

THE EFFECT OF FAMILY THERAPY ON THE ADJUSTMENT OF  
ADOLESCENTS FOLLOWING TERMINATION FROM A RESIDENTIAL  
TREATMENT FACILITY:  
A ONE, THREE, AND SIX MONTH FOLLOW-UP

by

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## CHAPTER ONE

### Introduction

#### The Family and Adolescence

##### The Family Life Cycle

Similar to developmental theories of childhood and adulthood, Carter and McGoldrick (1980) have espoused the notion that families progress through time entering and completing stages of development. From their point of view, a family is a "basic unit of emotional development, the phases and course of which can be identified and predicted" (p. 4). The family at each stage or phase of it's development has emotional tasks which must be fulfilled by the entire system in order for the family to continue a healthy, functional, developmental path through its existence. Developmental stressors such as the birth of children and unpredictable stressors such as sudden death, impact on the family's ability to complete the tasks necessary for it to successfully move through the life cycle (Carter & McGoldrick, 1980).

Carter and McGoldrick (1980) identify six family life cycle stages. The first of these is the unattached young adult. Upon marriage, the family now begins its second stage of the newly married couple. The birth of

the first child brings about the third stage: the family with young children. As the children grow, the family enters the next stage of its development: the family with adolescents. The fifth stage of the life cycle starts when the adolescents begin to move out on their own. Finally, the cycle comes full circle and ends with the spousal dyad in later life. Each of these stages brings upon the family unique developmental tasks which must be completed for healthy growth and change (Carter and McGoldrick, 1980).

Adolescent stage of the family life cycle. The adolescent stage of the family life cycle begins when the oldest child enters adolescence and is completed when the youngest child moves out and starts life on his or her own (Preto & Travis, 1985). At this stage of development, the family must accomplish developmental tasks specific for the adolescent to function in society as a productive member. According to Preto and Travis (1985), the three major tasks families in the adolescent phase must accomplish are: identity clarification, coping with sexuality, and separation. The growth into the adolescent stage involves not only the change in status of some or all of the family members, but also involves a complex emotional process that effects the emotional



system of the individuals within the context of the family (Carter & McGoldrick, 1980). Thus, if the family is unable to accomplish the tasks of moving itself through this phase of the life cycle, chances are the adolescent will also evidence stagnant growth at this developmental stage. Adolescents who are unable, either at the family level or the individual level, to accomplish the goals of identity formation and separation from the family unit often find themselves unable to cope successfully with life's struggles. In the end, they may find themselves placed in a context other than the family for helping them achieve adult status. For many, this context is residential care.

Conclusion. As one of the developments for the future of residential child care, Barker (1988) places "a greater emphasis on the family as a unit of treatment" first on his list (p. 13). Because of this trend, theories such as Carter and McGoldrick's (1980) family life cycle theory become increasingly important as a framework for viewing troubled adolescents. The adolescent in residential care must be seen as part of a larger unit, the family. Likewise, the family must be seen as something more than the sum of its parts, a system. Family therapy has emerged as a treatment

modality focusing on the assumption that the family is a system. Thus, selecting family therapy as a variable for study in this project grew out of the researcher's belief that adolescents in residential care are experiencing within their family systems the inability to accomplish the necessary developmental tasks they need to move into the next stage.

#### Purpose

The purpose for conducting this investigation was to determine the effects of receiving family therapy during residential treatment on the adjustment of adolescents following completion of a residential treatment program.

#### Definition of Terms

There were two independent variables identified for this study. Variable A refers to type of treatment, either family therapy or no family therapy. Variable B refers to the time of measurement at post-test, either one month, three months, or six months.

There were two dependent variables identified for this study. One dependent variable was adjustment in terms of relationships with family members, relationships with youth, and overall emotional state. The second dependent variable was participation in structured events and in terms of school participation and acceptance of aftercare.

### Hypotheses

It was hypothesized that those adolescents who had received family therapy would adjust significantly better than those adolescents who had received no family therapy.

It was also hypothesized that those adolescents who had received family therapy would participate in structured events significantly more than those who had not received family therapy.

## CHAPTER TWO

### Review of Literature

#### The Residential Care of Children

#### Early Developments in the Institutionalization of Children

Throughout history, there have always been means for dealing with children who are unable to live within some type of family unit. As early as the year 325 A.D., hospices were organized as shelters to care for destitute children (Hopkirk, 1944). In 1601, Henry VIII of England decreed that the State had the power to place children into the custody of workhouses in order to decrease the occurrence of vagrancy (Bremner, 1970). These are early examples of the how the need for the placement of children within some type of structured setting grew out of the larger societal needs. Many children during the 1600's were left homeless due to the death of their parents from war, diseases, and shortened life spans. To compensate for these orphans, laws were established enabling the State to incarcerate them into apprenticeships (Bremner, 1970). This tradition continued in the United States, with the advent of religious orders taking care of children (Hopkirk, 1944). Although society's reasons for placing children into

institutional settings have changed during the course of time, the practice of doing so continues.

Evolution of modern residential care. Modern day placement facilities, such as group homes and youth detention centers, are derivatives of the orphanages and institutions that were proliferate across the country following the Civil War. Many children during the late 1860's had lost either one or both parents to the war effort. Legislation by States within the Union established state and county children's homes to meet the needs of those children made orphans (Hopkirk, 1944). Also in the late 19th century, the birth of major cities and massive industrial development resulted in the establishment of the first institutions (asylums) for deviant children (Whittaker, 1979). With the implementation of these methods of care, the placement of children without families and away from troubled ones had been firmly established within our culture.

