STRUCTURAL FAMILY THERAPY WITH FAMILIES FROM DIVERSE BACKGROUNDS WITH AN ADOLESCENT INVOLVED IN THE MENTAL HEALTH SYSTEM

BY

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A Practicum Report
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of Manitoba in partial fulfillment of the requirements of the degree
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ABSTRACT

Manitoba is described as one of the most multicultural provinces in Canada with a population that consists of approximately 110 different ethnic groups. This practicum report describes the use of structural family therapy with eleven families in which the adolescent is involved in the mental health system. These families came from a variety of racial, ethnic, cultural, and socio-economic backgrounds. The majority are immigrants.

The report reviews the history of psychiatry and mental illness in Europe and North America and the literature on culture, race, ethnicity and family therapy. Three case examples are used to illustrate the use and utility of the structural family therapy model with racially and ethnically diverse populations. The clinical intervention is evaluated through the use of FAM-III and a client satisfaction questionnaire.

Conclusions reached as a result of this practicum intervention suggest that the structural model with its problem solving model and a focus on change is aptly suited for Manitoba's diverse population.
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And finally, a special thanks to my partner Nicola Martino, whose patience, support and faith in me made completing this report possible. This report is dedicated to my deceased mother for showing me the restorative power of prayer, struggle and perseverance.
NOTE ON LANGUAGE

The terms Black and white are used in this report as racial descriptors. Black or African American are used as interchangeable terms. The term Black is capitalized in this report to signify nationality.
INTRODUCTION AND OVERVIEW

Introduction

In a recent newspaper article, Trena Khan described Manitoba as the most multicultural province in Canada with a population that consists of approximately one hundred and ten different ethnic groups (Winnipeg Free Press, 1995, p. A1). McGoldrick, Preto, Hines and Lee (1991) argue that there is burgeoning evidence that ethnic values and identifications are retained for many generations after immigration and that they play a significant role in family life throughout the life cycle. They further argue that "ethnicity should be of interest to all family therapists, because cultural norms and values prescribe the rules by which families operate, including how family members identify, define and attempt to solve their problems, and how they seek help" (p. 546).

Al-Issa (1997) adds that while immigrants and ethnic minorities experience stressors common to all members of society (stressful life events and daily hassles), they also face stressors unique to them that are related to who they are and their experience within the majority culture. These stressors may lead families to mental health services.

In recent years, there has been a growing awareness among family therapists of the need to take into consideration cultural and ethnic factors in working with families. It is sometimes less apparent if this awareness has spread to psychiatry and the mental health profession.

It is highly possible that in a multicultural province such as Manitoba, whether
a social worker is employed in a school setting, mental health facility or a human service agency, a proportion of the clients seeking help would include families from a racial, cultural or ethnic group different from their own.

**Family Therapy**

Beginning in the early 1980's, feminist family therapists launched a critique which challenged patriarchal assumptions in family therapy. Feminist family therapists reexamined many of the premises and techniques that two generations of family therapists held sacred (Goldner, 1985; Hare-Mustin, 1978). This transformed the family therapy field to the point where, "by the 1990s....many of the major feminist points are no longer debated and the field is evolving to a more collaborative, but socially enlightened, form of therapy" (Nichols & Schwartz, 1997, p. 328).

Korin (1994) argues that feminists invited the discussion of oppression in families, but kept the focus on the politics of gender with less attention paid to the impact of race, culture and class on family relations. McGoldrick (1982) was the first to review the ethnocentricity in family therapy. A number of books and journal articles followed this publication.

However, there were still criticisms of the exclusion of class, race and skin colour in the ethno-cultural discussion. Nichols and Schwartz (1997) identify that, "in the 1990s, multiculturalism has become a dominant theme in family therapy, as reflected in the agendas for conferences of the major organizations in the field with such recent titles as "Social, Cultural and Economic Diversity" and "Culture, Power
and the Family" (p. 331). Hardy and Laszloffy (1994) welcome the popularity of issues of ethnicity but cautiously note "the inherent danger has been the tendency to couch highly charged racial issues in the less volatile language of multiculturalism. This phenomenon perpetuates the historic neglect of racial issues in favour of safer, more politically correct topics such as 'ethnicity' and 'cultural diversity' (p. 23)."

**Psychiatry**

The families in this practicum all had a family member involved in the psychiatric system some of whom were on psychotropic medications. It was interesting to find that the concept of culture was treated in most psychiatric textbooks as unessential to mental illness and psychiatric treatment (Helman, 1994; Klieman, 1988; Littlewood & Lipsedge, 1997). However, those involved in the field of culture and psychiatry believe that the field is slowly shifting. Psychiatric anthropologists and other cross-cultural researchers participated for the first time in the composition of the DSM IV (Castillo, 1997, p. 4). Although they view the impact they had on DSM IV as minor, they do see the expansion of DSM IV to include social and cultural factors as a signal for a change in future DSM publications.

**Objectives of the Practicum**

This practicum experience is an integration of social work, family therapy, psychiatry and racio-ethno-cultural diversity. The overall goal is to expand my knowledge in using family therapy with a family where a child is involved in the
psychiatric system and where the family may be from a racial minority group. The learning objectives of the practicum are:

1. Acquire a conceptual and theoretical understanding of structural family therapy.
2. Become familiar with the techniques of the structural family therapy model.
3. Develop skills in the application of a structural model of family therapy in working with families from diverse racial and cultural backgrounds.
4. Develop my knowledge of psychiatry and family therapy.
5. Examine myself as a therapist including how my race, culture, belief systems, values and perceptions may impact on my work as a therapist.
6. Receive supervision and feedback to challenge and expand my thinking and to facilitate my professional growth and development as an effective therapist.

Outline of the Practicum Report

The report is divided into seven chapters. Chapter 1 presents an overview of psychiatry and racial minority populations. A brief history of psychiatry will be presented. The founding fathers of psychiatry and their views will be noted. An analysis of psychiatry's relationship with racial minorities and the role of the Diagnostic and Statistical Manual and its cross cultural application will also be covered in this chapter. The chapter will conclude with a discussion on the usefulness of psychiatry in a multi-cultural society.

Chapter 2 will review the literature on culture/race/ethnicity and family
therapy. The chapter will begin with a definition of the three terms. The rest of the chapter gives an in depth review of the past and most recent publications in this area. Chapter 3 provides a review of the structural family therapy model. This chapter concludes with a position on the relevance in using this model with this client base. In Chapter 4, the methods, procedures and evaluation design used in the practicum will be addressed. A description of the intervention including the setting, the duration and the referral process will be presented.

In Chapter 5, the clinical cases will be presented. Three cases will be described, giving a flavour of the overall practicum experience. Chapter 6 will cover the overall evaluation of the practicum experience as well as a discussion of the findings including identification of commonalities and differences among families. The practicum will conclude in the seventh chapter. This chapter will conclude with a recommendation for future interventions based on the findings from this practicum experience.
CHAPTER 1

AN OVERVIEW OF PSYCHIATRY/MENTAL ILLNESS AND RACE

Introduction

The twelve families seen in this practicum included immigrant families from the Philippines, Jamaica, Pakistan, Ethiopia and other countries. All the families seen in this practicum had a family member involved in the mental health system. A majority of the adolescents had a DSM-IV diagnosis and were on psychotropic medication at the beginning of family therapy. Psychiatry as a discipline has its roots in Western culture, its major figures are almost entirely European and Euro-American and its database is largely limited to the mainstream population in Western societies. With such a background can psychiatry adequately treat families from a non-western culture?

Some have argued that the mentally ill have always been around. Hippocrates examined and treated many psychiatric patients before there were any psychiatrists he could refer them to. Alexander and Selesnick (1968) noted that Hippocrates himself appeared as an expert witness at a trial of an insane person. Writings about mental illness and psychiatry cover a long period and a wide spectrum. Given the scope of this report, this chapter will focus only on the general areas that shaped the way psychiatry has thought about race and diversity.

Historical Context

Ackerknacht (1968) argues that the history of psychiatry begins with the
Greeks. The definition of mental illness at that time entailed an acute disease of the mind accompanied by acute fever, foolish gesticulations and a small, full pulse (Ackerknecht, 1968). The treatment during this era involved isolation and "warm poultices of oil, to be applied particularly to the head, and also careful blood-letting. On the third and fourth day the head should be shaved and treated with cupping, leeches and scarification. Passive exercise such as rocking and a careful diet are indicated" (Ackerknecht, 1968, p. 13). Greek psychiatry was viewed as the first to use clinical observation and the first to attempt at a classification of mental illness.

During the medieval era in Europe the mentally ill were regarded as possessed by the devil and by evil spirits, or were considered to be witches or sorcerers who could produce the illness in others (Ackernecht, 1968). Hallucinations were thought of as the work of the devil. Demons were commonly exorcised. A number of women who were mentally ill were diagnosed as witches; some were executed and a large number were burned at the stake.

However, during the renaissance period a small group of more enlightened medical practitioners emerged. They made new contributions to psychiatry. They declared that many of the possessed and many witches had nothing whatsoever to do with the devil or with other supernatural forces but had become mentally ill for very natural reasons and merited medical attention and not the stake (Alexander & Selesnick, 1968). The renaissance saw a rebirth of humane attitudes towards the insane.

In the eighteenth century psychiatric achievements continued to surpass
earlier efforts. The belief in possession by the evil spirits was destroyed forever. The practice of psychiatry moved into asylums. During this era there was an increase in the number of asylums in places like Warsaw (1726) and Vienna (1784). The mentally ill were now placed in institutions. It was also during this century that the use of psychotherapy developed and began being practised in institutions (Ackerknecht, 1968). This period also saw the "active development of physical treatment methods" (Ackerknecht, 1968, p. 38). Physical methods of treatment included the use of electroconvulsive therapy, deep coma insulin therapy, leucotomy and other treatments which were regarded as forms of shock therapy. Other methods of physical therapy were, "the use of the Darwin chair where patients were rotated until blood oozed from their mouths, ears and nose. Castration.... the removal of the clitoris, starvation and enshacklement to walls" (Roder, Kubillus & Burwell, 1995, p. 204).

The Founding Fathers

Phillipe Pinel

Pinel was born in France. His father was a physician. Pinel is identified as bringing radical changes to psychiatry (Ackeknecht, 1968). He was instrumental in the creation of a number of hospitals for the mentally ill. Under Pinel's direction the hospitals became the main therapeutic tool. He pushed for physicians to live among the patients. He believed that by living in close proximity to the insane, the physician would be able to study their habits and personalities and follow the course of their diseases (Alexander & Selesnick, 1968).
The treatment method also changed under Pinel. He stopped the practice of beating the patients and the use of chains. He encouraged exercise and a good diet. He maintained the use of the strait-jacket but for shorter periods. Baths and douches were used but in moderation.

Pinel used his observation of hospital patients as the basis for creating a practical and simple classification of mental illness. Pinel was influential in changing society's attitudes towards the mentally ill and taught that the mentally ill were "sick human beings deserving and requiring medical treatment" (Alexander & Selesnick, 1968, p. 113).

**Emil Kraepelin**

Kraepelin was born in Germany. He was viewed as one of the leading figures in the history of psychiatric thought (Ackerknecht, 1968). Kraepelin's work has lived longer than that of any of his predecessors. Kraepelin was instrumental in creating the first psychiatric research institute in Germany. He also spent years meticulously gathering thousands of case histories, from which he evolved a system of descriptive psychiatry that is still used to classify patients on the basis of experience and manifest behaviour (Ackerknecht, 1968). Kraepelin was also described as a student of the brain. Kraepelin theorized that "the brain was the sole seat of all mental illness"; to this end, his research included "studying brain anatomy by dissecting the brains of dead rats, cats, people, whatever was available" (Roder et al., 1995, p. 101).

Like Phillipe Pinel, Kraepelin demonstrated repeatedly the importance of
utilizing in psychiatry the medical approach of detailed observation, careful description, and precise organization of data. According to Alexander and Selesnick (1968) "without this orientation psychiatry could never have become a clinical disciplined specialty of medicine" (p. 165). Ackerknecht (1968) argues that for a full appreciation of Kraepelin's achievements one must read his original work. A short review does not do justice to Kraepelin's ideas and his contribution to psychiatry.

**Sigmund Freud**

Freud has been described as one of the most important and influential figures in the history of psychiatry (Ackerknecht, 1968; Alexander & Selesnick, 1968; Kaplan Sadock & Grebb, 1994). Freud was born in Austria and spent most of his life in Vienna. His specialty after graduating from medical school was neurology (Kaplan et al., 1994). After being disappointed with the effectiveness of electrotherapy, he travelled to France to study hypnosis with Jean Marie Charcot (Ackerknecht, 1968).

Freud later abandoned hypnosis when he came to realize:

That despite its usefulness, hypnosis did have therapeutic limitations. For one thing not everyone is susceptible to being hypnotized. For another, Freud found that therapeutic results achieved by hypnosis were often transient; a symptom may disappear, only to be replaced by others (Alexander & Selesnick, 1968, p. 193).

After years of observing and working with his patients and seeing the limitations of hypnosis Freud developed a new technique called psychoanalysis. In this new technique Freud now "used 'free association' and began to study dreams and
parapraxes in order to be able to interpret neuroses. He recognised that the basic force in therapy was the phenomenon of transference" (Ackerknecht, 1968, pp. 93-94).

Although Freud's ideas contributed to "unravelling the mysteries of the human mind" (Kaplan et al., 1994, p. 237), his psychoanalytic theory was not quickly accepted. For ten years he remained isolated with his ideas. By 1902 he was joined by a small group of physicians including Alfred Jung. By 1908 the first international gathering of psychoanalysts was organized by Alfred Jung. In 1910 the International Psychoanalytic Association was founded.

Although over the years psychoanalysis has undergone major criticism and considerable revisions, several of Freud's fundamental hypotheses regarding the working of the mind remain central to psychiatric practice today (Kaplan et al., 1994).

Race and Psychiatry

For a good part of its history American psychiatry was dominated by racist thought. This has been documented through a systematic review of the articles in leading psychiatric journals such as, the American Journal of Psychiatry and the Psychoanalytical Review which was the first psychoanalytical periodical in English and was founded by two leading American psychiatrists (Thomas & Sillen, 1972). Whites were seen as most likely to become mentally ill because they were among the civilized group. "There was also the common opinion that the 'uncivilized races' (for example Indians and African slaves) had much less or no mental illness....the
lower races, the uncivilized, were less emotionally sensitive and were thereby protected from the strains of progress" (Brigham, 1845, p. 288).

The 1840 census was used to support the inferiority of Blacks and in turn the maintenance of slavery. The census showed no mental illness among the slaves in the south but the rate of insanity increased as the freed slaves moved north. "The census showed that the rate of 'insanity and idiocy' among Negroes was 11 times higher in the North than in the South" (Thomas & Sillen, 1972, p. 17).

The southern slave-holders and other anti-abolitionists used this statistic as scientific proof for the maintenance of slavery. Even the British Ambassador in America was attacked for wishing to abolish slavery since "as science had shown that elimination of the protected condition of the Black would reduce him to a state of civilization in which he ran a 7 percent chance of becoming an idiot or a maniac" (Prudhomme & Musto, 1972, p. 30).

It was later revealed that the statistics had no relation to reality. Many of the northern towns that were credited to have insane Blacks had no Black inhabitants. The Blacks listed were white patients in the hospital who were counted as Black (Thomas & Sillen, 1972). After some criticism the enumerator was asked to investigate himself. He obviously concluded that there were no errors. These fabricated statistics remained in the "government books to be cited for many years in the psychiatric literature" (Thomas & Sillen, 1972, p. 19).

The first issue of The Psychoanalytic Review (1913) carried a number of articles on mental illness in Blacks. The editor noted the "unique opportunity" that
psychiatrists had by living in the vicinity of African Americans: "The existence side by side of the white and coloured races in the United States offers a unique opportunity, not only to study the psychology of a race at a relatively low cultural level, but to study their mutual effects upon one another" (Evarts, 1913, p. 388). In the article "Dementia Precox in the Colored Race," the author implores that in order to understand dementia precox in Blacks, one must study their race history. However, Evarts proceeds to give a racial history of Africans based on an account of a trip made by Theodore Roosevelt. According to Evarts "we can accept the recent observations of the habits and character of the native tribes made by Roosevelt as equally descriptive of captives from which our ex-slaves sprung" (p. 389). Evarts continued in his report that on the safari Theodore Roosevelt met "strong, patient, child-like savages" and "happy go lucky porters," superstitious, with a strong belief in witchcraft but who do have a "great compensating gift, music. They all sing" (p. 391).

To further prove his 'theory' Evart (1913) adds that psychiatrists were beginning to think of insanity as a failure on the part of the individual to adjust to the demands of his environment. As such, it was inevitable that individuals from any race "in the upward spring" will fall because of their inability to change with changing conditions (Evart, 1913, p. 394). However, Evart saw the upward progress for the 'coloured man' to be "infinitely harder". The end of slavery meant that the coloured man was now free and was expected to "think for himself, and exercise forethought if he and his family are to live at all; two things which had so far not been demanded
and for which there was no racial preparation." (p. 394) It was then easy to understand why insanity was on the increase in the colored race. Evarts adds that because of the "vicissitudes of its history" (p. 394) the colored race is peculiarly prone to dementia precox. It is clear that Dr. Evarts' 'theory' was not scientifically based but more of racist preconceptions espoused by psychiatrists and other social scientists of the time.

Dr. John Lind (1913) from the Government Hospital for the Insane was another contributor to the psychiatric journal. In his article titled "The Dream as a Simple Wish Fulfilment in the Negro," Dr. Lind stated that the American student of psychology has a unique advantage in having ready access to a race "whose development is lower than the white race and which furnishes numerous individuals showing psychological aspects quite similar to those of the savage" (p. 295).

Dr. Lind used Freud's theory on children's dreams and argued that the minds of Blacks "especially the so-called pure-blooded Negro" are simple and less "complex than those of the Caucasian" and as such, Blacks represent the childhood stage of human development and their dreams were simple wish-fulfilment. To verify Freud's theory that the dreams of children are simple fulfilment of wishes, Dr. Lind obtained accounts of dreams from over one hundred Black people. Some of the dreams included "I dreamed I had a thousand dollars or I dreamed I was out having a fine time". Dr. Lind concluded that since the dreams were frank expression of a wish fulfilment and did not show the inner censor, the Black dreamers were of a "primitive type" with "primitive mental processes" (p. 300).
Another psychiatrist from a hospital for the insane published an article in the American Journal of Psychiatry (1921) on the psychological traits and the psychiatric tendencies of the southern Negro. His opening statement addressed the low level of evolutionary development characteristic of the Negro which led to particular types of mental health problems:

The Negro race evinces certain phylogenetic traits of character, habit, and behavior that seem sufficiently important to make the consideration of these peculiarities worthwhile; especially as these psychic characteristics have their effect upon and are reflected in the psychoses most frequently seen in the Negro....Citizenship with its novel privileges (possibly a greater transition than the first) was thrust upon the race finding it poorly prepared, intellectually, for adjustment to this new social order. Instinctively the Negro turned to the ways of the white man, under whose tutelage he had been, and made an effort to compensate for psychic inferiority by imitating the superior race (Bevis, 1921, p. 69).

Bevis (1921) also described some behavioral traits of southern Blacks that were "potent factors in the production of mental diseases" (p. 70), including gambling, laziness, promiscuousness and impulsivity.

In the same vein, Green (1914) wrote about the type of psychotic disturbances that differed along racial lines. For this 'study' Green used patients admitted to a state sanitarium between 1909 and 1914. One of his many conclusions was that whites were seen more frequently to be victims of depression, paranoid and organic forms of brain disease. The reason Green (1914) presented for the differences in depression and paranoia between Blacks and whites was "the Negro mind does not dwell upon unpleasant subjects; he is irresponsible,
unthinking, easily aroused to happiness, and his unhappiness is transitory, disappearing as a child when other interests attract his attention. He is happy-go-lucky, not philosophical" (p. 703). With respect to paranoia Green (1914) states:

The Negro is a creature of impulse, logical reasoning is not one of his qualities nor is his behaviour usually determined by a thoughtful consideration of its consequences. If the ability to reason from premises and to form conclusions as a result of such reasoning is characteristic of paranoid conditions, it should not be surprising to find that such conditions are more than twice as common in the White as in the Negro (p. 703).

Racism continues to be present in modern day psychiatry. Many studies have noted that African Americans run a higher risk of being misdiagnosed than Whites particularly in the area of schizophrenia and affective disorders (mood disorders). Blacks tend to be over-diagnosed with schizophrenia and under-diagnosed in the area of affective disorders (Littlewood & Lipsedge, 1997; Prange & Vitols, 1962; Raskin et al., 1975; Simon et al., 1973; Thomas & Sillen, 1972). It appears that the psychiatrists and clinicians in the mental facilities continued along the same vein as Bevis (1921) and Omally (1914) in the contention that Black people are depression-proof.

Prange and Vitols (1962) argue that depression is usually precipitated by the experience of a loss that typically involves prestige, esteem, real goods or an ambivalently loved person. The authors contend that the Southern Blacks had less to lose and were less apt to lose it, therefore they were less vulnerable to depression. Blacks can projectively locate the source of misfortune outside themselves. Whites are more introjective - a Freudian self-blaming mechanism
which is basic to depression.

Simon and his associates (1973) conducted a study which involved patients from 9 New York State mental hospitals. The patients were diagnosed by a research psychiatrist and by hospital clinicians. The research associates used a "structured mental status interview" in order to give a diagnosis to the patients. The researchers then compared their diagnoses with the hospital diagnoses. From the hospital clinicians Blacks were given the diagnosis of schizophrenia rather than affective illness more often than whites. The hospital clinicians diagnosed 15% of the whites, but not one of the Blacks, as having an affective disorder. However, according to the research psychiatrists, race and diagnosis were independent.

In another study, Raskin, Crook and Herman (1975) conducted an extensive multi-hospital investigation on a group of Black and white patients. The authors controlled for age, sex and social class. The authors found that Blacks were more likely to be diagnosed as suffering from schizoaffective disorder, whereas whites exhibiting the same set of symptoms were more often given a diagnosis of psychotic depression.

The reluctance to diagnose depression in Black patients is not limited to North American psychiatrists. Littlewood and Lipsedge (1997) state that depression is still diagnosed less commonly among West Indian and Asian patients in psychiatric hospitals in Britain than among British born patients. Adebimpe (1981) has argued that the Diagnostic and Statistical Manual (DSM) could be useful by encouraging the use of well defined explicit criteria which could help clinicians avoid
errors due to stereotypes and false positive symptoms. How relevant is the American diagnosis for minority racial groups?

The Diagnostic and Statistical Manual

The Diagnostic and Statistical Manual is published by the American Psychiatric Association. It is a manual of mental disorders. The first edition of the DSM was published in 1952. The publication of the DSM first and foremost elevated the significance of diagnosis. The DSM "was originally intended to stabilize psychiatric nomenclature in American psychiatry and to clarify the description of mental syndromes" (Tomm, 1990, p. 6).

The DSM II was published sixteen years later. This edition expanded the number of disease categories. Mental syndromes which previously were described as reactions were now defined as illnesses. The use of multiple diagnoses on a single patient became acceptable (Kurt & Kutchins, 1994). Moving from "syndrome" to "illness" aligned American psychiatry more closely with the rest of medicine (Tomm, 1990).

In 1980 the third edition of the DSM was published. The changes in this edition were extensive. The priority shifted to "precision and accuracy in making diagnosis" (Tomm, 1990, p. 6). Changes included "new features as diagnostic criteria, a multi-axial approach to evaluation, much-expanded descriptions of the disorders and many additional categories" (DSM-III, 1980, p. 7). An important revolution occurred in the publication of DSM-III - for the first time the manual was accepted not only in North America but also internationally. The DSM-III was
translated into thirteen languages. In 1987 a revised version of the DSM was published (DSM-III-R).

The current Diagnostic and Statistical Manual was published in 1994. The DSM-IV now includes 300 mental disorders and is 886 pages long while the first DSM listed 106 mental disorders and was 126 pages long (Torrey, 1997).

Diagnosis in psychiatry has been criticized from its beginnings, first by doctors themselves and also by sociologists. Adolf Meyer was a major opponent in the early years of the development of the statistical manual. He was quoted as saying that "statistics will be most valuable if they do not attempt to solve all the problems of administration and psychiatry and sociology under one confused effort of one word diagnosis marking the individual" (Grob, 1991, p. 426).

Karl Menninger (1963), an eminent psychiatrist, was a little more forceful in expressing his concerns about diagnosis: "we disparage labelling of all kinds in psychiatry insofar as these labels apply to supposed diseases or conditions of specific etiological determination....Patients who consult us because of their suffering and their distress and their disability have every right to resent being plastered with a damning index tab. Our function is to help people, not to further inflict them" (p. 47).

