Complementarity and Contradiction:
Using Strategic and Bowenian Approaches Together in Family Therapy

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A Practicum Report

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COMPLEMENTARITY AND CONTRADICTION:

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BY

MARVIN FRIEDMAN HAMM

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

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ABSTRACT

In this practicum, strategic and Bowenian models are utilized together in family therapy. The strategic approach is problem-focused and directive. It works to resolve problems quickly by shifting interactional patterns in the family. The Bowenian approach de-emphasizes the presenting problem to focus on broader family dynamics. The approach aims to promote change by promoting insight, and the therapy is longer term. These two divergent models are utilized together in therapy with seven families. The families include a diversity of family constellations and types of presenting problems. The FAM III was administered to families at pre- and post-therapy as a measure of clinical effectiveness. Case summaries and results of the clinical measures are presented, and key learning themes are highlighted. An evaluation is made of the advantages and disadvantages of using the two approaches together.

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INTRODUCTION

Jay Haley and Murray Bowen are two important pioneers in the development of family therapy. Each developed his own distinct model of family therapy. Haley is the primary force behind the development of *strategic family therapy*, and Bowen originated what came to be known as *Bowenian family therapy*. These two models are quite different from each other. Both work within a systemic paradigm, but strategic therapy and Bowenian therapy see the family system from quite different perspectives, and have different understandings of how families change. For example, strategic therapy keeps a focus on present interactions between family members, while Bowenian therapy views the family in a multigenerational historical perspective. Strategic therapy keeps a clear focus on alleviating the family's presenting problem, while Bowenian therapy shifts the therapeutic focus away from the immediate problem onto broader family dynamics. Strategic therapy seeks to change family members' behavior, while Bowenian therapy aims to help family members gain deeper insight into their family and themselves.

In my practicum I utilized these two divergent models of family therapy together in clinical practice with families. My goal in undertaking the practicum was to gain a grounding in the theory and practice of family therapy, to serve as a foundation for future practice in the field. To this end, I chose not to limit myself to working with only one model of family therapy. By using both strategic and Bowenian approaches, I hoped to gain a broader base of theoretical understanding and practical experience in family therapy.

As I began the practicum, I trusted I would find a complementarity between these two different ways of doing family therapy. I assumed that by using two different models, I would expand the range of theoretical and technical tools available to me in my work with families. A family is an incredibly complex and multidimensional organization. Each model of family therapy brings into focus an important dimension of the family, but no model sees the whole. By using two models I hoped to widen my perspective for understanding families and broaden my choice of hypotheses and interventions. Over the course of the practicum, I came to see that it was not easy to integrate these two divergent models in clinical practice. At times I did find a complementarity between the two approaches, and I was able to use insights and interventions from each model in working with a family. But often I was aware of the contradictions between the strategic and Bowenian approaches, and I felt pulled in two different directions as I struggled to define a therapeutic course of action. This practicum report describes how I utilized these two models of family therapy together, and highlights the points of complimentarity and contradiction I found in the process.

My interest in gaining a breadth of experience and exposure in the theory and practice of family therapy extends beyond my choice of therapeutic models. This wide focus is evidenced in every aspect of the practicum design. I chose to work with a variety of presenting problems, rather than limit myself to one type of problem. I worked with different family constellations: two-parent and single-parent, first-married and blended. And I had all three members of my practicum committee involved in supervision, so as to gain the benefit of each of their perspectives on family therapy.

At the beginning of the practicum, I defined the following specific objectives for my learning, within the broader goal of gaining a grounding in the theory and practice of family therapy:

1. To develop a functional working knowledge of two approaches to family therapy: strategic family therapy and Bowenian family therapy. To learn to utilize these two theoretical frameworks in assessing and intervening with families or couples with a variety of presenting problems.

2. To learn to utilize specific intervention techniques based on strategic and Bowenian theory.

3. To begin to integrate personally in my theory and practice a focus on present interactions in a family system (strategic theory) with a focus on family history and development (Bowenian theory).

4. To assess the usefulness and effectiveness of strategic and Bowenian approaches for family therapy.

5. To gain supervised experience in family therapy with families with a variety of types of presenting problems.

This report describes my experience in utilizing strategic and Bowenian approaches in therapy with families. The report is divided into five sections.

In Section One I outline the historical development, theory of family functioning, and intervention strategies of the strategic and Bowenian models. I discuss the differences and similarities between the two approaches, and describe briefly how I used them together in my work with families.

In Section Two the logistical details of the practicum are laid out. I describe the practicum setting, the means of obtaining suitable clients, the general procedure of the therapy, the supervision process, and the mechanism by which I evaluated the efficacy of the therapy.

In Section Three I give a synopsis of the therapy process with each family and present and discuss the results of the pre-therapy and post-therapy measures completed by the family members.

In Section Four I reflect further on the therapy process and highlight key learning themes which emerged in my work with the different family systems.

In the Conclusion of the report I evaluate the design of the practicum and comment on my experience of utilizing the strategic and Bowenian models of family therapy in clinical work with families.

SECTION ONE

LITERATURE REVIEW

Introduction

In preparing for my practicum, I studied the primary source literature for strategic family therapy and Bowenian family therapy. In this review of these two bodies of literature, I begin by briefly tracing the historical development of strategic and Bowenian therapies. Then I present a summary of each approach's understanding of family functioning, the nature of family problems, and the goals and intervention techniques of the therapy. I conclude this section with a brief analysis of the similarities and differences between the two approaches, and discuss how I combined these in my practicum work with families.

Strategic family therapy

Jay Haley originally coined the term *strategic therapy* to refer to the carefully planned and directive approach to therapy developed by Milton Erickson (Nichols & Schwartz, 1991). The term has come to refer to those approaches which apply Erickson's methods to family therapy, especially the "brief therapy" model developed at the Mental Research Institute in Palo Alto, California and the therapy developed by Jay Haley and his recent collaborator, Cloe Madanes. I am using the term *strategic family therapy* to refer to specifically Haley and Madanes' method of family therapy.

Influences in strategic theory

Haley and Madanes write mostly about technique rather than theory. And in describing their technique, they describe specific interventions rather than a general method of therapy. Theirs is a practical, hands-on approach to therapy; it takes some work to discern strategic therapy's theoretical underpinnings. My summary is based in Haley and Madanes' original writings (Haley, 1976, 1980, 1984; Madanes, 1981, 1990) and on the excellant overview provided by Nichols and Schwartz (1991).

Haley was heavily influenced by the three giants of family therapy with whom he worked: Gregory Bateson, Milton Erickson, and Salvador Minuchin (Nichols & Schwartz, 1991). A quick look at their ideas will help us understand the theory behind the techniques of strategic family therapy.

Haley was an original member of the team assembled by Bateson in Palo Alto in the 1950's to research family dynamics and schizophrenia. Bateson introduced the theory of *cybernetics* to the study of families. Cybernetics is the study of systems that are self-correcting, such as the thermostat system which regulates the temperature of your house. When families are seen through the lens of cybernetic theory, several dynamics come into focus (Nichols & Schwartz, 1991, pp 106-109):

1. Families have *rules*, or beliefs, which regulate the range of behaviors the family will tolerate, much as a thermostat limits how far the temperature can vary.

2. Family interactions have a circular nature; one action influences a second action which influences a third action which influences the first action.

Problem behaviors are part of such an interactional sequence (a *feedback loop*, in the language of cybernetics).

3. Families have mechanisms, such as guilt or punishment, by which they correct deviant behavior and maintain family equilibrium, much as the thermostat starts the furnace to correct the temperature.

4. Sometimes a family's corrective behavior does not solve the behavior but makes it worse. Then the family tries more of the same and gets caught up in a vicious circle which intensifies until the family breaks down or reorganizes its behavior with different rules and different interactional sequences.

Bateson also introduced the theory of *functionalism*, first developed in the field of anthropology. (Bateson was an anthropologist). According to this theory, seemingly strange cultural patterns actually serve a useful function in their cultural setting (Nichols & Schwartz, 1991). The behaviors make sense in their context. When applied to families, functionalism suggests that symptomatic or deviant behaviors serve a function in the family. If properly seen in its context, the problem makes sense.

Bateson was interested in understanding the family; Haley wanted to learn to change it. In his search for techniques to change families, he discovered Milton Erickson (Nichols & Schwartz, 1991). Erickson's approach to therapy differed sharply from the prevailing psychiatric traditions of his day, which appealed to an iconoclast such as Haley. Unlike psychoanalysts who ignored symptoms to focus on underlying causes, Erickson was highly focused on changing the symptom behavior. Where traditional psychoanalysis tried to increase the client's insight through interpretation, Erickson tried to change the

client's behavior. He assumed that if clients could only break out of habitual patterns of thinking or behavior, they had the wisdom to solve their problems or heal their symptoms. Where traditional psychoanalysis was a long and laborious process, Erickson believed people could change quickly. He took an active and directive approach to therapy, assumed responsibility for overcoming or bypassing clients' resistance to change, and moved to promote change as quickly as possible. Erickson's basic ideas about therapy - and many of his specific interventions - were wholeheartedly embraced by Haley. He combined them with cybernetic concepts in his work in Palo Alto in the late 1950's and early 1960's (Haley, 1973).

In 1967, Haley moved across the country to begin work with Salvador Minuchin at the Philadelphia Child Guidance Clinic. Minuchin's ideas about the organization of the family have strongly influenced Haley's more recent theory (Haley, 1976). In Minuchin's structural family theory, a family is seen as an organization. Any organization - a community agency, a national government, or a family - must have clear role designations and clear division of task functions (e.g., leadership) in order to operate properly. Where roles are not clear and the leadership structure is muddled, confusion abounds and nothing gets done. To function well, a family needs clear boundaries between its subsystems in order for the subsystems to properly fulfill their functions. The generational boundaries are particularly important; the family needs clear hierarchy and leadership. When the family deviates from a healthy structure, problems such as symptoms in individual members will result. If the family's structural flaws are corrected, the family will return to health.

While at the Philadelphia Child Guidance Clinic, Haley met Madanes. In 1976, they left the clinic and moved to Washington, D.C. to start their own family therapy clinic and training centre. Their more recent writing builds on the foundational ideas of these three originators of family therapy.

The nature of problems

Strategic family therapy focuses on helping families solve their problems. A unique strategy is developed for each situation, but the specific strategies are based on broader understandings of the nature and origin of problems in families.

Haley and Madanes think about problems in several distinct ways. First, they usually see problem behaviors as part of a sequence of acts between several people. Problem behaviors are part of an interactional loop. In therapy they try to identify the sequence in which the problem is imbedded. Sometimes the sequence involves just two people, but more often Haley and Madanes look for sequences that involve at least three people. The sequence of which the problem is a part may transpire quite quickly, or it may unfold over several months. Haley (1980) identifies a typical long-term sequence in families with troubled young adults: The parents start to argue, which upsets the young adult to the point he or she develops symptoms; the parents unite to deal with the symptoms, and perhaps hospitalize the young adult; in the hospital the patient gets better, but the parents, without the symptoms to focus on, begin to argue again, so the symptoms return.

The interactional sequences in which problems are imbedded are governed by rules which constrain the range of behaviors in the sequence. In the example above, the rule is that the parents' marriage cannot survive if they are left

to face each other. Understanding this, the therapist would intervene to challenge the constraining rule or belief and alter the sequence.

Second, Haley and Madanes sometimes see problems as a form of communication within the family. Problems may be metaphors or analogies for other difficulties in the family. For example, Madanes (1990) describes a single-parent family where the nine-year-old daughter is threatening suicide. Madanes interprets the girl's behavior as a metaphor for the mother's despair and depression, and intervenes to activate the mother instead of focusing on the girl's threats.

Madanes (1990) identifies several functions metaphorical problems can serve in a family:

1. They can serve to communicate for another family member. A son's violence, for example, may be expressing his mother's rage.

2. Metaphors may also displace the underlying problem, as the daughter's suicide threats displaced the mother's depression.

3. Metaphorical problems can function to promote closeness and attach people to one another, as in Haley's example of the young adult who develops symptoms to bring his or her parents closer together.

When the family's problem is a metaphor for other issues in the family, it is difficult to solve because the problem behavior means something else than it appears to mean. The family's attempts to solve the problem miss the metaphorical meaning and often exacerbate the problem. The therapist's task is to understand the metaphor and the function it serves, and then intervene to address the underlying issue more directly.

Third, Haley and Madanes often see problems as the result of flaws in the structure of the family, especially flaws in the family hierarchy. Haley, more so than Madanes, works from a structural understanding of the origin of problems and the changes required to solve them. He goes so far as to say that if there is an individual symptom, it is because the family hierarchy is confused (Haley, 1976). When the family hierarchy is inconsistent or unstable, problem behavior will be the result. For instance, if the parents sometimes take charge of the child and at other times let the child do as he or she pleases, the child will develop behavior problems. When the family hierarchy is confused or reversed, as in the family where a child is in a coalition with one parent against the other parent, problems are likely to develop.

Haley emphasizes the importance of clarifying and strengthening the generational hierarchy in the family (Haley, 1976). Many of his interventions have the goal of bringing the parents closer together and putting them firmly in charge of their children. Madanes (1981) extends this goal of realigning power and hierarchy to marital relationships. In therapy with couples she promotes egalitarian power relationships between partners.

Madanes shares Haley's focus on family hierarchy and power relationships in understanding how problems originate, but she has a broader understanding of the nature of power in the family. Haley tends to equate power with control; Madanes says that the exercise of power in the family can also involve protection and helpfulness. Her concept of *incongruent hierarchy* conveys her sense of these two dimensions of power (Madanes, 1981). She says that a symptom can be used by a family member to covertly influence others in the family. The

symptom can be used by its bearer either to gain control over others, or as a way of being helpful and protective in the family. This covert power of the symptom can be incongruous with the overt power arrangements in the family, and the result is a confused family hierarchy.

To illustrate how a symptom can be used to gain control, Madanes (1981) gives the example of a competent wife and a weak husband who drinks too much. Overtly the wife is in charge of the relationship. But the husband's drinking gives him power, as his wife cannot control the drinking, no matter how hard she tries. She is overtly in charge of the relationship, but he is covertly in charge. The two levels of hierarchy are in contradiction, and the couple is stuck in a frustrating repetitive sequence. The husband cannot afford to let go of his symptom until the overt power relationship with his wife is more balanced.

An illustration of how symptoms can be used by family members try to help each other indirectly is Madanes' (1981) story of a single-parent family where the oldest son has night terrors. The therapist sees the night terrors serve the function of getting the somewhat timid and overwhelmed mother to be strong and in charge. The boy is using the covert power of the symptom to get his mother to be in charge, resulting in a confused hierarchy in the family. The therapist intervenes to help the boy be helpful to his mother in a more direct way.

This difference in understanding the nature of power in the family is an indication of Haley and Madanes' somewhat different understandings of the motivations driving human interaction. Haley tends to see human interactions as interpersonal struggles for power and control, so he emphasizes the importance of appropriate hierarchy in families and sees problems as covert attempts to gain

control in relationships. Madanes sees people as motivated by a desire for power and control, but also by a desire to protect and care for each other. Many of her interventions are aimed to get family members to be helpful and protective in more direct and open ways (Nichols & Schwartz, 1991).

These three basic understandings of the nature of problems - problems as parts of interactional sequences; problems as metaphors serving a function in the family; and problems as the result of dysfunctional hierarchies - are emphasized in varying degrees in Haley and Madanes' writings. The only attempt to weave these different understandings of problems in a systematic theory comes in Madanes' most recent book, *Sex, Love, and Violence* (1990). In this book she sets out four basic intentions which guide families. Each of these intentions or motivations is associated with different types of problems and requires a different type of intervention.

The first type of family is dominated by a struggle for power and control. These families tend to develop problems like delinquency and drug abuse. The therapist working with this type of family should get parents to work together to take charge of their children. In the second type of family the desire to be loved prevails. Problems such as psychosomatic disorders, depression and anxiety are most common. Here the therapist should introduce more positive ways of giving and receiving love and attention in the family. A third type of family is shaped by a desire to love and protect. These families develop symptoms such as abuse and neglect, suicide threats and obsessive behaviors. With this type of family the therapist should change the ways family members love and protect each other, for example by showing children more positive ways of protecting their parents. A

fourth type of family is motivated by a desire to repent and forgive. These families have problems like sexual abuse and sadistic acts. With these families the therapist must find a protector for vulnerable family members, push for repentance by the abuser, and work to elicit compassion and a sense of unity.

While Madanes framework is not fully developed, it does offer a tentative schema for determining which types of strategic interventions are most useful for different types of families and family problems.

How families change

Strategic therapy is very much focused on changing behavior. Problems are seen as parts of interactional sequences; therefore problems can be resolved by changing the sequence of which they are a part. The strategic therapist's job is to help the family change the sequence. Making a family aware of the sequence, giving family members insight into what they are doing, does not usually help them change. It only mobilizes the family's resistance to change (Haley, 1976). Helping the family express emotions does not help them change their behavior either. The best way to help a family change the sequence and resolve its problem is to change the behavior of at least two people in the sequence (Haley, 1976). The therapist's primary goal is to get the family to act differently in relation to the problem. Changes in behavior will result in changes in feelings and perceptions, not the other way around. Madanes (1981) says "If a problem can be solved without the family's knowing how or why, that is satisfactory." (p. 79).

In practice, Haley and Madanes are not as rigidly behavioral as they say they are (Nichols & Schwartz, 1991). Haley (1976) acknowledges that emotional expression is a communication - an action - that may reshape an interaction sequence. And both Haley and Madanes use *reframing* - changing the understanding or meaning of a situation - as a technique to promote change in behavior. But reframing and other interventions at the cognitive or affective level are always used in the service of changing behavior, which is what they believe really changes clients' perceptions and feelings (Nichols & Schwartz, 1991).

Because they see the problem as part of a present interactional sequence, Haley and Madanes' focus in therapy is primarily in the present. They are not so much interested in how a problem developed as in how it is maintained and what function it serves in the present. In assessing the family they spend very little time exploring the family history. Instead, they try to understand the present dynamics in the family, including the interactional sequences they observe in the therapy session.

The direction in which Haley and Madanes try to change the family's interaction depends on how they understand the problem. When the problem is seen as due to a structural flaw, the intervention is aimed to realign the family structure. When they see the problem as serving a function in the family, the intervention is geared to change the payoff for the symptom or help the family meet its functional need in a healthier way.

Haley tends to focus on realigning the family structure, clarifying boundaries and strengthening hierarchy (Nichols & Schwartz, 1991). Following Minuchin's structural family therapy, his assumption is that when the structural

flaws are corrected the problem will resolve itself. Haley differs from structural therapists in his approach to realigning the family structure. The structural therapist moves directly to realign the faulty structure, for example by having an over-involved mother stop focusing on her child and begin talking directly to her husband about issues in their marriage. Haley would have the same goal of bringing the couple closer, but he would have them talk with each other about their child's problem. He keeps the focus of therapy on the presenting problem, because he knows the family is motivated to change the problem. He believes the therapist evokes the least resistance and gets the most therapeutic leverage by keeping a focus on changing the presenting problem.

Haley (1976) introduced the concept of doing therapy in stages in the process of realigning family structure. He says it is sometimes necessary to shift the family into another dysfunctional structure before shifting it toward the desired structure. Haley cites the example of his therapy with a family with a young boy who is terrified of dogs. His assessment is that the mother is over-involved with the child, while the father is quite peripheral. Haley builds up the father as an expert on dogs (he is a mail carrier), thereby giving him more authority than the mother in regards to the boy's problem. Then Haley has the father and son go buy a puppy. The father is to show the son how to teach the puppy not to be afraid. Haley has blocked the mother's involvement in the problem, so the father is now over-involved with the son. Once the boy overcomes his fear of dogs, the mother and father are brought closer together to focus on issues in their marriage.

Madanes more often sees problems in functional terms, although Haley sometimes does so as well (Nichols & Schwartz, 1991). Both look for the function the problem serves for the individual or family. For example, when Haley finds that an individual's symptom is giving her or him control over other family members, he might direct the client to go through an ordeal each time the symptom occurs (Haley, 1984). When the costs of the problem are increased so they outweigh the benefits, the problem often disappears.

When Madanes sees an individual using a problem to help or protect another person in the family, she finds ways the symptom-bearer can help the other openly and directly, so that he or she will not have to resort to symptoms. Many of Madanes case illustrations are about finding creative ways to help children help their parents openly, so they can let go of using symptoms to be covertly helpful.

Haley and Madanes generally assume families will be resistant to change. This eye to resistance reflects the theories which underlie strategic therapy. Cybernetic theory assumes families are predisposed to maintaining *homeostasis* and will resist any dramatic shifts. Functionalist theory assumes problems are useful to the system, so it will be resistant to letting them go. And Milton Erickson was very attentive to client resistance, and is well known for his inventive ways of bypassing or utilizing client resistance. Strategic therapy has adapted many of Erickson's techniques for dealing with resistance to family therapy.

Like Erickson, strategic family therapists assume responsibility for overcoming client resistance and promoting change which resolves the presenting

problem. This is not a collaborative or client-centered approach to therapy. Both Haley and Madanes are authoritative and directive in their work with families. They utilize a wide array of interventions to change interactional sequences. Their aim is to change behavior so as to eliminate the presenting problem and to eliminate underlying causes of the problem, be they structural or functional.

Intervention

Haley and Madanes develop a unique strategy or plan for each specific problem or situation, rather than repeating the same method for each case. But the intent of their strategy is always the same; they get the family to change the problematic sequence of behavior. The therapist tracks the sequence to get a clear picture of the problem. Then he or she develops a hypothesis as to its cause or function in the system. Then a specific intervention is designed and implemented to disrupt and alter the sequence in the desired direction.

In their therapeutic interventions, Haley and Madanes mostly give directives and assign out-of-session tasks, always with the intention of getting the family to alter the interactional sequence surrounding the problem. Haley (1976) describes how directives are to be designed and presented to the family. He says it is generally not useful just to direct the family members to stop doing something. If they could stop doing it, they would have already done so. Instead, the therapist should direct the family to do something different. To actually get them to do something different requires more than just giving them good advice. Haley says advice does not help because people do not have rational control over

what they do. Rather than giving advice, the therapist should design a specific directive to change the family's behavior around the problem.

Haley says a good directive should be precise, clear and do-able. Everyone in the family should have a part to play in the task. The therapist carefully presents and reviews the task with the family, and may even get them to act out the task in session. Any problems in carrying out the task should be anticipated and dealt with in the therapy session. And in the following session, the family is asked to report on the task.

Strategic therapists assume the family will be resistant to following their directives. They take great care in designing and presenting tasks so as to maximize the family's motivation and minimize the resistance. The therapist takes a stance as a authoritative expert in order to ensure compliance. He or she might have family members review their failed attempts at solving the problem, reminding them of their helplessness before the problem and making them more likely to follow the directives. The therapist can also remind family members of the seriousness of their problem, and use their desperation to build motivation to follow through on the directive.