From the early 1900's through the late 1940's, a shift in the needs of our society resulted in a change of the institutionalization of children. It was during this time that some children became dependent on the state not only because they were orphans, but also because they were "neglected, abandoned, cruelly treated or left

homeless for some other reason" (Hart, 1909, p. 10). According to Bremner (1974), children were no longer viewed as common paupers. Instead, they were seen as citizens who needed to be raised and given equal opportunity in education and humanitarian rights as children who had families. Thus, the pre- and post-World War I years, along with the depression of the 1930's, allowed for the increased need of what were now referred to as schools, children's centers, or study homes (Hopkirk, 1944). Even though substantial changes in the residential care of children were made during this time (Johnson, 1982), the involvement of the dependent child's family was non-existent.

#### The Role of the Family in the Residential Care of Children

The role of the family in the treatment of the dependent child prior to the 1950's is easy to discern. First, orphans had no availability of family participation due to their circumstances. It was the non-existent family that resulted in their placement into a facility. As for those placed in asylums, the pathology was seen as existing within the child (Whittaker, 1985). Whittaker (1985) also notes that those in detention centers needed to be separated from

"pathogenic, harmful environments" (p. 13). For these children, parents were seen as harmful and toxic to the treatment process (Letulle, 1979). Therefore, families were not included or involved in any way in the treatment of children raised in a residential setting. However, an important shift occurred during the 1950's and 1960's which had a significant impact on how children were treated within residential care (Whittaker, 1985). This change ultimately led to the consideration of families being included in the treatment process.

The importance of the environment. In the 1950's, two important discoveries within the field of residential child care were made. First, Bettlheim and Redl realized that the entire community in which the child lived while in care had the potential of being therapeutic (Whittaker, 1979). From this idea, they developed the milieu therapy approach whereby "treatment was extended from the therapy office and the fifty-minute hour to the total life space of the institutional setting" (Whittaker, 1985, p. 13). As Whittaker (1985) states, the total environment in which the child lived was used to effect behavior change. Similarly, Mandelbaum (1971) had discovered that children in a psychiatric hospital setting often repeated relationships amongst hospital

staff that were similar to the detrimental relationships they had with their family members (Letulle, 1979). Thus, it became important for staff at the inpatient hospital to not only be aware of prior familial patterns of functioning between the children and their family members, but also the potential of replicating those patterns within the hospital setting (Letulle, 1979). Again, this is another important and early realization that the context in which a child functions (i.e. the environment) is an important consideration for residential care.

The work of Rhodes (1967) and Hobbs (1966) in the late 1960's was another important influence in pointing towards the potential value of family participation in the child's residential treatment process. Lewis (1982) notes that ecological planning was developed by Hobbs and Rhodes as part of their Project Re-Ed. As Rhodes (1967) states:

there was no plan for long term residential treatment, isolated from the normal developmental forces in the child's life. The major societal systems or ecological units of the child's life, his home, his



school, and his neighborhood were considered the important factors. (p. 452)

Clearly, there was a conceptual shift during this time to include variables such as family, school, and community as influences affecting a child's behavior (Lewis, 1984).

Letulle (1979) notes:

As the intrapsychic view of behavior broadened to include interpersonal, interactional components ... there were corresponding shifts in the residential setting's response to families. These shifts, which began in the 1970's, were reflected in the literature on residential treatment. (p. 49)

Although until this time no actual family participation was included in residential treatment, it was the work of these pioneers that led to the large amounts of literature in the 1970's suggesting ways for family's to be included.

Family participation. Finkelstein (1974) discusses one of the ways families can be utilized to aid in the treatment of children. In her 1974 article, Finkelstein makes three basic recommendations for ways treatment facilities can involve family members. First, she

suggests agencies should move towards using whatever resources they have available to help parents realize their rights and strengths as the responsible persons in charge of their child's care. As one example, a project may ensure at the time of intake that the family is made fully aware of their responsibilities and must agree to them before admission is complete. These responsibilities include how often they may visit and how often they are to participate in evaluations. The family must understand from the beginning their role as members of the treatment team. Secondly, Finkelstein (1974) points towards the importance of the families setting goals for their child and themselves. The agency's responsibility lies in its being clear on whether or not these goals can be accomplished. Finally, home visits should be planned by the family when they want them. Too often visits home are planned to suit the agency's needs (Finkelstein, 1974).

In similar articles, Kemp (1971) and Littauer (1980) highlight the importance of involving families during the pre-admission stage. Kemp (1971) says, "From the beginning of treatment we make clear that our work is with families" (p. 230-231). During the preadmission stage, staff personnel make every attempt to help the

family become comfortable with their role in the treatment facility (Littauer, 1980; Kemp, 1980). After admission of the child, the family must agree to spend at least six hours per week working with the child directly in the milieu setting. This involvement may include eating meals, doing chores, or participating in recreational activities (Kemp, 1971). Likewise, Littauer (1980) utilizes the family within the cottage by requesting the family stay for an overnight visit and observe the activities of the milieu.

A final program that involves the family in a residential setting is discussed by Krona (1980). In this residential facility, the parents are given constant information concerning their child's progress towards or away from their goals. Again, the parents are involved in the treatment process from the time of intake until both the agency and the family feel it is time for discharge (Krona, 1980). Like the Finkelstein (1974) article, Krona (1980) also places an emphasis on home visits as being an integral part of the treatment process.

As the importance of involving the family during treatment grew, so did the literature on exactly how to include them. The comment made by Barker in 1982 seems

to have come true. He said: "Nevertheless, many disturbed children belong to poorly functioning families and other systems - but especially to troubled families. Moreover no child functions independently of the system to which he or she belongs. Detailed consideration of these systems is vital if a comprehensive plan is to be worked out. Much more general acceptance of this point of view has been a feature of the 1970s, and I believe will characterize all aspects of the treatment of disturbed children in the 1980s." (p. 637)

As the following examples will illustrate, the exact nature of how to include family's in residential care became more detailed and specific.

