APPLICATION OF AN EMPIRICAL MODEL OF SOCIAL WORK PRACTICE IN FAMILY SERVICE AGENCY

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Abstract

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In this project the historical dichotomy between social work research and practice was outlined, and a model of empirical practice which could be utilized by the social worker in a family agency was proposed.

The project involved the systematic application of an empirical model utilizing the single-subject or time-series design. The model was applied in various client situations in a family agency over a three month period, but the main focus of the project was the application of the model with a single case.

The project employed a single-subject design and data was collected during baseline and intervention by a within-interview measurement strategy. Seven areas of family interaction, operationalized into statements, were selected as targets of change. Audio-visual recordings of each interview were made, the tapes re-played, and the number of times each selected statement of interaction occurred within a one-hour interview was tabulated. The tapes were reviewed by the clinician and a clinical supervisor, in order to increase the reliability of the measurement strategy.

Supplementary, less objective data was used in addition to the concrete data, as an indication of clinical success.

The results of the project yielded concrete data on interaction change which suggested that intervention had been successful. It was found that clinical requirements did impose restrictions on carrying out certain research procedures which would have strengthened the conclusion that the intervention caused the changes in the interaction. However, it was found that utilization of the model required a clear specification of all components of the therapy process, which would allow replication of the project to occur. Utilization of this model also yielded valuable information on the effects of specific components of the treatment package.

The conclusion drawn from this project was that a model utilizing a single-subject design can be incorporated into clinical practice, and that it equips the clinician with objective information on his or her interventions with clients which would not otherwise be available.

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INTRODUCTION

This study was undertaken by a practitioner in a family agency. The main goal was to outline a model of practice which would allow the clinical social worker to assess interventions in an objective systematic way.

The social work profession has struggled since its beginnings to improve its knowledge base and to find ways of demonstrating its effectiveness. In the 1930's concern was expressed that social work practice should be founded on a scientific base (Karpf, 1931) and in 1958 the evolving definition of social work practice established in a general way the importance of knowledge based practice without emphasis on the need for evaluation (Social Work, 1958). The uncertainty within the social work profession concerning its scientific components led to the establishment of certain assumptions: A profession is customarily described as a combination of art and science, and while the art is demonstrated in the performance of the individual practitioner the science is found in the profession's body of knowledge and ways of thinking. A profession is recognized as growing stronger as the scientific component in its knowledge and thinking is increased, and every profession must find the balance between its science and art that will enable it to grow and improve the effectiveness of its service in society (Eaton, 1958). Bartlett (1970) summarized the social work profession's difficulty and suggested that the art rather than the science of the profession was the focus of the method-and-skill model in social work. The central concept

has been one of a helping service focusing on treatment and professional skills, but 'feeling' and 'doing' rather than knowing and thinking have been emphasized.

In latter years this concern has been receiving increasing attention in the profession and one conclusion drawn was that the production and use of research in social work have not been adequate for a profession that has committed itself to basing its practices on scientific knowledge. Recently, there have been indications of a growing determination within the social work profession to strengthen the relationship between practice and research (Briar, 1977b). Though the trend is changing, many practitioners still maintain the perceptions of research they obtained in professional schools. Evidence available suggest that students often graduate feeling that their research courses were not helpful, that even instructors showed ambivalence toward research, and, while recognized as being important to the profession, research was not seen as being relevant to practice to any large extent (Rosenblatt, 1968). It has been pointed out that practitioners and researchers have different perspectives on the profession, and this also stands as an obstacle to the use of research in practice(Rosenblatt,1968). For example, Kolenzon (1977) has looked at the impact of negative findings in social work research and has suggested that this has widened the gap between the practitioner and the researcher because of an unbalanced reaction by clinicians.

A component of the research-practice dichotomy is that an undercurrent of mistrust and a lack of confidence has pervaded the researcher-practitioner relationship, and that there has been a misperception of one another's roles

and functions. The basic difference has been one of function as social scientists have the primary function of understanding the world and producing knowledge that allows them and others to understand it better. Practitioners have the primary function of changing the world, assisting clients in bringing about desired outcomes (Rothman, 1977).

The state of the social work profession in regards to research can be summarized as follows: Social workers may regard research respectfully but they are reluctant to study research, they don't use research conclusions in their practice to help them improve their skills, and they have trouble accepting research with negative findings (Kirk, 1977).

Considering the historical negative relationship between researchers and clinicians, critical questions evolve concerning empiricism in the social work profession. What is scientific practice, and can there be a bridge between practice and research, with clinicians aiding researchers by adding to the knowledge available by doing research as they practice?

It has been suggested (Brill, 1973) that the social worker inadvertently may use the helping relationship to deal with personal problems rather than those of the client. This is because in the social work profession 'feeling' is often considered more important than knowing. This tendency is particularly unfortunate at a time when the knowledge base of the behavioral sciences has been expanding and since it has been recognized that operation from a base of intuition and personal understanding has produced little in the way of results. Fischer (1978), summarized the critical importance to the profession of ongoing assessment

of interventions in practice:

> Traditionally critical skills for theory and research analysis have not been a central part of social work students' and practitioners' knowledge base. But no profession can, or should expect to survive - let alone provide effective services to its clients - without building into its training and practice the capacity for such ongoing evaluation. Without continuing critical analysis, for example, the profession, or individual professionals, would never be in a position of knowing when to update, revise, or radically change its typical methods of operation. Without such critical evaluation, professionals could never make optimal choices as to which approaches are most (or least) effective (Fischer, 1978, p. 3).

A relatively new concept called scientific practice focuses on the tension in the art/science relationship of the helping professions. Its basic conclusion is that both art and science in combination are necessary to the helping profession, but in order to combine art and science a methodology is required which would enable the combination to emerge (Bloom, 1975).

The dichotomy between social work practice and practice knowledge has at its base a number of factors. This conflict has had a negative impact on the profession, and most importantly in the effectiveness of work with clients. The remainder of this study will look further at the development of a methodology which would enable the clinician to practice scientifically and thus with increased certainty as to his or her effectiveness.

CHAPTER II

REVIEW OF THE LITERATURE

A review of the literature indicates that there was concern expressed for the need for empiricism in social work as early as the 1930's. Karpf (1931) concluded that good technique would inevitably follow if practitioners would base their interventions on scientific discovery and test them through application in their daily tasks.

During the period between the 1930's and 1970's practitioners and caseworkers strived to systematize and find a scientific base for their knowledge, and there was general agreement among most practitioners, as to basic theoretical and methodological approaches to practice (Fischer, 1978). The social upheaval of the 1960's brought about a shift in emphasis for the profession, and many social workers abandoned providing individualized service to work on such global problems as poverty (Fishcer, 1978). The 1970's ushered in a new commitment to social case work (individualized or case-by-case service), but with a new and strong emphasis on more careful evaluation of practice and movement into what Briar (1973) has called the age of accountability. There was increased concern with providing evidence on the effectiveness of casework to third-party funders and consumers. However, Gingerich (1979) pointed out that these demands for accountability, while real and legitimate, are not the strongest arguments for evaluation by clinicians of their practice. Evaluation of clinical intervention, if done properly, would not only satisfy the demands of funders and consumers, but would allow the clinician to examine first hand his or her practice; an accumulation of a number of these

clinical evaluations would give some indications as to which interventions are most effective with which clients and in which situations, and treatment planning and predictions about outcome could then become empirically based.

The single-subject or time-series design has been receiving increasing attention by those concerned with clinical evaluation. The design was described in the literature by Campbell and Stanley in 1963 but it was not until the 1970's that it began to be widely discussed as a research method particularly relevant and useful for clinicians.

The single-subject design focuses on a single client rather than on groups and assesses the effectiveness of intervention by repeatedly recording and observing changes in the client over a period of time. " If there is a change concomitant with clinical intervention, a logical basis for concluding that treatment may have caused the change exists" (Gingerich, 1979, p. 107).

It has been pointed out that study of single cases is one of the foundations of research in a number of social and behavioral sciences, including sociology, psychiatry, psychology, anthropology, and social work. While the strategies or methods may vary, the concern with understanding individuals and their relationships with any number of variables through intensive case studies is a common factor (Fischer, 1978, p. 94).

The single subject design has been developed during the past decade by researchers within these disciplines involved mainly in studying behavioral change. Browning and Stover (1971) have recommended the use of the study of single cases by the experimental-clinical psychologist to

answer questions concerning behavior to be altered, factors that control that behavior, and the best techniques to use in promoting the change. Leitenberg (1973) has stressed the importance of single cases in psychotherapeutic research, and Hersen and Barlow (1973) have argued for the use of the single case design in the area of psychiatric research; together with Kazdin (1975), Hersen and Barlow (1976) have discussed utilization of the design in the area of applied behavior analysis in general.

Among those who have written on the utility of the single-subject design for conducting research on or evaluating direct service in counselling intervention are Briar (1977a), Fischer (1978), Howe (1974), Jayaratne and Levy (1979), Thomas (1978), and Gambrill and Barth (1980).

In 1973 Fischer reviewed a number of casework studies and concluded that casework was basically ineffective. However, Fischer (1973b), noted frequently in these studies the independent variable was not defined so that the exact nature of the casework technique was unknown. He has recently proposed that a strength of the single-subject design is that is necessitates the clear definition of all aspects of the treatment process (Fischer, 1978). Wood (1978) took another look at the research evidence of case work effectiveness. She concluded that first of all results generally did not point to case work effectiveness and concurred with Fischer's (1973b) finding that studies were often methodologically weak and often did not adequately define either the problem, the intervention, or the changes that took place. She recommended that practitioners apply the thought and methodology of research to practice and suggested that clinicians treat every case as an opportunity to test their practice theory.

Hudson (1976) has offered an explanation as to why the results of outcome experiments evaluating casework are so dismal. He has pointed out that students are often not shown that research is relevant to practice and in addition that research methodology may not be relevant to the problem at hand and recommends that clinical workers be taught methods to monitor their own progress with single clients. "Instead, we teach them group research procedures knowing full well that the overwhelming majority of those workers will never utilize such knowledge or skill within the context of their practice and its evaluation" (Hudson, 1976, p. 211).

Gingerich (1979), having recognized that group designs have many important advantages, recommended the single-subject design for day-to-day practice. He has pointed out that classical designs require relatively large groups, usually more than are available to clinicians. An additional consideration discussed is that research requirements often conflict with clinical objectives within the rigid control of group designs, and Thomas (1978) has presented a comprehensive discussion of practice versus research requirements in utilization of the single-subject approach.

One of the strongest arguments recommending this approach for use by the clinician has been presented by Jayaratne & Levy (1979). They have pointed out that research across cases with client groups minimizes the critically important characteristics of the uniqueness of the case or client situation and the clinician-researcher and the intervention package he or she utilizes. The term clinician-researcher is used to refer

to the clinician "artfully applying empirically derived scientific concepts" (Jayaratne & Levy, 1979, p.9), while attempting to bring about a desired outcome and at the same time attempting to discover cause-effect relationships.

