PRACTICUM

FAMILY THERAPY
WITH FAMILIES WHO
HAVE SPECIAL NEEDS CHILDREN

By

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A PRACTICUM PRESENTED TO THE FACULTY OF
GRADUATE STUDIES IN PARTIAL FULFILLMENT
OF THE REQUIREMENT FOR THE DEGREE

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HAVE SPECIAL NEEDS CHILDREN

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A Thesis/Practicum submitted to the Faculty of Graduate Studies of the University of Manitoba
in partial fulfillment of the requirements for the degree of

MASTER OF SOCIAL WORK

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ABSTRACT

Childhood disability is a life experience that has both long and short term consequences for the family. Traditionally Health and Social Services has tended to direct its attention on the individual child and that has been the major focus for service delivery. This emphasis has been on medical treatment, rehabilitation, or education of the child and it is only recently that professionals have broadened their perspective to include family functioning. This is a result of the study and understanding of Family Therapy, the foundation of which is based on the principle that the family is a system of which the individual is a part. "Though each unit is made up of several interrelated segments, a system is more than the sum of its parts and is therefore said to have emergent or synergistic qualities. In other words, a family system is not a collection of individuals, but an entity that exerts a powerful influence on its constituent members while simultaneously being subject to their influence" (Bernier, 1990, p. 591).

The purpose of this practicum is two fold. The first is to gain an understanding of family dynamics of those families who have a special needs child. The second purpose is to refine my skills as a family therapist. The models I chose to work with were the Structural and Solution Focused Models of family therapy. I also incorporated the use of the Genogram in the assessment of the family and used the FAM III as the measurement to assess change. Two case examples are presented to illustrate this approach.

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*This practicum is dedicated to the memory of a very close friend,

IRV GOLDSTEIN

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CHAPTER I   INTRODUCTION

Much has been written on the subject of families and most recently about the subject of Family Therapy. From the outset of my career, I have always known that I would like to work in the area of Family Therapy. As I began to work in the area of child protection, my observation was that not every family on my case load had dysfunctional patterns, but they did have difficulty coping with their lives. A number of my clients were normal families that had children with hearing impairments, physical or mental disabilities who were thrust into a situation whereby their needs were unique to them and I found I needed to gain more knowledge and experience to be an effective Social Worker.

It was when I moved on to work at the Society for Manitobans with Disabilities that I decided to use my practicum experience to learn more about families who had special needs children. I felt strongly that it wasn't only the children who had special needs, but the families as well. It became imperative to understand the dynamics of the special needs family, because while they were like any other family, they also had characteristics that were unique. I later learned that experiences such as grieving, chronic sorrow, developmental transitions, and adjustments were natural parts of the development of the family life cycle. The family also had systemic interactions that could be different than non-disabled families. This ranged from their own extended family system whereby the relationships with family members may be very disengaged or overly enmeshed, to

the interaction of external systems such as the medical, educational and vocational systems. There could be numerous helpers in numerous systems, or a family could be isolated and independent.

What happened next was a marriage of my two interests. I chose to study the art of being a Family Therapist with my interest in families that had special needs children and this practicum experience was born. My goal in undertaking this learning experience was to gain a grounding in the theory and practice of family therapy and to understand the family life cycle and unique characteristics of the special needs family. At the time of my exploration, I was interested in two models of family therapy: the Structural Model, pioneered by Salvador Minuchin, and Solution Focused Therapy, pioneered by Steve de Shazer. By studying both of these models, I hoped to gain a broader perspective of both theory and practice.

As I proceeded through the course of the practicum, I began to realize that while both models focus on solving the problem, both have very different perspectives on the method of finding the solution.

Minuchin's model focuses on elements such as hierarchy, triangulation, enmeshment and disengagement and problem solves by realigning the system to its proper structure, while de Shazer focuses on helping the family design how they would like to see the problem solved, considering them the experts in their situation.

There were times when I was able to integrate the two models, especially at the beginning of treatment, but there were times when the two seemed incongruent. This practicum describes how I was able to use these models and at the conclusion, I will detail the similarities and contradictions.

The goals of this practicums were designed to enable me to gain knowledge in the area of family therapy and understanding special needs families. The following were my personal learning objectives.

1. To gain a comprehensive knowledge of the impact of childhood disability on the family through the life cycle through a review of the literature and practice experience.

2. To acquire the skills and knowledge to apply an integrated model of structural and solution focused therapy as a practice model for intervening with these family systems.

3. To develop assessment and intervention skills in working with disabled children and their families through the use of genograms.

4. To be able to systematically evaluate the effectiveness of the selected approach in working with this specific population.

5. To receive feedback about my strengths and weaknesses as a family therapist.

ORGANIZATION OF THE PRACTICUM REPORT

This practicum report is organized into six chapters. The report begins with a brief introduction outlining the practicum goal of providing intervention from a structural family therapy model and a solution focused model of therapy to families who have special needs children. The learning objectives and intervention objectives of the practicum are also presented.

Chapter I provides the introduction and organization of this report.

Chapter II provides the literature review on (1) families who have special needs children, (2) implications for social work practice, (3) Structural Family Therapy and (4) Solution Focused Therapy.

Chapter III provides information on practicum methods, procedures, evaluation instrument, setting and client population.

Chapter IV provides case reviews outlining family historical data, clinical interventions, treatment outcomes and FAM III results.

Chapter V provides information on the prevailing practice themes discovered across cases treated during this practicum, and themes related to the models of practice in Family Therapy, and

Chapter VI provides a summary of the practicum experience outlining clinical issues and goal assessment.

CHAPTER II

LITERATURE REVIEW

Traditionally, research and literature focusing on childhood disability has been dominated by focusing on the individual child. It is only recently that research has begun to understand family dynamics, not only understanding the hardships, but also focusing on family strengths. Children learn strategies of coping and adaptation from their transactions with family members. Understanding the emotional impact of illness related stress on parents, siblings, and extended family members, and on the family as a system is critical for the helping professional.

This chapter is divided into three parts. The first part reviews the current literature pertaining to the understanding of families who have special needs children. In this context, children with special needs can be defined as children who have a chronic illness, a physical disability or a developmental delay. The second section discusses implications for social work practice, and the third is an overview of the literature explaining the models of Family Therapy used in this practicum. These three sections will give the reader an understanding of the foundation for the therapists ideology.

The framework for understanding these families will be within the context of the family life cycle. An overview of this type allows the practitioner to

understand how the family moves through time, having to meet the needs of their special needs child as well as their other children.

The first section will begin by looking at the family life cycle and how a child with a disability influences that process. It will then explore the impact of learning about the disability and its effect on the individual as well as the family. The effects of the family will further explore the stages of mourning, the chronic burden of care, marital adjustment, acceptance and the effects on siblings and extended family members. Finally, it will examine models of intervention for the professional.

The family life cycle is a series of developmental stages in which during a particular stage, the family's lifestyle is relatively stable and each member is engaged in developmental tasks related to that period of life (Duval, 1957). Carter and McGoldrick (1982) have identified six major stages of development and examined variations that influence these stages. These stages allow us to view the family in the context of normal patterns of development. Haley (1973) viewed family stress as highest at the transition points from one stage to another of the family developmental process and symptoms as most likely to appear when there is an interruption or dislocation in the unfolding family life cycle (Haley, 1973).

Carter and McGoldrick (1982) have identified a family as having a vertical and horizontal axis. The vertical axis includes patterns of relating and functioning that are transmitted through the generations in a family. These may include family attributes, expectations, taboos, and themes. The horizontal axis includes the anxiety produced by the stresses on the family as it moves through time, coping with the changes and transitions of the family life cycle. It includes both predictable developmental stresses and unpredictable events that may disrupt their lives. These include the birth of a disabled child, untimely death, war, unemployment, chronic illness, etc. Carter and McGoldrick believe that the degree of anxiety engendered by the stress on the vertical and horizontal axes at the points where they converge is the key determinant of how well the family will manage its transitions through life. They continue to state that it is imperative to assess not only the dimensions of the current life stress, but also their connection to family themes, triangles, and labels coming down in the family over time (Carter & McGoldrick, 1982).

Turnbull and Turnbull (1990) have identified a systems framework for a family with a disabled member. This model includes four components: 1) family characteristics which are the descriptive features that describe a family, 2) family interaction, which is the ongoing process of family relationships that is responsive to individual and family needs, 3) family function, which refers to the varying

categories of needs that a family requires such as economic or health needs, and finally, 4) the family life cycle which represents the sequence of changes that affect family through time. Turnbull and Turnbull have also identified a number of pertinent issues encountered by parents and siblings at life-cycle stages. These transition points may be particularly difficult for families who have a child with a disability. Being able to predict these stages, may not make the process of passing through them any easier, but it certainly validates the feelings and emotions that families experience.

Families with disabled children experience stages that are unique to them. The birth of an abnormal or chronically ill child may provoke a crisis for the family. All of the hopes and dreams associated with having a normal child are shattered, leaving the family confronted with a traumatic and unexpected situation. Sometimes, the family does not have an immediate diagnosis of childhood disability, but have indications that their child is not developing at the normal rate. This can prolong the crisis, and may induce a high state of anxiety. The family is affected on many levels. On one level, they may need to provide immediate care for the child, such as medical interventions, additional hospitalization, or support from other family members. On an interpersonal level, the family may be forced to deal with labeling, stereotyping, and isolation. On a cognitive level, the family is often forced to understand and process technical information, understanding the

diagnosis and its implications. Finally, on an affective level, the family has to begin to deal with their emotions (Ellis, 1989).

Various studies have described the ways in which most families deal with their feelings during this time. Collins-Moore (1984) describes a general pattern to parents' reactions. She states that there is initial shock, including denial and disbelief. While this is initially a coping mechanism, if prolonged, it can interfere with good medical management and psychological adaptation by both the parents and the child. Grief or mourning reactions are felt. Parents grieve for their loss of the "perfect child", for the missing or defective part of the child, for a perceived loss of their own self-esteem, or perceptions of ongoing losses in their lives due to the continuous responsibilities for the child. In addition, parents may carry guilty feelings about things they might have done differently or blame themselves for not producing a "perfect child". These feelings tend to be experienced by the parent as his or her own defect. Arising from these feelings, are often reactions of anger and depression. This anger can be directed towards themselves or to one of the medical professionals.

Solnit and Stark (1961) examined the grieving process following the birth of a disabled child, and they suggested that it most typically has three stages: numbness, disappointment, and re-experience. The parents must mourn the loss of the "perfect child" before they can accept the child they have. Drotar et al. (1975)

cites a sequence of typical reactions. They are: shock, denial, sadness, anger, anxiety, adaptation and reorganization, while Gargiulo (1985) identified three stages: Primary phase, characterized by shock, denial, and grief and depression. Secondary phase, marked by ambivalence, guilt, anger, shame and embarrassment; and the Tertiary phase which includes bargaining, adaptation reorganization, and finally, acceptance and adjustment.

There is a debate in the literature as to whether or not people adapt to the crisis in a clear patterned way of responses, or whether there is something known as "chronic grief". Olshansky (1962) argues that parents of handicapped children do not ever give up grieving for their child. His concept of chronic sorrow includes the idea that parents will continue to grieve for their child at different times and with different intensities. In his view, chronic sorrow is a natural reaction, and is considered normal and not pathological. Hillyer Davis (1987) agrees. She states, "The imposition of stage models on this experience distorts the experience and limits our understanding of the psychology of mourning" (p.352). Her study showed that parents descriptions of their sorrow show a course of recurrent, cyclic sadness. They were periodic rather than continuous. Kratochvil and Devereux (1988) in their study suggested also, that parents identified recurring grief. They suggest that some of the literature likens parents reaction to the birth of a handicapped child to that of mourning. However,

there is a significant difference between the birth of a handicapped child and the death of a child. With the birth of a handicapped child, the parents must begin to care for the child, not allowing any time to work through the mourning of the loss of the perfect child. "The handicapped child lives as a daily reminder of the loss, making it more difficult for parents to reconcile the loss and resume their lives" (p.421). The other important point they make is that the concept of defined stages, with progressive movement through these stages, presupposes the designation of a final stage of closure, adjustment or acceptance of the situation (Kratochvil & Devereux, 1988).

Wikler (1981) takes the idea of chronic sorrow one step further. She states that parents face stresses that continue over the lifetime. It is those times when there normally would be a developmental transition that stress and sorrow will be exacerbated. At various points in time, the parents loss of the fantasized normal child will be reactivated. Often times these are predictable. Her argument is that a crisis occurs following the diagnosis, but the conclusion that the gradually regained equilibrium is permanent, is probably incorrect. "Rearing a mentally retarded child brings with it a whole life of shattered expectations. If tension between what is expected and what occurs produces one crisis, (the diagnostic crisis) that dynamic also should hold for later periods of important expectations" (p. 284-285). She hypothesizes ten critical periods that are potentially stressful for

families. Five developmental crises can be identified on the basis of the normal child's developmental milestones such as the child walking, talking, starting school, the onset of puberty, and the twenty first birthday. The second group of critical periods include transitions away from the family making decisions and having professionals take on those tasks. The parents are reminded at each point that had their child been normal, they would not be involved in this process. The most obvious and most traumatic point is the professional involvement of the diagnosis. The next one is when parents consider the possibility of having others raise their child, followed by the developmental stage when the normal sibling at a younger age begins to perform at a higher developmental level than the retarded child. The ninth and tenth crises arise from child management problems and discussion about guardianship of the child as the parents grow older and worry about their own mortality (Wikler, 1981).

Drotar et al. (1984) in their study of families with a chronically ill child identify how chronic illness intersects with family and individual developmental issues. "For example, having a child with a chronic illness may present a special burden on the newly married couple who is in process of stabilizing family identity. The presence of a chronically ill child may threaten extended family members by intensifying concerns about death and / or dependency between parents and grandparents. Moreover, developmental transitions in the child's life can be

very much affected by a chronic illness. For example, in the case of life-threatening illness, anxieties about the future may disrupt the child's ability to individuate from the family in line with societal expectations. For this reason, it is no accident that the psychological problems of chronically ill children often present at critical times in development, such as the beginning of school or onset of adolescence, which require increased demand for independence" (p.105).

Hillyer Davis (1987) makes two important observations. The first one is that while one needs to be aware of the theme of recurrent grief, and the chronic nature of parental sorrow, it does not minimize the depth of pain for the person experiencing the feelings, nor does it obviate the need to address sadness and grief in an effort to help parents learn to cope. More important, Davis raises the issue of social and ethnic factors that complicate resolution. Some cultures may demand that a mother accept a handicapped child as God's will and her "cross to bear", thus stifling the mourning process. "The assumption that "good mothers" accept and love their children, no matter what, interacts with stage theories of grief, causing these mothers to perceive prolonged sorrow as a personal flaw" (Hillyer Davis, 1987, p.352). In other cultures, the stigma of a handicapped child may reflect on a father's manhood, causing him to deny the disability, reject the child, or blame the mother. Parents are expected to both mourn for the loss of

their idealized child, and accept him / her at the same time. The natural process of grieving is often not available to them.

While many theorists have presented becoming the parents of a disabled child as very traumatic and negative, these reactions are not necessarily experienced the same way by all families. Seligman & Darling (1989) suggest that because of the great diversity and lack of homogeneity among families, there is no single reaction or sequence of reactions that can be found in all parents of children with disabilities. They state, "...parental reactions would be interpreted within the context of the parents' interactional histories prior to their child's birth and their experiences afterwards. Parents attach meanings to their experiences as a result of definitions they have encountered in their interactions with others" (p.31). Seligman & Darling conclude that "the degree to which the family is in trouble may depend on how it conceptualizes or reframes its life circumstance, how supportive family members are of one another, and the availability of social support outside the family" (p.88).

In summary, the experience of families with special needs children in the family may bring crisis and adaptation. The notion of stages and chronic grief have been discussed, leaving some remaining questions. How do families cope? How do siblings adjust to having a brother or sister that have special requirements? Are there gender differences in coping strategies, and what are the

strengths that families exhibit? What are some of the differences between those families who cope successively and those who don't? These questions will be addressed in the next section.

Crinic et al. (1983) raise an important point when understanding the adaptation of families with special needs children. They note, "The impact of mental retardation is never restricted to retarded individuals; members of the immediate families and extended families are affected to varying degrees. The relationships and influences between retarded children and their families would also seem to be reciprocal and circular; i.e., although families are affected by the presence of retarded children, so too are the children affected by their families response" (p.125).

This is confirmed in a study done by Trute (1990). This study examined the importance of marital adjustment as a key predictor of family functioning in households containing young disabled children. Results showed that marital cohesion where parents worked as a team increased family strength. "A key element in positive family adaptation appears to be the level of dyadic cohesion" (p. 295). Two other factors emerged. It was found that when paternal education was factored in, higher education levels predicted higher overall family functioning. Furthermore, as marital consensus increases, and parents have a higher level of joint agreement of life issues, family functioning is further increased. Trute's study

also noted two other attributes. First, larger families tended to be more distressed and at higher risk, leading one to believe that larger families were overwhelmed with the demands of a large family and unable to have all the resources required. A second attribute related to family functioning was the availability of adequate financial resources. Trute notes, "One could not say that if you have a good income, your family will cope well with a disabled child, However, one could say that having a disabled child in the household will be of financial consequence to the parents" (p. 296).