As mentioned earlier, Finkelstein (1974) emphasized the importance of involving the family from the start. In 1980, she continued her work on involving families, but this time focused on how to include them more during treatment. As she states, "Family systems work must be the focus, whether parents are present or absent, alive or dead" (p. 35). Finkelstein (1980) presents a family-focused model that serves to keep the crisis that precipitated placement alive, so the child and the family can find a solution. The framework presented in this article has as its goal the change of every family member, rather than just the one in care. To accomplish

this, Finkelstein (1980) stressed the importance of extensive family involvement in the residential center. Also, frequent home visits are essential, with treatment staff making themselves available on an emergency basis to ensure effective intervention if visits become chaotic (Finkelstein, 1980). Finally, Finkelstein (1980) notes the importance of discharge planning and the need for "massive aftercare efforts" (p. 36).

In another article with a strong family orientation, Garland (1987) presents an extensive model for family focused treatment. Her model is based on a rationale involving: the role of the child care worker, the ability of parents to learn skills in a group setting, and the post-discharge adjustment research. Her model outlines ten strategies including: drawing on the family generation line, the inclusion of the entire family in special projects, increased responsibility of the parents in discharge planning, and encouragement of genuineness amongst staff personnel in their own limitations. Finally, difficulties that may function to block the implementation of this model are given, along with means to overcome them (Garland, 1987).

Articles by DeSalvatore and Rosenman (1986) and Anglin (1985) incorporate the use of groups as examples of effective parental involvement in residential

treatment settings. DeSalvatore and Rosenman (1986) make use of the parent-child activity group. In this procedure, parents and children participate in structured activities in order to assess and change family functioning on two dimensions: structure and process. Anglin (1985) makes use of education and support groups for parents of children in residential care. The author provides objectives, functions, assumptions of leaders, and ways to design a successful group (Anglin, 1985). These articles illustrate how specialized the participation of families in the residential care of adolescents has become.

Conclusion. Although it is widely accepted that families should be included in the treatment of adolescents in residential care (Carlo, 1985), proponents are still unclear about the most effective method of family participation. As Schneider (1985) concludes from his article, "It is clear from the review of the literature that there is far from unanimity on the issue of the role of the parents in their adolescents' therapy" (p. 39). This lack of clarity may be the result of an insufficient amount of empirical evidence surrounding the value of family inclusion. Of the articles presented espousing the importance of family, none of them utilized

controlled experiments to validate or refute their theoretical positions. Most of the articles present case illustrations of how models can be used, but no experimental design is incorporated into the study. Controlled studies may eventually lead to clarification of effective models. Until these studies have been completed, it should prove helpful to examine areas of literature that include the adolescent within a therapeutic context that involves the family. For example, research examining family therapy with adolescents provides some helpful directions for residential centers to follow based on theoretical as well as empirical support.

Family Therapy with Adolescents  
Adolescent Residential Care Populations and Family  
Therapy

Unfortunately, few have recognized the value family therapy may hold as a therapeutic change agent in the residential care of adolescents (McConkey-Radetzki, 1987). A review of the literature produced only one empirical study discussing the use of family therapy within an adolescent residential treatment center similar to the one discussed in this article. DeFoore (1984) studied the effectiveness of a family counseling

component as part of the treatment process for adolescents in a residential treatment center. Subjects involved in the study included 26 individuals assigned to one of two groups. The experimental group was composed of 16 adolescents whose family had received three or more family therapy sessions during the youth's treatment process. The control group consisted of ten individuals who received no family therapy. The results failed to support the hypothesis that the experimental group would show greater improvement (work-school adjustment following completion of residential stay) than the control group. However, the author did list several limitations to the study and "highly recommended that further evaluations of programs such as this one examined here be conducted in the near future" (DeFoore, 1984, p. 31). Although few empirical studies have examined the effectiveness of family therapy with adolescents in a residential treatment setting, family therapy has been used as the treatment of choice with adolescent populations similar to those found within a residential treatment facility.

Adolescent populations in residential treatment facilities. According to DeForre (1984), there are two basic types of youth who enter residential care. In the



first group, the residents are often those who have been removed from the home due to an unsuitable home environment. In this group, the problem appears to lie in the home. Such concerns as neglect, physical and sexual abuse, incest, running away, and divorce are the major focus. The second group of adolescents who enter care often fall under the rubric of problem youth. In this group, the problem usually is seen as residing within the adolescents themselves. Often, they are placed into psychiatric hospitals with adolescent wards or enter youth detention centers as juvenile offenders. Major concerns within these populations usually include drug and alcohol abuse, suicide, depression, and non-status offenses such as stealing, rape, and murder (DeFoore, 1984). Because the treatment facility examined in this study only provides services to those youth who appear in the former group, the literature on family therapy will be limited to only these issues.

Family therapy with adolescent populations. Family therapy has been utilized as a treatment modality for adolescents and their families who present issues such as incest, physical abuse and neglect, running away, and adjustment to divorce. For example, Fishman (1988) presents a model of family therapy in working with incest

victims. Fishman (1988) discusses the major therapeutic issues therapists must be aware of for family therapy to be effective with these families. These include battles for initiative (responsibility for change), protection of the child, and individual work with the victims. Most importantly, incest is a severe violation of boundaries, and in order to restructure the system, therapists must guide these families toward developing extra-firm personal and subsystem boundaries (Fishman, 1988). Reposa and Zuelzer (1983) present a multilevel mode of intervention in work with incestuous families. Family systems concerns such as separation-individuation, boundary clarification, coalitions, and power are viewed as major treatment focal points (Reposa and Zuelzer, 1983). Finally, Lutz and Medway (1984) utilize a contextual approach in working with families where incest is the presenting concern. According to them, filial loyalty, unwritten rules and concepts of trust must be challenged to facilitate change in these families (Lutz and Medway, 1984).

