Understanding the experience of families involved in family-based treatment programs

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Understanding the experience of families involved in family-based treatment programs

by

Sara Laurene Brandt-De Moss

A dissertation submitted to the graduate faculty in partial fulfillment of the requirements for the degree of DOCTOR OF PHILOSOPHY

Major: Human Development and Family Studies (Marriage and Family Therapy)
Major Professor: Harvey Joanning

Iowa State University
Ames, Iowa
2000

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This is to certify that the Doctoral dissertation of

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has met the dissertation requirements of Iowa State University

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CHAPTER I
INTRODUCTION

Adolescence has frequently been characterized as a period of turmoil and adjustment both for the child and family. The adolescent experiences changes in many areas including: cognitive development, self-esteem and identity, physical maturation, peer influence, sexuality and ego development. These changes often lead to delinquency, substance use, violence or family disruption, requiring therapeutic intervention. According to current literature, the prevalence of adolescents in the United States with serious emotional disturbance lies between 14% to 20% (Stroul, 1996; Pires & Stroul, 1996). Schools and court systems report feeling underprepared to assist these adolescents with their intensive and varied therapeutic needs. Juvenile courts in the United States handled more than 1.7 million delinquency cases in 1995. This figure represents a 7% increase since 1994 and a 45% increase since 1986 (Sickmund, et al., 1998) and indicates a critical need to examine the therapeutic services available to assist these adolescents and their families.

In 1984, the National Institute of Mental Health (NIMH) initiated a new federal program targeted at children with serious emotional disturbance. This program, called the Child and Adolescent Service System (CASSP) has been a major influence on the children’s mental health field stemming from policy and funding perspectives. CASSP is widely credited with creating the impetus which began to shift the way in which children’s mental health services were delivered (Stroul & Friedman, 1996; Lourie, Katz-Leavy, DeCarolis, & Quinlan, 1996) This paradigm shift moved the focus from treating the individual adolescent in a residential treatment setting to services which included the family and were offered in
the adolescent’s community. This change was largely prompted by the voice of families who felt ignored or blamed for their child’s difficulties and wanted to be included in the treatment process (Bryant-Comstock, Huff, & VanDenBerg, 1996; DeChillo, Koren, & Mezera, 1996; Karoloff, Friesen, Reily, & Rinkin, 1996; Tannen, 1996). Clinicians also reported dissatisfaction with the high level of adolescents who made changes while in residential care, but relapsed into old behaviors when placed back into the family system without therapeutic services for the family (Demmitt, 1994).

Consequently many social service programs have been created to address the needs of these adolescents, ranging from weekly outpatient therapy to residential treatment centers. These programs are described as family-based with varying degrees of family involvement in the treatment services. While this shift was made in response to practical concerns, clinicians have struggled to incorporate a collaborative approach with families in these treatment settings. Although active family participation has been endorsed by many programs, a great gap continues to exist between the intent to involve family members and the actual experiences of parents and professionals. Working from a collaborative approach is often different from the previous training experiences of professionals working in these systems and requires additional training and supervision to implement. A discrepancy in parent and professional viewpoints may cause conflict and hinder collaboration (Backer & Richardson, 1989). Collaboration may also be hindered by the family taking an overly passive or aggressive stance in their child’s treatment (Darling, 1988; Friesen, 1989). Often these stances are a result of previous negative experiences in which the families were not given the opportunity to collaborate and felt powerless and frustrated with the service
providers. Due to these obstacles, families report that they continue to be excluded or blamed as part of the problem (Lefly, 1989; Moroney, 1986). Thus, this approach to therapeutic services remains elusive to many mental health providers due to the complexity and balance which must be achieved for success.

While much theorizing has been offered in the literature, limited empirical research on working with families of adolescents has been conducted. The studies which have focused on adolescents serve primarily to understand adolescent development issues or adolescent in the family issues. Other research efforts have focused only on individual and narrow models of treatment for specific adolescent populations. From these studies, therapists are left to extrapolate how to best work with adolescents in family therapy.

Theories of family therapy also fail to take into consideration adolescent-specific issues. These theories often focus on processes happening in the family system or narratives being told by family members with little regard to the age of the family member. While the issues of gender and race have been acknowledged as important factors in the therapy process, little attention has been paid to specific developmental issues around age. Thus, clinicians attempting to provide family-based services for adolescents do so with minimal specific empirical knowledge or models which to follow.

In a recent publication, James Alexander (1999) asserts that the researchers contributing to the current literature have identified a small but well-researched group of family-based treatment programs. However, this literature focuses primarily on only two family-based programs: Multisystemic Therapy (MST) and Functional Family Therapy (FFT). Other programs which are identified, such multidimensional family therapy and
structural family therapy, target a specific and limited population such as adolescent drug
users (Liddle & Hogue, in press) or adolescents of a specific ethnicity (Alexander, Sexton.
& Robbins, in press). In Alexander’s article, support for these latter models are given
through citing a limited number of articles which are all currently in press. Alexander
reports that an article providing comprehensive evaluation and descriptive information for
family-based treatment programs will soon be available (Sexton & Alexander, in press).
Thus, with the exception of MST and FFT, the support that exists for family-based services
is primarily drawn from a small and currently unpublished base of empirical studies. For
example, at the time of this study, the author could only find eleven empirical studies of
adolescent family-based services in the professional literature. Eight of these studies
pertained to an ongoing research inquiry into the effectiveness of Multi-Systemic Therapy
(MST) (see Henggeler, et al., 1997). While several clinical qualitative and quantitative
outcome studies have been conducted by the MST researchers, they focus solely on the
MST model of therapy. Both the MST and FFT models target juvenile delinquent
adolescents only and do not provide information on services for treating adolescents with
other emotional and behavioral disorders. Thus, applied empirical knowledge and diversity
of models are not represented in the current literature.

Other studies focus on family involvement in a global or post-treatment perspective.
Based on a review of the literature, Kutash and Rivera (1996) tentatively conclude that the
family plays a significant role in the child’s outcomes after day treatment services. Several
studies have found that family motivation, family involvement, and family stability during
and after treatment were related to successful outcomes (Burns & Friedman, 1989; Cohen,
Kolers, & Bradley, 1987; Gabel & Finn, 1986; Sack, Mason, & Collins, 1987). However, these studies do not differentiate between adolescents and children nor do they study families specifically in the context of family-based services. Research is needed in this area to provide understanding of the needs of families with an adolescent, as well as to develop more diverse models of therapy which takes this empirical knowledge into consideration. Also missing, is process research focusing on the changes which occur for these families. Without such research, programs cannot effectively identify and elaborate on those areas which promote successful outcomes.

While many programs today include a family component, little attention has been paid to the experience of these families who participate in the therapeutic treatment of their adolescent (Demmitt, 1994). Except for practitioners' interpretations, it is not clear how clients themselves view family-based therapy. This missing information would provide empirical information as to the effectiveness of these services as viewed by the client. It is critical to know, for instance, the aspects of family-based therapy that clients find helpful, hindering, and unimportant. This information would be useful in developing accurate models to assist the therapist in working with adolescents and their families in family therapy. Practical utility would also be gained as clinicians begin to understand what is most and least helpful to assisting families with change. Only one empirical study of the client experience in family-based therapy was found by this author in the literature (Demmitt, 1994). This study examined specific experiences of families receiving services within a residential treatment program for purposes of program improvement.
Context of the Study

For this study, the author has chosen to focus on families of adolescents participating in a family-based intensive outpatient program. The program is short term, lasting between 6 and 12 months and provides services for adolescents from ages 12 to 18. In-home family therapy is conducted weekly and family collaboration is encouraged. The adolescents are also involved in group and individual therapy. Group therapy approaches are primarily cognitive-behavioral while the family and individual therapy is conducted according to the individual therapist orientation and needs of the family. Adolescents attend the program from 4pm to 8 pm Monday through Friday. Family Nights are held monthly and parents are welcome to sit in on their child’s group therapy at any time. This setting was chosen as this program format has become commonplace for the community-based treatment of adolescents. Ethnographic interviews will be used to understand the experience and process of change which does or does not occur for the family while involved in such a program.

Purpose of the Study

The following project attempts to develop a greater understanding of the provision of family-based services in an intensive outpatient program for adolescents. The focus of the study will involve attending to family experience to identify the change processes which do or do not occur. The information generated by this qualitative inquiry will be utilized to generate ideas for the development of a theory of adolescent-specific family-based treatment. In addition, this information will be offered to clinicians to inform current practices in adolescents in family therapy. Information generated by this qualitative study
will also be utilized to develop a meaningful quantitative assessment instrument for future outcome studies of adolescent family-based treatment programs.

Limitations of the Study

Issues which may limit the transferability of the study are:

1. Informant families interviewed in the study were families who had an adolescent involved in this particular intensive outpatient program.

2. Only qualitative data were gathered and examined for the study.

3. Informant families are primarily Caucasian from the Mid-western region.

4. The epistemology, values, and beliefs may bias the researcher’s perception of the subjects. The researcher’s biases which may have impacted this study include:
   A. The individual is the expert regarding her/his own experiences.
   B. Problems exists in relationships, not in isolation. Thus, to effectively treat the adolescent, one must work with their problem relationships.
   C. The truth is subjective to each person and does not exist independently. People co-construct problems and solutions through language and symbols.

Assumptions of the Study

1. The informant families included a range of families involved in this intensive outpatient program.

2. The focus of the study will generate new information regarding family involvement in adolescent intensive outpatient treatment programs.

3. The design of the study is deliberately subjective and qualitative.
Research Questions Posed by the Study

Based on the rationale discussed in the literature and the researcher’s native knowledge of the system, the following questions drive the inquiry. These questions are broad to encourage the exploratory nature of the evaluation (Cresswell, 1994; Fetterman, 1989).

The grand tour questions for this qualitative inquiry will be:

1. What is the experience of families involved in a family-based intensive outpatient program for adolescents?
2. How does the therapist perception compare with the experience of families involved in a family-based intensive outpatient program for adolescents?

The researcher will also utilize subquestions to gather information around the following questions:

1. Has change occurred for the family? What does this change look like?
2. How has family involvement impacted the treatment process?
3. What have been the barriers to progress? What has been helpful?
4. What has the family experienced as being helpful? Not helpful?

Summary

Chapter 1 describes the focus of the study and identifies factors which may impact the results. A review of relevant literature will be offered in Chapter 2 cumulating in a rationale and need for the study. The methodological design will be explained in Chapter 3. Chapter 4 will present the results of data collection and analysis. These results will be discussed in Chapter 5.
A shift from modern to postmodern thought has occurred over the last decade in the field of marriage and family therapy. Postmodernists believe that the world exists only as it is constructed through symbols such as language, behavior, and objects. As opposed to modernists, postmodernists do not presuppose that an objective reality exists which can be realized but rather believe that humans create their own reality. Thus postmodern theorists and clinicians do not present the therapist as the expert but rather as a facilitator, coach, or consultant to clients. The relationship between therapist and client is collaborative and mutually recursive with each bringing experiences and ideas to the table. Health and normalcy is defined by the postmodern theorist as being defined by the client with behaviors being evaluated on the basis of whether or not they are functional for that particular client. The client identifies the problem and the therapist and client work together in a mutually recursive manner to find solutions. Postmodern therapists are concerned with amplifying marginalized voices and working to rectify power imbalances. Postmodern suppositions primarily emphasize the social or relational creation or embeddedness of reality (Anderson, 1997).

While theory has shifted towards a postmodern orientation, research in the area of marriage and family therapy continues to be largely conducted from a modernist perspective. Theorists develop suppositions about change and systemic interaction based on clinical experience and findings in the scientific literature. However, few research endeavors or theoretical propositions emerge from a collaborative discourse between
professionals and clients. The experience of clients is largely ignored in developing outcome measurements or evaluations of therapy effectiveness. In addition, understanding client perceptions of treatment may lead to determining the most important aspects of treatment, as has been the case with group psychotherapy and research of this kind (Kivlighan & Mullison, 1988; Leszcz, Yalom, & Norden, 1985). In addition, there has been a call for research which includes multiple perspectives of clients and therapists (Moon, Dillon, & Sprenkle, 1990; Pinsoff, 1988; Wynne, 1988). In this way, a co-construction of narrative and experience is recorded which follows the suppositions of postmodern thought.

**Current Dialogue Examining Client Experience**

In conducting a review of the literature, this researcher found only eight articles examining the experience of the client in marriage and family therapy. Furthermore, only one of these articles looked at therapy services in the context of families with adolescents in therapy services and this project was undertaken as an evaluation of a specific residential treatment program resulting in poor generalizability. Co-creating the experience of the client comes from the tenets of postmodern thought informing some models of family therapy today. Postmodern models hold that the client and therapist actively create the client narrative or experience through symbols such as language and assigning of meaning to events. Clients are seen as being the expert on their own experience and the therapist serves as a consultant or facilitator rather than the expert.

In one article, a professor and graduate student teamed up to explore the experience of one couple in marital and family therapy to understand their perception of the therapy process (McCollum & Beer, 1995). This study was conducted to fulfill a dissertation
requirement. The article, written from the therapist's viewpoint, reflected on the results and process. The therapist comments on the vastly different viewpoints elicited between clients and therapist when reviewing videotapes of sessions with the researcher. Sessions which the therapist experienced as coherent, theoretically-based, and helpful, the clients saw as "corny" and "having a surface feeling." Results of the study indicate that the clients want direct advice from the therapist who they view as the expert. The clients felt they should defer to the therapist in the therapy sessions and wanted to know his opinions on their situation. Being understood was a powerful and healing element for the clients, much more so than techniques or theories followed by the therapist. The clients also resisted attempts at "solution-talk", reporting they felt the therapist did not understand the enormity of their problems. The female client expressed annoyance at being complimented and reported that focusing on "good times" did not make sense when a "bad time" had just occurred the previous evening. The writer suggests that "collaborative" therapy is not truly collaborative as clients' voices are not recruited to inform the therapy process.

Another study provided an ethnographic account of the experience of adolescent substance abusers and their families upon completion of therapy services at a university-based family therapy training clinic (Newfield, Joanning, Kuehl, & Quinn, 1991). A total of 12 families were interviewed who were predominantly white, middle-class, and had attended an average of 10 therapy session conducted by doctoral-level therapy interns. Seventeen adolescents including 10 males and 7 females were also interviewed. Seven domains of meaning were generated as follows: 1) expectations of counseling, 2) types of psychos and shrinks, 3) the setting, 4) individual versus family therapy, 5) characteristics of the counselor,
6) adolescent bullshitting, and 7) how counseling progresses. The researchers describe family therapy as an "ambiguous" experience in which the expectations and understanding of the client differs from that of the therapist in many regards. It is suggested that discrepant views may contribute to high dropout rates or lack of success. Participants' understanding of various disciplines in the mental health services sector was often quite different than that of the professionals and led to confusion and disappointment in some cases. Another finding is that adolescents were generally opposed to therapy, seeing it as unnecessary and invasive. Therapist characteristics identified with success included being caring and able to generate relevant suggestions for the client. The authors conclude, "Real understanding of families is but an illusion or delusion that we carry as part of our work." and "As a discipline, we understand very little about the people we work with." They suggest that therapists must be willing to be self-reflexive in their work with clients rather than clinging to models and theories as concrete objects rather than abstract thoughts in order to truly be effective.

In a similar study, (Kuehl, Newfield, & Joanning, 1990) twelve families presenting with an adolescent substance abuser were interviewed to develop a client-based description of family therapy. The sample consisted of families that were primarily white and middle class with varied family compositions. Five male and three female adolescent drug users ranging in age from 14 to 20 years old as well as their siblings were included in the study. Families were interviewed at approximately 51/2 months after completing the therapy process. Results indicate that families experienced the therapy process as occurring in the following stages: 1) introductory meeting, 2) assessment, 3) getting down to basics and
generating suggestions, 4) putting suggestions into practice, 5) sharing successes with the counselor, and 6) troubleshooting and follow-up. Adolescents described feeling scared and primarily listened and gathered information in the first three phases. Adolescents became more involved between sessions in phase 4 by trying to talk parents out of making changes. A significant decrease in drug use was reported by the adolescents in Phase 5 and the families reported feeling more comfortable with the therapist and therapy process at this stage. Other results of this study indicate that characteristics of the therapist are most closely linked to outcome of the therapy process. Specifically that clients that experienced their therapist as personable, caring, and competent were more satisfied than those who did not experience these therapist characteristics. Informants also suggested that therapists become "deaf" when the client does not adhere to the model from which the therapist is working. The clients experienced resistance on the part of the therapists who, at times, were not willing to accept the rejection of their suggestions by the client but continued to attempt to convince the client of the correctness of that perspective.

Gaddis (1998) conducted an inquiry into the experience of one client involved in a narrative therapy experience. This study was undertaken to fulfill a thesis requirement at the M.S. level. The data was collected by the Interpersonal Recall method (IPR) in which the client comments on a videotape of her therapy session with the researcher present. This study yielded 152 bits of data which were utilized to provide a description of this client's experience. The researcher reports that the data supported many of the suppositions of narrative therapy but also found that there are inherent risks to the client involved in this type of therapeutic encounter. Limitations of this study include a sample of only one
Demmit (1994) examined the experience of parents with an adolescent in residential placement. This study was utilized to fulfill a dissertation requirement at the Ph.D. level. The study was conducted as an evaluation of the experience of parents involved in this particular treatment program and was presented from a consultant role rather than that of an ethnographic inquiry. Thus these results are limited to the families involved with this particular program as well as those families willing to participate when much time and effort was required. In addition, the researcher also served as the family therapist for some of the participants. Results indicated that families do want to be involved in their child’s treatment but often feel blamed and excluded by the professionals working with their child.

Springer and Stahmann (1998) explored the use of telephone therapy with parents of children in residential care through a 21-item survey. The results indicated that parents of adolescents in residential treatment facilities viewed telephone family therapy as effective in helping family communication and functioning when therapist, parents, and adolescent were all included in calls. The researchers note that this was not an outcome study as it did not measure actual change but rather the perception of change. However, they also note that the perception of change is critical in the change-and-outcome process (Watson, 1992). Limitations include generalizability to other residential settings as well as usefulness of telephone family therapy in other situations.

Bischoff and McBride (1996) examined client perceptions of couples and family therapy by videotaping therapy sessions and reviewing these with clients who were asked to
identify both helpful and unhelpful aspects of therapy. Three thematic categories emerged from this data: 1) respect for the hierarchy inherent in the therapeutic relationship, 2) importance of therapist empathy, and 3) perceived helpfulness of various thematic therapeutic techniques. These researchers found that the hierarchical relationship between therapist and client was important in couples and family therapy but only when the therapist expressed empathy, understanding, and mutuality in the therapist-client relationship. The researchers suggest that this finding may indicate that collaborative therapy approaches may be merely a conceptual idea which is not born out by data. Another important result identified by the researchers is that clients are able to provide valuable information about the process of therapy. Limitations of this study greatly restrict its applicability as clients were seen by doctoral level students in a university-based clinic. Also, interviews were conducted by the therapists rather than an independent interviewer and may limit the depth and truthfulness of information collected.

In a similar study, Sells, Smith, and Moon (1996) examined both client and therapist evaluations of therapy services conducted in a university training clinic by doctoral level students. The researchers sought to identify both similarities and differences in perceptions and judgments from client and therapists. Domains of meaning which emerged were 1) changes associated with counseling, 2) important therapist qualities, 3) effective interventions or techniques, 4) ineffective interventions or techniques, 5) recommendations for future sessions, and 6) ethnographic practice evaluation. Results found that clients emphasized the importance of therapeutic alliance while therapists emphasized the use of formalized techniques. Both clients and therapists saw clear treatment goals as important to
success as well as the helpfulness of homework assignments. The use of ethnographic techniques led to immediate feedback for therapists which they reported was useful. Clients and therapists liked the collaborative atmosphere created by ethnographic research. This study utilized therapists to conduct their own interviews in one group while the researcher conducted the interviews in another group. Both therapists and clients felt that an outside person would be better to conduct the interviews.

In summary, the current literature on client experience is sparse but indicates that clients' perceptions often differ from that of clinicians in terms of their therapy experience and factors which effect therapy outcomes. While clinicians tend to focus on theoretical models and techniques, clients reported that factors such as the therapeutic relationship and therapist characteristics were the most important in determining their experience of the therapy process. Thus, the literature supports the value of asking clients about their experience of therapy and utilizing this information to better inform current knowledge of therapy effectiveness.

Process Research

Research in the field of marriage and family therapy has traditionally been conducted in the standard empiricist method informed by the identification and measurement of specific static variables. As the demand for outcome research began to grow due to social and political pressures, researchers attempted to conduct such research through static measures which compared results with pre and post test measures. Evaluation largely consisted of outcome research designs that compared overall effectiveness of two or more therapy models but failed to provide information within a particular model which led to
change (Gurman, 1987; Liddle, 1991). Family therapy clinicians and researchers have called for methods to systematically assess, monitor, and evaluate therapy practice in a process oriented manner which allows for the identification of specific change processes (Atkinson & Heath, 1987; Liddle, 1991; Wynne, 1988).

In a review of the literature on family therapy studies from 1980 to 1987, Bednar, Burlingame, and Masters (1988) concluded that the rigorous experimental outcome studies were premature for a discipline that had not yet operationalized essential areas of effectiveness within existing family therapy models. This finding calls for exploratory, discovery-oriented process research studies to identify the factors in therapy sessions which impact therapy effectiveness (Moon, Dillon, & Sprenkle, 1990; Pinsof, 1988; Wynne, 1988). Over the last two decades, a shift has occurred in the use of process research towards focus on the mechanisms of change. Much of this shift was made possible by the acceptance of recording devices in therapy sessions for the purposes of training and research.

Process research varies from traditional empirical research by attempting to understand processes through the framework of three concepts: activity over time, directional change, and movement towards completion (Pinsoff & Greenberg, 1986). Research in the area of therapy efficacy in past decades had been largely limited to outcome studies with little identification of change processes which led to the outcomes obtained. Process research allows researchers to identify the specific mechanisms of change which lead to the outcomes obtained rather than blindly presenting only outcome data. Thus, both
process and outcome research linked together, provide a clear description of varied aspects of the therapy experience and result in a more complex explanation of the therapy process.

In summary, process research is needed to assist in developing an understanding of how change occurs. Combining this information with outcome data allows a comprehensive picture of what is most beneficial to clients to emerge. Thus, conducting research on the client experience of therapy at multiple time points will assist in understanding how clients view the mechanics and process of change. This process research approach gives much more detail about what occurs in the therapeutic context that is most and least helpful to clients. This information can greatly enhance current understanding and beliefs about change in the therapy context.

Current Research

Rigorous program development and evaluation of adolescent family-based programs have been conducted primarily by researchers at the Family Services Research Center on Multisystemic Therapy and the Oregon Social Learning Center. Functional Family Therapy has also been developed and tested as a model with some success indicated in working with families with adolescents. A brief explanation of the work in each area along with the primary researchers and their works will be presented. Results of research on the evidence for including families in adolescent treatment is also presented. Both of the therapy models presented below are based on the cognitive/behavioral model of therapeutic intervention. The cognitive/behavioral approach combines the cognitive restructuring activities proposed by Ellis while behavioral models focus on operant and conditional learning proposed by Skinner and Watson in the field of psychology.
Multisystemic Therapy

Multisystemic therapy (MST) is an intensive family-based therapy model that addresses the known determinants of serious antisocial behavior in adolescents and their families. MST treats those factors in the youth's environment that are contributing to his or her behavioral problems. Such factors might pertain to individual characteristics, family relations, peer relations, and school performance. This model was developed based on the premise that correlates of delinquency are consistent with the social-ecological model which represents the theoretical foundation of MST (Henggeler & Boudin, 1995). On a highly individualized basis, treatment goals are developed in collaboration with the family and family strengths to create change. Specific interventions used in MST are based on empirically validated treatment approaches such as cognitive-behavior therapy and pragmatic family therapies. The primary goals of MST are to reduce rates of antisocial behavior in the adolescent, reduce out-of-home placements, and empower families to resolve future difficulties. The family preservation model of services delivery is utilized with low caseloads, home-based services, and time-limited duration of services.

Rigorous evaluation has been conducted of the MST model primarily by a group lead by Henggeler and Boudin. In 1995, Henggeler and Boudin (1995) reported that rigorous outcome studies had been conducted and indicated positive treatment outcomes. The samples were composed primarily of multi-problem families, many of lower class, minorities, and single parents. An initial treatment evaluation (Henggeler, et al., 1986) focused on inner-city delinquents who were predominantly male, black, lower-class, repeat offenders whose fathers were not present. These adolescents presented with a variety of
behavior problems. The effects of MST were compared to the effects of the usual services provided in the community (i.e., mental health, educational, vocational, recreational).

