half of the participants attributed change to their therapist's use of suggestions. Clients thought therapy played a major role in the change process. Several other factors outside of therapy, such as self-help books, other treatment modalities, medication, and group participation, were also mentioned. Swint concluded that it is the clients and not therapists who ultimately determine whether change has occurred, even if it is difficult for them to find the words to describe their experiences.

Fine and Turner (1996) conducted a qualitative study to explore how clients and therapists viewed their relationship as it evolved over the course of therapy. Semi-structured interviews were conducted with therapists and three couples with diverse histories and presenting problems. Two themes emerged from both clients' and

therapists' descriptions: role-taking which included actions and positions that the therapist and clients might take, and connecting, which included features of the relationship that implied engagement. Similarities between clients' and therapists' responses were noted regarding concern about therapist's judgments and side-taking, professional boundaries and limits, and the therapist connecting equally with each partner of the couple. Clients'

descriptions of the therapeutic relationship included the therapist's expert knowledge and personal qualities and traits. Therapists' descriptions differed from clients' in that the therapists were concerned about their power and influence, and about issues of trust and comfort. Fine and Turner concluded there are multiple aspects of the therapeutic relationship clients find significant and consider important to the outcomes of therapy, and that these aspects differ from those that therapists consider important. Exploring the differences may serve as a way for therapists to build relationships with their clients.

Research Related to Populations and Presenting Problems

Conran and Love (1993) interviewed a sexually abused 10 year old girl and her mother several months after they completed family therapy. The clients shared several opinions about their therapy experience. When this young girl was previously in therapy, she had been harshly interrogated by being "forced to sit in the talkative chair" (p. 72) and tell the story of her abuse. The experience of being forced to talk left her with little regard for therapy and therapists and with an escalating rage and anger months later.

However, in her more recent therapy experience, the therapist did not force her to talk about things she found uncomfortable and engaged her in activities she showed interest in, such as games. She also spent time "making friends" with the team behind the mirror. Her level of comfort increased as she realized the therapist and team meant what they said, and she responded by choosing her own time to discuss her abuse. The mother's prior experience in therapy left her feeling like she had little to say about how her daughter was treated. With the current therapist, she felt heard and respected, and appreciated the approach the therapist took with her daughter. The mother also felt the therapist was helpful in dealing with her life situation and contributed to the positive changes she recognized in her daughter.

Similarly, Shilts and Knapik-Esposito (1993) interviewed a bulimic 17 year old girl, her mother and therapist ten weeks after the family completed therapy. The purpose of the inquiry was to give the clients the opportunity to describe their views of family therapy, and to provide the therapist with ways to better understand the therapeutic process and how he conducted himself as a therapist. Two questions guided the interview. The first elicited the mother's and daughter's descriptions of what happened in therapy that made a difference in their life situation; the second elicited what the therapist learned from the family with whom he had worked. The clients responded to the first question by describing how therapy was like a conversation with a friend where they realized they could help themselves, rather than a lecture. Focusing on what was

working, on other ways of viewing the situation, rather than exclusively on the problem all contributed to the changes both mother and daughter experienced. Acknowledging the clients' strengths, resources and small successes was helpful in building the confidence and courage to make these changes. The therapist responded to the second question by saying he learned more about how he conducted himself as a therapist, and that he shared many of the clients views, though described differently, of various aspect of the therapy process. Shilts and Knapik-Esposito concluded with an invitation to therapists to consider how conversation in therapy contributes to creating new therapeutic realities for their clients.

Stith, Rosen, McCollum, Coleman and Herman (1996) interviewed pre-adolescent children to learn how they experienced participating in family therapy. Sixteen children between the ages of 5 and 13 participated. All had participated in at least four family therapy sessions at a university-based clinic. At the onset, the researchers established rapport by letting the children know they were the experts on their experiences in family therapy. A modified version of the constant comparative method of data analysis led to the development of four broad categories. The first was the reactions children have to the "technology" of therapy including live supervision. All the children seemed to accept the physical set-up (e.g., one-way mirrors, cameras, phone calls) as part of the therapists' efforts to help them. The second category was how they understood why they had come to therapy. Most responded by saying they had come with their family to solve an

existing problem. The third was how they describe what happens in therapy. Some children said talking was the main ingredient of therapy which included being understood and problem solving. Generally, children wanted to be included in sessions and liked activities that encouraged their participation. Children also shared that the personality and behavior of the therapist was an essential ingredient in therapy. The last category addressed changes they noticed both in and out of sessions. Many reported noticing changes as the result of participating in therapy. Changes included change in the process of therapy (e.g., feeling more comfortable) and changes in the family apart from therapy.

The researchers concluded that listening to children's voices can have several implications for therapists. Children like to be included in sessions, and they participate in different ways than adults. They become more comfortable with therapy when they know what is going on. Finally, they consider the personal attributes of the therapist as an important factor in the therapeutic process.

In another study, Broderick (1996) examined adolescents' experiences of family therapy in the private practice setting. Ten adolescents ranging in age from 14 to 19 were interviewed. All had participated in at least four sessions and had been the identified client when treatment was initiated. Broderick found that building a relationship foundation between teen and therapist was the basis for therapy and allowed for talking and being heard in session, gaining personal insights, taking responsibility for oneself, and recognizing results both in and out of sessions.

Family Therapy Models and Intervention Techniques

Mabrey (1995) documented clients' experiences of strategic therapy and their perceptions and descriptions of changes. Participants were interviewed using an open-ended format, and ethnographic analysis methods were applied to their responses. The families interviewed described positive changes, and the majority attributed those changes to their therapeutic experiences. Some of the families noted specific changes in relation to the presenting problem; others noted more general changes that affected many areas of their interactions both within and outside the family. Their descriptions of change also fit well with the descriptions of change within the strategic model. All of the clients commented on the therapeutic relationship and thought the therapist's directives were important aspects of the therapeutic experience and change process. The researcher concluded that clients views of therapy might introduce new perspectives for the continuation of the change process.

Several qualitative studies have been conducted regarding clients' experiences of reflecting team practices. Reflecting teams encourage therapeutic conversations between therapists and clients (Hoffman, 1988, cited in Sells, Smith, Coe, Yoshioka & Robbins, 1994). During the reflecting team process, clients and therapists enter into dialogues that often become part of the clients' decision making process, and result in new ideas, perspectives and alternatives from which they can choose.

Smith, Yoshioka, and Winton (1993) examined clients' opinions of reflecting teams to better understand their benefits to clients. An additional purpose of their study was to develop a set of questions that might productively be used to gather information about reflecting team practices. Eleven clients who attended family therapy at a university-based clinic and who had never experienced reflecting teams participated in the study. The post-session interviews were conducted over a three month period. Applying the constant comparative analysis methods to the clients' descriptions led to the development of three core categories: clients' understanding of the reflecting team, their appreciation of the reflecting team, and perceptions about limitations of the reflecting team. The recurrent theme in clients' statements was the value of having multiple perspectives offered by the reflecting team practice. Additionally, ten questions were developed as a means for other researchers to look at the unique nature of reflecting team practice. The researchers felt the previously recognized strengths of reflecting team practice had been affirmed by the study.

Sells, Smith, Coe, Yoshioka and Robbins (1994) interviewed seven couples and five therapists to get their reactions and perspectives about the use and process of reflecting team practice. This study was conducted at a university-based clinic over a four month period. Each participant was interviewed twice. The six domains that emerged from the analysis included benefits of its use, effects of gender, recommended use, contraindicated use, importance of creating spatial separateness between couple and

team members, and sequences of communication between the couple and team members that elicit change.

All the couples and therapists reported that reflecting team practice allowed for receiving additional opinions and perspectives, and it was generally helpful for them. The couples felt it was important to have both male and female team members to allow for gender-based differences in views. None of the therapists commented on gender as a concern. Participants thought that the team was especially useful when they were too close to their problems, had too many problems to solve, and when they were angry or fearful of expressing themselves. The team was then able to offer couples more options or to act as a buffer. Therapists' responses varied with regard to effectiveness. Some thought the team was most effective when the couple was stuck, or in crisis, while others thought it was when there was a specific issue for the team to address. Several disagreed, and reported the team was equally effective in supporting couples and acknowledging competencies. Some couples felt the team was not effective in the first few sessions before a level of trust and rapport was established. Others reported welcoming the varied opinions from the beginning. Most of the therapists felt the team was ineffective when there were no major problems to solve, no goals in mind, or no crisis. The separateness created by the team in the therapy room contributed to the clients' comfort level and to their not feeling intimidated by the situation. Clients also reported the separateness allowed them to have time to think about what was being said. Lastly, clients named the

steps that enabled them to hear what the team was saying and to have a different perspective on their problem. These steps included: the therapist heard and addressed the issue directly or consulted with the team; the team discussed the issue while clients listened; the clients felt the pressure was off them allowing them to sit back and listen; clients began to see issues differently. In contrast, therapists' descriptions were based more on techniques or strategies they used than on the process as described by the clients. The researchers concluded that the findings were of particular value for the clinician who works within a reflecting team setting.

The results of these two studies provided the basis for Smith, Sells, Pereira, Todahl and Papagiannis's (1995) study of how clients benefited from engaging in the process of reflecting team conversations. Four couples with varying experiences and who had not been a part of the previous research participated along with four therapists and four researchers. Interpersonal process recall methodology (Elliott & Shapiro, 1992) was used to examine how patterns of reflecting team conversations encouraged clients to develop multiple perspectives and refine theoretical assertions developed in the earlier studies. Immediately after a therapy session, participating couples watched a tape of the reflecting conversation they had just experienced, and commented on their experiences before, during and after the reflecting conversation. The results of this study showed that setting the stage was critical in helping couples to be open to multiple perspectives. For a reflecting conversation to be effective, a level of trust and credibility needed to be

established with the therapist and team to provide the context in which clients were ready to listen to the conversation. The researchers concluded that failing to prepare clients for the reflecting team's input diminishes the effectiveness of reflecting team interventions.

Several researchers have considered various aspects of clients' experiences of solution-focused therapy. Thomas (1994) conducted a post-therapy interview with a client to examine her experiences of solution-focused therapy. The client presented with a multitude of problems and a long history of trying various types of treatment and therapies. The focus of the therapy was on "her abilities to overcome her past problems, her strengths in coping with current tragedy and behaviors, and exceptions to her descriptions" (p, 49). During the interview which took place three months after therapy ended, Thomas engaged the client in a conversation regarding her views of the problem, change experience, view of self, and of the therapist's role and relationship in the process. In describing her experience of solution-focused therapy, the client thought if someone got through all the sessions and accomplished something, they should realize that they did the work, and they made themselves better.

In a qualitative study of solution focused brief therapy (SFBT), Metcalf, Thomas, Duncan, Miller and Hubble (1996) compared six couples' and their therapists' perceptions of what they found most helpful and what contributed to therapeutic change. Interviews were conducted separately with clients and therapists. Using the constant comparative method of analysis three themes emerged: the role of the therapist and what

actually happens in SFBT, why clients sought therapy and termination, and how change occurs. Clients saw therapists as more active and directive than therapists saw themselves. While only one therapist referred to taking an active stance in making suggestions, most of the clients described therapists as active and directive, e.g. making suggestions, providing guidance, and mediating. Clients and therapists gave similar reasons for why clients came to therapy. However, the language each chose to describe the circumstance was noticeably different with most therapists using pathological terminology. The clients and therapists expressed varying views regarding termination of therapy. Therapists described clients as having met their goals and choosing to terminate, while clients expressed disappointment and apprehension about having to terminate, and in some cases, before they were ready to do so. While most clients and therapists had differing descriptions of what contributed to the process of change, their overall views were similar. Clients thought listening, amplifying strengths, noticing and pointing out differences contributed to change. Therapists mentioned techniques such as punctuating the experience, validating, empowering and finding resources. The researchers concluded that clients are the experts on the process, success, and termination, and that the effectiveness of SFBT may not only be based on "miracles and techniques", but also on "assumptions that support accommodating, affirming and honoring clients' competencies" (p.347).

In the marriage and family therapy field, studying clients' experiences continues to be growing area for qualitative research. Listening to what clients have to say about therapy provides new insights and understanding of the therapeutic process. The researchers who considered both therapist's and client's perceptions generally found contrasting differences between the two perspectives. There were multiple aspects of the therapeutic relationship and therapy process that clients found significant and considered important to the outcome of therapy, and that often these aspects differed from those therapists considered important. The ensuing body of knowledge offers information about the similarities and differences between clients' and therapists' perceptions that can be used to bring the two together in the process of co-creating more meaningful experience of therapy.

CHAPTER III

METHODS

Design of the Study

This study uses a multi-case qualitative design to describe how parents of adolescents experience family therapy. During semi-structured interviews parents were asked about various aspects of their experiences of therapy. Qualitative inquiry and questioning requires a research design that is based on previous knowledge, observation, and a sense of curiosity about a specific phenomenon or population (Gilgun, Daly & Handel, 1992). Realizing that there is a unique experience with each therapeutic encounter, the primary aim of this study was to build a descriptive narrative of parents' experiences and perceptions.

The qualitative approach of this study allowed me to be both flexible and focused on the topic of inquiry and provided the framework to examine parents' views of reality and the meaning they attributed to the therapeutic experience (Strauss & Corbin, 1990). Since qualitative interviewing is open-ended, it provided the format for the flow of ideas to be conversational in nature. This allowed me to ask participants for facts and opinions, insights and descriptions regarding their experiences. Thus, the opportunity was created for new and unanticipated data to emerge between researcher and participants which then became the basis for further inquiry (Marshall & Rossman, 1989; Strauss, 1987).

It was agreed that co-principal investigators would participate in this project. Both are masters' candidates in the MFT Program at Northern Virginia Graduate Center of Virginia Tech. I focused on the parents; the second researcher focused on the adolescents. We worked together by interviewing both parents and adolescents, transcribing our own interviews, and providing each other access to the data from all the interviews. Once the data were collected, we worked independently on coding the data, although from time to time we discussed individual analyses as the project proceeded. This is my final report and is based on independent analysis and interpretation of the data.

In summary, the multi-case qualitative design and approach lends itself to answering the research question. There is also a goodness of fit between the nature of the phenomenon being studied and the purpose of the study. By recording language, themes and patterns of the parents, along with inductively developing insights from patterns of data, I worked toward developing an informative and useful description of how parents' experienced family therapy (Gilgun, Daly & Handel, 1992).

Description of Participants and Selection Process

Family therapists were considered participants in this study because they played a direct role in the process of recruiting parents from their clinical populations to participate in this study. Participating therapists had to be actively engaged in a private

practice setting for two years, and be either graduates of an AAMFT-accredited marriage and family masters program or have equivalent education and training in family systems.

We approached twenty therapists (the majority of whom were alumni of Virginia Tech's Marriage and Family Therapy program) who met the criteria and expressed an interest in learning more about our study. A total of five family therapists--three men and two women, all Whit--provided parents from their client populations who met the study's criteria. To be eligible, parents had to have participated in at least four therapy sessions, and either be in therapy currently or have completed within the last six months. In addition, they had to have an adolescent child between the ages of 12 and 19 who was the focus of treatment for at least some portion of the therapeutic experience. Parent recruitment was in the hands of the participating therapists. In addition to these criteria, therapists selected parents based on who they thought might be interested, able and willing to share their views of the family therapy experience, and who would provide us with useful information for our study. Each of the participating therapists reported having between three and six eligible families they thought would participate.

All of the participating therapists have had private family therapy practices for two to four years in a major metropolitan suburban area. All have at least a masters level education, and two have post-masters certificates in marriage and family therapy. Two of the five are AAMFT Clinical Members, one is an AAMFT Associate Member, one an AAMFT Approved Supervisor, and one an equivalent AAMFT Supervisor. Three are

Licensed Professional Counselors, and three also are qualified addictions specialists. The majority of therapists described themselves as taking a solution focused and family systems approach to their work with clients. Additionally, they employed theory and techniques based on cognitive/behavioral models, structural, narrative, collaborative, and brief family therapy. All participating therapists expressed genuine interest in supporting this project even with their busy schedules. They seemed to convey their enthusiasm to the parents who participated.

Fifteen parents participated in this study. They represented 11 families; nine families had adolescent sons between the ages of 14 and 17, and two families had 19 year old daughters. Nine of the families were currently in therapy and had attended between eight and 60 sessions over a span of four months to one and a half years. The two families who completed therapy did so within the last six months. They had attended between 20 and 50 sessions over a six month to two year time frame. All parents reported that their adolescent was the focus of concern for almost the entire course of treatment. Parents reported attending sessions from weekly to monthly, and this varied during the course of therapy depending on the issues at hand. Additionally, all parents reported expereincing a "good fit" with their family therapist.

The majority of the 15 parents in the study shared similar lifestyles and socio-economic status. Nine of the 11 families were two-parent families; three of these were remarried. One parent was divorced, and one was widowed. Family size ranged from

three to 11 members. Twelve of the 15 parents were White; one parent was African American, one Asian, and one Hispanic. Interviews were conducted with four couples together, four mothers and one father individually, and two single parent women. Parents ranged in age from 40 to 59, and all but one family reported incomes between $85,000 and $140,000 annually.

