Family Therapy Assessment and Treatment Planning: Two Case Studies

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Abstract

Family therapy has become a common and important part of residential treatment. The Beavers System Model (Beavers & Hampson, 1990) was developed to provide a means to understand the systemic functioning of families. Two dimensions are used in the Model: (a) Family competence, ranging from severely dysfunctional to competent and (b) Family style, ranging from open (centripetal) to closed (centrifugal). The combination of these two dimensions creates nine different categories of family functioning. To illustrate its use in residential treatment, the families of two adolescent students were analyzed using the Beavers Systems Model. Information for these analyses were obtained from case reviews and qualitative interviews. Implications for using the Beavers System Model to assist in residential treatment are discussed.

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The practice of involving the family during the course of adolescent treatment has become increasingly common. Some residential treatment centers and therapeutic boarding schools currently include a family therapy component. This can consist of over-the-phone sessions, visitation programs where families meet with their children and engage in therapy, or a combination of both.

There is considerable evidence that family therapy is an extremely effective treatment modality for children and adolescents. Liddle and Dakof (1995) reviewed the body of research examining the efficacy
of family therapy for adolescent drug abusers. They stated that of all the studies reviewed “not one study found that family therapy was inefficacious.” (p. 515). They also noted that several studies compared family based treatments of drug offenders with non-family based treatments, with family based treatments consistently resulting in better outcomes. Family therapy has also been shown to be effective in treating conduct disorders. In a meta-analysis examining the effects of family therapy in the treatment of conduct disorders, a significant effect size was found \( d = .53, n = 18 \) (Shadish, et al. 1993). A number of other published reports confirm these findings, once again with no studies suggesting that family therapy is inefficacious in treating adolescents with conduct disorders (Chamberlain and Rosicky, 1995). In an additional review of the literature about family therapy treatment for adolescents, Cottrell and Boston (2002) stated there is strong evidence of the effectiveness of systemic family therapy for treating children and adolescents with conduct disorders, substance abuse, and eating disorders, with some evidence that family therapy can also help children and adolescents with depression and chronic illness.

However, little research has been completed evaluating the effectiveness of family therapy in residential settings. In one study, Springer and Stahmann (1998) surveyed 47 parents of adolescents in residential treatment about the quality of family communication and their satisfaction with the residential program, and correlated their responses with frequency of parent-child, parent-therapist, and parent-child-therapist (or family therapy) phone communications. They found a positive correlation between the number of telephone family therapy sessions over a five week period and ratings of functional family communication, while no correlation was found between number of phone calls with just the child or the therapist and functional family communication. An additional positive correlation existed between the number of family therapy sessions and parent satisfaction with the residential program, while no such correlation was found between the number of phone calls with just the child or the therapist and parent satisfaction. One weakness of this study was there was no post-treatment evaluation of family therapy effectiveness.

At the New Haven Residential Treatment Center (NHRTC) in Spanish Fork, Utah in 2004, interviews with students were conducted
to identify the elements contributing to the most beneficial aspects of treatment. These interviews were tape recorded and transcribed, with the transcriptions subsequently reviewed. Students provided a wide variety of responses, with many mentioning beneficial events occurring during the course of family therapy.

As the students’ responses about family therapy were analyzed, an overarching model was sought to understand family dynamics and families’ progress in NHRTC treatment. Understanding the processes of therapy within a schema is an important part of treatment planning. This can be especially true when engaging in family therapy because of the complexity of the family system and the propensity of the system to distract the therapist from important therapeutic goals. Developed by W. Robert Beavers and Robert B. Hampson (1990), the Beavers Systems Model seems to address these issues in an accurate and productive manner.

The purpose of this paper is to provide an example of how The Beavers Systems Model can be used to conceptualize the experiences of adolescents and their families in treatment. Analysis from two actual NHRTC cases is used to outline the Model’s use. While identifying information has been changed to protect client confidentiality, the presentation of pertinent information from students’ files and transcriptions of client interviews will also be used.