Some of the directives given by Haley and Madanes are relatively straightforward, although they are always presented so as to maximize the client's motivation. For example, Haley (1976) has a couple who are out of the habit of being affectionate with each other go and behave affectionately in order to teach their child how to show affection. He avoids the couple's resistance by framing the task as something they are doing for their child.

Haley's prescription of ordeals is another example of relatively straightforward directives which alter the interaction around the problem. In one case, Haley (1984) has a client give a gift to someone she has a poor relationship with each time her symptom occurs. The task is something the client does not want to do - an ordeal - but it helps her improve her relationships. The ordeal dissuades her from having the symptom, and in the meantime she has to do something that is good for her.

These straightforward directives work when clients are highly motivated or compliant, or when the therapist is extremely persuasive. Often this is not the case, so most of Haley and Madanes' directives are less direct and more subtle in their handling of clients' resistance. The whole class of *paradoxical directives* is built around the premise that families will resist the therapist's directives. With paradoxical directives, the therapist uses the family's resistance to change to promote change (Madanes, 1981).

Paradoxical directives are counter-intuitive, the opposite of common sense (Nichols & Schwartz, 1991). The family is directed to do something that is in opposition to the stated goals of therapy. The therapist presents the directive and urges the family to comply, but hopes that the family will actually defy the directive and the therapist - and in their defiance change their behavior in a positive way.

Lynn Hoffman (1981) presents a good example of the successful use of a strategic-style paradoxical directive. A young couple came to therapy with a depressed three-year-old child. The mother was bright and well-educated, but she was having a difficult time dealing with the demands of two children and a purely

domestic existence. The father was very focused on his career. In therapy the child improved quickly, but then the mother seemed depressed. The therapist suggested activities to get the mother out of the house more, but she did not follow these. Sensing the resistance, the therapist changed direction and said that, at this time when the husband was needing to focus on his career, it was essential that the wife protect him from the distractions of domestic life. Under no circumstances was she to allow him to do any chores or be bothered by the children. He was to stay in his study and work. The following session the wife did not look at all depressed. She came in and rebuffed the therapist for having misread her character. In the week since the previous session she had undertaken several projects that took her outside the house, and her husband had washed dishes every night and cooked supper one evening while she went out to a concert. The therapist said he found it hard to believe his assessment had been so far off target, and expressed doubt that things would continue this way. Therapy was terminated, and a year later the couple reported they were doing very well.

Haley would explain this transformation in terms of power dynamics. He sees the symptom-bearer as having a great deal of power through the symptom. When the therapist directs the client to continue having the symptom, the client is placed in a bind. She can continue having the symptom, thus giving the therapist control over her. Or she can abandon the symptom to defy the therapist and "win" the power struggle. Haley sees people as motivated by a desire for power, so they defy the therapist and let go of the symptom.

Hoffman (1981) presents what I think is a more subtle explanation of the power of paradoxical directives. She says the family's symptom is part of a

delicately balanced relationship system. In the example above, the wife is situated in a slightly "one-down" position in relation to her husband, and the system resists any attempts to either raise her to an equal status or put her further down. Hoffman compares the family system to a see-saw. The therapist's paradoxical directive unbalances the system; he pushes the wife further down. The system recoils by pushing in the opposite direction to retain balance, thereby raising the wife to a more equal position with her husband. The therapist uses the balancing energy within the relationship system to realign the relationship.

Madanes (1981) describes three aspects of a paradoxical directive. (Note how all three are present in Hoffman's example). First, the therapist defines the symptom as benignly motivated to preserve stability and harmony in the family. The problem and its bearer are reframed as being helpful to the family. Second, the therapist prescribes the symptom-producing cycle of interaction. The family is told to keep doing what it is doing, and even to do more of it. The therapist exposes the sequence, but orders the family to maintain it. Third, when the family shows signs of changing, the therapist expresses puzzlement and disbelief and restrains the family from letting go of the symptom. All the way along the therapist is directing the family to do one thing, with the intention of getting them to do just the opposite.

Madanes (1981) has developed a whole array of *pretend techniques* as another way of bypassing family's resistance to change. She has found that clients are often more willing to follow a directive if it is presented as a playful or pretend activity. Many of Madanes' case examples of the use of pretend techniques involve cases where a child is using a symptom to be helpful to his or

her parents. The pretend directive gives the child a more direct way of being helpful, while at the same time undoing the incongruent hierarchy and placing the parents firmly in charge.

Madanes (1981) presents a number of cases studies to illustrate her use of pretend techniques. In one example (cited above) a single mother brought her ten-year-old son to therapy because he was having night terrors. Madanes suspected the boy was concerned about his mother, who spoke little English and had lost two husbands. Madanes began by asking each family member to describe his or her dreams, thereby reframing the problem as one of bad dreams. It turned out that only the boy and his mother had nightmares. When the boy had nightmares, the mother took him into her bed and told him to pray to God. She believed the nightmares were the work of the devil.

Madanes saw the boy's night terrors as both a metaphorical expression of his mother's fears and an attempt to help her. By being afraid, the boy was getting the mother to be strong. But in her attempts to help her son the mother was further frightening him by talking about God and the devil. Both mother's and son's attempts to help the other were actually increasing the other's worries.

Madanes directed the family to enact the following dramatization every evening for a week, and also each time the boy woke up from night terrors. The family was to pretend that someone was breaking into the house, and the mother was afraid. The son was to protect his mother from the intruder. In this way the mother's need for help was placed in the realm of pretend, and the boy was given a pretend way of helping her. The mother protested that she was competent to take care of herself and did not need someone to protect her, thereby reasserting

her role as leader in the family hierarchy. Madanes insisted the family follow the directive, which they did. The boy's night terrors completely disappeared.

In this and other case examples Madanes uses pretend techniques to shift the parent's neediness and the child's helpfulness to the realm of play and pretend. Before, the parent is covertly asking for help and the child is covertly helping through symptomatic behavior. In the pretend dramatization the parent overtly asks for help and the child overtly provides it. In the process the parent is challenged to assert his or her competence and leadership. The incongruent hierarchy of the child helping the parent is exposed and a more appropriate hierarchy is restored.

Strategic family therapy is an action-oriented approach to work with families. A whole host of innovative techniques and interventions are used to bring shifts in families' interaction. Haley and Madanes' writings contain numerous other vignettes of the clever and sometimes daring interventions they employ to help families overcome the problems that are plaguing them.

Bowenian family therapy

Historical background

At the same time that Jay Haley and Cloe Madanes were developing strategic family therapy, Murray Bowen and his colleagues were constructing quite a different approach to thinking about and working with families. They originally called their approach "family systems theory", but now their approach is identified by the name of its originator, as *Bowenian family therapy.*

Bowen was trained as a medical doctor with a specialization in psychiatry (Kerr & Bowen, 1988). He had a solid background in traditional psychoanalytic theory and technique. Bowen's initial research at the Meninger Clinic was with schizophrenic children and their mothers. In 1954 he moved to the National Institute of Mental Health in Washington, D.C. Here he continued his study of schizophrenic children, now including both their mothers and fathers in his research. He was struck by the degree of symbiosis or emotional fusion in these families, and began to develop a comprehensive theory of family functioning based on his observations. In 1959 Bowen moved to Georgetown University, where he continued his research and practice with less severely troubled families. He continued to develop his theory, and also moved into training family therapists in the approach he was developing. He continued this work until his death in 1990.

In the course of developing his theory, it appears that Bowen was relatively uninfluenced by the concepts and terminology which were dominating the developing field of family therapy. Bowen worked quite independently. He was critical of what he saw has a lack of clear theory underlying much of the emerging family therapy (Bowen, 1976). His goal was to develop a comprehensive theory which could explain all aspects of family functioning and serve as a solid basis for guiding therapeutic intervention with families.

Bowenian theory

Bowen's theory is laid out in two major papers'; "The Use of Family Theory in Clinical Practice" (1966) and "Theory in the Practice of Psychotherapy"

(1976). The most comprehensive presentation of his theory, *Family Evaluation*, was authored by Bowen's student and colleague, Michael Kerr (Kerr & Bowen, 1988). My summary of Bowen's theory is based on these sources, and on the summary provided by Nichols & Schwartz (1991).

Bowenian theory is centered around two counterbalancing life forces; those that bind personalities in family *togetherness*, and those that fight to break free toward *individuality* (Nichols & Schwartz, 1991). The togetherness force pulls us to follow others' directives, to be dependent and connected. The individuality force pushes us to follow our own directives, to be independent and distinct. Family relationships exist in some state of balance between these two forces, which operate at an instinctual level in all emotional systems.

The essentials of Bowen's theory are contained in six concepts (Bowen, 1966, 1976): *differentiation of self*, *triangles*, *nuclear family emotional process*, *family projection process*, *multigenerational transmission process*, and *emotional cutoff*. With these concepts he described how the interplay between togetherness and individuality forces shapes family functioning.

1. *Differentiation of self*

The concept of differentiation of self is the cornerstone of Bowen's theory. In his research with schizophrenics and their families, he noticed an intense emotional attachment and reactivity between the parents and the schizophrenic child. He coined the term *undifferentiated family ego mass* to describe this stuck-togetherness. From these observations he postulated that families with schizophrenic children represented an extreme form of stuck-togetherness.

Families which were less emotionally stuck together were less prone to developing symptoms. These observations led to the concept of differentiation of self.

Differentiation of self is both an interpersonal and an intrapsychic concept (Nichols & Schwartz, 1991). At the interpersonal level, differentiation of self describes how sensitive or reactive an individual is to the togetherness forces at work in a relationship. Undifferentiated people are very sensitive and responsive to group norms and values and to the anxieties and needs of people close to them. They have very little "self" distinct from their family or group. They have a high need to be in intense emotional contact with those close to them, and invest a great deal of their energy into these relationships. They have very little capacity for autonomous, self-directed functioning; they are either dependently attached or reactive and rejecting toward those with whom they have intense relationships.

More highly differentiated people have a much clearer sense of self and of their own values and beliefs. They are able to be emotionally close to others without losing their own identity, or without becoming totally reactive to the others' emotionality. They are able to tolerate strong feelings and opinions in another individual or in a group without automatically reacting, positively or negatively. These people invest less of their energy in relationships - although they are better able to have stable intimate relationships than undifferentiated people - so they have more energy to invest in goal-directed activity.

On the intrapsychic level, differentiation of self describes a person's ability to distinguish thinking from feeling (Nichols & Schwartz, 1991). Undifferentiated people hardly distinguish thoughts from feelings; their intellects

are so flooded with feelings they are almost incapable of objective thinking. They have poorly defined beliefs and values; they either make decisions on the basis of feelings or they unthinkingly adopt the values and beliefs of their family or group. Their behavior is largely governed by their feeling reaction - positive or negative - to those around them.

More differentiated people are able to separate thinking and feeling. This does not mean they are unfeeling; they are capable of strong feeling, but they do not "lose their heads" in the midst of strong emotion or high stress. They are capable of objective thinking about their feelings and about their relationships. These people are able to define clear beliefs and values, and can hold these without having to impose them on others.

Differentiation of self at the interpersonal and intrapsychic levels is related to the two life forces at work in relationships; togetherness and individuality. The togetherness force - the instinctual pull to keep us connected to, conforming to, and dependant on others - operates at the feeling level. Because undifferentiated people operate almost entirely at this level, they are governed by this force. The life force that pushes us toward individuality requires thinking and objectivity. Differentiated individuals can function in the midst of the strong togetherness forces at work in a family and maintain a clear identity because they are able to distinguish between their feelings and thinking. They are able to be close to others without being overwhelmed by the togetherness forces at work in the relationship.

Bowen conceptualized differentiation of self as a continuum, from totally undifferentiated persons who have no "self" - and severe psychotic problems - to

totally differentiated persons who are able to maintain objectively in all circumstances. Bowen acknowledged he had never met a totally differentiated person, but he had met individuals who were able to remain objective and non-reactive in situations of high stress for at least a short period of time.

Each person's basic level of differentiation is set in their family or origin. All individuals in a family are at or near the same level of differentiation, although some children may end up carrying more of their parents undifferentiation than their siblings do. (More on this below).

Bowen distinguished between a person's *basic* level of differentiation of self and his or her *functional* level of differentiation of self (Kerr & Bowen, 1988). Among less differentiated couples, where partners are quite emotionally fused, it is not uncommon for one person to functionally "lend" some of their self to the other. Couples form reciprocal relationships, for example where one person overfunctions emotionally and the other underfunctions. The overfunctioner becomes emotionally stronger as the underfunctioner's level of maturity and differentiation is functionally diminished.

2. *Triangles*

Bowen describes the triangle as the basic building block of families and other emotional systems (Bowen, 1966). He observed that a relationship between two people is inherently unstable; they fluctuate between closeness and distance. When anxiety is high in the distancing part of the cycle, a third person is triangled into the relationship. For example, one person may confide in a friend about his or her frustrations with the other. The friend is supportive, and the person feels

better. The shifting of anxiety around the triangle keeps the relationships from overheating, so a triangle is a relatively stable relational unit.

Typically in a marriage relationship, in times of conflict one partner will draw closer to their parents or to one of the children. The other partner may get more involved with his or her work. By drawing in the third parties, the couple stabilizes their relationship - but the conflict and emotional distance between them is solidified.

In times of low anxiety, a triangle usually has two insiders and one outsider, who is trying to get closer to one of the insiders. But as anxiety mounts one insider draws closer to the outsider, and the conflict shifts to the relationship between the outsider and the other insider (Bowen, 1966). In times of high stress each person in the triangle tries to be the outsider in an attempt to get the other two people to fight. Under very high stress the individuals in the original triangle may draw in other outsiders, creating new triangles until the stress in the system is "absorbed".

3. *Nuclear family emotional process*

Bowen uses the concepts of differentiation of self and triangles to describe the dynamics of a nuclear family (Bowen, 1976). Individuals leave their families with a basic level of differentiation of self. They find a marriage partner at about the same level of emotional maturity or differentiation. They look to this partner to give them emotionally what they did not get in their family of origin, and they become closely emotionally fused to the partner. This fusion is more intense the lower the level of differentiation of self. Inevitably the partner does not fulfil the

hopes and desires of the other, and each withdraws emotionally. The resulting conflict and anxiety in the marital relationship is dealt with in one of three ways:

1. One spouse may absorb the anxiety, maybe by continually giving in to the other to keep the relationship stable. This may eventually result in dysfunction in one of the spouses. The overfunctioning spouse may develop symptoms as he or she is emotionally "overworked" in the relationship. More often, the underfunctioning spouse develops symptoms (e.g., mental or physical illness, addiction, irresponsible behavior) as the anxiety he or she is absorbing becomes too much to carry.

2. The couple may have overt marital conflict. The partners may be openly angry and dissatisfied with each other and blame the other for problems in the relationship. Usually their periods of conflict are interspersed with times of intense closeness, and the partners are very emotionally stuck to one another.

3. The couple may triangle with one or more of their children, and the intense emotional involvement with the child may result in emotional impairment of the child. This pattern is so common that Bowen identified it as a separate concept; the *family projection process.*

It is as if a couple has a measure of anxiety and immaturity that must somehow be absorbed. Some families are able to bind their anxiety using one of these three ways. Others need to use two or three of these ways to fully absorb the anxiety in the family.

4. *Family projection process*

In families where the parents are more highly differentiated and not overly emotionally attached to their children, the natural individuation drive in each child is allowed to operate and the child separates from the parents to become a relatively autonomous individual. But in families with less differentiated parents, one or more children can become involved in an intense emotional attachment to the parents. The individuation process in these children is stifled (Kerr & Bowen, 1988).

In a traditional family arrangement, it is common for the husband to deal with dissatisfaction in the marriage by becoming over-involved in work or in other activities outside the home. The mother becomes over-involved with one or more of the children. She focuses her emotional energy on the child, and the child gets caught up in responding to the mother's anxieties and expectations. This attachment may show itself as a warm dependent bond or as an angry conflictual struggle.

Children who grow up to have emotional difficulties often feel they were unloved by their parents. Bowen says the problem is not a lack of love; the problem is too much emotional attachment (Kerr & Bowen, 1988). Children with over-involved parents remain emotionally needy and overly dependent on others. They have not had the opportunity to develop their ability to function autonomously. The more the parents are able to set appropriate boundaries between themselves and their children, the more able the children will be to take responsibility for their own lives.

5. *Multigenerational emotional process*

Often one child is more caught up with the parents than his or her siblings are. This child will have less emotional space in which to differentiate from the parents, and will grow up with a lower level of differentiation of self than his or her siblings. Other siblings who are less triangled with the parents become more emotionally autonomous. In this way some children emerge from a family with a lower level of differentiation than their parents while other children in the family are somewhat more differentiated than their parents.

It is not clear how one child gets selected to be more emotionally involved with the parents. It may be that he or she has a difficulty (e.g., a learning disability) that pulls the parents into a protective stance. Or a child may have some quality that attracts or repels a parent. Or a child may be born at a time of high stress in the family. Whatever the factor, the child most attached to the parents grows up to be a less differentiated self. As this process repeats itself over several generations, each time the most attached child emerges with a slightly lower level of emotional functioning. Bowen believed that schizophrenic children - whom he saw as almost totally undifferentiated from their parents - were the product of an emotional process that extended over many generations. Other individuals with severe emotional or behavioral problems are part of a similar process where the undifferentiation and immaturity is amplified from one generation to the next.

6. *Emotional cutoff*

Bowen maintains that all adults have some degree of unresolved emotional attachment to their parents. The lower their level of differentiation, they greater this will be. Freeman (1992) calls this unresolved attachment "unfinished business". Each of us emerges from our family of origin with some disappointments and emotional hurts. We deal with this unfinished business by emotionally distancing ourselves from our parents and families. Some people distance by moving far away, others do so by avoiding personal subjects in conversation or by never being alone with their parents. This emotional cutoff may be mistaken as independence or emotional maturity. In reality, emotional cutoff is a sign of emotional fusion and ongoing intense emotional involvement. The greater the degree of cutoff and emotional reactivity to parents and children, the higher the level of unresolved emotional attachment. In Bowen's words, "The person who runs away from his [or her] family of origin is as emotionally dependent as the one who never leaves home." (Bowen, 1976, p. 382).

The Nature of Problems

The development of problems or symptoms in families is a function of two variables: (a) the level of differentiation of self in the family, particularly in the parents, and (b) the level of anxiety or stress in the family (Kerr & Bowen, 1988). Families carry a level of chronic stress, and this is directly related to the level of differentiation of self in the family. When the level of differentiation is low, individuals feel intense pressure to think, feel, and act in ways that will enhance the well-being of those around them (i.e., the togetherness force in

relationships). Undifferentiated individuals are very susceptible to taking on the anxieties of those around them. They have little freedom to "be themselves". In families with a higher level of differentiation, anxiety is less easily passed from one member to another, and individuals feel less pressure to conform to the family norms. These families have a lower level of chronic anxiety.

The level of anxiety in a family is also impacted by external events. Death, divorce, unemployment, poverty, and other stressful events result in increased anxiety in the family. The stresses that come at times of developmental transitions (e.g., adolescence) also heighten anxiety. On the other hand, anxiety will decrease in periods of relative stability.

I have already described Bowen's concept of the nuclear family emotional process, which outlines the different ways anxiety is absorbed in a family. Symptoms - intense marital conflict, dysfunction in a spouse, or dysfunction in a child - develop when the level of anxiety in the family exceeds the family's capacity to absorb it. Symptoms are most likely to appear at times of heightened anxiety in the family. In families with a low level of differentiation and a high level of chronic anxiety, symptoms are likely to be more severe and ongoing, although some relatively undifferentiated families remain symptom-free in the absence of external stressors. And a more differentiated family, with a lower level of chronic anxiety, may develop symptoms after a prolonged period when external stress on the family is very high.

How families change

Based on these concepts of family functioning and the nature of problems, Bowen identified several ways that families can be changed to alleviate problems. He distinguished between changes which brought symptom relief, which he saw as superficial change, and more fundamental changes that come with an increase in the level of differentiation of self.

Symptom relief can come when the individual or family anxiety is lowered (Kerr & Bowen, 1988). For example, a poorly differentiated and lonely individual might find a new partner, and his emotional problems will disappear. A rebellious teenager may emotionally cut off from her parents and leave home, and the family's stress will be greatly reduced. A couple in conflict may triangle a third person into their relationship, and the anxiety in their relationship will be dissipated. (A supportive therapist working with one or both partners can serve to lower marital tensions in this way).

Bowen also noted that in periods of stress, nuclear families could be stabilized by emotional contact with the family of origin. The intensity of the emotional process in the nuclear family is softened by active contacts with the extended family. This contact does not result in any change in the level of differentiation of self in the family, but the support of the extended family helps the nuclear family weather periods of high stress. Conversely, increased contact with families of origin can bring greater stress to the nuclear family if the extended family is experiencing stress.

Bowen found that changes which brought symptom relief by lowering anxiety in these ways tended not to last (Bowen, 1966). When the family's

anxieties rose again, the symptoms would return. Lasting change was brought about only by increasing the basic level of differentiation of self of individuals in the family. Bowen experimented with a variety of methods to promote differentiation of self, most of which involved working with several family members together. But he says that fundamentally differentiation of self is an individual process. It is a process each individual must undertake for him or herself. As individuals in the family become better able to separate thinking from feeling, as they learn to see themselves and their relationships more objectively, they become less reactive to the emotions and anxieties of other members in the family. They become better able to think objectively and function autonomously in stressful situations. They become better able to take responsibility for their own actions, while leaving other family members to take responsibility for themselves.

The family operates as a system, which means that a change in one part affects all the other parts. Bowen believed that if one person in the family could maintain a more differentiated stance, this would result in all members in the family becoming more differentiated over time. He also believed that the most effective route to promoting differentiation was to work with the most motivated and highly functioning members of the family. Rather than focusing his therapeutic efforts on the person or persons with the problem, Bowen preferred to work with those members most likely to be able to maintain a more differentiated stance. Usually he worked with the parents in the family, assuming them to be the most powerful - and changeable - family members.

Because each family has a delicate balance between togetherness and individuality forces, and move toward greater differentiation by a family member will evoke a powerful reaction from the rest of the family as it tries to restore the balance. Without support, the individual who tries to take a more differentiated stance will not likely withstand the family's "change-back" maneuvers. (See Lerner, 1985 for a description of various "change-back" maneuvers and ways they might be resisted). If the individual is able to maintain their new position, over time other members of the family will also shift to a more differentiated stance.