The question of generalizability of results from studies using single-subject designs has been highlighted by Hersen and Barlow (1976) and they have argued that if single-case experiments are replicated, they may provide enough evidence for generalization for the clinician in his or her own practice. These replications may not ensure generalization across workers and settings but these replicated studies could then be used as the basis for carrying out broad group experimental designs.

One of the most recent discussions on the utility of the single-subject approach in practice has been presented by Gambrill and Barth (1980). They have summarized many of the issues already raised and have suggested that designs that do not exhibit rigid experimental control are still very useful for the clinician and add to the knowledge base of the profession.

The review of the literature illustrates that in the last decade there has been a trend towards finding a research methodology which can be incorporated into practice. A large number of writers have suggested that a methodology utilizing the single subject design presents the greatest potential.

CHAPTER III

An overview of the historical relationship between social work practice and research has been presented followed by a more focused scan of recent developments in the area of practice research. Several assumptions have emerged. First of all, there is a clear need to bridge the gap between research and practice so that practitioners are as informed as possible about the methods and skills which they use in interventions with clients. Second, any action a practitioner takes must be clearly defined. Otherwise measurement is impossible, and any results with negative or positive conclusions are of questionable benefit to the profession and do not add to practice knowledge. Third, objective evaluation by the clinician of his or her own practice is essential in order to receive necessary immediate feedback on effectiveness on an ongoing basis. Bloom (1975) has pointed out: "Doing social work without systematic evaluation throughout the entire process is like driving a car with your eyes closed - you're going places but you don't know for certain where you are or what you did that got you there, to say nothing of being a hazzard while you're in motion" (Bloom, 1975, p.177).

The recognition of these gaps within the profession precedes the next step which is the development of a methodology or framework within which practitioners can promote empiricism in their interventions with clients. The argument being presented is that a framework utilizing the single-subject design is especially relevant for the clinician, and more specifically for the practitioner in a family agency. That is not to

say that group design studies are not important to the profession and the clinician. Clinicians have the responsibility of choosing methods of intervention carefully, and the choice should be made following scrutiny of the research available, while researchers have the reciprocal responsibility of making these results accessible and understandable (Berger, 1974). However, assumptions concerning the state of research and practice and the recognition of the gap in their integration have been made. The need for clear definition of all variables in the intervention sphere allowing measurement to be made has been stressed in addition to ongoing objective evaluation which is essential to the practitioner.

There is a need for an empirical clinical model, and Jayaratne and Levy's (1979) model of empirical clinical practice encompasses a methodology which fulfills all of the above requirements for scientific practice. Five basic steps are involved in utilizing the model and they are as follows:

1. Defining problems and goals during preliminary assessment
2. Evaluating and selecting basic assessment methods.
3. Establishing a baseline
4. Selecting and implementing a research design
5. Analyzing results

(These stages will be defined in detail in Chapter IV, but they have been included here to illustrate the implementation of a single-subject design being utilized within a clearly defined framework.) The practitioner who utilizes a model of empirical practice if fulfilling certain requirements,

can be defined as a clinical scientist (Briar, 1977a)or a clinical researcher (Jayaratne and Levy, 1979). The clinical researcher is defined as one who has a working knowledge of the client system, an empirical orientation toward the intervention, an ability to put research designs and measurement procedures into operation, an ability to use empirical feedback that is obtained during intervention,and ability to evaluate and use the research of others.

Gottman, McFall and Barnett(1969)summarized major points in support of the utilizing of a methodology based on a single-subject approach: These designs provide important information for the clinician throughout intervention, and any data the clinician gathers may point out the need for changes in intervention strategy at certain times during treatment. Though most clinicians are not able to conduct experiments with controlled groups within the clinical setting, or would not want to, the time-series or single-subject design can equip the clinician with relatively strong statements about the effects of his or her interventions. The importance of such research to practice is clear:Practitioners doing research improve their awareness of the correspondence between intervention and assessment of clients' functioning, and they may also contribute information to be used in more sophisticated studies.

The argument has been established using the single-subject design in a profession where research and practice are often considered antagonistic. More specifically there are a number of factors which support the utilization of such a model by a practitioner in a family agency. The assumption is made that practice here is most often focused on the interaction among

family members, and will generally take the form of marital therapy, therapy involving whole families, or therapy with specific groupings within the family system. (These terms will be defined later in the study, but the assumption is being made that all these forms of intervention fall under the general definition of social casework, or providing individualized service, and which has been described previously in the study.

The problems in evaluation of interventions in family practice are apparent from reviewing the literature. Wells, Dilkes and Trivelli(1972) and Sigal, Barrs, and Doubilet (1976) have discussed the impact on casework practice of the interaction-based approaches to family therapy: they point out, however, the difficulties in evaluation and summarize much of the research evidence on the effectiveness of family therapy as "equivocal". Riskin and Faunce (1972) have pointed out the great differences in underlying purposes, interests, and assumptions in family interaction research and have pointed out that some models of practice may not be transferrable or easily replicated. They have argued that although the classical - experimental research method may be relevant to the linear causality model, it may not be applicable to the family - as-a-system (mosaic or circular causality model).

Wells and Dezen (1978) reviewed studies from 1971 to 1976 reporting outcomes of non-behavioral family therapies and cited numerous methodological and practical difficulties besetting the current body of research, one major difficulty being the lack of definition of the independent variable. Often what was called family therapy was comprised of a wide range of methods, some of which were unknown. Sometimes family therapy

was used in combination with other modes of therapy, and often little information on the exact treatment was available. Wells and Dezen concluded from this review that it seemed imperative for family therapy outcome research, especially in the non-behavioral approaches to begin to utilize single-case experimental design in order to better ascertain the relationships between outcome and particular elements in a method of treatment. They have supported use of a model utilizing single-case methodology as part of the ongoing investigations in family therapy research.

A practitioner in the family agency is faced with a tremendous array of new theory, techniques, and modes of treatment. Although the research is encouraging, particularly in the area of marital counselling (Beck,1975) and (Gurman, 1973) the clinician in a family agency is faced with the task of drawing from all these approaches and techniques a model which will prove effective for the case at hand. The assumption is being made that in general clinicians vary their approaches depending on the particular situation, and within an agency there may be tremendous variance in treatment models. Outcome studies may indicate whether an agency has produced overall significant change in the functioning of its clientele. However the argument stated is that only the single-subject design would objectively and clearly indicate exactly what approaches and methods worked with whom and why, for the basis of developing more effective practice.

In response to the concern that many cases cannot be evaluated empirically, Talsma (1976), described the review of one agency administrator who estimated that at least two thirds of all intake cases on his agency's caseload offered problems that were immediately amenable to single-case

designs. To summarize: "These research methods can and should be part of practice as consistently maintained and integrated into the activity of every agency, as, say, the morning coffee break. They provide a variety of grounds for caseworkers to begin both the evaluation of the success of their own practice and the laborious process of technique and knowledge building, which it is hoped will result in a greatly expanded repertoire of effective techniques that will be available to every caseworker" (Fischer, 1978, p. 124). Having established an argument in support of the utilization of a single-subject design by the family practitioner, the following chapter will describe the method used to test this argument.

CHAPTER IV

METHODOLOGY

In order to test the hypothesis that a model based on a single-subject design can be incorporated into practice at a family agency, it was decided to utilize the approach in a systematic way. The application of the model with a range of clients and client problems typically seen by the family practitioner should indicate its relevance and practicality for the clinician in family practice. The approach was utilized during a five hundred hour supervised practicum to be completed as a requirement for the Degree of Master of Social Work at Memorial University of Newfoundland. The practicum was to be completed in the student's area of specialization and afforded the opportunity to work towards improving skills, and to begin to evaluate empirically interventions with clients.

Catholic Family Service, Ottawa, was chosen for the practicum because of the quality of the supervision available and because it offered a very broad cross section of clients and client situations, with the main focus of interventions in the area of relationship or interaction difficulties. (See Appendix A for a breakdown of agency service).

The single-subject design was utilized within the framework of Jayaratne and Levy's (1979) empirical model of clinical practice. The model includes five basic stages and these will be outlined in the study.

Referrals to this clinician were primarily focused in the area of marital and family relationship problems and an overview is shown in Table I.

TABLE I

Number and Type of Referrals

Problem Category	Total
Marital Relationships	5
Family Relationships	7
Individual Functioning	3

Table I indicates the range of client and client problems seen over the total practicum period. However, the discussion of method focuses primarily on the utilization of the empirical model with a single case.

IMPLEMENTATION OF THE EMPIRICAL MODEL

Assessment (Stage I)

The primary goal of assessment is the compilation of information about the client system and interpretation of this data in a manner which allows the clinical-researcher to act. The first step is identification of a target problem or problems and specification of related goals for intervention (Jayaratne & Levy, 1979).

The focus of intervention was a family who requested assistance to deal with the stealing behavior of their thirteen year old son, and assessment was completed during the first two interviews with the family,

and was based on the observed interactions of the family during these two sessions. A detailed summary of the information received through intake and from the family is presented in Appendix B.

Problem Definition

The following problems were isolated during the assessment interviews :

1. Assumption of responsibility by the parents for their children's behavior.
2. Excessive parental control exhibited by frequent statements of telling each child what to do.
3. Severe blaming of the"problem child" (the boy who had exhibited the stealing behavior).
4. Absence of encouragement and affection in interaction.
5. Sibling comparison.
6. Absence of expression of feelings which were not negative statements concerning the problem child.

Note: The stealing behavior was not targeted for change because it had ceased prior to the family's first visit. Any recurrence would be noted by the family.

Goal-setting

Following the completion of problem definition, goal-setting could occur. Table 2 illustrates the goals established, the increase or decrease of these specified areas of interaction closely related to the target problems.

TABLE 2

Summary of Established Goals

Increase	Decrease
1. Shift in responsibility from parents to children	1. Sibling comparison
2. Affection and encouragement	2. Parents telling children what to do
3. Feeling (verbal expression of)	3. Blaming
	4. Parents speaking for children

Note: A quantitative change was not specified.

Evaluation and Selection of Basic Assessment Methods (Stage 2)

Measurement Strategy

The second stage of the empirical model includes the selection of measurement methods that the clinician-researcher would use during the third stage to measure where the client is in relation to the goals established. Four basic questions are considered:

1. When does measurement take place?
2. Who does the measuring?
3. What will be measured?
4. What instrument will be used to measure?