Along with incest, physical abuse and neglect are often presenting concerns of adolescents who enter residential treatment. Jurich (1989) utilizes a family therapy approach when working with families who

physically abuse their adolescents. According to him, these families may present four types of interactional patterns at the onset of therapy: "maladaptive normals, disillusioned idealists, dethroned despots, or chronic abusers" (Jurich, 1989 p. 30). Jurich (1989) then offers family therapy treatment approaches based on these family types. Fishman (1988) also presents information on how to work effectively with families who neglect or abuse adolescents. According to him:

working with explosive, violent families requires the therapist to keep firmly in mind four basic principles: first do no harm; create a therapy of experience; develop positive regard between family members; and deal with both the family and the broader context. (Fishman, 1988, p. 83)

Lastly, Crumbley (1985) suggests family therapy with families that abuse adolescents should involve work with extended families, the nuclear family, and subsystems within each of these family units. He recommends addressing both structural (boundaries, roles, enmeshment/disengagement) and contextual (loyalties, trust, unresolved life cycle) issues (Crumbley, 1985).

Another closely related concern of staff at residential treatment facilities is the adolescent runaway. Lappin and Covelman (1986) offer a family therapy approach to treating the runaway. Their perspective is based primarily on structural and developmental concepts. The treatment emphasis is placed on issues of generational hierarchy, conflict avoidance, and detriangulating the adolescent from the parental dyad (Lappin and Covelman, 1986). Similarly, Mirkin, Raskin, and Antognini (1984) believe the adolescent is often functioning within a family to perform three specific duties reserved typically for the parents. The function of the running away serves either to parent, protect, or preserve the family unit. The focus of treatment then becomes one of empowering the parents to perform these roles, thus freeing the adolescent from the responsibility of having to do them (Mirkin et al., 1984).

In regard to working with divorced families, Keshet and Mirkin (1986) suggest that acting out behaviors of adolescents from divorced families fall into three categories: reunion, diversion, and replacement. Unclear boundaries within the biological and divorced families appear to underly the presenting problems. Thus,

treatment is centered around completion of the emotional divorce between the former spouses thereby bringing about in the detriangulation of the child (Keshet and Mirkin, 1986). Often, determining whether or not both former parents should be included in family therapy sessions together is a difficult task. Weisfeld and Laser (1977) suggest having both parents participate in the treatment process for adolescents living in a residential treatment setting. As the authors state, "... including both divorced parents in the family therapy component of the program gave the family a greatly increased opportunity for success" (Weisfeld and Laser, 1977, p. 231). However, in some instances the spousal conflict may be so severe that conjoint sessions are disruptive, counter-productive, and therefore, contraindicated (Russell, 1987). Whichever the case, clearly a family therapy process is important in the treatment of divorced families with acting out adolescents. Although much valuable theoretical work has been accomplished by family therapists with regards to adolescents, its effectiveness as a treatment procedure should be established prior to embracing it as a way to alleviate symptoms presented by adolescents in residential care.

### The Effectiveness of Marriage and Family Therapy

In their 1981 review article, Gurman and Kniskern contend that there are two approaches in assessing the effectiveness of family therapy. First, a review of articles (Gurman and Kniskern, 1978) comparing groups receiving no treatment with groups receiving family therapy led the authors to conclude that family therapy is "often effective beyond chance" (p. 745). Secondly, when utilizing improvement rates, Gurman and Kniskern (1981) report that 73% of family cases improve during treatment. Other reviews of outcome literature involving family therapy are numerous (Wells, Dilkes, and Trivelli, 1972; Kniskern, 1975; Dewitt, 1978; Wells and Dezen, 1978; Pinsoff, 1981; Russell, Olson, Sprenkle, and Atilano, 1985). This author found it difficult to make any clear and definite conclusions concerning the efficacy of family therapy. However, when compared to other types of treatment modalities, family therapy is at least as effective or superior (Goldenberg and Goldenberg, 1985).

Outcome studies with specific adolescent populations. A recent review of literature on family therapy with adolescents by Breunlin, Breunlin, Kearns, and Russell (1988) produced two articles relevant to the

current discussion of effectiveness of family therapy with adolescent populations. Kroth (1979) utilized a cross-sectional longitudinal design to evaluate a family therapy treatment program for intrafamilial sexual abuse. Three comparison groups representing a group at intake, a mid-term sample, and a group at termination were matched on ten criteria to control for extraneous variables. Each group consisted of 17 (9 perpetrators and 8 unrelated non-offending spouses) subject families. Results indicated that of the 44 measures used in the study, 20 were statistically significant in a positive direction with respect to the efficacy of the family therapy treatment process. When comparing the two groups at intake and termination, some of the findings show: the 88% of the subjects (victims) reporting feelings of having a nervous breakdown had decreased to 6% at termination; none of the marital partners at intake reported increased sexual activity between them while at termination this percent had risen to 41%; an estimated 76% of the spouses reconciled as a consequence of therapy and remain together. Finally, Kroth (1979) reports:

Twice as many perpetrators and spouses feel  
'more open, honest and in control' of  
themselves at termination as they did at intake

( $p < .01$ ), and 100% feel 'things are a lot better than they used to be' versus 29% at intake ( $p < .01$ ). (p. 300)

The authors conclude that 82% of the measures used favored the efficacy of family therapy.

