FAMILY THERAPY AND CREATIVE VISUALISATION:
AN ADJUNCTIVE TREATMENT FOR ALLERGIES IN CHILDREN

by

SALLYJANE E. BODNAR

B.A. (Zoology) University of California, Berkeley, 1964

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Department of **Counselling-Psychology**

The University of British Columbia
Vancouver, Canada

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ABSTRACT

The purpose of the study was to explore the use of Creative Visualization in the context of Family Therapy for treatment of a family of a child with allergies. Based on a single-case research design, the study included pre- and posttest measures; baseline, continuous, and follow-up self-report of symptoms; plus examination of physician's clinical records to determine the efficacy of the intervention. A further purpose of the study was to explore the possible usefulness of a test being developed on the basis of the Psychosomatic Family Model, the Leuven Family Assessment, as an outcome measure.

The subject family was an intact family with one adolescent daughter whose most important allergic symptom was poorly controlled asthma, at least partially due to non-compliance with medical advice.

The measures included the Leuven Family Assessment, a measure based on the Psychosomatic Family Model, which has been developed for use with families of children with eating disorders; the Family Adaptability and Cohesion Scale (FACES III), a measure based on the Circumplex Family Model, which is a well-accepted measure of family functioning; symptom self-report; and consultation with the child's physician to report hospital admissions and emergency room visits.

The baseline period was two weeks, the intervention consisted of two weeks of Relaxation Training and eight weekly meetings for combined Family Therapy and Creative Visualization, and the follow-up consisted of telephone contact with the symptomatic adolescent beginning fourteen weeks after the last family therapy session and continuing for eight weeks.
Abstract

Post-therapy results show a trend toward expected changes in family structure and functioning and marked improvement in the asthmatic symptoms of the adolescent.

Creative Visualization is an intervention tool well worth further exploration in the context of family therapy; and the Leuven Family Assessment merits further investigation and development as an outcome measure.
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CHAPTER 1

INTRODUCTION

From the medical point of view, allergies are a dysfunction of the immune system. "Stress" is thought to exacerbate symptoms, but the allergic process is considered to be primarily a physical one treatable by avoidance of allergens, drug therapy, and/or desensitization therapy (Travis, 1976). However, the biomechanical model of the human body as separate from the mind which inhabits it is losing favor as medicine and psychology find more and more common ground. Research in the last two decades has increased our understanding of the neurobiological mechanisms which result in physical and/or mental symptoms, especially in the relatively new field of psychoneuroimmunology, which extends the traditional study of psychosomatics to the chemical and biological level (Spector, 1986). Research has shown correlations of certain personality types with types of disorder (Healey, 1983; Solomon, 1981; von Rad, 1984; Weiner, 1984); field studies of psychogenic disorders have shown correlations of life events and conditions of illness which are highly significant (Schepank, 1987); effects of stress on the immune system have been well documented (Cunningham, 1981; Kiecolt-Glaser, 1986; Miller, 1985; Palmblad, 1981; Shavit, 1986; Stein, Schleifer & Keller, 1986); conditioned immunological responses have been found in animal studies (Ader, 1981; 1985).

The concept of psychosomatics as a branch of medical science is gaining in acceptance as the search for a more holistic and systemic approach to health and disease broadens. Considerable work has been done on the possible physical and chemical mechanisms for translating social, familial and individual personality factors into biological processes (Ader, 1981; Rossi, 1986). The interactions between the mind and the body have been studied by psychologists, psychiatrists, and medical scientists. Medical research requires controls in
order to rule out the "placebo effect," the effect of the "imagination" or of the suggestion that the treatment in question will heal the malaise. Achterberg (1985) suggests that it might be more useful to study this so-called "placebo effect," rather than design research in order to avoid it. As medical practitioners widen their approach to consider the effects of lifestyle, family dynamics, and other environmental factors on disease, a search for methods of intervention which will take more of these factors into account has begun (Glen, 1984).

The popular press is full of advice about stress management (Masters & Houston, 1978; Witkin-Lanoil, 1986); various mind/body self-help techniques (Borysenko, 1987; Dychtwald, 1977); meditation or visualisation techniques to improve physical health and well-being (Gagan, 1984; Houston, 1982; Hay, 1984; Sheikh, 1989); and counsellors of many kinds advertise emotional health as a road to physical health (Common Ground is a publication in British Columbia in which this type of advertising is common). The work of Selye (1984) on stress and Simonton, Simonton and Creighton (1978) on the use of relaxation and visualisation in the healing of cancer are very well publicized in North America. Therapists of many theoretical persuasions use techniques of trance induction to shorten the duration of therapy, consolidate learning, and access mind/body processes (cf. Zeig, 1985).

At the same time, among some practitioners of systemic family therapy, there has grown a realization that one of the strategies for maintaining homeostasis in a family may be the creation or perpetuation of a physical symptom; or that a family may organize itself around a physical symptom in a way which perpetuates or worsens it (Christ, 1982; Gehring, 1985; Minuchin, Baker, Rosman, Liebman, Milman & Todd, 1975 & 1977). This possibility is especially relevant when there is a chronic illness in the family, and where compliance with medical instructions may be an issue (Blumberg, Lewis & Susman, 1984; Rissman & Rissman, 1987; Ritterman, 1982, 1983 & 1986). Approaches to the alleviation of physical
symptoms through the treatment of the family system vary greatly. This research project explores the use of so-called "trance phenomena" in the context of family therapy in order to produce a change in the organization of a family around a chronic symptom, in this case, asthma and other symptoms of allergic response. The resulting changes in the family promote improvements in the physical symptoms.

THE PROBLEM

Can creative visualisation and trance be useful in a family therapy context when there are issues of chronic illness and medical compliance between the child and parents?

NATURE OF THE STUDY

Single case studies have been used extensively in the literature of hypnotherapy and family therapy, as well as in other types of clinical reporting. They have been used as a means to report successes to colleagues, to disseminate and develop new theoretical techniques, and to draw causal inferences (Nugent, 1985). The limitations of this kind of reporting, especially in drawing causal conclusions, are great: No individual lives in an environment in which the only influence acting on him/her is the therapeutic process; and the criteria for success may easily be no more than the personal opinion of the therapist reporting the case. Therefore, the single case, anecdotal report, while it has its uses, can not be considered a research design from which generalizations can be made. With the development of single case experimental design, criteria for evaluation of external and internal validity have increased the usefulness of single-case research as opposed to single-case anecdotal reporting. This study attempts to avoid some of the limitations of single case studies through the use of pre- and post-treatment measures, self-report symptom
monitoring throughout the treatment process and as a baseline and follow-up, and a review of medical records, especially emergency room visits for treatment of asthma. However, as an exploratory study, it will not be appropriate to make causal generalizations nor to use the results in an explanatory way (Yin, 1986).

PURPOSE OF THE STUDY

This study is an exploration of the use of creative visualisation in the context of family therapy in order to improve the physical symptoms of allergies in a single case design using one family. Single case experimental design will limit the scope of the findings and will not permit causal generalizations to be drawn from the results, especially given the present state of the art of family therapy research and methodology. However, this exploration of the use of creative visualisation in the family therapy context when the physical health of a member is at risk will indicate that the use of this technique clearly bears investigation on a larger scale.

A secondary purpose is to explore the usefulness of the Leuven Family Assessment process (Kog, Vandereycken & Vertommen, 1985 & 1987) as an outcome measure. This is the only instrument which has been developed with the psychosomatic family model as a theoretical foundation. It has been used primarily as an assessment instrument in research and treatment for eating disorders. While this single-case study can not begin to test the appropriateness of this test for families of children with allergies, it does appear to indicate that further studies may be useful.
HYPOTHESES

Hypothesis 1

\( H_1 \) There will be a measurable difference in the intensity of intrafamilial boundaries as measured by the Leuven Family Assessment (Kog, Vandereycken & Vertommen, 1985, 1987, 1989a&b).

\( H_{01} \) There will be no measurable difference in the intensity of intrafamilial boundaries as measured by the Leuven Family Assessment.

Hypothesis 2

\( H_2 \) There will be a measurable difference in the degree of the family's adaptability as measured by the Leuven Family Assessment.

\( H_{02} \) There will be no measurable difference in the degree of the family's adaptability as measured by the Leuven Family Assessment.

Hypothesis 3

\( H_3 \) There will be a measurable difference in the degree of intrafamilial tension (avoidance/recognition of intrafamilial conflict) as measured by the Leuven Family Assessment.

\( H_{03} \) There will be no measurable difference in the degree of intrafamilial tension (avoidance/recognition of intrafamilial conflict) as measured by the Leuven Family Assessment.
Chapter 1: Introduction

Hypothesis 4

$H_4$ There will be a measurable difference in the family's way of handling conflict as measured by the Leuven Family Assessment Scale

$H_{04}$ There will be no measurable difference in the family's way of handling conflict as measured by the Leuven Family Assessment Scale

Hypothesis 5

$H_5$ There will be a measurable difference in the family's Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale (FACES III; Olsen, Portner, and Lavee, 1985.)

$H_{05}$ There will be no measurable difference in the family's Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale.

Hypothesis 6

$H_6$ There will be a measurable difference in individual Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale.

$H_{06}$ There will be no measurable difference in individual Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale.

Hypothesis 7

$H_7$ There will be an improvement in the child's asthmatic symptoms as measured by self-report and consultation with the child's physician.

$H_{07}$ There will be no improvement in the child's asthmatic symptoms as measured by self-report and consultation with the child's physician.
Chapter 1: Introduction

RATIONALE FOR HYPOTHESES

The psychosomatic family model proposed by Minuchin and his colleagues (1975) has been used extensively in clinical work and is frequently one of the grounding assumptions in theoretical papers about working with families (Dym, 1987; Ganley, 1986; Sargent & Liebman, 1985; White, 1979). In effect, this structural-systemic view of family dynamics treats the physical symptom or mismanagement of chronic illness as though it were a behavioral symptom similar to the acting-out, depression, etc., of children in response to the way the family has organized itself. The research in support of this view has been largely anecdotal, due in part to the lack of instrumentation based on this model. In fact, the methodology of clinical studies cited in support of this model have been highly criticized (Campbell, 1986; Kog, Vandereycken & Vertommen, 1989). At the same time, the hypnotherapeutic literature, also highly anecdotal, reports considerable success in using various trance phenomena with families in ameliorating physical symptoms and in consolidating and intensifying learnings in therapy (Aaroz, 1985; Aaroz & Negley-Parker, 1988; Zeig, 1985). This study is an attempt to combine family therapy and trance phenomena (primarily guided imagery or "creative visualisation") with an instrument designed to measure the theoretical constructs of the psychosomatic family model. The hypotheses are designed to determine whether there are changes in the family which coincide with changes in the physical symptoms. A well-accepted test of family functioning (FACES III) which is based on another family model with some similarities was used to help verify the findings.
LIMITATIONS OF THE STUDY

The most salient limitation of this study is that a single case can be used to make only very limited generalizations. In this case, since the family underwent a profound crisis at the same time it was being studied, it is also impossible to determine the "cause" of the changes or to reverse them, in an A-B-A-B research design, even if ethical considerations allowed a reversal in therapeutic effect. However, it can be argued that any therapeutic situation is not isolated in an individual or family's life, and it is important to continue exploratory research in this model and in the process of change in order to conclude whether treatment is efficacious or not.

Another important limitation of this study resides in the use of the Leuven Family Assessment instrument (Kog, et Al, 1989a,b) which is still in the process of development and thus, is still an unproven measure.
CHAPTER 2
REVIEW OF THE LITERATURE

PSYCHOSOMATICS, FAMILY THERAPY AND TRANCE PHENOMENA

The use of altered states of consciousness (hypnosis) for healing physical illness has a history which stretches back to primitive man. The state of trance and the power of suggestion have been used by medicine men, priests and shamans for centuries (Achterburg, 1985). Until the last two decades, however, these methods of healing were seen as individual, intrapsychic and even mystical and mysterious phenomena. In the last decade, faith healing, psychic healing, healing through the power of crystals or other magical objects has shown a resurgence in popularity while at the same time medical science has been advancing in understanding of the field of psychosomatics - the mind/body connection and the mechanisms whereby mental processes are transformed into bodily ones and vice versa. As more scientific understanding of the immune system and its connections to other physiological systems grows, however, the possible explanations for the effects of the mind on the body's healing functions have become more plausible, more supportable, and more useful in the sense of developing methods to intervene in the mind/body (Rossi, 1986; Rossi & Cheek, 1988).

The term psychoneuroimmunology was coined by Ader (1981) to describe the study of communication between the psychological, neurological, and immunological systems. The combination of electrical impulse and chemical messages moving through the body is clearly and significantly affected by environmental and cognitive processes which, whether they are called stressors or magic, placebos or faith, depend to a remarkable
degree upon our thoughts, feelings and beliefs and on our body's responses to them (Achterberg, 1985; Borysenko, 1984).

I will briefly outline here the three parts of the multilayered concept of psychoneuroimmunology, since it may be important in designing interventions; however, for a more detailed exposition of the information-transducing system of the mind and the body, see Rossi (1986). Rossi's model of the interaction rests on the concept of information transfer through the physiological systems of central nervous system, especially the limbic system, to the autonomic nervous system, the hormonal system, and the immunological system. In fact, all these systems function as information systems, communicating with each other and with the world outside of the body. The most commonly familiar example is that of the Stress Reaction, described in many popular books as the fight-or-flight response (Selye, 1984) mediated by the neurohormone adrenaline and affecting virtually every system in the body from the endocrine system to the digestive system. Most popular books recommend some sort of meditation and exercise program which improves the body's ability to relax and maintain a state of equilibrium which decreases the time spent in the stressed state. More recent authors such as Borysenko (1987) have begun to emphasize the emotional and cognitive components of the stress response: it is the meaning given to events and the perceived inability to cope with those events which make them harmfully stressful and which result in psychobiological symptoms. Wiedermann and Wiedermann (1988) and Henker (1984), have summarized evidence for these mechanisms on the molecular level.

PSYCHOSOMATICs AND FAMILY THERAPY

Psychologically, human beings exist in a matrix of relationships with other people. Just as information transfer within the body affects the physiological health of the organism,
so too does the kind of information from outside effect the human psyche and the emotional health of the organism. As research has begun to demonstrate, the complex relationships between our thoughts, our perceptions and our feelings alters the environment inside as well as outside the body (Black, 1969; Borysenko, 1984; Dlin, 1985; Faulstich & Williamson, 1985; Ikemi & Nakagawa, 1962). As the importance of relationships in forming and maintaining our cognitive and emotional climate becomes more clearly demonstrated (Gaddini, 1977; Rolland, 1987), the focus of intervention has turned to the family and to other systems of relationship, particularly when the health of children is the area of concern (Christ, 1982; Becker & Green, 1975; Healey, 1983; Sargent & Liebman, 1985; Travis, 1977; Wirsching & Stierlin, 1985).

The development of family systems theory and practice has led to a re-thinking of many of the techniques of interpersonal intervention and therapy. In a medical context, family systems medicine has become an important body of attitude and theory which considers the entire biopsychosocial matrix in which the human being with the symptom is embedded. The grounding assumption in this field is that physical or psychological symptoms of illness are expressions of dysfunction at some level of that matrix (bio, psycho, social, etc) and can be created and/or perpetuated, as well as ameliorated by interactions in that matrix (Dym, 1987). In no sense does this mean that illness or symptoms are imaginary, "all in the mind" or "emotionally based;" however, what is done in the mind has a profound effect on what happens in the body. And what is done in the mind is highly dependent on beliefs about illness, wellness, treatment and compliance. Add to that matrix of beliefs, much of which is unconscious, the secondary effects of the illness on one's life, one's family, and one's social relationships; and then consider the reciprocal effects of all those factors on each other. The "psychosomatic" approach to health is one in which the "psyche"
and the "soma" are considered to be interrelated in an inextricable way. It is impossible to say where to begin in a causal sense, since there is not exactly a starting point: it is system upon system interacting with each other (Bloch, 1989; Harkaway & Madsen, 1989).