The reasons these families sought family therapy varied. Presenting problems included the adolescent's clinical depression, substance abuse, school failure, grief issues and parent-adolescent relationship issues. When asked on the demographic form why the family attended therapy, eight of the parents included statements about their personal wants and needs in addition to those for their adolescent. For example, one parent wrote he wanted to learn how to deal with his family's issues; another parent wrote she wanted to improve communication with her child. In most families (n=8), all family members (including siblings) participated in the sessions. In the other three families, parents took turns attending with their son or daughter. All parents expressed satisfaction with their current therapy expereince.

We followed up with the therapists to document their general impressions concerning the differences between the group of families who initially agreed to be contacted by the researchers and those who did not give their consent. No names or identifying information was shared or solicited. The purpose of the inquiry was to clarify some of the basic characteristics of the sample. One therapist speculated that families

may have refused because they did not want to let an outsider into their therapeutic world. Unlike in a university-based clinic where there is live supervision and a therapeutic team, clients who are seen in a private practice are accustomed to working with only one therapist. Another therapist reported there were several parents who chose not to participate because they were either embarrassed by their problems, or had overcome their problems and feared the interview might reopen closed issues for them.

Procedures

The recruitment of therapists began in March of 1996 and was completed by July, 1996. Throughout the project, we contacted as many as twenty family therapists in private practice to create interest in learning more about the project. We had phone conversations or informal meetings to discuss our expectations and answer questions about the project with those therapists who expressed interest in participating. We also reviewed the therapist's roles and responsibilities, including the possible risks and benefits of participation. Therapists took this opportunity to ask questions and clarify their understanding of the project. Each family therapist who agreed to participate in the study (n=5) was then given the therapist's informed consent (see Appendix A) describing the study's basic purpose and design, confidentiality, and their right to withdraw from the study at any time. They were asked to complete the demographic form (see Appendix B) and sign the consent form if they chose to participate. These forms were mailed directly to us in a pre-addressed, stamped envelope.

Each therapist was also given several pre-stamped packets that included a letter introducing the study (see Appendix C) and a parents' and adolescent's release form (see Appendix D) to send to clients who showed interest in participating. Therapists contacted families who met the criteria and suggested that they speak with one of us concerning the study. Several of the parents' and adolescent's release forms were returned to us by the therapist. Others were mailed back to us by the parents in pre-addressed, stamped envelopes.

As potential participants returned release forms, one of us contacted the family by phone, introduced ourselves, and began to establish rapport. This proved to be a good time to answer questions about the study and describe what we needed in terms of their participation and time commitment. We let them know there would be two interviews and that we would be audiotaping both. We described the first interview as an in-depth, face-to-face interview that would take between 60 and 90 minutes. We described the second interview as a follow-up interview conducted over the phone for 15-20 minutes. All the families we spoke with agreed to participate. It was at this time that an appointment for the first interview was scheduled at a mutually agreeable time and location. Our first interviews took place in June 1996, and the last in November 1996. My co-researcher interviewed four parents and six adolescents; I interviewed 12 parents and four adolescents.

At the onset of the first interview each parent was asked to read and sign the parents' informed consent (see Appendix E) 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, every effort was made to focus on building rapport and a sense of collaboration with the parents. The remainder of the interview was semi-structured and was guided by pre-determined questions (see Appendix G). The research questions were aimed at creating a conversation with a purpose (Gilgun, Daly & Handel, 1992) thereby allowing for data collection and discovery through the free exchange of descriptions through language. At the end of the interview, parents completed basic background information (see Appendix F) including family size, structure, and ages, who attended the sessions, the number of sessions to date, if therapy was completed or not, and a personal description of why they attended family therapy.

The first interview took place with the parent or parents in their homes, and ranged in length from one to two hours. Before beginning the taped portion of the interview, I took as much time as needed to discuss the project and respond to their questions and concerns. Many of the parents expressed interest in sharing their story with the hopes of helping other parents in similar circumstances. Although the study was focused on parents' experiences in family therapy, most of them recounted stories of their sons or daughters and the issues that brought them to therapy. Parents offered me an inside glimpse of the their personal struggles and the unique ways in which they

handled them. The experience these parents had in common was the emotions they described--feelings of shock and disbelief, fear and hurt, blame and guilt. At times, parents struggled with talking about certain aspects of their experiences. I shared the idea with parents that they "could not give me a wrong answer," and that if they preferred not to discuss something, for whatever reason, it was perfectly acceptable. I would rely on them to let me know if they wanted to change the subject or discontinue the interview. If issues were to come up that warranted follow-up, I was prepared to suggest to the parents that they bring the subject up with their therapist either at the next session or over the telephone. As it turned out, this was never necessary.

The majority of parents participated in individual interviews (n=7). Of the four couples who participated in an interview together, both mothers and fathers maintained an equally interactive role. I was particularly mindful of creating opportunities for both parents to have their say, and found that occasionally the parents reminded each other that they had not yet answered my question. I found it most interesting that parents were also curious about how the other might respond, in addition to the fact that both parents felt they had something significant to contribute.

After the first interview was transcribed, I mailed a two-page summary of my initial interpretations to the parents within four to six weeks of our initial meeting. Within four days of their receiving the summary, I conducted the follow-up interview by

telephone with at least one parent from each family. Three of the fathers were not available and/or interested in participating in the follow-up interview.

The purpose of the second interview was to ascertain the trustworthiness of my interpretation of the participants' views (Yin, 1989). I used this interview as an opportunity for parents to respond to the summary, and to ask questions aimed at exploring potentially relevant themes. I was also interested in hearing what further thoughts they wished to contribute.

Second interviews ranged from 10 to 30 minutes in length. Parents often wanted to catch me up on events, their progress, and in several instances, the set-backs they had experienced with their adolescent. Since many parents expressed an interest in learning how other parent and adolescent participants responded, a synopsis of the findings from this study and from the study on the adolescents' experiences in family therapy will be sent to all the participants.

The data came from the in-depth and follow-up interviews with either or both parents. The combined interviews totaled 20 hours and resulted in approximately 300 pages of transcribed data. Before the first interview, pseudonyms and code letters and numbers were assigned to each therapist and parent so their real names could not be associated with the audiotaped interviews or transcripts.

Data Collection

The vehicle of data collection in this study was the semi-structured, in-depth interview. The questions and themes that guided this inquiry (see Appendix G) were based on a constructivist theoretical framework and literature review on clients' experiences in therapy. This base contributed to creating a sensitivity to ideas, patterns and categories in the early stages of this project. The guiding questions served to both focus and organize the data collection, and support the open-ended and exploratory nature of qualitative the research design. Every effort was made to expand the conversation and capture the parents' meaning, interpretations and subjective experiences especially as unexpected themes developed (Gilgun, Daly & Handel, 1992; Marshall & Rossman, 1989). The original questions and those that developed through the interview phase had a tendency to fall into five main categories: pre-therapy experiences and expectations, initial responses to family therapy, descriptions of the therapy process, helpful and not helpful aspects of therapy, and effects of therapy between sessions post-treatment. With each interview, I modified and redirected the questions to allow the most complete description of the parents' stories to unfold.

In qualitative research, memos are used to record abstract thinking and concepts about the data. Generally, they contain speculative comments about possible theory and relevance of emerging findings to existing bodies of research (Gilgun, Daly & Handel, 1992; Strauss & Corbin, 1990). I used memoing techniques routinely after an interview in

an effort to capture my initial reactions and impressions of the parents' worldview and my reactions as the researcher. I also wrote memos while listening to audiotapes, coding interviews, and reading about qualitative research or the literature on clients' experiences. Additionally, I found myself at some of the most unexpected moments thinking about the parents and their stories, coming up with a new question, or other new thoughts related to this study. These occasions were noted in my memos as well.

During the therapy process, it is sometimes suggested to clients that journaling may help them "think," track their progress, give them a new look at an old issue, relieve tensions, or help them find solutions in more efficient ways. I used journaling in similar ways throughout the process of collecting and analyzing data to record my reactions to the content, process, subtleties and emerging themes. In reviewing my early entries, I noticed that I became more consistent as I learned how to better use this technique.

In qualitative research, the researcher is one of the primary data collection instruments (Moon, Dillon & Sprenkle, 1990). Because of my own interests and experiences, both personally and professionally, I was not only intrigued by this topic, but also with the data collection process. Having had first hand experience as a parent of four teenagers, it was easy for me to identify with the participants. While generally this was advantageous, I was aware of the potential effect it might have on the direction of my inquiry. I hoped that my interests and experiences contributed to a sense of rapport with the participants. On several occasions, listening to their stories stirred personal

responses and caused me to be sensitive to whether my meaning system was adding a layer to theirs. I also "learned" that while participating as a researcher in this project, one's life does not stand still. On several occasions throughout this endeavor, personal situations caused me to step away from the data so as not to affect it with my own stories (Gilgun, Daly & Handel, 1992). In an effort to maintain my role as researcher, I recorded observations about myself and newly developed awareness in both my memos and journal, and consulted with my research advisor.

Unit of Analysis

The primary unit of analysis for this research project was the individual within the parental subsystem. The questions focused on how parents, as individuals, experienced family therapy. Additionally, parents described personal changes they experienced and those they observed in their family life as a result of therapy. Therefore, the unit of analysis of this study was the individual (Copeland & White, 1991).

Data Analysis and Interpretation

Data analysis in qualitative research is an interative and recursive process where data are collected and analyzed concurrently (Moon, Dillon & Sprenkle, 1990). Data were analyzed using the constant comparative method. The constant comparative method of data analysis is a systematic process where each incident is named or coded, compared with similar incidents, and organized into categories. Using this method allowed me to break down and fully explore incidents and develop concepts by identifying patterns and

themes within and across interviews. By applying the constant comparative method, I eventually came up with the four core categories and subcategories described in the following chapter.

The majority of data for analysis came from the 300 pages of transcripts of the recorded interviews with the participants. Some of the analysis also took place during the interviews themselves as I made choices about when to digress from the guiding questions and pursue new themes as they emerged. The first several interviews alone yielded over 100 codes. With each subsequent interview, new codes were created, categories reorganized and refined.

The data were coded and categorized using *The Ethnograph v4.0* (Seidel, Friese & Leonard, 1995), a computer program that assists in the analysis of data collected in qualitative studies. Each interview was coded and compared to previous interviews and categories organized in relationship to one another. Using this program facilitated sorting and examining, comparing and contrasting the data. Several of the first interviews were re-coded as themes and categories began to take shape. At the completion of the coding process, four core categories emerged with 20 subcategories.

A written journal, memos, various theoretical notes, extensive diagrams and notes from meetings with my faculty advisor were kept as data were collected and coded (Strauss & Corbin, 1990). Sorting entries in this written journal provided the opportunity to discover how categories came together around central themes. In addition,

these entries contributed to writing the summary and integrating the description of the data collected.

Throughout this project I had the opportunity to use multiple data sources in addition to interviews, and achieved at least some degree of triangulation and trustworthiness of the findings (Lincoln & Guba, 1985). In addition I conducted four adolescent interviews and read the other six interviews used in my co-researcher's project. Conversations I had with friends who had been to family therapy with their teenagers also contributed to my overall perspectives during this study. Routine consultations with my faculty advisor and collegial researcher served to test interpretations for validity and control for bias.

The final report provides a rich description of themes and patterns that reflect parents' of adolescents experiences in family therapy. My interpretation of the findings are illustrated in five case presentations and fieldnote quotations from the parents.

CHAPTER IV

RESULTS

Introduction

This research project was undertaken to develop an in-depth understanding of the experiences of parents of adolescents in family therapy. Parents in 11 families were interviewed with the aim of discovering how they experienced and responded to different phases of the therapeutic process. Seven parents from five families were chosen for the in-depth discussion of the results of this study. These particular parents were selected for several reasons. While no two interviews were alike, these parents seemed to represent the gamut of what other parents shared about themselves, their adolescent and therapy experience. They represent men and women of different ages, varying ethnic backgrounds, and family structures.

Each parent found unique solutions to his/her struggles and concerns, shared views, and described the changes that resulted from participating in family therapy--changes in themselves, their adolescent, family and situation. Yet similar themes echoed through many of the interviews. They spoke in different ways, yet almost with one voice, as they described the impact of having a son or daughter in distress. As categories emerged, I was able to begin to identify similarities and differences within and across interviews in parents' perceptions, beliefs and behaviors. The final core categories and concepts are presented in this chapter.

This section begins with **The Story** as a backdrop for the case studies. It is a summary of the common themes expressed by parents during the interviews. The story is followed by the definitions of the four core categories and 20 subcategories that emerged during data analysis. The background for each of the selected five cases is presented as the framework for the description of the findings that follows. The distinguishing characteristics of these families along with their stories are changed to protect their identity and maintain confidentiality for them and for their therapists. However, I include parents' own words from both in-depth and follow-up interviews to illustrate the subtleties of their experiences in therapy.

The Story: A Portrait of Family Therapy

The story is about parents who were faced with the heartfelt concern and emotion of having a troubled adolescent, and how they began, participated in, and looked back on the family therapy experience. It is also about parents' views of the therapeutic experiences that worked for them. Before seeking therapy, most parents described the family as being "in crisis." Their stories were colored with expectations, fears and guilt, and memories of unsuccessful treatment attempts, all of which shaded the work they had in front of them. Parents desperately wanted to add the light of hope to the picture. Even before the first stroke of the brush, parents had at least an idea of how their final portrait might look. Many knew they had the wrong tools, and some admitted they used unsuitable techniques when attempting to create a different picture for their family.

As situations became bleaker, parents found themselves consumed by frustration that led to calling upon the expertise of a family therapist. A few parents considered themselves skilled participants from the start. Others relied on the therapist to engage their sons and daughters, and started out by seeking their own level of comfort and safety before becoming involved in the process. Most parents considered themselves skilled in the art of parenting, though they had momentarily lost sight of what to do to "fill the gap" between themselves and their adolescent. The therapist's reassurance and vote of confidence encouraged them to again become actively involved in doing what they knew best--parenting their son or daughter. When parents were more trusting of the process, they noticed an increased confidence in themselves to handle the situations with their adolescent. This enabled them to contribute to the finer details of the process. Parents followed the therapist's example of adding a splash of color to brighten the picture they realized was unfolding before them. Many parents soon found themselves involved in the therapy process as if they had created its design themselves. Through this experience, many parents realized they were also an important detail in the landscape. When parents added their personal touch, it seemed as if the portrait began to take shape more readily for both themselves and their adolescent.

Participating in the research gave parents the chance to "step outside of the picture," if only for a moment, and reflect on their original work of art. While noticing its finest details and brightest colors, parents realized what they had contributed to the

continually evolving picture. Every parent evaluated the details of change both in and around themselves. Participating also gave some parents an appreciation of the finest details in their lives while it helped others to realize how close they were to having what they had pictured all along.

My role in the project was to record the details of what parents felt it took to come up with the final portrait. All I had to do was get them started and then stand back (if you can call all this work standing back!) as the details of the picture were filled in by these generous participants. In the following pages I attempted to share the view of what I learned from parents as they invited me to "look(ing) at the picture by stepping outside." I hope to represent their stories in ways that are both interesting and thought provoking.

Core Categories

The data analysis led to the formulation of four core categories which when viewed chronologically provide the conceptual framework for the description of parents' experiences in family therapy. The four categories are **Pre-Therapy Presentation**, **Supportive Therapeutic Climate**, **Family Therapy Process**, and **Post-Script to Family Therapy Experience** (see Table 1).

Pre-Therapy Presentation

Pre-therapy presentation is defined as parents' personal disposition and emotional state based on the conditions, events, and perceptions as they began therapy.

Parents in this study described varying aspects that contributed to their pre-therapy presentation**.** Many parents were open to the possibilities therapy might offer them. Several considered it their parental responsibility to seek therapy because what they were doing was not working with their adolescent. Some were hopeful and receptive to anything that might make the difference. Parents came to therapy at the end of their rope, in a state of panic, feeling guilty or somehow blamed, and/or internalizing their child's problems. Several parents presented as skeptical, defensive, and fearful. Subcategories of pre-therapy presentation include **family climate**, **prior treatment experiences**, **readiness**, **expectation** and **hopes and desires**.

Family Climate

The **family climate** refers to the prevailing family- related conditions and circumstances that led up to the decision to begin family therapy. Parents described varying degrees of **conflict** and **crisis** that contributed to the atmosphere in their homes.

Conflict. Conflict refers to the controversy that existed in each family between parents and their adolescent. Some parents described "normal" parent-teen relationships that deteriorated to the point where they were at odds with each other most of the time. For other parents, the conflict escalated to beyond the breaking point leaving them struggling to maintain any relationship and communication with their adolescent. Several parents described their adolescent's problems as creating "an intensity in the home" that eventually led to a state of "total chaos" affecting the entire family.

Crisis. Crisis refers to the seriousness of the situation in the family and ranges from "life's frustrating" to "life threatening." The majority of parents experienced themselves as in crisis and shared the emotional anguish, pain and suffering the situation caused them. Whether the story was about a suicidal adolescent or a newly diagnosed learning disability, parents described their crisis with the same degree of intensity and heart-felt emotion.