(Jayaratne & Levy, 1979)

Measurement Instrument

The family presented with difficulties that were behavioral and interactional, and the model of treatment chosen for intervention was a

factor in the choice of the measurement instrument. Brief Therapy, to be outlined in more detail (See Appendix C) was selected as an appropriate intervention model to use in treatment with this family. Following the procedures of this model of treatment the information gained from the observed interaction of the family within the interview situation forms the basis of therapy. Efforts were made to objectify a within interview strategy for collection of data. In order to minimize subjective interpretations and misinterpretations of client responses, written authorization was received from the family to videotape each session and data was gathered when the tapes were replayed.

Observers

The tapes were reviewed by the clinician and the clinical supervisor, and not only did the use of videotape recording (VTR) with two observers strengthen the measurement procedure by decreasing the risk of biased data, but it also was used to facilitate the supervisory process and was used with the family as a therapeutic tool. (For further discussion of the use of VTR in family therapy, see Paul, 1966). It was hoped that reliability would be increased by the fact that two separate individuals would identify the occurrence of the problems and goals when they arose over a period of time.

Measurement

The empirical model outlines the necessity of choosing the behaviors to be measured which will reflect as much as possible the goal statement (Jayaratne & Levy, 1979). A decision was made to operationalize and measure each of the seven categories of interaction summarized in Table 2,

Specifically a count would be kept of each time a statement of one of these categories occurred during a one hour session. Appendix D illustrates examples of each category of statement.

Multifactorial Measurement

A multifactorial measurement strategy would be most effective in observing change in a variety of areas (Jayaratne & Levy, 1979). It would also increase the reliability of causal statements. However, there were limitations in the choice of measurement tools: A clinical decision was not to measure behaviors at home because focus of intervention would be to change interaction and the interview was used as a primary means of intervening and of assessing the effects of intervention. In addition the family exhibited resistance to focusing on any behaviors that were not related to the"problem-child" and further exclusive focus on these behaviors was considered clinically inadvisable.

An index measuring global family satisfaction was tailored and administered to the family before the first week of therapy. However, this instrument did not yield accurate data and administration of the index was discontinued. (Appendix E includes a reproduction of this index with a discussion of possible explanations for its failure).

Frequency of Measurement

The ideal of the clinical research model requires a series of measures over time within each phase (Jayaratne & Levy, 1979). Measurement of the data took place before treatment (during the first two interviews), and while treatment was in progress in order to allow conclusions to be drawn regarding the impact of interventions.

Beginning Measurements - Issues of Validity and Baseline Procedures (Stage 3)

Baseline Procedure

The primary purpose of baseline measurement is to have a standard by which the effectiveness of an experimental intervention may be evaluated (Hersen & Barlow, 1976). "Experimental intervention" indicates that intervention is always experimental because there is no certainty before treatment what the effects of intervention will be.

The baseline for this study was established as the first two weeks the family was seen. It did not appear to be clinically advisable to extend this non-intervention period beyond two weeks.

Issues of Validity

A valid measurement device is one which measures what it is supposed to measure (Tripodi, 1974), but if the measurement device is implemented in a manner which interferes with predictive capability then the device has little or no value (Jararatne & Levy, 1979). Two threats to validity will be summarized:

Therapist Domain

The use of the interview as a primary means of measuring change poses some threat to internal validity. No intervention was introduced during the initial two interviews. However, the very basis of social work practice assumes the establishment of a worker-client relationship which begins immediately. In other words the establishment of rapport, and the personal characteristics of the therapist are likely to have some effect. Difficulty was experienced in simultaneously fulfilling the clinical demand for relationship building, while at the same time gathering pre-treatment baseline

data.

Concurrent History

This threat to validity is particularly important when working with clients in open settings. Efforts were made to explore with the family all occurrences in their environment which could have significant effects on their interaction. During treatment there was no evident major change in the family's day-to-day life (e.g. home, school, work, etc.)

Selection and Implementation of the Research Design (Stage 4)

In the typical experimental situation the researcher usually compares an experimental group that received treatment with a controlled group that did not. In the clinical research model there is no control group. The standards of comparison must lie within the client system itself and the client outcome measure during the time period when treatment is in effect is compared with the client outcome measure during the time period when there is no treatment. The comparison is internal and in this case the family in treatment serves as its own control (Jayaratne & Levy, 1979).

The single-subject design utilized in this study was the AB design. A baseline measurement of the target problems and goals was taken during the initial two interviews, and measurement of the same problems and goals was continued during the five weeks of intervention. These measurements of the seven indicators of change in interaction were taken simultaneously during both phases (baseline and intervention).

The reasons for utilization of this design were as follows: 1) The design offered a comparison of changes in the target problems and goals before and after intervention. 2) The design was suited to a treatment model such as Brief Therapy in which several kinds of interventions

make up the treatment package. It indicated which intervention had a particular impact on specific targets as all phases and interventions had to be specifically defined and discrimination made among the various aspects of treatment.

A discussion of some of the drawbacks of this design (AB) will be included in Chapter VI.

INTERVENTION STRATEGY

In utilizing the single-subject design the independent variable must be clearly defined both for the valuable information it offers clinically and for experimental purposes (Browning & Stover, 1971).

Time Period

Intervention was applied for four consecutive weeks following a two week baseline period; following week six there were two weeks when intervention was not applied and no measurement was taken as the family was unable to come because of illness. Intervention was concluded in week nine.

Mode of Treatment

On the basis of pre-therapy information (intake) a decision was made to see the family together. The referral indicated that the mode of treatment would be family therapy, family therapy being defined as follows: "A therapist engages in family therapy when he sees such natural units as parents and children, spouses, or members of the extended family, together as a group over most of the duration of treatment, with the goal of improving their function as a unit" (Wells et al.

1978, p. 252). The model of treatment was chosen on the basis of research findings. Reports were summarized (unpublished) of the findings of a large scale group (N =275) of moderately disturbed children and adolescents, treated with short-term (mean of nine sessions) systems-oriented family therapy. Using multiple outcome measures, 79% were rated as improved at termination (Wells et al., 1978).

Treatment Model

Within the broad framework of Jayartne and Levy's (1979) model the therapy was based on the theory and methods developed by Paul Watzlawick and Associates and called Brief Therapy. The treatment approach takes place within a usual maximum of ten sessions, is system-oriented, and interventions are based on direct observations in the treatment situation (Weakland, Watzlawick & Bodin, 1974). Appendix C includes a more detailed description of the methods and procedures utilized within this model of therapy.

TABLE 3

Summary of Intervention Process

Weeks (1 - 9)	Procedures
1. Baseline	Assessment - Goal-setting
2. Baseline	Assessment - Goal-setting
3. Intervention	Solution Exploration - Feedback
4. Intervention	Paradoxical Prescription
5. Intervention	Prescription Result Discussion
6. Intervention	Dealing with Stealing Behavior
7. No Intervention	Family Absent
8. No Intervention	Family Absent
9. Intervention	Termination - use of VTR

Table 3 presents an overview of the procedures of intervention followed in the present study. The details of these procedures are expanded in Appendix F.

CHAPTER V

FINDINGS

The previous chapter described the method involved in applying the empirical model of practice, utilizing a single-subject design in a family agency. The specific application of the model in treatment with one client was described. This chapter describes the results of intervention, including the overall results, and a breakdown of the results of each individual category of interaction.

Overall Results

The findings indicate that there was a significant improvement in interaction over the period of time the family was in treatment. The results of each category of interaction have been graphed and are presented in Figures I - 7 (pp. 29-38).

Eyeballing the results indicates a shift in level and trend for all categories. Eyeballing is not a statistical procedure, but this method was sufficient for clinical purposes in indicating whether or not intervention had been successful.

Change in all categories was evident with the first application of intervention. However, it is also apparent that change occurred in the second week of baseline in all areas, with the exception of statements of feelings and statements of parents telling children what to do; this finding suggested that the assessment process may have been instrumental in producing change.

The criterion for success in this study was a positive change (increase or decrease) in the outlined verbal behaviors, and there was no specification when therapy was begun as to how much improvement would

demonstrate that treatment was successful. The results graphed for each area of interaction depict the changes which occurred during the two phases of baseline and intervention. Follow-up measurement was not possible because of premature termination of treatment.

Blaming

Figure 1 depicts the change in the number of blaming statements, which decreased from 26-11. This represents a significant decrease from baseline to the end of intervention, but clinically the final result was determined to be unsatisfactory.

The objective data on blaming corresponds to the subjective observation made by the clinician throughout the treatment process. At the end of treatment the family continued to "scapegoat" the problem child. The greatest number of blaming statements originated from the father. The result suggests that there was not a significant change in the father son relationship during treatment.

The decrease from 18-10 statements between week four and five, indicate that the paradoxical intervention was effective in producing positive change in this category.

Parents Speaking for Children

Figure 2 depicts a decrease in the number of statements of parents speaking for children from 14-8. This result was encouraging as it was interpreted as a significant decrease in the control the parents were exercising. The final result warrants an additional comment. During the last weeks of intervention it was found that when one of the parents made one of these statements he or she often qualified the remark with