**The Beavers Systems Model**

The Beavers Systems Model was derived from clinical practice and associated research and observation. Beavers and Hampson wrote “when consistent patterns emerge from repeated phenomena under observation, as in clinical observation of families, they form the basis for theoretical hypotheses.” (1990, p. 3). Using observation to generate their hypotheses and research comparing clinical versus non-labeled or normal families, they delineated the characteristics of competent, well-functioning families. They concluded that family competence does not fall into discrete categories, but instead ranges on a continuum of functional behaviors. And while families with similar competence levels may have different styles of relating with one another, competent families are able to shift their style as developmental changes occur whereas dysfunctional families tend to be rigid in their styles. They
also confirmed the systemic notion that problems within the family system supersede individual psychopathology (Beavers & Hampson, 2003).

**Dimensions**

The Beaver’s System Model plots these concepts on two dimensions: (1) family competence and (2) family style. Family competence is defined as:

“How well a family as an interactional unit performs the necessary and nurturing tasks of organizing and managing itself. The major theme of this dimension is the structure of the family unit: the ability of the adults to negotiate and share leadership, and of the family to establish strong, clear generational boundaries is indicative of competence. Conversely, weak adult coalitions, which may induce a parent-child coalition and ineffective leadership are indicators of lower levels of system competence.” (Beavers & Hampson, 2003, p. 551.)

Competent families are able to resolve conflict and communicate in a functional manner. They show spontaneity, a wide range of feelings, optimism, and facilitate the self-esteem of family members (Beavers & Hampson, 2003).

Family style refers to the degree of centripetal (CP) or centrifugal (CF) qualities in the family. CP families are systems that are more closed. They rely on family members rather than on the outside world for support and satisfaction. CF families are open systems relying on the outside world for support and satisfaction. Relationships with friends are seen as more important than those with family members, and children leave the home earlier than their peers in families with a high degree of CF qualities (Beavers & Hampson, 1990, 2003).

As noted, the Family Competence and Family Style dimensions are plotted onto a model as shown in Figure 1. The horizontal axis represents Family Competence and the vertical axis represents Family Style. The arrow-shaped white space in the figure illustrates how more competent families possess a greater flexibility in style depending on
current demands (therefore not drifting toward stylistic extremes). The shaded notch on the severely dysfunction end shows how the least competent families lack flexibility, and instead implement extreme and inflexible CP or CF styles that do not change in response to different demands or circumstances. When families are rated in terms of style and competence, they can be plotted on the figure, providing an instant visual representation of their current level of functioning (Beavers & Hampson, 200).

**Family Types**

In the Beavers Model family competence is divided into five categories: Optimal, Adequate, Midrange, Borderline, and Severely Dysfunctional. As illustrated by the model in Figure 1, families in the Midrange, Borderline, and Severely Dysfunctional categories are more apt to have strong stylistic components (in either the CP or CF directions), while Optimal and Adequate families tend to apply both CP and CF styles in a flexible manner without progressing toward extremes. This creates nine family types, as described in Table 1 (Beavers, 1981; Beavers & Hampson, 1990, 2003).

**Methods**

**Subjects**

Case study data for this article comes from semi-structured qualitative interviews conducted as part of a larger research effort. Case studies are in-depth views of an important event or time period in the life of a single individual, and are commonly used to illustrate specific phenomena for the benefit of the audience (Bromley, 1986). “The value of the case-study approach is that it deals directly with the individual case in its actual context.” (Bromley, 1986, p. xi). Case studies and qualitative interviewing compliment each other, as qualitative interviewing is a non-directive, unstructured, nonstandarized and open-ended technique used to elicit information from individuals. (Taylor and Bogdan, 1998). For this study, 34 NHRTC students volunteered to participate in qualitative interviews about their therapy experiences.

The analysis of qualitative interviews begins with an initial reading of the transcripts to gain a holistic view of their content, and then during further readings statements made in the interviews are coded for thematic content (Giorgi and Giorgi, 2003). In this case, during
Figure 1. The Beavers Model of Family Functioning. (Figure provided by Robert B. Hampson, reprinted with permission.)