Prior Treatment Experiences

Prior treatment experiences refers to feelings and attitudes based on past involvement with other mental health professionals or treatment programs and resulting impact on readiness and expectations of the family therapy experience. All the parents except one had **prior treatment experiences** involving their adolescents, and most had several experiences. Many parents had either actively participated in family counseling components of their adolescent's treatment program, or had been to therapy with various mental health professionals. A few parents did not participate directly, and a few participated only occasionally. For those parents, simply having an adolescent in treatment affected them as a parent.

Usefulness. The central theme of prior treatment experiences was the degree of **usefulness** experienced by the parents. A few parents were satisfied with various other treatment programs and felt their adolescent received the guidance, structure and attention needed. However, the majority of parents provided an encapsulated view of therapists'

(and other mental health professionals') interactions that were not particularly helpful and/or supportive for them or their adolescents. Most of these parents felt their problems were addressed, but only on the surface without ever getting to the cause. Parents felt that therapists tended to spout "a lot of theory without any actions." One mother spoke of her frustration with "not getting anywhere," being stuck in a pattern of terminating before her son's problems improved, and then needing to return again. Another parent spoke of having to answer endless questions and never receiving any feedback. One even reported that a therapist told her the situation with her son "was hopeless."

Readiness

Readiness to begin therapy refers to parents' frame of mind and state of being toward therapy when they decided to try family therapy as an option. Parents' readiness was frequently related to the combination of the family climate and adolescent developmental issues. One mother figured it was time for family therapy after she had tried "to be everything to my children," and realized she was not succeeding. Several parents began therapy out of desperation to help their adolescent, and some began therapy to help themselves as well. Other parents considered therapy as the "last straw" and their only choice. Several shared they "didn't have time to think about it" because of the crisis state at the time. One parent described her desperation and became tearful as she shared "my son was going to kill himself ." There were several parents who feared

"running out of time" to make something happen with their adolescents since they were nearing the young adult stage of life.

Expectations

Expectations refer to parents' pre-conceived notions and beliefs about the content and process of therapy. In addition to repeating their histories and re-telling their stories, many parents expected family therapy might offer them the opportunity to "pick up on different ways of doing things" or for a therapist to know what advice to give them. Several parents mentioned they did not expect miracles from therapy, and did not consider the therapist to be a miracle worker. Almost all parents entered therapy believing "it would take a long time" for change to occur, and therapy was a process that "just takes time" and cannot be rushed. One parent expected that because therapy did take time "if we keep going, things will come out" as a natural result of participating in the process.

Hopes and Desires

Hopes and desires describe parents' aspirations and dreams for themselves, their adolescents and families that had to do with either participation or the outcome of family therapy. Parents' hopes and desires had a down-to-earth quality in that they were simple, realistic, and heart-felt. Several "hoped and prayed for the right therapist" who would both "connect" with their adolescent and "zero-in on the problem." Others hoped for answers and for "things to be brought out into the open." Another parent "hoped

that we would move forward as a family." Most parents mentioned desiring a better relationship with their son or daughter. For some that meant "filling the void" and having at least some communication between them. One parent shared that he simply "wanted the family to be whole again". And another, "...being the parent gives me hope...for my children, and maybe for my marriage."

Supportive Therapeutic Climate

The second core category, **supportive therapeutic climate** is used to describe parents' initial experiences in therapy as they began to "look at and open up issues." Describing the context of a supportive therapeutic climate provides the opportunity to consider which specific aspects of setting the stage both prepare and empower parents to engage in the ensuing process of therapy.

Many parents' idea of a supportive therapeutic climate was one in which the whole family came together with the therapist and talked about their problems "without holding back." Regardless of this description, conditions existed in the therapeutic context that had to be dealt with for this to happen. Many parents spoke of initially wanting to change their adolescent and not themselves. Others spoke of "being in denial" and "not wanting to hear it!" (the "it" being anything offered that was negative). Several parents described their adolescent's response to what was going on as "totally not interested" and "bored" along with conveying a "no-way" message by their body language. Parents' perceptions regarding the **focus of therapy, structure of therapy** and

therapist's contributions were what seemed to ultimately provide the therapeutic context that allowed parents and adolescents to come together with the therapist and discuss the issues.

Focus of Therapy

Focus of therapy refers to the notions that parents had about where they wanted the attention to be placed. When their preconceptions matched their experience in therapy, they felt supported in the context. Most parents also felt supported when the therapist took time to get to know them as parents and heard their views and addressed them along with the concerns they had about their adolescent. If an adolescent was "in crisis," parents felt supported when the therapist was able to evaluate the situation quickly.

Structure of Therapy

Structure of therapy refers to the arrangement of therapy by the therapist that supported family members' ability to express themselves in ways that allowed them to feel heard and understood. Parents described different aspects of the structure of therapy that contributed to their comfort level. Many parents commented that the structure of the sessions provided the chance to sit down all together and talk things over, and figure things out as a family—with the emphasis on "all together as a family." Several parents mentioned having a "one-on-one" with the therapist gave them a chance to share and receive feedback that validated their impressions, and helped them realize how they might

be contributing to the present situation. When the structure of therapy included only the adolescent and the therapist, parents had mixed emotions. Some parents felt left out and uncomfortable with not knowing what happened in the sessions. Even though they understood and agreed confidentiality was important, they generally "would die to know" what went on in the sessions without them. When the therapist's meeting alone with the adolescent was only an occasional occurrence, it had little effect on parents. Parents who valued and trusted the relationship the therapist had with the adolescent were generally accepting of the therapist's influence. Several parents also commented that therapists were thoughtful about when and how to involve parents in sessions. For example, one therapist made it a point to either speak with mom at the onset of a session or afterward by phone, and specifically to not bring her in alone at the end of a session. This structure allowed the adolescent to feel as if the therapists was not "telling all" to his parent, and for the mom to still feel connected with the therapist. Several parents shared that since the therapist made time for them individually, they felt a connectedness that was essential to fostering a supportive therapeutic relationship.

Therapists' Contributions

Therapists' contributions refers to the traits, functions, and behaviors exhibited by therapists that created a therapeutic context in which parents were able to consider new possibilities and begin the work required for change in their families. Parents also developed levels of trust and comfort based on therapists' contributions. The three

themes that emerged from the parents' descriptions of their therapists were **personhood**, **roles** and **involvement.**

Personhood. In this study, **personhood** refers to the qualities, characteristics and displays of humanness that allowed parents to be open, trusting and vulnerable. Parents found therapists to be caring, sensitive, gentle and sincere. Other parents mentioned therapists' competence, patience and non-judgmental stance as contributing to their increased comfort level. Several parents particularly felt connected and more relaxed when therapists shared their "human side," and when they presented as more than "theory driven" or "black-and-white-bookish." Several parents described therapist as being gifted and passionate about working with families like theirs. Parents felt these qualities contributed to their willingness to risk and be vulnerable.

Roles. Roles refers to parents' understanding and perception of the therapist's function in the therapeutic context. Most parents saw therapists playing the role of facilitator or mediator between themselves and their adolescents. Others specifically referred to therapists as specialists or experts who were capable of helping others with their problems. One parent thought of her therapist as the family's "life-line." Another saw their therapist as his son's "mentor and '12th-man' on the football team type person." When therapists were flexible in the role they played, parents reported feeling confident both in therapists themselves and in the ways they approached the families' problems.

Involvement. **Involvement** refers to the way therapists conducted themselves in relation to parents and adolescents. Parents described therapists' involvement in the context of therapy based on their initial observations and personal experiences. Therapists' involvement indicated they were observing, listening, and assessing the family's circumstances, and most importantly, that they were willing to confront when situations warranted. Several parents mentioned that therapists effectively used what they had learned about the family and/or situation at exactly the right time in the session. Because the therapist was involved, many parents felt they respected and understood what they were going through as parents.

Family Therapy Process

The **family therapy process** is the third core category and addresses how parents became involved, and how they related and functioned in the context once they experienced it as a supportive therapeutic climate. It also refers to parents' observations of their adolescent's responses and therapist's process within the therapeutic setting. The concepts identified as contributing to the family therapy process are **personal responses**, **reaction of adolescent** and **therapists' ways of working.**

Personal Responses

Personal responses during the process of therapy describes parents perceptions and behaviors as a result of feeling supported, validated, and an integral participant in the family therapy process. Under these condition, parents responded by allowing

themselves to be vulnerable and to face the hurt and pain of their situation. Several parents heard what they did not want to hear previously, and confidently asked the question "why me?" out loud without being afraid of the answer. Most parents found themselves willing to consider possibilities that helped them to get beyond past mental blocks. Parents also spoke of becoming aware of the family's direction--"the big picture," and viewed the therapy process as "helping them to help themselves."

As parents engaged in the process of therapy, they interacted consistently with their adolescent and with the therapist. Within this context, some parents noticed a dialogue opening between themselves and their adolescent, and communication taking on a new form. Other parents noted they took risks in session, tried new parenting styles, and in several cases "changed the rules" for their adolescent. One couple described the therapy process like "walking together down the right road." Parents reported interacting with therapists on an "adult-to-adult" level. Several referred to therapist as "keeping me in my place" and "not letting me get away with anything," and because they felt the therapist cared about them, such interactions were welcomed. Other parents noted their confidence level increased when interactions with the therapist allowed them to process "without judgment" what they had done right or wrong with their adolescent.

Reaction of Adolescent

Reaction of adolescent describes parents observations of their son/daughter's responses to the process of therapy. When the adolescent's reactions were positive,

parents felt confident and trusting of both the therapeutic climate and relationship. Several parents recognized day-to-day changes in their adolescent's way of relating that they specifically attributed to the work done in therapy. Other parents saw their adolescent come to terms and deal with difficult issues they had previously avoided. In the therapy process, parents also saw their sons and daughters moving towards becoming accountable and responsible for their own behaviors and problems.

Therapist's Ways of Working

Therapist's ways of working refers to how therapists engaged in the ongoing process of therapy. Many parents commented that the active role therapists played throughout contributed to their feeling challenged and encouraged by the process. Others appreciated feeling the therapist was always right there with them, and at the same time was looking beyond to see the bigger picture. Parents continued to feel connected with therapists who shared personal experiences to make a particular point. Parents appreciated when therapists dealt fairly and consistently with each family member, worked to create win-win scenarios, and were on both theirs and their adolescent's sides at the same time. Parents also noticed when therapists provided a role model and gave them new ideas about varying their parenting style.

Post-Script to the Therapy Experience

Whether parents and their adolescents have completed or are still participating in family therapy, each had their own **post-script to the therapy experience.** The **post-**

script describes parents' experiences of looking back, comparing where they were to where they see themselves now, and evaluating what it all means to them. Key elements parents included in the post-script are **parents' change response**, **change in family climate**, and **value of family therapy.**

Parents' Change Response

Parents' change response refers to the shift in perceptions and behaviors parents noticed in themselves as a result of participating in the therapy process. For many parents, change response represents personal growth, gain in awareness and insight, understanding and knowledge. Often they prefaced a change response with "I learned," referred to "the learning process," that they "began to see" and to "think differently." Parents felt more capable and confident in recognizing their role, responsibility and appropriate boundaries in relation to their adolescent and circumstance. Other parents experienced increased self-esteem and trusted themselves more. Parents also described behavioral change responses. Most parents mentioned communicating better, knowing when to be more outspoken and when to keep quiet, and that they were generally more ready and willing to discuss an issue than to avoid it. One dad spoke of not fighting his son or the situation as much. One mom "got out of the middle" of the family as a way to take care of herself. Others took new risks in parenting, and now avoided unnecessary conflicts.

Change in Family Climate

Change in family climate is the second component of parents' post script. It refers to change parents noticed in their interactions and relationships, as well as change among and within the family unit. Change in the family climate does not imply the problems in these families have been fully resolved. Most of the families were actively dealing with issues, both in and out of therapy, when they participated in this study. A sentiment common among most parents was "what we have now is better than it used to be."

Change ranged from "little milestones" to "major breakthroughs." A sign for parents that change had occurred was reflected in the nature of family conversations and ways of communicating. Parents experienced family members as more thoughtful and considerate, and as showing more patience and respect for each other. Family relationships also appeared stronger and more harmonious with fewer disputes occurring--father to son, brother with brother, husband and wife.

Value of Family Therapy

The **value of family therapy** refers to how parents felt about what happened in therapy when they stepped back from the experience. Parents valued aspects they considered significant, important, and purposeful, or those that were simply meaningful. Parents also valued the therapeutic process and relationship, and the contribution the therapist made to both. Many parents valued having an improved understanding,

increased confidence, and satisfaction with their decision making abilities. Others spoke of valuing the openness and newness with which they approached their adolescent, family and day-to-day living experiences along with having learned to cherish simple moments.

Lilly Bradley

Lilly Bradley was the third parent I interviewed. When I called to set the appointment, she seemed friendly and eager to participate and asked several questions about the project. We met a few days later on a blistering hot evening in her home. The cool air hit me as she opened the front door and welcomed me. The house was immaculate, and Lilly's warmth and pride could be heard in her voice as she let me know her son (the adolescent of focus) deserved the credit for its appearance. Her husband had taken their four children out for the evening. We sat and sipped cold drinks at her dining room table during the interview.

Initially, Lilly seemed nervous about the tape recorder running. We spent some time getting to know each other before formally beginning. As we proceeded, my sixth sense told me there might be a great deal of emotion connected with the story she was about to tell me. I let her know that whatever she told me and however she said it to me would be the right way, and that was all I was looking for. With this she relaxed and spoke convincingly of wanting to make a contribution to other parents because of all she had been through with her son. She hoped I would gain something of value from her story to share with other therapists, professionals and parents.

The story of the family's prior experience in therapy was a recurring theme in the first interview. Lilly clearly knew therapy was not working, yet they were caught in a cycle of attending a few session, dealing with a few issues on the surface, and being

gprematurely released only finding themselves needing to return. This provided a vivid contrast for the recent experience which has left her with a lingering sense of accomplishment and satisfaction five months after termination. She told me "it still works!! I'm amazed!"

The sense of amazement carried over to the second interview in that Lilly was again "amazed" after reading my summary. I was struck with how powerful the experience of research had been for her.

Findings

Lilly Bradley spoke of the many aspects of her family's circumstance and experiences that contributed to her **pre-therapy presentation**. The story of Greg's "getting into trouble" on a regular basis provided the backdrop for understanding the **family climate** in the Bradley's home. Looking back, Lilly also remembered Greg exhibited several distinct signs of depression. His grades deteriorated, he began cutting classes, and stopped attending varsity basketball practice. Tensions and **conflict** mounted when Greg ran away from home with a questionable crowd of teens. Lilly became particularly suspicious and wondered whether Greg and his new friends were involved with drugs. When she questioned him about his activities, Greg responded with several comments "about ending it all" which Lilly then began to take seriously. Lilly realized the family was in **crisis** when Greg came out of his room one night swinging a

baseball bat at everything. She related how scared she and her husband were at that point, and not knowing exactly what to do next were **ready** to try anything.

> And that's not Greg. And my husband went in there--Mr. Cool--calm and said "you're on restriction for a month". And Greg rolled up in a ball on the floor and started screaming. We called the police. "You need to do something! He's in the fetal position on the floor!!" The other kids were freaked out. I mean it was horrible. We had him admitted to the hospital. He was only there for two days. As soon as we got him out of the hospital I got a therapist.

Throughout their **prior treatment experiences**, the Bradleys continued to experience conflicts and **crises** in their family. Instinctively, Lilly knew there was something about therapy that was not working for them as a family, and especially not for Greg as an adolescent in distress. She felt the process stirred up conflict without moving towards much of a resolution or improvement for any of them. The therapy's lack of **usefulness** carried over into their **family climate** as each family member struggled to get along with the others and understand what was going on.

> It all happened so quickly...The first two weeks just flew by. I didn't really know what was going on. Then once you get into it you're under a microscope. It's intimidating. It's hard on everybody. Feelings start coming out that you didn't know were there. Then after that conflict...There was conflict in my house a lot because they didn't understand what was going on. It was scary.

Lilly felt that the therapist they were seeing focused on issues other than those that were important to her, namely her son. The therapist also seemed to "gang up" on Greg, and to look for what was wrong with Greg, and "made accusations about him". It was at the point when the therapist shifted the focus from Greg to the marriage and left

Greg in the waiting room for most of the session, that Lilly realized therapy was not helpful for any of them.

> The reason we were there was to help Greg. And she was spending all her time with my husband and I...Greg was in the waiting room wondering "What's going on in there? What are they saying about me?" And I think that was wrong...And I think it made him worse and worse and worse...He wasn't getting any better. He wouldn't say anything and was getting angry. I started saying "Wait a minute. Its not working."...We weren't getting anywhere.

Lilly finally began to understand her own responses to this therapist and treatment arrangement. It took some time for her to gather her nerve and confront the therapist with what was not working from her perspective as Greg's mother. Additionally, Lilly felt disempowered by the therapist, lost sight of her parenting abilities, and wondered if she had somehow failed in her responsibilities as Greg's mother. She went through "the blaming process" and felt as if "fingers were being pointed" at her. The turning point for Lilly came when she finally sat down with the therapist and said:

> "You know I'm a great mom. I love my kids. Sitting in here I feel like a failure." And she said "No not at all. I don't want you to get that feeling." I said "That's how I feel."