Valentine (1993) conducted a study of twenty five families caring for disabled children looking at the sources of stress and support available to them. Utilizing the ecomap as assessment tool, she suggests that there are four family profiles: the well supported family; the stressed family; the isolated family; and the overextended family. She emphasizes that these are based on clinical descriptions and suggest a clustering for the assessment of families. The well supported families indicated that they had more supportive relationships than stressful ones. These families report that they received the help and encouragement they needed most of the time. They communicate a sense of optimism and contentment, and report a sense of belonging. Stressed families indicated that they experience more stressful relationships with others than they did supportive ones. They describe such symptoms as chronic fatigue, ill health, physical complaints, sleep problems, anxiety

and confusion. It was also interesting to note that every family who reported a predominance of stressful relationships, also reported that they frequently felt angry and hostile. Isolated families reported few connections of either a supportive or stressful nature, leaving them with feelings of helplessness, sadness, and loneliness. Overextended families identified so many responsibilities and interactions with others outside their families that time and energy became a scarce resource. Families reported feeling overwhelmed and tired, not having enough time to do everything that needed to be done. These families were more likely to characterize themselves as frantic or suffering from occasional feelings of inadequacy.

Trute and Hauch (1988) in their study of successful adapted families tested the role of social support in the family adjustment to the birth of a developmentally disabled child. Their findings suggested that successful adaptation depended on families having small, but dense social networks of support. The women stated that the majority of their closest contacts were with other women, mostly long time friends. However, some were recent friends and many were with new family members. Therefore while the number of social contacts were small, they were abundant in support provision. They conclude by stating, "Parental skill in the utilization of extended family, friendship, and professional resources appear to be of high relevance in a family system's positive reorganization following the birth of a developmentally disabled child" (p.14).

Dunlap & Hollinsworth (1977) interviewed four hundred families to investigate some of the effects on the family having a developmentally disabled child. They looked at employment decisions, locations of where to live and vacations. They also assessed marital relationships and financial demands on the family. Their research indicated that the overwhelming majority of those interviewed did not perceive the developmentally disabled child to have significantly affected family relationships and activities. Where it indicated stress, was in the area of finances. The handicaps that imposed physical and time demands, and those requiring extra expense, were more likely to result in the family thinking the child had affected the family. The authors are quick to point out that the population from which the sample was drawn was predominantly rural and poor.

Another measure of the coping ability of the special needs family would be the divorce rate. Roesel & Lawlis (1983) conducted an investigation of the relationship of divorce rate as a measure of adaptive response to a diagnosis of genetic disability with associated mental retardation. They also attempted to identify predictors of those at risk for divorce. Their findings were very interesting. The parents of a mentally retarded / genetically handicapped child were found to have a significantly lower divorce rate than the general population. They cite Caplan when they report, "Caplan's (1964) theory of crisis tells us that the resolution of the crisis of the diagnosis of a genetically handicapped child may lead to a lower, the

same, or a higher level of functioning as a consequence of the crisis experience"
(p. 48). The two risk factors they cited were firstly, having a male child created
more stress, either because of the social expectations placed on having a male
child, or the fact that male retarded children tend to have more physical problems
than female children. The second factor that increased the risk for divorce was
where the mother has a first born genetically handicapped child in her early
thirties as opposed to the lower risk for families who have a later born child
when the mother is in her thirties. The explanation for this is that these families
are better prepared to cope with the birth of a retarded child because there are
older children to assist with the care requirements and because the parents
welcome the assurance of the continuing presence of a child in the home.
However, it is likely that parents who wait until they are in their thirties to have
a child, have high expectations of the event (Roesel & Lawlis, 1983).

Inevitably, people may divorce whether it is because of the added stresses
of having a disabled child in the home, or because general statistics show a trend
toward high incidents of divorce in our society. The question then arises: is there
a difference between the stresses and hardships in a two parent family or a single
parent family? McCubbin (1989) conducted a study of parental coping examining
twenty seven single parent families and twenty seven, two parent families of
children who had cerebral palsy. Her study looked at the difference in family

stresses, resources, family types, parental coping patterns, and child health indicators. Contrary to the expectation of the researcher, there was no significant difference in family stress between single parent families and two parent families. In fact, the study showed that the mean stress level in both family groups were characterized as moderate. One critical difference between the two groups of families, was that single parent families were more adaptable and flexible with an ability to change the power structure, negotiation styles, role relationships, and relationship rules in response to normative and situational stress. Two areas of vulnerability were found among the single parents. Lower financial well being, a major stressor, indicated not only a lower income and diminished ability to meet financial commitments but also lowered optimism about the family's financial future. The other area of vulnerability was that single mothers were not able to utilize helpful coping strategies that enhanced family togetherness, unity, and a positive outlook on their total situation as were mothers in two parent families. They felt that the absence of a supportive partner contributed to the lower scores on this coping pattern (McCubbin, 1989).

The sibling relationship is usually the longest and most enduring of relationships in a persons life. Unlike parental relationships which last 40 - 60 years, the sibling bond may last 60 - 80 years. The presence of a handicapped child changes the experience of other children in the family. A family with a

handicapped child offers siblings unusual opportunities for growth but also provides the opportunity for the development of problems.

Children who share in the anticipation and excitement of a new brother or sister, also share in the sadness and grief that accompanies the birth of a disabled child (Seligman & Darling, 1989). Trevino (1979) stresses the importance of including the entire family early on in the diagnostic phase, to consider the impact of the handicapped child on other siblings. She states that families with a handicapped child are by definition, high risk, threatened by a chronic and unsolvable predicament. The author contends that prospects for the normal children appear to be the worst for families in which:

*   there are only two siblings, a normal and a handicapped child;

*   the normal sibling is close in age to or younger than the handicapped

    sibling, or is the oldest female child;

*   the normal and handicapped child are the same sex; or

*   the parents are unable to accept the handicap.

In support of Trevino's view on including the entire family at the diagnostic phase, Wasserman (1983) notes that there is a lack of information

about the child's disability that is not shared with the other children. The author states that limited information confuses siblings in regard to several factors:

* being held responsible for a particular condition;

* whether it is transmittable;

* if and how to communicate to friends and family;

* implications the disabled child has for the siblings' future;

* how to respond to discomforting feelings; and

* how to relate effectively to one's sibling.

Children tend to have two views about the cause of a brother or sister's disability. One view comes from the information they have received from their parents and from professionals, and the other view is their private version which is rarely verbalized. The private view may reflect confusion or a cause-effect relationship fueled by fear, guilt, and magical thinking. That is why information should be shared with all members of the family, and at times repeated for the children who may understand more information as time passes and they mature.

An important issue is how the child relates to the handicapped sibling. Many siblings assume the role of being responsible for their handicapped brother

or sister. This can lead to feelings of anger, resentment, guilt, fear, loneliness, embarrassment, confusion, jealousy, pressure and frustration. (Powell & Gallagher p.111-114).

Not all siblings experience such negative feelings. Seligman (1988) notes in his review of the literature, that many siblings are compassionate, tolerant, empathic and appreciative of their own health. He further suggests that a child's disability brings family members together and that siblings who are involved tend to be well adjusted. He states that the critical variable is how the parents interact with their handicapped and non-handicapped offspring, for example, by providing ample time and by communicating their love and concern to all of their children.

There is some research to suggest that fathers may have a more difficult time than mothers accepting their disabled children. Lamb (1983) notes that fathers and mothers initially respond differently to the news that they have a disabled child. Fathers tend to respond less emotionally and focus on long term concerns, while mothers are more emotional and are concerned about their ability to cope with the burdens of child care. Because fathers are more concerned about the social status and occupational success of their children, and in particular of their sons, the disappointment manifests itself in extremes of intense involvement and / or total withdrawal. Fathers seem to have limited, routine involvement with their disabled daughters.

Cummings (1976) found that fathers of retarded and chronically ill children experience more psychological stress, lower self esteem, and confidence in their roles as fathers than fathers of non-disabled children. However, a more recent study suggests that fathers reported fewer symptoms of distress, higher self esteem, and more internal locus of control than mothers (Goldberg, Marcovitch, MacGregor, & Lojkasek, 1986). This may be due to changing attitudes and the availability of more support systems, or it may be as the researchers suggest, that men tend to deny and suppress their uncomfortable feelings.

Trute (1995) studied seventy-three households to assess the strength of key individual and situational stresses as predictors of psychological distress, measuring symptoms of depression in men and women who parent young children with developmental disabilities. Findings showed that mothers with young, disabled children showed significantly higher numbers of depression than fathers, while higher levels of depression in fathers were associated with less disabled male children. Trute speculates that mothers show higher symptoms of depression due partially to the excessive demanding role for these women. The responsibility of increased child care also contribute to lower feelings of self esteem, or an indication that the child has not yet been fully accepted by her. As noted earlier, fathers are more anxious about long term occupational goals. Trute notes, "One could speculate that fathers can accept this circumstance more fully when their son

is seriously incapacitated but find it more difficult to accept when disabilities are marginal and the social and economic potential of their child is unclear (p.1237)."

Grandparents also share in the disappointment of a disabled child. Having a grandchild is one event that ensures that future generations will be carried on by the baby. When a disabled child is born, there is anxiety and uncertainty. Seligman & Darling (1989) suggest that grandparents experience a dual hurt, not only for their grandchild, but also for their own child, whom they see burdened for life (p. 144). The grandparents may go through similar stages as their children, such as anger, mourning, denial and confusion. Their contributions can range from emotional support, respite, financial assistance to child care suggestions. Unfortunately, they can also add to the family burden by not accepting the child, or by not being emotionally supportive to their children. The birth of a disabled child to a troubled family can put more pressure on existing family tension and create some long term effect.

Professionals need to assess where they can support grandparents either by educating them or by supporting those that wish to be involved in the care of their grandchild. The grandparents may also need someone to talk to help them sort out their feelings or those who may find it difficult to come to terms with the families crisis. Each extended family has its own unique needs.

IMPLICATIONS FOR SOCIAL WORK PRACTICE

This broad overview of families who have a disabled family member can lead one to conclude that the child does not exist inside a vacuum.

Using a family systems model allows the practitioner to look at the family in its entirety, examining both strengths and weaknesses. While it has been acknowledged that having a disabled child creates many stresses for a family, it has also been noted that there are positive attributes to having a special needs child.

Providing family therapy for this population requires specific knowledge. After reviewing the disability literature, we learn that there are often issues related to deep pain and sorrow for a young family moving through the life cycle. The special needs family has dynamics that are unique unto themselves, and it is imperative that as service providers we understand the salient issues facing this kind of family.

One of the most critical aspects of working with this population is in assessing the family and how it functions. It is of utmost importance to understand the emotional impact of the disability on the parents, the siblings and the extended family. How has this family integrated this event into their lives? Have they mourned for the loss of the normal child they expected? Are they

continuing to mourn in the way Olshansky (1962) talks about "chronic sorrow"? Professionals can assess the boundaries, role alignment, sibling dynamics, and can help the family adjust and cope with the situation. Therefore, as a therapist working with this population it is my responsibility not only to understand how families with disabled children function, but to be knowledgeable in the area of family therapy and the understanding of how families function, both under normal and stressful situations.

The question for social workers is how can we intervene and support a family, utilizing their strengths and supporting their vulnerabilities? I have reviewed a number of models so that the reader can view the range of available services.

Opirhory & Peters (1982) employ a "stage model" to provide interventions to parents of newborns. This theory acknowledges that parents follow predictable stages of feelings and actions after diagnosis and that the professional should meet the needs of the client based on where they are in the different stages.

The Laborde & Seligman Model (1983) propose a model made up of three distinct counseling services:

> Educative counseling is where parents and family members need concrete information and guidance. This is needed at all stages of the child's development.

Personal advocacy counseling is where parents are trained to be their own case managers with or without the assistance of a professional. This is where parents can experience a sense of control over their own lives. The professional can move in and out of this role depending on the needs of the family and the stage of development.

Facilitative counseling is where the family needs professional help to deal with issues that they would like to change. This would be in the form of relationship counseling or psychotherapy. It would be this area that Social Workers would meet the needs of dysfunctional families as well as those families having difficulties with adapting to the child's disability.

Two other models of intervention that Seligman & Darling discuss, are the Behavioral Parent Training model used extensively by Harris (1983) and Kaiser & Fox (1986), and the Group Format model (Seligman & Darling, 1989). The first model targets families who are presenting behavioral problems with their children and this training offers a behavioral focused intervention. The second group called, The Group Format model, meets with groups of people for education, support or therapy purposes. "This model assumes that family problems arise from deficiencies in skills or information and that families function adaptively to meet their own needs when provided with accurate and relevant information. This view further

assumes that parents' emotional reactions are not problematic when they have the resources to perform adequately as parents" (Seligman & Darling 1989 p.169-170). This enables the professional to meet with more people and also provides support for group members to know that they are not alone in their struggles.

Valentine (1993) believes that social workers can play an important role in the lives of families with special needs children. "An outreach effort that emphasizes family strengths and empowerment can contribute to the building of positive relationships between social services, the community and the family" (p.120).

In conclusion, this review has looked at the family life cycle and the way in which families cope with a disabled child, both at the time of diagnosis, and over longer term. The reactions of parents, siblings and grandparents have been discussed acknowledging both the strengths and weaknesses of the family. Finally a number of models have been briefly touched upon to give the reader an introduction on ways to work with families who have a disabled member.

This next section will focus on the models of therapy that this writer chose to use when working with this population.

FAMILY THERAPY

By the early 1950s, there began a shift from the treatment of individuals to the treatment of families. The idea of seeing individuals in the context of their families is based on the concept of family systems thinking. Systems theory conceptualizes the relationship system and the functioning positions of the people who comprise the system (Kerr, 1981). "Systems thinking does not look for the cause within the individual. In contrast, systems theory conceptualizes the appearance of a symptom as reflecting an acute and / or chronic disturbance in the balance of emotional forces in that individual's important relationship systems, most particularly the family system" (Kerr, 1981, p. 234).

It was later in the 1960s that Salvador Minuchin and his colleagues began to apply the theories of family systems thinking to working with the poor from New York City's ghetto. It was through his effort to help these families that the model of Structural Family Therapy was born. This model describes families in terms of how they are organized, and in turn provides the therapist with specifications for diagnosis and treatment of the family. Colapinto (1991) describes structural family therapy as a method of conducting therapy that is predicated on a set of assumptions about the organization and dynamics of families, about how they relate to individual problems, and about the processes that effect change on families and individuals. The model shares with other family-

systems approaches a preference for a contextual rather than an individual focus on problems and solutions (Colapinto, 1991, p. 417).

Minuchin's theory rests on three axioms. 1. The individual's psychic life is not entirely an internal process. He or she is a member of a social system, usually a family to which he or she must adapt. The individual adapts to the system and in turn, he / she may contribute to stress in other parts of the system. 2. Changes in a family structure contribute to changes in the behavior and the inner psychic processes of the members of that system, and 3. When a therapist works with an individual or a family, his / her behavior becomes a part of the context. Therapist and family join to form a new, therapeutic system, and that system then governs the behaviors of its members.

The structural framework evolved as an attempt to describe the organizational transitions and shifts that families make over time. As such, the structural framework represents a developmental approach to normal functioning and shows particular congruency with the family life cycle model (Cantafio, 1989). An individual's growth and development depends upon the social systems with which the individual interacts. The psychological structure of the individual is viewed as interdependent with the person's social milieu and that milieu is treated as the medium through which the individual functions. The family is seen as "an open system in transformation" as "it constantly receives and sends inputs to and

from the extra familial, and it adapts to the different demands of the developmental stages it faces" (Minuchin, 1974, p. 50).

The family is the primary and most critical of all social systems, as it is the context in which an individual grows and develops. "Structural family therapy sees the family as a living organism, constantly developing and adapting to a changing environment. A well-functioning family is not defined by the absence of stress, conflict, and problems, but by how effectively it handles them in the course of fulfilling its functions" (Colapinto, 1991, p. 421-423).

Minuchin (1974) identifies four sources of stress which may affect the family. They are: 1. stressful contact of one member with extrafamilial forces, 2. stressful contact of the whole family with extrafamilial forces, 3. stress at transition points in the family life cycle, and 4. stress around idiosyncratic problems. In order to adapt to these influences, the family needs to realign its boundaries and restructure itself.

Besides emphasizing how families move and adapt through developmental phases, the structural model emphasizes one additional key component; family structure.

The set of rules which regulate and organize the interactions among members of a family determines its structure and these rules dictate the ways in

which relationships are organized. All families establish invisible rules about how the family should organize itself, and often these rules are a derivative of family of origin rules and expectations.

"Family rules develop primarily through a process of correlated differentiation: the behaviors of any two family members mutually accommodate in such a way that one develops selective aspects of himself or herself, while the other develops a complementary trait" (Colapinto, 1991, p. 422). Minuchin describes it this way; "In individual experience, the focus is on the individual as a whole. But when the complementary aspects of the self becomes parts of a whole, the other parts of that whole, which are also discrete entities, are seen as affecting the behavior and experience of all parts. Beyond the parts, there now appears a new entity: an organism, multi-bodied and purposeful, whose parts are regulated by the rules of the whole" (Minuchin, 1981, p. 192).