HEALTH/COMPETENCE DIMENSION

<table>
<thead>
<tr>
<th>Severe Dysfunctional</th>
<th>Borderline</th>
<th>Midrange</th>
<th>Adequate</th>
<th>Healthy</th>
<th>Optimal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centrifugal 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>often sociopathic offspring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>often borderline offspring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>often behavior disorders</td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Healthy 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centripetal 1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>often schizophrenic offspring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>often severe obsessive offspring</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centripetal 2</td>
<td>Centripetal 3</td>
<td>Mixed 4</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centripetal 4</td>
<td>Centripetal 5</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

STYLISTIC DIMENSION

| Poor boundaries, confused communication, lack of shared attentional focus, stereotyped family process, despair, cynicism, denial of ambivalence |
| Relatively clear communication, constant effort at control, "loving means controlling," distancing, anger, anxiety, or depression, ambivalence handled by repression |
| Relatively clear boundaries, negotiating but with pain, ambivalence reluctantly recognized; some periods of warmth and sharing interspersed with control struggles |
| Capable negotiation, individual choice and ambivalence respected, warmth, intimacy, humor |

9 8 7 6 5 4 3 2 1
Shifting from chaotic to tyrannical control efforts, boundaries fluctuate from poor to rigid, distancing, depression, outbursts of rage
<table>
<thead>
<tr>
<th>Family Type</th>
<th>Characteristics</th>
</tr>
</thead>
<tbody>
<tr>
<td>Optimal</td>
<td>Flexible, intimate, parents share power, boundaries respected, effective communication/negotiation, respect for individuality.</td>
</tr>
<tr>
<td>Adequate</td>
<td>Clear boundaries, intimacy, individual responsibility, more control. Parental coalition less effective but cooperative. Warm.</td>
</tr>
<tr>
<td>Midrange</td>
<td>Control, power differences, power struggles, unilateral decisions. Repressed or projected feelings, boundaries generally respected.</td>
</tr>
<tr>
<td>Midrange CP</td>
<td>Rules, propriety, image, and authority. Feelings repressed. Dependent, emotional women and strong, silent men.</td>
</tr>
<tr>
<td>Midrange CF</td>
<td>Control attempted using authority, manipulation, and intimidation, but doesn’t work. Open hostility, and blame. Early independence.</td>
</tr>
<tr>
<td>Midrange mixed</td>
<td>Parents alternate between fighting and stereotyped roles, children between respect and disobedience.</td>
</tr>
<tr>
<td>Borderline</td>
<td>Control prevails. Power struggles, little emotional support. Poorly defined boundaries, compromised separation and individualization.</td>
</tr>
<tr>
<td>Borderline CP</td>
<td>Covert attempts to control others’ thoughts and feelings. Unequal parental coalition, parent-child coalitions often occur.</td>
</tr>
<tr>
<td>Borderline CF</td>
<td>Stormy battles with direct assaults. Loose parental coalition. Little or no nurturance or support. Anger and rebelliousness.</td>
</tr>
<tr>
<td>Severely Dysfunctional</td>
<td>Extreme boundary problems, poor communication, chronic emotional distress. Cyclical dysfunctional patterns.</td>
</tr>
<tr>
<td>Sev. Dysfunctional CP</td>
<td>Closed, rigid system. Children don’t leave home. No individual identity. Unclear boundaries, relatedness is impossible.</td>
</tr>
<tr>
<td>Sev. Dysfunctional CF</td>
<td>Diffuse boundaries with outside world. Parents move in and out, children run away. Constant hostility and open conflicts.</td>
</tr>
</tbody>
</table>
the initial review of transcripts, it was noted that many of the students commented about the impact of their family therapy experiences. Some students’ remarks provided considerable detail, aptly illustrating characteristics of their families which can be conceptualized using the Beavers Model. While comments made during qualitative interviews are not usually used to contribute to case studies, those who conduct case studies often interview their participants as a way to provide further depth to the illustration of phenomena, so using the students’ narratives was appropriate. Therefore, five individuals whose comments were especially illustrative were selected for analysis. These students’ charts were reviewed for historical detail about how the family responded in family therapy. Based on that chart review, the two students for whom the family therapy process was clearly and completely described were selected to present as case-study illustrations.