The translation of the DSM-III manual meant the availability and use of the DSM outside of North America and the assumption of the universality of mental illness. From the publication of the DSM-III and its revised version criticisms of the manual were heard from psychiatrists from developing countries. Some have
criticised the diagnostic system "as being rooted in Western culture and not relevant or valid in other cultures" (Klerman, 1983, p. 11). Others have argued that the symptoms of mental illness in the third world differ considerably from those described in American and European textbooks (Wig, 1983).

The DSM-IV attempted to address some of the criticisms from the developing countries. The manual includes "a culture specific section, a glossary of culture-bound syndromes and the provision of an outline for cultural formulation....these are all designed for cross-cultural applicability" (DSM IV, p. xxv).

By making these changes has psychiatry been successful in moving away from its Eurocentric, racist foundation? Some have argued that the problem in psychiatry goes deeper to the point where there is institutional white racism in psychiatry (Littlewood and Lipsedge, 1996; Sabshin, Diesenhaus & Wilkerson, 1970). This presents itself where there is an institutional avoidance in dealing with the mental health services of racial minority families. Lewis and his colleagues (1980) address the variations in diagnosis and disposition of adolescents based on race. This is reflected in the variations in the admission rates of racial minorities into mental institutions.

The Manitoba Adolescent Treatment Centre Hospital Program opened in 1984. The MATC does not keep statistics on race or ethnicity of the clients admitted to the program. However, I conducted an informal survey on the staff who have worked in the program since its inception. Over the past 14 years staff could recall approximately eight adolescents from racial minority groups. The MATC is
the only adolescent treatment program of its kind in the province. The other two programs are within the major hospitals. With over one hundred ethnic groups in the province one could assume that there would be more diversity among the adolescent population in the program. Are some children being diverted to other forms of treatment programs?

There was a suggestion from one of the treatment providers that Paul (one of the adolescents from the practicum) should be placed at the Seven Oaks Youth Centre. Seven Oaks was a locked facility for adolescent with behavioural problems. Gordon states, "All too often the intake policies of .... agencies are geared to meet the needs of maladjusted children from intact, middle class white families....At the elementary school level, especially in predominantly Black or minority schools it is usually the case that not a single emotionally disturbed child is in treatment at any clinic" (as cited in Sabshin, et al., 1970, p. 789).

The MATC has recently began keeping statistics on ethnic groups in their programs. They have also opened a community service program. Hopefully this could allow for more diversity in the program and ensure the needs of all adolescents are being met. There is also a new direction in psychiatry where "the traditional biomedical paradigm is being replaced by a more holistic view that includes social and cultural factors in both diagnosis and treatment of mental illness" (Castillo, 1997, p. xv).

The introduction of the cultural factors in DSM-IV was seen as an expansion beyond the traditional boundaries of disease-centred psychiatry and leading to a
client-centred approach. Castillo (1997) describes client-centred psychiatry as: "rather than diagnosis and treatment of disease, diagnosis and treatment are centred around a client's thoughts, emotions, social context, and cultural identity" (1997, p. 5). This may help push psychiatry away from its Eurocentric past. However, there may be other areas that need changing. In commenting on the make up of the publishers of the DSM, Paula Kaplan states that "decisions about who is normal begin with at most a few dozen people- mostly white, mostly wealthy, mostly American psychiatrists" (1995, p. 31). The majority of the psychiatrists currently practising in Manitoba are white, male and middle class (personal conversation with a practising psychiatrist). Kramer (1973) also adds that over the years mental health workers in the United States "have been overwhelmingly white in numbers and spirit" (p. 8). The same can be seen in Manitoba.

**Summary**

This chapter has presented a brief history of psychiatry's Eurocentric past and some challenges for the future in its relationship with culturally diversity. With Manitoba's growing non-white and immigrant population psychiatry needs to ensure that it is meeting the needs of all adolescents. It will be useful in future research to look at the racial and ethnic composition of adolescent admissions into psychiatric facilities in Manitoba.
CHAPTER 2
A REVIEW OF THE LITERATURE ON CULTURE/RACE/ETHNICITY AND FAMILY THERAPY

Introduction

Psychiatry is not alone in its Eurocentric history. As stated by Hardy (1994) "the majority of the family therapy theory is constructed by white, European and Euro-American males" (p. 10). This influence pervades family therapy theory. A high premium is placed on patriarchal Eurocentric principles such as individualism, autonomy and competition. In the early 1980s the patriarchal Eurocentric biases in family therapy were extensively critiqued by feminist family therapists (Goldner, 1985; Hare-Mustin, 1978).

The early feminist critique in family therapy had been focussed on the politics of gender with less attention on race, culture, class or ethnicity (Korin, 1994). McGoldrick and her colleagues (1982) attempted to broaden the focus to address the ethno-centricity in family therapy with their book, Ethnicity and Family Therapy.

In this chapter I will present an overview of the literature on culture, race, ethnicity and family therapy.

Defining Terms

In the literature and in everyday discussions on cross-cultural issues in family therapy the terms culture, race and ethnicity are often used interchangeably. There is also an assumption that there is a mainstream culture which is white and that the non-mainstream groups are ethnic, diverse or minority. Before proceeding further,
it would be useful to attempt a definition of these terms.

**Race:** Anthropologists and geneticists speak of race to refer to a population sharing characteristics known to be inherited genetically (Shibutani & Kwan, 1988, p. 39). The validity of race as a purely biological variable has been hotly debated and rejected, and race has come to have a social and political meaning that, only in part, is related to its original biological roots (Yee, Fairchild, Weizmann & Wyatt, 1993). For example race is generally defined in terms of physical characteristics, such as commonalities of skin colour, facial features, and hair type, which are common to an inbred, geographically isolated population (Betancourt & Lopez, 1993, p. 631).

Carter (1996) states that scholars have noted that race was and continues to be a social construction wielded by white Europeans and Americans to establish social demarcations, elevate the white race and justify the oppression and exploitation of certain ethnic groups who are presumed to be inferior in intelligence, physicality, morality and culture" (p.3). In her analysis of the origins of race in American society, Smedley (1993) supports Carter’s (1996) view and reminds us that the idea of race began as a means to classify humankind.

Smedley (1993) further adds that "race should not be seen as something tangible that exists in the outside world which has to be discovered, described, and defined .....It is a cultural creation, a product of human invention" (p. 6). Rex concludes that the term race is a social construct, and that rather than looking at the biological basis of race, it is more meaningful to inquire how it is that people come
to be classified as racially different (Cited in Bolaria & Li, 1988, p. 15). For this paper, a definition from Carter (1996) will be used. Race, then, is defined as a concept that refers to a presumed classification of all human groups on the basis of visible physical traits or phenotype and behavioural differences (Carter, 1996, p. 15).

**Ethnicity:** Montagu (1964) made the suggestion to abandon the term race from all discussions of human affairs and substitute the phrase 'ethnic group'. Montagu (1963) argues that the term "race is a trigger word. Utter it and a whole series of emotionally conditioned responses follow... The term race takes for granted what should be a matter for inquiry. And this is precisely the point that is raised when one uses the non-committal 'ethnic group' (p. 24). According to Zeitlen (1984) the word ethnic is derived from the Greek ethnos, which refers to a number of people living together who share a common culture and language. Shibutani and Kwan (1965) define ethnicity as the sense of community experienced by "those who conceive of themselves as alike by virtue of their common ancestry, real or fictitious, and who are so regarded by others" (p. 23).

**Culture:** As stated by Devore and Schlesinger (1987) culture is a commonly used though not readily defined concept. Helman (1994) defines culture as:

> a set of guidelines (both explicit and implicit) which individuals inherit as members of a particular society, and which tells them how to view the world, how to experience it emotionally and how to behave in it in relation to other people, to supernatural forces or gods, and to the natural environment. It also provides them with a way of transmitting these guidelines to the next generation - by the use of language, art and ritual (p. 2-3).
Culture refers to "that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man [sic] as a member of society" (Zeitlin, 1984, p. 20). Zeitlin (1984) further adds that culture is transmitted non-genetically, that is, through the process of social interaction and learning. Betancourt and Lopez (1993) present a similar position in that culture represents learned systems of meaning that are shared by people in a particular context where the meanings are transferred from generation to generation. Falicov (1988) defines culture as shared world views and adaptive behaviours derived from simultaneous location in a variety of contexts. For this report the term culture is defined as the transition of knowledge, skills, attitudes behaviours and language from one generation to the next usually within the confines of a physical environment (Carter, 1996).

**Literature Review**

Minuchin and his colleagues (1967) were the exception in the family therapy arena in their ground breaking work with poor Black and Hispanic families in the U.S. Their study was based on the families of the boys who were placed at the Wiltwyck Residential School. The families were identified as from "mostly ethnic minority backgrounds (Negro and Puerto Rican), and they dwell in the congested, rat-infested ghettos and slums of New York" (p. 6). In their work with these families Minuchin and his colleagues (1967) developed specific techniques of therapeutic interventions that later developed into the structural family therapy model.

Although the families in the study were composed of a specific racial and
ethnic group Minuchin and his colleagues (1967) did not specifically address racial, ethnic or cultural issues as they applied to family therapy. The focus of their book is similarly "concerned with conceptualizations concerning disorganized, unstable, lower class families rather than those coming from the working class or more stable elements of the lower class" (p. 25). The book can be described as developing a model based on a socio-economic class context. Minuchin (1967) did not address how race impacted on how these families function or how race or ethnicity should be addressed in family therapy.

Papajohn and Spiegel (1975) specifically focussed on immigrant families in the United States. They used a transactional systems theoretical model to study the mental health and illness among three ethnic families. The families presented were Puerto Rican, Greek-American and Italian-American. A member from each of the families was experiencing a form of psychopathology. The study examined the acculturation process and the potential areas of stress confronting immigrant families in the United States.

In the Puerto Rican family the father suffered a "psychotic reaction after immigrating to New York City" (p. 46). An examination of the Puerto Rican working class culture—that is, value system- and the American middle class culture, was conducted in order to attempt to understand the adaptation problems of the Puerto Rican immigrating to the United States. The American middle class culture was used as a comparison because the authors saw this as the pattern to which immigrant families usually aspire upon migrating to the United States.
The authors identified strains that the immigrant Puerto Rican family may go through due to a contrast in the values between the two cultures. Puerto Ricans live for the 'present' and 'being' is more important than 'doing'. In relational issues the 'collateral' is more important than the 'individual'. These values are in sharp contrast with that of American middle class values where 'future time', 'doing' and 'individual' values are more important. The authors saw potential areas of stress confronting the newly arrived working class Puerto Rican family.

In presenting the three families Papajohn and Spiegel (1975) noted that, "to understand a person, one must understand his [sic] family. To appreciate the form and function of the family, one must understand its cultural determinants, which are of the utmost importance in assessing integration and conflict within a family and the psychic health and illness of its individual members" (p. 58).

In discussing the strains that the various immigrant families would experience in their acculturation process the authors omitted any exploration of race and skin colour as important dimensions particularly with the Puerto Rican families. Enguidanos (1995) emphasizes the effect of racism confronted by Puerto Ricans who migrate to the United States:

Confronting the mainland's racism and oppression of Puerto Ricans is devastating not only because they suffer wounding of their self-esteem, but because they find this kind of prejudice incomprehensible. Having been raised in a country where a mixture of races peacefully coexist, they find it impossible to understand that their worth in the U.S. is measured by their skin colour or by their accent when they speak English (Enguidanos, 1995, p. 333).
McGoldrick, Pearce and Giordano (1982) did what no one else had done previously which was to bring ethnicity and culture into the discussion about families. McGoldrick and her colleagues (1982) presented seventeen different American ethnic groups. They presented the history, traditions, family structure, family patterns and values of each ethnic group. They also suggested choice of therapeutic intervention methods of therapy for the particular ethnic group.

By broadening the context of the family beyond the white, Anglo American middle class norm, the book allowed the therapist to develop more sensitivity to the importance of knowing some of the characteristics of the ethnic group from which a family developed. As such, a therapist may no longer assume a family is sick just because they are different from the norm. McGoldrick and others (1982) hoped that clinicians could become sensitized to the ethnic factors that may be underlying a family's behaviour and the information in the book could be used to provide guidance in selecting ethnically-attuned interventions.

Although the publication of the book by McGoldrick and her colleagues paved the way for a number of related books in the following years, the book still drew a lot of criticisms. Liddle (1991) describes it as a "United Nations of content for the therapist to digest" (p. 655). Barot (1988) accuses McGoldrick and her colleagues of ignoring the global inequalities that affect family life and focussing on the positive aspects of ethnicity. He further adds:

Although it may be that she does not exclude the relevance of structural factors in her analysis, her theoretical identification of family with ethnicity is most likely to obscure the institutional factors such as
poor education, unemployment, bad housing and inadequate social and health care facilities which can seriously undermine family cohesion-a process which is not properly explained by primary emphasis on ethnic groups and ethnic identities (1988, p. 278).

A recent publication by Vincenzo DiNicola (1997) criticizes the concept of ethnicity and family therapy and instead replaces it with 'cultural family therapy'. DiNicola (1997) believes that the term ethnicity "creates outsiders rather than acknowledging that all cultures have a history and a geography and a figure/ground relationship to one another" (p. 2). A detailed review of DiNicola's (1997) work will be conducted later in this chapter.

Montalvo and Gutierrez (1983) query whether knowledge of the culture of the family seeking therapy would guarantee the therapist being more effective in dealing with that family. Montalvo and Gutierrez (1983) believe that a family can easily confuse a therapist: "By manipulating and restricting the therapist's attention to shared aspects of their way of being, families use culture as a defense. Therapists do well not to know too much and, instead, let the family guide them though the idiosyncratic aspects of the culture, keeping all the while a watchful eye on broader invariants such as the process of subcultural confinement" (p. 16).

Montalvo and Gutierrez (1983) suggest an alternative approach to the focus on the cultural dimension in family therapy. They suggest an inter-institutional perspective which could avoid families' ability to "use their cultural repertoire and uniqueness to hide their basic patterns of functioning, a focus on inter-institutional dilemmas seems more useful for family therapists than a focus on cultural
uniqueness” (p. 31). Inter-institutional means the interaction between the family of the minority subculture with the institutions of the surrounding host culture which could include school and work.

Montalvo and Gutierrez (1983) caution therapists against becoming overspecialized in their quest to become knowledgeable about various ethnic groups:

To make the cultural dimension more central than the family's interactions with the surrounding institutions is to invite excesses, both emotional and technical. Emotionally therapists will feel that unless they are within the skin of the culture, they understand little and can do less. Technically, therapists will require training in each particular ethnic and cultural background, confusing credentials on ethnicity with problem solving skills. The result would be a set overspecialized, baroque therapies in a field that still lacks basic research on methods as well as outcome (Montalvo & Gutierrez, 1983, p. 31)

Falicov and Hansen (1983) acknowledge the importance of ethnic roots in family therapy. However, in their book Cultural Perspectives in Family Therapy they focus on ‘cultural dimensions’ as opposed to ethnicity. The definition of cultural issues include behaviours and experiences from families' membership in a variety of different contexts. These include, "ecological setting (rural, urban, suburban), philosophical or religious values, nationality and ethnicity, types of family organization, social class, occupation, migratory patterns and stage of acculturation; or values derived from partaking of similar historical moments or particular ideologies" (Falicov & Hansen, 1983, p. xv). It is interesting to note that race was not one of the contexts identified by the authors.
In another article Montalvo and Gutierrez (1988) continue to criticize the trend of focusing on cultural and ethnic identity in working with families - specifically Puerto Rican families. They identify that problem solving skills were being trivialized and "the focus of accomplishment shifts to understanding the family from within the culture instead of helping them overcome the problem" (p. 184).

Montalvo and Gutierrez (1988) propose alternative uses for cultural identity notions. They argue that a clinician should be able to demonstrate effective clinical skills with an exploratory and respectful attitude towards a group cultural identity. They further add that "the integration of openness to culture with clinical skills entails not allowing ethnicity to become an ascendent and overriding consideration. Underlying philosophy should be: People are more similar than they are different. Rapport does not depend on cultural attunement only" (Montalvo and Gutierrez, 1988, p. 184).

One of the most detailed critiques of McGoldrick's (1982) book (and to some extent, family therapy's use of ethnicity) comes from anthropologist Tulio Maranhao (1984). He labels the volume as a "collection of articles that actually reads as a sort of Guinness Book of Cultural Stereotypes" (p. 267). Maranhao views the book as providing shallow prejudices about groups of nationals, prejudices that should be avoided especially by family therapists. He further adds that the book reduced family therapy to a useful tool to facilitate the process of cultural adaptation by immigrants. He adds, "in short, Ethnicity and Family Therapy is a collection of stereotypes about different cultural traditions, based on the false assumption that
America does not have a culture of its own, but is a collection of those other traditions struggling in the milieu of the New World to adapt and build a new reality” (Maranhao, 1984, p. 268).

In spite of his negative review Maranhao (1984) is able to identify some positive attributes to the use of ethnicity and culture as identified in the book. He adds that "some of the authors gave us glimpses of their creative imagination at work" (p. 274). One of those authors was Welts (1982) who presents an example of a case with a Greek family. Welts (1982) suggests using a technique of re-labelling the problems in medical terms with families who value a physical picture as opposed to a psychological discourse. Welts (1982) also joined the male member of the Greek family through a rhetoric resembling that of the Orthodox priest or of the husband's best man.

Four years after the first publication McGoldrick, Giordano and Pearce (1997) released the second edition of Ethnicity and Family Therapy. The number of groups presented increased from seventeen to forty. The editors answer some of the criticisms of their first book by broadening the focus to include the influence of race, gender, class, religion and politics on families. The groups are divided into eight categories with an overview chapter at the beginning of each section.

In the opening chapter -which is the overview of the field of ethnicity in family therapy- the editors address the issues of race and racism as well as class issues and their impact on families. However, McGoldrick et al. (1997) provide the reader with only cursory or scant attention to racial issues. Instead of addressing some
of the stereotypes of people of colour, McGoldrick et al. (1997) appear to reinforce them by adding "...Whites tend to remain oblivious of the profound ways that minorities support the lives of white families...as housekeepers and nannies, as nursing staff...in hotels or other public facilities where people of colour tend to be invisible, support workforce-those who clean the building, wash the dishes and so forth" (pp. 15-16). McGoldrick may have had good intentions by the above statements; however, they all fit into stereotypes of racial minorities, specifically Blacks. Racial minorities support the lives of white people in many other ways as doctors, as judges, as politicians, and as scientists. It is so often that one hears of Black people being mistaken by whites for cleaning staff, this stereotype does not need to be reinforced.

McGoldrick et al. (1997) could have identified the institutional factors such as poor education and limited funding for schools in racial minority areas in the United States that could account for the majority of racial minorities in these ghettoized jobs. These undesirable jobs that some racial minority people tend to take and the underemployment that occurs in this population could affect family functioning. As McGoldrick et al. (1997) so aptly add "we who are white therapists have a long way to go to expand our consciousness" (p. 16). In the area of a racial analysis I would agree.

Again, McGoldrick et al. (1997) fall short in addressing class issues. They identified the inequalities in earnings in American societies but do not elaborate on how that could impact families. There is no discussion on how lack of power and
control through class position can impact the health and psychological status of a family. "Individuals and families have unequal social power depending on their social and economic status which affects the dynamics of therapeutic relations and individual functioning" (Korin, 1994). McGoldrick et al. (1997) end the section with another generalization, arguing that despite the barriers that prevent groups from attaining upper class positions, a number of groups such as "Irish, Italians, Poles or African Americans, may have a distinct ambivalence or discomfort in moving up in class" (p. 17).

As in the first edition most of the chapters of this edition consist of "snapshots" of particular ethnic groups within the larger American society. McGoldrick et al. (1997) see these snapshots not as truths about a particular group but as a road map to some aspect of the terrain and as a guide to the explorer seeking a path. They are aware that critics view this sort of generalization about groups as reinforcing cultural stereotypes. However, McGoldrick et al. (1997) believe "that defining the ethnic paradigms is important to understanding ourselves and our clients" (p. xi). They also believe that articulating differences among groups is essential in order to sensitize clinicians to the range of values in American multicultural society.

DiNicola (1997) suggests an alternative way to address culture in the discussion about families. He proposed a synthesis of family therapy and transcultural therapy to illustrate his model of "cultural family therapy" (1997, p. 57). DiNicola (1997) identifies five problem areas in the approach to cultural diversity
represented in Ethnicity and Family Therapy by McGoldrick and her colleagues (1982 & 1997). He views the term ethnicity as a limited construct to imagine cultural diversity.

Following is a synopsis of the five problem areas identified by DiNicola (1997):

1) Ethnicity - homogeneity/static/troublesome: By presenting mini-ethnographies of various ethnic groups the authors ended up making broad generalizations about members of a group without taking into account individual and family subculture differences. It can also imply that ethnic groups are homogeneous regardless of social class, religion, education, employment and urban-rural differences. There is also the concern that the group remains static while people are influenced by other groups around them and as such change is inevitable.

2) Assimilation - prescribing a main stream model: DiNicola accuses those who focus on ethnicity as having assimilation as the presumed goal and model for how immigrants or racial minorities enter their host or dominant culture.

3) Cultural distinctions - who we are, why we are here, how we talk: Mainstream family therapy takes no notice of refugees and torture victims; as such they make no distinctions between immigrants and refugees and lump them all together with immigrants as "ethnics". Indigenous peoples and language issues are seriously underplayed in ethnicity and family therapy.

4) When the therapist is a stranger - identity issues, insiders, outsiders: There is near silence on diversity among therapists and in the construction of the therapeutic
system. There is no significant literature when the therapist is a racial minority member of society and treating mainstream families or when both therapist and family are cultural outsiders.

5) Expanding the context for family therapy: DiNicola (1997) believes that family therapy has re-framed all diversity issues as family problems, "that the family is the exclusive locus of pathology for mental illness, relational problems, and other human predicaments, as well as the key arena for their resolution" (pp. 62-66).

Later in the book DiNicola (1997) did identify some significant developments since he published his earlier critique of ethnicity and family therapy. DiNicola's (1997) model of cultural family therapy appears to be "based on narrative metaphors and social constructionist approaches- 'families as storying cultures' come together with my proposal for a synthesis of family therapy and cultural psychiatry" (p. 72).

It is difficult for the reader to get a clear understanding of what is cultural family therapy and specifically how is it radically different from the current literature and models available. However, DiNicola (1997) seems to present his cultural family therapy in the format of a number of "conceptual tools". These tools he describes as actions and thoughts of the therapist where they could be viewed as "informing perspectives that are conceptual and metaphoric, in that they invite us to think differently about families and cultures as systems" (p. 6).

A synopsis of the eight conceptual tools are presented. The eight codes are:

1) **Spirals**: which is a way of conducting the interview in which you gently skirt
around the issues and let the family members lead you to what they are looking for: how they define the problem, and what sorts of solutions are acceptable to them.

2) **Masks**: *cultural costume and camouflage*: this describes the way people express or carry their cultural or ethnic identity. Cultural costume is the particular set of recipes the individuals or families of a community employ to give meaning and shape to their experiences through shared ceremonies, rituals and symbols. The cultural costume becomes cultural camouflage when culture is invoked as a smoke-screen to obscure individual states of mind or patterns of interactions in the family.

3) **Roles**: the therapist takes an insider role where he comes in with shared common experiences or a cultural outsider role where one is lacking detailed knowledge about the culture and is prepared to learn the family's culture. 4) **Codes**: involves language and translation. It encompasses cultural translation and therapeutic translation. Cultural translation clarifies clients' idioms of distress and explanatory models to understand their predicaments. Therapeutic translation articulates clients' suffering in therapeutic idioms.

5) **Cultural strategies**: this tool involves the negotiation of cultural strategies that children and families use for adaptation and acculturation. 6) **Bridges**: involves an understanding of the family's problems by looking at the cultural aspects of the family life cycle. 7) **Stories**: is the use of multiple lens to create multiple descriptions of family life and therapy. 8) **Multiple codes**: involves the complex messages encoded in metaphor (figurative language) and somatic
(embodied meaning).

Even though DiNicola (1997) argues against the limitations and problems of the past literature on ethnicity and family therapy, he still did not present a complete alternative. He seems to be arguing for an anthropological, transcultural psychiatric marriage of family therapy. However, race or racism is not presented as a factor in family's stress or in the 'marriage proposal'. DiNicola (1997) actually states that "the people in this book are not constructed racially in the American sense of the term, which is to say, whether they are Black, Latino, White, Asian and so on. Canadians look at identity in terms of national origin, often reduced to spoken language; our major categories are English, French and Native" (p. 18). Is he saying that race could therefore play a minor role when families experience stress?