In this systemically-oriented system of explanation, description and intervention, it is to be expected that so-called physical symptoms have effects on the emotional state of the individual and on the family; and that the emotional states, family life cycle issues, and outside events will have effects on the physical health of the individuals in the family. The use of this model may be as appropriate with headaches of obvious psychogenic origin as with Hemophilia and other chronic illnesses of clearly organic "cause." In fact, the systemic models may have special usefulness where there are issues of compliance with medical management procedures (Minuchin, et al, 1978; Rissman & Rissman, 1987).

The development of family systems theory and practice has led to the formulation of models of family functioning which have shown promise in the family treatment of a wide variety of illnesses, including eating disorders (Ganley, 1986; Harkaway & Madsen, 1989; Kog, et al, 1989a & b; Minuchin, et al, 1978; Moriarty, 1984; Stierlin & Weber, 1989), allergies, especially asthma (Conners, 1983; Frey, 1984; Guntern, 1984; Liebman, Minuchin & Baker, 1974; Onnis, Tortolani & Cancrini, 1986; Negley-Parker & Aaroz, 1986; Ritterman, 1983; Travis, 1976; Wilensky, 1986), warts and congenital skin diseases (Barber, 1984; Wink, 1961); poorly-controlled diabetes (Boehnert & Popkin, 1986; Cedarblad, Helgesson, Larrson & Ludvigsson, 1982; Cerreto & Travis, 1984; Johnson, 1980), and hemophilia (Ritterman, 1982 & 1983), as well as more commonly regarded "psychosomatic" problems such as psychogenic pain (Liebman, Honig & Berger, 1976).
Attempts have been made to define useful models of family functioning in order to design interventions to use at the family level. One of the first was Minuchin's "psychosomatic family model" (Minuchin, et al, 1975 and 1977), which postulates that three factors in conjunction are necessary for the development of severe psychosomatic illness in children. First, the child is physiologically vulnerable. Second, the family has four transactional or organizational characteristics: enmeshment, overprotectiveness, rigidity, and lack of conflict resolution. Third, the sick child plays an important role in the family's patterns of communication and conflict, and this role is an important source of reinforcement for his/her symptoms.

**Enmeshment**

Pathological enmeshment is defined by Minuchin, et al (1977) as characterized by a high degree of responsiveness and involvement between family members. Family members take on a high degree of responsibility for the thoughts, feelings, and welfare of other members, including their health. There is a strong interdependence of relationships and poorly differentiated perception of self and other family members. There is exquisite sensitivity to each other and minor upsets are responded to rapidly with closeness. Personal autonomy is very low, reflected in a lack of privacy or excessive "togetherness." Often, the expression of opinions or feelings which are different than the accepted family norm are not accepted and may in fact be denied. Family members may intrude on each others thoughts or communications, even finishing sentences for each other. Subsystem boundaries are weak, and executive hierarchies are confused, leading to shifting coalitions and alliances which detract from real affiliation and individuation. The concept of boundary, individual
and intrafamilial, is an important one here, and one which is very useful in intervention, whether openly discussed or used metaphorically.

**Overprotectiveness**

Parents whose overprotectiveness retards the development of the child's autonomy and responsibility for him/herself are typical of the psychosomatic family. Nurturing and protective behaviors are constantly elicited and supplied as family members interact. In turn, the children, particularly the sick child, feel great responsibility for protecting the family. This protection may be in the form of symptom expression whenever there is the possibility of conflict in the family; distraction from conflict, especially between the parents, may be a major reinforcement for the illness.

**Rigidity**

Pathologically enmeshed families are heavily committed to maintaining family roles and rules past the stage in the family life cycle in which they were useful. This resistance to change will often become particularly evident in the families of adolescents, since ways must be found at that time in any family for changes in rules and transactions to allow age-appropriate increased autonomy while still maintaining family coherence and continuity. In rigid families, when events requiring change occur, the necessity for avoiding conflict may again result in expression of symptoms in order to distract from the threat of conflict.

**Lack of Conflict Resolution**

The rigidity and overprotectiveness of the family system, combined with the enmeshment and unwillingness to accept individual differences in thoughts and feelings,
result in a very low tolerance for conflict. Conflicts tend to be avoided, and when they do occur, they are rarely, if ever, resolved. There may be different mechanisms of avoidance: one spouse may leave the house when areas of difficulty are brought up by others. Conflicts may occur, but constant interruptions and subject changes may obfuscate any conflictual issue before it can be clarified and negotiated. Some families deny that there is any conflict whatever.

Further Development of the Psychosomatic Family Model

Kog, Vertommen, and Vandereycken (1989, 1987, 1985a&b, and unpublished) have revised and updated Minuchin's model (1975) for the purpose of concept-validation and instrument development in the context of their work with eating disorders. In their analysis (Kog, Vandereycken & Vertommen, 1985; and Kog, Vertommen & Vandereycken, 1987), they transform and operationalize the four somewhat overlapping concepts into four fundamental interactional dimensions: A) the intensity of intrafamilial boundaries, B) the degree of the family's adaptability, C) the degree of avoidance/recognition of intrafamilial tension, and D) the family's way of handling conflicts. Since the assessment process for this study has been taken from their work, their redefinitions are summarized here:

A) **Intensity of intrafamilial boundaries.** A measure of the degree to which family members behave, think and feel similarly (enmeshment pole) or differently (disengagement pole) from each other.

B) **Degree of family's adaptability.** Neither pathological nor healthy by itself, the evolution of the family in its stability and change on different system levels and at different time periods in family life is determined by its ability to adapt and change yet remain cohesive at the same time.
C) Degree of avoidance/recognition of intra­familial tension. Discarding the concept of "overprotectiveness," Kog, et Al (1985a) define this dimension as the degree of concern with each other's well-being and the extent to which family members criticize each other.

D) The family's way of handling conflicts. This dimension describes the family's way of problem-solving with regard to intrafamilial conflict. Conflict avoidance would be at one extreme of the dimension and conflict resolution at the other.

FAMILY THERAPY IN TREATMENT OF ILLNESS

Minuchin and his colleagues have used the psychosomatic family model as a guide for successful intervention with families in cases of psychogenic vomiting, headaches, gastrointestinal disorders, asthma, super-labile diabetes, and eating disorders (1975, 1977, 1978). Sargent (1982) and Sargent and Liebman (1985) have been particularly concerned with issues of compliance with medical recommendations and establishing age-appropriate responsibility for care of chronic illness in the family. Frey (1984) considers the model particularly important in compliance issues, particularly with adolescents, whose struggle to disengage from the family in a developmentally appropriate manner may bring the family to treatment through repeated crises. Stierlin (1983) has included a wide variety of illnesses of adolescent patients in a similar psychosomatic treatment model, including asthma, neurodermatitis, inflammatory diseases of the intestinal tract, breast and lung cancer and is in the process of extending the use of the model, with some modifications, to families of schizophrenic adolescents. White (1979) outlines structural and strategic approaches to working with psychosomatic families using this model.

Lask and Matthew (1979) reporting on a controlled study of children with asthma, found that only six one-hour sessions of family psychotherapy made a significant difference in objective tests of respiratory function. The family work concerned understanding the
individual's symptoms and behavior as arising from and feeding back into the general family system of interaction. An improvement in the psychological well-being of the family, especially in terms of adjusting attitudes toward illness, medication, fear of death, and experiencing of painful and frightening emotions, improved the over-all health of the child.

Models of individual treatment leave out the socio-familial context which may have provided the impetus for creating the mind/body strategies which resulted in the symptom and may be inimical to healing. Indeed, one of the intervention strategies for childhood asthma was "parentectomy" (Onnis, et Al, 1986); unfortunately, a temporary solution: upon return to their parents, most of the children's symptoms were as severe as before. These researchers have concluded, in fact, that any therapeutic intervention which is limited to dealing with the biological component of the asthmatic symptom and ignores the influence of family dynamics becomes itself a major "chronicity factor." Hypnotherapeutic techniques have been successful with individual asthmatic children (Diamond, 1959), as well as other illnesses; however, as Olness and Gardner (1988) emphasize, it is vitally important that the rest of the family support the child in developing autonomy. They have often found that complications arising from family dynamics have limited the efficacy of their program.

Many of the treatment issues have centered around encouraging the child to be responsible for his/her own medication, symptom management, and other age-appropriate decisions which may appear to be unrelated to the illness. Thus, compliance with the medical regimen becomes only one of the competencies which the child may acquire.

**TREATMENT MODEL FOR THE PSYCHOSOMATIC FAMILY**

Liebman, Honig, and Berger (1976) and White (1979) have outlined the goals of treatment using the psychosomatic family model as follows: phase one is concerned with
alleviation of the symptoms to decrease the use of the patient as a means of detouring family conflicts; phase two consists of identifying and changing those patterns in the family and extrafamilial environment that tends to perpetuate the symptoms; phase three consists of interventions to promote lasting disengagement of the patient by resolving chronic marital conflicts, thus dispensing with the need for the child's symptoms to function as a distraction. The under-involved parent is required to become more involved with the symptoms and the patient, and the parents are required to become more mutually supportive and to learn different ways of resolving conflict, especially between themselves.

It may be important to differentiate here between a treatment approach that appears to be effective versus the "truth" of the model it is based on. In a review of psychological treatment methods for asthmatic children, Conners (1983) cites Liebman et Al (1974) and Lask and Matthew (1979) as the only studies having even minimal scientific adequacy which indicate psychological treatment of any kind affecting the course of the illness. Both of these teams use a family therapy approach. Conners states that there is no rigorous evidence leading to the conclusion that a particular type of personality or type of family demonstrates asthma. While individual hypnotherapy and relaxation have shown promise, the studies have methodological shortcomings.

**HYPNOTHERAPY**

**Individual Hypnotherapy and Physical Illness**

Hypnotherapy with individuals is used as a primary or adjunctive treatment for many physical illnesses. Reviews such as those by Barber (1984), Golan (1986), Goldberg (1985), Hall (1983) and Olness (1986) cite many case reports and studies indicating that
hypnosis is a useful intervention in many physiological processes. Perloff and Spiegelman (1973) used hypnosis in a desensitization process for a child allergic to dogs. Diamond (1959) claims "complete" cure of asthma, as well as amelioration of many "bad habits." Hypnosis is used in individual treatment of Anorexia nervosa (Gross, 1984; Yapko, 1986) and in treatment of severe congenital skin disease (Mason, 1952; Wink, 1961). Examples of its use in case report indicate efficacy in such various symptoms as chronic headache (Fogel, 1984) and tics of Tourette Syndrome (Kohen, 1987).

Family Hypnotherapy

As a technique in working with families, hypnotherapy is used for behavioral symptoms as well as physical symptoms. There are many versions of trance phenomena in use with families (Churchill, 1986), ranging from conventional hypnosis with induction (Braun 1984), to guided imagery or creative visualisation (Ritterman, 1982 & 1983), and to "new hypnosis" which minimizes induction (Araoz & Negley-Parker, 1988). There is also a range of techniques called "Ericksonian" which include reframing, paradoxical techniques and more "naturalistic" uses of trance phenomena in the context of family meetings (cf. Zeig, 1985; Vol.II).

In her work with families with a hemophilic member, Ritterman (1982; 1983) has used creative visualisation as a way of markedly improving the physiological symptom by teaching children self-hypnotic techniques to minimize bleeding as well as improving family functioning so that over-involved and overprotective parents can allow their children more autonomy and more ownership of their own bodies. She describes herself as working simultaneously at two systemic levels: the "inside" of the individual, physiologically and intrapsychically; and the "outside" of the individual at the level of the family.
In their work with chronically ill children and their families, Negley-Parker and Araoz (1986) found four traits in all five families studied, which included two with asthmatic children: "1) a serious difficulty in spontaneously defining the sick child in terms other than the disease; 2) at least one family member who obtained some advantage from the child’s disease; 3) a great difficulty in the family visualizing themselves without the 'family sickness;' and 4) the sick child convinced s/he would never be illness-free." With the use of hypnotic visualization designed to address these family characteristics, marked improvement in symptomatology was seen, as reported by the children's physicians. In this very small study, two other families refused to engage in any imaginative involvement and thus acted as controls and were treated with traditional family therapy. Their treatment lasted more than twice as long as that of the families who were willing to engage in visualization.

Virtually all the research in the area of family therapy and hypnosis has been anecdotal case study and it is therefore difficult to evaluate it and to generalize from it (see following section). However, since hypnotherapy and other types of trance phenomena have been useful with illnesses, including asthma; and since family therapy has been useful with chronic illness, including asthma, especially when issues of compliance in adolescence are involved; and since hypnotherapy and family therapy have been used together in various ways: would a combination of family therapy and hypnotherapy be a useful intervention in cases of allergy, in this case asthma, in children?

SINGLE-CASE EXPERIMENTAL DESIGN

Nugent (1985) in his review of 74 articles from the American Journal of Clinical Hypnosis has proposed a framework to evaluate the internal and external validity of single case studies. He proposes that a minimal requirement of an AB design
using pre- and post-treatment objective measures, while providing more of a basis for causal inference, still does not rule out other explanations for change. A more reliable class of study would include repeated objective measures of the "problem" during treatment. Still more reliability would include the presence of stability information, thus ruling out history and maturation objections to causal conclusions. However, Crane (1983, 1985) points out the difficulties of applying single-case research design to family therapy research, at least at the present state of the art, including the present inadequacy of measurements which are still in the process of development as well as the virtual impossibility of devising a useful measurement process which does not also affect the family. Jacobsen (1988), while viewing single subject designs as the most clinically useful (“summary group statistics and significance tests are non-sequiturs for the clinician attempting to find a treatment for a particular problem or family”), finds practical difficulties in establishing baselines prior to intervention, inadequacies in the present state of establishing standardization of outcome criteria, and problems with selecting instruments relevant to the treatments being assessed. Wynne (1988) concludes, in his overview of the "state of the art," that exploratory, discovery-oriented studies be pursued given the present state of outcome measures, methodologies, process studies, and the peculiar problems of working with the systemic, not-quite non-causal model.

For the purposes of this study, therefore, it was decided to use a modified AB design using outcome measures developed by a team studying another "psychosomatic" family problem (eating disorders) using the theoretical foundation of Minuchin's psychosomatic family model (1975). In addition, self-report of symptoms, in the form of a chart to be
marked every day, was used as a baseline, as a continuing measure, and as a follow-up. The purpose of the study is not to make causal inferences, but to determine if this approach might be a useful one to explore further; and, secondarily to assess the practicality and/or usefulness of the Leuven Family Assessment process in this context.
CHAPTER 3
METHODOLOGY

SUBJECTS

This exploratory single case research consisted of a pretest-posttest design in the treatment of a single family with an allergic child. The family was chosen from several who called in response to a notice in the newspaper (Appendix A). It met the following criteria: it was an intact family with an adolescent child who had allergies, and all members were willing to commit to the four month process of assessment and treatment.

The mother was 52 years of age; the father, 54; the natural daughter, 16. From a previous marriage, the mother had three other children, one of whom had died at five years of age in an automobile accident. The other two now live within a few blocks of the present family unit: a son, 31, somewhat estranged; and a daughter, 29, a single mother with one child, who is close to this family. Neither of the adult children participated in the research process. The mother's medical history included asthma and eczema; the father's included no allergies, but a history of epilepsy which had been completely controlled with drugs for several years.

The 16 year old daughter had the following allergic symptoms: asthma; eczema, itchy skin on neck and under chin; bumpy, itchy skin inside elbows, bumps on inside of knees, dry, flaky eyelids; dry, itchy, sore lips. The most troublesome symptom, however, was asthma, for which she used Ventalin inhalers daily. She also complained of insomnia, secondary to inability to breathe. She had frequent headaches for which she sometimes took pain relievers. She had been skin tested by an allergist and demonstrated allergies to milk, cheese, oranges, molds, and animals. She described herself as allergic to dust, cats, dogs,
grasses, milk, wheat, mushrooms, yeasts and molds, and chocolate. As a child, she had been asthmatic, according to her mother, since age 4. At age 6, a severe episode of epiglottitis had resulted in a hospital stay and complete assessment. She had been allergic to grasses, expressed as eczema, since age two. Before the age of fifteen, she had been admitted to hospital for asthma only three times. Her mother wished to involve the family in participating in the research project because she perceived her daughter to be non-compliant with medical instructions and over-using medication to suppress symptoms rather than managing her illness.