The structural dimensions most often recognized in structural family therapy are subsystems, boundaries, and alignment. People are organized in the family according to generation, age, and sex etc. Where one fits into the structure can influence functioning, relationship patterns, and the type of family that is carried on into the next generation. Individual members can therefore be a participant in several subsystems. For example, a woman can be the member of many subsystems. She is a spouse in relation to her partner, a mother to her children, a

daughter to her parents, a sister to her siblings, etc. These subsystems form the foundation for the family boundaries and hierarchy. Rules that determine who should be in contact with whom for example are boundaries. Boundaries in a family can be rigid and impermeable, or too flexible and loose. "It is through the individual's adaptation to various subsystems that his or her identity is forged. In healthy families, subsystem boundaries are defined well enough to allow subsystem members to carry out their functions without undue interference but at the same time, flexible enough to allow contact between the members of the subsystems and others. Clarity of boundaries is more crucial than the specific composition of each subsystem" (Colapinto, 1991, p.424).

Alignment in families is when one member of the system joins another to carry out an operation. This dimension includes the concept of coalition whereby one member joins a second member in opposition to a third. This may be seen as healthy in the case of parents establishing rules and boundaries with a child, but may be unhealthy when a parent joins with a child against another parent.

As the family moves through time, the structure changes to accommodate its changing needs. Children grow up and leave, adults grow older, not only facing their own aging process, but their parents aging process. As these changes take place, boundaries need to be redrawn, and subsystems regrouped. Adaptation to new circumstances require the family to make a shift in the organization and

structure. This process involves varying degrees of stress and tension for all families. The absence or presence of problems does not indicate effective or ineffective functioning. The ability to adapt and utilize new ways of coping, providing each individual's growth, without sacrificing the continuity of the family, is the criteria for judging how a family adapts to the changes.

To sum up, Structural Family therapy emphasizes the three main components, a developmental perspective, family structure, and adaptation, that will provide the conceptual framework upon which the assessment of family functioning is based in this practicum.

While the Structural Family Therapy model provided the conceptual framework, a genogram was used to provide a visual tool to understand the relationships in the family. "A genogram is a format for drawing a family tree that records information about family members and their relationships that span over at least three generations. Genograms display family information graphically in a way that provides a quick gestalt of complex family patterns and a rich source of hypotheses about how a clinical problem may be connected to the family context and the evolution of both problem and context over time" (McGoldrick & Gerson, 1985, p.1). The genogram fits in very nicely with the Structural Model. Genograms help the clinician observe family patterns and events that may have recurring significance in a families history. It also helps both the family and the

clinician view the family historically: that is the structural, relational and functional information about the family that can be assessed both horizontally across the family context and vertically through the generations. The genogram can also point out strong coalitions, alliances, and boundary problems. The person identified as the one with the problem may be seen in the context of various subsystems, such as siblings, triangles, complementary and symmetrically reciprocal relationships, or in relation to the broader systems such as community, social institutions and the broader cultural context (McGoldrick & Gerson, 1985). As family members are questioned about the present problem, relationships and patterns evolve showing particular themes, family rules, and emotionally charged issues that present through the generations. Thus, the genogram is a useful, visual tool to highlight specific characteristics of a family over a span of at least three generations.

After obtaining a thorough assessment, a therapist must have a clear goal indicating the direction that therapeutic change will occur. The model that I chose to use for systemic intervention was the Solution Focused Model (deShazer, 1985).

This model compliments the Structural Model because of its premise that human problems are viewed to be primarily an outcome of the ordinary difficulties experienced in every day life (Cantafio, 1989).

The forerunners of this model were Milton Erickson, the Mental Research Institute's Brief Therapy Clinic (MRI), and the Brief Family Therapy Center (or BFTC). Both groups were highly influenced by Erickson's work.

Erickson's methods were very unique. Many family theorists have attempted to explore his theories in their writings.. Essentially, what Erickson did was to utilize what the client brought to him. "Erickson viewed clients as having within them or within their social systems the resources to make the changes they need to make" (O'Hanlon & Davis, 1989, p. 16). He was not interested in exploring the origin of the problem or in understanding how people became stuck. His view was that therapy "... was predicated upon the assumption that there is a strong normal tendency for the personality to adjust if given an opportunity" (Rossi, 1980, Vol.4, p. 505).

"Erickson's work was based on constructs which today remain as essential elements in brief therapy. He is credited with influencing the development of brief therapy on the basis of two points in particular. First, he placed a great emphasis upon accepting what the client offered, or brought to therapy, and utilized this to promote positive change. Even if what the client presented might be labeled as "resistance", Erickson transformed this into positive use in therapy. Second, although Erickson was concerned with altering overt, observable behavior and the effects of this behavior on the client, his methods to alter such behavior are based on implicit or indirect means of influence. Thus no attempt is made to correct underlining causes or disorders. Rather, energy is directed toward altering "problematic behaviors" by redefining and transforming them into positive usage" (Cantafio, 1989, p.72).

It must also be stated that Erickson was not completely solution oriented, nor was his therapy always brief. His work was too complex to be defined in any

one way. He did however inspire much of the brief, and then solution focused models of therapy.

O'Hanlon & Davis (1989) offer a brief history of the origin of the MRI Institute. In 1966, the Institute began a brief therapy project commonly known as Strategic Therapy. It was spearheaded by John Weakland, Paul Watzlawich, Richard Fisch, Arthur Bodin, and Carlos Sluzki. These therapists were convinced that therapy could be accomplished in a much shorter period of time than the norm. They worked with a deliberate time limit of ten sessions. One of their main principles was that they were going to try to resolve the presenting problem rather than to reorganize families or to develop insight. They called the treatment model "problem focused", because therapists working this way attempt to alleviate only the specific complaints clients bring to therapy. There is no attempt to look for the underlying pathology or source of the problem. Problems are considered to be made worse by people's unsuccessful attempts to solve that problem. They consider that the problem is the attempted solution.

The MRI group therefore believed that a relatively minor change in behavior was necessary to create change in the problem. This change was often initiated by asking family members to "do something different" than they had been doing to solve their problem in the first place. This is a basic premise which

underlines brief therapy. It's also important to note that in the MRI model, the therapist along with the client, agrees on therapeutic goals.

While the MRI model of brief therapy was being developed, Steve de Shazer in 1969, initiated and developed a model that began to focus on solutions rather than problems (de Shazer, 1985). His philosophy used the analogy of a skeleton key to characterize this focus. "He contends that the therapist does not need to know a great deal about the nature of the problems brought to therapy to solve them. More relevant is the nature of solutions. It is the key that opens the door that matters most, not the nature of the lock. Analyzing and understanding the lock are unnecessary if one has a skeleton key that fits many different locks" (O'Hanlon & Davis, 1989, p.21).

Solution focused therapy is different in another way. Because it focuses on solutions and family strengths, it starts with the premise that clients want to change their situation, and as such, denies the concept of resistance. They feel it is the role of the therapist who will work cooperatively with the family to help them meet their goals. "Every client is seen as having a unique way of cooperating and it is the task of the therapist to identify and utilize this form of cooperation" (O'Hanlin & Davis, 1989, p.22).

The central thrust of solution focused thinking is based upon the notion of constructing solutions. Walter & Peller (1992) identify three axioms.

1. Define what the client wants rather than what he or she does not:

2. Look for what is working and do more of it: and

3. If what the client is doing is not working, then have him or her do

    something different.

"Solution focused brief therapy is not a collection of techniques or an elaboration of a technique: rather, it reflects fundamental notions about change, about interaction, and about reaching goals" (Walter & Peller, 1992, p.6). Solution focused therapists have a way of thinking about how people change, and this model emphasizes individual strengths and resources. In fact, change is seen as an ongoing process and clients are asked in the very first session about changes that have already occurred in the family between the time of the initial contact and the first interview (de Shazer et al., 1986).

The therapist then creates an environment that encourages cooperation between himself or herself and the family.

A cooperative model is promoted through a number of processes. For instance, communication can be enhanced between the therapist and the family if the therapist incorporates the family's preferred phrases and words into messages. Other ways of promoting cooperation would include: highlighting exceptions to the rule, creating an expectation of change, formulating a vision of a successful future

and making this vision salient in the present, complimenting and validating family members for what they are already doing that is working for them, and accentuating any changes which family members make. (Cantafio, 1989).

De Shazer (1988) discusses structural therapy and solution focused therapy. He states that the primary task is for the client to do something different. For example, if a mother and a daughter come in for therapy, a structural therapist might see the solution to promote change in the hierarchy by getting mother to do something different. A solution focused therapist wouldn't care who came into the session. Either the mother or the daughter could come in as long as they did something different to change the pattern. This more general view, removes some of the constraints that are built into the structural model. He then goes on to say, "The next step is to look at what the therapist did that was useful in prompting mother to do something different. If she / he had been working on helping mother and daughter draw more appropriate boundaries or to realign the hierarchy, then mother's new behavior shows the usefulness of the approach in prompting something different to happen. It does not, however, prove the structural view or the concepts of hierarchy and boundary. It only shows that the structural approach can be useful" (de Shazer, 1988 p.8).

Jeffrey Bogdan (1986) compared problem formulation from both the Structural and Brief Therapy vantage points. He noted that Structural Therapy

would see troubled families as needing to have a problem, at least in the short term, or they would suffer from something worse, while the Brief Therapy Model would see the problem as the unintended side effects of well meant efforts to resolve problems.

In this practicum, the Solution Focused Model was used primarily in the intervention phase. People were given homework tasks after each session, asking them to do something different. The "homework" was often something the family could identify as something else they could attempt. When they were unable to identify a specific solution, I would often suggest to them that they each needed to act differently, but not to discuss what they had chosen to do until they came into the next session to talk about it. Thus, promoting the difference that makes the difference.

In this chapter, I have emphasized the three main areas of understanding family systems theory,

1. understanding those specific dynamics that are directly related to families with special needs children,

2. implications for social work practice, providing models of intervention, and

3. understanding family organization in the context of understanding two models of Family Therapy: Solution Focused and Structural Family Therapy.

CHAPTER III

PRACTICUM SETTING AND PROCEDURES

PRACTICUM SITE

The families receiving service in this practicum originated from two different sources, the Health Sciences Centre and St. Amant Centre.

The referrals from the Health Sciences Centre came from the Neuropsychiatry Team from Child and Adolescent Psychiatry. The patients identified in these clinics are chosen because of the special needs of the child. The child may be developmentally delayed, have a head or brain injury, or have multiple problems. Two of these families were referred to me and were seen and videotaped at the Health Sciences Centre.

The second set of referrals came from St. Amant Centre. The St. Amant Centre is a fully accredited resource centre offering outreach and residential services to individuals with developmental disabilities. Those families were initially going to be seen at the Elizabeth Hill Counseling Service located at 321 McDermot Avenue in Winnipeg. The Elizabeth Hill Counseling Centre serves as a training centre for undergraduate and graduate students in the Faculty of Social work and graduate students in the Department of Psychology, University of Manitoba. I began my practicum at the centre and saw one couple just once. It

then became apparent to me and to the remainder of the clients that it was more convenient to see them at the Health Sciences Centre.

The practicum was of four months duration extending from January, 1992 to April, 1992.

INTAKE CRITERIA

The families that were seen met the following criteria:

1. A family whereby a child has a developmental disability. Developmental disability "refers to a severe, chronic handicap that is characterized by permanent deficits in cognitive and adaptive functioning" (DeWeaver, 1983, as cited in Verstraete, 1991).

2. The family had been identified by another Social Worker as potentially benefiting from Family Therapy intervention.

3. The family voluntarily agreed to Family Therapy intervention and to be part of this practicum.

THE CLIENTS

The total number of families seen were six. One family discontinued after one session because of difficulties with child care arrangements, and five had anywhere from six to twenty sessions. Of the five families, three were nuclear

families and two were single parent families. There was a wide range of severity of the child's disability. A sampling of the disabilities included, autism, pervasive developmental delay, developmental delay, attention deficit disorder, cerebral palsy, and epilepsy. For the purposes of this practicum, two families will be discussed in depth. The names of family members and other identifying information has been changed in order to protect confidentiality.

PRACTICUM COMMITTEE

The practicum committee consisted of two representatives from the University of Manitoba Faculty of Social Work, and one external agency representative.

The principal supervisor was Dr. Barry Trute, Professor, University of Manitoba Faculty of Social Work. Dr. Trute has the expertise and knowledge of this population by his own clinical practice and research. Ms. Shirley Grosser, MSW, Associate Professor, University of Manitoba, Faculty of Social Work, was the second member of the committee. Ms. Grosser has a special interest in the coping abilities of and contexual supports for caregivers to persons living with HIV / AIDS. The committees agency representative was Ms. Doreen Draffin MSW, RSW, a Prevention Education Consultant and Family Therapist with families affected by addiction at River House, which is with the Addictions Foundation of Manitoba.

SUPERVISION

One hour supervision was conducted on a weekly basis between Dr. Trute and myself throughout the course of my practicum work. Videotapes were presented and reviewed, while my supervisor provided direction, hypothesis formulation, and skill development. Discussion took place with suggestions for follow-up or training. Dr. Trute was not only able to enhance my understanding of the family dynamics, he was able to help me understand myself, as a therapist and as a member that had temporarily joined the family system. This guidance was the most important part of my practicum experience.

CLINICAL EVALUATION

Ongoing assessment and evaluation are integral parts of social work practice. "In this sense, evaluation issues emerge from initial problem definition, various decisions made in regard to treatment alternatives, conclusions reached in regard to treatment outcomes, and plans or directives offered for future disposition of the client system" (Trute, 1985). Trute continues to point out that in evaluative terms, the question is: What "process" will lead to what "outcome"? How can a practitioner show that the interventions employed by the practitioner have a direct link to the change in the system? "To the evaluation researcher, ultimate success is achieved when outcome is closely tied to process" (Trute, 1985 p. 101).

The evaluation instrument applied in this practicum was the Family Assessment Measure (FAM III) as developed by Skinner, Steinhauser and Santa-Barbara (1983). All families seen in this study were requested to complete the FAM III. It was administered on a pre-test at the first interview and on a post-test at the last interview.

The FAM III is based on Canadian norms for both clinical and non-clinical populations (Trute, 1985 p. 104). It is comprised of three scales, each having a number of subscales. For the purpose of this practicum, the General Scale was exclusively used. The General Scale is composed of fifty items and it measures the strengths and weaknesses of the family, as identified by the family. The fifty scales are further divided into nine subscales. An overall rating, averaging over the seven categories is also provided. Those subscales are: task accomplishment, role performance, communication, affective expression, affective involvement, control, and values and norms. Two response style subscales, social desirability and denial are included in this scale (Skinner, et al., 1983). This measure enabled the family and me to target specific areas of concern. It also provided me with an opportunity to monitor and evaluate my clinical skills. The General Scale of the FAM III has a reliability coefficient (Cronbach's Alpha) of 0.93 for adults and 0.94 for children.

CHAPTER IV

CASE SUMMARIES AND EVALUATION

In this section I present the following two cases as examples of the families who were a part of this practicum. For each case I highlight the presenting problem, background information, family history, intervention and assessment. I also present and discuss the results of the pre-therapy and post-therapy FAM III measures. All names have been changed to protect client confidentiality and anonymity.

Couple A

My work with this couple is described in detail to illustrate how understanding the family of origin impacts on how relationships are formed and manifested in the present. This couple in particular, illustrate an excellent example of how the presenting problems can be directly related to patterns from the family of origin. My intent was to use the Genogram as a visual tool while using Solution Focused questions to help guide them toward the completion of their goals.

The therapy took place approximately once a week and lasted for four months. During that time the couple started to make some shifts in their relationship. As will be discussed later, some of the changes caused a major

depression for one partner. This occurred at the end of our time together and he was referred elsewhere for individual treatment.

My goal in discussing this family also includes describing to the reader what I learned from my experience with this family. This includes an analysis of how I saw my role as a clinician, what I learned as a therapist in the training of family therapy methods, and what it taught me about myself as a person.

Source and Reason for Referral

Chris and Susan were referred by my advisor, Dr. Barry Trute. Chris had heard Dr. Trute at a speaking engagement, and had expressed an interest in studying his own family of origin, hoping that it would help him understand himself and his relationship with his spouse and his children. Susan also expressed an interest in understanding herself and how she interacted with people, as she was very shy and introverted. When asked about specific issues, Chris stated that he had two concerns. He said that he was very quick to get angry with his family, and that he became too immersed in his political advocacy work and outside commitments. These obligations took up several hours of his time each week and he felt overwhelmed by them. Given his admission of a quick temper, I explored the possibility of domestic abuse, and both Susan and Chris denied any physical violence. Susan expressed similar concerns. She was hoping to improve communication between herself and Chris and like he, she tended to become so

involved in her projects, that she neglected her family and other responsibilities. She called them her "obsessions."

I then asked them a Solution Focused question projecting them into the future and helping them identify goals: "How will you know, when we are at the end of our meetings together, that you've gotten the kind of help you requested?" Chris stated, "I'll have more patience and spend more time with my family. Susan and I will go out, visit friends, play cards, or relax at home a bit more. I spend too much time on things I have to do. I don't relax enough and I judge myself by my accomplishments." Susan said she and Chris would be communicating more about day to day activities, they would be going out socially together, and most of all, she said that Chris would not be losing his temper as much.

