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Vergie Charlery

The Application of Dialectical Behavioural Therapy and Eco-systemic Structural Family Therapy with Children, Youth, and Families

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APPROVED/APPROUVÉ

Examiners/Examinateurs:

(First Reader/Supervisor/Directeur(trice) de these / stage spécialisé)

- Dr. Lea Tufford

(Second Reader/Co-supervisor/Co-directeur(trice) de these / stage spécialisé)

- Dr. David Hauser

(Committee member/Membre du comité / stage spécialisé)

Approved for the Faculty of Graduate Studies
Approuvé pour l'École des études supérieures
Dr. David Lesbarrères
M. David Lesbarrères
Dean, Faculty of Graduate Studies

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Abstract

Kingston Health Sciences Centre is committed to using three family therapy modalities with their clients at the Child and Youth Mental Health Clinic. Ecosystemic Structural Family Therapy, Emotion Focused Family Therapy, and Dialectical Behaviour Therapy are evidenced-based interventions, sometimes used as the sole method of therapy, but often times as an adjunct to other techniques for children and youth afflicted with mental health challenges. This thesis is an analysis of the three methods, using the literature review to provide context, and eliciting examples from three families, that were counseled throughout a five-month period.

Le Centre des sciences de la santé de Kingston s'engage à utiliser trois modalités de thérapie avec leurs clients de la Clinique de santé mentale pour les enfants et les jeunes. La *thérapie familiale structurale écosystémique, la thérapie familiale centrée sur les émotions et la thérapie comportementale dialectique* sont des formes d'interventions ayant une approche factuelle, parfois employées seules, mais la plupart du temps en tant que complément aux autres techniques pour les enfants et jeunes atteints de troubles de santé mentale. Cette thèse se veut une analyse de ces trois méthodes, utilisant une revue de la littérature existante à titre de contexte, ainsi que les exemples de trois familles qui ont reçu de l'aide et des conseils thérapie durant une période de 5 mois.

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This thesis is dedicated to a most gently soul, Nicole. No matter where you may be stationed in life, perseverance will be the key to your success. Do not stop trying!

I embraced the opportunity to complete a Master of Social Work, to build on the foundation of my Bachelor of Social Work, which was completed many years prior. As I reflect on these times, there are many who have facilitated my journey by providing support, guidance and / or advice. I wish to express a heart-warming thank you to Kyra, my youngest daughter, who had to endure me being constantly engaged in research; and who had to patiently "wait" for me to complete endless assignments before we could enjoy time together. This bears testimony to the sacrifices we sometimes make in pursuit of advancement. I thank my spouse for his motivational talks in times when I wondered whether this pursuit was a worthy endeavour at this point in my life. I am eternally grateful to Patricia at Hotel Dieu hospital, who afforded me the opportunity to be guided by her distinguished mentorship. Her passion for her clients and her conviction of the necessity for family therapy in healing youths was unmatched. I also wish to place on record my appreciation for Dr. Lea Tufford and Dr. David Hauser, who dedicated time to reading my work while providing feedback with the aim of helping me produce a body of work I could be proud of. Finally, it would be remiss of me if I did not thank the three families I worked with during my time at Hotel Dieu, who demonstrated that hard work and commitment to your children can eventually reap positive results.

Introduction

It cannot be over-emphasized the pivotal role that one's family plays in a life: their function in making members feel secure, in precipitating safety, and in the proper functioning of all members. To that end, therapists from all theoretical stripes believe that family life must be nurtured and strengthened. Extensive empirical research shows that members within mal-functioning family structures are more apt to be or become dysfunctional within the larger society and are more prone to mental health challenges (Fishman & Rosman, 1986; Minuchin, 1993; Ogden & Zevin, 1976). The negative tone set within one's family will often establish itself and provide the roadmap for moving forward unless these patterns are recognized and altered. It cannot be denied that there has been a notable change in family life within the past 20 years with the increasing rise of divorce and juvenile delinquency (Amato, 2010; Harris, 2018; Lucas, 2005; Rankin & Wells, 2014).

In addition to the dynamics of family life, the predominance of mental health challenges evident among the global population has placed families in the precarious position of navigating this difficult terrain together. In reference to mental health, the most vulnerable have been affected. Sometimes, it is a parent within the family structure with mental health challenges; and sometimes it is the child, or children. Regardless of who the mental health challenge afflicts, it is often the family as a unit that bears the burden (Nichols & Chabot, 1984). For the purpose of this paper, youth mental health challenges within the family will be the focus (Dimeff & Koerner, 2007).

It is in recognition of the predominance of youth mental health challenges that practitioners place tremendous emphasis on evidence-based, therapeutic family therapy interventions. Family therapy has evolved over the years, with different theorists

providing diverse theoretical perspectives on what it takes to function harmoniously as a family unit and what variables are detrimental to individual members and to the family structure as a whole. Prior to the evolution of family therapy as a recognized method of treatment, the individual was seen as an island, internal factors abounded, with a general disregard for external variables (Lusterman, McDaniel, & Mikesell, 1994). The family as an imperative to one's emotional and psychological disposition was inconsequential.

As mental health practitioners progressed in their perspectives, and as research and practical experiences proved, beginning from birth, human beings are influenced by their environment (Ogden & Zevin, 1976). One social worker that advocated for this perspective was Mary Richmond (1917) author of *Social Diagnosis*, in which she referenced the importance of cohesion within a family unit. On the very first page of Richmond's 1917 book, she quotes Dr. James Jackson Putnam who stated:

> One of the most striking facts with regard to the conscious life of any human being is that it is interwoven with the lives of others. It is in each man's social relations that his mental history is mainly written, and it is in his social relations likewise that the causes of the disorders that threaten his happiness and his effectiveness & the means for securing his recovery are to be mainly sought (p. 1).

Richmond describes in detail her desire to see social workers learn to think of the family as a whole. Consistent with today's views on the importance of the family when looking at the individual, Richmond reiterated that the journey through individual healing would not be successful until one looks at the family. She stated,

> In some forms of social work, notably family rebuilding, a client's social relations are so likely to be all important that family case workers welcome the opportunity to see at the very beginning several of the members of the family assembled in their own environment, acting and reacting upon one another, each taking a share in the development of the client's story, each revealing in ways other than words social facts of real significance (p. 137).

Pioneers such as Virginia Satir wholeheartedly believed in the power of the family in the making of the individual and the family's role in facilitating change in a person. She famously quoted, "every word, facial expression, gesture or action on the part of a parent gives the child some message about self-worth - It is sad that so many parents don't realize what messages they are sending" (Satir, 1988, p. 25). Jay Haley, one of the pioneers of family therapy and founder of the first family therapy journal, *Family Process*, believed that repeated behaviours between family members were significant and that the past is less important than future behaviours. Bowlby, in a 1949 published paper, *The Study and Reduction of Group Tension in the Family* wrote, "in the case of both child guidance and industrial consultation, the problem which is brought, be it a child who bites his nails, or a difficulty in selecting foremen, is seen to be but a symptom of a more complex problem" (p. 15). He believed that the problems he commonly found involved many, even all, the people with whom the so-called "patient" comes into contact. Bowlby strongly believed that with the child, the problem usually lay within the relationships between the members of the family.

Although these early theorists placed the significance of the family on an individual's functioning, family therapy being used consistently as a methodology in practice only began in the early 1950s after the Palo Alto project (1952), which thrust family therapy into the forefront and also conceptualized the family as a system (Bond, 2009). The four theorists, Bateman, Haley, Weakland, and Jackson, (1952) discussing the development of schizophrenia, argued that "we must expect a pathology to occur in the human organism when certain formal patterns of the breaching occur in the communication between mother and child, or any other family interaction (mother figures, father, siblings etc.)" (p. 12). The thought that families were to blame for the

development of schizophrenia in an individual was not openly accepted by the mental health community for long; but the concept of the family playing a fundamental role in an individual's overall functioning remained in the social work and psychology diaspora (Ackerman et al., 1982).

Mental health practitioners recognized fully that improvements in young people's mental well-being could not be accomplished solely by their own efforts (Cohen, 2017). The integration of the family into the journey to a healthy mind was seen as a fundamental objective of many family therapy techniques. This reality called for a variety of counselling methods, which involved the family, and began to be given prominence beginning in the 1970s and included Bowenian family therapy, which centered on the two counter-balancing forces of individuality and togetherness, whereby too much "I" (individualism) led to emotional cut-off, and too much "we" (collectivism) led to fusion (Macmillan, 1993). Accordingly, it was believed that unresolved emotional attachment to one's family must be solved before one can differentiate a mature healthy personality. Bowen's theory was concerned about identifying patterns that had originated in a family's past that have a hold on members in the present and in helping to unlock those patterns (Gurman & Kniskern, 1981).

Strategic family therapy was known as a problem solving approach, and stressed change within the family. Therapists set goals, and subsequently assist in resolving the presenting symptoms of the family, often believed to be the communication patterns of interaction among family members (Mikesell et a. 1995). Within Structural Family Therapy, Salvador Minuchin emphasized that all families have problems and that adaptive families would modify their structure to accommodate to changing circumstances, while dysfunctional families would increase their rigidity of structures

even if proven to no longer be functional (Minuchin, 1993). Symbolic / Experiential Family Therapy's primary goal on the other hand was growth, because of its strong commitment to individual awareness, self-expression, and self-actualization (Nichols & Chabot, 1984).

Psychoanalytic / Object Relations Family Therapy, with proponents such as Sigmund Freud and Erick Erickson, stated that people's identities are formed and maintained through relationships, and that we relate to people in the present based on our early experiences with primary caregivers (Erickson, 1982; Freud, 1923). Relational Cognitive-Behavioural Family Therapy stated that behaviour is maintained by its consequences and that behaviour problems are caused by dysfunctional patterns of reinforcement between parents and children, or between members of a couple (Nichols & Chabot, 1984). Irrespective of the modality used, the primary emphasis of change remains the individuals within the family structure and their relationships to one another.

In the *Handbook of Clinical Family Therapy,* Lebow (2005) states that today's state-of-the-art methods in family therapy, although diverse in their specific focus and their particular blueprint for intervention, share many core attributes. A number of transcendent core characteristics readily emerge from an analysis of twenty-first-century family therapies. Lebow states that these core characteristics include having a systemic focus on the family structure; having a bio-behavioural, psychosocial foundation; applying generic strategies of change; highlighting broad, curative factors such as the creation of hope and positive expectations for change; shaping strategies of change in relation to the difficulty or life issue that is in focus; labelling problems as problems; and building on empirical foundations (Lebow, 2005).

Although the theoretical lens across these approaches and the language for describing the methods for intervention may vary, almost all of the approaches include strategies that work with family structure. Such strategies are based on behavioural principles of learning, exchange, and task assignment. These include strategies that work with cognitions, narratives, or attributions; strategies based in psycho-education; strategies for working with affect; and strategies for working with meaning.

A fundamental challenge now facing many families is how to grow and thrive as a well-functioning unit where their young member(s), and sometimes their adult members, can be better equipped emotionally for life's challenges, both within the family structure and in the larger society. Whether this is done informally by the family alone or formally with the assistance of professionals, a considerable amount of effort is expended on this task. As mental health within today's society is much less stigmatized than in previous generations, many families openly identify their struggles and require the intervention of a professional to help them successfully navigate their lives. Left untreated, mental health difficulties in childhood and adolescence can lead to difficulties in school and a failure to develop friendships, occupational and social skills, and mental health problems in adult life (Rusch, Angermeyer, & Corrigan, 2005).

The World Health Organization (WHO) (2014) defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community" (p. 1). This definition asserts that mental health is fundamental to the well-being of individuals, families, communities, and the population in general. Mental health has implications for learning, developing healthy relationships, productivity, success, and economic development (Cohen, 2017). Conversely, mental

health problems and mental illness can result in dysfunction, low productivity, poverty, and social problems (Cohen, 2017). Mental health and mental illness exist on a continuum by which individuals can fall at various points. Genetics, our social situation, life events, age, or stage in life can determine one's state of mental wellness or un-wellness (WHO, 2014).

Kutcher and McLuckie (2010) note mental disorders in young people are the most prevalent medical condition causing disability in this population. The health profile of youth has shifted markedly as a result of our society's awareness that mental health has not received due consideration and as a result of an on-going campaign by mental health organizations such as the Canadian Mental Health Association (CMHA) to reduce attached stigma. For example, *The Mental Health Strategy for Canada (MHSC): A Youth Perspective* was launched in 2013 with the aim of "developing a supplemental document that highlights the experiences and vision of young people working toward system change and ultimately making the original strategy a more accessible document to all" (MHSC, 2013, p. 1). A population health framework view of mental health takes into account the varied and complex issues, which can influence mental health (WHO, 2014).

This framework underpins the Kingston Health Sciences Centre's (KHSC) provision of mental health services to youth, in conjunction with their families, as needed. Their mental health program provides services which focuses on the individual needs and differences of youth and their families. The centre pays special attention to the specific needs of children (12 and under), adolescents (13 – 17), and their families. "Family" is defined by the KHSC in its traditional sense, as those related by blood or through legal means such as adoption, fostering, marriage, or co-residence. Kingston Health Sciences Centre is a 2017 amalgamation of Hotel Dieu hospital and Kingston

General Hospital and services the greater Kingston area, as well as neighbouring communities such as Belleville, Gananoque, and Napanee. Serving a combined population of over 500,000, the Child and Youth Mental Health Clinic at the hospital navigates a myriad of complicated family mental health issues that would be common to more populated urban centres.

Within this paper I will provide an analysis of the family therapy methodologies utilized at KHSC that was employed while completing a practicum in 2019. These methodologies included; the use of Ecosystemic Structural Family Therapy (ESFT) with one struggling, young, Indigenous family; group family therapy using Dialectical Behavioural Therapy (DBT) with three families; and Emotion Focused Family Therapy. Chapter One will provide a description of the Indigenous family I counselled and the use of Eco-Systemic Structural Family Therapy, also using a literature review to provide context. This Indigenous family was burdened with challenges by virtue of their identity, which will be discussed. In Chapter Two, a brief background and the presenting issue(s) of the families will be provided and an analysis of the 16-week DBT group therapy session will be examined, using the literature review as the framework. The specific topics of discussion throughout the five DBT modules will include Mindfulness, Distress Tolerance, Walking the Middle Path, Emotion Regulation, and Interpersonal Effectiveness. As the modules are quite detailed, I will highlight only the most pertinent topics. Emotion Focussed Family Therapy is another preferred method used at KHSC. Although there was not an opportunity to apply it within the practicum, a literature review of the method and its practicality within the KHSC site will be provided in Chapter Three. I will provide a discussion and my reflection on family therapy, in addition to some views on the intergenerational trauma which plaques many families,

leading them to seeking family therapy in Chapter Four. I conclude in Chapter Five. It should be noted that verbal and written consent was received from the three families who are discussed within this paper.

Chapter One

Ecosystemic Structural Family Therapy with a young, struggling family

The Child & Youth Mental Health Clinic at the Kingston Health Sciences Centre (KHSC) utilizes Ecosystemic Structural Family Therapy to assist families struggling with children diagnosed with mental health challenges. While every file was not chronicled, a general survey of the families revealed that most of the youth were not strangers to emergency departments due, in part, to frequent suicide attempts and other self-harming behaviours. The majority of parents seemed to be out of options on what to do and were in a desperate search for answers. These families had reached an impasse and by referral from family physicians, emergency rooms, or community health centres with limited resources, had arrived at the Kingston hospital, Hotel Dieu site. After a one to two hour intake interview with a social worker, psychologist, psychiatrist, or mental health nurse, the family could be offered counselling as a unit, if assessed to be of benefit to the child, the parent(s), and / or the family as a whole. Most were looking for very clear answers and wanted a road map to reach the light, amidst a very dark journey. The fundamental challenge facing these families was how to live happily and grow as a whole with their "problem children."

