AN APPLICATION OF A FAMILY-CENTERED ECOSYSTEMIC APPROACH WITH IMMIGRANT/REFUGEE FAMILIES

BY

WIESLAWA KASTELIK

A Practicum Submitted to the Faculty of Graduate Studies
of the University of Manitoba in Partial Fulfilment
of the Requirements of the Degree of

MASTER OF SOCIAL WORK

WINNIPEG, MANITOBA

FALL 1987

ISBN 0-315-44089-9

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ACKNOWLEDGEMENTS

The completion of this practicum was achieved through much hard work - the work of some significant and encouraging people.

I am very grateful to Professor Ruth Rachlis for her most invaluable assistance, professional and emotional support through all stages of this work. I admire her energy, good will and patience in discussing and sharing freely her own creative thoughts and time. Thank you for that stimulating and supportive climate.

I greatly appreciate the opportunity of attending as a Teaching Assistant a Cultural Diversity and Social Work Practice course provided by Esther Blum. Her lectures and guidance were of profound inspiration and importance for my cross-cultural awareness development. Her valuable feedback to my written work is also greatly appreciated.

I thank also Jackie Rand, Family Therapist of Children's Home of Winnipeg for her feedback to my report.

At The International Centre, I am grateful to Ms. Liz Partyka for her help and most valuable cooperation in therapeutic work with the families.

Special appreciation to my husband, Boguslaw who through his encouragement and support made the experience easier.

Finally, I need to recognize strength and valuable contributions of all my clients and many others whose ideas enriched my own.

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INTRODUCTION

The learning objectives of this practicum were to demonstrate that the student had developed advanced clinical skills, by using the framework of family systems theory and practice, and by presenting her understanding of the theory and its application and intervention in family systems.

The student's next objective was to examine and identify the most effective approaches in working with families recently immigrated to Canada.

The chosen interventive procedures were rooted in systems theory and framed by the ecological paradigm. The ecological approach was used as an operational framework in which the family was seen to be simultaneously in interaction with its immediate environment while being influenced by the internal activities of its individual members. Culture, ethnicity and family past were taken into special consideration as distinctive circumstances which effect the process of family adjustment in a new country and have impact on therapeutic intervention.

Within that framework the application of the Structural Family Therapy Model to the newcomer family situation was examined. Working systemically with the individual, networking, cognitive intervention and paradoxical prescriptions were some other therapeutic endeavors put forth.

The intervention objectives were (1) to review the relevant literature and (2) to complete a practicum with 8 -

10 immigrant/refugee families under the supervision of an experienced family therapist. All members of these families were former Polish citizens, who have been in Canada no longer than five years.

The practitioner being a recent immigrant from Poland possesses a connectedness to the migration process which produced an inner drive to acquire more academic and practical knowledge about resources and preventive-therapeutic skills. As the practitioner believes that migration can be an exceptionally isolating experience for the family and for perhaps two-generations of its members who are not fluent in the language of the new country, she became interested in providing better help for them. Born out of that attempt was the challenging experience of going even beyond the professional family therapist role to search for supplements or alternatives.

Apart from that, the student became very interested in the Structural Therapy Model ever since she was involved with Children's Home. Children's Home of Winnipeg is a well known, multi-faceted agency particularly specializing in a systemic and family centered approach to children and families. Under a Summer Student Job Creation Program, the practitioner had the chance to be involved with the Family Therapy Department and their weekly organized peer group meetings. During four summer months prior to the beginning of her practicum, the student had an excellent opportunity to learn Structural Family Therapy Theory and practice through participating (passive) in the family therapists' group support discussions and then

by observing via a one-way mirror sessions with cases previously discussed. Furthermore, the student utilized opportunities to view agency tapes and studied literature and materials which were gathered at the department. In total, approximately fourteen families were observed and discussed during that time. This experience has made an indisputable contribution to the student's learning process and preparation for her practicum. This encounter is especially valued since "bug-in-the-ear" and videotaping equipment was not available for the student during her practicum.

The following report is the culmination of what the student has learned in meeting her objectives.

PART I

LITERATURE REVIEW

The literature review involves two sections. Section one includes a broad epistemological framework based on the ideas of general systems and ecology. This framework is extended and enriched by both the ethnic and immigrant component. The ethnic component entails the work of Edward Hall (1977, 1984) in order to enhance understanding of the diversity of cultural and ethnic circumstances and of McGoldrick (1982) in order to present the culture specific information. The Immigrant component involves the current state of knowledge concerning refugee/immigrant issues and the process of acculturation and integration. Refugee/immigrant issues will be presented based on different sources: articles, books, presentations, conference materials and the practitioner's own experience. The process of acculturation and integration was addressed primarily using the model developed by a systemic therapist Carlos Sluzki (1979).

Section two is committed to theory and family therapy practice. First, a Structural Family Therapy Model which was taken primarily from Salvador Minuchin's work will be elaborated. The social support network concept based on the practice oriented book of James K. Whittaker and James Garbariono (1983) and other methods implemented will then be presented.

SECTION ONE

CHAPTER 1: AN EPISTEMOLOGICAL FRAMEWORK AS APPLIED TO IMMIGRANT FAMILIES

The General Systems Perspective

The ideas of system and ecology have strongly influenced contemporary thinking about the family in both academic and clinical circles.

General systems theory constitutes a fundamental shift in the epistemological perspective. This perspective was initially developed as a science of living systems. As such, it focused on the characteristics of whole systems. Characteristics of organized whole systems include a differentation of parts, an order and a directedness of processes. Ludwig Von Bertalanffy, who first propounded general system theory, defined system as "complexes of elements standing in interaction" (1968, p. 33). In contrast with the closed systems in mathematics and sciences, a social system is open, that is, it is in a constant process of change subject to the inflow and outflow of information stimuli. Depending on the type of system, open systems either return to a present end state or evolve to a new state. A change in one part of the system affects the system as a whole and all of its parts.

Families are such open sociocultural systems that even the most closed families interact with the environment and exist at some level of organization. It is an important principle of systems theory that living systems including

families, have the capacity for growth and change if they are in appropriate transaction with their environments. Nevertheless family systems may experience many different stresses which disturb this transaction. For instance, there may be a lack of sufficient information from the environment or an experience of some form of breakdown in its usual feedback processes. This breakdown can be between family members (internal) and/or with the outside systems (external). As the communication becomes blocked or damaged, breakdown or dysfunction occurs. Even though a family may find these disfunctional patterns painful, they will often cling to them rather than face change as a family. Hartman and Laird (1983) consider that certain populations can be identified as being at risk because their age or their economic, social or environmental status has led them to be increasingly isolated. This process of social isolation can be pictured as increasingly diminished input flow. The situation of the aged in society is presented as a classic example of such a population and certainly immigrants/refugees are a very good example as well.

When general systems theory is the theoretical rationale underlying family therapy, an ecological model humanizes the systems approach by focusing on life transitions rather than on problems.

The Ecological Perspective

This perspective deals with the person and the enviroment. The environment and the different systems that compose it have a great deal to do with the process of adaptation and ability to cope successfully in a new country.

> "Adopting an ecological perspective, as Gordon (1969) conceptualized it, leads us to focus on adaptive (and maladaptive) transactions between persons and between the person and environment - in other words, the interface between systems. Such a view leads us to examine the sources of nurturance and stimulation which must be available from both the intimate and the extended social enviroment. It helps us evaluate the skills that a person or family must have to make appropriate use of possibilities in the environment and to cope with its demands". (Hartman, Laird p. 70).

In addition to recognizing the transactive nature of development, an ecological framework also considers the multiple levels at which environmental influences originate. Brofenbrenner (1979) describes the individual's environment as a set of Russian dolls. As one asks and answers questions about development at one level, this ecological framework reminds one to look at the next levels beyond and within the immediate settings for questions to ask and answer. For example, if there is an immigrant family in conflict over being unsuccessful in a new country and therefore having insufficient income one needs to look outward to the economy and to the

culture that defines personal worth in monetary terms and blames the victims of economic dislocation for their own losses. Yet, one needs to look at the family's culture and its definition of human worth, too. In addition, one must look inward to the parent-child relationships that are affected by the changing roles and status of the parents and to individual characteristics of each family member involved. Further, it is important to look "across" to see how the several systems involved (family, social networks, workplace, community, economy) adjust to new conditions over time. These swirling social forces are the stuff of which ecological analyses are made, namely, interlocking social systems.

Edgar Auerswald (1974), who has helped to develop an ecological perspective in mental health practice, presented a drama of a Puerto Rican family and problems which could have been avoided if an ecologically based program were employed right after their arrival to New York. He offered a comprehensive analysis of the factors related to the failure of today's American Social System. Particularily Auerswald presents unfavorably Western ideology with its hierarchical, linear thinking about space and time which leads to the fragmentation and specialization of American service delivery institutions. According to him any complex problems, and cultural transition is a good example, cannot be solved in a system that has evolved from a so-called "Western Epistemological Program ; therefore changing that program is of

paramount importance. This change involves looking differently at time, space, the model of the universe and taking a more flexible position with respect to family systems and wider social systems. Time and space are core elements of cultural differences, thus culture itself needs exploration.

CHAPTER 2. CULTURE, ETHNICITY AND FAMILY THERAPY

The Hall Model

Since in the therapeutic situation, many cultures may concur (ie. values of the society of origin, client's culture, values of the new society, student's culture and professional ethics) it was crucial for the practitioner to understand generally what culture is about. In his book "Beyond Culture" 1977, Hall describes culture as learned, with interrelated facets, pre-verbal and mostly a subconscious reality which is shared, and in effect defines the boundaries of different groups. He believes that real learning of any culture can only happen if one understands the unconscious aspects of culture because it is like a screen whose function is to filter out the known aspects of the environment.

Hall uses several gradients to explain cultural differences: sense of time, context, and commitment to action chains. A culture can be monochronic (doing one thing at a time; task oriented) or polychronic (doing many things at once; relationship is highly valued); it can be high-context (wholistic, group-conscious, a wise person in charge) or low-context (fragmented, logical, individually oriented, its system diffuses authority by delegation); it can be very committed to its action chain or haphazard about them. The action chain is the smallest complete component of culture. It is the ritualized pattern of events and often determines the symbolic value that accompanies each of the stages of

the chain. These different stages are always preceded by what Hall labels adumbrage - verbal and/or non-verbal communication foreshadowing the shift to the next stage.

The way in which the family forms its sense of time, the way they process reality, and the ritual patterns that give them continuity are the basic building blocks that make one's world known and predictable (Hall, 1977).

Hall's (1984) latest book "The Dance of Life - The Other Dimension of Time" is entirely devoted to time as a core system of all cultures. He studies time as an out-of-awareness system of communication and describes time as a cluster of concepts, events, and rhythms covering an extremely wide range of phenomena. In the Western world, time is seen as a single entity and this, Hall argues, is incorrect. As he studied people's behavior he discovered a wide discrepancy between time as it is lived and time as it is considered. In order to show interrelationships of different kinds of time, Hall classified it in the symbolic shape of a mandala square. He writes:

> "Each division in the mandala represents a radically different kind of clock. Viewed in this light and taking into consideration the different classes of time, it is important to note that the rules for understanding one category (one kind of clock) are not applicable to another category. It is hopeless to try to make sense of physical (scientific) time in terms of its, opposite, metaphysical time, and vice versa, or to apply the rules of sacred time to profane time. These classes of time are like different universes with different laws." (p. 16)

He provides the reader with a lengthy description of various clocks such as: biological, personal, physical, metaphysical, micro, sync, sacred, profane and meta time.

By reading all this there is a feeling of mystery - there is something essential in human beings and around them in the universe which is far less known. Time is an indispensable phenomena which makes human beings unique and similar, ties them up and alienates, absorbs every communication and sets the rhythms of peoples' lives. Hall also believes that the way in which people synchronize or dissynchronize could be used as an index of acculturation.

This student is especially interested in knowing more about how people influence each other in terms of rhythm. Particularly exciting is the concept of ryhthms as probable ultimate dynamic building blocks not only in personality but also in communication and health. One implication learned for practice is "listening" for the rhythms of the client. Without synchronized rhythm in therapy, the process of change is seriously disadvantaged.

Ethnicity and Family Therapy

Having a general understanding of culture, it is essential to explore the concept of ethnicity and its interrelationship with culture.

The peoples of an ethnic group share a common race, language, religion and/or national group (Lee, 1985). With immigration to a multicultural society, the ethnic group

continues to be an entity, however culture is transplanted and transformed through a dynamic interchange with the new environment. For a therapist who wants to identify what needs to be addressed in families with ethnic variances the work of McGoldrick, Pearce and Giordano in "Ethnicity and Family Therapy" 1982 is perhaps the best current source of specific information on various ethnic groups.

John Spiegel (in McGoldrick, 1982) presents an overview of Ethnicity and Family Therapy and suggests that when the culture is the focus from which to begin the therapeutic process in families undergoing acculturation, therapy needs to consider the strengths within ethnic families, particularly these strengths which facilitated survival. In order to find these strengths the therapist needs to contrast her own values and beliefs from that of the client. Helpful in that matter would be the work of Kluckhohn and Strodtbeck (1961) whose contribution to the classification of cultural value orientations is fully recognized by the author.

Kluckhohn's theory is based on the assumption that people all over the world face the same basic life problems but they do not cognitively or affectively find the same solutions for their problems. Furthermore, basic values are not seen as a superficial phenomenon, but deeply rooted, mainly unconscious and very pervasive so that they affect the patterns of behaviors and thoughts of peoples' areas of activity. Different dimensions of these cultural values include: (1) Orientation to Time - the temporal focus of human life: Past, Present,

Future. (2) Activity - the preferred pattern of action in inter-personal relations: Doing, Being, Being-in-Becoming. (3) The Relational Orientation - the preferred way of relating in groups: Individual, Collateral, Lineal. (4) The Man-Nature Orientation - the way people relate to the natural or the supernatural environment: Harmony -with Nature, Mastery-over-Nature and Subjugated-to-Nature. (5) The Basic Nature of Man - attitudes held about the innate good or evil in human behavior: Neutral/Mixed, Good, Evil (McGoldrick, 1982, p. 37).

All of these values can be set into first, second and third order value choices. Each value choice has its implications. For instance "the American middle class places the Future orientation in the first order position to the dimension of Time in human affairs.... It places importance on novelty and transience. Anything new becomes better than anything old... Youth is highly regarded as the representative of the future, while the elderly have so little future left to them..." (McGoldrick, 1982, p. 39) The values of a mainstream therapist may vary greatly from those of clients whose extended family is typically patriarchal and in which the senior male is the authoritarian head of the household. Becoming knowledgeable about the dominant values of the client would be a key to understanding different family problems in the process of sociocultural change.

In her overview McGoldrick emphasizes additionally the need for therapists to relate ethnicity in family process to

the broader context in which it evolves. Various distinctions become apparent upon examining different ethnic orientations. For instance, definitions of "family" differ between groups, as do family life cycle phases, the significance of different transitions, as well as occupational choices. All of these variations lead to a generating of characteristic problems, acceptance of problems, solutions to problems as well as whether or not these groups seek help for their problems.

Although North American and Eastern European culture basically seem to be similar, they vary in their concepts of family and ways of looking at the world. Therefore it was essential for the practitioner to develop self-awareness in addition to skills in identifying ethnic factors in families to enhance the effectiveness of the intervention. Among other ethnic groups presented in McGoldrick et al, there is a very instructive presentation of Polish families in the process of acculturation. The fact that the student had been a Polish citizen facilitated and enlightened the learning process.

Therapy with Polish American Families

Although the author, Sandra Mondykowski, (in Ethnicity and Family Therapy, 1982) writes about the generational waves of immigration to the United States, much information and implications for therapy are still relevant for recent migrants from Poland to Canada. Generally speaking, the

student took into consideration in her approach the various data and Mondykowski's advice.

Summarizing some core ideas she stressed that the ability to perform is crucial to Polish Americans for their identity is tied up more with doing than with being. Everyone is expected to work and little sympathy is wasted on failure but success (especially children's) is acknowledged and praised. For that reason mental illness is a terrifying situation because it impairs performance and involves loss of control over behavior. The assumption underlying the "Polish" method of problem solving is that the person is refusing rather than unable to change their own behavior. Yet behavior is more important than feelings and results are what matters, not understanding the behavior itself.

The Polish families are noted as rarely coming on their own initiative to a clinic for treatment since loyalty and mistrust of outsiders is strong. In normal circumstances a family first seeks help within the family structure, (nuclear and extended), then turns to the community including priest, co-workers, mutual-aid society, and clubs. Consequently once they come to a clinic, the therapist has to be cautioned that sometimes she is not treating one family but rather an entire unseen "Greek chorus" of the community and neighbourhood which might be present at every session. As well, Polish American families do not believe in going down with a sinking ship. Rather than have the whole family withdraw from their community, the family might expel the unchangeable deviant offender

and get community support to ease the family's guilt and sorrow.

Another caution Mondykowski expresses is that despite the expressiveness of Polish Americans, the therapist must not be misled by the easy demonstration of strong emotions. This usually is a distancing technique to intimidate the therapist so that she will not probe those feelings too deeply to avoid expressing a forbidden need; the need to be taken care of. Being taken care of implies weakness and inability to pull their own weight. Dealing with real feelings is probably precisely what they want to avoid. Furthermore no family member has permission to express anxiety which violates a family's expectation of stoicism. Showing a stoical face was probably a very adaptive behavior in peasant villages that were continuously invaded. The strong and hidden feelings are eventually dispelled in ways such as alcohol abuse and when to be "weak", to cry, or to "lose control" is permitted.

The author suggests that the approach of the therapist must be active, practical and down to earth. In the first session he/she should find one or two points of reference at which to identify with the family experience. This will be recognized as a sign that the therapist is secure enough to be a bit human with them. Usually Poles respond best to a style of informal, friendliness, sympathetic listening, and nonpatronizing understanding. They are more receptive to continued therapy when the family sessions are defined as task-

oriented explorations of the problem. Power struggles should be avoided. Self-deprecating humorous responses, perhaps joking about her/his own expertise is preferrable. The family needs to learn to negotiate with each other - to express strong emotions in some effective way. Thus, the therapist's role would be structuring angry confrontations and giving reassurance that they are not crazy.

Finally Mondykowski (1982) concludes that the therapist may get frustrated when family members listen attentively to all that has been suggested and then come up with a completely opposite plan. One needs to understand what "liberum veto" (denial - Latin) meant in Polish history when the individual member of Parliament had the right to obstruct the will of the Parliament and community as a whole. The members of a Polish family are likely ambivalent about authority and they may dig in their heels and argue over every insight. It is the student's experience that this kind of attitude was often seen as anarchistic by Immigration officers who could not understand why they need to explain everything in depth to Polish newcomers when others do not expect any rationale and seem to be happy with the rules.

In addition to Mondykowski's suggestions another notion in recognizing culture and ethnicity as meaningful attributes in the process of therapeutic change is important. Even though specialized knowledge of a given family's culture is necessary for effective therapy, one needs to distinguish a family's basic problem solving characteristics from its cul-

tural baggage. It is noticed, that by selectively involving cultural constraints, by misleadingly involving socio-economic pressures to justify their dysfunction, and by parodying ethnic blueprints, a family can delude the therapist into dealing with a cultural image rather than the real people. At that point it would be advisable to search for what is basic to the family rather than to focus on a family's idyiosyncratic cultural heritage (Montalvo, 1984).

CHAPTER 3 REFUGEE AND IMMIGRANT ISSUES

Introduction

Throughout the ages of civilization the plight of refugee has recurred as a result of religious and political persecutions, economic instability and demographic upheavals. One could almost say that migration is a trait of the human race. From this condition moreover, the growth of new breeds of societies and civilizations comes to pass. Yet the human socio-psychological dynamics of the process of migration and resettlement seem to have been neglected.

Traditionally, international migration has been divided into voluntary or planned transplantation, and involuntary or forced migration, comprising refugees, displaced persons, and forced laborers. However, voluntary migration is not always so voluntary. It is at times difficult to determine whether an individual emigrates of his own free will or because of anxiety over anticipated persecution which may, or may not, materialize. Psychologically, a voluntary migrant may be as much a refugee as an involuntary migrant (Weinberg, 1955). This specifically would apply to recent Eastern European immigrants.

Nevertheless one must not overlook the significant differences between political refugees and economic immigrants. Generally speaking, immigrants usually leave their country for economic reasons and, even if they have political

motives, the emigration is a planned process. Although having planned their change of environment, they are nevertheless faced with the shock of realizing that they have to change in order to survive, that they must do things differently, resolve problems differently and generally interact with their new environment in a different fashion. Such changes are bound to affect the relationships within the family as well as creating the necessity to develop new roles, new behaviors, new standards.

Refugees face additional problems because they leave their country for political reasons, often with only a few hours or days to plan their exit. There is no plan and the move is a rather sudden reaction to events. The Refugee class is set forth in the 1976 Immigration Act and Regulations and based on the following definition adapted from the United Nations Convention and Protocol Relating to the Status of Refugees:

> A "Convention refugee" is "any person who by reason of a well-founded fear of persecution for reasons of race, religion, nationality, membership in a particular social group or political opinion, (a) is outside the country of his nationality and is unable or, by reason of such fear, is unwilling to avail himself of the protection of that country, or (b) not having a country of nationality, is outside the country of his former residence and is unable or, by reason of such fear, is unwilling to return to that country." (p. 11)

Many Eastern Europeans, especially Poles are seen as

members of a "Designated class" under the Immigration Act and include persons displaced by emergency situations and persons who the Government of Canada recognizes as "specially designated classes" for humanitarian reasons.

In this practicum report the practitioner will frequently use the label "newcomers" for both immigrants and refugees and refer to Eastern European groups in terms of a culture which is different to that of North American. Although all her clients possess refugee class or designated class status, some of them, as well as others in the Polish newcomer community, tend to classify themselves in the immigrant class. The practitioner in her approach has chosen to use the client's own frame of reference in both the treatment and evaluation process.