Since its first publication in 1975, the journal, The Psychiatric Clinics of North America (1995) made history by devoting an entire issue to cultural psychiatry. In that issue there is a chapter titled "Cultural Perspectives on Family Therapy and Theory". This is a brief article with a tertiary look at the topic with a focus on ethnicity and families in the United States. The authors note the absences of the other concepts, such as, religion, gender and class. The authors present the reader with a few "principles of culturally informed family therapy" and "techniques of culturally informed family therapy" (Kaslow, Celana, & Drelin, 1995, p. 627).

Breunlin, Schwartz and Kune-Karrer (1992) present a multi-cultural meta-framework in addressing cultural beliefs and its impact on people's behaviour and expectations. Breunlin and his colleagues (1992) adopt a broad definition of
culture, "we do not view culture as synonymous with ethnicity but rather as a larger category that includes ethnicity, as well as other socio-cultural contexts (for example, race, gender, education, and economics)” (p. 195). According to Breunlin et al. (1992):

The multi-cultural meta-framework consists of a set of presuppositions (beliefs) about the importance of a multi-cultural perspective in the treatment of families; a matrix, which considers the many socio-cultural contexts of membership that contribute to value formation and their interaction with the therapists’s values; ways to utilize these contexts of membership in an assessment of the opportunities and constraints that each socio-cultural dimension may present; and therapeutic guidelines that consider the family's as well as the therapist's multi-cultural background (p. 199).

As stated above the multi-cultural meta-framework uses a multi-cultural perspective in the treatment of families. This has been the most useful tool presented in the literature on diversity in family therapy. This model gives emphasis not only to ethnicity or culture but to the many socio-cultural contexts of membership that contribute to value formation.

The authors identify two levels of socio-cultural context that contribute to diversity. The first level is cultural transition which is further divided into two dimensions: historical/generational sequences and immigration/acculturation. The authors do not see these two dimensions as static but as evolving over time as a result of changing ideologies or circumstances that influence the second level which includes economics, education, ethnicity, religion, gender, age, race, racial minority/majority status and regional background. The multi-cultural perspective
also looks at the "interrelatedness of socio-cultural contexts" or the cultural fit between the racial minority and the racial majority family, between the immigrant and the non-immigrant family, and between the family and the therapist. At the end of each socio-cultural context there are a list of questions that could be used as a therapeutic guideline in working with families.

Minorities and Family Therapy was published in 1989 and edited by Hardy, Saba and Karrer. This book consists of a number of articles by clinicians on their work with specific ethnic and racial minority populations as well as specific treatment strategies for treating racial minority families. The groups covered in this book include American Indians, Chinese American immigrants, and Afro-Americans from a northern, urban, inner city sample. There is also a collection of articles on specific health issues with racial minority communities such as AIDS and drug addiction. In his contribution Hardy (1989) introduces the concept of "the theoretical myth of sameness (TMOS) which is a belief system or way of thinking that is based on the notion that all families are virtually the same" (p. 18).

Although Hardy (1989) asserts that TMOS is common in family therapy training programs as well as some of the literature addressing racial minority issues and applicable to all families, he sees this as particularly prevalent in the approach a therapist uses when working with racial minority families. Hardy (1989) concludes by stating that "it is important that the next generation of family therapists be prepared clinically, theoretically, and experientially, to recognize and accept the multitudinous ways in which families in general are like all other families, like some
other families, but like no other family" (p. 33).

Man Keung Ho's (1987) contribution to the literature is based on his book which presents a "how to" work with families from four ethnic minority groups: Asian and Pacific Americans, American Indians and Alaskan Natives, Hispanic Americans and Black Americans. The chapters all share a similar format with the same standard outline in the presentation of each group. The author attempts to provide a briefing on the political, social and economic problems that each group faces in the United States as well as the strengths and contributions of each group. It also covers a number of guidelines and strategies in working with the particular group. Most useful is that at the end of each chapter the author presents a case to illustrate some of the principles discussed in the chapter. The reader is not left guessing because there is a note written to the side of the principles and guidelines that he discussed earlier. Some of the same criticisms can be applied to Ho (1987), as were made of the previous authors noted in this chapter. He too presents 'snapshots' and uses as 'mini-ethnographies' which again have the possibility of being stereotypical.

Tseung and Hsu (1991) take a slightly different focus in their contribution to the literature. They do not deal with family issues from particular ethnic groups. Instead they focus on "dissecting the various subjects of the family: family systems, subsystems, development, family group and dynamics, problems, assessment and treatment- all the areas which need to be covered comprehensively in family mental health from a cross-ethnic/culture perspective" (p. xiv).
Tseung and Hsu (1991) utilize knowledge of the family from a variety of disciplines in addressing culture and family therapy. They integrate cultural anthropology, social and cultural psychology, and international family psychiatry. This addresses some of the criticisms by Maranhao (1986) and DiNicola (1997) about ethnicity and family therapy's lack of use for anthropology and other disciplines in presenting their analysis.

In their examination of cultural aspects of the family Tseung and Hsu (1991) present the reader with a general overview of culture and families. As such, the topics presented in the chapters are not based on ethnic groups in North America but family systems in other societies throughout the world. Tseung and Hsu (1991) avoid creating "a sort of Guinness Book of Cultural Stereotypes" (Maranhao, 1986, p. 267).

The last two chapters of the book cover 'culture and family assessment' and 'culture and family therapy'. In the former chapter, some useful points are given in avoiding "cultural blind spot-cultural scotoma" (p. 171) and "cultural myopia" (p. 175) in assessing the family. However, the authors present a long and detailed family assessment format which they state should be used "in order to conduct culturally-relevant and clinically comprehensive family assessments" (p. 178). Curiously, the only area missing in this family assessment is 'race'. The book ends with a note: "It is essential for the culturally competent family therapist to recognize the cultural dimensions of a family system and possess rudimentary cultural knowledge of the family, so that a culturally relevant family assessment can be performed based on
a culturally appropriate understanding of family pathology and problems" (p. 212).

There are a few family therapy books dedicated specifically to racial minorities in North America. Sharon-Ann Gopaul-McNicol (1993) wrote one of the few books devoted to West Indian families living in the United States and Canada. The book is divided into three sections. The first part gives a brief historical background of the West Indies including the socio political and educational factors that impact people from the region. The migration history of West Indians to Canada and the United States is also presented.

The Caribbean (or the West Indies) is a region of sixteen independent countries, three French departments, five British colonies in varying degrees of autonomy, a U.S. commonwealth and a U. S. territory, and six semi-autonomous members of the Kingdom of the Netherlands (Kuralansky, 1992).

Afro-Caribbean people are the largest group in the region but they are not a majority in the areas formally colonized by Spain. Other racial and religious groups such as Amerindians, East Indian Muslims, East Indian Hindus, Indonesians and Sephardic Jews play major cultural roles in certain islands (Momsen, 1993, p. 3). Blending among these various ethnic and racial groups have created a kaleidoscope of races and cultures which, within a historical context of colonial racism, further created a colour/class division unique to the Caribbean (Sunshine, 1988).

Out of this 'cultural tapestry' Gopaul-McNicol (1993) attempts to create a West Indian family prototype without being accused of generalizing. She gives
Jamaica special mention and sees it as "differing in some aspects from West Indian culture" (p. 40).

Gopaul-McNicol (1993) suggests an integrated approach in working with West Indian families. The three approaches are multi-cultural, multi-modal and multi-systems. Multi-cultural involves cultural identity wherein the therapist helps the culturally different client to adapt to or reshape his or her psycho-social environment. The multi-modal approach focuses on the behaviours that get in the way of one's happiness and how one behaves when one feels a certain way, as well as what the sensations are and what bearing these sensations has on behaviours and feelings. Other models include Bowen's systems therapy which Gopaul-McNicol (1993) sees as useful because the therapists is portrayed as a teacher who utilizes an educational approach to therapy.

She also suggests that Minuchin's structural approach would fit for West Indian families because "it emphasizes that an individual's symptoms can be attributed to a family's failure to accommodate its structure to changing developmental and environmental requirements" (p. 127). Gopaul-McNicol also adopts Nancy Boyd-Franklin's (1989) multi-systems approach in working with West Indian families. In this approach the intervention is at different systems including the individual, the family, extended family, church, community, and social services. Gopaul-McNicol (1993) ends the chapter with a case example to illustrate the multi cultural/multi modal/multi systems approach.

It is reassuring to see published work on family therapy and West Indian
families; however, Gopaul-McNicol (1993) seems to be placing the West Indian families' problems in their inability to adapt. She states, "West Indians have difficulty 'letting go' and adopting the concept of biculturalism. Many of them live in the United States without being citizens or celebrating American holidays" (p. 129).

One queries whether the goal of family therapy is to facilitate a process of 'letting go' and adaptation for West Indian families. Gopaul-McNicol (1993) should follow those who see differences among people as something that could be embraced as complimentary patterns that could provide for cultural resilience. In spite of this, Gopaul-McNicol (1993) leaves the reader with some useful information on some aspects of Caribbean history, culture and socio-political issues that clients may bring with them to therapy.

Boyd-Franklin's book Black Families in Therapy (1989) is described as one of the most comprehensive works addressing Black families in relation to family therapy. The book is divided into four main sections. The first section explores the cultural context of African-American families. It provides the reader with a comprehensive background into some major cultural issues like racism, skin colour, extended family patterns and religion and spirituality. Boyd-Franklin (1989) uses specific case examples to highlight the issue being addressed. The second section begins with an indepth review of the person of the therapist and the use of self and values that we all bring into therapy. Boyd-Franklin believes that this exploration is useful for therapists in general but particularly for those who work with Black families. She believes that the psychosocial factors specific to Black families such
as race or racism, resistance and mistrust of mental health services can result in premature termination. As such, it is important for therapists to explore the general issues and assumptions they bring to therapy and to be sensitive to those of the Black families they treat.

Boyd-Franklin (1989) presents the three major models in the field of family therapy that have contributed to the treatment of Black families. They are the structural family therapy model, the Bowen model and the paradoxical strategic/systemic approach. The multi-systems approach is then presented. A case example is also presented to demonstrate the multi-systems approach. The third section covers the use of the multi-systems approach with different Black family structures including single parent family, Black middle class families and biracial couples. The last section covers the training and supervision of clinicians who work with Black families.

This book is a very useful contribution to the family therapy field. Boyd-Franklin (1989) avoids presenting a stereotypical snapshot of the Black family. Although she believes that Black families represent a distinct cultural group she also adds that within that group there is a tremendous amount of diversity. Boyd-Franklin (1989) identifies four areas which make Black families distinct from other ethnic groups: African legacy, history of slavery, racism and discrimination and the victim system.

However, Boyd-Franklin refutes the existence of an "entity of the Black family" (1989, p. 6). She keeps stressing the point in many parts of the book that
"there is no such thing as the Black family". The case examples reported in the book are drawn from a northern, urban sample of poor as well as middle class families. Boyd-Franklin does not present a cultural picture of the Black family but looks at what the families bring to therapy which are "many issues specific to their race, cultural background, history and response to mental health services that must be addressed" (1989, p. 4). Boyd-Franklin (1989) also leaves the reader with a multi-systems treatment approach to bring about change in the lives of the families.

In the book Understanding Race, Ethnicity and Power, Elaine Pinderhughes (1989) takes a slightly different approach on the topic of diversity. The book is divided into eight chapters. The chapters examine the dynamics of ethnicity, race and power and how they influence human functioning. There are specific chapters on "Understanding Difference", "Understanding Ethnicity", "Understanding Race" and "Understanding Power". Pinderhughes (1989) does not focus on a racial, cultural or ethnic group. Instead she looks at how ethnicity, race and power emerge in practice. This is one of the few books that includes the issue of power in cross-cultural clinical relationships. The last few chapters of the book covers the assessment and treatment approach when working with culturally different others. A teaching model is presented in the appendix. A group format is suggested where participants are taught "how cultural identity and issues of power and powerlessness traverse the various levels of human functioning and affect their own behaviour as service providers" (Pinderhughes, 1989, p. 211).
**Summary**

In this chapter an overview of the literature on culture, race, ethnicity and family therapy was presented. As stated before, family therapy earlier had the wake up call on gender issues from feminist therapists. With the 1982 publication of *Ethnicity and Family Therapy* the field took notice of the role of ethnicity and culture in family behaviours and patterns of family functioning. Family therapists' conception of culture has broadened beyond just ethnicity to include race, class and religion. In responding to a question on ethnicity in family therapy, Montalvo (1982) states:

"The danger of the interest in ethnicity is that it can distract us from the ways that poverty and social economic circumstances—and short sighted policy makers can smash trample the family. That is not pretty, but ethnicity is pretty. I have nothing against the interest in ethnic patterns in families. I appreciate a good story on how one uses a family's ethnic background in treatment, but if you get too preoccupied with that kind of thing you begin to miss the more important social dynamics, like making sure that a family gets descent health care or that it is not locked out of the job market (p. 39).

Family therapists need to remember that there are many contributing elements in a family's distress."
CHAPTER 3

CLINICAL MODEL OF INTERVENTION

Introduction

The structural school of family therapy has its roots in a residential institution for boys in New York. The boys who attended the school came from predominantly New York inner-city ghettos. The techniques used at the time, "psychoanalytic, long-term, growth oriented therapy" (Piercy & Sprenkle, 1986, p. 26), did not seem to be effective with the poor families with children at the institution. In order to gain entrance with these families Minuchin and his colleagues developed new techniques which were concrete, action oriented and directed at the here and now interactions of the family. Over the years Minuchin has broadened his theoretical base from its beginnings with low socio-economic families and applied his approach to all socio-economic classes and races (Minuchin and Elizur, 1989; Minuchin & Fishman, 1981; Minuchin & Nichols, 1993; Minuchin, Rossman & Baker, 1978). It is fitting to use this model with a practicum that focuses on work with families from a variety of racial and class backgrounds.

Structural Family Therapy

Structural family therapy is a method of conducting therapy that is predicated on a set of assumptions about the organization and dynamics of families, about how they relate to individual problems, and about the processes that affect change in families and individuals (Colapinto, 1991). Nichols and Schwartz (1995) succinctly
describe the model as a blue print for analysing the process of family interactions.

The structural approach gives the practitioner a concrete conceptual map about what should be happening in a family if it is to be functional; it also provides maps about what is awry in the family if it is dysfunctional (Becvar & Becvar, 1996). The essential components of structural family theory consist of three constructs: structure, subsystems and boundaries (Nichols & Schwartz, 1995). Each of these will be discussed briefly.

**Family Structure**

One of the primary concepts of structural family therapy is family structure. Family structure is the invisible set of functional demands that organizes the ways in which family members interact (Minuchin, 1974). The structure refers to the regulating codes as manifested in the operational patterns through which people relate to one another in order to carry out functions (Aponte & VanDeusen, 1981).

When a mother tells her daughter to pick up her toys and the daughter refuses until her father shouts at her, an interactional pattern is initiated (Nichols & Schwartz, 1995). If this pattern is repeated, it creates a structure where father is competent as a disciplinarian and mother is incompetent.

According to Minuchin (1974), "transactional patterns regulate family members' behaviour" (p. 51). These patterns are maintained partly by universal and partly by idiosyncratic constraints (Aponte & VanDuesen, 1981). For example, for effective family functioning all families have some kind of hierarchical structure with parents and children having different amounts of authority. There must also be a
reciprocal and complementarity of functions as between a husband and a wife accepting interdependency and operating as a team (Minuchin, 1974).

As such, "if one parent is supercompetent and responsible, the other will be less so; if the supercompetent one gets sick then the less competent in some other way will take over" (Nichols & Schwartz, 1995, p. 213). The other set of constraints or rules are mutual expectations that develop idiosyncratically within each family. As Minuchin (1974) explains "the origin of these expectations is buried in years of explicit and implicit negotiations among family members, often around small daily events" (p. 52). These behaviours become so ingrained that often their origin is forgotten and they are presumed necessary rather than optional. In as much, the roles and patterns become a part of the family's structure and the key to understanding the structure of a family is found in the observation of the processes within and between subsystems (Becvar & Becvar, 1996, p. 189).

**Subsystems**

In the structural model families are differentiated into subsystems (Minuchin, 1974). The structural theory defines three subsystems: the spouse subsystem, the parental subsystem and the sibling subsystem (Minuchin, 1974). Subsystem divisions in family are typically made according to age differences where the adults in the family constitute one subsystem and the children another. Gender and shared interest or abilities can also create subsystems. In a blended family, the ties of blood and history between parent and children may create subsystems- "his kids", "her kids" (Minuchin, 1996). Family members may belong to several
subsystems at the same time and hold different levels of power within each group. However, the rule among these subsystems for the functional family is that of hierarchy.

**Spousal Subsystem**

Families begin when two people join together to form a spouse subsystem (Nichols & Schwartz, 1995). The main skills required for effective functioning for the implementation of its tasks are complementarity and mutual accommodation (Minuchin, 1974). The couple must learn to accommodate to each others' needs and preferred styles of interaction. The process of accommodation where each gives and gets cements the couple as a unit. The couple must also develop complementary patterns of mutual support.

Nichols and Schwartz (1995) describe "exaggerated and moderate complementary roles" where the former can detract from individual growth and the latter can enable spouses to divide functions, to support and enrich each other. An example of a complementary role can be seen when one spouse has the flu and feels lousy, the other takes over. Complementary patterns can become pathological when they are so exaggerated that they create a dysfunctional subsystem. Minuchin (1974) also purports a boundary around the spousal subsystem that protects it from familial or extra-familial systems which can provide each partner with a safe psychosocial haven where they can give each other emotional support.

**Parental Subsystem**

The addition of children transforms the structure of the family into a parental
subsystem. "The spouse system must now differentiate to perform the tasks of socializing a child without losing the mutual support that should characterize the spouse subsystem" (Minuchin, 1974, p. 57). The spouses must continue to spend time together. However, a clear boundary must be drawn which will enable the children to interact with their parents but excludes them from the spouse subsystem.

In addition to maintaining some privacy for the couple the boundary establishes a hierarchical structure for the parents where they can perform their leadership functions. "Parenting requires the capacity to nurture, guide and control" (Minuchin, 1974, p. 58). In order to fulfil these functions parents must have the power to do so. The children must get the message from the parental subsystem that they are in charge. Minuchin highlights the mistake that sometimes therapists and parents do by describing the ideal family as a democracy or that a family is a society of peers. The family with children is not a society of peers. Becvar and Becvar (1996) add that "a family is not a democracy, and the children are not equals or peers to the parents. It is from this base of authority that the children learn to deal with authority and to interact in situations in which authority is unequal" (p. 191).

**Sibling Subsystem**

The sibling subsystem becomes important in families where there are more than one child. A peer relationship develops and by their daily interactions they continue experimenting with relationships. The sibling subsystem becomes a laboratory for supporting, enjoying, attacking, scapegoating, and generally learning
from one another (Colapinto, 1991). Children acquire interpersonal skills at different levels with the sibling subsystem which will later influence relationships as they move out into extra familial peer groups, such as the classroom, society and later the world of work (Minuchin et al., 1978).

According to Minuchin (1974), the boundaries of the sibling subsystem should provide children with a haven of protection from adult interference, so they can exercise their right to privacy, have their own areas of interest, and be free to make their own mistakes. The sibling system allows children to be children. However, sometimes therapists may be called on to act as a bridge in linking and interpreting the children's world and the extra-familial world.

**Boundaries**

Boundaries are rules which prescribe who should be in contact with whom about what. These boundaries are invisible barriers which can be depicted graphically as encircling lines that surround individuals, families and subsystems. Boundaries serve to protect the autonomy of the family. As such, the rules prescribing that children should not participate in arguments between the spouses, or that parents should knock before entering a teenager's room are examples of boundaries.

The ideal arrangements for proper family functioning is for clear boundaries between subsystems. Clear boundaries are firm yet flexible. Where clear boundaries exist "they must be defined well enough to allow subsystems members to carry out their functions without undue interference, but they must allow contact
between the members of the subsystem and others" (Minuchin, 1974, p. 54). In this case, the clarity of the boundaries is much more important than the composition of the subsystem. As such, a parental subsystem could include a grandmother. This arrangement could be functional as long as the lines of authority are clearly drawn (Minuchin, 1974).

Most families fall somewhere along a continuum between the two extremes of diffuse boundaries or enmeshment and overly rigid boundaries or disengagement. Enmeshment and disengagement are terms referring to a transactional style in families. As such, they do not imply qualitative differences between the functional and dysfunctional. However, when families operate at the extremes this could indicate areas of pathology (Minuchin et al. 1978). In describing a family along this axis, one is addressing questions of differentiation, permeability and rigidity of boundaries among and between individuals and subgroups in a family, and between the family with its subsystems and its social environment (Aponte & VanDeusen, 1979, p. 314).

The boundaries of disengaged subsystems are rigid and overly restricted. Disengaged individuals and subsystems are relatively isolated and autonomous. Family members are isolated from one another and from systems in the community of which the family is a part. Family members function as though they have little to do with one another. They go about their day to day business with little overt dependence on one another for their functioning. "Only a high level of individual stress can reverberate strongly enough to activate the family supportive system"
The boundaries in the enmeshed subsystems are diffused and family members function as if they are part of each other. Unlike disengaged systems where a high level of stress is needed before family members can offer support, enmeshed subsystems offer a heightened sense of mutual support, where stressful behaviour in one family member causes excessive reactivity in the others. In families characterized by enmeshed relationships the spouse subsystem devotes itself almost totally to parenting functions and as parents they spend a lot of time with their children and do a lot for them. Consequently children may rely heavily on their parents may be afraid to try new things and afraid to fail. The cost to both the child and the parents is a loss of independence, autonomy and experimentation.

**Assessment and Process of Change**

In the structural family therapy model assessment does not precede intervention but is an inextricable part of it (Colapinto, 1991). Assessment is also inseparable from joining because it is in the process of joining that the family's interactions and sustaining structures are observed. This then allows the therapist to assess and diagnose the interactive problems in the family. It also results in the formation of a new system: the therapeutic system. Minuchin (1974) listed three phases in the process of structural family therapy: 1) the therapist joins the family and assumes a leadership position, 2) the therapist ascertains the family's underlying structure and 3) the therapist intervenes to transform the family's structure.
The structural therapist must join the family and respect its members and its way of organizing itself. Minuchin (1974) views the joining process as the underpinnings of therapy. Minuchin and Fishman (1981) see joining a family as more of an attitude than a technique. Minuchin and Fishman (1981) purport further that joining "is the umbrella under which all therapeutic transactions occur. Joining is letting the family know that the therapist understands them and is working with and for them. Only under his protection can the family have the security to explore alternatives, try the unusual and change. Joining is the glue that holds the therapeutic system together" (pp. 31-32). Joining is a necessary prerequisite to the structural family therapy model because restructuring cannot occur if the therapist is unable to earn the trust of the family.

The process of joining the family involves all those manoeuvres and movements that demonstrates to the family and all its members that the therapist respects and accepts them, and by accepting them the therapist eventually earns the family's trust and becomes accepted as its leader. The manoeuvres that the therapist can employ in joining with the family include maintenance, tracking and mimesis (Aponte & VanDeusen, 1981; Minuchin, 1974)

"Maintenance refers to the accommodation technique of providing planned support of the family structure, as the therapist perceives and analyses it" (Minuchin, 1974, p. 125). A case example is with a Chinese family, where the therapist joined when he recognized and accepted that the family friend who was brought in by the family functioned in the traditional role of the second wife. The
therapist communicated respect, acceptance and understanding for the traditional roles of first and second wife (Kurtines & Szapocznik, 1996).

In tracking, the therapist leads by following what the family says and does and encourages the members to continue. "In it's simplest form, tracking means to ask clarifying questions, to make approving comments, or to illicit amplification of a point" (Minuchin, 1974, p. 127). An example cited by Minuchin (1974) involved an enmeshed family where the father stated that he did not like closed doors. Tracking this statement, the therapist found out that the children were never allowed to close their bedroom doors, that a brother usually slept in a sister's room and the parents' sex life was curtailed due to the doors being left open. The therapist was able to use the family and its use of doors as a metaphor for lack of clarity of boundaries.

Through mimesis the therapist joins the family by "becoming like the family or one of its members through adopting the manner of speaking, body language, tempo or other behavioral mode of communication of the family" (Aponte & VanDeusen, 1981, p. 331). Mimetic operations are usually implicit and spontaneous. Minuchin (1974) states that experienced therapists may perform mimetic operations without even realizing that they did it. Personal experiences or interests that are similar to those of the family can be used mimetically to join a family.

Joining is the proverbial "foot-in-the-door," it gives the therapist an entry into the family. It also provides the therapist with an opportunity for making a diagnosis.
In family therapy, a diagnosis is the working hypothesis that the therapist evolves from his or her experiences and observations upon joining the family. Minuchin (1974) distinguishes between a psychiatric diagnosis and a family therapy diagnosis: "A psychiatric diagnosis involves gathering data from or about the patient and assigning a label to the complex information gathered. A family diagnosis, however, involves the therapist's accommodation to the family to form a therapeutic system, followed by his assessment of his experiences of the family interaction in the present" (p. 129).