It also became apparent that the pattern of treatment in which the family found themselves stuck only complicated the problems with Greg and frustrated Lilly.

> We weren't getting any better. The therapist would release us, and a month later things would blow up, and we'd go back, and then she'd release us. We were into that type of routine.

It was the combination of these experiences and Greg's not getting what he needed from treatment that led the Bradleys to look for another therapist. Because of their prior

treatment experiences, Lilly had **expectations** about starting therapy again with a new therapist. Before beginning, she was "skeptical" about what might happen and anticipated the probing and questioning especially since the transition from one therapist to another was made when Greg was again in crisis. She also expected therapy to again stir up the family climate. Lilly clearly expected the next therapist would be one who focused on Greg and his problems. Lilly also understood that it took time to become comfortable with therapy and for change to occur. Her **hopes and desires** were for something better for Greg and different for herself and the family. In part, she figured things could not get worse, but only better for all of them, and hoped "sticking to it" with a therapist who understood her concerns about Greg would make the difference.

As the Bradleys began their new experience in family therapy, Lilly spoke of initially feeling intimidated and that things had been stirred up in the family yet one more time. She was leery of her new therapist, and spent much of the first two weeks wondering if things would be different this time, especially for Greg. Because she felt Greg was in danger, Lilly tried her best to "get into it" from the onset. Yet it was a struggle because of the disappointment with their prior treatment. It became quickly evident that something about this time was different for both herself and Greg. She experienced a **supportive therapeutic climate** almost from the beginning. Because so much of what did not previously work in therapy seemed to be based on the therapist, Lilly's descriptions of what she most remembers as working also has to do with the

therapist's contributions to setting the stage for therapy. She described her observations of the difference in the therapist's **involvement** with Greg.

> She seemed to be more in tune to Greg and his feelings. That made all the difference in the world...This therapist was more like "What does Greg think" and we'd get together and talk...She didn't gang up on him. She didn't point out that anything was wrong with him. She actually listened to him...

Lilly also initially experienced a difference in the therapist's **involvement** with herself as well.

> She just complimented you on everything and kept telling me what a good parent I was...what good communication we had...Things I always knew were there, but the other therapist had brought them down...

From the beginning, Lilly thought the **focus of therapy** matched her expectation in that Greg's issues were addressed first. At the onset, Lilly requested that the **structure of therapy** allow for the therapist to spend the time needed each session with Greg alone and on what was most important to him.

> I went to the therapist with my expectation. "You are Greg's therapist. And anything he says to you outside of saying he's going to commit suicide or harm another person, I don't want to know unless he wants to share it with me". She was a little uncomfortable with that at first. She never has someone come at her that way. And I said "He's not getting any better unless somebody can—he can't trust them, he's not going to get better". And she agreed to do it...She did take him in there by himself one or two times, and he was ready to have me in there...It started off the sessions where everything was Greg. She would listen to Greg for 30 to 40 minutes and bring me in...She didn't do anything behind his back. I mean I was never alone with her. She would take Greg in alone and then we'd be together. So Greg never felt that betrayal...What she did when she wanted a one-on-one, she'd call me, or I'd call her.

An aspect also contributing to Lilly's experience of the supportive therapeutic climate was the therapist's **personhood**. For Lilly, the therapist's humanness was a significant factor in her willingness to "get into it" and "stick to it." It did not take long for Lilly and Greg to feel as if they had found the right therapist.

> She's human, I guess. With some of the others I felt they were 'holier than thou'...She brought things up about her own life, too. I mean nothing personal really, but enough to make you realize that she was human, too...She was human to Greg. She wasn't someone who was judging him. He really relaxed after that.

Once she experienced the climate as supportive, the skepticism Lilly initially experienced faded and she learned it was safe to be involved in the process of therapy. It was also through participating in the therapy process that Lilly experienced being the good parent that she thought she was. This seemed to contribute to her noticing a shift in her **personal response** to therapy process. Almost at once there was something in it for her as well as for Greg. Lilly learned to relax, and trust herself, and be vulnerable with the therapist. Because the therapist did not belittle her and instead told her "you did the best you could," Lilly became comfortable even discussing what she considered to be mistakes in the way she handled certain situations. She also found herself looking forward to what she might learn from sessions and bring home to her husband and the rest of the family. Between sessions, Lilly noticed she approached situations with a new found confidence and attributed this to therapy. At one point she realized how comfortable and happy she was with therapy that she "didn't want to quit."

> The therapist was trying to reassure me of some things. And then as it went on and I started seeing concrete results in my son's behavior that I had never seen before. Then I started really getting into therapy...I was a little leery when I started. I really tried to get into it in the beginning even though it was an emergency. I just kept feeling he's not getting any better. What's going on here!? Well there were unresolved things the therapist brought into light...that was the first time I really saw where his pain was being placed and what really bothered him...I felt so comfortable telling her even the things that I had done wrong. She didn't belittle you. And when I'd walk out of there, I'd feel good about myself.

When I asked what was "getting into therapy like," Lilly replied:

> I got real excited. I mean like when Greg and I would do things like everyday that had to do with therapy. He started talking to me; I started talking to him. We started crying together...In a session we would get started, and the therapist would sit back. And we didn't realize it until 10 minutes later that he and I were just going back and forth.

In addition about the time Lilly felt the freer to participate, she began to notice the **reaction of her adolescent** to therapy. It was important for Lilly to recognize positive reactions in Greg especially given that his response to prior treatment was negative. It was not long before Lilly noticed that Greg was comfortable and relaxed with the therapy process and the therapist even with the focus on him. Lilly thought Greg felt he was not being judged or made to think something was wrong with him. Greg responded to the therapist's low-keyed and calming ways of interacting. If he did not want to go into detail on a particular issue, she would not press him for an answer, but simply mentioned getting back to it at a later time when he was ready. However, Greg seemed trusting of the therapist enough to meet the challenge of working through several tough issues. Even

though it took time to resolve what happened in the past, Lilly described the difference in Greg as being "like night and day."

The **therapist's ways of working** impacted Lilly and contributed to her feeling encouraged by the therapy process. Lilly felt the therapist "stayed in tune" and connected to what she was experiencing as a mother who wanted help for her son. Consistently, the therapist pointed out to Lilly and assured her that she was "doing all the right things." Eventually, Lilly was able to see for herself the ways she contributed to the changes she noticed in Greg. Lilly also appreciated the therapist's realistic approach to fixing what was fixable, and letting go of what could not be changed. With time, this shared philosophy also impacted Greg in a profound way as he let go of carrying pain of the past.

> The other thing that really worked was that "You can't fix everything." Nobody ever told us this, that there are certain people that you can't change. And certain things happen and you can't change and she told Greg "You are old enough that you are just going to have to accept this person the way that they are." It took time to come around...I think we needed to hear that and to let go...simply because there's no fixing it.

Lilly considered the therapist to be a model for her of how to better deal with Greg. She learned a great deal simply by watching the therapist's interactions and adapting them to her own parenting style. Once the therapist "got us on the right road", Lilly automatically took over the parenting role.

> She taught me a lot how to deal with Greg...a model for me. She taught me a lot watching her mannerisms and the way she was with him, and bringing out the good points in both of us. There were things that maybe I never knew I had.

> Greg and I would leave that office except for once and he and I would laugh all the way home...But just things like that. Just the way she would make us communicate on a deeper level, and just not about surface things.

Lilly's **post-script to family therapy** is a success story of family therapy at its best. She and Greg had completed therapy four months prior to when I interviewed her. This had given her time to reflect and observe her **personal change response** that resulted from participating in family therapy. The experience has left Lilly with an appreciation of knowing she is a great mom, a reminder of her many attributes, the confidence of knowing her best is enough, and an openness to new ways of relating.

> I can be more laid back...I just feel really comfortable with myself...I just feel real comfortable with my son. And I thank the therapist for that. I really do.

Additionally, Lilly recognizes many **changes in the family climate** that she attributes to completing the therapy process. Though she did not often speak about her marriage during the interview, she did say it has gotten "better and better and better" as the result of her continuing to use and share what she learned in therapy with her husband.

The changes she recognized in Greg were profound and touched many aspects of his life. Lilly sees Greg as more connected and accepting of relationships with his dad and siblings. She feels he is more truthful and does not hide things from her the way he used to. His grades improved; he has more friends and is involved in a wider variety of activities in school. While Lilly realizes Greg is not the perfect teenager, she is thankful

that Greg has found many new ways to enjoy life. She said "I'd so it all again if the person would turn out this good!"

I will end with where Lilly began the interview. She became tearful as she shared the **value of family therapy** for herself and her family. And for her, the opportunity to share what she valued was one of the reasons she chose to participate in this study. Lilly believes therapy with the right therapist literally saved her son's life.

> I believe that he would not be here if we had not finally gotten to the right therapist. He was going to kill himself. That was the reason for therapy, and the reason I want to share it is so it might save somebody else. 'Cause therapy does help. I don't think my son would be alive... (tearfully)

She concluded:

> I probably have forgotten a lot of the emotion that I went through, blocked it out. I don't know...As things got better its hard to remember how awful things were at times. It's hard to really put yourself in those shoes. I can still cry like I did tonight when we started. It's hard to remember Greg as being suicidal...It was just yesterday that he said this is the happiest he's ever been in his life.

Lilly Bradley provided me with many insights about being the parent of an adolescent in distress and relying on professional resources to get her through what was perhaps one of the most difficult times in her life. Lilly's strong presence, powerful story, and depth of her emotion was something I remembered as I prepared to interview other parents.

Ed and Jacquelyn Duncan

Ed and Jacquelyn Duncan were a well spoken, intelligent couple who spoke candidly about their experiences. They were both in their early 50's, and had two daughters, ages 24 and 18. Issues with their 18 year old, Megan, were the reason they began family therapy. She was very bright, though struggled in school, bordered on anorexia and experienced occasional anxiety attacks, all of which occurred over a period of several years. They sought advice from a multitude of mental health professionals before finally being referred to a family therapist by the school counselor. Almost six months after it ended, Ed and Jacquelyn still speak of their time in family therapy as a life changing experience for all of them.

When I first spoke with Jacquelyn about their participation, she said Ed's work schedule would not enable him to be part of the interview. We agreed that the two of us would meet early the next morning at her home. Within the hour, Jacquelyn called me back to reschedule. It seemed that when she told Ed about the project, he insisted that he be included if my schedule allowed. I was left with a curiosity and expectation of why and what Ed wanted to contribute, and I was pleased he wanted to participate. We met in their home about a week later for over two hours one evening.

From the onset of the interview, it was apparent that talking about their experiences with Megan brought back painful memories for both of them, and that the memories were something they wanted to share if it could help someone else in similar

circumstances. They spoke of what seemed like every last detail of their own short-comings, vulnerabilities and personal growth experience. I was left with the impression that they used all their energies to find a therapy that worked for their daughter whom they deeply loved and cared about. There do-whatever-it-takes attitude persisted until they had the results they wanted and relationships with which they were satisfied.

I conducted the second follow-up interview over the phone with both Ed and Jacquelyn, but at separate times. The connection Ed felt with the therapist was one of the themes of our second interview. Additionally, he spoke of the lasting effects of therapy for Megan and reported she was doing very well. Jacquelyn responded similarly and added that she and Ed had several positive experiences sharing their story with other parents.

Findings

The Duncans' **pre-therapy presentation** was a reflection of a build up of events and stressors in the family. For as long as they could remember, Megan showed signs of being a "troubled child." The situation was tolerable until she entered her teen years when she seemed to demand much more of her parents' attention. Ed and Jacquelyn described the feelings of desperation that permeated the **family climate** and most everything they did. They felt their lives were "turned upside down" and there were few places to get the help they knew was needed. Jacquelyn shared that if it had not been for

her faith and daily prayer she does not know what she would have done. Ed shared his perspective as well:

> Our lives turned upside down...more than anything I had ever seen, or anything I had ever been through. Nothing else had ever caused more stress in my life, and it spilled over into our lives...

There seemed to be no escaping the **conflict** between themselves and Megan. Her behavior was at times erratic, generally unpredictable and "heart-breaking" for them as parents. At times Megan's reactions far exceeded the adolescent norms. The Duncans sought help from a variety of professionals, including psychologists and a psychiatrist, none of whom offered much promise. There seemed to be no way of reaching her that worked. As the conflicts and tensions mounted, the **crisis** took hold of the family. The breaking point came when Megan refused nourishment of any kind for almost a week, and they decided to admit her to a local psychiatric hospital. Jacquelyn described the situation as so horrible that they felt as if they had no choice. Ed shared his wife's feelings echoing "It was the only choice we had since the situation was life threatening".

Their **prior treatment experience** only left Ed and Jacquelyn feeling even more isolated in their plight. They had many things to share about the lack of **usefulness** experienced throughout. Ed spoke about his frustrations with how the psychologist never seemed to venture beyond the presenting problems with Megan, and therefore, how they never reached any solution that fit the problem. For whatever reason, Ed never felt the counselors with whom he had been dealing were interested in hearing what he thought

of the situation. When I asked him to expand on feeling left out, Ed had the following to say:

> We had both gone through books, stacks this high. A lot of theory that we kept hearing. And you know we had read ugh... it was very easy for a counselor to manipulate those who were not very intelligent. The counselors seemed to have the same prescriptive solution to everyone who walked in. You spend your first two or three sessions listening, as in our case, to things you already knew. I found that many counselors that we talked to took a long period of time to not pay attention. We've always heard that they've got to treat the whole family but when you've got the whole family in there, they didn't listen to every member of the family. And there was more focus on the initial problem, and they talked about getting to the source of the problem, but really didn't listen to what caused it or get to it.

Jacquelyn was equally distraught about the lack of concern and understanding exhibited by those they were seeing. The psychiatrist was not particularly responsive to their state of crisis. When his office did respond, it was the secretary who called. This resulted in Jacquelyn's feeling blamed for Megan's lack of progress and incompetent for the way she was handling the situation.

> And the psychiatrist we couldn't get to the guy. We were in crisis and he might call back that day or several days later. Or his secretary who was an idiot would call and give this advise over the phone as if we knew nothing. And one of the things that she said was "You weren't attending my sessions." She set herself up as a self-proclaimed savior for the world. She had Saturday morning sessions. "No wonder you are having trouble. You aren't coming to our Saturday morning sessions!"

It followed that Megan was also not responding to prior treatment, and her condition and frame of mind only seemed to worsen with each different psychologist or psychiatrist she saw. Ed and Jacquelyn felt she never connected with any of them and

that she was not in a place where she even felt change was necessary. Her only motivation for participating in treatment was to get her parents off her back.

The Duncans state of **readiness** was linked to their feeling of desperation, their perceived seriousness of Megan's condition and lack of response to their numerous attempts to help her. Ed recalled his emotional state at one point:

> I physically had to carry her to the car and hold her crying like a baby myself. Tears streamed down my face, and Megan had never seen me cry...

Jacquelyn was equally distraught feeling that she had "somehow gotten lost" and did not know what to do next to improve the situation. She recalled how very painful the experience of seeing her daughter during that time was for her. The bitterness she experienced turned into a **hope** that someone would make a difference in their lives.

> I just wanted some hope and some answers...Yet, I kept thinking here goes one more. And how many can you go to before you kid will refuse to see anyone? I just felt it was the last straw, and I prayed to God that this would be the one.

Ed described his **expectations** of seeing yet one more therapist and having to begin the process again. He was reluctant to express hope and desires for fear of being disappointed. Yet he very much wanted a better relationship with his daughter.

> I guess I walked in a little bit defensive because of my past experiences not expecting much more from this one. While I figured I'd try anything. You got to go through the same repetition and history. You get a little bit into it and somebody forms an opinion.

The Duncans' experience of the **supportive therapeutic climate** hinged on the **therapist's contributions** and the way he first approached each of them. During the interview, it was almost difficult to get them to go into detail about their experiences.

They seemed more interested in my understanding how much the therapist contributed to the changes they experienced in themselves and Megan. Because they began family therapy in such a state of desperation, it was almost as if they were open to whatever might come their way without the cautiousness several other parents described.

From the beginning, Ed and Jacquelyn felt the therapist recognized the seriousness of the situation with Megan along with their state of desperation as parents. The **focus of therapy** at the onset was Megan. Yet the therapist was able to successfully engage the parents in sharing the spotlight with her in order to assess their role in the process. To gain access to the entire family picture, the therapist encouraged each family member to share their piece of the story by providing a **structure of therapy** that allowed this to happen. From beginning family therapy, Jacquelyn felt therapy was a safe place to express her feelings without being invalidated, or that it might cause more stress or conflict especially given that there were times she could not put words to what she was feeling. Ed commented on his early experiences.

> My view obviously he started out with the most urgent problem with Megan. That's why we were there. He did what he could there, and as he saw other problems that were identified with each of our relationships...He listened to Jacquelyn independently, and to me independently, and to Megan. And he really got to know...He took the time to listen to all the pieces of the background. ...He had the knack for bringing the right groups together to cause something to happen. It was all focused back on Megan...