The intent of the following section would be to explore the socio-psychological situation of immigrants and refugees with the focus on Eastern European families affected by this unique experience.

General Overview of the Socio-psychological Situation of Newcomer Families

To center on the dynamics of the socio-psychological dimensions of the immigrant experience is to touch the heart of the problems of the resettlement process even though in fact economics are also most basic issues.

The social problems facing an immigrant or a refugee occur at two levels: the universal and particular. The universal problems of illness, death, job loss or marital

problems can happen to anyone, but they acquire an intensity and evoke stronger reactions among those who have been uprooted from their cultural and social environment. The coping mechanisms that might have been developed in one's own culture to deal with these occurrences are of little value in the host society; one's views of how these problems should be handled, which are deeply rooted in a cultural value system, may now appear to be dysfunctional (Multicultural Workers Network, 1980, 1981).

Many researchers studying the refugee/immigrant's problems, have reported a high incidence of anxiety, depression, family problems, marital conflict, intergenerational conflict and school adjustment problems (San Suu Nguyen, 1982). The following circumstances should be considered as containing crisis elements and vulnerability to breakdown of the individual and family:

(1.) Migration as a sudden change. Migration itself should be considered an event which marks a change in the ecological balance and could be a starting point to a total sequence of events requiring clinical intervention. The consequence of this radical change is the loss of social status and the resulting loss of identity of immigrants and refugees. Eisenstadt (1954) emphasizes that migration is one of the most obvious instances of completed disorganization of the individual's role system and some disturbance of social identity and self-image is to be expected. In this sense,

migration has a desocializing effect. The psychological dangers of uprooting were observed in refugees during and after World War II. One of the most stressful facts of this process is that immigrants find themselves in usually completely different environments where they are unable to communicate and must deal with many obstacles to life goals.

(2) Importance of pre-immigration experience and reasons for leaving the country.

When one looks at the problems encountered by immigrants and refugees in a new country, one has to see that different dynamics are taking place regarding the adaptation of these diverse groups. Economic immigrants might accept more or less the social costs of their assimilation and even plan for them at the outset of their journey; they come with some idea of what they will do in a new country. Refugees experience loss as a result of the sudden exit from a known environment; often they have left a satisfactory position at home and a commitment to their society. They have fled out of necessity and fear, but often with little thought as to the demands that the immigration would place on them. Therefore this group might become more fragile, vulnerable and even appear to have the symptoms of psychiatric patients as a result of the displacement trauma.

It was highlighted at the Fall 1986 Standing Conference of Canadian Organizations Concerned for Refugees that there are several gaps in general information concerning the pre-immigration experience, health and mental health problems of

refugees and immigrants. Particularly, far less is known about the victims of torture and the effects of torture on "secondary victims , such as their spouses and children.

Amnesty International, the prestigious non-governmental human rights organization, defines "the willful infliction of pain and suffering by an individual or groups of individuals on another person or persons with the intention of punishing or coercing the will of this person or persons" as torture (Allodi, 1984, p. 4). The types of torture or methods vary from the primitive and brutal to the sophisticated and technologically developed. Torture methods can be classified into four groups: physical, by deprivation, by sensory manipulation and psychological. Within each group a score of severity can be devised, which when used together provides a quantifiable measure of the severity of the trauma (F, Allodi, 1984).

Often in cases of marital or family disfunctioning in refugee/immigrant families a therapist must explore the possibility of this kind of history. Where there is suspected, responsible action should be taken to address this very important and central issue for treatment.

(3) Sudden disruption of the family unit. Although the refugee/immigrant may now be in safe haven, there still remains the fear, concerns, and worries of the family members left behind. This is compounded by the inability to control or change their conditions resulting in feelings of loss, helplessness and frustration.

(4) Further fragmentation of family unit on arrival. Beginning a new life in a host country and having experienced uprootedness puts strain on the family unit. Roles often must be adjusted or changed as a consequence of economic realities. Common examples are women i.e. wife and mother, former housekeeper, becoming a breadwinner in the workforce while father goes to English classes and children go to school. The alternative of the mother remaining isolated at home attempting to maintain the home in an unfamiliar environment, while trying to keep ties to the past and the culture puts her in a particularly vulnerable position.

(5) Period of loss/mourning for their homeland. There may be necessity for grief work. Marris' theory (1976) holds that loss of culture is processed by a group in the same way and following the same stages as grief work in the case of bereavement. There are three central themes in the Marris model: (a) People resist change; (b) People need the space and emotional freedom to grieve the losses necessary to make change possible. People in grief tend to be in a state of ambivalence in which rationality is superceded by emotionality and ; (c) Integration has to contain some symbolic new version of old core values. Thus the therapeutic focus is not to eradicate old ways of coping, but to provide the client with new choices of life-ways.

(6) Disruption of a familiar social support network and lack of a new one when they emigrate. Since the known, traditional resources of the network of family and friends, or even institutions, are not available to the newcomer family, they cannot cope with many stress situations with which they were able to manage previously. This can be one of the factors which precipitate a crisis situation for an individual and family.

(7) Inability to communicate in English. This barrier isolates newcomers from the Canadian communities and at times seems insurmountable and the most stressful one. The studies have shown that Polish World War II combatants displayed symptoms of schizophrenia and other serious pathologies related to linguistic isolation in England after the war (The Standing Conference Materials, 1986).

(8) Lack of employment security, job satisfaction and frequent poverty. The occupational adjustment affects Eastern European families sometimes more intensely than anything else. Through the job there is an instant interaction with the host society, changes are often dramatic and adjustment must be made immediately. The occupational status of the adults in the family have an immense effect on housing, social status and identity for the individuals and their families.

As well, since refugees from communist countries tend to be disproportionately of the upper educational and occupational levels, they tend to experience greater downward occupational mobility than individuals of lower occupational

levels (Allman, 1986).

(9) False expectation and lack of pre-immigration orientation. Working voluntarily for the last five years with recent immigrants and refugees, the practitioner noticed a considerable difference in terms of the settlement and the adaptation process between those newcomers who possess unrealistic expectations and lack proper orientation and those who do not. It seems that disappointment and anger of those who were unprepared leads to unreasonable aggressiveness and total negativism towards everything that is new and unpredicted. These feelings usually do not last very long but at the beginning hamper seriously the successful adjustment process. While with the opposite group, all newness is accepted since nothing better was anticipated, and adaptation is smoother and somewhat easier. After discussing these issues in length with many Eastern Europeans, it would appear that the majority of them expected Canada to be in better economic shape, having no poverty, when in fact 30% of the Canadian population is living in poverty.

(10) Occurrence of intergenerational conflicts. Children acquire Canadian values and learn English faster and as a result they often take over the role of cultural and linguistic intermediaries or interpreters and assume a responsibility in the family that they otherwise would not have, precipitating a shift of power.

(11) Difference of cultural values and traditions. In the important area of employment, most immigrants are found to be exceptionally hard workers, more oriented to the task than the clock (The Standing Conference Materials, 1986). The different frames of reference, attitudes and work style often cause stress, misunderstanding and unpleasantness on the job and in other areas of social interaction. For instance immigrants from Socialist States find it difficult to cope with a "job market", where there is competition for jobs, resume-writing is required, and interview technique and "selling oneself" are most important. These are very strange concepts for them and some perceive it to be unfair and manipulative.

Women from Eastern Europe particularly complain that they are not treated equally with men from the beginning when interviewed at the Canadian Consulate. Usually they are not considered as possible breadwinners, looked on only as "an addition" to their husbands and quite often the professional woman is classified as a "housewife" in visa documents. (This experience happened to the student herself). A study made of all immigrants showed that:

> "the highest percentage of university graduates came from the Soviet Union (35%), and none from that country had less than a Grade 11 education. All the Socialist States, including Czechoslovakia and Poland, encourage and support higher education for women - in 1960, 30% of engineers and 75% of physicians in the Soviet Union were female. The proportion of

> immigrant working women from these areas exceeds that of Canadian women in general. This education is provided by the state, as are guaranteed jobs at fixed wage rates and social benefits and safeguards" (Multicultural Workers Network - The Family: Interventive Strategies in a Multicultural Context, 1981, p. 99).

It should be added that education is given very high priority in the newcomer family scale of values.

(12) Apprehension with the concept of mental health. Even though the health system in East Europe is similar to the Canadian, there are differences in the way the system works and who is approached first for help. A variety of informal helping and support networks are most extensively used and are popular. Especially in small towns and villages a local priest may be seen prior to the doctor or psychiatrist. Many, who might be labeled psychiatric patients or retarded have their pragmatic practical positions within communities and satisfactorily function without medication and the mental health system. Only in cases when the informal help has failed, is the formal authority asked to be involved.

(13) Learned suspicion and distrust of people in authority. In totalitarian societies people do not trust each other easily and they especially do not give any credit nor hold confidence in those who represent government. This attitude may appear alive even though circumstances change as in democratic Canada.

These 13 points, the practitioner believes, are important conditions which should be taken into consideration when working with East European newcomer families. One cannot overlook the fact that misconceptions and misunderstandings may arise through different concepts of what constitutes correct social behavior, a healthy family, and the adaptation and acculturation process.

The Migratory Process

The migratory process will be viewed from the model developed by a systemic therapist Carlos Sluzki. Carlos Sluzki (1979) suggests that the migratory process is made up of five distinct stages, each of which has specific types of urgenices, conflicts and crises. Graphically, he represented this universal pattern of the migratory process as the continum similar to the curve of performance under stress (Sluzki, 1979, p. 381). (See Figure 1 inserted).

Stage I - The Prepatory Stage

The process begins when the family makes the commitment to migrate. This requires some reformulations around rules and the functions of family members. This stage has important ramifications depending on how cognitively and emotionally prepared the immigrants were prior to immigration, as well as the motivations and connotations this

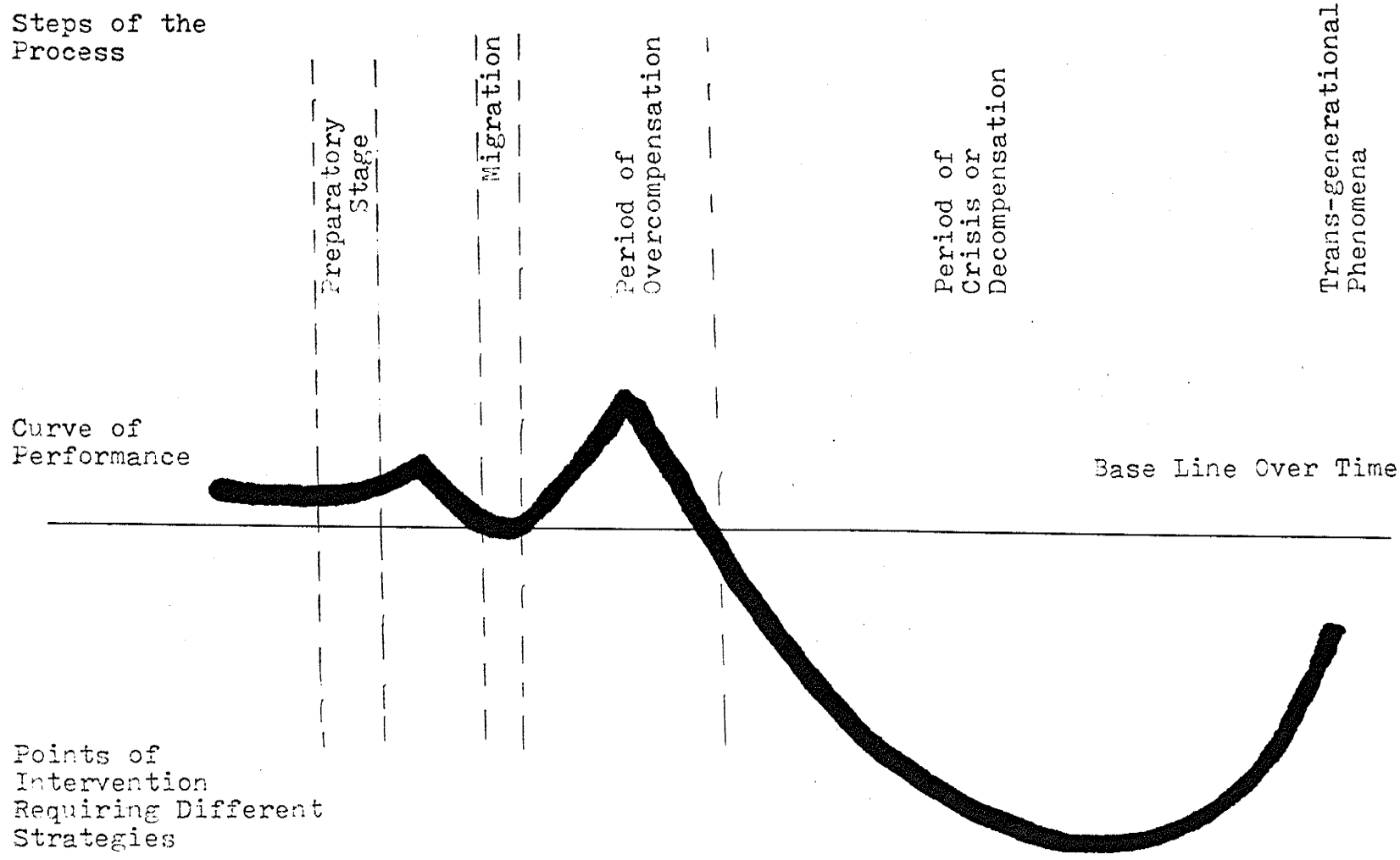


Fig. 1. Migration and Stress

Taken from Carlos Sluzki's article, "Migration and Family Conflict", 1979, p. 381

move has for the family.

Another important piece of information would be to assess who stands to benefit the most from the move and how much the decision was conjoint. This data together with the subjective connotation given by immigrants will be a significant source of knowledge about the family's coping style, rules and roles of each member, structure and patterns of authority.

Stage II - The Act of Migration

Migration itself is an important event which marks a change in the ecological balance of the family. It can vary in time (from a few hours to a few years) and legality; it can be voluntary (chosen) or involuntary (family was forced or psychologically determined to migrate); and it can be differently pre-planned as well as diverse in style (final versus temporary relocation). Each of these conditions have important implications.

Stage III - Period of Overcompensation

In the period immediately after arrival the family is likely to focus and to be preoccupied with the fulfillment of "survival" needs and the need to "do well". More complex relationships do not impinge at this point as Sluzki compares newcomers to "certain patients with a concussion who appear overall stunned and confused but maintain a narrow focus of

clear consciousness" (p. 384).

Strongly task-oriented negotiation of "first steps" in their new reality may result in an exaggeration of the family's existing internal patterns.

Stage IV - Period of Decompensation or Crisis

This period occurs when the family faces the facts of their new realities in full. The former dormant conflicts, difficulties and symptoms emerge and new demands are put upon the family. It is claimed that most immigrant families enter therapy in this stage of the process. The main collective task is that of change. The family needs to renegotiate rules or operational modalities which have been pivotal in the past and are no longer appropriate in a new milieu. The imperative is to maintain the family's identity and integrity while accomplishing a necessary reshaping.

The need for change arises strongly from the fact that various members of the family adapt at different paces. For instance children tend to achieve integration faster than the rest of the family. Thus, immigrant families are exposed not only to the well known "generation" gap but to an adaptational lag due to differential rates of adjustment.

The working parent is also in a better position to learn about and integrate into a larger community or network. For those who are not able to access retraining and language instruction, the door to future mobility is effectively closed.

Especially at risk during this period are migrant women who remain at home and often take the official "keeper of the past" role. As such, they continue to maintain a link with that which was lost and, for them, that which has substance and reality, as opposed to the new society where they have no real part to play.

This clinging to the past can cause a powerful vicious circle in which a homebound spouse becomes more and more dependent on the outward oriented spouse who responds with an even greater degree of independence and disengagement.

In concluding this period of transition Sluzki (1979) presents his Idealization/Denigration splits model. He suggests that some families may reach high levles of intrafamilial confrontation with some members standing for "old" values against those for the new ones. At this point the family may approach the therapist with somatic complaints, psychiatric problems or other dysfunctions.

Stage V - Transgenerational Impact

That which is not fulfilled or adjusted by the immigrants themselves tends to manifest in the second or even third generation in the form of a generational clash.

Also included in Sluzki's model is the concept of collective mourning. He describes situations where, depending on the conditions of migration and its success, mourning for the lost country and culture occurs to lesser or greater

degrees.

While the intervention needs to be in line with stage relevant issues (Sluzki, 1979), most importantly this practitioner had to identify the primary target for change. The assumption was that the interventions could be targeted toward the relationship between family and environment and in some other cases only toward the family system itself. In the first situation social support networks were considered to be of great importance in promoting a client's healthy adjustment whereas in the second instance, a structural family approach as proposed by Minuchin was chosen by the practitioner.

SECTION TWO

CHAPTER 4: STRUCTURAL FAMILY THERAPY MODEL

Historical Background

Structural family therapy with its philosophical roots in systems theory was developed primarily at the Philadelphia Child Guidance Clinic, under the leadership of Salvador Minuchin. This is probably not the exact historical punctuation since structural family therapy was a child of necessity and its beginnings could be traced to the Wiltwyck School where Minuchin and his colleagues worked with delinquent boys from New York (1967). One should also not discard Minuchin's childhood experiences of being exposed to alternative cultures as well as his work in the newborn state of Israel, where he had a unique opportunity to encounter cultural universals and cultural specifics with families arriving from all over the world. In respect of this, special consideration was given his model when choosing the most applicable approach with newcomer families.

For all that, the Wiltwyck experience remains a powerful encounter in creation of the model. There Minuchin had an outstanding chance to search for new concepts and alternative therapeutic approaches which would be effective with families from low socioeconomic backgrounds and from ethnic minorities. This early work set up to explore the structure and dynamics of these families resulted in the delineation

of two types of family structure: "disengaged" and "enmeshed" (Families of the Slums, 1967). These notions need careful interpretation as disengagement or enmeshment in some cultures might be very functional transactions in normal family life cycles. However these may be the actual dynamics to focus on when working with East European families who during their overcompensation period might exaggerate existing internal patterns to the extent of malfunctioning.

Minuchin continued his innovative work at the Philadelphia Child Guidance Clinic, and while simultaneoulsy he was cooperating with the Children's Hospital of Philadelphia he was introduced to the field of psychosomatic illness. Here, repeatedly, gathered clinical and research evidence showed a connection between certain family characteristics and the conditions of identified patients who would not respond to classical psychotherapy nor to traditional medical treatment. A new therapeutic approach began to evolve from the principles of general systems theory and looked at behavior and behavior change in the context of family boundaries, flexibility in transactions, conflict-resolution and rules. Starting from the belief that human problems can only be understood and treated in context, Minuchin attempted to broaden the entry points required to interface with the individual, the family and the societal system. Although, in principle his model is applicable to any human system in need of change, the family is seen as possessing some unique characteristics

that make it an accessible and rewarding field of application. One could also pinpoint that the model's underlying assumption is a culturally defined expectation that the family is a most relevant environment for a child where the parents are directly responsible for the child's well-being. The extent of such bias, if any, may be critical in some cultures but it appears in accordance and fitting to the East European frame of values and beliefs.

Tenets of the Structural Family Therapy Model

The family, the presenting problem and the process of change are three basic tenets of the model. The family is conceptualized as an open sociocultural system in transition which not only maintains itself but is also able to adapt to changing environments creatively (Minuchin, 1974). The individuals are seen geometrically as parts of larger systems composed of subsystems and are functionally interdependent in ways dictated by the supraindividual functions of the whole. Sometimes three generations of families are concurrently examined and viewed as exhibiting many triangles or trinagular relationships which may discourage growth. The set of rules regulating the interactions among members of the system is its structure. The structural family therapy model of normality is based on a hierarchical executive function. Hierarchical relations and coalitions are frequently in need of redefinition and of altering.

The family system is composed of subsystems identified by Minuchin as the spouse, parental and sibling subsystems (1974, p. 56-60). Family members belong to a variety of subsystems where processes of differentiation, learning, personality development and group identity take place. The rules which are necessary to define who participates with whom and in what kind of situations are called boundaries. Most families which fall within the normal range possess clear boundaries, which means that rules are understood, lines of responsibility and authority are clear yet the boundaries are flexible enough to allow members input from each other's subsystems. Minuchin (1974) depicts two other types of boundaries in families, that is disengaged or rigid and enmeshed or diffuse boundaries. Lack of communication and supportive functions of family members who may only respond to one another in crisis situations characterizes disengaged families. Families who function with extreme sense of closeness, belonging, loyalty and a high level of conflict avoidance are described as enmeshed with diffuse subsystem boundaries. Once the assessment of the family's structure has been done and the therapist has a beginning understanding of its organizational composition, a family map can be developed to assist in organizing information and formulating hypotheses about dysfunctional and functional aspects of the family.

The presenting problem is defined, described and framed

according to systems thinking as a transactional one and the emphasis is on maintenance rather than on causation. Hence, structural family therapy conceptualizes the problem behavior as a partial aspect of the family structure of transactions and stagnation. The family system as it is at the time of therapy entry supports the problem/symptom because this problem is a part of the present family's status quo. In connection with the presenting problem the therapist has to assess the structure of the system's perceptions of what the problem is. From the knitted web around the motive of complaint, the real presenting problem will emerge for the structural family therapist. Then, a treatment plan must be designed in order to change a variety of aspects of the family's circumstances. Change is expected to occur as a result of dealing with the problems, rather than talking about them.

In the process of therapeutic change challenging a family's definition of a problem is a necessary first step and then new alternative rules for transacting need to be explored. By giving the family an opportunity to experience transactional patterns that have not been allowed under its prevailing homeostatic rules, the therapist provokes disequilibrium and change and finally creates a forum for growth. With the idea that no family is resourceless, the therapeutic goal would be to create such a context that the system limits are forced in a quest for its potential strengths and

underutilized resources. The therapist's role is often compared to the job of a stage director, a dancer and a strange body in the family organism.