Ecosystemic Structural Family Therapy (ESFT) is a systemic, strength-based, and trauma-informed family therapy model that has evolved mainly from Structural Family Therapy (SFT) and Family Systems Theory (FSF) by Marion Lindblad-Goldberg and her colleagues at the Philadelphia Child Guidance centre and by faculty in the Philadelphia Child Guidance Family Therapy Training Centre. There are also overlapping assumptions about human nature from other modalities including a synthesis of Family Development Theory, Attachment Theory, Theories of Human Ecology, Developmental

Psychopathology, Traumatology, Emotional Regulation and cultural influences (Goldstein, 1969). Ecosystemic Structural Family Therapy is an evidenced-based family therapy approach designed to intervene with families of children who are experiencing behavioural health problems and are at risk of out-of-home placement (Lindblad-Goldberg & Northey, 2015). It includes four overlapping treatment stages: constructing a therapeutic system; establishing a meaningful therapeutic focus; creating key growth-promoting experiences and solidifying change, and termination (Lindblad-Goldberg & Northey, 2015). The ecosystemic approach was, at one time, considered to be one of several theories influencing research and practice with families. The focus now has grown to include the individual, the family as well as the larger social context (Lindblad-Goldberg & Igle, 2018). The provision of services in the homes of children in crisis also exists within the ESFT framework and dates back to the turn of the twentieth century with the inception of the child guidance movement and social services (Lourie, 2000). The basic tenets of ESFT centres on effective communication amongst family members which follows predictable patterns; that families create and function hierarchically, with ineffective hierarchies becoming problematic; and that family structural change produces individual change.

Also having prominence in Attachment Theory, the focus of ESFT is the family structure and not the individual, and examines the biological and developmental influences of family members as well as current and historical familial, cultural, and ecological influences (Lindblad-Goldberg & Northey, 2015). It is based on the fundamental assumption that child, parent, and marital functioning are inextricably linked to their relational environment. Lindblad-Goldberg and Northey (2015) outline five interrelated constructs that guide ESFT therapists in their understanding of clinical

problems: family structure; family and individual emotional regulation; individual differences (e.g., emotional attachment between parent and child between parents); and family development (Gehart, 2010).

a. Family Structure – Some are of the belief that the client is the problem, and should therefore, be the focus of the therapy. Structural Family Therapy, however, including ESFT "approaches the individual in his social context" (Minuchin, 1974, p. 2), with the aim of changing the organization of the family. This transforms the structure of the family group and ultimately alters the positions of family members. Ecosystemic Structural Family Therapy directs clinicians to focus on the way family members accommodate to one another (i.e., role complementarity or reciprocity), the mutual expectations of family members around daily routines (i.e., meals, sleep, work, recreation, intimacy), how close or distant the family members are (i.e., proximity and distance), how families organize and regulate themselves (i.e., boundaries and parameters), and the power differentials among members and generations (i.e., hierarchy) (Lindblad-Goldberg, Igle, & Simms, 2010).

b. Affective Proximity – Minuchin (1974) declared that the "clarity of boundaries within a family is a useful parameter for the evaluation of family functioning" (p. 54). He goes on to say that enmeshment and disengagement refer to a transactional style, or preference for a type of interaction, not to a qualitative difference between functional and dysfunctional. Most families have enmeshed and disengaged subsystems. Close and securely attached relationships are promulgated when family members feel they can count on each other during times of stress or perceived threat (Lindblad-Goldberg & Northey, 2015).

c. Family and Individual Emotional Regulation – In Ecosystemic Structural Family Therapy, there is a clear focus, in both case formulation and treatment implementation, on how family members regulate their emotional experiences, as well as make meaning of them (Lindblad-Goldberg & Northey, 2015). The recognition of emotional regulation as essential to family life not only acknowledges the interpersonal experiences of family members, but the intra-psychic and subjective experience of emotion (Lindblad-Goldberg & Northey, 2015).

d. Individual Differences – From the onset, SFT focused on facilitating the development of family systems that best fit individuals within the family by accounting for individual family member needs and promoting positive growth and development (Minuchin, 1974). In Ecosystemic Structural Family Therapy, therapists are encouraged to understand the individuals in the family and the various ways in which they interact (Lindblad-Goldberg & Northey, 2015).

e. Family development – The clinic, focuses on both existing normative and non-normative demands that families face as well as those previously encountered. The family life-cycle perspective allows Ecosystemic Structural Family Therapy clinicians to take a more macro viewpoint acknowledging that current challenges may have originated from inside and outside the family (Lindblad-Goldberg & Northey, 2015).

Relevant Background Information on Case Study Family

This family of four consisted of a mom, a common-law boyfriend (not the biological father of the mom's children), a teenaged daughter "R" and a pre-teen, younger sibling. Both daughters had a very warm and respectful relationship with mom's boyfriend. R reported that mom had threatened to send her to live with her biological father if her defiance and stealing did not stop, although mom stated emphatically that

she verbalized this only as a result of her frustration. R has been caught stealing, had been caught posting inappropriate images of herself to strangers online, had experimented with drugs, had multiple suicide attempts, was hyperactive, was said to be manipulative, and also suffered from anxiety. Mom had previous abusive relationships where R had witnessed some of this physical abuse. The relationship with R's father ended as a result of abuse.

Six years prior, R and sister were apprehended by Family and Children Services, and were consequently placed in foster care with the same family for six months where both girls reported verbal abuse. Maternal and paternal family history indicated anxiety, depression, alcohol abuse, autism, attention-deficit/hyperactivity disorder, bipolar disorder, schizophrenia and completed suicide.

Issues with R began in preschool with mom reporting hyperactivity and aggression towards her and other children. Medical staff believed then that she could be suffering from posttraumatic stress disorder and prescribed her medication, which was discontinued shortly after its start due to mom reporting no change. The family had been intermittently with KHSC for the past four years, and also had previous counseling sessions with outside agencies. During my sessions with this family, which took place once per week, R was in high school, enrolled in academic classes, achieving A's and was a very talented visual artist. Both R and younger sister were very polite, respectful young ladies. R reported a history of bullying from schoolmates, but stated that this abuse had subsided with age. She noted that she often spent time with people who encouraged skipping classes and drug experimentation.

Both R and mom were currently in a multi-family therapy, Dialectical Behavioural Therapy group, which occurred once per week. Mom felt she was out of

options and experienced stress as a result of her daughter's behaviour. At this point in the family's journey, R was still being accused of theft from school authority, neighbours and family members. Mom reported that she would lie incessantly, whether or not it made sense to do so; be defiant and not follow house rules; had numerous suicide attempts; and endorsed self-harm. If allowed on social media, R would post nude images of self to strangers. She had been caught experimenting with drugs during school hours. Mom felt it necessary to once again commit to family therapy in the hopes of getting some answers to her struggles.

It is evident from the above-cited example that this family was in crisis and had some significant struggles. The focus, according to mom and step-dad, should be on changing R's behaviour to make it conform to their expectations. Although it was taken into consideration that R's behaviour was very much chaotic, it was also important to assess her environment to ascertain other possible reasons for her struggles. According to the ESFT model, sessions would approach R and the remainder of the family within their social context, which would aim to modify the organization of the family to make it more functional. ESFT, which borrows predominantly from Structural Family Therapy and Systems Theory, theorizes that R is not an isolate. She is a member of a social system to which she must adapt; her actions are governed by the characteristics of the system, and these characteristics include the effects of her past actions. She is responding to stresses in other parts of the system; and is contributing significantly to stressing other members of the system (Minuchin, 2003). R can be approached as a subsystem, or part of the system, but the whole must always be taken into account (Minuchin, 2003).

First Session – *Constructing a therapeutic system*

Mom attended the first session with her partner in the absence of R so she could comfortably address her concerns. When questioned about expectations for therapy, step-dad stated that he wanted R to understand the ramifications of her actions both on her, and the family unit. Mom, however, was uncertain about her treatment goals, and indicated being perplexed and had seriously considered sending R to live with biological father, to foster care, or to a group home. Mom later affirmed that she used the "biological father" threat only as a scare tactic. She had, however, considered the Family and Children Services and group homes. Mom's sole focus had become R who required constant supervision, to avoid chaos. Her constant threats of suicide and inability to speak the truth, made her difficult to trust, according to mom. R was assessed by a psychologist and it was determined that she had some borderline traits. Mom and step-dad were asked whether they saw value in attending the sessions with R's younger sister to which they agreed.

It was assessed by mom and stepdad after the first session, that R needed a clear understanding of how her behaviour was affecting the lives of her family - behaviour modification and accountability would be important. Step-dad, her only father figure, played a central role in her life, and it was determined that he should be present as much as possible during sessions. He seemed to be the moderator between the two, when mom's emotions took over. Between sessions, the family was asked to refer to their DBT skills training to determine appropriate methods of regulating their emotions and to use their distress tolerance skills that had been taught in classes.

Analysis of First Session

As previously stated, Minuchin (1998) believed that children respond to stresses affecting the family as a whole. Exploring what the stressors were for R that had an influence on her behaviour would be paramount to facilitating any change. First sessions have changed from how ESFT was once practiced. During first sessions, therapists were encouraged to focus on the assessment of the interaction patterns of family members and to implement change producing strategies immediately as they saw fit. Now, after many years of empirical data collection and best-practices, therapists are encouraged to obtain a comprehensive bio-psycho, social, cultural, spiritual, assessment of the child or adolescent at both the macro and micro levels (Browning & Pasley, 2015). As R had been enmeshed within the mental health system since childhood – her previous assessments were used as a starting point, which were accessed from the hospital's cataloguing system.

The information obtained from mom and step dad was also essential for the assessment to move forward. Accordingly, as with many other theoretical approaches, ESFT stressed the importance of therapist expertise. Today, ESFT looks to the family, including the child, as experts in their history, and seeks their recommendations for treatment (Lindblad-Goldberg, Dore, & Stern, 1998). However, mom was uncertain about her goal(s) for treatment outcome. She knew she was extremely frustrated and sought options. Stepfather, as described in the first session, wanted R to understand how her behaviour was affecting others in the hopes that this realization could be the catalyst for change.

Ecosystemic Structural Family Therapy is focused on the robustness of the emotional connections between family members and growth promoting practices of the

family (Browning & Pasley, 2015). Although R was absent for the first session, it was clear through mom and step-dad's description that her emotional connection to family members was fragile, and a goal would be to change that dynamic. This family's quest for positive change had not been realized for some time. A strategy was needed to change the family dynamic, and to assist R in attaining her full potential. For ESFT, assessment and treatment are tied to development theory, which paves the way for recognition of short-term clinical goals of symptom relief (Lindblad-Goldberg & et al., 1998) (i.e., R's worrisome behaviour of self-harm, posting unsafe images on-line) and the long-term preventative goals of growth and development (i.e., R becoming and feeling emotionally connected to family members). This involved fostering change within many systems to include the child, (R) her family (mom, younger sister and step-dad) and the child's community (school, peers). According to ESFT goals, as described by Lindblad-Goldberg and Northey (2015), the objectives for the family counseling sessions would be to:

1. Resolve presenting problems and eliminate negative interaction cycles; (R's compulsive and erratic behaviours and the negative interactions between her, her sister, mom and step dad, her school mates, school authority, and even mom's friends and neigbours);
2. To shift the development trajectories of children, such that they are moving toward greater capacity for self-regulation and social-emotional competence; (R sometimes functioned emotionally younger than her chronological age and needed to learn age appropriate emotion regulation and distress tolerance; and eliminate her compulsivity);

3. To enable the family to organize and emotionally connect in such a way that they become more growth-promoting in their interactions with one another; (the negative communication cycle with R and the other members of her family was exhausting to other members, counter productive, and needed to change) and;
4. To enable relevant community systems to organize in such a way that, a family's efforts toward creating a growth-promoting context is nurtured (assistance from the school, or other community organization for example).

The four stages of ESFT infused within the process for this family included (1) constructing a therapeutic system; (2) establishing a meaningful therapeutic focus; (3) creating key growth-promoting interpersonal experiences that lead to incremental changes; and (4) solidifying changes and termination. Under ideal circumstances, these stages should be a smooth process with each new stage building on the other. This family and their dynamic were so complex that moving forward with the various stages proved to be very difficult. Stages three and four will most likely span many months or even years. Having been in therapy since a young child, R was in and out of in-patient treatment, and there existed intergenerational trauma within mom's family that would require further exploration. This task would be best suited for a therapist committed to a longstanding therapeutic relationship.

Constructing the therapeutic system

People will be most comfortable with a therapist that they can positively connect with. Within Structural Family Therapy, Minuchin (1998) referred to this process as "joining" which he described as the active participation of the therapist in becoming part of the therapeutic system. Before beginning family sessions, the therapists at KHSC usually have several opportunities to interact with members beginning with a one to two hour

intake; and often times during multi-family therapy sessions teaching Dialectical Behavioural Therapy. Hence the "joining" may begin in advance of the family sessions, making establishing a good therapeutic relationship smoother than would be otherwise expected. Minuchin (2003) stated that, "when a therapist works with a patient or a patient family, their behaviour becomes part of the context – therapist and family "join" to form a new, therapeutic system, and that system then governs the behaviour of its members" (p. 9).

Second Session – Establishing a meaningful therapeutic focus

It was revealed during this session that mom and step-dad had been unsuccessful within their respective College programs. They believed the pressures of family life with R contributed to this unfortunate turn of events although in hindsight they were willing to take personal responsibility. R was unresponsive to the comments from her parents, and proceeded to discuss her feelings about her time in foster care by itemizing several incidents, which had bothered her for many years. She was asked to score their significance on a scale of one to ten, with the majority being somewhat insignificant (1-5). A few events, however, scored in the range of 7-9, such as being left without dinner on a few occasions. Mom responded with emotion, while step-dad stated that he believed she was reacting "too personally" to events that were "tedious". He was asked to use the skill of "validation" as a method within this situation. R also gave insight into her self-harming behaviour, stating that it brought her some measure of control, although mom was skeptical. R's dislike of school had not dissipated in part because she was a subject of rumours. She recognized the need to attend classes, and had been assigned an escort to and from class to ensure her attendance. Younger sister was anxious and angry with mom

for giving the predominance of the attention to R and would be attending sessions with the family on a continuous basis.

Second Session Analysis

Minuchin (1998) posited that therapists should focus on growth-promoting practices, and the strength of emotional connections early in the therapeutic journey. Growth promoting practices within this family were scant and R's emotional connection to other members was of concern. They were, however, encouraged to continue family activities such as bike rides, which they enjoyed, playing chess and other family oriented board games, and to indulge in movie nights on occasion. According to ESFT principles, emotional connection and growth promoting practices are tied to child outcomes. The locus of R's severe emotional imbalance stemmed from her past history, in addition to the current situation in the home. Working with mom, stepdad and younger sister, to help maintain and nurture her would be another goal.