Instrument

Undergraduate university students who volunteered as research assistants conducted semi-structured interviews with each subject. The research assistants received six hours of training covering interviewing methods, rapport building, listening techniques, and using follow-up questions for clarification and elaboration. The interviews were conducted each time a participant advanced in the program’s five-level system. Each semi-structured interview began by asking students to identify the issues or problems they addressed since achieving their last level (or entering the program). Next the interviewer encouraged the student to elaborate about their progress with each problem, asking about specific efforts they made to address the issue, how the student changed, and which program elements were the most helpful. The interviews were tape recorded and transcribed, and portions of the transcripts are presented in the following case studies.

Case Studies

Case Study 1

Heather (not her real name) was 16 years old at the time of her admission. Heather had been in two other programs before her admission, running away from one and engaging in sexual activity with another student in the other.
Before entering treatment, Heather acted out in many different ways. She abused drugs, claimed that she had been in many physical fights using weapons such as chains, brass knuckles, and a knife, and said that she vandalized, helped steal a car, and broke into other peoples’ homes. She reported many symptoms such as depression, anorexia, anxiety, suicide attempts, mood swings, cutting, apathy, obsession with past boyfriends, and sleep disturbance. She also reported experiencing sexual trauma twice and having flashbacks, hyperarousal, recurring dreams, and other post-traumatic symptoms relating to that trauma. Interestingly she made the claims of aggressive and conduct disordered behaviors to a psychologist while completing an evaluation about a month after her admission, but not to her therapist nor to the facility’s psychiatrist, casting doubt on their veracity. Not surprisingly, her parents complained of Heather’s frequently lying and other dishonest acts.

Heather’s father stated his relationship with his daughter was warm and loving until she turned 11 or 12. On two occasions when she was 12 he reacted poorly to her temper tantrums, and thereafter chose to let his wife do all of the disciplining. After that time, he was not close to Heather, and Heather said that she had hateful feelings toward him and she did not care they weren’t close. She reportedly used his reactions to her temper tantrums to punish him when he tried to become involved with her. Heather’s mother described her relationship with Heather as strong, loving, and close, with excellent communication. She said the only conflict in their relationship occurred when she had to leave town on business. Heather told the evaluating psychologist she slept with her parents until she was 11 years old, and occasionally her mother still asked her to sleep with her.

Heather’s mother struggled with setting and maintaining appropriate boundaries. Heather was manipulative and her mother was frightened of losing the closeness she valued so much. On one occasion when her parents grounded her for drug use, Heather overdosed on a prescription medication from the medicine cabinet in retaliation. Whenever her mother or father insisted on appropriate behavior, Heather reacted with intense resentment and rage, and her parents quickly backed down.
On the family competence dimension of the Beavers Systems Models, this family scored in the Borderline range. In terms of specific competencies, power was held by the child in the family, and a strong parent-child coalition between Heather and her mother existed. Boundaries between family members were vague, illustrated by difficulty in setting and maintaining limits. The family’s conception of itself was incongruent with reality. For example, Heather’s mom described her relationship with Heather as close and connected, with good communication. However Heather constantly engaged in lying, manipulation, disobedience and disrespect, hallmarks of poor communication, and a lack of mutual trust. They also did not negotiate effectively, and did not take appropriate responsibility for their actions. They had considerable difficulty expressing painful emotions openly and effectively. Heather used intense emotions to manipulate her parents and her parents panicked when presented with genuine sadness or hurt.

Stylistically the family fit into the centripetal category. Conflict was covert and hidden, and Heather’s mother consistently emphasized the closeness of her relationship with Heather. Dependency needs were encouraged, and negative feelings were actively discouraged and avoided. This family fell in the Borderline Centripetal category (shown in Figure 2).