Ostensen (1981) studied the effectiveness of a family counseling component in relation to the recidivism of runaway teenagers. A total of 86 subjects were divided into two groups. The experimental group was composed of 28 families who had participated in three or more counseling sessions. A total of 45 nonparticipants in the family therapy program comprised the control group. At the three month follow-up period, only 7 of the 28 youth in the experimental group had runaway. As for the control group, 28 of the 45 subjects had experienced runaway recidivism. These results were statistically significant ( $p < .01$ ) leading the authors to conclude, "... conjoint family therapy is considered the most effective tool in working with runaway youth" (Ostensen, 1981, p. 10).

Conclusion. Adolescents who enter residential treatment facilities often present issues that are related to the family context in which they live. When viewed from a family therapy perspective, concerns such



as incest, physical abuse, running away, and acting out due to divorce appear to be related moreso if viewed in the context of the family rather than as individual adolescent pathologies. Adolescent behavior is often a function of the larger family system and indicative of possible underlying distress within the marital dyad (Fishman, 1988). Another ubiquitous theme arising out of the literature is the apparent encompassing value of family therapy models. Regardless of the presenting problem of the adolescent, the structural emphasis by Minuchin (1974), the contextual ideas of Boszormenyi-Nagy (1973) and the developmental approach by Carter and McGoldrick (1980) offer a guide to therapists who work with these specific adolescent populations. Further, outcome studies and comprehensive reviews of outcome studies suggest that family therapy is often as clinically effective as individually oriented forms of treatment (Breunlin et al., 1988). In conclusion, with a well extrapolated theoretical base for working with adolescents and some preliminary empirical support for its effectiveness, family therapy should be viewed as a viable form of treatment for adolescents who enter residential treatment facilities similar to the one discussed in this article.

## Summary

Since the 1960s, ecological factors such as the family have been widely accepted as being important in the treatment of adolescents in residential care. Since then, several methods have been used to include families in the residential treatment of adolescents. Helping families understand their responsibilities, frequent home visits, and parenting support groups have been utilized to ensure the family has been included in the treatment process. However, two limitations exist which highlight the need for further study. First, there is little empirical evidence on how best to include families. Theorizing and model building is critical, but these methods must be examined through the use of controlled studies. Secondly, as Parsons and Alexander (1973) note, "focus on families per se will not influence interaction patterns in a positive direction" (p. 200). Thus, simply involving the family may not be the answer. Instead, helping the family to change its interactional patterns may prove to be the critical element.

The goal of family therapy is to change the interactional patterns of family members so as to increase the likelihood of functional behavior in all of its members (Bross and Benjamin, 1982). Because of this,

family therapy's inclusion in residential treatment processes has the advantage of not being just another way to involve the family. Instead, the family in therapy can be assisted in finding ways to interact differently. Further, recent theoretical and empirical advances have suggested family therapy is a valid therapeutic treatment approach for populations of adolescents often found in residential care. For these reasons, outcome studies such as this one are important in helping to establish the value family therapy may hold as a therapeutic change agent in the residential care of adolescents.

## CHAPTER THREE

### Methods

#### Sample

The data for this study were obtained from pre-existing files for clients who had participated in a residential treatment program for adolescents. Because the aftercare program at this facility had only been in existence for four years, the files selected for this study were limited to those clients who had participated in the aftercare component of the treatment process. Thus, clients who had completed the treatment process prior to the start of the aftercare project were not used as part of the sample. The total number of participants eligible for this sample was 96.

#### Subjects

From the larger sample of 96, subjects were divided into two groups. The experimental group consisted of 15 clients who had participated in some type of family therapy process during their placement at the residential treatment facility. There were three criteria for being included in the family therapy group. First, more than one family member had to have participated in the therapy sessions. Sessions involving the individual adolescent, although in some cases family focused, were not included

in the experimental group. Secondly, the family had to have met for more than two therapy sessions. Lastly, the focus of the treatment had to be family oriented. The experimental group consisted of seven males and eight females. They ranged in age from 14 years to 19 years with the mean age being 16.3 years. The average length of stay at the residential treatment facility was 9.5 months. Finally, the average length of participation in the aftercare program was 5.4 months.

The control group consisted of 27 subjects from the larger sample who had not participated in any type of family therapy treatment process. To provide a greater degree of control for extraneous variables, not all of the subjects from the larger sample were used. Instead, the control group subjects consisted of a matched group. The experimental group subjects were matched on three variables accessible to the researcher. These variables included: severity of situation at admission, reason for dismissal from facility, and type of placement (i.e. family, foster care, grandparents, etc.) following termination. The control group consisted of 13 males and 14 females. The ages of the subjects ranged from 16 years to 20 years with the mean age being 17.7 years. The average length of time spent at the treatment

facility was slightly under ten months. Finally, the average length of participation in the aftercare program was 5 months.

#### Procedure

The data were collected from aftercare report forms submitted by aftercare workers who worked directly with the youth and families following residential treatment termination. These forms were then placed into the client files and made accessible to the researcher.

#### Treatment Facility

The treatment facility serves up to 130 youth in both residential and foster care. The residential treatment facilities are located in seven different cities throughout a mid-western state. Referrals to this agency may include some private placements, however the majority are placed through the social welfare system as youth in need of care or juvenile offenders.

#### Aftercare Program

The aftercare program at United Methodist Youthville was developed to insure that youth who return to their communities are provided with adequate services to increase the likelihood they can adjust and cope with situational and developmental stressors. The aftercare program is also designed to help youth and their families

adjust to each other after an extended period apart. With increased support available to the family and to the youth, reinstitutionalization can be avoided. The goal of the aftercare worker is not to change the individual youth or family, but rather focuses on education, resource development, advocacy, strengthening support systems, and developing creative strategies of problem solving with the family.

Aftercare workers are hired by the coordinator of aftercare services. Ideally, aftercare workers live in the same community as the youth and his or her family. There is no formal training for aftercare workers, however preference is given to those individuals with a Bachelor's degree in a human service area. These workers must spend one hour a week meeting with the youth and his or her family. The aftercare program begins upon termination from the treatment facility and lasts for six months, with negotiations beyond six months possible.