Third Session – Establishing a meaningful therapeutic focus

Psychiatrist and SW met with R and mom for session three. R was visibly in a very low mood and remained in that state for the duration of the session. The psychiatrist discussed R's medication and made the recommendation to change, and to also increase dosage. Through a synopsis of the past week, mom described R's continued theft, her lack of school attendance, and her poor attitude at home, and felt the family deserved some sort of normalcy within the home. She discussed the possibility of making permanent alternate living arrangements for R. R discussed her ongoing "frustration with everything" stating that her theft was in response to her feelings of isolation. Without access to a phone, she lacked the ability to communicate with the outside world. The restrictions on her freedom, such as being grounded indefinitely, were a constant burden and source of frustration.

Mom had contemplated calling the police to have R arrested but was torn between being punitive and being understanding and compassionate. R's response indicated that she was using her visual art skills as a coping mechanism and that she did not feel that self-harm was the answer to her issues, when questioned about the possibility of her acting on impulse. Mom and the psychiatrist committed to calling various institutions to initiate a placement for R because mom felt it would be in the best interest of all family members.

Third Session Analysis

This young, struggling family had a history of intergenerational trauma and whether ESFT sessions were going to elicit a positive difference was questionable. Structural Family Therapy and by extension ESFT, stresses that the dynamics of the family relationships and the structure of the family are very strongly shaped by the family's culture, race, gender, politics and economics (Magnavita et al., 2004).

When the therapist identifies structural patterns, it assists in spelling out what family members expect from one another as well as what they are doing with one another (Minuchin, 1998). Within this process, a therapist can see challenges and patterns. Through emotional regulation, a therapist can see how families help (or not) each other handle stress (Minuchin, 2003). These interactions are vital in determining whether children are developing their social and emotional competencies. Recognizing differences assists the therapists in becoming attuned to those within the family, i.e. their learning styles, vulnerabilities, trauma etc. (Magnavita et al., 2004). Family development helps therapists understand the emotional challenges that are being fought by the child(ren) as they move through a particular cultural context (Goldstein, 1969). As families progress, they will often develop predictable enduring patterns of interaction which are organized around day to day

tasks and the emotional challenges that stem from family life (Minuchin, 1998). This "family structure" is used to describe the manner in which families organize themselves.

The structure within this family had changed many times throughout the years. Significant others had prior incarcerations, while, R and sister had a history within foster care. The emotional connections made with mom's past partners needed to be broken and re-established with mom's new partner, thus re-establishing new structures. The patterns that developed are predicted by the expectations of family members about how tasks, needs, and connections are managed (Minuchin, 1998). Over time, interactions become entrenched and predictable and become known as rules or norms that regulate behaviours. Minuchin (1998) stated that all families possess a hierarchy (sometimes parents are at the top; sometimes the roles are reversed). In this case study, the hierarchy was blurred and that needed to change in order to move forward. Arriving at this juncture with this family was difficult; R's behaviour and a need to change her behaviour, was paramount with mom and stepdad.

Regardless of what form a family takes (single-parent, same-sex, multi-generational), Minuchin (1998) believed that all are differentiated into sub-systems and can include the individual, a couple, parent child dyad, siblings, grandparents, grandchildren, relatives or non-biological kin. Each individual is said to belong to more than one subsystem within a family. According to this thinking, it was difficult to see within which subsystem R belonged; she seemed to be isolated from all members of her family. Members and subsystems within growth promoting families have opportunities for learning life skills by way of experiencing challenges, levels of power, patterns of closeness and distance, and emotional relationships (Minuchin, 2003). The two dimensions of particular importance to this family and other families in crisis were (1) boundaries and (2) affective proximity. These will be discussed in session five.

Fourth Session – Establishing a meaningful therapeutic focus

This session included meeting with R, mom, and some members of her learning community to decide what options worked best for the family. A holistic approach was taken with this family including R's social and physical needs. The session was difficult and emotional for mom, R, as well as the administrators who described R as a pleasant young lady who was afflicted with many behavioural issues. It was concluded by school administration that R would continue to be monitored and escorted to all her classes. She would continue to have contracts with all teachers that would entail them signing daily attendance sheets and then reporting back to mom. On a weekly basis, mom would be given a synopsis of the good behaviour, and areas for improvement. Mom and stepdad would be permitted to "drop in" at the school unannounced to ensure that R was present.

Ecosystemic Structural Family Therapy requires that the therapist see the "structure" of the family and determine whether it needs modification. Minuchin (2003) stated that "when the structure of the family group is transformed, the positions of members in that group are altered accordingly, and as a result, each individual experiences change" (p. 47). Since meeting the family during multi-family therapy and now after four family therapy sessions the apparent structures were:

1. The inimical and nonverbal exchanges between R and mom;
2. The cyclic talk between mom and stepdad about R, who often remained silent while her behaviour was being described – the structure was the alliance of mom and stepdad at the exclusion of R;
3. The relationship between mom and the school administration who report to each other about R's behaviour(s);

4. The relationship between R and the school, which on the surface seems caring on the part of the school, and cold and mistrusting on the part of R – the structure was R's behaviour and the reactionary nature of the school and its staff.

The Systems paradigm and Structural Family Therapy whose philosophies drive ESFT, describe the following features as important for the therapist when seeing the structures within the family:

1. *Part and whole*. The larger system should be the initial focus and not the individual part or the isolated content. Therapist should also be cognizant of the transactional process within this system (Umbarger, 1983). For example, R is seen as predominantly the "problem" but therapy needs to focus on her within her family, school, and community.
2. *Information, error and feedback*. Communication feedback loops will be noticed within living systems and provide information about the activities of the system, which consists of "error" signals that tell any given subunit whether or not its behaviour is dissimilar to the overall design for the living of the total system (Umbarger, 1983). School administration and staff ally with mom and vice-versa. They spoke to R about areas of her behaviour they believed to be inappropriate.
3. *Feedback and homeostasis*. Homeostasis is defined as a "steady state of being that is necessary for life" (Umbarger, 1983, p. 17). Deviation-countering behaviour can occur when the overall design of the system is not at homeostasis (Umbarger, 1983), for example, R's overall behaviour and attitude.
4. *Life and tension*. The continual alteration of periods of growth with periods of stability (of morphogenesis with morphostasis) makes up the dynamic tension of life (Umbarger, 1983). Growth occurred on occasion when R would "behave".

5. *Circularity*. Cause and effect are circular and not linear (Umbarger, 1983). R's behaviour caused permanent grounding and loss of communication privileges, which then led her to theft in order to restore her sense of control and connection with peers. This behaviour then led to continued grounding and restriction of privileges.
6. *Change*. Change in the total system as well as in any individual part occurs with intervention into the whole as well as into any part. Both part and whole must change in some conjunction with each other, but not necessarily simultaneously (Umbarger, 1983). The "part" was R, the school and other members; the whole being the sum of all the parts. None of the parts were changing at any noticeable rate during the first four sessions.

Fifth Session – *Creating key growth promoting interpersonal experiences that lead to incremental changes*

This session seemed like a repeat of other sessions whereby stepdad stated that the week had been another stressor because identical behaviours were repeated by R to include more theft. Younger sister attended this session and stated that her annoyance with R is fueled by her monopolizing all of mom's time, being obligated to "take care" of her in the absence of mom and stepdad, and the uncertainty she often felt surrounding R's suicide attempts. Although R living elsewhere would not necessarily make her happy, younger sister believed that it could be for the betterment of the family. She also felt some measure of irritation towards mom for not spending enough time with her. It was revealed that the tension at home was affecting the relationship between mom and stepdad and R stating that she felt responsible. Family committed to modifying their communication skills in order to elicit less anger from each other.

Fifth Session Analysis

Under the premises of ESFT it is said that, "boundaries prove most critical for understanding the unique manner in which families actually function or regulate themselves within the organization they have constructed" (Magnavita et al., 2004, p. 45). Boundaries are said to assist in moderating one's involvement and the family hierarchy, consequently protecting autonomy and subsystems of the family (Minuchin, 1998). Boundaries are on a continuum of two extremes of diffuse (boundaries that create lack of clarity as to who should participate in a subsystem, allowing subsequent intrusion by non-subsystem members) and rigid (boundaries that hinder contact with and the flow of information among other family members) (Minuchin, 1998). The aim for families is to have clear boundaries, which designate unambiguously, who participates in various family roles, and protects the specific functions of a particular subsystem, while allowing for adaptive interchange with other subsystems (Minuchin, 1998).

There are role boundaries or generational hierarchy such as those found among grandparents, parents, and child roles. When the generational boundaries are reversed, children parent their parents, and control or take care of them emotionally. When the generational boundaries are collapsed, parents and children act as peers or when the child(ren) have an alliance with one parent against the other parent. These role boundaries will impact how power is distributed in a family. Power is defined as the relative influence of each family member on the outcome of an activity, and is often determined by his or her generational membership or developmental levels (Minuchin, 1998).

The literature also refers to boundaries as contact or involvement among family members, subsystems, and with institutions and individuals outside the family, R's school community for example. For this example, the boundary entails physical and or

psychological space to describe the amount of separation or distance between two or more influential domains (for R the dyad alliance of her mom and the school administration). Systems and subsystems could be under or excessively involved with these influential domains depending on one's perspective, R's mom and school may be described as excessively involved). Minuchin (2003) stated that overinvolved subsystems are enmeshed, while under involved systems are disengaged. Both the highly enmeshed and disengaged states can create conditions for significant child and family problems, whereby the enmeshed family will react to the slightest behavioural deviation, while the disengaged family will refuse to respond sufficiently. To function optimally as a family, clear boundaries must be present between, and within subsystems (Minuchin, 2003). One caregiver's leniency can be balanced by the strictness of the other, but this begins to cause problems when they are exaggerated or fail to shift to accommodate to changing circumstances (Minuchin, 2003).

Affective Proximity refers to how secure members feel in their relationships with other family members and is a subjective emotional experience (Lindblad-Goldberg & Dore, 1998). There was evidence that R felt emotionally disengaged from mom. Her disengagement from her biological father was a source of distress. This concept of attachment was expanded by John Bowlby (1988), who postulated that security and the emotional needs of a child are biological in nature and also drive behaviour. "If attachment goes well, there is joy and a sense of security; if it is threatened, there is jealousy, anxiety and anger; if broken, there is grief and depression (p. 3). Bowlby continued to say that "how attachment behaviour comes to be organized within an individual turns in high degree on the kinds of experience he has in his family of origin, or, if he is unlucky, out of it" (p. 3.). Attachment is a fundamental component of ESFT and is primarily concerned with how

attachment or lack thereof, affects the behaviour of children with a family. It is said that there can never be too much security. Affective proximity is needed so children can have confidence in their exploration of the world and to garner an emotional equilibrium. Bowlby (1988) stated that,

> The provision by both parents of a secure base from which a child or an adolescent can make sorties (an exit) into the outside world and to which he can return knowing for sure that he will be welcomed when he gets there, nourished physically and emotionally, comforted if distressed, reassured if frightened (p. 11).

By the same token, children who feel an inadequate amount of attachment will feel distress and anxiety, and will act accordingly.

Sixth Session – *Creating key growth promoting experiences that lead to incremental changes*

For the check-in, all members reported having "a very good week" with stepdad reporting that he was able to get some well-needed rest; younger sister reported that she was doing well and had not fought with R for the week; while R reported that her mood had felt improved and that she got along well with all family members. She was endeavouring to catch up at school with the assistance of step dad. Through the use of a genogram drawn by R and younger sister, they revealed that they had limited memories of their extended family with the exception of one maternal uncle; felt that mom's boyfriend was their "dad"; mom was the most significant figure in their life; and step-dad's family, including his children were important to them. It was also learned that mom was unsure of the identity of her biological father as it was not confirmed by her mom before her passing.

Sixth Session Analysis

An ecological approach to Structural Family Therapy involves examining the global view of the presenting problem(s), like the extended family, friends, community and

other institutions (Foley, 1983). For the therapist, it is important to explore whether children feel that their family, not including immediate caregivers play any major roles, negative or positive, in their lives. The way that children experience attachment to primary caregivers is strongly related to any past trauma, including intergenerational trauma (Bowlby, 1988). Research has shown that many children and caregivers with past trauma not only struggle with attachment, but experience emotional dys-regulation. Genograms are used at the hospital to trace family history of trauma, abuse, discipline etc., and can offer perspectives to the therapist about unresolved issues in the family, because "families have mysterious pathways of pain" (Minuchin & Nichols, 1993, p. 146).

Framo (1976) stated that going back in time, allows clients the ability to move forward in dealing with the immediate issue(s) in more appropriate ways, since their transference meaning has changed. Having at least one session where clients go back to the family of origin, takes the problems back to where they began thereby making available a direct route to etiological factors (Framo, 1976). The genogram allows the therapist to formulate hypotheses about the functions and dysfunctions of the past, and to make assumptions about what needs changing with current clients. Bowlby (1988) stated that relationship problems that adults have with their spouses and or children are reconstructions and elaborations of earlier conflict paradigms from the family of origin, and the Ecosystemic Structural Family Therapy paradigm believes it imperative to understand this concept during therapy sessions. There are four relationship patterns identified by Framo (1976):

1. Those who are over-involved with their family of origin where they take vacations together, or have to talk every day to a parent on the telephone;
2. The most commonly found pattern consists of superficial, non-personal contact. Family of origin is seen for duty visits several times a year and at weddings and funerals. People

following this course usually consider themselves as having resolved their problems with their family of origin in a mature way;

3. The next pattern, least frequent but with the most serious consequences, is typified by those who proudly proclaim that they are truly independent because they have cut themselves off completely from their families of origin. Such people never see their parents or siblings, or extended families at all. Some may regret this situation but claim it is necessary, and the only way they can keep their sanity. Others are extremely bitter toward a parent or sibling and may even go so far as to forbid their mates or children to mention the name of the offending relative. For these adults, that family member is dead. These people have the greatest likelihood of repeating with their mates and children, or any intimate relationship, the irrational patterns of the past; and

4. Last, there is an appropriate pattern of relationship to parents in adulthood, stemming from having established a self within the family of origin before separating from it. These people did not have a desperate need to stay with, or get away from, their parents; there is presently neither over-attachment nor angry distancing. There is more of an adult-to-adult, personal relationship with parents. Affection and a sense of obligation are still present, but not at the expense of one's present family or one's integrity of self.

Although what brings a family into therapy is the symptom of one member, or the person labelled as "being the problem" (Minuchin, 2003, p. 60), this so called "problem" is functioning within a larger system that needs to be looked at from many different angles to include a historical angle. The family life-cycle perspective allows the ESFT therapist to take a more macro viewpoint acknowledging that current challenges may have originated historically.

Seventh Session – *Creating key growth promoting interpersonal experiences that lead to incremental changes*

This third stage of therapy focused on creating interactional experiences that would promote growth or change for R, and her family, rather than a repetition of recurrent maladaptive patterns, more specifically, eliminating the core negative interactional patterns, which have manifested over many years. These would include: 1) strengthening mom's executive skills (how she responds to the needs of the two girls); 2) promoting co-caregiver alliances (mom and stepdad are sometimes positively aligned, but not always; 3) increasing tolerance of frustration (self-regulation). i.e., using their DBT skills; and 4) creating age expected parent-child connection / attachment (R's attachment to mom could be construed as minimal and she may not always feel validated) (Lindblad-Goldberg & Dore, 1998). During this stage, the therapist needs to encourage boundary making, increasing intensity, enactments, unbalancing, reframing, punctuation, etc. (Minuchin, 2003).

