THE USE OF SYSTEMIC THERAPIES IN THE PRACTICE OF COMMUNITY MENTAL HEALTH

A PRACTICUM REPORT

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by

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ABSTRACT

The writer conducted a practicum in the practice of systemic therapy, conducted at the Portage Mental Health Unit. The practicum was carried out over a period of eight months, during which he was the primary therapist in eleven cases, and participated "behind the mirror" in another eight cases. Individuals, couples, and families were all seen in the course of the practicum, with a focus on conducting therapy in a systemic fashion. The practicum report examines a number of schools of systemic thought, and discussed some of the themes which he found helpful in practicing systemic therapy. Two family evaluation scales were used for comparative purposes in familiarizing the writer with their suitability as measures of outcome evaluation. A discussion of their use suggests that FAM III was the more flexible measure, and most useful clinically.

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CHAPTER I INTRODUCTION

INTRODUCTION

This practicum began as a practicum in family therapy. Arrangements were made to conduct the practicum at a community mental health unit who, unbeknownst to myself at the time, took the models of family therapy and "pushed them to the limit". Expecting to find myself working with families and doing family therapy with them, I suddenly found myself seeing individuals, couples and families. What I found perplexing was that I knew somehow that I was doing family therapy with all of them, which was more of a feeling than an intellectual revelation. After all, the books, tapes and everything else I knew intellectually about family therapy describes family interviews, structures, processes and techniques. They didn't talk about what to do with a thirty year old man who tries to commit suicide eight months after separating from his wife and child. They didn't provide an obvious framework on how to do family therapy with a fifty year old man living with a friend he had made in an in-patient alcohol treatment unit after losing his job, wife, and self-respect. Yet these were some of the kinds of cases that were coming for help, and with the input and guidance of my practicum committee and the mental health team, I worked with them in a certain way. Knowing what I do about traditional modes of individual therapy I knew I was doing something different.

At the simplest level, I suppose the core difference between individual therapy and what I was doing was the recognition that symptoms have a root in the individuals' emotional context. Family took on a wider meaning than I had thought previously. Family could mean mothers, fathers, brothers, sisters, husbands, wives, children, aunts,

uncles, friends and so forth, living or dead, as long as they continued to have emotional meaning in the client's life. Any changes which I hoped to help clients make had to take their emotional context into account.

The other thing which seemed important in what I was seeing differently was in what my goals as a therapist were. My conceptions of normal, healthy and ideal became secondary to the more key concept of change. Milton Erickson (Haley, 1985) talked about the notion of geometric progression. Erickson illustrates the principle with the example of someone who begins with a penny and doubles it every day for a month. By month's end individual's penny would have multiplied into over a million dollars. Unfortunately, therapy isn't always so incremental. However, accepting the notion of geometric change seemed more helpful than starting out with the goal of turning my clients into millionaires at the outset. Stretching the metaphor a little further, it also seemed to be more fruitful to try to build on the pennies they did have, their competencies, rather than the pennies they didn't have, their deficits.

What this has to do with introducing the text of this report is to put a slightly different "frame" around the material presented. That is, while family therapy writings are explicit in their treatment of doing family therapy with families, they are less explicit in how to deal with other significant influential emotional systems in the client's life. The family/systems literature provides a number of starting points to initiate change (the metaphorical penny), points from which to shift from an individual locus of intervention to a systemic

one. The literature review intentionally touches on a number of key concepts in the family/systems literature. The intent was to highlight what "bits and pieces" I felt helpful in practising systemic community mental health, whether it be with individuals, couples, or families.

The first chapter deals with the history and development of early systems thought. It was included to highlight the various systemic mechanisms which were historically proposed to account for the development of symptoms and system impediments to individual treatment. The next three sections deal with three different approaches to systems therapy, structural and strategic family therapy, as well as the ecological model which deals with larger ecological considerations outside of the family. Following that is a description of the family life cycle, involving the various developmental stages and transgenerational influences on family life. The various techniques employed in these approaches are then examined. The literature review section concludes with a discussion of some of the different themes which emerged as the most salient to myself in terms of practicing systemic community mental health.

The next section describes the practicum work which was undertaken. The setting, case load and evaluation instruments are discussed in chapter three. Chapter four features three of the cases which were seen. The chapter concludes with a comparative examination of the evaluation procedures and instruments. The final chapter is a discussion of the practicum experience itself, a personal reflection of what the student learned in the course of carrying out this practicum.

CHAPTER II THEORETICAL FRAMEWORK

HISTORICAL DEVELOPMENTS IN SYSTEMIC THOUGHT

There are a number of excellent accounts chronicalling the history, development and growth of various contextural oriented "schools" which dominate today's literature on systems theory (Foley, 1974; Hoffman, 1981; Okun & Rappaport, 1981). Contextural focus as referred to here relates to viewing pathology in terms of the relationship environment of the individual, where symptoms are viewed as an expression of system dysfunction rather than residing inside the psyche of the symptom bearer. As stated by Howells

> "In family psychiatry a family is not regarded merely as a background to be modified to help the present patient alone. Family psychiatry accepts the family itself as the patient, the presenting member being viewed as a sign of family psychopathology." (Howells 1971, p. 21)

Similarly, Hoffman (1981) refers to the contextual view of symptoms as expressions of larger system functioning. She states,

> "Mental illness has traditionally been thought of in linear terms, with historical, causal explanations for the distress...But if one [sees the troubled individual] with his or her family, in the context of current relationships, one [begins] to see something quite different. One [sees] communications and behaviors from everybody present, composing many circular loops that played back and forth with the behavior of the afflicted person only part of a larger recursive dance" (Hoffman 1981 p. 6-7)

The face of mental health practice has seen some radical changes in light of this shifting view of mental illness, from internal pathology to the relationship contexts which shape, promote, and maintain mental illness. Family therapy is viewed as more than a modality by which mental illness can be treated, but rather as a new epistomology which describes the dynamics of mental illness in a way which compells examination of the relationship between the individual and his/her environment. The following discussion briefly traces the historical developments which marked this shift. The importance of these historical developments lies in the way they illustrate the contextural locus of intervention and the underlying principles involved; adapting and evolving to integrate new evidence, methods, client populations, and problems. The changing ecological fabric, changes in the family unit and service delivery systems necessitate looking beyond current methods and thought in family therapy. Clinicians must look backwards as well, in understanding systemic precepts and adapting to the new challenges of mental health practice.

A number of independent research/practitioner groups began to form in the United States in the 1950's, a time which most writers account as seeing the family therapy movement begin to take shape. In the psychiatric community, a small core of practitioners were becoming increasingly frustrated with the regression of their clients upon release from treatment institutions -- feeling that the power of the family to undermine therapy could not continue to be ignored. As well, there was growing momentum in the psychoanalytic literature to suggest that the current social environment of the patient deserved greater attention. Writers like Adler (1952) and Sullivan (1953) were breaking

with the Freudian therapy focus on the transference relationship and abreacting unconscious family conflicts of the past. Rather, they were giving more attention to social psychological concepts, including social roles and interpersonal relationships. As well, biologist Ludwig Von Bertalanffys' application of General Systems Theory to problems in the field of psychiatry in 1945 offered an integrative framework on which to organize these radical new formulations. Von Bertalanffy's analysis provided unifying principles relating to the system properties of boundary permeability, feedback, homeostasis and non-summativity (the whole is greater than the sum of its parts) which laid the foundation for the early systems thinkers (Von Bertalanffy, 1968).

Expanding on these works and incorporating observations from their own practice, a number of schools of family therapy emerged. Among the influential thinkers in the field were: Theodore Lidz, Lyman Wynne, Murray Bowan, Nathan Ackerman, Salvador Minuchin and the Gregory Bateson group. Bateson's group included Jay Haley, Don Jackson, John Weakland and Virginia Satir. Their respective contributions to the field are discussed below.

Out of his work with psychotic patients Theodore Lidz (1960) became interested in what differentiated families with psychotic members from those with "normal" offspring. He and his group developed the concepts of role reciprocity, referring to the functionality of the role structure in the family. Dysfunctional families were more likely to have rigid inflexible roles in Lidz's view. This lack of role reciprocity in turn could be manifested in one of two types of "schizophrenic families", either schismic or skewed. Families with marital schism were characterized by chronic hostility and withdrawal,

with no common purpose or reciprocity. Marital skew on the other hand referred to an imbalanced marital subsystem, with one spouse clearly subservient to the other. The general theme of Lidz's formulation related to how the resulting identity confusion experienced by the child led to pathology.

The contribution of the Wynne group (Wynne, Ryckoff, Day, & Hirsch, 1958, Wynne & Singer, 1963) related primarily to the unreal quality of emotional communication in "schizophrenic families". In his formulations this unclear communication stemmed from the dysfunctional way in which the conflicts between the individuals' needs and the familys' needs as a whole were handled. He coined the terms "pseudo-mutuality" and "pseudo-hostility" to describe the unusual way in which family members interacted -- masking an underlying desire for extreme conformity or intimacy. Wynne used the term "rubber fence" to refer to the tendency of the family to exclude any communication from outside the family which might pose a threat to its structure. The general theme of Wynne's formulations was that psychiatric distrubances in these families was a result of confused and rigid role structures which hampered personal identity development.

Murray Bowen and his group (1960) shared Wynne's conception of differentiation between family members as the backbone of pathological family patterns. He also made significant contributions in his writings relating to the multigenerational transfer of mental illness. While the idea that mental illness could be passed on within the family was not a new one, mainstream thinking in the field was largely confined to genetic or biological transmission. Bowen proposed that families have emotional characteristics that are also passed along from generation to

generation. Perhaps one of his most significant contributions to the field was the concept of triangulation, whereby if two people cannot communicate effectively or resolve their conflicts with each other, a third individual is drawn into the conflict in order to stabilize the relationship of the other two. While contemporary writings have more elaborate use of the term and its implications, triangulation remains a major concept in family therapy.

Nathan Ackerman (1966) was another practitioner who was influential in the emerging family therapy field. Beginning in the 1930's he was among the first practitioners to make the connection between pathology and family functioning. By the 1950's Ackerman had incorporated seeing the patient's entire family as part of his private practice. Treating the entire family as the unit of analysis for assessment and intervention was one of his major conceptual contributions. Another dimension of Ackerman's contribution was not so much his theoretical formulation of family therapy, but rather, in his genius for doing it. He, along with a handful of other therapists are noted for their intuitive grasp of how to promote change in dysfunctional families, and left the legacy of training tapes and material for others to observe, disassemble, and build new models with.

Salvador Minuchin (1974) is best known for his work in the development of Structural Family Therapy. As it is discussed in detail later in this chapter its concepts and contributions to the understanding and practice of family therapy are not listed here. Minuchin's later works grew out of his work with E. H. Auserwald (Auserwald, 1968) at the Wiltwyck School in New York, developing alternative treatment strategies in working with delinquent youth in the

early 1960's. Their analysis of the relevant community institutions and fields which impact the family's functioning gave rise to subsequent inquiry of issues relevant to the family's ecology.

One of the most influential groups of those noted here includes the Bateson group, based in Palo Alto. His colleagues included Hay Haley, Don Jackson, John Weakland, and Virginia Satir. The Bateson group's contribution as a whole related to ther "microscopic" analysis of the "bits" of communication they noted in dysfunctional families. In their landmark paper, "Towards a theory of Schizophrennia" (Bateson, Jackson, Haley, and Weakland, 1956) they introduced the concept of the "double bind". The double bind concept grew out of the Bateson group's interest in multiple levels of communication, the actual verbal content and the non-verbal or meta-communicational message about the verbal message.

In the double bind, the individual receives a conflicting message by one or more other members, where the verbal message is in direct opposition to the non-verbal (command) message, what they termed paradoxical communication. They postulated that repeated exposure to such paradoxical communications, accompanied by a signal that attempts to escape would be punished, would result in the schizophrenic breakdown. While the theory is considered too simplistic today, its impact at the time was significant. As well, the theme of paradoxical communication formed the basis for subsequent works exploring the use of paradoxical communication as a theraputic tool to change the family's distorted communications (Haley, 1963; Selvini, Boscolo, Cecchin, & Prata, 1978).

The Bateson group has been referred to as communication purists (Foley, 1974) because of their focus on communication, as opposed to

family organization. In addition to their general contribution to the purist thinking on systems theory and communication, the members of the Bateson group all had significant contributions to the field in their own right.

Don Jackson (1968) was credited with some thoughtful expositions of the cognitive dimensions to family transactions, and more importantly, the notion of family homeostasis -- similar to Wynne's "rubber fence". Jackson advanced the idea that part of the problem in creating changes in a system related to the potential disruption it posed to the whole organization of the family. He asserted that the status and roles of all the members in the family could be threatened by changing the way families dealt with problems. His notion of homeostasis was likened to the workings of a thermostat. Families were set on certain ways of functioning which would vary within certain limits, just as a thermostat tolerates certain amounts of fluctuation within its range. He likened changing families toward healthier functioning to resetting the thermostat altogether, which would upset the homeostatis of the family and generate resistance. While new theories have superceded Jackson's, defining the nature of this resistance provided impetus to examine ways to help the family work through its resistance. Another significant feature of Jackson's contribution was his ability to unearth subtle conflicts in the marital unit, and reorganize the couple into healthier ways of relating.

Whereas Jackson was the more cognitive oriented of the group, Virginia Satir was the more feeling oriented (Foley, 1974). Satir (1964)) is best known for her dramatic style and genius in unravelling the deep communicational distortions these families exhibited, thereby

making the symptom-bearers' behavior seem a natural consequence of the way the family related. Her deftness in exposing communicational discrepancies was central to her ability to "pull the label off of the identified patient", as was her ability to help the family accept their differences.

The last member of the Palo Alto group to be discussed here is Jay (Haley, 1977). Haley's contributions extend far, and he is in fact a central figure in the development of today's strategic school of therapy. As the strategic school will be discussed in greater detail elsewhere, this discussion will include only the most basic elements of his contribution. Haley viewed families as having hierarchies in generational lines such as grandparents, parents, and children. He also views them as having power structures within each generation. When two members of one generation were unable to successfully resolve their conflicts, a third member would be drawn in to stabilize the conflict, a triad. If the third member of the triad was from another generation or level of hierarchy, he saw this as representing a violation of hierarchy which in turn eroded the "normal" balance of power in the family. Primarily, Haley's work as far back as the Palo Alto period centered on his exposition of themes of power and hierarchical organization (Haley, 1977). Haley's contribution to clarifying and changing family dynamics includes organizing these themes by mapping out the family's communicational sequences into interrelated triadic units, and intervening at the most strategic points for overall systems change.