This answer gave me a lot of information. Solution Focused therapy is a model that builds exclusively on what the client wants to change. This question enabled the couple to identify their goals. In Solution Focused therapy, it is essential to have clear, measurable goals. While it is the client's responsibility to set a goal, the therapist takes an active role in helping the client establish attainable and concrete goals. "One of the most important reasons for specifying the problem clearly is so that a therapist can know when he has succeeded. Presumably, when treatment terminates and in a follow-up interview afterwards, a

therapist will want to know definitely whether he has achieved his therapeutic goals" (Haley, 1976, p. 41).

This information also told me that this couple had common goals. They wanted to have more social time together and both wanted to find a way to help Chris deal with his anger in more appropriate ways.

Background Information

Chris and Susan had been married for eighteen years. They had four children, two of whom were developmentally delayed. They reported that that was extremely unusual, for after their first child was born, they had gone for genetic counseling and were told that the likelihood of having a second mentally handicapped child would be unlikely. Their second and third children were normal, but their fourth child was also born developmentally delayed. The children ranged in age from ten to seventeen years of age.

When I explored what kind of impact having developmentally delayed children had on them and on their family, they reported that the birth of the children had been normal and they had no initial indication that anything was wrong until the babies started to develop. As time passed, they began to suspect that something wasn't quite right, causing them to be very worried and concerned, creating a lot of stress for them. However, by the time the diagnosis was

confirmed, they were relieved to know what the problem was and how to deal with it. They explained that the first few years were difficult, but that once they understood the situation and had school and respite services involved, they were managing quite well. By the time they came to see me, they seemed adjusted to their situation and Chris and Susan did not express the stress of having the children as a reason for referral. Rather the focus was on their marital relationship.

I initially was surprised when I found that their family life with the children was not something that was problematic. I entered the situation with my own set of biases assuming that not only would having four children be very stressful, but having two of them with developmental delays would be overwhelming. I was not correct. This information was corroborated by some of the literature that reports that in fact many families are quite strong and cope very well with handicapped children. This was an important learning for me for two reasons. Firstly, I learned that families cope with stress in different ways, over long periods of time and can be very successful, and secondly, I learned to keep an open mind and avoid bringing my biases into the therapy room.

Family History

I began by starting the genogram with Chris. I started with him because he seemed to be more motivated and I sensed that Susan with her shyness needed

more time to develop a trusting relationship with me. Some of the areas I wanted to explore were factual data, family patterns, alliances, secrets, emotional history and any major themes that emerged. We began by exploring his paternal and maternal grandparents. This is always an interesting process for me because it is often informative to find out what people know about their grandparents, the kinds of stories that are handed down through the generations, whether people knew their grandparents, and what kind of relationships they and their parents had with members of that generation.

A number of themes emerged in exploring Chris's family history. What I'd like to do is highlight some of the factual data and then describe the themes.

Chris was the second of six children. He described his parents relationship as "horrible." They did not get along with each other and both parents would use him as a confidant. He expressed his feelings of anger toward them for putting him in that position. When this was further explored, it came as quite a surprise to him to feel the intensity of his anger. In the session after this initial disclosure, he not only expressed his anger at his parents and the loss of being cheated out of a normal childhood, but he said that he had difficulty expressing any sad emotion and was embarrassed to show his feelings especially if it meant crying in the session. This led to a discussion of how the men in his family shared their emotions. He stated that his father didn't openly express his feelings. He was a

binge drinker and he would have "awful fights" with his mother that included shouting screaming and physical fighting. As a child, Chris would be reprimanded and hit if he started to cry. This revelation became a central theme in the family history and showed a direct relationship into the current family problem. This helped Chris identify how anger was used in his family of origin and how it taught him to deal with emotions and feelings.

As Chris continued to explore the relationship between the way he learned to deal with his feelings and his family of origin, he began to look at how this impacted on his relationship with his children. He was taught by his father to "do what you are told." He acknowledged that he had the same attitude with his children and then revealed how they were afraid of his anger. Chris would begin to show sadness as he spoke of the pain he had imposed on his children, but as he started to express the sadness, he would make an intellectual comment to deflect the feeling. This was pointed out to him and while he acknowledged it to be true, he was uncomfortable sharing those feelings. This was an area that slowly improved over the course of our sessions. Instead of making a joke or an intellectual comment, he would get quiet and sad when reflecting upon the past. As time progressed, both he and Susan came into the sessions telling me about incidents that had happened during the week that he had every opportunity to become angry about, but instead walked away for a while, or dealt with the situation in a calmer manner.

It is very sad to note, that while Chris began to make positive changes, at the very end of our contracted time together, he had what he called, a nervous breakdown or what was later diagnosed as a clinical depression and had to take time off of work. In retrospect, I know now that I could not see this coming. However at the time, I questioned myself about what I could have done differently. Did I move too fast? Did I push too hard? In my enthusiasm to work with this family, did I miss something I should have seen? I know that in working with families, that change doesn't happen in isolation. While Chris was changing, so was Susan. As will be discussed later, she also made some major changes and I will share my analysis about what happened in the system at that time.

Chris identified very closely with his father. He felt that like his father, he put a very high value on achievement, was a braggart about those achievements, and that he needed to be obeyed by his family. He also identified with his father by his difficulty expressing feelings other than anger. Chris did not like his father when he was growing up and it was a disappointment to him to realize that he was very much like him, in spite of the fact that he worked hard to be so different.

Chris reported that he and his mother had a closer relationship. She would use him to complain about his father and about his drinking. Chris said that he

always felt very uncomfortable about that role but as a child didn't know how to disengage from that dynamic. His mother grew up in a home where there was alcoholism, spousal abuse and suspected sexual abuse. Chris called her the martyr and said that he too had that quality.

Women in Chris's family system were not treated with respect and there were rumors to the effect that there was sexual abuse being perpetrated by his father. After giving birth to four boys, Chris's parents decided to adopt an aboriginal little girl. Chris knew very little about the adoption other than his parents wanted a little girl. When he was in his teens, a friend of his mother came to tell him that his sister was being abused by his father. This is another example of Chris being parentified. At that time however, he did not know what to do and chose to do nothing. Chris carried a tremendous amount of guilt about this and was still struggling to resolve it. This young woman now lived in another city and from what he understood, was "a drifter." Through our sessions, he resolved to make attempts to contact her and support her.

There are a couple of themes that emerge from this incident. The first theme is related to the role of women in this family system. The second theme is the blurred boundaries that occur not only between the generations, but between family members themselves. The third theme that emerged was the notion of secrets.

Women in this family were traditional homemakers whose primary task was to be subservient to her spouse and make a home for him and his children. Women sacrificed their needs for the needs of their families. This was not uncommon for families at this time. Where it made the largest impact was Chris trying to adjust to the present where men and women's roles are currently changing. He wanted to treat his spouse as an equal but did not have the role model for doing so. Therapy helped him to realize the differences between the kind of marriage his parents had and the kind of marriage he wanted with Susan. It was one thing for him to intellectualize that he wanted an equal partnership with her, but it was another for him to emotionally integrate that with everyday behaviour.

A major theme that was played out in this family was the fact that boundaries were very blurred. It is evidenced by the alcoholism, the sexual abuse, and the parentification of Chris by both of his parents. In exploring the blurred boundaries in his family of origin, Chris realized that he too was blurring boundaries with his daughter. He would often confide in her and tell her things that were bothering him. In addition, he would often ask her to go places and do things instead of asking Susan. He expressed his pleasure at having this kind of relationship with his daughter, but he began to realize that he too might be sharing inappropriately with her.

Chris was very much bothered by the secrets in his family. He stated that his mother and father did not share a lot of information with him. This is ironic given that they used him as a confidant, but he was ridden with guilt about his sister and other secrets he knew existed, but didn't know what they were, and never felt that he had permission to ask. As a child, this was very confusing because on one hand he was encouraged to be the recipient of his parents angst, but on the other hand, it was off limits to ask any personal questions.

As we moved into Susan's family of origin, we found many similar themes that tied in closely with Chris's family. The most dominant themes were of women being undervalued, feelings not being expressed, and alcoholism. She also carried themes of mental illness and tragedy.

Susan was the youngest of three children. She had an older sister and an older brother. She described her childhood as being very painful. As a girl and being the youngest, she felt rejected and unvalued. Family members treated her like a baby and she continued to feel that way into the present. She described having to sit in a high chair until she was six years old, never owning a bicycle, (while both her siblings did), and was not supported in obtaining her education past grade ten.

Susan's father was one of six children. He had several losses in his lifetime. His three year old brother died suddenly in a house fire, his fourteen year

old sister died of cancer and his other sister suffered from retardation and epileptic seizures. His father, a carpenter, had been hit by a car, and had to have his leg amputated. When I asked Susan what impact all of these tragedies had on her family she stated that she wasn't specifically aware of the impact, but did know that her grandfather was an alcoholic and he abused his wife, leading her to conclude that it was very stressful and relationships were very strained. She stated that her father was, and continued to be very critical, opinionated, judgmental and unappreciative of children, including his own grandchildren. She also stated that not only did this have an impact on her growing up years, but that it continued into the present where she felt unsupported by her father as she was struggling with the day to day management of her children.

Susan's mother died suddenly of a stroke in 1990. She said that she felt distanced from her mother as she was growing up. She said, "I don't think my mother was strong enough to stand up against my father. She also seemed kinda depressed." Susan went through a significant mourning period after her mother's death. She regretted not having a better relationship with her mother and not having the chance to say good-bye. Susan was able by understanding her mother's family of origin, to begin to come to terms with the fact that she too was brought up to hold men in higher esteem and to serve their needs before her own.

Susan expressed real sadness about feeling so inadequate about herself both as a child and as an adult. She spoke about fighting depression and feelings of hopelessness. She felt inadequate and said she becomes obsessed with her projects because it is the one area of her life that she feels she has some success. Susan felt that her feelings of inadequacy continued to be reinforced on a regular basis by Chris and by her father who joined them for dinner every Sunday night. She felt criticized by both of them and felt that she was on the receiving end of their frustrations and anger. She also felt hopeless because she felt she had no other mechanism for coping.

As therapy continued, Susan began to realize that she could become more assertive and get some of her needs met. This coincided with Chris's understanding that he had been too demanding by treating her the way he had been treated by his father. He also recognized that he had been treating her the same way her father had been treating her. Both, through therapy, began to see the role they played in maintaining the dysfunctional pattern in the system. They attempted to regain a new equilibrium by trying to shift the balance of power into a more egalitarian relationship.

Intervention and Assessment

This couple had a number of strengths. They were committed to each other, to the marriage, and both wanted to improve the quality of their relationship with each other and with their children.

The most significant part of the assessment was the genogram. Helping them identify how the patterns of the past influenced the present gave them insight into their own behaviour and patterns of interaction. Once they understood why they reacted in the way they did, I used Solution Focused questions to help them work toward their goal. Using the couple as the experts, they decided what tasks they wanted to do to improve their relationship. Some of those tasks included spending more time together. For example, they arranged their respite to accommodate them for going out on either Saturday night or for brunch on Sunday morning. They started to go for walks in the evening and tried to express interest in each others activities. These activities focused on allowing the couple to unite as a couple without the responsibilities of child care.

This was a critical intervention. Through the use of the genogram, we discovered that Chris had experience with blurred boundaries, both in the past and in the present. Strengthening the couple system helped define the boundary of their relationship and made them more cohesive as a unit.

The other area of intervention was helping them as a couple to identify ways in which they could handle emotions when potential volatile situations arose. Helping Chris identify where in his body he began to feel his anger helped him become aware of his physical response. He noted that it seemed to start with a feeling in his stomach which he soon began to recognize, and was able to stop himself from getting enraged. He decided that he would calm down by going for a walk, counting to ten or verbalizing how he was feeling at that moment. Susan made some remarkable changes by becoming more assertive when Chris got angry. She would acknowledge his feelings, share her own feelings and then they would talk about what was happening. This was not always a smooth process. Each session included some time reviewing what happened in the past week and how they managed to deal with situations that arose.

As Susan became more self assured and developed a sense of self, two things happened. She was able to talk to Chris about the disrepair of their home and they engaged upon a plan of painting and fixing up the house. They did this together and while it was hard for both of them to give up the time from their individual interests, they were proud that they accomplished this task as a couple.

The second accomplishment included Susan returning to school to upgrade her education. She enrolled in adult education and started work towards her Grade

12 diploma. This was supported by Chris and the children. Her father was not supportive but Susan was able to handle him in a much more assertive way.

FAM III Profile

While Chris and Susan appeared to have made a number of positive changes, the post-therapy FAM III profile shows a deterioration in their relationship. The pre-test FAM III (Figure 1) was completed at the beginning of therapy in February of 1992 and the post-test FAM III (Figure 2) was completed in June of 1993. The reason for the delay was Chris's breakdown. It occurred in the Spring of 1992 and due to his mental state, he was not able to complete it until one year later.

The first observation I made while reading the initial results were that Chris showed lower scores on Social Desirability and Denial Subscales, and such lower scores may reflect anxiety, while Susan scored in the average range for the Social Desirability and Denial Subscales. This suggested that his responses may have been somewhat distorted while hers may have been more precise.

The pre-test FAM III graph depicts Chris as having perceptions of average to high strength areas in his family relationships, while Susan shows an overall high average in the family problem area, suggesting that he sees the family as

being a much stronger unit than she does. Her graph shows distress in the subscale areas of task accomplishment, affective expression, and affective involvement, suggesting that she feels the emotional void in their family while he says it feels normal. Her concerns in the area of affective expression say that as a family, there is little or no emotional communication between them. This reinforced my belief that she felt disengaged from parts of the family, while Chris was over involved in his relationship with his eldest daughter and his advocacy work. Her dissatisfaction in the area of task accomplishment suggested that while Susan was aware of some of these difficulties, she didn't have the skills to problem solve these issues. This was evidenced by her passivity and lack of problem solving skills and Chris's authoritarian style. The results of the pre-test FAM III reinforced my belief that the couple system saw their situation from different vantage points.

The major theme in the pre-test FAM III is the divergent views that Chris and Susan have about their relationship. The profile fits in with what one would expect given his denial of the situation and her realistic concern for the state of their marriage.

The post-test FAM III (Figure 2) presents a very different picture for this couple. At this point in their relationship there is much more agreement to the notion of having problems and they agree on problem areas such as task accomplishment and affective expression.

In this graph, Chris shows that he may be more anxious and this is understandable given his recent breakdown and his emotional rawness. Susan shows some possible evidence of anxiety and I believe this was due to the fact that now that the problems were out in the open, she felt more anxious and vulnerable. Their situation had changed because of Chris's clinical depression, but the marital issues had not been completely resolved.

While Susan scored about the same in the overall rating range, she became more definitive in the areas of task accomplishment, affective expression, affective involvement, and now seemed unhappy with the level of control. This may have been due to her realization of how much control Chris had over their lives and how powerless she felt.

Chris still scored in the average overall rating range, but showed a remarkable jump from being satisfied with task accomplishment and affective expression to being dissatisfied in those areas. His view became much more consistent with her view of their relationship, and he is much more open about the seriousness of their difficulties. If one looks at the subscale of communication, we find that in the pre-test FAM III, the couple are quite a distance apart with Chris thinking that their communication was a strength while Susan thought it was normal. On the post-test FAM III however, they come much closer together on

the scale signifying that they not only acknowledge that they have problems, they are now openly discussing them.

I have attempted to go over in my mind to assess what happened to Chris that caused him to have a nervous breakdown. I have three possible explanations. One is that as Chris started to "feel" his feelings instead of intellectualizing them, he became flooded with emotion and didn't have the coping skills to deal with them. He began to realize the impact of his family of origin, how it impacted his choices, and he began to feel a great sense of loss. It is possible that when he completed the pre-test FAM III, he was operating in a sense of being unaware of the difficulty between himself and Susan, and that therapy brought those feelings to the surface. Therapy doesn't always make people feel better right away. Sometimes, as in this case, Chris had to feel his pain first and deal with his individual issues before he could deal with his relationship issues.

The second explanation is that as Chris was dealing with his feelings, Susan was moving away from him physically and emotionally. She had returned to school and was involved with her academics. She really changed one "obsession" for another, but unlike her other hobbies, this one was more threatening to their relationship. This obsession enabled her to become more educated and more independent. She also became more assertive and demanded more from Chris and their relationship.

The third possibility was that Chris was under a tremendous amount of stress. After he and Susan fixed up their house, they decided to move. They bought a new house and the children were very angry with them, because not only did this move mean a school move for them, it meant changing school districts and that had a major impact on what kind of educational services the special needs children received. This was coupled with the fact that there were going to be layoffs at his place of employment due to downsizing in his department.