Primary Techniques

An updated account of the model provided by Minuchin and Fishman place emphasis on the anlaysis of techniques and the theoretical and philosophical rationale behind the techniques. Primary techniques can be classified into two groups according to their main purpose to form the therapeutic context and to create disequilibrium and change. They are as follows: joining techniques such as maintenance, tracking and mimesis, and disequilibrating techniques such as reframing, enactment, boundary making, punctuation, and unbalancing (Minuchin & Fishman, 1981). The effectiveness of the therapy depends on the therapist's understanding and joining skills. Joining is not simply the process of being accepted by the family but it is being accepted as a therapist, a leader and agent of change. Joining well means to be capable for empathy, able to listen, be sensitive, genuinely interested in the family's drama and to operate in the direction of change. The therapist must be also competent in mastering techniques like maintenance, tracking and mimesis. Maintenance is the joining technique which concentrates on process; tracking comprises the therapist's accomodation to the content of speech; and mimesis is a nonverbal response to

the client's mood, tone of voice or posture (Minuchin & Fishman, 1981).

Other techniques such as enactment and boundary-making are employed in order to create a different sequence of events. Enactment is the actualization of transactional patterns under the control of the therapist. It involves highlighting dysfunctions, introducing alternative ways of functioning and probing the system's ability to accomodate to the introduced alternation. Boundary making is a re-structuring intervention aimed at disrupting detouring mechanisms and other conflict avoidance patterns. Challenging definitions of problems and fostering different family perceptions of reality can be achieved by applying reframing which gives altered and more workable perspectives on the presenting problem. By using intensity as a form of punctuation the therapist can then give messages to the family in ways which are opposite to their established manners. The basic strategy which finally creates disequilibrium and permits therapeutic change to happen is unbalancing. Actually all the therapist's activities may contain this strategy which permeates structural family therapy in general (Minuchin & Fishman, 1981).

In conclusion, it would be important to stress that the practice of structural family therapy requires a paradigm shift, a conceptual leap that no accumulation of techniques can substitute for. The model's tenets about family, presenting problem and process of change are the heuristic

motors that organize the structural therapist in his/her clinical work and have richer practical implications than the techniques themselves.

The use of structural family therapy in dealing with newcomer families was viewed as one, and perhaps the prime interventive alternative within the ecological paradigm. Since the model incorporates social environmental dynamics as an aspect of family intervention, the network approach is seen as strengthening structural change as the family is nested within its cultural community. Apart from that, some other approaches were applied in order to implement change within complex family situations at various levels of transition and need.

CHAPTER 5: OTHER METHODS IMPLEMENTED

Social Support Network

For a newcomer family who suffers the initial social isolation and alienation introducing the social network concept is seen by the practitioner as a most pragmatic task. It is also a paramount practice implication of the ecological perspective which strongly supports environmentally oriented intervention directed toward strengthening or establishing methods of social support.

James K. Whittaker and James Garbarino (1983) offer a clear conception of what social support networks are, why they are important, how they are identified and sustained, their limits and potential in different fields of practice. This work especially appealed to the practitioner because it attempts to find ways of utilizing and conjoining both formal and informal types of helping. These may be the most effective and compassionate responses for a newcomer family in need of help. Garbarino notes an important impediment which may develop at the very beginning of the therapeutic process:

> "The first step in finding and making use of these sources of helping is to take a close look at ourselves. Some of what we may interpret as unreasonable client resistance becomes much more comprehensible when we put ourselves in the client's shoes, when we empathize with him or her. Would we turn to strangers for help? Do we? Would we resist or reject help when it seemed to be delivered in a condescending or patronizing manner: Do

> we? Once we realize that our client's behavior is not radically different from our own, we have taken the first step in identifying and making use of social support networks as a way to enhance professional helping." (p. 6).

It is fully recognized and appreciated by the authors that volunteer lay helpers, networks of kin, friends, neighbors and community provide equally powerful types of helping to that of the formal counseling, educational, clinical and advocacy services of the traditional helping professions in the broad human service field.

As the authors note the goal of all professionals is to strive for a state in which everyone copes successfully with every stressful event and converts these stresses into growth-inducing challenges. This level of mastery is possible to achieve by attending to, facilitating, enhancing and collaborating with social support networks based on naturally occurring or possible interpersonal relationships. Besides social resources, of course, personal resources such as an individual's own characteristics and ability to respond effectively to the changing environment are crucial realities to ensure success and mastery. Nevertheless all of the organism's conditions are always in transaction with the environment and depending on the quality of social and community life more stress and inadaptative functioning or growth and adaptive functioning is created for an individual and family. Generally, people recognize how dependent on social support they are and furthermore, "many people seem to sense

that the best way to deal with trouble is to get together" (Whittaker, 1983), p. 22). This certainly will apply to newcomers who will be in need of banding together to share their common experience and concerns as well as to give and receive nurturance. In such circumstances the professional helper's role, as indicated by the authors, remains important but not as explicitly sufficient and indispensable.

In conclusion, the practitioner's main concern was to be cautious not to omit or neglect possible or vital preventive and remedial informal approaches. To initiate new networks and/or to test empirically and work collaboratively with that which has already been offered by the community and other non-professional helpers was the student's principle, as well as one of the ideas contained in this book. The practitioner also became aware of existing barriers and limits to implementing social support interventions in the family therapy field.

Cybernetic Systems Approach

This approach is often called the Calgary systems model since it was initiated at The Family Therapy Program at the University of Calgary in 1973. The Calgary model has areas of overlap and similarity with two of the prominent "pure" schools of structural and strategic family therapy. However, it varies for the reason that it encourages explicit awareness of maladaptive patterns and conscious deliberate action toward

change. This difference particularly attracted the student's attention as her experience has shown that Polish clients usually displayed high cognitive needs and were more co-operative once they better understood their behaviour.

Karl Tomm in Perspectives on Family Therapy, 1980, presents the Calgary model as concerned with cybernetic regulatory mechanisms and hierarchical systems orientation which allow for a broader base of theory and practice. The family as a basic social unit is always seen also as a part of the larger community or sociocultural system. Subsequently, problems that appear very complex are described on multiple levels and are organized into diagrammatic models. Circular Pattern Diagramming (CPD) is served to concretize and simplify the abstract systems and cybernetic concepts as applied to family relationships. CPD is not only advantageous for the therapist as it summarizes more data and implies a stable organizational structure with a feedback regulation but also for the family who can participate in drawing and gets some important explanations. As certain events are reinterpreted, family members have a chance to abdicate their linear conceptualization and the shift to circular thinking is facilitated. Some families reported that they found the circular explanations one of the most helpful aspects of therapy.

Tomm (1980) provides a few different figures presenting dyadic and triadic patterns and intervention strategies. Mapped psychodynamic and cognitive intervention deals with

common marital patterns of complementary blame withdrawl. Although the psychodynamic approach is oriented towards an exploration of deeper affective experience it is accompanied by cognitive exploration as well. In practice the therapist guides interpersonal perceptions and introduces corrective clarifitcations. Even though the concept of the circle is simple and easy to use, it promotes abstract and integrative conceptualization. The focus specifically has to be on the systemic elements in the family or related to a higher level of interlocking circles.

In conclusion the author states that much more research is needed to estimate the relative effectiveness of interventions at different levels to determine whether upward, horizontal or downward strategies would be optimal. Finally an important question he put forward "what problems in what families respond to what interventions and what therapists, when and in what way?" (Tomm, 1980). The practitioner would like to find some possible clues with regard to her clients.

Giving Directives

Apart from the structural approach the student had to learn more about giving directives as a specific problem - centered and pragmatically focused technique. It became apparent that some Polish clients were looking for concrete tasks which were designed to introduce change without any insight or understanding.

Strategic therapists have developed a body of powerful procedures designed for solving problems. The theoretical underpinnings of strategic therapy come from general systems theory and cybernatics, via the communications school of therapy. Joe Haley is one of the most well known representatives of that school. In 1967 he joined Minuchin and Montalvo at the Philadelphia Child Guidance Clinic. In his Problem Solving Therapy (Haley, 1976) he incorporates ideas taken from Minuchin about family structure and hierarchy which is reflected in the fact that he assigns tasks that affect, not only the presenting problem, but also the family's structure.

Giving Directives (in Haley, 1976, pp. 48-80) is an important section devoted to explaining what kind, how and when directives should be given. Since the main goal of therapy is to get people to behave differently, directives are aimed at making those changes happen as well as intensifying the relationship with the therapist. Directives are also used to gather important information about how the family organizes itself around the given task.

Directives could be straightforward or paradoxical, simple or complex and involving more than one or two people. In fact even the marital dyad should be looked at as a triangular relationship since a couple doesn't form a totally independent relationship.

Straightforward directives are planned with the goal of changing sequences of interaction in the family by introducing action. When using this approach it is crucial that a clearly

defined presenting problem be negotiated so the design of a task becomes easier and accurate. Then the directives should be clearly given rather than suggested. Two examples of directives given by Haley (1976, pp. 60-63) are as follows:

> 1. A father and son are asked to do a minor thing that the mother would not approve of. It will be difficult for the mother to arrange what they do when the thing must be something she does not want.
>
> 2. A father who is siding with his small daughter against the wife may be required to wash the sheets when the daughter wets the bed. This task will tend to disengage daughter and father or cure the bed wetting.

Sometimes the therapist should give directives in metaphorical ways without making explicit what she wants to happen. Some clients seem to follow a better directive if they do not know that they received one (Haley, 1976).

Paradoxical directives are different because the therapist tells the family that she wants to help them change but at the same time she is asking them not to change. The idea of such an approach is that some families are very resistant to the help offered therefore the therapist makes the family members resist her so that they will finally change. Some of Haley's (1963, 1976) examples are:

(1) A couple who regularly fight in unproductive ways are requested to have a fight.

(2) A spouse is asked to complain about a symptom at times when the symptom is not occurring, so that the other

spouse will not know whether the symptomatic spouse is really symptomatic or only following the therapist's instructions.

The therapists's expectation would be that the family either rebel against such instructions or follow to the point of absurdity and recoiling. Haley finds paradoxical directives most useful with families who are relatively stable, and thus will not follow instructions.

Since the nature of the paradoxical approach is confrontational and provoking defiance, not many therapists feel comfortable in using it. Nevertheless, in strategic family therapy a specific plan is designed for each problem and there are no contra-indications in terms of client selection and suitability. Furthermore, the approach allows the therapist to borrow from other models any techniques that could be useful in solving a presenting problem and achieving therapeutic progress.

In conclusion it should be emphasized that "everything done in therapy can be seen as a directive. Whatever a therapist does is a message for the other person to do something, and in a sense he is giving a directive" (Haley, 1976, p. 50). Since all therapists wittingly or unwittingly use directives, the question is not whether to use it, but how to use them effectively.

Systems Approach with Individuals

Consistent with systemic theory an approach to the

individual client should include other members of the significant system and relate to the ongoing transactions in which that client participates. The directives discussed above, for instance, could be very useful in systems oriented work with an individual who is actively encouraged to engage in particular behaviours which might facilitate a new experience and introduce sought change.

Wachtel and Wachtel (1986) have outlined important implications for how to proceed clinically when only one person is present at therapy sessions. It is suggested that circular interviewing possesses a challenge and an advantage for these individuals to think of themselves as part of a system and to make them participant - observers of their own reality. Some questions may be designed to discover how the individual likely perpetuates his/her own problems by his/her very effort to solve them, while other questions could help to gain a larger perspective on this person's difficulties. It is important for the therapist to take an active role in transforming general statements into descriptions of specific behaviours and in exploring contextual and systemic matters (Wachtel & Wachtel, 1986).

Once the therapist understands and explores structural and interactional dysfunctions within the individual client's family system, a variety of active interventions based on systemic views can be utilized. Some examples are well elaborated by Wachtel & Wachtel (1986) and include: giving tasks, developing interpersonal skills in the case of lack of skills

needed for new ways of interacting, gradualism, role playing and role reversal, modeling, suggestive interpretations, paradox, predicting a relapse, reframing, relabeling and positive connotation.

In conclusion it should be stressed that thinking about the individual form a systemic perspective poses many advantages but this is not to say that individual psychotherapy can be left out or ignored. Recently the literature has revealed an increased interest in the selective and integrated use of concurrent family and individual therapies. These therapies together can achieve more than either therapy alone - the whole is greater than the sum of its parts (Steinhauer and Tisdall, 1981). Besides, therapists need to have access to more than one methodology and should be skilled in a range of approaches to problems so that they can match the work of therapy to the needs of clients.

PART II

THE PRACTICUM

CHAPTER 6: INTERVENTION

Description of Setting

This practicum was conducted at various settings including the Psychological Services Centre at the University of Manitoba, The International Centre, Immigrant Access Service, the student's house and clients' homes. Most of the referrals came from The International Centre. The practicum took place over approximately 9 months, beginning October, 1986 to July, 1987. Clinical supervision was provided by Ruth Rachlis, M.S.W., Professor at the School of Social Work, University of Manitoba.

The lack of a uniform placement was a consequence of the experimental and client-focused nature of the practitioner's intervention. As was previously described, immigrants and refugees are not frequent clients of established mainstream agencies, not because they don't have problems but because they are very reluctant to participate in sessions provided in a language other than their own (English) and in strange settings. One client labeled the Family Services room a "sterile and superficial" place.

Therefore, in order to provide them with the opportunity and access to clinical help, the student decided to be as flexible as possible and agreed to negotiate with individual

families to conduct sessions in a place which would be comfortable for them and supportive for family therapy.

The Psychological Services Centre was the most convenient setting for the student and her supervisor, but unfortunately difficult to accomodate for most families. Besides, 7 out of 8 families could barely manage in English, hence making live supervision rather impossible. Therefore, special recording with the student's interpretation was necessary. The student received two to three hours of supervision bi-weekly and many opportunities for consultation and discussion in between.

The International Centre and Immigrant Access Service were very supportive of the family therapy concept, especially in that both agencies are seeking means to provide their clients with such clinical help. These agencies are receiving referrals of newcomers to Canada from different sources (legal, educational, social agencies, health centres, the families themselves and communities) with requests for assistance, assessment, interpretation, instrumental help and bridging with mainstream agencies. Although the character of their formal goals differ substantially, the practice differs slightly, and basically both the International Centre and Immigrant Access are unable to provide family therapy even when urgently needed because the agencies' workers do not possess these skills.

Recordings of families seen by the practitioner were

made according to each agency's requirements and the practitioner's needs. This involved an initial assessment form, a family assessment report with the family developmental history, various dimensions of family structure and functioning and different mapping i.e. genogram, Eco-map, structural mapping and circular pattern diagrams. Additional progress and evaluation notes were compiled on all families.

Description of Clients

In five families out of the eight seen by the student the identified problem was child related. The three others were referred as generally having serious problems with adjustment resulting in family members symptoms of depression, mental illness and family dissolution. Of the eight families, there were three single parent families, four were nuclear families and one was a childless couple and included the man's mother and stepfather. A total of seven families were seen initially as a family. The eighth client although seen individually was viewed from a systemic perspective and change occurred as a result of the treatment rippling through the whole family.

Two families remain in treatment, at the time of writing, one family moved to Toronto, four families terminated upon mutual agreement that the problem contracted for therapy was solved. The individual client withdrew having made an independent assessment that her goals were achieved.

All of the families were newcomers from Poland to Canada who have been here no longer than 5 years. Most of them had good educations and represented the middle class in Poland but in Canada they were only working class or poor receiving social assistance. The occupations held in Poland of the males and females included: 2 engineers, a mechanical technician, an economist, a teacher, 2 carpenters, a coal mining technician, 2 architects, a ceramics artist and 2 accountants.

Only 2 families out of eight came directly from Poland and therefore these did not experience the transitory stage of waiting at a refugee camp. However males of these families went through harsh interrogation and were imprisoned in Poland for political reasons. At some point coming straight from one reality to another with a one way ticket might be a shocking encounter; on the other hand as the clients put it: "It was somehow easier, because the decision was made, no time to think and debate but must cope with the reality and survive. Besides after what we have suffered in our homeland it could not be worse here." The six others spent a considerably long time in German, Austrian and Italian refugee camps.

The Evaluation Model

For the most part the practitioner took clincial evaluation to mean an examination of the efficiency of social work direct interventions which were aimed at alleviating family problems. Basically, this examination required the systemic monitoring and evaluation of the process and outcome of

treatment on a continuous basis throughout the assessment, implementation and follow-up stages.

At the time of the practicum proposal the student planned to use The Family Assessment Measure (FAM III) developed by Harvey A. Skinner (1984) for evaluating family structure and patterns of interaction. However due to the fact that this measurement was not culturally tested or sensitive, the practitioner had to search for other alternatives. As her role became more complex and identified targets and priority areas that needed attention were often located outside family interactions, special record keeping to measure the impact of her action on the family was desired. Another reason for not using FAM III or any other measures popular in the family therapy field was the existence of a language barrier and time limitations.

The advantage of the chosen qualitative method is that it places importance on discovery. The undertaken therapeutic outcomes might be unpredictable and a different hypothesis might be set at the end of the treatment process. This gave the practitioner an outstanding opportunity for tentative testing of some of her ideas with newcomer families as the therapy proceeded. Besides intuition, exploration and insight which are characteristics of qualitative research, the methods are also emblematic of the social work practice process and highly relevant to the practicum issues.

Robert Bogdan and Steven Taylor (1975) provide the reader with a range of possible approaches, guidance on how

to conduct a study and use imagination, sensitivity and creativity in an intellectual effort to get the most out of qualitative research. They discuss qualitative methods as connected to the phenomenological perspective concerned with understanding human behavior from the client's own frame of reference. The presented methods include participant observation, use of personal documents and open-ended interviewing. What is especially useful and appeals to the practitioner is that these methods are descriptive and holistic in nature, and that it can be used in a variety of ways. Data obtained from personal documents and unstructured interviewing offered interesting findings for the overall practicum evaluation.

Personal documents as presented by the authors, permit the study of facets of people, events and settings which are not directly observable. This data needs to be examined in the context in which they were produced because they reflect what a person thought and felt at one point in time and in one context. Hence, the researcher might gain an intimate view from the perspective of one who has experienced them and examine her own basic commonsense assumptions about the nature of reality (Bogdan, 1975). Moreover documents like letters, diaries, pictures and autobiographies enable the practitioner to view her clients in relation to the history of their time and to examine how they were influenced by various social, political and economic currents. This was primary used as a therapeutic tool when dealing with

pre-emigration experience and mourning.

The open-ended interviewing method was used as a part of both the social stage and problem formulating stage of family therapy. Data was coded in terms of themes and hypotheses. Some interviews were taped and all were transcribed in the clients own words and without interpreting or changing the meaning of their words. The same was repeated after a period of time, usually as a follow-up procedure undertaken with each family. The first step in collecting important data was working together with all family members on a list of family concerns (Appendix 1). On most occasions the practitioner had to assist the clients in filling out the questionaire because of language problems. By doing that the student had the opportunity to gather additional information which came spontaneously in their comments to specific questions.

Furthermore, previously described structural family therapy techniques were used in order to observe factual interactions between family members. If these interactions were primary targets for change, the follow-up interviewing was structured accordingly to solicit relevant data. This data needed to be discussed also in terms of the practitioner-family relationship since her rapport with and acceptance by family might affect the given data over time. Besides, the family's perspective on an experience could change over time as well as their understanding of "truth" or "reality", therefore presenting them for what they were was the ultimate goal

for this qualitative evaluation.

There is also some current criticism of qualitative methods with regard to generalizability of findings to other settings and subjects and forcing reality into a preconceived structure. The authors write that:

> "We admit that the criticisms of qualitative methods are not totally without reason. Qualitative researchers must be aware of the distortions produced by their methods. However, potential bias and distortion is the price we must pay to gain understanding of complex social settings" (Bodgan & Taylor, 19, p. 13).

In conclusion, using qualitative methodology's evaluation procedures, reference and descriptive data were derived from the clients own written and spoken words and from observable behaviour during sessions and after termination as part of follow-up. This means that each family required separate and independent evaluations from their own frame of reference. In that context some themes were gathered common to these eight families and presented as recommendations in Chapter 8.

Since each measurement possesses its advantages and limitations, the biases may be overcome by using multiple (global and focal) methods. Thus, additional assessment and evaluation instruments were implemented in cases where family environment transactions were a target and resource for change. An Eco-map was used as a pre and post test instrument to determine whether any changes occurred after the intervention which had a clinical significance. Special

attention was paid to opening the boundary between a particular family and the outside world, together with the building of reciprocal connections with the larger community. Participating and actively helping other people and newcomers was seen as a very positive sign of better family functioning and growth. The Eco-map was also a very helpful tool in ordering priorities and generating shared plans with the family for further intervention.

In conclusion, the practitioner believes that she was able to compile sufficient and complex data throughout the treatment process, via feedback and by combining it with her own and the advisor's observations obtained a comprehensive and accurate monitoring of process and outcome.

CHAPTER 7: THE APPLICATION OF ECOSYSTEMIC APPROACH

The following chapter includes the presentation of all practicum cases. Due to the intricate nature of the problems and the diverse interventions implemented it was decided that only one case (Family X) be extensively elaborated. The subsequent seven cases are discussed in a less detailed manner, used in varying degrees according to their applicability to universal and specific immigrant issues.

Since the practitioner was asked by her clients to protect them and not reveal identifying information, most of the data will be disguised. As much as possible the family members own description of problems and clinical data will be presented as a back-up for analysis in the case of Family x. This case description includes:

(1) basic information concerning the family;

(2) the presenting problem;

(3) family history;

(4) overall assessment with;

(5) the goals contracted formally or informally;

(6) the intervention; and

(7) the termination and evaluation of therapy.

Family X: Case Illustration

(1) Basic Information

Family Members - Ewa, single mother, 32
Adam, son, 4 years,
Ed, estranged father, 30

Number of sessions conducted as family therapy: 15

Number of other meetings: 8

Reason for referral: Self-referral to the International Centre because of family dissolution and problems with Adam who was labeled "abnormal" and "requires special treatment". Simultaneously Adam was referred by his day care to the Child Development Clinic for an assessment.