STRUCTURAL FAMILY THERAPY

The structural model of family therapy has been most widely influenced by Salvador Minuchin (Minuchin, 1974; Minuchin, 1978). In the structural model the family is viewed as an interdependent organism consisting of larger systems and identifiable substructures which emerge in the "normal" course of development (Minuchin and Fishman, 1981). The family's overall function in the structural view is to provide a protective and nurturant environment in which individual and family needs are met. It also serves a "screening" role as to which societal values and behavior are incorporated into its functioning. In this latter function, the family unit as a whole can be viewed as an organism adapting to the larger societal system.

The central tenet on which structural therapy lies is in promoting healthy organization and interrelationship between the different subsystems in the family, appropriate to their respective developmental requirements, and to the emotional environment of the family as a whole. The general developmental tasks of the family environment as a whole change over time as the composition of the family changes, and these dictate what subsystems are required to maintain a balanced internal organization.

To introduce corrective changes to the family's organization, however, the therapist must have a model of "normal" functioning in order to establish helpful theraputic goods. The family life cycle, which will be discussed later in more detail, is an important context to consider in planning therapeutic interventions.

In order to relate normal family functioning to dysfunction and interventive techniques, one may draw on Gurman and Kniskern's (1981)

description of the "structural theory of family personality". They identify four related universal concepts in understanding family functioning: family structure, subsystems, boundaries, and adaptation to stress.

Family structure refers to the various transactions (verbal and non-verbal) which communicate complementary demands between family members. These transactions regulate the behavior of the family members, representing both the power hierarchy and the means by which mutual expectations are met. Family structure is the overall picture of how the different individuals and family subsystems fit together as a whole.

The second concept is that of subsystems. The functions and tasks of the subsystems in the different developmental stages are illustrated in greater detail in the discussion of family life cycle. The subsystems most frequently referred to in viewing families includes the parental subsystem, the marital subsystem and the sibling subsystems. The functions served by different subsystems in the family are different enough to merit being considered apart from the overall functioning of the family as a whole. For instance, sibling negotiation is distinctly different from negotiating marital conflicts. The primary importance in viewing development in subsystem terms lies in what it reveals in terms of differention and the division of labour. The subsystem is the primary unit of socialization for various tasks and developmental functions.

The third concept, and perhaps the most critical to the structural family therapist, is that of system boundaries. System boundaries define the rules as to who participates in what subsystems and

functions. Likewise, these rules regulate the flow of support or interference the subsystem exchanges with other family members. Using the example from above, the degree to which teenagers become involved in resolving parental conflicts would be a measure of the strength of the boundary around the parental subsystem. In a well-functioning unit the boundaries are clear and the lines of authority and responsibility are well-defined.

The varying degrees of flow are characterized by three types of boundaries: clear, rigid, and diffuse. Clear boundaries permit open communication while at the same time protecting members to fulfill their subsystem functions. Rigid boundaries constrict support and input, and are characterized by minimal interaction and nurturance. Individuals functioning in such a subsystem are usually isolated and overly autonomous. This is referred to as "disengaged". The last type of boundary is referred to as diffuse or blurred. Where boundaries are diffuse, the members are over-involved and overly dependent, with no clear lines of authority or responsibility. Communication and problem-solving are typically confused and disruptive under these conditions, and disruption in any one part of the system reverberates to all other parts. Minuchin (1974) calls this "enmeshed".

Summarizing the above, the family structure consists of the transactions in the system, which in turn is differentiated into subsystems organized around various tasks and functions. The ability of the subsystem in carrying out its functions are determined by "operating rules" or boundaries which regulate the transactional flow between subsystems and other family members. In healthy functioning families the boundaries are clear and fluid, permeable enough to allow necessary

input while providing protection from undue influence.

Gurman and Kniskern (1981) cite adaptation to stress as the fourth and final dimension of the structuralist view of family personality. They refer to four types of stresses which require family adaptation. These include: developmental, transgenerational, idiosyncratic, and external stresses.

When developmental stresses, such as teenage requests for greater autonomy are coupled with transgenerational stresses, the family as a whole may be taxed in its ability to adapt. For instance, parents who's own needs for adolescent autonomy were inadequately dealt with by their parents may have no experience or skills in balancing autonomy and control. Their difficulty in addressing these issues arising from their own family of origin (transgenerational stress) combined with the normal developmental requirements of their own adolescents, may generate substantial anxiety in the whole family. The family's response to the stress may vary from rigid adherence to its accustomed habitual patterns, to flexible negotiation and exploration of new responses, rules, and roles to accommodate the new requirements. Likewise, idiosyncratic stresses such as illness or job loss may require new and different behaviors on each of its members and the family as a whole to adapt in a healthy way. In the same way, accommodation to demands external to the family such as school and community may promote family growth. This growth or adaptation can be in terms of adapting to the actual stresses themselves, and at a deeper level, learning how to change its own power structure, rules, and roles about changing itself. Gurman and Kniskern (1981) state that the degree of flexibility the family demonstrates in its ability to adapt in such ways are a

significant characteristic of family personality.

The final section of the structural analysis relates to ways which the mass of transactional activity the family displays may best be organized to characterize the dysfunction. By organizing the data about the family in a meaningful way the structural therapist can formulate hypotheses, goals, and plan interventive strategies to reorganize the family to meet the structural goals. Gurman and Kniskern (1981) paint a descriptive portrait of family structure in terms of its global socializing functions. They relate internal differentiation and organization of the family to how it deals with historical, developmental, and external stresses. Aponte and Van Duesen (1981) present a framework with more of a transactional focus, with less emphasis on the global influences affecting the family. Their emphasis is on internal functioning as it relates to how the family deals with issues of conflict and power. Aponte and Van Duesen (1981) suggest that dysfunctional structural organization is best classified according to the structural dimension most closely related to the problem, whether it be boundaries, alignment, or power.

Boundaries, as already discussed, relate to the systems' rules as to the degree of interconnection between family members. In families characterized by enmeshment, there is little room for the socialization and/or functional requirements for individual growth to be met -- due to intrusion by other family members. Any deviation from the family "norm" is responded to with "excessive speed and intensity" (Okun & Rappaport, 1980, p. 142). In disengaged families, the nurturance and guidance functions required to promote healthy interpersonal functioning are lacking. In these families, there "tends to be no response, when a

response is necessary (Okun & Rappaport, 1980, p. 142).

Alignment refers to the "agreement" or "disagreement" between two or more members as to how some family "operation" or "rule" should be enacted. One form of alignment can be an alliance, in which two or more members share a common interest, with no necessary action against a third party. Coalitions on the other hand, imply joint action on a third party. These coalitions share several common forms in underfunctioning families -- including stable coalitions, detouring coalitions, and triangulation (Aponte & Van Duesen, 1981). Stable coalitions refer to rigid, fixed coalitions where two or more members consistently side with each other against another, regardless of the issues or operations at hand. Detouring coalitions are a variation of stable coalition, whereby one member is consistently scapegoated in order to diffuse the stress between other members. Triangulation refers to conflict resolution via a third party being drawn into a conflict between two members or groups, providing support or serving as a buffer for the conflict.

In viewing the family in light of power dynamics, the central question is who has the influence to define the rules of relationships and transactions in various family systems and "operations". Dysfunctional families frequently exhibit imbalanced power relationships in the marital unit, or weak executive functioning (parental subsystem). Another common dynamic is inappropriate influence or intrusion (power) of extended family into the parental functions -- undermining or supplanting the authority of one or both parents.

Having discussed the structural formulation of normal family structure, development, and an organizing scheme for viewing

dysfunction, the discussion now turns to Strategic Therapy.

STRATEGIC THERAPY

The strategic school of therapy and its theorists (Haley, 1977; Madanes, 1981) choose as their focus the transactional patterns which contribute to dysfunction. As opposed to spatial arrangement, the strategic therapist attempts to change the temporal sequences in which the family is "stuck". In short, the locus of intervention is on the patterns of interaction, rather than the structure in which those patterns are embeded. While there is overlap between the structural and strategic orientations, as highlighted by Hoffman (1981), and Stanton (1981), they represent two relatively distinct theoretical bodies of literature.

Borne out of Bateson's communications oriented group, the strategic therapists concern is with self-reinforcing communication sequences which serve to maintain symptoms (Weakland, Risch, Watzlawick, & Bodin, 1974). Like the structuralists, they view symptoms as maintained by the same behavior which is meant to solve them. They view the goal of therapy as solving the problems which the client(s) request help for -- and only those problems. They suggest that because symptoms serve to stabilize system dysfunction, removal of the symptom should force system reorganization. As a result, they are disinterested in structure. In fact, the term "strategic" was coined by Haley, alluding to the strategic way in which interventions are designed to fit the problem.

Owing to their communicational orientation the strategic therapists attend to behavioral sequences very closely, with particular emphasis on the process (non-verbal/metacommunicational) aspects of the communications between members. One such emphasis is on how the sequences of behavior or communication are "punctuated", determining the

weight given to different content issues and the family's reality (Jackson, 1968). Haley emphasizes the power aspect of these communications, how people in a relationship struggle to define the relationship and the power to determine who defines it. In the words of Foley, the therapist

> "is interested in the rules of the system, that is those thoughts, feelings, and behaviors that are not acceptable in a particular family. The therapist must ferret out those rules, and depending on his approach to theraputic change, either overtly or covertly, move the family towards new and less painful ways of relating". (Foley, 1974) p. 158.

Of particular interest to the strategic therapist is the relationship between the symptom(s) and the communicational "maneuvers" which people engage in to control the relationship, which may include symptomatic behavior. Based on the early notions of double-bind, the strategic therapists have amplified on the effects of such paradoxical communication, out of which many variations of therapeutic constructs have been generated. These include notions of symptom maintenance, dyadic and triadic relationships, the therapeutic relationship, and strategies for intervention.

Madanes (1981) views symptomatic behavior as a way of dealing with dominance to equalize a power imbalance created by two incompatible power structures. Madames refers to "hierarchial incongruity" when discussing power imbalances. In her conception of distressed marital couples, she suggests that the symptomatic person can be in an inferior position to the other spouse, who then can become involved in trying to help him/her. This can reverse the power balance, putting the symptomatic spouse in the superior position by virtue of his/her "maneuvers" which may defeat the other spouse's attempt to solve the

problem.

Haley (1977) and Madanes (1981) take the notion of heirarchy and paradoxical communicatation one step further in the extension of their analysis of triadic interaction. They view conflicting communications from two members on one level of hierarchy directed towards a third party on another level as form of double bind. In distressed families these coalitions across hierarchical or generation lines are intense and repetitive. Haley has called this form of dysfunctional triad the "perverse triangle". In dealing with larger systems Haley uses triadic interaction as his organizing principle, viewing family/system interaction sequences as a series of interrelated triadic interactions. Regardless of system size, dysfunction is viewed as a means of equalizing a power imbalance in some higher level of hierarchy. Due to their inclusion of heirarchical lines in viewing communicational sequences, Hoffman (1981) has suggested that Haley and Madanes bridge the gap between the "communication purists" of the strategic school and structural family therapists. Nonetheless, they are considered representative of the strategic school by many writers (Stanton, 1981).

The focus of the client-therapist relationship in strategic therapy is quite simply, change. Clients come to therapy with problems which the therapist clarifies into very concrete targets for change. The therapist formulates directives which are assigned as "take-home" tasks which the client is to undertake, with the goal of changing the behavior specified as the presenting problem. In the case of family systems, task design requires that the therapist incorporate the family sequence around the problem into the design of the task, attempting to change both at the same time.

Given the relative simplicity of the strategic school in its problem focus and emphasis on change, the means by which the therapist enacts the change is perhaps the most complex element of strategic intervention. While the client(s) may follow the task in a straight forward way, the strategic therapist carefully monitors resistance to both the task and the therapist, being attentive to the process/control maneuveres which impede change. Haley is perhaps the best known of the strategic school in describing resistance based techniques, borrowing from his process observations of the therapy of Milton Erickson (Haley, 1973). The primary feature of these writings were the reliance on paradoxical techniques. In Erickson's hypnotherapy the therapist encourages resistance, thereby obliging the system to change by resisting his/her directives not to change.

For the most part, the strategic school is atheoretical in its approach, anchoring its methodology in the straight forward concept of change, and utilizing the client(s) resistance as leverage to create change. The hypothesis/intervention design process includes many other factors, relating to what problem(s) the particular symptom represents -- its metaphoric meaning. As well, much attention is paid to how family members relate, so that the therapist can "frame" his interventions in ways which seem reasonable to the family.

As indicated by Hoffman (1981), the strategic model is a very parsimonious one in its precepts, which understates the artistry and complexity of its application. As well, the therapy process involves much more than an all encompassing paradoxical directive, but rather, involves a progression of strategic changes. The therapist attempts to replace one form of abnormality with another in a series of changes such

that ultimately the symptom is no longer needed.

THE ECOLOGICAL MODEL

In the same way that systems therapists view individual symptoms as being interconnected to the relationship context of the family, the ecological view posits that family functioning or dysfunction holds a similar connection to the larger cultural/social context to which it must adapt. Minuchin (1974) writes of the socializing function of the family unit in assimilating the behavior, norms, and values of the larger culture, adapting them to its own functioning. The boundary between family and society is the focus of ecological theory, viewing the structural relationships and operations of social, political, and economic contexts as having a significant impact on family organization and functioning.

Holihan, Wilcox, Spearly and Cambell (1977) make the distinction between envirnomental and transactional applications of ecological theory to mental health practice. Likewise, in examining ethnicity and ecology Spiegel (1982) speaks of six foci which comprise the transactional field; universe, soma, psyche, group, society and culture. Essentially, these writers address the person-in-family-in-environment fit, providing a framework of analysis of problems which suggests a number of points and systems where intervention may be made. In the words of Foley (1974)

> "What an ecological perspective gives is a more complete picture... Within a framework of a system concept, it looks at the various systems and subsystems involved to get a total picture of what is happening. It then focuses precisely on the interfaces between these systems in an attempt to produce change. It takes account of the multiplicity of data without emphasizing one aspect at the expense of another". p.179

The following discussion moves in a progression from the smallest unit of intervention, the individual, through to larger system influences and

contexts. Issues relating to larger system functioning include economic considerations, social organizations, helping systems, and mental health delivery systems themselves.