When making a diagnosis, the therapist examines six areas of the family's interactions. These include the family structure, resonance, developmental stage, flexibility, family life context, and the identified patient's symptoms (Minuchin, 1974; Minuchin & Fishman, 1981). After successfully joining, the therapist formulates a plan and moves into the next phase of treatment - restructuring. Nichols and Schawrtz (1996) add that a therapist without a diagnostic formulation and a plan is defensive and passive. That is, "instead of knowing where to go and moving forcefully, the therapist lays back and tries to cope with the family, put out brush fires and help them through a succession of incidents" (p. 231).

Minuchin (1974) describes restructuring as the therapeutic interventions that confront and challenge the family into changing. He further explains that in restructuring, the therapist functions like the director and the actor: "He creates scenarios, choreographs, highlights themes, and leads family members to improvise within the constraints of the family drama. But he also uses himself, entering into
alliances and coalitions, creating, strengthening, or weakening boundaries, and opposing or supporting transactional patterns. He uses his position of leadership within the therapeutic system to pose challenges which the family has to accommodate" (pp. 138-139).

In bringing about changes the therapist employs a range of challenging techniques developed by the structural model. Three techniques will be described: enactment, boundary making and unbalancing (Aponte & VanDeusen, 1981; Minuchin, 1974; Minuchin & Fishman, 1981).

George Simon (1995) has suggested that enactment is the heart and essence of structural family therapy. According to Minuchin and Fishman (1981):

Enactment is the technique by which the therapist asks the family to dance in his presence. The therapist constructs an interpersonal scenario in the session in which dysfunctional transactions among family members are played out. This transaction occurs in the context of the session, the present, and in the relation to the therapist. While facilitating this transaction, the therapist is in a position to observe the family members' verbal and nonverbal ways of signalling to each other and monitoring the range of tolerable transactions (p. 79).

Although the therapist generally creates the context for enactment, families can sometimes engage spontaneously in interactions that the therapist can transform into enactment (Minuchin, Lee and Simon, 1996). It is not always that enactments will result in instant changes in family's interactions. The family may need to repeat the experience before new patterns can be maintained. A therapist may prescribe homework or tasks as a way of extending an enactment beyond the boundaries of the session (Colapinto, 1991).
In using the boundary making technique the therapist "modifies patterns of over- and under-involvement by allowing some members but not others to participate in a transaction" (Colapinto, 1991, p. 438). Examples of boundary making are when the therapist physically changes the seating arrangements to allow the spouses to talk to each other without interruptions from the children. The therapist can also sometimes use phrases or statements at the beginning of the sessions indicating that no one speaks for each other in the session. In the boundary making the therapist aims at changing family subsystem membership, or at changing the distance between subsystems (Minuchin & Fishman, 1981).

In unbalancing, the goal is to change the sometimes rigid hierarchical relationship of members within a subsystem (Minuchin & Fishman, 1981). In unbalancing the therapist takes side or joins in a coalition with one individual or one subsystem in order to unbalance and realign the system. The therapist needs to know when to use an unbalancing technique because it can become very risky in a session. The therapist's goal is to benefit the entire family and the family must always sense this fact. If he or she is entering a coalition against certain members they must know that this step is transitional and above all he or she is allied with the whole family in the therapeutic system (Minuchin, 1974, p. 150).

Enactment, boundary making and unbalancing are a few of the techniques used by structuralists in challenging the dysfunctional transactional patterns that keeps a family stuck. In a recent book Minuchin states that techniques may be important in training but the process of becoming a therapist involves a great deal
more than techniques (Minuchin et al., 1996).

**Outcome Studies**

Structural family therapy has been identified as one of the most researched models in family therapy. Its efficacy has been demonstrated with difficult families where children including adolescents are the identified patient (Breunlin, Breunlin, Kearns & Russel, 1988; Gurman & Knisken, 1981; Minuchin et al., 1978; Szapocznik et al., 1989).

In one of the earliest studies of structural family therapy Minuchin and his colleagues (1967) examined the effectiveness of the structural model with families of low socioeconomic status at a school for boys in New York. The boys were placed in the school because of problems including delinquency, aggression and other behavioral problems. The study consisted of 12 client families and 11 non-client families. Family patterns in both groups were evaluated prior to the onset of family therapy. Parent-child relationships in client families were reported to be more frequently clustered at the extremes of enmeshment and disengagement than were those in non-client families. At the end of therapy (between six and twelve months) a global evaluation was used to assess overall functioning in 11 of the 12 client families.

The therapists in the study reported clinically significant improvements in 7 of the 12 client families. Patterns of executive behaviour shifted in the client families after treatment. Mothers used less behaviour control than before, yet were more effective in their use of directives. The older children also increased their requests
for leadership from their mothers. Enmeshed relationships in these families were reported to have shifted to more functional boundaries between the parent and child subsystems.

Another study was conducted on psychosomatic families by the Philadelphia Child Guidance Clinic and the Children's Hospital of Philadelphia (Minuchin et al., 1975, 1978). The initial focus of the research was the relationships between emotional arousal and episodes of ketoacidosis in children with diabetes mellitus. Pediatricians at the hospital had observed that emotional precipitants in the child or the family often accompanied the episodes. The researchers studied over 200 cases where a cyclical relationship was identified where family conflict would precipitate the eruption of ketoacidosis. The symptom would subside after hospitalization only to reemerge when the child returned home. The study was also expanded to include anorectic and asthmatic children.

The psychosomatic families were found to differentiate themselves from other families by the manner in which they managed conflict. They diffused conflict by triangulating the child. This resulted in the splitting of the spouse dyad. Also a parent child coalition would be formed which resulted in a negative relationship between the peripheral parent and the child. Detouring conflict in the parental subsystem also occurred through an overemphasis on the concerns for the symptomatic child.

Based on these findings, Minuchin and associates (1975, 1978) undertook two studies to evaluate the effectiveness of structural family therapy in modifying the
dysfunctional family processes in these families. The first study was comprised of 13 diabetic, 10 anorectic and 10 asthmatic families. The second study (Minuchin et al., 1978) consisted of 53 anorectic families. No controls were used. Therapy lasted between 2 to 24 months and follow up was conducted after 6 to 80 months.

At the end of treatment and follow up most of the children in the psychosomatic families improved greatly in both symptom and psychosocial behaviours. Deterioration or re-hospitalization was rare. Gurman and Kniskern (1978) state that for ethical reasons no control group was used with families with psychosomatic children. However, even with this limitation, they argue that based on the treatment outcomes, structural family therapy should be considered the treatment of choice with psychosomatic families.

Cross-Racial Application

As stated earlier structural family therapy was initially developed from work with a specific racial and cultural group (poor Black and Hispanic families). Over the years the structural therapy model has been applied to all socioeconomic classes and races. However, there are a number of reports highlighting the success and usefulness of the structural model with families from diverse groups.

Nancy Boyd-Franklin (1989) believes that the structural approach being "primarily a problem solving one" (p. 122) is useful for working with Black families. She adds that for Black families the idea of going for treatment is relatively new, as such family therapy approaches that appear to pry before trust can be established may be rejected. The structural approach is focus, clear, concrete and directive.
Boyd-Franklin (1989) adds that with the focus on change, it directs the energy of the family toward the future and improvement rather than toward the past and blame (p. 122). Boyd-Franklin (1989) also identifies the concepts of 'boundaries', 'alignment' and 'power' as useful when dealing with cross-generational issues and the complexities that Black extended family kinship can create at times.

Marshall Jung (1984) propagates the use of structural family therapy with Chinese families. Jung (1984) adds that the "model focuses on structure which is the essence of the Chinese family" (p. 373). Jung (1984) also identifies the different concepts in the structural model - emphasis on social context in which family lives, appropriate generational boundaries, joining, focus on strengths and the therapist as an authority figure and change agent - and uses examples to show the suitability of the model for families in the Chinese population.

Szapocznik, Scopetta, Aranalde and Kurtines (1978) in their study with Cuban families have proposed that structural family therapy is well suited because of the match between this approach and the value orientations and interpersonal style preference of Hispanics. Szapocznik, Murray and others (1989) conducted a study that compared structural family therapy, individual psychodynamic child therapy and a control condition for 69 six-to-twelve-year-old Hispanic boys who presented with behavioural and emotional problems. The results suggest that structural family therapy was more effective than psychodynamic child therapy in a one year follow-up (p. 577).

Structural family therapy has been well tested and used with ethnically
diverse families of various socio-economic classes globally. In spite of this Hardy and Laszloffy (1994) still caution the therapist in ascribing universal meaning to some of the concepts, particularly enmeshment, when working with some racial minority families. They noted that Watson and Protinsky (1988) found that enmeshment is correlated positively with healthy ego identity development among black adolescents. However, this concept is sometimes associated with pathology in some families.

**Summary**

Structural family therapy focuses on the family and not on the individual. In working with changing the family the structuralist takes into account the individual, family and social context in which the family and its members live. Structural family therapy is characterized by its emphasis on hierarchical issues. The basic structural concepts are boundaries, subsystems, alignments and complementarity.

The goal of family therapy is to identify and change maladaptive patterns of interacting that keep the family from achieving its goals. Intervention is designed to resolve presenting problems by reorganizing the family structure. This can be achieved by seeing the family in action. As such, assessments require the presence of the entire family so that the therapist can observe the structure and the dysfunctional patterns.

The therapist joins with the family and makes a diagnosis which includes the problem and the structure that maintains and supports it. After successfully joining with the family the therapist can challenge and orchestrate change in the family's
dysfunctional and maladaptive patterns. Restructuring techniques can be concrete, forceful and often highly dramatic. In transforming families Minuchin (1996) also argues that the therapist should expand her or his intervention to agencies that provide services to families. These agencies should be considered as part of the family context. The therapist should expand her or his interventions in the directions of creating organizational changes that are family friendly.
CHAPTER 4

DESCRIPTION OF PRACTICUM

METHODS, PROCEDURES & EVALUATION DESIGN

Introduction

This chapter will provide a description of the practicum including the setting, the intervention, and the evaluation tools use in measuring the outcome.

Setting and Duration

This practicum was completed at the Manitoba Adolescent Treatment Centre (MATC) during the period January 1997 to August 1997. The Manitoba Adolescent Treatment Centre is an accredited non-profit, independent organization which provides mental health services for children and adolescents. It consists of the hospital program, a community services program which includes the Acute Treatment and Consultation Team, Community Child and Adolescent Treatment Services, Educational Psychiatric Services and Youth Forensic Services.

The hospital program has a residential and a day treatment program. There are nine assessment beds and sixteen long term treatment beds in the hospital program. Educational services for adolescents in the hospital program (residential and day treatment) are provided through the Montcalm School which is located on the premises and is operated in partnership with the Winnipeg School Division # 1.

The Community Child and Adolescent Treatment Services (C-CATS) began operation in September 1994. It is located away from the hospital program. The C-CATS provides community based treatment services for children and their families.
The families that were seen during the practicum came from the C-CATS and the hospital programs. Eleven families were seen for the practicum requirement (see Appendix A). The length of therapy ranged from a minimum of three sessions to a maximum of ten sessions.

Supervision

Dr. Don Fuchs of the Faculty of Social Work, University of Manitoba, was my practicum advisor. The other members of my practicum committee were, Dr. Diane Hiebert-Murphy, Faculty of Social Work and Kris Balchan, Family Therapist at New Directions for Children and Families (formerly Children's Home of Winnipeg). Dr. Fuchs provided ongoing supervision. Dr. Hiebert-Murphy and Mr. Balchan were available for consultation as needed. The majority of the family sessions were videotaped. This allowed for self-review, consultation and supervision.

Description of Intervention

The eleven families seen in this practicum were made up of seven immigrant families and four non-immigrant families from various racial, social, religious and cultural groups. There were families from The Philippines, Panama, Jamaica, Pakistan, Eritrea and Canada. In only three families were the children born outside of Canada. The families came from working class and middle class backgrounds. English was the second language for four of the eleven families. Christianity, Islam and Judaism were some of the practising religions. Three out of the eleven families had a child in the residential program for a period of time. In five of the eleven families the child was on a psychiatric medication. The psychiatric diagnoses
included depression, mania, brief psychosis and Asperger's Disorder. The medications included Prozac, Ritalin and Haldol. Therapy sessions were held in the families' homes and in the therapist's office. Sometimes adolescents would be seen individually at a fast food outlet or other restaurant.

There were a lot of problems in getting referrals for the practicum. My first criterion was for a number of families from racially diverse groups. I contacted Children's Home of Winnipeg, St. Boniface Hospital Family Therapy Department, Mount Carmel Clinic Cross-Cultural Program, Winnipeg Child and Family Services - South, Immigrant Women's Association of Manitoba and Manitoba Health- Cross Cultural Mental Health Program. These organizations were all unable to provide a significant number of racial or cultural minority families. Mount Carmel Clinic had the families but the program coordinator believed that referrals out of their program could have an impact on the income of their contract staff. Ms Linda Perry, intake worker at the MATC hospital program who works jointly with the Health Sciences Adolescent Psychiatry Program, facilitated seventy percent of the referrals. The families Ms Perry felt fit my criterion were opened to me through the MATC's Community Services Program. One family was referred directly through the Health Sciences Child and Adolescent Psychiatry Department.

**Evaluation Design**

Two instruments were used to evaluate the practicum. The Family Assessment Measure III (FAM III) (Skinner, Steinhauer, & Santa-Barbara, 1995) was the outcome measure used with the families. The instrument was administered
as a pre- and post-test to families. Some families were given the test during the second or third session. Some families did the scale at home and others completed it in my presence. I provided explanations of the concepts to the families who were recent immigrants and had some difficulties with reading English. The post-tests were given to the families at the termination of therapy. They were all completed in their homes without assistance from me.

The FAM III is a self report instrument that provides quantitative indices of family strengths and weaknesses (Skinner et al., 1995). The FAM III is based on a Process Model of Family Functioning which provides a conceptual frame work for conducting family assessments and research (Skinner, Steinhauer & Barbara, 1983). The FAM is based on Canadian norms (for sample questions see Appendix E).

There are seven concepts assessed by the FAM. A brief description follows. One of the overriding goals of the family is the successful achievement of a number of basic, developmental and crisis tasks, (Task Accomplishment) is deemed to be the most basic activity of the family. It is through the process of task accomplishments that the family attains or fails to achieve objectives central to its life as a group. The functions that accommodate these tasks include "allowing for the continued development of all family members, providing reasonable security, ensuring sufficient cohesion to maintain the family as a unit, and functioning effectively as part of society" (Skinner et al., 1995, p. 1).

Successful accomplishments of the tasks involve family members being
assigned to various roles and in which they are willing to perform effectively (*Role Performance*). Communication is an important tool in *Role Performance*. "The message sent needs to be clear, direct and sufficient, then mutual understanding is likely to occur" (Skinner, et al., 1995, p. 1). Crucial in the communication process is the content, intensity and timing of feelings involved (*Affective Expression*). When families are undergoing stress, affective communication is most likely to become blocked or distorted. (*Involvement*) refers to both the degree and quality of family members' interest in one another.

The process by which family members influence each other is (*Control*). "Critical aspects of *Control* include whether or not the family is predictable versus inconsistent, constructive versus destructive, or responsible versus irresponsible in its management style" (Skinner et al., 1995, p. 2). The manner by which families define the tasks and how they proceed to accomplish them may be influenced by (*Norms and Values*) of the dominant general culture and the families' own backgrounds (Skinner et al., 1983).

FAM III assesses the family from three different perspectives: 1) the General Scale, which focuses on the family's health or pathology from a systems perspective; 2) the Dyadic Relationship Scale focuses on relationship between specific pairs in the family; and 3) the Self Rating Scale which focuses on the individual's perception of their functioning in the family.

FAM-III is viewed as having excellent psychometric properties. As stated by Skinner et al. (1995): the overall reliability coefficients are very good. In the General
Scale for adults it is .93 while the overall reliability coefficient for children is .95. In the Dyadic Relationship it is .95 for adults and for children it is .94. In the self rating scale for adults it is .89 and for children .86. The coefficient alpha score on Social Desirability for adults and children is .87. The coefficient alpha for Defensive is .65 for adults and .70 for children.

A consumer satisfaction questionnaire (CSQ8) (see Appendix I) was also used to evaluate treatment outcome. This was a non-standardized instrument. It was an eight item questionnaire. The questions related to the families' satisfaction with the services, skill of the clinician, what was the families' experience, what was helpful, what was least helpful. The questionnaire was mailed out to the families. A stamped return envelope was included in the mailing. None of the questionnaires were returned.

Conoley and Bryant (1995) argue that paper and pencil measures may not be the most culturally sensitive methodology a therapist can employ to assess a family from an ethnic minority culture. Bray (1995) adds that most of the family measures are based on family relationships validated with white, Anglo middle-class families. Although, one of FAM's strength is that it is based on Canadian norms, it is unclear in the description of the families used in developing the measurement if it included an ethnic/racial/religious/culturally diverse group of Canadians.

Would the normative sample have included a Sikh family, Native family, Chinese family, Jewish family and would they have been recent immigrants or first, second or third generation Canadians? Did it account for socio-economic status as
well? While assisting the families in completing the FAM one of the main problems was the definition of family. For the Jamaican mother it was difficult for her to view her family as the five members of the household - that is - the nuclear family. Her sister and her father had a continued presence in their lives although they resided away from her home. Conoley and Bryant (1995) believe that the items may mean something very different among certain minority families. As such, the results should be interpreted with caution when used with families from minority cultures.
CHAPTER 5
CASE STUDIES

Introduction

The Families Studied

A total of eleven families were included in the study. Their characteristics are presented in the accompanying table at the end of this chapter. Three of my eleven cases will be discussed in detail and analysed in this chapter. These cases were selected because they represent the types of the families seen. They posed different types of challenges and they illustrated the use of the structural techniques with families within the context of cultural diversity.

To illustrate the nature of the intervention and its outcome each case will be presented and discussed according to the following format:

1) Brief description of the family
2) Source and reason for referral
3) Summary of initial interview
4) Structural assessment
5) The racial/cultural/class context
6) Treatment goals
7) Strategies to implement goals
8) Description and analysis of therapy

Alternate names have been used to maintain the confidentiality of the families concerned.
CASE 1: The Robertson Family

The Robertson family consisted of a forty-six year old mother (Barb) and a fourteen year old boy (Paul). Barb is a white Manitoba-born Canadian. Paul's father (Dave) is a Black Chicago-born American. Barb and Dave separated when Paul was under a year old. His father remained in Vancouver and Barb returned to Winnipeg. Barb is the second in a sibling group of eight. Barb's family all live within close proximity of her home in a predominantly white working class neighbourhood in the city. Dave resides in Vancouver and his family lives in Chicago.

Source and Reason for Referral:

Paul was referred by the school counsellor for a psychiatric assessment. Following Paul's transfer from one high school to another his attendance became sporadic and he preferred to stay at home in his room and work on the Internet. The referral source had requested an urgent assessment because "Paul was refusing to return to school, was locking himself in his room, pacing the floor at night, had not eaten in three days, had expressed a desire to kill himself, was refusing to talk to the social worker or the psychologist and had bolted from the house when they came to the home. He was also verbally abusive towards his mother and had threatened to physically hurt her".

A member of the Community Services Crisis Team went to see Paul in his home. He was not thought to be depressed. The clinician recommended family therapy. The clinician who was white believed that Paul might benefit from therapy
with a person of colour. Barb later refused therapy. She stated that Paul would not speak to anyone. Barb had started seeing an individual therapist. Paul attended the first session and refused to return. The following week the school counsellor and Barb’s therapist called the MATC and the Health Sciences Centre intake workers and demanded that Paul be removed from his room under the Mental Health Act or the Child Welfare Act and be placed at the MATC or the Seven Oaks Youth Centre. At this point I decided to arrange a home visit.

**Summary of Initial Interview:**

I was expecting to conduct this interview with a highly resistant adolescent who would choose to stay in his room and speak to me through the door. However, when I arrived at the home Paul appeared well groomed and patiently sitting in the living room. He had black tightly curled hair. He was of average weight and looked his stated age of fourteen. Barb was a petite white woman. There was no obvious physical resemblance between Paul and Barb. Paul had a warm smile and a pleasant personality. It was not difficult to engage Paul. He responded to all queries. He had no plans of killing himself. He believed that his mother thought that he was depressed. He gave no explanation for not attending school. He added that he actually planned to return to school the following Monday. When asked about his father, Paul stated that he spent Christmas 1996 with his father in British Columbia. Prior to this visit he had not seen his father since his birth. There were also plans to visit his paternal family in Chicago during the summer.

At the end of the meeting I spoke to Barb in the kitchen. She commented
that she was surprised that Paul talked to me. She added that when she got home
he had showered and was waiting for my arrival. She expressed concern about his
non-attendance at school and his isolation in his room. She added that her
individual therapist suggested that Paul be placed at the Seven Oaks Youth Centre.
The therapist requested that I contact her as soon as possible.

A session was scheduled with Paul and his mother at my office the following
week. At this session mother reported on the meeting she had with the school
personnel to facilitate Paul's return to school. The school decided to place him in
a class "for bright children who have an attendance problem". They would also
allow him to do one course by correspondence.

Barb gave some background information. She stated that she met Paul's
father in Winnipeg. They relocated to British Columbia after their marriage. A few
months after Paul's birth she returned to Winnipeg. She found it difficult to live with
her husband due to his drinking and physically abusive behaviour. She also felt
isolated in Vancouver with all her family in Manitoba. She returned to full time work
when Paul was approximately two years old. She felt guilty about leaving Paul. As
such, when she returned home from work she would spend a lot of time with Paul.
She never had another relationship. Paul became her relationship. She stated that
she and Paul did a lot of things together. These included going for walks and
shopping. Paul described his relationship with his mother as friends and "she
always takes me for walks. I feel sometimes she treats me as her husband".

I used the flip chart to draw a family map. Paul said he never saw himself
below his mother. He said that when he was growing up he was on the same level with his mom. He stated that now he is above his mom. "So you are the king of the castle?" "Yes", he said with a smile on his face. I then asked about chores. Paul answered that he never did any chores, mostly because he never received enough money. Barb did the cooking, cleaning, shovelling the snow, mowing the lawn, putting the dogs outside, cleaning their mess, doing Paul's laundry and picking up after Paul. Barb complained that Paul had recently begun calling her names. He also took the scissors and cut the telephone line when Barb was calling a relative at a time when Paul was acting up. Paul attempted to justify his behaviour because Barb used to hit him when he was younger. Barb challenged Paul on his story, however she admitted that she has a bad temper and had in the past been verbally aggressive towards Paul. However, in a last minute plea for help Barb ended by saying that she was becoming afraid of Paul and was worried that he was becoming like his father who she left because of his abusive behaviour.

Structural Assessment:

In this single parent family system the boundaries between mother and son were diffuse and the mother could not exercise an executive function in the home. From the information provided Barb, as expected, had a very close relationship with Paul while he was growing up. There was no one to challenge the boundary between the parental subsystem and the child subsystem which was extremely permeable. Paul participated in parental day to day dealings and Barb participated in Paul's day to day functions. Paul performed a role as his mother's confidant and
provided his mother with emotional support when needed. The extreme enmeshment in this mother/son dyad included Paul sharing his mother's bed until a few weeks before the behavioural problems surfaced.

Barb maintained the same degree of involvement with Paul she had when he was a child and continued with the same intensity as he moved into adolescence. Barb never attempted to form any other relationships outside of the relationship she had with her son. This degree of involvement, although appropriate for a child, may suffocate an adolescent. The blurring in the boundaries continued as Paul continued to share his mother's bed as a teenager. Barb did not help Paul make the necessary transition to adolescence. It was convenient for her to keep him in her bed to nurse him when he was a baby. This continued when he experienced nightmares and would come to her room. Barb left him in her bed to avoid any nightly hassle at getting him back to his room. Paul escaped the unhealthy relationship with his mother by locking himself into his room. He removed the lock from the outside making it impossible for anyone to enter.

The racial/ethno/cultural context:

Paul's father is Black and his mother is white. Paul has black textured curly hair. He has a light brown skin colour. The school officially identifies him as 'mulatto'. In its current usage 'mulatto' covers someone who is of varying factions of African and European heritage (Root, 1996). It should be noted that not all racially mixed people view this as a positive designation, nor is the term widely used in common speech especially among Blacks. White mainstream society further
defines him as Black. His mother attempted to raise him with a non-racial identity in a predominantly white community. To her he was neither Black nor white he was simply “my son Paul”.