The move toward greater differentiation of self can only happen in an atmosphere of lowered anxiety. When individuals are anxious or defensive, they will hold tightly to their usual ways of seeing themselves and others. Only when their anxiety is lowered will they be able to examine and rework their stories about themselves and their families. According to Bowen's theory, change comes with gaining objectivity, which is a product of insight and new understanding of oneself and one's relationships.

Intervention

In the Bowenian approach to family therapy, the goal is to lower anxiety and then to foster increased differentiation of self. Symptoms are de-emphasized; the therapist listens to the family story of the problem enough so that the family is not put off, but then begins to work to shift the focus of therapy from the problems and the identified patient to broader family dynamics, and finally to the individual effort to differentiate.

Bowen tried different approaches to promote greater differentiation of self (Bowen, 1966). Early in his career he met with the parents and the identified child patient together, trying to work on differentiation in this central family triangle. He found little success using this approach. He was more successful when he began meeting with the parents alone, even when the family presented with a child-related problem. In effect, the therapist formed a new triangle with the parents and promoted differentiation in this triangle. (More on this below).

In the mid-1960's Bowen undertook to reposition himself in his own family of origin. (He tells the story in Anonymous, 1972). When he reported his efforts and learnings to his students, they began to make similar efforts in their own families of origin. Bowen noticed that the group of trainees who undertook this work reported positive changes in their own marriages, and also became better therapists through the process (Bowen, 1974). He began to direct his therapy clients to re-open relationships with their parents and siblings, and coached them as they sought to take a more differentiated stance in these relationships. He found that clients who did this reported significant improvements in their relationships with their spouse and children. As a result of his observations, Bowen began to use family of origin work as his primary method of promoting differentiation of self in his clients.

Kerr (1985) suggests that it is easier to differentiate and become more objective in one's family of origin relationships, and then apply this learning to relationships in one's immediate family, than it is differentiate while focusing directly on the more intense immediate family relationships.

Bowenian therapists describe several distinct phases in their therapeutic process. Freeman (1992) says that therapy has an assessment phase, beginning phase, middle phase, and ending. In the assessment phase with the family - usually just the parents - the therapist takes a thorough and precise history of the presenting problem, of the history of the couple and immediate family, and of each partner's extended family. The therapist is beginning to look for patterns and connections between the symptom and stressful events in the immediate and extended family. At this point these are not brought to the attention of the family as the family members are probably too reactive to think clearly about the problems. But in taking this history the therapist is beginning to shift the focus of the therapy from the presenting problem to broader family dynamics.

In the beginning phase of therapy, the focus is on relationships in the immediate family. The therapist is working to lower anxiety and foster more objective thinking and understanding. In this phase Bowen worked just with the couple, even if their presenting problem involved a child. Freeman (1992) does involve the children in this phase, but only after the parents are calmer and can listen to the children's stories without reacting or becoming defensive.

Bowen understands this phase of the therapy process with the couple in terms of his concept of triangles (Bowen, 1966). The therapist forms a *therapeutic triangle* with the couple. If the therapist can engage the couple and maintain a differentiated stance, the couple will gradually become less reactive. The therapist must maintain a neutral and detached position. He or she must avoid taking sides, taking responsibility for solving the problem, dominating or submitting, or otherwise becoming reactive to the emotional dynamics of the

couple. The therapist keeps a focus on the process of the couple's interaction and does not get hooked into solving content issues. The therapist does not allow the couple to argue or attack each other in session. If necessary, the therapist has each partner direct themselves to the therapist, in order to help the partners listen to each other without having to react to defend their position.

The primary tool of the Bowenian therapist is the question (Nichols & Schwartz, 1991). Rather than give advice or offer interpretations, the therapist asks questions. A couple may come in blaming each other for their relationship problems. The therapist's questions are designed to help each individual reflect on his or her role in the relationship. The questions are aimed to get through the person's reactivity to their reasonableness. If the therapist is able to maintain a neutral position and ask questions that provoke reflection without heightening anxiety, with time the couple will become less blaming - of each other or of the "problem" child - and more focused on examining and changing their role in the relationships.

Once the couple is calmer, Bowen would do some teaching about the basic principles of triangles and reciprocity in relationships. This information is of little value when the couple is more reactive; they will just use it to support their own positions in the conflict.

As the couple shifts from a reactive stance and each partner becomes more interested in changing him or herself, the original symptoms will probably fade away. Now the therapy shifts to the middle phase. The focus shifts to the family of origin. The therapist may continue to work with the couple, or just with one individual, if the other partner is unmotivated or unavailable. In the beginning

phase, therapy sessions are scheduled weekly. In the middle phase they are less frequent - maybe once a month or so - and the therapist becomes more of a consultant to the clients as each works on his or her relationships with parents and siblings.

The process of returning home begins with the individual learning more about his or her family and its history. Then relationships with parents and siblings are opened up, often with brief visits home. In this way the old family triangles are reactivated. The person then works to "detriangle" him or herself, much in the way that the therapist took a neutral yet connected stance with the couple at the outset of therapy. With knowledge about the dynamics of emotional systems, good coaching from the therapist, and a great deal of practice, the individual learns to be a more differentiated, less reactive self in his or her family of origin. Bowen reports that individuals who make such shifts find they are also able to function with greater maturity and objectivity in relationships in their immediate families and in their workplaces and social groups.

Bowenian therapy can extend over a period of several years. Therapy is completed when the individual has successfully opened relationships with parents and siblings, detriangled in these relationships, and developed a greater capacity to be in close emotional contact with his or her family while maintaining a clear individual identity.

Conclusion

The differences between strategic and Bowenian therapy are immediately apparent. Their similarities may be less obvious. Without getting into a full

analysis of the differences and similarities, I want to highlight those I found most relevant to my practicum experience.

1. Strategic and Bowenian approaches understand problems and the origin of problems quite differently. Bowen sees problems as symptoms which appear when the family's level of anxiety exceeds its capacity to absorb anxiety. The problem is a symptom of a deeper malaise in the family. The Bowenian therapist does not focus on the problem, but on the underlying cause. The therapy aims to lower the level of anxiety in the family and then promote greater differentiation of self in the key players in the family - usually the parents.

Haley and Madanes see problems in one of three ways: (a) The problem may be symptom of a deeper issue - a flaw in the family structure, particularly a confusion or weakness in the family hierarchy, or (b) the problem can be a misguided attempt by one member of the family, usually a child, to be helpful to the family, or (c) the problem may be a form of communication - a metaphor. For example, the problem-bearer may be expressing the despair of another family member. Each of these different understanding of a problem is quite distinct, and warrants a unique type of intervention.

The strategic therapist very much focuses on the problem. In most cases therapy is terminated once the family's presenting problem is alleviated

2. Strategic and Bowenian approaches have quite different understandings of how to promote change in the family. Strategic therapists mostly focus on changing behavior; Bowenian therapists try to promote insight.

Therapists in both approaches try to get a clear and objective understanding of the interactional patterns and relationship dynamics in the

family. But in strategic therapy it is the therapist who gains this insight. Then he or she uses this understanding to design directives to get the family to change its patterns of interaction. The family does not need to understand what is happening or why it is doing the new thing; family members only have to act differently. If the clients resist changing their behavior, the therapist finds clever ways to use this resistance to promote change.

The Bowenian therapist tries to get the family - or at least key members of the family - to gain the insight. First the therapist guides the clients to new insights into the present family dynamics. Then the therapy moves on to help the clients deepen their capacity to be objective and insightful. When the client gets defensive and puts up resistance, the therapist backs off and finds a different approach to helping the clients see him or herself more objectively.

3. Strategic and Bowenian therapists have different views on who should attend the therapy session. Strategic therapists are working to change action, so they want all the actors in the room. They almost always meet with the whole family. Bowenian therapists are working to promote insight and objectivity, so they want to meet with the family members most capable of gaining insight and objectivity. They usually meet with the parents, or in some cases with just one member of the family. They believe seeing the whole family together only serves to heighten reactivity, which is an obstacle to becoming more differentiated.

4. Both Bowenian and strategic therapists tend to be quite emotionally detached from their clients, but in quite different ways and for different reasons. Strategic therapists take the stance of "experts". They use a detached expert

position to gain leverage in their attempts to get families to act in new ways. They take a lot of responsibility for getting families to change.

Bowenian therapists take a "neutral observer" or "researcher" stance with families. They are attentive and curious, but not overly supportive and not emotionally reactive. They try not to take responsibility for getting the family to change, believing that helping clients to take responsibility for themselves is an integral part of the therapeutic process.

The differences between strategic and Bowenian approaches are such that they cannot be easily combined into one harmonious therapeutic method. I chose not to try to develop a systematic integration of the two approaches for my work with families in this practicum. My integration of the two approaches was more fluid; I used strategies and understandings from each approach as these seemed to fit with my work with each family.

In my initial assessment of the family, I consistently took a detailed family history and made a genogram of the family. I also explored with the family the interactional patterns surrounding the presenting problem. I was wanting to gain an understanding of both the short term interaction sequences (strategic therapy) and the longer term intergenerational family patterns (Bowenian therapy) as a basis for intervention.

Given the relatively short term of my involvement with families, I did not attempt to enter into "middle phase" Bowenian therapy, where the clients open up relationships in their families of origin. My use of Bowenian interventions was

limited to those interventions usually used during the "beginning phase" of therapy.

In my interventions I quite freely utilized techniques from both strategic and Bowenian (beginning phase) approaches, or I combined techniques from each. The direction my intervention took with each particular case was shaped by the nature of the presenting problem, the nature of the clients, and the specific direction for intervention worked out in consultation with the case supervisor. I will be commenting on my experience of utilizing these two approaches together in the Conclusion section of this report.

SECTION TWO

PRATICUM SETTING AND PROCEDURES

Setting

All but one of the couples or families I worked with for this practicum were seen at the Community Resource Clinic (C.R.C.). The C.R.C. is operated by the University of Manitoba's Faculty of Social Work and Department of Psychology. It is located at 321 McDermot Avenue in Winnipeg. The C.R.C. serves as a training centre for undergraduate and graduate students in the Faculty of Social Work and graduate students in the Department of Psychology.

The C.R.C. offers counselling services at no charge to clients. Many of the individuals and families who receive services are low income, and a significant proportion are residents of the inner city. Services are available for individuals (adults or children), couples, and families. Clients refer themselves to the C.R.C. for services, or they are referred by other agencies or professionals (e.g. Child and Family Services, Children's Home, Klinic).

One family (the C. family) was seen at the Psychological Service Centre (P.S.C.). Like the C.R.C., the P.S.C. is operated by the University of Manitoba's Department of Psychology and Faculty of Social Work. It is located at 161 Dafoe Building on the University of Manitoba campus. The P.S.C. serves as a training centre for graduate students in the Department of Psychology and the Faculty of Social Work. Again, there is no charge for counselling services.

Clients

My goal in doing this practicum was to gain clinical experience with a range of families and problems. I did not restrict either the type of family configuration or the type of presenting problem in selecting my clients. The clients I worked with included three couples (one married and two unmarried), a single-parent family, and three two-parent families (two "first-marriage" and one "blended" family).

Clients seen at the C.R.C. were selected from the waiting list of the clinic, after consultation with my advisor as to their suitability for my practicum. In selecting families, consideration was given to the nature of the presenting problem. Cases where the presenting problem might reasonably be addressed in relatively short-term therapy were given priority.

I had intake sessions with nine families at the C.R.C. Of these nine, three families did not return for therapy after the intake session. Six families entered into the therapy process. Of these, five were self-referred to the C.R.C. The sixth family was referred to the C.R.C. by Child and Family Services.

The family seen at the P.S.C. was referred to Centre by a psychologist at the Manitoba Clinic. Originally I had planned to see families only at the C.R.C., but at the mid-point of the practicum term I was concerned that I was not getting enough clients from the C.R.C. waiting list to fulfil the requirements of my practicum. I consulted with my advisor, and we decided I would see one family at the P.S.C. Initial contact with this family was made by Prof. Diane Hiebert-Murphy, and my work with the family was part of the requirements for the "Change and Stability" course (47:729). With this family I worked with a co-

therapist, Ms. Petra Roberts, a fellow graduate student in the Faculty of Social Work.

Of the seven couples or families who entered into the process of therapy, two couples unilaterally terminated therapy before the end of the contracted sessions - one after six sessions and the other after seven sessions. The remaining five families completed the therapy process. At the end of my practicum term, one of these families was transferred to another therapist for ongoing therapy. The other four families terminated therapy when my work with them was completed.

Procedure

In my work with each family I followed the same general procedures. Therapy sessions were 60-90 minutes in duration. Sessions were scheduled once a week, as schedules allowed (with the exception of the E. family, where we met once every two weeks).

The first two or three sessions were given to intake and assessment. In these sessions I did the following:

1. Worked with the family to come to a common understanding of the issues to be addressed in therapy.

2. Obtained an understanding of the interactional sequences which surrounded the presenting problem.

3. Took a history of the nuclear and extended family and constructed a genogram with the family.

4. Had the family members complete the FAM III measure of family functioning.

5. Contracted with the family to meet for a specific number of sessions (usually five), after which they could evaluate if they wanted to continue our work together. With each family I clarified that I would not be available beyond the end of my practicum term (April, 1995).

After intake and assessment, the process of intervention varied from family to family. The direction of my intervention was developed in consultation with my case supervisor.

Termination with the family came when the clients unilaterally terminated (as two families did), or when both the clients and I agreed the presenting problem had been satisfactorily resolved, or when I came to the end of my practicum term. Where possible, I had each family member complete the FAM III measure again in our final session.

All therapy sessions were videotaped. In addition, a file recording was done for each session, in accordance with agency protocols. File recording for each case included an intake report, process recordings for each session, and a termination summary. All sessions were also recorded in the agency's computer data file system. All file recording was monitored by the case supervisor.

Supervision

Supervision of my clinical work was shared by the three members of my practicum committee. Four cases were supervised by Dr. Barry Trute. I had a

one-hour supervision session with him weekly through the course of my practicum work.

Two cases were supervised by Dr. Diane Hiebert-Murphy. I met with her for a weekly hour of supervision on each case for the duration of my work with these two families.

One case was supervised by David Charabin. We met for one hour bi-weekly, and for most of our supervision sessions were joined by Linda Perry, a staff therapist at the C.R.C. who was providing individual therapy for the son in this family (the E. family). In addition, David Charabin picked up supervision of the cases which had been under Dr. Trute's supervision during Dr. Trute's absence over the last month of my practicum term.

Although each supervisor had his or her own distinct style of supervision, the supervision sessions all had a similar format. Usually I presented a synopsis of my previous therapy session with the family. On occasion I would bring videotapes of the session to supervision, and the supervisor and I would view a portion of the tape together. The supervisor provided consultation and direction in hypothesis formulation, intervention planning, and skill development. Based on our discussion and the supervisor's input, I would formulate a plan for my next session with the family.

Evaluation

In clinical practice, the clinician can evaluate the effectiveness of the therapy through his or her observations of the client's functioning and through the client's self-report. These sources give the clinician a valuable perspective on the

impact of the therapy process on the client, but this perspective is based on subjective perceptions. Both the clinician's and the client's perceptions are open to bias and distortion. And these perceptions do not yield measurable or quantifiable information on the effectiveness of the therapy.

More precise and objective information on the effectiveness of the therapeutic intervention is available through the use of standardized measures designed for this purpose. These standardized measures can be used as multiple measures or as pre- and post-tests in clinical practice.

Family functioning is difficult to measure; family interaction is a complex and multi-dimensional process. Standardized measures which assess dimensions of individual functioning do not adequately capture the complexity of the family system. In recent years several standardized measures which look at the family as a unit have been developed. These measures are designed to assess the nature of transactions between family members, including more global dimensions of family functioning such as communication and family cohesion.

My practicum was designed to include therapy with a variety of types of family constellations and presenting problems. I needed an outcome measure which could be used with a broad range of family types and problems. The measure I selected is the Family Assessment Measure (FAM III). The FAM III is a self-report measure which has family members report their perceptions of their family's functioning. The measure was designed by Skinner, Steinhauer, and Santa-Barbara (1983).

The FAM III is based on a process model of family functioning. The process model provides a framework for integrating key concepts of family

systems theories. The model assumes that the overriding goal of the family is the accomplishment of a variety of basic, developmental, and crisis tasks. The family must organize itself to get these tasks done. The FAM III assesses seven dimensions of family functioning as they relate to this overriding goal: *task accomplishment, role performance, communication, affective expression, involvement, control,* and *values and norms.* Each of these dimensions has a cluster of questions relating to it, and the measure is scored along these seven sub-scales.

The FAM III consists of three components:

1. The General Scale focuses on the family as a whole system. Respondents are asked to rate the functioning of their family as a whole. The General Scale is made up of 50 questions. In addition to the seven sub-scales listed above, the General Scale has two additional sub-scales which assess the person's response style: *social desirability* and *denial.*

2. The Dyadic Relationships Scale examines the relationships between specific pairs in the family. It consists of 42 questions, covering the seven dimensions of functioning in the dyadic relationship specified.

3. The Self-Rating Scale, also with 42 items and seven sub-scales, focuses on the individual's perception of his or her functioning in the family.

The three scales may be used separately or together. In my practicum I used only one scale with each family. For most of the families I administered the FAM III General Scale. In two cases I administered the Dyadic Relationships Scale. The Dyadic Relationships Scale was used when the presenting problem involved only the relationship between the two family members present in

therapy, and when other members of the family did not appear to be significantly involved in the problem. With these cases it was felt that the phrasing and focus of the questions in the Dyadic Relationships Scale made it a more appropriate and relevant measure than the General Scale.

The originators of the FAM III report on several evaluations of the measure's psychometric properties (Skinner, et al, 1983).
The FAM III was found to have an overall coefficient alpha of .93, demonstrating that the sub-scales of the measure have a strong internal consistency (i.e., individuals' responses to the different items of the sub-scale are consistent with each other). Also, the FAM III was found to "significantly differentiate between problem and non-problem families" (p. 104).

No evaluation of the test-retest reliability of the measure - assessing the consistency of the test results over time - was reported. The authors do suggest that the results obtained reflect the individual's assessment of family functioning at the time. The individual respondent's emotional state of level of motivation may influence the accuracy of the self-report (Skinner, et al, 1984). No evaluations of the FAM III's construct validity or predictive validity are reported by the designers of the measure.

Norms for response scores on each of the sub-scales have been established, based on scores from a representation of Canadian families. Individual family members' scores are compared with the established norms in interpreting the test results.

The FAM III can be used with adults and adolescents. It is not recommended for use with pre-adolescents. When using the measure with

families with pre-adolescent children, I only administered the measure to the parents and older children.

In my practicum work with families, I administered the FAM III to family members at the beginning of the therapy process, as part of my intake and assessment. I again administered the measure at termination. Usually it took clients about 20 minutes to complete the measure.

SECTION THREE

CASE SUMMARIES AND EVALUATION

In this section I present a summary of the practicum cases. For each case I highlight the presenting problem, provide relevant family background, and give a brief synopsis of the treatment process. (Central themes in the treatment process will be discussed in greater depth in the next section of this report). For each case I also present and discuss the results of the pre-therapy and post-therapy FAM scores.

The N. Family

Case Summary

The N. Family is a Caucasian, two-parent family with three sons, aged 17, 15, and 11. The parents came to therapy identifying two issues they wanted to address. First, they wanted to improve their relationship with their oldest two sons. Both boys were into drugs, street crime, and running away from home. This behavior had begun a little over a year ago. When I first met the parents the oldest son was under detention at the Manitoba Youth Centre and the younger son was in and out of the home. The two boys had just robbed their parents of over $1000, and both parents were very angry and frustrated.

Second, the parents wanted to strengthen their marriage relationship. One year ago they had separated for three months, at the mother's initiative. (The boys started getting into trouble around this time). They had been in marriage counselling for three months, and had spent a lot of time talking with each other

during the time of their separation. They felt their relationship was much stronger now than before, but wanted to strengthen it even more.

In doing a genogram with the couple I learned that both parents had conflictual relationships with their own parents in adolescence. Dad's father died when he was 11, and soon after he began running away from home. He ended up in detention and then in a foster home. Mom ran away from home when she was 16. The couple met at age 17, married, and had their first child when they were 18 years old.

I met with the N. family for a total of 18 sessions. The first 15 sessions were with the parents only. These sessions were spaced over a period of eight months, as the couple's attendance at therapy sessions was sporadic. Their attendance was most regular at times of crisis with their sons. My initial plan was to meet with the parents for a few sessions, help them become less reactive to their sons, and then proceed to work with the whole family together. But the boys' behavior escalated and both ended up serving some months in the Youth Centre. The 15-year-old was released in the last month of my practicum term, so I concluded therapy with three sessions with the parents and this son.

Much of my work with the parents involved helping them process their reactions to their sons' behavior. The stress of the conflict with the boys impacted on the marital relationship. Using a Bowenian approach, I explored with Mom and Dad their different styles of reacting, identified the patterns - he got angry, she withdrew - and had them describe steps they could take to stay more connected to each other.

The parents began realizing they had lost control of their own emotional states - and their lives - in their reacting to their sons' behavior. Again using a Bowenian approach, I had them reflect on their own part in the relational dynamic between them and their sons. They committed to stop picking up the pieces for their sons' misdeeds, identified ways they could maintain greater emotional equilibrium, and resolved to focus more on their relationship with each other and with their youngest son.

In the concluding sessions with the parents and the 15-year-old son, I had the parents talk about ways they might get hooked into taking responsibility for his behavior again (e.g., protecting him, trying to control him). I also had the boy identify ways he could resist his temptation to run away when he got into conflict with his parents.