In their discussion on the transactional applications of ecological models to mental health, Holihan et al. (1977) address the issue of working with individuals from an ecological view. In addition to consideration of the different systems which impact the individuals functioning, they make the shift from the traditional focus on individual pathology to viewing adjustment in terms of the individual's transactions in his/her relationship contexts, focussing on relational competancies. That is, rather than viewing individual pathology and moving outward to external systems, the therapist assesses the social environment and moves inwards. In support at their contention regarding the importance of the individual's relational contexts, Holihan et al. (1977) cite evidence that psychiatric reactions to life stresses are very significantly modified by the social supports one has.

It appears that social factors not only play an important role in the individual's reaction to life events, but the involvement of natural supports in response to crisis reactions as well (Langsley and Kaplan, 1964). In a controlled study, they examined the differences in rates of recidivism between individuals who were hospitalized during crisis as opposed to being seen by a Family Treatment unit, who worked with the client and his/her family on a brief outpatient basis. Engaging family resources and blocking external pressures which might exacerbate the crisis, the team worked with the goal of restoring the individual to pre-crises levels of functioning. By de-emphasizing pathological processes and engaging natural supports, the brief family crises

approach dramatically reduced both recidivism rates and the length of time to return to "normal" functioning.

In addition to engaging family supports in dealing with symptomatic behavior, Erickson, Rachlis and Tobin (1974) define four modes of network intervention, geared to mobilizing and organizing community supports. Included in their discussion are: network as resource grouping, network as curative grouping, network as interpreter of help seeking behavior and networking as mitigator of multiple agency involvement. By engaging informal social supports the family may be better able to organize its internal functioning and adapt to the larger economic and community context. This is the next area of discussion.

Aponte (1976) and Auserwald (1968) are perhaps the best known of the ecological theorists in their treatment of ecomonic context as they affect family functioning.

Aponte (1976) states that the conditions of poverty serve to distance the family from other units in their ecology which could help them achieve greater self-determination. Having less access to external support, the family turns inward to "pool its resources", resulting in poor differentiation and underorganization. Compounding the problem may be a corresponding underorganization in the social institutions, such as schools, in dealing with the problems which arise. Likewise, if the social agencies and helpers fail to act in concert with one another they can further perpetuate or intensify the problems (Hoffman & Long 1969). Social organizations such as welfare, school, mental health, child welfare and the medical profession can increase the family's sense of helplessness if they fail to consider the whole picture of their involvement with the family, and are not consistent in their goals for

the family.

Both Aponte and Auserwald advocated greater integration of services in order to help. Their use of team conferences including all involved helpers and the family was one means of assessing and intervening into the entire contextural field. Auserwald (1968) further advocated for a contextural view in the philosophy of helping services, attacking the idea of interdisciplinary teams in favour of "holistic" health professionals who would take a total systems view of the problems.

FAMILY LIFE CYCLE

Minuchin and Fishman (1981) describe four significant transitional stages in the family life cycle, each with their own attendant tasks and structures. The first of these is the couple formation stage, where the couple develops rules about the nature of their relationship to each other (reciprocal or dominant-submissive), establish patterns of division of labour, means of resolving conflict, negotiate mutual values and expectations, and deal with their new couple identity in relation to friends and extended family. This "spouse subsystem" evolves over time but remains as the subsystem in which the needs of the marital or couple relationship are dealt with. Proponents of both structural and strategic schools frequently point to unsatisfactory couple functioning as the "root" of the dysfunction which reverberate to other parts of the family system (Jackson, 1968; Minuchin, 1978; Satir, 1964).

The next stage of development occurs when the couple has children, the "family with young children". The spouse subsystem remains, but is reorganized and a new subsystem developes - the "parental subsystem". New parent-child relationships are formed, with each spouse having an individual relationship with each child. As well, the parents as a unit represent a relationship to all the children. The boundary around the parents signifies a generational line or separation, and serves functions relating to socialization, guidance, and control. It is at this interface that the child learns how to deal with authority, responsibility, and ways to communicate with such figures. In addition to the parental role, the couple must negotiate with their own parents regarding the grandparents roles.

The children themselves form another subsystem, the sibling

subsystem. The functions met within this subsystem relates to peer socialization, learning to interact with equals in play, conflict, emotional support and so forth. Parental guidance and control is balanced against the child's needs for personal learning and identity, in terms of extrafamilial contacts as well as the sibling subsystem.

The next stage is the "family with school age or adolescent children". With age comes increasing need for autonomy, and the increasing competence on the child's part in his/her attempts to negotiate new rules and force greater accommodation from the family. The peer group becomes strong competition for the family's influence and parental authority. This can be an intensely stressful stage, where parents balance control against autonomy, and make the adjustments required to launch the child into the world as an adult in his/her own right. Haley's (1980) "Leaving Home" is perhaps the most detailed exposition of working with families experiencing difficulties launching their young adults.

The last stage in Minuchin and Fishman's (1981) developmental model is the "family with grown children". Having launched the children, the couple is once again alone. The spouses now shift generational roles and family roles, redirecting their energy to each other, outside interests, developing their adult-adult relationships with offspring, and grandparenting roles in the event of grandchildren. In later life the couple also deals with issues of loss of spouse, physical decline, life review, and preparation for their own eventual death.

McGoldrick and Carter (1980) conceptualize the family life cycle slightly differently than Minuchin and Fishman (1981). They view adolescence as distinct from disengaging from the family, toward

independent adult functioning. They call this the "unattached young adult" stage. The individual's main tasks in this stage relate to differentiating him/herself from the family of origin, involving the separation from parents and a "mutually respectful" shift to adult-to-adult relating. That is, rather than being subordinate as in adolescence, the young adult learns to deal with his/her parents as an adult in his/her own right. If done in a healthy fashion the young adult is free to form his/her own adult identity, with his/her own goals, values, friends, and working life. If not, the young adult remains emotionally triangulated and carries this into his/her own married or family life (Bowen, 1978).

McGoldrick and Carter (1980) take their analysis one step further by stating that the family's propensity for dysfunction can be viewed as falling along a vertical and horizontal axis. The horizontal axis reflects the "normal" developmental stresses to the family. The vertical axis represents transgenerational stresses arising from inadequate differentiation as discussed above. They further state that when horizontal (developmental) stresses intersect with vertical (transgenerational) stresses, the levels of anxiety in the family take a "quantum leap". When this occurs the family is at risk of developing dysfunctional coping responses, unable to perform the "normal" developmental tasks and progress in the "usual" sequence.

When the family's developmental blockage is severe enough, some member of the family may adopt the sick role as part of the maladaptive solution. If these patterns become crystallized, the homeostasis regulating the interrelationships between family members and the system-subsystem structure may become "stuck". Likewise, the identified

patient may be relegated to maintain the "sick role" until the system alters its course.

INTERVENTION TECHNIQUES

Having discussed the theoretical basis of Structural, Strategic and Ecological models, examination of their interventive techniques will now be made. As Ecological models are oriented to larger system issues beyond the family boundary rather than as a set of methods for dealing with internal family functioning, they are not included in the interventions discussion which follows. The contribution of ecological theory to systems therapy lies mainly in the identification of ways in which social setting affects the internal functioning of the family.

The commonalities between structural and strategic approaches are many, which at times obscures the differences. In many ways their differences in techniques relate to the degree of emphasis which they place on the methods they use, and the language which they use to describe them. In order to provide some clarity, their basic differences in theoretical grounding and goals of therapy will be highlighted and then related to the means which they employ to meet their respective ends. As will be seen, many of the underlying principles and approaches are similar. As structural family therapy is more elaborate in its theoretical grounding, it is also more extensive and explicit in its description of techniques.

As suggested above, there is a difference in emphasis between how the structural and strategic models view problems and approach change. Likewise, their goals differ. In the structural view, family structure and organization create and maintain symptoms. In the strategic view symptoms are communicative acts, maintained by or locked into repetitive transactional/communicative sequences. Hence, the form of intervention for the structuralists is on altering boundaries, whereas strategic

therapists emphasize intervention into communication processes. The goal of structural therapy is the reorganization of the family to a healthier structure, in order that symptomatic behavior no longer expresses its deficiencies. Strategic therapy has symptom removal as its goal, assuming that once the symptom is removed the communicational distortions around the symptom will right themselves.

As is evident from the above, strategic therapy maintains a simple approach to problems in regard to its theoretical base, and how it views problems, intervention and goals. Likewise, its intervention methods are loosely defined relative to structural methods. Primary methods of change in the strategic school relate to reframing of symptoms and transactions around symptoms, paradox and task assignment. These are common to structural interventions also, but as stated previously, there is a difference in terms of emphasis of the techniques and the specificity with which they are used. Structural therapists tend toward utilizing these techniques in a way specific to achieving a change in system structure and boundaries.

In the words of Minuchin,

> "patients move for three reasons. First, they are challenged in their perception of reality. Second, they are given alternative possibilities and make sense to them. And third, once they have tried out the alternative transactional patterns,new relationships appear that are self-reinforcing." (Minuchin, 1974, p. 119).

In keeping with their epistomology, Minuchin and Fishman (1981) suggest there are three general classes of intervention in structural therapy. These relate to challenging the symptom, challenging the system, and challenging the family reality. These "challenges" are typically non-confrontational ones, applied in an atmosphere of support

and validation. The therapist may present the challenge in a straight-forward or direct way, making his observation explicit to the family. Alternatively, the therapist may offer the challenge in an indirect or implicit fashion.

Challenges to the symptom involve linking the symptom to the transactional solutions with which the family has tried to solve the problem, which in turn "hang" on the family structure. The goal of the associated techniques is to redefine the family's view of the problem and having done that, to move the family toward alternative cognitive, behavioral, and affective responses. Techniques which relate to symptom challenges are enactment, symptom focusing, raising the intensity and reframing.

In challenging the family structure the therapist works toward reshaping the structure of the family by changing the distance between different family members and holons, toward more "normal" developmental and functional organization. As well, the therapist attempts to realign the family such that coalitions and inappropriate conflict management methods are no longer required to maintain the "disturbed" balance. Typical restructuring techniques include boundary marking, unbalancing, teaching complementarity, and highlighting the individual's membership in various holons. Differentiation of this sort can be in the form of focusing on the experience of being in a holon, and changing the different members self definition from undefined family participation to one specific to his/her holon.

The last class of interventions relates to challenging the family reality. Families construct realities about values, behavior, problems, and how to deal with those problems. As the family's unhelpful solution

to their problem is created and/or maintained by the reality they have constructed, the therapist may challenge that reality. Using a technique called reframing, the therapist attempts to establish a new therapeutic reality for the family, one which generates alternative meaning for the thoughts, feelings, behaviors and transactions in the family. In the most general sense, reframing involves redefining the dynamics and events in the family, altering the subjective meaning of different experiences, and allowing for the exploration of alternative ways of dealing with its problems. At times these redefinitions may involve straightforward exploration, education, or guidance. Examples would include families who have inadequate knowledge or skills to deal with new developmental demands. Alternatively, reframing may be employed to introduce a therapeutically strategic reality, such as in the case of providing a rationale for a paradoxical intervention.

Structural therapies focus on getting the family to interact in ways that mirror its natural way of functioning. The therapist then alters the ways it relates, with the intent of creating changes which will generalize to its ways of functioning outside of the session. Aponte and Van Duesen (1981) view this process as a progression in transactional terms, with each stage having its own set of interventions. Their "stages" of therapy include the creation of a transaction, then joining with the transaction and finally, restructuring the transaction. This is viewed as a repetitive cycle in this writer's analysis, as the therapist unravels the family matrix, its rules, roles, and structures, and takes system change to increasing depth.

In terms of technique, another repetitive sequence within this

cycle is that of joining and accommodation (Gurman and Kniskern, 1981). In joining, the therapist relates to family members in a purposeful way. The therapist joins the system as its leader, creating an atmosphere of security and helpful support. In accommodation, the therapist attempts to adopt the family's style, to blend in. Once joined to the system the therapist engages a number of techniques to bring about change. These include: actualizing transactions, utilizing symptoms, escalating stress, marking boundaries, paradox and task assignment (Gurman and Kniskern, 1981). Reframing, which can be employed with any of these, has been discussed elsewhere.

Actualizing transactions, or enactment, refers to getting the family to engage in its usual ways of relating. Open ended questions or probes may be asked in order to elicit information about the family's patterns of interaction. Through careful attention to the nuances of who answers what kinds of questions, how family members relate to each other, and what kinds of perceptions family members hold toward each other about different areas of family life, the therapist is provided a "window" into the family's functioning. Through identifying typical transactions and patterns the therapist can generate hypotheses about the family's structure. In turn, this is helpful in generating hypotheses about how the symptom relates to the family's structure .

In utilizing the symptom, the therapist attempts to reduce the secondary gain of the symptom. That is, the positive functions which the symptom(s) serve for the different members of the family are diminished. For example, if a child's symptomatic behavior is observed to bring the parents closer together, the symptom's positive function or secondary gain is as an indirect means of distance regulation. In such

an instance the therapist may intervene into the distance regulation mechanisms of the family through the symptoms themselves. By changing the meaning of the symptoms or changing the family's behavior around the symptoms they no longer serve their original purpose.

One method of utilizing symptoms is symptom exaggeration or prescription. By encouraging the symptom the therapist increases the dimensions of the symptom beyond the point that it can serve its purpose (Aponte and Van Duesen, 1981). For instance, if a child's bedwetting elicits parental concern and unity, a lengthy ritual in the middle of the night may provide the parents with an incentive to develope alternative means to demonstrate their caring. Another means to utilizing the symptom involves de-emphasizing the symptom. By de-emphasizing the symptom the therapist attempts to reduce the emotionality which the symptom serves to concentrate. Using the example of bedwetting, the therapist might propose that it is not important, that often several nights of lying in a wet bed will deter that behavior. As the parents' concern for the child's comfort may have inadvertantly reinforced that behavior, the aim of such an intervention is to decrease the unintended reinforcement value of such responses to the symptom.

Whether the therapist chooses to employ symptom prescription or de-emphasizing symptoms as a means to bring about change, the intended result is to diminish the value of the symptom to serve some other purpose in the system. Other means by which symptoms can be utilized are essentially reframing techniques, redefining the interpretation that the family has of the symptom. This is done in order to open new structural pathways or modify the affective meaning that it has held for

everyone experiencing it.

It should be noted that structuralists employ symptom utilization techniques as a means to bring about structural modifications to the family. This is in contrast to the strategic therapists use of such techniques. Strategic therapists utilize symptoms with greater latitude, applying the technique with individuals, in interpersonal relations, and in the family context. As well, it should be noted that while structuralists use such techniques, they are much more central to strategic interventions - where task assignment and extra-session change are emphasized over in-session interaction and restructuring of the family.