Erik Erikson (1968) the pioneer of the concept of identity, defines it as the creation of a sense of sameness, a unity of personality felt by the individual and recognised by others as having consistency in time-of being, as it were, an irreversible historical fact. One of the main tasks of adolescence is finding a separate definition of self or, to use Erickson’s term, an identity.

One of the many problems associated with a non-racial identity is that families are remiss in actively preparing the child for racial prejudice that they may encounter. Black-white children are fundamentally viewed as African-American when dealing with the larger world (Miller & Miller, 1990). As such, Paul needs to be taught Black-Canadian survival skills in order to ensure healthy bi-cultural adaptation.

Barb is a white single parent raising a Black child in a predominantly white environment. One of the challenges for Barb is how to parent a Black child in the absence of a racial role model. Miller and Miller identify that the primary tasks of Black parents are to:

1) negate dominant cultural messages which undermine self esteem and efficacy, (2) validate uniqueness, (3) teach strategies for emotional and physical survival in the face of racism, and (4) foster the coping mechanisms for dealing with legal and defacto discriminatory experiences (1990, p. 170).

Adolescents from mixed race relationships have an added dimension in
searching for a racial identity. There are various studies which advocate that children from biracial, Black/white unions should claim both their heritages by identifying themselves as biracial (Bowles, 1993; Winn & Priest, 1993). This becomes even more complicated when for years the "one drop rule" applied where those who had even one drop of Black blood were considered to be Black and thus had to identify themselves as Black because society would ultimately categorize them in this way (Kerwin et al., 1993, p. 221). It should be noted that the "one drop of blood" rule originated in the antebellum U. S. south and was created to maximize the number of slaves (Ramirez, 1996). Ironically this test was not used to identify Native Americans or any other racial groups. There is a movement in the United States to lobby the government to add a multiracial category in the year 2000 census (Blustain, 1996, p. 21). Paul may not have to deal with this issue at this level in Canada. However, a bi-racial child in Manitoba is an ethnic minority, and must therefore acquire coping skills related to minority existence (Miller & Miller, 1990).

**Treatment goals:**

1) Establish clear boundaries between the parental and the child subsystem.

2) Help Barb assume the position of executive in the family.

3) Strengthen the boundary around the child subsystem.

4) Help Paul develop a positive racial identity.

5) Assist Barb in seeing her role in Paul's development of a positive racial identity.
6) Facilitate Paul's return to school.

**Strategies to implement goals:**

1) Create distance between Paul and Barb by encouraging Barb to develop activities in the community which do not include Paul.

2) Teach Barb how to instill racial pride and racial identity in Paul.

3) Use myself as racial role model for Paul.

4) Encourage Barb to involve the paternal extended family in Paul's development of a positive racial identity.

5) Help Barb articulate her expectations of Paul by preparing a list of household responsibilities during the family therapy session.

**Course of Therapy**

From the first visit to Paul's home I observed that there were no symbols representing his mixed race. I took Paul to a Caribbean restaurant. This was to assess his level of comfort in a predominantly black environment. He was willing to explore different foods and particularly enjoyed the dessert. During the evening I tried to focus the discussion on 'black-youth-culture' and identity. I did this by asking Paul about music and sports and various books and authors.

Paul did not show any discomfort when talking about issues with racial undertones. He did not have any specific sports heroes. He did not own any musical compact disc by a black artist or a person of colour. Paul kept some of the dessert and when I took him home he excitedly wanted his mother to share in the dessert.
I felt I had begun to join with Paul and there was a commitment to continue therapy.

Sessions Three and Four:

From the third session a formulation of this single parent family structure began to evolve. Barb did what many single parents will do by placing Paul's needs ahead of her own. Everything revolved around Paul. The same level of involvement Barb had with Paul when he was a young child continued into his adolescence, to the point where Paul commented that "she treats me like her husband". I asked him to expand on what that meant. He added that "we always have to go for walks". Barb explained that she thought it helped after they had an argument for them to take a walk and talk things over.

It is common in some single parent families that parents tend to rely on their children for companionship. In an effort to be there for her son Barb abandoned other aspects of her life and focussed on being a mom and a friend to Paul. Barb was committed to her son. This was an enmeshed parent/child relationship. The goal here would be to guide the adolescent to develop some form of autonomy. Paul had already dramatically moved into his room and locked his mother out. Barb complained that Paul still used her room. The next step was to encourage Barb to develop a life outside of her parental role. I suggested that Barb contact a friend and have a 'woman's night out' or take an evening course from the leisure guide. By the next session Barb should come up with an activity that did not include Paul. Barb said she felt pity for Paul being at home during the day. She felt it was her
responsibility to get him out after supper.

Barb came in very angry for the fourth session. She was angry that Paul spent his day at home disturbing her at work by phoning and "pestering" her about the Internet. Barb emphasized that the agreement was "no phone calls at work unless it is an emergency". Paul responded that he did not think he was "pestering". Mother responded "you phoned me three times....what part of no don't you understand?". Apparently, Paul had completed an application for connection on an Internet provider called Blue Sky. He did not mail the application; instead he wanted his mother to phone the company and lie that she had mailed this application form and had not received the service. Paul then expected the company to make the connection to the customer.

Barb was attempting to assert her executive position as the parent and made it quite clear to Paul that she was not doing anything more to facilitate his non-attendance at school. "He's bored. He should be in school around the kids and doing things". Paul responded "that's what you think I should be doing". When I asked Paul what he thought he should be doing he said "I have no idea what I should be doing....I don't care". I queried aloud why would Paul think that Barb would lie for him and make a new Internet connection while he was not attending school? Barb responded "because I do what he tells me to do....I don't know how to deal with this anymore". Barb was expressing a feeling of helplessness and hopelessness that the situation will not change.

I had to intervene to alter Barb's view of the situation and to hold on to her
parental power. "Barb, it is difficult for you knowing how much you want your son to have an education and to see him jeopardising those chances by staying at home, but you are making steps to handle the situation by standing firm with Paul that the Internet connection is not up for negotiation". Paul did apologize to his mother and promised that he would not be calling her at work for anything other than an emergency. He added that he would not bug her about any Internet service including America On Line or Blue Sky.

At this point I felt I should introduce race into the therapy session. Up to this point I had known little bits of information about the precipitating factors that led to Paul's school avoidance. I knew he was in a 'special class' and he was removed from the class by the principal. I wanted to explore if there were any connections between his race and his removal. I also wanted to explore racial identity issues with Paul. Barbara Okun (1996) sees an avoidance of addressing racism and identity issues in therapy as similar to modern racism. She adds "modern racism exists in the training and practice of mental health practitioners. The training ignores the significance of racial identity on the psychological development and functioning of Whites and people of colour, and cross racial therapist-client dyads minimize or ignore racial issues" (1996, p. 212).

I felt myself becoming uncomfortable in introducing the topic of race. From the following excerpts you will notice that Paul appeared to minimize incidents that might have racial undertones. His mother on the other hand was very clear in saying that the incidents were racially motivated and she should have explored
them further:

Therapist:  How do you see yourself ... what do you call yourself?
Paul:  What do you mean?
Therapist:  Like I call myself a Black woman?
Paul:  Nothing.
Therapist:  At this stage children go through an identity stage. Do you see yourself as Black?
Paul:  Yes.
Therapist:  How do others see you?
Paul:  I have no idea.
Therapist:  (To Barb) How do you see him?
Barb:  I see him as Black. I see a lot of hurt he suffered ... I kind of let it roll off my back and say that Paul is a tough kid he will survive that ... a lot of incidents he told me about and I just say ah! these people are ignorant and it continues on and on ... there has been times he has been teased, I think it bothers him a lot more than he says.
Therapist:  Does it bother you ... can you recall any incidents?
Paul:  Actually I can't.
Paul:  I remember one incident ... but people don't say anything to my face.
Therapist:  Did it ever bother you?
Paul:  Yes, sometimes.
Therapist: You went to a very white school.
Paul: So is my previous school.
Therapist: Were you the only Black student?
Paul: In the school?
Therapist: In some of your classes?
Paul: At one school, in all of my classes.
Therapist: At home your mom is from a large extended family and you are the only Black person?
Paul: Yes.
Therapist: Do you ever want to be different?
Paul: No.
Therapist: Sometimes in classes they say things which could sometimes be offensive towards a group of people or culture. Could you recall anything like that happening?
Paul: No not really.
Therapist: So you can't recall anything happening?
Paul: Like in early grades? Most likely in one school.
Therapist: Did you then come home and tell your mom what was happening?
Paul: No ... not always... it did not really bug me.
Therapist: Barb, you feel there were things-
Barb: Definitely! I can pick out a few incidents that happened when he came home upset ... At day care-
Paul: The two brothers?
Barb: I came to pick you up at the day care, you were quite nasty to me and you ran away?
Paul: I can't remember that, I was probably four or five.
Barb: You were old enough to walk home. I left you because I could not chase after you. Dave brought you home because you were mad at me. The director of the day care brought him home. These boys had called him the "N" word and he was very upset-
Paul: The "N" word? Oh yeah.
Barb: He was nasty to me and ran away.
Paul: Oh that was when I was 6 or 7, I can't remember.
Barb: Then there was another incident when you were on the bus with Steven and when you got off this lady was following you all and told Steven why was he hanging around with bad people and I asked you to tell me who was this woman...
Paul: I don't remember, I don't remember, I don't keep these things fresh in my mind.
Barb: And the other incident at school?
Paul: John Bailey?
Barb: No they were checking your hair for lice and--
Paul: I don't think that was racist.
Barb: I don't know what it was but she was checking the kids hair in the
lunch room for lice - something they do regularly and she did not want to check his hair because it was dirty. Paul has a shower every morning before he goes to school.

Paul: Actually she was touching my hair and she goes “do you ever wash your hair?”

Barb: Even if it wasn’t race these things can be hurtful.

Therapist: When you were in high school you were in a special class?

Barb: No. In a previous school I was in a grade 7 advanced class.

Therapist: You left that special class?

Paul: I was kicked out and continued grade 7 in a regular class. Then at high school I went into grade 8 and spent about 2 months.

Therapist: When you got kicked out do you think it was because you were black you got kicked out.

Paul: No.

Therapist: Then why do you think you got kicked out?

Paul: I don’t think I had enough marks or something.

From this segment I will say that racial issues were silent in the home. Although Barb stated that she identified Paul as Black, I believe she kept that to herself and did not share it with Paul. When Paul said he saw himself as black I think for the first time he was asked that question and responded to a leading question. Paul was raised race blind and colour-blind. He knew he belonged to a
minority group by the racially defined incidents which occurred throughout his growing years as well as the media image of Blacks and racism. He became aware without anyone telling him that he was the only Black child in the school.

Similarly, the mother’s passive non-confrontational style in addressing Paul’s experiences of racism did more damage to Paul’s development of a positive sense of personal worth and self-esteem. In order to face the negative experiences which eat away at a child’s self esteem and hamper the development of a positive racial identity the parent needs to assist the child in developing or fostering ego-strength. Reddy (1994) identifies this dilemma when the parent is white and the child is black. She adds that “if your family is white, you would not have to teach your child to protect himself from hurtful words and particular dangers. If you are black, you would have familial and personal experience to draw upon in teaching your child how to negotiate the world safely, with his self esteem and sense of possibility protected” (p. 105). A white parent with a Black child may have to start from scratch.

Miller and Miller (1990) propose one way of teaching children how to address discrimination:

A biracial child has been called a "nigger" by a peer in the school classroom. The parent who offers only sympathy is using a passive coping style, while the parent who calls the school and the offending child’s parents has used an adaptive active approach to handling the incident. Active coping helps the child correctly perceive racism and teaches how to handle discrimination without feeling personally stigmatized (Miller & Miller, 1990, p. 172).

I continued to explore in this session the home environment. I asked about
pictures or other positive Black or mixed raced items in the home. Paul responded that there was nothing. Barb reminded him that there was a photograph of the paternal family on the wall. Paul stated that he never noticed anything on the wall. It was also established that there were no books or discussion by Barb about Black literature, art, history or culture.

Barb: You are right, his life is very white.
Therapist: (To Paul) so you grew up pretty white.
Paul: Yes, pretty much.
Barb: Very much so and we just did not hang around with anybody outside of our family. We have one East Indian friend, we went to her place a few times that's about it. I don't know anybody in Winnipeg. In Vancouver is another story. When we came back we started from scratch. I kept in my little neighbourhood-
Paul: Which is totally white.
Therapist: You have to find an identity I guess.
Paul: I guess so.
Therapist: How are you going to go about finding an identity?
Paul: I guess ... I don't know.
Barb: I had thought about that when he was young. I thought probably a big brother - but they stop at age twelve. All he's had is his mom. Unless I had moved to the inner city.
Barb: We are planning to go to Chicago this summer. It will be an eye opener for Paul.

Therapist: To see his people. (Paul laughs).

Barb: His head will swizzle and his eyes will be as big as 'gauze'.

Paul: Why?

Barb: Mine were! It is just a different world from Canada ... posters on the bus and on the street, commercials on TV, everything was Black everything, everything. I know what he must feel with his life here.

Barb: Never thought much about it, never thought that it would make a difference. (To Paul) Does it?

Paul: What are you talking about?

Barb: Submerged in this little neighbourhood with all my family. First thing you said about Vancouver when you came back was that you did not mind living there. You saw a lot of different cultures.

Paul: I don't like Winnipeg at all.

Sessions five, six and seven:

Session five was spent constructing a genogram (see Appendix B). This allowed Paul to get a graphical understanding of his mixed race heritage. An interesting exchange took place towards the end of the session. Barb was informing me of how bright Paul was and "so full of confidence"; but now he does not like himself. Paul responded that he liked himself now. Barb told him he could
not like himself because he is always saying "I am too fat, I am ugly, I am too short and my hair".

This revelation about hair opened up another avenue for Paul to talk about a major point for Black and mixed race identity formation in children. I shared with them my experience when I moved to the Winnipeg in assuming that any hairstylist would be able to cut my hair. However, when I called several Salons for an appointment I was politely told that they do not do Black hair. This infuriated me to the point that I wanted to call the Human Rights Commission and lodge a complain.

Barb stated that they have tried many hairstylists and they have all done a poor job. Paul would invariably come out crying. Lately he has been using a hat to cover his hair. He recalled going to one shop where they did not even comb his hair but just used the razor. He said he came out with big holes all over his hair. I gave them the telephone number of an experienced male Caribbean barber.

By the next session Paul came in without his hat. Barb stated that they went to the shop after leaving the session. They got an appointment right away and Paul had the best hair cut of his life. He also got a number of products to keep the hair manageable. Paul was feeling like a new person.

During the middle phase of therapy a letter was received from the referral agency requesting an urgent meeting to address the inability by the MATC Community Services program to address the treatment needs of the adolescent, being "possible depression and risk of suicide". The referral agency believed that a psychiatric assessment was requested and to date the intervention consisted of
a recommendation for the mother to attend a "support group for parents raising black children and a social work student from the MATC who has visited the home twice and taken Paul to a Jamaican restaurant".

Imber-Black (1991) advises that when a family is referred for therapy by another system, the family therapist should immediately begin to think in macro-systemic terms. As such she recommends a family-larger-system assessment be conducted. This assessment begins with finding out which larger systems are currently involved with the family and the crucial piece is to discover how these systems and the family define the problem and preferred solutions.

When my involvement began with the family they were involved with the school psychologist, the school social worker and a private therapist. Imber-Black cautions that family-multiple-helper systems are often beset by disputes over who holds the "correct" definition of a problem. These problem definitions may be shaped by the particular beliefs that underpin specific agency or professional mandates. In the case of this family, the school psychologist may define Paul's problems as "psychological maladjustments." The social worker may define the same behaviours as based on the single parent status.

According to Imber-Black (1988) situations like the above can lead to a symmetrically escalating battle over what problems should be addressed and what the appropriate solution should be. Various alliances and splits can emerge as certain family members and certain helpers join in supporting particular problem definitions or promoting preferred solutions. This appears to have occurred in this
Imber-Black (1988) recommends that a family-larger-system interview be held as part of the assessment process. This interview was held without the family members. Present were the school psychologist, the social worker, a representative from the school division, the private therapist, the program manager from the community services program, the mental health clinician who did the initial assessment interview, and myself. There were clear alliances in the room with the school and the private therapist on one side and the MATC group on the other side.

The tone and manner from the educational team was rather cold and hostile. The individual therapist presented her definition of the problem which included Paul being at high risk of physically assaulting his mother. She believed that the solution should be a locked placement or admission to a psychiatric facility. It is interesting to note that the therapist had seen Paul with his mother on only one occasion at which time Paul walked out of the room after a few minutes and refused to go back. The mother continued seeing the therapist on an individual basis.

The social worker believed that Paul was depressed and suicidal. The perceived solution was a psychiatric assessment with probably a trial of pharmacotherapy. The psychologist saw Paul as having emotional problems. He was not clear on a solution. None of the systems were successful in engaging and joining Paul in a therapeutic relationship. They did not necessarily agree with my view of the problem; however, it was agreed that I should continue with the family therapy intervention. In addressing their concerns for Paul's suicidality they were
told that mother could take him to the Children's Hospital emergency if he became suicidal. The school system planned to submit a referral for a psychiatric assessment through the Child Guidance Clinic.

Two significant issues emerged during the meeting. One was that Barb felt that a disproportionate amount of time was spent by me with Paul and that she was not able to talk to me individually about things she was not comfortable saying in the presence of her son. It was also interesting to see how the members of the different macro systems saw their definition and preferred solution as the truth rather than one more point of view. Racial identity issues were not acknowledged as a contributing factor to Paul's presenting problems.

The following day I met with Paul for a planned individual session. We went to another restaurant. This time Paul talked about an incident which occurred while he was waiting for his mother at MacDonald's where a security guard asked him to leave. He told the guard his reason for being there and indicated to him that he had money. Upon leaving a white old man offered him money. Paul felt insulted and harassed. We explored if he was approached because of his skin colour and how he could deal with similar incidents in the future.

I arranged an individual session with Barb. She admitted that she was feeling that I was blaming her for not exposing Paul to Black history and Black culture. I remarked that my tone may have appeared judgmental. Barb agreed that part of Paul's problems could be viewed from his negative experience as a result of his skin colour. She identified a number of situations over his life which she knew were
racially motivated but she never did anything about them. She added that Paul would always pick up on incidents and she tended to minimize them. She said "I can't believe that anybody could be so ignorant and hurt people just because of the colour of their skin."

Barb used denial because if she was to accept that it was because of his skin colour she would then become very worried because she would realize that her child is facing a bigger problem which she does not understand or have the knowledge to help him. For Blacks their radar is up at all times, as such, they may arrive at a conclusion of racism with which it could be hard for a white person to concur. Barb talked about experiencing different treatment from some people when she is out shopping with Paul than when she is alone.

**Sessions Eight and Nine:**

After the individual session with Barb the relationship improved. Barb appeared more comfortable during the remaining sessions. In order to break some of the patterns that occurred in the home and to continue moving Barb into her parental position I decided to have mother and son participate in an exercise of identifying each other's responsibility as members of the household. I used a flip chart. I wanted Barb to be in control of this exercise which was to negotiate a set of responsibilities that would be consistent with her son's emerging needs as an adolescent and would also meet her need as a parent to guide and protect.

Barb identified her responsibility as a parent which included providing food and shelter for Paul and setting limits. Paul's responsibilities included taking care
of his laundry, the yard work, mowing the lawn, shovelling the snow, cleaning the
dog’s mess, cleaning his room and sharing in the dishwashing.

Barbara Coloroso (1995) adds that “from the day we start letting them take
responsibilities and make decisions, until they leave our home, it is helpful to have
a plan to constantly increase the number of responsibilities and decision-making
opportunities. Then when they do leave they will be making their own decisions and
assuming full responsibility for their behaviour” (p. 75). Paul was also expected
to start into his special classes in a few days. His exam for the correspondence
course was scheduled within the next four weeks. Paul indicated that he planned
to complete the examination even though he did not study.

**Sessions Ten and Eleven:**

In the weeks leading up to this session I was becoming concerned about the
slow pace that change was occurring in this system, particularly Paul’s continued
resistance to returning to school. I was also concerned that if Paul did not attend
school this term there was no guarantee that he would return in September. I
consulted with one of my advisors. She recommended bringing some intensity to
the session by confronting Paul on his attendance. Barb came in a few minutes
before Paul. She stated that she was very angry with Paul.

Barb reported that the night before Paul demanded that his window be
covered because people were watching him from the street. Barb felt that she was
ready to give up. She did not want the windows to be covered. She felt all the
windows in the kitchen were covered because Paul was concerned about people
watching him from the back lane. She added that to appease him she complied and covered the windows. Barb was angry with herself for allowing Paul to be in charge. Paul came in about fifteen minutes later. Although Barb was very upset for a few minutes before Paul arrived she did not display any feelings of anger when he walked into the room. Paul presented just as calm.

However, I used this opportunity to increase the emotional intensity in the session, to bring some of what goes on in the home into the room, I told Barb to talk to Paul about what she was sharing with me earlier. An emotional exchange took place between Barb and Paul. Without my encouragement Barb firmly presented Paul with a bottom line. "I love you, I am worried about you but I cannot continue seeing you waste your life and terrorize me in the process. I expect you to attend school, I expect you take on your responsibilities at home. If you cannot do that then I feel I am failing as a parent and maybe you should live with foster parents while we work on these issues." Tears were flowing form Paul's eyes but he still maintained a defiant look on his face.

Paul did not write the examination for the correspondence course which was scheduled for the same day. His reason was he "just did not feel like doing it." I told Paul that his apparent anxiety around people staring at him in his home and his continued refusal to attend school had left me with concerns that a psychiatric assessment may be helpful to rule out biological problems. Paul appeared surprised and hurt at my sudden reformulation of the problem as bio-chemical and possible referral to a psychiatrist. He turned his hurt into anger. He tried arguing
that people always close their blinds in the night because it was easier to see indoors during the night than the day. I added that this may be true but using the description from his mother, it appeared that he was becoming obsessive and unable to negotiate with his mother and accept that she did not want the last window in the house to be covered up. Paul then told his mom that he would remove the blind when he returned home.

It was difficult for me to mention to him the referral to a psychiatrist. It felt like I was using a psychiatric referral as a threat. I also felt like I was giving up on him. The session ended with a promise to give Barb and Paul a call with the date for the psychiatric assessment.

The day after this session I received a call from an intake worker from the Child and Family Services. Barb apparently had followed through on her ultimatum. The worker indicated that the 'after hours staff' received a call from Barb requesting removal of her son from the home. As it did not appear to be an emergency the agency agreed to follow up the following day. Barb had given the worker my number. I contacted Barb. She stated that when they arrived home Paul was still very upset and angry. He immediately removed the window covering as promised. However, he then threw a pot of boiling water from the stove. Barb felt that he was overstepping his boundary and she refused to be intimidated by him and feel like a victim. She stated that "I was surprised that I picked up the phone and asked them to take him; I don't know if I would have been able to see someone take him away but I could not take his behaviour anymore. I am not going to behave like a
victim anymore."

Barb then added that Paul ran out of the house after she made the phone call. He came back home a few hours later with his eyes all swollen from crying. He was still in bed when she left for work. But by the time she arrived at work he began calling her and begging her not to put him into a foster home. He told her that he had called the school and would be attending school the following day.

Barb came alone for the eleventh session. She reported that Paul had continued attending school since the incident. She apologised for Paul's non-appearance. She said that he was angry with me for saying that he needed to see a psychiatrist. He refused to ever see me again. She reported major changes in the pattern and interactions at home. Paul was doing his chores at home which included his laundry, and taking care of the dogs. She continued to spend time with her friends and attend a night class in the community. Paul was no longer wearing his hat. He goes to the barber regularly because of the rate his hair grows. She was not sure how long this change will last but she was quite relieved that he was out of the house and interacting with peers.

One more appointment was set up for the completion of the FAM post-test and to terminate therapy. A day before the appointment Barb called and stated that Paul had no plans of attending the session; however, he continued attending school and interacting with his class mates. She said he was still facing racist remarks at school but he comes home and they are able to discuss them without minimizing his experience. One student called him a "wigger", which meant a 'white nigger.'
I encouraged Barb to continue maintaining her parental role. This should be easier now that she had a 'bottom line' and Paul knew what it was. The FAM forms were mailed to Barb. Barb and Paul were also leaving for Chicago soon after school ended in July. Barb was pleasantly surprised that Paul's father sent a cheque to cover his travel arrangements.

After another failed attempt to set up an appointment with Paul I contacted Barb and we terminated therapy. I felt the maladaptive pattern had finally broken and the system was unstuck and they had begun to move in a functional direction. Paul's identity issues would be further nourished and solidified from the time he would be spending with his paternal relatives. I left it open for Barb to call if Paul did not attend school at the beginning of the September semester.