Subjects included 57 juvenile offenders in the MST condition and 22 juvenile offenders who received some alternative community-based treatment. In addition, 44 non-offending adolescents served as developmental controls. The outcome data were derived from pretreatment and post-treatment assessment sessions involving standardized evaluations including personality inventories, behavior ratings, and self-report. Adolescents in the MST condition had decreased behavior problems and decreased association with deviant peers. In addition, their families showed an increase in warmth and affection. Youth in the comparison group showed no changes in behavior problems while their families showed deterioration in warmth and affection. The non-offender families showed appropriate developmental relationship changes.

The Family and Neighborhood Services Project focused on violent offenders and utilized community-based masters level therapists in the MST condition (Henggeler, et al., 1986). Eighty-four offenders at risk for incarceration were randomly assigned to receive either MST or the usual services of the juvenile justice system. Results, based on arrest and incarceration data collected at an average of 59 weeks following referral to the project, found that adolescents in the MST condition had significantly fewer criminal charges (1.20 vs. 2.48) and arrests (0.87 vs. 1.52), a significantly lower recidivism rate (43% vs 67%) and significantly less time in out-of-home placements (5.8 weeks vs 16.2 weeks). Thus, the researchers concluded that MST was more effective and less expensive than usual services. The results of a 2.4-year follow-up (Henggeler, et al., 1993) indicated that the adolescents
in the MST condition were twice as likely to not be re-arrested as compared those in the usual services condition.

In another study (Borduin, et al., 1990) 210 chronic juvenile offenders were randomly assigned to either an MST or individual therapy condition. The average age of the adolescents was 14.7 years. 67% were male, 67% were Caucasian, 32.2% were African-American, 65% were from families with low socioeconomic status, and 50% lived with two parental figures. Pretests, posttests, and follow-up treatment assessments of the individual functioning of family members, family relations, peer relations, and school performance were conducted. Standardized instruments were used to assess the perspective of family members and teachers, while measures of family interaction were obtained. A multivariate analysis of variance was conducted for data analysis. Adolescents in the MST condition had fewer behavior problems, parents self-reported decreased psychiatric symptoms, and considerable evidence of positive changes in family relations emerged. Family changes included increased family adaptability and positive communication with decreased conflict and hostility. In contrast, such changes did not appear for adolescents or their families in the individual therapy condition. Rates of recidivism at four years indicated that 22% of adolescents in the MST condition had been re-arrested, in contrast to 72% of the adolescent in the individual therapy condition. Even comparing adolescents who dropped out of the study early, a lower rate of recidivism was found for the MST condition than those adolescents in the individual therapy condition (47% vs 72%).

In another study, 84 serious juvenile offenders were randomly sorted into an MST group and comparison group receiving the usual services through the Juvenile Court
System (Henggeler, Melton, & Smith. 1992). The average age of participants was 15.2 years. 77% were male, 56% were African-American, 42% were Caucasian. 2% were Hispanic. 26% lived with neither biological parent and most came from lower to lower-middle class households. A multivariate analysis was used to determine significant effects. At post-treatment, the MST adolescents were less likely to have serious criminal charges than the comparison group. At a 59-week follow-up, adolescents in the MST group had significantly fewer arrests than did the comparison group (.87 vs 1.52). The MST adolescents also reported a significant reduction in criminal activity than did the comparison group. Families with an adolescent in the MST condition reported increased family cohesion and decreased adolescent aggression with peers. Families with adolescents in the comparison group experienced a decrease in family cohesion and no significant change in adolescent aggression with peers. Another follow-up at 2.4 years, indicated that adolescents in the MST group approximately doubled the chances of avoiding re-arrest as opposed to the comparison group. The efficacy of MST was not moderated by demographic or psychosocial variables.

The Missouri Delinquency Project (Borduin, et al., 1995) examined the long-term effects on multisystemic therapy on the prevention of criminal activity in serious juvenile offenders and built on work already conducted in this area (Henggeler & Borduin, 1990). This study was significantly improved over past studies by: 1) a larger sample size to permit subgroup comparisons, 2) longer follow-up period, 3) observational measures of family relations and, 4) a comparison group. Two hundred families with a 12-to 17-year old adolescent offender were referred by Juvenile Court. Because 24 families dropped out after
pretest. 176 were randomly assigned to the MST or individual therapy conditions. Standardized outcome measurements were used to measure individual adjustment, family relations, peer relations, and criminal activity. Repeated measures multivariate analysis of variance (MANOVA) and ANOVA's were used to evaluate whether significant changes between pre and posttest measurements occurred. Results indicate that in the MST condition the following were found: 1) increased family cohesion and adaptability, 2) increased family supportiveness, 3) decreased conflict/hostility between family dyads, 4) decreased symptomology in parents (by self-report), and, 5) decreased behavior problems with the adolescent. Most significantly, MST produced long-term changes in these adolescents as they were significantly less likely to be re-arrested than comparison adolescents within 4 years after treatment. If the MST adolescents were re-arrested, the nature of their offenses were less serious than those adolescents re-arrested in the comparison group. The relative efficacy of MST was not moderated by measured demographic characteristics suggesting that MST is equally effective with youths and families of divergent backgrounds. Favorable changes in the adolescent's peer relations did not change in either group. However, a similar study (Henggeler, et al., 1997) found that findings for decreased criminal activity were not as favorable as previously when treatment fidelity was not checked.

In a study conducted by Henggeler et al. (1992) through a community mental health center, violent and chronic juvenile delinquents were randomly assigned to receive MST or the usual services provided by the juvenile court services. At posttest, adolescents in the MST group reported less criminal activity and their family members reported greater family
cohesion and reduced adolescent aggression than did the control group receiving usual services. The participants ranged across gender, race, and socioeconomic class with no differences found. In a follow up at 59 weeks, the adolescents in the MST condition had significantly fewer re-arrests (.087 vs 1.52) and weeks of incarceration (5.8 vs 16.2). At a 2.4 year follow up, the adolescents in the MST condition continued to have lower re-arrest rates than did their counterparts in the usual services group.

In a university-based study, Borduin et al. (1995) randomly assigned 200 juvenile offenders to individual outpatient therapy or MST. At posttest, adolescents in the MST condition had significantly decreased psychiatric symptoms and families were more cohesive, adaptable, and had improved communication in comparison with the individual therapy group. At a 4 year follow up, adolescents in the MST condition had a significantly lower recidivism rate (22%) than individual therapy adolescents (72%).

In a more recent study, Henggeler et al. (1997) conducted a randomized study through a community mental health center to determine key features of the MST training protocol that are critical to success. Two hundred juvenile offenders and their families were randomly assigned to MST or the usual juvenile justice services. While the MST participants showed decreased symptomology at posttesting and decreased incarceration at a 1.7 year follow up, the 26% reduction in re-arrest was not significant in contrast to the findings of prior studies. Analysis of treatment adherence indicated that therapist adherence to MST treatment principles was an important predictor of long term reduction in criminal activity and incarceration.
Outcome studies for MST have also been conducted with special populations of interest such as substance abusing adolescents, abused children, and children with medical problems (See Henggeler & Borduin, 1990). However, as these topics are not specifically being addressed in the current study, these studies have not been included.

**Functional Family Therapy**

Functional Family Therapy (FFT) is an empirically grounded, family-based intervention program for youth with behavioral problems. The program was initially developed to treat middle-class white families with delinquent and "pre-delinquent" youth but has recently included poor, multi-ethnic populations with multiple problems. A major goal of Functional Family Therapy is to improve family communication and supportiveness while decreasing the intense negativity so often characterizing these families. Family members learn to identify and communicate needs, find solutions to family problems, and create behavior change. This program was initially administered in a clinical setting but more recently moved to home-based delivery of service in some areas. Research focuses on two primary areas: skills of the therapist and family assessment. Therapists must possess a high level of both structuring and relationship skills in order to effectively help families in the therapy process (Alexander & Parson, 1982). Relationships skills are particularly important during the therapy phase whereas structuring skills are primary during the education phase. Therapists who are strong in only one set of skills often only have success in one phase which does not allow the therapy process to be effective. Alexander and Parsons (1982) conclude that treatment fidelity and therapist characteristics are of primary importance in providing effective therapy with the Functional Family Therapy model.
Under the area of family assessment, families are rated on three levels: 1) relationship level, examining interdependent properties of the family, 2) functional level, identifying adaptive or maladaptive reoccurring outcomes of family members' behavior, and 3) individual educational level, assessing distinct behavioral, emotional, or cognitive changes that are structured and maintained by each family member. Thus assessment and intervention in Functional Family Therapy are interrelated and ongoing.

A randomized evaluation of FFT was conducted with 86 families of adolescent offenders who were referred by juvenile court and had complete file data (Alexander & Parsons, 1973). Thirty families were assigned to either client-centered or FFT treatment, and the remaining families were assigned to a wait-list control group. Recidivism rates indicated a significantly better outcome for those families in the FFT group (26%) than those in the client-centered (47%) or control (73%) group. This study did not give baseline arrest rates which prevents comparison across groups and diminishes the value of the study.

Oregon Social Learning Center

While the Oregon Social Learning Center is not known for a specific model of family-based therapy with adolescents, it does serve as a research center on the issues at the core of this type of therapy program. The Oregon Social Learning Center is a non-profit, independent research center with the goal of finding ways to help children and parents as they cope with day-to-day problems which arise. Their research focuses mainly on factors related to the family, peer group, and school experience which contribute to healthy social adjustment in key settings, including the home, school, and community during childhood, and the workplace, intimate relationships, and parenthood during adulthood. The
researchers also work to identify factors which lead to problems at different stages of life, such as temper tantrums and misbehavior in childhood, delinquency and substance use in adolescence, and failed relationships in adulthood. Much of the work done by these researchers is informed by Family Systems Theory which posits that family members behave in interactional patterns in which the behavior of one affects all other family members as well. Since 1990, these researchers have also served as the Oregon Prevention Research Center which addresses issues of prevention of antisocial behavior problems during childhood. The work at these two centers is supported solely by federal research funds, grants from private individuals and foundations, and state and local service contracts. The centers are particularly known for: 1) direct observation of child and family social interactions in home, school, and community settings, 2) identifying family and peer group social interaction patterns and other factors related to the development of aggressive behavior, 3) designing and implementing interventions for children and parents to help encourage successful adjustment and discourage aggressive behaviors within the family, school, and community, 4) applying advanced statistical methodology to the analysis of longitudinal data on child and family processes and outcomes, and 5) developing and improving child and family assessment techniques. Data collected during the center’s longitudinal studies represents work with more than 2,400 local families. Research is often drawn from the existing database and data sets are consistently retained for future use.

While much of the findings emerging from the research efforts at the Oregon Social Learning Center contribute indirectly to our understanding of developmental, issue-specific,
and relationship issues, this review will focus only on those studies directly examining the
evaluation of mental health service provision to adolescents and their families.

In 1991, a study was conducted in which 22 families of chronically offending
juvenile delinquents were randomly assigned to parent training treatment (PTT), or to
service traditionally provided by the juvenile court and the community (Bank, Marlowe,
Reid, Patterson, & Weinrott, 1991). The sample consisted primarily of white, middle class
families with a male adolescent delinquent. Offense rates, institution time for the
adolescents, and prevalence rates for police contact were compared using multivariate
analysis. Results indicate that the PTT families exerted quick and effective control over
their sons' delinquent behaviors. Relative to the control group, PTT families were able to
establish control with significantly less reliance on incarceration. Thus, the effectiveness of
parent training treatment was supported with chronic delinquent adolescents. The
researchers found, though, that clinical work was extraordinarily difficult with these
families.

A scattered body of studies with encouraging results regarding the identification of
youths at risk for delinquency existed in the early 1980's. Loeber and Dishion (1983)
conducted a review of these prediction studies which identify both individual characteristics
and social variables which impact occurrence of delinquency. The specific number of
studies reviewed is not given but in excess of 20 studies are cited. Criteria for inclusion
included: 1) predictors must have been taken at least a year prior to the measurement of the
outcome of delinquency, 2) must use objective firsthand predictors, 3) both retrospective
and prospective data were included, and 4) personality tests to identify youths at risk were
not included. The review focused on males but included studies on mixed gender populations. Studies solely on the female population were not included. Predictive factors identified were: 1) child’s problem behavior between ages 6 to 9 years increased substantially. 2) assessments done by multiple assessors were more accurate. 3) aggression during ages 9 to 15 years. 4) children who are daring or disobedient are often also aggressive. 5) antisocial or predelinquent behavior at the age of 12 to 14 years. 6) incidences of stealing from ages 5 to 15 years indicate a high chance of recidivism. 7) youths involved in stealing are also likely to be involved in other covert acts such as lying, wandering, or truancy. 8) dishonesty by age 10 and truancy by age 12. 9) at age 18, fighting after drinking alcohol was predictive of delinquency while self-reported aggression was predictive of delinquency. 10) youths committing property offenses are have a higher rate of recidivism than those committing offenses against people. 11) association with delinquent or deviant peers even at an earlier age is a predictor of delinquency. and 12) low academic achievement. Social or situational variables found to be predictive of delinquency are: 1) low socioeconomic class of family, 2) delinquency of other family members, 3) lack of parental discipline, supervision, and structure in the home, and 4) certain families are more at risk for delinquency than other families. The authors found that many of the studies lack multiple criterion for comparison and comorbidity purposes which limit their usefulness.

A developmental model of antisocial behavior was suggested in an article by Patterson, DeBaryshe, and Ramsey (1989) which offers evidence for the hypothesis that a specific route for chronically delinquent behavior exists. This route begins first with ineffective parenting practices which lead to child conduct disorders. Contextual variables
which influence the family interaction process are also considered. These conduct-disordered behaviors lead to academic failure and peer rejection which in turn lead to an increased risk of depressed mood and involvement in a deviant peer group. The authors conclude that efforts at intervention and prevention should be aimed at assisting parents with effective parenting practices when children are younger and including a focus on academic achievement and peer issues with older children.

Reid and Patterson (1989) continue with the theme of the previous article by asserting that although such factors as parent criminality, social and economic disadvantage, child temperament, and marital discord systematically affect the development of antisocial behavior, their influence is mediated by the extent to which they disrupt day-to-day parenting practices. These authors assert that irritable, ineffective discipline and poor parental monitoring are the most influential determinants of the early development and maintenance of antisocial behavior.

A study examining the family experience in preadolescence and later development of delinquency was conducted by Coughlin and Vuchnich (1996). Participants were 194 families with one male child in the fourth grade in the first year of the study. Mean age of the boys was 9.7 years. Participants were almost entirely Caucasian with at least one parent unemployed in one third of the cases. Families were recruited from neighborhoods with high levels of delinquency according to police records. The sample included 80 two biological parent families, 55 single-mother families, 11 single-father families, and 59 stepfamilies. Effects for quality of parent-child relations, parental discipline practices, family structure, and family problem-solving were found. Intelligence, socioeconomic
status, and peer relations were used as controls. Being part of a single-parent or stepfamily more than doubled the risk of delinquency that began by age 14 but did not increase the risk between ages 14 to 17. The increased risks associated with poor peer relations and antisocial characteristics were constant across family structures. Effects of family problem-solving were found only in single-parent and stepfamilies.

In a review of the current literature on female delinquency, Hoyt & Scherer (1998) report that the studies on delinquency focus primarily on males with little attention focused on differences of delinquent females. While this review provides many citations, the authors do not report how many articles were reviewed or from where they were drawn. Females respond to therapeutic placement differently than males. The authors report that while males tend to respond with steady improvement after a troubled start, females appear to begin quietly and then express more problem behaviors. The authors suggest, therefore, that treatment strategies used for males may not be appropriate for use with females. While intervention programs are available, female delinquents are more likely to receive intervention focused on acting out behaviors rather than the internalizing concerns that are potentially more important. In this article, existing theories and research on female delinquency in the literature are critiqued. The authors report that empirical studies and theoretical development regarding female delinquency is scarce. They report that these studies are hampered by biased sampling, inadequate sample size descriptions, measurement inadequacies, and design restrictions. This article goes on to review current studies which provide data about factors contributing to the etiology of female delinquency or test a theoretical perspective on female delinquency. Factors found to be associated with female
delinquency include: 1) abuse as a child, especially sexual abuse, 2) family processes such as multiple family disruptions, poor parental supervision and monitoring, marital discord, and lack of economic opportunity, 3) exposure to family violence and parent criminality or antisocial personality, 4) parent controls are more effective for females in late adolescence as opposed to males in middle adolescence, and 5) lack of parental acceptance and high conflict with parents. The authors conclude that the issue of female delinquency requires greater scrutiny and empirical study to meet the specific needs of female delinquents.

In summary, while several researchers have developed an empirical link between disturbed adolescents and their family context, less research has been conducted in applying this knowledge. While both the MST and FFT models of family-based treatment for adolescents have been empirically supported, a diversity in such models is lacking. In addition, these family-based treatment programs focus primarily on juvenile delinquents and do not account for adolescents who suffer from emotional or behavioral problems but are not juvenile offenders. Thus, additional research in the area of family-based adolescent treatment models is needed to develop a more diversified field of options which meet the needs of a broader range of adolescents.

**Adolescent Development**

As people move from childhood, through adolescence and on to adulthood, they undergo a variety of changes. These changes occur across several areas and encompass a variety of spectrums. A brief review of the changes which occur will be presented as well as an overview of these developmental processes in the family context will be offered.
Developmental Stages

Adolescents cannot developmentally be grouped as a whole due to the significant number of changes they undergo while crossing through the bridge of adolescence. Weiner and Elkind (1972) suggest that adolescents go through three stages: 1) early adolescence, corresponding primarily to the junior high years, 2) middle adolescence, referring primarily to the high school years, and 3) late adolescence, beginning in the last year of high school until the person creates the self-identify of an adult. As any causal observer could report, adolescents at each of these stages is vastly different in their physical, emotional, cognitive, social abilities and focus. Thus, recognizing these divisions allows a deeper understanding of the development of the process of moving from childhood to adulthood.

Erik Erikson, a well-known psychoanalyst, proposed that humans go through eight stages of psychosocial development throughout the lifespan. Within each stage is a crisis that must be overcome. He focused much attention on the onset of adolescence when many biological, cognitive, and personality changes are occurring. Erikson called this stage Identity versus Identity Diffusion. In this stage, adolescents struggle to integrate basic needs with the changes which have occurred. If successful, this process leads to a sense of ego identity or understanding of who one is. If not successful, role diffusion occurs in which youths do not know who they are to themselves or others. This may lead to an overreliance on peers, intolerance of others, and conflict with parents, siblings, and peers. This stage has the ability to greatly impact future adult functioning in many ways.
Cognitive Development

Much of the basis for our understanding of cognitive development stems from the work of Jean Piaget. While much of Piaget's work was observational and required additional empirical confirmation, this work has greatly influenced our understanding of how human beings grow from infancy to adulthood. In the area of cognitive development, Piaget suggests that cognitive development occurs in stages, each stage representing a new manner of cognitive functioning. Piaget suggests the following stages: 1) preoperational stage, 2) concrete operations (ages 7 to 11 years), 3) early formal operations (ages 11 to about 14 years), and 4) late formal operations (ages 15 to 19 years) (Dacey & Kenny, 1994).

While adolescents are most likely to be in the last three stages, the manner in which the child is able to cognate is vastly different in each stage. Specific processes that are affected include perception, learning, reasoning, problem solving, and language (Weiner & Elkind, 1972). An adolescent in concrete operations becomes concerned with why things happen and gains elementary logic skills. The concrete operational child does not consider possibilities that are not real. Children at this stage develop an understanding of rules and may believe that rules must be followed at all costs. These children are also able to develop understanding of the concept of causality. Children in this stage are able to perceive more and organize more complex stimuli than younger children found in the preoperational stage. Adolescents in the concrete operations stage focus on the observable or "concrete" issues. These adolescents are often curious, absorbed, and mentally active as they develop these new mental capabilities. The tools of thought are assembled but still need the refinement that takes place in the formal operations stage.
Piaget postulated that the stage of formal operations occurred when the adolescent could begin to consider the form an argument could take rather than just focusing on the content. Piaget suggested that formal operations consists of four major aspects of human thinking: abstract thinking, logic, metacognition, and hypothetical reasoning. Adolescents in the early formal operations stage begin to understand abstract thought. These adolescents start to understand the complexities of symbol systems and language capabilities. For these adolescents, thinking skills become much more orderly and systematic. Adolescents in the early formal operations stage begin to think about their thinking. They are able to understand that they may have motives for their behaviors and can analyze their own thoughts. These adolescents can retrace the process of their thoughts when decision making and can identify thinking errors. Lastly, these adolescents are able to think about facts which may only be hypothetical and do not have data present to support them. They develop the capability to logically evaluate such possibilities even when they cannot exist. Thus, adolescents in the early formal operations stage are able to be introspective, plan ahead, consider and incorporate various beliefs, consider alternatives, and test hypotheses. While adolescents in the early formal operations stage have many of the same tools as adolescents in the late formal operations stage, they are not as sophisticated in their use of these tools.

For adolescents in the later formal operations stage, abilities are used more quickly and new skills are mastered. These adolescents become able to comprehend systems of symbols as in trigonometry or notations on musical notes. They become sophisticated in understanding religious and political symbolism. They problem solve more quickly and
effectively and become capable of finding problems as well. These adolescents begin to understand propositional logic rather than just the basic rules of logic. These abilities lead to more complex use of thought. These adolescents are better at looking at their thinking and finding the errors they have made. They can notice patterns in their thinking and adjust accordingly. A significant change is the adolescents' ability to think through problem solving in a scientific way. They look for alternatives and are able to keep bias from forming their answers. They establish a plan to solve problems and can consider multiple sources of information. Adolescents in formal operations are able to think beyond what they can see or are told. They can think about thinking, about why they and other people believe what they believe, and understand simile and metaphor. The adolescent becomes capable of self-reflection about him or herself and may begin to question or change previous behaviors. These stages have profound implications for therapists working with adolescents in the family therapy setting.

Another related concept worth mentioning is that of social cognition. This construct occurs when adolescents begin to think about how they relate to others. This stage usually begins to occur in early adolescence but becomes more pronounced in the middle adolescent years (Dacey & Kenny, 1994). An important aspect of social cognition is the formation of egocentric thinking when the adolescent begins to think more about her or himself and their behaviors as if they are on stage. This change in thinking leads to two related constructs: imaginary audience and personal fable. Imaginary audience occurs as the adolescent perceives that other people are also preoccupied with the adolescent's thoughts and behaviors which creates additional self-consciousness. Personal fable is the
adolescent’s personal feelings of invincibility and uniqueness which lead to increased risk taking. Each of these constructs may lead to the adolescent’s increased concern with peer acceptance or lack of concern about consequences of serious behaviors.

Identity Development

William James laid the foundation of our current thinking about identity development with his model of the self. James suggested that self-concept, or the “me” is how we think about our physical, social, and psychological qualities. Other thoughts and beliefs about how one changes over time yet remains the same individual, is called the “I”. This set of beliefs is important to a person’s self-identity. The development of a clear, realistic, and integrated self-concept becomes the basis for identity development.

Development of self-identity for adolescents is impacted by the changes experienced in cognitive development as discussed in the previous section. Harter (1990) suggests that four changes in self-concept occur during adolescence which contain emotional risks. The first is the development of abstract thought. In early adolescence, the person may describe himself by only his physical characteristics that can be seen. However, as abstract thought develops, the adolescent is more likely to begin to define himself according to internal personal characteristics such as wishes, motivations, and emotions. These assessments are more difficult to confirm or disconfirm than are concrete characteristics and thus present more risk for some adolescents who develop unrealistic self-concepts. The second change in the differentiation of the self-concept as the person enters adolescence. Early adolescents describe themselves as having a larger number of roles than do younger children. These adolescents begin to view themselves differently in each role. Thus the problem for the
adolescent becomes deciding who is the real self. Harter (1990) suggests that persons in middle adolescence are most likely to be troubled by conflicting views of self. Cognitively, they can realize that they behave differently with different people but don't understand why. As adolescents age and their cognitive skills develop further, they begin to understand that it is normal to behave differently with different people. A third change is the development of the ideal or imagined self-concept. Adolescents develop their idea of what they would ideally like to be. Problems can arise when this ideal self and actual self are very different. This discrepancy can lead to anxiety, depression, or disappointment in oneself. This difference tends to be greatest in mid-adolescence as the ideal self is often unrealistic due to egocentric thinking. The last change is the development of introspection where the adolescent begins to question who she is. These adolescents may become very concerned with what others think of them and may have difficulty separating their views from that of others who influence them.