Whereas symptom utilization is more a hallmark of strategic therapy, escalating stress is a structural family therapy technique which is employed to promote in-session change of the family (Gurman and Kniskern, 1981). Also referred to as "raising the intensity", the rationale for utilizing these techniques is that troubled families frequently have developed ineffective or inappropriate ways of reducing stress. By raising the intensity, the therapist moves the family beyond its usual coping strategies, to "try on" ways of accomplishing healthy resolution. The therapist may raise the intensity by emphasizing differences between members, draw out implicit conflicts which are usually denied, or block transactions so that several members are isolated from conflict -- diffusing interference from other members. Regardless of the techniques employed, the general theme of stress escalation techniques is to raise the tension in the family so that they are more receptive to accepting restructuring techniques -- as new ways of reducing the stress.

Marking boundaries is another type of structural therapy intervention, geared toward altering the permeability of boundaries around the system and its subsystems. The therapist brings about structural modification by helping the family to establish new rules which are in line with personal growth and autonomy. To that end, the therapist may block the usual transactional patterns to highlight existing subsystems, or construct new subsystems (Aponte and Van Duesen, 1981). Blocking the usual transactional patterns involves identifying repetitive patterns which the family engages in which impede subsystem functioning, and blocking them. The therapist may, for example, prevent an overinvolved mother from interfering in a conflict between two adolescents, thereby marking a boundary around the sibling subsystem to perform its peer negotiating functions. The therapist may also construct new subsystems, providing instruction and guidance as to the specific functions of different subsystems, defining the appropriate composition of the subsystem's participants in carrying out their "normal" socialization and/or nurturing functions. Alternatively, where there is some appropriate subsystem differentiation, but the boundaries are too underdeveloped to protect against inappropriate external interference, the therapist may reinforce or highlight the "healthy" patterns (Aponte and Van Duesen, 1981).

The structural view of paradox may be best represented by Papp (1981). It involves relating the symptom to the regulation of the family through a series of redefinitions, such that any change in the symptom will result in changes in other parts of the system - affecting everyone in ways which they may not want. By doing so, the family's resistance to changing its rules of self-regulation is bypassed, as the

family is "confronted" with the "choice" of changing its current means of regulation and protection, or the symptom. Given that the relationship between the symptom and the regulating mechanisms are thus "exposed", the family finds it increasingly difficult to "use" the symptom for regulation. Structural therapists utilize such descriptive paradoxical techniques when straightforward restructuring techniques meet with resistance. The strategic approach on the other hand is more elaborate in its treatment of paradoxical techniques, and uses them much more extensively.

In considering the strategic schools' approach to paradox, it is important to note the strategic conception of symptoms, relating to how the problem is maintained by the very behavior which is meant to solve it, in a self-reinforcing sequence. The strategic therapist attempts to create a series of changes within the system, successively replacing one form of unhealthy solution with a less unhealthy one until the symptoms are no longer part of the dysfunctional sequence. In some instances, the strategic approach suggests that the therapist encourage resistance, obliging the system to change by resisting the injunction not to change.

Several paradoxical techniques commonly cited by the strategic school include restraint from change techniques, symptom prescription, and prescribing relapses. In restraint from change directives the therapist takes a strong therapeutic position in constantly challenging the family's wish to change, claiming minimal powers to help. Resisting the therapeutic position that little can be done and that change is not desirable, the family alters its course. In symptom prescription, the therapist legitimizes the symptom by emphasizing the positive aspects of the symptom, reframing it from negative to positive. Having done that,

the therapist essentially encourages the system to do what it is already doing. By changing the symptomatic behavior from an involuntary part of a larger dysfunctional sequence to behavior which is under the systems voluntary control, the meaning of the symptom changes (Haley, 1985). The final paradoxical technique discussed here is prescribing a relapse. In relapse prescriptions the therapist disclaims responsibility for the positive changes made, predicting a return to previous modes of functioning. In order that the systems competency is preserved against the therapist's dire predictions, the system maintains its positive changes.

The first step in using paradoxical interventions is to carefully define the symptomatic behavior in question. Next, the therapist redefines or reframes the symptoms. In doing so the symptoms change from being involuntary acts to voluntary, which are deliberate acts. As voluntary acts are more understandable to the family than involuntary acts, the anxiety generated by the previously mysterious symptom may be reduced. In turn, the uncertainty which the family may feel about its own ability to deal with the symptom effectively may be enhanced. In addition to redefining the symptom, the therapist typically reinforces that definition with a rationale as to why the symptom should continue, in order that the paradoxical prescription seems reasonable to the family.

Paradoxical techniques such as restraint or relapse predictions may be introduced in a vague or open-ended way, or may be part of a specific assignment as is more often the case in symptom prescription. As with paradox, the next set of interventions discussed, task assignment, is more of a strategic based method than structural.

In the structural model, task assignment is employed for several reasons. First, the family's response to the task can offer much information to the therapist in terms of the family's functioning; its resourcefulness, competencies, degree of flexibility, secondary structures and so forth, which is useful in identifying potential points of resistance. Secondly, if in-session resistance runs high, the structural therapist may assign tasks in order to bring about extra-session change. The above holds true in the strategic approach as well.

Strategic writers point as well to the basic notion of assigning tasks simply to get people to behave differently, setting a tone for therapy as being a process of active behavior change. With each change, the client-therapist relationship is intensified. Haley (1976) points to two types of directives, the first being in the form of direct advice and straightforward tasks. The second type, paradoxical directives, involves encouraging resistance within this context of change. Taking the view that the family is stabilized around one member's being the problem, any significant change in behavior is viewed as a way of creating instability. This instability may then be utilized to restructure the communicational/meta-communicational sequences in the family. In short, task assignment may serve as a vehicle for setting an active tone for therapy and as a vehicle to constructively utilize resistance which may be created by the changes which the therapist attempts to introduce.

In Stanton's (1981) analysis, the structural and strategic modalities can be used interchangeably, with the degree of "resistance" the family exhibits being the deciding factor. When the therapist is

unable to change family functioning via the structural mode, he suggests the therapist use strategic methods -- focusing on paradox and extra-session change. The rationale for this is in the greater attention strategic therapists pay to dealing with resistance and the power of strategic techniques to circumvent it. He also suggests that the structural approach be adopted in other circumstances, as structural techniques are more straightforward and less "volatile" than strategic ones.

In comparing the structural and strategic approaches, (Hoffman, 1981) suggests that their differences in approach are real, but not without concurrence. In discussing the practice of structural and strategic therapies, she concludes that strategic therapists

> "can well say that they do not have to bother with the structure of the family -- they know it by heart. In the same way, the structural therapist can elect to ignore the particularities of the symptom on the behaviour sustaining it; he knows very well how to recognize a symptomatic cycle and to break it. [likewise]...if the structuralists need to admit their knowledge of process, the strategists need to admit to their knowledge of form" (Hoffman, 1981, p. 278).

THEMES IN THE SYSTEMIC PRACTICE OF MENTAL HEALTH

What follows is an application of the systems literature to the provision of community mental health services, with particular reference to direct clinical services. The author has attempted to highlight those themes which pertain to systemic intervention, regardless of whether the locus of intervention is tied to in-session or extra-session change, or regardless of whether the family is available to actively participate in therapy. The primary focus then, is on applying systems models in a "safety net" service such as community mental health. By this it is meant that unlike services such as Child and Family Services or family therapy centres where the need for family involvement is readily apparent, community mental health centres receive a great variety of referrals. Likewise, the connection between the symptoms and the family may not be as obvious to the client, family, or referring agent, as is the case with problems such as child behavior problems, for instance. Finally, there might not be any family or spouse, and if there is, they may not be willing to actively participate in therapy.

It is for those types of situations that the principles and techniques which are employed need to be flexible to the constraints posed against engaging in the classical conception of family therapy. What follows is an attempt to identify some of those features which distinguish systemic therapies from traditional models of individual therapy, whatever the nature of the problem and whatever the nature of system the therapist has available to work with.

In applying systems therapy to mental health practice, a number of relevant themes emerge. Regardless of the type of problem or referral, scope of assessment and intervention can be greatly enhanced by

consideration of the emotional field in which the symptom bearer resides. Hoffman (1981) speaks of a new epistomology in therapy, stating

> "This new way isn't Bowenian; it isn't structural; it isn't strategic; and it isn't attached to any single therapist. It is in some sense systemic but it isn't necessarily modelled on the work of the Milan Associates....It is profoundly Batesonian, and yet Bateson does explicitly address it. (Hoffman, 1981, p.345).

Among the themes in this new epistomology discussed here are: systemic problem definition, systemic resistance, family developmental stages and tasks, intergenerational transmission of scripts, differentiation, and strategic tasks.

Problem definition in ecological practice represents a wide departure from traditional psychiatric models, where the problem is thought to reside within the individual. Holihan et al. (1979) describes the ecological view of psychological adjustment or symptoms in terms of the person-environment fit, and with an emphasis on effective coping rather than maladjustment or pathology. Their view of psychological adjustment in transactional terms provides a more positive and workable "frame" with which to view problems - allowing the therapist to explore how symptoms may actually be connected to a variety of different systems. These may include family, helping agencies, social, occupational, and interpersonal systems. Holihan et. al. (1979) suggest that assessment and treatment of the symptom should begin with external forces and move inwards. This is in contrast to traditional views which have intrapsychic processes as the starting point, and move outward from there.

In addition to viewing the individual adjustment in terms of

external forces or contexts, systemic problem definition includes examination of symptoms in terms of their communicative and/or structural component. Symptoms may hold power in a system, stabilize conflict between two or more individuals, or express deficits in system organization (Haley, 1977; Minuchin, 1974). Again, this is in contrast to individual therapies which approach symptomatic behavior from varied standpoints such as unresolved intrapsychic conflicts, historical antecedents, insufficient insight, or inadequate structuring of environmental rewards and punishments. Regardless of whether the symptoms are influenced by historical factors, poor insight or environmental contingencies, systemic therapies are concerned in dealing with these only insofar as they affect the current emotional context of the symptom bearer.

Several related concepts in systemic problem definition include circularity and problem "fit". Together they allow for defining problems in terms that are current, dynamic, and take into account the emotional functions which the symptoms serve. By shifting from historical and individual processes, the dynamics around the problem are given greater focus, providing an overall picture with which to identify strategic points and subsystems in which to intervene.

While basic to systemic thinking, the notion of circularity bears mention. Rather than thinking of problems in a historical linear cause-and-effect fashion, circularity points toward thinking in terms of symptoms maintaining and being maintained by systems. Interaction around the symptom and interactional disturbances themselves are viewed as syntonic, with the individuals in the systems serving as contexts for each other in mutually confirming, albeit, dysfunctional ways.

Likewise, the notion of "fit" (Dell in Hoffman, 1981) goes beyond linear thinking, referring instead to how behaviors in a system have complementary functions, that they "fit" together in some meaningful way in terms of the needs of the different participants and the overall system. Summarizing, the concepts of circularity and problem fit go beyond interactional approaches in that they look toward system organization, transactions, and needs in understanding the symptoms.

Moving from an internal definition of symptoms to a systemic one not only creates a different focus for change strategies, but creates new options and allows for the identification of potential setbacks to therapy. Introducing a systemic definition of the symptom to the family may have profound implications for therapy. Rather than symptoms being seen as a result of mysterious intrapsychic mechanisms residing in one individual, they are defined as a natural expression of system problems. As families typically think of symptoms in terms of residing within the individual, the family reality may be radically changed in the course of providing explanations which account for the influence of the family. For instance, reframing a childs' "acting out" to "helpful sacrifice" in promoting parental unity creates many new pathways for change, creating opportunities for the whole family to behave in a different way in order to "work on" the symptoms. Conversely, the function of the symptom in maintaining the balance of the system may be threatened, which necessitates that the therapist anticipate system reactions to any changes which redefining the problems might lead to. Hence, the implications of change in relation to the symptom are of much greater importance. This is the subject of the next theme, systemic resistance.

Various accounts of "resistance" have been forwarded to explain the

properties of systems which serve to hamper change efforts. Jackson's (1968) notion of homeostasis essentially states that systems/families resist change as part of an "unconscious" effort to maintain the systems equilibrium or status quo. More recent thinking has turned toward the notion of coherence (Dell, 1981) which suggests that families/systems do not actually resist change, but rather simply act in a manner coherent with its own balance between equilibrium and disequilibrium. Dell (1981) argues that systems are evolutionary in nature, with "resistance" being an artifact of a lack of change at any given point in time. Another proposition, a Batesonian concept discussed by Bogden (1984) argues that "conservatism" against change is maintained by virtue of the systems having an organized perception of its members behavior, a reality which is mutually supported and validated. Symptomatic behavior in his view is maintained by an "ecology of ideas" which if left unchanged, includes the symptom.

While these varying accounts examine "resistance" in different ways, they all have heuristic value in viewing the difficulties which families/systems may experience in the change process. One element which all address is that change in even one member can create instability in the entire system. The change can "ripple through" the entire system and effect reorganization, or generate enough discomfort to the system to activate regulatory mechanisms which exacerbate the symptomatic behavior. It is important then that the systemic therapist be cognizant of the regulatory mechanisms of the system regarding instability, to monitor them, and to channel the instability in ways which are helpful.

The next theme to be discussed involves the family life cycle. In

keeping with the transactional focus of systemic therapies, attention to communications, boundaries, and generational lines is of great significance. In order to frame these transactions into meaningful terms, a model of "normal" is necessary to gauge potential dysfunction. Models of normal family development outline the various tasks, roles, and functions which different members in the system should be engaged in for healthy functioning. These models allow for analysis of developmental needs at the individual, subsystem, and family system level. From this, the therapist may identify how current functioning may set needs in conflict, or where previous developmental tasks dealt with unsatisfactorily may affect current functioning.

Among the various family developmental themes discussed here are: identifying developmental needs in conflict with family rules, developmental blockages in current family life stemming from family of origin (transgenerational stress), and two related concepts, concerning family scripts and differentiation of self. While the first two have greater application when actively working with the family as a whole, the latter two deal more with historical influences - applicable to family and individual work. The use of historical influences in systemic therapy as opposed to psychodynamic formulations is perhaps articulated best by Minuchin, who states,

> "The premises of psychodynamic therapy are that change occurs in the individual through cognitive-affective re-encounter with the introjected past. This encounter occurs through a symbolic relationship with the therapist...(as opposed to systemically where) emphasis is on the exploration of the conflictual past and on interpreting it in the present." (Minuchin, 1974, p.91).