Social worker met with family without step dad. The week seemed relatively uneventful for all with R reporting having been ill, yet, was upset with mom for seemingly holding a double standard with her and younger sister. Younger sister for example could take items without asking for permission without consequence from mom, while she would receive punishment on a regular basis. Mom believed the comparisons were unjustified and that R was trying to divert attention away from her behaviour.

A Core Negative Interaction Pattern (CNIP) was conducted with R and mom on paper so they could describe what transpires when R "misbehaves". It was shown that, misbehavior transpires from R, grounding or taking away of privileges from mom, and the cycle would be repeated. Mom and R worked in tandem to describe what behaviours would be consistently required (3 weeks in a row) in order for R to regain privileges.

Seventh Session Analysis

One aim of ESFT is to change the behaviours, emotions, and beliefs that keep members stuck in a non-functioning pattern (Lindblad-Goldberg & Dore, 1998). The CNIP or Core Negative Interaction Pattern was conducted with R and family so they could try to identify the negative patterns that were preventing them from moving forward. Therapists need to emphasize the organizational structure of the family in terms of its hierarchy, boundaries, and alliances for example, and how those variables influence the ways in which it influences everyone's behaviour (Lindblad-Goldberg & Dore, 1998). The social worker also needs to pay attention to the interaction between caregivers and extra-familial people and institutions, and cultural variables of the family. R is being closely monitored by school staff at the request of mom to ensure that she behaves appropriately, does not skip class, is punctual, completes her homework, and refrains from stealing the property of others etc. Her frustration about this situation, and mom's response to her frustrations were a constant focus during sessions.

The fact that the family is Indigenous brought some issues to the fore. The pendulum, for better or worse, has swung within Children and Family Services. They were extremely hesitant, for example, in getting involved with this family, stating that they did not have adequately trained staff to deal with Indigenous families in crisis. Irrespective of the fact that mom reached out to the agency as a cry for help, they approached the issue carefully, not wanting to upset the balance of the situation any more than already was obvious. Whether they will pursue this case and assist mom was an unknown when the practicum ended.

Therapeutic change for R's family can take place within parental executive functioning, child coping skills, co-parent alliances, non-adaptive emotional attachment

patterns, emotional regulation, and extra familial supports to family members (Minuchin, 1998). The therapist can assist families in reorganizing or restructuring the ways in which members relate to one another, for example, creating or enforcing boundaries, rebalancing power or clarifying hierarchies (Lindblad-Goldberg & Dore, 1998) (this was attempted during session eight). The most common interventions used in Ecosystemc Structural Family Therapy are behavioural enactments and validation of family member strengths, which can help members learn new ways of relating, and to help with emotional regulation and distress tolerance skills (Foley, 1983). The family, for example, was always encouraged to practice their Dialectical Behavioural Therapy skills for distress tolerance, and the validation of others. ESFT also addresses thinking (SW helped R realize that mom was trying her best and that her efforts were all attempts to help her heal), beliefs, reframing (reframing their responses so the other person felt validated and understood), constructing adaptive narratives (both mom, younger sister, and R were to think before responding in anger) psycho-education, and the use of rituals.

Additionally, the use of emotional challenge and emotional support to encourage new, interpersonal interaction patterns was used; for example, speaking to, and looking at each other when speaking, rather than the therapist, not interrupting others when speaking, and even the use of a talking stick to ensure that everyone got a fair chance to engage. The treatment process included engaging family members whose interactions maintain the problem as well as those who were impacted by it (Minuchin, 1998). Mom was asked from the beginning whether she wanted to include younger sister and stepdad in the process. It was imperative to include younger sister, as the impact on her would be detrimental if not addressed. Additionally, people who have the potential to support the therapeutic system, and can assist in the development of new relationships or interaction patterns (R's school for

example) were actively engaged in the treatment process (Jones & Lindblad-Goldberg, 2002).

Eight Session: *Creating key growth-promoting interpersonal experiences that lead to incremental changes*

In the final stage of ESFT treatment, the goal was to help the family integrate different themes generated in therapy as well as assist them in developing a clear understanding of how their behaviours produces their desired outcomes and how they could continue to improve their circumstances (Lindblad-Goldberg & Dore, 1998). During this stage the responsibility for evoking change shifts from the therapist to the family members and the focus is on how families would deal with the problem that arose during therapy and new ones that would emerge as they live their lives (Minuchin, 1998). The social worker met with the whole family, psychiatrist, and the supervisor who would be taking over sessions with the family. Mom discussed last week's meeting with Children and Family Services where they discussed possible out of home placements for R. Family was informed that the possibility of R being removed from the home was slim.

Mom referenced a letter, which R wrote to her where she discussed her depression and threatened self-harm. Both mom and step dad stated that these letters were frequent and that it may be an attempt to divert attention from something inappropriate that she had done. R was asked to describe what she expected from mom and stepdad when writing such letters and stated that she wanted them to acknowledge that she was hurting. The session was spent discussing and practicing more productive ways of responding to R's need for validation; and other ways R could communicate her hurt that did not involve threats of self-harm. Time was spent working with the family to identify CNIP's that they have been using that were not productive. The family was asked to take the week to identify interaction patterns among all members, that they had been using that did not work in their favour, and

to think collaboratively of other more productive methods.

This was my last session with the family but will not be their final session in therapy. I did, however, wanted to solidify with them the concept of CNIP and how each member was contributing to the cycle; and to recognize that there were alternatives to their norm. Specific goals were developed collaboratively with mom, stepdad, and R to include but not limited to continual CNIP recognition, and validation of members.

Chapter Two - Dialectical Behaviour Therapy

Marsha Marie Linehan stated that she developed Dialectical Behaviour Therapy (DBT) to address the pain and suffering of suicidal people with borderline personality disorder and to aid them in finding a life worth living (Linehan, 2015). DBT has since been adapted to assist other client groups including families with troubled adolescents. The Kingston Health Sciences Centre has many clinicians trained in DBT for individuals, as well as skills training for struggling families. I had not been previously trained in DBT and had the privilege of facilitating a multi-family therapy group once per week for 2.5 hours with three families. The flexibility of DBT in treating clients whose issues are complex became apparent within these sixteen weeks. Often, as Salvador Minuchin and other family therapy leaders have observed, one individual within the family unit should not be the sole focus of treatment.

DBT with parents or families utilizes the same theory and strategies as DBT with individuals, but also assesses the ways family members affect each other (Swales, 2019). The key focus of DBT multi-family therapy skills training is to decrease the cycle of inaccurate expression and invalidating responses (Swales, 2019) among family members. Family interventions may occur with or without the youth patient; however, at KHSC, the youth was always present. Family interventions can be an efficient and effective way to augment outcomes for individuals in DBT (Fruzzetti, 2011), and includes skill acquisition, skill generalization, improving the motivation of the client to employ skills rather than old dysfunctional responses, and intervention in the environment (social, family, work etc.). The objective of the multi-family therapy skills training at KHSC was to empower parents and other family members with skills and to help them be effective within their roles, because it affords the youth and even the parents the opportunity to

practice what they have learned in a real-life environment. The philosophy of DBT multi-family therapy recognizes that caregivers can often be very relevant to the healing of a client's emotional pain, and suicidal behaviour or aggression. Within this chapter, I will discuss what I believe were the most relevant and significant aspects of the sixteen-week, multi-family therapy sessions for the three families, make reference to our classroom discussions, as well as some of their comments during debrief at week sixteen.

Families were identified through intakes at the Family and Youth Mental Health Clinic, after referral from family doctors, emergency departments or community health services. If it was determined by the social worker, psychiatrist, psychologist or mental health nurse that the family could benefit from DBT skills training, they were asked whether they would be willing and / or able to commit to the time and effort. Families gave their written consent to keep the personal information of other members in confidence; to consent to avoiding any personal relationships with other members, and to respect the rules and responsibilities of the group. This included being on time for class, attending all sessions unless absolutely necessary, (i.e., illnesses, appointments that cannot be missed etc.) and respecting the integrity of those in attendance. Any more than two absences would disqualify any member from continuation with the skills group. Every Thursday from 5:00 – 5:30 p.m., families arrived with their supper, sat at the designated table set for eleven people (seven family members, one MSW social worker, two MSW students and one psychiatrist) and ate supper as a group.

Skills training always began with either a mindfulness activity or "fun group activity" to get members focused and ready for training. At approximately 6:30 p.m., there would be a ten to fifteen minute break, followed by the continuation of training until 7:30 p.m., when homework would be assigned. One of two MSW students would

facilitate the training under the supervision of a psychiatrist and a MSW social worker. The two-hour training sessions were shorter than the 2.5 hours standard DBT for adults, based on the assumption that adolescents have shorter attention spans than adults; however, the identical skills were taught with the exception of Walking the Middle Path which is exclusive to adolescent groups. Homework would be reviewed during the first half of the session, and although families were never forced to participate, I often called on less talkative clients to engage, both in homework sharing, and general discussion of topics. They could always decline, but for the most part, clients responded very well to being asked to speak. Members would always receive validation from a staff member in reference to their thoughts, beliefs and / or experiences, if not readily provided from a family member. It was sometimes necessary for the MSW or psychiatrist to caution some members for inappropriate comments targeted at another member of their family. Such pejorative comments were against the rules and regulations mutually agreed upon by all participants, and could also publicly demean someone who was putting effort into their healing.

Family One

This family included a sixteen-year old (adolescent one), and a mom and dad in their mid-forties. Daughter one, had been diagnosed with depression and generalized anxiety disorder from a young age, had self-regulation issues, and reported being lonely from a lack of peer friendships. She was very pleasant and was always eager to participate in all sessions. Both mom and dad had a history of trauma. These families had been participating in family therapy for several years, and were strong candidates for DBT multi-family therapy.

Family Two

This family was described in detail in Chapter 1 under Ecosystemic Structural Family Therapy, but only R and mom participated in DBT.

Family Three

This family was a two-parent family with a seventeen-year old adolescent (dad only attended two sessions). Daughter had anxiety issues and suffered trauma from a young age. She had a very close relationship to both parents. This family also participated in family therapy using Emotion Focused Family Therapy on a weekly basis with an MSW.

Dialectical Skills Training for youth struggling to control their emotions and behaviour is intended to be a sixteen-week program, but can be modified to be longer or shorter as required, based on the needs of the families. Teens with emotional and behavioral dys-regulation develop a myriad of problems including, but not limited to, difficulties establishing a stable sense of self and forming fulfilling relationships with others. Linehan (1993) reported that trying to re-regulate often results in problematic impulsive or avoidant behaviour. Emotional dys-regulation in adolescents is addressed within the skills training guidelines and is in line with the five major problems associated with emotional dys-regulation: Mindfulness skills assist with self-awareness and attentional control while reducing suffering and increasing pleasure; distress tolerance assists with reducing impulsivity and accepting reality as is; emotion regulation assists with increasing positive emotions and reducing negative emotions; interpersonal effectiveness assists with improving and maintaining peer and family relationships and building self-respect; and walking the middle path assists with reducing family conflict by teaching validation, behaviour change, and dialectical thinking and acting (Rathus &

Miller, 2015). The majority of adolescents fall on a continuum from typical, relatively asymptomatic to severely emotionally and behaviourally dys-regulated. The youth who are referred for comprehensive DBT treatment are typically diagnosed with two or more DSM-5 disorders in addition to other life problems, similar to the families previously cited.

Module One – Mindfulness Skills

Every moment is a fresh beginning – T. S. Eliot

Everything has is wonder, even darkness and silence,
And learn, whatever state I may be in, therein to be content
------Helen Keller

At the beginning of each module are quotes like those above, which were written on Bristol board and displayed on the wall of the designated room. Quotes were read out loud by the facilitator before the beginning of the mindfulness exercise or the "fun activity". This module on Mindfulness was meant to teach participants about nonjudgmental awareness and being fully present in the moment, becoming aware of their current emotional state and urges, which would eventually teach them how to select appropriate responses to situations, rather than impulsive reactions that do not work to their benefit (Rathus & Miller, 2015). This module was divided into two sessions and was taught in week one and week six. The activity chosen for the first class was both "mindful" and an icebreaker where participants and facilitators were required to form a circle while holding hands. Requirements were to jump in, out, left or right for the duration of the five-minute exercise, with specific instructions to either "say what I say, while doing what I say", or "say the opposite of what I say, while doing what I say", or "say the opposite of what I say, while doing the opposite of what I say", etc.

To orient participants to the basics of mindfulness, families were asked to take note of the way in which they chose to hold their neighbour's hand – was their hand

facing forward, or was their hand facing back, and whether or not that affected their comfort level. The males in the group quickly noted that they were holding hands facing back. One male member indicated that he was not comfortable holding hands with others any other way, although this had never actually occurred to him. The teenager from Family Two expressed her discomfort in holding hands in general, particularly with those that she had never met. This simple, yet matter-of-fact statement was not a notion that she had ever given much consideration. The facilitator discussed the benefits of mindfulness:

1. Being mindful can give you more choices and more control over your behaviour;
2. Being mindful can reduce your suffering and increase your pleasure;
3. Being mindful can help you make important decisions;
4. Being mindful can help focus your attention and make you more effective and productive;
5. Being mindful can increase compassion for yourself and others;
6. Being mindful can lessen pain, tension, and stress and in turn, improve your health (Rathus & Miller, 2015).

As a first class, participants seemed understandably reluctant to share their thoughts with strangers. The teens particularly shied away from volunteering, and allowed parents to either speak on their behalf, or to share their own personal experiences. There were no participants present who practiced mindfulness in their personal lives, nor did any give it much thought or consideration within their day-to-day functioning.

A discussion ensued about what mindfulness meant to participants, and whether they believed the exercises could be useful to them and their future goals. Examples

were elicited from the participants about how not paying attention or not being aware of themselves or their surrounding impacted their lives over time. Responses received seemed to suggest that, although family members were not routinely dedicated to the practice of mindfulness, they were in-tune with the philosophy. The teenager from Family One, for example, stated how her emotions often get in the way of her day. Being able to identify those emotions and also notice how her reactions to certain stimuli affected her immediate happiness could possibly make her a happier being. Examples were also elicited about times when members were more aware and focused and whether that helped them function better, emotionally, behaviourally, cognitively, and interpersonally. In week sixteen (final week) during the feedback, mom from Family One stated that the module on mindfulness was particularly poignant for her from the onset, and stated, "mindfulness, I think…I personally have really gotten better with how I react and talk about things or don't talk about things…I make sure I think before I speak whereas before I really just yelled, screamed or worried about it later".

The lesson continued with a discussion about, Reasonable Mind (ruled by thinking, facts and logic), Emotional Mind (ruled by feelings and urges) and Wise Mind (included both reason and emotion) while participants followed the lesson with mindfulness handouts. As an illustration of emotional mind, teenager from Family One discussed her ongoing struggles with feelings of isolation and loneliness at school, and became emotional when stating that this bothered her, and had for quite some time.