The family was told that treatment sessions would include the whole family in order to investigate possible healing effects of family structure.

**INSTRUMENTS**

**Leuven Family Assessment**

The assessment process was developed with special reference to Minuchin's "psychosomatic family model" (1975), by Kog, et Al (1985a, 1985b, 1987, 1989a &b). It consists of two behavioral measures (direct observation and a behavioral product) and a self-report measure (Appendix B). The behavioral measures consist of a series of standardized interaction tasks which are analyzed according to a behavioral coding system. The process is designed to measure the position of the family on four structural continua or Dimensions:

- **A)** the intensity of intrafamilial boundaries;
- **B)** the degree of the family’s adaptability;
- **C)** the degree of avoidance/ recognition of intrafamilial conflict; and
D) the family’s way of handling conflict.

It is a multitrait multimethod approach which has the virtue of approaching the same degree of complexity as the system it is designed to measure. The assessment process was videotaped; analysis of the tapes was done by three independent raters experienced in family process work, using a "rater's questionnaire" developed by Kog, et Al (1987). The nature of the study was exploratory, and since there were only three raters, one family, and the scale of ratings only 1-3, it was not possible to statistically analyze this data. Therefore, a qualitative analysis was done on the ratings profiles. With a larger sample, analysis of behavioral observation data would be done by Profile Analysis (Johnson & Wischern, 1988). Analysis of family task results was done according to Kog, Vertommen, & Vandereycken (1987). In that paper, they concluded that convergent and partially discriminant validity was proved for the concepts "boundaries," "adaptability," and "conflict." This holds true for the behavioral methods, but they concluded that the self-report method measured other concepts. Since it is hardly surprising that family members may evaluate their family system differently than would an outsider, they have carried out an exploratory factor analysis on the self-report measure. They concluded that this part of the test measured three scales: conflict, cohesion, and disorganization. Since the significance of the self-report measure is inconclusive at this point, the data from this part of the testing process was not used in the present study. In their ongoing development of this procedure, Kog, et Al (1989) propose testing of larger samples and including normal families in the samples. The reliability of the Leuven Family Assessment can not yet be evaluated, as it is still in the early stages of development (For a detailed discussion of evaluation of the test, see Kog, et Al, 1987 and 1989a&b.)
Family Adaptability and Cohesion Scale III (FACES III)

As a comparative measure, the Family Adaptability and Cohesion Scale III (FACES III; Olsen, Portner & Lavee, 1985) was also administered as part of the testing process (See Appendix C). It is well-recognized as a measure of family functioning (Campbell, 1986) and is based on Olsen’s Circumplex Model of Marital and Family Systems which focuses on cohesion and adaptability. Since the relationship between cohesion and adaptability and family functioning is postulated to be a curvilinear one, the results of this measure are plotted on a grid and are described in terms of flexibility vs. rigidity and separation vs. connectedness, rather than reported statistically. The results for a dysfunctional family will place family mean and/or individual scores outside a central core, while functional families are believed to score within the mid-range on both scales. There are twenty items comprising the two scales "Cohesion" and "Adaptability." The manual claims a total reliability of .68 in internal consistency and test-retest reliability of .80 (adaptability) and .83 (cohesion). "Very Good" face and content validity is claimed, and measuring the correlation - or lack of it - between the scores of family members is part of the important information in evaluating the family. Families with adolescents, for example, show marked differences in scores between the adolescent children and the parents. The manual also claims good group discrimination.

Symptom Assessment

During the first meeting with the family, permission slips were signed which allowed the researcher to discuss the patient with her physician and to investigate her medical records. The symptomatic adolescent was given a series of dated charts listing her symptoms and asked to note at the end of each day the number of times she experienced
each one and to grade the severity of the symptom from 1 to 5 (Appendix D). Upon completion of the second assessment (posttest), medical records were checked for dates of hospital visits and admissions. Follow-up telephone calls were made to the adolescent at approximately weekly intervals, beginning three months after the last treatment session, and she was asked to rate each of her symptoms for the previous week on a scale of 1-5.

**PROCEDURE**

The symptom charts were given to the adolescent two weeks prior to the first assessment, in order to establish a baseline. Between the pre-treatment assessment and the first relaxation session, there was a two week interval in order to continue baseline or determine if the assessment process itself had any obvious effect. After the two weeks of "relaxation only" sessions, there was another two week interval with no intervention in order to observe possible effects of relaxation only. Two thirty-minute audiotapes were made of the first "creative visualization," one for the daughter and one for the parental dyad, and they were asked to listen to them each night upon going to bed (see Appendix H). The eight family therapy and "creative visualisation" (CV) sessions took place weekly with one exception, the third meeting cancelled by the therapist due to illness. There was a seven week interval between the last family therapy plus CV session and the post-treatment assessment. (Fig. 4-8, Appendix F, shows visual outline or "timeline" of the entire procedure). The first family therapy plus CV session was separate for the daughter and parents, though given on the same day. It had been intended to meet the family all together; however, on the scheduled date of the first session, the daughter was in hospital, recovering from a life-threatening asthma attack. The audio tapes were given to the family at the end of these first family therapy plus "CV" sessions. All sessions were audiotaped. One family
therapy session, intended to explore the symptoms of the daughter in the absence of her parents, consisted of forty-five minutes with the family and forty-five minutes of individual work with the daughter, who refused creative visualisation (#4). Another session (#5) was so long and so conflictual that no creative visualisation was used.

For details of the intervention, including Relaxation sessions and Family Therapy plus Creative Visualization sessions, see Appendix I. Clinical observations are discussed in Chapter 5, along with the other results. For a brief overview of therapeutic issues in this family, see Chapter 6: Summary and Conclusions.

Follow-up telephone contact was maintained in order to continue collecting data on the adolescent's symptoms beginning three months after the final family meeting and continuing for 9 weeks.

This combination of self-report measures, behavioral observation of family tasks, evaluation of written tasks, and clinical observation, as well as a symptom-based self-report chart, consultation with the daughter's physician, and inspection of medical records dating from earliest childhood were used as indicators of family and symptom change.
CHAPTER 4
RESULTS

LEUVEN FAMILY ASSESSMENT

The results of the behavioral product measures (Table 4-1; Appendix E) and the behavioral observations (Figs. 4-1 to 4-4; Appendix F) will be discussed together as different measures of the same dimensions. It was not possible to statistically determine interrater reliability on the behavioral observation section of the assessment, because the sample (one family) and the range (1-3) were so small; therefore, the profile analysis of the behavioral observations is qualitative only. Similarly, statistical norms and standard deviations are unavailable for the behavioral product measures at this time; data is discussed in terms of trends or movement along a continuum.

Dimension A; Intensity of Intrafamilial Boundaries

Behavioral Product

The question of boundaries in the family is measured as a behavioral product by the number of answers spontaneously agreed-upon in a questionnaire asking personal preferences in a variety of areas. A high degree of spontaneous agreement would correspond to Minuchin's concept of enmeshment (1975), where disagreement is discouraged, if not forbidden. On the system level this family scored in the mid-range of the continuum (-48 = extremely fixed boundaries; +48 = extremely loose boundaries), moving in the direction of more fixed boundaries between the pretest (-1.3) and posttest (-8.0). On the generational level, the subject family moved from a position indicating cross-
generational intrusion on the pretest (negative score) to a score indicative of firm generational boundaries on the posttest (positive score). On the Individual level, measured by the difference between the highest and lowest spontaneous agreement scores, the results were the same pretest and posttest (8.0), indicating that the degree of differences between family members remained the same. However, when the actual spontaneous agreement scores are more closely analyzed, it appears that there has been considerable movement along the continuum as well as a change in the relative positions of each dyad's scores. The pretest highest score of +4 was between the mother and the daughter and the lowest was -4 both between father and daughter and father and mother. In the posttest, the highest spontaneous agreement score was still between mother and daughter, but had moved down to -4. The lowest spontaneous agreement score was now between the father and daughter, at -12; and the spontaneous agreement score between the parents was down to -8. In Minuchin's terms (1975), these scores would indicate less overall family enmeshment and clearer intergenerational boundaries in the posttest; however, the way this particular score is reported in the method of Kog, et Al (1989) does not reflect this difference.

Behavioral Observation

In the behavioral observation, Kog, et Al (1989) consider the question "do the parents talk with each other?" in the preparation part of the disagreement task to be the best measure of the dimension Intensity of Intrafamilial Boundaries. Item 1b (Fig. 4-1; Appendix F) corresponds to this question and showed no change pretest to posttest; the rating was "moderate" presence of the behavior (Questions asked raters appear below the ratings profile). However, taken as a whole, the ratings profile indicates only 3 interaction categories which remained the same pretest to posttest, out of a possible 12 items. Upon
examination of individual items and comparing pretest to posttest ratings, it appears that there was an increase pre- to posttest in everyone’s communication during the Introduction (Items 1a, 2a, 4a) and during the Interest Task (Item 8); that the parents communicated more with each other than with their daughter during the Disagreement Tasks (Items 2b, 4b) in the posttest though not in the pretest; and that the parents formed an alliance between themselves during the Interest Task (Item 5b). During the Disagreement Task, when the subsystems were required to operate separately, there was much talking between the generations pretest and none in the posttest (Items 2b, 4b).

Taken together, the Leuven Family Assessment measures for Intensity of Intrafamilial Boundaries indicated a posttest trend toward more clearly defined boundaries; therefore, the null hypothesis (H₀) was rejected and the hypothesis (H₁) was retained.

H₁ There will be a measurable difference in the intensity of intrafamilial boundaries as measured by the Leuven Family Assessment (Kog, Vandereycken & Vertommen, 1985,1987,1989a&b).

Dimension B; Degree of Family's adaptability

Behavioral Product

Kog, et Al (1985a) have redefined the concept of rigidity of Minuchin, et Al (1977) as a continuum according to the degree of the family’s adaptability; the behavioral product measure of adaptability consists of asking the family "who prefers to do what with whom?"

The degree of organizational adaptability moved from 0, extreme organizational variability at the time of the pretest (0 = minimum organizational constancy); to a posttest
Chapter 4: Results

25 (100 = maximum organizational constancy), in the direction of more organizational constancy (Table 4-1: Interactional part, Interest Task).

Behavioral Observation

In the behavioral observation part of the assessment, the Degree of the Family's Adaptability is measured by means of the comparison between the results of the same interaction categories scored during two different tasks (Fig. 4-2). Kog et Al (1989a) consider the difference between Items 1a and b, assessing the amount of attention-seeking behavior in the individual parts of the interest and criticism tasks, to be the best measure of this dimension. The subject family scored higher on both these items in the pretest than in the posttest; in fact, in the posttest, during the criticism task there was no attention-seeking behavior (Fig. 4-2; Items 1a,b). Items 3a and b indicate an increase from little or no verbal disagreement in the family to a moderate amount. The profile of Item 12 asking about the relative contribution of children and parents to the negotiation about the problem of the parents (a and c) and the problem of the children (b and d) reflects the fact that in the pretest there was no discussion of the problem of the parents; all the time was taken by an unresolved discussion of the problem of the daughter. In the posttest, the discussion was more balanced, as evidenced by the rating of a "moderate" contribution by everyone.

It is interesting to note that Item 15, measuring the "evolution of distance between family members" during the interest task and the criticism task changes from a rating of 2 to 3, describing the increase in physical closeness of the parental dyad.

Considering only the comparison of the same interaction categories between the two different tasks, it appears that the family has changed somewhat to a less flexible stance.
Referring to Fig. 4-2, the number of possible changes in interaction categories is 17; there was no change either pretest or posttest in 7 of the 17. There were only 4 changes in the posttest and there were 7 changes in the pretest, indicating more consistent behavior patterns in the posttest.

In summary, then, both measures of adaptability indicate a trend toward less adaptability in the posttest. Therefore, the hypothesis (H2) was retained and the null hypothesis (H02) was rejected. See discussion of this dimension in Chapter 5 for observations about the direction of the change, which was unexpected.

**H2** There will be a measurable difference in the degree of the family's adaptability as measured by the Leuven Family Assessment.

**Dimension C; Avoidance/Recognition of Conflict**

**Behavioral Product**

Minuchin's concept of "overprotectiveness" (1975) redefined by Kog et Al (1985a) is measured in the behavioral product section by the analysis of the written results of the criticism task. This score reflects a high degree of conflict recognition, the maximum being +3 and the minimum being -3; and the change from 2.6 to 2.3 pretest to posttest is probably not a significant difference (Table 4-1: Criticism Task).

**Behavioral Observation**

In the behavioral observation (Fig. 4-3), there is also not much change evident pretest to posttest: of the 10 items, only 4 show a change from 2 (moderate) to 1 (none).
question considered to be most significant by Kog et Al (1989a) as an indicator of conflict avoidance "is the illness of the child mentioned?" is the same pretest to posttest and is in the negative (Items 2 and 3), indicating that this family does not avoid conflict, at least through the means of the illness in the child.

Both measures of Avoidance/Recognition of Intrafamilial Conflict show no change, therefore, the null hypothesis (H03) was retained and the hypothesis (H3) was rejected. It is important to note that Kog, et Al (1989a) have concluded that this dimension is likely superfluous because of its considerable overlap with dimensions A and D. Their results on this dimension appear to be ambiguous.

H03 There will be no measurable difference in the degree of intrafamilial tension (avoidance/recognition of intrafamilial conflict) as measured by the Leuven Family Assessment.

Dimension D; The Family's Way of Handling Conflict

Behavioral Product

Minuchin's concept "lack of conflict resolution" (1975) is broadened by Kog et Al (1985a), but is fundamentally a question of the family's style of conflict and whether they are able to reach satisfactory resolution. The behavioral product measure is a written exposition of a problem from each generation and written solutions both to the problem of the parental generation and to the problem of the child by both subsets. The behavioral observation takes place while this written product is being developed and afterward discussed. In the pretest, there was no resolution to either problem, a score of 10 (the maximum, indicating no
resolution; 2 is the minimum, indicating spontaneous resolution); and in the posttest, the parents problem was very quickly, almost spontaneously resolved, while the daughter's problem was not discussed for a total score of 7 (Table 4-1: Disagreement Task).

Behavioral Observation

In the behavioral observation (Fig. 4-4), Kog et Al (1989a) consider the best measure of this dimension to be the question "is there a tense atmosphere in the family?" after the criticism task. Pretest rating was 2 (moderate), changing to 1 (absent) on the posttest (Item 2b). During the introduction the observed tension in the family was much greater in the pretest than posttest (Item 1a). Perhaps the most notable change was in Item 4a-d regarding the contribution of the parties to the negotiations: from no contribution (a rating of 1) in the pretest to moderate contribution (a rating of 2) in the posttest.

Both measures indicate an increase in the ability to resolve problems and more willingness to discuss them in the posttest than in the pretest. Therefore, the hypothesis (H4) was retained and the null hypothesis (H04) was rejected.

H4 There will be a measurable difference in the family's way of handling conflict as measured by the Leuven Family Assessment Scale

FAMILY ADAPTABILITY AND COHESION SCALES (FACES III)

The pretest and posttest raw scores are provided in Table 4-2 and 4-3; Appendix E. They were plotted on the grid provided by Olsen, et Al (1985) as illustrated in Figure 4-5, 4-6 and 4-7 Appendix F. The typology of the Circumplex Model of Family Functioning defines a family as being in the balanced, mid-range, or extreme ranges of four basic quadrants:
flexibly separated, flexibly connected, structurally separated, and structurally connected. Based on the mean scores, pretest 33.3 on the Cohesion scale, 29.0 on the Adaptability scale and posttest 31.3 Cohesion, 29 Adaptability, there is no significant change in the structure of the subject family, as measured by the mean score; and it is described, according to the typology, as in the mid-range between "chaotically separated" and "flexibly disengaged" both pretest and posttest (Fig 4-5; Appendix F). This family mean score is within the 30th percentile for families of adolescents, suggesting that while the subject family would not be considered to be in the "balanced" category, this family structure is not unusual for this stage of the family life cycle. The family mean is just below normal range for Cohesion (39.8 SD 5.4) and just above normal range for Adaptability (24.1 SD 4.7).