Ed particularly welcomed having a one-on-one with the therapist, and for the first time in a counseling situation, felt someone was interested in what he had to say. Ed commented on his early experiences.

> When I described this, the whole history of how I felt, to the therapist, and the 20 plus years I kept bottled-up and couldn't really say for fear of hurting someone. The therapist didn't invalidate it or ignore it. It turned out he ended up validating a lot of the things...Later some of these things got said that I never could have addressed without the therapist.

Many of therapist's contributions were recognized by the Duncans as early as the first session of family therapy and contributed feeling as if they were in the right place and the right therapist. In particular, aspects of the therapist's **personhood** were something they referred to throughout the interview. Ed and Jacquelyn each expressed the therapist's enthusiasm for his work and considered it vital to their family's success in therapy. Jacquelyn shared her observations:

> You know, its a personal style and he's just got it, and if you don't really love people and want to bring them through bad times you need to pick another profession. They need to have a passion for what they are doing. Absolutely, and our therapist does right down to his bones.

Ed supplemented her statement with:

> He's an active listener combined with an ability to turn listening to problems into possible solutions...He has a gift that I have never seen for understanding people...He loves people. He would give anything to everyone else

Additionally, Ed and Jacquelyn appreciated the therapist's willingness to admit he might not have all the answers for them. Their sense of humor was evident when they joked about "being a tough case," and how they teased the therapist about "pulling out

the rule book to look this one up." At the same time they credited the therapist with playing the **role** of the family's "life-line." They also described the therapist's role in ways that were similar to other parents--as a mediator or coordinator of the family's efforts to understand each other by listening to what each of them had to say. The therapist would then share his perspective of the situation. Ed summarized early observations of the therapist's **involvement**:

> He is the first person I have ever run into who was able I think, was able to listen, to put it together, and to validate or invalidate each of us, our views of ourselves, or other members of the family.

Another aspect of the therapist's involvement that contributed to Ed and Jacquelyn's initial experiences of being in a supportive therapeutic climate was the therapist's use of self. The Duncans found new meaning in their situation when the therapist shared pertinent aspects of his personal life. For Ed and Jacquelyn, it meant he understood what they were experiencing as parents, and fostered a trust in the relationship and process.

Ed and Jacquelyn became involved in the therapy process as the level of trust increased and it felt safe in the context to take risks. Their most immediate **personal response** to the therapy process was experiencing it as "a breath of fresh air." At times Ed and Jacquelyn found themselves consumed with a sense of relief, peace and calm which they greatly appreciated even if it only lasted for a short time. Both spoke of facing tough issues, being open to feedback from each other and the therapist, and

accepting opinions they had previously ignored. Many of the **therapist's ways of working** contributed to doing the work it takes to make personal changes. Ed candidly shared:

> He told us a lot of things we didn't want to hear, but so what!...There were times I couldn't see that I had done anything, and I began to hear how others perceived me in a ways that no one else had described. He listened and he understood, and described all the things that were frustrating me, and perhaps were affecting others...and my relationships. I knew myself pretty well. And the therapist was able to come along and describe me in words like nobody else and how others see me in my home...There's an example of when all three of us would get together...He'd say things that I didn't want to hear and I relaxed. Then when we'd all get together, he'd say "Ed!, this is true about you. How do you fell about that Jacquelyn and Megan?" "Absolutely, that's Dad! That's Dad!" Oh, OK. I needed to hear it not just from the therapist but from the two of them and he had a way of bringing it out so they had opportunity in a non-threatening environment to ventilate a little bit toward me if they needed to do that, and it was out in the open now. So ha! not hidden anymore. So we were able to talk about it as a family because he brought it out. Whereas here in the house it may have become a bigger deal...

Jacquelyn's personal responses to the therapy process were less specific. While she was comfortable with the process, it was difficult for her to describe the conditions of the therapeutic context that supported her feelings. She connected and responded to the therapist and felt comfortable and trusted herself to jump right in at the onset of therapy.

For the most part, both Ed and Jacquelyn delighted in the **reaction of their adolescent** to therapy. While there were times Megan clearly exhibited a "don't bother me" attitude, most of the time she was a willing participant in the therapy process. The therapist's ways of working let her know "he cared about her and was going to understand and help her," unlike those who had gone before him. The Duncans felt the

therapist was the first person who listened to her, and understood her perspective, and helped her deal with her parents. Jacquelyn observed:

> Megan also had internalized this sincere feeling. She knew that here's a man that gives a damn. "He really cares, and he's not going to give up. He's going to be there. And he's not going to let me fall through the cracks"...She trusted him and felt like she wasn't going to disappoint him. She might disappoint us, but not him.

Ed and Jacquelyn's **post-script to family therapy** was uncomplicated. In the months since completing family therapy, they reflected on their **personal change response** and almost could not distinguish between where therapy ended and life began. Ed has a new found appreciation of what he brings to relationships and has continued to ponder the notion expressed by the therapist, "Your need not to be vulnerable interferes with your ability to connect." He expects growth and change will continue to be an ongoing process. On the other hand, Jacquelyn struggled to describe the changes into words. It was easier for her to share what she observed in others. Yet she knows she is more relaxed in her approach to parenting and has learned to connect with Megan in ways that have resulted in a new relationship.

The Duncans recognized a **change in family climate** specifically in relation to Megan and attributed them to their family therapy experience. They described "just getting along better" and felt it was easier to share their affection and appreciation with one another. Ed and Jacquelyn said that had I asked Megan about changes she has noticed, she would say they are "off my back" and that she experiences a sense of

freedom to connect that is now based on her choice to do so. They offered several notes Megan wrote to each of them that seem to confirms their perceptions. Jacquelyn also felt Megan was taking a "healthier" approach to her life and displayed a new self-confidence and feelings of self-worth.

Given the seriousness of the situation and desperation both Ed and Jacquelyn spoke of at the onset, the **value** they placed on family therapy was profound. They echoed each other's sentiments, "credit family therapy with saving our family" and expressed the sense of satisfaction they get from seeing positive changes in Megan. Additionally, they now have a new appreciation and impression of therapists. Working with their therapist, Ed and Jacquelyn experienced a genuine and lasting sense of his caring and concern for each of them. Ed and Jacquelyn continue to feel a connection with their therapist, and regardless, they know he "would be there for them." I was struck by their openness and willingness to share the details of their story with me and with other parents who experience similar hardships with their adolescents.

James Ambrose

James Ambrose was the sixth parent I interviewed. Originally, his wife set up the interview to include both of them. At the last minute when his wife could not be available, she called to say James would still be willing to meet if it suited my purposes. She commented that his answers might be different without her there. This left me curious about how their experiences of the same situation differed and not quite knowing what to expect.

James and I met just before dinner one evening at his home. Since this was the first time we actually spoke, we began with what generally occurs during the initial phone conversation. I answered his questions, explained my interests, and what I hoped to accomplish with this study. He spoke of his long standing interest in human nature and shared his views on family and values.

At the beginning of the interview, James let me know he was not a newcomer to family therapy. Over the last five years, James participated on several occasions because of situations with his other children. This time, however, the reasons for beginning therapy came as a shock to him. His 15 year old son, Corey, had "gone down hill real fast" when he became involved with the wrong crowd of kids and mixed up in gang activities. Corey's mild learning disabilities further complicated the problem and were reflected in the deterioration of his school work. It became apparent James was

profoundly affected by this sudden turn of events and the ripple was felt throughout the entire family.

The interview passed quickly as I moved from question to question. James was a fascinating man who shared candidly about his family background, the role spirituality played in his life, and dreams for his family's future. While it was apparent the present situation was very troubling to him, James seemed to "take one day at a time," give "thanks for the little things," and could "recognize what is working". I was struck by his expressiveness and the depth of our conversation, and was grateful the scheduling worked out the way that it did.

When I called to schedule the second interview, James said the situation with his son had deteriorated and they were still in therapy. The story James told during the second interview was a sad one. Yet I continued to hear words and expressions of hopefulness and encouragement from him. He said he learned a long time ago "one cannot change others, but only change oneself," and he spoke of his commitment to do just that.

Findings

James' **pre-therapy presentation** was different than other parents I interviewed. His experiences were every bit as painful and serious in his mind as those shared by other parents. Yet there was an eagerness and attitude with which he approached the situation that was different.

The **family climate** in the Ambrose household was filled with tension and accompanying shock when you realize you have a son in trouble. James spoke of how suddenly his relatively calm world, was upside-down and in a state of total chaos. All at once Corey was someone James hardly knew. James also faced the fear of dealing with something he admitted knowing little about. Even the thought of why Corey was attracted to a gang was something James could not comprehend, and fueled the **conflict** between father and son. James blamed himself for missing clues along the way that may have indicated Corey was headed for trouble. I sensed James felt an immediacy and urgency to resolve the crisis in the family. While it was only alluded to, there seemed to be conflict between James and his wife based on her choosing to play the role of protector and to minimize the notion that Corey was in trouble.

As mentioned earlier, James was not a newcomer to family therapy. Unlike many other parents whom I interviewed, James' prior treatment experiences proved to be extremely useful to him and his family. Years ago when therapy was first suggested as the way for the family to deal with problems, James resisted for a long time and left participating up to his wife. When a particular situation with one of the children was getting worse, James decided to join the rest of the family in therapy. His resistance wore off as he recognized the **usefulness** of therapy. This experience contributed to James' **readiness** to return to therapy when he found himself again in a situation that required treatment.

> I decided to go to therapy and became more and more comfortable...I made a lot of changes of how I look at therapy...So that when my son got into this trouble, I was completely open.

Based on prior treatment experiences, James had certain **expectations** of what therapy would be like. He anticipated much of what would go on during the initial phase of therapy and about the role the therapist would play. Because he previously had experienced a level of comfort with disclosure, his expectations fit the routine he had come to know.

> They would get a history on each one of us. I looked at myself as a piece of a puzzle and I saw the therapist as someone trying to put those pieces together to come up with a picture. They would get into my marriage since it would be a vital portion...they would dig into that...It would take a long time for this therapy session to go on. I did not expect any miracles...or any guarantees...and I knew it was going to be expensive.

James also had expectations of how Corey would respond to therapy. He anticipated Corey would cooperate and be an active participant especially since he was the reason they found themselves again in family therapy. James' **expectations** of himself expected he would be an integral part of what went on and considered himself as part of both the problem and solution. And finally, James had expectations of how he wanted the therapist to involve him in the process.

> ...For my therapist to know that I have my own mind that I think for myself, that I am open to new ideas, and that I express myself. I don't need anybody to talk for me. I'm capable and educated and can speak my mind...

James expressed his hopefulness with the outcome:

> Hopeful! Got to have hope that things will get better, that things will improve. That's the key. You've got to have hope. And not expect things to happen all of a sudden, just little steps. Solutions come a little bit at a time...I want a my family to be whole again. I want to have a family I can relate to and be in harmony with...

James recalled experiencing a **supportive therapeutic climate** due to his initial expectations being exceeded by the **therapist's contributions**. It did not take long for James to recognize and appreciate aspects of the therapist's **personhood**. Her caring gentle ways and low keyed approach to the family created the context for James to question and hear the answers to share his insecurities, and to feel supported. She effectively filled the **role** of expert and teacher as she became **involved** with James and his family.

> My initial experience was ...because of the person counseling us, it was more than I expected. She was extremely good not only at identifying the issues and problems, but also looking at each piece, each one of us. I was very impressed with her professionalism...She is very low-keyed at what she does. I feel very comfortable in terms of asking questions or for clarification. She sets the mood. She's very helpful...She listened to what I had to say and gave me another piece to put in the puzzle...She also gave me a good idea in this particular case of what it would be like to be invited to join a gang...something I have not experienced so I cannot associate with that.

For the most part, James described the **therapy process** as a time when the family was engaged in conversation that helped them sort out the problems that dominated their every day lives. This time around, the focus was on Corey and the problem James had with his gang involvement. For the most part, each family member willingly spoke their

mind and acknowledged each other's perspective. James noticed Corey generally was an active participant even though it seemed difficult for him to express himself.

> He has been more open...because the therapist has concentrated on him and asked specific questions and he had no choice but to answer...He's been on the hot seat. I'll bring up issues and confront him...in a professional setting so he doesn't shut down. In therapy he is asked more questions and begins to open up.

Sometimes Corey let it be known, either by his lack of participation or body language, that he did not want to be in therapy. There were other times when Corey **reacted** to the process by shifting the focus off himself or by getting up and leaving the session in much the same way he did at home when he was uncomfortable. James thought since he was bringing Corey to therapy that he should be an active participant. When James recognized that Corey managed regularly to shift the focus of therapy elsewhere, just as he did at home, he was left feeling frustrated and as if he was wasting time.

Regardless, James remained a willing participant in the therapy process. Of all the parents I interviewed, James' **personal response** indicated he recognized that the family was a system where change in one member caused change in another. James believed the only person he could change was himself. His change would, at least in some small way, cause change the family. Intellectually he knew he could not change Corey. Yet he struggled with the pain and frustration of not being able to get Corey to understand that his choice to be involved in a gang potentially placed him in dangerous situations.

> It's like a dance. If someone gets out of step or stepped on...it has a big impact. I look at what I need and what the family needs. I try and look at the unit and look at myself. I know that I cannot change anyone. Only they can change themselves if they wish. Perhaps by bringing it out into the open and discussing how I feel.

James used certain aspects of the therapy process to his advantage. With family members having to face the consequences of their behaviors session to session, James felt the therapeutic process provided him a sense of stability, and a place to bring out the issues on his mind.

> They are held accountable. For instance if certain things are not done...if others don't do their part, they know they are accountable next week because I'm going to bring it up. So it works from that perspective. You have an anchor. You know that you are going to go back there on a regular basis and discuss the issues. You have a choice. Do you want to be comfortable or on the hot seat?

Over time, James' level of confidence and trust in the therapist grew because of the way she made it a point to listen to his concerns and gently encouraged him to consider new possibilities for handling the situation with Corey. The therapist's sense of timing in bringing up tough issues fit with what James was ready to hear and made it easier for him to consider her suggestions. This also reinforced his feeling that the therapist knew what he was going through.

> It helps when you have a lot of confidence in the therapist and I have a lot of confidence with her...I trust her. She has acknowledged what I have said. She has listened to what I have to say and given me another piece...that has helped me understand...

Additionally, James appreciated the therapist's **way of working** with the family. Several times in the interview, James mentioned observing how the therapist engaged the

family in the process and used the family's responses to each other to make something happen between them in the session. This indicated she was using what happened in the session to understand what happens within the family on a day-to-day basis, and this understanding ultimately contributed to helping the family to help themselves.

> I would say something and she would turn to the person right away she would get his or her view...She did not necessarily look at it as truth. She was looking beyond to what was making up the whole picture....I could tell she was looking deeper than she was hearing. She realized that I don't see things the same way.

For all these reasons--feeling understood, comfortable, trusting and supported--James was able to accept the therapist's candor and deal openly with the difficult issues he faced with Corey. Even when the situation was at its worst, James spoke of relying on and trusting the therapist's perspectives, and how helpful he found their relationship and interactions to be.

> The therapist gave me some clues that everything is not what I expect...that I need to be more flexible...that I need to let Corey be responsible for his actions. It was in the back of my mind, but it was not until the therapist put it right in front of me that this was a process...without guarantees...The therapist is good at putting me back in my place and... guides me...helping me sort things out.

James' **post-script to family therapy** was related to his belief that change and growth are an ongoing process during one's lifetime. In the face of adversity and when one family member is "out of step" with the others, James believed that change for the rest of the family was inevitable.

> When you're on the road to change, be ready for new issues to pop up that need to be dealt with even if it disrupts the treatment process. Change is constant and part of the process and needs to be looked at. Just because we have an agenda

doesn't mean we can't stop. Nothing is short-term when it comes to dealing with personal problems.

He also described more immediate **change responses** that resulted from participating in therapy, how he saw himself and his relationship with others, and what he learned from his experiences.

> I now use I-statements therefore nobody can take my feelings away...I try to face them...try to be open to what they are saying...I can look at the problem, be open, be vulnerable...The key is to be flexible to be able to change. When I hit a stumbling block, I move....look at new ways and new ideas...I have just learned that I get more out of being open than closing doors. I learn more. My life becomes better...Now I am much more aware....and realize the world is not going to end. I've learned I'm not Corey and I can only guide and not change him. And its coming to terms with those things during therapy sessions. It has helped in putting things in perspective, He's not me...I can breath better. I feel better. I am able to have hope. I am able to deal with the problem in another way than before. Therapy is no longer a dirty word...It is a procedure I have found out about that has been helpful to me.

James described **changes in the family climate** based on the "little things" about family life he appreciates no longer takes for granted. While the change in circumstances with Corey between the first and second interviews caused him pain and anguish, James continued to maintain a positive outlook for himself and his family focusing on what he has, and not on what he does not have. The following quote was from the first interview. Yet the attitude prevailed during my follow-up interview with him.