To practice the "Observe" skill, participants were asked to imagine going to an aquarium and watching fish in a large tank and how people tend to notice what swims in front of them – the features, colours, shapes and sizes of the fish. As the experience changes, people attend to those changes. To practice "Describe" participants were then

asked to orient their mind to their thoughts and to jot down a hash mark / check mark every time a new thought surfaced. They were then asked to observe a picture and to write down what they saw without interpretation. For example, "I see a frown on her face", rather than, "she looks like she has an attitude". The teenagers were of the opinion that describing without the interjection of feeling or opinion is a very difficult task. Parents were in agreement that to do so regularly required skill and that most people, including them, habitually add their "opinions" to what they believe they are seeing. It was agreed by all, that this could perpetuate discrimination, stereotype, and develop beliefs that may or may not be factual.

To practice "Participate", the class was asked to think of a recent time in which they were participating fully, becoming one with whatever they were doing, or being "in the zone", and to also think of a time when they were only half-engaged in an activity, or when they were multi-tasking; and to differentiate between the two. Facilitator then taught the three "How" skills of (a) do not judge, (b) stay focused and (c) do what works. Teenager from Family Three, made reference to the educational environment and losing focus when in class, and suffering the consequences of not completely understanding the lesson taught in class. Conversely, when she is fully engaged in her dance lessons, the experience is more satisfying and enlightening.

The mindfulness module was surprisingly well received by the class. Family Three (during the debrief), when asked what skill they routinely used since starting DBT skills training, stated, "mindfulness techniques…we are now constantly thinking about everything we are doing". Mindfulness activities preceded all subsequent classes and sometimes, the classes also ended with a brief mindfulness break. The MSW supervisor

encouraged clients to take hold of their thoughts without judgment, and to try their best to become attuned with their feelings.

Module Two / Sessions 1, 2, 3, 4 – Distress Tolerance (Week 2, 7, 11)

Nothing is more desirable than to be released from an affliction, but nothing is more frightening than to be divested of a crutch.
-----James A. Baldwin

It is our choices….that show what we truly are, far more than our abilities.
-----Albus Dumbledore (in Harry Potter and the Chamber or Secrets, by J. K. Rowling

During these modules, families were taught how to tolerate difficult situations and emotional pain if the problem could not be solved right away (Rathus & Miller, 2015). Sessions one to three taught crisis survival skills, while session four focused on changing the experience of the distress, by distracting, self-soothing, and improving the moment; in addition to the pros and cons of impulsive and effective action. The strategies within this model were meant to help families survive "crisis" without making their situations worse through impulsivity. The skills provided short-term solutions that may not make one feel better, but would help them bear the pain by not engaging in maladaptive problem-solving behaviours, including substance use, disordered eating, and self-harm.

Orientation to Distress Tolerance (Week Two)

This session oriented families to the meaning of distress tolerance, which by definition is withstanding, rather than changing or getting rid of, an unwanted situation (Miller et al., 2015). Participants learned that distress tolerance was not meant to make you feel better. All family members and facilitators were very vocal in sharing personal experiences. Adolescent from Family One for example, discussed using food as a comfort when in distress. It was noted, that being soothed by food is temporary contentment that does not make the uncomfortable situation dissipate. There was general consensus that we (facilitators and family members) as a collective, all have at one point

within our journeys, acted impulsively as a means of dealing with pain. The adolescent from Family Three told the class of her ongoing anxiety when getting into any vehicle; anxiety suffered as a result of an automobile accident many years prior. Through the use of distress tolerance skills learned during the DBT modules, she reported during week thirteen that she had persevered and had successfully completed her road test.

Improve Skills (Week Two)

It was discussed that self-soothing is a form of self-care during a crisis and each of the five senses could be used. It does not come naturally and is a skill that requires an enormous amount of practice. The class worked on "Crisis Survival Skills: Self Soothe with Six Senses"/distress handout. "IMPROVE Skills" were discussed at which time families committed to using at least two IMPROVE activities during the week if faced with distressing situations. The adolescent from Family Two, a gifted sketch artist, committed to using that talent if ever in a distressing situation. The adolescent from Family One, a fantastic baker, would hone her skills in the kitchen as a means to distract temporarily, from any distressing event, thought, or impulse. The adolescent from Family Three designated dancing as a tangible pursuit for the week, in an effort to practice distress tolerance.

TIPP Skills (Week Seven)

Before discussing the TIPP skills, the class discussed pros and cons of acting skillfully, more specifically, acting in a way that will not make your situation worse. Participants were asked to do this whenever they were facing doing something that they would rather not do, i.e. going to the doctor, studying for a test, and getting out of bed to go to school. The adolescents from the three families suggested ideas such as forcing yourself to get out of bed early to get to class on time, avoiding junk food by eating fruits

and vegetables, studying for a test well in advance of the test date, and speaking politely to parents in order to avoid arguments.

The facilitator wrote on the board some examples of maladaptive behaviours solicited from participants, after which time, we discussed as a class, the pros and cons of engaging in those behaviours. Some maladaptive behaviours discussed included skipping class to avoid being punished for not completing homework or avoiding a quiz for which one is unprepared; alcohol or cannabis consumption with peers who may be considered a negative influence by parents; and not dedicating sufficient practice for an upcoming dance recital, but instead spending time with friends. Teens and parents acknowledged, that the maladaptive behaviours discussed could elicit immediate gratification, but the lasting consequences may, and often are, detrimental. The adolescent from Family Three discussed her familiarity with not putting adequate practice time into recital and consequently being disappointed if the final exam grade was sub-par. The class discussed the points that needed to be taken into consideration when deciding whether acting skillfully or unskillfully was worth their effort:

- What does the problem behaviour do for you? Adolescents from Family Three agreed that experimenting with alcohol and recreational drugs for example, may bring a modicum of popularity in high school among a certain crowd, but will deem you untrustworthy with parents and school staff if you are caught.
- What are the pitfalls of the behaviour? i.e. drug experimentation is without question, detrimental to the growing brain of an adolescent, and could, in the long run, become habitual.
- Do the pro(s) and con(s) have long-term or short-term effects, or both?
- Identify any patterns of maladaptive behaviour; and

- Building a life for the long term by considering the pros and cons.

Together, we learned that (1) TIPP (**T**ip the temperature of your face with very cold water, **I**ntense Aerobic Exercise, **P**aced Breathing and **P**rogressive Muscle Relaxation) skills, change your body chemistry to reduce arousal; (2) TIPP skills work very fast, within seconds to minutes, to bring down arousal; (3) TIPP skills are as effective as dysfunctional behaviours (like drinking, using drugs, eating and self-harm) at reducing painful emotions, but without the negative short-term and long-term results; (4) TIPP skills work like fast-acting medications but without the cost of medications or the after effects that some medications cause; (5) TIPP skills are easy to use and do not require a lot of thinking; and (6) some TIPP skills, like paced breathing, and some parts of progressive relaxation can be used in public without others knowing that you are using the skill (Rathus & Miller, 2015).

The facilitator discussed her TIPP skill, which included jogging ten kilometres a day. The adolescent from Family Three was the only youth with exercise (dancing) included in her weekly routine, although, she had not used it previously as a form of crisis management. There was general consensus from youth and adults alike that placing one's face in cold water seemed impractical, particularly if the crisis were to take place away from home. Paced breathing was seen as a more viable and "normal" way to add immediacy to a crisis situation. Mom from Family One noted that when in crisis, TIPP skills provided quick and safe strategies to avoid disaster, and if practiced regularly, could eventually become second nature; however, it would also require a great amount of self-discipline to train one's mind to utilize these strategies; discipline that most adolescents, by virtue of their stage in life, do not yet possess. The facilitator stated that the key words used by this parent were, "if practiced regularly", and noted that much of

what is learned within DBT needs to be learned behaviour that can become routine, if applied regularly.

As a class, we discussed putting together a crisis survival kit, which would later be brought to share with the class. What was meant to be a routine, uneventful sharing experience, turned out to be slightly challenging for some. Mom from Family Two described some of the items in her kit such as headphones for listening to music. When asked what genre of music she preferred, she mentioned rap, and explained that this had been her inclination since youth. Both moms from Families One and Three interjected, stating that the language used in rap music was analogous with some of the stereotypes common in society about a certain minority group. The conversation between the two moms lasted several minutes, which, from my observation, was quite unnerving for the mom from Family Two. This was evidenced by her uncomfortable use of two stress balls, in addition to her verbalizing to me that she felt distressed. She was asked by the psychiatrist to respond to the opinions of the two mothers, and stated that rap music may seem oppressive to some, but that she related to the messages of the artists by virtue of her background and experience. She viewed their language through a historical lens and not a repressive lens; and as a cultural expression that some may not fully grasp, but that it brought her great comfort. The reaction from mom from Family Two, who was faced with this sudden and unexpected distress situation, epitomized the response the facilitators hoped to exemplify to the class. Although stressed, she was able to admirably consolidate all that she had been previously taught about distress tolerance, including, withstanding the discomfort, and not acting impulsively. Instead, she displayed the virtue of discipline, and calmly exercised the forbearance of listening and accepting another person's view.

Half-Smile/Accepting Reality (Week Eleven)

The mindfulness exercise for this week was the practice of the half smile. Families were told that facial expressions and posture influence emotional state and vice versa. Assuming a more accepting physical stance will communicate to the brain that we are in a "better mood". Smiling fully or at the very least, assuming, the "half smile" (relaxing the facial muscles) will communicate physical calm and emotional contentment. This activity elicited many giggles from participants, adolescents and adults alike, who believed that this would be a difficult task particularly if they were very upset. As the class practiced use of the half smile, adolescent from Family Two stated that the activity made her anxious, and that she could not imagine "half smiling" being a realistic activity for her. Adolescent from Family Three was in agreement, believing it to be contrived, and that this would not be a tactic that she would aspire to use. Mom and adolescent from Family One stated that they believed others would see past the façade and know they were "faking happiness". The facilitator explained the difference between the fake smile, which could create distress; the full smile, which may be difficult and sometimes impossible when in distress; and the half smile, which is very slight and requires little effort.

The basic premise of this module centered on teaching families strategies to consider so their life stressors would not trigger more stress. The crisis survival skills outlined would need to be consistently practiced to be effective and some may not be appropriate for all individuals. Is it appropriate, for example, or even feasible, to walk with a crisis survival kit everywhere? Of course, that is an individual response. Participants believed that having stress balls, music, and soothing scents on hand would be achievable, and they committed to their use in the future. Many of the crisis survival

methods were short term, with the exception of "Accepting Reality" which ironically is a skill that is extremely difficult for many, even those without dys-regulated emotions.

Another critical issue for these families was what situation(s) exactly constituted a crisis. When adolescents are emotionally fragile, the slightest antecedent will seem catastrophic in their already crumbling world (Swales, 2019). Caregivers who are already over-burdened may not be adept at recognizing the crisis (Minuchin, 1993) or may not have the desire to acknowledge it. To mitigate this dilemma of adolescent and caretaker will, the distress tolerance module aimed to teach participants that the response to the "crisis" was much more important than the actual perceived "crisis" (Rathus & Miller, 2015).

Module Three / Sessions 1, 2, 3, 4 – Walking the Middle Path (Week 3, 8, 12 & 15)

It really boils down to this: that all life is inter-related. We are all caught in
An inescapable network of mutually, tied into a single garment of destiny.
----Martin Luther King, Jr.

The wave cannot exist for itself, but is ever a part of the heaving surface of
the ocean
---Albert Schweitzer

This sounds simple and it is, but it's not easy
---Jon Kabat-Zinn

Miller, Rathus, and Linehan (2007) developed this module specifically for teens and families in order to address polarization, non-dialectical thinking, and behavioural patterns experienced by families with emotionally dysregulated adolescents. This module outlined that opposing views can both be true, and that there is more than one way to solve a problem or viewing a situation (Miller et al., 2007). With this perspective, participants can work on changing painful or difficult thoughts, feelings, and circumstances while also accepting themselves, and others. For parenting, "Middle Path" connotes the belief that authoritative parenting is linked to healthy adjustment in children

(Rathus & Miller, 2015). Diana Baumrind (1995) outlined the three different types of parenting styles (authoritative, authoritarian, and permissive). The preferred style, authoritative parenting, described parents who:

- Listen to their children
- Allow their children to express opinions
- Encourage their children to discuss options
- Foster independence and reasoning
- Place limits, consequences and expectations on their children's behaviours
- Express warmth and nurturing; and
- Administer fair and consistent discipline when rules are broken

Throughout this module the group discussed understanding or at least acknowledging their children's points of view even when disagreeing with this view; which is more specifically known as validation. These lessons were imperative for all the parents who struggled with recognizing their child's opinions, thoughts, behaviours and / or feelings, while not exhibiting tolerance for the unwanted opinions, thoughts, behaviours and feelings. Mom from Family Three chronicled a situation when their teen pleaded to be driven to a friend's house at 10 pm to "hang out" due to boredom, at a time when she, (mom) was in her pajamas and ready to retreat for the night. Mom from Family Two wondered why it was necessary to validate her teen's desire for a later curfew. The facilitator used this opportunity for families to role-play validating each other using the aforementioned real life situations. It was collectively and individually determined that using language such as, "why would I drive you to your friends' house so late?", or "why do you need to stay out so late?" are counterproductive ways of promoting effective communication, in addition to being destructive conversation starters

when attempting to validate another person. Rather, sentences such as, "I know you are bored, are you able to spend time with your friend tomorrow, because I am tired"; or "I'm tired, and ready for bed at the moment, can you drive yourself" project understanding and are less confrontational. The curfew scenario provided an occasion for parent and child to negotiate a new curfew, or for mom to provide justification for the curfew, and / or the teen to explain their desire for a different time.

The feedback after sixteen-weeks of class seemed to suggest that the work on validation provided greater impetus and opportunity to the families on various methods of walking the middle path. For example, one family stated, "…..it worked well for my family because we learned how to be gentle at times when trying to validate somebody and having an easy manner, because you are not trying to scare them." Another family indicated, "…validation was a big one for us because sometimes especially when it is at the end of the day and you are tired and you may have an automatic '*for goodness sake'* and a negative reaction to whatever the thought is, and its actually real to her, and you should listen and deal with it". Family Two explained that "they now use a lot of validation at home…we would be arguing or whatever and trying to get our point across, and then we remember the class. We would tend to talk over each other a lot, and I think that's been the most useful for us…"

I believed this module was particularly significant for families, as most people, the three families included, struggle individually with accepting, or even understanding another person's perspectives with which they disagree. Families with adolescents who have intense emotional dys-regulation and suicide ideation / attempts have a hard time seeing the perspective of their teen (Koons, 2008). Validation skills help families handle differing perspectives by showing acceptance or understanding of how another person

sees a situation, even if they do not agree (Miller et al,. 2015). If we validate the other person's perspective, it lowers the emotional intensity of the person with whom we are interacting and increases the chance that he / she will remain in the conversation (Linehan, 1993). As emotional intensity decreases, the person's communication will reflect a more accurate and effective expression of his or her emotions, and it will become easier to validate their feelings (See appendix 6).

Module Four / Sessions 1, 2, 3, 4 – Emotion Regulation (Week 4, 9, 13 & 16)

I am not at all in a humour for writing; I must write on till I am
---Jane Austen

You can't stop the waves, but you can learn to surf
---John Kabat-Zinn

Gross and Thompson (2007) stated that to understand emotion regulation, we first need to know what is being regulated. That seemed to be a fundamental issue with the three families for this section of skills training. Members, particularly the adolescents, seemed uncertain as to what conditions needed to exist that would qualify them as having an emotion. Is it what they felt when a teacher would embarrass them in class (adolescent two), the confusion about not having any friends at school (adolescent one), the annoyance of parents asking too many questions (adolescents one, two and three), or the uncertainty and anxiety of leaving home for college (adolescent three)? These were all legitimate questions, and were relevant to participants based on class discussions.