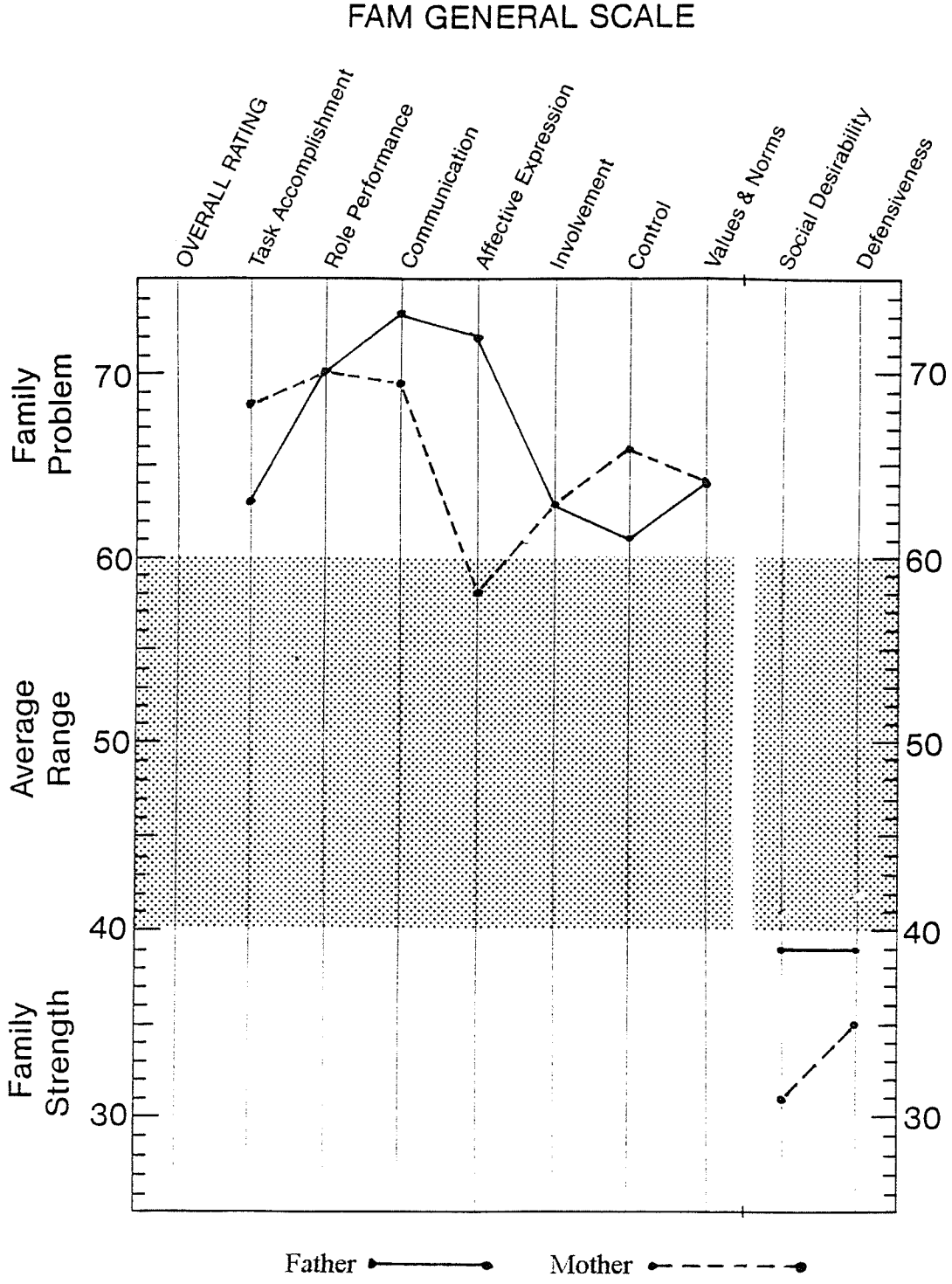
At termination at the end of my practicum term, the relationship between the parents and the two younger sons was quite calm. The parents were still very angry at the oldest son, who was still in detention. I predicted to them that they would be tempted to slip back into old patterns when the oldest boy was released from detention, as the 15-year-old would again be torn between loyalty to his parents and loyalty to his older brother.

FAM profiles

I administered the FAM at pre- and post-therapy to both parents, but not to their children. The pre-therapy FAM profile (Figure 1) shows both parents scoring in the problem range in all areas. The scores for Mom and Dad were remarkably similar (with the exception of the Affective Expression subscale);

Figure 1

N. Family
Pre-Therapy FAM Profile



both agreed that there were real problems in the family, and they agreed on the nature of the problems.

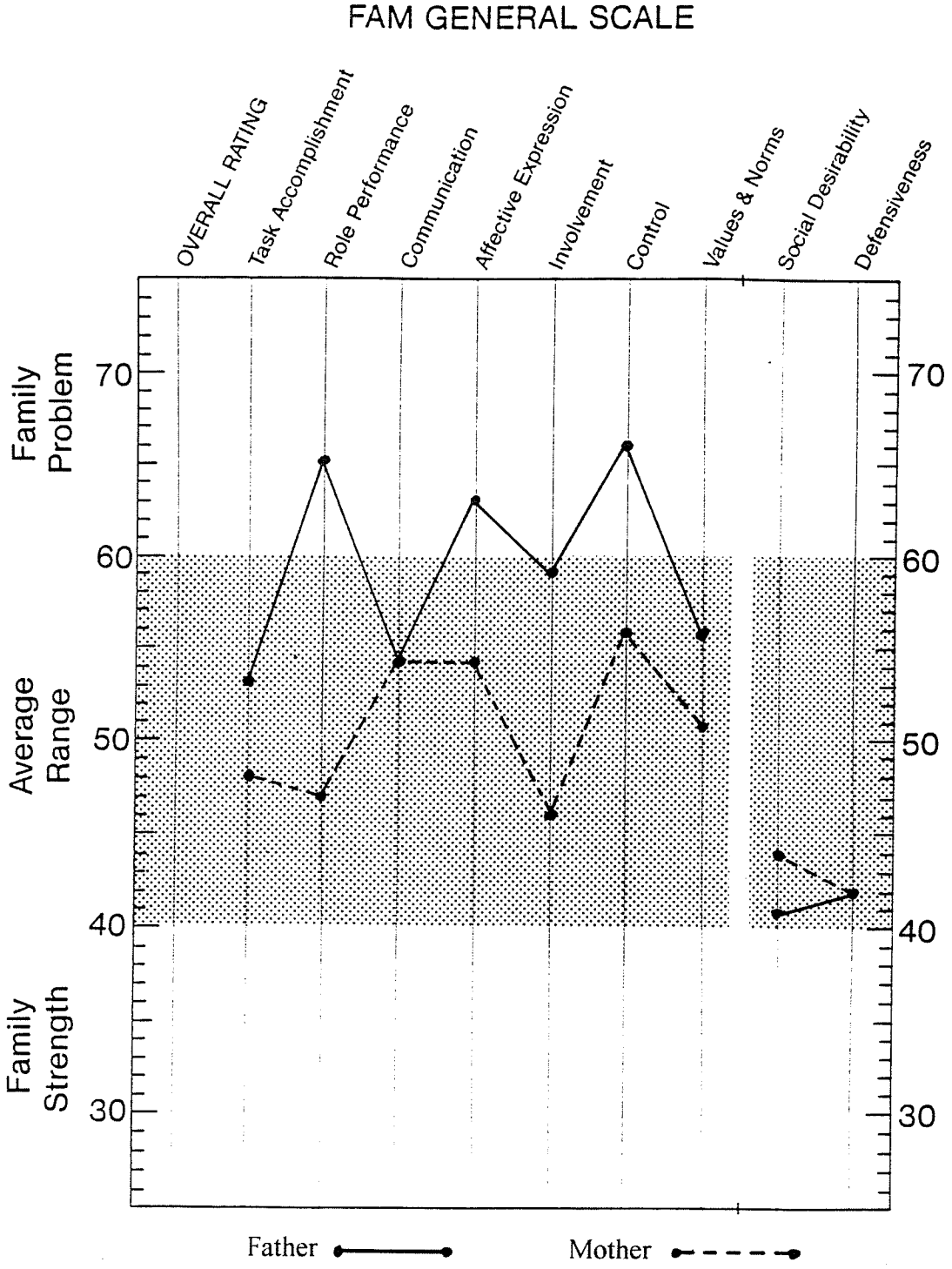
In clinical sessions Mom stated she had dramatically shifted her role in the family since the separation; she was less directive and "in charge" now. The high scores on Role Performance may reflect the family's struggle to realign roles in response to Mom's changes. Both parents scored high on the Communication subscale, reflecting the breakdown of communication between the parents and the two older sons. It may also indicate some communication difficulties between the parents. Dad's score on the Affective Expression subscale was considerably higher than Mom's, which I suspect reflected his concern about her emotional withdrawal in times of high stress.

In the post-therapy FAM profiles (Figure 2), Mom was much less anxious about her family than at the outset of therapy. All her scores were in the average range. Dad's scores were also lower than before, but less so than his wife's. His scores on the Role Performance, Communications, and Control subscales were still in the problem range. In the final therapy sessions - with the 15-year-old son present - Mom took an open and conciliatory stance with her son. Dad was quiet for much of these sessions. I suspected he was not fully in agreement with his wife's position. His high score on the Control subscale was indicative of his concern for clear structures and consequences in parenting. A difference in parenting styles may have been re-emerging. Unfortunately therapy terminated before this could be brought into the open and addressed.

Overall, both parents were less reactive to their sons' behavior as therapy ended. I believe they made progress in taking responsibility for their own

Figure 2

N. Family
Post-Therapy FAM Profile



emotional states and for their relationship with each other, leaving their sons more room to begin taking responsibility for their own behaviors.

Shelly and Sam

Case Summary

Shelly and Sam are a First Nations couple who had been living as married since the birth of their daughter one year ago. They had been "going together" on and off for two years before this. Shelly is 27 and Sam is 21. Shelly has four children from previous relationships, aged eight, six, five, and two.

The couple presented several issues for therapy. First, both identified communication as a problem. Shelly felt she could not raise issues and concerns without Sam becoming defensive and angry. In the past he had physically abused her, but he had not hit her since the birth of their daughter. Second, Sam did not feel free to go out alone because Shelly did not trust him around other women. He did admit he had sexual affairs in the past as a way of hurting Shelly. Third, difficulties in Sam's transition into the role of step-father to Shelly's children emerged over the course of therapy.

Both Shelly and Sam grew up in chaotic families. Shelly's mother was murdered by her father's former girlfriend while on a drinking binge when Shelly was eight. Shelly became a parentified child, and was in and out of foster care while her father had a series of partners. Sam was physically abused by his alcoholic father and his uncles, and he hinted of being sexually abused as well.

Shelly had been in individual therapy for several years. Sam had not been in therapy before.

I met with this couple for a total of 17 sessions. I began by seeking to establish a context of safety for our work together. We talked about Sam's violence toward Shelly, and I was convinced this had stopped. I learned that Sam was hitting Shelly's two-year-old son. I informed the couple I was obligated to notify Child and Family Services. They agreed to make the report to their case worker. To my surprise, they were willing to continue in therapy after this incident.

The couple's relationship was quite volatile, and a clear sequence of interaction emerged: Shelly raised concerns or feelings with Sam, he became defensive and threatening, he left the house for a time, and then she called him back and they reconciled. Given this volatility, Shelly began to use therapy as a forum in which to raise a series of concerns and issues: her anger at Sam for abusing her, her worries about his relationships with other women, and her concerns about his relationship with her children. In each case, Sam reacted defensively. He became angry and threatening, then frustrated and withdrawing. I worked with him in session to help him move through his reaction to the point where he could face Shelly's concern and respond appropriately.

The processing of these conflicts in the therapy session served to alter the previous interactional sequence. Before the conflict had been left unresolved because Sam withdrew from the relationship. With my coaching, the couple was able to resolve several conflicts. As the couple worked through several difficult issues in session, they reported greater openness and affection between them. They were able to work through several lesser issues on their own, outside of our sessions.

Having identified the key interactional sequence and shifted the pattern (a strategic technique), I moved to solidify the changes by employing Bowenian and cognitive techniques to help Sam and Shelly gain insight into their pattern. We identified family-of-origin experiences and cognitions that lay beneath their reactions to each other. Through this process it became clear to Sam that his reactions to Shelly were related to unresolved issues from his family of origin. He thought he had dealt with his anger at his parents and his self-loathing. As he realized he had much more personal work to do, he stated his readiness to enter into individual therapy. At termination both Shelly and Sam identified individual therapy for Sam as the next step in their healing journey.

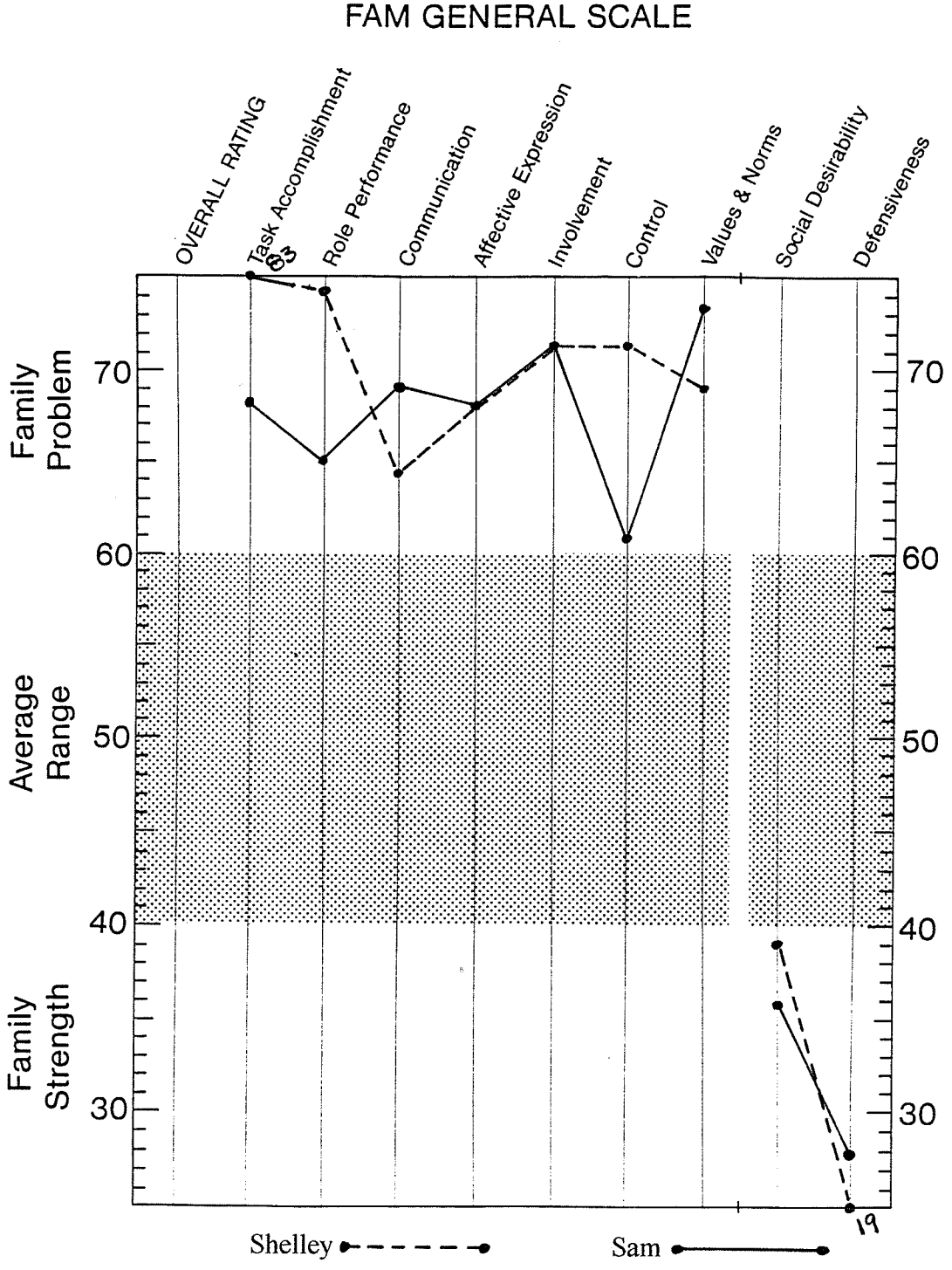
FAM Profiles

Both Shelly and Sam had quite elevated scores on all subscales of their pre-therapy FAM tests (Figure 3). Both were very distressed about their relationship when they came to therapy. Each later told me they had been suicidal when I first met them. Shelly scored very high on the Task Accomplishment and Role Performance subscales. In sessions she indicated her dissatisfaction with Sam's lack of involvement in performing the functional tasks of parenting and housework. She was overburdened with parenting five young children, and desperately needed him to do more of the work.

The couple's scores on other subscales were quite similar, with the exception of Control. I am puzzled by Sam's lower score on this subscale. At intake he indicated his unhappiness with Shelly's lack of control over her children.

Figure 3

SHELLEY & SAM
Pre-Therapy FAM Profile



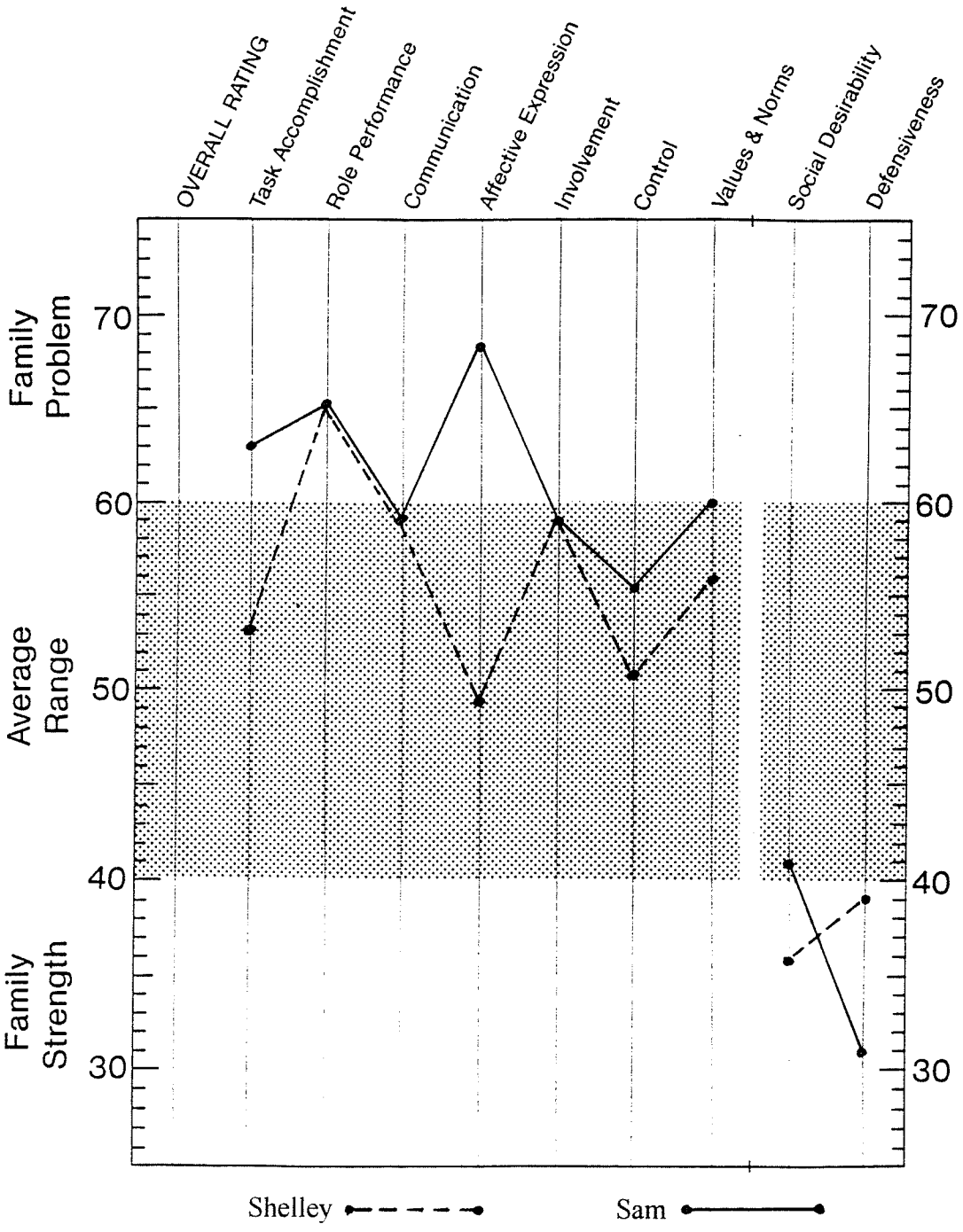
At the completion of therapy, both partners scored considerably lower, with many scores in the average range of the scale (Figure 4). Shelly's scores showed the greatest change. In therapy sessions with this couple, I frequently devoted more time and attention to interacting with Sam than with Shelly. She talked to me about the imbalance she felt in the sessions. Yet my impression was that much of my work with the couple involved addressing Shelly's issues in the relationship - even as I focused my attention toward Sam. As therapy ended many of those issues had been resolved to Shelly's satisfaction, as indicated by her post-therapy test scores. Sam was becoming more involved in parenting, and they were working more closely together as a team. This change was reflected in Shelly's lower Task Accomplishment and Role Performance scores. The couple was communicating better and feeling more connected to each other (Affective Involvement). With better communication, they were better able to find agreement on issues of discipline, rules, and values (Control, Values and Norms).

Sam's scores showed a less dramatic improvement. His score on the Affective Expression subscale was still quite high. Trust remained an issue for Sam, as might be expected given the untrustworthiness of key people in his childhood. Both Sam and Shelly's scores on the Role Performance subscale were still in the problem range, indicating they were not fully satisfied with the division of labor in the family. At termination, Sam was still somewhat reluctant to take on the step-father role with Shelly's children. He stated that he did not feel competent as a father. Again, his reticence was most likely related to unresolved family of origin issues.

Figure 4

SHELLEY & SAM
Post-Therapy FAM Profile

FAM GENERAL SCALE



The M./F. Family

Case Summary

The M./F. family is a blended living-as-married family that has been together for four years. Mr. M. (Robert) is francophone; Ms. M. (Lillian) is anglophone. Robert has five children from a previous marriage: a 17-year-old son, 15-year-old daughter, 14-year-old daughter, 12-year-old son, and 11-year-old son. Lillian has four children from a previous marriage: a 17-year-old son, 16-year-old son, 12-year-old daughter, and nine-year-old son. At present four children live with the couple: Robert's 14-year-old daughter and 11-year-old son, and Lillian's 12-year-old daughter and nine-year-old son.

These two families have had a great deal of difficulty in coming together. Both parents describe Robert's family as chaotic and unstructured. Robert says he sees now that he was not very aware of what was happening with his children when he was a single parent. His two oldest children really ran the family. Lillian's family is very structured, and she maintains vigilant control. (Robert describes her as a"real battle-ax"). These two family "cultures" have not blended together very well. When the two families came together, Robert's older children opposed Lillian's authority. She accuses Robert of ignoring his children's attacks on her and siding with them when she tried to discipline them.

In their first year together, the parents learned that Robert's oldest son was sexually abusing Lillian's daughter, as well as his own 15-year-old sister and 12-year-old brother. The son was expelled from the family and went to live with his mother. A year later, Robert's 15-year-old daughter left the family after intense conflict with Lillian. One year ago, conflict between Lillian and Robert's 12-year-

old son intensified. Both parents say they almost separated in their disagreement on how to deal with the boy's behavior. Finally they placed him under the care of Child and Family Services for six months. They came into therapy just as they had decided to extend his placement. Conflict between the parents over this decision prompted them to seek therapy.

