Family Therapy With Adolescents

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ABSTRACT. This article presents a research study undertaken in the context of a consultation to provide family-therapy supervision. Families with adolescents were randomly assigned to four therapists, two who used verbal methods and two who used action methods in conducting therapy. The families were given pre- and post-tests using the Family Relationship Inventory. Family goals were established by the end of the second session, and families were assigned to one of four levels of dysfunction. The methods of the study are described, and the outcomes discussed. Although not generalizable, the results indicated that with certain levels of family typology, action methods produce higher family agreement regarding goal attainment and therapy satisfaction.

THE EVOLUTION OF SYSTEMS THEORY in the provision of family therapy has had a major impact upon our thinking regarding therapy. A basic tenet of systems theory is that the "whole is greater than the sum of its parts" (von Bertalanffy, 1956). This view enables the therapist to focus attention on the relationships and interactive patterns within a family, rather than on the individual attributes of family members. Systems theory postulates that the process of interaction will remain relatively consistent among family members, regardless of changes in content (Koman and Stechler, 1985).

When a family enters into therapy with an adolescent designated as the identified patient (IP), one of the tasks of the therapist is to understand and to intervene to change the family's nonfunctional interaction pattern. The therapist does this through observation of the family's style as the members respond to questions and share areas of concern. Usually, a therapist creates a context for enactment (Minuchin, 1974) whereby the family recreates a typical scene that might take place at home. Generally, this enactment is done in a verbal fashion rather than as it might have been done in a real-life situation with movement and dialogue.

As a structural family therapist originally trained in psychodrama and action methods, I have adapted structural theory (Minuchin, 1974) and psychodrama theory (Moreno, 1946, 1959, 1969) to my orientation of

therapy with families. This produces a form of therapy that is more active than that of most family therapists. It is a form of therapy that I find works especially well with adolescents who are involved in family therapy. Generally, adolescents are less comfortable with verbal communication than they are with activity. Through the use of action methods during the therapy process, they tend to feel less "one-down" from the adults.

Research Context

I am frequently asked to provide supervision to family service agencies within my area. The agency mentioned in this article employed two former psychodrama students of mine as family therapists. Beyond my primary work as a director of a marriage and family therapy graduate program, I conduct psychodrama training courses from time to time. These two individuals, previously trained in standard family therapy, took the 10-month training course in psychodrama in order to use it as an adjunct to their primary therapy modality. I was asked by their agency to consult with six family therapists who were working with families with different levels of complexity. As I listened to the staff discuss some of their cases, I was aware that they were dealing with families at all four levels of Weltner's Family Assessment and Intervention Continuum.

Weltner (1985) contends that it is important to match therapeutic style to various families' levels of development. He has divided families into four levels. Level 1 families are those who are dealing with life and death issues because of an ineffective executive capacity. These families have had no basic nurturance and protection. Level 2 families are those in which authority and limits are the key issues. Here the executive system is not providing sufficient control so containment is the primary concern. Level 3 families are those dealing with intergenerational legacies. These will emerge essentially in the form of boundary problems with individuals, subsystems, and intergenerationality. Level 4 families are those who have the freedom to focus more on enriching family life. Their struggles generally focus around issues of inner processes and interactive styles that enhance intimacy.

This typology is helpful when a therapist assesses families. It enables me, as a consultant, to consider the range of families the therapists are handling so that I can facilitate their delivery of appropriate interventions.

Because two of the family therapists had received training as psychodramatists and wanted to use more action methods within their therapeu work and the other therapists had had no psychodrama training, I face this dilemma: How could I meet both needs at the same time? Our conflic was resolved when we decided to turn the consultation into a research proj-

ect. At the same time the project was being conducted, I provided supervision in family therapy. A major area of supervision work went on in this context and will not be focused upon in this article. Rather, I will focus here on a brief discussion of the Adolescent Family Therapy Project. Although instrumentation was used that was put to statistical analysis, it will be referred to only briefly. The goal of this article is to consider action versus verbal methods of work with adolescents. Another article, now being prepared, will deal with specific outcomes of the project and provide major statistical analysis.

Research Design

Families with children aged 13 through 17 were randomly assigned to one of four family therapists until each therapist had six client families. Families with two parents or a single parent were selected, but families with drug- or alcohol-abusing adolescents were eliminated. Following the first two family-therapy sessions, the family was presented to the consultant and the six-member team for a brief consultative session. At that time, the six therapists ranked the family according to Weltner's levels, using a two-stage ranking agreement. This resulted in placing three families in Level 1, nine in Level 2, five in Level 3, and seven in Level 4. Two of the therapists trained as structural family therapists would use standard structural methods in their work with the families. The other two therapists, who were essentially trained in structural family therapy and had also had psychodrama training, would work with families through the use of action methods within each session. These methods might include the use of sculpting, role playing, psychodramas, sociodramas, or other action methods. The essential goal was to de-emphasize verbal methods and to stress the use of action techniques.