The adolescent from Family Three for example stated during debrief at week sixteen, "I think emotion regulation was a big one for me…they were all important, but being able to identify the emotion and know how to deal with it, not just going, "I feel like not doing anything today" and asking why you don't feel like doing anything today and breaking that emotion down". Emotions arise when an individual attends to a situation and sees it as relevant to his or her goals (Gross & Thompson, 2007).

The families participating within this DBT skills training had various challenges that made them different, yet very similar. Family Two for example, struggled with intergenerational trauma. Family One had difficulty setting appropriate boundaries, while Family Three were uncertain about discipline. All families had adolescents that required professional assistance in order to appropriately deal with their emotions.

As classes progressed, mom from Family One often passionately expressed the benefits she believed she was deriving from the skills training. For example, stating, " I think all of them were pretty bang on…with the whole DBT…realizing how you react and don't react, with tones and everything; as well as co-workers, other family members, friends, all around, I am quite shocked at how useful it is". Adolescent from Family Two on occasion referenced her use of her distress tolerance skills (drawing) when needing to cope. Adolescent three expressed that she never remembered any of the acronyms taught (DEAR MAN for example) but always recognized when she used the philosophies of any one skill; stating, "…you may not remember the acronym for it, but you know that you are using one of the tools that we were taught."

Collectively, the class discussed making long term goals, which according to DBT philosophy will allow adolescents to "build a life worth living" (Rathus & Miller, 2015). Adolescent one aspired to be a successful baker and hoped to be accepted into culinary school after high school graduation. Working towards that goal meant practicing her baking skills at every opportunity, which as reported, she was happy to do. Adolescent two expressed wanting to become a successful journalist, but also realized that for this goal to come to fruition, she needed to first graduate from high school with above average grades; which, in turn, translated into being consistent with her class attendance. Adolescent three would be attending post-secondary in the fall away from

home, and endeavoured to be very successful at her studies, while emphasizing her independence from her parents for the four years at university.

It was accepted by participants that the challenge of building a life worth living required an approach that was not always easy; but it needed to be confronted if they were to secure a good future. As reported by adolescent two, friends, for example, often pressured her into skipping classes, and to succumb to those stresses would be in contradiction of her goal of steady class attendance; in the realization of the long-term goal of graduating from high school and enrolling in university. Adolescent three stated during the debrief at week sixteen, "I feel like a teenager that is leaving home for the first time. I feel like I am leaving the nest and what happens if I digress? That is my concern, if we get off the rails a bit – this will remind us and keep us on the right track".

Module Five / Sessions 1, 2, 3, 4 – Interpersonal Effectiveness (Week 5, 10, 14 & 16)

Love is like a precious plant. You can't just ……think it's going to get on by itself
You've got to keep watering it. You've go to really look after it and nurture it.
---John Lennon

When people talk, listen completely.
---Ernest Hemingway

This module began with a fun activity that was meant to depict to the participants the consequences of imbalanced personal relationships. To illustrate this, participants, including facilitators, were paired with one other person. They were instructed to stand side by side and to lean sideways, shoulders touching, onto the other person while simultaneously walking approximately fifteen metres. Although meant to be a fun activity, families realized very quickly that if both partners were not consciously attempting to remain balanced onto the other person, one member of the team would have to work much harder to remain standing. The facilitator explained that the activity could be juxtaposed with our real life personal relationships. Within a relationship, having a

lackadaisical attitude, taking too much, or not giving enough, can negatively affect someone else. The jovial nature of this exercise did not diminish the seriousness of its purpose.

Within this module we addressed getting what you want from others, which could be accomplished with DEAR MAN (**D**escribe, **E**xpress, **A**ssert, **R**eward, **M**indful, **A**ppear confident and **N**egotiate) skills. This also included learning how to say no to others and building and maintaining positive relationships with GIVE (**G**entle, **I**nterested, **V**alidate and **E**asy manner) skills. Mom from Family Three divulged to the class that she felt that she had been dedicated to being a mother to her children for years and had inadvertently neglected friendships, and by extension, a social life outside the home. The realization that her youngest would now be leaving the nest to pursue her independence magnified to her and her husband, that, they needed to expend energy into pursuing their interests. Rathus and Miller (2015) asserted that "a solid social support network helps one tolerate distress and fulfilling, low-conflict relationships help build positive emotions and buffer against negative ones" (p. 228). Whether or not it was in response to mom's comment about seeking outside interests, adolescent three became emotional, excused herself from the class, and had to eventually exit for the night with mom by her side.

Mom from Family Two discussed her inability or reluctance in saying no to others, particularly if they were members of her family. Her guilt about saying no stemmed from her upbringing, when it was often reinforced to her that family members are to provide assistance to each other when they are in need. Mom from Family One, who claimed to have no qualms with saying no to anyone, gave her recommendations on handling family members. She believed that saying no should be approached from the standpoint of explaining to the other person how their need could negatively, albeit

temporarily, affect your life. Mom from Family Two stated that doing as suggested would most likely create turbulent waters, but that she would attempt to skillfully navigate through. On the last day of classes, during week sixteen, mom from Family Two confidently stated " these classes taught me more ways to have self-respect when referring to my family and friends; I can now say no confidently when I am not comfortable in a situation".

Getting what we want from others requires skill and good timing, and although success is subject to many external factors beyond ones control, there are personal skills one can adopt to reap rewards. This lesson on getting what we want provided participants with an opportunity to role-play using DEAR MAN skills. Mom from Family One detailed how, within the last week, she had successfully used this skill to get a pay increase from her management. She chronicled how she spoke of her strengths confidently and matter-of-factly (easy manner), listened attentively to her supervisor's point of view (interested), while also validating those views, and invariably doing all this as gently as possible. The class understood from all three mothers' personal experiences that people generally pursue their needs in furtherance of their happiness. Some things are beyond their ability to influence, while others (saying no, asking for what you want, pursuing personal relationships) are within their realm of power. Mom from Family One stated during debrief, " classes taught communication skills that none of us have ever learned about…I almost feel like this should be a grade ten course – having a communication course would be much more useful, and teaching things like interpersonal skills".

Like traditional DBT, skills training for families with dysregulated adolescents focuses on the dialectic between acceptance and change; accepting one's issues and

challenges, while at the same time attempting to change unproductive and destructive behaviours. It is not difficult to conclude that many caretakers with adolescents find themselves at a crossroads, whereby they are no longer able to appropriately and successfully navigate their journey. To avoid disaster, some families choose dialectical behaviour therapy skills training and therefore choose to harness what little hope may remain in a manner that seeks to include all members in the healing of the family unit. The five modules, mindfulness, distress tolerance, emotion regulation, walking the middle path and interpersonal effectiveness are all intended to teach participants that a better life can be lived once better decisions are made. During the sixteen-week training, family members worked diligently towards their healing all the time, and responded admirably towards each other and the therapists, the majority of the time.

Through patience and the guided intervention of a psychiatrist and a MSW, the three families managed to recognize and stave off many issues that had been plaguing them for years. It was not only the adolescents within the groups who required behaviour modification, and to recognize this, was half the battle. As one parent asserted, "…I am constantly now going, maybe I should think before I say anything, and really, really think about it…so, I think it is huge. It opens your mind to say that everyone has stuff to deal with and these are really good techniques for learning to deal with the stuff". It is comments like these, which highlight some of the successes of family therapy interventions. There is no doubt that some members will continue to struggle in their quest for improved mental health. However, with the completion of the sixteen-week skills training, they are well poised to implement the many learned strategies towards the path of healing.

Chapter Three - Emotion Focused Family Therapy (EFFT)

Families who have developed and maintained secure emotional bonds are best able to weather storms and successfully move through the conflicts typically associated with adolescence (Stavrianopoulos, Faller, & Furrow, 2014). Conversely, families who lack sufficient robust attachment bonds will often find that they grapple with relational conflict (Stravrianopoulos, et al., 2014). Some will seek assistance from mental health professionals while others will relinquish defeat in the face of adversity.

Emotion Focused Family Therapy provides tools to parents to heal what ails their child, themselves and the family as a whole (Foroughe, 2018). Parents are seen as the solution to their children's issues, irrespective of what that issue is - addiction, anger, eating disorders, depression etc. The philosophy behind EFFT holds that as parents assist their children in their struggles, relationship bonds will strengthen, and parents can be proud of the fact that their efforts led to a stronger and more prepared individual (Foroughe, 2018). When children know that they can rely on their caregivers, better and stronger attachments can be formed (Elliot, Watson, Goldman, & Greenberg, 2004). They are also more apt to turning to caregivers in times of need, rather than friends or strangers for "emotional wounds are best healed by those closest to you, with whom you have the strongest attachment" (Foroughe, 2018, p. 98).

Teaching parents the concepts of EFFT so they can impart and use the language within their relationship with their children is the theory behind EFFT training at Hotel Dieu Family Therapy clinic. A therapist, who, by all accounts is a stranger to the child will not be as efficient using EFFT concepts, as a parent with the same skill sets (Goldman & Greenberg, 2015). It is proposed that bonds are stronger between parent and child versus child and therapist (Foroughe, 2018). Across two, eight-hour sessions,

caregivers are taught EFFT language and skills by a MSW and Psychologist and are encouraged to use these skills towards the "healing" of their relationships with their children, the final objective being the healing of the child (Strahan et al., , 2017). The therapists are seen as facilitators to the process of the healing relationship between parent and child.

I was fortunate to witness a few hours of this training at the hospital, yet within that small span of time, it was evident that all the parents arrived confused, scared, and wanting immediate answers to their struggles. They wanted to know what to say, when to say it, how to say it, and wanted a timeline of when they could expect results. They all had the same thing in common – a child who "needs help" and whom they no longer recognize, and frustration and anger from having tried all different tactics with little to no results. Parents are first taught that:

- Emotions are key to identity
- Emotions are a guide for individual choice and decision-making
- Lacking emotional awareness or avoiding unpleasant emotions can cause harm
- Emotions may render them unable to use important information (Strahan et al., 2017).

There are two key skills to be learned (1) "emotion coaching by supporting their loved one in the processing of emotions", and (2) "engaging in a process of relationship repair to facilitate the healing of old wounds and the release of child and caregiver self-blame" (Strahan et al., 2017, p. 260).

Throughout the first session, the MSW and Psychologist teach caregivers how to become aware of their emotions; how to welcome, allow and regulate emotions; how to describe their emotions clearly and in detail, how to increase awareness of multiple layers of emotional experiences, and how to identify most direct reactions. During the second

session, caregivers are taught how to evaluate whether their emotions are helpful or unhelpful in various situations; use helpful emotions to guide actions; learn how to identify the source of unhelpful emotions; how to change unhelpful emotions; develop alternative, healthy ways of coping with situations that often elicit maladaptive emotions and form personal scripts that help challenge the destructive thoughts that may be associated with unhelpful or maladaptive emotions. The end goal(s) of the two day sessions are for caregivers to learn for themselves, and to impart onto their children, how to experience rather than suppress emotions for the betterment of family functioning.

Emotion Focused Family Therapy (Johnson, 1996, 2004) is an integrative approach to family therapy that draws from both humanistic/experiential (focusing on present experience and empathic responding) and systemic (focusing on patterns of interactions within families) approaches to therapeutic change. Susan Johnson is known as the originator of Emotion Focused Therapy (EFT), which addresses distress in adult intimate relationships and helps couples better understand their emotional responses and those of their significant other (Wittenborn et al., 2006). Emotion Focused Family Therapy was developed from the concepts of EFT and is used during family therapy sessions (Lindblad-Goldberg & Igle, 2018) and prioritizes emotions as the key organizers of inner experiences and interactions in close relationships (Johnson, 2004). Emotional experiences among family members is the focus, using concepts from attachment theory; and strives to identify and restructure distressing cycles of interaction that create and sustain attachment insecurity among family members.

The goal of EFFT is to promote secure bonds among family members, such that the family unit can serve as a secure base from which adolescents can grow and develop. Emotion and emotional responses are seen as the key elements that define the quality of

the attachment bonds between identified patients and their families (Wittenborn et al., 2006). Thus, EFFT is concerned with articulating and understanding the emotional experiences of each family member. In particular, the EFFT therapist helps clients explore and re-examine their emotional experiences in a way that increases emotional accessibility and responsiveness in their relationships with their family members (Lindblad-Goldberg & Northey, 2015). Lindblad-Goldberg and Igle (2018) note this aids parents in fostering a secure base, wherein adolescents seek help and caretakers provide appropriate support. This ultimately supports the redefining of the family as a safe foundation from which the teenager can grow and develop. A 2-year, follow-up study on relationship distress in the parents of chronically ill children, a population at high risk for divorce, suggests that EFFT has fewer incidences of relapse than does behavioural therapy, and that some clients, even if faced with stressful events, continue to improve in the 2 years following termination from therapy (Cloutier, Manion, Walker, & Johnson, 2002).

From an attachment perspective, seeking and maintaining secure relationships is a primary motivating force that is active throughout life (Bowlby, 1988). The theory claims that there is no such thing as too much dependency; only effective or ineffective dependency (Bretherton, 1992). Research proves that youth who feel security with attachment figures have a more coherent, positive, and articulated sense of self (Moretti & Peled, 2004). Secure bonds are the natural antidotes to the traumas and terrors that life inflicts on many adolescents, who sometimes struggle with being at the confluence of youth and adulthood (Johnson, 2002). Behaviours that attempt to create safety, closeness, and security in close relationships are called attachment strategies, since they

are designed to create and strengthen attachment bonds (Bowlby, 1988). Fear, hurt, and uncertainty activate attachment needs and lead youth to engage in attachment strategies.

The primary focus of change in EFFT involves identifying the negative cycles of interaction (similar to Ecosystemic Structural Family Therapy), accessing the emotions that are both a response to and organizers of these cycles, and reprocessing these emotions to create new responses that shape secure bonding events and new cycles of trust and security, which is said to be different than cognitive restructuring, problem solving, or skill building (Bowlby, 1988). In EFFT, it is assumed that once emotional bonding occurs between caregivers and youth and the interactional cycle has become secure and supportive, problems can be solved. It is emotional experiencing and reprocessing that are seen as a key component in changing negative cycles and creating a safe connection in families (Wittenborn, 2006).

In EFFT the therapist is an active agent in teaching parents important EFFT concepts; and also plays a role in helping to facilitate change for clients. The therapist assists caregivers in identify their negative cycle(s) and accessing the emotions that underlie it, and then actively helps develop new ways of interacting that lead to powerful bonding events and new, safe cycles of interaction with their children (Foroughe, 2018). EFFT concepts are derived from those of EFT, but with a focus on caregivers and children. Because emotional experiences are fundamental to human functioning, they can often occur before cognitions, making vital contributions to information processing (Greenberg, 2010). Therefore, many of us rely on our emotions when making decisions in our daily lives. It makes sense therefore that family members tap into their emotion bank when working through relationship struggles. The emotions that we feel as we live our lives are stored in memory and are often re-lived (Greenberg, 2010). For example,

the disappointment a parent feels when learning they have been lied to by their child; or the anger that child feels from the consequences they face from that lie or conversely, the happiness they both feel after a great accomplishment at school (an excellent calculus mark for example). In EFT, these emotional memories are referred to as emotion schemes and contain four elements:

1. Situational-Perceptual experiences which involves immediately assessing current situations and emotionally charged memories, such as noticing that you have just been embarrassed by someone, and remembering having felt that same emotion when your mom or dad spanked you in public.
2. Bodily sensations and expressions such as feeling your heart race, similar to how you felt when you got spanked.
3. Implicit verbal-symbolic representations, including self-labels such as "ugly" or "burden" and "unwanted".
4. Motivation-behavioural elements such as your need to please others to avoid feeling embarrassed, shamed, or abandoned.