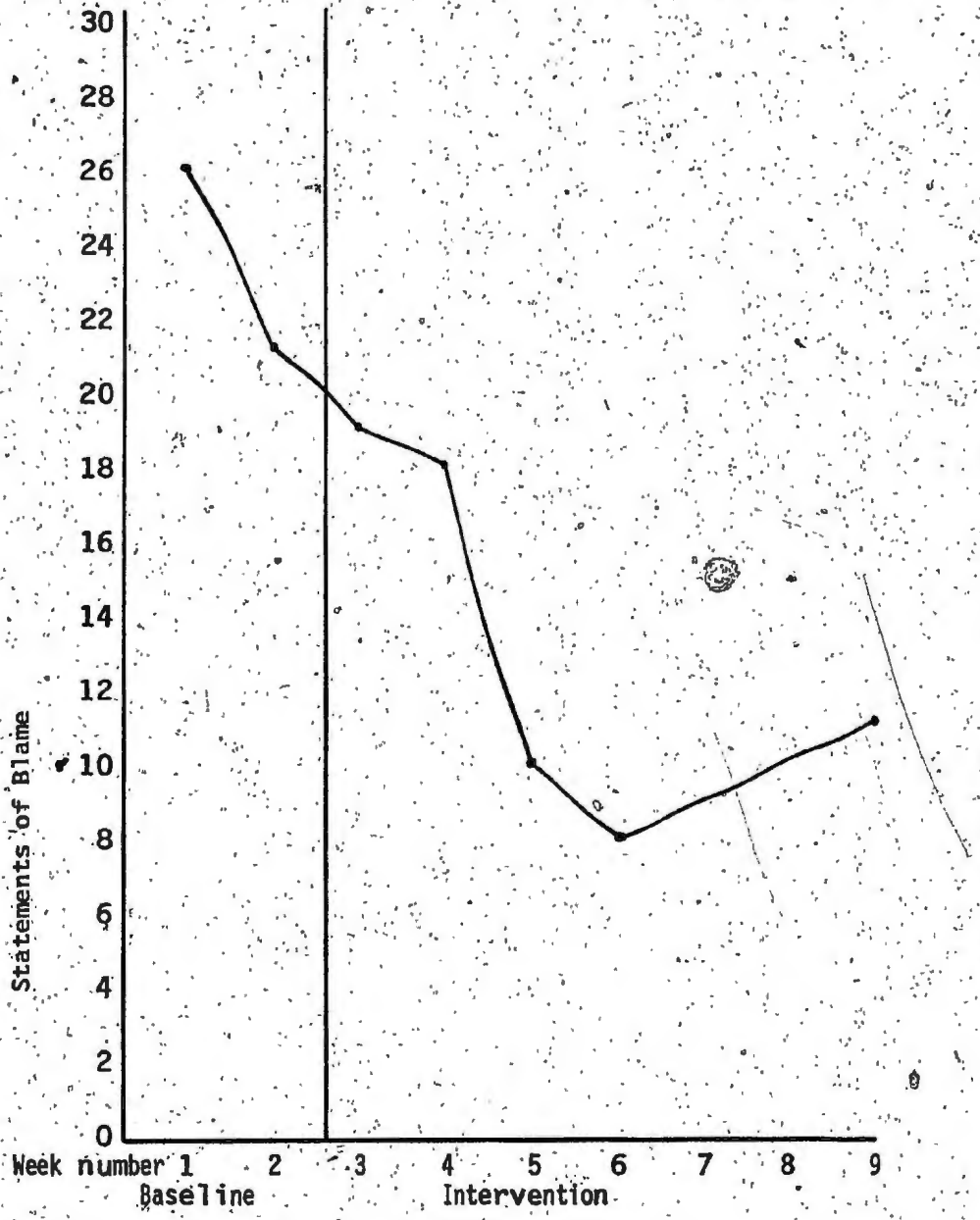

Figure 1. Number of Blaming Statements.

Notes. The measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

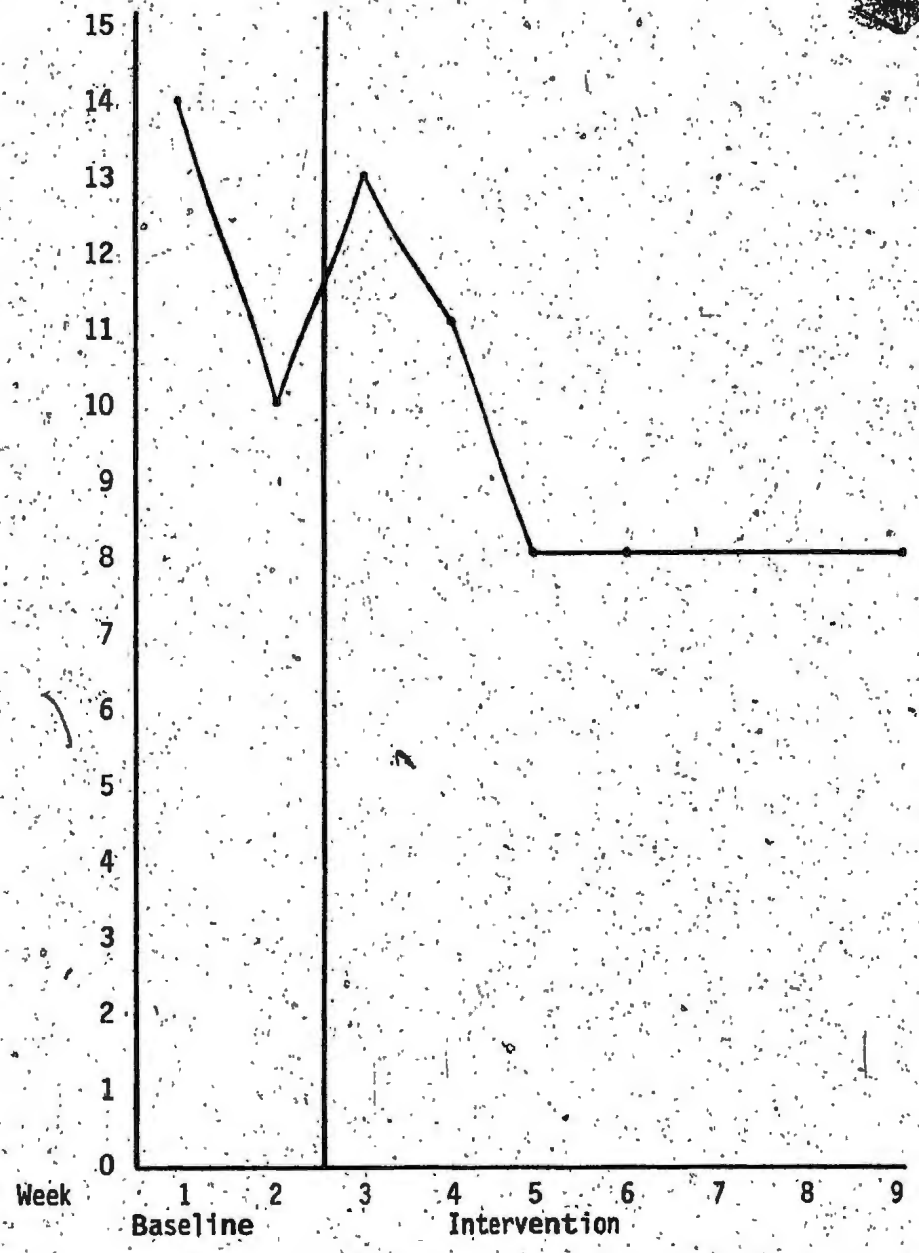

Figure 2. Statements of Parents Speaking for Children.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

a comment indicating that another approach would have been more effective.

The paradoxical intervention appears to have been effective in producing positive change as the results depict a decrease from 11-8 statements when it was introduced. The results in this category suggested that intervention had produced positive change but that additional treatment was indicated.

PARENTS TELLING CHILDREN WHAT TO DO

. . . The results depicted in Figure 3 suggest that this category of statement was completely eliminated following intervention. This category corresponds closely to statements of parents speaking for children, and again suggests that there was a decrease in the amount of control the parents exercised throughout the intervention process. The accelerated decrease between weeks four and five following the introduction of the paradoxical prescription is especially significant. The intervention was introduced primarily as a means of demonstrating to the parents that excessive control had produced an undesirable effect. In other words, as the control increased, the interaction and behavior had worsened. The decrease of statements in this category suggest that the intervention had produced a positive change in approach by the parents.

Feelings

The number of statements of feelings increased from 1-6 and this result was considered quite significant clinically. The members of the family were resistent throughout therapy to focusing on, or verbally

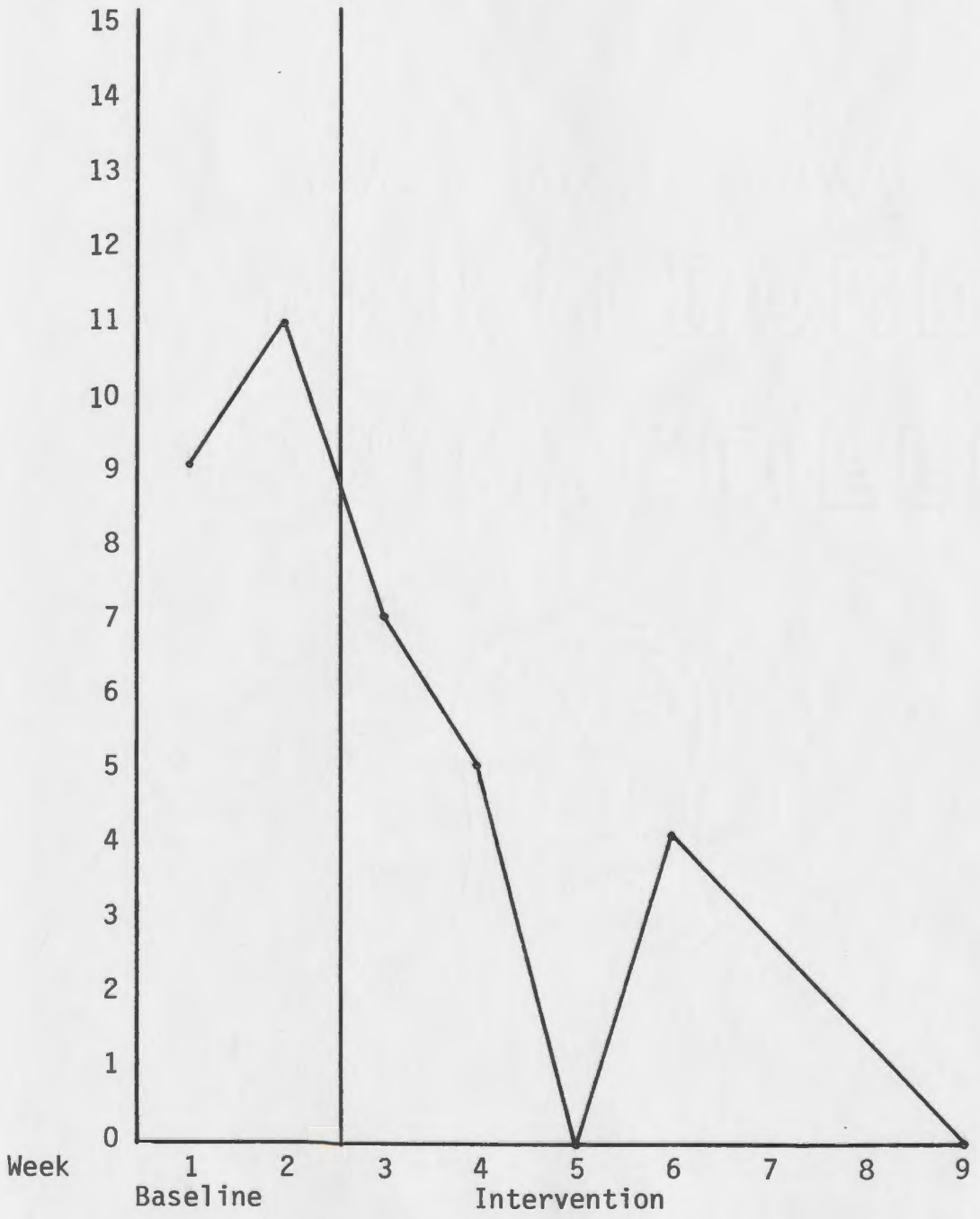

Figure 3. Statements of Parents Telling Children What to Do.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

expressing feelings. Family members did express feelings non-verbally (e.g. tears, sighs, downcast faces) but there appeared to be a family rule which prohibited their open expression. Often when a family member would make a move in this direction, another member would divert the interaction back to a reminder of the problem child's negative behavior, which in turn appeared to re-inforce this behavior. This was a difficult reaction for the family to change but the results indicate that intervention was successful in this area. (See Figure 4).