A strongly related concept to self-identity is that of self-esteem. While self-identity identifies who the person is, self-esteem assess if the person likes who they are. Thus self-esteem is part of self-concept. A well-defined self-concept leads to high self-esteem which in turn often leads to successful behavior (Rosenberg, 1985). Self-esteem is linked strongly to adolescent motivation towards success, achievement, and mental health (Darcey & Kenny, 1994). Adolescents with high self-esteem often do well in school (Bell & Ward, 1980) and have an internal locus of control (Rosenberg, 1985). However, increases in life stress can result in lowered self-esteem leading to emotional and behavioral disorders. Adolescents generally build self-esteem by doing well in areas important to that person as
well as the perception of what others think of the adolescent (Harter, 1990; Rosenberg, 1979). Adolescents who feel that the people around them like them, will also like themselves. During adolescence, the opinion of peers is very important while the importance of parent’s opinions remain important but less so than for children. In early adolescence, self-esteem relies heavily on the opinion of others, however, this effect decreases in later adolescence. Self-esteem often is lowest at ages 11 to 13 years, possibly because of all the changes the adolescent experiences at these times (Petersen, Kennedy, & Sullivan, 1991). In addition, adolescent girls are more likely to experience a greater loss of self-esteem than are adolescent boys (Rosenberg & Simmons, 1972). The strength of the decrease in self-esteem is also linked to the timing of school transitions and physical maturation (Brooks-Gunn & Peterson, 1983). Thus, fluctuations in self-esteem have many sources and can profoundly affect the identity development of adolescents.

**Personality Development**

The study of personality across the lifespan has significant implications for developmental studies of children and adolescents. Longitudinal research findings suggest that temperament in early life can be predictive of later personality traits and subsequent concerns (Rothbart & Bates, 1998). Early emerging differences on the dimensions of ego control and ego resiliency are often correlated to problem behaviors later in life. For instance, preschool boys rated as highly impulsive were significantly more likely to self-report antisocial behavior in late childhood and early adolescence (Block, 1995). Silva (1995) found that at ages 3 and 5 years, boys and girls rated as impulsive, irritable, and distractible, upon reaching late childhood to middle adolescence, had more behavior
problems including externalized symptoms of conduct disorder, hyperactivity, and inattention. Caspi, Henry, McGee, Moffitt, & Silva (1995) also found that shy, fearful, and passive children, especially girls, were more anxious and inattentive in adolescence. Bates (Bates, Bayles, Bennet, Ridge, & Brown, 1991) found that management problems in infancy were associated with later externalizing problems. Mothers were able to predict, based on their child's emotionality, the amount of externalizing and internalizing behaviors their child demonstrated at older age (Rende, 1993).

While these results have profound implications for the study and prediction of child development. Caspi (1998) warns that these studies must be examined in the light of their many limitations. Many different temperament scales and different outcome measures are used in various studies which makes comparison and accurate identification of disorders difficult. Each of the studies presented in this review are limited either by small sample size, homogeneous samples, or specifically identified populations of children. Another limitation is the use of parents as raters of their child over time which introduces maternal variables to the analyses. Another concern is that correlations between temperament and behavior disorders may only exist at the extremes of a continuum rather than on a consistent basis. Finally, some studies focus on broad and general areas of behavior which may obscure important differences in the developmental importance of distinct behavioral characteristics.

Many factors appear to influence the development of personality over the lifespan. Research efforts are just beginning to look at the genetic, environmental, and transactional processes that serve to shape personality development at various points in the lifespan. Many factors influence this development including genetics, shared environment, non-
shared environment, and life events. However, understanding how these processes work is still elusive. When viewing these changes from a life course perspective, attention is drawn to the individual circumstances and environmental factors that influence life decisions. Life is seen as a dynamic process in which turning points are encountered as the individual reaches major decisions at various life points. These life points may include marriage, military service, or social bonding to institutions. For instance, Sampson and Laub (1993) theorized that delinquent behavior in adolescent males would be reduced if social bonds to adult institutions were developed in adulthood. This hypothesis proved significant in their subsequent study of 500 delinquent and 500 non-delinquent adolescents followed through adulthood. Results suggested that, while continuities existed, job stability and marital attachment were significantly related to reduction in delinquent behavior. Thus, both continuity and change processes are explained. The lifespan perspective allows the reader to distinguish between the appearance of continuity and change in personality development which impacts the process of human development.

Physical Development

One of the more obvious signs of adolescent development is the physical and biological changes referred to as puberty. This period is a time of tremendous change in height, skeletal and body composition, weight distribution, and change in secondary sex characteristics such as pubic hair, breast development, and change of voice. Reproductive capabilities also commence in both genders with females experiencing ovulation and menstruation and the males undergoing sperm production. Females tend to begin their observable growth and change before males.
One facet of physical development that causes concern for many adolescents is the lack of uniformity in which puberty is experienced. Female adolescents who mature earlier than their peers may feel uncomfortable that they appear different and males may show more interest in them. Male adolescents who mature earlier are often rewarded with sports positions or envy of the other males. However, males who develop later may be subject to teasing by peers and may develop a poor self-concept as a result (Koff, Rierdan, & Stubbs, 1990). Body image is a primary factor in an adolescent’s development of their self-esteem (Dacey & Kenny, 1994).

**Adolescent Development in the Family Context**

While adolescence is generally perceived as a period in which the child separates from the influence of the family, the literature points to several areas in which this influence continues to be critical. Family factors often impact identity formation and self-esteem in adolescents which, in turn, are linked to specific emotional, psychological, and behavioral adolescent outcomes.

As discussed previously, identity formation is a crucial aspect of adolescent development. While adolescents do begin to spend more time with peers rather than their families, they continue to be influenced by their family interactions. This influence tends to be circular as the family serves as the context for the developing adolescent while the characteristics of the developing adolescent also influence the family’s relationships. While adolescence is a period of separation and personal development, the connection to family undergoes changes but does not disappear (Grotesvant & Cooper, 1986). However, parents can and do effect their adolescent’s self-esteem through their expectations and
relationships to the adolescent. Parents who set extremely high expectations or show little approval can decrease the self-esteem of their adolescent. Conversely, parents who allow their adolescents to set their own goals with parental support, can increase their adolescent’s self-esteem. Self-esteem is then related to other positive outcomes such as positive academic performance.

As the adolescent undergoes physical development, emotional distance increases between the adolescents and their parents (Steinberg & Hill, 1978). Increased conflict and decreased closeness occur in middle adolescence but the changes are tend to be somewhat reversed in later adolescence. Smetana (1989) suggests that parent-adolescent conflict in early adolescence occurs as adolescents focus on developing autonomy while parents focus on preserving the family system. The extent to which adolescents and parents agree on issues being under personal control increases with age which may lead to a decrease in family conflict over these issues. These roles and boundaries are renegotiated throughout the period of adolescence but become less conflictual as parents and adolescents begin to agree on such roles.

Adolescent identity development is influenced by many sources, including the family. Grovesvant and Cooper (1995) found that interaction in the family, which allows adolescents to express and develop their own point of view in a supportive environment, assisted identity formation. Thus parents can influence their adolescent’s identity formation by allowing communication and exchange of ideas in the family even if they do not mirror that of the parents. Lack of healthy identity formation is linked to drug use, unprotected sex, and delinquent acts.
The composition of the family can also influence adolescent development. In single-parent families, mothers have more connectedness and lowered individuality with their adolescents (Welsh, Powers, & Jacobson, 1991). Thus, less conflictual relationships were noted in these stable, single parent families as opposed to two parent families. When examining the effects of remarriage, Vuchinich, Hetherington, Vuchinich, and Clingempeel (1991) found that adolescent females have more difficulty adjusting to a stepfather than do adolescent males. These findings have profound implications on the development of adolescents in varied contexts.

Hauser, at a). (1984) found that families facilitate ego development of their adolescents through four distinct methods. These include: 1) enduring engagement with the adolescent even in the most difficult times. 2) parents’ self-disclosure and sharing in appropriate ways. 3) tolerance of novelty, ambiguity, and uncertainty. and 4) tolerance of unwanted and unexpected emotions. Adolescents who experience these contexts in the family view the family as more adaptable and cohesive than do their peers who lack these contexts. High levels of ego development were found to moderate depressive effects of early maturity in girls (Rierdan & Koff, 1993). Conversely, the strongest predictor of depression was adolescent’s dissatisfaction with cohesion and adaptability in their families (Cumsille & Epstein, 1994). Family cohesion and support were inversely related to adolescent depression. In a non-clinical sample, these effects were buffered by social support from peers but this affect was not found in a clinical sample.

Parenting style can be classified in many ways. Baumrind has studied the topic extensively and has proposed that parents fall into six categories of parenting styles. These
include: authoritative, democratic, directive, good-enough, nondirective, and unengaged. These categories represent an expanded list of her initial three categories which were authoritarian, authoritative, and permissive. (For a complete discussion of these categories see Baumrind, 1991). Baumrind also examined the effect of these parenting styles on adolescent characteristics. She found that adolescents from authoritative and democratic families were competent, resilient, optimistic, and not alienated. Heaviest drug use was present in adolescents experiencing an unengaged and nondirective parenting style. The adolescents experiencing an unengaged parenting style were more anti-social, lacked self-regulation and social responsibility, demonstrated more internalizing and externalizing behavior problems, and rejected their parents as role models. Barnes & Farrell (1992) found that low levels of parental support and monitoring were predictors of drinking, drug use, deviant acts, and school misconduct. Adolescents with authoritative parents scored higher on psychosocial competence and lower on psychological and behavioral dysfunction (Lamborn, Mount, Steinberg, & Dornbusch, 1991). Steinberg, Lamborn, Dornbusch & Darling, (1992) suggest that parenting style moderates influence of parenting practices on the child’s development by transforming the nature of the parent-child interaction and by influencing the child’s personality.

**Summary**

Adolescence is a time for tremendous growth and change which is impacted by a number of factors. It is clear from the current literature that families can greatly impact the development of their adolescents. However, harnessing this influence in a therapeutic setting has not been widely researched and is limited by problems with practical
applicability. Developing an understanding of how adolescents themselves view having their families involved with their development in a therapeutic context would provide a new level of description which is not currently available in the literature.

**Looking Forward**

While the incidence of behavioral and psychological problems in adolescence continues to rise, professionals attempting to assist the families of these adolescents have only a small body of work from which to draw knowledge and reassurance regarding what treatment models are effective and helpful. The models which have been studied extensively focus only on adolescent juvenile offenders and fail to include much of the adolescent population which enters treatment services. In addition, while static outcome data has been collected, few efforts exist to understand the process of change in these therapeutic contexts. While the importance of family involvement is indicated in the literature for the successful treatment of adolescents (Burns & Friedman, 1989; Cohen, Kolers, & Bradley, 1987; Gabel & Finn, 1986; Patterson, et al., 1989; Sack, Mason, & Collins, 1987) and a governmental mandate has been issued to encourage family-based, community-centered treatment options (Stroul & Friedman, 1986), professionals continue to struggle to collaborate with families in providing truly family-based treatment models (Stroul, 1996). Although professionals are aware of the value and importance of involving the family, there have been no studies designed to understand the family's perception about family-based adolescent treatment programs and how they would like to be involved in the treatment process. This literature review demonstrates the need for a study to develop an account of the experience of families who have an adolescent in family-based, community-centered...
treatment by demonstrating the need for family involvement and the need of professionals to know how to collaborate with these families.

Thus, professionals are left to wonder how families experience these family-based programs. With a shift to a largely postmodern approach dominating the current thinking in the field of marriage and family therapy, professionals continue to struggle to collaborate with these families because they do not have an understanding of what these families experience or need in the treatment experience. The current study seeks to provide these answers. Specifically, what is the experience of families who have an adolescent involved in a family-based community-centered treatment program and how do they believe their needs could best be met?

The unique contribution of the current study is to put into practice postmodern ideas through research. To that end, while understanding the contextual information presented in a review of the literature, it is also important to approach the participant families as sources of information that cannot be found anywhere else. Thus, it becomes possible to truly hear what these participants have to say rather than superimposing our current knowledge on their experience. Therefore, we must strive to put aside, for the time being, what we have learned here so that we can approach the participants in a truly postmodern manner.
CHAPTER 3
METHODS

This section will discuss the choice of qualitative methodology for this inquiry. A description of the informants and ethnographic interviews will be offered. This section also includes an explanation of the procedures used for data analysis. Criteria of rigor will be discussed.

Overview of the Procedures

The researcher was interested in understanding the experience of families with adolescents involved in a family-based intensive outpatient program. This information was gathered from the families themselves as well as the therapists working with them in this process. This researcher was also interested in developing an understanding of how families perceive and achieve change in this therapeutic context. In a previous inquiry, therapists, staff members, and administrators involved with program currently being investigated identified a qualitative shift which appears to occur for the adolescent and family at approximately the third month of involvement in the treatment program (Brandt-De Moss, 1998). This qualitative shift included indicators such as reduced cognitive thinking errors, reduced occurrence of negative behaviors, brightened affect in the adolescent as well as empowerment of the parental subsystem and a focus on other family issues not previously addressed.

In an attempt to capture this shift, ethnographic interviews were conducted with families at the second and fourth months of treatment. Therapists working with each participant family were also interviewed at these times to provide additional contextual
information as well as to compare the experience of therapists and families. To allow for the possibility such a qualitative shift was not identified, the researchers used non-directional questions to focus on the general experience of the participants. Directional probes were used to detect evidence of change or lack of change processes as needed if the participants did not volunteer the desired information. This use of an emergent design allowed the researcher to identify the contrasts in experience between the family and their therapist.

Data was analyzed in a recursive and emergent fashion so that categories of meaning were allowed to emerge from the client and therapist experience. Patterns of thematic analysis informed the questions for the second set of interviews with the participants.

Assumptions and Rationale for a Qualitative Design

Over the last decade, it has been suggested that there is a need for research methodology which allows the researcher to conduct process research (Greenberg & Pinsof, 1986) and is consistent with systems theory (Atkinson, Heath, & Chenail, 1991; Keeney & Morris, 1985; Newfield, et al., 1990). While quantitative research is useful for testing hypotheses, it has not been as useful when the researcher is attempting to record and learn a person's experience (Lincoln & Guba, 1985). Qualitative research provides such methods which allow researchers to use a methodology consistent with systems theory (Moon, et al., 1990) and to conduct process research (Rice & Greenberg, 1984). Researchers operating from a qualitative or phenomenological perspective seek to understand the meaning of events, actions, and interactions in their naturally occurring contexts from the participants' perspective (Moon, et al., 1990). Research questions in qualitative inquiry attempt to guide
the initial phase of data gathering while allowing flexibility in the design to permit responsiveness to the data. Such flexibility is generally not available with quantitative methodologies (Lincoln & Guba, 1985; Patton, 1988).

The primary difference between qualitative and quantitative methodology lies with assumptions used to guide the inquiry. In quantitative research, theory is first established prior to gathering data and the design remains constant. The assumption is made that objective reality exists and the researcher will gain understanding of this reality by manipulating and controlling variables (Creswell, 1994). In contrast, qualitative research recognizes reality as constructed by the individuals involved in the inquiry and that no "objective reality" exists (Brotherson, 1994). Qualitative inquiry allows these divergent experiences to converge and create a full and interrelated description of the experience under scrutiny (Guba, 1981). Qualitative inquiry assumes that the researcher and respondent influence one another in a mutually recursive manner. Therefore the qualitative researcher seeks to minimize such distance from the informant to fully understand the perception and experience under inquiry (Creswell, 1994). Thus a qualitative approach allows a variety of perspectives to converge, producing a thick description of multiple experiences and allows the research design to be flexible as it is informed by the participants (Lincoln & Guba, 1984).

Given these assumptions, the qualitative paradigm provides a useful approach for studying the complexity of human interaction. Joanning and Keoughan (1997) state:

The strength of this approach to research is its evolutionary nature. Quantitative research assumes a theoretical model which is established prior to beginning a
project and is not changed during the project. Such an approach does not take advantage of information generated during the course of the project. Qualitative research allows the model to evolve during the project, thereby taking advantage of valuable information gathered in the inquiry. (p 4)

This research involved understanding family experience with a family-based intensive outpatient program. A qualitative design was selected because it enhanced the investigator's ability to understand the informant's perception regarding a specific life experience (Brotherson, 1994).

The primary tool used in qualitative inquiry for data gathering and analysis is the researcher. Data are mediated through the researcher as a human instrument rather than using surveys, inventories or machines (Merriam, 1988). The researcher is thus allowed to respond to incoming information and has the ability to evolve as an instrument to meet the needs of the inquiry as these become known throughout the study. Further, contextual information is gathered and incorporated which might otherwise be lost in quantitative methods (Angera, 1997).

The Researcher as Instrument

The primary instrument used in qualitative research is often that of the researcher herself. While the researchers cannot eliminate all their biases, they can strive to inform the reader so that the reader can take these into account. Thus a brief section on each researcher is presented next.
The primary researcher was 28 year old white female. As a doctoral student in a Human Development and Family Studies Department with a specialization in Marriage and Family Therapy, this therapist completed a one year clinical internship at the site under study. Prior to this internship, the therapist was already employed at this site as a full-time family therapist for one year. In these roles, the primary researcher had continual contact with clients, becoming increasingly aware of the experience of the families involved in the program. Additionally, the researcher is a Licensed Marriage and Family Therapist and has approximately four years of clinical experience. Through the course of education and employment, the researcher has had involvement in facilitating family therapy work with adolescents and their families as well as conducting group therapy.

The primary researcher became interested in understanding the process of change through her experiences as a staff member in various treatment programs. While many programs are offered, few are based on empirical evidence which identifies and incorporates beneficial aspects of the process of change. One program in particular led her to question the usefulness of putting funds into social services programs with little empirical basis. The program served adolescents referred for drug and alcohol use as well as a variety of additional problems. The program director was a recovering alcoholic who had gained sobriety through the twelve step Alcoholics Anonymous program. The residential treatment program was rigidly based on the Alcoholics Anonymous model with little flexibility for the needs of the adolescent population being served. Many of the adolescents were gang members with little family contact and no time for religious beliefs. Thus the clients
expressed much frustration at being expected to succeed in a program that was so far removed from their worldview. Developmental issues for adolescents were not taken into consideration when developing this program. Thus recidivism was very high with little evidence of successful change on the part of the adolescents or their families. This experience led the primary researcher to wonder about the causes of change in a therapeutic environment while working with specific populations.

When the primary researcher gained employment at the research site under study, she became interested as to the reasons behind the success of the clients. Adolescents are often viewed as difficult to work with but changes were consistently evident for the adolescents involved in the STAY Home program. A primary difference noted about this program was the family focus. Thus, the primary researcher became interested in the impact of family involvement on the success of the adolescent. This interest led to the current study which seeks to understand this involvement and how it affects treatment outcomes.

A potential bias of the primary researcher is her belief in the success of the Short Term Alternatives for Youth (STAY) Home program. This researcher is trained in marriage and family therapy and works as a family therapist with the STAY Home program. Thus, the researcher believes that family involvement in the treatment of their child likely affects the treatment outcome for that child. This belief should be considered in reviewing the conclusions drawn in this study.
Secondary Researcher

The secondary researcher was a 50 year old white female. Like the primary researcher, this researcher was a doctoral student in Human Development and Family Studies with a specialization in Marriage and Family Therapy. This researcher also completed a clinical internship at the site under study and has been employed at this site as a therapist and supervisor for six years. This researcher identified that she also believes in the success of family involvement in adolescent treatment programs. However she also identified that she does not believe the program is successful with all types of adolescents and has seen several fail in this program. The secondary researcher has previously been involved in qualitative research. The secondary researcher worked collaboratively with the primary researcher through the phases of data collection and analysis.

Outside Interviewer

The outside interviewer has no specific connection with the program or agency under study and provided evidence of any bias that may have occurred due to the other interviewers also being therapists at the agency. This interviewer indicated that he has also conducted research examining the effect of including families in adolescent treatment services and believes that family involvement is an important component of these services. This outside interviewer was a 40 year old white male with a Ph.D. in Human Development and Family Studies with a specialization in Marriage and Family Therapy. This interviewer is a professor at the graduate level in a Human Development and Family Studies program and teaches qualitative methods. He has seven years of experience in the area of family therapy and has conducted numerous qualitative and quantitative research inquiries.
**Dependability Auditor**

The researcher’s major professor served as a dependability auditor supervising all aspects of the study. The auditor has extensive experience directing qualitative projects. The auditor ensured that the project conformed to accepted practices in qualitative research throughout the study duration. The dependability auditor has no ties to the agency being studied. The dependability auditor indicated that he has conducted research in the area of adolescent drug abusing adolescents and believes that family involvement is a key component to the success of therapeutic services to the adolescent population.

**Procedures**

This section includes a detailed description of the development of the study and the procedures which were used to recruit, protect, and gather information for the current inquiry.

**Site Approval**

Access to the site and participants was gained through the director of the Mid-Iowa Family Therapy Clinics, Inc. First, the primary researcher approached the director and requested permission to conduct this inquiry. Benefits to both the informants and clinic were described. The primary researcher then submitted a written proposal which provided extensive detail of the steps which would be taken to access, recruit, and conduct ethnographic interviews with the informants. The director granted permission to the researcher to conduct this study as well as to publish such outcomes as were found. The researcher agreed to share the results with the director to further enhance the current program.
Responsibility to Participants

The appropriate information has been submitted to the Human Subjects Review Board at Iowa State University explaining the procedures to be used and measures taken to ensure the dignity and protection of the rights of participants. Issues addressed include confidentiality, lack of recourse by professionals, and participants to be fully informed about the study and their rights regarding the study. The Human Subjects Review Board has reviewed this information and has given permission to proceed with this research inquiry (Appendix F). An informed consent statement was signed by each participant prior to data collection which fully explained the expectations, potential risks, and benefits of the study. Participant rights were also clearly delineated including the right to terminate participation at any time without recourse (Appendix B). Special care was given to ensuring court-ordered program participants that they would not be penalized in any way for nonparticipation.

Informants

In order to gain a wide variety of perspectives congruent with the nature of qualitative research, families from three of the five program sites were interviewed. The decision to include these three sites was made as each program is fully established and has been in operation at least one year. The other two program sites have recently been established and are not fully operationalized at this time. Thus, these programs were eliminated to allow for the process of flexibly working around inevitable kinks in the new programs settings which potentially could bias the data collected. In addition, the same person serves as the director of the three programs chosen and oversees all aspects of each
of these three program sites. She conducts all trainings and has developed a specific curriculum which is followed in these three programs. Thus consistency of program application can be found at each of the three program sites selected.

The informants in the study were selected using an opportunistic, purposive sampling strategy (Glaser & Strauss. 1967). The researcher developed criteria which informants were required to meet to be eligible for participation in the study. Families must have had an adolescent participating in the current program for two months at the time of the first interview. Both families, adolescents, and therapists must have been willing and able to commit to interviews at the second and fourth months. These two criteria evolved from a previous study in which therapists, staff, and administrators of this program identified a qualitative shift which occurs at approximately three months (Brandt-De Moss, 1999). Families were selected to allow for diversity of family composition, age, and gender of the adolescent, and court ordered or voluntary clients. Family composition included single parents, stepfamilies, biological parents married, adoptive parents, and parents with paramour. Adolescents were categorized as being in middle adolescence (12 to 15 years) or late adolescence (16 to 18) years. Families must have been working with a therapist of the current program to participate as this is an important component of this model of service delivery. Families were selected through referral by program staff as well as the researchers who were participant observers at the program site.

Informant Recruitment

Potential informants referred by program staff or selected by the researchers were first contacted by phone to screen for informants who met the established criteria.
Informants who met the proposed guidelines and expressed an interest in participating in the study received a copy of an informational letter (Appendix A) and the informed consent which described the project in detail (Appendix B). Included in these forms were the purpose of the study, expectations of the informants, a general idea of the topic, as well as informant rights. Informants were contacted again by the researchers via telephone to confirm willingness to participate. Researchers requested that the participants sign a consent form and complete a brief demographic questionnaire prior to the first interview.

**Ethnographic Interviews**

Interviews were conducted with families from each selected program site. The number of participant families was determined as redundancy of the data was attained. Interviews were conducted slightly beyond saturation to account for attrition. However, concern for attrition of families was not indicated as supported by a previous study which cited the dropout rate at the fourth month as being less than 10% in the program under study. This finding may be because services are initially approved for a six-month period. Interviews were conducted with a total of seven families and continued until saturation of the data was reached, indicated by redundancy of information. Interviews were conducted with an additional two families beyond saturation to adjust for potential attrition. These interviews were conducted separately with the adolescent and the parents of the adolescent to allow for divergent opinions. When it appeared that the parents had divergent experiences or one parent was not involved, the researcher utilized separate interviews with the parents as well for part of the time allowed. Interviews with the parents lasted from 1 ½ to 2 hours each. Interviews with the adolescent were shorter to allow for a shortened
attention span and less verbal fluency. Interviews were conducted at the residence of the family at a time most convenient for the family. Therapists interviews lasted approximately one hour and were held in the intensive outpatient setting.