According to EFT, people are able to re-experience emotional memories over and over again through various triggers, sometimes years after the event has transpired. These emotional experiences previously described are the focus of EFFT intervention with families.

It is recognize that although emotions are important to human survival, they sometimes get in the way as a result of a person's past, their emotional needs and how, and if their needs can be met within their environment (Greenberg, 2002). Therapist teach caregivers to first "sort" the type of emotion that they or their child is feeling; more specifically how to differentiate between whether what is being felt is a primary emotion,

which are a person's direct initial reactions to situations, such as sadness from a death or anger from being betrayed (Goldman & Greenberg, 2015), or secondary emotions which are responses a person feels to their thoughts and feelings rather than to the situation (Goldman & Greenberg, 2015). For example, is the parent feeling guilty in response to disciplining their child, or anger in response to feeling guilty about having to discipline their child? Is the child feeling anger at the parent for being disciplined, or shame from the anger that they feel? Being able to differentiate those emotions from each other is an important skill for families. It will help them focus on the correct emotion, thus improving communication.

Similar to DBT skills training concepts, EFT makes a distinction between primary states that are adaptive and those that are maladaptive. Primary, adaptive emotion responses are the first and natural response of a person to a current situation that would help them take appropriate action (Foroughe, 2018). An example could be the appropriate response of anger after you have just been robbed. This emotion will propel you to call the authorities to report the crime in the hopes of receiving some justice. Primary maladaptive emotions are less reliable and are old familiar feelings that are repeated over time such as feelings of anxiety, frustration and disappointment, despair and fear that many are plagued with (Foroughe, 2018). These emotions linger in a person's world and are often linked to inappropriate behaviour (Foroughe, 2018), i.e., consuming alcohol to numb the emotion of sadness. In other words, problems are not often solved when these emotions are consistently present.

For families to connect emotionally and see change, primary adaptive emotions should be used for their ability to organize helpful actions, while maladaptive emotions should be regulated, and if possible, transformed into more adaptive emotional responses

(Greenberg, 2010). For example, the caregiver who becomes angry that their child has disregarded curfew for the second time in a week, can take this opportunity to sit with the child to discuss the appropriateness of the curfew. Could the curfew be too early for example? Can it be adjusted based on circumstance? Is there a reason why the child is violating the curfew? Many possibilities exist for parent and child to recognize the negative emotions that are transpiring from this curfew scenario and they can use the opportunity to discuss emotions and the underlying issues in order to come to a resolution. Caregivers and children also need to distinguish between primary and secondary emotions – and bypass the secondary emotions so their healing can begin (Foroughe, 2018). Feeling guilty about being angry is counter-productive. Therefore, tapping into the anger (primary emotion), while letting go of the guilt (secondary emotion), would be the recommendation to caregivers.

Although not privy to the entire training session for parents on EFFT, I continue to be impressed by the number of families who were present for the preliminary session, and who seemed genuinely interested in finding an answer to their family struggles. The caregivers were noticeably concerned about the children under their care, took comprehensive notes, asked many questions (some could not be adequately answered) gave specific examples to illustrate what many of them go through on a daily basis and listened attentively hoping to benefit from the wisdom and experience of the two therapists.

Chapter Four - Discussion

With the exception of genetics, our family plays the biggest role in how we behave, how we develop emotionally, how we think, and how we feel about others and ourselves (Framo, 1992). Illness (physical or emotional) in a family member impacts on the structure or the system, and the structure or system, impacts on the illness (Seely, 1985). Some therapists believe that a broader approach to treating the mental health challenges of youth through family therapy interventions is required, since childhood and adolescence are widely regarded as a pivotal time for preventing the worsening of mental health challenges.

According to the philosophies of Dialectical Behaviour Therapy, Emotion Focused Family Therapy, and Ecosystemic Family Therapy, many of the behavioural issues of youth are rooted within the family system, or the structure of that system, and thus, the therapist should aim to bring fundamental changes to the family unit in order for the individual to improve. Opportunities exist for families within the Kingston and surrounding area to seek evidence-based therapy, which are strongly guided by years of empirical research. The evidence-based modalities used at Kingston Health Sciences Centre brings credence to Salvador Minuchin's claim (1998) that the family is the source of greatest happiness and equally greatest heartache. Using the ESFT case study, it was evident that R's numerous, historical family struggles contributed to her becoming a very troubled young lady. However, her youngest sister seemed unfazed by it all, stating once during a session that, "it's all in the past". Both young lives had been fraught with sudden changes and many sobering events, yet two very different outcomes were witnessed.

According to Dr. Gabor Mate´ (2005), although these two girls have the same parents, how each child perceives the parent will be the guiding principle in who they are as young ladies, and who they become later in life. While one may view mom in a certain way and view dad in one light, the other can have a completely opposite understanding and vision of their parents. It is also important to note too, that the family environment that siblings are born into may not be identical. While one child may have been raised at a time when caregivers were economically secure, for example, another sibling could have experienced the polar-opposite circumstance (Mate´, 2005). The stressors of the system may have changed. The happiness level of each parent may have shifted, increased, or decreased. Because the family is a living system, communication and feedback are important (Swales, 2019), therefore, lasting change is dependent on modifying the balance and alliances so that better permanent change becomes a reality (Burnham, 1986). R's family being asked to conduct a Core Negative Interactive Pattern (CNIP) was imperative so they could recognize their pattern. Thus, a goal would be on working to eliminate these patterns from their repertoire of behaviours, or modifying them to achieve better results.

Minuchin (1998) also discusses subsystems within Structural Family Therapy, which are the smaller units of the system that exist to carry out various family tasks, and without which the family system would not function. Some functions are considered temporary such as ensuring your child gets to therapy on time or helping with homework, while others are permanent, such as parenting your offspring. Minuchin (1974, 1993, 1998), notes that of importance are the spousal, parental, and sibling subsystems. The spousal subsystems (marriage or common law partners) are vital because the ways in which they support and nurture each other will be telling in how well structured and

functional the family becomes. They should, in theory, operate as a team. The parental subsystem, on the other hand, comprises those responsible for the care, protection, and socialization of the children. Structural family theorists state that healthy parental subsystems, do not operate in a cross-generational alliance, which is defined as having members of two different generations within it. Take for example, if R and her mother were colluding to obtain love or power at the expense of the step-dad and the younger sister. Parental subsystems much change as children age. Example, curfews should be modified and independence should expand to make them more age appropriate. Sibling subsystems are the same generation and can be affected by age differences. The smaller the age gap, usually, the closer the siblings are psychologically.

Another aspect of ESFT within the case illustration was boundaries, defined as the physical and psychological factors that separate and organize people from one another (Swales, 2019). Minuchin (1974) stated, that "for proper family functioning, boundaries of subsystems must be clear" (p. 26). Clear boundaries contain rules and habits that allow members to enhance communication and relationships as dialogue is encouraged, permitting members to freely give and receive feedback. Rigid boundaries are inflexible, facilitating difficulty relating in an intimate way with each other, causing further detachment. Conversely, in diffuse boundaries there is not enough separation between members, which consequently creates dependency among members. Lastly, dysfunctional families often create coalitions defined as an alliance between specific family members against a third party (Minuchin, 1974). A stable coalition is a fixed and inflexible union (such as two caregivers) that becomes a dominant part of the family's everyday functioning. A detouring coalition is one in which the pair hold a third family

member responsible for the difficulties or conflicts with one another, thus decreasing the stress on themselves or their relationship.

Family therapy poses challenges. Prominent among them is treading the waters lightly so that caregivers do not feel attacked and undermined. The basic premise of Emotion Focused Family Therapy and Ecosystemic Family Therapy is that the child's behaviour is inextricably linked to their family environment, including the possibility of having insecure attachment to caregiver(s). The question thus arises as to whether parents subconsciously believed that therapists were implying that they were ineffective. Therapists who pay particular attention to body language and their chosen words may be able to quell those fears. Conversely, never communicating to the child that they should not take responsibility for their own behaviour was important. It can be a tricky balance between trying to portray to the clients that environment is important, yet keeping in mind too, that personal responsibility cannot be discounted.

R's family also suffered from intergenerational trauma. According to the Aboriginal Healing Foundation (2008), some of these consequences that affect many Indigenous families, include challenges such as substance abuse, poverty, family violence, and loss of personal and collective propriety, or rules of conduct, which traditionally provide checks and balances in human relationships. Rakoff, Sigal, and Epstein (1966), in their paper on children and families of concentration camp survivors, first introduced the concept of intergenerational trauma when they described how the effects of the Holocaust were transmitted to future generations, and defined it as the cumulative emotional and psychological wounding that is transmitted from one generation to the next, also noting subsequent generations are left with the consequences of what happened to their parents and grandparents.

Ecosystemic Structural Family Therapy, Emotion Focused Family Therapy, and Dialectical Behavioural Therapy do not make allowances for Indigenous or ethnic families, who are often burdened with past traumas (Garcia-Preto, Giordano & McGoldrich, 2015; Ho, 1987). At the core of the modalities, however, is the belief that healing the individual begins with healing the family and the relationships within. Duran and Duran (1995) stated that working with the Indigenous individual requires that interventions involve the whole family, but more often than not, historical considerations make the task a very challenging one. They stated that once the therapist is aware of historical issues, he / she can begin to implement some of the available strategies from the more mainstream approaches. Duran and Duran (1995) also state that therapies involving communication (EFFT), structural, and other systemic approaches (ESFT) are effective if the therapist is knowledgeable about Indigenous culture and is willing and able to validate (DBT philosophies) some of the historical issues that have affected the lives of the family and the culture at large. Empowering the family comes through validation within the context of the therapy sessions so that they become aware that some of the family issues are due to outside structural forces (e.g., racism, slavery, Residential school, Sixties Scoop, etc.).

In *Seeking Mino-Pimatisiwin* (the "good life), Hart (2002) writes that when working with Indigenous families, therapists need to concentrate on the dynamics between family members (similar to ESFT and EFFT). He encourages therapists to ensure that each family member accepts other family members. The relationship between family members is seen as a focal point during the therapeutic process. According to Hart, the therapist should review whether family relationships are balanced in that

everyone's contribution to the family is respected by other family members, and to acknowledge and understand the interdependence present in the family.

Working with these families using ESFT and DBT brought into sharp focus the fragility of the young spirit and magnified the interdependence of family members, sometimes to the detriment of one or many. More often than not, the non-adults within the system are the ones who will be at a disadvantage. Adults, by virtue of their age, are responsible for their lives, mistakes, and the consequences of any decisions they may take. By contrast, youth are usually confined to the homes of their caregivers and tied to the rules and regulations therein. Some lack the insulation of a loving and supportive home. This highlighted the vulnerability of children, and how indeed the structure of their family can make all the difference in the world to their circumstance and outcome.

The DBT, multi-family therapy skills training underscored the importance of teaching youth skills that will eventually lead to self-reliance and resilience in order to buttress the difficult times most have ahead. This practicum was a reminder that while some internal forces play a part in the mental health of youth, the family does indeed play a role in the outcome and not just their healing. Within their sphere of influence are the family and their relationship to one another. Similar to individual therapy, ESFT, DBT and EFFT philosophy implies that family members must be resolutely committed to the process. Sixteen weeks of DBT for two hours per week is no small feat for families who work outside the home and have other commitments. Yet only one class was missed by two youth due to previously scheduled engagements. This illustrated that despite challenging family circumstances, families were committed to the healing process. Whether or not this is an accurate reflection of most other families who are recommended for therapy at the hospital is an unknown. For the most part, the three DBT families

conducted their sessions with a sense of dignity, mutual respect, and an internal desire to find answers that have escaped them for years.

Conclusion

In many cases, our families leave the greatest and most lasting impression on our lives. Sometimes, unfortunately, it is in the form of hurtful, emotional scars, which may bear testimony during one's youth or adulthood. Our families can also be a source of healing for those who suffer from tragic mental illness. They can bring to the fore, strengths that families are noted for, during times of adversity when unity is required, such as a non-judgmental therapeutic listening ear and reassurance that circumstances will improve. Families of all stripes continue to look to professionals for answers and to find hope for the struggles to which they face. In the 1950s at its genesis, family therapy was not immediately regarded as a noteworthy modality to treating the individual. Several decades later in the 1970s, pioneers such as Salvadore Minuchin contributed immensely to bringing this modality to the forefront before it could be given its rightful place within psychotherapy. Although shunned at first as a viable form of therapy, it did not dim the spirits of those who championed its worthiness. New creative content were inspired such as Structural Family Therapy, Bowenian Family Therapy, and Systemic Family Therapy, to name a few. Family therapy has stood the test of time and is becoming a modality receiving increasing prominence with youth who exhibit mental health challenges (reference). The cumulative impact of family therapy cannot be understated. Unquestionably, its fundamental tenets bring into disrepute the notion that the individual alone, irrespective of their mental functioning, is to blame for family dysfunction.

The research conducted for this paper indicated that family therapy is still in its infancy theoretically, but had been used in practice for much longer. In environments such as the Kingston Health Sciences Centre, it is being cultivated and promoted as a

viable alternative to individual therapy. Champions of family therapy were committed to the idea of a holistic approach to therapy whereby the family unit and external environment can be both impediments, and catalyst to healing.

Three of the newer emerging family philosophies, Emotion Focused Family Therapy, Ecosystemic Family Therapy and Dialectical Behaviour Therapy skills training for families, call for a broad embrace of changing, or modifying communication patterns, or the structure within a family, before individual members could be expected to heal. All three modalities were geared towards relegating members to seeing value in working together as a unit, rather than leaving one person to his or her own devices. The intent, of course, was to broaden the scope of options for those who struggle.

Within the realm of ESFT, which relies on structural philosophies, the therapists explores the interaction of the various personalities within the system, their community and their past experiences. In the case illustration with R's family for example, it became evident that her past and that of her parents and extended family were strongly tied to her present behaviours and struggles. Ignoring these factors, which the family brought to therapy, and strictly relying on R and her presenting problems would prove futile for all involved. According to the theory, a change in R's behaviour would happen when the organization or structure of the family is modified. Intervention is most successful when taking all variables into account, including that of parents, siblings, schools etc. Time will tell whether the structure of one's family influences them for better or for worse (Minuchin, 1974), depending whether their hierarchy is well organized and well understood.

A major premise within Ecosystemic Structural Family Therapy was that a persons' symptoms are best understood as rooted in the context of family transactional

patterns (Lindblad et al., 2018). Because the family, and not the individual is seen as the client, it is the hope that with assistance from the therapist, through structuring or restructuring of the system, all members will become stronger. If all works well within Ecosystemic Structural Family Therapy, families will develop and sustain more appropriate and more functional ways of communicating and interacting with each other and also instill boundaries with a clearly stated hierarchy that all members respect and understand (Lindblad et al., 2018).