The introduction of the paradoxical intervention appeared to have no effect in this area and in fact this was the only week in which there was no positive change.

Appropriate Responsibility

The increase in statements in this category from 1-6 as depicted in Figure 5 suggest that intervention was successful. One of the major difficulties that had confronted the family was the parents' conviction that protection of their children from any consequences of their (the childrens) actions was fulfilling their responsibility as parents. The increase in these statements suggested that a change had occurred in the parents' perception of their role and they began to suggest to their children that they could not be protected indefinitely from adverse consequences following their irresponsible behavior.

The paradoxical intervention appears to have been effective as statements of appropriate responsibility increased from 2-8 following its introduction.

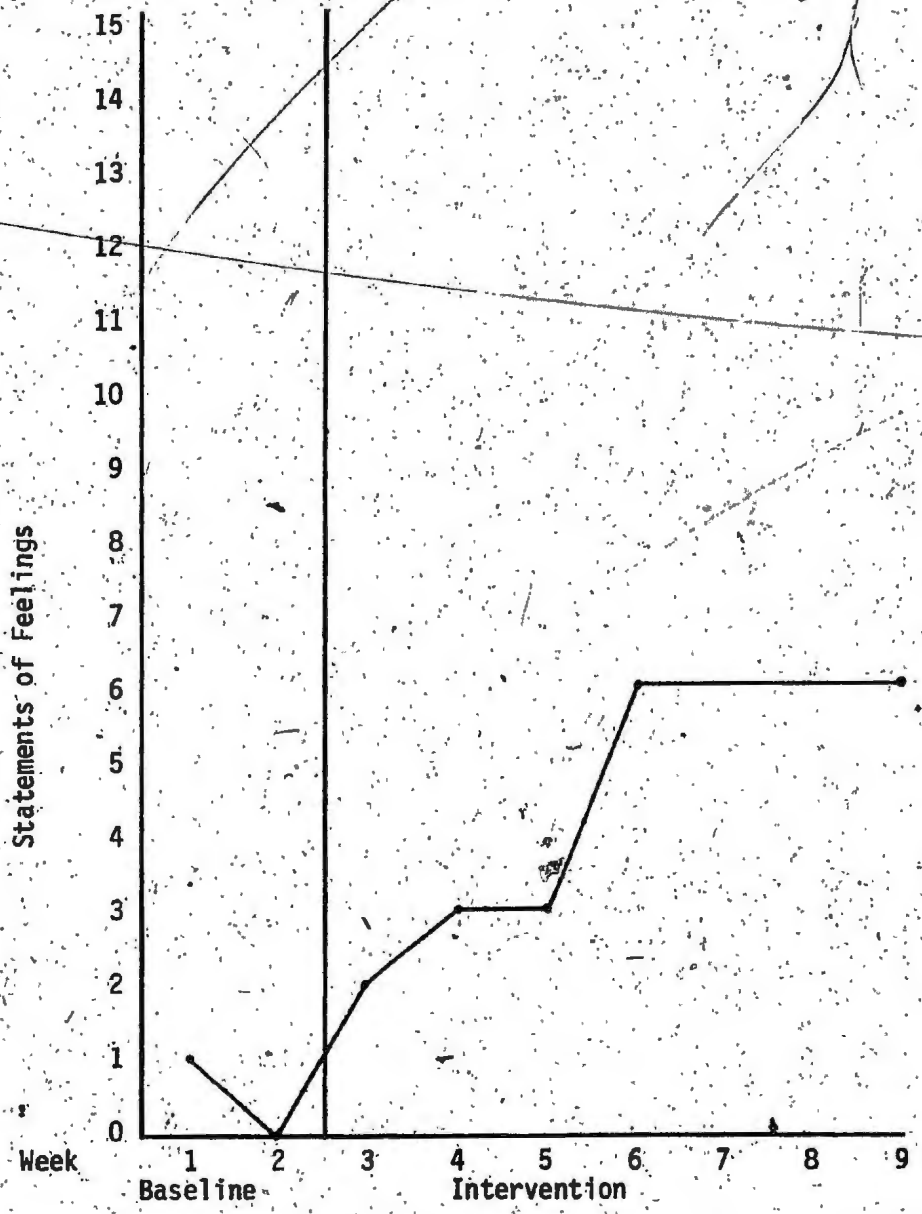

Figure 4. Number of Statements of Feelings.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

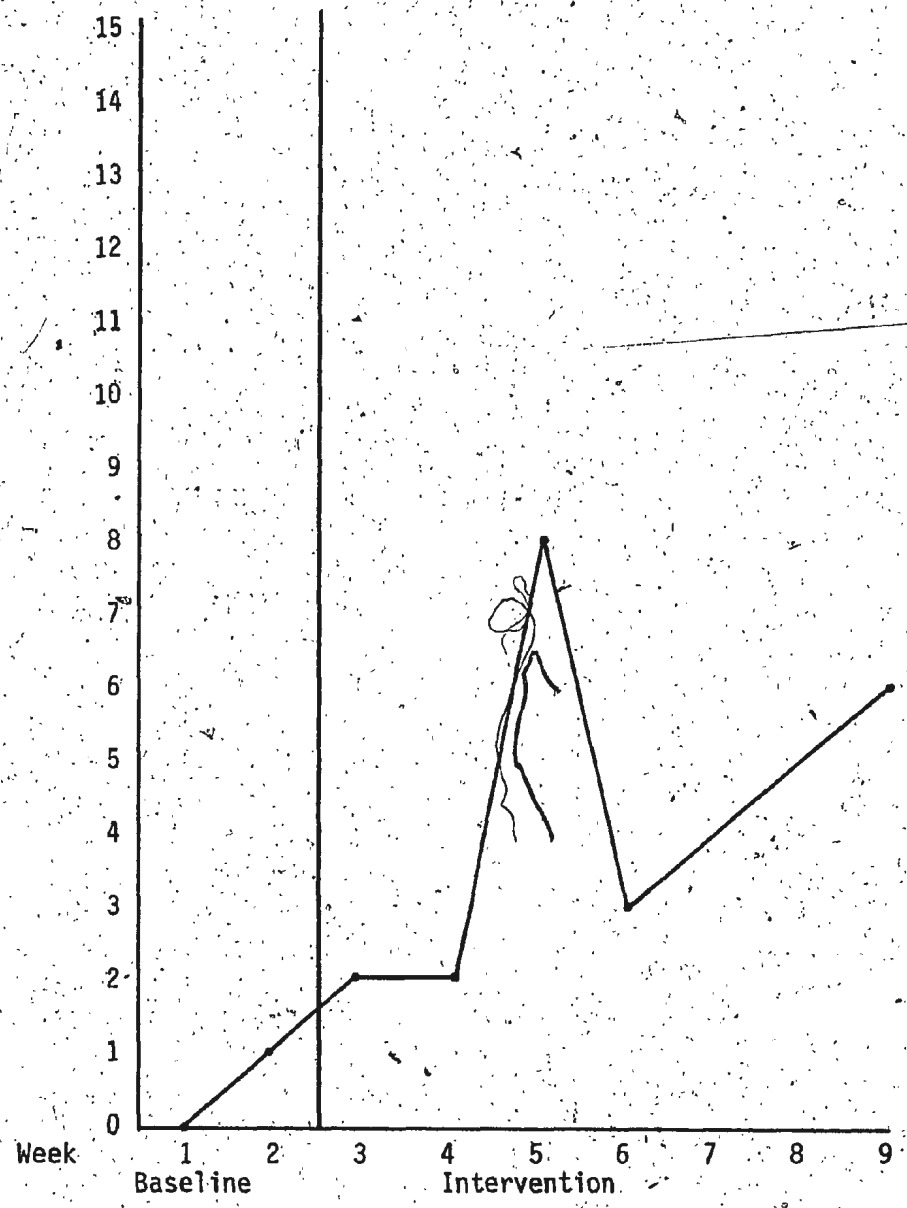

Figure 5. Statements of Appropriate Responsibility.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

Sibling Comparison

Figure 6 depicts a significant decrease in statements of sibling comparison. The results indicate that the behavior was close to elimination (one statement at the end of treatment). The decrease of sibling comparison was reflected in the improved relationship between the problem child and the sibling with whom he had been compared. As this relationship grew stronger it appeared to prohibit the use of this strategy by the parents in focusing on the problem child in a negative manner.

Encouragement and Affection

Figure 7 illustrates an increase in statements of encouragement and affection from 0-8.

The family's interaction at the onset of treatment was characterized by a pronounced absence of affectionate content, and positive behavior was rarely re-inforced or encouraged. The positive change in this category was especially significant clinically, as it was observed that improvement in this category appeared to facilitate positive changes in other categories. The improvement in the "climate" of the sessions effected by the introduction of affection and encouragement appeared to produce increased willingness by the family to change.

In contrast to other results indicating a positive effect resulting from the use of paradox the results in this category indicate that the intervention had a negative impact, as a number of statements decreased from 8-4 when the intervention was introduced.