#### Family Therapy Services

At the time of this study, the residential facility had just begun to provide its client population with comprehensive family therapy services. Thus, many of the families included in this study received family therapy services from a variety of sources. Some of them

received services from the youth's social worker who had received training in family therapy. Others received family therapy through their community mental health agency. No comprehensive information is available regarding the specific nature of the therapeutic process. Information such as which family members were in attendance at therapy sessions, the number of sessions of therapy the family participated in, and how many sessions a month took place is unavailable.

#### Instrument

The instrument used was titled the Aftercare Monthly Report form. This form asked aftercare workers to provide information about the adjustment of certain aspects of the adolescents' life following termination of the treatment facility. These aspects include the youths' relations with other youth, how they are doing in school, their relations with family members, their overall emotional state, and their acceptance of aftercare. Any change in youths' living arrangements and contact with the law is also recorded. (Please see appendix for example of instrument).

#### Experimental Design

The design for this study is a 2 x 3 factorial. The two independent variables are treatment (variable A) and



time at follow-up (variable B). Variable A has two levels. Level one is received family therapy and level two is didn't receive family therapy. Variable B has three levels. Level one is follow-up at one month after termination. Level two is follow-up at three months following termination. Level three is follow-up at six months following termination.

The dependent variables are adjustment to living following termination of the residential treatment component and participation in required structured settings. Adjustment to living consisted of the variables relationship with other youth, relationship with family members, and overall emotional state. The variable for participation consisted of performance in school and acceptance of aftercare.

#### Statistical Analyses

A factor analysis revealed that the variables for relations with peers, relations with family members, and overall emotional state were closely related enough to be computed into one factor for overall adjustment following termination of the residential component (See Table 1). Thus, one score was computed for adjustment at each of the three times at follow-up. Similarly, the factor analysis also revealed a second factor which included the

variables school performance and acceptance of aftercare were closely related enough to be computed into one factor for participation in required structured activities. Again, one score was computed for participation at each of the three follow-up periods.

A repeated measures multivariate analysis of variance was used to determine any significant differences in the adjustment and participation of youth at one, three, and six month intervals following termination of the residential treatment process. Because of the attrition rate (missing aftercare reports or families quitting aftercare), only 18 valid cases were identified for use in the MANOVA procedure. To remedy this, the means for each factor at each time interval were replaced for the missing data. For example, the calculated mean for adjustment at three months of all other subjects for which data were available was used in place of all missing data for only the adjustment factor at the third month time period. This allowed for the inclusion of all the cases (N=42).

## CHAPTER FOUR

### Results

#### Manova

Two 2 X 3 repeated measures multivariate analyses of variance were utilized to test for significant differences between the independent and dependent variables means using SPSSX (Norusis, 1988) (See Table 2). The first analysis used family therapy as the independent variable, and adjustment at one, three, and six month follow-up times as the dependent variable. The second analysis used family therapy as the independent variable, and participation in structured settings at one, three, and six month follow-up times as the dependent variable. Both univariate and multivariate tests of significance are given. In order to report univariate tests, assumptions concerning the variance-covariance matrix must be met. A Mauchly's test of sphericity (Norusis, 1988) indicated that the time within-subject effect for both dependent variables is not significant and therefore the null hypothesis of sphericity is not rejected (See Tables 3 & 4). Thus, univariate results were utilized as valid tests of significance. Reporting univariate results is important because they are more powerful than multivariate tests,

especially with smaller sample sizes as used in this study (Norusis, 1988). If the univariate and multivariate tests are significant, the null hypothesis asserting no relationship between the variables can be rejected. The .05 level of confidence ( $p < .05$ ) was used.

#### Tests of Significance for Family Therapy and Adjustment

Between-subjects effects. Univariate tests show there was no significant between-subjects effects for the independent variable family therapy and the dependent variable adjustment at follow-up,  $F(2,39) = 1.09$ ,  $p = .302$  (See Table 5).

Within-subjects effects. Univariate tests show a significant within-subjects effect for the independent variable time at follow-up and the dependent variable adjustment,  $F(2,39) = 3.20$ ,  $p = .046$  (See Table 6). The subjects became better adjusted across time. Multivariate tests, however, only approximate significant results ( $p = .062$ ) (See Table 7).

Interaction effects. Neither univariate tests (See Table 8) nor multivariate tests (See Table 9) produced significant interaction effects for the two independent variables family therapy by time at follow-up,  $F(2,39) = .84$ ,  $p = .434$ .

### Tests of Significance for Family Therapy and Participation

Between-subjects effects. Univariate tests show there was no significant between-subjects effect for the independent variable family therapy and the dependent variable participation at follow-up,  $F(2,39) = .06$ ,  $p = .806$  (See Table 10).

Within-subjects effects. Univariate tests show a significant effect for the independent variable time at follow-up and the dependent variable participation in structured events,  $F(2,39) = 7.42$ ,  $p = .001$  (See Table 11). The subjects participated better across time. Multivariate tests also show a significant effect between the independent and dependent variable (See Table 12).

Interaction effects. Both univariate and multivariate tests failed to show any significant interaction effects for the independent variables family therapy by time on the dependent variable participation in structured events,  $F(2,39) = .64$ ,  $p = .532$  (See Tables 13 and 14).

### Summary

Only two significant effects were revealed by the multivariate and univariate results from the two MANOVAS. The results indicated that the independent variable time

at follow-up has a significant effect on both dependent variables adjustment and participation after termination from the residential treatment facility. However, no significant results were found involving the independent variable family therapy, either as a main effect or as an interaction effect with time at follow-up on the dependent variables adjustment and participation.

Table 1.