I met with the parents for 14 sessions. I met with the parents and the four children for one session, as part of my assessment. I decided to work with the parents alone because I saw conflict between them as the central difficulty in this family. Their differences over parenting were only the most visible manifestation of the divisions between them.

Therapy sessions with the parents were often quite chaotic. The couple moved between blaming each other for the problems with the children and theorizing about the causes of their family problems - which was only a more subtle form of blaming each other. Using a strategic approach, I worked to identify interactional patterns and to intervene to shift these patterns. For example, I noted that Lillian overfunctioned in parenting and homemaking as Robert underfunctioned. I gave him the task of planning and cooking a meal at least once a week. Her task was to not interfere by prompting or criticizing him about the meal. Shifting to a Bowenian intervention, I highlighted the sequence of interaction in the triangle involving the parents and a child (usually his), and had them identify ways they could take responsibility for changing their part of the sequence. After several such interventions, Robert reported he thought he was getting better at taking his share of the responsibility in parenting and homemaking.

The tension between Robert and Lillian intensified as she became more stressed by her university studies, near the end of my work with them. The tension erupted in a violent confrontation. Lillian got angry with Robert for going out without informing her, and punched him in the head repeatedly when he came home. Violence erupted again that evening. Robert threatened Lillian with a fist, and she responded by kneeing him in the groin. I worked with the couple to process these incidents, and had them develop and commit to an action plan to avoid a repeat of the violence.

The level of stress between the couple decreased after this session. At this time Lillian had completed her university term, and the external stresses on the family had decreased.

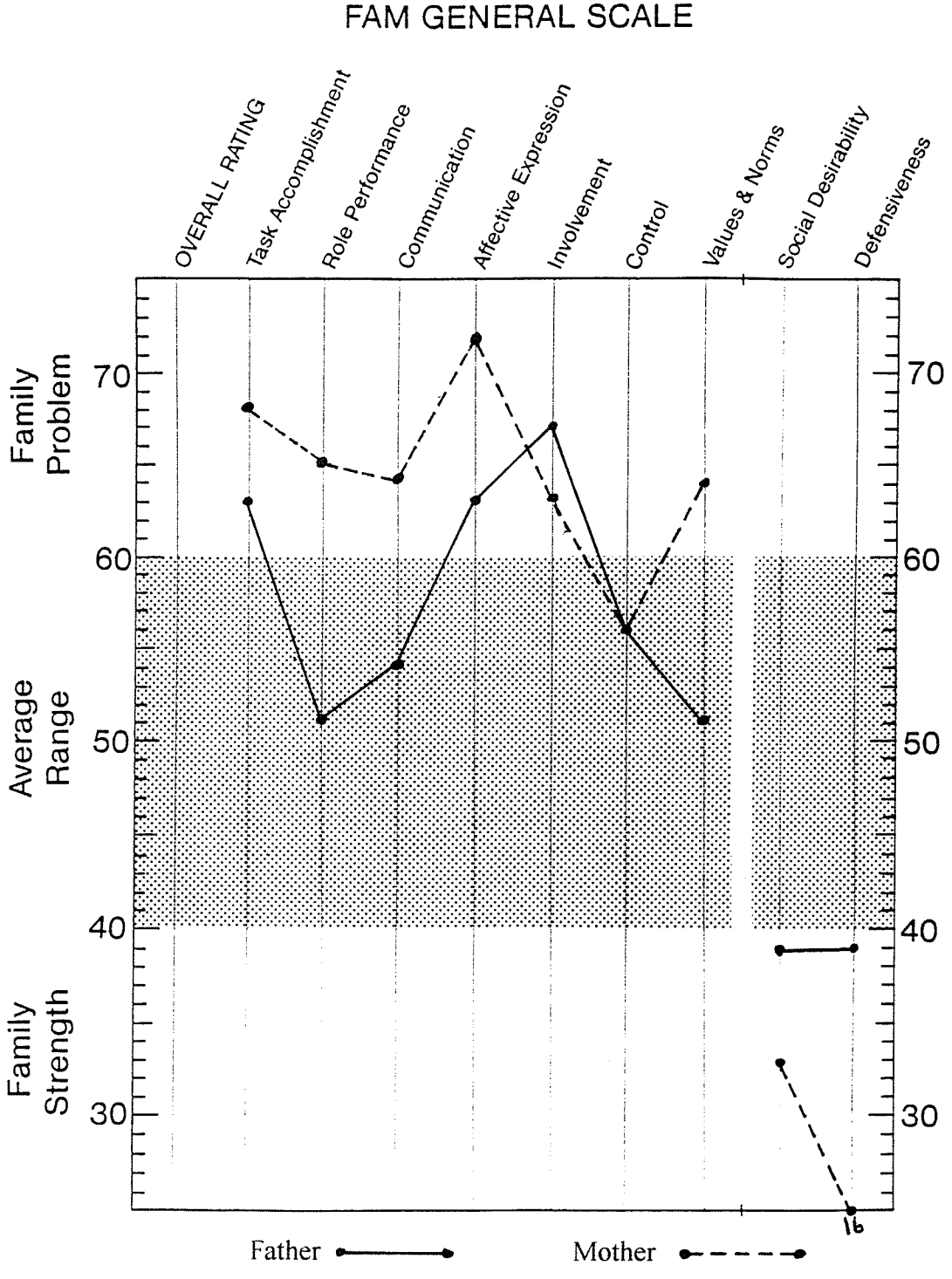
FAM Profiles

Lillian's pre-therapy FAM profile (Figure 5) shows that she carried a high degree of anxiety about the family, as indicated by her low scores on the Social Desirability and Defensiveness subscales. Her scores on the other subscales were probably somewhat inflated as a result of her level of anxiety. She had very high scores on several subscales, the highest being Task Accomplishment and Affective Expression. In session I observed that Lillian expressed her feelings strongly and immediately. Robert was more cautious and reserved; his feelings took much longer to surface. Lillian's high score on Affective Expression may indicate her frustration with this difference of emotional style.

Robert's scores on the pre-therapy FAM profile were lower overall than Lillian's. His higher score on the Involvement subscale may reflect the degree of intensity and lack of autonomy he felt in his relationship with her.

Figure 5

M/F. Family
Pre-Therapy FAM Profile



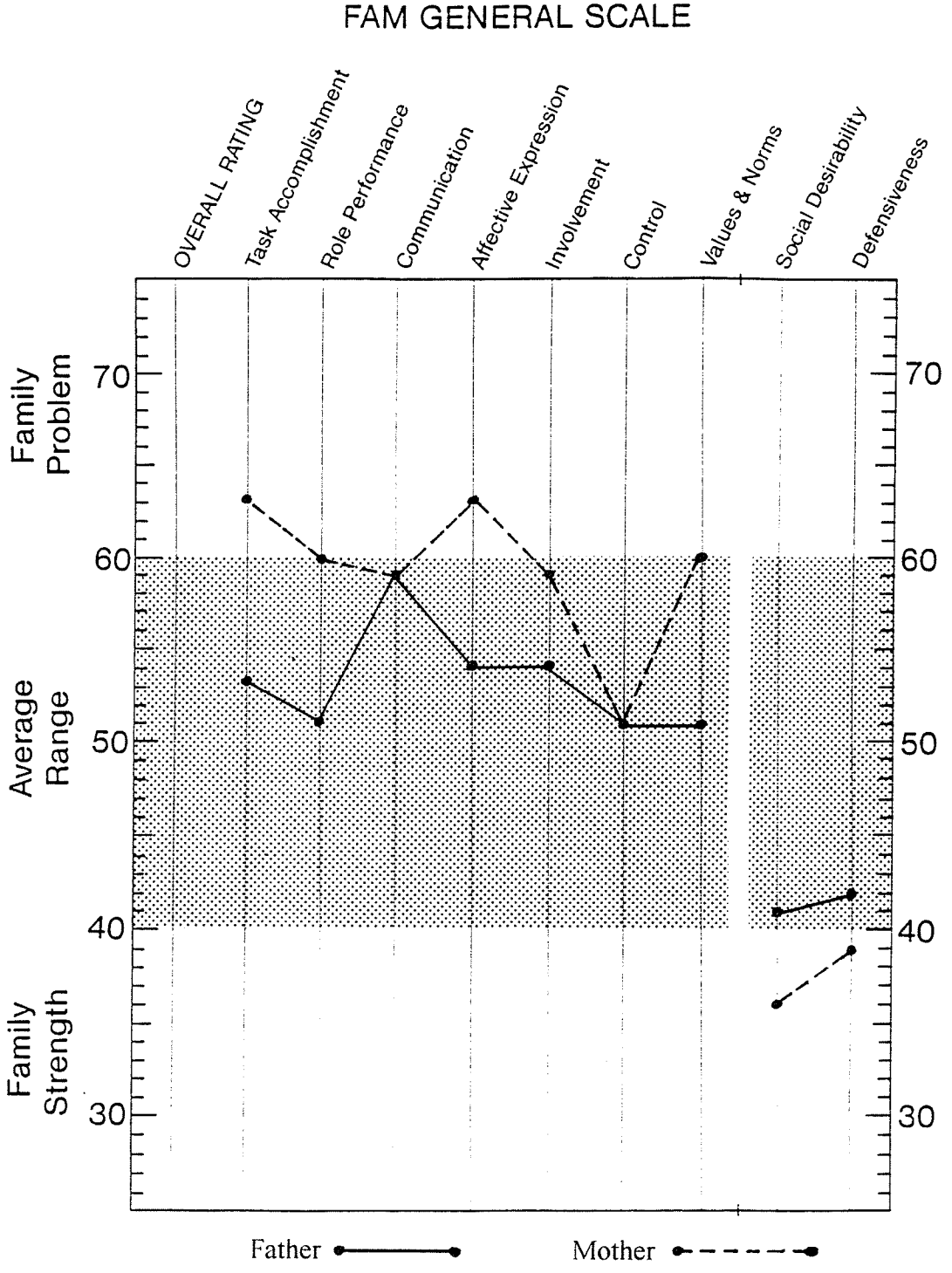
Lillian's post-therapy FAM profile (Figure 6) was remarkably similar in shape to her pre-therapy profile, except that her scores on each subscale were lower. Her scores on the Social Desirability and Defensiveness subscales were higher. These results indicate that Lillian's level of anxiety has decreased over the course of therapy, lowering her scores, but she still sees the family functioning much as it did before therapy.

Robert's post-therapy FAM profile had all scores in the average range. His scores on Task Accomplishment and Involvement showed the greatest decrease, while his score on the Communication subscale increased slightly from his pre-therapy score. He appeared to be feeling more secure in the relationship, as indicated by his lower score on the Involvement subscale.

My clinical impression is that this couple continued to be very susceptible to internal and external stresses on the family. Anxiety in one parent quickly spread to the other. I did not observe any significant improvements in the couple's capacity to deal with stresses over the course of therapy. In Bowenian terms, there was no observable increase in the level of differentiation of self in either partner. Differences between pre-therapy and post-therapy test scores reflect an overall decrease in the level of anxiety in the family. I believe this was primarily the result of the couple's involvement with a third party (myself), and secondarily due to a reduction in external stresses with the end of the university year. I expect that a future increase in stress will again result in increased conflict and dysfunction in the family.

Figure 6

M/F. Family
Post-Therapy FAM Profile



The C. Family

Case Summary

The C. family is an intact, two-parent Jewish family. The oldest daughter, age 19, lives with her boyfriend. The 17-year-old daughter and the 14-year-old son live with the parents. The family came to therapy with concerns about the son. He has learning difficulties, and his school performance has been below average since early childhood. The parents stated that no clear diagnosis of their son's difficulties had ever been made, but he had been placed on Ritalin one year ago and his school performance had improved somewhat. The parents blamed the school for not adequately addressing their son's difficulties. School personnel blamed the parents for not cooperating with efforts to help the boy.

Mother and son reported that the father frequently yelled at the boy, especially when trying to help him with homework. They wanted this addressed in therapy. Dad said he recognized his yelling was a problem, and he was working to correct his behavior.

Dad was very involved in his work and in community activities outside the home, and Mom and son complained that he was seldom home. They both wanted him to be more involved in the family. The son wanted to do more activities with his father, and Mom wanted her husband to take more responsibility for household chores.

The 17-year-old daughter was doing well in school and the parents had no concerns about her. The 19-year-old daughter had a very conflictual relationship with her father. She claimed he had yelled at her continuously as she was growing up. She ran away from home at age 16, lived in a group home and then

with a series of boyfriends. Only in the last year had she somewhat stabilized her life and returned to school. The parents learned one year ago that their daughter had been sexually abused by her aunt's boyfriend at age 14.

The mother also had a learning difficulty. As a child she had been labelled "mentally handicapped". She had fought all her life to overcome the stigma of this labelling, and saw herself as having done very well in life given her difficulties in her school years.

The C. family was seen at the Psychological Service Centre. I saw the family together with a co-therapist, Petra Roberts. We had eight sessions with the family. The first four sessions were attended by mother, father, 17-year-old daughter, and son. The 17-year-old daughter stopped attending after the fourth session. The 19-year-old daughter agreed to come to just one session. We interviewed her individually to obtain her perspective on the family.

Our first task with this family was to negotiate a consensus on the focus of the therapy. The family, especially the father, wanted a formal diagnosis of the son's learning problem. We were not equipped to provide such a diagnosis. The mother and son were also concerned about the father's yelling, but the father was resistant to being singled out in this way. After several sessions we framed the goal of therapy as "helping the family help the son". We identified two distinct areas to be addressed: (1) his academic difficulties, and (2) his emotional needs.

On the academic front, we obtained testing results from the school, identified possible resources for further diagnostic testing, and helped the family identify tasks related to choosing a school placement for the son for next year. This exercise seemed to help the parents move beyond just blaming the school for

what it was not doing for their son. The mother took initiative and began pursuing resources to help her son strengthen his academic performance.

In the area of emotional needs, we focused on the relationship between father and son. We affirmed the father's success in stopping the yelling, and assigned tasks to promote positive interaction between father and son (a strategic technique). They followed through on some of these tasks, and both indicated they were pleased with their progress. The mother confirmed that her husband was becoming more involved with their son in a positive way.

FAM Profiles

Pre-therapy FAM profiles were obtained for all five family members (Figure 7). Post-therapy profiles were obtained for the father, mother, and son (Figure 8).

The pre-therapy profiles supported our clinical observations of relationships in the family. The oldest daughter had very high scores, except for low scores on the Social Desirability and Defensiveness subscales. She was very anxious about the family, and saw problems in all areas. Her scores were quite different than those of any other family member, indicating the generalized conflict between herself and the rest of the family.

The 17-year-old daughter's profile was quite similar to her father's, supporting our observation that they were closely allied.

The father's and mother's profiles were quite divergent, with the mother tending to see more problems than the father. The divergence may be evidence of underlying conflict between husband and wife. This was seldom expressed openly

Figure 7

C. Family

Pre-Therapy FAM Profile

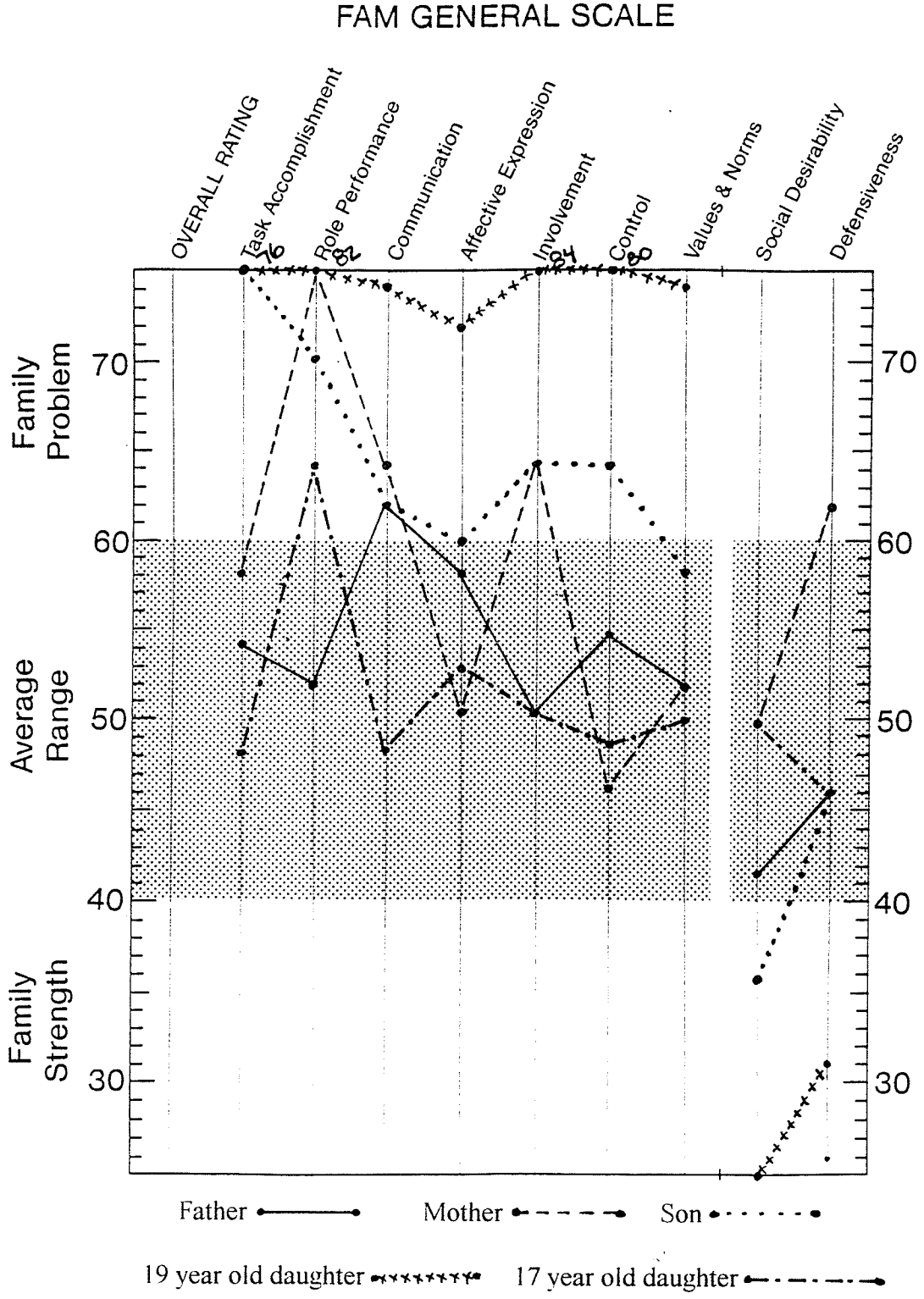
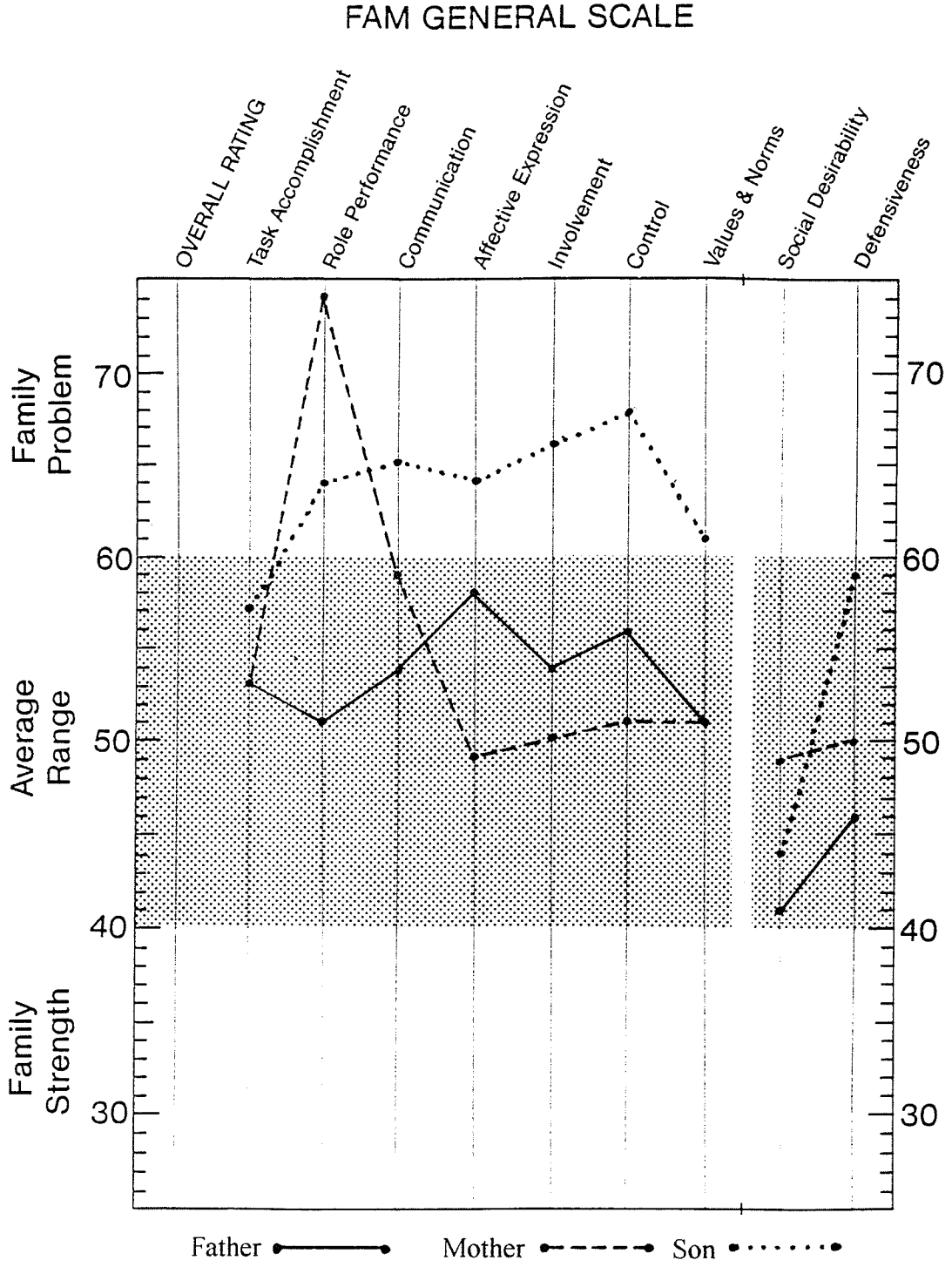


Figure 8

C. Family
Post-Therapy FAM Profile



in session, but we hypothesized that this covert conflict contributed to the mother's over-involvement with her son and the father's withdrawal to activities outside the home.

All the family members except the father had high scores on Role Performance. When asked about this, the mother said her score indicated her concern about the unfair division of labor in the household. She felt she did most of the work and her husband did very little. Her husband confirmed there was an inequity, but minimized its seriousness.