Interviews were conducted by a primary and secondary researcher who were also therapists at this specific agency. Each family was assigned to the primary or secondary interviewer based on feasibility of scheduling. Approximately the same number of families were assigned to each interviewer. All interviews in connection with that family were conducted by the researcher assigned. This included first and second interviews with the parents, adolescents, and therapists. Researchers did not have personal knowledge or acquaintance of the participants prior to the interviews. This criteria was achieved through the use of multiple interviewers. Because both the primary and secondary interviewer identified a potential bias towards the success of the program, steps were taken to identify if bias occurred. Content of the interviews was reviewed to ensure that all comments by the participants were not positive. Several of the participants identified negative aspects of the program and these aspects were also present in the categories which emerged in the data analysis. An outside interviewer with no ties to this specific agency was also utilized to conduct memberchecking to allow for detection of bias which may have occurred as a result of the multiple roles of the researchers and therapists. This outside person checked the accuracy of the data by utilizing the summary provided to the family and asking about the family’s comfort in being interviewed by an employee of the agency. This person reported that no bias was detected.
One initial interview at each program site was initially analyzed and debriefed to secure feedback about the clarity of the questions, the appropriateness of the questions to the research, and to determine which technical areas the researchers needed to improve. Debriefing about these areas were utilized after the interviews to obtain this information. The researcher reviewed this feedback with her major professor to determine if the data gathered obtained the desired information. It was determined that some adjustments were needed to clarify the questions asked of both the parents and adolescents. All interviews were audiotaped to preserve data and allow for transcription of the data.

Parents and their adolescents were initially asked to address the following grand tour question:

*What has been your experience with this program?*

As the interview progressed, subquestions were used to probe for specific areas of interest if they were not raised by the participants. Subquestions for parents included:

*In what ways, if any, has this program been helpful?*

*In what ways, if any, could this program be more helpful?*

*What changes, if any, have you experienced since beginning this program?*

*In what ways have you been involved in your child's treatment? What effects, if any, has this involvement had on your child's treatment?*

Subquestions for the adolescent were more structured as the original unstructured questions produced confusion and lack of response by the adolescents. These subquestions included:

*What was life like before you started the program as compared to now?*
How has your family’s involvement in the program been helpful to you, if at all?

Have you experienced any changes since starting this program? If so, what changes?

The grand tour question remained identical for the second interview. Tentative subquestions asked of the parents were as follows. These questions emerged as indicated in thematic analysis of the data from the first interviews.

What is different for you and your family since our last interview? How has the program played a role in that, if at all?

Have the issues from the last interview been resolved? If so, how?

What has been valuable to you so far having been through this process?

Looking back on your experience with the program, how would you describe the process you have been through?

Looking back on your experience with the program, what advice would you give the treatment team working with your child?

Subquestions for the adolescents in the second interview were:

What do you think of group? Family therapy? Do you see family therapy and group as being helpful together or do you see them as separate from each other?

What do you think of having your family involved in your treatment?

How has your family’s involvement affected your treatment, if at all?

Have you experienced any changes since the last time we met?

Subquestions were used as appropriate to the participant’s response. Initial interviews provided a baseline indication of which to compare the difference in the second set of
interviews. Prior to the second interviews, participants were reminded of the previous interview responses as a reference.

Questions posed to the therapists were similar but asked about the therapist's perception of the family experience. Thus the grand tour question in the therapist interviews was:

*What do you believe has been this family's experience with this program?*

Subquestions were as follows:

*In what ways do you believe this program has been helpful to this family?*
*In what ways could this program be more helpful to this family?*
*In your perception, has change occurred for this family since beginning the program?*
*Has including family services been important in assisting the family reach their therapeutic goals?*

As with family and adolescent interviews, second interviews with the therapists began with the same grand tour question. Subquestions again were informed by thematic analysis of the first interviews. Subquestions included:

*As you look at the process this family has been through, how do you think they would describe it? How do you see that process?*
*What do you think has been most valuable to this family, if anything?*
*In what ways is this family different from the way they were the last time we met?*
*Why do you think these changes have occurred?*
To what extent does this family feel comfortable in being involved in their child's treatment? How willing are they to be involved?

What have been the barriers to change for this family?

Again, subquestions were appropriate to the response of the therapists. Participants were reminded of previous interview responses for reference.

**Member Checks**

Member checks were conducted with the participants by providing a synopsis of the analyzed data from each interview for that participant. These synopses were sent to the participants within ten days of the interview with a request to correct any misinformation. Participants were also encouraged to add any additional thoughts as desired at that time. These member checks were conducted after each interview to ensure accuracy of the data. An additional overall synopsis was created when all interviews had been conducted. This synopsis was given to random families to check for overall accuracy as well.

**Criteria of Rigor**

Qualitative researchers engage in a number of steps to ensure the results accurately reflect the experience of the informants and are adequately conveyed to the reader to produce clarity and understanding (Guba, 1985). In the present study, a number of measures were taken to ensure readers' confidence in the truth value of the findings. Given that the final determination of trustworthiness lies with the reader (Creswell, 1994), steps towards credibility, dependability, and transferability are presented to demonstrate indicators of rigor.
Credibility

Establishing credibility requires demonstrating isomorphism between one's data and the phenomena being studied. The researcher must search to fully understand the multiply constructed realities of the participants experiencing the phenomena and accurately portray these realities to the reader. In quantitative research, this construct is referred to as internal validity (Brotherson, 1994). Researchers utilized a number of methods to ensure credibility.

First, the researchers engaged in continual peer debriefing throughout the study. This method allowed the primary researcher to check for accuracy and prevent bias. Secondly, memberchecking methods were used in an ongoing manner. Accuracy was checked with informants during the interview and a written summary of the material was also sent to the informants after the interview for feedback and clarification. These steps subjected the researchers' organization of the data to the scrutiny of the persons who provided the information (Lincoln & Guba, 1985). Third, the researchers utilized negative case analysis, continually refining interpretations of the data based on new information that did not fit the initial interpretations (Lincoln & Guba, 1985). Fourth, triangulation of the data sources (audiotapes, transcripts, field notes, observer notes, peer debriefing tapes, member check and participant responses to statements) and researchers (a primary and secondary researcher) supported credibility of findings. Last, both researchers maintained prolonged engagement with the site, the participants, and the data, further ensuring credibility in this method of inquiry.
Dependability

Dependability refers to consistency or stability and is comparable to reliability in quantitative design. Techniques to ensure dependability of the data include group debriefings, multiple researchers, and an audit trail (Guba, 1981). The researcher used five techniques to ensure dependability in this research study. Debriefings of interview experiences with participants occurred immediately following the initial interviews to allow the researchers to secure feedback regarding the clarity of the questions, the appropriateness of the questions to the research, and to determine the technical areas of improvement needed by the researchers. Peer debriefing was conducted between the researchers to compare findings, beliefs, attitudes, and thoughts concerning the emerging research design. The study employed multiple researchers and journaling which assisted the researchers in identifying biases which may have affected interpretation of the data. Lastly, the primary researcher maintained a continual audit trail focusing on the day to day decisions made as the study progressed. Given the emergent method of inquiry, the audit trail served as a method to track the project development throughout the analysis and completion of the study.

Transferability

This term refers to the ability to transfer findings of the study to other contexts. This criteria is referred to as external validity in the quantitative methods. The researcher used four specific methods to address this indicator of trustworthiness. First, the researcher has provided a clear definition of the purposive sampling guidelines and methods used for soliciting participants. Second, a thick description of participant characteristics and the
research context provides a detailed understanding for the reader. Thirdly, the researchers kept field notes during interviews to include contextual information which aided in providing a thorough description. Fourth, the researcher provided detailed information about the program under study including results of a demographic study completed earlier. This thick description enables the reader to make judgments regarding the transferability of results to other contexts.

**Methodological Tools**

Two methodological tools were used to gather data in the present study. Ethnographic interviews were used to probe for the desired information and field notes were kept to record contextual information.

**Ethnographic Interviews**

Interviews are characterized by an individual conversation between a participant and the interviewer. In-depth information is gathered with a resulting thick description of the experience of that individual or individuals. Advantages of ethnographic interviews are the increased information gathered in comparison to focus groups, ability to follow up on leads presented by the participant, and lack of challenges to the participant's viewpoint which may encourage greater honesty and information by the participant. Disadvantages to ethnographic interviews include extensive time and resources expended on interviews and transcribing, equipment failure, and lack of interaction between participants. A concern with the use of interviews was that of responder bias, a bias which occurs when the participants give answers which they believe the interviewer wants to hear or having concerns with how they would be viewed (Creswell, 1998). For instance, families asked if...
their experience mirrored that of other participants. Some of the participants also seemed to want to approval of the interviewer. However, when the interviewer responded empathetically to participant statements, the participants became more verbal about their concerns. The interviewers took precautions to ensure that the participants felt comfortable with the interviewers and understood that the information would be kept confidential. The interviewers spent the initial part of their time in the first interviews by making small talk with the participants and thoroughly explaining the researcher's role in the agency. The participants were encouraged to ask any questions at this time which were answered promptly. This portion of the interview was not taped to allow for comfort of the participants. The interviewers reported that some of the participants initially appeared uncomfortable with the interview but became more talkative and forthcoming after the initial conversation. In addition, debriefing was done with the participants after each interview asking if they would have felt more comfortable with an independent interviewer. All participants reported either that this did not matter or that they preferred the interviewer had knowledge of the program so they would not have to explain everything.

Field Notes

Researchers often keep a journal with them in which they record their observations and thoughts while interacting with the participants. This method allows researchers to present a clear picture of their thought process and provides a double description of the experiences recorded. These notes may also be used as a tool to check for researcher bias and may be reviewed by an outside peer to assist in data analysis. Disadvantages include
having to write field notes while engaging in other activities and incorporating these notes into the write up of the study.

**Data Collection and Analysis**

Qualitative data analysis involves bringing order, structure, and meaning to a large set of data (Marshall & Rossman, 1995). The method of data collection and analysis in the current study has been followed based on Tesch's steps to an organizing system (1990) and the Developmental Research Sequence of Spradley (1979). The analysis process began with the first data collected and continued through the final written product.

Tesch proposes eight steps in the process of developing an organizing system for unstructured qualitative data. These steps result in a clear schemata from which to understand and interpret large amounts of data. These steps are presented as summarized in St. George (1994):

1. To begin, Tesch suggests reading the data carefully as they come in. The goal is to get an overall sense and familiarity of the material. Any thoughts that occur during this reading are recorded.

2. While reading each data document, it is important to focus on the main ideas rather than the exact content. It is important to pay attention to the transitions between topics. Topics are identified by noting what they statement is about, thereby distinguishing it from the actual statement content. Topics should then be recorded in the margin of the document next to the passage to which it corresponds.
3. Once three to five sets of the data have been read and topics recorded in the margins, a list of topics contained in each document is prepared. The list of topics particular to each document are recorded in a column labeled with the document name. When all columns are assembled (one per document), topics are then compared across documents. They are placed into clusters which group and name the topics according to their degree of relatedness, and three new lists are prepared. The first list contains clusters of topics that are similar to one another and appear frequently across the documents. The second is a catalogue of topical clusters that are unique and appear only in some of the documents, but are germane to the study. The third list is a record of the leftovers, those topics that do not fit into clusters.

4. Each of the clusters has been given a title which captures the range of topics incorporated within the cluster. The cluster names are then applied to a fresh copy of the original set of data materials. One or more of the cluster names that best describe or contain each bit of data are written next to each statement in the original data document. This indexing verifies or reveals shortcomings in the organizing system. The last element of this step is to try this same application system of the cluster names on new data.

5. With large data sets, similar clusters are group to form larger categories. This step resembles Step 3 and is a step in refining the organizing system.
6. The categories are then given coded abbreviations if necessary, as the clusters are coded. Using the entire data set, categories are recorded next to the appropriate text. The text may be labeled with more than one category name.

7. To look at the complete collection of the data, each category name becomes a heading for the preliminary analysis. These headings are followed by the actual content labeled with that category name. Each category is summarized by looking at commonalities, differences, contradictions, or missing information within that category related to the research focus.

8. Revising is done as necessary.

Sorting through the narrative data began immediately after an interview was completed so no information was lost or subject to long-term recall. The researcher first listened to the audiotape and began to reference the field notes against the narrative data. Key words, phrases or highly illustrative quotes from these multiple sources were identified and entered into a computer. The interviews were then transcribed for purposes of in-depth analysis. While viewing the transcript, the researcher identified brief synthesis statements which summarized the main thought or content of a section of the raw text. The criteria for defining pertinent statements were as follows:

- Text that was important or related to the research questions.
- Text that was important to the informants, based on direct acknowledgment, analogical indications and/or broad consensus.

The text was decontextualized (Tesch, 1990), taking the synthesis statements and grouping them into clusters based on some emergent commonality. The researcher then
submitted these synthesis statements, or topics, to the participants as a member check, requesting corrections or clarifications if needed. The researcher then compared her identified topics with the membercheck information for accuracy.

This process was completed for each ethnographic interview. Once multiple interviews were conducted and analyzed, similar topics were grouped together to form clusters of topics. These clusters were named to reflect those topics within each. Once all data documents were analyzed into clusters, these clusters were further refined into categories of clusters and named to reflect the clusters within. Categories were grouped into three sets:

- categories similar across groups and individuals.
- categories unique to a group or individual
- leftover items

Lastly, similar categories were grouped into larger domains of meaning which are named to reflect the collection of categories included (Spradley, 1979). In this study, these domains reflect the group of participants and time of the interview to provide contextual organization.

The researcher reviewed the member check data and field notes to add contextual information to the data. Illustrative quotes and segments were added in narrative form. The text was then edited to produce a seamless, readable text. Revision was done as needed during collection of subsequent data with a resulting product summarizing the overall data analysis results. Negative case analysis was used in which data which did not fit current conceptualizations were not thrown out but rather the imposed structure on the
data was changed to include that information. The final product produced a conceptual structure containing three orders of abstraction which built upon one another. This final report was written in great detail, offering quotes and detailed descriptions to fully convey the context and experience to the reader.
CHAPTER 4

RESULTS

The results presented in this chapter emerged from the data collected through forty-two interviews with adolescents, their parents, and their therapists. All data from the eighth family was dropped as they chose not to participate in the second round of interviews. The data were analyzed according to Tesch's steps to an organizing system (1990) and Spradley's concept of domain indentification (1979). Analysis was conducted continuously and in conjunction with ongoing data collection. Immediately after the first interviews were completed, a summary of the participant's comments were summarized and sent to the participants for correction and elaboration. Participants' reviews of the material and comments were also included in the data analysis.

As soon as each interview was completed and transcribed, the researcher who had not conducted the interview served as a product auditor. This researcher took the original data documents and assigned a topic phrase to each bit of data present. This researcher then compared her work with the detailed field notes taken by the interviewer during the interview. A complete listing of topics was thus compiled from the two researchers' work. After the preparation of these lists and resulting memberchecks, the information was organized into a card sort (Spradley, 1979), placing each discrete piece of data into related piles of topics. These groups of data were assigned titles that captured the range of the topics to form clusters. When all the data had been sorted, these clusters were assigned to categories of clusters to further refine the large data set. The categories were then arranged in three categories: Major Categories (topics that were distributed across the majority of
participants). Partial Categories (those categories that were particular to a subset of the participants). and Leftover Categories (those topics that were both unique and infrequent). This process was conducted for both sets of interviews conducted with each group of participants.

The filtering and refining process of data as they were gathered led to the set of categories described below. Categories from the first to the second set of interviews with each group of participants remained largely the same. The major categories which emerged were: Changes, Adolescent Perceptions, Family, Experience of Treatment, Continued Issues, Perception of Services, Family Involvement, Family Experiences, Needs of the Family and Program Success. Partial categories included Suggestions and Needs. Leftover topics were listed not as categories but as individual ideas that did not fit into any of the other categories. Each category will be discussed individually and will include a description of the clusters contained within as well as samples of the data as illustrative of the central thought and variation within the category.

**Participant Demographics**

Seven families, including adolescents and their therapists participated in this study. The eighth family chose to not participate in the second round of interviews and all their information was subsequently dropped from the study. No reason was given by the family for this decision to not participate. A brief description of these participants will be offered to aid in contextual description for the reader. These descriptions were compiled through the use of a brief demographic questionnaire filled out by each parent participant (Appendix G).
Seven families participated in this study. These selections were made through purposeful sampling with the greatest diversity based on the given criteria desired. These criteria included gender, age, family composition, and court-involvement versus voluntary services. A list of families recently entering the program was obtained and names were chosen from this list based on pertinent demographics. All participants who were contacted agreed to participate in this study at the start.

Three male and four female adolescents enrolled in the program were included. The males' ages ranged from 14 years to 17 years of age. The females' ages ranged from 13 years to 16 years of age (See Appendix C). Four of the adolescents were categorized as being in early adolescence while the remaining three were defined as being in middle adolescence. Family compositions included: biological parents(2), mother and stepfather(1), mother-only(1), adoptive mother and stepfather(1), adoptive parents(1), joint custodial mother/stepfather and father/stepmother(1).

Parent occupations included: carpenter, receptionist, music teacher, internal operations auditor, homemaker, patient care technician, activity assistant, shipping clerk, operating engineer, home health aide, and mechanic. Families ranged widely in socioeconomic status and education level attained. Education levels ranged from partial high school to graduate and professional training. Three families had household incomes between $0 to 30,000 yearly, two families fell in the middle range ($31,000 to $59,000) and two families fell into the $60,000 income category.

Four of these children were court-involved in treatment and designated a Child In Need of Assistance (CINA) by the court system. This designation places control of services
within the discretion of the court with recommendations by the treatment team. Three of these families had requested voluntary services from the Department of Human Services and were not under direction from the court in any way. The adolescents presented with a variety of issues, those primary being non-compliance, aggression, school issues, and substance use. Diagnoses of the adolescents included: Oppositional Defiant Disorder, Obsessive-Compulsive Disorder, Paranoid Delusional Thought Disorder, Paranoid Schizophrenia, Frontal Lobe Disorder, Attention Deficit Disorder, Borderline Personality Disorder, and Learning Disabled. One child was diagnosed as low functioning. Two of the adolescents were returning to their families from residential care.

A total of five therapists from a possible eleven were interviewed with two therapists interviewed regarding two of their client families. Therapist ages ranged from 50 years to 27 years of age. Education and clinical experience also varied with all but one therapist having an M.S. degree and at least three years of postgraduate clinical experience. Therapist approaches included narrative, structural, solution-focused, psychoeducational, strategic, and parent training.

**Analysis of Qualitative Data**

Twenty-two major and two partial categories of meaning emerged from the completed set of 42 interviews. Categories have been grouped into the following domains: Adolescent 1, Adolescent 2, Family 1, Family 2, Therapist 1, and Therapist 2 to designate which participants were interviewed and if the first or second wave of data is being presented.
Major Categories: Adolescent 1

The major categories were those that emerged from the data obtained from all or a majority of the adolescents at Time1. They were: Changes, Adolescent Perceptions, and Family.

Changes

Two distinct clusters were identified in this category. Changes for the Adolescent and Change in the Family:

The adolescents were able to identify both behavioral and perceptual changes which had occurred for them since starting the program. The adolescents were eager to identify several of their own behavioral changes which had occurred during the first two months of the program. Many of these changes were reported by the majority of these participants. These changes often coincided with the primary presenting issues of the adolescents including school issues, non-compliance, and aggression. More changes in behavior and perception were noted by adolescents at the time of the first interview than during the second set of interviews. The adolescents often described change that was immediate and intense. Behaviors were described as having changed significantly or completely rather than incremental changes or shifts to new negative behaviors. The adolescents were primarily focused on issues with family and school that had led to their involvement in the program. The most frequently cited changes were school improvement, better coping with anger, and respect for parents. One adolescent commented, “My parents are a real good influence and I need to listen to them.” Another adolescent explained, “I don’t argue as much with my family anymore. Or if I do, I don’t get mad and blow up.” All the adolescents reported that
their interaction with parents had changed significantly and that the adolescents contributed
these changes due to their own perceptual and behavioral changes rather than something the
parents had changed. Each adolescent’s relationship with his or her parents had been
characterized by stress, anger, poor communication, and defiance by the child as described
by the child. The adolescents were forthcoming about their negative behaviors and
interactions which had led to participation in the program.

School attendance and performance also improved for many of the adolescents. All
of the female adolescents interviewed except one mentioned changes in relation to school
issues. None of the males identified school changes. For many, prior to the program, they
had little interest in school and often were truant, failed to complete work or were
disruptive. Few of the adolescents reported wanting to make behavioral changes at the
onset of the program as they did not view school to be important or worth the effort. All
the adolescents who presented with school issues also had other behavioral problems in
other settings. Significant behavioral changes were reported in terms of school issues.
Several adolescents reported that they were attending school on a daily basis, had improved
their grades significantly, and were more interested in school. Several of these adolescents
also reported that being in the structured environment of a shelter placement had greatly
improved their ability to concentrate and complete schoolwork. The positive reinforcement
received with a successful learning experience was described as creating an interest in
school and a belief that the child could be successful academically where this idea had not
been considered previously.
The adolescents reported that they felt more confident, happier, and had become more assertive. One comment was, "I feel a lot better about myself. I know I can do it. I just feel really good about it." Several of the adolescents reported feeling happier because they had a place to talk about problems and people who listened to them. Some also commented that starting on medications had helped them start feeling better as well. "I am happier, because I am on Prozac... coping. Also probably because I'm getting the stuff that I've been stuffing in, out." The female adolescents also reported that they had changed peer groups and no longer spent time with negative peers. However, this change was often due to limitations being imposed by parents or the program.

One interesting result was that these adolescents also reported applying their coping tools outside of the program in situations with the family, school, and peers. One adolescent gives an example of how she uses these changes with her brother. "We still argue a lot. Like he picks more fights now and tries to fight with me and I just don't go along with him and I would have before I started here. I would have like hit him or something but now I keep my cool because it's not worth it." Another adolescent also reported that he was no longer staying out all night or partying all the time but instead following his parents' rules at home. Most of the adolescents reported that they were making better decisions at home and school because they did not want to be given consequences for poor decisions. When asked what her experience with the program had been so far, one adolescent replied, "Well, I've gotten a lot of stuff taken away and I'm sick of it!"
A primary change for the majority of the adolescents is that they are coping better with anger. "Well, before, when I got angry, I just would like explode. Now I use my stop and think and I use my tools. Or I think about my tools and stop doing it and how, what's gonna be the outcome." Another adolescent summed it up nicely by pointing out, "Before the shelter and the program, I could do pretty much what I wanted. But it's really strict here and I don't do anything because I know I'll get consequenced!"

Several of the adolescents also reported perceptual changes which had occurred for them. This change was not surprising given the cognitive restructuring approach of the program. However, while some of the adolescents simply cited examples of how their perceptions had changed, others actually commented that they knew their thinking had changed and were able to discuss how their thinking influenced their behaviors. The differences were present across gender and ages. One adolescent said, "I used to be out of control a lot. But now the way I think is different. I feel I have control over what I think and what I choose to do now." Others suggested their perception of parental authority had changed. "I got more respect for my parents because I realized they have a higher authority than me. Just being here and listening to all the people and hearing all their problems and realized that my parents are a real good influence and I need to listen to them." Another adolescent explained,

"I keep my cool better, a lot better. because I can control...it gives me a way to control my thoughts. I try to be able to tell exactly when I'm having a problem. It's kind of hard. But afterwards, I can understand it and
prevent it from happening again if that issue comes up again. My thoughts have changed a lot.”

The participants also commented on being able to see how their behavior impacts others and feeling embarrassed about past behaviors. This led to behavioral and perceptual change for many of the adolescents. One female adolescent who had just returned from residential care had this comment,

“The way I think is completely different. Not just in the way, not all good and not all bad. Just like things I never noticed before. ...But until I got in group and saw the way the other kids talk, like “they are just trying to pick on me,” “they don’t really want to help me,” “I don’t want to get sent away.” “I don’t need to be here”.... I didn’t know that I should think like that. I didn’t notice it. I used to be totally like that. And I realize that I am not like that anymore. It kind of hurt to see that some kids are just starting out on the path that I’ve already been on. They are going to have to really work. People can sit there and lecture you for hours, but it is not going to change the way you think unless you decide to change it yourself. I guess, my whole thinking about everything is just totally different, you know.”

Three of the adolescent report that their behavioral change is not consistent and that they need to continue to make changes. Some of these adolescents had also been placed in shelter care, away from their families until they were able to change their behaviors enough to be successful at home. However, even outside of expectations, the adolescents were able to identify that their changes were not yet comfortable or consistent. One adolescent
admitted, "I don’t put as much effort into it as I should.” Another reported, “I need to start participating more. But it’s embarrassing to talk about your family stuff in front of people who don’t need to know your business.” Another adolescent reported that he uses his tools at the program but did not always choose to use them when he did not think it would be noticed.

An interesting finding is that the three adolescent males reported that they had not made change. “I don’t think anything has changed.” However, when asked more structured questions, each adolescent was able to give an example of at least one way in which he had changed. “Well, I just have more respect for my parents and my attitude has changed a little bit.” Each adolescent male gave concrete examples of changes which have occurred since starting the program even when initially reporting no change had occurred. These males reported both behavioral and perceptual changes including general attitude, anger control, and respect for parents.