I did contact Barb on my return from vacation. She delightedly informed me that everything was okay. Paul had even started taking on extra courses. He viewed the other students in the class as not being serious about school. He will hopefully be moving to a regular class in December. Barb's employment status may change with a possibility of her relocating or receiving a severance package from her employer. She thought Paul would like to relocate; however, he now prefers to live in Winnipeg until he finishes high school.

**Evaluation: FAM III**

The FAM III profiles at pre- and post-test for Paul and Barb are summarized in Table 1 and shown graphically in Appendix F. In general Barb and Paul both rate overall family functioning as problematic in the pre-test. A wide discrepancy can be
seen in the area of Role Performance. Barb sees this as a major problem area (80) while Paul views no problems in Role Performance (48). This reflects Barb's inability to get Paul to take on some responsibility in the home and Paul's level of comfort in maintaining the status quo.

At post-test the scores for Barb and Paul were within the healthy range in all areas of family functioning. Only one area was identified as a problem and that was Role Performance for Paul (70). This was completely opposite to the pre-test where Barb saw the problem in this area and Paul felt everything was great. Now the figures were almost identically the opposite.

The results of the measurement supports my clinical impressions of this case. One of the goals in this intervention was to create developmentally appropriate boundaries between Barb and Paul. This was accomplished through the individual therapy sessions Bard had with her therapist. During the family therapy sessions some of the interventions were targeted at the mother-son enmeshed relationship. Barb was given a task to arrange bi-weekly activities with a friend or family member. After Paul moved back to sleeping in his own room, he continued freely going into his mother's room without permission. Barb decided to install a lock to her bedroom. This served to place appropriate barriers between the mother and the adolescent. This also meant that Paul would have to ask permission before going into Barb's private space.

Another goal was to restructure the family system whereby Barb could reclaim her parental executive position in the family. This was done over the course
of the sessions. The exercise where I used the flip chart to identify the unequal manner in which tasks were done in the home created a new list with Paul taking on more responsibilities. The reversal noted in the FAM scores under Role Performance (see Table 1 and Appendix F) could be due to Paul doing more chores in the home.
Table 1

The Robertson Family: Pre/Post-Test Scores on FAM 111 General Scale

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Paul Pre</th>
<th>Paul Post</th>
<th>Barb Pre</th>
<th>Barb Post</th>
</tr>
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<tr>
<td>Overall Rating</td>
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<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>Task Accomplishment</td>
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<td>48</td>
<td>80</td>
<td>48</td>
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<tr>
<td>Role Performance</td>
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<td>Communication</td>
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<td>54</td>
<td>60</td>
<td>52</td>
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<tr>
<td>Affective Expression</td>
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<td>48</td>
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</tr>
</tbody>
</table>
Case 2: The Thomas Family

The Thomas family consisted of Noriega (37), Patsy (35), and their three children. Fourteen year old Joy was the identified patient. Eleven year old Jane was the middle child and seven year old Don was the last child and only male sibling. Noriega migrated from Panama and Patsy migrated from Jamaica. Joy and Jane were born in Panama. Don’s place of birth was Jamaica.

Reason for Referral:

This family was referred to me by a mental health clinician from the community services program. The clinician had received the referral from the community school. They were concerned that Joy appeared withdrawn. They were having difficulty engaging her in school work. She appeared to read a lot but the school was not sure she was understanding what she read. The clinician had a number of individual sessions with Joy. She later had Joy assessed by a psychiatrist. Joy was given a trial of anti-depressant medication (Prozac). The clinician, who was white, was experiencing some difficulty in engaging the family. The referral was made to me to add to my practicum requirements.

Summary of Initial Interview:

The first interview took place at the family’s townhouse, in the north end of Winnipeg, close to the end of the summer vacation. The middle child Jane was at camp. Don and Joy were in their rooms when I came to the house. The father was in the basement. I introduced myself to Patsy. She appeared shy and quiet. Patsy called the two children from their rooms to join us in the living-room area. However,
after introducing myself to them Don put on the Nintendo game and proceeded to play, while Joy, who came down with a book continued to read. Noriega did not come up from the basement.

After introducing myself I told Patsy that I was referred by the clinician to do family therapy. Patsy did not understand what therapy meant. This was understandable. In the Caribbean there is a lack of exposure and familiarity with the field of mental health and psychotherapy. Problems are kept within the family and are sometimes shared with close friends and god-parents. The only outsiders who are permitted to intrude are ministers or priests (Gopaul-McNicol, 1995). In order for her to get an understanding of my role I used the example of the church and school. "You know when you talk to a pastor if you have some problems at home or you talk to the teacher at school when the children are not doing well in school? Well, my role is similar only I am meeting the whole family, hopefully to help all family members in solving the problem. I also have formal training in working with families."

I had to be cautious in describing my role. Social stigma is attached to anything relating to 'mental health' in the Caribbean. Most people believe that a person is either 'normal' or 'crazy', and only 'crazy' people seek help and are sometimes forced to seek help. These 'crazy' people all end up in the mental institution (or as it is commonly called the 'mad-house') where they are branded as 'mad' for the rest of their lives.

Patsy gave a little background information. She stated that she was born in
Jamaica and migrated to Panama where she met and got married to Noriega. She had the first two children and then returned to Jamaica when they were quite young. A few years later she visited Noriega in Panama and became pregnant with their son. Patsy returned to Jamaica before the birth of her son. She lived with extended family while she made arrangements to migrate to Canada.

Although the identified patient was the older child, Patsy changed the focus of her narrative to the second child. She stated that some months ago Jane disclosed to her that she was "molested" by an older male friend of the family while she lived in Jamaica. Patsy took Jane to a doctor. There was no physical evidence of abuse. Patsy also took Jane to be healed by the Pastor. However, Jane is still "very angry" and appears to "hate all men including her father." Patsy added that Jane and her father are always arguing.

Patsy believed that it was because of the abuse that Jane does not get along with her father. Patsy stated that she confronted the male family friend when he visited Winnipeg. This person denied the allegations. He also returned to Jamaica. Patsy never reported the alleged abuse because of fear that she could lose her children. She added that she has been on medication for depression for a number of years. She believed that if her children were taken away from her she would have to be committed to a psychiatric hospital.

I decided to withhold therapy until I clarified the reporting of the alleged abuse. Patsy wanted me to speak to Noriega before I left. She added that he feels left out because people exclude him and focus only on Patsy. Noriega is trying to
reclaim his role and status in the family.

I went to the basement to meet Noriega. The room in the basement had a television, a bed and a chair. Noriega remained lying on his back on the bed while we talked. He said he only arrived in Canada approximately ten months ago. He had been disappointed since his arrival. He thought he would have been able to get a job as soon as he arrived. But he was told that he had to go back to school. He could speak English but he could not read or write it very well.

He attended English as a Second Language classes. However, he did not believe he was getting a lot from it because most of the students could not speak English so most of the classes were spent on pronunciation. He also experienced difficulty with the bus routes but he still persevered and continued to apply for work at various places. He also expressed disappointment with the children's behaviour.

The Racial/Cultural Context:

Patsy was born and grew up in Jamaica. Her husband Noriega was born in Panama where he spent all his life until he migrated to Canada a few months ago. Two of the children were born in Panama but grew up in Jamaica. Jamaica is an English speaking country located in the Caribbean. Panama is a Spanish speaking country located in Central America. Although the majority of the population consist of Spanish and 'mestizo' Indians, the construction of the Panama canal in the late nineteenth century brought in a large number of construction workers from the Caribbean including Jamaicans. There were also Cubans, South Americans, Europeans, Chinese, and Blacks from the United States (Sunshine, 1988).
The labourers who did not die from the harsh working conditions of the Panamanian jungle stayed and formed part of the Panamanian working class. Migrant workers from the Caribbean continued to flock into Panama into the twentieth century.

Noriega's father made Panama his home as a young man when he was approximately twenty-two years old. He met Noriega's mother who migrated from Britain with her parents. They got married and had six children. Patsy met Noriega when she migrated to Panama in search of employment. They got married a few months later. Although Patsy and Noriega are both Black, one is from a predominantly English speaking culture and the other is from a Spanish speaking culture. In Panama, Patsy was the immigrant adjusting to living in a Spanish speaking country with its distinct culture and language. However, in Canada they are both immigrants to a new environment based on alternative values and behavioural norms which could threaten family cohesion and stability (Sluzki, 1979).

The migration process can become more stressful when children are involved. If children attend public schools and interact with the larger society they may adopt different values. If parents accommodate to cultural transition more slowly than their children, already existing instability within the family may be accelerated (Trute, 1988). In this case the problem became even more severe because Noriega joined the rest of the family two years after they arrived and was unable to fully understand the language. This placed him in a more disadvantaged
position.

Noriega has some catching up to do. Besides having to adjust to a new culture which includes cold and brutal weather that means different modes of dressing, he has to deal with reuniting with his family and regaining his parental role in a system where his children have more power than him because they understand the language and he is unable to fully communicate with them because they do not understand his language. He is also unable to be the 'breadwinner' of the family because, due to language and other barriers, he cannot find employment. In these situations the cultural context should be noted through the assessment and intervention.

Religion and Spirituality:

After consulting with the experts in the child welfare agencies and the reporting procedures it was agreed that because the abuse incident occurred in another country and the alleged offender had returned to that country there was no obligation to report the alleged abuse.

After many futile attempts to contact the family by telephone I decided to visit the home. Noriega was alone in the house. He indicated that Patsy had moved out with the children. Noriega did not know where she took the children. He added that her sister had also left her husband and that Patsy and her sister were staying together.

When this occurred Noriega had only been in Canada for a few months. The family was on social assistance. Noriega had no knowledge of the welfare system
and had no supports other than Patsy's extended family. Patsy left him in the three bedroom town house which he had to vacate by the end of the month. He had no money and he was about to experience his first winter. I assisted Noriega in applying for social assistance. I packed a 'care package' for him to cover the few days while he awaited his appointment. I also showed him where he could access the various food banks, soup kitchens and clothing stores.

Noriega claimed to be quite confused by Patsy's departure. He believed he was starting to develop a relationship with his children and this would cause another disruption in the family. Noriega added that all he could recall was that Patsy's behaviour had changed after a recent visit to Jamaica. Patsy went to Jamaica for a few days to attend a funeral. Noriega stated that she came back and began acting "strange". She told him that she could not live with him anymore. Noriega said that Patsy had visited an "obeah" woman in Jamaica and came back with "pieces of wood" and a bottle of liquid potion in which she soaked her head every night after praying loudly in the basement. Noriega showed me the bottle with the liquid. It was very dark in colour and had a very strong odour. It appeared to be a mixture of a variety of herbs and liquid.

Obeah is widespread throughout Jamaica and a few other Caribbean islands. Obeah is a system of African beliefs and rites that survived throughout slavery to the present day in one form or the other in the Caribbean (Brice-Baker, 1996, p. 92). When Africans were brought to the plantations as slaves they attempted to continue their religious beliefs and practices.
In the slave world people turned to African religions such as Shango and Kumina, or to obeah (sorcery) for spiritual and practical help. Through the dances and drumming, masks and rituals, the slaves realized a link to their ancestral home. At the same time these practices were used to provide protection against the planters. The obeah man or woman could give the slave a charm to be worn to protect him against the cruelty of the overseer (Sunshine, 1985, p. 16).

Brice-Baker (1996) states that obeah is widespread throughout the island of Jamaica as well as throughout the Jamaican immigrant population in the United States. One can argue that it is just as common among the immigrant population in Canada. Some families in distress may consult spiritists. These obeah 'consultants' or practitioners are believed to be able to control evil spirits, which tend to be perceived as the causes of the family troubles. Patsy went to Jamaica and consulted with the obeah practitioner. The therapist with an understanding of the role of religion in the lives of people from the Caribbean should not dismiss or ridicule their beliefs. Likewise, if the client believes that prescriptions such as herbal baths will be empowering, the practices should not be discouraged. However, the therapist can simultaneously encourage the client to examine alternative choices and to accept some responsibility for his or her situation (Gopaul-McNicol, 1993).

I contacted Patsy's brother-in-law and was told that she was at a shelter. The children had returned to school. I met Joy at her school and gave her a note to take to her mother. The next time I saw Noriega he told me he was served with court documents as Patsy was requesting a legal separation. I explained to Noriega what the court documents meant. Noriega also needed direction in getting to court as
well as the procedure involved in accessing Legal Aid.

A few weeks later Patsy contacted me when she moved into a new town house. Noriega moved into a rooming house close to the town house. An appointment was made to meet the entire family.

First Session:

This session was held at the Thomas' home. All family members were present. Noriega was currently living in a house close to the home of Patsy and the children. Noriega was spending a lot of time with them and returning to his place when he was angry about something in their home. In this session each family member openly talked about the past and their relationships with each other.

Because they left Panama at a very young age Joy was the only child who had some memory of her father. The other two children had no memory of him. Don was conceived in Panama but Patsy did not inform Noriega she was pregnant when she left. There was no contact between Noriega and Patsy when she left Panama. Joy recalled having an old photograph of her father in their home in Jamaica. But Patsy did not attempt to maintain the father's presence or memory in the children's lives after the separation. Joy never thought she would see her father again.

A few years later Patsy left the children in Jamaica and migrated to Canada. The children stayed with extended family. Approximately two years later the children joined their mother in Winnipeg. The girls reported that upon arriving in the airport Don did not recognize his mother. During the period apart from his mother
he had formed a maternal and an emotional attachment to other care-givers in Jamaica. Patsy and the children experienced major problems in adjusting to each other. She stated that at one point she called the child welfare agency to take the children because they were beyond her control.

This is a common problem among some immigrant families from the Caribbean. It is common for parents to migrate initially without their children. For a few years they will attend school or work more than one job in preparation for the children's arrival. They will then send money and a barrel of goods at different periods during the year. These children are sometimes called "barrel children". This is because some children do not see their parents for years and the only connection they have with their parents is through a cardboard barrel filled with food, photographs and clothing (Larmer, 1996).

Due to the prolonged separation the children may not view their parents as the primary care-givers and may continue to seek guidance from other relatives who are back in Jamaica. By attending school and interacting with their peers they may also be exposed to the way their counterparts interact with their parents. This may result in resentment towards their parents' discipline and parenting styles, perceived by the children as outdated.

When Patsy contacted the agency they suggested that she enrol in a parenting course. Patsy attended the parenting program which she felt successfully helped her bridge the two styles of parenting. She developed a better understanding of the children.
Just as the children were adjusting to their mother and a new country their father joined them in Winnipeg. As stated earlier, the only child who remembered Noriega was the oldest girl. The last time she saw him was when she was three years old. Don had never seen him.

All the children remarked that they were happy to have a father in their lives. They added that "he was nice when he came to Canada". As time went by they said he changed and "sometimes he's mean to us". It is interesting to note that most of the complaints about the father came from the second child and the boy. Patsy's wish was that Noriega learn to understand the children.

Structural Assessment:

This is a family in transition. The composition of the family has changed a number of times over the years. It started out as a two parent family. It later changed to a single parent family with extended family supports. After a couple of years it reverted to a single parent system in a foreign country. As the family was adjusting to the new system a major change occurred with the father joining the system. The single parent system had to readjust the family boundaries to accommodate this new member.

Noriega was an outsider who had to fit into a role which was vacant for years. Patsy and the children, after some difficulties, had developed their own patterns and style of relating to one another. The children were related to this person by blood but he was still treated as an outsider similar to the way a step-parent is treated before being accepted into the new family. When a step-parent joins a single-
parent system, this new parent may be treated as an outsider who is supposed to learn the 'right' accustomed way of doing things, rather than as a new partner who will give as well as receive ideas about child-rearing (Nichols & Schwartz, 1994). The more Patsy and the children maintain their familiar patterns without making the necessary changes to absorb Noriega as an equal partner the more he may feel as an outsider and the more resentful he may become.

While the family system is struggling to readjust its boundaries to include their father, there is also the marital status of the couple. It is probably unclear to the children if Dad is in or out of the family. The divorce papers are still pending. Noriega would like Patsy to withdraw the court documents. Patsy is only prepared to do that if she sees some changes in Noriega’s attitude towards the family. Noriega is sometimes seen as a "divorce-dad" and sometimes as an "in-house dad". One of the goals in therapy will be for the parents to clarify their relationship and then move on to other structural adjustments.

Treatment Goals:

1) Enable Noriega and Patsy to resolve their marital conflicts and reach a decision on their marital status and Noriega's role in the family.

2) Encourage Noriega to attend a parenting support group.

3) Help the family talk about the cultural differences among the family members and the impact it has on the father's role in the family.

4) Assist the parents in working as a team.

5) Strengthen the relationship between the Noriega and the children.
Strategies to Implement Goals:

1) Have a few sessions with Noriega and Patsy. Use these sessions to explore the issues that are keeping their relationship in limbo.

2) Help Noriega to work through the cultural differences and acknowledge that being a child in Canada is not like being a child in his home country.

3) Help Patsy to support Noriega when he consequences the children.

4) Discuss opportunities that would increase Noriega's participation in the parental subsystem.

Course of Therapy

Most of the family therapy sessions were conducted in the home. Patsy spent most of the day on a job training program. After the program she went home to prepare supper. The sessions were held after supper. The living space where we met was always chaotic and disorganized. Breakfast plates with left over food could be found where they were left from the morning.

Sessions Three and Four:

The first part of this session involved the family members completing the family questionnaire. During their interactions after the completion of the questionnaire certain patterns could be seen. There was an alliance between the father and the oldest girl. The second child, Jane, was loud and vivacious and more aligned with her mother. Although Joy was relatively quiet she supported her father in redefining situations or by giving other examples to show the positive side of her
father's action.

During the first session at the family's home seven year old Don participated by contributing clearly what he saw as the family problems but by this session he had lost interest in the process. At times would express some interest when he heard something that caught his attention but otherwise he quickly resumed his interest in colouring or playing with his toys.

In order to attempt to shift the boundaries that kept the father out of the system a task was assigned to the family to come up with an activity that they could do together which would be of interest to all of them.

The fourth session was an individual session with Noriega. This took place at the office. He provided further background information. He stated that he lived with Patsy in Panama for approximately six years. During that period Patsy spent a lot of time travelling to Jamaica. She bought clothes from the 'free trade zones' in Panama and commuted to Jamaica to sell them. Noriega said that he was the main care-giver for the children. He got assistance from his mother and other extended family members. Noriega said that he dreamt about the U. S. invasion of Panama and called Patsy in Jamaica to come and take the children from Panama. The invasion occurred after the children arrived in Jamaica. He added that the relationship was terminated when she left Panama and only resumed when she migrated to Canada.

Noriega professed to be committed to living with his family and taking on an active role in the home. He added that he misses them when he is away from them.
for any long periods. But he would like them to show him some respect. He would also like Patsy to support him when he disciplines the children. He said that the children are expected to do their chores before watching television. However, they would take their snacks to the living room and refuse to do their chores. He would then deny them the privilege of going to a friend's place. However, when Patsy returned home they would complain and she would rescind his decision. Patsy's actions were undermining his authority and role as a parent. Patsy was reinforcing his role as an outsider and maintaining him outside the parental boundary.

**Session Five:**

This session was held in the home. The family members had decided on the activity, going to the pool on Sunday evenings. They all remarked that it was fun and they planned to continue this activity. The remainder of session five was spent in sharing with the family members the result of the family assessment questionnaire.

**Sessions Six and Seven:**

This session was held at my office. The children were present for the first half of the session. The children identified a few changes in their interactions with their father. However, when the children left the session the story presented by the father was not of inclusiveness but of continued exclusion. The following excerpt describes the interactions and patterns among the family members:
Therapist: Patsy how are things with Noriega?

Patsy: Good days and bad days. More good days than bad.

Therapist: Are you okay with the living arrangements ... having his own apartment?

Patsy: I don't know how to handle when he is there. If he is in a bad mood and the kids are in a bad mood I will tell him to go away.

Therapist: When the kids are in a bad mood, what does that mean?

Patsy: Most of the time it is him and them and it is hard to handle the both of them. I have to be the middle person.

Therapist: An example?

Noriega: Throw their stuff down and don't pick it up and I tell them and they get vex and ...

Therapist: So the place is in a mess which I have seen ... my question is why do they leave the ketchup bottle by the television?

Patsy: While they are watching TV they may use it on some fries and they pour it and leave it right there when they get up.

Noriega: They don't pick up.

Patsy: If I tell them they will pick it up but if he tells them it will be something different. That means they don't reach the point of respecting his voice too much, that's why I keep saying to him to go and do the parenting course. You have to be so strong in your words, not threatening or things like that. Mean stuff or name calling will not
help.

Noriega: I like how things are going now. I have no problem with the big one. Is the other two. I don't see how a course will help me. They have to learn to listen.

Therapist: That is not working as a team. Patsy you need to back him up and don't let the children see a division in the team.

Patsy: I try that.

(Noriega made a face and a sound under his breath when Patsy made the comment.)

Therapist: Did you make a face?

Patsy: Oh yes! For a while there I told him I will step back.

Noriega: What day it was I was trimming Don's hair because he does not like to comb his hair and he is carrying on while I am cutting the hair. That boy cuss me and she laugh he! he! he! Then "Don you should respect your father."

Patsy: I realized that was wrong and I went to Don after and told him that it was wrong to speak to his father that way and I should not laugh because it was not funny.

Noriega: I don't say sometimes she deal with problems okay but sometimes they get out ah hand. I does feel like hitting them or something. Now ah days I just let them do what they want and I stay in my little corner. As long as I don't get in trouble with them everything is okay with she.
Otherwise we have a discussion about the children and things not nice. So I try the least not to have any problems with them.

The discussion in this segment indicates that although Patsy complains that she wants Noriega to take a more active role in parenting she continues, however unconsciously, to align with the children and thus maintains Noriega's differential role in the parental system. Noriega's metaphor of staying "in his little corner" solidifies that boundary between himself and the children as well as himself and the family system. The challenge was to move Noriega from the sidelines into the parental arena. I also had to challenge the enmeshed relationship Patsy had with the children which prevented either parent from exercising executive authority in the system.

I decided to bring the parents together by creating a context for Noriega to display his competency as a parent. This was possible because he was able to be the parent with Joy, the oldest child. However, I found myself being caught up in the content of the session and not looking at the process. Every time Noriega challenged Patsy in her alignment with the children she resorted to a victim role of "you are putting too much pressure on me". Instead of observing what was going on and paying attention to the meaning, I was getting caught in the details. This prevented me from challenging Patsy and Noriega with the understanding that everyone is part of both the problem and the solution.
Therapist: Noriega, you are saying that the children get out of hand and Patsy's intervention does not work all the time and when you intervene Patsy gets vex ...

Noriega: Yes!

Therapist: But your intervention is hitting them?

Noriega: No! I don't feel like always hitting them but I want them like to get rid of their stuff that they have all over the place. By the time them come in all the jacket over the place you can use them to wipe your feet.

Therapist: You think Patsy can make the children clean up the place.

Noriega: Yes, she could make them clean up.

Therapist: You think she could do more than she is doing right now?

Noriega: Yes.

Patsy: Yes, there again is pressure because I am just doing what I could do.

Noriega: But they don't pay me no mind, is you them listen to.

Therapist: You could do more but they don't listen to you?

Noriega: They don't pay me no mind, just leave them like that.

Patsy: Yes that's what he's saying, They don't listen to him.

Therapist: Then there's more pressure on Patsy?

Patsy: Yes, way too much. For him from day one he came in there and it's just the worst kids he has ever seen.

Therapist: He sees them as ---

Patsy: It's true. He just find the least things they do is just this, that, that and
the other. I hate to compare them with other kids but not that they are the worst kids as he's putting it. I can't see them that way as he's seeing them. He did not know how far they were and what they went through? They are at a level now that they will listen if I am persistent but I have my bad days too.

Therapist: Noriega, it seems that you are resisting one way for you to contribute in a more balanced way is to do the parenting course.

Noriega: I don't know, may be I can give it a try.

Therapist: You do have to take a parenting position in the house. You can't have a position in the house that you will stay in a corner. Then why are you there?

Noriega: To see that things go good.

Therapist: You need to participate and help Patsy out. Parenting three children is a full time job.

Noriega: I know that but still them does give me hell when they mother there. Worst when their friends come over. The smaller ones—can't talk to none of them.

Therapist: Is it the same for you Patsy? When the friends come over they are out of control?

Patsy: Not really out of control in a sense they wouldn't listen to me but I think it goes back to the way he treats them. Because if my sister is there and she talks to them in a stern voice they would listen. But if
the first thing he will say is call a name I think that's the biggest issue is the name calling that triggers something off and they will become outrageous and then he starts and is at that time I can't handle it.