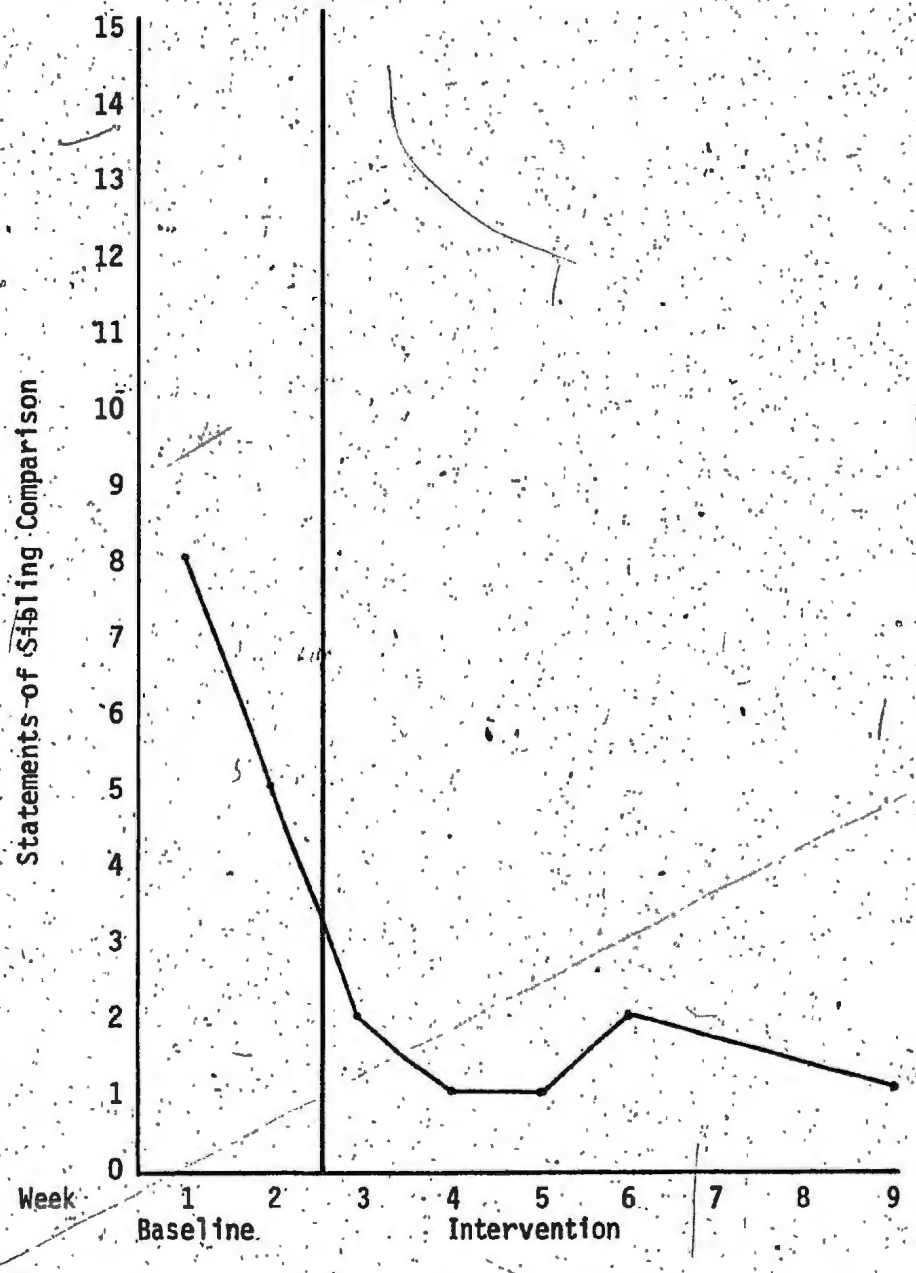

Figure 6. Number of Statements of Sibling Comparison.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

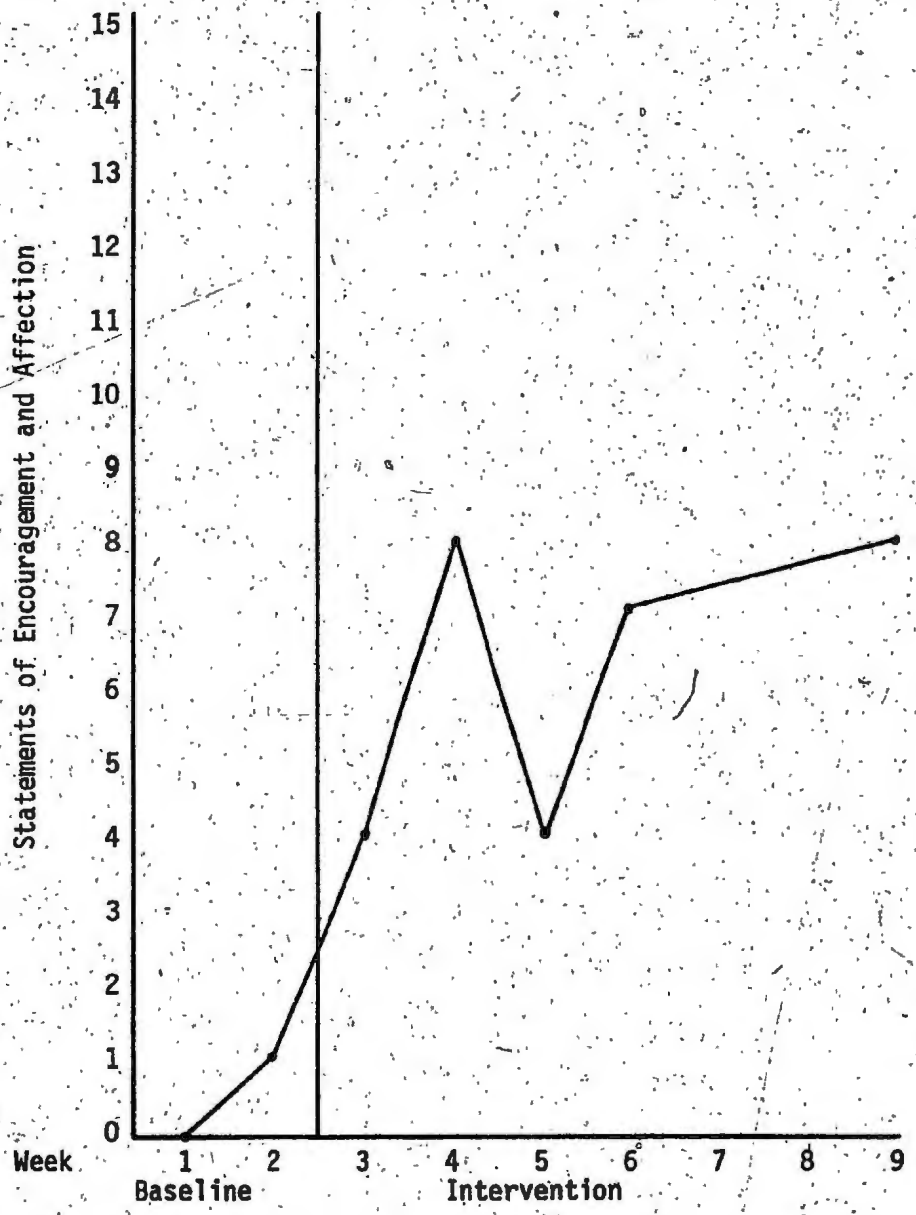

Figure 7. Number of Statements of Encouragement and Affection.

Notes. Each measurement was taken during a one hour period. There were no measurements taken during weeks 7 and 8.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

This chapter will present a summary of some of the major issues involved in utilizing the empirical model of clinical practice. The first section of the chapter will present a discussion of the application of the single-subject design within the empirical model as outlined in the single-case study. The discussion in this chapter will also include the difficulties encountered while utilizing the approach with a wide range of clients and client situations. A number of recommendations for the practitioner will be outlined including a final summary of the implications of utilizations of the single-subject approach for family practice and the profession.

DISCUSSION OF RESULTS FROM CASE STUDY

Baseline data

There are several limitations to making a strong causal statement as to the effects of intervention. Since it was possible to obtain only two data points in the baseline period it cannot be said with certainty that this is a true representation of the pre-treatment data patterns. Jararatyne & Levy (1979) have suggested that there be a minimum of three data points during baseline, when a multiple-point measurement strategy is being employed. The shortness of the baseline period presented difficulties for statistical analysis, as the strength of statistical procedures rests on the assumption that there is sufficient pre-treatment data in which to make statistical comparisons. In the

findings of the case study, eyeballing the data yielded sufficient information for clinical purposes. It is recognized, however, that a statistical procedure, if possible, would certainly have strengthened the conclusion that intervention had produced the illustrated changes.

Premature Termination of Treatment

The family's decision to conclude treatment was a factor in not being able to make a strong causal statement, as it was not possible to obtain post-treatment data which would indicate whether the changes in interaction had been maintained.

Design

The choice of the AB design was discussed in reference to the strengths earlier in the study (pp.23-24). However, if the original state of functioning can be re-instated by withdrawing or reversing intervention, there would be a stronger argument to support the conclusion that intervention was responsible for the changes. A decision not to use a withdrawal-reversal design was made for two reasons. It seemed ethically questionable to attempt a return to pre-treatment functioning for the purpose of making a causal statement as pre-treatment functioning had been quite destructive for the family system. The possibility also existed that the exact treatment program could not be replicated for a number of reasons including, for example, unexpected and unplanned events in the family's natural environment.

The second reason why a reversal design was not chosen was because it seemed quite unlikely that the changed interactions of a family of six could be altered to exactly replicate the baseline condition. However, had measurement been possible during the two weeks of non-treatment when the family was ill, the advantage would be that the conditions needed

for a withdrawal design would have been present and it might have been possible to obtain valuable data on the family's functioning in the absence of intervention.

Objective Data: Therapeutic Implications

The clinician and the family felt that there had been significant improvement in functioning, but as the data indicates (see Figure 1) the number of blaming statements, though reduced, indicated a need for further intervention. Use of a single-subject design assisted the clinician in objectively demonstrating to the family the status of their interaction.

Utilization of the single-subject design also yielded valuable data during intervention, for example, when the findings indicated an accelerated change in several of the categories when the paradoxical intervention was introduced (see Figure 1, 2, 3, 5 & 7). An ongoing assessment of the effects of each weeks intervention also facilitated the planning of strategy for each session and was a valuable clinical aid. Feedback during intervention was given to the family during treatment, and the objective demonstration of gains was a positive reinforcement which again facilitated the therapy process.

Utilization of Supplementary Data

In addition to the information gathered from the within-interview measurement, supplementary information as to the effects of intervention was obtained. For example, two significant events occurred outside of the interview situation. The problem child developed a plan to reimburse

the stolen money and followed through on his solution without involvement from his parents. He was also involved in one more incident of petty theft and the parents were aware of the behavior but advised their son that responsibility for resolution of the difficulty was his. The child made restitution and accepted the consequences for his action. These events represented a significant change in the family's previous pattern of handling the difficulties related to the son's behavior and the problem of how it should be handled appeared to be resolved. Thus, in addition to the objective findings of changed interaction (see Figures 1-7), more subjective data was available to strengthen the conclusion that treatment had been successful.

The use of supplementary data is particularly important when data is gathered by a within-interview strategy. The interview itself is an artificial situation for the family, and changing interaction may in some ways be due to the family's desire to please the clinician (Campbell and Stanley, 1963). It is difficult without supplementary information to assume that the changes can be generalized into the family's natural environment. For a further discussion see a study by Postner, Guttman, Sigal, Epstein and Rakoff (1971), which looks at the changes in participation and affective expressions during the course of conjoint family therapy as related to outcome.

Generalizability.

Brief Therapy appears to have been an effective model in producing change with this family. It would be difficult from this single study to make general statements about the effectiveness of this model of therapy

with other families in difference situations. However, since the single-subject approach required clear and concrete specification of goals, treatment and observed effects, the replication of this study could be made and a number of replications would strengthen the argument for the model's effectiveness.

Summary

The use of the single-subject design yielded objective data which indicates that intervention was successful, and valuable data was received by the clinician on particular segments of the intervention package. The availability of concrete data facilitated the therapeutic process, and a replication of this study would increase practice knowledge concerning the effectiveness of the Brief Therapy model of treatment.