Where historical influences are probed in therapy, they are introduced for the purposes of providing a basis of insight and re-interpretation

in terms of current functioning, in the clients current context, and creating new alternatives for behavioral change. The emotional field in which the client(s) reside are the focus of that change, with the therapist orchestrating changes to transactional patterns, systems structure, or styles of personal relating.

In terms of developmental needs in conflict with family rules, the concept of "normal" becomes important in recognizing the socializing function of the family in terms of assimilating the values and norms of the culture. To balance its various internal needs and the external needs of the different members, differentiation into various subsystems along generational lines is necessary. As well, those needs change with time and as family composition changes, requiring that the family be flexible in adapting to those changes. With increasing age the general requirements of the family shift from nurturance and protection to increasing autonomy in the realm of sibling and peer socialization. If this shift from dependence and parental involvement to autonomy and adulthood is not responded to by increasing differentiation, or runs counter to the systems level of emotional connectedness (engagement), boundary issues become salient features of the problem in the form of developmental stress. Likewise, if conflicts within different subsystems are detoured across generational lines boundaries are affected, interfering with normal developmental processes (triangulation). These aspects of family functioning may be addressed in family therapy if the "identified patient" is an acting out or withdrawn teenager for instance, or may surface as developmental blockages later in life in individual, couple or family functioning. In such instances these dynamics may be addressed as historical influences

in current functioning, as transgenerational stress.

In addressing the issue of family functioning as affected by transgenerational stress, Walsh (1982) writes,

> "Earlier socialization of family members, leading to particular solutions regarding the issue of separation-individuation, is related both to prevailing value preferences regarding the desirability of particular modes of interrelationship and to unique historical cohort factors... in determining the manner in which the issue of separation and closeness is resolved across the family life cycle." (Walsh 1982, p.197)

Developmental blockages in current family life may most visably be illustrated in families experiencing difficulties in giving appropriate independence to adolescents. Parents whose own adolescence was marked by a failure to individuate in a healthy way (transgenerational stress) may deal adequately with small adolescent problems, only to find themselves unable to deal with some new adolescent problem which arises (developmental stress). Unable to solve the problem from within the range of their own family experience, set of values, and construction of reality, the problems may escalate and their attempted solutions may escale them further. The problems may further escalate if parental conflict runs high or parental values and needs regarding closeness differ. McGoldrick and Carter (1982) discuss how family themes are passed down through the generations, including

> "patterns of relating and functioning that are transmitted down the generations in a family, primarily through the mechanism of emotional triangling (Bowen, 1978). It includes all the family attitudes, taboos, expectations labels, and loaded issues with which people grow up." (McGoldrick and Carter, 1982, p.169)

These family scripts and emotional triangulation processes form the basis of the next two family life cycle themes discussed.

While there is some convergence between family scripts and levels

of differentiation, they are fairly distinct in meaning. While levels of differentiation may affect the degree to which family scripts are internalized by the individual(s), scripts themselves refer to the content of the self-identity which the individual internalizes from his/her family of origin.

Scripts themselves may affect the individual's self-perceptions, styles of relating, and view of self in interpersonal relationships. Family definitions and responses to behavior, while growing out of system needs, can persist and remain a significant part of the individual's self-identity, regardless of whether those labels are congruent with perceptions outside the family context. For instance, an individual whose childhood temper tantrums served to regulate parental distance may continue to perceive him/herself as having difficulty maintaining self control, producing uncertainty as to how to respond to conflict. Such a script may serve to maintain a self-fulfilling prophecy. The lasting quality of these scripts are important to note, as they may be significant influences long after the family of origin has dissolved (Bowen, 1978).

In addition to specific aspects relating to personal identity, general values, orientations, and rules of relating are transmitted through the family culture. Scripts regarding achievement, sex-roles, couple, and parenting behavior are examples of general orientations which are heavily influenced by the family of origin. Likewise, patterns of communication and rules of dealing with conflict in close interpersonal relationships are deeply affected. For instance, a child who is inducted into parental conflict may carry dysfunctional scripts and ways of buffering conflicts into his/her adult functioning if s/he

is unable to view his/her behavior from the proper distance as an independent adult. Differentiating oneself from this type of triangulation is the core of Bowenian styled therapy (Bowen, 1978). Hoffman (1981) suggests that it may be most useful in families with strong kinship networks, where conflict is dealt with by means of emotional distancing, secrecy, or pseudo-communication.

In the Bowenian view, the individuals' adjustment is best understood in terms of his/her levels of differentiation of self. By this, he means the degree to which the individual is able to differentiate his/her emotional world from his/her intellectual understanding of it. This is particularly important if the individuals' graduation to adulthood is not adequately dealt with in the family of origin. That is, if the individuals' emotional connection to the family of origin does not accommodate his/her adult identity as separate from the family, s/he may remain "stuck" at the level of emotional maturity which the family permits. In families characterized as enmeshed, the individual may experience a fusion of emotion and intellect, which in turn blocks growth and autonomy. This may also hamper the individuals' ability to establish healthy interpersonal relationships outside the family, owing to his/her adherance to family values, scripts, allegiances, attitudes and so forth.

The primary vehicle for change in the Bowenian styled therapy is to help the individual(s) to objectify these emotional processes. When the family unit is the level of intervention the goal is to help the different members of the family to take ownership of their own thoughts, feelings, and behavior. That is, the personal boundaries of the individuals in the family are strengthened, as distinct entities in the

"ego mass" of the family. When the individual is the unit of treatment the same issues are addressed, as they relate to the individuals' significant emotional contexts.

Bowen also contends that poor individual differentiation can continue to cause problems long after the individual has physically left the family of origin, if s/he does not somehow deal with the triangulation symbolically. He calls this pseudo-emotional cut-off. In summary, the essence of Bowenian therapy relates to strengthening personal boundaries, by way of objectifying emotional processes, triangulation, and family programs. This in turn permits the individual to pursue adult growth, autonomy and self-direction.

The final theme addressed here relates to strategic tasks. Strategic tasks may take a number of forms, from symptom focussed techniques designed to alter transactional patterns around the symptom, setting subsystems in conflict to alter boundaries or generational lines, to attempts to unbalance the system through one individual.

Strategic tasks using symptom focussing techniques are one type of systemic intervention which takes the symptom bearers' context into account. Rather than defining and treating symptoms in terms of historical antecedents and intrapsychic processes, the symptoms relationship to the current environment is deemed important. When the family is actively involved in therapy these techniques may be used to alter transactional patterns around the symptom. Likewise, recognizing the communicative power component of symptoms, and recognizing the importance of context, these techniques may be applied in any type of system.

Another means of altering transactions or boundaries through

strategic tasks involves subsystem interventions. The therapist may set subsystems in conflict through assignment of tasks designed to raise the intensity of the family's extra-session behavior. In doing so, the therapist attempts to push the family beyond its usual forms of interaction and altering boundary permeability.

In terms of issues relating to differentiation, boundary permeability is a primary target for change. As previously discussed, current family system can be viewed and acted upon in terms of different subsystem boundaries, and levels of involvement of the different family members to the overall family system. Likewise, at the individual level, levels of differentiation the individual has attained determines the permeability of his/her personal boundaries (Okun and Rappaport, 1980). Levels of differentiation then, can affect the individual's functioning in other relational contexts in a number of ways. Borrowing from Bowen"s notion of objectifying emotional processes, helping the individual to change his/her transactional patterns in terms of boundary clarity or emotional distance can serve to facilitate adjustment to different relational contexts.

Regardless of the contexts being dealt with, the ultimate goal is to help the client(s) to maintain a variety of flexible emotional systems, flexibly connected within a framework of keeping a healthy emotional or communicational distance.

In conclusion, the discussion of themes relating to systemic therapy in the provision of mental health services has touched on a variety of areas. Systemic problem definition relates the importance of looking outside the individual rather than to internal processes in understanding problems. Likewise, systemic notions of resistance

reinforce the importance of recognizing that symptoms, as painful as they may be, can also stabilize other problems in systems. The importance of this is that any attempts at change must take into account the systems' response to it, those responses which alerted the early pioneers of family therapy to recognize the importance of the family in mental illness, and ultimately to a better understanding of all human problems. The importance of the family as the unit of treatment was first acknowledged by them.

In terms of family functions and effects on the individual a number of these themes have been discussed. Models of family development provide a framework with which to identify where the family's functioning may impede "normal" growth, development, and adjustment to the larger society. Whether these problems surface while they are happening, are passed on from generation to generation, or create problems later in life, models of "normal" family development provide an alternative to biological and intrapsychic approaches. As stated previously, the focus of therapy is on changing the individuals' functioning in current contexts, not catharting past ones.

Finally, the notion of strategic tasks reflects a focus on the meaning of symptoms in their context. While families may not always be present, available or appropriate to engage, family influences can be addressed by strategic means. Likewise, symptoms themselves may take on properties of their own, which can be diminished through strategic tasks.

Foley (1974) has alluded to the power of systemic techniques outstripping the language to adequately describe them. Perhaps one of the reasons for this power is that by focussing less on techniques,

models, and theory, the complexity and variety of contexts in which problems surface are not overlooked. Reinforcement from a father is different from reinforcement from a brother and is different yet from a friend. Family therapies recognize this difference when they talk about boundaries, nurturance and autonomy. Common to all systemic therapies is their attention to human connection, and ways in which symptoms are attempts to balance personal needs with human connection, be it with social networks, spouses, or family.

CHAPTER III PRACTICUM SITE AND PROCEDURES

DESCRIPTION OF SETTING

The practicum was conducted through the Portage Mental Health Unit, at the centre of the region designated as the Central Region by the Manitoba government. The central office was located in the Government Building in Portage La Prairie, which also housed a variety of other social service departments. The catchment area served by the Portage Unit included a rural population of approximately sixty thousand people, served by seven full-time mental health workers. Additionally, the supervisor of the team carried half of a full-time load, and one other worker was employed half-time. Two of the workers were based in satellite offices located in Carman and Manitou.

The writer saw clients from the Carman satellite office located thirty-five miles Southwest of Winnipeg. The catchment area served by the Carman office was comprised of a rural population of approximately ten thousand people, located within a thirty-five mile radius from Carman. The economic base of the area was agricultural along with the attendent commercial and service sectors which service it. The population itself was a relatively stable one, rooted in the family farm tradition, conservative and hard working in the tradition of the Protestant work ethic.

The various professional disciplines which were represented within the Portage team included social work, psychology, psychiatric nursing and nursing. The Portage team had a strong committment to the provision of mental health services in the least disruptive means possible for the client, involving family and community systems in the process. Consistent with that philosophy the unit had incorporated the procedures and techniques of a number of systemic models into the practice of

community mental health. The use of team consultation, live supervision and team supervision were routinely practiced.

The writer's committee was chaired by Dr. Barry Trute, who acted as primary advisor. Ongoing consultation with Dr. Trute was undertaken as the practicum was in progress. Mr. George MacDonald was the on-site supervisor for the practicum, the mental health worker responsible for the Carman office. Ms. Elizabeth Hill was the third member of the committee.

Live supervision and case consultation were provided on-site by Mr. MacDonald, on average for approximately four hours each week. In addition, the writer had the opportunity to observe and supervise Mr. MacDonald on a number of cases. Team supervision with Mr. Grant Dunfield was undertaken in several cases and Mr. Dunfield also assisted in live supervision in several cases. Ms. Norma Tessier of the Manitou office provided live supervision in one case.

The duration of the practicum was eight months, from December of 1983 until August of 1984. The writer spent two days per week at the Carman office, and in addition attended the regular staff meetings, training tape sessions and professional development workshops. The writer was also in attendance at the monthly professional development seminars conducted by Mr. George Enns of the MacNeil Clinic in Saskatoon.

DESCRIPTION OF CLIENTS

Selection of cases was made on an ad hoc basis, with no selection criteria in place. That is, they were assigned as the referrals came in. Approximately half of the referrals were self-referrals, with the remaining referrals coming from physicians, schools, and Children's Aid. In the course of therapy a number of different agencies were involved at different points, including a school principal, school counsellors, probation officials, and the R.C.M.P.

Clients represented a variety of demographic characteristics. The age range was from 14 to 75 years of age. Employment status was also varied, with three clients being unemployed, three being self-employed, and the rest being involved in varied types of salaried employment. Employment, education and income were generally skewed to the lower end of the scale.

A total of 11 cases were seen, involving 23 family members. Families were the treatment unit in 4 cases. Two cases involved couples, and 5 cases were seen as individuals. In two of the individual cases the presenting problems revolved around separation issues, and were focussed on the problems the adults were experiencing in response to the separation.

The total number of sessions was 66, yielding a mean of 6 sessions per case. Two cases were single session consults, one case was seen twice, and one case was seen three times. Of the remaining seven, two were client terminated as a result of sudden moves, and the other 5 terminated in a planned way. The range in number of sessions was from one to eighteen.

In addition to those cases under the direct supervision of the

writer, approximately 8 cases carried by other members of the Portage team were followed on an ongoing basis. These were primarily cases which were under the supervision of Mr. MacDonald. Mr. Dunfield was present as senior consultant in live supervision for approximately half of those cases.

EVALUATION

Assessment and recording were done in a manner consistent with those prescribed by the mental health unit at which the practicum was held. Background demographics, presenting problem(s), initial assessment of dynamics, hypotheses, goals and ongoing progress and developments were all noted. For the purposes of the practicum three evaluation instruments were utilized in addition to the clinical formulations arrived at through direct observation and consultation. Two of the instruments were standardized family assessment measures. The third was a target complaint measure constructed by the writer for pre-post measures of the effectiveness in those cases where individuals were seen.

The family assessment measures used here were the Family Assessment Measure III (FAM III) and the Family Adaptability and Cohesion Scales II (FACES II). The writer had several purposes in employing these measures. First and foremost, the writer used the opportunity to familiarize himself with the instruments in clinical practice, hence the use of two different measures for comparative purposes. The exercise was useful in two ways. First, the suitability of the measures to augment direct observation of family dynamics and aid in the formulation of treatment goals was evaluated. Secondly, the instruments were adopted as pre-post measures of effectiveness of the interventions used. Both tests were represented on a pre-post test basis.

The target complaint measure was constructed as a symptom focused measure, consistent with the strategic nature of the therapy undertaken with the clients who were seen on an individual basis. Owing to its simplicity and lack of psychometric basis, discussion of its suitability

is limited here. It should be noted that it is a subjective self-report measure with face validity only. The interested reader is referred to Appendix 1 for its examination.

What follows is a description of the family measures along with interpretive information and discussion of their psychometric properties.