Since there was no significant change in the family mean score pretest to posttest, the null hypothesis (H05) was retained and the hypothesis (H5) was rejected.

**H05** There will be no measurable difference in the family's Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale.

However, as Olsen, et Al (1985) note in their manual, mean scores tend to eliminate the possible differences between family members. Indeed, it is important to note the extreme difference between the scores of the adolescent and the scores of both parents (Table 4-2).

Individually, the adolescent scored below normal range both for cohesion and adaptability pretest and posttest. Pretest cohesion was 16, posttest 19; normal range for individuals is 39.8 SD 5.4. Pretest adaptability was 18, posttest 16; normal 24.1 SD 4.7. Father’s scores on cohesion were within normal range, but shifted from high normal, 42, to low normal, 34; his adaptability scores were above normal but shifted from 37 pretest to 32
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posttest, towards the norm. Mother's individual scores were within normal range for cohesion, pretest 42, posttest 41; and above the norm for adaptability, pretest 32, posttest 39. When the individual scores are plotted on the same grid (Fig. 4-6), it becomes apparent that the differences between subsystems are very great, the adolescent falling in the extreme range of the "structurally separated" quadrant and described as "rigidly disengaged" and moving toward a more rigid position on the posttest; and both parents locating in the mid-range of the "chaotic" quarter and moving (pretest to posttest) from the "chaotically connected" to the "chaotically separated" due primarily to the pronounced change in the posttest score of the father, though the mother moved in the same direction to a lesser degree.

The pretest mean scores of the parental dyad were Cohesion 42, Adaptability 34.5. Posttest, the mean scores moved from the chaotically connected to the chaotically separated part of the grid, Cohesion 37.5, Adaptability 33.8. Normal scores for couples are Cohesion 38.5 SD 4.7, Adaptability 24.1 SD 3.6. The daughter's scores remained on the border between rigidly disengaged and structurally disengaged, moving posttest to a more rigid position. The Parental Dyad scores and adolescent scores are plotted on the Circumplex grid shown in Fig. 4-7 (Appendix F).

Since there was a qualitative change in the positions of the individuals on the Circumplex Grid resulting in movement from one section to another, especially on the part of the father and parental dyad, the hypothesis (H6) was retained and the null hypothesis (H06) was rejected.

There will be a measurable difference in individual Adaptability and Cohesion as measured by the Family Adaptability and Cohesion Scale.
Chapter 4: Results

According to Olsen, et al. (1985) this discrepancy between individuals in the family can be calculated as Discrepancy Scores which are independent of the mean scores and are a measure of the differences between family members. All possible combinations are shown in Table 4-3. The total family discrepancy score changed very little, 22.2 to 21.2. The discrepancy scores of the parental dyad moved from 5.0 pretest to 9.8 posttest, an increase of 4.8. The husband-adolescent score changed the most, decreasing 10.3 points from 32.2 to 21.9; and the wife-adolescent score increased only 2.3 points from 29.5 to 31.8. Norms and standard deviations are not given for these scores. However, Olsen, et al. (1985) comment that parent-adolescent discrepancy scores are usually higher than all other discrepancy scores.

SYMPTOM ASSESSMENT

Figure 4-8 shows a timeline of the baseline, interventions and the daughter's asthmatic symptoms. Figure 4-9 shows the follow-up data obtained at approximately weekly intervals by telephone. The adolescent's refusal to comply with the instructions to note her symptoms for various intervals during the research was analogous to the lack of compliance with medical advice. The one instruction with which she (and everyone in the family) complied for the entire time period was to listen to the audiotapes every night at bedtime. The only consistent keeping of the symptom charts was the four weeks prior to the last family meeting. During that last four weeks, with only one day's exception (midweek 13) the adolescent was taking her prescribed medication (Theophylline) and using inhalants as prescribed rather than as needed. The asthma symptoms had abated to once per week with severity levels no higher than 2 (out of 5). This compares with a baseline high of 8 times per
day and severity of 4 (end of week 1), no oral theophylline (though it had been prescribed), and use of inhalers as often as eight times a day. Again, compliance with the terms of the research process was analogous to compliance with the medical regimen. It is quite likely that the emergency room hospital visits of weeks 4 to 8 reflected even higher ratings of asthma times severity. However, it appears that the adolescent's resistance to caring for her illness was expressed in her refusal to note her symptoms, as well as in her refusal to cooperate with her parents. These emergency room visits, and the refusal to comply with the therapist's instructions, continued throughout the period during which the intervention consisted of relaxation only. The autogenic training exercises were rarely done by the parents, and even more rarely by the daughter outside of the two family sessions.

It is important to note that the day before the family therapy and creative visualisation sessions were due to begin, the daughter suffered a life-threatening asthma attack, which necessitated a five-day stay in hospital. Following that event, there were only two emergency room visits, both of approximately two hours duration and both of which were secondary to bronchial infection (viral). One took place midway through the Family Therapy and Creative Visualization intervention and coincides with the three sessions in which the therapeutic issues involved conflict between the adolescent and her parents. The other occurred the week after the intervention had been completed. There were no emergency room visits during follow-up nor in the interval between the posttest and the follow-up, in spite of another bronchial infection.
Chapter 4: Results

There was clear improvement in the adolescent's asthmatic symptoms as measured by self-report and hospital visit data obtained from her physician; therefore, the hypothesis was retained and the null hypothesis was rejected.

H7 There will be an improvement in the child's asthmatic symptoms as measured by self-report and consultation with the child's physician.
CHAPTER 5: DISCUSSION

INTERPRETATION OF FINDINGS

Boundaries

In the written part of the Leuven Family Assessment, scores indicate a move toward more fixed boundaries on the system level and on the generational level; and showed no change on the individual level. In the behavioral observation, taken as a whole, the changes in the family seemed to be in the direction of clearer hierarchical boundaries in that the parents spoke together more and an alliance between them was more evident. This alliance did not appear to be at the expense of their daughter, since both parents also seemed to be more tolerant of the differing opinions of their child. In the behavioral observation there were several indications of clearer boundaries, with a shift toward more parental closeness and less involvement with their daughter when the assignment required the subsystems to operate separately. At the same time, general communication between generations was greater in the posttest during the introduction and the break, indicating communications on the whole were more free. This finding may also reflect more comfort with the testing situation and/or the therapist by the time of the posttest. However, spontaneous comments by the raters upon completion of the behavioral observations indicate considerable change in the way the family interacted. More playfulness, especially between the parents was particularly remarked upon. The raters attributed these changes to the intervention rather than to increased familiarity with the testing process.

The FACES III scores, when plotted on the grid, also indicate more separation (less family cohesion) in the posttest, especially on the part of the parental dyad; the adolescent
did not make a significant shift in this dimension, according to her individual scores on FACES III. However, her scores already indicated considerable separation, to the point of disengagement.

Clinically, the parents were able to decide together which issues were the responsibility of the adolescent (school, friends, personal health) and which were the responsibility of the parents (curfew, manner of treating parents, chores). They were also able to decide together on consequences for misbehavior, a profound change from before intervention, when that had been the mother's sole responsibility. The parents evidenced much more closeness, taking their first vacation together on their own just before the posttest; as well as demonstrating considerable faith in their daughter by leaving her on her own for five days.

Adaptability

In the Leuven Family Assessment, the written part demonstrated increased organizational constancy and the behavioral observation indicated decreased adaptability. FACES III results were more ambiguous. The family mean was just above normal on adaptability and the family mean score did not shift; however, the father's adaptability score shifted downward, from a "chaotic" position on the grid to a more "flexible" one and the mother's shifted upward, for a net parental dyad change of less than 1 point downward. The result was a significant shift on the circumplex grid for the parental dyad in the direction of more separation (Fig.4-7), an important shift in view of the stage of the family life cycle, when separating and individuating without losing cohesion becomes the family task. According to the Psychosomatic Family Model (Minuchin, 1975), it was expected that the subject family would be "rigid;" on the contrary, it appeared that the family was, if anything,
too flexible. Therefore, the movement of the family towards less flexibility or adaptability which was indicated by both measures and confirmed clinically, could be interpreted as a move toward more optimum family functioning.

Clinically, it appeared that both parents became more clear in their expectations of their daughter and of each other and the family became less disorganized, at least in the sense of everyone knowing what to expect in the way of rules, consequences, and expectations. It appeared that less "adaptability" and less "flexibility" meant less chaotic family organization. Perhaps most importantly, the parents had begun to decide together how they would structure the family and became more consistent with each other.

Avoidance/Recognition of Conflict

The results of the Leuven Family Assessment show very little, if any change in this dimension. Kog, et Al (1985) have developed this measure as an operationalization of Minuchin's concept of "overprotectiveness" (1975). They conclude that it is too vague a concept to measure and in their test this dimension appears to have a high degree of overlap with the dimension D: "Family's way of handling conflict" (Kog, et Al, 1989). The present researcher does not recognize the value of this part of the test; it is unclear on the face of it how it would measure "overprotectiveness." FACES III does not refer to this concept.

Clinically, it could be said that the overconcern of the mother and her attempts to control her daughter's activities, health measures, and other parts of her life would constitute "overprotectiveness," at least certainly from the daughter's point of view. When this concept was discussed with the family, they agreed on it's existence, and the parents agreed to minimize their involvement in their daughter's life.
Chapter 5: Discussion

The Family's Way of Handling Conflict

The Leuven Family Assessment indicates that there is less discomfort in the presence of conflict and more ability to resolve conflict.

Clinically, the family's pattern of conflict was addressed as a central issue in the work. The family strategy of control through fear of conflict and through fear of illness or "bringing on an attack" was identified. The skill of attending to unresolved family of origin issues which blocked resolution was learned. The increased clarity of generational boundaries, expectations, and consequences decreased the necessity and therefore the frequency of some of the conflict; and the skills of negotiation and communication could be learned once the tendency toward automatic avoidance of conflict was unlearned. Overall, the observed tension in the family was much greater in the pretest than in the posttest, and while this may be a reflection of familiarity with the assessment process and with the therapist, spontaneous remarks on the part of the raters indicated their judgement of an observable improvement in family atmosphere.

Observations Regarding FACES III

It is clear from the scores and the plotting of the scores on the grids that the adolescent has a very different view of the structure of the family than her parents. The discrepancy scores indicate a balanced-incongruent family. There is not much discrepancy between the parents as to their view of the family, but there are great differences between each of them and their daughter. It could be said that the perception of the daughter that the family is extremely rigid and separate to the point of disengagement balances the parents' view of a tendency to chaos and enmeshment and vice versa. Olsen, et Al (1985) comment that adolescents normally have different perceptions of the family from the
parents so discrepancy scores between parents and adolescent would be expected to be
greater than between the parental dyad. Normal values are not given, however. The
pretest-posttest differences in discrepancy scores indicate that the couple has slightly
increased their differences in the way they perceive the family to be, the husband-adolescent
differences have decreased, and the differences between the wife and the adolescent have
remained about the same. These findings fit the clinical observation that there appears to be
increased tolerance of differences overall and more closeness between the father and
daughter. Taken together with the family mean score, which has remained virtually the
same, it is possible to conclude that the overall family structure has retained its stability,
while the individuals have shifted positions, both on their own and in relation to each other.

Symptom Assessment

Throughout the intervention and baseline periods, it appeared that the resistance of
the adolescent to following medical advice was analogous to her refusal to keep her symptom
charts. She reported in family sessions that she was taking her oral medication and using
the inhalants as prescribed after the life-threatening asthma attack which occurred just
before the "Family Therapy plus Creative Visualization" sessions began, but she did not
comply with the instructions to record her symptoms until midway through the Family
Therapy intervention. It is quite likely that the hospitalization had a profound effect on both
the adolescent's and the parent's willingness to make some changes in their ways of handling
the illness and their relationships. It had an effect on the relationship between the
adolescent and her doctor, which he described as becoming more personal and less
automatic: he required her to visit the office weekly to discuss her symptoms and the effects
of the medication. He also had a meeting with the parents in which he gave them essentially
the same message that they were learning in the family therapy sessions: that their
daughter's body and the responsibility for it belonged to her and that she was capable of
making her own decisions in regard to her illness. He also advised them that he would be
their daughter's physician and not theirs (the former family physician had just retired), an
interesting intervention in terms of clarifying boundaries on the medical level. His comment,
in our meeting, was that adolescent asthma can be extremely difficult to control and that he
often found conflict with parents to be associated with attacks; he did not, however, make a
causal connection beyond the usual "stress exacerbates the symptoms."

INTERNAL AND EXTERNAL VALIDITY

Was the intervention responsible for the changes in the family and in the
adolescent's symptoms?

Kazdin (1982) lists the following threats to internal validity: history, maturation,
testing, statistical regression to the mean and multiple interventions. In this study, results
show a history of increasing family conflict and worsening physical symptoms; it is
impossible to know whether the life-threatening asthma attack alone would have been
enough to make the requisite changes in the family; or, conversely, whether that event was
what motivated the family to place more value on the therapeutic process. The family life
cycle was in a phase of great transition; the time when the last child is preparing to leave
home and establish her/his own autonomy is normally one of profound change and is usually
accompanied by family conflict (Friesen, J., 1983). The maturation of the child, especially at
adolescence can not be ruled out as a possible explanation for the changes, especially since
she underwent a profoundly frightening asthma attack during the research period. That
life-threatening experience could have had the effect of another intervention; certainly the
increased involvement of the physician after that event would constitute an additional intervention.

How does anyone evaluate therapeutic change and its sources, given the present state of measurement in the field? Wynne (1988) recommends that exploratory, discovery-oriented studies be pursued, since criteria for improvement and the state of outcome measures are presently so undeveloped. Bloch (1989) postulates that change is a reflexive process that is not the "result" of stress on the family, nor the ability to deal with it; but rather the "co-evolution" of the family system, the support systems, the illness and the treatment(s). Stierlin and Weber (1989) point out that as therapists and observers we are always part and parcel of the results of our observations. The difficulty is in determining how an intervention impacts a living system which is continually being influenced by events around it.

However, given the short period of the intervention, less than half of one year in the life of this family; and given the profound change in the symptoms of the adolescent and the clinical self-report of the parents about changes in conflict patterns; and given the acceptance of five of the seven hypotheses (only H03 and H05 were retained); it may be concluded that something in the environment had a salutary effect on the family. Among those influences was this study, including the testing process, the keeping charts of the symptoms, and the multiple but coherently constructed interventions of family and hypnotherapy. The entire process, from beginning to end, constituted an invitation to become more self-aware and to change some patterns of relationship.

An attempt has been made to present this study in a way that others can replicate it; however, the dynamics, motivation and external events will not be the same; also the interaction between the therapist and client(s) would not be the same.
Chapter 5: Discussion

JUSTIFICATION OF THE STUDY

This study is an exploration of the use of family therapy and creative visualisation in the treatment of a family with an asthmatic child. As such, it extends the work of Negley-Parker and Aaroz (1986) and Ritterman (1983) who use hypnotherapy as an integral part of family therapy in cases of chronic illness; however, these workers report their results in anecdotal single-case form. In this study, a test which is being developed on the basis of the psychosomatic family model of Minuchin (1978), was used to determine the efficacy of treatment. In addition, a baseline, continuous, and follow-up symptom assessment was used to further increase the validity of the findings. It appears that there have been some changes in the family and there have clearly been some changes in the asthmatic symptoms due in part to increased compliance with the medical regimen.