IMPLICATIONS FOR FAMILY PRACTICE

Utilization of the single-subject design within the empirical model was carried out with a number of different clients and client situation throughout the practicum which would be typically seen by the family practitioner. Some of the issues which arose are worthy of discussion.

Client Observations

The within-interview method of measurement was used in the case study outlined. However, with many of the clients seen, it was

necessary to focus on behaviors which occurred outside of the interview situation. Quite often, the clients themselves were the only available observers. Using this method, clients gathered data on their own behavior and reported back to the worker. It was found that clients became more active in the therapy process because their input was required in tailoring a measurement device which was unique to them and their situations. Clients reported that observing their own behavior had the effect of increasing their awareness of their own functioning. This increased awareness often acted as a deterrent to their negative behavior, and a reinforcer of their positive behavior.

This phenomenom may pose a threat for research purposes, as the measurement of behavior may itself be effecting change. However, it was found that self-observation techniques had positive implications for therapy as intervention is more likely to be effective if the client remains fully involved in the process. (See Appendix G for a measurement tool which was tailored by the clinician and the client.)

A summary of a number of factors which should be considered in using clients' observations in research, including a practical list of do's and don'ts, has been presented by Howe(1976) and this discussion is a useful guide for the clinician-researcher utilizing a single-subject approach.

Natural History

It was found that there were difficulties in measuring the behavior of clients in open settings because of natural history. For example, one client who presented with insomnia was asked to note her sleep pattern for a seven day period for baseline purposes. During the measurement period the client began taking tranquillizers which confounded the data, and restricted measurement of this behavior pattern. Some of the difficulties resulting from natural history could be overcome by more emphasis on the rationale for measurement with the client and enlisting client support in minimizing the effects of the environment. In practical terms, however, it must be recognized that there are factors in the environment over which neither the client nor the clinician has control.

Research versus Practice Objectives

One of the most critical issues in the application of the single-subject design was the issue of research versus practice objectives. It has been pointed out (Thomas, 1978) that depending on which takes precedence research and practice objectives have different implications for intervention and can result in conflicts that have negative effects on the service, on the research, or both. When the focus is on service, the concern is with the changes in client (s) interaction or functioning, rather than on demonstrating that the intervention is responsible for the change. However, the purpose of research with single-subject designs is to demonstrate that an intervention provides experimental control over target behavior (Thomas, 1978).

The case study illustrated some of the recognized comprimises to research which were dictated by service objectives, including the shortness of the baseline, the inability to obtain follow-up data, and the use of the weaker design. To further illustrate, the use of the AB design met service objectives, but it could be described as a weak design in establishing causality (Hersen & Barlow, 1976). It has been pointed out, however, that no single-case study can with certainty demonstrate that an intervention will always have a given effect on selected dependent variables. Replication is necessary, and a successful repetition of an AB design, using the same intervention across clients with similar problems, can lead to generalization of findings. It can be concluded that data gathered in settings where considerations related to service take precedence can help point the way toward useful exploration within a more rigorous framework. (Gambrill & Barth, 1980).

Single-subject designs can be said to lie on a continuum which may range from being exploratory and offering the basis for tentative conclusion concerning the effects of intervention, to intensively controlled designs which enable strong causal statements to be made (Gambrill & Barth, 1980). The conclusion drawn is that efforts anywhere on this continuum are useful for the practitioner, and restricting activities to designs which are rigid overlook important contributions to the development of knowledge which clinicians can make using less rigid designs.

CONCLUDING COMMENTS

The goal of this project was to outline a model of practice which would enable the family clinician to empirically demonstrate effectiveness with clients. Historically, evaluation of practice has been limited to outcome studies which indicate whether or not an agency has produced significant overall change in the clientele it has served. Other outcome studies have looked at the results of such broad areas of treatment as casework or conjoint marital and family therapy. These methods of research have increased practice knowledge, but have not been particularly useful for individual clinicians in their day-to-day practice. They have not equipped clinicians with specific information concerning their own individual methods of intervention which are generally uniquely tailored to the specific client and client situation.

Clinicians often must rely on completely subjective data as a means of determining the effects of their interventions. These have included reports of clients who indicate how they view their own change in functioning, and the worker's own evaluation of the client's progress. There has seldom been objective data available to the clinician for evaluation purposes.

The results of this project were very encouraging. Utilization of the procedures which comprise a model of practice based on the single-subject design yielded information on the effects of intervention which would not otherwise have been available. Use of the model also revealed

particular effects of various components of treatment models suggesting which particular interventions had the greatest impact. Objective evaluation which indicated that an intervention was successful increased clinician confidence that the same method would be effective in similar client situations.

In addition to the advantages which these procedures brought to the evaluation process, it was found that the clients responded positively to increased involvement in the therapy process and this factor increased the likelihood of clinical success.

It is recognized that use of the procedures which comprise the empirical model do require the performance of additional tasks by the clinician. This involves tailoring measurement devices, and using ongoing assessment procedures. The value of the model, however, for the practitioner who is concerned with enhancing the effectiveness of interventions with clients makes these efforts a worthwhile exercise.

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APPENDIX A

OVERVIEW OF SERVICES OFFERED BY CATHOLIC FAMILY SERVICE

(designed for client use)

SERVICES AVAILABLE AT CATHOLIC FAMILY SERVICE - OTTAWA

INSTRUCTIONS:

This description of the counselling and educational services of Catholic Family Service is intended to give you, the user of our services, a summary of all the programmes offered. Generally, our clients have heard about or have been referred to our agency for only one of our services, and they are not aware of the other ways in which they may make use of the agency. Also, people's needs change, and so we expect that many of our clients may want to use different services at different times. The services described in this brochure have been developed over a period of many years to meet the changing needs of our clients, but we fully expect that they will continue to change. Thus, we would like to encourage you to identify other needs that are not being met by our current services, so that we may develop new programmes.

Please check off any of the services that you feel you could use now or in the immediate future. This information will be helpful for us to plan and schedule our services, especially the group programmes. Feel free to add to the list in the space provided in the "other" categories.

Please return this form to your social worker or group leader.

COUNSELLING SERVICES:

Counsellors giving the following services have graduate degrees in Social Work or Educational Psychology or have a community college certificate in

social service work. The basic philosophy of the counselling given is growth-oriented and as such is concerned with freeing the individual to reach his or her own potential and make his or her own choices in an authentic manner, both in his or her own life and in the multiple relationships in which we are all involved. To this end it is systems oriented in the here and now and as well is concerned with the family of origin as an influential system. There is also an awareness of psycho-dynamics, particularly in relation to the individual in the system. The counselling is also educational in that it is concerned with helping people learn skills to deal with various stresses and stages of development, changing life styles and roles. Techniques used are chosen to meet the needs of the applicant be it individual couple or family. These include various communication techniques, transactional-analysis, Gestalt, assertiveness training, value and role clarification, modelling, contracting, reality-testing and others.

Marital Counselling: The primary focus is on the relationship of married or unmarried couples, with the aim of helping the couple to achieve a better understanding of the purpose of their relationship, and finding new ways to reach that goal, e.g. improved communication, better sexual relationship, etc.

Separation, Divorce and Conciliation Counselling: Similar to marital counselling, but the focus is on deciding whether or not the couple is going to remain together, and dealing with the emotional and practical consequences of their decision, including adjusting to new roles and life styles.

Individual Counselling to Adults: Persons may also be helped to explore their relationships on an individual basis; to make decisions; to learn how to understand and cope with stressful situations at different stages in their lives; and/or learn new behaviour patterns, including communication skills.

Individual Counselling to Children and Adolescents: Helping them to cope with the problems affecting them at their particular stage in life. Under sixteen years of age, counselling is given only with the knowledge and consent of parents. Over the age of sixteen, parental consent is not necessary.

Parent-Child Relationship Counselling: The focus is dealing with conflicts, communication difficulties, changing needs, expectations and roles, and other problems which may arise between parents and children.

Family Counselling: Attention is given to the interaction between all family members, rather than on the specific relationships mentioned above, with the emphasis being on strengthening the family as a unit.

Personal Growth Groups: These groups are offered periodically. Methods used are Gestalt, Transactional Analysis, Assertiveness Training, and other communication techniques. Common problems may be the basis for forming a particular group.

EDUCATIONAL SERVICES:

Parent-Child Communication Groups: These are ten-week courses aiming to help parents be effective in bringing up their children to be responsible, independent adults. The two main sources are Dr. Thomas Gordon's "Parent Effectiveness Training" and Rudolph Dreikurs' "Children: The Challenge". Discussion, role-playing and exercises complement the presentation of material. These courses are open to couples and single parents. Advanced groups are offered to graduates.

Open-Forum Counselling: An educational approach to family interaction, based on the method of Dr. Alfred Adler, with the aim of strengthening family bonds in an atmosphere of mutual respect and recognition of mutual needs, by focusing on specific areas of concern in the family. A team approach is used, and sessions may be open to observers, such as other parents and persons involved in dealing with children and families, such as teachers, nurses, etc.

Christopher Leadership Course: A course aimed at helping individuals to grow in self-confidence, by learning to organize their thoughts simply and clearly, and to present them effectively, and by learning to share their feelings better with close ones or strangers. The main technique is speaking on one's feet to a group twice each night.

Marital Communication Groups: Groups are periodically offered for couples who want to improve their mutual communication in the context of a group experience. Various communication techniques are used.

Talks to Public Groups: Upon request, talks may be given about topics related to marriage and family life, such as communication, parenting and preparation for marriage.

Other:

Name _____ Telephone No _____

Address _____

APPENDIX B

CASE HISTORY

CASE HISTORY

Family Composition

Family C was comprised of seven members. Father was a 38 year old stationary engineer, an only child who described himself as an "extremely hard worker" and a "family man". Mother was 38, and worked part-time as a homemaker and part-time as a factory worker. Her family of origin was comprised of her parents and five siblings. The oldest child, Vicki, was an 18 year old who attended Grade XII, and who was successful academically and socially. The 11 year old, Willy, was described by the family as the "clown". He was attending Grade VI and doing average work in school. Ricky, age 13, was described by the family as "the problem". Ricky was having some problems in school, and was described as disrespectful and unmanageable by his parents. The second youngest boy, Georgie, was six years old and in kindergarten. Although there was a baby, aged 11 months, (who did not attend therapy) Georgie was often described as the"baby of the family".

Information Available Before the In-person Interview (Intake)

The family had contacted the agency describing difficulties with their 13 year old son Ricky, who had been apprehended while stealing money from his grandmother. There had been no polic involvement and it appeared probable that the stealing behavior was not current. Agreement was reached with the intake worker that the whole family would attend therapy, with the exception of Patti (the 11 month old).