> The signs are that we are dancing much better right now. We are getting along...more harmony than in the past. We are each more responsible how we should say things and we should say them...I'm happier now in the family than when I went into therapy, and that is how I gauge it. There is more harmony in the house. My wife and I are getting along much better. We are dancing the same

> steps...It's not my fantasy of what I want 100%, but it is something I can live with and embrace.

James grew up thinking that going to therapy was something to be ashamed of and keep secret. Because he recognized the **value** for himself and family and experienced profound changes and growth even during the bleakest of times and situations, James hopes the experience for his children will be different than his initial one.

> Perhaps that unlike me, my children because of the therapy they have gotten, that they will not fall into the trap that I did...that therapy is something you don't admit to as I did. I'm hoping that they will see how healthy it is to get the help that you need. People do get stuck and need help in getting out of it.

Paul and Judy Falcone

Paul and Judy Falcone were eager and willing participants in this study. When I spoke with Judy to arrange for the interview, she mentioned her interest in learning more from me about what other parents were experiencing in similar circumstances. It was interesting to me that from the beginning Judy seemed to feel as if there was something she would gain from participating. Finding a time for the interview was challenging because of their long work hours, commitments to their other children's activities, and caring for Paul's seriously ill father. We finally got together two weeks after our first phone conversation. As I drove into their neighborhood, I thought of how it reflected the typical activities of middle America: joggers, people working in their yards or on their cars, teens playing basketball and street hockey, little ones on hot wheels, skateboarders, and elderly couple out for an evening stroll. The bustling activity in the neighborhood both matched the tempo in their home and mirrored the description of their busy life. Perhaps this was the most challenging interview to settle into (and my fourth). There were many interruptions throughout as I was introduced to each member of the family including the family's pets. Never the less, I welcomed their hospitality and interest.

It quickly became evident to me that the Falcones wanted me to know all about Todd, their 15 year old son who was the focus of therapy, and that they had investigated many options, sought answers and help for him. As I listened to their story, I realized it sounded similar to the three that preceded it, not the words as much as the expression and

emotion with which it was told. By comparison Todd's problems seemed to be related more to adolescent development and parent-teen relationship issues than some of the other stories I heard. Yet both parents expressed their heart-wrenching feelings of guilt, fear, and concern about the situation with their son in ways that were as powerful and stirring as the parents whose child had been suicidal.

Other aspects of this interview that stood out were that Judy talked almost twice as much as Paul, how both of them frequently used "we" to describe individual experiences, and how they often finished each others sentences and thoughts, seemingly with a degree of accuracy. In the moment, I was concerned about each having their own say. It was not until later that I realized how well they worked together and supported each other regarding the problems they faced with Todd.

I had an equally challenging time catching up with Paul and Judy to complete the second interview. As it ended up, I spoke only with Judy. She shared in detail what they thought had been an improving situation with Todd was not turning out as hoped, and they were somewhat discouraged. At this point, they were continuing to see their family therapist on an irregular basis. Judy did again inquire about what I was learning about the experiences of other parents almost as if it might hold some answers for their family. I again let her know I would be sharing the results as soon as they were available.

Findings

The **pre-therapy presentation** of the Falcones was based on the their experiences of dealing with various "professionals." Paul and Judy felt as if they asked many of the right questions and received few answers that made a difference in getting to the source of the problem or learning how to handle Todd.

Todd had trouble adjusting to his freshman year in high school. He displayed a poor attitude toward school work and violated enough of the rules to get himself suspended for a few days. While they look back and admit the problems were in the making for the last several years, Paul and Judy felt Todd fell victim to peer pressure by cutting classes with friends and also experimenting with alcohol and marijuana. They participated in endless conferences with school administrators and counselors, a social worker, and psychologist which resulted in feeling as if "no one heard our concerns." Equally frustrating for Paul and Judy was the fact that Todd failed to connect that his poor attitude and risky behaviors potentially stood in the way of his successfully completing high school. Todd was more interested in here and now than in his future. Paul commented:

> He wants to be just like his friends. He's letting everything else control him...He doesn't want to hear it from his parents. He doesn't want to hear the old lecture deal....There for a while there wasn't a positive thing out of his mouth...

During the last few months, Paul and Judy experienced their tensions and frustrations permeating the **family climate**. According to Paul and Judy's descriptions,

saying the situation created **conflict** between parent and teen was understatement. Constant battles and disagreements erupted between Todd and his parents. Paul and Judy attempted to plead, bribe, and even reward the least little effort they recognized in Todd-- none of which seemed to make any difference. The situation reached the point where Paul and Judy did not know what to expect next. It became more and more difficult for them to deal with the uncertainty and unpredictability that characterized their every day living. Todd did not respond to their gestures and attempts to help and support him through this tough period in his life. Paul wondered if somehow they were to blame.

> It was like another phase of adolescence was moving through like a freight train. And I think he was trying to figure out "What can I get away with?". I think for attention...We keep asking ourselves "Why didn't we catch it sooner?". It hurts 'cause what did we do to deserve this kind of behavior? We give all that we can give. And he doesn't understand.

Both Paul and Judy felt stuck. Given there was almost no recognizable change, neither knew if they were making any progress at all. Though constantly in search of answers, they were beginning to feel the situation was somewhat hopeless. Judy described the feelings of being in **crisis**. She spoke of their times of confusion and anxiety and the moments when they were scared and feared "running out of time" with Todd. Guilt also played a role and they questioned whether that what they were doing was enough.

> You go through this guilt thing. You don't have time amidst the crisis to dwell on it. Sometimes we don't know if it's normal teen stuff or something else, and its frustrating trying to figure it out...I'm panicking because I don't know how to help my child...He has a few years to get it, and I'm running out of time...

Their only **prior treatment experiences** was with a clinical psychologist who evaluated, tested, re-tested and counseled Todd. Paul and Judy were not included in treatment process on a regular basis. Never the less, they considered the treatment experience to be **useful** from the standpoint it provided additional explanations for Todd's behavior. The experience also seemed to help Todd until he identified the counselor as being another authority figure in his life. Judy commented:

> He looked at the counselor as a medical authority figure...Authority figures he does not get real close to. He likes to throw up his guard and back off. He doesn't know what else to do...

The Falcones' state of **readiness** was tied to the overall experience of asking many questions and not receiving answers that made a difference. Throughout the interview they referred repeatedly to "running out of time" to make a difference in Todd's life. The systems with which they were involved only seemed to perpetuate the problems. An example of Paul and Judy's frustrations was that the consequences of Todd's school suspension was to spend the day at home doing nothing. It seemed more like a reward to them than a punishment.

> That's when we had enough!! He's not getting anything he needs. We've got to so something. But we don't know what else to do...

By this time, Paul and Judy were able to describe what they thought would make the difference for Todd in therapy. They took turns sharing the **expectations** of what they wanted from a therapist, the **roles** they wanted him to play, and the process:

J: I thought if I can get a therapist...
P: Who is not an authority figure...
J: Who will work with Todd ...
P: A mentor, the 12th man of the football team, so to speak...a listening post...
J: That's exactly right. What I wanted. I knew what I wanted him to do. The question was could he?...And we'll say "This is what we want. Can you do it?" and hope the answer was yes...Give us as wide a resource base as you can. Use everything available to you...your colleagues, other families, the internet. Don't leave anything unturned. And be willing to go outside the parameters. Don't just text-book-it. And we'll listen to what you are telling us...you are trained to know how to go about it.

And Judy spoke about what they wanted for themselves:

We need someone to work with us, to tell us when to punish him. I need help. I don't know what I'm doing right! I don't know what I'm doing wrong! And if I'm even close.

Paul and Judy's **hope and desire** was to find the right therapist who could meet their expectations, and who would relate to Todd in a way that led to a change of heart and change in behavior before it was too late. In ways similar to other parents, they spoke of wanting Todd to have a productive and fulfilling life.

For the Falcones, the experience of a **supportive therapeutic climate** was contingent on whether the therapist met their expectations by creating and maintaining an environment in which Todd was the **focus** and responded in recognizable ways. They wanted to be included in the **structure** in a way that allowed them to be heard and understood. As it was, their expectations were met at the onset and a sense of hopefulness was restored for them and for Todd. Judy shared memories of how the earliest sessions progressed, the role and **involvement** of the therapist.

> We went and talked to him, and we'd leave and he'd talk to Todd. Most of the time Todd would be laid back on the couch totally bored not wanting to be a part of it. Finally, by the third time, the therapist called us in. Sometimes he sees different ones of us at different times. "This is the approach I'd like to take. He doesn't need another authority figure. I'm going to do more of the telling you what he's done right, role play kind of thing, and not getting on him about things he's done wrong, but trying to help him see how he could have been different...

Looking back, Paul and Judy felt at least at some level, Todd wanted help and that he was encouraged by the connection he experienced with his therapist. They were also more relaxed with the **therapy process**, and felt as if things turned around due in part to the **therapist's ways of working** with all of them. Judy described the **reaction of their son** and what they considered to be the turning point in therapy.

> The therapist does things, little things that are not black-and-white bookish. At one point he came out and Todd said something about being hungry, and the therapist said "Let's go get something to eat." They went out and did their thing...kind of like a business lunch...And I think at that point everything started to connect, and we had a major break through...After that he'd participate more, and this time we went over something. And Todd said "we're done, and you can leave now, Mom." OK, I'm out of here...and that made me feel so great that he felt that he had someone to talk to...I know he's got issues, questions and things...

And Paul expressed similar sentiments about Todd's connection with the therapist.

> It was like a gap had been bridged. You know here's someone that can talk to Todd, yet he isn't an authority figure. He's not the police. He's not the religious type individual that says "You'll do a, b, c, d, or God will punish you". It's a guy thing.

Paul and Judy's **personal responses** to therapy indicated the process was working for them as well. Based on the therapist's involvement with them on a regular

basis, therapy became a comfortable place where they explored their concerns, had their questions answered, and their parenting skills validated.

> And he says "You've tried this and you've done really good." Like the therapist told us we did good getting Todd to be responsible. "Keep that up. What about this?" and he'd help us modify. It's nice to hear someone say these are the things that you've done right. Or you're lucky because...so many children aren't that way. So we can see the positive things when we have so many negatives in our way.

Even though Paul and Judy did not fully experience the hoped for **change in the family climate** and continue to struggle with Todd, the progress they made was evident in their **post-script to family therapy.** Both agreed on **their change responses.** They approach Todd and their circumstances with a different attitude and consider alternative ways of dealing with what is before them. They work as a team and are mindful of each others strengths and weaknesses.

> We try to analyze it first now before we make a determination. We do a lot more communicating even if we don't agree. We try and are getting pretty good at discussing it. No one has to be right. Each has something to contribute even if we take polar sides and are different. That's good. We make each other think...We were trying to figure out what Todd was thinking, and have to be careful before we place restrictions on him.

Paul and Judy **valued** various aspects of their family therapy experience. While they do not have all the answers they want, The Falcones recognized there are a multitude of options to consider. They also realized making choices is not about being right or wrong, but rather experimenting to find what works for them as parents. They valued the connection with their therapist, felt as if he was "on their side" and considered him a

readily accessible resource. And perhaps more than anything, they valued being together and working as a family and what they learned about each other during the process. Judy shared how they look back on their experiences in therapy.

> Knowing you are not alone by yourself trying to fix this is worth the price of the therapy, and everything else you get on top of it is icing. Just knowing you are not doing this alone... And the fact that you are all there together says something enormous. That you are all together trying to work on this...All of us together stand a much better chance of finding things to work and solutions and techniques than anyone of us by ourselves.

Denise Hendrick

Denise Hendrick is the single mother of two adolescent children who were both the focus of therapy. Gary, a 15 year old, was diagnosed with Attention Deficit Disorder just prior to beginning the seventh grade, and finds it difficult to keep up in school. Fourteen year old Susan struggles with self-confidence issues of being a teenager and was caught experimenting with alcohol in the last few months. Denise works hard to meet the challenges of single parenthood, generally feels overextended and not respected by her children.

In spite of her busy schedule, Denise found time to see me the day after I called to set the appointment. When I arrived, the entire family met me at the door. Their home reflected that togetherness was a daily part of their lives in that it was somewhat crowded, looked comfortably lived in, and was adorned with a gallery of family pictures. As Denise and I settled at the kitchen table, both the teenagers made themselves scarce. Though initially she appeared nervous and anxious about the interview, Denise spoke openly about her experiences in therapy. It became clear to me that the therapy process affirmed and elevated Denise's position as the mother to where she felt capable of meeting the challenges of her family's circumstances. Her responses indicated she cared deeply for her children, and shared their hurt and pain, confusion and frustrations. Denise struggled with letting them each know how deeply she cared in ways they would

understand. At times she shared so much detail so quickly that I lost what to ask next and what points to clarify.

During the second interview, Denise seemed more relaxed. As a result, it seemed easier to focus my line of inquiry and to gather powerful descriptions of Denise's therapeutic experiences.

Findings

Denise Hendrick shied away from therapy because she was brought up to believe needing help from others to solve problems was a sign of weakness. Consequently, her **pre-therapy presentation** reflected this belief in that she was nervous, felt guilty for needing help and most of all feared criticism for the way she was handling the **conflict** between herself and her children. Denise's fear for Greg and Susan was readily apparent especially given what she believed they were exposed to every day at their local high school. The stories other parents told left her concerned about their safety, peer pressure, and immoral ways of thinking and behaving. Denise began to realize the only conversations had with Gary and Susan were to warn of dangers or restrict their friendships and activities. Gary's and Susan's rebellious response mirrored those of others their age. Denise knew she was probably too hard on them and more rigid than she needed to be. She was simply scared and did not know a better way to handle the situation. These factors all contributed to her **readiness** to at least try therapy. Denise's

hope and desire was "to be a forever family," and she realized that she might be standing in the way of what she wanted most.

> I was trying to be everything to my children--mother, father, God if you will. I mean, you know, the controlling force and I was trying so hard... I was shy about telling a stranger about things, and there are things I didn't want my kids to know how I felt or my hang-ups about what the kids are doing or whatever...I wanted to shy away from help because I feel like they'd say "You're not right, Mom. This is right."

All Denise knew about therapy and therapists was from what she learned growing up and from the way they were portrayed on television. Her **expectations** were based on preconceived images and her fear that somehow therapy would interfere with her role as a parent. Denise clearly stated she wanted a therapist who understood and shared her value base.

> I saw therapists as someone who's trying to undermine my responsibility in raising my children and that's the thing uppermost in my mind...I wasn't going to let anybody interfere with it and initially, this is what I thought about therapists, and this is why I didn't go to a therapist sooner. Because they have their half-cocked ideas that it's all right to do this or that "whatever makes you feel good" kind of thing.

To her surprise, Denise encountered a **supportive therapeutic climate** at the onset of her experience in therapy which she credits to the **therapist's contributions.** The therapist's **personhood** combined with his willing **involvement** indicated to Denise his genuine interest in working with them. She felt he communicated his sincerity and interest in helping them improve their family situation from their first meeting.

> Well, it did not take long to get through those feelings as far as our relationship with the therapist was concerned...I mean, he's just a great guy. He displayed

> such patience...you can tell when a person is patient and genuine and whether or not the person is just doing their job. You know, I felt from the beginning that he sincerely wanted us to do better...Nothing phased him. He just was non-judgmental...His training, I mean he's very professional yet he's personable and I could feel that. I could feel genuine concern and caring coming from him for me and for my children...He was able to relate to us.

The **focus** of therapy was primarily on the communication and interactions between Denise, Gary and Susan, and was supported by the **structure**. During most sessions, all three would meet with the therapist and discuss what was important to them individually and collectively. Occasionally, the therapist met with Denise alone. She particularly liked these opportunities to express what was on her mind, talk about her fears and vulnerabilities without worrying what the children would think. Denise felt this prepared her for the work they did in session as a family. Denise described her views of the **therapy process**.

> Family therapy is where everybody has a chance to say what they want to say uninterrupted. I had to learn that too because I'm always interrupting. Uninterrupted and without retaliation, you know they're afraid to say something because they think it's going to hurt my feelings so they're no going to say it. Family therapy is interaction you know...

Denise experienced various **personal responses** to the therapeutic process. She particularly appreciated the opportunity to have thought provoking conversations with another adult who understood and provided useful feedback. Throughout the process, Denise felt the **therapist's ways of working** communicated respect and elevated her position as the "head of the house."

> When I was able to go with the therapist and I got to know him and just spill out, you know let it out more so that he could help me more with the pain that I was carrying not just from childhood things but all the way up to this point and with the anxieties I had for the tomorrows. You know being able to talk to him as an adult...I looked up to. I could tell him anything and relax with him and he wasn't shocked at anything...He would say "You know, you're saying this." He'd give it back to me the way he thought I was saying it and that would make me think... That would help...I mean he respected me, and he always said "Denise, now it's your house and if you say that this is it then this is it."

The therapy process also gave Denise the opportunity to observe the **reaction of her children**. She could easily see Gary and Susan felt relaxed and comfortable with the process and therapist. They candidly shared what they felt were issues with their mother and opinions of their circumstance. It was difficult for her when she found herself the subject of a session. Yet she recognized Gary and Susan's involvement as positive sign that they were beginning to see a bigger picture that included her as the mother.