(2) The Presenting Problem

At the time of the student's involvement, the father (Ed) left his family and Winnipeg. Although absent, he was a significant figure in the problems and therapeutic intervention. There was a mortgage and debts to pay. Ewa was despondent as she had been housebound and dependent on her husband. This was compounded further by her lack of knowledge in spoken English. There were problems with their son since he began to walk (1 year old). Ewa's description of the problem was as follows:

> "He is completely out of my control now, when his father left us so suddenly. He was less difficult to manage before Ed was gone. But I think that the turning point in our family life was soon after Adam was born and Ed started his own business. Because money making became his obsession he was coming from work very late, and gradually he stopped communicating with me and withdrew from family responsibility. Then he started to beat me up and called me dirty names. He was more and more abusive to the extent that I ended up in hospital. After I came back from hospital I told him that the next time I will call police. But I did not keep my word and he did not stop his abusive behavior but one day he simply disappeared. I have no money at all and I do not know what to do first".

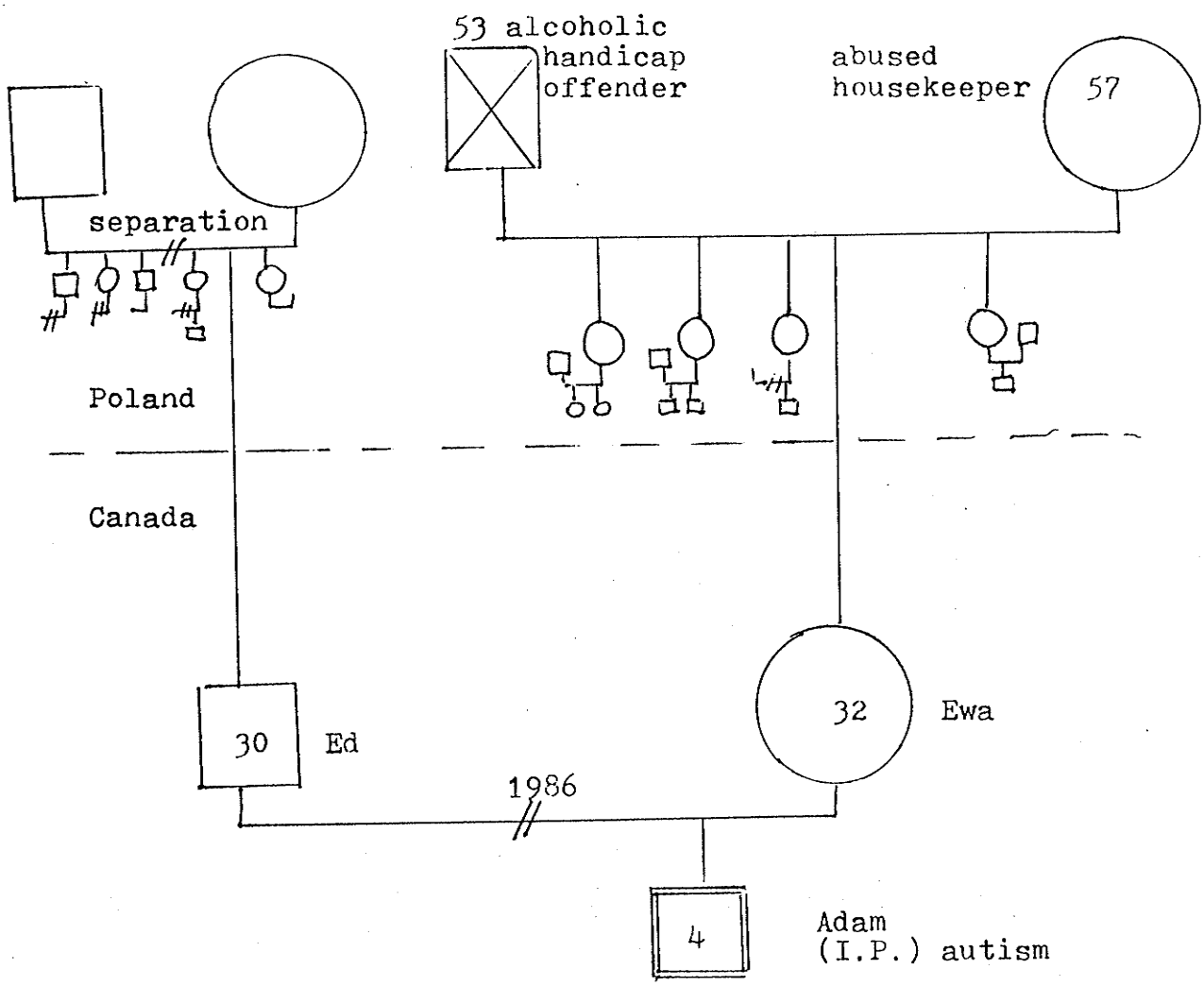
She elaborated further on what she meant by saying that Adam was out of her control. She said that she cannot change any of his acts ie. screaming without reason, hyperactivity, disobedience, attacking other - usually smaller children, aloofness and general aggressiveness also towards her. Ewa also informed the student that day care staff see Adam as terrible, perhaps retarded, very definitely slow in his emotional and social development, semiautistic and an extremely difficult child to manage.

(3) Family History

Family X has been in Canada four years. They came directly from Poland where the father, Ed, was imprisoned for political reasons. At the time of their arrival Ewa was pregnant. Two years later her mother came to visit them in Canada for three months and helped Ewa with Adam and the household. The marital problems were already present as Ewa and Ed argued about money matters, his overinvolvement with work and his drinking. Being unsuccessful with his business, Ed considered going back to his homeland. The whole family took a trip to Poland and found out that the political and economic situation was worse than before and that they could not live in the old country. Besides, their extended family and social network were not of much help with their family problems. Thus, they returned to Canada searching desperately for other solutions: Ed by heavily drinking and beating up his wife, Ewa by being overinvolved with her son and the home.

Shortly after their return, he left Ewa and their son without saying where or why he was going. He was not heard from until he had a car accident in Toronto and the police contacted Ewa. By that time the student had been working with Ewa and Adam for three months.

The inserted Gemogram I provides the reader with important data concerning families of origin, their relationship and positions.



It was essential for proper intervention planning to know that Ewa grew up in a family where her father used physical punishment to "discipline" his wife and his female children. She was taught to be a victim and was brought up to be submissive, passive, and helpless, and to be dependent on a man who will take care of her. Her mother and three sisters remain married and suffered an unhappy relationship for the children's sake. This is the message she got not only from her family of origin but also from the Polish community. That tradition is challenged by Canadian reality and her own desire to take the initiative and responsibility for her own happiness.

While drawing the gemogram and talking about the past, important data came to surface. First of all, culture and transitional baggage became evident. The communication with Ewa and Adam was such that she was giving cues and indications of what her preferences were. She liked to use metaphors and not be precise, thus the communication during the sessions needed to be symbolic, wholistic and more in gestalt. Hall (1977) described such persons as high-context people.

(4) Assessment

The practitioner's central hypothesis was that Adam's behavior had an important function in expressing a problem within the family system and between the family system and larger systems, and that these were points of necessary change and intervention.

The presenting problem was related to the process of family dissolution and served a crucial function of being an aid, antidote and challenge to change the state of dificient family-environment interaction.

To frame the presenting problem according to systems' thinking as a transactional one, the practitioner focused on maintenance and not on causation. To begin conceptualizing the problem behavior as a partial aspect of the family structure of transactions, one could say that as a result of Ewa's and Ed's dysfunctional interactions, their child was gradually escaping into selfness. This process started when he was 1 year old, and went to the extent of being labeled by Child Development Clinic as "autism". When Ed left his family, Adam's behaviour became exaggerated; his individual boundary was tightened, more rigid and closed to outside influences, In this dramatic way Adam gained total autonomy fron now an even more protective and involved mother and a distance to the family's drama. Meanwhile his symptoms required the isolated mom to become engaged with the outside world. The "battle" was called to negotiate family flexibility and adaptability.

Acknowledging the fact that in a successfully functioning single-parent household the parent should be able to tolerate a relatively flexible hierarch (Morawetz & Walker, 1984), the pattern of "need complementarity" was one of the hypothesis to be dealt with during sessions. The social isolation experienced by Ewa tended to intensify the mother-child relation-

ship and served to foster decreased functioning in her parenting. Moreover, it was found out that Ewa's beliefs about suffering and sacrificing her life were supportive of her overinvolvement with Adam.

Observed by the practitioner and as reported by Mom at home, Adam's behaviour was as follows:

- Adam engaged Ewa in rhythmic repetitive activities such as opening their apartment's door and calling anybody to come. He called "come, come, hi you...".
- He got out of the apartment in every possible circumstance (door unlocked).
- Fights often occured around the door - Mom wanted to stay, he pulled her out.
- Lack of eye-contact.
- Ritualized manoeuvers ie. engages in constant "on-off" light switching.

A holistic picture which emerged promptly from all the gathered information showed a lack of significant resources available in the family's world, nonexistance of any support and the stressful nature of the relationship between the family and the environment.

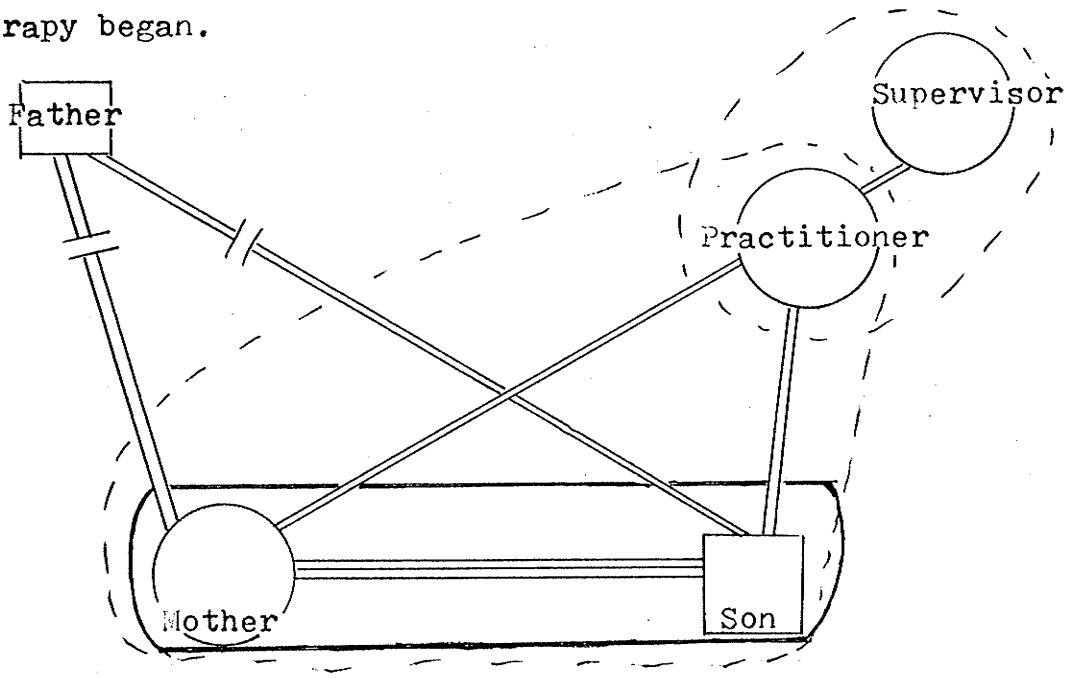
In conclusion, the student did not want to overlook the fact that many psychologists and psychiatrists view "autism" as internally based and caused together in conjunction with an unresponsive mother who is negatively impacting on an initially malfunctioning infant. Or, as stated by Des Lauriers

and Carlson (1969)

> "(Autism) is consequent to an inborn functional neurophysiologic imbalance (which results in) an absence in the autistic infant of any real capacity to send out signals or cues to which the parents could appropriately respond" (p. 74).

The practitioner does not negate the fact that Adam possessed an inborn predisposition to "autism". Her hypothesis was that this predisposition became evoked or provoked by the family circumstances including transitional difficulties (i.e. to a new country and parenthood) and evolved into an exaggerated state of "sickness" as the family situation worsened. An essential piece of information to support this assumption was that Adam was examined frequently as a baby (less than 1 year old) and assessed as a perfect child in his development. He stopped maintaining eye-contact when two and half years old, exactly at the time of the precipitating crisis.

Structural assessment and map of the family when family therapy began.



In terms of boundaries there was a lack of contact between the Father and Mom/Son system. Ewa belived that they were not a family anymore and that she had to function as a single mother. She wanted to contact her husband only through a legal lawyer. When asked she easily disclosed family matters ie. violence, conflicts and legal issues.

The boundary around Ewa and Adam was rigid. They were isolated and disengaged from any outside influence ie. they did not possess any support network of their own. The boundary was solidified by her feelings of stigma ("left by my husband, I must be a terrible wife") which somehow was imposed on her by the established Polish community as well. The larger community maintained their isolation also by asking such questions or statements at her Catholic Church: How come you come alone? Your son is misbehaving and you do not discipline him well. The result was Ewa stopped going to the church.

Ewa's boundary became more enmeshed with Adam. She was intensely concerned about her son's well-being and completely neglected her own needs. On the other hand Adam's boundary was closed and disengaged from Mom and the "rest of the world" as the symptoms were described.

The boundary around Ewa, Adam and the practitioner were open and clear, that is, it was in a constant process of change subject to the inflow and outflow of information stimuli, as they were appropriate in the transactions with

the environment and themselves.

The boundary around the student and her supervisor was also open and clear as there was flexibility and creativity allowed and without the pursuit of a rigid organization of interaction, power and control.

In terms of the power hierarchy, as the vertical spatial relationship shows, the father was deemed to have more power. There was a lack of parental authority and age appropriate hierarchy. Ewa stated: "I am often confused because it seems that he determines my functioning and runs my life too often".

The student believes that she established a leadership position from the very beginning. At that point of time the student did not place herself over the father with whom she did not have contact and could not practically control his behaviour nor did she replace or change his position. Besides it was not her immediate goal for the therapeutic intervention.

Interactional patterns between Ewa and Ed could not be observed but with the assumption that there was a lot of unfinished business, the student believed that there were still invisible ties between him and both Ewa and Adam.

The relationship between Mom and son was very close. She reported that:

> "I cannot go to the washroom by myself because he screams and wants to go with me. Sometimes I have to sleep with him. He does not let me do anything without his involvement. I am preoccupied 24 hours, because even when he sleeps I think about my son".

Behavioural data observed in the sessions indicated that in fact Ewa was enormously attentive to what Adam did. Her

posture and movements corresponded with what he was doing and she experienced difficulties in concentrating on anything other than her son. Adam became more hyperactive when she managed to turn her attention to something else. Although exhausted Ewa felt comfort from being overinvolved with her son since it was the only closeness she experienced.

One might speculate about how much of the functioning in a single parent family is that of overinvolvement and over-protectiveness. Transitional issues, marital problems and social isolation naturally intensified the parent-child relationship. The tremendous amount of energy invested in building a "better life for her son" and Ewa's parental caring should be considered as her strength. This energy and her determination to "do well" was the source of possible change, since Ewa started to complain about being trapped in a world of her son, without any "good results or outcomes". Also her ability to survive without her husband had been a strength given what she said about how dependent she was on him. As well Ewa's motivation and willingness to cooperate and change whatever was assessed as important yielded positive achievements in the therapeutic process. Also the way she and Adam engaged with the practitioner and utilized community resources (social services, medical) should be considered as a family strength.

Nevertheless many other aspects of family functioning were assessed as not working well. First, the father's estrangement hampered a greater resolution of the emotional attachment

between the spouses and had a negative impact on the legal intervention. His disappearance especially unanticipated made working through this harder. This does not contradict the fact that this cut-off might also have had a positive side. It could be seen as an opportunity for Ewa to find her own strength and build on it and reach out for more independence.

Second, the boundary between single parent household and their environment was not clear. They were closed and isolated. Social support network building was a necessary component in establishing effective functioning of this family.

Third, the family hierarchy did not work well. Appropriate parenting in Polish culture always required the use of authority because as Minuchin stresses "parents cannot protect and guide without at the same time controlling and restricting" (Minuchin, 1979, p. 58). How much nurturance, guidance and control was needed depended on the child's developmental needs and Ewa's capacity. Four year old Adam obviously needed a mother who was a leader with power to carry out her executive functions.

Fourth, the overprotectiveness was not working well at the point of entry to therapy. The demands on single parent families are such that traditional norms regarding affective involvement, autonomy and differentiation may be impossible to maintain (Morawetz and Walker, 1984). Nevertheless the extent of overinvolvement between mom and son exaggerated and hindered successful adaptation.

(5) The Goals of Therapy

Formally contracted goals of therapy were as follows:

(a) A change in Adam's behaviour, the optimal result being age appropriate behaviour; abatement of such symptoms as temper tantrums, disobedience, hyperactivity, avoidance of eye-contact, fighting with other children.

(b) Ewa may have more time for herself and needs to take care of herself ie. improve her English, plan for her own career, keep in touch with people and social agencies which are helpful.

The subsequently discussed goals for treatment were:

(a) a change in mother/son interactional patterns; and

(b) a change in the family environment boundary, their flexibility, openness and closeness. Ewa wanted to be helped with finding appropriate resources in the community and social services.

The nature of this family's transactional relationships with the world around it was a crucial factor that appeared to have potential for change. In this case the family was expected to change not only as a result of family therapy focused on dysfunctional interaction within the family system but also as a result of altered surroundings. The practitioner's functions as a therapist were complemented by her concurrent actions as a network facilitator.

(6) The Intervention

In the first session the practitioner spent most of the

time joining with both the mother and her son. In particular she was very anxious and needy to ventilate her feelings about the losses she had experienced. The time was especially given to talk about all the scary issues such as the lack of money and loneliness. The priority was to identify sources for financial support which was City Welfare; arrangements for that were made immediately. The next discussed matter was the legal situation of the family. Again Legal Aid was contacted in order to set an appointment together with an interpreter from The International Centre. The rest of the time was devoted to identification of Ewa's own individual coping mechanisms that she could use to gain control of the situation. By offering practical and empathetic support in assuring her that the situation could be handled, some of her tensions were relieved and generally she felt better.

The next few sessions were concurrently directed towards current instrumental issues as well as mother/son interactions. Practical matters, for example interpretation, transportation, babysitting arrangements, were almost always present at each session with the family but gradually diminished as Ewa improved her English and had other resources to use.

The first step in structural intervention was a positive reframing of the I.P.'s behaviour. This was a rather ongoing process since other people including professionals were constantly interfering by giving opposite, that is , negative framing to Adam's behaviour. It was even suggested to remove

him from the home and place him at the St. Amant Centre. However the Child Development Clinic and community services which were later contacted by the practitioner were very supportive to family therapy.

The message frequently sent by the practitioner to Ewa was that Adma's disturbing behaviour had a helpful function in the family. She was told that he protected her from being passive and depressed, and helped her to reach out in order to become less isolated. In this sense Adam was in a superior position to Ewa by the fact of helping her and protecting her from dealing with problems like mourning. Ewa was overly involved in trying to change Adam's behaviour and did not have time to look at her own life and decide what to do. Yet, by trying hard to change him she was relieved from taking responsibility for her life. The more she tried the more the symptoms were maintained.

Reframing Adam's behaviour as helpful and protective gave a new perspective on how Ewa might give up her hard work and not feel guilty about it. Especially this positive frame fostered a different perception of reality and changed the definition of the original complaint about her son. With the new meaning the whole situation was more workable and alternative transactions could be introduced. This reframing also had built-in implicit expectations as to what action should be prescribed.

The following sessions were dedicated to restructuring prescriptions. At the beginning the practitioner used some kind

of modeling of Adam's acting out, kicking and screaming when Ewa tried unsuccessfully to please him or catch and calm him. At that point Adam was taken and placed on the practitioner's lap and held for the next 15 minutes. By embracing him tightly he was not allowed to kick or jump off. No matter how noisy he was or how active and forceful he was in his fight against such strength and power over his body, he was not able to win. Finally he obeyed by sitting quietly and not disturbing the conversation with his mom. The goal of this manoeuver was to show Ewa that her son can cry, scream, fight and still comply afterwards. He could even be quiet and somehow content that he was grounded ultimately. This was labelled as "now you feel so good, secure and happy. Because it is good to feel somebody's power and embracing body pressure, that is like a safety belt".

The next step was to help Ewa to become a good, strong reliable safety belt, so Adam did not need to tyrannize her for lack of that. During the following meeting she was asked to keep her son on her lap for 10 minutes and make his body feel grounded. She was instructed: "If he fights more, you press more so he knows that you are serious and in control. Adam needs and wants that control. As long as he fights you must respond because it means that he is not satisfied with your strength and it is your job to give him that satisfaction and security. Also, be prepared that he will be testing your firmness and potency during out meetings and at home. But by now you know what he is asking for and you are ready to fulfill

his needs".

As Ewa became successful in making Adam calm and felt confident about her capabilities, a more difficult task was introduced. The target for change was Adam's aloofness. Different activities which were the basics of a Theraplay repertoire were introduced (Jernberg, 1983). These activities were illustrated rather than just verbally described to communicate some of the sensations which both Ewa and Adam should experience. Using the normal mother-infant unit as the model, the following were the classifications of maternal behaviour that were considered for their attachment promoting and autonomy enhancing qualities:

(a) Structuring. The mother limits, defines, reassures, speaks firmly, clarifies, holds and restrains her child.

(b) Challenging. The mother teases, encourages, plays peek-a-boo, makes noises for imitating, wiggles her finger for catching.

(c) Intruding. The mother tickles, bounces, swings, giggles, hops at, and pounces on her child.

(d) Nurturing. The mother rocks, holds, nuzzles, feeds, cuddles, envelops, caresses, and hugs her child (Jernberg, 1983).