All families were given the Family Relationship Inventory (Michaelson & Bascom, 1982) upon entry into therapy and were retested at the end of therapy. Families had to complete at least 6 therapy sessions. No more than 12 sessions were to be included in the study as we were working within a brief therapy context. Three of the originally assigned families were replaced during the study so that a total of 24 families could be maintained. An adolescent in one family had a drug problem that emerged during the course of therapy. One family terminated after the second session and one after the third.

Process

The therapists using structural therapy methods followed the standard procedures of that model, which include the following elements: accom-

modation to facilitate joining with the family, including the statement of positive connotation of each family member; gathering data around the problem being presented by the family; tracking the content of family communications and behaviors; and encouraging an enactment of a typical family issue within the context of the therapy room. In restructuring the operations they used, the therapists included marking boundaries, escalating stress, blocking, developing implicit conflict, joining in alliances or coalitions, and the use of tasks outside of therapy. The focus of the major work dealt with the transactions within boundaries, power, and alignments of the families.

The therapists using action methods operated from the same conceptual frame—structural family therapy. However, their methods, essentially psychodramatic or modifications of that form, enabled the therapists to use action as the primary modality. The assessment was done by accommodation to join each family member and gain positive connotation for each. A brief problem statement was drawn from each individual, and an overall statement was presented for the family. Following this, the therapist asked the members to sculpt how each saw the difficulties in their family, then sculpt how they would like the family to be if it were changed to meet individual and family needs. This provided an assessment as well as a definition of the goals of the individuals and those of the total family. In the second session, an action genogram was completed. This is a standard genogram, recorded on a large flipchart. The processing of relationships and triangles is done in action, with the use of empty chairs to represent extended generations or other significant members not present.

Issues introduced at each subsequent session were role played or put in the form of psychodramas. For example, with Level 1 families, who need a great deal of support to enable them to meet basic needs, the following techniques were used: describing the family social atom, creating a container for family resources, role playing basic life skills, enacting sociodramas to facilitate learning to use social agencies and supports with power, developing behavioral patterns to manage daily living tasks and role playing these to discover pitfalls, learning to involve others and yet keep boundaries of family unit intact. For Level 2 families, one example presented was that of a parent talking about his rigidity with control of his adolescent son. The parent was asked to talk about his own father/son relationship. This was transposed into a psychodrama, with his family taking auxiliary roles for him. After the debriefing, the psychodrama's implications for the difficulties being experienced in this nuclear family were considered. Another example was the use of an enactment around the dining table. The scene was established, and family members took their places around the table. After a dysfunctional enactment took place, instructions

were given to make the situation work so that the family could solve the problem at hand, which related to the curfew for an adolescent daughter. This kind of role play enables the therapist to facilitate skill development in Level 2 families who lack executive control.

The use of future projection roles were very helpful in enabling the adolescent to establish self-determined goals that were constructive, and not just reactive, to current family conflict. The use of sculpting the boundaries within the family, as perceived by each member, and then doing boundary-change work at an active level enabled the families either to tighten boundaries or make them more flexible. Using space to sculpt power imbalances within the system helped move the group into action dramas that could produce changes so that families could grant, when appropriate, more decision-making power to the adolescents. Sculpting was also used to show the various alignments in the family and to give the family new ways of modifying these so that more interaction patterns occurred with dyads, triads, and so on. No one would be locked into a persistent interaction pattern. Those are all helpful changes to make when working with Level 3 families.

Families were asked to make family drawings to show how they might spontaneously operate together. Here, nonverbally, they had to negotiate space and style of production. Other art media were used in other sessions. The use of music, so important to adolescents, was also a medium of exchange. Playing music and discussing what it meant, both in terms of the words in songs and the rhythms, were methods that were mutually beneficial to adolescents and parents. Fostering enactments that facilitated the sharing of individuals' inner experiences and feelings were frequently goals of psychodramas with families at Level 4.

These are only a few of the methods used by the action-oriented therapists to intervene with the problems presented by the families.

Outcomes

At the end of the research period, the data were examined from three perspectives. First, all families, having agreed with the therapist to strive for specific goals during their work together, analyzed their accomplishments on a Likert-type scale, indicating the degree to which each family member felt the goals had been accomplished. A specific family goal had to be rank ordered by an entire family. This ranking ranged from 0, meaning no goal attainment, to 4, meaning goal attained. Outcomes are presented in Table 1.