The family’s patterns clearly manifested themselves during the first few minutes of the first family therapy session and were the focus of therapy for the next few months. The therapist noted the presence of many power struggles and “depth charges” (i.e., incendiary comments designed to elicit a reaction). Heather’s mother quickly began to protect Heather’s feelings and to blur parental-child boundaries while her father immediately pulled away from his wife and daughter. As the family exhibited these patterns during the next couple of months, they were identified and explored. Toward the end of this period, the focus of therapy came to rest on the relationship between Heather and her father. This shift in focus was most visible during a session when the family was discussing Heather’s obsession over a particular boyfriend. As Heather’s mother began engaging in her typical pattern of “fixing” Heather’s problem, Heather’s father interrupted with a provocative comment about Heather’s behavior. The resulting focus
Figure 2. Heather’s family’s position on the Beavers Model indicated by the letter A. (Figure provided by Robert B. Hampson, adapted and reprinted with permission.)
shifted to the pattern of interaction between Heather and her father, and this pattern recurred over and over again during the next few months. Heather’s father was confused by strong emotions and became the primary force that shut down emotional expression in the family. As a result, Heather worried that her intense emotional experiences meant that she was “crazy.” This issue became an important part of the work between Heather and her father. Her father focused on listening more effectively, balancing his reactions to his daughter, and responding to her emotions without trying to quell them. As time progressed the family managed emotional interactions more adeptly and at the end of therapy the family’s ability to effectively process emotions had improved. Heather developed better emotional regulation skills and her family learned to support her effectively as she experienced intense emotions. In Heather’s interview, she made several comments about changes in her father, such as “he always got left out of stuff, so we let him be included and say what he needed to,” and she gave an example of a time when she confided in him and he responded well. Heather also said regarding her mother “I feel like me and my mom’s relationship isn’t negative anymore.”

Heather illustrated the family’s increase in emotional competency by saying:

“I used to not cry for like a year, and then I would explode one day and I would just bawl, so I started crying a lot, just crying a lot, when I had those kind of explosions, I started having them more frequently, and then it wasn’t as big, it was less and less and less and it was more normal and okay for me to cry. And at first I kind of had to force myself to cry because I couldn’t do it, and then after I did it, it felt good so I would do it over and over. And it helped a lot.”

In terms of boundaries and family structure, the family moved from very unstructured and excessively flexible to modestly structured with substantial flexibility. As Heather’s relationship with her father strengthened, he naturally became somewhat more participative in the process of negotiating and maintaining boundaries, thereby contributing to her mother’s authority and creating a little more stability. Yet the parents still struggled with unity in their position, with
a desire to include Heather as an equal partner and with consistency in setting and maintaining appropriate boundaries. One comment from her interview illustrates this:

“We made rules about . . . [drugs], what I can and can’t do, and it’s basically no drugs or alcohol, which I’m perfectly fine with. And my parents have the same rule now, for at least the first 30 days that I am home, they can’t drink or do anything like that, and then we’re going to reevaluate it every 30 days for them, but not for me. And we made positive consequences, too, so that I would be okay with the rules and not want to break them. I get a car if I test negative for drugs for a while.”

She added, “It’s hard for me I guess, so we had to kind of negotiate.”

Heather’s account indicates a small degree of improvement in the family, although difficulty with boundaries persisted as illustrated by the equality to which Heather alluded (“And my parents have the same rules now”), and by the oversized reward of getting a car for compliance to what should be basic standards in the family. Before these issues could be addressed (and as an apt illustration of the structural work the family needed to do), Heather’s parents removed her from treatment long before she was considered ready to discharge so that she could begin school with her peers at the beginning of the school year.

Case Study 2

Sarah (not her real name), a 5 year old girl, was admitted because of anxiety, depression, substance abuse, and conflict with parents. She was perhaps predisposed to these problems, having experienced considerable trauma in her early childhood. Her biological parents were alcoholics and her biological father was physically violent to her mother, beating her often to the point of serious injury. Sarah was a frequent witness to this violence and as a young child demonstrated significant responses to the trauma of her environment including self-mutilation. During this time, she was allowed to wander the streets without adult supervision, and generally went to school only once a week. Parental rights were terminated when she was nine years old and
she moved with her sister and two brothers into a home for parentless children. Neither of her parents contacted their children again, and her mother died a couple years later. Her brothers were adopted together shortly after entering the home, and Sarah and her sister were also adopted together by a different family a year later.

Sarah began exhibiting signs of depression about four years after the adoption. Her depression worsened to the point that she frequently withdrew and isolated from others, failed academic classes, experienced difficulty concentrating, developed sleep disturbances, began cutting on herself, and made one suicide attempt. She also began to act out behaviorally, lying to her parents, sneaking out of the house, and abusing substances. Her substance abuse reflected her distress; she related that she used because it made her feel like everything was okay.