Faces II

The FACES II (Family Adaptability and Cohesion Evaluation Scale) was developed by David H. Olsen, Candyce Russel, and Douglas Sprenkle (1979, 1980). It is a thirty item Likert scale which measures family functioning on two dimensions, family adaptability and family cohesion. A unique feature of the scale is that it is completed twice upon administration, once for how members see the family (perceived functioning) and again for how they would like it to be (ideal functioning). This provides an indirect index of satisfaction each member holds in relation to how the family currently functions.

The family cohesion axis of the scale relates to the level of emotional bonding family members hold toward each other and the degree of individual autonomy they experience. Specific concepts/questions which constitute cohesion are: independance, boundaries, coalitions, time, space, friends, decision-making, and interests and recreation.

There are four levels of cohesion ranging from extremely low (disengaged) to moderately low (separated), moderatly high (connected), and extremely high (enmeshed). The two moderate levels, separated and connected, are considered to be relatively balanced functional levels of family cohesion.

Family adaptability is the second dimension to the circumplex model and is defined as the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress. Specific concepts used to diagnose and measure the adaptability axis are: family power (assertiveness, leadership, discipline), negotiation style, role relationships, and relationship roles.

The four levels of adaptability range from rigid (extremely low) to structured (low to moderate) to flexible (moderate to high) to chaotic (extremely high). As with cohesion, the moderate scores represented in the structured and flexible range are considered to be balanced family functioning.

Cohesion and adaptability scores are plotted along two axes, with the point at which they intersect being considered the ideal functioning family. Expanding outward on the plotting grid are various combinations of the four levels of each dimension yielding sixteen distinct types of family functioning. Four of these types are moderate (balanced types) on both dimensions. Eight are extreme on one dimension and moderate on the other (midrange types). The remaining four types are extreme on both dimensions (extreme types). The interested reader should refer to Appendix 2 for its examination.

The definition of balance is critical to the circumplex model. The operational definition of balance refers to the family scores falling into the two central levels (balanced). Extreme levels on both dimensions represent fairly severe dysfunction.

The strength of FACES II in terms of validity and reliability is limited. As its development is ongoing, and as yet incomplete, further

testing and refinement is in order. Current figures suggest adequate internal consistency with a Cronbach's Alpha of .90% (N=2412). Test-retest reliability was a respectable .84 based on a study of university and high school students (N=124). The representativeness of this group and sample size for a scale of this type are questionable however. Sensitivity to change with clinical populations requires further examination. Likewise, as factor analysis was utilized in the tests construction, construct validity and content validity are unsubstantiated. Over all, the test has good face validity based on useful and parsimonious clinical concepts, as well as good internal consistency. Its limitations relating to the need for further refinement and external validation with clinical populations are also of note.

Fam III

The FAM III Scale (Family Assessment Measure III) was developed by Harvey Skinner, Paul Steinbauer, and Jack Santa-Barbara (Skinner, Steinhauer, & Santa-Barbara, 1983). It has three component scales, the General Scale, a Dyadic Relationship Scale, and a Self-Rating Scale. The General Scale and Self-Rating Scales are completed once when administered. They contain fifty and forty-two items respectively. The forty-two item Dyadic Relationship Scale is completed by the respondant once for each other member in the family. In a family of five for example, the respondant would complete four separate Dyadic Relationship Scales, describing their relationship to each other member.

Each of the three component scales are further broken down into seven subscales, which are described in the following discussion of the

conceptual basis of FAM III.

FAM III is based on the process model of family functioning, which posits a specific interactional sequence between seven distinct attributes of family functioning. Moving in a progression from relatively concrete observable concepts to the more abstract are: task accomplishment, role performance, communication, effective expression, effective involvement, control, and values and norms. With some over simplification it can be stated that the model presumes that task accomplishment determines the ability of the family to effectively integrate family and individual needs and achieve its objectives to adapt as a healthy functioning unit. The other dimensions are process variables which influence the family's effectiveness in task accomplishment, hence the name process model of family functioning.

Given the three component scales, including profiles on each dyadic pair in the family, and the nesting of seven subscales within each component scale, FAM III provides substantial flexibility in the way the results may be used. At its simplest level, FAM III provides an overall index of health/pathology of family functioning, as drawn from the General Scale. Detailed matrices of each members interaction with each other member on all seven subscales can also be obtained from the Dyadic Relationship Scale, generating a wealth of information as to the various interrelationships within the family. Finally, each member's perception of his/her functioning within the family is measured by the self-rating scale.

In interpreting the FAM III profile, discrepancies between different family members' scores may also yield significant information relating to family processes, aside from the obvious differences in

perception. Two additional subscales on the General Scale, Social Desirability, and Defensiveness serve to assist in the interpretation of discrepancies between different family members.

Summarizing the above, the General Rating Scale can be used as an overall index of health/pathology in the family. For more detailed analysis each of the scales can be broken down into seven subscales to identify particular weaknesses in family's functioning. Conflict and alliances between specific family members can also be identified from the Dyadic Relationship Scale. Finally, interpretation of discrepancies between the different family member's perceptions of functioning is facilitated by the inclusion of Social Desirability and Defensiveness Scales.

As with FACES II, FAM III continues to undergo further study and refinement. Analysis of a varied sample of 475 families indicates that FAM III is reliable and differentiates between clinical and non-clinical families. Reliability is high for both children and adults, who have different normative profiles, and across the respective scales. Subscale reliability is somewhat more variable than the ideal, but overall remains respectable. Alpha co-efficients for the different scales are as follows: Adults - General Scale .93, Dyadic Relationship Scales .94, Self-rating Scale .89, Children - General Scale .95, Dyadic Relationship Scale .89, Self-rating Scale .86. Subscale ranges for the General Scale are .60 - .87, and the Dyadic Relationship subscales range from .59 - .82. The authors have identified weaknesses in the reliability for several self-rating subscales, particularly task accomplishment, involvment, and control subscales.

CHAPTER IV CASE REVIEW AND ANALYSIS OF INTERVENTIONS

CASE EXAMPLES

The following case examples illustrate the interventions and use of evaluation instruments as undertaken in this practicum. The names which are used have been changed to maintain client confidentiality.

The format for describing the cases and evaluative measures is as follows: 1. Presenting problem, 2. Background information and etiology of presenting broblem. 3. Assessment of system dysfunction/clinical observations. 4. Goals. 5. Interventions 6. Evaluation and case conclusions.

THE A FAMILY

Mrs. A. called to arrange an appointment for her sixteen year old son Ben. Ben had recently received a two week suspension from school, and as a condition of his return he was to undergo counselling. The suspension was in response to Ben's coming to school drunk, the second occasion on which he had done so. Mrs. A. felt there were other problems which Ben needed to deal with, including alcoholism, anti-social, irresponsible, and delinquent behavior. At the time of the initial phone contact she expressed fears that his attitude would lead to his being placed in a juvenile lock-up and eventually to prison.

Background and Etiology

Mrs. A. was thirty-five years old, and successfully employed with the government . Ben's biological father was killed in an automobile accident three years prior. Ben had been arguing with his father in the vehicle when the accident occurred.

Father had been twenty years older than Mrs. A. and prior to his death had physically deteriorated with a heart condition, to the point where he was virtually bed-ridden. Mrs. A had always been the primary disciplinarian in the family, more so as father's health failed.

Mrs. A. began to date a long-time acquaintance several months after father's death, a thiry-six year old contractor named Sam. They had been sporadically co-habiting for the previous year and planned to marry in August, four months from the time of initial contact with the mental health service. At the time the three of them were in therapy Sam was frequently away from the home for extended periods, owing to the nature of his business. Money was an important issue to both Mrs. A. and Sam.

Ben's father had willed most of his sizable farm to Mrs. A. She and Sam planned to sell it and retire within five years, despite their relatively young age. Ben had expressed an interest in farming the land himself, but Mrs. A. disqualified any such plans, calling them unrealistic in light of the irresponsibility she saw in him.

In terms of Ben's symptomatic behavior, Mrs. A stated that the problems predated the death of the biological father, and that the relationship between Ben and her had always been tense. Mrs. A cited attitude problems from an early age, and noted that Ben first drank at the age of eleven, along with some older friends from nearby farms. Despite having been assured that Ben was not alcoholic by a worker from the Alcoholism Foundation of Manitoba, she considered him one. She placed part of the blame on the older friends Ben continued to associate with.

More recently the problems were surfacing at school, which the school counsellor ascribed as being mostly growing out of Ben's angry demeanor. Ben also had been involved in a number of petty delinquent acts, primarily drinking and angry destructive behavior.

Ben had been involved with a number of different counsellors in the past, including the school counsellor, a mental health therapist, an AFM worker, and probation officers. All had concurred that Ben's problems were rooted in family dysfunction in the writer's discussions with them.

Assessment of System Dysfunction

In structural terms, it was hypothesized that historically (when the biological father was alive) the generational boundaries were blurred, with Ben being triangulated between a weak submissive father

and a controlling and distant mother. Ben's acting out behavior served to engage Mrs. A with father, as her own power struggles with Ben typically required mediation by father to arrive at some solution. As well, Ben's acting out behavior served to diminish Mrs. A's power, as she had to share control with father. The marital conflict and balance of power was mediated by Ben, owing to the blurred boundaries and triangulation.

Mrs. A's fiance was also a submissive individual, but at the time of therapy was only peripherally integrated into the family fabric. An alliance between Sam and Ben was hypothesized, albeit less intense than with the biological father, as the "marital relationship" was too recent for the marital conflicts to be as intense as they had been with biological father. Ben's current symptomatic behavior was hypothesized to be more of a perpetuation of previously ingrained patterns of communication with mother than triangulation into marital conflict, although that possibility existed as well. Conversely, it was hypothesized that the new step-parent Sam was or could be triangulated in mother-son conflict.

The patterns of interaction between Ben and Mrs. A were considered to be the focal point of the current dysfunction, in light of the perpetuation of the symptoms in father's absence and the relatively peripheral role Mrs. A's fiance played as new step-parent/husband at this stage of their relationship. Ben's presentation was that of a very angry young man, expressing it through either sulleness, sarcasm or angry outbursts. Mrs. A for the most part acted in a controlling and harsh fashion. When she did become softer with Ben he would withdraw and remain sullen, to which Mrs. A would again return to threats and her

controlling manner. Sam avoided their conflicts most of the time, but was drawn in to mediate at other times, as the biological father had been.

Goals

1. Clarifying and altering the communication and transactional patterns between Ben and Mrs. A with particular reference to power and distancing behavior.
2. Reframe Ben's behavior as less problematic and less irresponsible, allowing the family to redirect the energy it expended controlling Ben, to healthy growth.
3. Strengthening the generational boundaries (marital and parental) as a more appropriate avenue for Sam to be involved than his triangulated mediator role.
4. In conjunction with the above, to facilitate Ben's individuation in a healthy way.

Interventions

A family interview was arranged for the first session. Mrs. A, her fiance Sam, and Ben all attended. The therapist spent much of the first session joining with the family, getting background information and probing the dynamics of the family.

The family expressed reluctance at coming for counselling, to which the therapist contracted for four sessions of family counselling to meet the requirements of the school, thereby allowing the therapist to redirect the resistance and allow more time to join with the family. Therapist attempts to set goals with the family were unsuccessful as

Mrs. A requested changes in Ben but couldn't concede to a request on Ben's part that he not be sent to boarding school the next fall if his behavior improved. The therapist assigned the task of discussing goals amongst themselves for the next session.

While the family had talked about goals before the second session, the session began with a discussion about their failure to arrive at any goals. Ben's reciprocal request not to be sent to boarding school was cited as the reason for their inability to settle on goals. As the intensity grew, Sam became drawn into the discussion as the mediator. As the discussion progressed Sam allied himself with Ben, to which Mrs. A became more resistant.

The therapist refocussed the session to the differences in Sam and Mrs. A's perceptions of family functioning. Sam admitted to feeling that Mrs. A was too critical and controlling with Ben, and to his feeling compelled to mediate their conflicts when they escalated. The therapist reframed Mrs. A's controlling behavior as being too close to Ben, which sometimes drew them into conflict. Sam was given the assignment to help Mrs. A pull away from Ben when they became too close rather than join in as mediator. The therapeutic goal was to block the usual pattern and draw clearer generational boundaries. Goals relating to communication and Ben's behavior were set.

In session three the same issues were addressed and clarified further. Ben resisted the changes, withdrawing and questioning his coming to the sessions. It was hypothesized that this represented an issue of trust for Ben, who was accustomed to receiving blame in the family. The therapist attempted to convince Ben that the purpose in coming to the sessions was to make things better at home, not just to

reinforce that blame. Ben continued to show reticence, and Ben was given the choice as to whether he wanted to come. The intent of this was to diminish his resistance by giving him a mature choice, and to reinforce the genuiness of the therapist in wanting to help everyone with the situation, not just to control him. As well, it altered the meaning of the act of withdrawal, as a legitimate choice rather than simply as an act of rebellion. This was for Mrs. A's benefit as well, as her anxiety and controlling manner with Ben only served to escalate control issues.

Ben did not come to the fourth session, and neither did Sam as he made other business committments.

Sam did not attend any further sessions for the same apparent reason, despite the therapist's efforts to get him re-involved. As the therapist conducted the next session with Mrs. A by herself, the session was used to track Mrs. A's family of origin in great detail. The therapist connected some of her current family problems to family of origin patterns, highlighting the developmental blocks she had held from her own unhealthy launching. As her father had died when she was thirteen, her siblings pulled together to maintain the family farm. As well, they all felt mother was too weak to challenge, so there was little adolescent testing behavior. As her siblings had done, Mrs. A lived at home under conditions of unquestioning co-operation and excessive responsibilities until the age of sixteen, when the frustration and demands became too much to bear.

The therapist validated her for the difficulties she experienced and how difficult it must feel in letting go of Ben in the best way, as her own circumstances in adolescence were so different from adolescence

today. Also, in a reframing effort the therapist probed with Mrs. A how Ben's irresponsible behavior might be an attempt to help her be more relaxed and less work oriented. Likewise, in a probing fashion the therapist reframed Ben's irresponsible behavior as possibly an attempt to draw Mrs. A closer to Sam in a fun way.

Following the session the therapist called Ben at home and was successful in convincing Ben to resume therapy. Ben was much more responsive in the sessions following the special invitation from the therapist.

Session five began with validating Ben for coming, and recontracted with the family for four more sessions, as the contract for the school's requirements was completed. In light of the previous session's work with Mrs. A regarding her own unhealthy "launching" and Mrs A's own controlling behavior toward Ben, the therapist subtly directed them to a goal geared toward helping them to negotiate Ben's separation in a more "grown up way" and improve communication in the family.