> The children could see that he was just as fair to them as he was to me. All our feelings were just as important to him. Mine were no more important to him than Gary's or Susan's. You know, as a group and then as individuals...Sometimes it took me awhile to acclimate myself to what was brought out in session...into my everyday life because my children would say "you're not living up to your end of the bargain," and they'd go back and tell the therapist "She's just hollering at us anyhow and she this and that." And I'd get indignant...It took me awhile...I learned a lot."

In her **post-script to family therapy,** Denise described the many profound changes she experienced as a result of having participated in therapy. Almost from the beginning, Denise realized there was something there for herself as well as for her children, She was also one of the parents who recognized the role she played in her children's

struggles, and knew if she changed herself, changes would occur for them as well. Denise listed many **change responses** that she attributes to having participated in therapy.

> It's been helpful to me because the session brought out things I didn't realize were bothering me. Especially some of my set and concrete ways. The way I was thinking or the way I was reacting...I was too rigid...and the therapy helped me to see alternative methods and ways of dealing with the specific situation...It helped me see that though my motives might have been good I was going about it in the wrong way. I was creating more frustration and pain for the children...It helped me to see I was not being clear to them...helped me to analyze it in terms of "trust these kids; you've taught them well; you know you aren't in the dark ages here and there is a choice where everybody can be happy and still live within what is right"...It was my abuse of authority...I am humble enough to recognize that I can't solve all the problems.

Just as she expected, Denise recognized **changes in the family climate** and the effects therapy had on Gary and Susan. She delights in having teenagers that get along with each other!

> They are not fighting each other as much as they did. They are showing more patience and respect to each other and I can give some credit...to the therapist for that. The children realize that mom has feelings and mom just wants what's best for them, and...I think because of therapy we got working as a unit as a group. I mean we can fall through the cracks. If we are going to work as a group I mean we have to hold on and lock it in. I think that they saw that in the therapy...so we get along better.

There are several aspects Denise has come to **value** from her experiences in therapy. She feels as if she has been left with a new understanding of her children that improved their relationship and their sense of being the "forever family" Denise had hoped for.

> I needed to hear my children verbalize the pain that they were feeling and didn't want to tell me because they love me and realize the pain I was inflicting, out of

> love, I mean was misdirected, yet it was because of my love and concern for them. I listen to my children more, and that is good.

Denise valued the relationship with the therapist both for the influence he had on her and especially the one he had on her children. As a single mother of teenagers, Denise welcomed an influence she could trust and rely upon.

> He had similar set of values that I wanted to see my children keep...the way I wanted to see my children and so it wasn't like compromising your principles...I feel in my heart and in my intellect that he is good enough guy that if he told the kids that "you should do this" it would be right. I don't believe that he would tell my children anything wrong. I really trust him and I think that is an important thing.

Table 1

Core Categories

Pre-Therapy Presentation
- Family Climate
  - Conflict
  - Crisis
- Prior Treatment Experiences
  - Usefulness
- Readiness
- Expectations
- Hopes and Desires

Supportive Therapeutic Climate
- Focus of Therapy
- Structure of Therapy
- Therapist's Contributions
  - Personhood
  - Roles
  - Involvement

Family Therapy Process
- Personal Response
- Reaction of Adolescent
- Therapist's Ways of Working

Post-Script of the Therapeutic Experience
- Parents' Change Response
- Changes in Family Climate
- Value of Family Therapy

CHAPTER V

DISCUSSION

Introduction

The purpose of this study was to examine parents' of adolescents experiences in family therapy. To accomplish this objective, I conducted in-depth and follow-up interviews with 15 parents who had participated in family therapy with their adolescent in a private practice setting. When asked what it was like for them to be part of the therapy process, participants willingly provided me with detailed views of their personal experiences. A constructivist theoretical framework guided the investigation. By using the constant comparative qualitative method of analysis, emergent categories and themes became apparent. In the previous chapter, I presented the categories and themes which described the subtitles of the parents' therapeutic experiences. Five case stories were selected to illustrate the categories and how they were supported in the parents' reflections of therapy. Parents' verbatim quotes were used to further embellish the findings.

This chapter begins with a summary of the findings and how each is supported by previous research. Next is a discussion of the limitations of this study, followed by the implications for clinical practice and implications for future research. I conclude with a personal post-script about conducting this study.

Summary of the Findings

Parents in this study were asked to describe varying aspects of their experiences in family therapy. During the semi-structured interviews, I asked broad questions aimed at soliciting parents' descriptions of the therapy process at various stages of their participation. They shared experiences prior to beginning and during therapy along with their perceptions based on either their continued participation or on having completed treatment. The inquiry was intended to gather information about the process rather than the content of their stories. I have focused on four areas in this summary: parents' view of "reality", the therapeutic process, relationship with the therapist, and perception of outcome and change.

Consistently, parents shared the circumstances of their adolescent's troubles that preceded the first therapy appointment. I invariably was left feeling it was important for me to understand how this piece fit into the big picture, and that parents' recounting of their stories in some way helped parents make sense of what had happened. Regardless of what they had been through with their son or daughter, many parents experienced a range of intense emotions. Whether their child was suicidal or had recently been diagnosed with a learning disability, parents' expression and depth of their emotion was described in much the same way. Many parents also carried feelings of guilt and self-blame, asked themselves "why us," wondered what clues they had missed, and questioned whether

they had done enough for their child. I also became aware of the strength, resilience and resourcefulness they exhibited during what they described as very troubling times.

Sprenkle and Piercy (1992) suggested that discovery-oriented research informs us about the general state of the family and provides a richer understanding of the challenges they face. They also discussed the importance of realizing and nurturing the strengths, competencies and resiliency of help-seeking families. When considering parents' stories through a constructivist lens, one realizes that people are constantly in the process of making sense of themselves and of their experiences. What I found myself dealing with was not "truth," but rather parents' "reality" of their perceptions and experiences. Parents' stories indicated they had developed a connection in therapy that was based on the understanding of their "reality." During the research interview, it also became important for them to connect with me around the same understanding of their "reality."

Most parents also were aware of the "reality" of the world they were stepping into. They came to therapy with expectations of what would happen in session. For all but one parent, these expectations were based on prior treatment experiences involving their adolescents and occasionally themselves most of which were unsuccessful. Parents spoke of being skeptical and scared. Many expected therapy to be difficult on everyone as unknown or ignored issues surfaced. Some expected life to potentially get worse before getting better. Yet each believed it was best to "hang in there" through this initial phase of therapy. Parents knew it would take time to sort through and address the

problems and feelings that surfaced, and described therapy as a "process" and not a "quick fix."

The parents in this study indicated because they did "hang in there," therapy became a safe place to ask questions, explore possibilities, and practice new ways of parenting. They used metaphors such as "safety net," "like having a conversation," " an anchor," "like going to an oasis," a place to learn how to "dance together better" to describe their experience of the therapy process. Those parents who decided to become actively involved in the therapy process experienced personal gain and satisfaction. They recognized differences in their outlook and interactions, and overall increased levels of sensitivity and understanding. Parents gave many examples of what was helpful to them and described conditions that contributed to their feeling comfortable, confident and non-threatened by the therapy process.

Sentiments similar to those of parents in this study have been frequently cited in professional literature on clients' experiences of the therapy process (Bischoff & McBride, 1996; Elliott & Shapiro, 1992; Llewelyn, 1989; Rennie, 1990; Sells, Smith & Moon, 1996; Wark, 1994). In general, these studies reported that clients found reassurance and relief while participating in therapy. Therapy also became a place for clients to gain insight and awareness, consider possibilities and take risks in session, and that these factors contributed to clients' experiencing therapy as useful and a safe place to address their problems.

Parents also knew how they wanted the therapist's role to play out particularly with their son or daughter. In several scenarios, parents requested that therapists focus on the adolescent exclusively. When therapists ventured from the text-book based theory of working with the adolescent in the context of the family and honored the request, parents felt understood by the therapist and supported by the therapeutic context. Parents' request for "child therapy" (p.260) was addressed by Kuehl (1993) who suggested that taking a collaborative approach to child and family therapy can both enhance assessment and the overall therapeutic process. It also communicates to the parent and child a respect for their opinions and lays the groundwork for building cooperative working relationships. Utilizing parents as "expert consultants" (p.266) encourages their participation in family sessions. Additionally, seeing the child without the parents often allows freer expression of pent up emotions without fear of retaliation.

Additionally, parents responded positively to a structure that provided one-on-one time with the therapist to discuss their perspectives and concerns without restraint and free of judgment. Many felt that for the first time someone heard and understood what they were communicating. Most parents felt therapists understood what it was like for them to parent an adolescent in today's world. When parents' "realities" were validated by the therapist, they felt increasingly confident and competent as parents and more inclined to participate in the therapy process. According to Duncan, Solovey and Rusk (1992), when a therapist takes a collaborative therapy approach from the onset,

maintains genuine interest, avoids taking sides, and validates each person's concerns and connection to the problem, clients become willing participants in the therapy process.

In this study, parents consistently identified several aspects of the therapeutic relationship as contributing to their overall positive experience. Many parents considered the therapist an "expert" in dealing with emotional problems. In seeking therapy, parents hoped therapists could provide them with answers and solutions to their difficulties that they had failed to come up with for themselves. They relied on the therapists' knowledge, experience and direction about how to best proceed. This finding supported the earlier research of Bischoff and McBride (1996) who suggested that "the expert role of the therapist was expected and desired" (p.125). They reported clients seemed to gain something from perceiving the therapist as an expert, and found it comforting to have someone with whom they could confide and who was an expert at resolving problems. Similarly, Fine and Turner (1996) reported that clients relied on therapists' expert knowledge to guide the therapy process, and welcomed therapist's advice and teaching new ways of communicating and relating.

Many of these same parents also felt the therapist acknowledged them as "expert" parents particularly regarding their adolescent. Their relationship with the therapist contributed to their feeling validated, respected and empowered as parents. In some ways, proposing the "therapist as expert" and the "parent as expert" concurrently is almost a contradiction. It seems as if the therapists effectively maintained a working alliance and

relied on consultation with the parents during the therapy process to create a cooperative, collaborative client-therapist relationship throughout.

Within the field of marriage and family therapy, the necessity of developing a collaborative client-therapist relationship has been both a recurring topic in professional literature (Anderson & Goolishian, 1988, 1992; Barnard & Kuehl, 1995; deShazer, 1991; Duncan, Solovey & Rusk, 1992; Miller, Hubble & Duncan, 1995) and the reported findings of several studies (Beer, 1993; Bischoff, McKeel, Moon & Sprenkle, 1996; Sells, Smith & Moon, 1996; Swint, 1995). The characteristics central to successful therapy regardless of the therapists' theoretical orientation included therapists' empowering clients, focusing on competencies, attending to client's subjective experience, and working to develop an on-going, collaborative working relationship.

Parents frequently referred to their therapist's "humanness." Many parents reported appreciating when their therapist shared personal experiences and were impressed when their therapist took what they considered to be a non-text book or non-theoretical approach to the family. Several mentioned they admired their therapist for admitting he/she did not have all the answers. Others felt therapy was useful and effective when the therapist recognized and used the family's process and not simply the content of their stories to create an in-session experience. Very few parents mentioned specific techniques or interventions that they found to be particularly meaningful or helpful.

These results support earlier research indicating that clients favor the therapist's genuineness, sincerity and being with them in the moment over specific techniques and prescriptive solutions (Beer, 1993; Broderick, 1996; Kuehl, 1987; McCollum & Beer, 1995; Miller, Hubble & Duncan, 1995; Rennie, 1990; Sells, Smith & Moon, 1996).

The majority of parents who participated in this study described "picture perfect" outcomes and changes in their everyday lives that resulted from participation in therapy. Several other parents experienced set-backs with their adolescents or had not yet achieved the hoped for results from therapy. Regardless of the outcome or change, they all spoke of their satisfaction with their family therapy experience. Parents' active participation in the therapy process and their relationships with their therapist contributed to feelings of accomplishment and satisfaction with personal daily life experiences and relationships within their families.

Limitations of the Study

As with most studies, there are several limitations to this study. First, the sample size of fifteen parents did not allow for absolute theoretical saturation. The participant selection process was one of convenience. The therapists approached parents whom they thought would readily volunteer detailed descriptions of their therapy experiences. I can only assume the therapists' choice of clients was based on who they felt had a "good" therapy experience and whose story would be interesting to this research project. The participants also were not a diverse group in terms of socio-economics, education and life

styles they maintained. Also with so few participants, the data did not support findings of any significance related to ethnicity or gender considerations.

The findings reported are not generalizable in the traditional sense. In quanitative research "sampling is based on selecting a portion of the population to represent the entire population to which one wants to generalize" (Strauss & Corbin, 1990, p. 190). In qualitative research, the researcher does not attempt to generalize to a population, but rather describes a phenomenon and specifies the conditions under which the phenomena exist, the associated action/interaction and outcomes. The theory applies to the situations studied and "to no other" (Strauss & Corbin, 1990, p. 191). While the findings of this study are rooted in time, place and a specific population, they only begin to explore parents' of adolescents views regarding their participation in family therapy. Additionally, the findings provide an alternative view for family therapists to consider who find themselves working with this population. Atkinson, Heath and Chenail (1991) offer the opinion that "establishing the trustworthiness of the insights generated through exploratory research is the job of those who are consumers of the research, and not the job of social science researchers" (p. 163). Consequently, the usefulness of these findings is left up to those who are inclined to read this report.

And finally, since this is the first qualitative research project I have undertaken, I cannot begin to pretend that I knew exactly what to do when and for exactly what purpose. Throughout the project, I made many efforts to compensate for my

inexperience. Routine consultations with my academic advisor provided me the constant feedback and guidance that I needed. Additionally, extensive reading, previous academic work, and clinical and volunteer experiences with adolescents and their parents served to guide me through this project.

Implications for Clinical Practice

Several implications for working with parents of adolescents in clinical practice are rooted in the larger societal context. As with any client, it is important to consider the parents' worldview and experience of parenting adolescents in the late 1990's. One of the many messages today's parents receive seems to be based on the notion that parenting adolescents is a monumental, complex and arduous task. Another is that the world is a dangerous place for today's adolescents. For many parents this turns out to be "reality." Parents arrive for therapy in their own state of crisis as they struggle with a son or daughter in trouble and with giving up the ideal image they held of their adolescent. It might be useful for family therapists and others working with parents of adolescents to be sensitive to the present state of the communities from which these parents come. Therapists should also not underestimate the fears, concerns and dangers that parents believe their adolescents are exposed to every day or those offered as the presenting problems at the onset of therapy.

Regardless of a therapist's theoretical orientation, studies of clients' experiences consistently report the influence and power of the client-therapist relationship. It is a

therapist's relationship skills and personal characteristics, and not techniques or interventions that clients consistently refer to as meaningful in their therapy experiences. As with anything else, becoming a therapist is a process that takes time, and some "get it" and others "do not get it." Some become good therapists, and others become creative therapists. How does one measure the difference? The implication is for therapists to be themselves--human, caring, empathetic and understanding--and to leave the "rule book" on the shelf as much as possible. Clients appreciated therapists who showed genuine interest and a passion for helping families improve. As therapists encourage and support clients to trust themselves, so should therapists trust and rely on use of self and share certain aspects of themselves that are appropriate or meaningful for the client to hear even if it means admitting not having all the answers.

A unique aspect of this study was that the participants attended family therapy in private practice settings. In a period during which family therapy is becoming increasingly business oriented, issues of client satisfaction are also becoming increasingly important for private practitioners to consider. When parents arrive for family therapy with their adolescents, it is they and not the adolescent who are the consumers of therapy. Findings from this study and others that have explored clients' experiences provide family therapists with valuable and rich sources of information that when used can bring a new dimension to the therapeutic process. Additionally, by providing ways for therapists to improve their skills, they can better demonstrate to their clients and to

their managed care and insurance companies, that as therapists, they care about providing effective, relevant and accountable mental health care services.

Implications for Future Research

There continues to be a call for research aimed at obtaining clients' perspectives of the therapy process, change and outcome, and the therapeutic relationship. By comparison to other topic areas in family therapy research, there are few studies, either quantitative or qualitative, that report clients' experiences in therapy.

While involved in this qualitative research project, there were times I had more questions than answers. As I reviewed, coded, re-coded, looked within and across cases, I found what seemed to be endless avenues to pursue. Future research with a more varied population and with parents whose experience in family therapy was less than satisfactory would add depth to the current findings. It would also be interesting to pursue a line of inquiry with the parents who reported experiencing a set-back with their adolescent during the follow-up interview and what contributed to their continued satisfaction with therapy.

Several studies considered both the therapist's and clients' perspectives in the same cases as the means of comparing, contrasting and discovering both the similarities and differences. Interviewing participating therapists would also have added an additional dimension to this study as well.

As mentioned earlier, so many of these parents exhibited a resilience, strength and resourcefulness that was most impressive. Investigating the effects of adolescents on parents and parents' coping skills might also prove to be interesting and provide additional information that contributes to understanding this complex time in the life cycle.