My conclusion is that it is probably a combination of these explanations that not only caused his breakdown but caused the FAM III to show such dramatic shifts. I would also conclude that while Chris took out time to work on his individual issues, the marital issues were left unsettled. I made a few attempts to have Chris and Susan come in for one final session and to recommend to them the need for ongoing counseling. They stated that it was a busy time of the year and did not wish to pursue any further meetings.
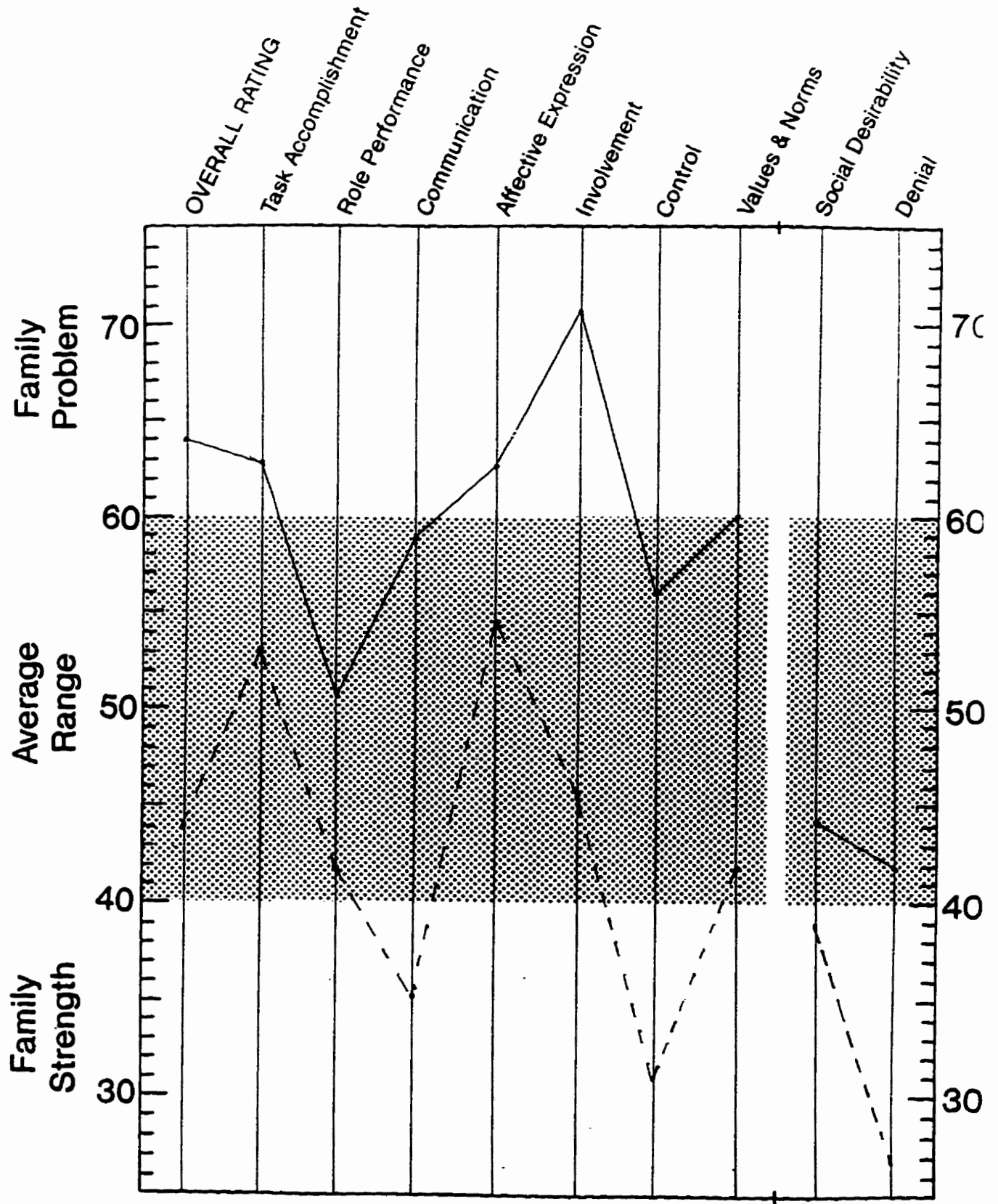
FAM GENERAL SCALE

Figure 1 PRE-THERAPY
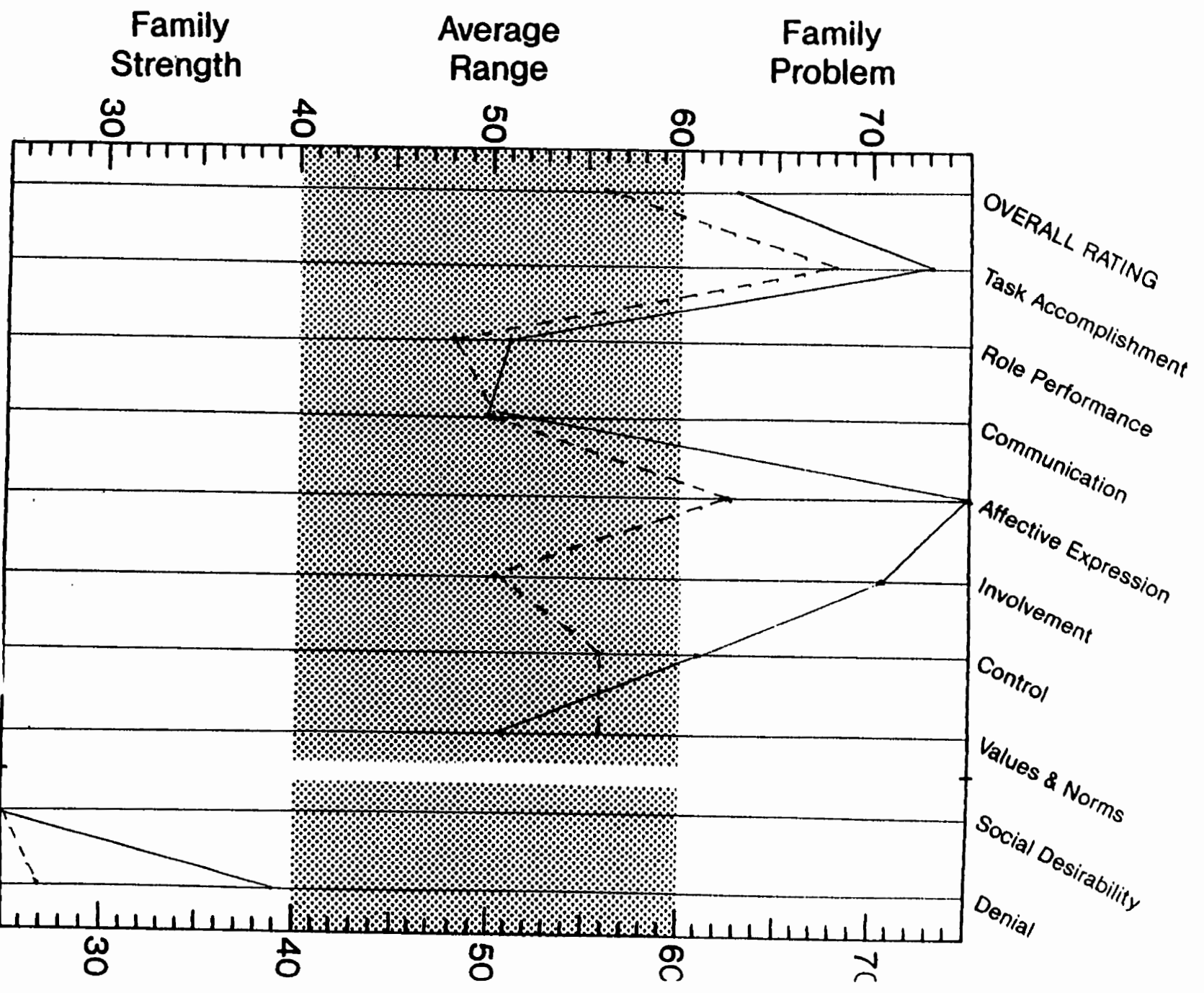
Chris & Susan

- - - - - - - - Chris

_____ Susan

Figure 2 POST-THERAPY

Chris & Susan
Chris
Susan

Couple B

My work with this family is described in detail to illustrate how a child with a disability can render a family impotent and how the child can become the focus of the parental relationship and of the extended family. The family history provides a backdrop for understanding the coping skills of this couple. I began the assessment by doing a FAM III and a Genogram of both parents families, but the intervention was two fold. The first priority was to get this couple to become more cohesive, for their primary focus had shifted from their role as a couple to their roles as parents when their world began to revolve around their son's needs. Secondly, the intervention was to use solution focused treatment emphasizing behavioral strategies to cope with the stress of the management of the illness.

This couple is markedly different from Couple A in that although the family history was significant, they were not able to make a connection and place a value on the patterns or themes in the same way. Couple A was able to connect themes that occurred in the past that had impacted on the present and thus change their behavior. This couple seemed to think in much more concrete ways and helping them develop specific coping skills became the focus of therapy.

These parents were two people who were as opposite as night and day yet shared a deep sense of love and commitment to each other that was remarkable. They were dedicated to each other and to their son and it was their

use of humor and laughter that was the strength that saw them through all kinds of adversity.

Source and reason for referral

George and Carey were referred by the Neuropsych Team in the Child and Adolescent Out Patient Psychiatry Department at the Health Science Centre. I was a member of that team which included a psychiatrist, a neuropsychologist, an occupational therapist, a nurse and myself, a social worker. We met weekly to assess families where the children in the family had neurological disabilities. This family came to my attention through the neuropsychologist who had been primarily responsible for the testing of the child's abilities. It became clear to her that the parents were experiencing some extreme distress over their child's disability and could use support and counseling.

Background Information

George Sr. and Carey had been married for sixteen years. They met while George was a drummer in a band and Carey was working as a secretary in an insurance office. Four years after they were married, George Jr., (Georgie) was born. Carey quit her job to stay at home and George Sr. continued working as an electrician during the day and playing in the band on weekends. When Georgie was three years of age, he experienced his first epileptic seizure. He continued to

have grand mal seizures for one and one-half years. During that time the parents visited numerous physicians, attempted many different types of medications, and had many hospital admissions for their son. Once the grand mal seizures were under control, Georgie continued to have mini seizures every day. In fact, he could have up to seventy per day. They included symptoms of dizziness, nausea, and entering into what his mother referred to as "a glazed over look." The medical explanation for the seizures was lesions on the brain and two lesions on the inside of his eye.

Carey described the last eight years as "hell on earth." Georgie had been through six MRI's, CT scans, medication that caused personality changes, assessments in London, Ontario, and concerns that the lesions had been a tumor.

She continued to express her frustration at the school system and public at large feeling that because Georgie wasn't in a wheelchair, people did not respect the fact that he was disabled and had special needs.

George Sr. and Carey had an extremely difficult time adjusting to their son's illness. Shortly after he became ill, Carey began to experience panic attacks that reached such high proportions that she developed agoraphobia. George Sr. took on the responsibility of taking Georgie to all of his medical appointments and doing the household errands. A social worker at the Children's Hospital identified

Carey's disorder and referred her to the anxiety clinic where she undertook psychological treatment.

George Sr. had what Carey called "habits." He had compulsions to take care of his body and health. He had rituals that he would follow every day to meet the needs of the compulsions. For example, he would wake up early, have specific rituals around his hygiene, would exercise and go running for an hour and a half, would eat breakfast (of the health food muffins he had made the night before), would go and lie down for awhile and finally, would get up and exercise again for an hour. This was a routine he felt compelled to follow every day. He also had habits of compulsively washing his hands, obsessing about what he ate, and calling home to Carey on an average of twenty to twenty-five times a day to see how Georgie was doing.

Carey was totally the opposite. She didn't care what she ate, and in fact preferred high fat foods, smoked and gambled. Their opposite choices of lifestyle drove each other crazy.

When they were referred to me, Georgie was eleven years old, and from the ages of three until the present, this family had been under a tremendous amount of stress. Their lives had been full of medical appointments, psychological appointments, educational appointments, all surrounded by hopes and failures.

By the time they saw me, Carey's agoraphobia was under control. She was able to leave the house but would often return after feeling anxious. When she came to our first appointment, she sat next to the door and half way off the edge of her chair in case she had to leave. As a result of her anxiety she and George Sr. would only go out to do errands or visit family. They never went out to eat or go to the movies, which is something they had previously enjoyed. One of the greatest difficulties Carey encountered was the feelings of guilt that she carried. Her family had a strong genetic component of epilepsy and she as a child suffered with grand mal seizures. She took on the responsibility for Georgie's epilepsy thinking that if it weren't for her, he would not have this disease.

George Sr. was still immersed in his rituals but his anxiety had increased and he spoke about feeling depressed. He was feeling listless, having difficulty concentrating at work, and having problems sleeping. Phone calls to home continued to be a problem for all three of them, as he felt compelled to find out how things were going, and Carey was answering the phone all day trying to reassure him. In addition, he was experiencing back pain that was impacting on his mental as well as physical health.

Georgie was stuck in the middle of all of this and was experiencing a great amount of distress. First of all, he was having numerous seizures a day that often necessitated him to call his mother to come and pick him up from school.

This caused conflict between all three of them because while initially Carey was overprotective and wanted him home, she now was wanting him to "tough it out" in school. This was partly at the suggestion that Georgie's seizures, while real, were also brought on by stress. This created conflict between the parents as George Sr. wanted Georgie at home and safe when he wasn't feeling well.

Secondly, Georgie was caught in a loyalty battle between his parents life style choices. Carey fed him hot dogs and french fries, while George Sr. tried to get him to eat vegetables at every meal. George Sr. wanted Georgie to get some exercise every day while Carey encouraged him to stay in and play games with her. They would often have loud verbal exchanges in front of him arguing their different points of view.

Georgie was also experiencing difficulty at school and with peers. Due to the amount of absences and his special treatment at school, he found it difficult to make and keep friendships causing him to feel very sad and isolated.

In addition to having the aforementioned difficulties, Georgie had developed his own anxieties and rituals. He was extremely anxious about getting to school on time, and had fears about being beaten up (even though that had never happened). He would wake up at six o'clock each morning and would fight with his parents because he wanted to leave the house before eight o'clock to get to school. His parents didn't want him going that early, and neither did school

officials. Once he left his home to go to school, he would run as fast as he could, running all five blocks to get there. Georgie had no rational reason for this behaviour, but he felt compelled to do it and they continued to argue about it. He would also have daily rituals and routines when he returned from school.

Mostly, each member of this family was afraid that Georgie was going to die. While this was a primary fear, it was something they had never discussed together as they each wanted to protect each other from feeling their pain and suffering.

The other source of stress for this family was a foster child they had living with them. Due to difficulties with finances and the fact that Carey did not feel comfortable leaving the house every day, they decided to become foster parents. They told Georgie that it was because they needed the money. Not only did he feel guilty that his mother couldn't leave the house during the day, he hated his foster brother for the attention he received from Carey. George Sr. was very ambivalent and in fact ignored the foster child most of the time.

A consultation with the neuropsychologist gave me further information. She said that Georgie has both seizures and cognitive limitations. He had a non-verbal learning disability, had low average intelligence, had difficulty with spatial skills, poor organization skills, poor social skills and difficulty taking direction. She continued to say that her experience with the parents was that they had high

expectations of Georgie and were very overprotective of him. She also wondered if he had performance anxiety causing him to rush through things, or if there was any secondary gain in his behaviour, such as an attention seeking method.

Family History

George Sr.'s maternal family was from Italy. His mother immigrated to Canada with her older nine brothers and sisters when she was just a girl. She met and then later married George's father Jack in 1940, right before the war. Jack's family was of British descent and he was the youngest of three children. George Sr. knew very little about his parent's relationship. He had an older brother who was born in 1945, while he was born in 1951. Unfortunately, his mother died at home of cancer in 1962 when he was eleven years old. He described himself as a fire setter before her death, and he was so traumatized by her death that he began to stutter soon after. He also had a disabled leg from birth and the kids would tease him by calling him "stuttering peg leg." Within a five year span of his mother's death, all of her siblings died of various forms of cancer. This caused severe trauma and loss and George Sr. felt that illness had destroyed his family.

After his mother's death, his father's sister came to live with them to take care of the family. She was described as Victorian and very religious. George Sr.'s father was never at home, and his aunt raised the boys to be religious and

taught them that sex was very bad. He described his father as being a person who worried about many things and had a number of compulsive habits. He had had a heart attack two years before his wife's death, and later in 1982, died of heart failure. When I saw this family in 1992, George Sr. had still not spoken to his older brother. Apparently, there had been a dispute with respect to the estate and they had not had any contact since that time.

Several themes emerged from this family system. The major theme was the one of illness and loss. George Sr. grew up in an environment where everyone he loved, abandoned him either by death or by choice. When his mother died, he not only lost her, he lost his father who immersed himself in his work, leaving the parenting job to his strict Victorian maiden aunt. Then over the next five years, he lost his aunts and uncles to cancer. The pattern repeated itself when after his father's death, he and his brother severed their relationship due to a conflict over the estate.

George Sr. knew that when he loved someone they would leave. He vowed to himself even before he was married that he would not let that happen again. He also vowed that he would be a different kind of father to his children, by being attentive to them, teaching them things, playing sports with them, and being an important part of their lives. This is what drove him to keep his marriage working.

The other theme that emerged was how individuals expressed their feelings and communicated in this family. George Sr. said that nobody in his family ever got angry or expressed many emotions. After his mother's death, his aunt moved in without any explanation or discussion. There wasn't any kind of mourning period allowed and everyone went on as if nothing had changed.

The other theme, that ties in with the lack of expression of feelings, is the obsessive compulsive habits and the high anxiety that George Sr., his father and his son experienced. There may be some recent argument to suggest that Obsessive-Compulsive Disorder can be chemically induced and can be inherited. I believe that if that is true, then in this case the symptoms were exaggerated by the fact that this family did not have permission to show any expression of feelings. Suppressing those feelings only increased their anxiety.