As the petitioner tried to keep the sessions spontaneous, flexible, and full of happy surprises, she was responsive to cues given to her by mother and the child in specific written instructions for homework. She was asked to find 20 to 30 minutes every day to play with Adam in a specially designed

fashion. What was begun in therapy sessions had to be continued at home. Ewa had to maintain her being in a charge position and not give opportunities for Adam's own rituals. Engaging him in eye-to-eye contact was extremely important although a difficult task because Adam was a master at escaping into his cocoon. Mother was also invited to do recordings of what happened and to bring these written notes to the next appointment so these could be discussed together.

The intervention can only be considered a success if Adam had come to perceive his mother as clearly differentiated from himself, omnipresent, and fun. During the process, the child experienced tentative acceptance, negative reactions and a growing and trusting phase, when the pleasure of interacting with mother was in a normal, reciprocally satisfying way.

In conclusion it should be added that Ewa's response to theraplay was that she was shocked with the beauty of its simplicity and connectedness to the most basic of human needs. She said that she has always trusted in the power of non-verbal communication, body language and touch. Besides, her cultural background supported such therapeutic approaches because in Poland hugging and kissing was of special value and more widely used than here in Canada.

Although direct structural interventions were most effective with this family one paradoxical prescription was given after the seventh meeting when mother "relapsed" into a sacrificing, lenient, protective and manipulated by presiding status quo routine. At that point Ewa was asked to do "reversal"

in order to help her join with her "difficult to reach" child. The observed relationship was such that whenever Mom was overly engaged in pursuing her son, he escaped into his "autism". His reaction intensified her effort to please and pursue in such a dysfunctional manner that it only escalated the symptom, and therefore maintained the vicious cycle. The therapist role was to revise the pattern by instructing Ewa to ensure that she would be unavailable for Adam and preoccupied herself in the same bizarre way he was.

The rationale was that if Ewa acts as crazily as he did the symptom of his flight would not be required and therefore diminish. Moreover they both needed to have guaranteed time to be on their own and spend time together by being separated and completely differentiated. In general they both learned that there were many different ways which they could implement in order to effectively relate to each other.

Simultaneously with the structural therapist role the practitioner had to extend her therapeutic work and become a change agent in the family surroundings. This mainly meant that she had to contact and and work cross-culturally in the mainstream social services and also create a new social support network for the family. The most important financial support was provided by City Welfare; Community Social Services found money to employ a special child worker at Adam's day care and also an English speaking male respite worker who visited their home once a week. This was an excellent opportunity for Ewa to take care of her own needs and to go out or stay home, speak

English and watch someone else handling Adam.

Meanwhile Ewa was accepted at ESL School and was able to meet other people. Additionally, the arrangements were made in order to connect her with other Polish newcomers, some of whom had similar marital problems. Ewa started to become a model of a well functioning single mother in the Polish community. Helping others was a very important factor in maintaining a positive picture of herself.

The practitioner spent a lot of time negotiating, advocating and bridging gaps in services which were not prepared to deal with newcomers who do not speak English and do not understand the rules. For instance, Adam's day care staff did not understand why Ewa who placed a high value on "action chain" completion (Hall, 1977) always kept him home when he had a cold or some other minor health problem. On the basis of an assumption that she did not need day care, they informed her about the termination of Adam's placement. The practitioner needed to explain to both sides the misunderstanding.

Because of this student support, Ewa was able to use her old way of coping. She also learned what is needed in Canada in order to have this choice - to be precise, to provide the mainstream agencies with required information about time length of absentism and an explanation. She finally realized that in Canada not many things are understood by themselves, and the meanings of her symbols are not necessarily inherent in the situation or internalized in the person that is addressed.

Although time consuming, the meetings were nevertheless very effective at the Child Development Clinic where representatives of the day care, community social services and health care system were brought together to discuss issues and find ways to work cooperatively and successfully.

(7) The Termination and Evaluation of Therapy

Upon mutual agreement that the goals contracted were reached termination took place after 6 months of treatment. The structural shift which occured in this single mother family was a consequence of direct structural intervention in conjunction with environmental changes. Qualitative methods (personal) documents, open-ended interviewing) were used as a part of the problem formulating stage and for overall evaluation. The descriptive data derived was taken into account with some isolated variables in order to identify direct effects throughout the therapeutic process. Some variables which were evaluated by Ewa, the practitioner and the respite worker who was personally interviewed, were as follows:

(a) frequency of Adam's tantrums;

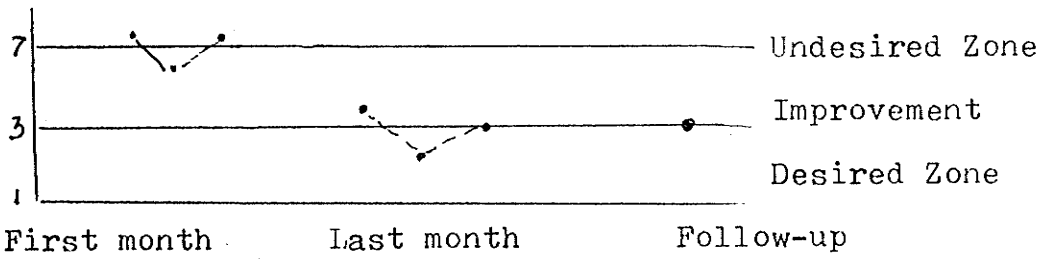
(b) eye-contact between son/mother, Adam/therapist;

(c) Ewa's time and activity schedule.

In terms of frequency of tantrums and Adam's ability to maintain eye-contact, observer reports and the practitioner's direct observation methods were utilized. In order to prevent unreliable observations the practitioner clearly and specifically defined how and what should be recorded. Frequency

measures involved simply counting the number of times tantrums and eye contact occured during a given period of time. This was a very practical method held in a natural environment at the beginning of treatment and at the termination stage. The undoubted value of this evaluation method was its directness and closeness to the presented problem and yet its simultaneous effect as a therapeutic treatment towards desirable changes. Also as a repeated measure it provided feedback to Ewa and enabled the practitioner to revise the treatment program.

For an easy visual identification of the treatment, progress line graphs were used as follows: a frequency of tantrums chart illustrating the measured recurrence of tantrum in the first month (3 days were picked) and the last month (3 days) of the treatment.



Some changes occured towards the desired direction but not to the desired level. It was also identified by the mother and the respite worker that Adam was finally able to maintain eye-contact quite often and always when challenged to do so.

The practitioner noted direct effects of treatment to the family interaction hierarchy and boundary. Since Ewa became busy with her social life she had a chance to connect more with

adults and let Adam have a lower position as do other children. Besides, she learned how to interact well with her son. The improvements of Adam's behavior were observed at his day care and therefore Ewa was informed that soon the respite worker would not be needed.

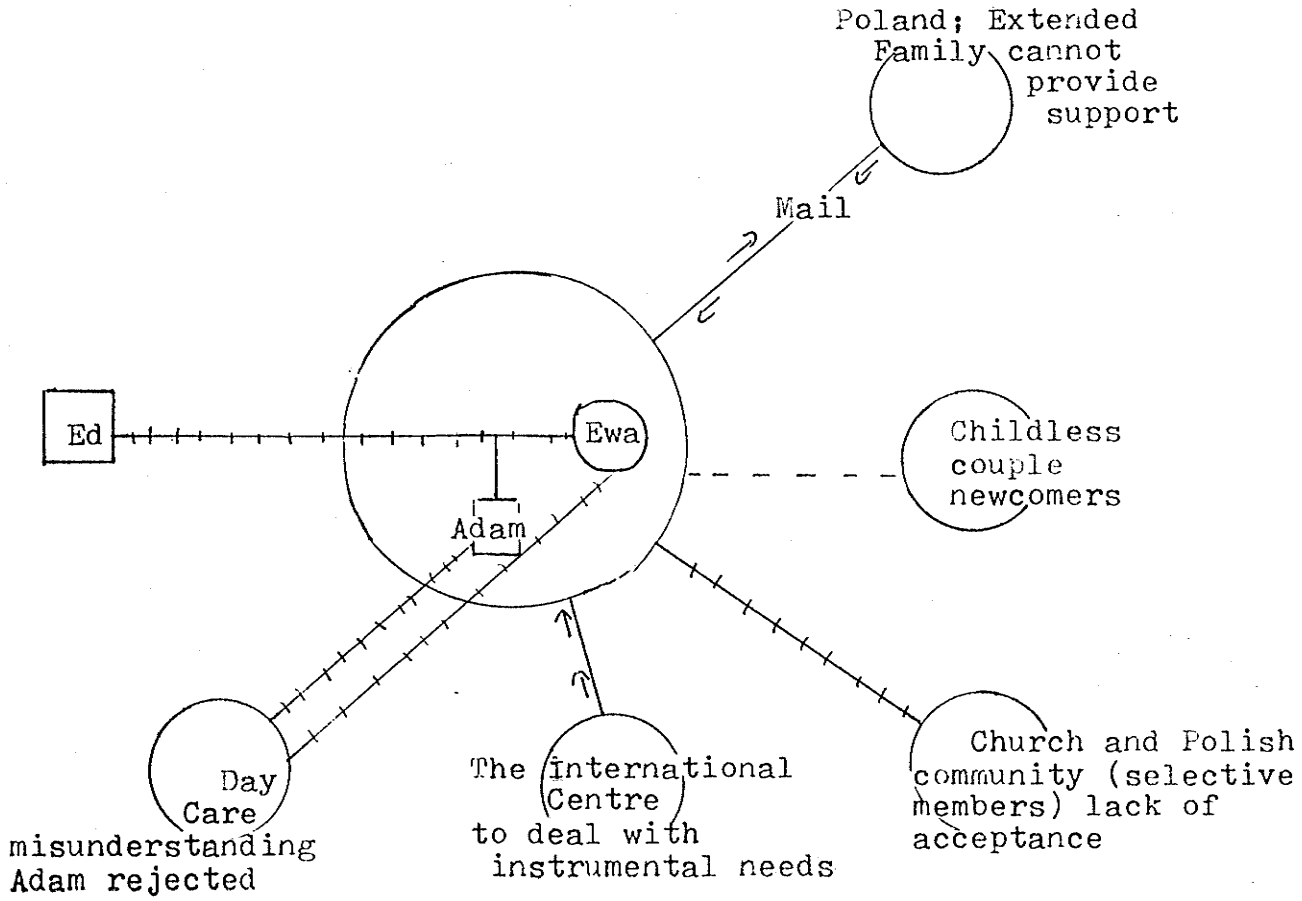
Inserted are two Eco-maps to show visually the impact of the ecosystemic approach on Ewa's and Adam's life space. The first map demonstrates the family's stressful and poor ties with the outside world. By picturing her family life space, Ewa increased her understanding of what was happening with her family. Because of Ewa's preference for informality, the style which promoted spontaneity and causuality in dealing with these and other issues was always favoured. Since this student and Ewa shared the same culture it was not a difficult task to be in the same rythm without synchrony of which the process of change would be seriously disadvantaged (Hall, 1984). She became then very cooperative and active in a process of enriching that map. She expressed her content that there was something else besides her relationship with Adam to work on.

The second Eco-map presents the established nurturing and supportive environment. Although some variables may be alterable and temporary at the moment, the importance is an apparent shift from alienation to healthy human bonds and links with a larger community. The Social Service delivery of mainstream agencies has also evaluated as having improved quality of their services as a result of the cross-cultural intervention. Furthermore, the practitioner acknowledges that once initiated, Ewa

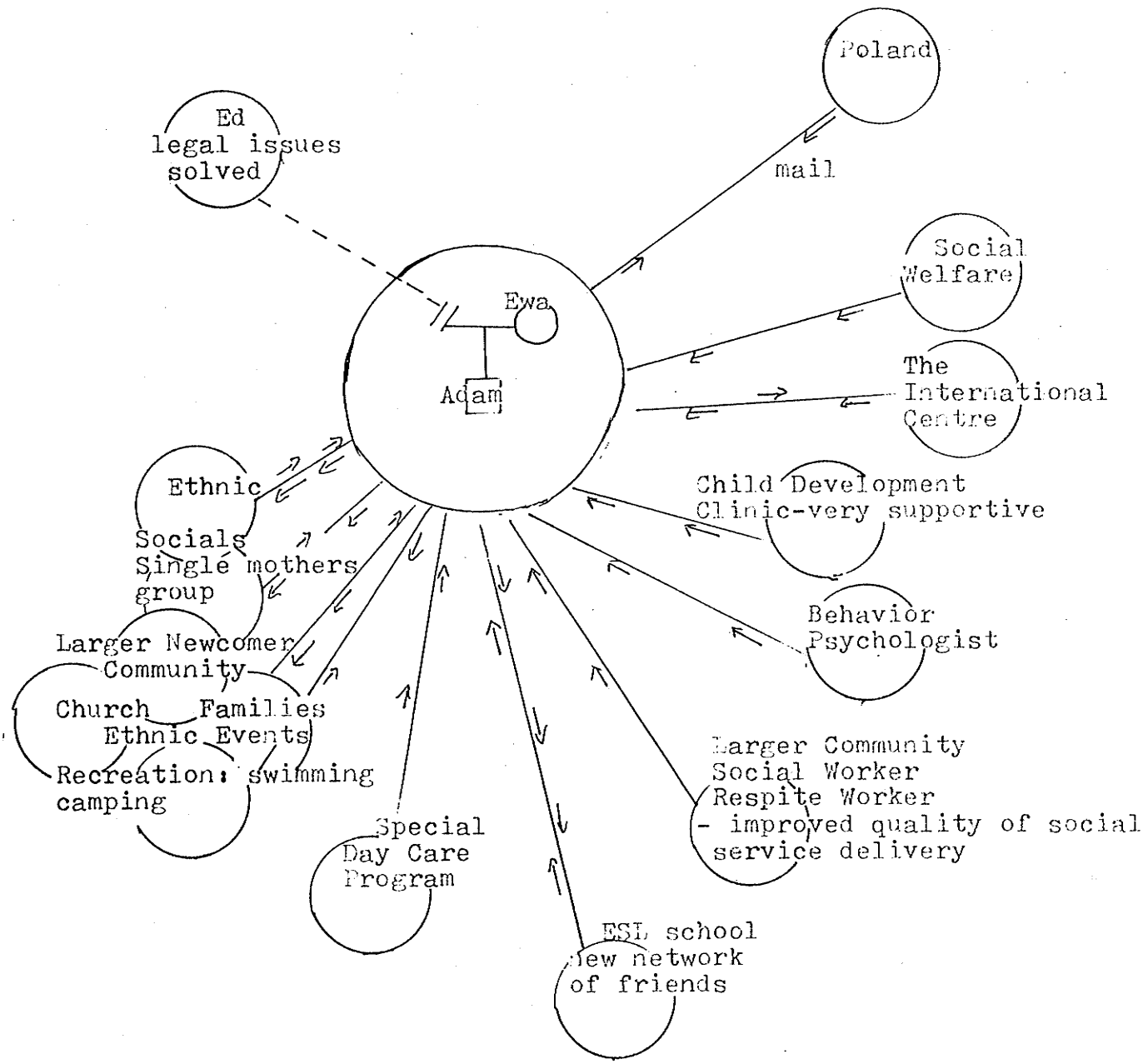
became creative in discovering environmental resources for herself and others. She was congratulated for her skills and rewarded by those she helped.

In summary, the universal problems of family dissolution, illness and social isolation which can happen to everyone, were intensified and maintained by specific problems of newcomers. These distinctly different factors were the father's 6 month political imprisonment, the family's involuntary (psychologically) transition, Ewa's lack of English, lack of mutual (family & environment) understanding of cultural differences and gaps in social services for immigrants. The practitioner's role of cultural broker had an important impact on the overall outcome.

Eco-map at the time of the first interview



Eco-map at the termination stage



Nature of connections: ——— for strong

------- for tenuous ⊣⊣⊣⊣ for stressful

→ → → flow of energy, resources, etc.

Summary of Other Cases

In this part of the chapter the practitioner will review the remaining seven families A -G. As noted in the chapter introduction regarding the length of the descriptions, only highlights will be given of the events which the practitioner assessed as pivotal for family functioning. The presentations include general information about the family, the presenting problem with interpretation, the action undertaken and the final evaluation. The pre- and post-test questionnaires filled out by each family are attached in Appendix 1.

Family A

The "A" family was a two parent family with two children. Both parents were in their fourties and possessed university degrees, the older son was in his teenage years and the younger a newborn baby. The family was self-referred requesting family counselling to help them manage their 12 year old, Rob who was described as misbehaving at school and disobedient at home. The repeated complaints from both mother and father in the firsst session were about his not taking care of his room, lack of respect for his parents, not doing homework, being harsh and dangerous towards the baby.

The teacher informed the mother that Rob interrupts classes, is hyperactive, not motivated to get the grades of which he is capable and generally neglecting school rules.

Rob, on the other hand, stated that he should be able to

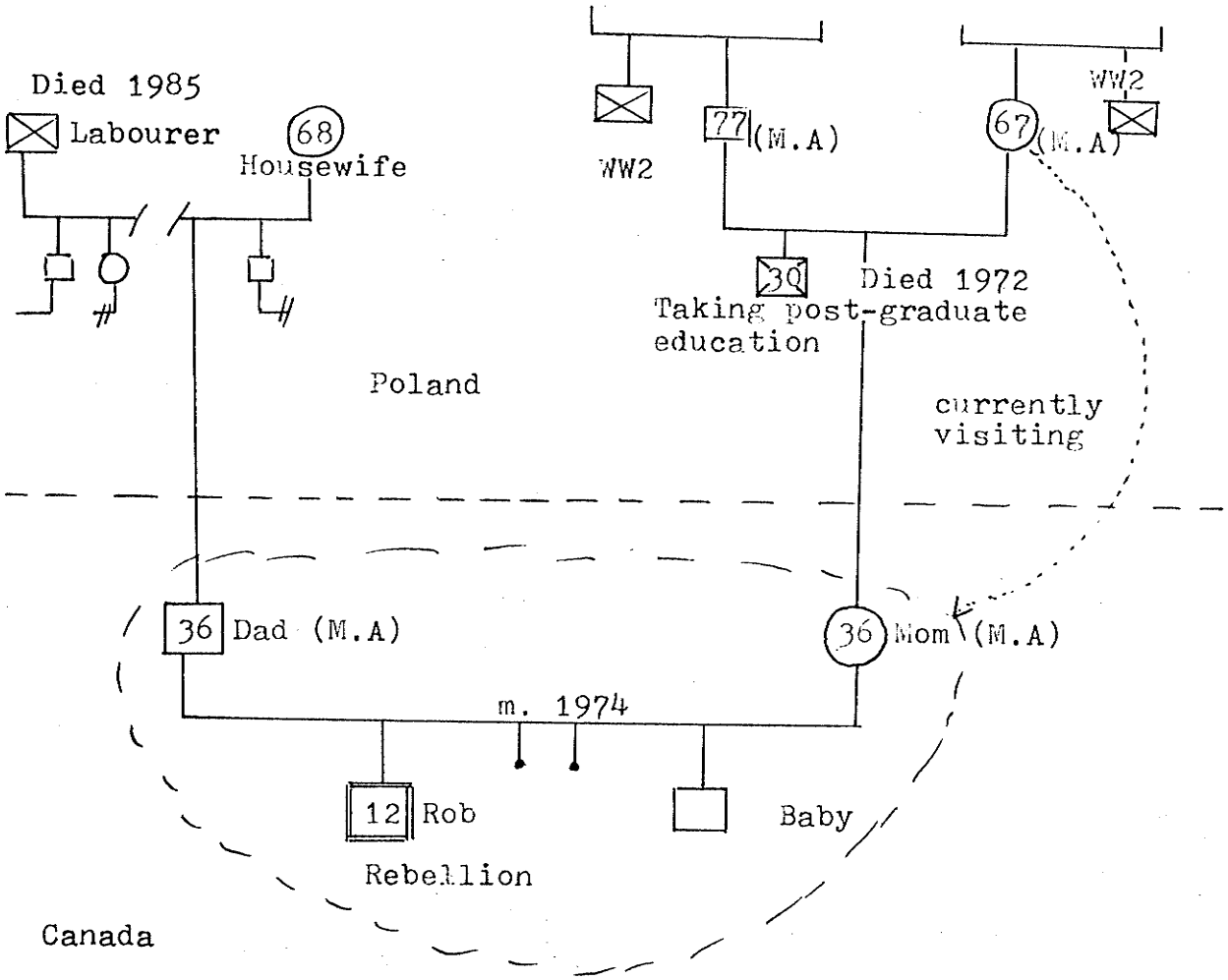
do things his peers are allowed to do, for instance watching TV and skateboarding more frequently, going out and playing more instead of doing things like spelling or Polish school homework. Spelled out by the clients the expectations with regard to therapy was the mitigation of the presenting problem ie. Rob is going to be a well-behaved boy.

In the second and third session the practitioner rejoined the family and explored what they did as a family in the past and as a couple, as well as something about each of their families of origin. Consequently as everyone talked, many generational issues and conflicts emerged.

Taken from the genogram inserted (p. 90) clinical data showed the inter-generational stress of deceased males (Rob's grandfather when his father was a young child, the mother's brother when she was approaching adulthood, two beloved uncles of Rob's mother). A high anxiety level was communicated by Rob's mother when those issues came to the surface. Neither she nor her husband wanted to disclose sufficient information about how their families of origin accomplished their developmental cycles as well as how it impacted on their own. In addition, conflictual involvement with both families of origin was depicted, as specific behaviors and events were pictured during sessions. One of the given reasons for immigration was to distance themselves from the families of origin, but that geographic separation was not much of a solution.

In addition, the process of leaving their own country and adapting to Canada created a great deal of stress for

Genogram II Family "A"



the family. Problems with Rob started five years ago prior to coming to Canada at the refugee camp in West Germany where there were "no rules for children because other parents and we too, were preoccupied and worried about the future." The first year after their arrival to Winnipeg was described as horrendous because of the lack of economic security, a car accident, parents health problems and a lack of English. Currently they have successfully accomplished most of the tasks they set for themselves, including climbing up on the professional career ladder. Both parents believe that everything "could be wonderful if only our son would change".