The exploration of the efficacy of the testing process was also an important justification of the study. According to Jacobsen (1988) there is a great need to explore instruments relevant to the models and treatments used in family therapy. A major difficulty in family therapy research lies in the paucity of instruments for measuring outcome. The Leuven Family Assessment used in this study is the only test based on the psychosomatic family model, and it shows promise as an indicator of family system change. Much greater usefulness will be demonstrated when more data about normal families and other so-called "psychosomatic families" has been gathered. It could be said that the extension of the use of the test to the family of an asthmatic child is premature; however, it appears that the changes measured by this test have meaning, at least as evidenced by the similar clinical findings. This study must be considered as only one of many needed to explore its usefulness.
Chapter 5: Discussion

This study also responds to a call by Nugent (1985) to use more rigorous single case research design. The use of pre- and post-therapy measures and symptomatic self-report baseline, during intervention, and follow-up reduces threats to internal validity and supports the position that the changes were due to the intervention.
CHAPTER 6 SUMMARY AND CONCLUSIONS

In this study, the present researcher has used creative visualisation in the family treatment of an allergic, asthmatic child. The underlying model on which treatment was based, the Psychosomatic Family Model, is a well-accepted and commonly used one, but the use of creative visualisation with families is relatively new.

This study has also extended the use of a test based on the psychosomatic family model developed for use with families with eating disorders to one with an asthmatic child, and used the test as a pre-test posttest measure.

A single subject research design was employed to evaluate the efficacy of the treatment and also to examine the usefulness of the test process.

The subject family was an intact natural family whose youngest child suffered from allergic symptoms, particularly asthma attacks. An underlying issue in this case was the adolescent's unwillingness to comply with medical instructions, resulting in a life-threatening asthma attack just prior to the implementation of the treatment plan. The motivation of the family was, therefore, extremely high. Baseline assessment indicated increasingly severe attacks as well as increasing family conflict on this and other issues. Relaxation therapy alone had no effect, either on the family or on the symptoms. In fact, the symptoms appeared to be worsening, culminating in the afore-mentioned hospital stay just after the two-week period of no intervention before family therapy/creative visualisation was to start.

After four weeks of family therapy and creative visualisation, the adolescent was continuing the medication schedule started by the Physician in the hospital, had resumed keeping daily records of her symptoms, and was experiencing more control of her life and her
body. The conflict in the family continued, but both during therapy sessions and outside of them, resolutions to issues and problems of long-standing were being developed. The pattern of conflict in the family changed from one of power-struggle to one of problem-solving. Concomitant changes included increased closeness between the parents and increased responsibility for herself on the part of the adolescent.

By the time of the posttest, seven weeks after the last family therapy session, the adolescent had suffered only one asthma attack severe enough to warrant a visit to the emergency room; it was secondary to bronchitis and she was sent home after 2 hours. During the follow-up period, the adolescent had suffered another bronchitis, but had only very mild asthma symptoms which did not require a visit to the hospital. This young woman has decided that when she is 18 (one year from now) she will be working on decreasing the use of drugs and taking better care of her body; during follow-up she expressed relief that her parents were leaving that up to her.

While it may be argued that the observations of the therapist are biased and subjective, it is nevertheless an important part of any case study to describe the observations of the person who has been relying on those observations to determine the direction of the work. While the general direction of treatment, toward clarification of interpersonal boundaries, increased tolerance of differences, and improvement in family strategies for conflict resolution can be stated at the outset, the creation of the moment-to-moment therapeutic strategy is based on the experience and clinical observations of the therapist. In the subject family, the patterns of interaction which had grown through the years together included a focus on conflict with the daughter which gave the parents the illusion of closeness but which prevented them from focussing on each other and increasing their intimacy as a couple. Their need to redevelop their own relationship, especially in view of
the growing autonomy of their daughter, was being held back by their overconcern for her. At the same time, every time the daughter had a conflict with the mother, the father would join the two, to the exasperation of the daughter and the delight of the mother. It appeared that one function of the mother and daughter conflict was in order to engage the father in a kind of relationship with the mother. Paradoxically, as we decreased the distance between father and daughter, by prescribing that he be the one to take her to hospital, and that he spend time with her without teasing her, the distance between the "overinvolved" mother and daughter increased and the closeness between mother and father increased.

Clinical notes bear out this change: the husband had become more engaged with the daughter, spending more time with her without conflict, becoming more tolerant of her different opinions and allowing her to make more of her own decisions and teasing her less; and the parental dyad had become more tolerant of differences between themselves. The closeness of the parents seems to have increased, while their ability to tolerate and resolve conflict between themselves and between the generations has also increased.

In conclusion, it may be said that the process of family therapy using creative visualization is a useful intervention for further exploration. I would agree with Negley-Parker and Aaroz (1986) that the use of creative visualisation can significantly shorten the time needed to improve family functioning and amelioration of physical symptoms.

I conclude also that the Leuven Family Assessment process merits more investigation as an outcome measure. Kog, et Al (1989a&b) continue to improve their procedure; certainly results from other sample populations including a normal sample would greatly extend its usefulness.
BIBLIOGRAPHY


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APPENDIX B LEUVEN FAMILY ASSESSMENT

The assessment process is a two hour process which is video-taped. It includes a behavioral and a written component.

Introduction

The investigator explains the purpose of the family meeting and also the use of the video recording (confidentiality is guaranteed). She emphasizes that there are no right or wrong answers. She then announces she has to prepare a few things and moves to the adjacent observation room that is on the other side of a one-way mirror (the investigator will always leave the room after having explained a task, and written directions for each task are left with the family for reference). The interaction during the next three minutes is videotaped in order to observe the family’s first reaction to the research setting. The researcher returns and describes the first task.

Interest-Task

This task is comprised of an individual and an interactional component.

**Individual**: Each family member is given a twelve-item questionnaire (see below). Each question allows seven response possibilities. Every family member has to choose two answers s/he likes most and two s/he likes least. Members are told not to discuss or compare answers. (20 minutes).

**QUESTIONNAIRE A**

*Directions*: Answer each question by placing the word "most" or "least" next to the item you like most or least. You have 20 minutes to complete the questionnaire. Do not discuss or compare your answers.

1. What do you like to do the most and the least in leisure time?
   - watching TV at home
   - job-related activities
   - socializing with friends
   - going to the movies
   - playing the stock market
   - carpentry
   - sports

2. Which type of movie do you like most and least?
   - science fiction
   - historical film
   - psychological film
   - comedy
   - western
   - thriller
   - cartoon

3. Where do you like to dine out the most and the least?
   - gourmet restaurant
   - vegetarian restaurant
   - Chinese restaurant
   - self-service restaurant
   - fish restaurant
   - sandwich bar
   - hamburger house
Appendix B: Leuven Family Assessment

4. In what do you like to involve yourself the most and the least?
   ______ encounter group ______ theatre
   ______ Third World ______ nature
   ______ your neighborhood ______ sports
   ______ hobby club

5. In which way do you like to travel or spend your holiday the most and the least?
   ______ with a house trailer ______ a cruise
   ______ in an apartment ______ in a cabin
   ______ in a tent ______ in a hotel
   ______ hitchhiking with a backpack

6. Which type of work do you like most and least?
   ______ taking care of patients ______ housework
   ______ research activities ______ handcrafts
   ______ counselling ______ sales
   ______ repair work

7. Which dish do you like the most and the least?
   ______ steak ______ lamb
   ______ tongue ______ turkey
   ______ vegetarian casserole ______ fish
   ______ rabbit

8. Which values do you find most and least important?
   ______ liberty ______ forgiveness
   ______ honesty ______ responsibility
   ______ equality ______ willpower
   ______ friendliness

9. Which color do you like most and least?
   ______ blue ______ yellow
   ______ green ______ red
   ______ white ______ black
   ______ brown

10. What kind of profession do you like most and least?
    ______ craftsperson ______ sportsperson
     ______ self-employment ______ researcher
     ______ teacher ______ artist
     ______ medical assistant

11. Which animal do you like the most and the least?
    ______ dog ______ tropical fish
        ______ cat ______ rabbit
        ______ monkey ______ lamb
        ______ canary bird

12. In what type of residence would you most like to live?
    ______ apartment ______ mansion
    ______ country house ______ farm
    ______ communal house ______ welfare house
    ______ isolated house

Appendix B: Leuven Family Assessment

**Interactional**: The family is given one copy of the same questionnaire now only listing the first six items. The task is changed: each member must choose only one of the seven response alternatives and must specify with whom s/he prefers to engage in the activity described. Therefore, a deliberation in the family may be needed. (20 minutes)

*Directions for family*: Each family member chooses only one activity and specifies with whom he/she would prefer to engage in the activity described. All may choose the same or different choices.

**Family-Criticism Task**

**Individual**: Each family member is given three cards. On each card there has to be written one thing the person does not like in the way the family interacts at home. This must be clearly formulated because these issues will be discussed later on. (10 minutes).

*Directions for family*: Write on each card one thing you do not like in the way the family interacts at home.

**Interactional**: The family members have to read out each criticism. Now, they have to deliberate which criticism is most important for them at that moment. Then the remaining criticisms must be ordered from the most to the least important. (20 minutes.)

*Directions for family*: Put all the cards together and read each card aloud. Decide which criticism is most important for you as a family at this moment. Put the remaining cards in order from the most to the least important.

**Break**

The family is given fruit juice, crackers, cheese and cookies, including a food to which the child is allergic, and asked to stay in the room. The video tape of this break gives an impression of the family interaction around food. (10 minutes).

**Disagreement-Task**

Each subsystem, "parents" and "children," separated in the room, has to choose one subject (problem) on which they disagree with the other subsystem and write it down on a card. They have to put the card on the table without discussing it with the other subsystem. Then, each subsystem must write down on a separate list their proposal for resolution of their own problem and of the problem formulated by the other subsystem. Once finished writing, negotiation may start. First, the parents explain the problem they have chosen, the children say what they think about it, and finally parents and children try to achieve resolution. The parents write this agreement on their card. Afterwards, the children explain their problem and a similar negotiation follows. (30 minutes).

*Directions for family*: (copy given to each subsystem)

1. Choose one problem on which you disagree with your children (parents), and write it down on the card.
2. Place the card on the table without discussing it with your children (parents).
3. On separate pieces of paper, write your solutions to the two problems.
4. When you have finished writing, negotiate as follows: first, parents explain the problem they have chosen, children say what they think of it, and try to come to an agreement about it. Then, children explain their problem, parents say what they think of it, and all try to reach agreement.

SELF-REPORT and FACES III

Each person in the family is asked to complete the FACES III questionnaire (Olsen, Portner, and Lavee, 1985: See appendix C) and the questionnaire of Kog, et Al (1989). They may take as long as they like.
APPENDIX C FAMILY ADAPTABILITY AND COHESION SCALE

FACES III
David H. Olson, Joyce Portner, and Yoav Lavee

<table>
<thead>
<tr>
<th>1 ALMOST NEVER</th>
<th>2 ONCE IN A WHILE</th>
<th>3 SOMETIMES</th>
<th>4 FREQUENTLY</th>
<th>5 ALMOST ALWAYS</th>
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<tbody>
<tr>
<td>1. Family members ask each other for help.</td>
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<td>2. In solving problems, the children's suggestions are followed.</td>
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<td>3. We approve of each other's friends.</td>
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<td>4. Children have a say in their discipline.</td>
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<td>5. We like to do things with just our immediate family.</td>
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<td>6. Different persons act as leaders in our family.</td>
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<td>7. Family members feel closer to other family members than to people outside the family.</td>
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<td>8. Our family changes its way of handling tasks.</td>
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<td>9. Family members like to spend free time with each other.</td>
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<td>10. Parent(s) and children discuss punishment together.</td>
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<td>11. Family members feel very close to each other.</td>
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<td>12. The children make the decisions in our family.</td>
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<td>13. When our family gets together for activities, everybody is present.</td>
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<td>14. Rules change in our family.</td>
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<td>15. We can easily think of things to do together as a family.</td>
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<td>16. We shift household responsibilities from person to person.</td>
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<td>17. Family members consult other family members on their decisions.</td>
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<tr>
<td>18. It is hard to identify the leader(s) in our family.</td>
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<tr>
<td>19. Family togetherness is very important.</td>
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<tr>
<td>20. It is hard to tell who does which household chores.</td>
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**APPENDIX D SYMPTOM CHART**

**SYMPTOM CHECKLIST:**

- Number of times each day symptom is experienced
- Severity of symptom on a scale of 1 (mild) to 5 (severe)

**Date:**

<table>
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<tr>
<th></th>
<th>Monday</th>
<th>Tuesday</th>
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<th>Saturday</th>
<th>Sunday</th>
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<tr>
<td>- Knees</td>
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<tr>
<td>- Eyelids</td>
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<tr>
<td>- Lips</td>
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<td>- Pain reliever</td>
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**NOTES:**
APPENDIX E TABLES

Table 4-1. Leuven Family Assessment: Behavioral Product Measures

<table>
<thead>
<tr>
<th>DIMENSION</th>
<th>INTEREST TASK</th>
<th>PRETEST/POSTTEST</th>
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<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>INTEREST TASK</strong></td>
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</tr>
<tr>
<td></td>
<td><strong>Individual</strong></td>
<td></td>
</tr>
<tr>
<td>A</td>
<td><strong>Intensity of Intrafamilial boundaries</strong></td>
<td></td>
</tr>
<tr>
<td></td>
<td>(spontaneous agreement index)</td>
<td></td>
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<tr>
<td></td>
<td><strong>System level</strong></td>
<td>-1.3  -8.0</td>
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<tr>
<td></td>
<td>-48=extremely fixed boundaries;</td>
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</tr>
<tr>
<td></td>
<td>+48=extremely loose boundaries.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Generational level</strong></td>
<td>-8.0  +4.0</td>
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<tr>
<td></td>
<td>+ = firm generational boundaries;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- = cross-generational intrusion.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Individual level</strong></td>
<td>8.0  8.0*</td>
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<tr>
<td></td>
<td>=diff betw highest and lowest scores.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Interactional</strong></td>
<td></td>
</tr>
<tr>
<td>B</td>
<td><strong>Degree of family’s adaptability</strong></td>
<td>0  25.0</td>
</tr>
<tr>
<td></td>
<td>(degree of organizational constancy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0=extreme organizational variability;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100=extreme organizational constancy)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>CRITICISM TASK</strong></td>
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</tr>
<tr>
<td>C</td>
<td><strong>Intrafamilial tension</strong></td>
<td>+2.6  +2.3</td>
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<tr>
<td></td>
<td>(recognition-avoidance of conflict ratio)</td>
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<tr>
<td></td>
<td>Min.=-3; Max =+3</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>DISAGREEMENT TASK:</strong></td>
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</tr>
<tr>
<td>D</td>
<td><strong>Family’s way of handling conflict</strong></td>
<td>10.0  7.0</td>
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<tr>
<td></td>
<td>Min.=2, spontaneous resolution;</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Max.=10, no resolution</td>
<td></td>
</tr>
</tbody>
</table>

* Reflects degree of intra-familial differences with respect to boundaries. See page 30 for interpretation of this score: while there is no apparent change in the degree of intrafamilial differences, there has been movement along the continuum.
### Table 4-2. FACES III: Individual and Family Scores

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Family Mean Score</strong></td>
<td></td>
<td></td>
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<tr>
<td>Cohesion</td>
<td>33.3</td>
<td>31.3</td>
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<tr>
<td>Adaptability</td>
<td>29.0</td>
<td>29.0</td>
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<tr>
<td><strong>Parental Subsystem Mean Score</strong></td>
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<tr>
<td>Cohesion</td>
<td>42.0</td>
<td>37.5</td>
</tr>
<tr>
<td>Adaptability</td>
<td>34.5</td>
<td>33.8</td>
</tr>
<tr>
<td><strong>Father</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesion</td>
<td>42.0</td>
<td>34.0</td>
</tr>
<tr>
<td>Adaptability</td>
<td>37.0</td>
<td>32.0</td>
</tr>
<tr>
<td><strong>Mother</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesion</td>
<td>42.0</td>
<td>41.0</td>
</tr>
<tr>
<td>Adaptability</td>
<td>32.0</td>
<td>39.0</td>
</tr>
<tr>
<td><strong>Adolescent</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cohesion</td>
<td>16.0</td>
<td>19.0</td>
</tr>
<tr>
<td>Adaptability</td>
<td>18.0</td>
<td>16.0</td>
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</table>