To summarize then, in George Sr.'s family system, the major themes are of loss, illness, abandonment, lack of affect and compulsive behaviour. There was no evidence of any kind of abuse or chemical addiction in the system.

What is fascinating is that George Sr. met and married someone so completely opposite from him. Carey was loud, vivacious, and quite an extrovert. She was very direct in her communication style and when she was feeling angry, the whole family knew it. They all were terrified of her and it became apparent in the sessions that Carey held and expressed the anger in the household. George Sr.

and Georgie were very passive, internalized their anger, and expressed it by being ill. Minuchin would characterize this as a "complementarity" in their relationship. He quotes Fritjof Capra when he states, "The relativity and polar relationship of all opposites are merely two sides of the same reality: since all opposites are interdependent, their conflict can never result in the total victory of one side, but always be the manifestation of the interplay between the two sides" (Capra (1975), as cited in Minuchin (1981), p. 192).

Carey came from a very small close knit family. Her only sister was two years older than she, and her parents were married for thirty years before her father died of a brain aneurysm in 1972. His side of the family carried the genetic link for epilepsy. Both he and his sister had epilepsy and he passed it down to Carey and her sister. When I asked her what her experience was growing up with this disease, she said that she was often upset because her family minimized the problem. She was on medication to control the seizures and if she did have a seizure, they would just deal with it as if it was a normal way of living. She outgrew her seizures at adolescence and was hoping that Georgie would do the same.

Carey's paternal grandfather was abusive and an alcoholic. She said that she believed she got her temper from him. Her maternal grandfather was also a mean spirited person and her mother's two brothers were alcoholic and gamblers.

Carey described herself as being close to her mother and would often leave Georgie there to be baby-sat. She spoke to her sister and mother several times a day and counted on them for support.

The major themes that emerge from this system are the genetic links and the impact it had on family members, the closeness of the family members, and the way they dealt with emotion.

There are some similarities and some differences between the two families. George Sr. came from a family that ignored feelings while Carey's family wore their feelings on their sleeves. George Sr. came from a family where people were disengaged and went their separate ways while Carey's family was enmeshed and knew each other's business. Both families experienced the early death of a parent and a predisposition for health related difficulties. The other similarity was that both George Sr. and Carey came from their families with very anxious personalities, although they reacted differently. George Sr. used his compulsions and obsessions to deal with his anxiety while Carey used her smoking and gambling as a way to deal with her anxiety. The interesting part was to see how they lived in the present with their idiosyncrasies.

Intervention and assessment

I saw this family once a week over a four month period for the purpose of this practicum, and then I continued to see them for three more years as a part of my work requirements. The family system made numerous changes collectively and individually and I will for the purposes of this paper, limit the discussion to the changes made during the time of the practicum.

This family system had many dynamics going on at different levels. On a micro level, they were enmeshed and triangulated with each other while Carey was triangulated and enmeshed with her mother and sister. George Sr. on the other hand had lots of "unfinished business" with his family of origin. He had numerous losses from both the past and the present that he was having difficulty acknowledging and dealing with. On a meta level, this family was also triangulated with the larger systems such as the medical and educational system. On one hand they were reliant upon them for service, and on the other hand, they were angry at them for not fixing their son. Some of the central themes were fear and loss.

With all of the various areas of difficulty it was overwhelming for me to begin to know where to begin. I was convinced while doing the genogram that this couple did not utilize their past patterns as a way of understanding or of changing the present. They seemed to be wanting to please me by giving me the information rather than using it as a tool for change.

I began by asking them to set goals for our time together and the one thing that became clear was that they wanted Georgie to get better. When they realized that it was impossible for me to make it happen, they identified that they needed help in coping with the illness and the uncertainty of their lives. I then proceeded to ask them the "miracle question" (de Shazer, 1988 p.5). This is where the family is asked to imagine what their lives would be like if the problem were solved. I asked, "Suppose that one night, while you were sleeping a miracle happened and the problem disappeared, and you were coping in a better way with Georgie's illness. What would be different? How would you know that the problem had been solved?" Answering this question builds the expectation that the problem will be solved and helps the family move in ways that actually resolve the problem.

George Sr. said that if there was a miracle, he'd be less anxious, he'd be calling home a few times a day instead of twenty times a day and he would be enjoying life a lot more. When asking him to define that in behavioral terms, he said that he and Carey would go out occasionally, they wouldn't fight as much and he would actually enjoy spending time with his son instead of worrying about him so much.

Carey said that if she experienced the miracle she would be getting out of the house more often and she wouldn't feel as anxious. She was able to describe

a pattern whereby as soon a Georgie became ill, she and George Sr. would become very tense, start arguing about everything, she would feel very agitated, and she would become immobilized. She said that if there was a miracle, they would be able to handle the ups and downs of the epilepsy without it turning their lives upside down.

Georgie answered in a most enthusiastic way. It was almost as if he was experiencing the feelings of the goal attainment. He felt that if he was coping with this illness in a better way, he'd be staying at school when he became dizzy and wouldn't have to call his mother to take him home. He also said that if there was a miracle, his parents would stop fighting about him.

Two strong common denominators of all three answers were that if the miracle happened, there would be less arguing between the parents and less anxiety in the family system. The family dictated to me which direction to follow. The first task was to help them break the pattern of "when Georgie begins to feel ill, the whole family begins to fall apart." This was a very difficult habit to break. One of the ways I attempted to facilitate this to happen was to strengthen the couple system. Homework assignments were given to the parents to spend quality time together that did not include Georgie or the subject of his illness. The results were interesting. At first, Georgie was threatened by his parents unity. He wanted to go out with them or would sabotage their efforts by saying that he

wasn't feeling well. He soon began to see that this was not going to work as his parents were working very hard not to give into their worry and stay home with him or take him along. After a few weeks, Georgie began to realize that some of the pressure had been removed from him. He found that his parents were fighting less and he wasn't getting dizzy as often at school.

His parents, on the other hand were enjoying their time together and began to realize how much influence Georgie's illness had upon them. They found that they had missed being with each other and that it somehow had decreased some of the anxiety between them.

The real test of this change came about eight weeks into the therapy when Georgie was scheduled for his yearly MRI. It was a time where traditionally George Sr. became extremely anxious, to the point of not sleeping at night. The family really struggled with this time, waiting to see if the lesions had changed shape or if they had moved at all. Throughout this time, parents and Georgie had a slight relapse. They began to fight more about what Georgie ate or what he did. After the MRI and everything was cleared, we were able to analyze that period of time together. They all noticed that even though they argued and felt stressed about the test, it was not as intense as it had been in the past. This period of reflection also enabled them to identify the pattern more clearly and helped them identify what role they themselves took in perpetuating the pattern.

The next intervention used to develop couple cohesiveness was to help them learn to support each other when they were feeling anxious. It traditionally would happen that George Sr. would begin to worry about Georgie's health and instead of sharing it he held it inside and Carey would begin to notice his anxiety by the way he was behaving. Instead of addressing his worry, she would yell and scream at him for something he was doing and this would lead to an argument creating conflict in the household. I was able to bring this pattern to their attention and had them communicate in my office about other ways they thought they could handle the situation. They concluded that they would try two different strategies. George Sr. decided that when he was feeling anxious he would find a way to deal with it by telling Carey how he felt or if he felt he needed medical reassurance he would call Georgie's doctor. Carey agreed that if she saw him behaving in an anxious manner, she would talk to him about how he was feeling rather than yell and scream at him. Carey decided that if she was feeling anxious, she would talk to George and let him know. The stipulation that was built in was that while each one would share their feelings, the other was not to take ownership or feel responsible for those feelings.

This exercise was an enormous challenge for this couple as they were so tuned into each other and reacted automatically. Not only was there an element of fear there was a strong disposition to protect each other against difficult feelings.

The other variable was that every time George Sr. was overwhelmed with fear and anxiety, Carey's feelings of guilt would surface.

Helping them to unite "in the service of their son" helped reframe their need to be cohesive and supportive to one another. This process took many months because as in the pattern of Georgie's health, the situation was always going up and down.

The area that underlined most of their anxiety was the fear that Georgie would die as a result of the epilepsy. This was difficult to face, especially for Carey as her father died from a brain aneurysm and she was afraid that the lesions could cause her son to die. The best intervention for this family was to be able to sit down and talk about their feelings. The theme of protection was very strong and they all wanted to protect each other. This was one area where talking about the losses of the past enabled them to understand the origin of their fear. Talking about it enabled them to deal with each other in an open and more intimate manner rather than act on it. They concluded that this fear could be with them for years to come, but at least now "it was on the table" and they could begin to face it.

The next intervention took place between Georgie and his parents. This was the biggest challenge because it seemed to have so much power in the family. This intervention was also the one with the most humor and laughter.

As I said earlier, George Sr. and Carey had very different views on how to raise their child. George Sr. wanted him to eat right, exercise, get enough rest and be dressed appropriately for the weather. Carey believed that Georgie should have a choice about those things. She fed him whatever he wanted to eat, encouraged him to play cards with her until late into the evening and felt that if he was cold outside he would put on snow pants and a warmer jacket. These divergent views caused numerous fights and always in front of Georgie. He spoke about wanting to please both of his parents, but really liking his mother's way better. He enjoyed the flexibility of her style but acknowledged that his father's way was more sensible. Our sessions over this topic were many, not always fruitful, and in the end they agreed to a couple of things. One was not to argue in front of Georgie. After they realized that it was causing him more stress and may be contributing to the number of seizures he was experiencing, they decided it was not in his best interest to do so. The second intervention they agreed to was to follow the Canada Food Guide and possibly consult with the hospital dietitian to determine the best diet for their son.

The end result was that the parents had less arguing about what he should eat or do and George Sr. withdrew from the fights by letting Carey take charge of Georgie's diet. This was done with the proviso that she would attempt to follow the Canadian Food Guide and Georgie would get more of a balanced diet.

From a family systems perspective Georgie found ways to identify and align with both of his parents. His relationship with his mother was accentuated by depending on her and wanting to be like her by simulating eating and recreation habits, while he was aligned with his father by emulating his need for compulsive behaviour and his high level of anxiety. While this allowed him to be close and loyal to each parent it also created both inner and outer conflict for him and the family.

In summary then, the major interventions that took place were helping this couple become more cohesive by establishing clearer boundaries regarding being a couple first, and then parents, and by getting them to support each other when they were feeling anxious. Getting them to open up and talk about their fears allowed them to feel closer together and diminished their need to protect each other as much, and lastly, helping the parents respect each other's lifestyle without imposing their disagreements upon Georgie allowed this family to make a number of changes. The end result was that Georgie's seizures were less frequent due to the reduced stress in the family, and when he did have an epileptic episode, his parents had more coping skills.

FAM III Profile

The successful changes that this family made is evidenced by the pre and post-FAM III results. In the pre-test FAM III (Figure 3), Carey and George Sr.

identify a couple of areas that are creating a lot of stress for them. Carey in particular is expressing unhappiness in the subscale areas of Task Accomplishment, Role Performance and Affective Expression. When I asked her how she understood the difficulties in these areas, she quite bluntly told me that she felt like she was the parent for three boys, with George Sr. having the most demands on her time and energy. This is further evidenced by the serious divergence in the subscale of role performance. George Sr. appears to be content with his role while Carey is at the top of the problem area stating that it is just terrible for her.

George Sr.'s overall rating was in the average range. He stated that he was mostly satisfied with his relationships, but that he constantly worried about Georgie and that it interfered with his ability to lead a "normal life." He said it entered his thoughts all during the day and into the night.

The pre-test FAM III shows that they both held the common view that they were a family in serious trouble. They both had high scores in the subscale area of affective expression. This indicated to me that there was an emotional void in their lives and while they both acknowledged that it was a problem, they weren't able to communicate it to each other.

The post-test FAM III shows remarkable changes, especially for Carey. All of her scores are reduced to the average or family strength range. She had made significant changes with some of the outstanding ones being: 1. She no longer had

a problem leaving the house and feeling anxious. In fact, she actually enjoyed going out again and went to play bingo, or gamble all by herself. 2. She no longer took on the responsibility for the feelings of her family. She was able to separate her feelings from theirs, and not get as angry when she felt helpless to change them. 3. She and George Sr. were able to re-establish some of the closeness they had lost, and 4. Carey noticed how stressful it was for Georgie to be caught between the love and loyalty of his two parents. When confronted with a situation where she thought he felt triangulated, Carey would deal with it by working it out with George Sr. and leaving Georgie out of the discussion.

George Sr. made significant changes as well. He reduced his phone calls home every day from twenty times a day to three times a day. He stated that he still felt anxious, but didn't obsess about it as much. That was an interesting observation made by him, in that the post-FAM III communication subscale showed a higher level of unhappiness than in the pre-test FAM III. My impression was that in order to have more peace and harmony in the household, George Sr. found other ways of coping, and one of them was not to argue with Carey about Georgies diet. While the remainder of the subscales show a decrease in dissatisfaction, the subscale of values and norms are a bit higher and slightly in the problem area. Again, I can only speculate that George Sr. was made more aware of the acute lifestyle differences between himself and Carey.

Georgie had also made a number of changes even though he was too young to fill out any of the FAM III scales. His anxiety had reduced sufficiently that he was experiencing fewer seizures and staying in school more often. His need to run to school was still evident, but he chose to solve the problem by finding a friend to walk to school with. In addition, he still tolerated his foster brother, but the family decided to make special one to one time for him so that he did not feel left out. This also was an improvement for the foster child, who now got to spend more time with George Sr.

All in all, this family was functioning at a much higher rate. Anxiety was reduced and boundaries were much more fluid, allowing members to move around without creating additional stress. The couple system was strengthened and as they became more cohesive subsystem boundary lines were much clearer. This was very helpful for Georgie who often took on adult responsibilities in the area of affective expression. As time passed, they continued to have many trials and tribulations to test the changes they made. For the most part, they were very successful and if they did regress to old patterns, they were able to bounce back.

I thoroughly enjoyed working with this family. They taught me so much about change and the willingness to work at change. They were terrified about the illness and what it could do to their family, yet they conquered their fear to make

changes so that "maybe" the situation could be better. It was quite a risk for them and I admired their courage.

They also taught me about laughter and the use of humor in therapy. As chaotic as things often became, they were able to laugh at themselves and invited me into the fun. This, to me was a tremendous strength in this family, and I have attempted to transfer this sense of humor to other families that I work with. I occasionally bump into a member of the family in the hallway at the hospital and am greeted with warmth and laughter, reminding me of why I chose this profession.
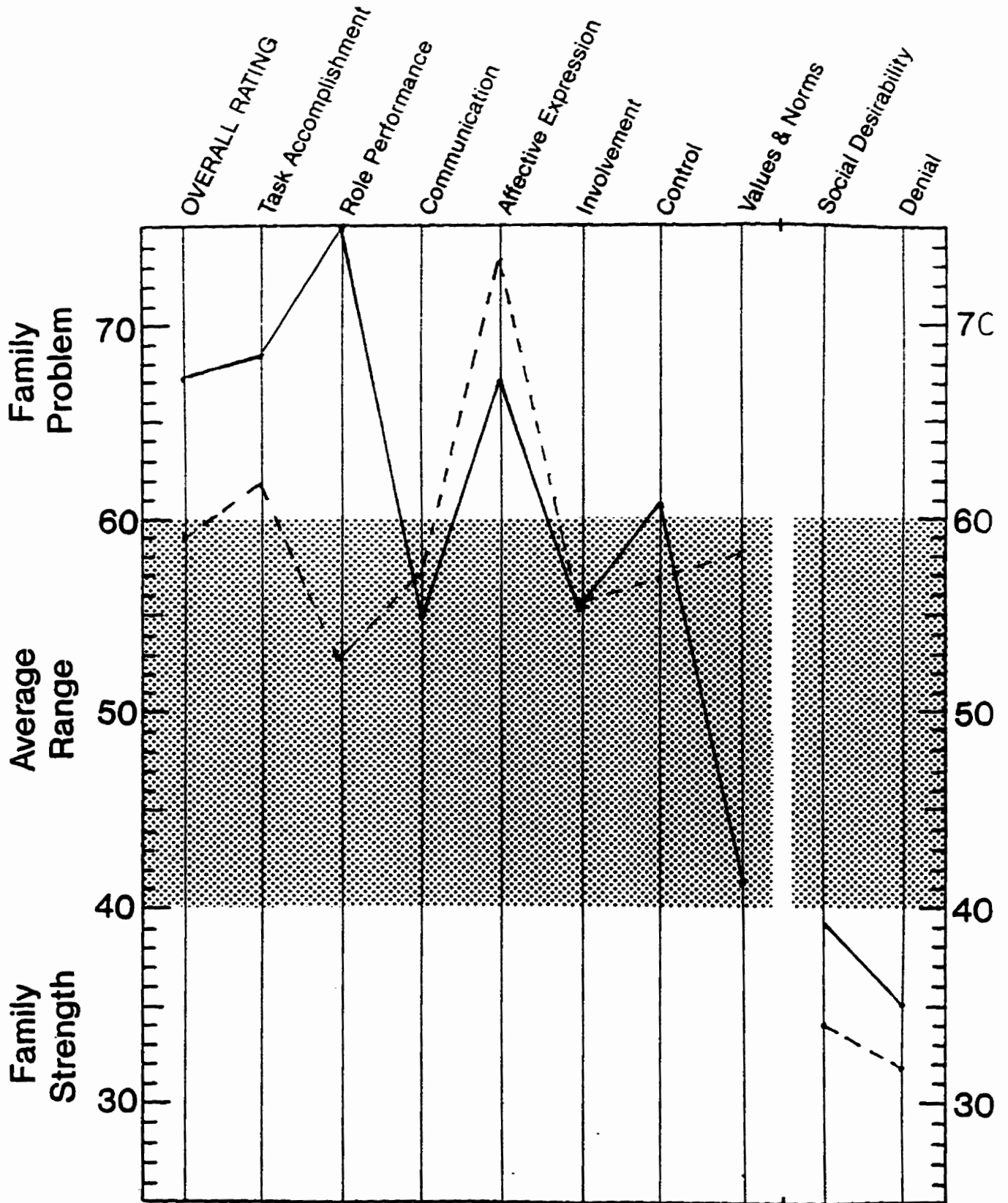
FAM GENERAL SCALE