In terms of relationships in her adoptive family, Sarah related that by the time they admitted her to residential treatment her trust with her parents was severely impaired. She complained of difficulty communicating with them, saying her mother frequently interrupted her and her father was always working. Her mother also observed that Sarah seemed to idealize her biological mother, and would often compare her adoptive mother to this idealized image with negative results. But other family relationships seemed good. Both Sarah and her mother reported that the marital relationship was strong and healthy, with appropriate closeness and open communication between parents. Yet Sarah was uncomfortable with this open marital communication because she was frightened by the normal conflict that arose. She displayed some post-traumatic stress symptoms when conflict arose, becoming distressed and having difficulty remembering an upsetting event or her resulting feelings in any degree of detail. She had a strong fear of rejection and reported she didn’t feel like she fit into her adoptive family.

The application of the Beavers Family Systems Model to this family was somewhat complex as the family was a blend of two distinct families, a biological and an adoptive one. These two families were very different in both competence and style, but both contributed to Sarah’s interactional patterns and sense of self-identity. Therefore,
many of the problems of adapting to her new family were illuminated by looking at both families in terms of competence and family style.

Sarah’s biological family rated very low on competence. Chaos reigned, both parents were severe alcoholics, physical violence was prevalent, and Sarah was poorly supervised at a young age. Sarah described herself as “parentified,” suggesting a fairly strong parent-child coalition existed between Sarah and her mother. In any case, the coalition between Sarah’s parents was very weak. Negotiation and constructive problem-solving was nonexistent, and communication was grossly ineffective. Sarah’s parents could not tolerate each other’s individuality, and their expression of feelings was limited to violent anger and corresponding fear. The household was depressed and conflicts were unresolvable. On the Competence Dimension of the Beavers Systems Model, Sarah’s biological family scored in the Severely Dysfunctional range.

In terms of stylistic components, the family possessed a strong centrifugal (CF) style. Family members sought satisfaction from the outside world, and in Sarah’s case this happened at an extremely early age. Intimacy was discouraged, conflicts were very open, family members were aggressive, and warmth was rarely communicated. This family can be categorized as Severely Dysfunctional Centrifugal.

Conversely, Sarah’s adoptive family demonstrated a high level of competence. Leadership in this family was shared by her parents, who enjoyed a strong parental coalition. The parents experienced a considerable amount of closeness in the family, but Sarah found this closeness difficult to internalize. Negotiation and conflict resolution between Sarah and her parents was difficult, although her parents were effective in negotiating between themselves and with their other children. In terms of emotional expression, the family’s skills were moderate but Sarah’s skills were poor. She had trouble understanding what she was feeling, and often projected her fears and worries onto her parents. They were not aware of what she was doing and were limited in their ability to effectively respond to it. In addition, some emotions were mildly discouraged, including anger and sadness. Nevertheless the tone of the family was warm, affectionate, and optimistic. Even during the first family therapy sessions while Sarah was in residential
treatment, family members seemed to enjoy themselves as they interacted with each other. Sarah’s adoptive family’s overall rating on the competence dimension of the Beavers Systems Model fell in the adequate range. On the style dimension, the family tended toward the centripetal (CP) range, (although the theory behind this model generates the hypothesis that they were able to move flexibly between centripetal and centrifugal styles). They enjoyed being close to one another, and emphasized closeness within the family. This family fell in the Adequate category. (A visual representation of the position of Sarah’s families on the Beavers Model is found in Figure 3.)