History as Described by the Family in the Initial Interview

The family described the situation leading to the request for therapy.

Ricky had been confronted by his grandmother in the act of taking money from her closet. The grandmother estimated that the total amount stolen including the recent amount was over $3,000.00. Ricky insisted that the amount was "under $2,000.00" and admitted to taking money "on and off" for some years.

Mr. and Mrs. C. described a range of problem behaviors with which they had been concerned, including the stealing, disrespectful behavior to his parents and "irresponsibility" in performing his obligations. The family had not been in therapy before and described their efforts to "keep it in the family". These efforts included paying back money which Ricky had stolen, severe lecturing, keeping him under close supervision, and "not leaving money around". Mr. and Mrs. C. admitted that none of these efforts had worked and stated that some solution must be found or they feared Ricky would find himself in trouble with the law.

Mother and Father described themselves as good parents who worked extremely hard so their children would have all possible benefits, such as a yearly vacation. None of the other children exhibited significant problem behavior and Mr. and Mrs. C. were convinced that if Ricky would "shape up", the family would be completely happy. The children contributed little with the exception of Vicki who agreed with her parents. Frequent reference was made to the fact that Vicki was a model student and "the complete opposite of her brother". The parents worked hard to demonstrate to the therapist that if Vicki could be a model child the problem obviously lay with Ricky, and was unrelated to their mode of parenting or other relationship factors.

APPENDIX C

THE BRIEF THERAPY MODEL

THE BRIEF THERAPY MODEL

1. It is system oriented - presented problems offer what the client is ready to work on, an indicator of whatever is wrong, and a concrete index of any progress made.
2. These problems are viewed as situational difficulties between people - problems of interaction.
3. Such problems are seen primarily as an outcome of everyday difficulties which have been mishandled.
4. Normal transitional steps in family living are seen as the most common and important difficulty that may lead to problems.
5. Problems are likely to develop by the over emphasis, or under emphasis of difficulties in living.
6. Original difficulty is often met with an attempted solution that intensifies the original difficulty.
7. Chronic symptoms are viewed as the persistence of a repeatedly poorly handled difficulty.
8. Resolution of problems is seen as mainly requiring a substitution of behavior patterns, so as to interrup the vicious positive feedback circles
9. Means of promoting beneficial change are sought, which work. Often seemingly "illogical" remedies are prescribed.
10. Change can be effective by "thinking small", by focusing on the symptom presented and working in a limited way towards its relief.
11. Conceptions and interventions are based on direct observation in the treatment situation.

PROCEDURES

Within a usual maximum of ten sessions, therapy goes through in a four step procedure.

Step 1: A clear definition of the problem in concrete terms. (also a basic requirement of the empirical model).

Step 2: An investigation of the solution attempted so far - "This reveals what maintains the undesirable situation and where change has to be employed".

Step 3: A clear definition of the concrete change to be achieved. (also complimentary to the empirical model)

Step 4: The formulation and implementation of a plan to produce this change.(Watzlawick,Weakland and Fisch, 1974)

APPENDIX D

EXAMPLES OF STATEMENT CATEGORIES

Examples of Statements of the Seven Categories of Interaction Measured

1. Statements of Blame: "You'r no good"; "You'll never change"; "Only for you we'd be happy".
2. Statements of Encouragement and Affection: "It seems like you're trying"; "We know we can depend on you"; "We appreciate your effort".
3. Statements of Speaking for Children: "You don't seem to want to raise your marks"; "You don't care about pleasing Mom and I"; "You want to be caught and punished".
4. Statements Indicating a Shift in Responsibility: "It has to be something he wants to do"; "I'm beginning to realize it's not my responsibility"; "We can't solve this problem for you".
5. Statements of Sibling Comparison: "Why can't you be like your sister "? "You two are like black and white"; "We never have trouble like this with your sister".
6. Statements of Telling What to Do.: "You should study harder"; "You have to act like a man"; "You're going about it the wrong way- try this".
7. Statements of Feeling: "I feel discouraged"; "I feel frustrated because we can't solve this problem"; "I feel encouraged when I see you try".

APPENDIX E

INDEX OF FAMILY SATISFACTION

Index of Family Satisfaction

An additional measurement procedure employed in the case study was an index of family satisfaction (See pp.74-76). This index was tailored by the clinician to measure the family's level of satisfaction, and was based on an index developed by Hudson (1976) to measure marital satisfaction.

Each family member was asked to complete an inventory between the first and second sessions. The results indicated that each family member was completely satisfied with the family's interaction, and felt a strong sense of being accepted by the family. The results of this index were in complete contradiction to the picture the family presented in the interview situation, and from their own description of the situation at home where all members agreed there was excessive blaming, criticizing, and negative interaction. There are several possible explanations as to why this measurement tool did not accurately measure family satisfaction. First, the measurement tool itself was not refined or sufficiently sensitive to pinpoint accurately family members' satisfaction with their interaction. Second, this family presented with a very strong need to be perceived as a "good" family. A family rule apparent from assessment was that it was perfectly alright to criticize Ricky, but there was strong resistence to any suggestion that the family as a whole might need to change. The data given on the index possibly reflected a further effort by the family to convince the clinician that it was stable, and that therefore change was required solely in the behavior of the problem child. Hudson (1980) has published an index which measures discord in family relationships which could be utilized in a similar client situation and testing has indicated that it is a reliable measurement tool.

INDEX OF FAMILY SATISFACTION

NAME _____ TODAY'S DATE _____

This questionnaire is designed to measure the degree of satisfaction you have with your family at present. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can.

1. I feel that this family is affectionate enough.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
2. I feel that my family treats me badly.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
3. I feel that my family really cares for me.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
4. I feel that if I had a choice, I would not be in this family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
5. I feel this is a trusting family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
6. I feel that our family is breaking up.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
7. I feel that my family doesn't understand me.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
8. I feel that our family is a good one.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
9. I feel that ours is a very happy family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
10. I feel that our life together is dull.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME

Index of Family Satisfaction (continued)

11.	I feel that we have a lot of fun together.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
12.	I feel that I can confide in my family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
13.	I feel that our family is very close.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
14.	I feel that I cannot rely on my family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
15.	I feel that we do not talk enough together.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME.	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
16.	I feel that we manage agreements and disagreements very well in this family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
17.	I feel that in our family, we do a good job of managing how we spend our money.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
18.	I feel sometimes that I'm not a part of the family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
19.	I feel in our family that we get along well together.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
20.	I feel that our family is very stable.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
21.	I feel that my family is pleased with how I act.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME

Index of Family Satisfaction (continued)

22.	I feel we should do more things together.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
23.	I feel that the future looks bright for our family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
24.	I feel that our family is empty.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME
25.	I feel there is no joy in our family.	RARELY OR NONE OF THE TIME	A LITTLE OF THE TIME	SOMETIMES	GOOD PART OF THE TIME	MOST OR ALL OF THE TIME

APPENDIX F.

INTERVENTION PROCEDURES

INTERVENTION PROCEDURES

Assessment (Baseline)

Weeks 1 - 2

During the first two sessions there was no intervention into the family's interaction. The family outlined their reasons for seeking therapy and the clinician gathered information by asking open-ended questions. Examples of these questions are as follows:

a) How does this family make decisions?

b) What are the rules in this family?

c) Who makes the rules?

d) What happens when rules are broken?

e) What are some of the activities this family is involved in?

Intervention

Week 3

The family expressed willingness to work on the problem of Ricky's stealing behavior. During this session solutions which had been attempted were described in greater detail, and possible new solutions explored. During this session Ricky developed a plan for returning the stolen money and this was re-inforced by the clinician encouraging the family to support but not to interfere in the implementation of this plan. During this session, the clinician began giving feedback on interaction, utilizing reflecting comments such as:

(Week 3(continued)

"there appears to be a lot of anger in this family": "The parents seem to do most of the talking in this family";"Feelings are not expressed in this family very often. Are you aware of that"?

Week 4

The clinician attempted a paradoxical intervention (This is the apparent encouragement of undesirable behavior or what is perceived as undesirable behavior. The technique is used to lessen such behavior or bring it under control). This is an important procedure utilized frequently in the framework of the Brief Therapy model (Watzlawick, et al. 1974). The clinician suggested to the parents that they "loosen their control on Ricky for one week, "to see how bad things can actually get". The assumption was being made by the clinician that there would probably be an improvement in the son's behavior, as the attempted solution by the parents of excessive control seemed to be exacerbating the problem. The family accepted this prescription with some skepticism, but at this point were willing to demonstrate to the clinician why they had to be so controlling.

Week 5

The results of the prescription were discussed. The parents concluded somewhat reluctantly, much to their surprise that their son's behavior had improved in the absence of excessive control. The remainder of the session was used to explore the differences between being a "good " parent and being a "responsible" parent. Extreme parental control was reframed (placing what might be perceived as a negative behavior in a positive context)by the clinician as a sincere desire by the parents to protect their children from harmful consequences.

Week 6

A significant event had occurred between weeks five and six. The son was involved in an incident of stealing. His participation in the occurrence was relatively minimal but during week Six the family looked at possible solutions. Agreement was reached that Ricky would handle this incident by reporting his participation in the event and accepting the consequences. The parents agreed that they should not intercede on his behalf.

Week 7-8

The family was absent due to minor illness.

Week 9

The family announced it had decided to conclude therapy. The reasons given were that all members agreed there had been improvement and there were practical difficulties in getting everyone together for the sessions. Although the original problem of how to deal with the stealing behavior appeared to be resolved, there was still scapegoating of Ricky and it was suggested by the clinician that the family continue therapy for at least three more sessions. The family would not agree to this and the remainder of the session was used as a summation of therapy and the changes which had occurred in the interaction. During this session selected parts of the previously recorded material was shown to the family with the focus on demonstrating to them some of the changes which had taken place in interaction.

APPENDIX G

A TAILORED MEASUREMENT TOOL

A TAILORED MEASUREMENT TOOL

The following measurement tool was developed by the clinician and a client who stated that her problem was "depression".

Together, the clinician and client were able to operationalize and define the client's depression as follows:

1. Feelings of Depression. The client defined her feelings of depression as crying bouts. She agreed to count the number of times crying bouts occurred, on a daily basis.

2. Social Activities. The client reported that the frequency of her social activities was an indicator of whether or not she felt depressed. She was asked to count the number of times she engaged in social activities on a daily basis.

3. Personal Grooming. The client reported that her manner of grooming was an indicator of whether or not she felt depressed. Grooming was defined to include whether or not the client washed her hair, bathed and laundered her clothing. The degree of grooming was rated by the client each day as following on a scale from 1 - 10, and was rated on a daily basis.

Note. The previous behaviors were measured by the client for one week before treatment began, and throughout the intervention period.