#### Norms for FACES III

<table>
<thead>
<tr>
<th></th>
<th><strong>INDIVIDUALS</strong></th>
<th><strong>COUPLES</strong></th>
<th><strong>FAMILIES</strong></th>
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<tr>
<td></td>
<td>Mean</td>
<td>S.D.</td>
<td>Mean</td>
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<tr>
<td>Cohesion</td>
<td>39.8</td>
<td>5.4</td>
<td>38.5</td>
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<tr>
<td>Adaptability</td>
<td>24.1</td>
<td>4.7</td>
<td>24.1</td>
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Table 4-3. FACES III Discrepancy Scores

<table>
<thead>
<tr>
<th></th>
<th>Pretest</th>
<th>Posttest</th>
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</thead>
<tbody>
<tr>
<td>Family</td>
<td>22.2</td>
<td>21.2</td>
</tr>
<tr>
<td>Parental Dyad</td>
<td>5.0</td>
<td>9.8</td>
</tr>
<tr>
<td>Husband-Adolescent</td>
<td>32.2</td>
<td>21.9</td>
</tr>
<tr>
<td>Wife-Adolescent</td>
<td>29.5</td>
<td>31.8</td>
</tr>
</tbody>
</table>
APPENDIX F FIGURES

Fig. 4-1. Leuven Family Assessment Behavioral Observation
Intensity of Intrafamilial Boundaries

ITEM # | 1 | 2 | 3
---|---|---|---
1a | | | +
1b | | + | -
2a | + | + | +
2b | + | + | +
4a | + | + | +
4b | + | + | +
5a | | | +
5b | | + | -
6 | | | +
7a | | + | -
7b | | + | -
8 | | | +

PRETEST ———— POSTTEST ————

Ratings profile: Scores represent average of 3 raters.
Range: 1 = behavior is absent
2 = behavior present to a moderate degree
3 = behavior present to high degree

RATERS QUESTIONNAIRE: DIMENSION A: BOUNDARIES
(Item numbers correspond to Fig. 4-1)

1. Do the parents talk together? a. Introduction
2. Do the children talk to the parents? b. Disagreement Task
3. Do the children talk together? a. Introduction
4. Do the parents talk to the children? b. Disagreement Task
5. Are alliances formed within the family? NOT APPLICABLE; question omitted
   a. Break
   b. Interest task: Interactional part
6. Do the family members try to reach a common family answer? Interest task: Interactional part
   a. Introduction
   b. Break
8. Does communication between family members occur? b. Break

Interest task: Interactional part

74
Fig. 4-2. Leuven Family assessment; Behavioral Observation
Degree of Family’s Adaptability

<table>
<thead>
<tr>
<th>ITEM #</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 a</td>
<td></td>
<td></td>
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<tr>
<td>2 a</td>
<td></td>
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<td></td>
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<td>3 a</td>
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<td></td>
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<td>4 a</td>
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<td>5 a</td>
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<tr>
<td>16 a</td>
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</tbody>
</table>

PRETEST ———— POSTTEST ………

Ratings profile: Scores represent average of 3 raters. Range: 1 = behavior is absent, 2 = behavior present to a moderate degree, 3 = behavior present to high degree
Fig. 4-2. (Cont.) Rater's Questionnaire

RATERS QUESTIONNAIRE: Dimension B: ADAPTABILITY
(Item numbers correspond to Fig. 4-2)

1. Does attention-seeking behavior occur?
   a. Interest task: Individual part
   b. Criticism task: Individual part

2. To what extent do family members discuss their own preferences/criticisms?
   a. Interest task: Interaction part
   b. Criticism task: Interaction part

3. Does anyone verbally disagree in the family?
   a. Interest task: Interaction part
   b. Criticism task: Interaction part

4. Does one of the parents take sides with the children? Disagreement task:
   a. Problem of parents
   b. Problem of children

4. Do family members interrupt each other?
   a. Interest task: Interaction part
   b. Criticism task: Interaction part

5. Do family members talk?
   a. Interest task: Individual part
   b. Criticism task: Individual part

6. Do family members give comments on the task?
   a. Interest task: Individual part
   b. Criticism task: Individual part

7. How long does the family discuss the problem? Disagreement task:
   a. Problem of parents
   b. Problem of children

8. Are coalitions formed?

9. Does anyone whisper?

10. Is there guidance?

11. Do the children support each other?

12. What is the contribution of the parents in the negotiation?

   What is the contribution of the children in the negotiation?

13. Does exploratory behavior occur?

14. Does attention-giving behavior occur?

15. What is the evolution of distance among family members?

   a. Interest task: Interaction part
   b. Criticism task: Interaction part

16. How much dialogue is observed in the communications?
Appendix F: Figures

Fig. 4-3. Leuven Family Assessment: Behavioral Observation: Avoidance/Recognition of Conflict

Item #

<table>
<thead>
<tr>
<th>Item</th>
<th>Pretest</th>
<th>Posttest</th>
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<tbody>
<tr>
<td>1a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
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<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
<tr>
<td>c</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5a</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Ratings profile: Scores represent average of 3 raters.
Range: 1 = behavior is absent
2 = behavior present to a moderate degree
3 = behavior present to high degree

Raters Questionnaire: Dimension C: Avoidance/Recognition of Intrafamilial Conflict
(Item numbers correspond to Fig. 4-3)

1. Does attention-seeking behavior occur?
   a. Introduction
   b. Criticism task: Individual part
   c. Break

2. Do family members talk about asthma or about IP?
   Break

3. Do family members talk about allergies or about the IP?
   Introduction
   a. Introduction
   b. Break
   c. Criticism task: Individual part

4. Does attention-giving behavior occur?
   a. Introduction
   b. Break
   c. Criticism task: Individual part

5. Do family members give comments on task?
   a. Interest task: Individual part
   b. Criticism task: Individual part
Appendix F: Figures

Fig. 4-4. Leuven Family Assessment; Behavioral Observation
Family's Way of Handling Conflict

ITEM #  1 2 3

1a
b
2a
b
3
4a
b
c
d
5
6

PRETEST ——— POSTTEST

Ratings profile: Scores represent average of 3 raters.
Range: 1 = behavior is absent
2 = behavior present to a moderate degree
3 = behavior present to high degree

RATERS QUESTIONNAIRE: DIMENSION D: FAMILIES WAY OF HANDLING CONFLICT
(Item numbers correspond to Fig. 4-4)

1. Is there a tense atmosphere in family?  a. Introduction
   b. Break
   b. Break
3. Does one of the parents take sides with the children?  a. Disagreement task: Problem of parents
4. What is the contribution of the parents in the negotiation?  Disagreement task:
   a. Problem of parents
   b. Problem of children
   Interest task: Interaction part
5. Are coalitions formed?
6. To what extent do family members compare the criticisms in order to rank them?  Criticism task: Interaction part
Appendix F: Figures

Fig. 4-5. FACES III
Family Mean Scores

CIRCUMPLEX MODEL
OF MARITAL & FAMILY SYSTEMS

In plotting the couple or family into the Circumplex Model, mark the specific location that most accurately reflects the actual scores.

BALANCED  MID-RANGE  EXTREME

PRETEST  POSTTEST
x  O

79
Fig. 4-6. FACES III
Individual Scores

CIRCUMPLEX MODEL
OF MARITAL & FAMILY SYSTEMS

In plotting the sample or family into the Circumplex Model, mark the score location that most accurately reflects the sample score.

BALANCED
MID-RANGE
EXTREME

MOTHER
FATHER
ADOLESCENT
Fig. 4-7. FACES III
Parental Dyad and Adolescent Scores

CIRCUMPLEX MODEL
OF MARITAL & FAMILY SYSTEMS

In plotting the couple or family into the Circumplex Model, mark the specific location that most accurately reflects the actual scores.

BALANCED

MID-RANGE

EXTREME

PRETEST  POSTTEST
Fig. 4-8. Timeline, Self-Report Symptom Assessment and Emergency-Room Visits

Baseline  Relaxation only  Family Therapy and Creative visualization Intervention  Seven week break
Two week break  Two week break

ASTHMA FREQUENCY X SEVERITY  VERTEALIN (# times/day)  EMERGENCY ROOM VISITS

(Note non-compliance in weeks 3 and 4 as well as weeks 6 to 13 resulting in no self-report data.)
Appendix F: Figures

Fig. 4-9. Follow-up Data: Self-Report of Symptoms obtained by Telephone

(Note no emergency room visits during follow-up period nor between posttest and follow-up)
Appendix G Autoegenic Training Handout

Autoegenic Training

Autoegenic training was developed by Johannes Schultz in Germany in the 1930's. It is taught in Europe to schoolchildren to promote healthy interaction of the body and mind. The earliest effects noted, usually within two weeks, are greater relaxation, reduced anxiety, better sleep, apparently improved memory and greater motivation. It consists of very simple commands or suggestions to oneself which are easily learned.

You may lie down on a couch, bed, or floor; or you may prefer to sit up in a comfortable position. Your legs should be slightly apart with your feet leaning outwards, and your body should be straight and not curved in any way. You can place a cushion under your knees, back and/or head for support. Be especially sure that your head is in a comfortable position.

Check out your muscles and make sure there isn't an area that is holding in any way. Your arms should lie loosely by your sides, hands relaxed. Make sure your hands are not clasped and your feet are uncrossed.

Some Important Points:

When you are repeating the phrases of relaxation to yourself try to allow the sensation to come to you rather than forcing it to happen. This passive concentration will become easier to experience as you continue to practice.

Like any skill, relaxation takes practice in order to be learned. Slow practice with many short repetitions make it easier to learn, so spend a few minutes a few times a day. Practice at least once each day, but three or more times will be best. Practicing in bed at night when you can't sleep can be very useful.

You may find it useful to practice in many situations, lying in bed, sitting at your desk at work or at school: the more places you can relax in, the more accomplished you will become.

To Begin Practice:

Make yourself comfortable in your chosen position, breathe easily, and silently repeat to yourself a few times

"I Am Completely Calm"

The first exercise is to produce relaxation in your muscles. Many people experience the sensation of heaviness, but others experience lightness, tingling, or warmth. Heaviness is the sensation used here, but use the word for whatever sensation you experience when your muscles are relaxed. As you say the words to yourself, give up the expectation that the heaviness will happen, just say the words and allow yourself to relax.
Focus your attention on your dominant arm and silently repeat...

"I AM COMPLETELY CALM"
"MY RIGHT/LEFT ARM IS VERY HEAVY" (4-6 times)
"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY HEAVY" (4-6 times)
"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY HEAVY"
"I AM COMPLETELY CALM, COMPLETELY CALM"  
Follow the same sequence for your other arm and for each of your legs. When you have finished for that session, move yourself out of this state by "CANCELLING:"

SHAKE YOUR ARM HARD... BREATHE DEEPLY ... OPEN YOUR EYES ...

You may find it useful to "CANCEL" in the middle of the exercise sometimes, so you get the feeling of moving in and out of the relaxed state.

STAGE TWO:

When you can easily experience the feeling of relaxation in your limbs, whether it is heaviness, lightness, or whatever; the next stage - WARMTH - aimed at relaxing your blood vessels is added.

Your training routine now will be:

"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY HEAVY"  (4-6 times)
"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY WARM"(4-6 times)
"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY WARM"
"I AM COMPLETELY CALM"
"MY RIGHT ARM IS VERY WARM"(4-6 times)
"I AM COMPLETELY CALM, COMPLETELY CALM"

CANCEL

SHAKE YOUR ARMS ... BREATHE DEEPLY ... OPEN YOUR EYES.

If you are having difficulties getting a feeling of heaviness and warmth, try to have a picture in your mind helping you with this. For example, seeing your arm lifting out of a bath of water can help you with heaviness, or seeing a heavy blanket on top of your arm, or a helium balloon attached to your arm if relaxation feels light to you. Picturing your hands in warm water may help you sense the warmth. Or you may put your hands in warm water just before this part of the exercise, so they are warm when you begin.

HEART EXERCISE

For this exercise you should get a sense of a phrase that is comfortable for you. This could be either "MY HEARTBEAT IS SMOOTH AND CALM" or "MY HEARTBEAT IS CALM AND REGULAR" This is a personal choice, so spend some time considering your
heartbeat and finding a phrase that fits for you. When you have chosen something, add it to your routine as follows:

"I AM COMPLETELY CALM"
"MY RIGHT ARM IS HEAVY AND WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY LEFT ARM IS HEAVY AND WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM" (4-6 times)
"I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM" (4-6 times)
"I AM COMPLETELY CALM, COMPLETELY CALM"

CANCEL:

SHAKE YOUR ARMS ... BREATHE DEEPLY ... OPEN YOUR EYES

BREATHEING EXERCISE:

Even after only 2 or 3 training sessions many people report that their breathing has become calmer and more regular. Again, a phrase that is comfortable for you is fine.

Your training routine now becomes ...
"I AM COMPLETELY CALM"
"MY ARMS ARE VERY HEAVY" (4-6 times)
"I AM COMPLETELY CALM"
"MY ARMS ARE VERY WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM" (4-6 times)
"I AM COMPLETELY CALM"
"MY BREATHING IS PASSIVE AND DEEP" (4-6 times)
"I AM COMPLETELY CALM"
CANCEL

SHAKE YOUR ARMS ... BREATHE DEEPLY ... OPEN YOUR EYES

ABDOMEN EXERCISE:

After you have learned to relax your limbs and chest organs, you can now learn to calm down your abdominal organs with the phrase - ABDOMEN FLOWINGLY WARM - or - STOMACH PLEASANTLY WARM.

"I AM COMPLETELY CALM"
"MY ARMS ARE VERY HEAVY" (4-6 times)
"I AM COMPLETELY CALM"
"MY ARMS ARE VERY WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM" (4-6 times)
"I AM COMPLETELY CALM"
"MY BREATHING IS PASSIVE AND DEEP" (4-6 times)
Appendix G: Autogenic Training Handout

"I AM COMPLETELY CALM"
"MY STOMACH IS FLOWINGLY WARM" (4-6 times)
"I AM COMPLETELY CALM, I AM COMPLETELY CALM"

CANCEL

SHAKE YOUR ARMS ... BREATHE DEEPLY ... OPEN YOUR EYES

HEAD EXERCISE:

The last phrase increases peacefulness of body and mind, and also alerts us to concentrate on mental tasks. A warm, relaxed body with a cool forehead feels very comfortable.

"I AM COMPLETELY CALM"
"MY ARMS ARE VERY HEAVY" (4-6 times)
"I AM COMPLETELY CALM"
"MY ARMS ARE VERY WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM" (4-6 times)
"I AM COMPLETELY CALM"
"MY BREATHING IS PASSIVE AND DEEP" (4-6 times)
"I AM COMPLETELY CALM"
"MY STOMACH IS FLOWINGLY WARM" (4-6 times)
"I AM COMPLETELY CALM"
"MY FOREHEAD IS COOL AND SMOOTH" (4-6 times)
"I AM COMPLETELY CALM, I AM COMPLETELY CALM"

CANCEL

SHAKE YOUR ARMS ... BREATHE DEEPLY ... OPEN YOUR EYES

SUMMARY

Sit or lie in a comfortable position.
ALLOW the sensations to happen.
Focus on breathing deeply into your abdomen for a while.