Some of the adolescents were able to describe changes but were unsure that the program prompted these changes. “I think it (change) might have even started before started the program but the program pushed me along.” Another participant suggested, “I think my meds have really helped me get on track. I don’t think it had anything to do with the program.”

Changes in the family were also frequently mentioned during the first set of interviews. However, most changes cited were similar and centered around improved respect and reduction of conflict with parents. Most of the adolescents described their relationships with their parents as having improved, often contributing the changes to better
communication. They specifically cited family therapy as a primary time for the family to sit down and talk about what was happening between the family members. One adolescent described one change this way.

"It's really weird because I will go talk to her (Mom), the things that I wouldn't have ever talked to her about. One day, I asked her to come into my room and talk and that was the first time I had ever done that, ever in my whole life. I remember asking my mom just to listen to me... most of the time I would just call friends or something like that instead. It actually felt good to do that. It's different for me because instead of stuffing everything, I can talk to her now and she understands me better."

The adolescents report feeling more comfortable talking with their parents and feel their parents are more likely to listen in therapy or when discussing the program. The adolescents report that they feel better understood by their parents and have learned to be more respectful and accepting of their parents' decisions. Many of the adolescents reported that they used to argue and fight a lot with parents and siblings because they did not care how they treated others or they did not feel cared about by their families. Several of the adolescents mentioned that the changes were due to forming a closer relationship with their parents because the parents demonstrated that they cared about the child by getting involved in the child's treatment. One child in particular felt this has been the best aspect of his involvement with treatment. "I just have more respect for my parents because they've put a lot of time and effort into me and before I didn't see it. Like before they never seemed to care or have time for me but now I know they do. And it's made things a lot
better between us.” Other children felt cared about because parents had to make an effort to attend therapy and group in another town while the child was in a shelter placement. One adolescent reported that her relationship with her parents was much better but that she still fought and argued with her brother as much as before. Some of the adolescents pointed out that while their family relationships had changed, there often were still problems and this change was inconsistent. One adolescent described it this way, “We (mom and I) get along better. When we get along, we get along better at that time, but when we don’t get along, we get along better than what we were.” Some reported that the change occurred in how they resolved the conflict rather than an actual reduction in the frequency of the conflict.

Another change in the family that several of the adolescents mentioned was a shift in the power structure. In several cases, the adolescents noticed that the parents had begun to have expectations for the adolescent and would follow through with consequences if needed. While the adolescents did not specifically verbalize how they felt about these changes, they did comment that they felt more cared about and respected their parents more in these situations. “I’ll probably lose some of my friends ‘cuz they do drugs and stuff and mom will probably say I can’t hang out with them anymore... But that’s okay because I probably should spend more time at home with my family anyway. I never used to be home.” A couple of the adolescents reported that they were challenged by program staff to discuss issues with parents and even asked parents to attend group specifically to do so.
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medications cleared up their thinking or made them able to cope rationally with issues which they had not been able to do prior.

Several of the adolescents commented that having their families involved in their treatment helped them to change. "Well, my family knows about my Borderline Disorder. It helps because they’ve learned how to help me when I am having problems. They can give me grounding statements and stuff. That way I can work on my stuff even when I’m not at group, like when stuff happens at home. That way I can change more and get done with the program."

Some of the adolescents offered their pearls of wisdom regarding change. One suggested, "You have to decide to change yourself or it will never happen. And then, when you do decide to change, you have to be willing to hear stuff that you might not want to hear and can’t get all defensive and stuff because people are just trying to help you change."

In discussing specific changes with a 16 year old male, he commented, "There’s been some change but I’ve only been here two months. I think there will be change down the road but everything takes time and you got to be patient about things or you will want to give up too soon." Another adolescent reported that she knows she needs to change but, "My mom loves this program because she thinks it teaches discipline and I’m learning the stuff but it’s hard to do. But I expect rejection from my mom because, like, if I change my whole attitude, what’s she gonna say?"

Peer advice and relationships were also thought to impact change. One adolescent stated, "If I had a problem, I used to ignore my parents and go to my friends which was not helpful... I guess, the way people my age think is irrational and they fight. I wouldn’t get
the best advice. I usually would get in trouble again.” Other adolescents saw their peers making changes that they wanted and this served as motivation to help them to make changes. Several of the participants did comment that making change is difficult and takes time so they were sometimes inconsistent or didn’t work as hard as they should because they got tired and frustrated at times.

All of the female adolescents interviewed reported that they like the program. Many mentioned the group environment as an being important place where they could talk to people who could relate to them and cared about them. They cited getting feedback and being able to help others as being important and making them feel good about themselves. Two of the male interviewees suggested that the program, “is a waste of time, boring.” and “takes too much of my time.” One of those males commented that the program was too long and found it boring that he had to wait for others to discuss their issues. He suggested that the group process was not helpful and that he would benefit more from individual therapy less frequently. He also identified that group ran too late so that he did not have time for his activities when he got home in the evenings. He suggested that the group time was not adequate for everyone but then ran too long so groups should be made smaller and run for shorter time periods so he could get home. He also complained that he was embarrassed to be picked up at school by the program staff in front of his peers. The other male reported that he would rather be participating in school activities and did not feel he needed to attend the program. He reports that the staff goes over the same things all the time and he does not get anything out of the groups. The third adolescent male reports that he gets more from family therapy because they are working specifically on his issues. He
did, however, verbalize that he likes the environment of group where there are peers he can relate to and who care about him.

One adolescent reported liking the groups but suggested giving the participants more freedom to discuss what they wanted rather than having a structured topic each time. She also wished that the group leaders would focus more on having conversations with the adolescents rather than just asking questions. About half of the adolescents reported that they did not need to be in the program or that they did not initially want to attend the program. Two of the adolescent males still felt they did not need the program while the others were focused on the benefits they were getting. One adolescent female reported, "I really didn't want to attend at first. But it is not as hard as I thought it would be at all. I was thinking it was going to be these mean, horrible people just out to get me, and they're not. It's really easy. The group members and staff are compatible, you know, you can get along with them." Another adolescent pointed out that she can talk to her group peers but not her peers from school because they wouldn't understand. Another adolescent female reported that she has a difficult time talking in front of a group and feels embarrassed.

Most of the adolescents mentioned that the program is time-consuming and doesn't leave them any time or energy for themselves. They get home late and are tired so don't want to interact with family or friends. One adolescent remarked that his life is much more structured now because of school and the program which doesn't allow him time to get in trouble.

Many of the adolescents described the program staff as being strict but nice and sometimes grouchy. They felt the staff would listen to them and be fair but felt the program
had a lot of rules. Most adolescents reported liking or not having much of an opinion of their therapists. One adolescent female reported,

"My therapist is cool. I like her so much. I click with her really well. She is the first therapist that has ever cried because of something that I said that actually made her cry. I had never had a therapist cry for me before.

It was so cool!"

Other adolescents also reported that their therapists were nice and easy to talk to. Two of the adolescents reported that their therapists were mean and did not like them.

Family

This category was compromised of two clusters, *Family Involvement* and *Family Therapy*.

The adolescents interviewed unanimously supported having their families involved in their treatment. However, there were some differences of opinion as to how much involvement and in what ways. Family involvement in this program includes daily reports on the child to the parents, weekly family therapy sessions, monthly Family Nights, open groups where parents are always invited to participate in their child’s groups, school reports to the family daily through program, including the parents as members of the child’s treatment team in all aspects of treatment planning and decision-making, attending meeting of the professionals, and requesting that parents attend all psychiatric appointments with their child.

Adolescents consistently described their families as being supportive of the program and their child’s participation. The adolescents described feeling supported by parents
taking the time to learn the same tools as the child was learning and assisting the child in using the tools at home. One male adolescent reported, "My parents give me support and encouragement to participate more in the program." Comments were also frequently made that having the common topic of the program provided a starting point for conversations between family members where communication used to be minimal. The adolescents verbalized enjoying their role as experts on the program tools and often taught their parents these tools as well. They saw these times as enjoyable and felt that the parents respected them more when realizing that the child was learning useful skills. The adolescents felt that their families had a better understanding and appreciation for the work the adolescent was doing which made the adolescents feel better about themselves as well as their family members. The adolescents felt that their parents should be involved in their lives and reported often feeling that they had become disconnected from their parents in the past and did not feel their parents cared about them. One female described her feelings as, "It's a good thing they're (my parents) are involved because I think it's important for them to be part of my life, important for them to get involved in my life. That's just pretty important and I'm not sure they've seen that before." Two adolescents verbalized feeling that their families were not very involved in the program and both wanted more involvement by their parents. One adolescent reports, "They don't participate in anything at all unless my therapist practically drags them down there (to the program). I think it would be better if they would participate more because it's helpful when my mom did come to group and stuff. I wish they were more interested." The other adolescent, who was in a shelter placement commented, "It feels like I am the only one working on this, on my treatment. I
know it is my treatment but its like she (mother) doesn't want to help. I'm supposed to work on my relationship with her but its kind of hard with her not doing anything."

The adolescents focused primarily on three areas of family involvement when asked: family therapy, daily progress reports, and sitting in on group. Most adolescents identified family therapy as having made a difference in getting the parents involved with the child's treatment. Family therapy is often used to teach program skills to the family and to allow the adolescent to use these skills in the family setting. The adolescents also felt like family therapy increased communication which allowed the adolescent to be better understood and respected by the family. The adolescents reported that because of the parents also learning program skills, the parents were more interested and involved with them even when the therapist was not present as they could still discuss and apply the program tools. "It's pretty helpful because I know if I have a problem with something, they know what I am talking about in therapy and they can back me up on stuff and help me figure out my problems." One interesting finding was that several of the adolescents saw group as being for them while family therapy was more for their parents. Several of the adolescents felt that having the family involved made sense because their parents also needed therapy and could get it through the family therapy component of the program. Two of the adolescent females and one adolescent male focused on the importance of family therapy to themselves. The others reported that family therapy was important because it helped their parents or improved the family interaction.

Another frequently mentioned component was the daily progress reports to the parents from the program staff. Staff would talk with the parents directly each night when
bringing the child home and the parents were encouraged to contact the staff as well if
needed. One adolescent admitted, "I hardly talk to her (Mom) when I get home so she
really doesn't know what's going on unless she talks to the program staff." When asked
how things would be different if her parents were not involved, one adolescent quite
candidly declared, "Oh boy, they wouldn't know what was going on! They wouldn't know
how I felt, about my feelings, and what I'm thinking and stuff. It would feel like they were
kind of excluded if they weren't involved." She went onto explain that she sometimes likes
having them informed but wishes she could decide which things the staff would tell them
because sometimes she gets embarrassed about things. Most of the adolescents saw the
daily reports as being important to the parents but not really concerning them. They did
acknowledge that it made getting away with stuff more difficult because the parents
eventually found out.

Encouraging parents to sit in on their adolescent's daily group therapy received
mixed reaction. Some adolescents felt that this involvement would be very helpful but that
their parents had not yet done so. One adolescent suggested, "It would be interesting
because it'd be different because she will hear me changing while I'm here. Like seeing the
progression of how I'm doing and how I act there and to see what's different from how I
act at home." Another adolescent reported that he wants his parent to attend group more
often because he finds it easier to talk with his mother about things at group then when
they are at home. He reports that it has been very helpful when she has attended group and
that it is easier to talk about his behaviors when she is there. Other adolescents reported
that they would be embarrassed if their parent sat in on group but that it might not be too bad at times.

Monthly Family Night was also seen as an important piece of family involvement by almost all the adolescents. Again, the majority mentioned that their parents attended Family Night but did not go into much detail. This could be because the adolescents see Family Night, like family therapy, as being for the parents rather than themselves. The adolescents liked that they got to teach their parents tools and to demonstrate what they had learned. One adolescent suggested having more frequent Family Nights so “they could see my progress. I could show them everything I’ve learned and they would be proud of me.”

Many of the adolescents also commented on the lack of time they have with their families due to the intensity of the program. Some suggested that having the family members involved was necessary to give them a chance to see one another and try out new skills. Other adolescents suggested that the program took away too much time from being at home with family and friends and should be scaled back in frequency.

Family therapy emerged as its own category as the adolescents frequently mentioned it. However, the reactions were again mixed. About half of the adolescents felt that family therapy was helpful to them in improving communication with their families. Two of the adolescents reported feeling that the family therapist helped their parents understand their point of view and that the parent would not have listened if the therapist had not been on their side. One adolescent described it as, “Therapy gives me a place to tell my side of things and my parents listen because the therapist is there. They would not listen
Another adolescent who had been in numerous therapy contexts previously commented.

"Before, when we'd have therapy, we would go in a therapy room and then we'd go out and we'd act like none of that ever happened. Like we never talk about what we had just discussed. It was really emotional. But now we do, my mom and me will go and talk about what was talked about then. Which is a big deal for us. It's real important."

Other adolescents reported that they did not think family therapy did any good. They saw it as a waste of time and suggested that their parents continued to attend but that they be excused as family therapy didn't have anything to do with them. Many of the adolescents saw family therapy as being directed towards the parents and not really towards them.

**Major Categories: Adolescent 2**

Four major categories emerged from the interviews conducted at the fourth month of treatment with the adolescent participants. These categories were: *Changes, Family, Experience of the Program, and Continued Issues.*

**Changes**

While the adolescents reported that several changes had occurred for them since the first interview, many of these changes were the same changes which had been reported in the first interview. However, the adolescents were much less focused on specific behavioral changes and more focused on how these changes were impacting their lives. Another point was that, while the same comments were recorded, they were generally offered by different adolescents than in the first interview. Some of the most obvious changes were the three
adolescents who had earned days off from the program due to positive changes. These adolescents ranged across gender and age. Two of these adolescents had previously been in residential treatment services and were enrolled in the current program to assist their transition back into the family and community. One of the adolescents reported that he had earned his way from an alternative to a mainstream school, had earned two reduced days, and had been given permission to get a job. Many of the adolescents had experienced significant changes in their living environments since the first interview. At the time of the first interview, two of the adolescents were still in shelter placement while two others had recently returned home from shelter care. At the time of the second interview, those four adolescents who had been in shelter care had all returned home while two others had been sent to shelter care. One of the adolescents was sent to shelter care on two different occasions between the interviews. These transitions were reported to have greatly impacted the changes the adolescents were experiencing.

One adolescent reported that she had opened up and was participating much more in group now that she had returned home to her family. She reported that she is no longer depressed and doesn't isolate herself from others but rather seeks them out to talk about her problems. She reported that her experience with the program has gotten a lot better and that she is now getting a chance to prove herself to the adults in her life. Other adolescents also reported that they are more talkative in the group process and can more readily accept feedback given to them by peers and the group leaders. One adolescent reported that she changed because, "I wanted to and to get out of the program and on with my life". Another adolescent who had recently been sent to shelter reported that he has gotten serious about
the program and now uses group to talk about his issues as well as giving feedback and being more appropriate than at the time of the first interview. He admitted that he used to think group was boring and not helpful and would sleep in group but had to change his perceptions and behavior in order to work his way out of shelter.

Many of the adolescents’ changes focused more on their relationships with family members than in the first interview. Several of the adolescents reported that they continued to work on communication and respect with their parents which has significantly improved their relationships. One adolescent who was sent to shelter admitted, “Before my parents were working hard and I wasn’t but now I’m having to work a lot harder to get out of shelter and back with my family.” Another adolescent reported that she is now comfortable discussing many issues with her mother that she would not have discussed in the past so does not need the group to process with as much anymore. Another adolescent reported that she no longer attempts to manipulate her mother and challenges her brother when he tries to do so.

Several of the adolescents reported that they were now able to see the effect their behaviors had on others and this caused them to want to change. They described themselves as caring more about other people’s feelings now whereas they didn’t care about how they affected others in the past. One adolescent reported that his family has become much more affectionate, emotional, and supportive of each other. Another stated that, while she had stopped hitting her stepfather by the first interview, they actually were getting along now and he was making an effort to see her in shelter care in another town. The adolescents who had returned from shelter all reported that they continued to do well in school and had
not been spending time with negative peers who might get them in trouble. Once adolescent suggested. “Shelter was like reality check for me. I had better do what I’m supposed to or I’ll get sent back!” Another adolescent reported that she was getting tired of the program and felt that the program staff and therapist were too nosy. “I can’t wait to get my own place and live on my own. Everybody’s like being nosy to me. I’ve got this thing about people getting in my business. Just recently. I don’t know why.”

A younger male adolescent who had been sent to shelter and previously felt the program was a waste of time proclaimed. “It’s a totally different me now. I like myself a lot better because I respect authority more, I accept “no” for an answer, I’m more responsible. I don’t get in trouble, and I just feel better about myself.” He also mentioned that he felt proud that he had made these changes when others did not believe he would be successful and he enjoyed proving them wrong.

Family

The same two clusters which formed this category were a repeat of the first interview, Family Involvement and Family Therapy. This category was also found in the first set of interviews. The adolescents mentioned similar items as previously but appeared to be more focused and accepting of their families’ involvement with their treatment. One adolescent said.

“If I don’t want my mom to know something, I don’t like it when they talk (program staff and parent) then. But I know it has to be done. She is just as much a part of it as the program and deserves to
know. Like, if I wasn’t doing my homework and didn’t want my mom
told, it would be manipulating my mom. And the program staff wouldn’t
agree with that.”

Other female adolescents suggested that it would be embarrassing for their parents to know
everything from the program. One said, “I like the individual therapy too because
sometimes, I don’t want to talk about certain stuff in front of my parents. It would be
embarrassing, ya know?” Another adolescent reported that she would be embarrassed if her
mom attended group because she acts differently with her mom and her peers. She stated
that the feedback from her peers would be embarrassing if her mom heard it. However, she
also reported that her mom was afraid to attend the group because she did not want to be
the only parent present.

Again the adolescents reported that having their families involved was important so the
families could support the adolescent. One stated, “Sometimes I feel like some things
should be left at group. And other times, I feel it’s really important for your family to be a
part of your treatment. It’s really important if they’re supportive of you. My family is
really supportive of me and my treatment.” She goes on to explain that having her parents
better understand how she is feeling has helped and how she expresses these feelings has
really helped out a lot.

Another female adolescent reported that family involvement is the most important
part of the program for her because her main issue is her relationship with her mom. She
explained, “Having my family involved is a lot better. The whole time at residential was a
waste of my time. My goals there to be working on weren’t even the reasons I got there.
The reason I got there was the stuff at home. Here, I can be at my own home and do that stuff and be interactive. but yet, if something gets out of control, they still have access to me to put me back the way it should be.” Another male adolescent reported that he wants his family to be more involved because they would respect him more if they could see the work that he is doing and how he has changed in the program. However, he stated that he does not believe this lack of family involvement has affected his treatment at all.

Several of the adolescents again mentioned that family involvement was important because it allowed the rest of the family to get help as well. They pointed out that their family members also needed to make changes which made it easier for the adolescent to change. One adolescent described it as, “I’m glad my mom finally got involved. Now I feel like we’re in this together.” Another adolescent saw his family’s involvement as helpful because, “They (professionals) actually listen to the adults and my parents can actually get something done.”

As in the first interviews, family therapy again emerged as a cluster. The adolescents verbalized being more involved in family therapy than in the previous interviews. They described their participation in the family therapy process rather than describing it as being for their parents as they did in the first interviews. The adolescents focused on the benefits of having regular family therapy sessions and described the interactions as important to building the relationships between family members. Benefits described were: closing a big communication gap, learning to express our emotions more appropriately, helping parents see point child is trying to get across, teaches the adolescent
more about herself all the time, and provides information on the adolescent’s diagnosis and how to handle. Another benefit described by one adolescent in shelter was.

“I’m having family therapy in shelter now and think that’s helping a lot. Because we’re getting me to explain and to talk. We’re actually interacting a lot more as a family now, and I’ve been opening up a lot more in group. Before, I was pretty shut down and didn’t talk a lot but I feel the need to talk a lot now because I know that if I don’t talk, it’s just gonna build and get me nowhere.”

One adolescent male suggested that family therapy was no longer needed because all the family issues had been dealt with. Another adolescent male reported that he found family therapy to be more helpful than group but often didn’t follow through with what the therapist taught them to do. The majority of the adolescents reported liking their therapist. “She has a good personality and makes me want to work harder. She motivates me because she’s enthusiastic and has all the answers. She’s kind of like me in a lot of ways.”

Experience of Program

This categories was made up of three clusters. Overall Experience, Group, and Group Leaders.

The adolescents described having mixed feelings towards their overall current experience of the program. The questions that asked of the adolescents which brought out this category was regarding their experience of the various components of the program. Many of the adolescents reported that they did not see group and family therapy as having anything to do with one another. They felt that family therapy was to discuss family issues
while group time should be left for issues such as school and peers. However, some of the adolescents did report using the group and therapy components interchangeably to generate ideas or get feedback. One adolescent also mentioned that he applied the tools he learned in group to what he was doing in family therapy so he saw these component as being together. Other adolescents also reported that what they discussed in group, they applied to outside situations such as the family and school.

Overall, the attitude toward the program continued to be positive. One participant described it as a positive tool to transition from residential placement back to home. She reported that it kept her focused on treatment stuff and gave her structure while allowing her to be back at home. Several of the adolescents who had been in shelter commented that combining shelter placement with the program was very helpful because “it supplied both the structure and tools to get back on track.” One adolescent also commented that she uses that shelter experience to keep herself on track now that she is back at home because she does not want to go back.

Some of the adolescents were less enthusiastic about the program. One commented, “I don’t really think I’ve gotten anything valuable from the program. It was pointless to listen to other people’s problems.” It should be noted that adolescent was no longer attending the program at the second interview and had instead begun intensive individual therapy with his family therapist. Another adolescent who was pleased with the program pointed out, “But it is really stressful to be in the program because it takes up so much time.” Another adolescent complained that some of peers in group gave a lot of unimportant information and wasted too much time. “Sometimes I get frustrated, and have
Overall, the adolescents described the program and their experience as positive but did have a few dislikes to point out.

The adolescents all reported that they got many benefits from the group component of the program. One adolescent described group as “a place where I can discuss relationship problems and school stuff. I've found a peer in my group that I click with so much... so it gives me friends to have here. Even if I don't see them again, I can still talk to them here, because they're in my group. It's not embarrassing to talk about this stuff to them. It's a safe place for me.” She goes on to explain that she can't discuss many of these issues with her peers because they would just laugh and tell everyone. An adolescent male reports that he looks forward to group sometimes because “They care about you and help you and don’t make fun of you like your other peers might.” Another peer credited group with helping her to open up more by talking about things and getting feedback. This adolescent had changed programs and commented that she preferred a group with less peers which made it easier to talk more. She also reported feeling more confident in the more relaxed setting of the program site in a house as opposed to the office-based group.

Some of the adolescents saw group as being helpful and interchangeable with therapy. One adolescent commented, “Sometimes I get advice from my therapist on how to bring things up in group. And if things are bad in family therapy, I use the group to talk about it and find solutions and stuff.” A female adolescent reported that she feels they get a lot done in group because they stay focused. Another described group as giving her lots of information on how to deal with her problems and a place to get things out as sometimes it
is difficult to talk to her mom about things. One comment that was made suggested that group can be very productive if everyone stays on task. However, this adolescent felt that having younger peers in group often led to more behavior control issues and took away from the usefulness of the time. On the other hand, a younger male adolescent reported that he prefers to be with younger male peers as, "It's easier to talk with younger peers because they respect what you have to say and I don't have to be scared about saying the wrong thing".

The adolescents overwhelmingly reported liking the group leaders. One commented, "My group leader is so cool, because she's quiet but really nice. She understands a lot. She's really strict, as in cracking down hard on us, but she's still nice and fun to be with." Most of the adolescents described the group leaders as nice, supportive, and caring but strict. Several commented that they could joke around with the group leaders because they had a sense of humor. This characteristic was important to the adolescents because, "I mean, who wants to be all serious and depressed all the time?!" Another adolescent reported that her group leader, "is really understanding and gives good feedback too. She likes to challenge your thinking and that really helps. I believe she knows how to help me. I really trust her because she has helped me before." The adolescents also appreciated that the group leaders were "fair, dealt with problems right away, talks about what needs to go on, compliment and praise you, and feels like a friend should be."
Continued Issues

While many adolescents reported feeling good about their progress, they were able to identify issues which needed continued work. One adolescent reported that he was unable to maintain his grades and was forced to quit the sport he was being allowed to participate in. Another adolescent reports that she was sent to shelter for being “disobedient, defiant, and got in a whole bunch of trouble.” She reported that she realizes that she is not ready to go home yet and will be going to foster care instead which makes her nervous. She stated that she knows that both she and her parents have a lot of work to do on themselves before they will be ready to give home another try. Another adolescent who reported that he is struggling at home stated that he does not always use his skills at home with his family because they don’t always work. Another adolescent commented that she is looking forward to learning more about her diagnosis and how to handle her behaviors now that she knows what is wrong.

Leftover Comments

The comments included in this section were made only by one or two participants but seemed directly relevant or insightful so were included. These comments did not fit into any other categories.