In terms of the transitional phase, this family was approaching a stage when they needed to renegotiate rules and operational modalities which have been pivotal in the past but were no longer appropriate in the present circumstances. The imperative was to maintain the family's identity and integrity while accomplishing a necessary reshaping. There were many changes occuring within each individual and subsystem that should, in turn, reverberate in the whole system, producing a kaleidoscopic rearrangement of parts.

It seemed that although the family was opening its portals to the flow of extrafamilial influence, since the parents were reaching out into the Polish and mainstream community and furthering their own professional development, it was not opening up their boundaries (internal conditions) to allow Rob to go along his own path. Moreover in terms of behavioral

control, the family style was that of being rigid and chaotic at the same time. Although chaotic was perceived by parents as flexible, when pinpointed and clarified it ended up rigid. What appeared to be occuring in sessions and was reported as taking place at home related to maintaining control over Rob. Both parents wanted to have control over him, and each imposed it while sometimes giving it up. When this happened the other parent overcompensated to restore the control given up, therefore resulting in a vicious circle of losing control.

The need for change arose strongly from the fact that Rob achieved integration in the new milieu faster than the rest of the family, who stood strongly for "old" values that clashed with those of the new ones. For instance discipline and punishment are some of the most frequently used words in Polish schools and homes. Every pupil is expected to be neat and completely obey any authorities. As well, there was always homework and many other responsibilities or chores which may be absent in Canadian homes. In this family it was evident that there was more of a work focus with less time given for play. Moreover Rob became quickly fluent in English which resulted in a "shift of power" at the beginning of this family's adjustment. In order to rebalance it, parents had to, as they said, "set more control" recently.

Another characteristic of their cultural transition (and some other families presented) was additional Saturday classes for Rob. The parents wanted for their son, an education in the

native language, and an appreciation and respect for Polish culture and values, in an effort to preserve identity and that which was considered valuable from the past. Nevertheless, when Rob entered the Canadian education system, he found that the focus was oriented to the future alone, in the sense that his past was discounted or ignored and the emphasis was on rapid acculturation. He has changed schools a few times already and it only complicated the nature of the child-parent relationship since Rob was influenced by his peers, advertisements and the system, while the parents kept high expectations of achievements and cultural values from the past.

Area of affective problem solving and behavioral control became the most important issues to address for this particular family so that interventions could be carefully orchestrated. First of all Rob was framed as the pivotal person for the past and present of the family. He was presented as displaying many roles, that of tester, challenger, separator, change agent, worshipper of heroes and experimenter. As the challenger he served a crucial function as an aid in helping the family system to accomplish its developmental tasks. He fought for his own autonomy and freedom in a very dramatic way, which kept everybody engaged in negotiating family flexibility and adaptability. This allowed for a confrontation on the unfinished process of the parents' separation from both families of origin. The marital subsystem was also called to

struggle and work out former individual and systemic difficulties with their family life cycle and face many conflicts within. Also, the presenting problems had a very important function in the system's cultural transition. The aim was to not be "stuck" in the past but reshape and adjust to the present.

The subsequent goals for treatment were to challenge the family's view of Rob as deviant in order to facilitate a more positive and accurate perception by the parents. This was achieved by introducing the described positive reframing and creating meta rules for negotiating old rules and roles. It was evident that the family's successful functioning and adjustment had to contain some symbolic new version of old core values. Thus the therapeutic focus was not to eradicate old ways of coping, but to provide them with new choices of life-ways. Since Rob was framed as a "change agent" and "keeper for the new" his job and assigned task was to introduce and explain new things. Each time his parents were to arrange a time for a discussion so that the three of them could come to a conclusion about what and how these new things might be implemented in their life. Every speaker had to be prepared to give his or her arguments, pros or cons, and tried his/her best to be clear and creative. For the next appointment they were asked to bring final results and their own evaluation of what was happening. Everyone was commended for doing such a good job with the underlying message being that it takes

time and energy because a special "creative" child requires special creative parental skills.

Normalization of Rob's position within the family system occured as a result of giving him an appropriate amount of power and time to explain his point of view. A change in the parents' perception consequently initiated a process of re-structuring the family pattern of interaction. Once the family was happy about how they were able to discuss and enjoy the time spent together a new task was introduced by the practitioner. It was to search out new ways of freeing Rob from the duties of being a "change agent" so that he could become responsible for himself and develop controlled age appropriate behavior. He was then asked to improve his grades at school according to his outstanding ability.

During the course of treatment, another therapeutic goal was to strengthen the marital boundaries so that it became a strong primary system. Plotted with other issues was the practitioner's attempt to get the adults to work out their unresolved generational issues. At the beginning some time was devoted to unresolved grief but both parents did not really at that point want to deal with anything that they called past and previous problems. However they agreed on working together as a couple on establishing parental consistency and outlining clear expectations for Rob and each other. The outcome of the three homework assignments and directives was a clear list of Rob's responsibilities. Both

Father and Mother had to make sure that they did not contradict each other when dealing with Rob.

Towards the end of the practitioner's involvement it became apparent that the spouse subsystem had to face denied marital problems rooted deeply in their past. The practitioner's role was bound to highlight the importance of exploring alternative ways of handling the so called past. Some help was provided in clarifying boundaries around the family by stressing limits on grandparent influence. On the basis that grandmother was to visit in the next week anticipated situations and reactions were discussed.

The termination was a result of Rob's improvements in his behavior at home and school. By that time his grandmother had already arrived and agreed to help his parents to maintain the established list of responsibilities and also respect his higher position of "mature teenager". This was the last task for the family including the visitor who also participated in the termination stage (twelfth session).

The questionnarie and open-ended interviews were used in order to evaluate the outcomes of therapy. Generally speaking the parents contracted for family therapy because of their son's behavior and once the changes were noted the motivation for continuing the process of change in the marital subsystem was weakened. The scores on the pre-test questionnaire showed that both parents perceived their son as the only problem and were satisfied with the other family dimensions. The second

questionnaire pictured client satisfaction with the obtained treatment outcomes. The personal interview with Rob's teacher supplemented the positive picture of the parents with regard to Rob's considerable behavioral change during classes as well as his better and more frequent involvement with his peer group. Although the problem symptoms diminished, the intrinsic marital problem was not solved at the termination stage. Unless each of the parents gain a clear sense of self and sufficient connection with each other, the practitioner cannot evaluate the treatment outcomes as definitely positive even though formally contracted goals were achieved. Nevertheless the process of change was initiated and as indicated by the parents is continuing.

In conclusion the problems of this family were more universal in nature because it could happen in any family that a child presents those problems which were not dealt with by the marital subsystem. The cultural and transitional issues, however, needed specifically to be addressed and in that matter the practitioner's work took on new dimensions.

Family B

Family B was a two parent family with two children: 11 year old Ada and 3 year old Jack. The family entered therapy upon the recommendation of the Child Guidance Clinic where Jack was referred by his kindergarden teacher. The reason for referral was Jack's lack of verbal communication and passivity

at school. The results of tests of intellectual ability showed that his I.Q. and academic potential are in the average range. Jack's indifferent attitude and lack of achievement in kindergarden were suspected to be due to possible family problems related to immigration. Both parents were not fluent in English which hampered family-school communication and cooperation. The family had been in Canada three years. Both parents admitted that they suffered a lot of problems regarding their financial situation, conflicts with the sponsor (his brother) and health. On top of that they did not know any English and were not able to find any sources of financial help because they were not eligible for social assistance.

The couple reported a very good marital relationship prior to the migration. Since that time however they had increased difficulty communicating and enjoying family life. The father acknowledged that he was drinking heavily and that his wife was experiencing an emotional breakdown. Both children were left behind, growing quietly and "without problems". However as Ada became more involved outside the family with her school and peers, Jack was turning into a more and more silent child, attached to mother and disengaged from father. Mother said that Jack is shy like her; withdraws in difficult or stressful situations. Speaking in English at school for him was seen by her as very difficult. She added "I would probably behave the same way". Jack was not very talkative in Polish either.

Before the time of therapy entry some positive changes

had already occured, considering that their economic problems were solved and a network of friends was built. The father satisfied with his job stopped drinking and mother was not housebound as much since she was also working and bringing in money.

The structural assessment of the family was an overinvolved mother and a peripheral father. Jack's voluntary speechlessness was framed as a kind of worrying about his parents' future and caring about his mother's "shyness in English". Both mother and father were asked to think about how they can support and provide emotional satisfaction to each other so Jack can be freed from this worry. For the next meeting, a home visit was proposed by the father who was very busy with his job. The practitioner agreed to come on the condition that Jack shows how silent he could be and that he try not to talk in either Polish or English. During that visit Jack was sitting quietly behind his sister and maintaining sincere eye contact with the practitioner. However, at the end of the session he stood up and said in English "Before you go you should see my rabbit". When he brought his pet he was commended for being obedient and then disobedient because it was an appropriate time to communicate. Together with the practitioner some instrumental tasks were discussed and finally implemented. First of all, for the parents going out twice a week to learn more English was recommended and accepted by the family. The father was additionally assigned to help Jack with his home-

work in English, while the mother had to observe and report at the next session how well they were doing.

The straightforward message was that what was once functional during the "hard" time was not useful anymore. A growing son now needs more of his father's encouragement to behave like every other pupil in his class when the mother needs the time for herself.

The couple was asked to come alone to the fourth session. This session involved a review of assigned tasks which the couple had done. They were given an opportunity to speak freely and express their feelings and future plans. It became apparent that the couple had not done this frequently and that there was some unfinished business around his drinking and her fear of repetition. The next two sessions were completely devoted to a cognitive intervention strategy exclusively with the parental dyad. A circular pattern diagram was used to present how their overinvolved/withdrawn complementarity created a vicious circle of maladaptive interactional patterns. The practitioner's role was to stimulate direct interaction between them concerning interpersonal perceptions. The assumption was that once the marital subsystem problems were being solved then consequently the parent-child subsystem interaction would change and the presenting problem of Identified Patient could vanish.

Some improvements were needed in the nature of family-environment transaction. As the family members communication

could be described as high-context and the kindergarden staff as low-context, the action undertaken was designed to foster better understanding between these two systems.

The seventh session was about termination and overall evaluation. The couple expressed satisfaction about the treatment although they admitted their initial reluctance towards family therapy. This was due to the lack of understanding of contradictory messages they received from the Child Guidance Clinic and Jack's school about the voluntary nature of their involvement. They perceived this information as an attempt to manipulate them. Thus, the questionnaire they filled in during a pre-test did not illustrate any areas of dissatisfaction or problems.

The incredible strengths of this family were evident in the amount of love and caring each family member displayed to each other. Besides, one needs to acknowledge a survivor vitality and power considering their early settlement experience. The communication and boundary dysfunctions seemed to be minor in comparison. A two month follow up indicated a maintained positive picture of family functioning. They informed me that Jack is doing well at school and communicates. When mother attends evening classes, the father stays at home enjoying time with the children. The Child Guidance Clinic informed the Immigrant Access Service that this family's case is closed.

Family C

Family C consisted of two parents and two male children; Alex 9 years old and Stan 5 years old. The way they were referred to the practitioner was quite complex but characteristic of the practicum circumstances. The family was in Winnipeg three months when the mother asked Alex's teacher to refer him to a speech therapist for a stammering problem. The teacher refused to do so because she did not see any problem other than Alex not being able to communicate in English. Because the teacher suspected some misunderstanding around the issue she requested an interpreter from the International Centre. The interpreter had the impression that the whole family required counselling and therefore, contacted the practitioner to discuss the issues.

Both parents possess University degrees but only Ron, the father worked in his profession in Poland, while the mother (Roxana) was raising their children. Ron was imprisoned for political reasons and he got "special" treatment together with criminals who had psychiatric problems. They came directly from Poland to Winnipeg. As Ron described it "within eight hours we changed our reality from Moon to Earth". The previous bread-winner role was reversed since Roxana knew English and started to work the month following arrival. She was happy in Canada since she had always wanted to leave Poland and did not feel any guilt or sentimental attachments. It was the opposite for Ron whose adjustment was in jeopardy from the beginning.

Both boys seemed also to have problems with accepting school and day care. They said that they did not feel like learning a new language. Alex was always seen as a sensitive child who had some problems with speaking but in Canada his stammering worsened. Besides he started to have nightmares and walking in his sleep which did not take place in Poland. Stan on the other hand started to wet his bed and sometimes his pants.

The observed behavior displayed at the beginning of the practitioner involvement was both parents' irritation when Alex was speaking. The mother and father tried interchangeably to help him to be clear thus they were finishing his sentences or even talked for him. They admitted that they are impatient because it seems to be his fault since he can read without repetition or involuntary stops. An important tracking onset would be that Alex, when he was 3 years old, started to stammer when his mother went to France for three months. Father was busy 24 hours a day and Alex stayed with his grandmother.

As a result of what was observed and communicated, this family was assessed as able to respond with the full spectrum of feelings experienced in human emotional life. However, the mother seemed to respond with less tenderness than Ron when Alex was tearful. She was also rather distant and disengaged while the father was angry because of the boy's behavior. Alex said that daddy hugs more than mommy because she is preoccupied with something else. It was also found that the parents frequently left the boys alone at home during the day and even

more often at night assuming that they should not be scared.

The intervention began by blocking dysfunctional transactional patterns and giving Alex rights to speak for himself. The parents were told that sensitive children need more sensitive attention. The purpose of the program designed was to ensure that the boys feel and experience love and caring.

Alex's school teacher was contacted to discuss the possibility of speech therapy. It was suggested that in the next school year (Fall, 1987) Alex be assessed for the special therapy.

After four sessions the mother said that Alex stopped wandering during the night. The prescribed routine she consistently followed was being with the boys before bed time, reading nice stories or telling fairy tales. Some stories were discussed in detail during the two sessions attended only by the parents. The practitioner's belief behind this directive was that if the children will be getting attention in a new and unaccustomed way, this activity, itself, should involve certain structural changes in the family. The cultural dimension which was operative in the intervention was the reinforcement of clear family structure and roles in respect of responsibilities and parental emotional involvement with the children.

Another important task was to facilitate the father's adjustment. Alternatives and some issues from his past (the client had a desire not to reveal in this report) were dis-

cussed. Again an informal support network from the newcomer community was placed in operation. A casual well paid job for Ron was found when he finished ESL school.

During the eighth session termination was discussed. The parents were pleased with the new established routines of being with their children. They found out how little they knew about their child's world which they came to enjoy so much. The positive feelings were especially strengthened by increased functioning and well-being of their children and Alex's achievements at school. The first observable outcome of the changed interactions was Alex's sound sleeping without interruptions and Stan's dry bed. At the time of termination Alex was still stammering but his overall flow of speaking was improved. This was also confirmed by Alex's teacher who at the follow-up said that in her opinion a speech clinician is not necessary. Three months after termination the family lived in their own house together with their recently sponsored family (Roxana's sister with her husband and their children). Three out of four adults were working and doing well in general. Stan did not display any symptoms and Alex kept improving.

Family D

Family D consisted of a single mother Giga (27 years old) and two daughters, Mary (5 years old) and her sister (1 year old). Giga was self-referred to The International Centre seeking help for herself and Mary. She left her husband in

Alberta and drove all by herself with her children to Winnipeg. Both she and her husband arrived in Winnipeg five years ago and stayed for three years, then moved to Alberta. The marital problems started in Winnipeg and migration to a different province was an attempt to solve it. Unfortunately their marriage did not improve and Giga decided to leave her husband who physically and psychologically abused her and betrayed her constantly.

She got shelter at her friends home but did not want to stay longer than two weeks. It was necessary to organize some furniture and financial support as well as find an apartment. The legal separation also had to be arranged. These primary instrumental tasks were basic corner stones of Giga's feeling better, however, simultaneously intensive therapy was conducted with her and Mary who became very hyperactive and cried alot because she missed her father. Giga on the other hand was full of guilt, anger and intertwined depression over the whole situation.

Meanwhile her friends, who were an older childless couple, took over Giga's responsibility as a mother and primary care giver. This system's structure looked like a two parent family with three children. However Giga did sense the dysfunction of such an arrangement and she was very eager to change it. Thus, she moved to the first apartment which was found by the practitioner and joined a newly created network of newcomers from the Polish community.

At that time the intervention began to focus on the mother and the daughter exclusively and on both of them as an independent subsystem. Giga was given especially prescribed material for battered wives to read and it was discussed from a feminist perspective. Also, the child's unspoken fears and concerns regarding the sudden separation from her father were dealt with through the story-telling technique. Father and daughter had been very close right up to the time of the separation. For Giga it was a most difficult task to articulate her hostile feelings towards her husband. Thus she was asked to tell Mary a story about being hostile and jealous of people she once loved and coming to terms with the feelings. These stores were to be about both past and current experiences.

Story telling experienced by both the parent and the child has the advantage of not only giving the parent permission to feel all possible feelings but also provides a method which allows the adult to work indirectly with her own issues without having to consciously "own" the problem. Thus, by telling the child stories in which the even though disowned feeling is of central importance, the parent is exposing herself to these feelings in a diluted way (Wachtel, 1987).

After the sixth session when everything began to normalize for this family, the father came to Winnipeg with the project of a new life for the four of them in Alberta. He proposed that he move from their former comfortable apartment to another closely located one which he intended to share with

another woman. He promised to leave all the necessities for the children and Giga at that apartment and pay all requested alimony. This was a really appealing prospect and after writing up an offical agreement with him, Giga and the daughters moved back to Alberta.

Three weeks later Giga called on her own initiative saying that everything seemed to work well and according to the plans. The contract prepared together with the practitioner included a demand to go to "Evolve" in Alberta for training for offenders. On that day Giga's ex-husband informed her that he started that program because he wanted to keep his word and become competent in solving his problem of being violent. Giga also mentioned that for her the drawing of their Circular Pattern Diagram on a piece of paper (done the last day) was very striking and gave her a flash of insight which resulted in relief of her underlying guilt feelings. Two months later the practitioner phoned for follow-up data. Giga was pleased to communicate that they both stuck to their plans, and that she was accepted for a training program to become a social worker. She perceived herself as a strong and "adequate" person once she was able to specify her needs and pursue her career. She also expressed some trust in her husband and agreed to shared parental custody. Since she felt a full confidence in professional help she engaged Mary in group therapy for children of divorced parents because she sensed that the child needed additional help.

Even though the treatment was not finished and all desired goals were not attained the overall evaluation of the outcome seems to be positive. The quality of the family systems change was clinically significant and promising. Moreover in the event of future crises or other problems Giga is more than competent and skillful in finding solutions and sources of help.

Family E

Family E was a single parent family referred by The International Centre because of Nina's (23 years old) depression. She recently immigrated to Canada from a refugee camp where she spent two years. At the time of her arrival she was eight months pregnant. The father of the baby requested her to have an abortion, therefore she left him. Soon after her arrival she gave birth to a healthy baby boy.

Nina was described by the Polish speaking worker from The International Centre as needy of friends and some feminist counselling. In fact the referral worker was involved with Nina from the very beginning providing a lot of empathetic support and was building the ground work for creating a network for her. The practitioner was asked to deal exclusively with Nina's depression. In that case the International Center's worker employed the case manager position with the practitioner supplementing her action.

The presenting problem appeared to be loneliness linked

with the lack of any support network, depression and unfinished business regarding her extended family. Nina was preoccupied with frustrating and distorted thoughts about the financial and emotional problems of her mother and unmarried sister with two children. Refocusing from her own problems permitted her not to deal with her own reality. Her family in Poland did not know that she had a baby and could not support them.

The first sessions were dedicated to grief resolution because Nina needed to gain meaning for the experience of loss (of home, of family of origin, and of partner and father of her child). Personal documents i.e. photos and letters were used to grieve about what was left. This essentially tied the therapeutic work to the past and to Nina as a part of her extended family system. She was the oldest, very responsible parental child. Her father was an alcoholic and her mother was fanatically devoted to the church, so Nina was left to act as a parent to her three younger siblings.

The first goal, therefore, was to free her from her extended "parental" duties in such a way that it would provide a clear sense of the past and an acceptable way for the future. Testing both past and future in search of some thread of continuity was similar to a central stage of grief work held by the Marris' (1976) theory and following the same stages as grief work in the case of bereavement.

An additional explanation of cultural conflicts that she was experiencing was necessary. This student hypothesized that

Nina as a single mother in Poland would experience not only financial hardship but also pressures to marry since acceptance of an "illegitimate child" on the part of the Polish society is not readily gained. This single mother now transplanted into a society which is more responsive to her needs (financial, child care, social programs) "penalizes" and "ostracizes" herself by imposing the old reality onto the new with the purpose of resolving her inner conflict of cultures.

Rituals around writing letters, some of which were mailed and others kept in a special box, were implemented together with the writing down of a list of simple everyday tasks with a reference to future projects and long-term goals regarding Nina's own career and her baby's well-being. With such a pre-meditated and rational agenda Nina became more and more outwardly oriented, thus involved in the ESL School, and a new network of friends among whom some were English speaking tenants of her apartment building.

The formal termination was discussed at the ninth session as Nina felt well and connected with her group so her needs of belonging, acceptance and sense of continuity were satisfied. The practitioner still keeps in touch with Nina and her baby but on an informal basis.

The evaluation of the therapy had to take into consideration the very important role of The International Centre's action. For the first time the practitioner did not need to focus on anything other than the internal functions of the

individual and family systems because much of the ecological and instrumental work was done by the settlement counsellor.

Working together in a coordinated and consistent manner resulted in a proper channelling of energies, and effective use of time towards a productive and beneficial process for the client.

Presently Nina goes to her ESL classes three times a week where her son is in a day care. She also babysits interchangeably with other mothers and goes out quite often. She regained her good sense of humor, rarely worries about her family in Poland and is very helpful to other more recent newcomers.