The effects of blending these families are illustrated by some of Sarah’s comments during the interview. She said “I didn’t feel safe talking to them or sharing anything about me.” She believed “my parents don’t love me, they don’t care about me,” and said “I’ve always wanted to have a relationship with my parents, but I was always scared of rejection or they won’t love me or anything like that.” She had difficulty trusting her parents’ implicit offers of love and warmth, but instead was fearful that they would abandon and betray her like her biological parents. In other words, she responded to her current family based on her experiences with her former family, thereby injecting the family system with the maladaptive, under-functioning style she was used to experiencing. Based on this assessment, family therapy interventions focused on enhancing emotional safety in the family and supplying Sarah with skills to respond appropriately to that safe environment. This happened in several different ways as treatment progressed. At the beginning, many family therapy sessions began with Sarah feeling upset, worried, fearful, or sad. While the therapist coached, the family practiced listening skills and the expression of empathy. Sarah related “it’s so weird, because before my parents were the last ones I ever wanted to talk to before, you know? But now, they’re actually more comfortable than talking to staff. I guess that’s a good thing because I’m not going to be living with staff all the time, you know?”

The middle months of therapy continued with emphasis on communication and empathy, but also moved into negotiation and conflict resolution. During that time, it was apparent that Sarah expected her parents to respond like her biological parents. She experienced
Figure 3. Sarah’s biological family’s position on the Beavers Model indicated by the letter B and her adoptive family’s position indicated by the letter C. (Figure provided by Robert B. Hampson, adapted and reprinted with permission.)
considerable anxiety when conflicts arose, and was afraid to trust her parents to be balanced and appropriate in their reactions to her. Those fears were a major contributor to the arguments and power struggles they experienced before she entered treatment. In the interview, she said

“the therapist made it safe for me to arrange things, [Talking] to each other, [trying] not to get into a conflict or power struggles and just [finding more] ways where we don’t have to argue or anything like that. We have a compromise. . . he could tell . . . where our conversation was going. If it was going toward a power struggle instead of trying to compromise or deal with things and figure them out, so he tells us where to go towards, you know. That sets a good example for us, I guess.”

Ultimately, when asked “what helped you to really improve your relationship with your family?” She answered:

“I guess for me to realize that they do care about me, that’s the big thing. Because before I came I was like, ‘Oh my parents don’t love me, they don’t care about me.’ . . . Just realizing that my parents do care about me and love me. They also want me to get into a closer relationship with them. I don’t know, kind of myself giving, opening up myself to others. Before I used to do things all on my own, I didn’t want anyone’s support, but when I open up more it brings me closer to other people.”

Conclusion

The Beavers Systems Models skillfully encompasses the systematic elements comprising family competence. Using this model to characterize families in treatment creates a framework where effective interventions can be designed and then implemented and where progress in treatment can be tracked. In order for this to work, ongoing assessment is necessary.

Ongoing assessment involves regularly evaluating the family’s functioning on both the competency and style dimensions. Beavers
and Hampson suggest using the Beavers Interactional Scales to do so (Beavers and Hampson, 1990; 2003). The Beavers Interactional Scales have therapists videotape the family while they discuss what they would like to change in their family. Then, while watching the video, they rate the family’s interactions on 11 competence and 8 style continuums. Ratings are tabulated and plotted on the model. (Videotaping families during residential treatment can be impractical, but having them complete the discussion over the phone can be an acceptable alternative.) Completing the Beavers Interactional Scales is instructive as the components of competence and style are well defined within the scale, and so the areas in which to intervene are clearly identified.

For example, as mentioned, Sarah’s adoptive family fell in the Adequate range at the beginning of treatment. Using the competence areas from the Beavers Interactional Scales, their strengths included a strong parental coalition, leadership shared between parents, a higher degree of openness and receptiveness to each other, and a positive, warm tone within the family. Their weaknesses were moderate difficulty with negotiation, Sarah’s tendency to keep secrets from her parents resulting in a lack of clarity in communication, a mild lack of accountability within different family members, restrictions in the amount and type of affect the family would tolerate, and mild difficulty feeling and expressing empathy for each other. Family therapy focused on communication skills and appropriate responding to others’ emotions. By conducting periodic evaluations during the course of therapy, the therapist could note whether the family was improving in these target areas and whether they were weakening in any of the other competency areas.

Using ongoing assessment to direct treatment planning is beneficial as therapists treat the complex and challenging family issues commonly encountered in adolescent residential treatment. Doing so can help to maintain the focus of therapy on critical areas in the face of distractions, can assist the therapist in recognizing when efforts meet with systemic resistance to change, and can decrease potential frustration and confusion as families’ complexities are delimited and categorized.
References