"HEAVINESS" "I AM COMPLETELY CALM"
"MY ARMS/LEGS ARE HEAVY"
"I AM COMPLETELY CALM"

"WARMTH" "I AM COMPLETELY CALM"
"MY ARMS/LEGS ARE WARM"
"I AM COMPLETELY CALM"

"HEART" "I AM COMPLETELY CALM"
"MY HEARTBEAT IS SMOOTH AND CALM"

"BREATHING" "I AM COMPLETELY CALM"
"MY BREATHING IS PASSIVE AND DEEP"
"I AM COMPLETELY CALM"

"ABDOMEN" "I AM COMPLETELY CALM"
"MY STOMACH IS FLOWINGLY WARM"
"I AM COMPLETELY CALM"
"HEAD"  "FOREHEAD IS COOL AND SMOOTH"
"I AM COMPLETELY CALM"
CANCEL  SHAKE ARMS ... BREATHE DEEPLY ... OPEN EYES

When you have become completely familiar with these training exercises, they can be abbreviated to ...

CALM ... HEAVINESS ... WARMTH

HEART AND BREATHING COMPLETELY CALM

ABDOMEN FLOWINGLY WARM

FOREHEAD COOL AND SMOOTH
APPENDIX H AUDIOTAPE SCRIPTS

INDUCTION:
- Find yourself a comfortable position, wherever you are. Take some time to pay attention to your body and what is the most comfortable position for you at this moment. Make sure you are well-supported and that there are no places where you are folded up that might cut off the circulation when you are really relaxed. Loosen any tight clothing you may be wearing...
- Now, Just close your eyes and listen to the music for a moment... You don't really need to listen to what I'm saying, just hear the sound of my voice, and the music, and let any other sounds you hear just help you to relax and be more comfortable.
- Allow yourself to become aware of your breathing...., take nice deep breaths ...and let it all out, each time .... With every breath feel the cleansing, relaxation of each breath, as you let all the tension and tightness flow away from you.
- While that is happening, allow the muscles in your shoulders to go limp, completely limp....., just let them go, Allowing any sounds you hear to be part of the relaxation as you listen to the music.
- As the muscles in your shoulders are letting go, Allow the relaxation to go down your right arm, into your hands and into your fingers. As you listen to the music and the sound of my voice just let it flow right down into your left arm and hand and into your fingers.
- Allow that relaxation to go down, flowing into and relaxing the muscles of your chest and your back and your stomach, all the way to your right leg, into the thigh and calf and toes.
- You might feel the weight of your right leg, you might feel a lightness or warmth, or different sensations as you allow your attention to flow into it and let it go,..... or you might not feel anything there..... Whatever you feel, ... Just let those relaxation sensations flow into your left leg down through the thigh and the calf and the foot and the toes, just letting yourself remain aware of all the sensations in your leg and in the rest of your body.
- Let yourself be aware of the relaxed sensations of your arms, you may feel heavy or light or tingly or you may not feel much of anything. Whatever you feel, let yourself relax into it more.
- Let yourself feel the top of your head, letting go of all those scalp muscles, let your forehead go, and your eyebrows. Allow your jaw to relax, and let that relaxation flow all the way from the top of your head through your face and your jaw and your neck; down your shoulders and into your arms; down your chest and your back and your stomach and into your legs all the way down to your feet.
- As you listen to the music and hear the sound of my voice while I count backwards from 100 to 90, allow yourself to relax and be comfortable. You might just be aware of your breathing while I count
  - 100 as you get more and more comfortable
  - 99 that relaxation falls all the way down your body to your feet
  - 98 you might be aware of different parts of your body, let those awarenesses allow you to relax even more
  - 97 ...96 ...
  - 95 more and more relaxed, drifting with the music ...
  - 94 ...
  - 93 allow every muscle to relax and feel more and more comfortable and calm, just as relaxed as you want to be now....
Appendix H: Audiotape Scripts

- Allow yourself to drift into your special place, your own healing place. Picture your place in your own way; hear the sounds of your special place, the soft movement of the air; feeling the sensations of your place, seeing whatever is there for you.....
- Breathing in the clean, fresh air, feeling the refreshing, warm sensation of the light, seeing your own special healing place with relaxed, calm warm feelings.

- As you experience yourself in your very own special place, become aware of the special light, a healing light, which surrounds you like an aura, an energy field .... healing energy, surrounding your whole body, giving your whole body a beautiful glow .... Notice now that one beam is brighter than all the others,...

---- Tapescripts identical to this point ----

FOR THE ALLERGIC CHILD:

- And let that bright beam of healing light bathe your skin, especially those areas of your skin which need special healing ... on your neck, under your chin, inside your elbows, inside your knees, all around your eyes and your eyelids and around your lips, ... let that special healing light bathe your skin with its healing energy.
- As you listen to the music, you can realize that you don't need to listen to everything I say consciously ... your unconscious mind will take in whatever it needs to help you heal yourself and it will continue to learn through the day and night whatever you need to know and to do to heal yourself.... you can just listen to the music and the sound of my voice and relax comfortably, letting that special, beautiful light bathe you in healing energy.
- And let that special, brighter beam of healing light shine into your nasal passages, down into your throat and into your bronchial tubes and in the tiny alveoli of your lungs, as you breathe gently in and out, relaxed and comfortable and calm, picturing that healing light gently cleansing and relaxing, opening and healing all the little muscles and surfaces and passages inside your body and inside your breathing. You might feel a healing sensation or normal sensation, or you might not feel anything, just picturing that beautiful light cleansing and healing all the breathing parts of your body.
- As you listen to the music, relaxed and calm, leave a beautiful, protective, healing afterglow on your skin, on the surfaces of your breathing passages from your nose to deep into your lungs.
- Another beam of beautiful healing light shining in a healing way penetrating your body, normalizing all your body's systems. Harmonizing all those systems in a healing way, separately and together, all working together ....
- Your skeletal system, all the bones and their ligaments, tendons and joints;
- The muscular system, from the tiny muscles of your face and scalp to the large, strong muscles of your thighs and calves, and the long ones from your scalp, down your neck, all the way down your back;
- The digestive system, your mouth and stomach and intestines, taking in nourishment and discarding what you don't need;
- The excretory system, filtering and discarding old used, unneeded wastes and toxins you don't need in your body or your mind...
Appendix H: Audiotape Scripts

- The circulatory system, heart beating sending chemical messages through all your arteries and veins, returning through the liver and kidney and spleen, cleansing all the chemicals you don't need any more;
- The respiratory system, nasal passages, sinuses, throat, bronchial tubes, lungs, chest muscles, air gently moving in and out;
- The immune system, all the protective cells and chemicals which defend your body from harm and illness;
- The hormone system, chemical messengers travelling to every part of your body;
- The nervous system, your brain and all your nerves, sending messages, receiving information, thinking and dreaming and feeling and knowing.....
- All the systems, even the ones you don't consciously know about and never consciously think about, let them all balance, harmonize, as you listen to the music and breathe easily through the day ...
- Now let one beam of golden glowing healing light shine to the front part of your brain, clearing, cleansing, allowing all the negative thoughts and feelings to evaporate into the light, flowing away from you, let all the hurt and angry feelings flow away from you, leaving you calm and relaxed and comfortable.
- Into the left side of your brain let the light clear that part of you, all the way to the back of the head.
- Into the right side of your brain, clearing and revitalizing, letting the negative thoughts and feelings evaporate into the light and flow away from you.
- Let those healing chemicals flow from your brain down into your skin, around the eyelids, around the lips, down your neck, flowing down into your elbows and your knees, all around your skin all over your body. Part of your unconscious, every moment of every day, without your even being aware of it, will keep those healing chemicals flowing with your breathing, healing all the systems of your body. Healing, balancing, harmonizing all the chemicals, all the hormones, all the systems which are you and your body. Your immune system will day by day become more balanced, increasing the power of healing yourself throughout your body.
- In the daytime as you listen to this tape, when the music ends you can count from 1 to 5 by yourself and wake up calm, refreshed, clear-minded and relaxed.
- When you listen to this tape in the nighttime, in your bed, ready for sleep, when the music ends, you will drift into a relaxed, peaceful sleep, knowing that your unconscious will remember and take care of the healing without your conscious attention, while you breathe easily throughout the day and night, drifting with the music ....
- Now allow the wisdom of the body/mind to grow as you listen to the music, allowing into your consciousness whatever you need to know and remember to heal yourself and harmonize yourself with yourself, your family, your friends, and your world.

FOR THE PARENTAL DYAD:

After Induction, which is identical to child's tapescript:

- Notice now that one beam is brighter than all the others,... and let that bright beam of healing light bathe your body, especially those areas of your body which need special healing ... It may be your joints, all the bending places between your bones,... Your shoulders, elbows, knees and spine,...it may be your muscles, especially old injuries, needing more healing,... might be parts of your body you hold tight to, needing more letting go, more relaxation and healing.

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- Let that special bright beam of light linger on your shoulders and neck, allowing the tension to evaporate into the light, and on your throat, allowing your breathing to become easier and freer. Allow that beam of light to find the places in your body which are needing healing and just let the light surround those areas with the special glow of healing energy.

- As you listen to the music, relaxed and calm, leave a beautiful, protective, healing afterglow on your skin and on all the places inside and outside that need healing at this time.

- As you listen to the music, you can realize that you don't need to listen to everything I say consciously ... your unconscious mind will take in whatever it needs to help you heal yourself and it will continue to learn through the day and night whatever you need to know and to do to heal yourself.... you can just listen to the music and the sound of my voice and relax comfortably, letting that golden light bathe you in healing energy.....

- Another beam of healing, golden light shining in a healing way penetrating your body, normalizing all your body's systems. Harmonizing all those systems in a healing way, separately and together, all working together ....

  - Your skeletal system, all the bones and their ligaments, tendons, and joints;
  - The muscular system, from the tiny muscles of your face and scalp to the large, strong muscles of your thighs and calves, and the long ones from your scalp, down your neck, all the way down your back;
  - The digestive system, your mouth and stomach and intestines, taking in nourishment and discarding what you don't need;
  - The excretory system, filtering and discarding old used, unneeded wastes and toxins you don't need in your body ...
  - The circulatory system, heart beating sending chemical messages and nourishment through all your arteries and veins, returning through the liver and kidney and spleen, cleansing all the chemicals you don't need any more;
  - The respiratory system, nasal passages, sinuses, throat, bronchial tubes, lungs, chest muscles, air gently moving in and out;
  - The immune system, all the protective cells and chemical which defend your body from harm and illness;
  - The hormone system, chemical messengers travelling to every part of your body;
  - The nervous system, your brain and all your nerves, sending messages, receiving information, thinking and dreaming and feeling and knowing...

- All the systems, even the ones we don’t consciously know about and never consciously think about, let them all balance, harmonize, as you listen to the music and as you breathe easily through the day ...

- And let one beam of special, glowing healing light shine to the front part of your brain, clearing, cleansing, allowing all the negative thoughts and feelings to evaporate into the light, flowing away from you, let all the hurt and angry feelings flow away from you, leaving you calm and relaxed and comfortable.

- Into the left side of your brain let the light clear that part of you, all the way to the back of the head.

- Into the right side of your brain, clearing and revitalizing, letting the negative thoughts and feelings evaporate into the light and flow away from you.

- Let those healing chemicals flow from your brain down into your body, normalizing and harmonizing as they flow into your entire body, every little corner of it. Part of your unconscious, every moment of every day, without your even being aware of it, will keep those healing chemicals flowing with your breathing, healing all the systems of your body.
Healing, balancing, harmonizing all the chemicals, all the hormones, all the systems which are you. Your immune system will day by day become more balanced, increasing the power of healing yourself throughout your body.

- In the daytime as you listen to this tape, when the music ends you can count from 1 to 5 by yourself and wake up calm, refreshed, clear-minded and relaxed.
- When you listen to this tape in the nighttime, in your bed, ready for sleep, when the music ends, you will drift into a relaxed, peaceful sleep, knowing that your unconscious will remember and take care of the healing without your conscious attention, while you breathe easily throughout the day and night.
- Now allow the wisdom of the body/mind to grow as you listen to the music, allowing into your consciousness whatever you need to know and remember to heal yourself and harmonize yourself with yourself, your family, your friends, and your world.
APPENDIX I FAMILY SESSIONS; OUTLINE AND SCRIPTS

Relaxation Sessions

In order to partially control for the effect of relaxation alone, two relaxation sessions without family therapy or visualisation were conducted.

The first session began with an introduction to the Autogenic Training method of relaxation training and each family member was given a set of instructions (Appendix G). The family was instructed to practice relaxation skills as often as possible, a minimum of twice a day. The "relaxation sessions" consisted of a short relaxation induction, a deepening of counting backwards from 100 to 90, and five minutes of music only. The ending consisted of counting from 1-5 with the instruction to awaken relaxed, calm, refreshed, and clear-headed (See below for more detailed outline). When everyone had returned to their usual state of awareness, they were asked how they experienced the relaxation. There was some discussion of hypnosis, visualisation and other trance phenomena. The family was also told that relaxation alone may have a profound effect on symptoms. No attempt was made to intervene in family dynamics, other than to emphasize that everyone has their own experience. The creation of the audio tape was discussed in the second session and the physical symptoms of each member of the family were discussed, in order to design the tapescripts to be specific for the adolescent and for the parental dyad (See Appendix H for Tapescripts). The same relaxation procedure as in the first session was then used.

RELAXATION SESSIONS SCRIPT

Request removal of hard contact lenses.

- Sit comfortably, feet on the floor, so you don't cut off the circulation as you relax. Just close your eyes and listen to the music for a moment. You don't need to listen to me, just hear the sound of my voice - every sound you hear will help you to relax and be more comfortable.
- Be aware of your breathing, take nice deep breaths and let it all out. With every breath feel the cleansing, relaxation of each breath, as you let all the tension and tightness flow away from you.
- While that is happening, allow the muscles in your shoulders to go limp, completely limp, that's it, just let them go. Allow the sounds you hear to be part of the relaxation as you listen to the music.
- Allow the relaxation to go down your right arm, into your hands and into your fingers. As you listen to the music and the sound of my voice just let it flow right down into your left arm and hand and into your fingers.
- Allow that relaxation to go down, flowing into and relaxing the muscles of your chest and your back and your stomach, all the way to your right leg, into the thigh and calf and toes.
- You might feel the weight of your right leg, or different sensations as you allow your attention to flow into it and let it go.
Appendix I: Family Sessions; Outline and Scripts

- And let that relaxation flow into your left leg down through the thigh and the calf and the foot and the toes, just letting yourself remain aware of all the sensations in your leg and in the rest of your body.
- Let yourself be aware of the relaxed sensations of your arms, you may feel heavy or light or tingly or you may feel nothing. Whatever you feel, let yourself relax into it more.
- Let yourself feel the top of your head, letting go of all those scalp muscles, let your forehead go, and your eyebrows. Allow your jaw to relax, and let that relaxation flow all the way from the top of your head through your face and your jaw and your neck; down your shoulders and into your arms; down your chest and your back and your stomach and into your legs all the way down to your feet.
- As you listen to the music and hear the sound of my voice while I count backwards from 100 to 90, allow yourself to relax and be comfortable. You might just be aware of your breathing while I count
- 100 as you get more and more comfortable
- 99 that relaxation falls all the way down your body to your feet
- 98 you might be aware of different parts of your body, let those awarenesses allow you to relax even more
- 97 ...96 ...
- 95 more and more relaxed
- 94 ...
- 93 allow every muscle to relax and feel more and more comfortable and calm
- ... 92 ... 91 ... 90

(SILENCE, LISTENING TO MUSIC 5 MINUTES)

- When you are ready to slowly come back to this room, you can keep these pleasant feelings; you can remain relaxed and comfortable, remembering what it was like to be so relaxed and comfortable. When you practice this relaxation in the coming week, in whatever convenient times or forms you choose, you will remember these feelings and experience them again.
- As I count slowly from 1-5 you will be wide awake at the count of 5 and feel really relaxed, calm and refreshed and clear-minded.

Family Therapy and CV Sessions

The general outline of each session was approximately three quarters to one hour work on family issues, one-half hour creative visualisation with music, and fifteen minutes of time for processing responses to the trance experience. Each creative visualisation was planned to incorporate or in some way address the issues of the family and the goals of the therapy.