Family F

Family F consisted of a mother, father and a teenaged son. The practitioner dealt with only one member (the mother) of this family because both father and son did not want to come. Krysta (32) was perceived by them as the only problem, one which had nothing to do with them. She was referred by an Immigrant Employment Unit to assist her in seeing a psychiatrist - she refused to go. Her behavior was described as very bizarre and dangerous for herself. Krysta was fired from her cleaning job because she "lost time and space orientation, was talking to herself and doing ridiculous things instead of working".

At the time of the first interview Krysta was in better

condition because she finally visited her family doctor who diagnosed schizophrenia, referred her to a psychiatrist and provided her with appropriate drugs. The immediate need was to assist her in the process of becoming a permanent patient of the psychiatry department. Krysta denied her illness for 3 years and did not talk to anyone about her hallucinations and anxiety. This problem started in a refugee camp where she spent eight months with her family. Only once had she asked her husband if he hears voices. Ever since then their once good relationship deteriorated to the point of being artificial until they completely stopped communicating and lived separate lives in separate rooms in the same apartment. While Krysta did not know anybody, her husband had a network of friends he never invited home.

Their son most of the time was involved with school activities and his peer group. He did not understand what was going on with his mother but they did have contact.

An assessment of this situation could be described as the lack of a good fit between Krysta's coping capacities and the qualities of the impinging environment which embedded her in a social isolation that worsened her dysfunction. An important ramification of this family's transitory process was the fact that Krysta was not emotionally prepared for immigration and did not share in her husband's decision prior to departure.

The intervention involved ecosystemic work with the

environment, the family and Krysta as an individual. Work with the environment included advocating, facilitating and mediating with Krysta's former employer, the Health Sciences Centre, the ESL School, and creating a new support network for her.

Changes in the family system's structure and interactions required prescribed directives and homework to which all members would be prepared and motivated in implementing. This task appeared to be difficult since none of the family members wanted to cooperate in that matter at the beginning. It took three sessions of role-playing and a cognitive approach to convince Krysta to give it a try. The biggest success for her was when her husband agreed to share a room and bed with her. They also started to communicate around instrumental matters but not affective ones.

Krysta stopped coming after the fifth session on the basis that her goals were achieved. She said that she talked with her husband who was also happy with the new situation, and felt that extended help was unnecessary. The practitioner acknowledged the cultural bias with regard to mental health treatment, however, this was framed positively as a motivation to be well, and a sign of family strength.

This was further confirmed when a three month follow-up was done. The picture indicated a two breadwinner family, going out together and possessing the same support network. Krysta remained a steady patient of the Health Sciences Centre.

Retrospectively evaluating the overall approach the practitioner admits that she failed to be effective in approaching and engaging Krysta's husband and their son. The experience for the practitioner was valuable, however, as she learned to deal with a "difficult to engage" family as opposed to the other relatively easy and often extraordinary cooperative families.

Family G

The practitioner was asked by a Polish doctor to meet with a recently immigrated couple because Rick, 37 years old, began seriously complaining about being in Canada and expressing suicidal thoughts. His wife Maria, 35 years old, shared his opinion about Canada but enjoyed learning English and expressed hope about a better future. The couple lived with their sponsors (Rick's mother and step-father) upon whom they were totally dependent.

The initial meeting with the couple was held at The Immigrant Access Service. The sponsors refused to take part in the sessions. Rick's description of his situation was that he felt lost, that he knew no one and that everything was strange and ugly. He expressed feelings of hopelessness, lack of faith in his ability to cope in this new surrounding. Maria was very sympathetic and supportive of her husband. She added that the situation at the sponsor's home was very difficult for both of them and also Rick's mother who seemed to be very unhappy with her husband. She believed that her mother-in-law was

psychologically abused by Rick's step-father who was very odd in his behavior towards people in general. Unfortunately neither they themself nor Rick's mother know many people and were afraid of making changes. It was also said that the neighbourhood was hostile towards the sponsor who was of a different ethnic origin and was thought to have participated in suspicious activity with the Germans in World War II.

At the time of the first meeting the problem appeared to be the lack of individual coping capacities in a new environment, the characteristics of which contributed to Rick's demobilization and depression. A closer look and cicular questioning, however revealed an additionally confused family hierarchy and dysfunctional interactions among four members of that family. First Rick's mother got very close to her son detouring her husband and her daughter-in-law, who in response became more oriented outside the family and motivated to adjust. At the same time Rick's step-father felt rejected and started to build his resentment towards the trio-coalition. The only power he possessed was money therefore, he became more and more controlling and interested in spending to the extent of obsession.

From the structural family therapy perspective Rick became the I.P. of the confusing and dysfunctional interactions. He was infantilized because he lost his previous position of successful breadwinner. Also as an adult and spouse he had to cooperate at a child's level and show gratitude and appreciation for this position. Moreover he was expected to fulfill his mother's

needs for love and care she could not get from her husband. In response to this contradiction Rick began to operate in a "sick" position.

The initial planned intervention was to help the couple become acquainted with other newcomers. Going outside the sponsor's "prison" and finding other people to identify with was expected to be a wealthy source of potential strength to cope with stress. The identification of natural helpers and building a social network was undertaken simultaneously with structural and cognitive manoeuvers. Since the sponsors did not come to any sessions, immediate interactions were not observed nor could they be manipulated during the meetings. Therefore picturing the family's life space and discussions about other alternatives for the couple led them to plan a separation from the sponsors. Yet for the time being the couple became aware of unclear boundaries and the hierarchy within each family. The straightforward message from the practitioner was that each adult must take responsibility for himself and herself and behave accordingly. For Rick and Maria it also meant improving English and searching for work; instrumental problems with which they were helped. Rick was told to complain only one hour a day about Canada to anyone who wished to listen to him.

It happened that the couple was encouraged by new friends to move and start an independent life. They even offered them a loan until they found jobs. The fact that others who were also

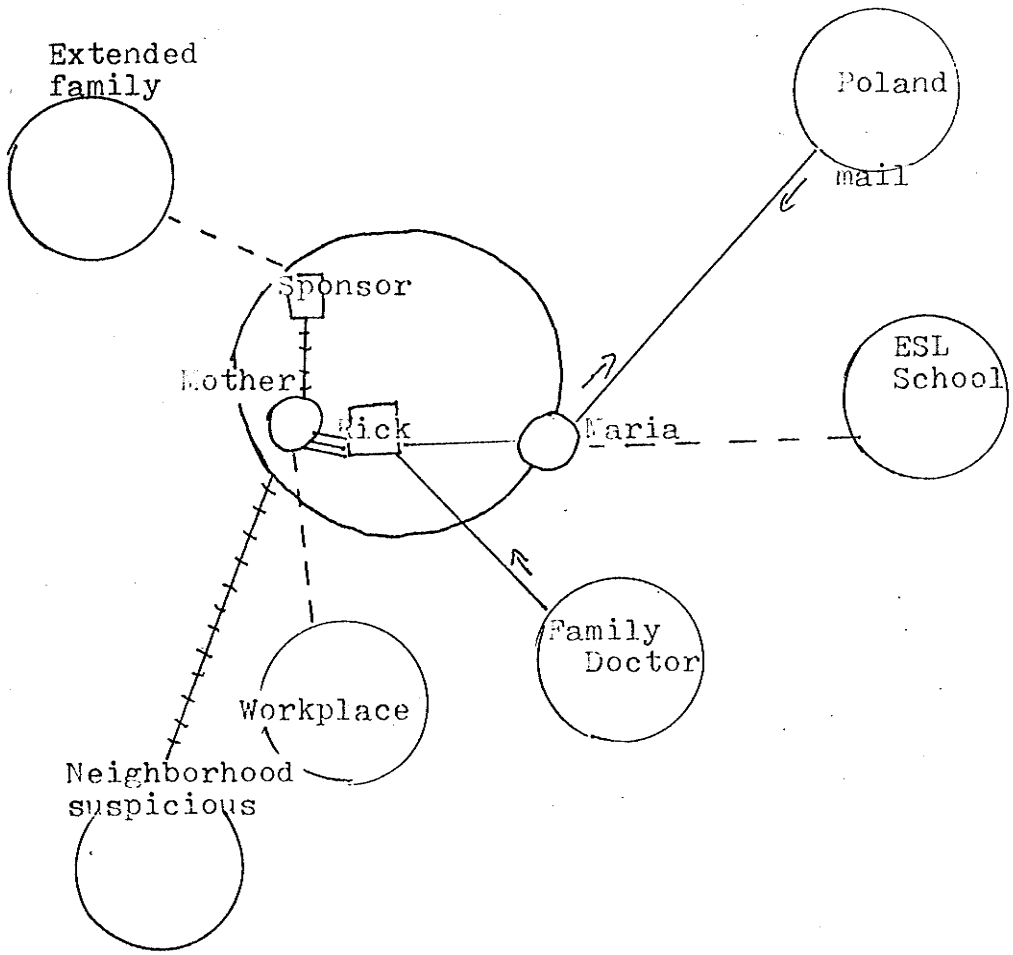
newcomers were able to handle the same strange environment challenged their feelings of the necessity to closely relate to their sponsors.

The fifth session was towards termination and cognitive penetration into Rick's perception of the situation was provided. The practitioner intended to convey a sense of optimism and hope that things would change for the better if one invests energy and faith. He was motivated to understand his emotional conflicts, to recognize and to deal with his reactions. Maria wanted to cooperate in coaching and facilitating desired changes. She said she knows what to do because of her experience of being weaker because the situation was reversed in Poland. They were welcomed to contact the practitioner in case of need. Rick phoned after two months to say that they are doing very well, going to ESL classes daily and working evenings. Besides, he was very pleased because his mother finally left her husband's house and requested a divorce. She rented an apartment close to their place. It was Rick's idea to not share the same apartment.

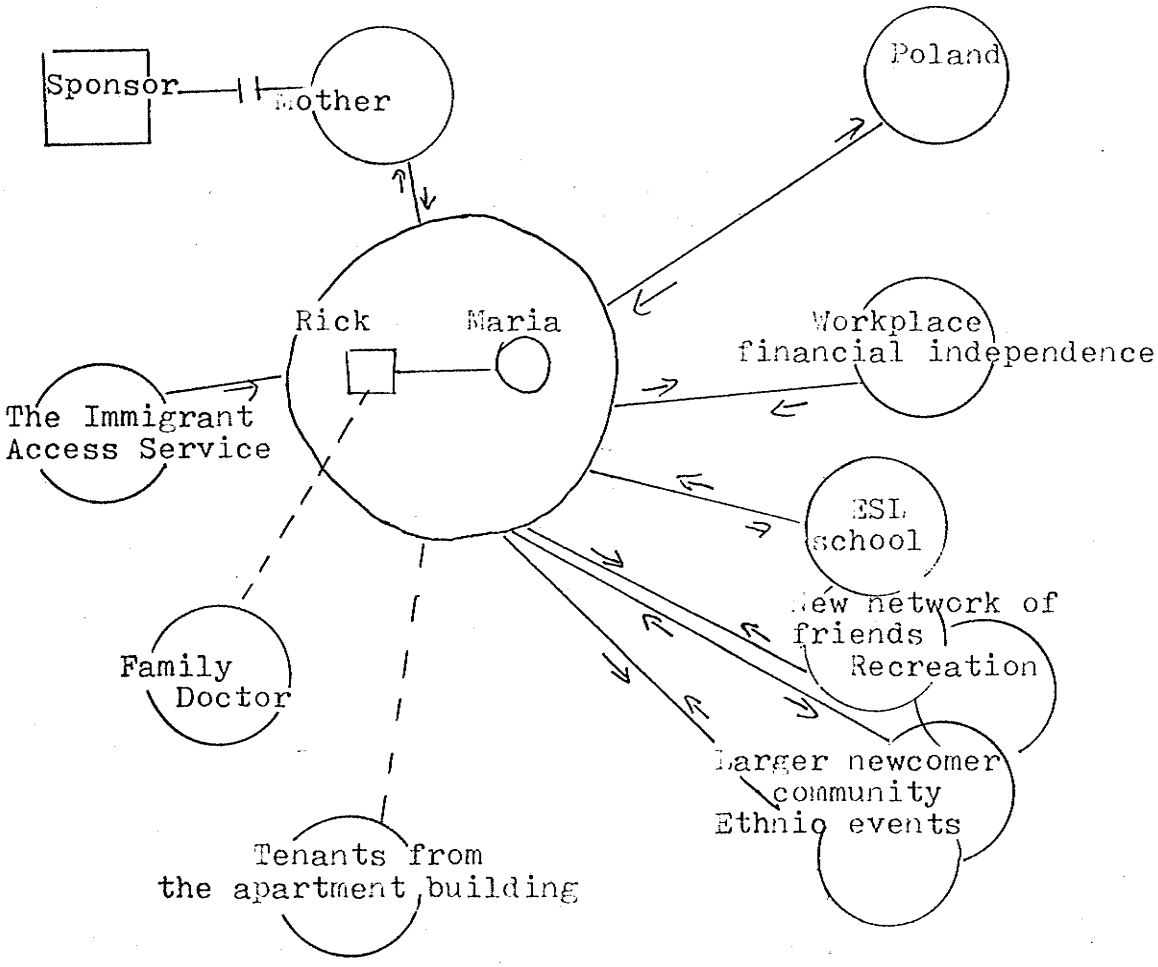
The simultaneous interventions focusing on building a network, structural changes and cognitive growth were successful. Separation and financial independence altered the families interactions, changed structure and reduced stress for the couple. New ways of coping were learned. Although Rick and Maria did not cognitively and affectively find the same solutions for their problems they both preferred a pattern of doing in action, were focused on present, preferred mastery over nature and

believed in individual way of relating in groups. The inserted eco-maps show significant differences in nature and quality of the couple's life before and after the practitioner's involvement. The final comment with regard to such quick success would be that formally initiated ecosystemic intervention may culminate in an amazing creative world of informal human ties. The survival strengths of most immigrants are no doubt contributive factors to a fast transition once the environment becomes a target of change.

1. Eco-map at the time of the first interview.



2. Eco-map at the termination stage.



CHAPTER 8: SYNTHESIS AND CONCLUSION

Overall Evaluation

1. Methodology

Consistent with qualitative methodologies, this practicum's evaluation procedures involved analysis of the descriptive data derived from the clients own written and spoken words and observable behaviour during sessions and reported 3 months after termination. Basically, this evaluation required the systematic monitoring of the progress and outcome of eco-systemic approach on a continuous basis throughout the assessment, implementation and follow up stages.

The first component of the clinical evaluation consisted of specifying the objectives of family therapy that had been negotiated with each family. These objectives were usually specified in concrete and observable form and stated in terms of what the family system will do or be like when the intervention is completed. The process objectives involved the establishment of the therapeutic conditions that were judged to be necessary for family system change. Thus sometimes the objective of the treatment undertaken was a change in the family's surroundings in order to establish good family-environment interactions. While in contrast, outcome objectives concerned the achievement of the desired changes in the family system structure, actions and interactions. A few selected variables were measured using quantitative methods in order to provide feedback to the clients on their progress and to

enhance motivation and to confirm positive therapeutic expectations. For example some measured variables were as follows:

(a) frequency of tantrums (Family X)

(b) ability to communicate with others at school (Family B)

(c) recurrence of stammering and bedwetting (Family C)

(d) the amount of time the couple spend together (Family F)

(e) alleviation of the family member depression (Family G)

(f) the composition of family environment transactions (Family X, B, C, D, E, F, G)

As previously described in all cases, these variables improved towards the desired level and showed a better quality of family internal and external transactions.

Self-report methods were used with all eight families. This included open-ended interviews, client's direct observation and monitoring, and a questionnaire constructed by K. Saulnier for internal use at The Psychological Centre. This data was compiled with my observations and assumptions as well as feedback obtained from some significant others, teachers and members of the Polish community. That feedback was always in favour of the implemented therapeutic approaches because the communication channels became more open, the families more involved in community activities, and better

mutual understanding was achieved.

In all cases, an attempt was made to reconstruct the history of migration and resettlement and in selected cases a genogram was used to differentiate current situations from the historical context.

Eco-maps were used as an assessment and evaluation tool to determine whether environmental changes were achieved. As an example there are four eco-maps included in the case presentation of Family X and G. These maps portray their situation before and after treatment, highlight and present the improved degree and quality of their connections and relationships with the outside world.

Clients feedback was an additional piece of data utilized in the evaluation. In Appendix 1 the questionnaires indicate the family members' (except Family F) concerns and satisfactions with how they were doing in a specified area of family life. Almost all scores taken at the end of the treatment show improved satisfaction or evidence of identified problems which emerged as a result of family restructuring and the abatement of symptoms presented by the child (Family A). The outcome data obtained from the questionnaire was discussed with each family as to determine any bias which may have been present due to their desire to please the practitioner. Furthermore, this data was combined with other independent sources; (newcomer community, friends, teachers) observations so as to evaluate adequately these changes. All of this yields positive

feedback about the overall effectiveness of the ecosystemic approach in family-centered therapeutic work with newcomers to Canada.

In conclusion it was not an easy task to handle such complex data and determine how much of my effort contributed to such positive outcomes. In the process of my involvement many other factors interacted and intertwined in the remedial process. In that very interactional process my most positive contribution was that I initiated and strongly supported the process of change in the lives of these eight families. However, it was through their energy and all of our hard work that improvements resulted. As well without the newcomer community, The International Centre and other social agencies cooperation this process would have been much more difficult if not impossible.

I have other comments which I believe to be pertinent.

2. Other Summary Statements

During the course of performing this practicum, I had been astonished by the resourcefulness and adaptability of individuals and families. After my summer job at Children's Home (in 1985 prior to undertaking this practicum) I was prepared to deal with clients with possible resentment to family therapy and resistance to change which I assumed to be more persistent among newcomer families than observed during sessions with those who were Canadian born. This assumption

did not hold true. In fact in only one of the eight families was it difficult to engage the total family in coming to the sessions. However by implementing the suggested changes given to the one member who came to the sessions they participated indirectly. This does not mean that these family systems were easy to change and did not require "hard" work. Hard work was necessary and related to being very flexible, committed, and prepared to apply as many different approaches as needed with family systems and their environments. Operating from as many viewpoints as possible almost simultaneously was the hallmark of the ecosystemic approach and the only one which could be implemented when complex sets of changes were required with these newcomer families.

Eight families came with different problems, some of which were directly related to their present situation of being immigrants. Problems of others certainly had roots in former unsolved generational issues (Family A) or problems which were initiated prior to their arrival in Canada (Family F, C). Immigration had a considerable impact on the functioning of all families by exacerbation of former difficulties or the creation of new ones. This was especially true for families X,B,C,D and G whereas for the remaining families A,E and F problems would have been experienced with or without migration. It is likely nevertheless that they would not require the same kind of professional help because the natural support network would have been in operation. Conversely, one can also speculate

what is available in Canada but not in Poland. In the case of autism for instance, there lacks the opportunity for them to receive assistance.

In terms of migration stages, three families (C,E, and G) were less than one year into their adjustment process. It is of interest that these clients were very successful in helping themselves after quick and appropriately targeted help. The therapeutic work with them seemed to be easy as the dysfunctions were "fresh and new" in new circumstances. These families were also more prompt to change as Sluzki (1979) describes that stage to be a period of overcompensation when immigrants are preoccupied with the fulfillment of survival needs and the need to "do well".

Families X,A, B, E, F were more or less in the decompensation stage which is claimed by Sluzki as very difficult and a period when most immigrant families are likely to enter therapy. In each family a cluster of factors held different importance in their migration episode. Yet the common need among these families was the reshaping of rules and interactions along with certain operational modalities which had previously been functional in their lifestyle. In the case of family X and E the imperative was to accomplish this change after the dissolution of the family unit. I believe that gaps in social service delivery and the lack of any preventative programs contributed to this process since symptoms of family dysfunction had been noted earlier by the immigrant

agencies as well as the Polish Community and neighbours. While in the case of family F where the process of family dissolution was seriously advanced, immediate intervention assisted this family to renegotiate their rules and remain intact.

How little was needed to start the healing process was a very striking discovery for myself and my clients, as well. This was especially startling when only informal help from the community at large and the smaller ethnocommunity was immediately available. By smaller ethnocommunity I mean the group of new immigrants seeking refuge from the political and economic climate in Poland, who had similar experiences of waiting in refugee camps or being imprisoned in Poland and sharing the East European block reality. The older more established Polish ethnic community of World War II Veterans and the earlier immigrated landless peasants were of less help, however. This is due to many differences in the process of their adjustment and experience, and often a mutual distancing attitude or misunderstanding.

Due to the atmosphere of alienation from the larger Polish Canadian community, Polish newcomers most often sought out more meaningful experiences and relatedness with other newcomers. This strong identity need of most families was always taken into consideration during the course of this practicum. As the once alienated clients become tied into the net they also began to play a significant role as that of

reciprocal receivers and givers of support. For six families the gratification of their need to experience a sense of belonging contributed to an enhanced sense of personal esteem and has had a therapeutic effect on their overall family functioning.

The Structural Family Model and other methods applied, I found to be very useful and powerful in altering internal dysfunctional family interactions. Almost all the families were facing structural changes regarding the family's perception of reality, their boundaries, hierarchy of power and family rules.

Through the joining process I attempted to win the trust and essential rapport with my clients in order to have them feel confident in expressing their feelings without fear of disclosure or judgment. As I also carefully studied the family's vocabularies, assumptions and what was important to them, I had to be creative in my approach rather than slavishly following procedures. Thus, for instance, I did not ignore the boost to motivation that cognitive understanding can provide in the middle of structural intervention when working with a family possessing a great desire to understand rationally. Families B, C and G were very responsive to both straightforward advice with some theoretical explication, as well as to the lack of such ready explanation. As I saw them changing, developing their own unique definitions of the world and growing, I was able to sense the family's

evolutionary process which was accompanied by changes in the family's external environment.

It is my belief and insight that my clients tended to demand more cognitive understanding of what they were undergoing, sometimes suspicious of manipulation or being taken for a fool, as our culture has shared and allowed certain expectations to exist. One could postulate that when culture is not shared between therapist and client there exists perhaps more uncertainty and therefore tolerance for less cognitive understanding. The comfort of culturally appropriate expectations may not exist.