The father's post-therapy FAM profile was virtually identical to his pre-therapy profile. Only his score on the Communication subscale was lower. All his scores fell in the average range of the scale. The mother's post-therapy profile was also very similar to her first scores. Her score on the Role Performance subscale remained high; her concern about her husband's abdication of household responsibilities had not been addressed in therapy. Her score on Involvement was significantly lower, perhaps reflecting her approval of her husband's greater involvement with their son.

The son's scores on most subscales were higher after therapy. The exception was Task Accomplishment; he reported a marked improvement in his family's ability to identify and complete tasks. His overall profile suggested he continued to see his family relationships as problematic. As therapy progressed we noticed he was beginning to give voice to some of his concerns. His FAM profile indicates there was still much he was not saying. His degree of distress may actually have increased over the course of therapy, or perhaps he had become better able to acknowledge his degree of distress.

The E. Family

Case Summary

The E. family is a Caucasian, single-parent family. The father had just been awarded custody of his three sons, aged 14, 6, and 4 years. The two youngest sons came to live with the father several months before therapy began. The 14-year-old was living in a foster home, and moved in with his dad halfway through the period of therapy. My work was with the father and 14-year-old son. Child and Family Services requested therapy for them to help them rebuild their relationship.

The relationship between the father and mother had been very conflictual, and the oldest son had been emotionally caught between his parents. The parents had separated four years ago. The children were in the care of the mother until she was charged with physically abusing the oldest son. The boys were apprehended and the father was awarded custody.

The son was emotionally immature, and had problems with behavior control. Most notably, he was prone to angry, violent outbursts at school and in the foster home. These had been decreasing in frequency and intensity. He was in individual therapy at the C.R.C., and I consulted closely with his therapist in my work with the father and son. The father had previously been in individual therapy at the C.R.C. His therapist had worked to help him be in touch with and express his emotions in order to diffuse his explosive anger.

I met with the family bi-weekly for a total of 21 sessions. The first four sessions I met with the father alone. After this I met with the father and son

together. I also had several meetings with other professionals involved with the family, including the social workers, teachers, and foster parent.

This issue of trust quickly became the main theme of therapy. The father was very worried that the son would revert to his old behaviors - particularly the angry outbursts. He did not trust the son's progress in controlling his behavior, and was convinced the boy needed to learn to verbalize his feelings to release his anger - as the father had learned to do. The son did not trust his father's commitment to him. He was afraid the father would place him back in foster care if he acted out or lost control.

I offered the therapy sessions as a context for father and son to identify and work through issues that came up in the process of reunification. For example, we spent several sessions negotiating "rules and consequences" for the son on his return home. I also worked to help father and son strengthen the emotional bond between them, repeatedly encouraging them to spend one-to-one time together.

On his extended visits, and then as he moved home, the son was able to avoid angry outbursts. He worked hard to adjust his behavior to meet his father's expectations, and his father was pleased with the progress the boy was making. But even through the son was preforming to expectation, the father continued to show lack of trust and emotional distance toward his son. For instance, he refused to give his son a key to their home, and spent very little one-to-one time with him. I tried to address this issue in therapy. We identified the cognitions which kept the father from trusting his son, and explored how he might bypass

these. I had him role play the part of his son in an attempt to increase his empathetic understanding of his son's emotional experience.

These interventions were only nominally successful. The father continued to demonstrate a lack of trust in his son, and as we moved to termination the son expressed increasing frustration with his father's controlling and distant stance. He began to act out some (e.g., staying out at night), but generally continued to demonstrate greatly improved behavior.

My work with this family ended just as they were moving out of the "honeymoon phase" of the reunification. I regret that we had to terminate at this point, as I sensed the father and son were moving into a more difficult time in their relationship. I offered to transfer them to another therapist, but the father felt he wanted to try to work things out on his own for a while. The son continued to see his individual therapist, and she agreed to serve as a consultant to the father as needed.

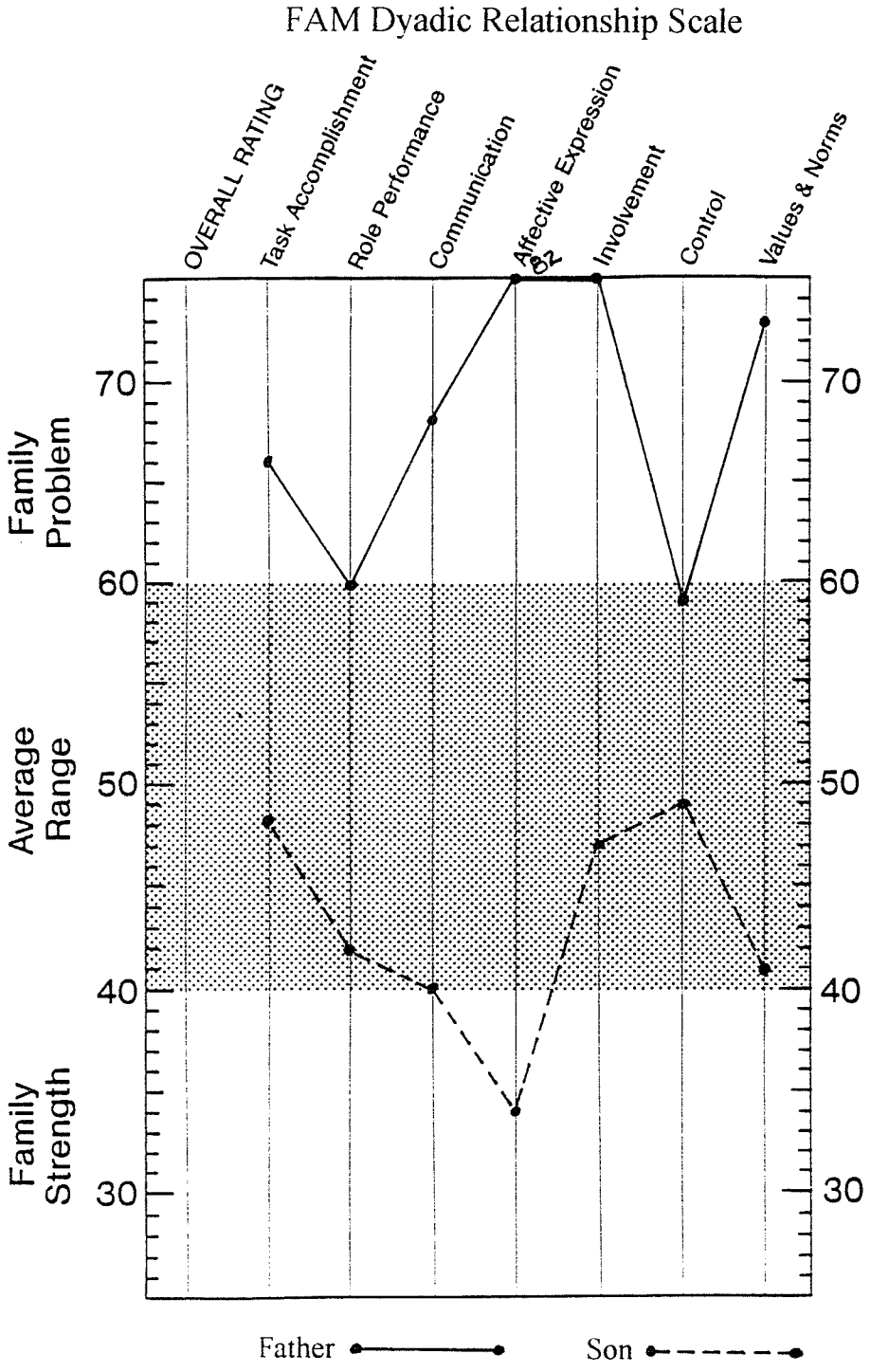
FAM Profiles

The father and son completed the FAM Dyadic Relationships Scale. The pre-therapy profiles (Figure 9) showed that the father saw a lot of difficulties in his relationship with his son. All his subscale scores were in the problem range. The high scores on the Affective Expression and Involvement subscales corroborate the father's articulated concerns about his son's lack of verbal expression of emotion and about the lack of emotional connection between them.

The son scored very low on all subscales, in the low average or strength range of the scale. His individual therapist reported that the son showed a strong

Figure 9

E. Family
Pre-Therapy FAM Profile



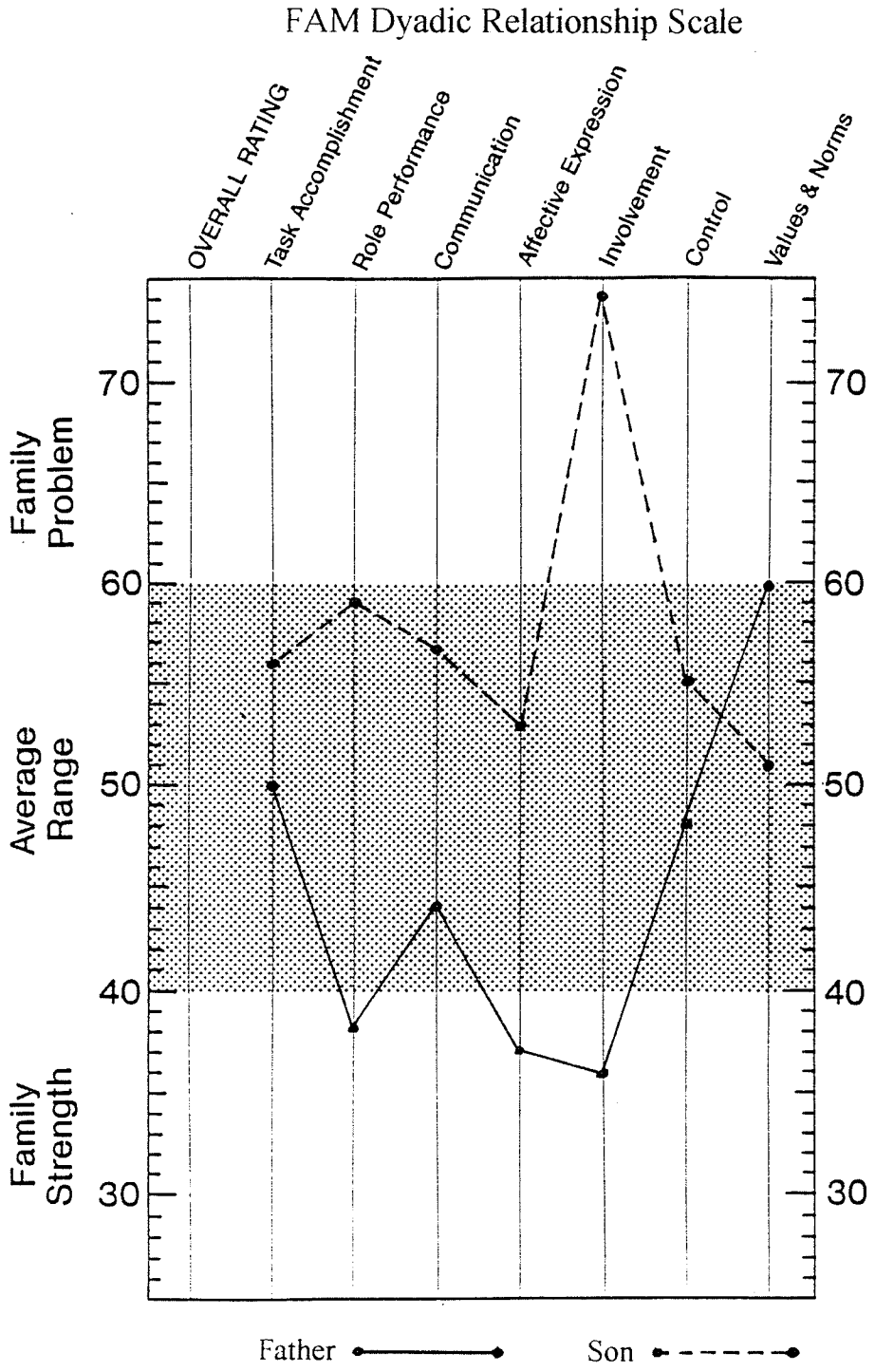
tendency to see his parents and other significant people in his life as all good or all bad. His FAM profile showed that he was idealizing his relationship with his father at the outset of therapy.

I was surprised by the post-therapy FAM profiles for this family (Figure 10). The father's and son's profiles were reversed from the pre-therapy scores. The son's scores went up, with most subscales scoring in the high average range. The son's score on the Involvement subscale was very high in the problem range, indicating his concern over his father's lack of trust in him. I believe the son's post-therapy scores were a more accurate evaluation of the relationship than his pre-therapy scores were. The son showed some progress in his ability to make a more balanced assessment of his relationships.

The father's post-therapy profile had all scores in the low average or strength range, with the exception of the Values and Norms score. Now his lowest scores were on the Affective Expression and Involvement subscales - where he had the highest scores at the outset of therapy. I expected the father would score lower than at pre-therapy, as I saw his level of anxiety about his ability to deal with his son's behavior decreasing. But these very low scores do not fit my clinical impression of his view of the relationship. I did not have a chance to discuss these results with him, as the test was administered in the final session.

Figure 10

E. Family
Post-Therapy FAM Profile



The B. Family

Case Summary

The B. family is a Caucasian, two-parent family with two sons, aged 17 and 15. The husband, Frank, and his wife, Shirley, had been separated for nine months when I began meeting with them. The sons were living with the mother.

Frank and Shirley have been married for over 20 years. They separated four times before, most recently six years ago. They agreed that each previous separation had been at Frank's initiative. The present separation had been initiated by Shirley. She was upset because Frank had been spending a lot of time with a woman friend. Shirley accused him of caring more for this woman and her children than he did for his own wife and children. Frank admitted he had been in an "emotional affair" with the woman, but denied sexual involvement. He had cut back his involvement with her. Frank was repentant and wanted to move back home. Shirley was resistant and insisted they try marital therapy before she would take him back.

Frank had been severely physically abused by his father in childhood. His mother had been emotionally unavailable and unable to protect him. She too was beaten by the father. Frank had been running away from home at an early age, and it appeared he had continued this pattern into adulthood. He had been in individual and group therapy over the past two years dealing with issues related to the childhood abuse.

In therapy it became clear that Shirley was closely aligned with her sons against her husband. Frank had been emotionally peripheral to the family unit for many years.

I met with the couple for a total of seven sessions. I began by exploring the history of the couple and their families of origin. Then I returned to a strategic focus on the couple's present patterns of interaction. We spent one session identifying specific things Frank could do to begin to rebuild Shirley's trust in him. To help the couple begin to act on the items they identified, I gave them a directive to take each other out on a "date" in the coming week. In the next session they reported this had gone well, so I repeated the assignment. Next I explored the couple's pattern of dealing with conflict, seeking to identify the interactional sequence by which they withdrew from each other. I saw that Shirley withdrew from Frank when she was angry or frustrated with him, giving him the "silent treatment". He pursued her for awhile, then gave up and withdrew into activities outside the family - sports or relationships with other women. By identifying the larger sequence, I began to reframe the couple's separations. The couple saw Frank as the culprit. I was identifying a pattern in which both withdrew, and therefore both had responsibility to change their part of the interaction.

Over the course of therapy, the couple on several occasions cut off communication with each other over minor misunderstandings. The connection between them was very tentative, and each was hypersensitive to any sign of withdrawal in the other. Therapy terminated after one such incident. Frank interpreted an action by Shirley as an indication she was not committed to therapy. He made a cutting remark, she got angry, and they stopped talking. Shirley decided not to return to therapy after the incident.

FAM Profiles

Because of the abrupt termination of therapy, I only obtained a pre-therapy FAM profile from this couple (Figure 11). After completing the measure, both Frank and Shirley commented that they had a hard time knowing how to answer the questions. They indicated their answers were different if Frank was considered as part of the family or not. Given this confusion, the test scores may not accurately reflect the couple's perception of their relationship.

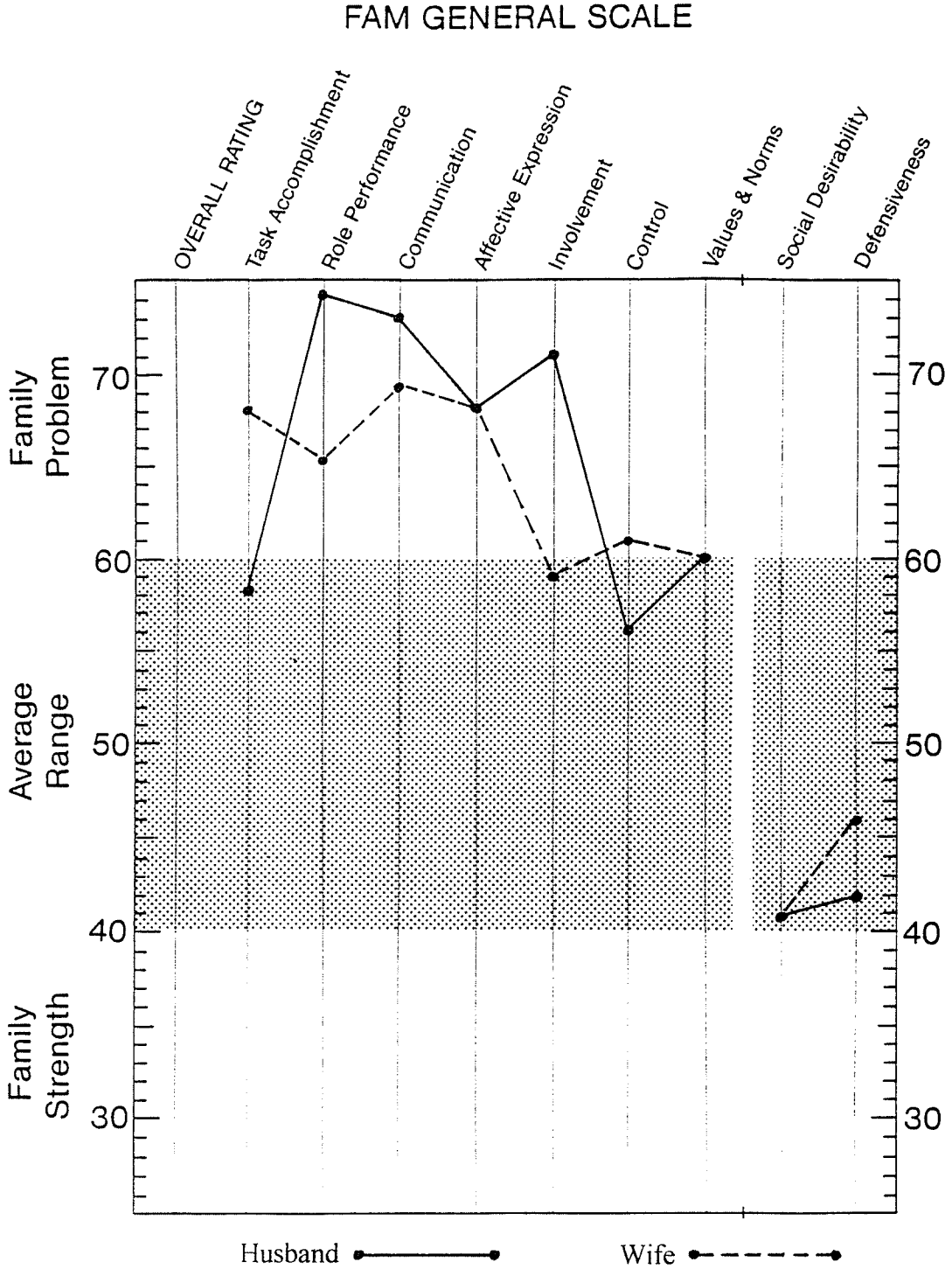
Frank scored highest on the Role Performance, Communication and Involvement subscales. The high Role Performance score may reflect his perception that he has not adequately fulfilled his responsibilities in the family.

Most of Shirley's scores were lower than Frank's, although they too were all in the problem range of the scale. I am surprised that her score on the Involvement subscale is not higher, given what I observed about her guardedness toward her husband. It may be that she was answering the questions thinking more of her relationships with her sons, with Frank absent from the home.

The couple's confusion in answering the questions highlights the importance of ensuring the standardized measure is fully understood before the respondents complete it. In retrospect, it may have been better to use the Dyadic Relationships Scale with this couple. This scale might have given me a more accurate picture of how they saw their relationship.

Figure 11

B. Family
Pre-Therapy FAM Profile



Dan & Linda

Case Summary

Dan and Linda are a Caucasian couple, both in their mid-30's. They live in a rural community near Winnipeg. They came to therapy wanting help to decide if they should get married or separate. They first met two years ago. They began dating, and Linda became pregnant one month later. They had lived together off and on since that time. Linda had moved out on Dan one week before I first met with them.

The couple identified a series of difficulties in their relationship. First, they had difficulties in their sexual relationship. Dan had a problem with premature ejaculation. Both were very frustrated by this, and they had stopped having sex. Second, Linda saw Dan as being over-involved with his mother and siblings. They all lived on the same farmyard, and operated a business together. Linda had lived with Dan in the family "compound" for several months, but complained that she felt like an outsider. This had prompted their most recent separation. Third, Linda was very concerned about Dan's periodic drinking bouts. Her father and previous partners had been alcoholics, and she vowed never to live with an alcoholic again.

I met with the couple for six sessions. They identified building physical and emotional intimacy as their first priority. I gave them the strategic-style task of spending an evening together, watching TV and being affectionate - but no sex. They came to the next session, after Christmas break, reporting that Linda had overcome her hesitancy about the relationship. Now she wanted to get married.

Dan was not quite trusting of her change of heart, and wanted to hold off announcing their wedding plans.

I probed about the relationship issues they had identified earlier. It quickly became apparent these had not been resolved. In the next session Linda again expressed her strong feeling that Dan's family was more important to him than she was. I told Dan his job was to convince Linda that she really was most important to him.