There were many opportunities missed in this segment to challenge Patsy. In fact, I unconsciously aligned with Patsy and the children and further pushed Noriega in his little corner. Although a parenting course may help Noriega, at this point he had enough skills to parent the children. I had to find ways in the session to highlight Noriega's competence. They both agreed that the children were out of control. I asked Noriega and Patsy to use the next fifteen minutes to talk to each other and come up with one task that they could ask the children to do and also to agree on a consequence if it is not accomplished.

They decided that they would inform the children that Tuesday and Wednesday of the upcoming week the television would remain off for half an hour when they return from school. During that time they would be expected to put their jackets away and eat their snacks at the kitchen table. The television would go on after they were finished. This exercise would be done prior to Patsy's return home. Patsy agreed to support Noriega if the children complained to her when she came home.

When the task was reviewed at the next session Joy was the only child who complied. The younger two argued and complained. I identified with the successful part of the intervention. I congratulated the parents on their ability to come with a
joint parental decision based on working on the tasks for the children. I also complemented Noriega. He was able to get one child to complete the task. I decided to try and unite the parents to do something together about the problem that they both agreed they have with the two younger children. I told the parents that the two children believed that they were divided as parents. As such, it was up to them to show the children that they may have marital problems but they could work together on the children's behaviour problems. Again, I asked Noriega and Patsy to spend a few minutes and come up with a statement to say to their children. They identified the points they wanted to make to the children which included that they would be working as a team and they would be supporting each other with regards to rules and consequences. They practised how they would speak to them. The children were called back into the session.

Patsy: Since your father joined us things have been a little tense at times. I have made some mistakes and feeling like I am always caught in the middle with you guys and your father. But your father and I have decided that as your parents we will be working together and we will be supporting each other with regards to rules and consequences. We expect you all to treat us with respect. We love you and will always consider your opinions but it is our responsibility to make the final decisions. Any questions?

The children sat silently watching their parents. Seven year old Don had a smile on his face. I felt that the boundaries had been shifted by breaking up the
mother-children alliance and creating a mother-father alliance. Knowing that the
children might test this new alliance and fearing that the old patterns could re-
emerge, I assigned a task for the parents. I asked them to set aside fifteen minutes
every evening to discuss and try and reach an agreement on daily parenting issues.

**Session Eight:**

During the eighth session it appeared that the patterns which had started to
emerge in the last session were continuing to hold. The parents sat side by side
presenting a picture of unity. The children respectfully took their places in the room.
The family had continued attending family swimming at the YMCA. The parents
reported doing the fifteen minutes discussion every other night. Little battles came
up but they were able to address them without Noriega going to his "little corner".
The remaining subsystem to be addressed was the spousal unit. It was decided
that this would be addressed at the next session. The couple was asked to come
in without the children for the next session.

**Sessions Nine and Ten:**

At this point in therapy Noriega still had his own place and the divorce was
still pending. Over the past few months Noriega had been spending most of his
time with Patsy and the children. He would go to his place during the day when the
children were at school. Patsy was not ready to withdraw the court documents and
Noriega was not ready to give up his place. However, Noriega claimed that he
loves his children and his wife and wanted to be a part of their lives. Patsy believed
that he loved them but was not yet ready to dismiss the request for a divorce. She
wanted to see more of a commitment from Noriega.

In looking at the couple's history it should be noted that in their marital history they had not spent any long periods together. As noted earlier, Patsy commuted from Panama to Jamaica regularly. She purchased clothing and other consumer items in Panama and sold them in the markets in Jamaica. In Winnipeg they lived together for a few months. They now live a few houses away from each other. They wanted to keep things the way they were at this point. They stated that the children were aware of the arrangement and if the divorce was to become final they did not plan to change the father's access to their home.

The structural family therapy model is a problem-focused approach. In this case the attempt was not to resolve all the problems encountered by the marital unit; rather, the attempt was to resolve only those aspects of the difficulties between the spouses that were interfering with their ability to deal with the problems with the children. I felt this was accomplished. The parents had begun to work together as a team around the problems with the children. The children were treating the parents with greater deference and respect. I terminated therapy during this session. I left it open for the couple to contact me when they felt they were ready to work on other marital issues.

A follow-up call was made to Patsy. She stated that the children were doing great. Joy, the identified patient, was no longer on anti-depressant medication. The school also commented on the progress Joy had made. Joy has identified a future career as a teacher and has started volunteering in the local day care at their
church. Patsy continues to attend an evangelical church where evil spirits are routinely evoked out of people's bodies. The living arrangements are still the same. She was also working part-time.

**Evaluation: FAM-III**

The FAM-III profiles at pre-test for individual family members are summarized in Table 2 and shown graphically in the Appendix G. The family did not complete a post-test. The FAM test was not given to seven year old Don. The pre-test indicates that three of the family members believe that the family is functioning within the average range. Noriega is the only family member who identifies problems in all areas of family functioning except Affective Expression (54). However, it is important to note that Noriega is not really in the clinical range because his scores are all below 70.

The FAM pre-test does not corroborate the clinical impressions I had from the two sessions with the family. It also is opposite to what the family members shared with me during the initial interviews. Noriega, the father who had been in Canada less than twenty-four months and to whom English was a second language, was the only one whose results corroborated my conclusions from the interview. I also assisted Noriega by attempting to explain the concepts to him. Conoley and Bryant (1995) suggest that interviews, observations and enactments as more useful tools to use in assessing families from racial minority cultures (p. 118). Probably a Problem Checklist as identified by the family would have been a more useful way to measure changes. The family did not return the consumer satisfaction
questionnaire.
Table 2
The Thomas Family: Pre/Post Test Scores on FAM-111 General Scale

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Noriega</th>
<th>Patsy</th>
<th>Joy</th>
<th>JANE</th>
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<td>Subscale</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
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<td>**</td>
<td>**</td>
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<td>Task Accomplishment</td>
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<td>40</td>
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<tr>
<td>Denial</td>
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Case 3: The Santos Family

The Santos family consisted of Chito (48), Mona (46), Mary (19) and fifteen year old Carlito. When therapy began Carlito was in the residential program at the MATC. The father and mother migrated from the Philippines in the early seventies. Chito is employed with a transportation company and Mona is employed in a health care facility.

Source and Reason for Referral:

This was the second admission of Carlito to the residential program at the Manitoba Adolescent Treatment Program (MATC). Carlito was in the day program in August 1995. After a few days his parents took him out of the program because of an incident where Carlito and another adolescent male client were found in the washroom having sex. Carlito was also hit by a car (causing minor injuries) during a lunch period at MATC. His parents lost confidence in the staff's ability to provide adequate care for their son. At the point of discharge Carlito was diagnosed with Asperger's Disorder.

In September 1996 another referral was made to MATC. The family complained that Carlito's behaviour was putting the family at risk. Carlito was readmitted into the residential program. The complaints from his family covered a variety of behaviours. These includes an obsession with the brand name American Crane toilets. Carlito destroyed the toilets in the home and demanded they purchase the brand name he preferred. His parents complied. He ordered expensive items on his parents' credit card. His parents had all knives and sharp
instruments under lock-up because of Carlito's constant threats to kill everyone in the home. When he was angry he turned on the burners on the stove and threatened to set fire to the house. He called the Police himself and ask to be locked up for the bad things he does. After approximately five weeks at the MATC Carlito was seen by the psychiatrist and diagnosed with Hypomania and mental retardation. He was placed on medication (Haldol and Benztropine mesylate).

Summary of Initial Interview:

The four members of the family came in for the first interview. Carlito was the focus of the discussion. All the family members including Carlito himself identified Carlito as the problem. Chito stated that Carlito does not want to live with any rules. He sees Carlito making unnecessary financial demands on them with no understanding by him of their present financial situation. Due to ongoing 'restructuring' at both parents' workplace their long term employment status remains unclear. They complained that Carlito makes extraordinary demands on them and they have difficulty refusing his demands. Two of those demands include purchasing a vehicle costing just under forty thousand dollars and selling their house so that Carlito could live in another area.

Carlito's sister Mary talked about his desire to be the older sibling. As such, he calls her 'adorable' and she acts the role of adorable when she is like a "pet or a kitten" and talks "like a baby" to him. Mary explained how she used this helpless style in building back Carlito's confidence about crossing the streets after the accident. She had to pretend that she was a "little adorable kid" that needed his
help. The family members identified a number of other incidents where Carlito would not eat the supper prepared because he was certain his mother poisoned the food. When the tension escalated he would then call the Police and ask to be locked up. During this interview Carlito said that he believed that he needed some medication from his psychiatrist that could stop him from being bad.

**Structural Assessment:**

During the first few months of his stay in residence Carlito never exhibited any of the behaviours his family experienced with him at home. From the seating arrangements to other interactions in the family session the pattern observed was that of a family made up of three parents and one child. Carlito sat between his mother and sister. Chito sat away from the triad. Mary and her mother never allowed Carlito to say anything without giving him reassurance and support. He was treated with 'velvet gloves'. When Chito made any comment which appeared negative such as "Carlito needs to learn to live with rules", Mona and Mary quickly added a positive spin to the comment such as, "he likes some rules".

In the room Carlito was being treated like a preschooler. Chito's position appeared to be that of an outsider. The mother and daughter seemed to be aligned around the parenting of Carlito. It is interesting to note that the structure described at home is one of Carlito in control of the home, that is, Carlito in an executive position. However, the structure that appeared in the session was of Carlito the adolescent being treated in an infantile manner with no voice of his own.
The racial/ethno/cultural context:

Chito and Mona migrated from the Philippines in the early seventies. They came to Canada one year apart from each other. They met in Winnipeg in 1975 and got married in 1976. The two children were born in Winnipeg. The Santos's continued their active involvement in the Catholic Church. Carlito's Godmother continued to be a support for the family and Carlito during his stay at the MATC.

There is a stigma attached to mental illness among some communities in the Philippines. According to Rita (1997), Filipinos believe that only people who are dangerously insane and socially disruptive require psychiatric care. As such, apprehension and disdain is shown toward anyone believed to be mentally ill. Another important cultural view is that mental illness is a familial disorder. This adds to the shaming effect Carlito's admission to a psychiatric facility will have on this family. Mr. Santos presents as a very proud man. His only son admitted to a psychiatric unit could have a devastating impact on his patriarchal position in the family and the surrounding Filipino community.

Treatment Goals:

1) Relieve Mary of her parenting role.

2) Strengthen the father-mother parental system and the spousal system.

3) Strengthen the sibling subsystem

4) Assist the family and Carlito in his transition back to the community

Strategies to implement goals:

1) During an enactment have Mary "fired" from her parental role by all members
of the family.

2) Consult with the rest of the hospital team in preparation for Carlito's return to the community. Also work with the family's supports in the community to create a healing context with the possibilities for recuperation and a return to healthy functioning.

**Course of Therapy**

I met with this family for approximately eight sessions. The first two sessions were held with all family members and subsequent sessions were held with the parents. On a few occasions Carlito joined the first half of the session. All the meetings were held at the office. Carlito's primary worker on the unit asked to participate in the family therapy sessions. The family diligently attended all planned sessions. As such, there was no need to have sessions in their home or other alternative settings.

**Session Two:**

This session was held with all four family members. The primary worker (Peter) was also present. The seating arrangements remained the same with the triad together and the father outside of the group. The focus of this session was Carlito. The time was spent addressing various incidents that occurred on the residential unit. It was difficult to bring the focus on family dynamics. The main reason being the presence of Peter. He was seen by Carlito as the person to talk about unit issues. As well, the parents also used this opportunity to address
Carlito's complaints.

An artificial separation is created when a child is placed in a psychiatric facility, as well as a transfer of responsibilities from the family to the hospital staff. The family continued organizing and interacting on a day to day basis without Carlito, while Carlito created his own pattern of interactions with his new 'hospital family', Peter being his main care-giver. With Peter in the session it seemed like two families in therapy. The hospital or foster family who can talk about the day to day interactions and the biological family with little more than complaints to address.

Minuchin and Elizur (1989) succinctly describe what occurs when an adolescent is hospitalized: "parents lose power, and the medical framing given to their problems increases their dependence on professional guidance, inasmuch as only professionals are supposed to know how to handle mental patients. The boundaries of the family become less well defined" (p. 112). The family therapist's role and work becomes quite a challenge.

Session Three:

Carlito was excluded from the first half of this session. Carlito had spent the weekend at home. The parents wanted to discuss the incident that had occurred over the weekend. They stated that with little or no provocation Carlito began threatening to kill everyone in the house. They felt that they all were like prisoners until the Police arrived. Carlito wanted the Police to take him to the Manitoba Youth Centre. The Police gave him a warning about his behaviour and left. Carlito apologised to his family and the rest of the weekend was spent on "pins and
needles" waiting to return him to MATC.

When Carlito joined the session he was asked to give his account of what occurred on Sunday. He stated that he did something bad and that he needed to speak to a judge in order to be punished. He wanted to be placed at the Seven Oaks Youth Centre. I asked Carlito if he had ever faced any consequences for any of his actions. He said the only time he was punished was when he broke the neighbour's window and had to clean the neighbour's yard for a week. I queried why Carlito threatened his family but not the staff. I tried to identify Carlito's powerful position in the home. I used the term 'man of the house' which had been used by the family recently and interpreted that Carlito acted as the head of the house. This gives him the power to do whatever he wants and get what he wants without any consequences for his actions. Carlito responded that he was the man of the house because his family had an "illness". I expanded on the theme of illness and concurred with Carlito that the illness was that his family loved him too much. Carlito is at the top of the hierarchy in this family system. In future sessions intervention needed to be made to assist the parents in taking back control and power from Carlito - that is strengthening the parental system.

**Session Four:**

Carlito came into this session very angry. For the first time since his residential placement he was threatening to kill the staff. He believed that if he did so he would be placed at the Manitoba Youth Centre. He kept repeating that he was bad and his family did not want him so he should be at the Youth Centre. The
usual pattern ensued with the 'three parents' reassuring Carlito that he was not bad.

I asked Carlito what he needed from his father and mother to help him stay at home.

Mona and Mary continued to answer for Carlito. I interrupted this interaction and asked Mary:

Therapist: Do you help in parenting Carlito?
Mary: Yes.

Therapist: That must be tiring?
Mary: Yes, sometimes especially when he is like this.

Therapist: It is good to help your parents but I know you have university exams and assignments due; probably your parents would allow you to take a break and leave the parenting up to them?

Therapist: (To parents) Is it okay for Mary to leave the parenting to you?
Parents: Yes.

Therapist: Carlito, two parents is enough, isn't it?
Carlito: Uh huh.

Therapist: Mary you can wait in the waiting room.

The session continued. Again, I posed the question to Carlito about what he would like from his father to help him stay at home. Mona continued to answer and give her view of what Carlito needs to do. During the sessions Mona was very talkative and would not be interrupted in her narrative. During her monologues Chito maintained his silence. I told Mona to be quiet and allow Chito and Carlito to talk to each other. Every time she intervened I stopped her from talking. In
speaking to his father Carlito would respond to him but kept his eyes on his mother. Carlito said that if he and his father could do more things at home then things would be better. Carlito said some of the things he would like to do with his father include playing basketball or fixing something around the house. He added that he used to be sexist and hated his mother and sister. He said he no longer hates them. When asked about his father, he could not recall ever hating his father but he does not like it when his father is loud at home. Chito responded that he had no problems doing things with him.

I later asked Carlito to wait with his sister outside. I then asked each parent if there were anything the other could do to make the home safe when Carlito is there. I wanted to push Mona and Chito to talk to each other and remove the focus from Carlito. Chito immediately changed chairs and sat facing Mona. He became quite vocal and animated in his presentation. He accused Mona of being lazy, never doing anything around the house and constantly complaining of being sick. He believed that if she would get up and put on some shoes and go out walking as he sees many women older than her do she would not always be feeling sick. Chito complained that he is "Mr Mom or Super Mom". He said he does almost everything in the house including the cooking, cleaning, laundry, yard-work everything. He said they do not do their share.

Mona responded in tears and stated that her husband was too controlling and was unable to understand that her moods and lack of motivation was due to the menopausal stage that she was going through. She believed his unreasonable
demands, such as his insistence that they eat together at a certain time, were indicative of his controlling behaviour. Chito believed that eating together was a way of making sure the family did things together. He continued to blame Mona for Carlito's remarks about hating his mother. He accused her of not being there for Carlito since early childhood because she returned to work "three months after he was born". He believed that if she had cared for him she would have stayed home longer with him. Because Chito worked nights he took care of Carlito during the day, "that is why he would not like you because you were never there for him, all his doctor's appointments or anything". Chito ended by saying that he would like Mona and Mary to "chip in and do their share".

By moving Mary out of the room and moving Carlito from the triangle, a space was created for the problems in the parental and couple sub-system to surface. A strict adherence to gender-role stereotypes and patriarchal family structure is common in some Filipino families (Rita, 1996). Mona appeared to have challenged that norm by returning to work after her maternity leave. As such Chito blames her for Carlito's attitude towards her because she did not stay home to do her 'job'. Although he took up the housekeeping and child rearing tasks he continues to do them while harbouring great resentment towards his wife. I decided to work with the couple for the next few sessions.

**Session Five:**

Again, the first half of the session was held with Carlito present. Issues around the unit were addressed. I wanted to bring back the intensity and the
emotions from the last session. I wanted to address the issues of power in the family and how it is used in the dynamics in the home. Mona reported that she and her husband have different styles of working. She sees her Chito as very active; as such, he always needs to be doing something. She does work around the house but due to her husband's schedule he is able to do more than she is able to do. Chito works from twelve midnight to eight in the morning. He takes Mona to work and prepares lunch before picking her up at one. He also prepares supper and expects the family to have supper together before he takes a nap before leaving for the midnight shift.

Chito was much softer on his wife in this session. He said that she was tired because she worries about the children. He felt that he knew what the problem was and there was nothing he could do, so why worry. He expressed his disappointment in Mary. He expected her to be independent by now. Chito expected that Mary would be able to bring breakfast in bed for them. Mona saw herself caught in between Mary and her father when they argued. When I asked about Carlito's aggressive behaviour at home and what role he could play, Chito's response was:

Chito: I don't think he would do anything [to Mona and Mary] ... they just have to move away.

Mona: It is easy for you to say because you are never there when he is acting up and you do not have any bruises from him like Mary and I.
I know he could hurt us if he wants to because now he is bigger than us. So what he does is scare us. He has us living in fear. We always have to watch him. We know when his fist starts to clench that he is getting angry.

**Therapist:** Do you intervene when you are home.

**Chito:** I could stop it but what's going to happen to me? I lose my cool and what's going to happen to me? You guys will charge me. I used to be a bouncer in a hotel on main street...

**Mona:** I did not know him then.

**Chito:** I know how to defend myself. I don't use it because I am not stupid.

**Mona:** Mary tries and use words to make him laugh to try and change his thoughts. Like when he is coming home on Friday we will hide the knives...but then he can use a chair or smash the cabinet.

**Chito:** He will never do anything.

**Mona:** You never know.

**Chito:** Some guys at work who were abused as children...

**Therapist:** Was he abused?

**Mona:** No. If anything he was the one abusing us because we knew he had a problem and we allowed him to do whatever he did.

**Chito:** Sometimes it is like he has a split personality.

The women in this family appear to be living in an environment which
involves abuse by the males. I did not challenge Chito on choosing not to protect his wife and daughter from his son. It seems that Chito is allowing Mona to live in fear of her son as a way of getting back at his wife. The intervention needs to shift the family structure from a male dominated one to a more egalitarian distribution of power between the males and females in the family.

Session Six:

The first half of the session was used to draw a genogram and get some family history (see Appendix D). The second half of the session was spent discussing Carlito’s return home for the Christmas break. The parents were also told that after the break Carlito would be transferred to the day program. The couple then engaged in a discussion about rules for Carlito when he returns home. An argument ensued and Mona began crying and expressing her fear of Carlito being in the home and even more fearful when Chito is at work. Chito then asked if she would like him to stop working. He was angry that she was crying and added that she does not allow him to intervene with Carlito. Chito described a common scenario. He stated that when Carlito is becoming agitated and he intervenes Carlito will call his mother and demand that she go into the bedroom with him. Mona tries to calm Carlito down but he becomes more agitated. This goes on until Carlito threatens to get a knife and kill everyone. At some point the police may be called if he does not calm down.

Mona then said that she intervenes because she is afraid of what her husband will do because he is usually drunk. This opened up new issues. Chito
stated that he had no other choice but to drink and smoke because he is lonely and they do nothing together. He added that 'they' are always talking and laughing together (meaning mother and daughter). He continued to talk about the table never being prepared for him, the dishes never being done. He said he thinks about leaving but he is worried that they would not make it without him. He added that he wanted a better relationship with his family. Mona stated that her husband wants to control them.

As therapy proceeded I found that at each session I got a new piece of information and there was an inability on my part to connect these pieces of information to an overall theme and consequently an intervention plan. For the next session I planned to present a synopsis of the issues and develop some mutually agreed upon goals to work on.

**Session Seven:**

By this session Carlito had been home for approximately eight weeks. I asked about Chito's job situation because of recent news reports of expected layoffs at his workplace. This opened up the issue of father's drinking. Mother said it was getting worse with the uncertainty of his job. The couple began arguing and the theme of exclusion and isolation was presented by Chito. The issue of Carlito going to a group home also resurfaced. To Mona's surprise, Chito stated that he had told his wife to terminate the pregnancy (with Carlito) but she did not; now she has to live with it. Chito became quite animated and vocal. He could not sit in the chair. He kept blaming Mona for all the problems. He then moved his complaints to lack
of intimacy in their relationship. He added that he still believed that they could work out their problems but he saw coming for therapy as not too useful because I made him say things which then upset his wife. He felt that they had enough of a bond together to work things out themselves. He added that their purpose at MATC was to find help for their son.

I asked Mona how she felt about what her husband said. She stated that she could not recall his suggestion about an abortion. When asked if she loved her husband Mona continued crying. Chito expressed disappointment that she did not answer but later added that they do not have to tell each other ‘I love you’ because in the things they do for each other they know how much they love each other. Chito stated that they would be terminating therapy because they have their own work to do.

I made a number of mistakes in this intervention. Although the presenting problem was the adolescent boy’s mental illness, the dynamics in the home had a major impact on the boy’s functioning in the home. By the ‘premature’ end of therapy what remained unresolved was an emotionally abusive alcoholic father who desperately wanted to have a traditional home and who punished his wife daily for not living up to his expectations. I was not allowed to take control of the therapy. At the end I allowed the father to dictate the end of therapy without allowing the mother a voice in this decision. I believed culture as well as gender played a big factor in this family’s functioning.

I received a call from Ms. Santos two weeks later. She stated that
terminating therapy and having Carlito home was a victory for Mr. Santos. She added that he was always embarrassed that his son was in a mental institution but he was not trying to make the home safe now that Carlito returned. She said that he terminated the therapy because he was also embarrassed about the marital and sexual problems he brought up. I invited Ms. Santos to return for individual therapy. She said she would think about it and call back at a later date. Carlito eventually transferred to a community school. He did not stay too long in that setting. The family is awaiting a specialized group home placement.

**Evaluation: FAM-111**

Only pre-test scores were available for this family. The family was not willing to complete the post-test. The FAM-111 pre-test for individual family members are shown in Table 3 and shown graphically in Appendix H. Again the pre-test scores do not support the clinical observations and assessment. There was no assistance given to any of the family members in filling out the scale. The scores indicate that besides Mary all other family members share similar perceptions, namely that there are no problems in the way the family functions. Although Mary’s scale indicated problems in a number of areas her Denial score is very low suggesting that her responses may be distorted. The family did not return the client satisfaction questionnaire.
Table 3

The Santos Family Pre-Test Scores on FAM-111 General Scale

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Chito</th>
<th>Mona</th>
<th>Mary</th>
<th>Carlito</th>
</tr>
</thead>
<tbody>
<tr>
<td>Subscale</td>
<td>Pre</td>
<td>Post</td>
<td>Pre</td>
<td>Post</td>
</tr>
<tr>
<td>Overall Rating</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Task Accomplishment</td>
<td>64</td>
<td>*</td>
<td>44</td>
<td>*</td>
</tr>
<tr>
<td>Role Performance</td>
<td>52</td>
<td>*</td>
<td>44</td>
<td>*</td>
</tr>
<tr>
<td>Communication</td>
<td>54</td>
<td>*</td>
<td>50</td>
<td>*</td>
</tr>
<tr>
<td>Affective Expression</td>
<td>50</td>
<td>*</td>
<td>50</td>
<td>*</td>
</tr>
<tr>
<td>Involvement</td>
<td>50</td>
<td>*</td>
<td>46</td>
<td>*</td>
</tr>
<tr>
<td>Control</td>
<td>56</td>
<td>*</td>
<td>42</td>
<td>*</td>
</tr>
<tr>
<td>Values and Norms</td>
<td>56</td>
<td>*</td>
<td>42</td>
<td>*</td>
</tr>
<tr>
<td>Social Desirability</td>
<td>44</td>
<td>*</td>
<td>40</td>
<td>*</td>
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<tr>
<td>Denial</td>
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<td>*</td>
<td>50</td>
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</tbody>
</table>
CHAPTER 6
IMPLICATIONS AND FINDINGS

Introduction

This chapter will identify some of the commonalities and differences among cases shown in this practicum study. The usefulness of the structural family therapy model with this population will also be reviewed.