Factor Analysis for Dependent Variables: Factor Matrix

Variable	Factor 1	Factor2
Youth	.74228	-.54167
Accept	.59145	.63855
Emosta	.90727	-.22984
School	.54775	.62029
Fam	.88333	-.12095

Table 2.

Cell Means and Standard Deviations for the Dependent Variables: Adjustment at One Month

	Family Therapy	No Family Therapy
Mean	2.644	.236
Standard Dev.	.886	.786

Adjustment at Three Months

	Family Therapy	No Family Therapy
Mean	3.092	2.733
Standard Dev.	.668	.851

Adjustment at Six Months

	Family Therapy	No Family Therapy
Mean	3.059	2.833
Standard Dev.	.557	.725



Table 2 Continued.

Participation at One Month

	Family Therapy	No Family Therapy
Mean	2.411	2.473
Standard Dev.	.760	.676

Participation at Three Months

	Family Therapy	No Family Therapy
Mean	2.829	2.618
Standard Dev.	.973	.602

Participation at Six Months

	Family Therapy	No Family Therapy
Mean	2.937	2.965
Standard Dev.	.742	.539

Table 3.

Summary of Tests Involving 'Time' Within-Subject Effect:  
Adjustment

Mauchly Sphericity Test, W =	.99638
Chi-Square Approx. =	.14143 with 2 D. F.
Significance =	.932

Table 4.

Summary of Tests Involving 'Time' Within-Subject Effect:  
Participation

Mauchly Sphericity Test, W =	.97838
Chi-Square Approx. =	.85254 with 2 D. F.
Significance =	.653

Table 5.

Summary of Univariate Tests of Between-Subjects Effects:  
Family Therapy and Adjustment

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	42.44	40	1.06		
Constant	927.97	1	927.97	874.7	.000
Famther	1.16	1	1.16	1.09	.302

Table 6.

Summary of Univariate Tests of Within-Subjects Effects:  
Time and Adjustment

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	27.68	80	.35		
Time	2.22	2	1.11	3.2	.046

Table 7.

Summary of Mutivariate Tests of Significance for Within -  
Subjects Effects: Time and Adjustment

Test Name	Value	F	Hyp. DF	Err.DF	Sig of F
Pillais	.133	2.98	2	39	.062
Hotellings	.153	2.98	2	39	.062
Wilks	.867	2.98	2	39	.062

Table 8.

Summary of Univariate Tests of Interaction Effects:

Family therapy by Time with Adjustment

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	27.68	80	.35		
Famther by Time	.58	2	.29	.84	.434

Table 9.

Summary of Mutivariate Tests of Significance for  
Interaction Effects: Family Therapy by Time with  
Adjustment

Test Name	Value	F	Hyp. DF	Err.DF	Sig of F
Pillais	.038	.779	2	39	.466
Hotellings	.040	.779	2	39	.466
Wilks	.962	.779	2	39	.466



Table 10.

Summary of Univariate Tests of Between-Subjects Effects:  
Family Therapy and Participation

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	30.88	40	.77		
Constant	846.90	1	846.90	1097.16	.000
Famther	.05	1	.05	.06	.806

Table 11.

Summary of Univariate Tests of Within-Subjects Effects:  
Time and Participation

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	27.00	80	.34		
Time	5.01	2	2.51	7.42	.001

Table 12.

Summary of Mutivariate Tests of Significance for Within -  
Subjects Effects: Time and Participation

Test Name	Value	F	Hyp. DF	Err.DF	Sig of F
Pillais	.270	7.20	2	39	.002
Hotellings	.370	7.20	2	39	.002
Wilks	.730	7.20	2	39	.002

Table 13.

Summary of Univariate Tests of Interaction Effects:

Family Therapy by Time with Participation

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	27.03	80	.34		
Fanther by Time	.43	2	.22	.64	.532

Table 14.

Summary of Mutivariate Tests of Significance for  
Interaction Effects: Family Therapy by Time with  
Participation

Test Name	Value	F	Hyp. DF	Err.DF	Sig of F
Pillais	.031	.616	2	39	.544
Hotellings	.032	.616	2	39	.544
Wilks	.969	.616	2	39	.544

## CHAPTER FIVE

### Discussion

#### Restatement of Hypotheses

##### Hypothesis 1:

It was hypothesized that adolescents who had received family therapy would adjust significantly better following termination of a residential treatment process than those adolescents who received no family therapy. The results did not support this hypothesis. There were no significant main or interaction effects between family therapy and adjustment at one, three, and six months follow-up.

##### Hypothesis 2:

It was hypothesized that adolescents and their families who had received family therapy would participate in structured events significantly more following termination of a residential treatment process than those adolescents and their families who received no family therapy. The results did not support this hypothesis. There were no significant main or interaction effects between family therapy and participation at one, three, and six months follow-up.

### Explanation of Results

Although no significant results were discovered between family therapy and adjustment or participation, below are possible explanations for these findings. First, further analyses of the data revealed an approximate significant main effect relationship  $F(2,39) = 2.21, p = .14$  between family therapy and adjustment when only comparing the follow-up data at three and six months (See Table 14). This finding suggests that family therapy may have a greater impact on adjustment in a long term sense, rather than short term. Significant effects of family therapy may not be seen until between six months and a year following termination of the residential treatment program. Subsequently, future research projects similar to this one should include follow-up procedures at least through one year.

Another possible explanation for finding no significant results involves the time at which families begin and end family therapy services. According to Lewis (1984), ecological factors such as family and community are a critical determinant in whether or not successful adjustment is made following termination from a residential treatment facility. Further, Lewis (1984) states that some studies indicate a supportive

environment following termination is more likely to assist in adjustment than the treatment received while in residential care. Not all of the families participating in this study were able to receive family therapy services following the youth's termination. Significant effects may have been found if better methods were utilized in determining whether or not families continued family therapy services in conjunction with aftercare services. Because support gained through a therapeutic process appears to be important in terms of successful adjustment, future research projects of similar nature should take into consideration when the family therapy services were provided.