Among the issues discussed in this session were Mrs A's own launching and how it related to her having difficulty "letting go" of Ben. Related themes of trust, responsibility, having fun, and life as a sixteen year old were also discussed.

The assignment for that week was for Ben to be responsible for the spare house key, a relatively neutral content issue which Ben had previously expressed discontent with. As he usually returned home from school before Mrs. A. returned from work, he was usually locked out. Up until that time she had not trusted him with a key, citing different examples of his irresponsibility as reasons. While this was a small task, Ben was very pleased with even this small adult responsibility

entrusted to him.

The sixth session followed much the same themes as session five, examining issues of freedom and responsibility. A school project Ben had been procrastinating on was selected as a content issue on which to further practice their negotiation skills. Ben's reticence was used to further probe the issue of responsibility. In the course of the negotiations Ben demonstrated a reluctance to commit himself to taking it upon himself to complete the project. The therapist paradoxically framed his inability to commit himself as deferring the responsibility to Mrs. A. The therapist further suggested a restraint from change directive, whereby if Ben was feeling too much responsibility was being given to him he should put off the project in order to get Mrs. A to take the responsibility of making him complete the project.

Ben brought up several new issues this session, relating to Sam and his feeling at times of being excluded. Clarification of Mrs. A's involvement with Sam and with Ben was undertaken, and it was negotiated that Ben be allowed to quietly watch television upstairs when Sam was sleeping over and Ben was having trouble sleeping. Prior to that he was only allowed to do so when Sam wasn't home. Mrs. A was given the directive to come and talk to Ben about what was troubling him on these occasions.

By session seven it was becoming more evident that Sam was not going to re-engage in therapy, and the focus on negotiating a healthy individuation was maintained. It was hypothesized that if conflicts between Ben and Mrs. A could be successfully negotiated Sam would not be drawn in, hence a change in the family pattern. Conversely, if Ben were to become better differentiated, he would not be triangulated into

potential marital conflicts between Sam and Mrs. A.

The focus of this session was again on issues of responsible negotiation. The issue of Ben driving the car was selected as one content area. Another was Ben's school performance, which required immediate improvement if he were to avoid failing his grade. A plan was negotiated for completing the required work before year end. Ben was again resistant to commit himself to doing it. As with the previous session, the therapist suggested that he could defer the responsibility to Mrs. A if it were too much to handle. The therapist paradoxically questioned whether Ben could do it but wished him well in his efforts.

The eighth session was the final session. Themes relating to Mrs. A's own unhealthy launching were highlighted and how it contributed to their difficulties in negotiating a friendly separation. Responsibilities which Ben had successfully taken on were also reviewed. A restraint from change prescription was also given, that it would be hard for Mrs. A to quit worrying about Ben, and that at times it would be difficult for her not to smother him.

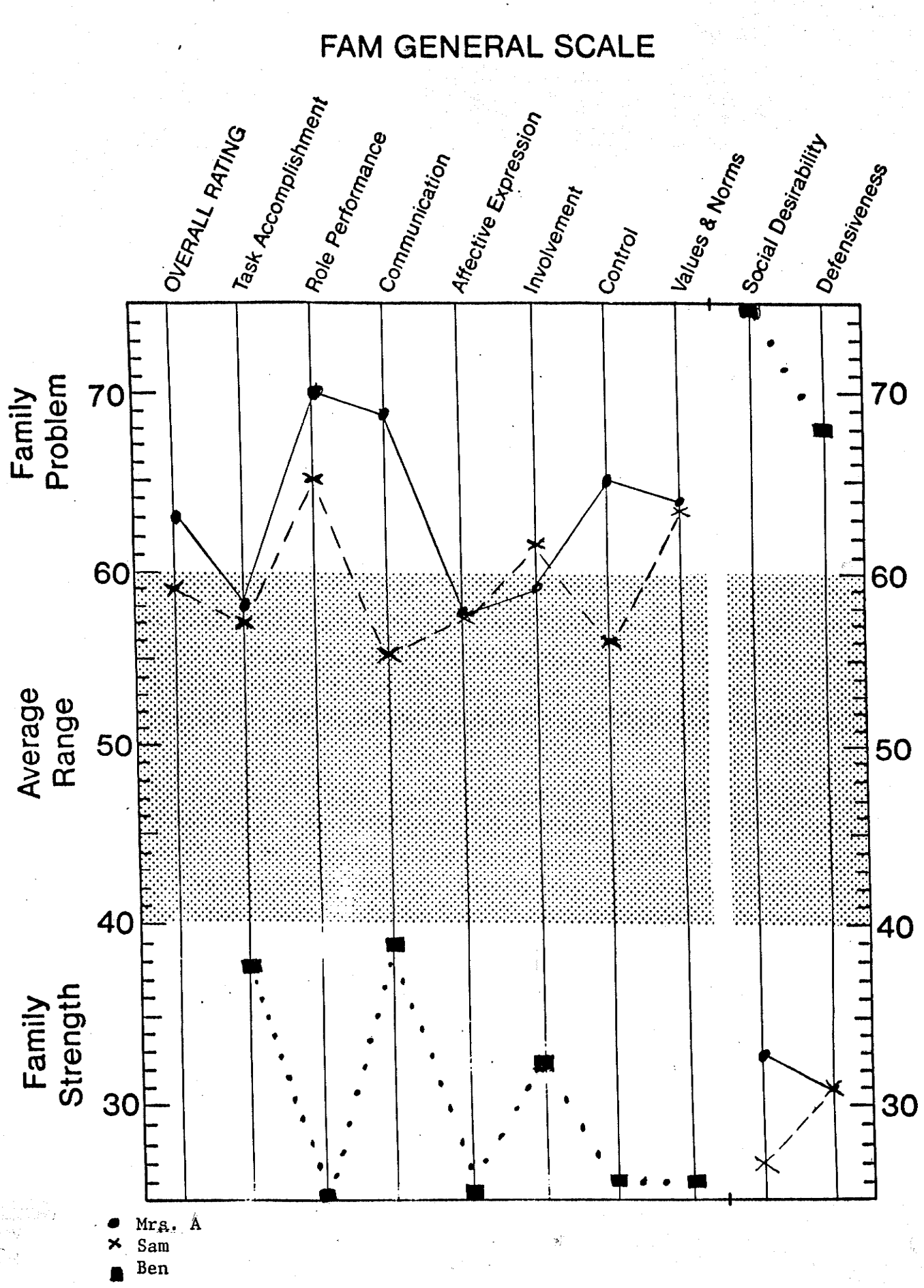
In consultation with Mrs. Norma Tessier who was providing the writer with supervision on this case, the decision was made to terminate with the family as some resistance was being sensed regarding making larger changes. While the gains they had made were relatively fragile, further sessions at that point could be counter-therapeutic, undermining the gains made to that point. Termination was mutually agreed upon between the family and the therapist. The family was encouraged to re-engage if problems arose.

Evaluation and Case Conclusions

Figure 1 highlights the pre-therapy profile on the FAM III General Scale. Most notable are the unusually low scores registered by Ben, which were not consistent with his demeanor early in therapy, namely sullen and angry. Examination of the Social Desirability and Defensiveness Scales scores at 75 and 68 respectively indicate that Ben's scores were suspect. The authors of the Scale (Skinner et al. 1984) indicate that Social Desirability and Defensiveness scores over 60 suggest that both the elevation and shape of the FAM III profile may be distorted. Such elevated scores can also signal that the therapist has not adequately joined with the client, and that issues such as trust and confidence may be hindering honest reporting. This may well have been the case, as Mrs. A. had taken Ben to a number of helpers in the past, with what may have been an agenda to reinforce her view of the problem as his "attitude problem". While Mrs. A. had little success in having this view supported by the other therapists, there was little progress made for Ben or the family as a whole in their other attempts at therapy. It was observed that Ben appeared to be much more open in the sessions after he had tested the therapist's genuiness about not just focussing on Ben's problems, by testing whether the therapist was being truthful in giving him the choice about attending the sessions.

Mrs. A's overall rating was 63. As scores over 60 have been identified as representing family problems, Mrs. A's score signalled significant family problems. At 59, Sam's score approached the problem range, but fell 1 point short. Despite falling on opposite sides of the cut-off scores for problem versus non-problem families, Sam's and Mrs. A.'s scores were quite consistent. It is also of note that they both

FIGURE 1 Pre-therapy A Family



scored quite low on social desirability and defensiveness, which usually indicates levels of anxiety about what is happening at home.

An area of concern for both Sam and Mrs. A related to the role performance dimension, with Mrs. A scoring 70 and Sam scoring 65. This could in part be attributed to the relatively new status of the relationship and lack of definition as to Sam's new role. Given Mrs. A's controlling style, Sam's integration into the system may have held greater concern for her. While this discrepancy was slight several moderate discrepancies were noted between Sam and Mrs. A.

Skinner et al. (1984) suggest that incongruency between family members may be as indicative of family problems as elevated scores. Incongruities on the communication subscale showed differences with Sam scoring within the normal range at 54, and Mrs. A. scoring 69. Examination of their communication ratings of the Dyadic Scales indicated that they had identical scores in relation to each other (52), and a much smaller discrepancy in their respective scores toward Ben. Sam scored communication with Ben at 52 and Mrs A rated it at 60. As with role performance this may in part have been due to Mrs. A's concerns regarding Sam's integration into the family. Given the size of the discrepancy, the writer also hypothesizes that part of the discrepancy may have been a result of Mrs. A's feeling communication as a family was inhibited when Sam was involved, as he tended to view her as too critical of Ben. From this the writer also suggests that they had not yet come together as a parental unit in terms of parental expectations and communication, and the possibility of a weak alliance between Sam and Ben (blurred generational boundaries).

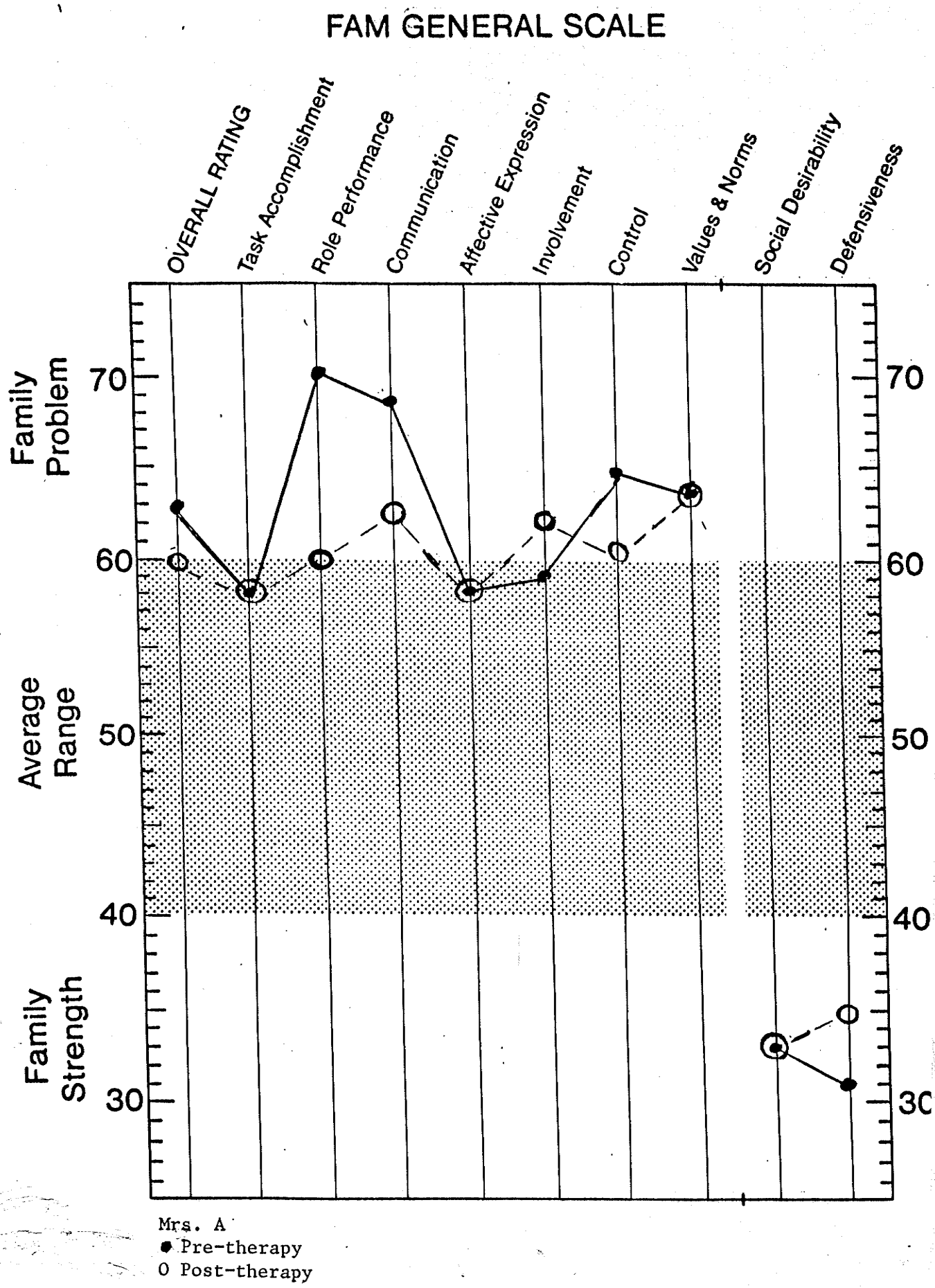
Related to the above were the discrepancies noted on the control

subscale. Again, Sam scored within the normal range at 56, while Mrs. A perceived control as a family problem at 66. Their scores in relation to each other were similar. Sam rated control between the two of them at 48, Mrs. A at 51. A major discrepancy was noted in their ratings of control in relation to Ben, with Sam scoring 62 and Mrs. A scoring 75. Consistent with the conclusion above regarding communication, Mrs. A and Sam had not yet come together as a parental unit. It was interesting to note, however, that while Sam rated control as a problem with Ben on the Dyadic Subscale, he did not see control as a problem as a family.

The above findings on the FAM III profiles were consistent with the structural assessment that there were discrepancies in terms of parental expectations and control, creating conditions which would promote a father-son alliance, weaken parental boundaries and hamper negotiation and conflict resolution between Mrs. A and Ben. As the marital unit was relatively new and low in conflict, triangulation into marital conflict was not as likely.