Family therapy. The eight sessions were designed to clarify and strengthen intrafamilial and individual boundaries, encouraging individual autonomy, and to establish the responsibility of the adolescent for management of her own body, illness, and life. The parents were encouraged to clarify their limits and to decide together on consequences for their daughter's testing of those limits. This goal had a triple purpose: the first, to engage the father and to disengage the over-involved mother; the second, to uncover and work on the
parental dyad's ways of dealing with conflicting issues; and the third, to establish the parental hierarchy and define the responsibilities of the daughter versus the responsibilities of the parents.

In the process of therapy, many techniques of family therapy were used, including: reframing; teaching of communication, conflict resolution and negotiation skills; process questioning; etc. (For an overview of treatment issues in this family see Chapter 5: Discussion, for clinical observations and Chapter 6: Summary and Conclusions.)

**Creative Visualizations.** (For transcripts of visualizations, see below)
The creative visualizations were designed to deepen and enhance the learning on a metaphorical level, and to help each individual make the connection between physical symptoms and their process as a family. They were designed to metaphorically clarify and strengthen individual boundaries and autonomy, and also to promote accessing of individual and family resources for healing (Rossi, 1986).

All visualizations began with a similar induction and included reference to each person's "special healing place." Music behind the voice of the therapist was *Dreamflight II* (Ernst, 1987) or *You are the Ocean* by *****. At the end of each session, everyone in the family was asked to describe what they wished to share of their experience, and approximately fifteen minutes of discussion took place.

The first visualization was very similar to the audiotapes made, concentrating on healing of specific physical symptoms, relaxation, feelings of well-being, etc.(Appendix H). In the visualisation at that first session, the physical symptoms of each member were mentioned in a general way in order to give them an idea of what to expect in their own audiotapes.

The second visualization included putting troubles and worries in a red balloon and watching it float away (Walch, 1976), then picturing the family under a healing light, experiencing feelings of loving and caring for each other and experiencing the connections between each other which will never be severed, even though each person may distance from the others at times. Then they were asked to take a walk in their own healing place and to bring back an object which would symbolize what he/she needs to know to heal body, relationships, or feelings.

Third visualization after induction was taken from Houston (1982) "Contacting your body wisdom," Wherein a wise person is met deep inside a mountain and asked a question regarding the personal needs of the moment.

In the fourth session, after a short family session, it had been planned to use the ideodynamic healing method of Rossi and Cheek (1988) for the daughter alone; however, she refused trance work, so we discussed the issues in the family from her point of view for the remainder of the session.

Session 5 was a nearly three hour session which included no visualisation. The pattern of family conflict was demonstrated, described, and some of the family-of-origin issues which maintained it were clarified. The issue was the daughter's failure in school and her wish to transfer from the French Immersion program. In this session, which I consider to have been central to the treatment process, the interruption of the conflict situation for a creative visualisation would, in my judgement, have been artificial and counter-productive.

The sixth session continued work on conflict resolution, focussing on setting limits and defining personal boundaries. The daughter left the session in the midst of conflict and did not, therefore, experience this visualisation. After the usual induction, when the subjects
had been asked to experience themselves in their own safe healing place, they were asked to
focus on a part of themselves that most needed healing and then to experience their personal
boundary inside of which they carry their own thoughts, feelings, perceptions, beliefs, etc.
They were then asked to experience meeting another person and recognizing that person's
boundary as separate from their own, and then to leave that person and again experience
their own body and boundary alone.

In the seventh session, the creative visualisation concentrated on a particular
symptom, chosen by each individual before the induction, but not identified aloud. After
reaching the healing place, subjects were asked to again experience their own boundary and
then to concentrate the special healing light on the place in their body where they
experienced the symptom they had chosen. The process of Rossi (1986) "converting the
symptom into a signal" was then used with some modifications.

In the eighth and last session, which again separated the parents and their
daughter, the parents chose to evaluate their progress and discuss possible future issues
rather than visualize: in the session with the daughter, Rossi's symptom conversion process
was used again.

**INDUCTION:** used in all sessions, though shortened somewhat in later sessions:

- now, Just close your eyes and listen to the music for a moment... You don't really need to
listen to what I'm saying, just hear the sound of my voice, and the music, and let any other
sounds you hear just help you to relax and be more comfortable.

- Allow yourself to become aware of your breathing..., take nice deep breaths ...and let it all
out, each time .... With every breath feel the cleansing, relaxation of each breath, as you let
all the tension and tightness flow away from you.

- While that is happening, allow the muscles in your shoulders to go limp, completely limp....,
just let them go, Allowing any sounds you hear to be part of the relaxation as you listen to
the music.

- as the muscles in your shoulders are letting go, Allow the relaxation to go down your right
arm, into your hands and into your fingers. As you listen to the music and the sound of my
voice just let it flow right down into your left arm and hand and into your fingers.

- Allow that relaxation to go down, flowing into and relaxing the muscles of your chest and
your back and your stomach, all the way to your right leg, into the thigh and calf and toes.

- You might feel the weight of your right leg, you might feel a lightness or warmth, or
different sensations as you allow your attention to flow into it and let it go,..... or you might
not feel anything there.... Whatever you feel, ... Just let those relaxation sensations flow into
your left leg down through the thigh and the calf and the foot and the toes, just letting
yourself remain aware of all the sensations in your leg and in the rest of your body.

- Let yourself be aware of the relaxed sensations of your arms, you may feel heavy or light or
tingly or you may not feel much of anything. Whatever you feel, let yourself relax into it
more.
Appendix I: Family Sessions; Outline and Scripts

- Let yourself feel the top of your head, letting go of all those scalp muscles, let your forehead go, and your eyebrows. Allow your jaw to relax, and let that relaxation flow all the way from the top of your head through your face and your jaw and your neck; down your shoulders and into your arms; down your chest and your back and your stomach and into your legs all the way down to your feet.

- As you listen to the music and hear the sound of my voice while I count backwards from 100 to 90, allow yourself to relax and be comfortable. You might just be aware of your breathing while I count

- 100 as you get more and more comfortable

- 99 that relaxation falls all the way down your body to your feet

- 98 you might be aware of different parts of your body, let those awarenesses allow you to relax even more

- 97 ...96 ...

- 95 more and more relaxed, drifting with the music ...

... 94 ...

- 93 allow every muscle to relax and feel more and more comfortable, and calm, just as relaxed as you want to be now....

... 92 ... 91 ... 90

Allow yourself to drift into your special place, your own healing place. Picture your place in your own way; hear the sounds of your special place, the soft movement of the air; feeling the sensations of your place, seeing whatever is there for you.....

-breathing in the clean, fresh air, feeling the refreshing, warm sensation of the light, seeing your own special healing place with relaxed, calm warm feelings.

Continue with the further contents below:

SESSION 2

- as you allow yourself to relax and enjoy your own special place, notice the quality of the healing light, shining on you and those parts of you that most need healing right now, just enjoy the calm warm feelings as that special healing light surrounds you in comfort.

- now notice there in your own special healing place near you a red balloon, with a basket hanging from it and a pencil and paper in the basket. Now take that pencil and paper in your hands and write down all your troubles and worries you've brought with you and you carry around with you. Just take a minute to write down those troubles and worries, just a few words or sentences to represent each one ....
Appendix I: Family Sessions; Outline and Scripts

- Now place that paper and pencil into the basket underneath that red balloon and watch that red balloon float away.... taking all your troubles and worries away with it..... you can always get your cares and worries back when you need to attend to them, but for now just let them float away, you don't need to carry them around all the time.

- And as you watch that red balloon float up, up into the air, you can allow a sense of relief to flow through your body, relaxing you and comforting you even more.

- As you relax and enjoy your own special healing place, turn away from that red balloon, receding into the distance and experience yourself there with your family, see them standing or sitting, feel their presence in your special healing place. Here you are together, the three of you, a family and there are other members who are here only as memories, even just from an hour ago. And as you let that special healing light washes flowingly over you, you might want to let all your hurt and angry feelings just flow away from you, evaporating into the light; there is a time for expression of those feelings, but that time is not now, in this moment. Let all those loving, caring feelings you feel for your mom flow toward her and toward those memories of her, and those loving, caring feelings flow toward your dad.... At let yourself feel the caring, loving feelings coming from your mum and your dad. And let yourself know that whatever you are doing, wherever you are, those caring loving feelings are inside you because that part doesn't change.

- Send loving caring feelings to each other and experience the loving caring feelings coming from each other. Feel the connections between you, then see the light split into three beams of healing light, one for each. Experience the connections as you move away from each other and notice the feelings as you come back together, then move away again.

- Let yourself move away into your own safe place, all alone, enjoying on your own and recognize that those connections between you are still there, even when you are not together, and that they will always be there. In your own special healing place, take a walk, look for things that have meaning for you, look for some object that you can bring back which will remind you of what you need to know to heal your body, your relationships, your feelings, whatever is important to you right now. Discover it, touch it, think about why you need it right now, keep walking so you can bring it back.

SESSION 3

- Now take a walk from your own special healing place down into a beautiful valley, taking your time, enjoying the fresh air, walking easily down the steep path, around the rocks and trees.

- At the bottom of the hill, walking along, come upon a door in the side of a low hill, a door with a key hanging next to it. Take the key, unlock the door, and close the door or leave it open, whichever you prefer, whichever you are most comfortable with. Walking along the corridor, feeling curious, relaxed, calm, expectant, experiencing the beautiful, soft healing light of this healing place. Noticing the beautiful pictures on the wall, scenes of interesting things, organic shapes, beautiful colors, leaving behind your cares and worries, fears and troubles, so you can give your full attention to the question you have come to ask.

- Walk along the corridor, enjoying the feelings, the sights, the soft sound of your own relaxed breathing, and come upon another door, which you open now and look in to see a lovely room with a great feeling of peace and calm, and in a chair in this lovely room is sitting a very wise person who may look like someone you've met before, but maybe not....
Appendix I: Family Sessions; Outline and Scripts

- This wise person calmly says "I know you have a question for me." So you ask the question, in words, or pictures, or feelings, or maybe all or those ways......
- Give yourself some time to explain your question and receive the answer in whatever form it comes..... words, visions, sounds, feelings, whatever form it comes......

(silence, only music for approximately 2 minutes)

- When you have finished with your conversation, your question and answer, take a moment to thank the wise person and then ask if there is anything you can do for him or her?
- As you take your leave, the wise person gives you a gift, and you take your leave, knowing you can always come back, whenever you have a question, or even to learn what your next one will be.
- Walk back along the corridor, slowly thinking about what you have learned and how you will remember it. You can pick up your worries and concerns, your everyday bothers, where you left them if you want to; or, you can look them over carefully and leave some of them behind if you want to ....
- As you walk back up the hill after closing and locking the door, you can think about coming back to this room, bringing back whatever you want or need from this experience.
- And as I count from one to five you will begin to wake up and when you return you will be relaxed, clear-minded, refreshed.

SESSION 4: no visualisation; adolescent refused trance.

SESSION 5: no visualisation; highly conflictual, very long session.

SESSION 6

As subjects prepared for this visualisation, they were asked to think about "how you do conflict, how you set limits and how you want to set limits; about the boundaries in your family and how you differentiate who is who and what is what."

During the induction, phrases were introduced referring to paying attention to the unconscious, creative part of yourself, the part of you that knows what you need right now.

- As you imagine yourself in your own safe healing place, create what you need to be there. Let that beautiful, healing light surround you and concentrate on the part of you that most needs healing right now. It might be your body, it might be your thoughts, your perceptions, your feelings..... whatever you need. Allow that special glowing light to outline your own body, your own being, the place where you end and the other stuff begins. It might be your skin, but for most people, its a ways out from your skin.... Really get a sense, let that light outline for you, your own body-place and your own boundary where you feel safe. It might be farther out from you in different parts of your body, might be thicker or thinner in places....
- Now imagine yourself walking around in your safe place, taking your boundary with you. This is the part of you that is all you; no one else, only you. Inside this space are your thoughts, your feelings, your body, your being. Your perceptions, your interpretations, your beliefs, all those things which are all you and no one else..... And experiment with that
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boundary - let it move in closer to you and farther away from you... so you can be sure of the distance that really exists in your being.

- And now, imagine that someone is way far off in the distance and you are walking toward that person. And you are aware of that person's boundary as well as you own - that special healing light is outlining the boundary of that person. And go only as close to that person as you wish to. It is completely up to you how close to that person you want to get, whether you want to touch .... and experiment with that distance. Come a little closer, a little farther, so you're really sure what you want that distance to be.

- Now thank that person for allowing you to experience yourself in their presence and walk away..... And experience yourself alone again. Now just take some time to feel your body and do whatever you want. You may wish to see some other people, you may wish to be alone.... but whatever you do remain aware of your own boundary.... As you listen to the music....

(two minutes of music only)

As part of bringing subjects out of the trance state, they were asked to "bring your new awareness of your boundary with you, experience it with everyone in your life, every day."

SESSION 7

This session is based on Rossi (1986) "Converting a symptom into a signal," page 175. As subjects prepared for induction, they were asked "As you start to relax, pick a physical symptom you have, just any symptom you might want to explore..
In the special healing place, subjects were asked again to experience their own personal boundaries, inside of which they carry their own thoughts, feelings, etc. and to allow the special healing light to surround that boundary.

- Now remember that physical symptom you are curious about. Allow that special healing light to concentrate and become stronger on those parts of your body which experience that symptom...
- On a scale of 1 to 100, where 100 is the worst, what number expresses the degree to which you are experiencing that symptom right now?
- Recognize how that symptom intensity is actually a signal of just how strong another, deeper part of you needs to be recognized and understood right now.....
- Allow your creative unconscious, your inner mind to help you access the deeper meaning of your symptom, as you relax and get more comfortable....
- You can review the first time you experienced that symptom.....
- Now ask that symptom what it is saying to you...
- You can discuss with your symptom what changes are needed in your life.....
- How will you now use that symptom as an important signal?
- Take some time now and finish your conversation with your symptom....

(2 minutes music only)

SESSION 8

Induction includes: You need lots of little strategies, that creative part of you knows your parents and knows what you need to do in order to be who you are.... and somehow,
Appendix I: Family Sessions; Outline and Scripts

your symptoms are connected to all that. And so, when you discover strategies that you need... and you won't only need them at home, you'll need them with everybody. You'll need them out in the world. When you discover what these strategies are, your symptoms will get better....

( short relaxation induction)

- While you are in your safe place, experience the healing light, breathing in the beautiful healing light, allow that beautiful healing light to surround your whole body, and surrounding your boundary; helping you to experience your own self..... your own feelings, your own thoughts, your own body, your own perceptions,m your own decisions, your own responsibilities, your own fears, your own joys......
- Pay special attention to your own physical symptoms.... choose one you want to concentrate on right now, one you are curious about... And assign that symptom a number between 1 and 100 that indicates just how much or how little you are experiencing it right now.... and allow yourself to recognize how that symptom intensity is actually being a signal of just how strongly another deeper part of you needs to be recognized and understood right now....
- And while your creative unconscious, that part of you that knows what you need, knows what you want..... let that part of you help you access the deeper meaning of your symptoms.
- And also to review the original sources of your symptom. When did it begin?..... and how did you do that?.....
- You can ask your symptom what it is saying to you....
- You can discuss with your symptom what changes are needed in your life.....
- And now ask yourself how will you use your symptom as an important signal in your life....
- You can ask your inner mind how your consciousness can cooperate at this time in resolving that problem or that symptom....
- And now you can do what ever you like as you listen to the music; take a journey wherever you want to go... and bring back from your journey and from this experience whatever you need to know.

(2 minutes music)

VISUALISATION ENDING

Each visualisation ended with the following paragraph:

- Now, as you prepare yourself to come back to this room, I will be counting from one to five and you will awaken still relaxed, and calm, clear-minded and refreshed... bringing back with you whatever you need to know from this experience, whatever you want to remember....
- One.... two.... three..... four........ five...... And you can open your eyes whenever you feel ready to come back to this room.