The pre- and post-therapy results of the Family Relationship Inventory were compared for the two groups. The FRI consists of 50 cards with

TABLE 1—Agreed Family Assessment Regarding Therapy-Goal Attainment

Type of family	Rank				
	0	1	2	3	4
	Verbal method				
Level 1		1	1		
Level 2		1	3		
Level 3			2	1	
Level 4		1	1	1	
	Action method				
Level 1			1		
Level 2		1	2	2	
Level 3				1	1
Level 4				1	3

words or phrases descriptive of some personal characteristic or behavior. The individual respondent (or family unit) is asked to assign each item to one of three columns—self, another member of the family, or "wastebasket." The therapist reads the cards, and each family member records the words under one of the headings. Each item has a plus or minus valence so that each column can be totalled. The final score is obtained by subtracting the smaller sum from the larger. A profile is then created showing how each individual in the family system perceives himself or herself and every other family member. A familygram of negative and positive valence is then created for each member of the family. Most often, identified patients or scapegoats within families receive the most negative responses. The goal of treatment is to change the direction of the valence so that all family members have positive responses.

Those families that we acknowledged at intake as Level 1 families reflected little change in the FRI at the end of therapy, no matter which therapy modality was used. Level 2 families that had treatment with action methods showed a trend toward more positive interaction, but it was not significant. Level 3 and Level 4 families in action-method therapy had a significant difference in positive relationship interaction. In families at those levels, no significant differences were found with verbal methods, although change was recorded in the positive direction.

For the third method of evaluating this project, a process-evaluation form was developed. It contained six statements that each family member ranked on a Likert scale, with 1 being low and 5 high. The evaluation form included the following:

1. The degree of motivation I had for participating in family therapy was essentially positive by the end of the third session.
2. I felt that during therapy all members of the family were given equal focus to work on family issues.
3. I believe that the problem(s) we came to therapy for have been, for the most part, changed or eliminated.
4. Beyond problem solving, I believe that I have learned, through therapy, more choices for dealing with my living within this family.
5. In general, I felt respected by the therapist during our sessions.
6. The style in which the therapist conducted the therapy sessions seemed to match my own needs and those of my family.

Following the questions, a space was provided for comments by individuals.

In the analysis of this brief evaluation, we examined separately the responses of the adolescents and the adults. In general, adolescents and adults had more areas of agreement in the action-method group than did those in the verbal group. Mothers gave more 5 rankings than did fathers. No IP in the verbal group gave a ranking of 5, and no IP in the action group gave a ranking of 1. Table 2 gives a summary of the items for adolescents who were the identified patients.

Conclusion

This was an exploratory study that examined two methods of working with adolescents within family therapy. The sample is far too small to make generalizations. The use of measurements that reflect a wider range of family functions along with the interactional scales of the FRI, such as the Family Assessment Measure (Skinner, Steinhauer, and Santa-Barbara, 1984) or the Family Adaptability and Cohesion Evaluation Scales (FACES) (Olson, Sprenkle, and Russell, 1979), would provide a more in-depth profile of changes from pre- to post-therapy. At the same time, it would appear that, in some categories of families, work with adolescents within a family-therapy setting may be more adequately facilitated through the use of action methods. In this study, a greater number of the families agreed that they had attained their goal for therapy when action methods were used than when verbal methods were used. The positive valence of family interaction patterns, as reported on FRI, also increased for Level 3 and Level 4 families who were involved in active family therapy. Motivation for willing-

TABLE 2—Summary of Adolescent IP Ranking of Six Evaluation Questions

	Rank				
Item	1	2	3	4	5
		Verbal group			
1	5	3	4		
2	1	5	5	1	
3	2	3	7		
4	3	4	3	2	
5	1	4	4	3	
6	2	4	6		
		Action group			
1		3	5	2	2
2		1	6	3	2
3		1	4	4	3
4			3	5	4
5		1	4	4	3
6		1	3	8	

ness to participate in therapy increased more through the use of action methods. More families agreed that each family member was given relatively equal focus when action methods were used. More adolescent IPs who were involved in action methods reported that they had an increase in family living skills. They indicated that their sense of being respected during the therapy process had a slight increase. There was also a stronger belief that the style of therapy delivered matched the needs of the adolescent and the family when action methods were used.

Activity is a function of adolescents (Carter and McGoldrick, 1980), and the use of action methods within the therapy process, rather than verbal methods alone, may facilitate engagement more readily in families with an adolescent. The engaged client will more likely experience being respected and empowered and thus be more willing to risk self within therapy. The potential for creativity is enhanced, and spontaneity emerges, which increases choices. The increase in choice options highlights distinctions that facilitate the change process.

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