Figure 3 PRE-THERAPY

George Sr. & Carey

- - - - - - - - George Sr.
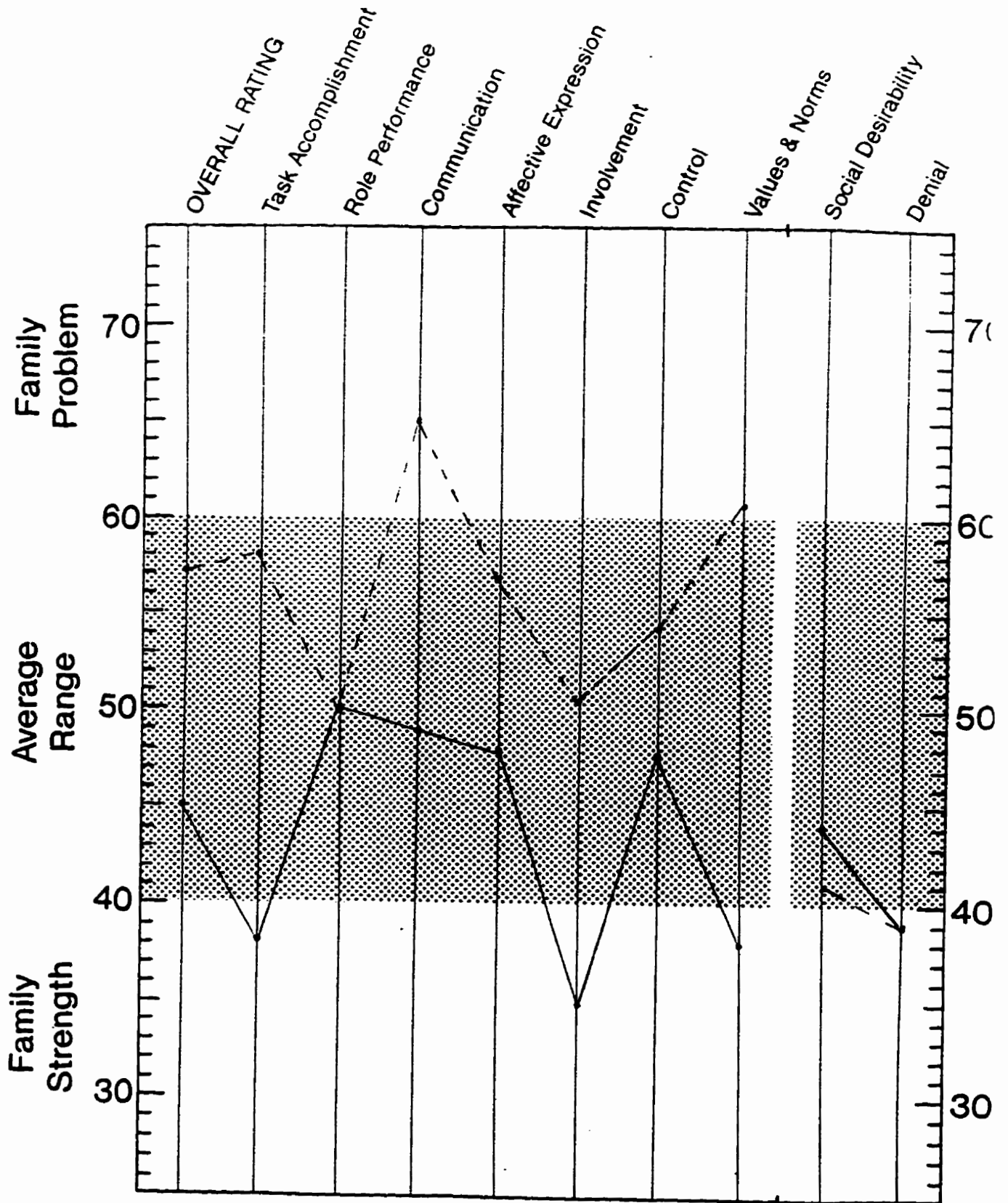
_____ Carey

FAM GENERAL SCALE

Figure 4 POST-THERAPY

George Sr. & Carey

- - - - - - - George Sr.

_____ Carey

CHAPTER V

LEARNING THEMES

As I sat back to reflect upon my practical experience in working with this population, I began to wonder about what I learned from this experience. I asked myself, how has this made me a better person and therapist? What did I learn about human beings and their capacity to live under extraordinary circumstances? I further began to reflect upon what I learned from the families with special needs children. Were there any common themes that I could bring together to enhance my understanding of their needs? What could I have learned from this group that I could transfer to other families I would be working with? What did I learn about the therapeutic techniques that I chose to work with? My goals at the beginning of this practicum were to gain an understanding of family dynamics, refine my skills as a therapist and to be able to use the Solution Focused Model and Structural Family Therapy Models. How did I do at accomplishing those goals?

In this chapter I would like to explore two specific areas of knowledge that emerged from this practicum experience. This is not an exhaustive list, but they represent highlights of areas that stand out in my mind as being relevant both to me and any other clinician who may choose to work with families who have special needs children. I also believe that these are applicable to the general

population. The first area I'd like to explore is what I learned from this population. What was instructive for me about understanding this group and what were the common themes that emerged across the families? What made sense to me in terms of understanding the literature and how it related to the families I worked with? The second area is what I learned as a Family Therapist. What did I learn about the models that I chose to work with? Would I do anything different or would I integrate these two models again when doing family treatment?

Families with Special Needs Children

The literature presented a framework for understanding the families I worked with. Two points in particular stand out. The first one and probably the most relevant one was that not all families with special needs children are families in distress. I had first noticed that when I had my work experience with Child and Family Services and reviewing the literature corroborated my belief. I understood that they were normal families with specific needs of their own and while intellectually I knew they were normal I did have a strong belief about these families. The bias I entered with was the notion that having a special needs child in the family was an enormous burden on the family as a unit. I felt sympathy for anyone who had to deal with the disabilities on a daily basis and admired them for their courage. Both the literature and the practice taught me

that these families can be healthy, strong, united, and accept their situation with great pride and honor. I learned that there are families who become stronger and more cohesive as a result not only accepting their situation, but embracing it with hope and caring. They acknowledge the difficult times, but feel that it makes them a better and stronger family.

The second point in the literature review that gave me an overview was the concept of "chronic sorrow" (Olshansky, 1962) or "recurring grief" (Kratichvil & Devereux, 1988). These theories suggest that parents never actually give up grieving for the loss of their "perfect child" but that stages of mourning are activated at specific junctions in life. When I thought about this concept I realized that moving through the life cycle means constantly giving up the last stage of development and moving on. This invariably means loss and change and is applicable to the general population. My experience in working with this population is that not only do they go through life cycle changes, they tend to have an exaggerated form of loss and anxiety about entering new stages. For example, when parents launch a young adult into the world they are concerned about that child getting an education and obtaining the skills to live independently. When a young disabled child is of age, parents worry about whether or not that child can survive independently, knowing that they may not be able to obtain the necessary skills and worrying about how they will survive when they die. In both situations you have parents who are concerned about their children but with the

disabled child the parents have many more critical issues to struggle with. The concept of "chronic sorrow" or "recurring grief" would suggest that at a time like this the parents would re-mourn the loss of the "perfect child". This is something I observed when working with these families.

The next section describes more specific themes that were threaded through the families I saw.

DISTANT OR ABSENT FATHERS

The most distinct theme to have emerged from the families I saw was the theme of distant or absent fathers. The term distant father is intended to be a broad meaning referring to fathers that were physically present but absent from any kind of emotional or intimate relationship with their children. In every one of the families I saw, there was either an emotional or physical absent father. Of the two, the most prominent theme was where a father was present, but there wasn't a strong emotional attachment, or the father didn't share his feelings with other members of the family. Sometimes feelings were disguised by too much drinking, angry outbursts, or neglect. Corneau states, "It is not that men have no sensitivity: it is rather that they are forbidden to express it if they want to be considered men by other men. In this sense, becoming a man requires cutting oneself off successfully from both heart and body. In fact one is all the more a man if he manages this amputation without crying or complaining. Men are cut off from

their emotions because they have not seen their fathers or other men expressing their inner feelings" (Corneau, 1991, p 24-25).

Chris and Susan

Both Chris and Susan came from families that had emotionally distant fathers and both not only felt regretful about it, but they also came to understand how that loss impacted on their lives and their relationship. Chris's father John, had a history of a tumultuous relationship with his father and ran away from home when he was fifteen years of age. So it wasn't a surprise to find out that he did not have a healthy role model to learn from. Chris described his father as vain, a braggart, and a binge drinker. While he used Chris to complain to about problems with his wife, he didn't have a good relationship with his son. Chris felt very sad about the loss of the relationship with his father, and was torn between not wanting to be like him, but yet having similar qualities. He recognized that he was similar to his father because he had a temper, he needed to be obeyed, he placed a high value on achievement, he was a braggart, and most of all, he had difficulty expressing his feelings.

Susan came from a very structured and traditional family where men were held in high status. She described her father as critical, opinionated, and judgmental. Susan felt that no matter what she did, it was not good enough to please him. She stated that although she saw him once a week for dinner, she felt

very distant from him and went as far as to say that she did not love him. At thirty nine years of age she still felt like a little girl wanting to please her Daddy. Through therapy she was starting to give up that dream and accept her father as a man who had his own struggles and learned patterns of behaviour from his parents.

Having distant relationships with their fathers complicated Chris and Susan's relationship. They both knew that they wanted different relationships with each other and with their children, but didn't have the blueprints, or models to follow. They became trapped in old roles and didn't know how to escape. Through therapy, they were able to see how the roles, rules and expectations of the past impacted on their relationship. Chris said he wanted Susan to be more assertive, but when she tried, he emulated his father by becoming authoritarian and angry. That was a pattern that Susan had grown up with and as a result she would back down. Our sessions together enabled them to practice new behaviors and new ways of communicating. They slowly shifted and Susan became more assertive, while Chris began to express more feelings. As was stated before, Chris had a nervous breakdown and this changed the balance of the relationship even more so where Susan had to be dominant and take over more decision making and responsibilities.

Carey and George Sr.

George Sr. was eleven years of age when his mother died of cancer. He lost his father at the same time. George describes his mother as the main caregiver in his early years, but as she became increasingly ill, she was unable to care for the household. This shifted the responsibility to George Sr. and his brother Mark. After his mother's death, his aunt came to take over the household responsibilities while his father became immobilized by his wife's death. He would spend many long days at work, only to return home late in the evening. George Sr. said the biggest loss was that not only was his father not there physically, he withdrew from the family emotionally. They never spoke about their mother or how family members were feeling without her being there. Life just went on. This was expressed as a major loss for him and he vowed that if he had a son, he would do all the things he wished his father would have done, such as play ball, hockey, go to sports games and have a warm loving relationship.

Georgie's illness brought on two losses for him. First of all, having a son reminded him of not having had his father to spend time with and secondly, Georgie wasn't able to do the physical things that George Sr. was longing to do. Everyone felt that he was too fragile and that any athletic activity could cause a seizure. This left a large gap in the kind of relationship that George Sr. wanted with his son and he withdrew physically and emotionally. Therapy enabled him to

get in touch with those losses and he began to realize that he could have a close relationship with Georgie by doing things such as walking, bike riding, collecting hockey cards and other more sedentary activities. Most of all, he could develop a close relationship with him by sharing feelings, being a good role model and, just being there for him when times were tough.

Carey's father died when she was sixteen years of age. She said that he was an alcoholic and that they did not have a very close relationship. As we went through her family of origin, she found it difficult to remember very much about him. She felt very close to her mother and to her sister, but not her father.

This couple has had the joint experience of having lost a father through emotional withdrawal and by death. I speculated whether or not Careys father was a distant father even before his death, given that he was an alcoholic and she had very few memories of him. George Sr. was able to assess the relevance between his inconsistent relationship with his father and the kind of relationship that he wanted with his son while Carey was not able to make the connection between her relationship with her family of origin and her current family. She was able to understand the patterns and similarities, but didn't think it had any relevance to her.

In both of these families we notice that the male role model is either distant or absent completely. It is interesting to note that while I did not discuss

the other families in this practicum, all of them struggled with this issue. The general theme was father loss and its impact on the family. They all talked about the sadness of not having their father around, how it impacted on their parenting ability and their emotional attachment to their families.

This theme became relevant in the current family systems. The couples emulated their parents by continuing this same pattern of distant fathers. There are two reasons for this. First, these men only had their own fathers as role models and they carried their emotional system from one generation to the next, as did the women. Second, as noted in the literature, families who have disabled children tend to be traditionally organized where the mother has primary home and childcare responsibilities (Trute, 1995). In these families the mother was not employed outside of the home leaving the fathers with the financial responsibilities, while they had primary responsibility for the home and the children.

Part of the work with these families was to first of all, help them to understand the impact of father loss and what it meant to the current family system, help the fathers take on more of an emotional role, while helping the mothers relinquish some of their control, and thirdly to help strengthen the couple system to become more cohesive and operate as a team.

In the next section I will discuss the difficulties with boundaries that these families experienced.

BOUNDARIES

One of the ways Minuchin characterizes the structure of a family is by assessing the boundaries of the family system. He suggests that there is a continuum where enmeshment is at one end and at the other extreme there is a disengagement of family members. Enmeshment is characterized by blurred differentiation, distance is decreased and the sense of belonging interferes with autonomy. At the other extreme, in a disengaged family system, rigid boundaries impede communication and the notion of individual members' autonomy is more important than the interrelatedness of family members. Most families fall within the middle range and patterns may change through the life cycle. Extremely enmeshed or extremely disengaged patterns indicate possible areas of difficulty in the family system (Walsh 1982).

Chris and Susan

There were a number of boundary issues in this family system. In Chris' family of origin, we have many examples of crossed boundaries. His parents often parentified him at inappropriate times. He stated that they both would use him to complain about the other spouse, or confide in him about their own problems. This left him very confused and angry. On one hand he enjoyed having the closeness of the relationships but on the other hand he was being placed in an adult position when he did not have the skills or emotional capacity to deal with

the issues. He wanted to feel close to his parents but not by having to meet their needs. This caused great conflict inside of him as he was torn between wanting to be close but resenting the way in which his parents sought him out.

The other example of a crossed boundary is evidenced by the alleged sexual abuse of his adopted sister by his father. While there was only speculation about the abuse, Chris believed it to be true. His father may have attempted to justify the abuse by thinking that she was only an adopted child, but nevertheless, she was his child and it was not only illegal, but immoral. This is a clear example of a parent crossing a parental boundary by using his child for sexual gratification.

In Chris and Susan's family, boundaries were blurred between Chris and Susan and Chris and his older daughter. Chris and Susan identified their disengaged relationship as a problem from the outset of therapy. They talked about each of them having their individual interests and that those interests kept them from spending time with each other and other family members. Chris also spoke about his over involvement with his daughter. He would often take her out to community activities and spend more time talking and paying attention to her than to his wife or other children. He prided himself on having such a close relationship with her but through our sessions he realized that he may have been giving his daughter more attention than his wife. Therapy helped this couple

recognize their difficulty with disengaged boundaries with each other and the enmeshed boundaries that Chris had with his daughter. While Susan acknowledged that she had the primary responsibility for the day to day activities of the younger children it appeared to fall within the normal range of the boundary continuum. She and Chris had a suitable arrangement for the other children. He would participate in the morning and evening routine with the children and was responsible for the community systems organization while she took care of their home and was responsible for the other needs of the children. Both were content with their level of participation and were flexible enough to change whenever necessary.

George Sr. and Carey

George Sr. came from a very disengaged family. It is difficult to be certain what his family was like before his mother died, but we do know that after her death, his father disengaged from the family and a maiden aunt was brought in to take care of the household. George Sr. describes his relationship with her as very strained. He did not like her and she didn't seem to have any affection for him. She was strict, held high Victorian values and was unavailable emotionally to the family. His father threw himself into his work and never remarried. This disengagement is further evidenced by the rift between George Sr. and his brother who did not speak for years after their father died.