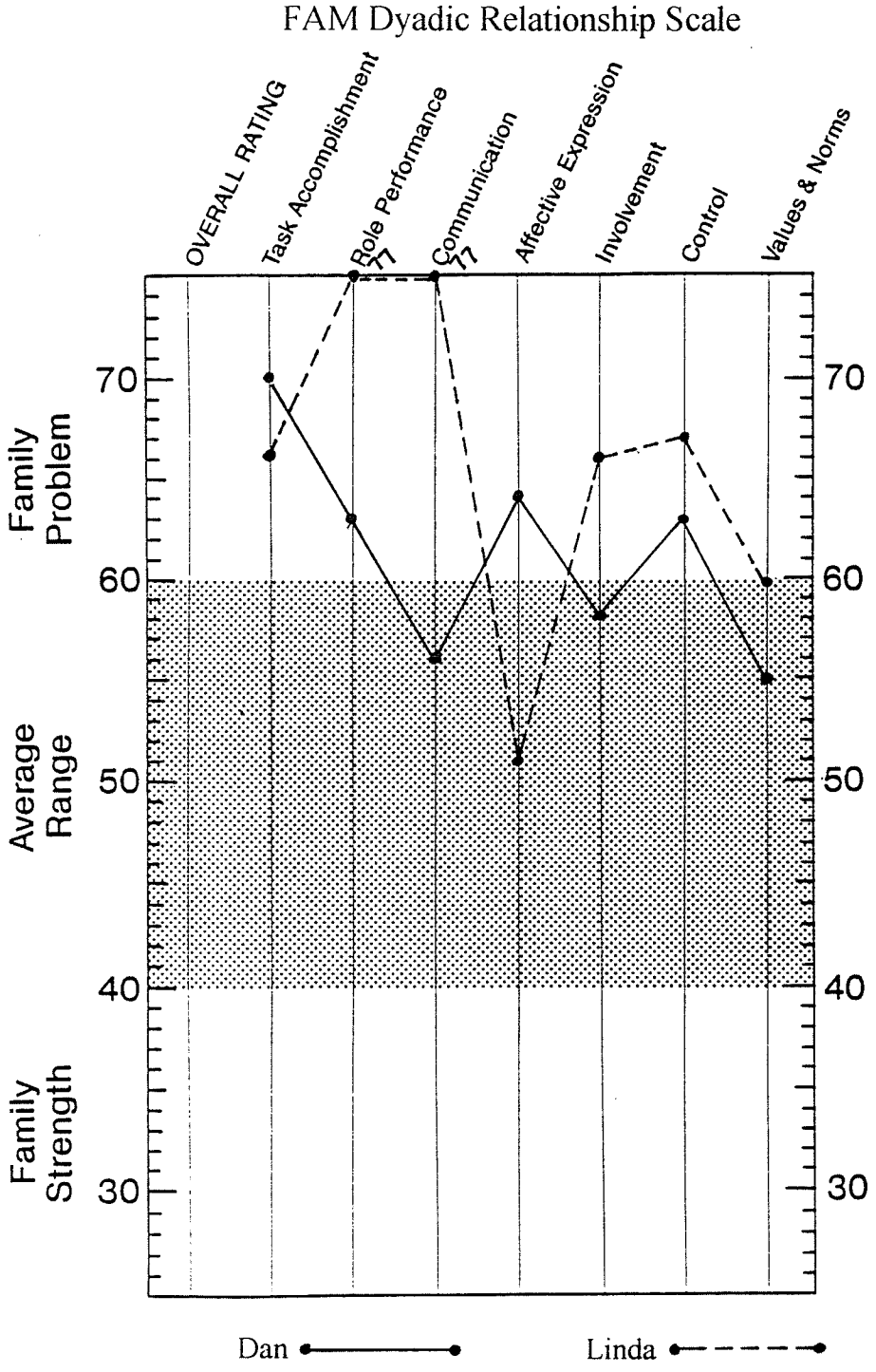
The following session came after an incident where Dan came to Linda's home very drunk. Linda was distraught about his behavior; Dan minimized the problem. After this session Linda called to terminate therapy. She had decided to end the relationship, and she was bracing herself for a legal battle with Dan over custody of their son.

FAM Profiles

I had Dan and Linda complete the Dyadic Relationships Scale. In the pre-therapy FAM profile (Figure 12), Linda's scores were higher than Dan's on five of the subscales, and all but one of her scores were in the problem range of the scale. Her presentation in sessions corresponded with the degree of concern about the relationship revealed in the FAM measure. I am puzzled by Linda's lower score on the Affective Expression subscale. My impression was that Linda loudly and repeatedly expressed her dissatisfaction to Dan. He did not listen well, and rarely articulated his own frustrations. Linda's score may reflect her perception that she expressed her own emotions freely.

Figure 12

DAN & LINDA
Pre-Therapy FAM Profile



Dan's scores on over half of the subscales were quite divergent from Linda's, indicating that he saw the relationship and its problems quite differently than she did. This was apparent in the therapy sessions, where each tried to convince the other of their view of the problem (i.e., "It's your fault!").

Due to the abrupt termination of therapy, I did not obtain a post-therapy FAM profile for this couple.

SECTION FOUR

LEARNING THEMES

In the time I was working with the families described in the previous section, it seemed to me that each case was entirely unique. Each family's problems were unlike any of the others. The hypotheses and intervention strategies generated in collaboration with my supervisors were different for each case. I was not limiting myself to one theoretical approach, or to one type of intervention. Some days I described my approach as "eclectic"; most of the time it just seemed disjointed.

After completing my clinical work, I went back over my process notes and supervision notes for each case. I began to look for common treads running through the jumble of hypotheses and strategies. Were there similarities in the issues that families brought to therapy? Were there concepts that seemed to explain dynamics in the different cases? Were there interventions that seemed to work in a number of different situations? Were there commonalities in the questions and struggles that emerged for me from each case?

As I reflected on the different cases, a number of common themes did begin to come into focus. I will highlight three of these here. These three themes by no means exhaust the commonalities that appeared as I reflected on my clinical work. I have selected these three because they relate most directly to the application of theory to clinical practice.

Trust

In their presentation of the various dimensions of family functioning, Karpel and Straus (1983) describe the "ethical dimension" of relationships. They base their presentation on the work of Boszormenyi-Nagy (1973). Central to the ethical dimension of relationships is the notion of *trust* and *trustworthiness*. Trust in another person is primarily a response to the trustworthiness of the other. "Trust is the readiness to depend on someone who we have reason to know is dependable" (Karpel & Straus, 1983, p. 44). Trustworthiness involves one's words and intentions, but primarily it involves one's actions. "The degree to which a person can be trusted is measured by the extent of his or her efforts to consider the other's side and to be as fair and as responsible as possible in an effort to balance what both (or all) parties deserve" (p. 45). In a primary relationship, when one person's actions are not trustworthy - when they do not act dependably or show adequate effort to be fair and responsible - the other's trust in them is diminished or broken. The person whose trust is broken may feel hurt, betrayed, and embittered.

This concept of trust and trustworthiness is not picked up in strategic therapy or in Bowen's writings. I introduce it here because it was such a strong theme in several of my cases, most notably Shelly and Sam, the B. family, and the E. family. In my work with these families I was struck by the difficulty of rebuilding trust that has been broken. I also observed some patterns in the process of rebuilding trust.

Shelly and Sam

In the first years of their relationship, Sam had been very hurtful and abusive toward Shelly. He walked out on her repeatedly, had sexual affairs to hurt her, and was physically violent toward her. He had stopped beating her and having affairs when their daughter was born, but he continued to be verbally abusive on occasion. And he still frequently threatened to end the relationship. Shelly was very hurt by Sam's actions. Clearly he had not been a trustworthy partner to her.

In therapy with the couple, I addressed the issue of trust at several levels. At the process level, I worked to help the couple develop a better capacity to address unresolved issues. I encouraged Shelly to give voice to her frustration and anger toward Sam, and provided a controlled context in which his defensive and threatening reactions could be more contained. I worked with Sam to help him understand and control his aggressive actions toward Shelly.

At the content level, we addressed the breakdown of trust related to Sam's violence and sexual affairs. Sam had stopped hitting Shelly, and he had stopped having affairs. He had been consistent in this for almost a year when therapy began. His actions showed that he was being more trustworthy. This was an absolutely crucial first step to rebuilding Shelly's trust - but it was not enough.

Shelly was very angry with Sam for his violence toward her, and she was very angry that he did not allow her to express her anger about this. When she did begin to express it, he became angry and threatening until she stopped. A critical turning point in therapy came when Shelly gave voice to her anger in session. I asked her what she needed from Sam. She needed him to hear and validate her

feelings. He resisted, he got angry, he made excuses, and he walked out of the session. But later that night he came back and told Shelly he was deeply sorry for what he had done to her. He made no excuses, and offered no rationalizations for his actions. When he was able to do this, Shelly was able to let go of some of her anger and resentment toward him.

Shelly was very distrustful of Sam in relation to other women. He complained about her lack of trust in him, and insisted he had no intention of having another affair. My first response was to try to make a distinction between two sources of Shelly's distrust: (1) Sam's past infidelity, which had stopped, and (2) Shelly's previous boyfriends and her father, who had all been unfaithful. This distinction was not helpful, and not appropriate at the time. My supervisor pointed out that it was only appropriate to search for the roots of distrust in an individual's past once it has been firmly established that there is no basis for distrust in the present relationship. In this case, Sam's trustworthiness in relation to other women had not been firmly established.

Several sessions later the couple came in and announced a breakthrough on this issue. It turned out that Shelly's distrust had been focused on Sam's contact with three young women. Shelly suspected that the women had sexual intentions toward Sam, but Sam insisted they were only friends. The breakthrough came when Shelly learned from a third party that the women really were "after" Sam. Sam was able to acknowledge the validity of Shelly's concern, and admitted he had been naive in his dealings with the women. In session, Sam committed to being more guarded with these women. In response, Shelly's trust in Sam's commitment to fidelity increased.

In reflecting on the process of rebuilding trust between Shelly and Sam, I see there were two parts to the process. First, Sam changed his actions; he stopped hitting Shelly and having affairs. He maintained this new behavior over an extended period of time. Second, Shelly was able to give voice to her hurt, anger, and concern, and Sam was able to acknowledge the validity of her feelings, take responsibility for his actions, and apologize. When Sam did this, Shelly was able to consider forgiveness and reinvestment in the relationship. The order of this sequence is crucial. First the offender changes his behavior, then there is a process of apology, forgiveness, and reconciliation. In this way, Shelly's trust in Sam began to grow stronger. Of course her trust was not completely restored in the process. This would only come after many years of trustworthy behavior by Sam.

The B. family

A key issue in the B. family was Shirley's lack of trust in her husband Frank. He had left her and their sons a number of times over the course of their marriage. When he had been present, he had often been very involved in sports or other activities outside the family. Shirley did not trust that Frank was really committed to her and the kids.

Frank readily acknowledged to Shirley that he had been wrong to leave her. He said he had made a mistake in getting involved with another woman. He was sorry, and said he had changed his ways. Now he wanted to come home and show Shirley and the boys that he could be a good husband and father. Shirley

was not ready to have Frank move back home. His apology did not really address her mistrust. Two things were lacking.

First, Frank had not shown by his actions that he was trustworthy. The words of apology meant little if they were not supported by an extended period of trustworthy behavior. Frank said he knew he had to prove himself, and insisted he needed to be living at home in order to show his trustworthiness. Shirley said he had to show some trustworthiness before she would let him come home.

Second, Shirley did not feel that Frank really understood how much she had been hurt by his behavior. When she started to talk about this in session, he cut her off by saying that he could not change the past. He said he knew he had done wrong, but he was tired of hearing about it. By refusing to listen to Shirley express her pain, Frank was indicating he was not really willing to face how his behavior had hurt her. His apologies rang hollow because he did not fully acknowledge or take responsibility for the hurt he had caused.

My first intervention with this couple was to contract with them for ten therapy sessions. During this time, Frank would not move back home and the question of his return would be put on hold. In this way I was creating a period of time in which Frank could build some track record of trustworthiness before the question of his returning home was addressed.

My next intervention was to have Shirley itemize for Frank the actions he could do that would build her trust in him (e.g., spend time with the boys, spend time with her). I also had the couple list actions that Frank could do that would further destroy Shirley's trust in him. This exercise made it clear that rebuilding trust involved trustworthy actions.

Then I gave Frank and Shirley a directive to go on two "dates" each week. Each was responsible to initiate one of these dates. My intent was to create interactions that would give Frank an opportunity to show by his actions that he was committed to the relationship.

The couple terminated therapy after seven sessions, and with this they broke off their attempts to reconcile. I did not have a chance to process this decision with them, so I am not sure I fully understand why they terminated. It was clear that Shirley's lack of trust in Frank was based on years of experiencing his untrustworthiness. He was apologizing for his actions, but he was not fully facing and acknowledging the pain he had caused Shirley, and he had not really begun to demonstrate that he was trustworthy. Unlike Sam, he had not shown that he was capable of changing his behavior. His words of apology meant little because they were not yet supported by actions. In therapy I could help define for Frank what trustworthy behavior looked like, and create opportunities for him to demonstrate it. But Shirley needed some concrete evidence of trustworthy behavior over a period of time before she could let herself hope for a different type of relationship with Frank. When he continued to break off communication with her over small conflicts, I suspect she concluded that he had not really changed, so she terminated therapy.

The E. family

With the E. family, the issue of trust quickly became the main theme of therapy. The son was worried that the father would return him to foster care if he misbehaved or lost control of his temper. The father was worried that the son

would become angry and uncontrollable, so that he would not be able to parent him. The father also interpreted the son's misbehavior as a sign that the son was rejecting him. The father feared that his son really did not want to live with him. Both very much wanted the relationship to work, but each did not trust the other's commitment to the relationship.

When I started meeting with the father and son, they had just begun having weekly visits. Over the following months the visits became longer and more frequent, and then the son moved back home. Over this time the son's behavior problems decreased markedly. He had a few angry outbursts at school, but none with his dad. And he was able to change other behaviors that his father was concerned about (e.g., teasing his brothers). Clearly the son was trying very hard to please his father. The father acknowledged these efforts and expressed his appreciation.

After two months of the son living at home, his behavior continued to be much improved, although he did have occasional "lapses" (e.g., not coming home when he was supposed to). But the father was not showing a growing trust in his son. He continued to be vigilant in watching for the son to revert to his old ways. The lack of trust was symbolized for father and son by the father's refusal to give the son a key to the home or to allow him to be in the home alone.

At this point I felt the lack of trust was more of an individual issue for the father than a relational issue between father and son. The son was being relatively trustworthy in his behavior, yet the father was not trusting. In session, the father admitted he felt a block to deepening his trust in his son. He saw the boy's changed behavior, yet he kept expecting him to revert back to his old ways.

At this point in therapy I shifted my focus to addressing the father's lack of trust as a personal issue. My interventions are briefly outlined in the previous section of this report.

In reflecting on this case, I ask myself if it was appropriate to begin to treat the father's lack of trust as an individual issue. Trust is built in response to trustworthiness. The son's behavior had improved. but the change was relatively new and there were some behavior lapses. If this were a relationship between peers, the father's continuing lack of trust might be accepted as understandable and appropriate. But this is not a peer relationship; it is a parental relationship. In a parental relationship, the parent has the greater responsibility for the emotional climate of the relationship. It is the father's responsibility to nurture his son. In this case, I believe the father had a responsibility to take the risk of increasing his trust in his son. The son needed to know that his father was committed to him. The father's lack of trust communicated the opposite - that the son's status in the family was tentative. In this circumstance, I think it was appropriate to deal with the father's mistrust as an individual issue, and to work to directly address his internal blocks to trust.

Conclusion

I found Karpel and Straus's concept of trust and trustworthiness to be very helpful in my work with these families. They demystify trust; trust is based on trustworthy actions. Based on my experience with these three families, I suggest the following as further guidelines for the therapeutic task of rebuilding trust:

1. Where trust has been broken, trustworthy actions by the offender are the basis of renewed trust. But actions alone may not be enough. At the appropriate time, the offender also has to acknowledge that his or her actions have hurt the other, and take responsibility for those actions.

2. When the apology and acceptance of responsibility are not supported by changed, trustworthy behavior, the words are of little value in rebuilding the other's trust.

3. In some cases, trustworthy behavior by one person may not be met by corresponding trust in the other. The non-trusting person may have difficulties with trust based on their experience in previous relationships. The decision to shift to an individual focus in these cases should be taken carefully, and the shift should only be made once the offender's trustworthiness has clearly been established. A consideration of the balance of responsibility in the relationship (i.e., peer or parent-child) should be included when making this decision. When the shift is made to an individual focus, the issues may still be relational, but the focus of therapy shifts from the present relationship to the individual's family of origin relationships.

Triangles and family hierarchy

Bowen describes the *triangle* as the basic building block of families and other emotional systems. Two people in a conflict draw a third person into their relationship to absorb the conflict and anxiety between them. Bowen's concept of the *family projection process* describes show triangulation happens in the nuclear family. Conflict between the husband and wife is dealt with by one partner

getting over-involved in activities outside the home, while the other partner gets over-involved with one or more of the children.

Haley often sees family problems as the result of flaws in the family hierarchy. When the parents are not unified in their parenting, and one parent allies with a child against the other parent, the appropriate generational hierarchy of the family is distorted. The strategic therapist moves to correct the hierarchy by bringing the parents closer together and strengthening their control over the children.

In their own way, Bowen and Haley are describing the same dynamic. There is a conflict between the parents, and they are not united in their parenting. One parent is more closely aligned with the children and very involved with them, or each parent may be aligned with one or more children. The children are drawn into the parental conflict, and the conflict is not resolved. Bowen's conceptualization focuses more on the fluid emotional dynamics of the triangle; Haley emphasizes the organizational needs and power dynamics in the family. Bowen and Haley each have their own approach to intervening in this common family dynamic. Haley works to shift the interactional sequences in the triangle and to place the parents firmly in charge. Bowen works to diminish the emotional reactivity and increase the level of differentiation in the parents.

The family dynamic described by these concepts was at work in each of the two-parent families with adolescent children I worked with in this practicum. The presenting problems of the families were different, but underneath each one was this pattern.

In the C. family, the father was very involved in activities outside the home, and also closely aligned with his 17-year-old daughter. The mother was very emotionally involved with the 19-year-old daughter and the 14-year-old son (the identified patient). The father was in open conflict with both of these children. Mother and father were distant from each other, and there were hints of conflict between them, but this conflict was not openly expressed.

In the M./F. family, each parent was protective of his or her own children and hostile toward the other's children. A typical interactional sequence had either Robert or Lillian angrily reacting to the behavior of the other's child. Then the biological parent moved in to protect their child, and the conflict shifted to the husband-wife dyad. This sequence repeated itself over and over, each time intensifying the conflict between the parents.

In the B. family, the conflict between Frank and Shirley was dealt with by mutual withdrawal, interspersed with flashes of open conflict. Frank withdrew into sports or relationships with other women. Shirley withdrew into silence and into her relationship with her sons. She even referred to them as "my boys", never as "our boys". As my supervisor pointed out, she seemed more married to her sons than to her husband.

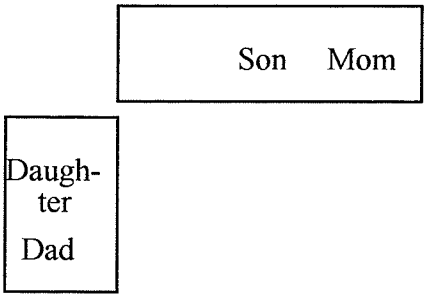
In the N. family, the parents described how they had parented when their sons were younger. The father was a strict disciplinarian. When the boys misbehaved, he would lay down strict consequences. The boys would go to their mother, and she would coach them on how to approach their father. Using their mother's advice, the boys would get their father to soften his position. The parents had insight into this pattern and its harmful effects. They felt they had

found ways of being more united in parenting their 11-year-old son. I observed that when the 15-year-old son returned to live at home, the conflict in parenting began to show itself again.

I used different approaches in working with these families. With the C. family, my intervention was based on a strategic approach. With the N. family and the M./F. family, my interventions were based on a Bowenian understanding. (The B. family terminated therapy before I could address the triangulation dynamics). I will describe my intervention with the C. family here, and my intervention with the N. family and the M./F. family in the next sub-section.

The C. family

With the C. family, my co-therapist and I worked to shift the relationships in the triangle involving father, mother, and son. The emotional dynamics of this triangle were depicted in the family seating arrangement in our early sessions. The family members positioned themselves like this:



The mother and father sat at opposite ends of the sofa, reflecting the distance between them. The son sat close to the mother, and the 17-year-old daughter sat close to the father, indicating their respective parental allegiances.

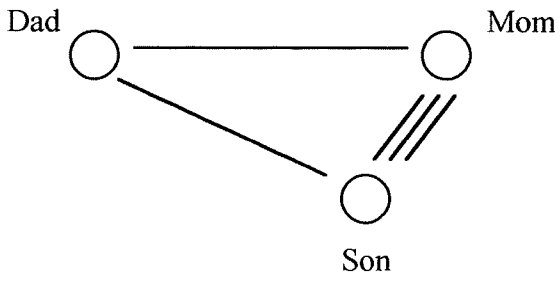
The mother and son complained that the father frequently yelled at the son, especially when helping him with homework. And the son stated that he wanted to spend more time with his dad. The father said he recognized his yelling was a problem, and he was "working on it". We decided to focus our efforts on bringing the father and son closer together in a positive manner.

After several sessions, mother and son confirmed Dad's report that he had stopped yelling at his son. We affirmed his success. We told the father that his son really wanted to see more of him. We coached him on ways he could interact with his son to build the son's self-esteem. We explored activities the father and son would like to do together, and gave them a directive to exercise together (Dad's idea) and build a model together (son's idea) in the following week. They did not follow through on our directive, but over the next few weeks they engaged in a number of activities together. They cleaned the garage, played games, and went out for lunch together. The father also proudly reported that he had helped his son with a math problem and maintained an affirming tone throughout.

While the father and son were doing more things together, the mother got very busy with tasks related to the son's school placement for next year. At the outset of therapy she had been quite immobilized in dealing with the situation. Now she was shifting to an action mode and taking a leadership role in this area. She was still focused on her son, but her involvement became more instrumental as the father took a somewhat more nurturant role.

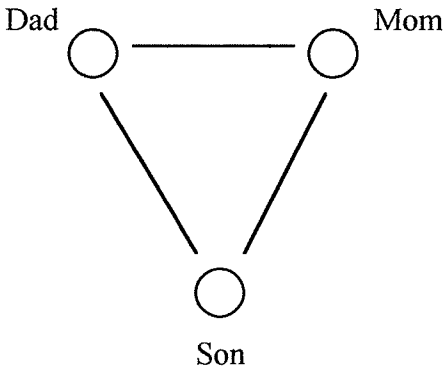
Toward the end of our contracted eight sessions, we took an initiative to bring mother and father closer together. We theorized that the parents would have to move closer to each other if they were to maintain a more balanced relationship with their son. We gave a directive for mother and father to meet to discuss how to implement new strategies for helping their son learn. They did not follow through on this directive, and we were concerned that they continued to have little communication between them.

To this point in therapy we were primarily working from a strategic model, using directives to shift interactional patterns and alter the family structure. In our final session we changed our approach. We wanted to undergird the shifts in the relationship triangle by helping family members gain insight into their family dynamics. We gave feedback on our observations of their family dynamics and did some teaching on issues related to the adolescent stage of the family life cycle. We diagrammed their relationship at the beginning of therapy like this:



Mother and son were very close, and father was quite distant from both of them.