One adolescent female commented that she enjoys being involved in the community of therapist and staff people working with the program. She said, “I think it’s kind of cool because you act like you have a little community. It’s like you all interact together and I like it because I get to be a part of that.” This comment was made in response to a
debriefing question regarding the adolescent's feelings about being interviewed by a therapist from the agency.

Major Categories: Family Time I

First round interviews with families at the second month of treatment yielded a total of five major and one partial categories. The major categories are: Perception of Services, Family Process, Family Experiences, Needs of the Family, and Family Involvement with the partial category titled Suggestions.

Perception of Services

The first category encompasses two distinct clusters which emerged. Perception of Treatment and Experience of Staff and Therapist. In the first cluster, parents had many varied perceptions of different aspects of their child's treatment. Many of the parents indicated that they saw the program as providing behavioral control of the child. This was often the first step taken as most parents verbalized feeling out of control of their child and helpless to make changes. Parents focused on the aspects of the program which appeared to be working including the structure, positive examples, opportunity to share feelings with an adult, helping the child see the need to respect others, message to the child that they need to develop skills, and positive peer interaction. One parent commented, "She's realizing that everybody is serious about making sure she does what she's supposed to do and is concerned about her getting better." One parent reported that the child's presenting issue of school truancy had been dealt with through shelter placement and that she believed the child was ready to return home. She verbalized feeling confident that the child would follow expectations because she now believed that she would be given consequences if she
did not. Thus the parent suggested that the child return home and continue services to address issues in their naturally occurring environment.

Parents also reported on the aspects of treatment which were helpful to them directly such as learning parenting skills and acquiring the tools necessary to regain behavioral control of their child. Many of the parents reported that seeing other parents struggle with the same issues helps them feel they are not alone. "It's nice to know that other people are going through the same things." Parents also identified that having the problems externalized with a diagnosis was helpful as they no long felt so guilty about their child's problems. One family reported that involvement in the program "gives us reassurance we aren't out of our minds!" Many parents also reported feeling hopeful that the program would help them regain control and help their child when other services had failed in the past.

The parents reported that the whole package of services offered was important including family therapy, individual therapy, and group in conjunction with the family involvement options. One parent noted that the child looked to the therapist rather than the parent for approval and permission. A couple of the parents suggested that the initial process of identifying and supplying what the child needed was fragmented and poorly managed. "It feels like pieces keep getting added on and this extends the time she is away from home." One family's perception was that the treatment team was also confused about what the child needed which led to confusion and frustration for the parents. "It seems like they aren't even clear on what the goals should be here." They suggested that the program needs to be willing and able to adjust to each child as needed. However, these parents also
commented that they expected that their child would have to be institutionalized and this program was currently buying him time at home so they could live with the process. Several parents acknowledged the ability to attend their child’s groups but verbalized concern that this would be infringing on the child’s time and not wanting to spoil things by intruding. One parent commented, “I would like to go but I don’t want her to shut down if I attend her groups.”

The parents described the program staff as nice to the children and looking out for the childrens’ best interest. They appreciated that the staff took the time to be detailed regarding their child’s progress on a daily basis and to answer questions. The parents found that they could get helpful feedback from the staff but did point out that the staff was very busy and did not always have time to address questions or concerns. These experiences varied some between program locations. The therapists were also perceived as helpful, knowledgeable, and trustworthy. Several of the parents remarked that the therapist made the difference and was the catalyst for change. “The therapist has really been the key for us.” The parents reported that their efforts to parent their child were supported by the therapist and, even between sessions, the therapist would return phone calls immediately. The therapist was seen as helpful in facilitating communication as the adolescent would often talk to the therapist when they refused to talk to the parents directly.

**Family Process**

Under this category, two clusters emerged, *Process* and *Communication*. The family process category encompasses both a description of the actual process the families went through as well as the changes which occurred in the course of that process.
Descriptions of the families' process dominated the interviews as families appeared relieved to have someone to talk to about their experience who would not come back to harm them with this information. While four of the families described the process as being fairly smooth, the other three families reported a difficult, frustrating, and confusing experience. The two participant families that could be characterized as well-educated with high socioeconomic status reported the most difficult process of understanding the service system and how to get what their child needed. Several of the families had already been involved in trying to obtain services for their child prior to this program. Some of the families remarked that this factor was not acknowledged while other families felt that finding this program was the end of a frustrating process for them. "We've been going through this for a long time," The three families who described their process as most difficult, struggled most with giving up control of their child to the treatment team. "It seems like I don't even get to be her mother anymore." The parents reported that they felt they had a right to be part of the treatment team but did not know how to go about making this happen. These parents were most concerned with getting information and understanding how to make things happen. The parents expressed frustration that they were not heard by the treatment team and thus their child did not have all needs met initially. "It seems like they're not listening to us." The parents then reported that their attempts to be heard by the treatment team either were ignored, resisted, or heard but not acted on. Some parents explained this response as the treatment team also being confused and not having enough knowledge of the child to make informed decisions early in the treatment process. Some parents expressed frustration that, "Not only are we having trouble working as a team but we can't
even agree on what the problems are.” Two parents reported that they agreed to initial restrictions on contact with their child but that the time limit was greatly expanded once the child was on that restriction and they felt helpless to do anything about it at that point. The process became more smooth for some of the families shortly before the first interview through a meeting of the full treatment team including the parents to identify goals and an action plan. However, one parent reported that a meeting of the professionals for her child was promised but the professionals failed to follow through with setting one up. Thus the parent felt she was unable to do anything until a professional contacted her. “All I can do is sit here and wait for them to call me.” However, the parent reports that “you have to be nice and polite when they have your daughter’s life in their hands, basically.” Several of the parents reported that it was difficult to start their child in the program. However, some of the parents felt immediate relief from stress as a result while others felt more stressed due to uncertainty and loss of control over their child’s well-being.

Several of the parents acknowledged that participating in treatment services was also a process that would take time and were not concerned that their child’s changes were inconsistent. Most parents expressed delight that their child was showing changes and seemed happy to give the process time because it was working. “Everything isn’t fixed yet but it’s gotten a lot better!” The parents who were unsure if the program was working, struggled most to decide how to work with the treatment team. These parents reported wanting more information and options than they were given so they understood that they were making the best choice possible for their child. “We just don’t feel like we know the options so it’s hard to decided what’s best for him.”
Another cluster which emerged was communication. The parents focused primarily on communication in two areas: communication with the professionals regarding treatment planning and communication with the staff regarding daily progress and concerns. Many of the parents reported that the professionals failed to communicate with one another. They suggested that the professionals all meet to talk rather than using individual communication methods which became confusing and unclear. The parents wanted to make sure that all the professionals involved with their child had the pertinent information which appeared to be lost between professionals at times. Several parents expressed discontent that they were not able to have direct contact with the psychiatrist and that outside professionals who knew the child were not included on the treatment team. One family reported, “We felt we got lost between the psychiatric, social, and program pieces”. Several parents suggested that the therapist increase contact with the program staff as well as increased daily contact with the school to monitor the child’s academic performance.

Families felt much more positive about the communication with the program staff and therapist regarding daily concerns and progress of their child. The parents commented that having daily detailed communication was the key to preventing manipulation by the child and forcing the child to take responsibility for behaviors. One parent reported, “We adults all have to communicate to get control, participate in the discipline process, and follow through so she doesn’t get away with things.”
Family Experiences

This category was formed from three clusters of information which could be called *Experience of the Program, Support and Changes*. This category describes the way the parents' overall experience has been within the framework of the program and their results.

Parents reported having both positive and negative feelings regarding their experience with a family-based program. Parents liked the results that they saw in stabilizing their child's behavior and affecting change quickly. Parents reported that the program has been "a positive experience all around", "the program has helped a lot", and "the program has helped to gain control of the child." One family in particular that was struggling with a young adolescent female in a joint custody situation reported that the program was exactly what was needed to help give them the information and tools to deal with their child. These parents reported feeling like part of the treatment team and were able to give input and make the final decisions for their child. They stated that they felt hopeful and encouraged after the first two months of treatment because they had seen more progress in their child than in a year worth of individual therapy previously. Other parents reported feeling thankful that the program was available to help take the stress and guilt off parents who don't have the information or tools to parent their child. The parents liked that the program "doesn't just pick on one person, but reached out to families.

Other comments were less favorable. Parents reported feeling confused and anxious and not feeling anybody understood what they were going through. They reported, "We had to ask what the information means and how to use it." They also conveyed that they did not know what questions to ask at the intake session as they were already emotionally
drained from past efforts to control their child's behavior. Other parents agreed. "The intake was difficult because we got so much information before we even knew what was going on." Another family commented, "We were given information at the intake but it was hard to remember everything because we were pretty emotional." Other parents stated, "We had second thoughts at intake. The intake person just assumed we had an awful kid." The parents also felt that the professionals made assumptions about the child even though the parents had information that would have clarified these ideas. A couple of families commented that the professionals tend to treat the child like all others and did not take special circumstances into consideration. However, these parents also commented that while holding a meeting of the professionals immediately to determine needs would have been ideal, the professionals needed time to see there were other issues than just behavior. One parent stated, "What we wanted was not seen as valuable." Other parents reported that they were very confused by the entire social service system and would have liked more guidance and information about what they could expect and the roles of each professional. Parents commented that they felt out of control of their child's treatment and one parent even reported that she felt she was taken out of the parent role and replaced by the therapist. One parent reported, "We had to get permission from the program straight off the bat." This parent described feeling powerless with the professionals and that the more people who got involved, the less the parent's opinion counted. Several parents expressed surprise at the length of the program and or how long their child stayed in shelter care. One parent who had several frustrations summed it up by saying, "We do feel like at least everyone is trying."
Several parents commented on the amount of time and effort the program requires. One parent described the family piece as intensive and time-consuming. Others agreed that parents must put a lot of time and focus on the child. Several of the parents remarked that they wish their child was at home more. “We hardly ever get to see her because she is at school and then the program. We really miss her.”

Another topic which was frequently cited was that of support, both the presence and absence of such. Many of the parents felt that the program itself was very supportive of their efforts to parent their child. The parents described the program as taking stress off them by assisting the parent with consequences and backing up what the parent told the child. “So the program, it like took off this incredible stress.” While many parents reported feeling the child did not believe they would follow through with consequences, the child did believe that the program staff and professionals would do so and thus chose to change their behaviors. Parents also reported that, in addition to warning their children of consequences, the professionals and staff consistently followed through even when the parent struggled to do so. Parents also reported feeling supported by the staff and therapist by their availability and willingness to discuss concerns and give information on a daily basis. Parents liked having an open line of communication with the program staff so that issues at home could also be dealt with at the program. One parent described it as, “My daughter would think that she only had to behave at the program if I couldn’t call and have the group leaders consequence her for behaviors at home too. She’s learning that she can’t manipulate me anymore because the adults all work together.” Many described the program as, “a backup for parents when we haven’t been taken seriously in the past.” The parents also found that
they got support from the professionals through meetings of the all involved professionals when the child was not making the expected changes. Parents reported that having the daily stress and feelings of being out of control of the child resolved reduced significant stress on all family members. One family described the experience as: "We’ve come out of the closet and everybody knows we have our family problems and they’re stepping forward to help." Many parents commented that they have felt alone with their situations and were embarrassed to admit this to anyone so were not able to get support until this program experience.

Many parents suggested that they would like even more support from the professionals and contact with other families. Parents consistently requested a parent support group to help them deal with feelings of guilt and burnout. Another family suggested that families could also provide mentoring to the newer families which would provide a connection and additional support without relying on the professionals. It was noted that it is difficult to reach the therapists and staff at times when the parent needs support. One parent commented, "Everybody is so busy all the time, it’s hard to get ahold of someone when you need them." Several parents suggested that one support person or crisis team be established specifically for this purpose. Another set of parents requested that the program go further by providing overnight care or respite services for families that had been dealing with problem children for a long time. They described having to give up their social life and family times due to a lack of resources to care for their child at those times. They point out, "People don’t understand that as a difficult child ages, friends and
family members get burnt out and stop offering to help when we also are feeling the greatest need for this type of support."

Parents also reported feeling a lack of support for their needs and opinions when interacting with the treatment team. Several parents reported that the professionals did not provide answers or reassurance that the parents requested initially. Many parents suggested that holding a meeting of all involved professionals early on in the process would have been helpful to them in feeling they were heard and their child’s needs were understood clearly. One set of parents described it as, “We felt on our own a lot.” They suggested that it would have been helpful to feel more included in the treatment planning and be heard by the professionals regarding the needs of the child and the family and that this would have smoothed the process for them. One parent reported that she felt the treatment team listened but did not do anything about her concerns. She felt that she had to learn to navigate the system quickly and was unable to get things done because she didn’t know how to go about getting heard. Other parents echoed this experience.

Parents reported being surprised by the speed in which they saw changes occur for their adolescents. Overall, parents reported similar changes as did the adolescents but parents tended to describe the changes as more inconsistent and less encompassing than did the adolescents. The parents reported unanimously that they had seen positive changes in their adolescents’ behaviors. It was reported that the adolescents had learned that they must take responsibility for their behaviors. “She understands now that her behaviors affect everybody, not just her.” They reported that their adolescents had become more positive and less demanding. The adolescents are described as being easier to direct and more
positive towards what goes on at home. Parents of violent adolescents consistently reported that their adolescents were no longer physically aggressive although they were often still verbally aggressive. The adolescents were less abusive to themselves, their families, and family pets. Parents reported that their adolescents were opening up more and sharing feelings which improved the parents' understanding of the child's behaviors. One parent commented, "It helps that I understand what's going on with him when we've talked about it in therapy." Parents also reported that their adolescents were more aware of the effects on others of their behaviors and had become more rational and logical. Parents reported that as the adolescent's behaviors changed, the adolescent developed more self-esteem and became more assertive.

Parents also described changes they had made as being in response to their child's changes. Parents reported having a better understanding and more patience with their child due to the child's attitude improving and better communication. The parents reported that they were less stressed as a result and were able to be better parents to their adolescent and other children in the home. Parents described themselves as moving from friend to parent roles, becoming more consistent, and learning to work together to parent their child. Parents also commented that they had to learn to let go of their child in some ways which was easier when the child was making better decisions. "I know I need to let go but I used to worry about her all the time. Now I feel better about that." Parents reported feeling less guilty and more able to enjoy their adolescents. Parents did point out that these changes were often inconsistent and occurring only because the adolescent feared the consequences of negative behaviors.
Needs of the Family

This category encompassed three clusters of topics: Needs, Issues, and Information. The families were able to identify several issues which continued to be problematic. The issue cited most often was the need for information. Parents reported feeling that they could not make informed decisions for their children because they did not have all the information. “We need to have all the information so we can make an informed decision about what is best for him.” Parents reported feeling they lacked information about treatment options, diagnosis and treatment modalities, theoretical basis and success of the program, qualifications of professionals, and practical logistical information about the program. Parents also reported wanting to understand the social services system and what is expected of them as part of the treatment team. The parents stated that they wanted to know, “What can we expect?” and felt that having this information would have helped them identify if the current treatment approaches were working or if a new approach needed to be considered.

Parents of adolescents with less usual diagnoses expressed frustration at the lack of information regarding their child’s specific needs. These parents were often attempting to assess what their child’s capabilities were so they knew how to set expectations for the child. Parents also suggested that more practical information be given in written form at the intake session regarding issues such as break and summer schedules, contact numbers, and basic tenets of the program.

Parents also identified struggling with making changes in the way they perceived and parented their child. These parents acknowledged that parenting issues continued to need
attention and that, many times, these issues opened up other relationship issues in the family which also required addressing. “We still have trouble agreeing and she uses that against us.” Parents reported that they also struggle with their own issues such as depression which often interfere with their ability to parent their child. Parents reported being concerned about their adolescent’s transition from shelter care to home and suggested that this transition would open up several new issues not currently present.

**Family Involvement**

Two clusters made up this category, *Family Involvement* and *Family Therapy*. Parents consistently supported the family involvement aspect of the program although they found that it took a lot of their time and energy. Parents reported that their most frequent involvement was through daily contact with program staff when the child was brought home each night. Families reported that being involved and informed was imperative to their child’s success because the parents are able to regain the power in the family. “If we weren’t involved, we wouldn’t know anything!” Parents also consistently reported that their involvement showed the child that they were cared about and motivated the child. Many of the parents verbalized wanting to be as involved as they could in their child’s treatment to speed the process and show the child they were invested and trying to help. Parents were surprised at being invited to sit in on their child’s groups at any time and verbalized being concerned that this would shut down their child. However, parents who did participate reported being surprised at the openness of their adolescents in the group setting and reported that this experience was very helpful to them. “I was concerned that going to her group would shut her down but she was really open.” Many parents
commented that they were unable to attend the groups due to work conflicts but reported that they wanted to do so. Other parents reported that they enjoyed being able to drop in on their adolescents whenever they wanted which kept the adolescents on their toes. “It keeps her honest when I can show up at any time.”

Parents reported that they found the monthly Family Nights to be most informative and consistently suggested that they be held more frequently. Parents also pointed out that they often had to miss the monthly Family Night with such chaotic family situations and would like more opportunities to attend. They also commented that there was not enough time for all parents to talk and more frequent meetings would remedy this problem. Parents reported being anxious to learn the tools of the program so they could understand and help their adolescents at home.

Only one family identified family therapy as their primary family involvement. They reported that the family therapist gave them reassurance that they were okay. This family reported not having much family involvement otherwise because of their busy schedules. They commented that they hoped to become more involved in the future because they felt it was important to the child’s success and feelings. One parent identified feeling pressured to be involved because otherwise her child “would be the only one without a parent there and she would feel I didn’t care.”

Families consistently brought up the topic of family therapy as being the most helpful component of the program in helping them regain control of their households. The parents reported liking the parent education aspect of family therapy and felt more in control and confident because they were gaining skills and knowledge of how to parent
their child. The parents usually saw their therapist as working collaboratively with them and being respectful of the parent's needs. "She gives us suggestions but always lets us make the decision." The therapists were seen as helping the family address issues which were not otherwise able to be discussed in the past. Parents felt they were able to get to know their child through family therapy because the child trusted the family therapist and was more willing to discuss issues in the family therapy setting. Parents consistently noted that family therapy has been helpful to all members of the family and the changes affect everyone in the home.

The most interesting result of the family involvement category was that families consistently wanted more family involvement. While families verbalized surprise at the amount of family involvement already included in the program, they verbalized willingness and a desire to be even more involved in specific components for the parents. They generally cited wanting more information or support through these additional suggestions for family involvement.

Suggestions

Parents had several ideas for improving their experience while participating in their adolescent's treatment services. Many of these suggestions emerged from the results presented previously. Many parents suggested that professionals need to gather more complete information when the child first begins the program and to use this information to develop an comprehensive treatment plan in which all professionals and the parents are involved. "We had a lot of information but the treatment team didn't seem to want to hear it." The parents also suggested that providing more information on issues mentioned
previously would allow them to be of more assistance to the treatment team in meeting the specific needs of their child. Parents also wanted basic program information to be available in written form at the intake session so it could be referred to at a later time when the parent was less overwhelmed. Parents wanted more specialized parent training and more frequent parent support nights so they would know prior to problems how to handle situations. "It would help a lot if we could know how to deal with a situation before it happened instead of having to always call the therapist to find out how to react." Parents also would like to learn from past parents' experiences either through mentoring, presentations, or videos describing their experiences. Parents would like information about specific stages of treatment and how to know when their child is on track to success. Parents also suggested that their children's groups be held later or on weekends at least once a week to allow for more parent access.

Leftover Category

At least three of the families provided an interesting response to their member checks. They reported being surprised that the information had been recorded so accurately and expressed their appreciation for this. They reported initially being concerned that their experience would be misconstrued or misunderstood by the researcher. These families generally appeared uncomfortable and anxious about the interview process prior to the first interview. In the second set of interviews, they appeared much more relaxed and open.
Two major and one partial category emerged from the second wave of data from parent interviews. The major categories were Process and Changes, with a partial category called Needs.

**Process**

Three clusters of data are included in this category, *Process With Treatment Team, Process With Child's Treatment,* and *Therapy.* Two distinct processes emerged from the parents' second round interview data, the process with the treatment team and the process of their child's treatment. Parents generally reported feeling like their processes with their child's treatment team were significantly more smooth than in the first round of interviews. Many of the parents who described feeling frustrated with this process in the first interview, described it as a necessary process that the treatment team had to go through. Parents were much calmer about their interactions with the treatment team and they verbalized feeling more in control and more informed than previously. However, they commented that while they felt the treatment team was more on track, there was still a lack of knowledge about how to meet the child's specific needs and the treatment team did not appear to have the necessary information. One set of parents commented, “When I look at what we’ve gone through, I would think this process would be really intimidating to families with less resources. I would think they would feel very defensive.” These parents also commented that, while they felt confused and frustrated with the process, they made an effort to avoid hostility or conflict with the treatment team because they felt this would not help their child. Parents reported that the professionals tended to focus on their areas of knowledge and did
not make much effort to find the needed information. "It seems like none of the professionals at the table now have the answers." In the two higher SES families, the parents report that they had to do research to find such information themselves. They suggest that for a long time, people did not listen closely and when they did begin to listen, they did not have the answers. Some of the parents pointed out that they have been seeking help for their children for many years and that the child gets more difficult to manage with age. A couple of these parents commented that they had not been successful getting help for their child over the past several years so were at least thankful for the behavior stabilization that the program offered. Parents saw a need to reassess the child's progress more often so appropriate adjustments could be made without wasting so much time in the process. When asked, one set of parents described their process as, "It has been hell. It has been like getting run over by a truck!" The parents who had initially reported problems in the process with the treatment team reported that these issues had been resolved. Parents also commented that it was easier to accept issues and new ideas when they felt more in control of their child's treatment. "Things are better now that he is back at home."

One family reported that the family issues had been resolved but that the child had difficulty making the transition back into the school from shelter. These parents expressed concern at the lack of preparation for transition and felt the treatment team did not interact enough with the school system prior to this transition. Some parents suggested that the treatment team needs to widen its focus from the family to include the larger context of the child. Others complained that the professionals in various agencies did not have enough
interaction to make the process work well. "I think the agency needs one person just to coordinate between all the agencies."

Other families reported that the process has been a bit overwhelming but that they are very happy with how the treatment team has stepped in to support and assist them. These families acknowledge that the process is "scary but worth it." One parent commented that she didn’t necessarily like the decisions the treatment team made but that she “got what she came for” from the program as a result. One family suggested that their process ended when their child began the program. They reported feeling that the process they went through previously trying to get help for their child through insurance was "pointless and frustrating and we are just so glad this program does all that for us!" Several of the parents reported that they would not suggest any changes for the process and that they were very impressed with the work of the treatment team.

Parents also described a process that they were going through with their child’s treatment. In all, six of the seven families had a child placed in shelter care within the first four months of treatment. While most parents saw shelter placement as necessary and helpful, they felt that making the transition to and from shelter added another level to the process they went through. These parents described stages in which they had to transition their children back home or a crisis point in which the parent realized the child needed more than they could get in the home for a time. Parents reported feeling that the treatment process itself was important to mention because of the uncertainty and inability to know what was coming next created stress for the families. One set of parents whose child went through several shelter and hospital placements remarked, "The process was very fractional
with pieces everywhere. We felt like things were jumping from place to place and we were
the only consistent adults looking out for our child.” They suggested that a better plan
needed to be laid out ahead of time to prevent this fragmentation and chaos with services.

Many parents reported that getting help for their child was “the hardest thing I’ve
ever done.” One parent said that she didn’t want to be forced to get help but in hindsight
realized it was the best thing she could have done. This parent was one of those that had
many frustrations with the treatment team and their process initially. Another parent
reports that they were hopeful at first but feel like they just go back and forth with their
adolescent and are feeling frustrated and burnt out. “The program is fine, the problem is the
child. It’s just not working with him.” Other parents also described regression by their
child in the past two months although most felt the child had gotten back on track with the
interventions used. Several parents described the process as going through stages in which
the child would make progress and then fall back. They commented that understanding
these stages helped them hang in during bad times. “It’s easier when I know this is just part
of the process so I don’t make such a big deal out of it.” Some of the adolescents were
described as able to do well in some areas but not consistently well in all areas which caused
outsiders to not understand the depth of the problems. One parent remarked, “They would
understand a lot more if they had responsibility for this kid 24 hours a day!” Parents also
commented about the child’s continued reliance on the therapist and staff to communicate
and stay on track. Parent also saw this as being part of the child’s process.

Parents identified that they continued to have issues to address. A couple of the
parents described their children at times as still being defensive, argumentative, and
inconsistent which caused stress in the family. One family expressed concern that the child did well everywhere but home and that the younger siblings were beginning to imitate his negative behaviors. Other parents reported struggling with their child’s developmental issues such as interest in sex and wanting independence. One family suggested, “We haven’t really changed as a family yet. We still have a lot of overhead. He (the adolescent) needs to understand that he does not rule the roost at home before things will be easier.”