Commonalities and Differences

A detailed description of the characteristics of the families seen in the practicum is featured in Appendix A. Seven out of the twelve families seen in this practicum were immigrants. In four of the seven families English was the second language. In only one of the seven families the children were born outside of Canada. One of the seven families migrated within the last two years and the majority came to Canada over ten years ago. Six of the families were from single female parent households. Four of the twelve families were of mixed race. These four families were single parent with three of the mothers being white and the fourth mother biracial. (This mother grew up with a white female single parent).

All the families shared a minority experience in race, culture, ethnicity and religion. However, the three white single parents also shared a similarity based on parenting black children in a predominantly white society. Self esteem and identity issues were present in the children in two of these three families. The one child for whom this was not an issue came from a home environment where she was exposed to images of herself. Although the only parent was white the home
reflected a multiracial identity. Her mother made a conscious effort to raise the child with a multiracial identity exposing her to the history and culture from both parents. The child also had contact with the extended family from both groups. The other two children grew up in a predominantly white home environment with no visible portrayal of their mixed race identity. Where the first child had story books and novels with images that looked like her, these two children never had those opportunities. They were first confronted as different when they moved out of home and began interacting in the public sphere, that is, day care, preschool and the public parks.

It would have been useful in addition to family therapy if these mothers could have been able to connect with each other in the form of a support group. This is not to say that these children’s problems are directly related to their bi-racial identity. However, adolescence, with its potential for being a stressful stage as they struggle for independence and to know who they are and where they fit into society, is a time when race and identity become a factor. Multi-racial family groups can be beneficial in networking, providing support, sharing information, role modelling and normalizing the experience for bi and multiracial children. It took Paul’s mother ten years to find a hairstylist who could cut his hair. If she had access to a group she would have been able to get some information to alleviate some of Paul’s earlier bad experiences. Access to and development of a multiracial family group could continue after family therapy ended. This would give families an informal support system.
The perception of mental illness or seeking mental health support is always coloured by culture. This was clearly seen in the referral process. Only one of the twelve families made a self referral. The other referrals came through the school or were provided as part of the residential program. Many immigrant families that are more likely to seek help from a priest or spiritual counsellor (Brice-Baker, 1996; Gopaul-McNicol, 1993; Rita, 1996). Most of these families do not view sitting and talking to strangers in a mental hospital as an appropriate way to solve their problems. Joining becomes extremely important in working with these families. The structural model with its emphasis on joining and establishing a therapeutic relationship as the first step in working with a family is a useful tool with all families but particularly important for use in a culturally specific context (Boyd-Franklin, 1989; Jung, 1984; Kurtines, & Szapocznik, 1996).

Boyd-Franklin (1989) also commented on the resistance of Black families in the U. S. in approaching and utilizing treatment. She noted that Black families are usually sent for treatment by schools or social welfare agencies, often under considerable threat or pressure. This contributes to their resistance and reluctance to engage in the process. Families may also see mental health centres as "White institutions". As noted earlier, mental health workers over the years have been overwhelmingly white in numbers and spirit (Kramer, 1973). Families who see themselves as different in colour, race and class values may not view mental health centres as a particularly useful resource. When they do they may leave frustrated or be labelled as 'difficult' or 'resistant'. 
All the families were given options to meet outside of the office. This facilitated a comfort level with the families and allowed them to exercise some control over the process. A number of sessions were held in their homes. Some individual sessions were also held at various local community restaurants. Although a family may be willing to meet in their home, one needs to be conscious that there is an appropriate way to enter and be respectful in a family's home. The therapist is a stranger and an outsider in the family's environment.

Some family-oriented theorists argue that formal assessment (such as the FAM) is unnecessary for clinical practice (Bray, 1995). Others argue that existing measures and instruments do not (cannot) adequately capture the richness of family dynamics and therapy (Sprenkle & Bischoff, 1995). A major problem in using formal assessments for measuring healthy functioning families is that most of the models are based on white, European origin middle class families and do not necessarily include variations that may occur for families from different cultural and ethnic backgrounds. The FAM-111 was an inappropriate measure for the majority of the families in this practicum. For the measure to be useful or accurately represent the family's problems each item has to be explained to the family members. This will not address all the limitations because the item may still have one meaning in the Canadian 'mainstream culture' and a different meaning among certain racial minority families. It seems that a level of acculturation may need to be reached by all family members for them all to share the mainstream meanings for all items.

Instead of a pen-and-pencil assessment tool, future measurements could be
conducted by a combination of interviews, observations and a problem checklist. The checklist could be compiled from priorities identified by the family during the interview. The therapist could add to that list dysfunctional patterns he/she may observe in the initial interview with the family and from her/his own clinical assessments. Where there is a need for an additional pen-and-pencil assessment, the Brief FAM General Scale which contains 14 items might be used. This is a shorter scale in comparison to the FAM General Scale which contains 50 items. The therapist may still need to explain the items; however, this will be dependent on the level of acculturation the family has reached. One of the advantages of using the FAM is that it represents 'Canadian norms'. It must be acknowledged that these norms may not be congruent with the norms of the cultural group to which the family belongs.

Six children were on psychotropic medication at the beginning of family therapy. By the end of therapy three children discontinued the medication. A fourth child terminated the medication sometime after therapy ended. There is no data in this practicum to support a relationship between family therapy and the termination of medication. However, diagnosis and medication can sometimes narrow the focus to individual pathology. Family therapy can broaden that focus and instead of emphasizing pathology the individual can also be viewed within a family context. Minuchin (1974) identifies one of the differences between a family diagnosis and a standard psychiatric diagnosis:

An individual diagnosis is a static label, which emphasizes the
individual's most salient psychological characteristics and implies that these are resistant to changes in social context. In family therapy, individuals and families are seen as relating and changing in accordance with their social context. The advantage of an evolving diagnosis related to context is that it provides openings for therapeutic intervention. Diagnosis and therapy become inseparable (p. 131).

In the family sessions with two adolescents and their families a different reality of the presenting problems was observed. Tensions were present among family members, specifically between mothers and fathers and the fear by the adolescents that they may separate. In another family a long lasting unresolved family problem added more stress to the adolescent's mental illness. Family sessions were able to help family members address the problem and in so doing ease the stress to individual family members.

**Analysis of the use of Structural Family Therapy**

Structural family therapy was employed as the primary model of intervention. As I noted in Chapter 4, there are a number of reports highlighting the success and usefulness of this model with families from culturally diverse groups (Boyd-Franklin, 1989; Jung, 1984; Szapocznik et al., 1978; Szapocznik et al., 1989). The structural family therapy model proved to be just as useful with this culturally diverse population.

Many concepts in the model fit with the population. The emphasis on the social context in which family lives allowed me to be aware of the social, cultural, economic, and environmental factors, as well as family dynamics that may contribute to the family's problems. The intervention moves beyond changing the
family patterns but also provides assistance and direction to family members in obtaining essential services. Noriega was left in the apartment after the family separated. As he had recently migrated from Panama, Noriega needed assistance in accessing basic needs like food, warm clothing and financial help. In structural family therapy this assistance is not separate from family therapy but an integral part of it.

The concepts of generational boundaries and hierarchy were useful for parents who migrated from countries such as the West Indies and Pakistan. It is common in some immigrant families that the adolescent is expected to be obedient and deferential to parents at all times. The right of parents to impose standards of behaviour and punishment is regarded as a natural parental prerogative. Boundaries and hierarchy clarify and solidify the parents' role as the executive in the family system and the ones with the authority to provide leadership and protection to the children. Parents are allowed to be in charge but not in the sense of arbitrary authoritarianism.

In the case of the Smith family (see Appendix A) my role was to make the rigid boundaries between Ms. Smith and her sixteen year old daughter more flexible. Ms. Smith experienced conflict between herself and her three older children. They all left home prematurely due to what they viewed as Ms. Smith's harsh rules. In therapy, a number of sessions were spent on modifying the communication patterns between Ms. Smith and her daughter so that they could understand each other better while maintaining the hierarchy within the parental-
child subsystem. The adolescent no longer felt ignored or not being heard when decisions were being made for her.

The structural family therapy model with its focus on the family system was also well suited for the families from Pakistan and the Philippines. In these families there is a strong belief on the centrality of the family. Other models with a focus on the individual would have been contrary to the cultural beliefs of these families.

The concept of joining is an integral part of structural family therapy. Joining is the proverbial ‘foot in the door’. It gives the therapist an entry into the family. This is extremely useful in families who do not trust outsiders as helpers. Successful joining goes beyond establishing a therapeutic relationship. It shows the families that they are understood, respected and accepted by the therapist.

Many of the core concepts, methods and procedures in structural family therapy are uniquely suited for working with this culturally diverse population. However, there are few drawbacks in the model. Structural family therapy focuses primarily on the present, that is, the present interactions that occur among family members. This limits addressing family of origin issues which are sometimes paramount in immigrant families. Structural family therapy is a short term model. Some of the families would have benefited from long term intervention. For therapy to be conducted successfully at least two family members need to be present. This is because the model relies on observation of interactions. Verbal accounts of family dynamics are useless. As such resistance from family members in attending sessions may impede the use of the model.
**Family Therapy and Psychiatric Hospitals**

There are potential problems for a family therapist working in a psychiatric hospital. Some have argued that in the past hospitals have traditionally functioned within their own enclosed contexts, whereas family therapists have tended to shun the institutions which seem uninterested in reforming their structures and implementing new directions (Minuchin & Elizur, 1989). However, one of the unique aspects of the MATC is that since its inception there has been a family therapy component. In spite of this, the medical authority and the social worker/family therapist sometime speak different languages. As head of the treatment team the medical doctor may talk about the treatment of the individual’s mental illness while the social worker talks about dysfunctional family patterns. The challenge is to agree on a joint family diagnosis and treatment plan and maintain and support the focus on the family context.

**Clinical Implications**

Mental health institutions in Canada are publicly funded and as such they are responsible to ensure that services are available to the full variety of groups and cultures that make up the population. The agencies need to portray a culturally diverse friendly environment so that groups can see these agencies as a resource. The starting point could be with staff composition. Mental health institutions must make a concerted effort to employ clinicians from minority racial-ethnic backgrounds. These staff may bring a wealth of the kind of first hand cultural knowledge that is valuable in working with diverse groups. Being a part of the milieu can also add to
informal discussions of racial and cultural issues among the staff. This could result in an openness and sensitivity to racial, ethnic and cultural differences by members of the organization. Institutions and agencies that show this commitment give a very clear positive message to the various communities that they serve.

Family therapy is a part of the medical education for psychiatrists. A small amount of social science has been offered halfheartedly in the curriculum (Littlewood & Lipsedge, 1997). As such there may be few opportunities for a psychiatrist in training to be exposed to teaching material that looks historically at the critical role of race and mental illness. Manitoba is home to immigrants from all over the world many of whom may come with different help-seeking behaviours and different beliefs about the causes and treatment of mental illness. A cultural formulation should be an integral part of a psychiatric assessment. The expansion of DSM-IV to include social and cultural factors is a welcome change. Castilo (1997) argues against taking a universal approach to assessment, diagnosis and treatment. He views people as more than biological organisms, "they have thoughts, feelings, emotions, social relationships, and above all, they have culture...a mentally ill person is more than just a "broken brain" (p. 55).

**Summary**

In order to achieve desired psychotherapeutic outcomes it is necessary to identify treatment models that are sensitive to the cultural characteristics of the family. For instance families may come into treatment with a cultural belief in spirits. It is important not to dismiss or ridicule this belief but to encourage the family to
examine alternative interpretations of the problems.

Therapy which is present oriented and intervenes to manipulate existing dysfunctional patterns within the family and between the family and its environment is a more useful intervention model (such as structural family therapy). Clients may also be motivated for treatment through the use of concrete and obtainable objectives. It is also important for the therapist to assess whether and how the stresses of racism affect the family's functioning.

This chapter presented some of the commonalities and differences in the diverse group addressed in this practicum. I also noted some clinical implications for the delivery of mental health services to an ethnically diverse population. Further studies are needed in this area to add to these findings.
CHAPTER 7
CONCLUSION

Use of Self/Therapist Variables

At a five day workshop in New York, Salvador Minuchin said to the participants: "therapist know thyself". A therapist needs to examine and explore his/her own culture and family, including beliefs, values, biases, and constraints that he or she may bring to the therapeutic encounter. I am a Black woman from the multiracial country of Trinidad and Tobago which is located in the Caribbean. I am from a working class background and migrated to Canada in the early eighties to attend university. I came to Canada in my mid-twenties having experienced the Black Power movement and activism in the labour movement. I came with an analytical understanding of race and class issues.

My first degree in Political Science broadened my understanding of international issues, the nature of underdevelopment, and the relationship between the 'underdeveloped' and the 'developed' world. Political Science also equipped me with a generalized knowledge about the role of the state and its use of power and an awareness of the structure and dynamics of political organizations. My Social Work degree added another layer to my experience. Consequently, my employment as a social worker in the northern region of Manitoba exposed me to an aboriginal population who were being marginalised by systemic racism and poverty. I was also confronted with state sanctioned use of power, where the state gave social workers the power to take children away from their parents, and I
became an agent of the state. In that system the family, or more the parents were the focus for change. The ‘agents’ were not trained to broaden their focus on the social and economic issues that limited parents’ abilities to be available for their children.

My background does influence my therapeutic style. I still view myself as a Trinidadian living in Canada. I chose not to lock away my past and discard the key. I chose not to be a Trinidadian-Canadian. I try to bridge the two worlds. The structural family therapy model suits my style. I am comfortable with authority. The structural family therapist does more than listen. He or she becomes an interventionist and an agent of change. She/he joins the family and brings the family drama into the therapy room whereby creating a context in which family members are encouraged to interact directly with each other. During the enactment the therapist withdraws to a middle distance position and takes on the role of a curious observer. Over the years structural family therapy has also broadened its family context to include organizations and agencies that impact on healthy family functioning.

This practicum has challenged some of my own thinking. I queried whether a white woman could effectively parent a Black child. However, that belief changed when I met Ms. Silver and her ten year old daughter, Jada. This child had no identity problems. She liked herself and was able to discuss racial issues without internalizing negative attitudes from others. Her environment frequently reminds her that she is different. On a number of occasions when I picked her up from school
or when we stopped for a snack on our way to a session she would be asked if I was her mother. This question came from her peers and adults. In the company of her mother she is confronted with the curious and open stares from others. In spite of this Jada, with her mother’s active and perceptive support, is growing up confident in her identity as a Jewish-Canadian-Jamaican girl.

As a Black therapist I found I had to be cautious about over-identifying with Black family members. In the case of the Richardson single parent family, I found myself over-identifying with Paul and excluding the mother who was white. I may have been playing out my bias against white parents with Black children. I worked with the Richardson family before I met the Silvers. I was losing my neutrality as a therapist and took on the role of Black friend and teacher to Paul. Fortunately, midway in therapy I was able to regain my neutrality and was able to confront Paul on some of his negative behaviours which had little to do with his skin colour.

I shared some similarity with most of the families in this practicum in the form of gender, immigrant, and minority experience. This made joining easy to accomplish. It also made it easy to address race and power issues with the families. It would be useful for a white middle class Canadian-born therapist to work with this racially diverse population and compare the interventions and outcomes for both therapists. My thinking has not changed in the usefulness of structural family therapy model with a racially diverse group. In a conversation with Salvador Minuchin he indicated that his theoretical and conceptual thinking remained the same. However, he identified changes in his techniques and practice over the past
thirty years. He has absorbed the techniques and thinking of people he admired. They include Carl Whitaker, Jay Haley and feminist therapists Rachel Hare-Mustin and Virginia Goldner. Minuchin added that family therapy will be more effective if we tolerate multiple approaches. This is most relevant in working with members of racially diverse groups.

**Conclusion**

This practicum started off with the intervention to conduct structural family therapy with a number of families. It was later expanded to families from diverse groups, both immigrant and non-immigrant families, where the adolescent was involved in the psychiatric system. This proved both challenging and rewarding. Having this intimate look at psychiatry was new to me. Coming from a non-white, non-western, somewhat traditional socio-centric country, psychiatry's ideology of zeroing in on the internal world of the individual (in this case adolescent) seems strange to me.

Later my research revealed that there are changes occurring in psychiatry, as noted by Dr. Stephen Fleck: "Our profession needs to get used to thinking and conceptualizing in systemic terms; the human condition is one of systemic interdependence from cells to celestial levels. The most crucial system interphases, however, are the individual and his or her immediate context: family, community and culture" (1995, p. 200).

The introduction of cultural factors and the outline for cultural formulation is the first attempt in the DSM to alert clinicians that assessment of a mental disorder
should be made within the cultural context of the client and to judge the implications that culture has for clinical assessment and treatment (Castillo, 1997). There is hope that psychiatry will move into the era of inclusiveness and equal access in treatment.

During this practicum I had the opportunity to spend a week at the Minuchin Centre for The Family in New York. Two days were spent with Dr. Salvador Minuchin. He conducted two live family sessions. I was fortunate to see a master therapist at work. He made enactment seem so easy. He made therapy look so easy. Nichols and Schwartz (1994) state that, "the best way to become an effective clinician is to begin as a disciple of one particular school. Apprentice yourself to an expert- the best you can find- and immerse yourself in one system. After you have mastered that approach and practised it for a few years, then you can begin to modify it, without losing focus and direction" (p. 402).

I was unable to find an expert; however, I have chosen to be a disciple of Minuchin's structural family therapy school. Although when I am working with a family I am always thinking what interventions might have a chance of helping the family change its structure, I cannot ignore the other variables that may impact families. I also think about the race, skin colour, gender, culture, class, immigration history, minority status and power issues of the family present in the therapy room. I have a long way to go to become an expert or to feel extremely effective. I still get caught up in details (content) and pay less attention to patterns (process). However, I am confident that with practice, reviewing videotaped sessions and
seeking out supervision when needed I will be able to see myself, the family therapist, as an agent of change.
Bibliography


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APPENDIX A

CHARACTERISTICS OF THE 11 FAMILIES
<table>
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<tr>
<th>Family name</th>
<th>Race</th>
<th>Immigrant Status</th>
<th>Socio-economic Status</th>
<th>Religion</th>
<th>Family Composition</th>
<th>Language Spoken</th>
<th>Medications Used</th>
<th>Diagnosis of Identified Client</th>
<th>Presenting Problems</th>
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<td>Santos</td>
<td>Asian</td>
<td>Parents migrated from the Philippines</td>
<td>Middle</td>
<td>Roman Catholic</td>
<td>Two Parent Family (19 year old girl and 15 year old boy (IP))</td>
<td>English and Tagalog</td>
<td>Antidepressants</td>
<td>Hypomania</td>
<td>Please see detailed presentation in Chapter 5</td>
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<td>Spenser</td>
<td>Black</td>
<td>One Parent migrated from Jamaica and one parent migrated from Panama</td>
<td>Low</td>
<td>Fundamentalist - Christian</td>
<td>Female Single Parent. Father spends periods in the home (14 year old girl (IP), 11 year old girl and 7 year old boy)</td>
<td>English &amp; Spanish</td>
<td>Prozac</td>
<td>Depression</td>
<td>Please see detailed presentation in Chapter 5</td>
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<tr>
<td>Davis</td>
<td>Black</td>
<td>Parents migrated from Jamaica</td>
<td>Low</td>
<td>Fundamentalist - Christian</td>
<td>Female Single Parent (15 year old boy (IP))</td>
<td>English</td>
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<td>Anxiety Disorder</td>
<td>Somatic complaints, dysphoric affects and school refusal</td>
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<td>One parent Canadian born and one parent Jamaican born</td>
<td>Low</td>
<td>Judaism</td>
<td>Female Single Parent (10 year old girl (IP))</td>
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<td>No diagnosis</td>
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<td>Depression</td>
<td>Withdrawal/Lethargic/Tearfulness</td>
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APPENDIX B

ROBERTSON FAMILY GENOGRAM
Appendix B
THE ROBERTSON FAMILY

American Indian
African Black

Rosie

David
Alcoholic

Carol
Scottish/Native

John (48)

Lynn

Dave
Married 1975
Divorced 1983

Barbara (46)

Ken (45)

Paul
DOB: June 25, 1982

Linda (32)

Glen (40)

Tia

David (38)

Tanya

Deceased
Alcoholic
APPENDIX C

THOMAS FAMILY GENOGRAM
Appendix C
THE THOMAS FAMILY

Deceased
Appendix D

THE SANTOS FAMILY

- Died in 1995 aged 80+ yrs
- Died in 1956 aged 30 yrs
- Died in 1975
- Died in 1950's

- WPG
- Phill
- Phill
- Phill
- Phill

- Married in 1976

- CHITO
- CARLITO DOB: 1981
- MARY DOB: 1977
- Deceased
- Alcoholism

- MONA

- Phillippines
- Winnipeg
APPENDIX E

FAM-II GENERAL SCALE: SAMPLE STATEMENTS
APPENDIX E

SAMPLE STATEMENTS FROM THE FAMILY ASSESSMENT MEASURE
GENERAL SCALE

The General Scale of the Family Assessment Measurement is made up of fifty statements comprising nine subscales. Respondents are asked to indicate a specific level of agreement with each statement; each response is then assigned a numerical value. The values of the statements within each subscale are added together to obtain a raw numerical score. These scores are converted into standard scores and the results are then charted to obtain a FAM profile for each respondent. An overall rating of family functioning is obtained for each respondent by adding the totals of his/her subscale scores (excluding the response style subscales of defensiveness and social desirability) and dividing this sum by seven.

Sample statements from each of the nine FAM-III subscales are presented below:

Task Accomplishment:
  When problems come up we try different ways of solving them.

Role Performance:
  My family expects me to do more than my share.

Communication:
  We argue about who said what in our family.

Affective Expression:
  We tell each other about things that bother us.

Involvement:
  We feel loved in our family.

Control:
  Punishments are fair in our family.
Values and Norms:
   The rules in our family don’t make sense.

Social Desirability:
   My family and I understand each other completely.

Defensiveness:
   Sometimes we are unfair to each other.
APPENDIX F

ROBERTSON FAMILY FAM-III PROFILES
Appendix F

FAM-III ColorPlot™ of Family Perceptions

Key to Results Profiled

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Green = Family Strength  Yellow = Average or Typical

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### FAM-III ColorPlot™ of Family Perceptions

**Key to Results Profiled**

- **Green** = Family Strength
- **Yellow** = Average or Typical

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APPENDIX H

SANTOS FAMILY FAM-III PROFILES
# FAM-III ColorPlot™ of Family Perceptions

**Key to Results Profiled**

- **Mary**
- **Carli**
- **CHTC**

**Green = Family Strength**  **Yellow = Average or Typical**

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Appendix H  THI SANTOS FAMILY  PBB-7007

APPENDIX I

CLIENT SATISFACTION QUESTIONNAIRE (CSQ8)
Appendix I
The Client Satisfaction Questionnaire (CSQ)

Please help us improve our program by answering some questions about the services you have received. We are interested in your honest opinions, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received?
   - 4 Excellent
   - 3 Good
   - 2 Fair
   - 1 Poor

2. Did you get the kind of service you wanted?
   - 4 No, definitely not
   - 3 No, not really
   - 2 Yes, generally
   - 1 Yes, definitely

3. To what extent has our program met your needs?
   - 4 Almost all of my needs have been met
   - 3 Most of my needs have been met
   - 2 Only a few of my needs have been met
   - 1 None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him/her?
   - 4 No, definitely not
   - 3 No I don’t think so
   - 2 Yes I think so
   - 1 Yes definitely

5. How satisfied are you with the amount of help you received?
   - 4 Quite dissatisfied
   - 3 Indifferent or mildly dissatisfied
   - 2 Mostly satisfied
   - 1 Very satisfied

6. Have the services you received helped you to deal more effectively with your problems?
   - 4 Yes, they have helped a great deal
   - 3 Yes, they have helped somewhat
   - 2 No, they really didn’t help
   - 1 No, they seemed to make things worse
7. In an overall, general sense, how satisfied are you with the service you received?

4  3  2  1
Very satisfied  Mostly satisfied  Indifferent or mildly dissatisfied  Quite dissatisfied

8. If you were to seek help again, would you come back to our program?

4  3  2  1
No definitely not  No I don’t think so  Yes I think so  Yes definitely

ADDITONAL COMMENTS:

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PLEAS ATTACH ADDITIONAL SHEETS IF YOU WISH