Then we diagrammed the relationship structure they had been moving toward over the course of therapy, and which they should continue to move toward:



We observed that father and son had moved closer together, so that the son was more equally positioned between father and mother. We pointed out that this had happened in a literal way in the therapy room; the son was now seated closer to his father and further from his mother than before.

We went on to explain that the task of a family with an adolescent is to let the adolescent move away from the parents and become more independent. The son's job was to take more and more responsibility for himself. The parents' job was to let him do this. The father commented that this meant the mother would have to "loosen the apron strings". She acknowledged, a little teary-eyed, that letting go of her "baby" was going to be difficult.

We concluded our explanation of the diagram by saying that when the children grow up, the parents are left with just each other. Sometimes this means they have to work on their relationship again. They did not comment on this. We felt it important to introduce the issue of the couple relationship, even though we would not be able to address it in our work with the family.

Over the course of therapy we saw a shift in the C. family structure. Father and son came closer together, and mother and father began moving in the same direction in their parenting efforts. At termination, they were still not working closely together as parents, and underlying conflicts between them had not been addressed. In further therapy with this family it would be important to further strengthen the parental dyad, which would require addressing issues in the spousal relationship.

From reactivity to responsibility

According to Bowenian theory, when families have a low level of differentiation, or are in a high state of anxiety, family members are very reactive to the togetherness forces at work in the family. They are very sensitive and reactive to the emotional states of others. They put a great deal of energy into taking care of each other, trying to change each other, or protecting themselves from each other. They have little capacity to think objectively about their own role in the family interaction.

Bowenian therapists work to lower the level of anxiety in the family, and then to increase the key family members' capacity for objectivity. The therapist's goal is to increase the individual's understanding of the family relational dynamics and their place in them, and to increase their capacity to take responsibility for their own actions and feelings, without becoming overly reactive to the emotionality of others.

I utilized interventions based on this Bowenian understanding with two families whose triangulation process I described in the previous sub-section; the N. family and the M./F. family.

The N. family

In the N. family, the two oldest sons were entirely out of control. The parents were very reactive to the boys' acting out. They were angry and frustrated, yet at any sign of positive change by the boys they rallied to help the boys get back on track. They dropped criminal charges (the boys had burglarized their own home), let the boys move home, and fought to get them back into school. Then the parents were shattered when the boys hit the streets again a few weeks later.

This pattern repeated itself several times. A few months into therapy, the parents came to a session feeling very discouraged and angry. The boys were on the run again. The parents complained they had lost control of their lives. They had spent a whole year "like a yo-yo on a string", their emotions up and down in reaction to their sons' behavior. I responded by asking them to define for me what they saw as their responsibility as parents, and what they saw as their sons' responsibility. Was it their responsibility to pick up the pieces for their sons' misdeeds, or was it their sons? Was it their responsibility to get the boys to change, or was it their sons' responsibility? They began to realize how they had been putting a great deal of energy into helping their sons straighten out their lives, while the boys had been taking very little responsibility. They wanted to stop doing this.

Then I asked the parents to identify strategies that had helped them maintain some emotional equilibrium, even when the boys were acting out. Each was able to identify one or two ways they had done this. I encouraged them to use these strategies in the coming week.

The next session the parents announced they were feeling much more peaceful about the situation with their sons. They felt more in control of their own emotions. The mother, who was familiar with 12 Step programs, said she now realized that she was addicted to reacting to her sons' behavior, much as she had once been addicted to alcohol. Following the First Step, she acknowledged she was powerless to control her sons. When she acknowledged this, she was able to be less focused on them.

In the following sessions I worked with the parents to help them maintain their focus on their own relationship and on their relationship with their 11-year-old son, while not reacting to their older sons' behaviors. In the final three sessions, when the 15-year-old son joined the therapy process, I kept this focus on the parents not taking responsibility for their son's behavior. I underscored to the boy that his choices were very clear; he could live with his parents, or he could return to the Youth Centre. (He was on very strict probation). It was his responsibility to choose. I asked the parents how they might be tempted to again take responsibility for their son's behavior. How might they be tempted to control him or protect him? How might they resist these temptations? With these questions I was trying to build their understanding of the ways they might be pulled back into a reactive stance, so that they could better resist this pull.

Kerr (Kerr & Bowen, 1988) very succinctly describes the dynamics at work in a family like the N. family, and my intervention was largely based on his description. Kerr says that adolescents with a weak "self", who are very stuck to their parents, often rebel by attaching to a peer group with the most anti-parent values. This can set in motion an escalating cycle, where the adolescents rebel and their parents intensify their involvement to keep the adolescents from ruining their lives. The adolescents react to their parents' attempts to control them and become more rebellious. The more the adolescents can blame their parents for their problems, the less responsibility they have to take for their own behavior. The cycle is broken when the parents stop telling the adolescent "you should..." - which only provokes the child to do the opposite - and instead focus on what they themselves will or will not do. As the parents stop reacting and focus on taking responsibility for their own behavior, the adolescent is freed to begin taking responsibility for his or her own actions.

This intervention strategy seemed to have a positive impact on the N. family. At termination, the parents showed an increased capacity to stay focused on their own actions, rather than simply reacting to their sons. The 15-year-old son seemed to have a stronger sense of his responsibility for his own behavior. He had only been living back home for one month, so the parents' new stance had not yet faced a severe test.

The M./F. family

In therapy sessions with Robert and Lillian, there was a high level of reactivity between them. They repeatedly made blaming or defensive statements toward each other. They also gave other clues that they were very fused together

as a couple. For example, Robert complained that Lillian did not like him to go on outings to the museum or movies by himself. On another occasion, Lillian reported she had resolved a dispute over when to have supper by cooking and eating by herself. This was a new thing; until then she had always insisted on having supper together. The couple seemed to have little capacity for autonomous action. They operated almost as one emotional unit, with only a weak interpersonal boundary between them.

I tried a number of interventions with this couple, most of them aimed at helping the couple gain insight into their patterns of reactivity and take responsibility for changing their part of the interaction. Among the interventions I tried were the following:

1. I highlighted the reciprocal nature of the couple's interaction around parenting and household duties. She over-functioned while he under-functioned in this area. The more responsibility she took, the less he took, and the less he took, the more she took. I gave a directive for him to cook one meal in the following week. She was not to prompt him or criticize his effort. He did not follow through on this directive for several sessions, but I kept repeating the directive each week. When he finally did cook a meal, she criticized his effort.

2. I drew attention to the triangulation pattern (described above) where each protected his or her own children against the other parent's efforts to discipline them. I diagrammed the pattern of interaction on the board. Then I asked what changes each has made, or could make, in their behavior to interrupt this sequence. Each partner identified several changes he or she wanted to make in order to lessen the conflicts over parenting each other's children.

3. After the violent incident between Robert and Lillian, I drew up a contract stating that each was responsible for avoiding future incidents of violence and specifying the actions each would take to stop a conflict from escalating to the point of violence. They each agreed to abide by the contract. In a follow-up session, I asked them to identify things they could each do to not "pour fuel on the fire" when a conflict arose.

4. In one of our final sessions, I met with each partner individually for a portion of the session. I asked each what they liked about their relationship. What changes did they want to see in their relationship? What changes could they make to help these relationship changes come about? Lillian identified several specific changes she would like to make in her behavior. For example, she wanted to stop undermining Robert's parenting of her children. Robert identified changes he had already made, and went on to list a series of changes Lillian should make. I commented that I found it interesting that he thought she should do all the changing.

Over the course of therapy with this couple, I noticed some reduction in the level of reactivity between them in session. And they reported some changes in their family interaction. Robert was taking more responsibility for parenting and housework. They were able to work together in disciplining their children on a few occasions. The couple showed some capacity to gain insight and alter their behavior, yet I had a sense these changes were not solidly established. Under stress, I suspect they will quickly revert back to old patterns.

Looking back on this case, I wonder if my therapeutic strategy was appropriate. I was using an insight-based approach, but for most of our time

together the couple was in quite a state of anxiety. They had little ability to relax their defenses and reflect more objectively on their situation. I wonder if a more strategic approach, using specific directives to interrupt interaction sequences, would have been more effective. Or, alternately, I might have used more of our time for individual sessions for each partner. When I did meet with each one alone, they were less reactive and showed a greater capacity for reflection.

In my work with these families, I based my interventions on either a Bowenian approach or on a strategic approach, or sometimes utilized the two approaches alongside each other. In the next section I conclude this report with some personal reflections on the usefulness of these two approaches for my clinical practice with families.

CONCLUSION

As a conclusion to this report, I want to offer my personal reflections on the design of this practicum and on the learning it held for me. I will comment on the clinical evaluation measure I used (The FAM III) and give a brief critique of the strategic and Bowenian models of family therapy. Then I will offer my conclusions as to the feasibility of using these two approaches together in clinical practice, and close with comments on my learning in relation to the learning goals I laid out for myself as I began the practicum.

The FAM III measure

I found the FAM III to be a useful aid in my clinical practice, especially in the assessment process. The pre-therapy tests served to corroborate and broaden my clinical impressions of the areas of difficulty in the family. The results also gave an indication of the degree of distress family members carried about their family relationships, and highlighted who was most concerned about the family difficulties. By comparing the profiles of different family members I also got a sense of the level of agreement - or disagreement - between them as to the nature of the problem. In some cases this helped me better understand the relationships between the family members.

The post-therapy test results gave me an impression of the nature and degree of changes in the family over the course of therapy. I did however find it difficult to discern the meaning of shifts in the FAM profiles from pre- to post-therapy. Were lower scores at post-therapy an indication of real changes in the

level of family functioning, or were they an indication of a temporary reduction in the level of distress and anxiety in the family? The measure itself cannot provide an answer to this question. It only presents a picture of how the family member sees the family at the time. As a clinician interpreting the test results, I still had to rely on my clinical impressions of the family to interpret the meaning of changes in the test scores. The degree of clinician subjectivity in evaluating the impact of the therapy process might be decreased by administering the measure again at three or four months after termination. The use of a follow-up measure would give a better indication of the durability of changes in the family.

In the practicum I worked with a number of families where the presenting problem was conflict between the marital partners. The FAM III gave me a picture of how the couple saw the whole family's functioning, but I found myself wishing that my measurement tool would give me more information about the couple relationship. In retrospect, it may have been prudent to utilize a second standardized measure - one focused on assessing the couple relationship - with cases where couple conflict was the presenting problem.

Utilizing strategic and Bowenian approaches

I began this practicum with a general knowledge of the strategic and Bowenian models of family therapy. After studying the original writings of Haley and Madanes and of Bowen and his colleagues, and after using these two models in clinical practice, I feel I have a good basic working knowledge of the two approaches. I also have a clearer sense of what I find useful in each model - and of what I do not find useful.

The strategic model

Haley and Madanes' approach to therapy is action-oriented and directive. It is problem-focused, and works to shift the family's behavior surrounding the problem they present for therapy. A structural conception of the origins of family problems underlies much of the strategic approach, especially in Haley's writing. I found this structural understanding helpful. The emphasis on clear generational hierarchy and unified family leadership was especially relevant to my work with families with parent-teen conflicts. These structural concepts gave me a clear picture of the direction in which my interventions should be moving the family.

I also found the strategic emphasis on identifying and altering the interactional sequence in which the family's problem is imbedded to be most useful. This is a key insight - that problematic behaviors are developed and maintained as part of a sequence or circle of interactions, and that shifts in one part of that sequence will impact the whole pattern. I used this insight and strategy, in one form or another, with almost every family I worked with in this practicum, and it has become a basic component of my therapeutic approach. But I found I often used this strategy in a slightly different way than Haley and Madanes do. In the clinical examples they write about it appears they give directives to get the clients to change their behavior, often without the clients really understanding to what end or for what reason the directive is given. I was more open and upfront in exploring with my clients the key interactional sequences surrounding the problem, because I assumed that if they gained insight into their relational patterns this would help them change the patterns. On occasion I also involved clients in identifying new behaviors that would alter the

interactional sequence that surrounded the problem. We worked together to design behavioral tasks they could use to change their patterns.

In Haley and Madanes' writing, the therapist-client relationship sometimes takes on adversarial overtones. They tend to assume that the family system will resist change. The strategic therapist's job is to overcome this resistance and induce positive change. When this position is taken to its extreme, by definition the therapist is working against the family. From this perspective, the therapist has to overcome the family members' resistance by overpowering them (e.g., by taking an "expert"stance) in order to get them to follow directives. Or the therapist can "trick" the family into changing with the use of paradoxical directives or pretend techniques.

This adversarial stance which creeps into the strategic model does not fit well with my personal style or values. I much prefer to take a collaborative stance with families, working together to understand and overcome problems. I found myself reluctant to use some of the intervention strategies of strategic therapy. In particular, I did not use paradoxical directives with my clients. I recognize that sometimes a family system carries internal resistance and contradictions such that a paradoxical directive may be the only way to "break the log jam". However I was not able to attain a high enough level of comfort or degree of understanding of this technique to use it with clients in this practicum. Instead I tried to use gentler and more collaborative means to induce change in families.

I was also resistant to thinking about problems as serving a function in the family, as Haley and Madanes sometimes do. A functionalist view of problems

implies that the family needs a symptom-bearer. Seeing the family in this way can move the therapist into a suspicious posture toward the family, again pushing therapist and client into an adversarial relationship (Breunlin, Schwartz, & Kune-Karrar, 1992).

In summary, I found the strategic focus on clear generational hierarchy and on identifying key interactional sequences and assigning behavioral tasks to be useful in my clinical practice. But I was reluctant to assume an "expert" or adversarial stance with my clients, preferring a collaborative stance which is more respectful of the clients' desires and efforts for change.

The Bowenian model

Bowen, much more than Haley and Madanes, devoted himself to developing a theoretical understanding of family functioning. I found Bowen's theory to be the real strength of his model. His theory is broad and comprehensive, so it can account for variables at different levels of context. For example, the theory includes an understanding of the individual's intraphysic process (e.g., his or her capacity to differentiate feeling from thinking) and at the same time can account for the impact of larger societal events on the family. The theory can describe a family's present relational process (e.g., the family projection process) and at the same time see the family in the historical context of the multigenerational family system. Bowen gave me a way of thinking about the complex relationship between the family's problems, the emotional maturity of its members, and its historical and social context. His theory can account for a good deal of complexity in conceptualizing a family's functioning, yet the essence of

the theory is explained in a handful of relatively simple concepts. Of these key concepts, I found the concepts of *triangles* and the *nuclear family emotional process* to be especially useful for understanding a family's dynamics.

I also appreciate the therapeutic stance espoused by the Bowenian model. The Bowenian therapist is gentle and respectful, yet not so emotionally involved as to lose objectivity. The therapist works to help the clients gain insight into themselves and their families. I found this stance to be more compatible with my personal style than the more directive approach of the strategic therapist. I especially valued Bowen's emphasis on the use of questions to promote reflection and insight. I gained a great appreciation for the therapeutic power of good questions.

I did find aspects of the Bowenian model that I consider to be drawbacks. The primary drawback I see is that Bowenian therapy is a long-term therapy (a year or more) that requires a high level of commitment to personal change by the clients. The heart of Bowenian therapy is the middle phase, where clients work to differentiate themselves by going back and reworking relationships in their family of origin. In the course of this practicum I never moved into this phase of therapy with any of my clients. It seems few counselling agencies or family therapists have the luxury of offering such long-term therapy in today's climate of fiscal restraint - and few clients have the high level of motivation required to continue in therapy for this length of time. For this reason I do not see Bowenian therapy, in its pure form, as a practical model for family therapy in the '90's.

A second drawback I see to the Bowenian model is the absence of emphasis on therapeutic technique in the literature. As a beginning therapist, I

wanted to know how to use this model in the therapy session. How could I move to lower a client's anxiety? How could I help clients move from blaming the other toward examining their role in family interaction? What types of questions help clients begin to think about their families more objectively? Bowen and his colleagues write very little about technique. Bowen believed that technique without theory was not helpful, so he devoted himself to helping therapists understand families (Nichols & Schwartz, 1991). He was loath to write "how-to" manuals for beginning therapists. I found it difficult to know how to translate the theory into practice in my clinical work.

In summary, I value Bowen's comprehensive theory of family functioning and appreciate the tone of Bowenian therapists' relationships to their clients. But I found the intervention strategy to be too vaguely defined for my needs as a beginning therapist and too long-term to be widely useful in the course of this practicum.

Strategic and Bowenian: Complementarity and contradiction

When I began this practicum, I thought the strategic and Bowenian models might prove to be complementary. I hoped the strengths of each model might compensate for the weaknesses of the other. At first this seemed very possible. The strategic model provided theoretical tools for identifying the salient family interactions surrounding the presenting problem, and the Bowenian model provided a way to understand these interactions from a historical and developmental perspective. If taken together, these two vantage points should provide the therapist with a comprehensive understanding of the family.

Bowenian theory provided a structure for seeing the family in a wholistic way, in its various levels of context, and the strategic model provided practical tools to produce rapid shifts in family patterns. Maybe it was possible to create a hybrid of the two approaches, combining Bowen's sophisticated understanding of family functioning and strategic therapy's action-oriented and relatively brief intervention strategies.

Over the course of the practicum the complementarity I hoped for was only partly realized. In assessing families I was able to utilize theoretical tools from both models. For example, I did a genogram with each family, which gave me sense of the larger family dynamics and the development of the presenting problem. With each family I also tried to identify key interactional sequences, which helped me understand how the family's problem was maintained. Taken together, the two models yielded a great deal of information on the family's functioning.

I found it more difficult to utilize the two models together in the intervention stage of therapy. At times I was able to weave techniques from the two models together into a relatively coherent intervention. For example, with the C. family I began by using strategic directives to shift the family structure, and then supported the shifts with Bowenian teaching on triangles and the family life cycle. More often, though, the contradictions between the two approaches loomed large at this stage of the therapy process. I found myself being pulled in two directions as I tried to utilize the two models together in planning intervention strategies. Should I meet with the whole family together (strategic) or only with the parents (Bowenian)? Should I take a directive, "expert" stance

with the family (strategic), or should I be more laid back and just ask questions (Bowenian)? Should I build emotional intensity in session in order to induce a crisis and prompt change (strategic), or should I work to lower defensiveness and promote a calm and reflective tone (Bowenian)? Should I maintain a focus on the presenting problem (strategic) or de-emphasize the symptom and shift the focus to wider family dynamics (Bowenian)? Should I concentrate on getting the whole family the act differently in relation to the problem (strategic), or should I help key members of the family gain insight into themselves and their family (Bowenian)?

For each of these questions I had to choose one direction of the other. I could not somehow integrate the two opposites. In most cases I could not simply choose one intervention tool from the strategic toolbox and use it alongside another tool from the Bowenian toolbox. For example, I could not decide to build intensity in session and then suddenly shift to asking questions and promoting insight. Based on my experience in this practicum, I have to conclude that the strategic model of therapy has a very different understanding of how families change than does the Bowenian model. The two models cast the therapist in very different roles vis-a-vis the family. The interventions move at different speeds and in different directions. I did find points of complementarity in using these two approaches together, but more often I found contradiction and incompatibility.

Looking back over my clinical work with the families described in this report, I feel that at times my interventions lacked clarity and focus because I did not have one coherent model for the process of therapy or the process of change. I

continually had to choose between two models that pulled in different directions, and I did not have clear guidelines for deciding which direction to choose in which instance. My hypothesizing and planning for intervention was weakened by this lack of clarity.

On achieving learning goals

My primary learning goal in this practicum was to gain a grounding in the theory and practice of family therapy, to serve as a foundation for future practice in the field. Looking back on the practicum experience, I believe this goal was partially realized.

I designed the practicum so as to gain broad exposure to a variety of ways of doing therapy. I chose to utilize two very different models of family therapy, and I have described some of the difficulties of using these two models together. Despite these difficulties, by using two models I was able to learn two different ways of understanding families, two different ways of thinking about the process of change, and two different sets of intervention strategies and techniques. I found aspects of each model to be useful, and will carry these into future clinical practice.

I chose to work with a variety of family constellations and with a variety of types of presenting problems. I gained exposure and experience with a range of family therapy situations, and I found I learned a great deal from each unique case. Of course in choosing a breadth of exposure I limited the depth of my learning in regard to any one type of family or family problem.

I also chose to get clinical supervision by three different supervisors, again with the intention of gaining exposure to different ways of doing family therapy. I found that each supervisor had a somewhat unique style and emphasis in approaching families, and I valued the opportunity to learn from each supervisor.

Clearly I gained a wealth of experience and knowledge from this practicum. But did I gain a *grounding* in theory and practice to serve as a *foundation* for future practice? These two images convey a sense of firmness and solidity. My hope was to use this practicum to build for myself a solid core of understanding of how to think about families and of how to go about promoting change in families. At the end of this practicum experience, this grounding or foundation does not feel as firm and solid as I had hoped it would be. I gained a breadth of exposure, in the ways I have described. But I feel I have a ways to go in incorporating the different approaches and theories and techniques into a coherent whole that makes sense for me. I have begun to do this, but the task is far from complete.

I do have some pieces of the foundation in place. Specifically, I have learned to think about families and how they work using a Bowenian framework. I look for patterns of fusion or differentiation, for emotional triangles, and for ways difficulties are transmitted from one generation to the next. I add onto the Bowenian framework some concepts from structural family therapy (learned in my study of the strategic model). I especially look for confusions in the family hierarchy and for boundary problems between subsystems and between individuals. I also look to identify the key interactional sequences which define the family structure and surround the presenting problem.

I have less clarity in understanding how to intervene in families to promote positive changes. I have stated my concerns about the limitations of both the strategic and Bowenian intervention models. I do not feel comfortable with the tone of the strategic therapist-client relationship, and I think the Bowenian model takes too long to be very usable. I will continue to use intervention strategies from both models, but I have more thinking and learning to do before I can claim to have a solid and comprehensive understanding of the means by which I want to promote change in families. Specifically, I want to learn more about where and when intervention strategies from the two models might best be used. Are there types of families or family problems that are best addressed using a strategic approach? A Bowenian approach? I think answers to these questions will only come as I gain more experience doing family therapy with different types of families and different types of problems.

By using two very different models of family therapy together, I gained exposure to different theoretical and technical tools for clinical practice. Based on this experience, though, I hesitate to recommend that future students follow this path. The two models of therapy I used have contradictory understandings of how to promote change in families. Because I was trying to integrate these two approaches, my clinical work lacked a coherent focus and direction. If two different models of therapy are to be utilized together in a future practicum, I recommend that a very clear understanding of how they are to be integrated be developed before the clinical practice is begun. Otherwise, I believe it would be wiser to work with one coherent model of therapy. Once the student is grounded in one approach, he or she can add to this foundation using insights and

techniques from other models. In using two divergent models, as I did in this practicum, the process of constructing a foundation of theory and strategy is inhibited.

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