#### Significant Results

Although not hypothesized, significant results were found between the independent variable time and its effect on adjustment and participation. As the results indicated, those youth and their families showed better adjustment and were more willing to participate in structured events in the later follow-up periods. These findings are important for several reasons. First, they highlight the importance of conducting long-term follow-up studies. It appears that a successful adjustment of the youth back into the family takes longer than one or



two months. Secondly, these findings suggest that the youth and the family need time to cope with the adjustment, and difficulties during the first one to two months are expected. Placing the youth back into the treatment facility during this one to two month period may be premature as the effects of the treatment process may not be seen for three to six months following termination. Finally, residential facilities should keep in mind the adjustment process following termination is long-term. Too often, the expectation is that the youth will return home from residential treatment and adjustment should be immediate. These results indicate that successful adjustment is a process and continues well past the immediate arrival of the youth back into the home.

#### Future Recommendations

Because the small sample size (N=42) and missing data may have effected the non-significant findings, it is recommended that future investigations utilize larger sample sizes. Also, researchers may want to consider use of some type of self-report measures by the families and the youths along with reports by the aftercare workers. For workers, what may appear to be poor adjustment may to the family appear to be a major improvement. Along these

lines, collecting data prior to the admission of the youth into the facility may aid in assessing the degree of adjustment after termination warranted for each youth. Finally, some type of reliability should be maintained amongst the aftercare workers. Operationally defining adjustment would provide a set of standards for the aftercare workers to follow. This should help eliminate uncontrollable sources of variance between the factors targeted for study.

#### Implications

Substituting means for missing data, as was done in this study, has certain implications for researchers. Because the goal of using a MANOVA design is to discover any differences between means, substituting means for missing data increases the likelihood that no significant results would be found since the variance amongst the means would be lessened. Therefore, it is imperative that researchers use as many ways as they can to assure that missing data is avoided.

Implications for clinicians working with adolescents after they return home include the importance of receiving family therapy immediately after the termination date. The data presented here suggests that there is a critical period in which families need time to

adjust. This process may be important, if not necessary, in the families continuation along the developmental path.

### Conclusion

As the importance of including the family in the residential treatment of youth continues, so to will the need for finding ways of achieving this goal. This project studied the effects of family therapy on the adjustment of youth after their completion of a residential treatment facility. Although no significant effects were found, it is important to keep in mind that this study was conducted as a pioneering effort. Few studies have examined the potential value family therapy holds as an encompassing process for assisting families who have an adolescent in residential care. Studies such as this one need to be replicated taking into account the recommendations made herein before any decisive conclusions can be drawn regarding the use of family therapy in conjunction with residential services for youth.

Table 15.

Summary of Univariate Tests of Between-Subjects Effects:  
Adjustment at Three and Six Months

Tests of significance for adjustment using unique sums of squares

Source of variation	SS	DF	MS	F	Sig of F
Within cells	29.97	40	.75		
Constant	661.94	1	661.94	883.47	.000
Famther	1.66	1	1.66	2.21	.145

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APPENDIX

Aftercare Monthly Report Form

1. Since the youth has been back home how has his/her adjustment been in: (Please circle the appropriate response)

- a. His/her relations with other youth?

Very Good	Good	Average	Poor	Very Poor
1	2	3	4	5

- b. How he/she does in school?

Very Good	Good	Average	Poor	Very Poor
1	2	3	4	5

- c. His/her relations with family?

Very Good	Good	Average	Poor	Very Poor
1	2	3	4	5

- d. His/her overall emotional state (happy, content, angry, etc.)?

Very Good	Good	Average	Poor	Very Poor
1	2	3	4	5

- e. His/her acceptance of Aftercare?

Very Good	Good	Average	Poor	Very Poor
1	2	3	4	5

2. Has there been any change in the youth's living arrangements?

Yes      or      No      If yes, please explain.

3. Has there been any contact with any law enforcement agency from any member of the youth's family?

Yes or No

If yes, please explain.

4. Please use this space below to share any relevant information on the youth's success or failure in reintegrating into the family or community.

THE EFFECT OF FAMILY THERAPY ON THE ADJUSTMENT OF  
ADOLESCENTS FOLLOWING TERMINATION FROM A RESIDENTIAL  
TREATMENT FACILITY:  
A ONE, THREE, AND SIX MONTH FOLLOW-UP

by

DOUGLAS MICHAEL THOMPSON

B.S., Clarion University of Pennsylvania, 1986

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AN ABSTRACT OF A MASTER'S THESIS

submitted in partial fulfillment of the  
requirements for the degree

MASTER OF SCIENCE

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KANSAS STATE UNIVERSITY  
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#### ABSTRACT

The purpose of this study was to test the effects of two independent variables, family therapy and time, on two dependent variables, adjustment and participation in structured events of adolescents following their termination from a residential treatment facility. The data was obtained from monthly aftercare report forms submitted by aftercare workers. Data were collected at one, three, and six month follow-up periods. The experimental group consisted of 15 subjects and their families who had received family therapy while the adolescent was in residential treatment. The matched control group of 27 subjects received no family therapy services. A 2 X 3 factorial design with two dependent variables was used.

Results from a MANOVA procedure indicated a significant main effect for the independent variable time at follow-up ( $p < .05$ ) on both dependent variables of adjustment and participation in structured events. No significant effects for family therapy on adjustment and participation were found. The hypotheses that adolescents and their families who had received family therapy would adjust and participate in events significantly better than the control group families were not supported.