Changes

This category was comprised of two clusters. Changes and Benefits. Parents also described many changes in the second round of interviews but these descriptions were much more process-and detail-oriented. Parents continued to describe changes in their adolescent’s academic performance, interaction with the family, and positive behavioral choices. Parents reported that their family relationships had improved significantly due to the adolescent’s increased communication and willingness to accept feedback and direction from the parents. They described their adolescents as happier, having more confidence and self-esteem, less likely to give into peer pressure, and more thoughtful. Some parents commented that they were also changing in response to the changes by their adolescent and were feeling less stressed and more understanding. Parents also described changes they continued to make in parenting. Rather than relying on the professionals for support and follow through, parents reported having become more able to apply tools on their own and were feeling more confident about their ability to manage their child’s behavior.

Three of the families reported that their adolescent’s behavior had gotten worse since the first interview. Two of these adolescents had been placed in shelter and were
already showing improvement. Another family reported that their child began to backslide when given some privileges but responded positively when parents removed those privileges. The parents again remarked that they were pleased with the positive changes but felt "we are not there yet!"

Parents also identified aspects of the program which they felt were beneficial to creating change. The structure of the program was seen as most valuable to helping the adolescents become motivated to change. "I think the structure itself has been the greatest benefit for her, both at home and the program." Parents also commented on the support they were given to create change at home which allowed them to regain control. One set of parents commented that it was beneficial they were able to see the child's capabilities in the program so knew what to expect at home. Several parents saw shelter placement as a benefit of the program. They reported that their child benefited from the structure of the shelter and realized that they needed to get serious about change. The parents also identified that they felt shelter took a tremendous amount of stress off them because "we don't have to patrol him every night now!"

Needs

This categories was comprised of four clusters of data, Needs, Family Issues, Information and Advice. Parents reported a variety of needs that they and their adolescent faced. They also offered suggestion for how these needs could be met by the professionals working with them.

Some parents reported still feeling they did not have the necessary information to really understand their child’s needs and options. Several families reported that they had
not gotten more information as requested since the first interview. Most families reported not having a meeting with all professionals since the first interview. One family commented that they had to learn about resources and laws themselves in order to get the professionals’ cooperation. “We have had to really go out on our own to get the information.” Several parents wanted information on diagnoses that had been assigned to their child and how to work with that specific diagnosis.

Families also verbalized feeling burnt out and not sure what options were available to them. One need mentioned was an academic program where children with problems could get comprehensive care. Another parent wondered how the child would react to the reduced structure of summer and wanted suggestions on how to address this issue. Several parents commented that their situation was unique due to their child’s diagnosis. “I think our child is different from others because of his diagnosis.”

Families also suggested that the professionals sometime view all adolescents as problems so don’t focus enough on the positives which occur. One parent commented, “Yes. I know my child has problems but she’s not a delinquent. I felt like they assumed the worst.” Parents again suggested that the services be tailored to meet each child’s individual needs and that someone be added to the team who specifically can find information on medical and social service type questions. Some of the parents suggested that it would have been helpful to have one person specifically to navigate through all the agencies and transitions.
Leftover Category

About half of the parents expressed interest in the study and what responses had been gathered from other participants. They asked questions about specific results and wanted to know if their experience was similar to others. Questions were asked about the uses of the study and how it might impact the current functioning of the program. Several participants asked if the interviews would continue every two months and asked to be included if this occurred.

Two parents remarked at how useful the interview process was for them. One parent said, “It’s been really neat to sit down and talk to you about all this because we really have to stop and think about what has happened.” Another parent referencing her membercheck summary commented that she was so glad to have that summary and wanted to share it with the treatment team because it really captured their whole experience in a way she didn’t think she could communicate otherwise. Other parents also reported that they would discuss topics from their interviews with their treatment teams. These families had been asked to refrain from these discussions until the data collection process was complete to prevent bias.

Major Categories: Therapist 1

Three major categories emerged from the first round of therapist interviews. They are Families’ Experience of Treatment, Change, and Program Success.

Families’ Experience of Treatment

This category encompassed four clusters of data, Perception of Treatment, Process, Role of the Therapist and Family Involvement. The therapist participants described the
families they were working with as having varied perceptions of their child's treatment. About half of the therapists reported that the families felt very positive about the program and were pleased with the changes their child had made. The therapists noted that the families appreciated the program's collaborative approach which encouraged parents to have input and make decisions with the treatment team regarding their child's care. Several therapists commented that the parents reported expecting to feel blamed as they had in past experiences but this did not happen. One parent told the therapist, "This is the first place where I have felt I'm not at fault." Overall they felt that the families had a positive experience thus far. These therapists reported that the families felt the child was getting something positive from the program. The therapists commented that some of the parents saw the program as only behavioral control. Other therapists reported that their families were looking for a cure-all and were disappointed at the amount of time and effort that was required.

Other therapist reported that their families felt they were in an adversarial relationship with the professionals working with their child. One therapist commented, "I know that this family is very frustrated but I don't think they understand what we are trying to do." One therapist felt that the family wanted to support the program but were concerned because they did not really understand how it would help their child. Another therapist reported that she was taken by surprise by the intense sentiments expressed by one parent who stated, "Child abusers have more rights than I do!"

The therapists also noted that the families experienced the program as being very time-consuming, both for the parents and child. Several of the therapist suggested that the
parents were confused about what the program taught and did not see the impact of the group therapy as the adolescent did. Another therapist reported that her family was concerned that she thought they might not like her.

The therapists described processes that both the adolescent and parents were going through. Adolescents were seen as trying to get out of the program at first and then trying to pretend to make changes. When the adolescents realized they would really have to work, this often created a crisis which, at times, led to negative behaviors and chaos. One therapist commented, “We always say things are going to get worse before they get better and I truly believe it!” The therapists reported that these crises do not last long and then the adolescent appears to start working and making initial changes. Some parents became reinvested with such a crisis while others “completely flipped out and began questioning the program.” Another therapist reported that her family saw a need to take control and then a shift occurred for them. One therapist reported, “I think that the whole process was really key for this family. And while it has been very difficult for them, it’s what they needed to take control and show their child they cared.” Several therapists described these mutual processes as “a roller coaster ride.”

Therapists saw their families who had a child in shelter placement struggle the most. They reported that these parents felt they lost control of their child and felt threatened that the child would not be returned home. However, these parents felt more comfortable once the child did return home and often were able to get themselves unstuck from their focus and move onto therapeutic issues.
Parents were also seen as struggling with the process of understanding what was expected of them with their child's treatment. Some parents are described as tired and happy to let the professionals take over. Other parents are seen as struggling for control of their child and getting stuck in frustration with the process. One therapist described a parent as "struggling to sort this out. She is trying to figure out her own thinking because she has been surpassed by the child at this point and does not understand."

Therapists described their roles with the families as a mediator, facilitator, and advocate. They reported that they worked to support what the family wants and to encourage the family to accept the program and support the child. "It's important to help the family support the program or it won't be successful." The therapists stated that they teach the parents about the program and try to connect them to the group process. The therapists identified that they are responsible to look at the individual needs of the child and family and to work with the other professionals to have those needs met. Several therapists reported that they strive to empower parents to do something different through learning of tools and skills. One therapist also commented that it is important to support the program in the family to prevent problems.

Therapists saw their efforts at creating family involvement as having mixed results. Only two of the therapists felt their families were involved at an appropriate level. Two other therapists reported that their families were not involved enough. They attributed this to the time requirements of the program and a belief by the parents that the child would not participate if the parent got involved. One therapist commented, "I think if they would have been more involved up front, the crisis which produced change would have occurred"
earlier.” Three therapists reported that their families appeared to be overinvolved in a way that was not helpful to the process. However, in one family, this overinvolvement was also seen as indirectly helping the treatment because the adolescents saw this involvement as his parents caring about him.

All of the therapists believed that family involvement is vital to success for the adolescents. Several therapists echoed the comment. “The family system won’t change without the parents and the child will not want to change unless the family is involved.” Therapists consistently commented that the parents could benefit the child by learning the program tools to use at home but this was not happening for most of the families. The therapists also felt the parents would benefit with learning the tools so their thinking would also change in a positive way. One therapist suggested that parents are not interested in the tools until they see them working and then want to learn them as well. In some families, the therapist saw family involvement as giving the parents and child a common focus which allowed them to work together and created bonding. Family Night was seen as a primary way to get families hooked into the program setting and to help them get involved. One therapist commented, “Many parents really don’t want to be a part of this. They just want us to fix the problem for them.” The therapists were often frustrated with the lack of hands on involvement by the parents and attributed this to fear or a lack of investment by the parents.

The therapists reported that family therapy was the most useful component at this round of interviews. The therapists reported that they feel conducting therapy in the family’s home gives them a chance to really know the family. Some of the therapists felt
they know the family better than the program staff and can help the staff as needed. Many therapists focused on parent skill development at this stage. The therapists reported trying to use program tools and feedback in the family therapy setting to familiarize the family with these tools. The therapists generally felt that the parents were receptive to specific suggestions. The therapists noted that they work with family issues in the context of the child's behavior so the parents do not feel blamed.

Change

Three clusters made up this category, Changes, Benefits, and Barriers to Change. The therapists reported several changes made by the adolescents in the family context but with less focus on changes made by the families. The adolescents were described as more easily directed and aware of behaviors. The adolescents were described as happier, less hopeless, more expressive, less violent, and having brighter affect and a better appearance. One adolescent was described as having more developmentally appropriate behaviors such as focusing on school, peers, and getting a job. The parents were described as becoming more of an authority figure and feeling empowered because the child listens to them. Parents were described as more consistent, structured, and united to prevent manipulation by the child. "The parents have started to learn to stay together instead of fighting over the child." The parents' perceptions of the adolescents also began to change as they began to hold the child responsible and allowed the child to become more independent and capable.

The therapists also identified several barriers to change focusing on parent behaviors and perceptions. Two therapists commented that the parents were separating themselves from the child's program and not utilizing all that was being offered to them. One therapist
commented. “It’s frustrating because what they need is right there but they aren’t taking advantage of it.” Other therapists also commented that the parents were not learning the tools of the program which prevented them from assisting their child at home. One therapist pointed out that she believes her parents felt uncomfortable because the child knew the tools and “they didn’t so they dismissed it.” Some parents were seen as being very stuck in focusing on treatment team issues which prevented a focus on positive changes. One parent was seen as sabotaging the program because she felt threatened by the therapist’s relationship with her child. The therapist suggested, “I think she sees me as competition for her child.” Other parents were coping with feelings of being bad parents. Many therapists felt that the parents needed to change their perception of their adolescent. One therapist reported feeling that her family was set up to have problems because they experienced a tremendous amount of transition prior to being told they had to participate in this program as a last effort. This therapist felt she was presented in the expert role which put the parents on the defensive. “I really was set up to fail by the DHS worker because these parents were forced to come to us and I was presented as the expert.” Other parents were viewed as feeling that the therapist was trying to prevent their child from returning home which created problems with a therapeutic alliance. One therapist mentioned that the parents she was working with were so focused on not being blamed that they were unable to accept any suggestions or feedback. Other therapists were struggling to understand the needs of the child, some of who had difficult and unusual diagnoses.
Program Success

This category includes the clusters of Program Success and Suggestions. While the therapists were being interviewed specifically about their experiences with these families, they also offered some general ingredients necessary for the success of the program. The primary ingredient was the involvement and investment of the parents in the child’s treatment. The therapists agreed that the program could not be successful without this involvement due to the limited power the child had to change the family system. Several therapists commented, “When parents aren’t involved, the kids aren’t usually very successful.” It was also seen as important for the parent to learn the program tools and to use these at home with the child. This allowed the parent to gain control of the child at home as well as continuing the child’s treatment when not at the program. Families who had greater resources than others were seen as having more success in the program. One therapist identified successful families as “families who go through the program quickly, are able to accept feedback, are insightful and really listen.” One therapist commented that families need to feel immediate benefits in order to maintain investment in such a time-intensive program. Other therapists pointed out that the intensity of the program was vital in helping the child make change.

Therapists also had suggestions for improving the program. One specific suggestion which was repeated by many of the therapists was the need for more Family Nights or parent nights. They also suggested creating a mentoring system for more and less experienced families to get support and ideas. Therapists really wanted to find a way to require parents to be more involved at the start. “I wish we could make group attendance
mandatory for the parents as well so we could get them involved." They also suggested that groups be made smaller so group leaders have more time to communicate with parents and to encourage their involvement. Another therapist suggested using quantitative testing measures at intake to provide a faster assessment of the needs of the child and family.

**Leftover Category**

Three of the therapists commented that the families they were working with were not typical clients. However, when trying to describe how the family was not typical, two of the therapists concluded that their families really were not that different from other families in most characteristics.

**Major Categories: Therapist 2**

Two major categories emerged from the second set of therapist interviews. They were *Family Process* and *Change*.

**Family Process**

This category emerged from four clusters, *Process, Shifts, Working with the Team,* and *Family Involvement.* Only one therapist reported that her family did not seem to have gone through a significant process since the first interview. All the other families had experienced a significant transition or shift with their adolescent which the therapist experienced as normal and necessary. Several of the transitions were made to or from shelter placement. These transitions were seen as stressful for most of the families but positive in creating change. Two of the family’s processes were described as creating barriers to change and the therapists were struggling to get the families back on track. "The family is really stuck and I don’t know how to get them moving again," lamented one
therapist. Two sets of parents were seen as becoming much more open and comfortable when their child returned from the shelter. All the families who had children return from shelter had been able to implement more structure and consistency in their homes and were seeing success. These relationships were described as having much less conflict and more open communication than previously. Two other families had taken the step of regaining control of their child by placing him or her in shelter care. These families were described as struggling with the decision to make this change and requesting support from the treatment team to do so. These parents had begun to put responsibility on their children rather than blaming themselves. "They finally figured out that they've done everything that they have been asked and he is still making poor choices. Now they can accept that this is his choice and are putting this responsibility on him." These parents were also seen as becoming much less angry towards the treatment team and more confrontative with the child. The therapist suggested this change has occurred because they no longer feared the consequences of escalating the child's behaviors while he is in shelter. Many parents were pleased that behavioral control of their child had been achieved by this time. Only one set of parents felt their child had not made positive changes. However, the therapist disagreed, pointing out that the child made many positive changes in all other areas and initially at home. These parents were seen as angry and needing to change their perception of their child. The therapist reported, "These parents want the child to do all the changing but aren't willing to look at how they parent him." Another therapist described feeling frustrated with her parents, "They are working against one another with one getting in the parent role and the other rescuing." Two therapists were struggling to keep their families focused on positive
changes rather than getting sucked back into negativity. Three therapists indicated that marital problems between the parents had become an issue since the first interviews. Another therapist saw her parent as being scared of change and struggling to see herself as a good mother while providing structure. Another parent learned to give her child independence but the child then tried to pull the parent back in. Many of the therapists perceived their families to be more comfortable with the program and saw increased family involvement. Many of the therapists commented that lasting change was just beginning, that these adolescents and their families still had a long way to go.

A few of the therapists specifically identified shifts which occurred for families during the past two months. One family was described as doing everything they asked but still frustrated with their child's behaviors. The therapists suggested that the parents were able to recognize that the child need them to take charge by placing him in shelter care. The therapist reported that this incident created a shift in how the family parented the child and related to the therapist. She stated, "The energy is different now. They are focused on the positive and what is working now instead of all the negatives that were the focus before."

The families who had been struggling to work with the treatment team were also seen as undergoing a change. These families were able to hear the professionals and be open to feedback once their children returned home. One therapist reported, "I think they didn't feel like we were hearing them and we didn't feel like they were hearing us." She also commented that she has taken a backseat role with this family and the parents have taken over the treatment planning for their child. This therapist described her process as extremely collaborative but was unsure if the parents would have the same perception. She
attributed this in part to the parents being unaware of the amount of collaboration she had
done with other professionals as well. "I don’t think they would see me as being as
collaborative but then they haven’t seen a lot of the work I’ve done behind the scenes."
The other parent who had been struggling with the team process was reported to be much
more open to suggestion and working hard to be part of the treatment team. The
therapist’s perception was, “But she still is questioning how much control she really has and
still feels like an underling on the team.”

The therapists also described their parents as being much more involved in the
treatment process. The therapists attributed this to a higher level of comfort with the
program and more knowledge of the program tools. One set of parents was seen as being
forced into more involvement by having to drive to another town for therapy because their
child was in shelter. One family had required constant prompting to get involved with the
program and report that they do not believe the child wants this involvement even though
he tells them differently.

Change

Three clusters made up this category, Change, Family Issues and Barriers. The
changes reported by the therapist in the second interview were generally reflections and
expansions of the change reported previously. The adolescents were described as being
more open and able to handle confrontation. The adolescents consistently maintained and
improved on their school successes and this often was no longer mentioned as a treatment
issue. Therapists also reported that the adolescents had begun to teach their parents the
program tools which led to improved relationships and bonding.
Parents were seen as being more confrontative with the child and able to process conflicts. One parent was described as, “She has made a significant change by starting to identify her daughter’s needs as separate from her own.” Parents were seen as listening more to the adolescents and shifting their perceptions accordingly. One therapist reported that her therapeutic relationship had changed. The family was seen as “relaxed, friendlier, joking more, asking more personal questions, warmer and more joined to the therapist.”

Therapists saw the group process as making the most impact on creating change for the adolescents. The group was described as a safe place to process, be heard, be validated and receive positive strokes. A couple therapists commented, “I really think she’s gotten the most benefit from group.” Several adolescent females were described as having really joined with the group leaders and using them to get feedback on family issues. The most valuable component of the program for the parents identified by the therapists included having a place to talk with family in family therapy, feeling supported, that things are not their fault, and having the therapist advocate for the parents.

Some therapeutic issues were identified by the therapists as still needing to be addressed. In two families, the problem was seen as the parent’s relationship which prevented change. Several parents continue to struggle with following through and need support to do so. Another therapist reports that the family sees the child as not capable of change while other parents are not using the tools available to them.
CHAPTER 5
DISCUSSION

This was a qualitative study designed to elicit the perception of participants' experience with a family-based adolescent treatment program. The study was designed to provide a thick description of this experience from the perspectives of the adolescent, parents, and therapist working with the family. The Major Categories which emerged from the study were: Changes, Adolescent Perceptions, Family, Experience of Treatment, Continued Issues, Perception of Services, Family Involvement, Family Experiences, Needs of the Family and Program Success. Partial categories included Suggestions and Needs. These categories included a range of responses and comments that the participants offered. They also reflected an appreciation of the experiences that were common to the participants as well as to the differences.

A total of forty-two interviews were conducted with seven adolescents, fourteen parents, and five therapists. These interviews were conducted at the second and fourth months of treatment services to obtain a picture of the process of change which occur in family-based treatment programs. The participants employed a wide range of responses which provided new and interesting information regarding the lived experience of families as they perceive it rather than relying on what researchers and clinicians believe occurs. The responses, for the most part, supported the justification for the study. While participants confirmed what researchers already believed to be true, that family involvement in adolescent treatment programs is a vital component, they also expanded the current understanding of how these treatment programs can better collaborate and help these
families. These results suggest that both parents and their adolescents want family involvement in treatment programs for a variety of reasons. Adolescents report feeling less blamed and more supported with this involvement. They also suggest that treatment would not be successful without such family involvement as the adolescents would be able to manipulate their way through the program. The parents wanted to be involved to show support for their child as well as to regain control of their homes. These parents also believed that family involvement was crucial for preventing manipulation by the adolescents.

The current program under study as well as the MST and FFT models of adolescent treatment programs are based on the concepts of Family Systems theory. This theory posits that persons do not exist in a vacuum but rather their behaviors must be viewed in the context of their relationships with others. Thus, family members' behaviors impact one another in an interactional manner so that specific patterns of interaction are formed. These patterns may be functional or dysfunctional at any given time. Thus, when developing programs for adolescents, it is important to include their context, or the members of their families as well in order to affect change.

The participants also provided information that was not previously known regarding the level and types of involvement which they would find most helpful. Furthermore, the participants added information about a new domain which could be identified as Larger Systems Issues. While family systems theorists examine the relational effect of families, they have generally failed to take into consideration the larger effect of social service professionals forming a new system to provide assistance to that family system. Thus the systems becomes layered and the potential issues multiply. Thus, while the results would
indicate that theorists are on target with their systemic thesis, it would appear that they have not taken these ideas far enough to fully benefit client families. While some attention has been paid to the ideas of ecosystemic (Brofenbrenner, 1979) or multisystemic (Henggeler, 1997) systems, these ideas have not received much attention when working with larger social service professional systems.

An interesting finding was the direction taken by the participants in response to the type of open ended questions used. Participants chose to focus more on the interaction of agency personnel and practical matters rather than discussing therapy process or therapeutic reasons for change. The participants identified several areas of interest which the researcher had not expected at the start of the study.

The results demonstrate the ability to gain the perspective of therapy participants through a simple method: asking them! For years, researchers have created measurement instruments and developed research ideas based on their beliefs about the client experience. The results of this study demonstrate that clients are able to provide a clear and detailed description of what the therapy process is like for them. This information can then be used to develop quantitative assessments which include the perspective of the clients themselves.

**Major Points**

One benefit of this study is its three-dimensional nature which examines the family experience from three viewpoints at one time. This task is also a difficulty of the study in that a tremendous amount of information leads to difficulty discerning what are the major points of the results. Thus, a brief overview and discussion of the results will be presented here.
Similarities and Differences

The advantage of eliciting three different viewpoints of the same event includes creating a more comprehensive description as well as providing information about differences of perspectives. While the adolescent development literature might suggest that the perceptions of early and middle adolescents would be significantly different from that of the adults, this generally did not hold true. The adolescents and their parents often described similar changes which had occurred and both stressed the need for family involvement. Both reported liking their therapist and found that family therapy was helpful to the parents. Consistent with the concept of egocentrism in adolescence, the adolescents were more focused on changes they had made individually as well as how the individual components of the program affected their treatment. However, in the second set of interviews, this egocentrism tendency was less pronounced and the adolescents were more in tune with their parents by being focused on family issues.

Parents differed from the adolescents in that they were more focused on the process of developing and assessing treatment needs for their child. The parents spent significantly more time discussing their process of joining the treatment team and developing an understanding of the program than did their adolescents. These parents often verbalized feeling out of control of their adolescents at the start of treatment and consequently also felt they lost control of the choices being made for their child in the treatment setting. Some parents viewed this process as having responsibility taken off them and appreciated the reduction in chaos and stress in their lives. This difference in perception and resulting experiences is consistent with the ideas of narrative therapy which suggests that people
develop a story or narrative about events around them which then take on the meaning of
the story which is being told (White & Epstein, 1990). This finding suggests that parents
have a significant amount of choice in how they experience being involved with their
adolescent’s treatment.

Therapists and parents gave similar accounts of their experience but therapists were
more likely to describe these experiences in a process language than were the parents. In
the first round of interviews, parents tended to be focused on content-specific matters such
as gathering information and learning about the program. Therapists tended to focus more
on the interactions between the families and those people around them. This result would
be consistent with the theoretical basis and training of family systems therapists who focus
on interactions rather than cause and effect. However, this result may also be indicative of
some of the difficulties parents encountered in working with the professionals in the
treatment team concept. Parents seem to shift to a more process oriented view in the
second interview enabling them to see their issue in a more interactional way which
appeared to offer solutions to them.

Therapists and adolescents seemed to see the experience of the adolescent in a
similar fashion. They reported similar changes in behaviors and perceptions although the
adolescents described more change than did the therapists. This similarity may indicate that
the therapists and adolescents were viewing their changes in the context of the
cognitive/behavioral model of therapy used in this program. It may be further indicated that
parents were not as comfortable or familiar with the concepts of the cognitive/behavioral
model and thus did not have more similar perceptions. The therapists were more aware of
the process that the adolescent was going through and used this information to keep the adolescent focused and motivated. The therapist and adolescent seemed to view their relationship in the same manner and felt this relationship was helpful to the adolescent in interacting with the family.

These results provide an interesting point of discussion. While therapists and adolescents seem to be working from the same perspective, parents appear to be fumbling for a framework from which to view the program and changes which their adolescent was experiencing. This may indicate a need to further incorporate parents into the cognitive/behavioral model that is taught in the group therapy component. This may allow parents to be more comfortable with the process and develop a better understanding of how they can be part of the process. This would also provide more of a common ground between the treatment team and the parents in creating a treatment plan for the child.

Adolescent Development

Few differences in results based on age were found in the data. This finding is surprising given the cognitive focus of the program under study. However, participants were not asked specifically about the individual treatment models used but rather about their overall experience of the program which may explain some of this finding. However, given the differences in the cognitive abilities and depth of personality development of adolescents, some differences would have been expected. This finding may be due to the limited sample size of this current study.