Looking retrospectively from a structural family therapy perspective at the presenting problems and interventions one might conclude that my role was theoretically inconsistent or even contradictory to it. I switched from informal to formal methods, from being equal friends to respectful leader during the course of structural intervention. Through this time I held the belief that being eclectic and flexible was the most effective way to help these families to be happy in their new milieu and ecological context. There were many factors which contributed to utilizing one or another action. To my knowledge and experience there does not exist one universal therapeutic approach. However, the approach I found most applicable and creative in seeking alternatives and a generally wide array of options, was the so-called by Auerswald (1987), ecosystemic one.

At this evaluation stage, I became more aware of the fact that the ecosystemic paradigm differs significantly from other family systems therapy paradigms. Auerswald (1987) clarified the basis of methodological confusion and distinguished five paradigms based on different definitions of a family. An ecological system (or ecosystemic) paradigm defines a family as a coevolutionary ecosystem located in an evolutionary timespace. Family therapy that uses the reality rules of the ecosystemic epistemology adopts a radically different way of thinking, different that is from the predominant Western thought system. Taken from the new science epistomology it contains a rule of monism and a rule that truth be defined as heuristic. Traditional, reductionistic methods in therapeutic work and outcome research are abandoned by ecosystemically oriented therapists and researchers.

I attempted as much as possible to employ this kind of thinking while cooperating with social delivery systems not designed to operate ecosystemically. I was very surprised how rarely professionals from different fields take into consideration the whole picture of newcomer family circumstances. For instance, in the case of family X where the child was autistic, the health professionals viewed the case solely from a sickness perspective. There were no questions about any key events or the overall family situation until I brought it up for discussion. The process then became very attuned to the needs of this family. In that case eco-changes evolved

through improved mutual communication, friendliness, understanding of the nature of the subjective reality and cultural differences.

Cultural differences were sometimes the most crucial issues in the process of these eco-changes. Shared reality between the family and their reference group in Poland, their collective understanding and memory became halted and crystalized following migration due to separation from the reference group of origin. Immigrants are usually left with only internalization and the subjective part of their culture which by then will be in the process of transformation and adaptation since the host country and the immigrant experience affects it. This process was well illustrated by some family members when they were explaining how from being previously future oriented (which resulted in their emmigration), they were finding themselves in Canada focused only on present time, strongly task oriented, while in Poland they preferred some 'being'("passing through time") than 'doing' type of action (Kluckhohn and Stodtbeck, 1961). I also tried to determine what the family's value conflicts and confusions were, and how their aculturation process impacted on and related to their adjustment in Canada. This significant process is seldom recognized by both the immigrants themselves as well as by the established social agenices. The active role of cultural broker which is similar to Bowen's (1978) concept of "coach" undertaken by me made an important contribution and was a necessary step

in achieving the planned therapeutic goals. I also learned that balancing between two or three cultures requires very special skills. As yet, I discovered that in order to challenge well established mainstream social services one needs to be very diplomatic but persistant. Being diplomatic was not an easy task for me because in Poland I learned different skills in negotiating.

Another question that arises is whether I was able to engage in such a role because of my similar to that of my clients' cultural background as well as previous professional background (M.A. in clinical Psychology). An especially beneficial and determining factor in terms of positive outcomes was language. Using interpreters is often handicapping; while having professionals who speak the immigrant's language and are acquainted with ethnic specificities becomes an undoubted advantage (Tyhurst, 1977; Nguyen, 1981). Unfortunately I do not possess sufficient data to hypothesize about how successful might be a Polish speaking Canadian born therapist or cross-culturally trained workers who are not of the same background.

Evaluation of Personal Objectives

This practicum was intended to provide an opportunity to develop advanced clinic skills in work with family systems. Additionally, my objective was to increase my own understanding of family systems theory and examine the most effective approaches in working with families recently immigrated to

Canada. In fulfilling these goals, the practicum served a challenge and an opportunity to test my assumptions and biases.

The learning process involved commitment to studying, organizing and synthesizing relevant literature and other sources of clinical data. It also required volunteer involvement in different committees dealing with generic and mental health issues, torture victim issues and participating in various conferences and workshops concerned with the immigrant/refugee plight. Through this unique process of learning and experience I gained valuable understanding about the present state of knowledge regarding the immigrant population and the dynamics of social policy change.

As pertaining to professional skill development, the mastery of coping with crises experienced by most neophyte family therapists (Harvey, M., 1980) was unavoidable. Of special concern was the issue of professional boundaries. To achieve and maintain a delicate balance of being informal and formal, friendly yet directive, leading and eqalitarian was a learning challenge.

Understanding that becoming a skillful therapist is an endless and multifacted process was an invaluable discovery and imparted an awareness and drive for future work.

Recommendations

In view of the numerous factors affecting the well-being of newcomer families, there is certainly no simple procedure

which would promise success in the family therapy field. However, a number of conditions which may prompt family problems at each migratory stage could be reduced or eliminated by well placed and timed information, evaluation and intervention.

Providing that not all things can be prevented and families will from time to time fall into "traps" I would like to start with specific recommendations arising from this practicum and employed qualitative methodology. Subsequently, I will make other general recommendations from my experience and observations.

First, I have to acknowledge the applicability of Sandra Mondykowski's recommendations presented in the Literature Review (p. 16-19) whose ideas and suggestions seemed to match my family's needs and expectations. Yet I would like to add and stress the following recommendations:

1. The majority of my clients displayed strong cognitive needs to know and understand. For my families as well it was very important to provide insight into their behavior and explanations from a common sense knowledge base; and sometimes comparing them with other people in similar situations.
2. All kinds of mapping are recommended for their visual and cognitive benefits in the assessment, treatment and evaluation processes. A genogram is useful to gather family history and to learn how the family organizes around different issues and help the family cope with the present in more objective and

realistic ways. Circular Pattern Diagrams and Eco-maps are also of much help when dysfunctional family internal or external interactional patterns need to be addressed.

3. It is important to determine pre-immigration experiences and previous problem solving capabilities. On the basis of cultural differences, the therapist needs to negotiate what can be maintained and strengthened, and what will require adaptive behaviours on the part of the family.

4. When it is difficult to dialogue and examine the client's culture referring to universal values and beliefs is recommended. For instance, Christian values are easily understood by a majority of Eastern Europeans. I had an occasion to observe quick results in referring to the issue in question in terms of universal, human values while challenging their perhaps very different realities.

5. An ecological assessment with careful examination of needs and resources can help the family toward a mastery of the situation. It is very important to assist the newcomer family to negotiate the environment in accordance with the new role demands placed upon the family. The intervention should be creative and designed to be consonant with the family system and larger systems' present tolerance for change.

6. It is also a necessary task for the family therapist to assess newcomer family relationships to larger systems (Immigration, schools, welfare, hospitals, Immigrant service agencies, etc.) prior to intervention. Immigrant families and

public schools very often interact in a cycle of mutual blame, and as Imber Coppersmith (1982) presents it, contribute inadvertantly to a dysfunctional triad in which a child cannot be loyal to home without being disloyal to school and vice-versa.

7. When it is necessary to make referrals, clients ought to be taken and assisted through to other agencies or settings rather than merely being sent or asked to contact the settings on their own.

8. An important caution in working with political refugees is the necessity to be aware of the role that political orientation has in making a referral so as to avoid unnecessary clashes or indirect antagonisms between client and professional.

9. Easily available and ready access to services, with a built-in policy of follow-up interviews would be optimum for effectiveness and continuity.

10. Rigidly used family therapy approaches are not recommended in work with the newcomer family. The ecosystem perspective and a broad creative approach to crisis prevention and intervention are more useful and powerful tools in shaping environments and family systems.

11. Professionals that are affiliated with psychology, social work, medicine and psychiatry may utilize increased involvement of lay volunteers and nourish what is most vital in all social support strategies, their informality, mutuality, and reciprocity. This also means that immigrants need to be approached rather

than expected always to act on their own initiative. These helpers need to be alert to any symptoms of deeper rooted problems initially presented as instrumental or somatic in nature. Especially during the first migration stages more intensive empathizing and closeness as well as informal actions are required.

12. Wherever a larger immigrant community exists, its members should be actively encouraged and supported through the various levels of government to obtain training and to provide the social and mental health services to their respective communities. Professionals speaking the immigrant's language and/or having a migrant experience should be sought and engaged in the preventative/therapeutic process. Using an interpreter who is a non-professional adds a further complicating dimension to the communication process and is not a sufficient solution.

13. The final recommendation arising indirectly from this practicum involves a wide view and ecosystemic plan of what should be done in order to prevent and help on a continuum at various "stations" of the newcomer family's long journey. Ideally this plan should start before immigration at points of transit ie. the refugee camp by disseminating relevant, realistic and up-to-date information about the economic and socio-cultural conditions in the host country. Accurate information is particularly crucial at the point of entry into Canada. At this most needy and impressionable time a multilingual team of counsellors should be available to the immigrants.

These counsellors and the information material ought to be attuned to the needs of a number of ethnic and racial groups. An Ethnic-Sensitive Social Work Model (Devore & Schlesinger, 1981) could be of much help at all levels of social service delivery.

Additionally, environmentally oriented prevention and intervention could be directed toward strengthening or establsihing methods of social support. The community at large has to be prepared and educated in order to reduce undue mutual psychosocial discomfort as a consequence of acculturation. The school system, social, health, government institutions, churches, and the mass media may exert a positive influence in the long-term endeavour of fostering tolerance and familiarizing the local population in a constructive way with the various immigrant groups. All of this,would be desirable in order to cut down significantly on unnecessary human suffering and produce substantial benefits over the long run by accelerating the adjustment of newcomers.

APPENDIX I

E V A L U A T I O N

Q U E S T I O N N A I R E

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "X" – EWA

X pre-test O

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)	X			O	
2. Sharing feelings like anger, sadness, hurt, etc.	X			O	
3. Sharing problems with the family	X			O	
4. Making sensible rules	X			O	
5. Being able to discuss what is right and wrong.	X				O
6. Sharing of responsibilities	X	O separation he does not do anything			
7. Handling anger and frustration		X		O	
8. Dealing with matters concerning sex	X	O			
9. Proper use of alcohol, drugs		X			O
10. Use of discipline	X			O	
11. Use of physical force	X past			O	
12. The amount of independence you have in the family	X				O
13. Making contact with friends, relatives, church, etc.			X		O
14. Relationships between parents me + my husband	X			O	
15. Relationships between children one					
16. Relationships between parents and children	X			O	
17. Time family members spend together	X			O	
18. Situation at work or school			X	O	
19. Family finances		X	O		
20. Housing situation				X O	

21. Overall satisfaction with my family	X			O	

Make the last rating for yourself:

22. Feeling good about myself	X			O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "A" - MOTHER

V pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			V Sun	O	V
2. Sharing feelings like anger, sadness, hurt, etc. w/ my Son	V Son		O		V
3. Sharing problems with the family	V Son		O		V
4. Making sensible rules				V	O
5. Being able to discuss what is right and wrong.	V (Son)			O V	V
6. Sharing of responsibilities				O	
7. Handling anger and frustration	V (Son)		V O		
8. Dealing with matters concerning sex				O V	
9. Proper use of alcohol, drugs					V O
10. Use of discipline	V (Son)			O	V
11. Use of physical force					V O
12. The amount of independence you have in the family					V O
13. Making contact with friends, relatives, church, etc.				V	O
14. Relationships between parents Spouses			O 2		V
15. Relationships between children				V	O
16. Relationships between parents and children		V		O	
17. Time family members spend together					V O
18. Situation at work or school			V (Son)		V O
19. Family finances				V O	
20. Housing situation				V O	
21. Overall satisfaction with my family				V O	

Make the last rating for yourself:

			2 V		
22. Feeling good about myself				V O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "A" – FATHER

x pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family		X	O		
4. Making sensible rules			X	O	
5. Being able to discuss what is right and wrong.		X	O		
6. Sharing of responsibilities		X	O		
7. Handling anger and frustration			XO		
8. Dealing with matters concerning sex				XO	
9. Proper use of alcohol, drugs					XO
10. Use of discipline			X	O	
11. Use of physical force			XO		
12. The amount of independence you have in the family				XO	
13. Making contact with friends, relatives, church, etc.				X	O
14. Relationships between parents			O		X
15. Relationships between children				X	O
16. Relationships between parents and children		X		O	
17. Time family members spend together					XO
18. Situation at work or school		X		O	
19. Family finances				XO	
20. Housing situation				XO	
21. Overall satisfaction with my family				XO	

Make the last rating for yourself:

22. Feeling good about myself				XO	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "A" - ROB

X pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			X	O	
2. Sharing feelings like anger, sadness, hurt, etc.			X	O	
3. Sharing problems with the family				X	O
4. Making sensible rules			X	O	
5. Being able to discuss what is right and wrong.				X	O
6. Sharing of responsibilities				X	O
7. Handling anger and frustration	did not understand		X	O	
8. Dealing with matters concerning sex 2	X			O	
9. Proper use of alcohol, drugs				X	O
10. Use of discipline			X	O	
11. Use of physical force			X	O	
12. The amount of independence you have in the family				X	O
13. Making contact with friends, relatives, church, etc.					O X
14. Relationships between parents				X	O
15. Relationships between children			X		O
16. Relationships between parents and children				X	O
17. Time family members spend together				X	O
18. Situation at work or school			X	O	
19. Family finances				X O	
20. Housing situation		X		O	
21. Overall satisfaction with my family				X	O

Make the last rating for yourself:

22. Feeling good about myself				X O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "B" - MOTHER

x - pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				O	X
2. Sharing feelings like anger, sadness, hurt, etc.			O	X	
3. Sharing problems with the family				X O	
4. Making sensible rules				X	O
5. Being able to discuss what is right and wrong.			O	X	
6. Sharing of responsibilities				X	O
7. Handling anger and frustration				X O	
8. Dealing with matters concerning sex				X O	
9. Proper use of alcohol, drugs			X	O	
10. Use of discipline				X	O
11. Use of physical force				X O	
12. The amount of independence you have in the family				X O	
13. Making contact with friends, relatives, church, etc.				X	O
14. Relationships between parents				X	O
15. Relationships between children				X	O
16. Relationships between parents and children					X O
17. Time family members spend together			X	O	
18. Situation at work or school				X O	
19. Family finances				X O	
20. Housing situation				X O	
21. Overall satisfaction with my family				X	O

Make the last rating for yourself:

22. Feeling good about myself				X O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "B" - FATER

X pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					X O
2. Sharing feelings like anger, sadness, hurt, etc.					X O
3. Sharing problems with the family				X	O
4. Making sensible rules				X	O
5. Being able to discuss what is right and wrong.				X	O
6. Sharing of responsibilities				XO	
7. Handling anger and frustration				X	O
8. Dealing with matters concerning sex				X	O
9. Proper use of alcohol, drugs				XO	
10. Use of discipline				XO	
11. Use of physical force				XO	
12. The amount of independence you have in the family					XO
13. Making contact with friends, relatives, church, etc.					XO
14. Relationships between parents				X	O
15. Relationships between children					X O
16. Relationships between parents and children					X O
17. Time family members spend together			X	O	
18. Situation at work or school				XO	
19. Family finances				XO	
20. Housing situation				XO	
21. Overall satisfaction with my family					X O

Make the last rating for yourself:

22. Feeling good about myself					X O

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "C" - MOTHER

X pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)			X	O	
2. Sharing feelings like anger, sadness, hurt, etc.			X	O	
3. Sharing problems with the family		X		O	
4. Making sensible rules		X	O		
5. Being able to discuss what is right and wrong.			X	O	
6. Sharing of responsibilities				OX	
7. Handling anger and frustration			X	O	
8. Dealing with matters concerning sex			XO		
9. Proper use of alcohol, drugs				XO	
10. Use of discipline		X		O	
11. Use of physical force				OX	
12. The amount of independence you have in the family			X	O	
13. Making contact with friends, relatives, church, etc.			X	O	
14. Relationships between parents				XO	
15. Relationships between children				XO	
16. Relationships between parents and children				X	O
17. Time family members spend together		X			O
18. Situation at work or school			X	O	
19. Family finances			X	O	
20. Housing situation				XO	
21. Overall satisfaction with my family				X	O

Make the last rating for yourself:

22. Feeling good about myself				XO	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "C" - FATHER

X pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		X		O	
2. Sharing feelings like anger, sadness, hurt, etc.			X	O	
3. Sharing problems with the family			X	O	
4. Making sensible rules		X		O	
5. Being able to discuss what is right and wrong.			X O		
6. Sharing of responsibilities			X	O	
7. Handling anger and frustration			X O		
8. Dealing with matters concerning sex			X O		
9. Proper use of alcohol, drugs				O X	
10. Use of discipline		X		O	
11. Use of physical force					X O
12. The amount of independence you have in the family			X	O	
13. Making contact with friends, relatives, church, etc.			X		O
14. Relationships between parents				X O	
15. Relationships between children				X O	
16. Relationships between parents and children				X	O
17. Time family members spend together		X		O	
18. Situation at work or school		X		O	
19. Family finances		X	O		
20. Housing situation			X	O	
21. Overall satisfaction with my family				X	O

Make the last rating for yourself:

22. Feeling good about myself				X O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY 'C" - ALEX

X pre-test O post-test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X O	
2. Sharing feelings like anger, sadness, hurt, etc.			X	O	
3. Sharing problems with the family		X		O	
4. Making sensible rules (Not for my brother)		X		O	
5. Being able to discuss what is right and wrong.			X	O	
6. Sharing of responsibilities			X	O	
7. Handling anger and frustration			XO		
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline		X		O	
11. Use of physical force				XO	
12. The amount of independence you have in the family		X	O		
13. Making contact with friends, relatives, church, etc.			X	O	
14. Relationships between parents				X O	
15. Relationships between children			X	O	
16. Relationships between parents and children				X	O
17. Time family members spend together			X	O	
18. Situation at work or school			X O		
19. Family finances			X O		
20. Housing situation				X O	
21. Overall satisfaction with my family				X	O

Make the last rating for yourself:

22. Feeling good about myself				X	O

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "D" - GIGA Post-test taken over the telephone

(V) - pre-test (P) - post-test as moved part of follow-up

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		V		P	
2. Sharing feelings like anger, sadness, hurt, etc.	V			P	
3. Sharing problems with the family	V			P	
4. Making sensible rules			V		P
5. Being able to discuss what is right and wrong.		V			P
6. Sharing of responsibilities	V		P		
7. Handling anger and frustration		V		P	
8. Dealing with matters concerning sex	V			P	
9. Proper use of alcohol, drugs				V	P
10. Use of discipline			V	P	
11. Use of physical force	husband V			Kids V	generally P
12. The amount of independence you have in the family				V	P
13. Making contact with friends, relatives, church, etc.		V			P
14. Relationships between parents	V			P	
15. Relationships between children					V P
16. Relationships between parents and children		V		P	
17. Time family members spend together	V		P		
18. Situation at work or school				V P	
19. Family finances	V		P		
20. Housing situation		V		P	
21. Overall satisfaction with my family	V			P	

Make the last rating for yourself:

22. Feeling good about myself		V			P

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "E" – NINA

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)	X		O		
2. Sharing feelings like anger, sadness, hurt, etc.		X		O	
3. Sharing problems with the family	X		X	O	
4. Making sensible rules					O
5. Being able to discuss what is right and wrong.		X		O	
6. Sharing of responsibilities alone					
7. Handling anger and frustration		X		O	
8. Dealing with matters concerning sex			OX		
9. Proper use of alcohol, drugs					O X
10. Use of discipline				X	O
11. Use of physical force				O	
12. The amount of independence you have in the family			X	O	
13. Making contact with friends, relatives, church, etc.		X		O	
14. Relationships between parents single					
15. Relationships between children only child					
16. Relationships between parents and children					
17. Time family members spend together				X	O
18. Situation at work or school		X	O		
19. Family finances		X	O		
20. Housing situation				XO	
21. Overall satisfaction with my family		X		O	

Make the last rating for yourself:

22. Feeling good about myself		X		O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "G" - MARIA

X-pre test O post - test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X O	
2. Sharing feelings like anger, sadness, hurt, etc.				X O	
3. Sharing problems with the family			X	O	
4. Making sensible rules			X	O	
5. Being able to discuss what is right and wrong.				X O	
6. Sharing of responsibilities			X	O	
7. Handling anger and frustration				X O	
8. Dealing with matters concerning sex			XO		
9. Proper use of alcohol, drugs			X	O	
10. Use of discipline				X O	
11. Use of physical force				X O	
12. The amount of independence you have in the family			X	O	
13. Making contact with friends, relatives, church, etc.			X		O
14. Relationships between parents family in law	X			separated O	
15. Relationships between children no children					
16. Relationships between parents and children family in law & us		X		O	
17. Time family members spend together			X	O	
18. Situation at work or school				X O	
19. Family finances		X	O		
20. Housing situation	X			O	
21. Overall satisfaction with my family		in law X		my X O	

Make the last rating for yourself:

22. Feeling good about myself				X O	

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

FAMILY "6" - RICK

X - pre test O post - test

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)	X		O		
2. Sharing feelings like anger, sadness, hurt, etc.	X		O		
3. Sharing problems with the family			X	O	
4. Making sensible rules		X		O	
5. Being able to discuss what is right and wrong.	X				O
6. Sharing of responsibilities			X	O	
7. Handling anger and frustration	X		O		
8. Dealing with matters concerning sex				X	O
9. Proper use of alcohol, drugs				X O	
10. Use of discipline				X O	
11. Use of physical force				X O	
12. The amount of independence you have in the family		X			O
13. Making contact with friends, relatives, church, etc.	X			O	
14. Relationships between parents	X			X US	O general
15. Relationships between children					
16. Relationships between parents and children					
17. Time family members spend together		X			O
18. Situation at work or school	X			O	
19. Family finances	X		O		
20. Housing situation	X			O	
21. Overall satisfaction with my family		X	O →		O US

Make the last rating for yourself:

22. Feeling good about myself	X		O		

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