Many parents reported that participating in this project was meaningful for them and provided the opportunity to reflect on what was significant about their experiences in family therapy. A line of inquiry aimed at further examining the value of participating in research interests me and would contribute to a growing body of knowledge related to participants' experiences of research.

Personal Post-Script

The words and phrases to describe my experience do not seem to come easily at this point. It is challenging to condense into a few paragraphs what I have learned and how I have been influenced by this study. As with everything else, creating, designing, working on and completing a thesis project *is a process*. It has been a growth experience I underestimated, and I am inclined to believe its effects will be with me for a long time to come--both personally and professionally.

In "playing back" the experience and applying "interpersonal process recall" and reflecting on "meaningful moments" (Rennie, 1990), several aspects do in fact stand out in relation to my role as researcher, as an aspiring therapist and as a parent. (Will the

interative process forever affect my thinking?!) I am not yet able to say exactly how I might apply some of the notions I am left pondering.

The first as researcher the parents I interviewed were so willing to offer me a glimpse and in many ways include me in their private therapeutic world almost as if I had been a part all along. I continue to be curious about several as if they had been my own clients. In listening to several of the audiotapes again, I *heard* and *felt* how powerful participating in the research had been for several parents in particular. Having the profound effect they described was something I had not expected to encounter (and as mentioned earlier, a thought provoking topic for future research). And lastly, while reading several other studies on clients' experiences, I was enthralled by their richness, depth of discussion, and touched by the results.

As an aspiring therapist, I find myself facing change even before I get started. Several considerations will inform my work with parents' of adolescents and any other client as well. I am left feeling also that some of my thinking as a therapist he been reinforced and validated. I have come to realize more than before that therapy is a world, a culture of its own, and it is vital to welcome participants into that world. Also, understanding the "reality" the client presents with for therapy is essential to the process. As a new therapist, realizing that tip-toeing around tough issues for longer than clients need to might not be useful or effective in the long run. I look forward to inviting clients to have another type of conversation about therapy--to step outside the process

and reflect back on it. And lastly, parents responses indicated therapy does not necessarily stop when they walked out the door or when they completed a course of treatment. Like everything else, it too is a process.

Having parented teenagers (n=4; two of four have made it to their 20's!), I have also been personally touched by this project beyond what I ever expected. When I read and reread the statement "Talking about how one conducts one's own qualitative research is like doing qualitative analysis of one's own process" (Murphy, 1992, p.156), I realized why I could not seem to escape the intensity of studying about parents of adolescents. I consider myself one of the "lucky" parents, and at the same time have experienced many of the same emotions (even during the course of this project) they described--the pain, fear and guilt along with the joys, happiness and peace and satisfaction of knowing I am a good mother. This research project has affected my daughters as well. I'm not quite sure how, and joke that time will tell if they select masters programs with theses requirements or not!! We have all become closer; I learned from some of these parents how to be a better parent by paying attention to my daughters in different ways.

While this has been more work than I ever imagined, I am glad for the way it has turned out, and look forward to carrying, even if only in some small way, the messages from the parents who participated in this study.

References

Anderson, H., & Goolishian, H. (1988). Human systems as linguistic systems: preliminary and evolving ideas about the implications for clinical theory. Family Process, 27, 371-393.

Anderson, H., & Goolishian, H. (1992). The client is expert: a not-knowing approach to therapy. In McNamee, S. And Gergen, K. J. (Eds.), Therapy as a social construction (pp. 25-39). London: Sage Publications.

Atkinson, B., Heath, A., & Chenail, R. (1991). Qualitative research and he legitimization of knowledge. Journal of Marital and Family Therapy, 17, (2), 175-180.

Barnard, C.P., & Kuehl, B. P. (1995). Ongoing evaluation: in-session procedures for enhancing the working alliance and therapy effectiveness. The American Journal of Family Therapy, 23(2), 161-171.

Beer, J. (1993). "If you could look in a mirror through another person's eyes": Unpublished doctoral dissertation. West Lafayette, IN: Purdue University.

Bischoff, R., & McBride, A. (1996). Client perceptions of couples and family therapy. The American Journal of Family Therapy, 24,(2), 117-128.

Bischoff, R., McKee, A., Moon, S., & Sprenkle, D. (1996). Therapist-conducted consultation: using clients as consultant to their own therapy. Journal of Marital and Family Therapy, 22(3), 359-379.

Breunlin, D. C., Breunlin, C, Kearns, D. L., & Russell, W.P. (1988). A review of the literature on family therapy with adolescents 1979-1987. Journal of Adolescence ,11, 309-334.

Broderick, K. (1996). Constructing a successful therapeutic experience with adolescents: a qualitative study of adolescents' experiences in family therapy. Unpublished master's thesis, Virginia Polytechnic Institute and State University, Blacksburg, VA.

Chamberlain, P., & Rosicky, J. G. (1995). The effectiveness of family therapy in treatment of adolescents with conduct disorder and delinquency. Journal of Marital and Family Therapy, 21(4), 441-460.

Copeland, A.P., & White, K. M. (1991). Studying families. Newbury Park, CA: Sage Publications.

Conran, T., & Love, J. (1993). The talkative chair: a child's experience of sexual abuse intervention. Journal of Systemic Therapy, 12(2), 68-85.

deShazer, S. (1991). Putting differences to work. New York: Norton.

Duncan, B. L., Solovey, A. D., & Rusk, G. S. (1992). Changing the rules: A client directed approach to therapy. New York: The Guilford Press.

Efran, J. S., Lukens, R. J., & Lukens, M. D. (1988). Constructivism: what's in it for you?. The Family Therapy Networker, September-October, 27-35.

Elliott, R., & Shapiro, D. (1992). Client and therapist as analysts of significant events. In S. Toukmanian & D. Rennie (Eds.), Psychotherapy process research: Paradigmatic and narrative approaches. London: Sage Publications.

Estrada, A., & Pinsof, W. (1995). The effectiveness of family therapies for selected behavioral disorders of childhood. Journal of Marital and Family Therapy, 21(4), 403-440.

Fine, M., & Turner, J. (1996, October). Therapeutic relationships: what client couples and therapists say. Poster session presented at the annual meeting of the American Association for Marriage and Family Therapy, Toronto, Canada.

Garfield, S. L. (1994). Research on client variables in psychotherapy. In A. E. Begin & S. Garfield (Eds.), Handbook of psychotherapy and behavior change (4th Edition). New York: John Wiley.

Gergan, K. J. (1985). The social constructivist movement in modern psychology. American Psychologist, 40(3), 266-275.

Gilgun, J., Daly, K., & Handel, G. (1992). Qualitative methods in family research. Newbury, CA: Sage Publications.

Hoffman, L. (1988). A constructivist position for family therapy. Irish Journal of Psychology, 9(1), 110-129.

Kantor, D., & Andreozzi, L. (1985). The cybernetics of family therapy and family therapy research. In L. Andreozzi (Ed.), Integrating research and clinical practice. Rockville, MD: Aspen Systems.

Kuehl, B. (1987). The family therapy of adolescent drug abuse: family members describe their experience. Unpublished doctoral dissertation, Texas Tech University, Lubbock, TX.

Kuehl, B. (1993). Child and family therapy: a collaborative approach. The American Journal of Family Therapy, 21(3), 260-266.

Kuehl, B., Newfield, N , & Joanning, H. (1990). A client-based description of family therapy. Journal of Family Psychology, *3*(3), 310-321.

Lietaer, G. (1992). Helping and hindering processes in client-centered/experiential psychology. In S. Toukmanian & D. Rennie (Eds.), Psychotherapy process research: Paradigmatic and narrative approaches. London: Sage Publications.

Lincoln, Y., & Guba, E. (1985). Naturalistic inquiry. New York: Sage Publications.

Llewelyn, S. (1988). Psychological therapy as viewed by clients and therapists. British Journal of Clinical Psychology, 27, 223-237.

Lussardi, D., & Miller, D. (1992). A reflecting team approach to adolescent substance abuse. In T. Todd and M. Selekman (Eds.), Family therapy approaches with adolescent substance abusers (pp. 231-250). Boston: Allyn and Bacon.

Mabrey, L. (1995, November). The experience of strategic therapy: Clients' perspectives. Paper presented at the annual meeting of the American Association for Martial and Family Therapy, Baltimore, MD.

Mahrer, A. R. (1988). Discovery-oriented psychotherapy research: rationale, aims and methods. The American Psychologist, 43(9), 694-702.

Mann, B. J. , & Bordin, C. M. (1991). A critical review of psychotherapy outcome studies with adolescents, 1978-1988. Adolescence, 26(103), 505-541.

Marshall, C., & Rossman, G. (1989). Designing qualitative research. Newbury Park, CA: Sage Publications.

McCollum, E., & Beer, J. (1995). The view from the other chair. The Family Therapy Networker, 19(2), 59-62.

McNamee, S., & Gergen, K. L. (Eds.), (1992). Therapy as a Social Construction. London: Sage Publications.

Metcalf, L., Thomas, F., Duncan, B., Miller, S., & Hubble, M. (1996). What works in solution-focused brief therapy: A qualitative analysis of client and therapist perceptions. In S. Miller, M. Hubble & B. Duncan (Eds.), Handbook of solution-focused brief therapy. San Francisco: Jossey-Bass Publishers.

Miller, S., Hubble, M., & Duncan, B. (1995). No more bells and whistles. . The Family Therapy Networker, 19(2), 53-63.

Minuchin, S. (1974). Families and Family Therapy. Cambridge, MA: Harvard University Press.

Moon, S. M., Dillon, D. R., & Sprenkle, D. H. (1990). Family therapy and qualitative research. Journal of Marital and Family Therapy, 16(4), 357-373.

Murphy, S. (1992). Using multiple forms of family data: identifying patterns and meaning in sibling-infant relationships. In J. Gilgun, K. Daly & G. Handel, (Eds.), Qualitative methods in family research, (pp.146-171). Newbury Park, CA: Sage Publications.

Newfield, N. A. , Joanning, H. P. , Kuehl, B. P. , & Quinn, W. H. (1991). We can tell you about "psychos" and "shrinks": an ethnography of the family therapy of adolescent drug abuse. In T. C. Todd & M. D. Selekman (Eds.) Family Therapy Approaches with Adolescent Substance Abusers (pp. 277-310). Boston: Allyn & Bacon.

Peterson, C. (1990). Theories of counseling and psychotherapy. New York: Harper & Row.

Pinsof, W. M. , & Wynne, L. C. (1995). The effectiveness and efficacy of marriage and family therapy: introduction to the special issue. Journal of Marital and Family Therapy, 21(4), 341-343.

Preto, N. (1989). Transformation of the family system in adolescence. In B. Carter and M. McGoldrick (Eds.), The Changing Family Life Cycle: a Framework for Family Therapy (pp. 255-283). Boston: Allyn & Bacon.

Regan, A., & Hill, C. (1992). Investigation of what clients and counselors do not say in brief therapy. Journal of Counseling Psychology, 39(2), 168-174.

Rennie, D. (1990). Toward a presentation of the client's experience of the psychotherapy hour. In G. Lietaer, J. Rombarts & R. VanBalen (Eds.), Client centered and experiential psychotherapy in the 90's (pp. 155-172). Leuven: Leuven University Press.

Seidel, J., Kjolseth, R., & Seymour, E. (1995). The Ethnograph v4.0. Amherst, MA: Qualis Research Associates.

Selekman, M. D. (1993). Pathways to change: brief therapy solutions with difficult adolescents. New York: Guilford Press.

Sells, S., Smith, T., Coe, M., Yoshioka, M., & Robbins, J. (1994). An ethnography of couple and therapist experiences in reflecting team practice. Journal of Marital and Family Therapy, 20(3), 247-266.

Sells, S., Smith, T., & Moon, S. (1996). An ethnographic study of client and therapist perceptions of therapy effectiveness in a university-based training clinic. Journal of Marital and Family Therapy, 22(3), 321-342.

Shifts, L. , & Knapik-Esposito, M. (1993). Playback of the therapeutic process: he said, she said, they said. *Journal of Systemic Therapies, 12*(2), 41-54.

Sprenkle, D. H. , & Piercy, F. P. (1992). A family therapy informed view of the current state of the family in the United States. *Family Relations, 41,* 404-408.

Smith, T., Sells, S., Pereira, M., Todahl, J., & Papagiannis, G. (1995). Pilot process research of reflecting conversations. Journal of Family Psychotherapy, 6(3), 71-89.

Smith, T., Yoshioka, M., & Winton, M. (1993). Qualitative understanding of reflecting teams I: Client perspectives. Journal of Systemic Therapies, 12(3), 29-41.

Sprenkle, D., & Piercy, F. (1992). A family therapy informed view of the current state of the family in the United States. Family Relations, 41,404-408.

Stith, S., Rosen, K., McCollum, E., Coleman, J., & Herman, S. (1996). The voices of children: pre-adolescent children's experiences in family therapy. *Journal of Marital and Family Therapy, 22*(1), 69-86.

Strauss, A. (1987). Qualitative analysis for social scientists. Newbury Park, CA: Sage Publications.

Strauss, A., & Corbin, J. (1990). Basics of Qualitative Research. Newbury Park, CA: Sage Publications.

Swint, J. (1995, November). Clients' experiences of therapeutic change: A qualitative study. Paper presented at the annual meeting of the American Association for Marriage and Family Therapy, Baltimore, MD.

Thomas, F. (1994). The experience of solution-focused therapy: post-therapy client interviewing. Case Studies in Brief and Family Therapy, 8(1), 47-58.

Todd, T., & Selekman, M. (Eds.), (1991). Family Therapy Approaches with Adolescent Substance Abusers. Boston: Allyn and Bacon.

vonGlasserfeld, E. (1984). An introduction to radical constructivism. In P. Watzlawick (Ed.), The Invented Reality. New York: Norton.

Wark, L. (1994). Client voices: a study of client couples' and their therapists' perspectives on therapeutic change. Journal of Feminist Family Therapy, 6(2), 21-39.

Wylie, M. (1994). Swallowed alive. The Family Therapy Networker, 18(5), 20-33.

Yin, R. (1989). Case Study Research. Newbury Park, CA: Sage Publications

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.

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.

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

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 Researcher	(703) 631-4985	Karen Rosen Faculty Advisor	(703) 698-6027
Kevin D. Broderick Researcher	(703) 698-6033	Eric McCollum Faculty Advisor	(703) 698-6018
Ernest R. Stout Research Division	Chair, IRB (540) 231-9359		

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.

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._____

Best time to call_____

_____ Location of Practice_____
Therapist's Signature _____

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.

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 occassion 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.

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.

_____ _____

Participants' Signatures 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 Researcher	(703) 631-4985	Karen Rosen Faculty Advisor	(703) 698-6027
Kevin D. Broderick Researcher	(703) 698-6033	Eric McCollum Faculty Advisor	(703) 698-6018
Ernest R. Stout	(540) 231-9359	Chair, IRB Research Division	

Appendix F

Parent Background Questionnaire

Name_____Male / Female
Address_____Family Income_____
_____

Family Members_____Age _____ Male / Female
_____ _____ Male / Female
_____ _____ Male / Female
_____ _____ Male / Female
_____ _____ 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 G

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 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?

VITA

MARYANN SHERIDAN WALSH

6506 Rock Crystal Drive
Clifton, VA 20124
703-830-4949

EDUCATION

M.S., 1997, College of Family and Child Development,
Virginia Polytechnic Institute and State University
Major Area: Marriage and Family Therapy
Thesis: "Looking at the picture by standing outside,":
A qualitative study of parents' of adolescents experiences in family therapy.

B.S., 1972, Villanova University
Major Area: Nursing

PROFESSIONAL EXPERIENCE

1994 to 1996 Intern, Marriage and Family Therapy
Center for Family Services
Virginia Polytechnic Institute and State University
Falls Church, VA.

1995-1996 Intern, Marriage and Family Therapy
Fairfax County Head Start Transition Project
Annandale, VA

1993-1995 Member, Intervention Team and Student Assistance Program
Centreville High School
Clifton, VA

1972-1990 Charge Nurse, Clinical Instructor, Supervisor
Lieutenant Commander, US Navy Nurse Corps
Washington, D.C.

PRESENTATIONS AND WORKSHOPS

Walsh, Maryann S. and McConnell, Emily K. Leadership Camp. Three-day seminar/workshop for high school student and adult leadership team. August, 1994, 1995.

Walsh, Maryann S. Everything you want to know about teens and are afraid to ask. Seminar presented to parents of adolescents, Centreville High School, April, 1993.

Walsh, Maryann S. Today's teens and HIV. Seminar presented to parents of adolescents, Centreville High School, January, 1993, 1994, 1995.

PUBLICATIONS

Snyder, W., Herman, S., Shepley, R., & Walsh, M. (1996). Professional friends: MFT interns found that home-based therapy fosters familiarity. Family Therapy News,27(3), 25.

AWARDS

Graduate Student Research Award, Parents' of adolescents experiences in family therapy: A qualitative study of therapy, American Association for Marriage and Family Therapy, October, 1996.

PROFESSIONAL AFFILIATION

American Association for Marriage and Family Therapy, Student Member