Some gender differences were noted as the males initially verbalized less support for the program and felt the program would not be helpful to them. This finding is in
agreement with theorists in the literature that suggest that therapy is seen as a feminine pursuit as it involves discussion and revealing of abstract ideas and feelings (Doherty, 1991). Females were also reported in the literature to be more influenced by family in the middle adolescent period than are males which again may be indicated with these results. This result bears further inquiry into the gaps in providing gender-appropriate treatment for adolescents.

Family Involvement

Both families and their therapists identified family involvement as a crucial component of a successful adolescent treatment program. While the parents verbalized a desire to participate in the program, they were reluctant to take advantage of several options that would have increased their family involvement. This hesitancy could be attributed to the parents' uncertainty about what their role is to be with the treatment program and their fear that they will be the only parent participating. Parents also verbalized concern that some forms of involvement would not be welcomed by the adolescent and would serve to shut the adolescent down. However, for the most part, the adolescents indicated that they wanted their parents to be involved in these activities and felt that this involvement was helpful.

Parents reported wanting a higher level of family involvement than was offered in the current family-based program. This finding has important implications for the many programs that struggle to truly become family-based and do not offer as many opportunities as the parents in the present study were given. Parents also requested that their involvement be increased through curriculum designed specifically for them in the form of
parent skills training or a parenting support group. Parents also wanted more involvement with other families that were experiencing the same problems and could provide mentoring and support to one another.

**Parent Needs**

Parents reported feeling frustrated and confused by the process of becoming involved in their child's treatment. These parents were able to make specific suggestions for ways to get these needs met. The therapists also saw the struggle of these parents and were at first frustrated by the parents' behaviors. However, in the second interviews, both the parents and therapists were more clear on the causes for these problems. They suggested that parents take out their frustrations on the treatment team because they do not feel safe escalating their child when in the home. They also suggested that parents feel as though they are losing control of their child and are scared by this perception. Parents suggest that providing information and options would greatly reduce their fears and make the process more smooth.

**Individual Treatment Needs**

Therapists described part of their roles as identifying and meeting the individualized treatment needs of each child and family. However, some parents consistently felt that this process was not happening. Parents reported that they did not feel heard by the professionals and that past information on the child was not utilized. In situations where the child had unusual needs, the parents reported feeling that the treatment team lacked the expertise to help their child but would not acknowledge this problem. The therapists
reported feeling that they did have the necessary expertise but that the families did not understand what they were trying to do or realize their child's capabilities.

**Collaboration**

While each of the therapists saw herself as collaborative with families, not all the families experienced this collaboration. Some families felt like they were removed from the parent position and had to be allowed to make decisions about their child. Other parents did not seem to desire collaboration per se but instead wanted the therapist to be the expert by telling them what the problem was and how to fix it. Other families did experience collaboration by the therapists and reported that this process helped them feel less guilty or to blame. These parents reported feeling empowered and were receptive to suggestions by the therapist.

**What Works**

Adolescents gave a clear description of what they felt was helpful to them in making changes. Many commented that structure and consequences were effective in motivating them to make change. A supportive and non-punitive atmosphere was cited as also being important to the adolescent in order to open up and become receptive to changing their thinking. In this atmosphere, the adolescents welcomed feedback that challenged their thinking. The adolescents also reported that, as they made these changes, they became more assertive, confident, and began to like themselves more. This finding supports the current literature on adolescent identity development claiming that adolescents often measure their self-esteem by their ideal rather than by how they see themselves.
Limitations

While this study has yielded interesting and informative results, certain limitations are present. First, it must be pointed out that this study is based on the experience of families participating in only one treatment program and has not been compared in any manner to an alternative non-family-based program. Thus, it could be suggested that these findings would also be true for families participating in programs which are not family-based. In addition, the cognitive and behavioral basis of the group portion of this program likely has a strong influence on the client's experience and outcomes. Thus, programs that do not have this same approach or all the same components may not offer the same experience. This program has much flexibility in how individual needs are met as well as therapist orientation so the results may also reflect individual therapist characteristics and orientation. It should be noted that all the therapists included in this study were female so issues of gender in regards to therapeutic relationships were not considered. A major limitation of this study is the exclusion of ethnic diversity. The program serves primarily Caucasians from the Mid-West and the sample reflected this program composition. While an attempt was made to incorporate diverse ethnic backgrounds, no participants were available at the time of the study that fit this criteria.

Another limitation is the lack of description of the problems each adolescent presents. While some adolescents had been given a diagnosis by a psychiatrist, this was not true for all participants. The diagnoses that had been given ranged from behavioral to personality to psychotic issues. This broad range of problems supports the results across a large sample but provides less detailed information about specific experiences. It should be
noted that much of the current literature on family-based adolescent treatment programs target only juveniles who have been arrested and are in the juvenile court system. This study did not include juvenile delinquent adolescents so would not be directly comparable to current studies.

**Implications for Practice and Research**

The purpose of the current study was to begin to examine the experience of families with adolescents in family-based treatment programs. However, there are still many areas within the context of adolescent family-based treatment programs which need to be explored. Future research could focus on the overall experience of families rather than limiting their perceptions at two and four months of treatment. Future research could also focus on specific populations, different problems, or on gender or age specific inquiries. Research is also needed to determine how the participants in the present study compare to those participants in the juvenile delinquent samples of many of the current family-based program studies. In addition, research into the areas of therapist characteristics and orientation should be pursued. There is also a need to conduct studies in other geographical locations.

The method of data collection in this study was ethnographic interviews. Future researchers may find that using focus group methodology will produce more consensus on experience due to the interactive nature of such groups. Thus a larger sample size could be included with a wider range of experiences. Quantitative assessments of this population derived from the information gathered in this study would also allow for more diversity and a larger sample size.
It may also be helpful to conduct such an inquiry with families who do not complete this type of treatment program. The current program studied has a low level of overall attrition so this opportunity did not arise. This may provide valuable information on how to keep families engaged in the treatment process, preventing attrition.

As a follow up to this study, it would be interesting to continue collecting data with these participants until they terminate services. This would provide a more complete picture of the process the families experience while in such a program. Many of the participants reported that they found the interviews helpful and would be willing to continue their participation if needed.

Furthermore, it would be interesting to present this information to the administrators and professionals working with these families to provide an interactive study of how such information could be incorporated into current programs.

While participants in the current study described their overall experience with the treatment process, little attention was paid to the actual therapy process which occurred. Future research could focus more clearly on this therapy process by specifically identifying that topic as the area of interest, thus shifting the context for participants. Questions could focus on issues such as specific times when the therapy was most and least helpful. Other questions could examine the participants’ perception of the therapist and how this affects their ability to make change. Participants in the current study did not give information specifically about the therapy process even when encouraged to do so.
The results of the present study serve to answer some questions while raising others. The participants provide a clear message that families want to be involved in their adolescent’s treatment and that they see this involvement as vital to success. They also give us a description of what they think successful inclusion of families should look like. This finding should be further tested and added into already existing measures of success in treating families. Thus, in a truly postmodern approach, professionals will collaborate with families in defining success and failure as well.

The findings indicate that families want to be supported in their efforts to be involved in the therapeutic treatment of their adolescents. They suggested that increasing communication regarding expectations and treatment information is vital to assisting parents in understanding how they can best help their children in this process. Families want to be valued for the expertise they have regarding their child and feel they have something valuable to offer to the treatment team professionals. Families may struggle to understand how to participate in such a family-based program and would like more information about expectations of them. Families also need encouragement to take advantage of the options available to them and may not feel they are truly welcome to do so. When families feel supported and heard, they report having a positive therapeutic experience. Clinicians and researchers can benefit from listening to the participants’ voices in applying this knowledge to create a more positive treatment experience for adolescents and their families.
APPENDIX A

CLIENT INFORMATIONAL LETTER

Dear Families.

Mid-Iowa Family Therapy Clinics, Inc. is committed to providing the best possible services through our Short Term Alternatives for Youth (STAY) Home program. Mid-Iowa Therapy Clinics, Inc. is striving to ensure that we are in line with this mission. However, due to the great number of families we serve, at times it is difficult to evaluate if we are doing our best in the eyes of the families we serve.

In an effort to hear the voice of our client families, we are asking for volunteers to participate in individual interviews. The aim of the interviews is to ask family members to evaluate their experience with our STAY Home program to help us improve what we do in order to best meet your needs. We are interested in hearing about all aspects of your involvement in the program including the STAY Home program and your family therapy experiences. We know each family has different situations and we would like to hear your experiences.

The requirements of the project are minimal. You will be asked to participate in an initial individual interview and then will be interviewed again approximately two months later. These interviews will be held at your home or at the Mid-Iowa Family Therapy Clinics, Inc. offices if you prefer. The interviews will be conducted by an Iowa State University graduate student who is also a therapist on staff at Mid-Iowa Family Therapy Clinics, Inc. These interviews will last approximately 1 to 1 ½ hours and will begin in October. To ensure we do not miss any of your valuable input, we will be taking notes, audiotaping the discussions, and later transcribing them to determine common themes of the experience. Although we will be taping your responses we will not identify your name. All responses will be confidential.

Your participation is voluntary. There are no penalties if you chose not to participate in this study. This study is independent of any requirements which may have been made of you by the court or your Department of Human Services worker. Thus, being court-ordered to the STAY Home program does not in any way require that you participate in this project. In addition, declining to participate will not in any way effect the services or recommendations provided for your child.

We will be contacting you by telephone to remind you of the interview date and time in which you have agreed to participate. If you have any questions, please feel free to contact Sara Brandt-De Moss at 465-5739. We look forward to working with you!

The Mid-Iowa Family Therapy Clinics Research Team
APPENDIX B

CLIENT INFORMED CONSENT

Dear Participant,

The following project is designed to gather your evaluations and experiences of receiving intensive outpatient treatment services from Mid-Iowa Family Therapy Clinics, Inc. In collaboration with Iowa State University researchers, Mid-Iowa Family Therapy Clinics, Inc. is attempting to evaluate its services and make necessary improvements to provide the best care possible. The information that you and your family provide will be shared with a group of Mid-Iowa Family Therapy Clinics, Inc. administrators and therapists. As you have been previously informed, the interviews should last approximately 1 to 1-1/2 hours and will be held two months apart. Further, to ensure none of this valuable information you provide is lost, the interviews will be audiotaped, notes will be taken, and later transcribed for analysis.

It is hoped that the information you provide will enable Mid-Iowa Family Therapy Clinics, Inc. to continue providing services you think are satisfactory and make changes where necessary. In all, it is hoped your participation will allow Mid-Iowa Family Therapy Clinics, Inc. to provide the best possible services for clients. This project is not designed to cause any discomfort; however, if you do feel that you do not want to continue to participate at any time throughout the interview, you may choose to quit without any repercussions. Further, your responses will be taken very seriously and therefore it is asked that you be as honest and open as possible.

Your participation in this project is entirely voluntary and will not have any negative effect on the services or recommendations being provided on behalf of your child if you decline to participate. This project is independent of any requirements which may have been placed on you by the court or a Department of Human Services worker.

In order to protect the confidentiality of each person’s responses, it is asked that all information stays within the confines of the interview setting. In addition, facilitators will code and analyze the information provided in such a way to ensure that no participant names will be identified. Audio tapes will be destroyed within one year from the time of taping.

If you have any questions throughout the project please feel free to discuss them with Harvey Joanning (Project Supervisor) at (515)294-5215.

I have read and understand the above information. I understand my participation is voluntary and that I may withdraw at any time without prejudice to me.

Participant ___________________________ Date: ___________________________

Witness ___________________________ Date: ___________________________
## APPENDIX C

### PARTICIPANT DEMOGRAPHICS TABLE

Table 1. Participant Demographics

<table>
<thead>
<tr>
<th>participant</th>
<th>age</th>
<th>gender</th>
<th>family composition(^1)</th>
<th>court ordered</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>13</td>
<td>Female</td>
<td>M, SF</td>
<td>YES(^2)</td>
</tr>
<tr>
<td>B</td>
<td>14</td>
<td>Female</td>
<td>M</td>
<td>YES</td>
</tr>
<tr>
<td>C</td>
<td>13</td>
<td>Male</td>
<td>A, M, F</td>
<td>YES</td>
</tr>
<tr>
<td>D</td>
<td>16</td>
<td>Male</td>
<td>M, SF</td>
<td>YES</td>
</tr>
<tr>
<td>E</td>
<td>16</td>
<td>Male</td>
<td>M, F</td>
<td>YES</td>
</tr>
<tr>
<td>F</td>
<td>16</td>
<td>Female</td>
<td>M, SF</td>
<td>NO</td>
</tr>
<tr>
<td>G</td>
<td>14</td>
<td>Female</td>
<td>M</td>
<td>NO</td>
</tr>
<tr>
<td>H</td>
<td>13</td>
<td>Female</td>
<td>M, SF &amp; F, SM</td>
<td>NO</td>
</tr>
</tbody>
</table>

\(^1\) M = mom, F = father, A = adopted, SM = step mom, SF = step dad

\(^2\) Yes, but dropped
APPENDIX D

FAMILY SUMMARIES

A1
-some progress, not a lot though
-also regression
-not sure if normal up and down
or serious regression
-this program makes a difference
as compared to other placements
-child's attitude and demeanor
toward parent changed
-no longer badgers Mom
-some regression in badgering parent
-parent more stern and consistent,
not giving in
-in past, others would tell parent to
change parenting and wanted to but
court but not able
-more emphasis on parenting skill
building in this program than others
-program reaches out to families rather
than just picking on 1 person
-has not been to FN
-FT has helped all family members
-FT has changed perception of child
-parents now sees behaviors as part of
personality
-parents understanding how child thinks
-getting to know child through FT
-not involved in child's past tx
-therapist is the difference
arrange
-therapist gives answers to questions,
trustworthy
-SF getting to know family better
-parent/step getting to know each
other better
-child starting to accept SF due to FT and
being home
-parenting help from therapist making
change

A2
-parent sits in group and supper
-child closemouthed but starting to open up
-mom concerned child not coming home
-parent frustrated as has timeframe but does
not believe tx team does
-sees child working hard to come home
-confusing info on child by various people
-psychosocial should have been done initially
-feels parent has lost control of bringing child
home
-feels powerless with professionals
-has alternative to get lawyer but not sure
would help
-not clearly understanding requirements of
social system
-expectations unclear, poorly explained
-tx team also confused about process
-wants child home from shelter
-still wants child in program but at home
-shelter not necessary, can get same at home
-disagrees with IT on presenting issues
-truancy dealt with as child now knows conseq
-many other issues coming out now as child
opens up
-believes other issues can be done at home
-not getting answers
-tx team not disagreeing child should come
home but not meeting of the professionals to
arrange
-mom excited for standing to understand what
to expect
-DHS worker also a primary contact
-feeling frustrated and upset as not being
informed
-meeting of the professionals not arranged
-difficult reaching therapist/worker
-parent has to do contacting
-parent misses child, not patient now
-sees FT as primary family involvement

-only one FN due to FT and canceled

-have sat in on grp a few times

-can support parenting though therapist

-feel supported by program

-helpful to inform staff on home

-back up available to call

-family pres not effective due to lack of back up

-child more positive, less demanding

-child more positive towards what's going on at home

-was rude to parent, demanding, now less

-percept change: child seeing, maybe accepting some of her own actions as not acceptable

-child can identify past irrational beliefs

-group helpful, can see self in others of where has been and is now

-peer interaction important

-individual therapy important, helps a lot

-combination of indiv, family, group import.

-have not had full services combo before

-difficult to see changes with less contact while in residential

-not enough time with child while in residential

-could see inconsistent change when returned from residential

-structure of program important

-expectations, consequences led to b/h change

-has and is still changing

-program gave child positive examples

-not there yet but better

-child more aware of b/h and alternatives

-changes due to conseq and seeing others and how they act

-IT framed as need for child to be responsible

-prog has helped see need for respect others

-prof not keeping word

-prof not agreeing on progress(prog/shelter)

-brighter affect

-parent feels child ready but held up by psychosocial

-felt ps/soc should have been done at intake

-concerned about neg peer influence at shelter

-feels out of control with shelter too

-no longer able to be in parent role

-child has good repertoire with IT

-not getting message is a bad parent

-child looks to therapist, not parent

-believes issues dealt with conseq/parenting

-feels against all prof

-frustrated, doesn't see pt of expressing

-feels got talked into restrictions for child

-has to go against social services and court

-prof listen but not giving needed answers

-struggling with child in shelter

-therapist disagreed with parent in psy/soc

-have to be nice, polite, hold child's life

-parent sees issues related to drug use, in past

-issues dealt with but prof going over again

-team not working together, not able to agree on prob

-feels tx focused on child opening up

-not a concern for parent

-no therapy for first month

-child has opened up, shared feelings

-hard to work on family issues w/ shelter

-issues already decided in FT sometimes

-changed b/h and attitude

-likes dif FT and IT

-did not realize therapy only starting

-unclear how psy/soc works

-process more organized, all services at

-beginning to get child home quickly

-helps to share feelings with adult

-a lot prof involved makes parent's opinion

-1st month not all in place

-wants child working on issues at home

-child knows will be conseq at home now

-parents tries to do whatever needs, or asked
-family involv leads to child talks more freely with parent

A3
-trying to figure out if program working
-many questions about tx
-child not making progress in past
-what can we expect? Is it working?
-changed child’s medications
-allowed profs to created program for child
-would like to make sure of prof involved in child’s care informed
-given diff diagnosis but not able to get info
-looking for answers on current diagnosis
-would like to hear directly from psychiatrist
-FT coaching helpful
-FT helps with parenting skills to handle child
-FT provides reassurance that family not to blame
-child feels we care about him
-not that far yet
-child not throwing things
-others to take care of child takes stress off
-asking a lot of questions from all prof
-child is talking more about his feelings
-child is less angry, aggressive
-child has made changes in program and school
-medication change important
-full service package important
-would like referrals, respite, overnight assistance
-family is emotionally drained and confused at intake
-family had been through hospital previously, were burned out. emotionally drained
-listen first in intake
-give more practical information in intake
-provide support for parents at intake for bringing child to program
-such as principles of treatment
-theories and other accepted support for prog
-basic info would be helpful such as logistics, break schedules in pamphlet form at intake
-moving groups and staff change led to chaos
-comm. with program better now
-staff busy. sometimes don’t have enough

D1
-mom likes prog
-attended group to defend herself.
-found child manipulating
-felt much better after group
-gets up early so hard to attend grp
-wants to attend groups
-support grp for parents to help with stress. ideas
-SF has not probs with child.
-child knows how to work mom
-mom feels she is over-emotional
-support grp would give sense not alone
-mom always dumps on SF (roles)
-much info FN. a lot to remember
-FN-not enough time for all parents to talk. feel guilty
-only 1 FN due to funeral
-FN-did not expects children involved
-FN-enjoyed learning cycle
-involved through sheets, staff contact
-staff contact about 1/wk by staff
-child has improved
-more aware of what causes anger b/n Mom and child due to family involv
-family still dealing with child recog acting on awareness, self-control
-prog positive all the way around
-child still backslides
-child learned cycle but not applying on a regular basis
-parents also learned and use cycle
-comm improved. child more open
-child use to bottle feelings, now more honest with parents
-family change occurred when Mom came to grp
-prog doing what came for
-glad can go to grps. would want to if
time to address parent concerns and questions
- treatment team not in touch with psychologist
- professionals need to talk to each other all at once
- initial conference with all treatment team at intake needed
- would like to know qualifications of staff and therapists
- has been a process to get all professionals and parents in agreement on treatment needs and goals
- process beginning to come together with meeting of the professionals recently
- parents feel they lose control of child, asked to trust professionals

- wants to attend child's group but doesn't want to intrude on child
- therapist told grps also for parent involve, leads to faster change
- parent involve key to program
- child has to talk with parents if involv
- mom shocked at openness in grp
- parent able to accept some b/h as normal (percept change)
APPENDIX E

TOPICAL CLUSTERS/CATEGORIES

Changes
- learned must take responsibility for behaviors
- child has made a lot of positive changes
- parent now sees behaviors as part of child’s personality
- child not throwing things
- child angry but controlled herself at meeting of the professionals
- child has made changes in program and school
- child has improved
- parents also learned and use cycle, communication improved, child more open
- child more aware of behaviors and alternatives
- parent able to accept some behaviors as normal
- child learning to respect herself
- child use to bottle feelings, now more honest with parents
- brighter affect
- child more positive toward what’s going on at home
- child knows will be consequences at home now
- child’s attitude and demeanor have changed
- child can identify past irrational beliefs
- parents understanding how child thinks
- child not violent since starting program
- changed behavior and attitude
- changes due to consequences and seeing other children and how they act
- parenting moving from friend to parent role
- more aware of what causes anger between child and parent
- child closemouthed but starting to open up
- child has open up shared feelings
- no longer badgers parent
- some regression in badgering parent
- child more positive, less demanding
- changed child’s medication
- child is less angry, aggressive
- child is talking more about feelings
- perceptual change: child seeing, maybe accepting some of her own actions as not acceptable
- was rude to parent, demanding, now less so
- child learning to respect authority as mom becomes more of a parent
- parent more stern and consistent, not giving in
- child taking poor risks
child not giving school sheet lately
-child not violent since start of prog
- for child - no anxiety, feels cared for, polite, understands parameters, less demanding, easier to direct

Process

- many other issues coming out now as child opens up
- did not realize therapy only starting
- not there yet but better
- has and is still changing
- parents still struggle to follow through
- process beginning to come together with meeting of the professionals recently
- one parent ready, other rescues
- family still dealing with child recognizing and acting on awareness, self-control
- medication change important
- believes other issues can be done at home
- some progress, not a lot though
- has been a process to get all professionals and parents in agreement on treatment needs and goals
- trying to figure out if program working
- communication with program better now
- child will still blow up at mom
- still has attitude and mouth
- process more organized, all services at start help get child home more quickly
- have to be nice, polite, professionals hold child's life in their hand
- treatment team not in touch with psychologist
- child still backslides
- professionals don’t know when child will be ready, don’t want to get parent’s hopes up
- child learned cycle but not applying on a regular basis
- parent feels child ready but held up by social services
- treatment team not disagreeing child should come home just not meeting of the professionals to arrange
- also regression
- wants child working on issues at home
- not sure if normal up and down or serious regression
- parents rescued child in past
- not that far yet
- want trust/honest but takes time
- family becoming reinvolved now child learned tools
- family felt hopeless at first
- moving groups chaotic
- child has long way to go
- a lot of stress, decreased support with long term problems
- CINA freaked out parents, confusing, scary
- child harder to handle each year
### TOPICAL CLUSTERS

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<th>Major Topic</th>
<th>Unique Topic</th>
<th>Leftover Topic</th>
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<td>Support</td>
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<td>Debriefing</td>
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<td>Experience of Program</td>
<td>Need for Information</td>
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<tr>
<td>Experience of Therapist and Staff</td>
<td>Suggestions</td>
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<td>Process</td>
<td>Family Issues</td>
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<td>Changes</td>
<td>Perception of Tx</td>
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<td>Family Involvement</td>
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### FINAL CATEGORIES

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APPENDIX F

HUMAN SUBJECTS REVIEW FORM

Last name of Principal Investigator: Brandt-DeMoss

Checklist for Attachments and Time Schedule

The following are attached (please check):

12. Letter or written statement to subjects indicating clearly:
   a) the purpose of the research
   b) the use of any identifier codes (names, *'s), how they will be used, and when they will be removed (see item 17)
   c) an estimate of time needed for participation in the research
   d) if applicable, the location of the research activity
   e) how you will ensure confidentiality
   f) in a longitudinal study, when and how you will contact subjects later
   g) that participation is voluntary; nonparticipation will not affect evaluations of the subject

13. Signed consent form (if applicable)

14. Letter of approval for research from cooperating organizations or institutions (if applicable)

15. Data-gathering instruments

16. Anticipated dates for contact with subjects

First contact

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Last contact

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17. If applicable: anticipated date that identifiers will be removed from completed survey instruments and/or audio or visual tapes will be erased.

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18. Signature of Departmental Executive Officer

[Signature]

Date:

Department or Administrative Unit:

19. Decision of the University Human Subjects Review Committee

☑ Project approved

☐ Project not approved

☐ No action required

Name of Human Subjects in Research Committee Chair

Patricia M. Keith

Date:

Signature of Committee Chair

[Signature]
APPENDIX G

DEMOGRAPHIC QUESTIONNAIRE

Client code

The following questions will allow us to describe the participants in this study.

1. What is your age? _____

2. Occupation ________________

3. Marital Status (Check one)
   _____Single   _____Married   _____Divorced or separated
   _____Living with partner   _____Widowed

4. If you are divorced or separated, has your ex-spouse been involved in your child's treatment services with the STAY Home program? _____Yes   _____No

5. Would you describe yourself as:
   _____African American   _____Caucasian   _____Hispanic   _____Other

6. In which category does your annual household income fall? (Check one)
   _____$0-$30,000   _____$31,000-$59,000   _____$60,000+

7. What are the primary concerns for your child?
   _____aggression   _____non-compliance   _____substance use   _____school issues
REFERENCES