Dialectical Behaviour Therapy skills training, has been successfully used for several years. DBT's premise of balancing acceptance and change, while skillfully providing validation of feelings enables members to learn skills in order to behave more appropriately towards each other. Throughout the sixteen-week training provided to three families with struggling teens, dialectical strategies were taught in order to elicit and promote a strong and caring ethos among members. The lessons attempted to inculcate the skills of mindfulness, meant to "increase nonjudgmental awareness of present experience and to improve attentional control" (Rathus & Miller, 2015, p. 97); Distress Tolerance, intended to "help clients tolerate difficult situations and emotional pain when the problems could be solved right away" (Rathus & Miller, 2015, p. 126); Walking the Middle Path, with the hopes that "families recognized the necessity to evaluate and understand a situation from multiple and often opposing perspectives", (Miller, Glinski, Woodberry, Michell, & Indik, 2002, p. 572); Emotion Regulation Skills, so participants could learn how to "label and understand their emotions with the aim of reducing their vulnerability to their emotions; and Interpersonal Effectiveness skills intended to learning skills for "building and maintaining positive relationships" (Rathus & Miller, 2015, p. 228). The five modules should make families more amenable to

creating validating environments, which is said to be the catalyst in enhancing open channels of communication, and in making adolescents feel valued and understood. This will consequently support their development and healing.

Kingston Health Sciences Centre also provided Emotion Focused Family Therapy Training for caregivers to assist them in helping themselves by teaching strategies related to emotional attachment. The aim was not to become expert mock therapists, but rather to produce meaningful results through their action and their words with their children. Attachment theory, pioneered by John Bowlby, was the premise used to educate parents in helping their children, and is based on the following principles: People are wired to connect with one another emotionally in intimate relationships; there is a powerful influence on children's development by the way they are treated by their parents, particularly by their mothers; and a healthy child has experienced a warm, intimate and continuous relationship with a mother figure that is enjoyable to both parties (Bolwby, 1988). KHSC promoted the view within EFFT, as with their other family theory modalities, that the best way to view and treat family issues is to view the individual not in isolation, but as one emotional entity with all family members.

Emotion Focused Therapy, developed by Susan Johnson in the 1980s, is an evidenced-based therapeutic model used to treat couples. Emotion Focused Family Therapy is modeled on the same fundamentals as EFT and strives to identify and restructure unhealthy cycles of interaction that create and sustain attachment insecurity among caregivers and their children. An adolescent's ability to exude confidence and resilience and the way in which they interact with others in their environment is often a direct result of the quality of attachment with their parents (Bloch & Guillory, 2011). KHSC two-day training program created an enabling environment for the establishment

of more secure attachment between caregivers and adolescents, meant to subsequently promote adolescents adaptive functioning and emotional adjustment (Stragan et al., 2017). When children reach adolescence, their peer group become increasingly important; however, caregivers are still needed and required to provide them with emotional support in times of distress. It is for this reason that "Emotion Focused Family Therapy, views the ability of adolescents to connect with their caregivers and the ability of caregivers to be emotionally responsive and interpersonally engaging as key to promoting adolescent psychological and emotional health" (Bloch & Guillory, 2011, p. 231). Caregivers actively stepping up their efforts and devising new approaches and strategies that will respond more adequately to the developmental needs of their adolescent is imperative within EFFT training.

It is expected, that a significant amount of work and effort will be expended by caregivers to ensure success; seen specifically as the emotional stability of their child. It is this effort that will inform the success of caregivers after receiving their two-day training from experienced therapists who whole-heartedly believe in the power of family in facilitating healing of their members. EFFT views attachment failures as leading caregivers and adolescents into developing reactive patterns of conflict, which eventually impedes growth, and development of the youth (Stillar et al., 2014).

Family therapy enables members to identify negative patterns between members as well as their reactive positions that foster pain and insecurity in the family system (Swales, 2019). The challenge of raising emotionally healthy children is complex, as evident from this research paper; however, most parents are indefatigable in their efforts to ensure a safe and secure environment for their children. The three therapeutic modalities discussed all have unique characteristics, yet they share the commonality of

including families, particularly caregivers, as fundamentally imperative in the healing of their children.

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Appendix A

MULTI-FAMILY DBT GROUP EVALUATION QUESTIONNAIRE - May 2019

Has attending the group had a positive effect on any of the following (please check all that apply)

1. ☐ Wellbeing
2. ☐ Confidence
3. ☐ Feelings of isolation
4. ☐ Understanding of family members
5. ☐ Coping with day to day challenges
6. ☐ Dealing with peers/coworkers/friends
7. ☐ Stress levels
8. ☐ Ability to support family/friends
9. ☐ Self esteem
10. ☐ Other (please specify)

Of the following DBT topics, which ONE do you felt was the most useful to you:

A: Emotional Regulation
B: Walking the Middle Path
C: Interpersonal Effectiveness
D: Distress Tolerance
E: Mindfulness

What would you say were the most useful aspects of the group to you personally? (please check all that apply)

☐ Support network for me
☐ To feel connected
☐ To meet others with similar conditions
☐ To share information
☐ Listen to guest speakers
☐ Benefits it brings to my child/parent
☐ To reduce my stress levels
☐ The group hosts
☐ Free to attend
☐ To increase my knowledge
☐ To better understand my family members
☐ To get practical advice

☐ To help educate others

☐ Other (please specify)

What skill was the most useful/relevant to you? Check ALL that apply:

___Wise Mind
___ DEAR MAN
___ FAST
___ Validation
___ Grounding/Mindfulness Techniques
___ Radical Acceptance/Accepting Reality
___Willingness
___ PLEASE
____ Self-Care Tool Box
___ THINK skills
___ BRAVING
____ Other

Please circle on the scale of 1-5 with 1 being the lowest, the **usefulness** of the skills learned in your everyday life

1 2 3 4 5

Do you think the sharing of a meal prior to group staring was beneficial? Please circle one.

YES NO Maybe

How would you rate each of the following:

	Poor	fair	good	very good
1. Content	_____	_____	_____	_____
2. Activities	_____	_____	_____	_____
3. Facilitation	_____	_____	_____	_____
4. Discussions	_____	_____	_____	_____

On the following scale, please indicate *how effectively* you used your preferred skill in another domain of your life:

1 2 3 4 5 6 7 8 9 10

How did you feel about the group's meeting room environment? Is there anything you would change? Please explain.

How did you feel about the group member to facilitator ratio? Please Circle:

**Facilitators were: Dr. Kahn, Patricia, Students Sarra & Vergie

Too Little Facilitators Just Right Too Many Facilitators

Are you interested in participating in the family engagement committee? (Committee which is parent /youth who have utilized the mental health system at the hospital and how to improve services)

YES NO Maybe

Do you feel you require further assistance post group? Please specify:

Parent:

Youth
Are you interested in continuing with family therapy that matches to your family and individual needs post-group? Please Circle:
YES NO MAYBE

How did you find the length of the Group to be in appropriateness? Please Circle one:
Too Short Just Right Too Long

What was the strength(s) of the Multi-Family Therapy Group this session?

What can be improved upon for the next group?

Would you recommend this group to someone else?
Yes No Maybe

Thank you for all your feedback and participation

Appendix B

Distress Tolerance Handout 7

Crisis Survival Skills: IMPROVE the Moment

IMPROVE the Moment with:

Imagery Imagine very relaxing scenes of a calming, safe place. Imagine things going well; imagine coping well. Imagine painful emotions draining out of you like water out of a pipe.

Meaning Find or create some purpose, meaning, or value in the pain. Make lemonade out of lemons.

Prayer Open your heart to a supreme being, greater wisdom, or your own Wise Mind. Ask for strength to bear the pain in this moment.

Relaxation Try to relax your muscles by tensing and relaxing each large muscle group, starting with the forehead and working down. Download a relaxation audio or video; stretch; take a bath or get a massage.

One thing in the Moment Focus your entire attention on what you are doing right now. Keep your mind in the present moment. Be aware of body movements or sensations while you're walking, cleaning, eating.

Vacation Give yourself a brief vacation. Get outside, take a short walk, go get your favorite coffee drink or smoothie, read a magazine or newspaper; surf the web; take a 1-hour breather from hard work that must be done. Unplug from all electronic devices.

Encouragement Cheerlead yourself. Repeat over and over: "I can stand it," "It won't last forever," "I will make it out of this," I'm doing the best I can."

Appendix C

Distress Tolerance Handout 14

Accepting Reality: Choices We Can Make

Five optional ways of responding when a serious problem comes into your life:

1. Figure out how to solve the problem.
2. Change how you feel about the problem.
3. Accept it.
4. Stay miserable (no skill use).
5. Make things worse (act on your impulsive urges).

When you can't solve the problem or change your emotions about the problem, try acceptance as a way to reduce your suffering.

Why Bother Accepting Reality?

Rejecting reality does not change reality.

Changing reality requires first accepting reality.

Rejecting reality turns pain into suffering.

Refusing to accept reality can keep you stuck in unhappiness, anger, shame, sadness, bitterness, or other painful emotions.

Radical Acceptance

RADICAL ACCEPTANCE is the skill of accepting the things you can't change.

RADICAL = complete and total accepting in mind, heart, and body.

ACCEPTANCE = seeing reality for what it is, even if you don't like it.

ACCEPTANCE can mean to acknowledge, recognize, endure, not give up or give in.

It's when you stop fighting reality, stop throwing tantrums about reality, and let go of bitterness. It is the opposite of "Why me?" It **is** "Things are as they are."

Life can be worth living, even with painful events in it.

Appendix D

Distress Tolerance Handout 17

Ways to Practice Accepting Reality

1. Acceptance of reality <u>as it is</u> sometimes requires an act of CHOICE.

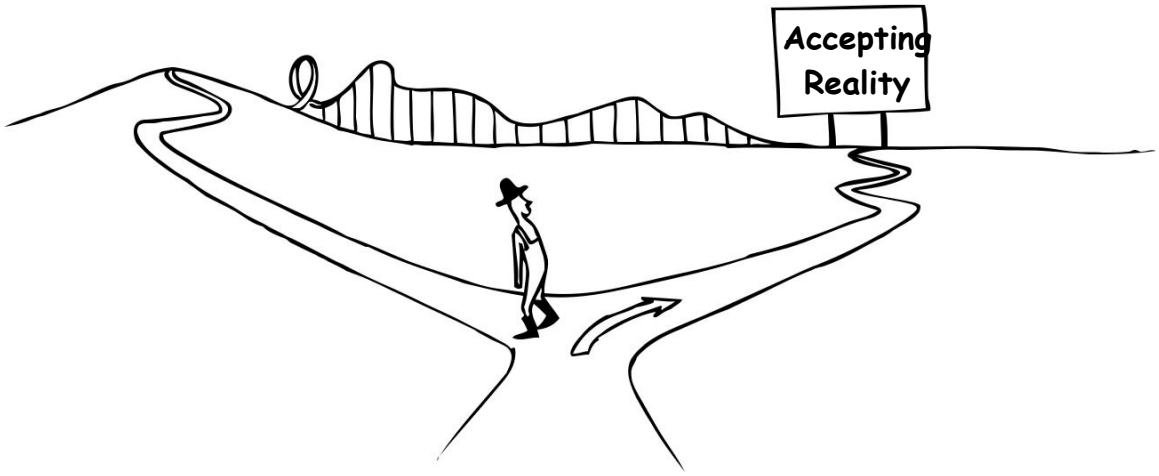
2. Breathe mindfully to be in the moment and to help develop a more accepting mindset.

3. Accept reality with your face: half-smile.

4. Rehearse in your mind those things that you would do if you really did accept reality *as it is*.

5. Practice willingness.

6. Remember to turn the mind back to accepting Reality Road.



Appendix E

Walking the Middle Path Handout 6

What's Typical for Adolescents and What's Cause for Concern?

Typical	Not Typical: Cause for Concern
1. Increased moodiness	Intense, painful, long-lasting moods; risky mood-dependent behavior, major depression, or panic attacks; self-injury or suicidal thinking
2. Increased self-consciousness, of feeling "on stage," increased focus on body image	Social phobia or withdrawal; perfectionism and unrealistic standards; bingeing, purging, or restricted eating; obsessive about or neglectful of hygiene
3. Increased dawdling	Multiple distractions to point of not being able to complete homework or projects, lack of focus that interferes with daily work or tasks, regularly late for appointments
4. Increased parent–adolescent conflict	Verbal or physical aggression, running away
5. Experimentation with drugs, alcohol, or cigarettes	Substance abuse, selling drugs, substance-using peer group
6. Increased sense of invulnerability (may lead to increased sensation seeking or risk taking)	Multiple accidents; encounters with firearms; excessive risk taking (e.g., subway surfing, driving drunk or texting while driving), getting arrested
7. Stressful transitions to middle and high school	School refusal; bullying or being bullied; lack of connection to school or peers; school truancy, failure, or dropout
8. Increased argumentativeness, idealism, and criticism; being opinionated	Rebellious questioning of social rules and conventions; causing trouble with family members, teachers, or others who attempt to assert authority over the adolescent

What's Typical for Adolescents and What's Cause for Concern?

Typical	Not Typical: Cause for Concern
9. Increased sexual maturation; sexual interest or experimentation	Sexual promiscuity, multiple partners, unsafe sexual practices, pregnancy
10. Becoming stressed by everyday decision making	Becoming paralyzed with indecision
11. Increased desire for privacy	Isolation from family; breakdown of communication, routine lying, and hiding things
12. Strong interest in technology; social media	Many hours per day spent on computer, on high-risk or triggering websites; casually meeting partners online; revealing too much (e.g., "sexting," overly personal posts on Facebook, Tumblr, Instagram, in blog)
13. Messy room	Old, rotting food; teen not able to find basic necessities; dirty clothes covering floor Chronically

Appendix F

Walking the Middle Path Handout 8

Validation

VALIDATION communicates to another person that his or her feelings, thoughts, and actions **make sense** and are understandable to you in a particular situation.

SELF-VALIDATION involves perceiving your *own* feelings, thoughts, and actions as making sense, accurate, and acceptable in a particular situation.

INVALIDATION communicates (intentionally or not, through words or actions) that another person's feelings, thoughts, and actions in a particular situation make no sense, are "manipulative," or "stupid," or an "overreaction," or not worthy of your time, interest, or respect.

Remember: Validation - Agreement

Validation *does not* necessarily mean that you like or agree with what the other person is doing, saying, or feeling. It means that you understand where they are coming from.

WHY VALIDATE?

- Validation improves relationships!!!!
- It can deescalate conflict and intense emotions.
- Validation can show that:
  ||We are listening.
  ||We understand.
  ||We are being nonjudgmental. ||We care about the relationship.
  ||We can disagree without having a big conflict.

WHAT TO VALIDATE?

- Feelings, thoughts, and behaviors in ourselves or others

Validate the valid, not the invalid. You can still validate the feeling *without* validating the behavior. For example: Validate someone feeling upset about a low test grade even though you know he or she didn't study, but *don't* validate the lack of studying that led to the low grade.

Appendix F

Emotion Regulation Handout 8

ABC PLEASE Overview

How to **increase** positive emotions
and
reduce vulnerability to Emotional Mind

Accumulating positive experiences

Build mastery

Cope ahead of time with emotional situations

Treat **P**hysica**L** illness

Balance **E**ating

Avoid mood-altering drugs

Balance **S**leep

Get **E**xercise