Carey came from a family where the mother and daughters were enmeshed. As stated previously, she was not close to her father and he died when she was twelve years of age, however she was very close to her mother, her sister and to her aunt. These relationships had carried on into the present where they spoke several times a day and Carey would consult with her mother about decisions that had to be made. This relationship did not seem to effect George Sr. My guess was that it helped him balance the relationship so that whenever he wanted to disengage he could do so without abandoning Carey, which was really his own projection.

The current family had very blurred boundaries that fluctuated constantly and was a great source of confusion for Georgie. Given their backgrounds, George Sr. would vacillate from becoming too over involved and too overprotective to the other end of the continuum where he would completely disengage and avoid any emotional involvement with his son, his foster son and his wife. Interestingly, Carey followed the same pattern. She was either too involved with Georgie by being his friend and being too overprotective, or she would yell at George Sr. and Georgie to get out of the house and do something together under the guise of advocating for their relationship This chaotic pattern was extremely difficult for Georgie. He wanted to be close to his father but was subjected to his father's "yo yo" pattern of relating. Ultimately he resorted to be close to his father by emulating his obsessive behaviour and by trying to please

him by eating properly. On the other hand he was torn between feeling too enmeshed with his mother but not having his father to balance the relationship. Because this family was triangulated and the parents were unable to maintain their own boundaries, Georgie had no choice but to develop symptoms of his own bringing this family in for treatment. The treatment issues were to help define the families boundaries by strengthening the couple subsystem, strengthening the father - son relationship and helping Carey disengage from the enmeshment with her son.

The treatment goals in working with these two families were to help reinforce the boundaries between the subsystems. The couples needed identification and strengthening as a unit, while the children needed to be relieved of the pressure of having to fulfill their parents adult needs. It is easy to see how a family who has a special needs child can lose sight of its boundaries. If the father has the financial responsibility while the mother takes the responsibility of home and family, it is reasonable to say that she may have a stronger bond with the child and because the child needs more attention, the family would feel the effect of her involvement. It may also be said that at an earlier time the mother was more involved with the child due to medical and educational appointments and that being more involved was useful and necessary. However, when it no longer serves a useful function it becomes a barrier in the family system. It is especially helpful for the clinician to be aware of these potential difficulties so they can help the family restructure itself.

FAMILY THERAPY THEMES

When I decided to do my practicum and to advance my skills as a Family Therapist, I struggled with which model I wanted to follow. I had begun this practicum with a general knowledge of both the Solution Focused Model and the Structural Model of Family Therapy. There were many things that I liked about each and decided that I would try to combine them both, thinking I could hone my skills in both models.

In the Structural Model, Minuchin provides a concrete way of understanding how families operate and how they are organized. Understanding how the family is organized provides the therapist with guidelines for diagnosis and treatment of the family. It provided me with a framework with which I could examine the family as a whole, or as smaller parts. It was as if I was sitting on my own shoulder and could see the family from a distance, or I could feel myself as a part of the system, which provided me with objectivity when I needed it and empathy when I needed it.

This theory also recognizes that the individual does not live in a vacuum but is part of a greater whole, a social system to which he or she may have to adapt and that when a therapist becomes involved with a family, he or she become a part of that social system. Minuchin calls that process "joining". This is

where the therapist must accept the family's organization and style and blend in with them to provide leadership.

Assessing the families structural dimensions is another useful way of understanding the family dynamics. Subsystems, boundaries and alignment are ways of understanding how people form relationships and interact in the family unit. Where one fits into the structure determines functioning, patterns, hierarchy, triangles and how one generation is connected to the next.

The other concept in this model is the notion of families moving through time in developmental phases and how families adapt to change. The concept of families moving through the life cycle provides the therapist with a framework of what is normal development and what is not. It allows the therapist to assess the families functioning in terms of where they are in the process of the life cycle and how that intersects with the problems they bring into therapy.

This theory also recognizes that the absence or presence of problems does not indicate effective or ineffective functioning. It assesses how the family copes with the problem and whether or not it is effective and adaptive.

Solution Focused Therapy acknowledges Structural Family Therapy by giving credence to the notions of the family life cycle, boundary formation, hierarchy, joining and other techniques. However, it uses the family as the experts of what

needs to change and the therapist is more of a facilitator than a new member of the family system. Solution Focused Therapy is an interactive process which involves the clients and the therapist and the context in which they work together. The therapist and clients work together to form common goals and these goals are defined in behavioral terms. The therapist believes that the family has all the resources they need but are not using, and Solution Focused Therapy focuses on problem resolution, not the reorganization of the family unit or in creating insight. In Solution Focused Therapy, since interactive patterns can be seen as both individual and systemic, the belief is that all it would take is just one person to behave differently to break the pattern. Therapists do not believe that you have to have the whole family in the room to effect change and will work with either an individual or a subsystem of the family. Their goal is to get the family to do something different.

Structural and Solution Focused Therapy: A Comparison

I started this practicum with a general base of knowledge of both theories. My understanding of Structural Therapy was grounded in my BSW learning experience as well as general reading I had done. My knowledge of Solution Focused Therapy was formulated by having taken numerous workshops, hearing many lectures, including Steve de Shazer, and having many hours of reading and studying the model. It seemed as if it was a model that fit my style as a person

and as a therapist. I am much more prone to work with the perspective that the client is the expert and that they have the resources to change. I also believe in working in a consensual model where therapist and client are equal. I also believed in this model because it focused on the positive things people were doing to attempt solutions rather than using interpretations and insight. It all looked so simple! I was taken aback when I attempted to use the model and ask the "miracle question." The clients didn't respond in the way they were supposed to and I got stuck. It wasn't so simple any more. This is how I felt throughout this experience. The theory was great, and there were times when it was extremely useful to have the frame of reference, the positive attitude of the model and the specific techniques, but I couldn't get it off the ground to do the assessment and once the assessment was in process, it was difficult to shift gears.

I especially found this to be true with this population. Both couples needed the opportunity to tell their story, to talk about the pain they had experienced and the day to day struggles they encountered. Solution Focused questions didn't promote those kinds of opportunities. Asking them the "miracle question" elicited the response of wanting their child to be normal, which was impossible. It was very difficult for them to envision what a miracle would look like, and I began to feel embarrassed about asking.

One of the criticisms of this model is that therapists can get caught up in following the technique without paying attention to the needs of the client. Often times we can get so immersed in following the "recipe" that we are not able to see that the client needs time to tell their story, feel their emotion and talk about problems rather than solutions (Lipchik, 1994). Another area that Lipchik refers to as a difficulty is the area that some therapists have with the notion of goal setting. She states that many times therapists will focus on goals before they have joined with the client or as she says, "One of the greatest pitfalls for brief therapists is subtly or unwittingly imposing their own goals on their clients" (Lipchik, 1994, p 38).

The time that Solution Focused Therapy was very useful was after the initial genogram was completed. Asking the family to scale their problem from 0 to 10 was an excellent way of getting them to assess where they were and where they were going to. For example, I asked Georgie where he was on the scale from 0-10 with respect to feeling frightened when he ran to school. He said a 10. I then proceeded to ask him where on that same scale would he like to be. He said that he'd like to be a 1 or 2. Then I asked him "If you are a 10 today, what do you think you have to do to move down a notch?" He thought about it, mentioned a few solutions and I asked him to pick out one solution that he would be willing to try over the course of the next week. He chose to leave home later when more kids would be walking to school and he would be less

frightened and would try to walk instead of run. The following week I asked him where he was on the scale and he replied "a five." I did what many solution focused therapists do and that was to "cheerlead" him by giving him lots of positive feedback. I then processed with him to find out what he had done differently and talked to his parents about what they noticed was different. He replied that he walked to school later and that there were many more kids on the street so he felt less afraid. His parents said that he seemed to have more self confidence and that made them proud. While this exchange was going on, Georgie was beaming from ear to ear. Then I said to him, "If you are a 5 on the scale today, what do you want to do to move it down a notch and get closer to your goal?" He replied that he wasn't quite sure what to do. At that point I suggested that this week he should do something different, to surprise his parents and come in next week to discuss it. They came in the following week and when I asked him where he was on the scale he replied that he was at a number 3. The same cheerleading process took place and he said that what he decided to do was to ask a friend to walk with him and he was much less frightened. The parents were delighted. This technique worked well in a couple of areas. It helped Georgie learn that he has mastery over his own problems and he can control and take responsibility for his actions. Not only did that increase his self esteem, it helped to differentiate the enmeshment between him and his mother when in the past he would expect that she take care of the problem and fix it. It also helped define

the boundaries whereby he could leave his parents while he sought out a friend for companionship.

This process works beautifully with children but it also works with adults. I used the homework by asking the couples to do something different, I asked them to define, in a behavioral way what they would be doing if their relationship were closer, and I asked them to scale the quality of their relationship and what they needed to do to move it a notch on the scale. The beauty of this model is that the families define what it is that they need to do to improve their lives. The therapist facilitates this process keeping the structure, boundaries and organization in mind which is where the structural model was beneficial.

As stated before, Minuchin's model provided the foundation on which to build solutions. He provided the blueprint through which the therapist can view the family and its functioning, allowing him or her to develop the diagnosis and course of treatment. For me it was essential to be able to understand the operation of the family before I could figure out what the family needed to get back on track. The key elements for me were being able to identify hierarchy, boundaries, triangles and patterns of complementarity. These principles allowed me to do a thorough assessment and identify strengths and weaknesses in the organization of the family. For example, it provided a way for me to understand the relationships between the parents and the children in this practicum.

Understanding boundaries helped me define one of the major problems with Couple B. As the reader may recall, Carey was enmeshed with Georgie and George Sr. was isolated. The goal was to get this couple to strengthen their boundary and help Georgie have his own sense of identity.

The concept of complimentarity helped me to understand why George Sr. and Carey, who were so opposite, would have been attracted to each other in the first place. "In individual experience, the focus is on the individual as a whole. But when the complementary aspects of the self become parts of that whole, which also are discrete entities, are seen as affecting the behaviour and experience of all parts (Minuchin, 1981, p. 193). As opposite as these two people were, they complimented and balanced each other to become a whole.

The questions that beg to be asked are, would I integrate these models again in a family therapy situation and would I design a practicum based on the different styles of treatment. The answers are yes and no.

I often integrate these two models in my current practice in much the same way as I did in the practicum. I have continued to use the FAM III as a measuring tool, the genogram to give me an organized picture of the family and how it functions, and when I attempt to promote change, I use Solution Focused theory and questions. I find that it gives me a total picture and more assurance

that I am not missing anything. I feel comfortable using the integration of these two models and I find it helps me help the clients I am working with.

Through this practicum experience I feel I have a better working knowledge of both models and feel comfortable with integrating aspects of each model.

Where I believe these two theories fell short for me was that learning and practicing two models felt like a very large task. I now believe that a clinician should be well grounded in one theory before attempting to work in another. Once there is a strong foundation of theory and practice, it is easier to expand one's repertoire and try new things. If I had to design another practicum I would concentrate on learning one model at a time, reducing the confusion that trying to integrate two models can bring.

CHAPTER VI

CONCLUSION

In conclusion, I would like to present a discussion of the practicum offering my personal reflection on the practicum experience, what I learned and how I have integrated that learning into my every day practice. Then I will comment on the clinical issues that I have been made aware of, to be followed by a reflection of assessing whether or not my learning goals were achieved.

Working with families who have special needs children has taught me, in an intimate way, what it is to see strength, courage, and commitment. There are many challenges that people have throughout their life time. Some people in our world live every day facing loss, war, disease and chaos. Those people seem remote and far away, especially on the TV screen. People in our community don't have to face those kinds of atrocities, but we still live with child poverty, prejudice, inequality, violence and every day problems of survival. It wasn't until I became intimately involved with this practicum population that I felt human strength in a personal way. I believe I experienced it differently because as I said earlier, I felt that I could move in and out of their system as if I were sitting on my shoulder and observing. Although I have personally known many individuals who have overcome many obstacles, I never had the objectivity that I encountered when doing this work. This has helped me to grow and become less judgmental

of people, how they cope with their lives and make the decisions they make. It increased my appreciation for people growing up in their families and surviving in a way that fits for them. It has also increased my tolerance for those around me who make decisions I do not agree with. I am grateful for this learning and know that it is something that will stay with me for all time.

The other important learning for me was how to use humor in treatment. I remember after my first interview with my first couple and how nervous I felt with the idea of being taped and supervised. I spent the session being officious and anxious. As the session progressed and the couple started arguing I became more serious and my body language became rigid. That couple didn't return. They said that they had difficulty with childcare provisions. In my supervision and review of the tapes, Dr. Trute pointed out to me how I must have been perceived by the family and how serious I was. His recommendation to me was to relax and lighten up. I have never forgotten that advice. Now when I am trying to join with a family, I will smile, crack a joke, and do my best to lighten the mood, for I now realize that the family is much more apprehensive about the therapy than I ever imagined. This also taught me about the therapeutic use of self and how that impacts on the relationship between the therapist and the client.

The other area of using humor in therapy was with Couple B. In spite of their entrenched differences, they were always ready to laugh at themselves. They

had a wonderful sense of humor and invited me to share in the fun. I have since found that it is actually a fine art to know when to join in the families humor and when to stay more focused. First of all, some people use laughter and humor as a defense and try to defer the sad feelings of the moment by breaking into a funny remark. It deflects the family from seeing that person's pain and also protects other family members from feeling their own pain. This is something the therapist should be aware of and use in the treatment of the family.

Secondly, one or two persons in the family system may think something is funny while one individual may not. If the therapist joins in and laughs with the first set of people, the third one may see that as aligning against them and the therapist taking sides and losing their neutrality. This can destroy the trust between client and therapist and could prematurely end therapy.

The third danger, is a family laughing and joking about issues that are not funny. These issues might include belittling someone, laughing about issues that are violent, abusive, prejudicial and offensive. The therapist would have to remain distant from that and challenge or reframe the families belief system.

The best way to use humor is to allow the therapist to see and nurture the humor that is already existent in the family. Most families will share that at some point and if the therapist is amenable to it he or she can draw it out. Laughter brings people closer together and can heal old wounds.

Clinical Issues

In conclusion, the use and applications of the Structural Model of Family Therapy and Solution Focused Therapy were applicable to this population. It allowed me to understand the "gestalt" of the family dynamics while it also provided the clients with concrete ways to deal with their situation. This confirms my belief that people learn and integrate knowledge in different ways. I had a teacher who once taught me that there are three kinds of experience: thinking feeling and doing. All three influence each other and when you change one, the others will change. This is very true for therapy. The skill for the therapist is to be sensitive and to determine how their client will learn best. Will it be by thinking differently, feeling differently, or doing things differently? Which one will be a catalyst for the other? Using these two models allowed me the freedom to explore that with the individual families.

The two couples I described had their own patterns of change. Couple A started to think about things in a different way and as a result changed their way of feeling and manner of doing. This is where the Structural Model was most appropriate. It allowed me to assess the organization of the families covering the two generations and helped the couple to understand the choices they consciously and unconsciously had made. As a result, Chris started feeling his feelings for the first time, something he never had permission to do. In doing so, he had the

breakdown that enabled him to review what had gone on in his life and then allowed him to work on his individual issues. That review included the loss of the kind of relationship he had wanted with his parents and his father in particular, his guilt over his sister's abuse, and most of all the way he expressed his feelings through anger and what effect that had on his family.

The Solution Focused Model was much more useful with Couple B. They were so deeply entrenched in their obsessive behaviors and habits that they needed to do things differently before they could think or feel differently. They responded to the behavioral goals that we set out at the beginning of therapy. As they started to change their behaviour and have some success, they began to relax and see that there were other ways to experience Georgie's epilepsy. It didn't change the situation, it just changed their ability to cope with the illness and not let it take over the family.

Goal Achievement

My primary objectives in this practicum were to gain a comprehensive knowledge of families who have special needs children, to acquire the skills and knowledge of assessment and family therapy treatment with this population, to be able to assess my own skills in this area of work and to determine my strengths and weaknesses as a family therapist. I believe I accomplished all of these and more.

I feel confident that I have a broad overview of this population, what their family dynamics may be and what their needs may be. This is not to say that I have a preconceived notion of these families but that I have a general framework of reference that I did not have before. I believe that this framework provided a strong foundation for me to build my family therapy skills upon. It is one thing to read and study this topic and quite another to integrate that knowledge with the practice of being "a change agent".

The most beneficial aspect of this learning experience that helped me realize my goals was the supervision and guidance that was provided for me. Meeting Dr. Trute on a weekly basis allowed me to keep up to date track on how I was doing and how the therapy was progressing. Viewing the videotapes enabled Dr.

Trute to point out both the strengths and weaknesses of my use of therapeutic self and of the interventions I chose to use. This enabled me to return to the next family session with a sense of direction and confidence that I was doing the right thing. I then could return the following week and debrief about the past session while planning for the next. It was most helpful.

Working with this population widened my horizons in terms of having to work with other systems. With some of these families, I became involved with the educational system, the child welfare system, the greater hospital system and the Family Services Branch of government. Each involvement provided me with more learning and more experience.

The other goal achievement was the ability to demonstrate the usefulness of the selected measurement tool, the FAM III. I found the measure to be very effective in identifying areas of strength and weakness in the family system. This also allowed the family to set goals in specific areas and work on areas they felt needed to be assessed. The FAM III proved to be very effective in helping me assess whether or not change took place in the treatment phase and whether or not I had been effective as a clinical therapist.

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