Post-therapy data was confined to Mrs. A's report. As indicated in Figure 2, there was a marginal change in the overall rating to 60, down from 63 on the pre-therapy measure. While this signals slight improvement overall, Mrs. A's score stradled the cut-off level for family problems. Improvement of the scales relating to the therapeutic targets were more pronounced on two of the three scales which showed improvement, but only moderately so. Again the scores were still in the problem range, with communication decreasing to 64 from 69 and control dropping to 61 from 66. While this was consistent with the writer's clinical observations, role performance dropped beyond that which

Figure 2 Post-therapy A Family



have been expected on the basis of the differentiation issues addressed, but a change of that magnitude was unexpected. It may be that as Mrs. A and Ben improved in their ability to resolve conflict, albeit moderately, Mrs. A was less concerned about alliances between Ben and Sam. Alternatively, as Mrs. A pulled back from Ben and recognized his approaching independence, issues of parental agreement and potential conflict regarding roles may have been taken more lightly by Mrs. A. Finally, while Sam was not present in the latter part of therapy, it may be that Sam and Mrs. A addressed some of the issues on their own. As no profile was available from Sam, this remains speculative.

One final point regarding the FAM III profile relates to another anomaly found. Mrs. A's score on affective involvement increased from 59 to 64, into the problem range. The writer speculates that while Mrs. A was able to disengage herself somewhat in terms of control, it was at some cost in terms of her affections or perceived affection from the other family members. It should also be noted that Mrs. A's scores in regard to defensiveness and social desireability did not change. This indicates that she still may have been experiencing a high level of anxiety about what was happening at home. Consequently, her scores may have been somewhat inflated overall.

Informal observation of the changes made should be prefaced by reiterating that both the writer and consultant Norma Tessier did view the gains as being weakly rooted in the family system.

The most marked change in this writers observation was in relation to the ability of Mrs. A and Ben to negotiate with some degree of resolution. As well, Ben's demeanor and approachability seemed greatly enhanced.

With regard to the acting out behavior which brought them into therapy, there were no legal entanglements, complaints of drinking or school problems in the course of therapy. At a meeting of Social Service professionals from their community several weeks later Ms. Tessier learned that Ben's absence from their caseloads was conspicuous enough to be noted. The high school counsellor also reported that Ben's acceptance at the school was notably improved, primarily due to his improved conduct as noted by both the teachers and the school counsellor.

THE B FAMILY

The identified patient, Tracy aged fifteen, was referred by her mother in response to learning from the school that Tracy had essentially held her class "hostage" for forty-five minutes one day by threatening to commit suicide in class. She did so by drawing a knife across her wrists, mocking the action of slashing them. Tracy had been experiencing problems in the school for the past three years, but to date this had been the most major incident.

Background and Etiology

The B family consisted of Mr. B, a fifty-two year old labourer, Mrs. B a fifty-two year old housewife, brother Rudy aged eighteen, and Tracy. Rudy and Tracy were both adopted in infancy. In contrast to Tracy who was considered the family failure, Rudy enjoyed some social status in the community owing to his ability in sports.

Tracy's school problems first began three years previous, when she had failed her grade seven. Since that time the parents reported that she had felt out of place with her classmates. Several months prior to therapy she had been placed in a special class.

The parents' frustration with the school ran deep. They felt that in the past the school had exaggerated their reports of Tracy's negative behavior and poor academic performance. As well, they blamed the school for maintaining poor communication with them. The latter was evidenced by the fact that it took two weeks for them to be informed of the knife incident. The parents were also unhappy with Tracy being placed in a special class. They projected many of the home problems onto the school, in particular that the regimentation at school was creating

non-compliance at home.

Assessment of System Dysfunction

The B family was a system hypothesized to be deficit in leadership, boundaries, involvement and role structure. Sex-role rigidity and dysfunctional communication patterns were also noted.

Leadership in the family was lacking. Family goals and expectations were confused, as was hierarchy and role structure. Overtly, Mr. B was the executive leader of the household, with Mrs. B being a parental subordinate. Covertly, the family's perception of Rudy's elevated status in the community yielded him executive power in the family in many ways.

Parental boundaries were rigid, and owing to the lack of parental direction and cohesion, expectations were few in addition to being weakly transmitted. The complementary nature of the parental relationship further weakened parental authority. Mr. B considered behavioral control in the home to be Mrs. B's responsibility, at whom he periodically issued directives. Similarly the marital unit was complementary and distant.

Session observations suggested that Mrs. B was enmeshed with Tracy. Mrs. B acted as Tracy's voice when stressed. However, scores on the FACES II Scale indicated such extreme disengagement that an alternate hypothesis was developed. It was hypothesized that Tracy was triangulated into a vacuum in marital and parental involvement. Mrs. B's speaking for Tracy was hypothesized as symptom maintaining in nature, blocking clear communication and maintaining the family balance of power.

Goals

1. To facilitate appropriate differentiation and hierarchy in boundaries and strengthening sibling subsystem boundaries.
2. To correct sex based inequalities, introducing greater symmetry to marital, parental and sibling subsystems.
3. To strengthen marital and parental functioning, with respect to cohesion, direction and exploration of new alternatives.
4. To alter dysfunctional patterns of communication, including promotion and enhancement of negotiations, clarifying communication, and getting Tracy to speak for herself.
5. To set and enforce limits in a clearer, more consistent and realistic manner.

Interventions

The B family was seen for eighteen sessions over the course of seven months. The first session was February of 1984, and termination was mutually agreed upon in August of that year.

A family interview was set for the first session. It was attended by Tracy, Mr. B, and Mrs. B. The therapist attempted to arrange for Rudy to come but was unsuccessful. The session was spent joining with the family, gathering background information, and probing family communication and dynamics.

Probes regarding the alleged suicide/hostage event revealed that it was in fact attention seeking behavior, with low intent. The parents had not discussed the incident with Tracy directly, and were much relieved.

It soon became apparent that father was disengaged, having lifted

mother's "grounding" of Tracy after the incident because he didn't think it was worth "creating a fuss" at home over the incident.

In the course of probing the family about the different relationships Tracy expressed her resentment about the preferential treatment Rudy received in the family. As well, she expressed her feeling that they didn't care about her, as she was always overshadowed by Rudy's accomplishments.

The second session involved more information gathering. The most significant new information concerned the family pattern around Tracy's symptomatic behavior. While the disciplinary duties were primarily deferred to Mrs. B, the family pattern served to punish Mrs. B in her attempts to do so. When Mrs. B would attempt to discipline her, Tracy would become quarrelsome, to which Mr. B became angry with the both of them for disturbing him. Mrs. B would feel unsupported and subsequently withdraw from the conflict, her disciplinary authority having been undermined. The therapist challenged the pattern in a neutral way, highlighting how it served to perpetuate Tracy's misbehavior as it gave her relative immunity from discipline. Mr. B resisted the suggestion that if he were to become involved Tracy's misbehavior would decrease, reiterating his need to relax when he got home. He deferred the responsibility to Mrs. B to find alternate ways of dealing with Tracy, like loosening her standards. In light of the resistance generated the session focus was shifted to how they handled Rudy's discipline, as there never seemed to be any concerns about noise level where Rudy was concerned. They indicated that he was given greater latitude because he was more demanding, and it was easier to give in to him than fight, even if it was at Tracy's expense. Tracking how Rudy's demands came at

Tracy's expense they disclosed that Rudy frequently demanded that Tracy make him snacks, clean his messes, and deferred his chores to her. The therapist challenged the appropriateness of the parents supporting Rudy's demands on Tracy, drawing a boundary around the sibling subsystem.

The session concluded by emphasizing the positive changes in Tracy's behavior as of late and reframed parental demands as coming from caring rather than maliciousness as Tracy had suggested. A restraint from change injunction was given, that the family needed to keep from changing too quickly to avoid upsetting the habits the family was accustomed to.

Father was absent for the third session. Mrs. B reported that since the last session she had confronted Rudy when he tried to get Tracy to carry out his personal chores. Rudy reluctantly abated, placing him in a more appropriate position hierarchically.

Probes into communication, power and alignment revealed that Tracy spoke for herself more when Mr. B and Rudy weren't home, primarily as she wasn't the target of criticism in their absence. Therapist attempts to promote helpful communication between mother and daughter by requesting that Mrs. B talk with her daughter and provide some guidance revealed a significant pattern. When Mrs. B became frustrated, Tracy withdrew as she perceived Mrs. B as lecturing. In turn Mrs. B would attempt to guess at Tracy's motives as Tracy withdrew. In triadic communications Mrs. B ultimately ended up speaking for Tracy, unless blocked from doing so. The therapist punctuated the discussion by highlighting the pattern. Sex differences in the family were explored further, addressing the disparity in status and roles. Mrs. B was

validated for the difficult position she was in, having to protect Tracy from the powerful males in the home while at the same time disciplining her. The session was concluded with emphasizing the importance of Mr. B's participation in the sessions. Rudy's presence was again requested as well.

Neither Mr. B or Rudy came to the fourth session. This reinforced several of the hypotheses regarding system dysfunction. First, it reflected father's disengagement from the family. Secondly, Rudy's participation in the family's problems was not being acknowledged by the family. This may also have been symptomatic of his elevated status in the family. Finally, the sex role division of the family may have been one of the dynamics involved with Mrs. B. dutifully performing the "women's work" of the family - attending to the emotional tasks of helping Tracy with "her problem".

The content issues focussed on in this session related to school problems which had again surfaced during the week. Despite having been grounded for the weekend Tracy had spent Saturday away with friends. The failure to stick with consequences was addressed, and mother was asked to reassert her parental authority. Mrs. B's attempts to diffuse the conflict by externalizing the problem as the school's was blocked. Tracy's behavior was framed as normal adolescent testing, for which Mrs. B was to take charge. Mrs. B was directed to be clear in her communication, with the therapist focusing her and blocking her from talking for Tracy. Tracy co-operated and admitted to feeling more comfortable with clear rules.

The session concluded with again emphasizing the need for Mr. B's help. The importance of having both parents pull together to give Tracy

clear expectations and consequences, and to enforce them together was reinforced. The home assignment was for Mr. and Mrs. B to get together and specify their school expectations, listing them and the consequences for not meeting up to them. They were to also have weekly contact with the school, which the therapist arranged in a meeting with the school principal, along with her return. As relations between the parents and the school were strained everyone's co-operation was reaffirmed. As Tracy's transfer to a special class was made for behavioral rather than academic reasons, an agreement was made that if her behavior improved she would be returned to the regular classroom.

The therapist was informed in session five that Tracy had lost enough weight in recent months to be of medical concern. The physician which Mrs. B. had taken Tracy to had "diagnosed" Tracy as bulemic. The bulemic behavior was hypothesized to be passive resistance to weak parental functioning, an attempt to bring the parents together and increase their involvement with her. The bulemic symptoms were considered to be symptomatic of the system dysfunction, in the same way as the "suicide" symptoms. To avoid multiple helpers working at cross-purposes the therapist arranged to take over her weight monitoring from the public health nurse, who had been involved at the doctor's request. Strategies for dealing with the behavior were also discussed.

Mr. B again failed to attend the session. In consultation with Mr. MacDonald it was decided to involve Mr. B indirectly, in light of the rigidity of the sex-role and parental dynamics. The relationship between Mrs. B and Tracy was framed as being too close, as evidenced by Mrs. B's continued habit of speaking for Tracy. It was assigned that Tracy and Mr. B were to talk for ten minutes a day without any

interruption. Immediately after supper was agreed upon as it was a relaxed time when both Tracy and Mr. B were usually home.

Sessions six and seven maintained a similar focus. The communication exercises with Mr. B were monitored. Mrs. B noted how difficult it was for her not to interrupt their conversations. She was managing to do so however, allowing for a change in pattern between Tracy and both parents. Mrs. B was much more conscious of her speaking for Tracy. Subtle probes for marital conflict were made, to no avail.

Session six concluded with emphasizing how the closeness between Mrs. B and Tracy was misdirected in that it tended to revolve around conflictual issues rather than fun events. In light of the success of the "talking assignment" Mr. B's involvement was expanded to include taking over the monitoring of school problems. Mrs. B was given the assignment to initiate a fun activity for Tracy and herself. These same tasks were reassigned in session seven.

Despite no new major incidents, Mrs. B continued to bring in minor complaints about Tracy and requesting medications. As few new changes were being noted in family functioning at this point in therapy, individual sessions were arranged for Mrs. B and Tracy for session eight through ten. This did not generate any new openings for change, but their situation remained stable.

An attempt was made to engage Mrs. B in more assertive behavior with Mr. B to generate a more symmetrical relationship, with the hopes of facilitating communication around issues of parental expectations and promoting shared parental responsibility and involvement. She resisted any such change. Termination was suggested at this point, with the frame that the only avenue left untried would require Mr. B's help.

Mrs. B was able to convince him.

Sessions eleven through thirteen were conjoint sessions with Mr. and Mrs. B. Despite their continued complaints over Tracy's minor misbehavior and requests for medications, straightforward attempts to have them develop mutual rules and consequences met with failure.

In an attempt to indirectly address marital conflict and address the sex-role imbalance, Tracy's behavior was framed as an attempt to teach Mrs. B. how to fight with the powerful Mr. B. In consultation with Mr. McDonald it was prescribed that they were to pretend to fight twice a week. This was to be done within hearing distance of Tracy. The therapeutic goal of this "pretend fighting" was to provide Mrs. B. with a safe forum for Mrs. B. to practice assertion, with the ultimate goal of helping the parents negotiate family rules and involvement in a more symetrical fashion. It was also hoped that Mrs. B. would be better able to request Mr. B's involvement and feel more invested in carrying out her parental functions as they would also include her desires for the family. The goal of having them carry out the assignment within earshot of Tracy was to empower Mrs. B. in Tracy's eyes, in the hopes of detriangulating her from any subtle pressures she might feel to weaken Mr. B. for Mrs. B. A more nebulous goal in the assignment was to raise the intensity of the family, in order that they would more readily accept change. Following the third session with that focus Tracy ran away from home.

The family returned several weeks later, stating they all felt closer after the experience. It was hypothesized that family anxiety following the crisis was high, and that in order to preserve the system everyone was more invested in preserving the calm. This included

increased parental involvement and concern. This was evidenced by the fact that the parents did make more of an effort to engage in family activities, involvement which had been difficult to establish prior to the crisis.

Sessions fifteen through eighteen were conducted over the summer, where few new issues arose, in part because weekday routines and structure were more relaxed. The sessions focussed primarily on recognizing Tracy's age, with her approaching sixteenth birthday signalling the importance of balancing freedom with setting the stage for responsible adult behavior in the world outside the family. As Tracy had talked about quitting school they were encouraged to have a mutually agreed upon plan for how to deal with that issue, and alternatively, agreement regarding their expectations if she did quit.

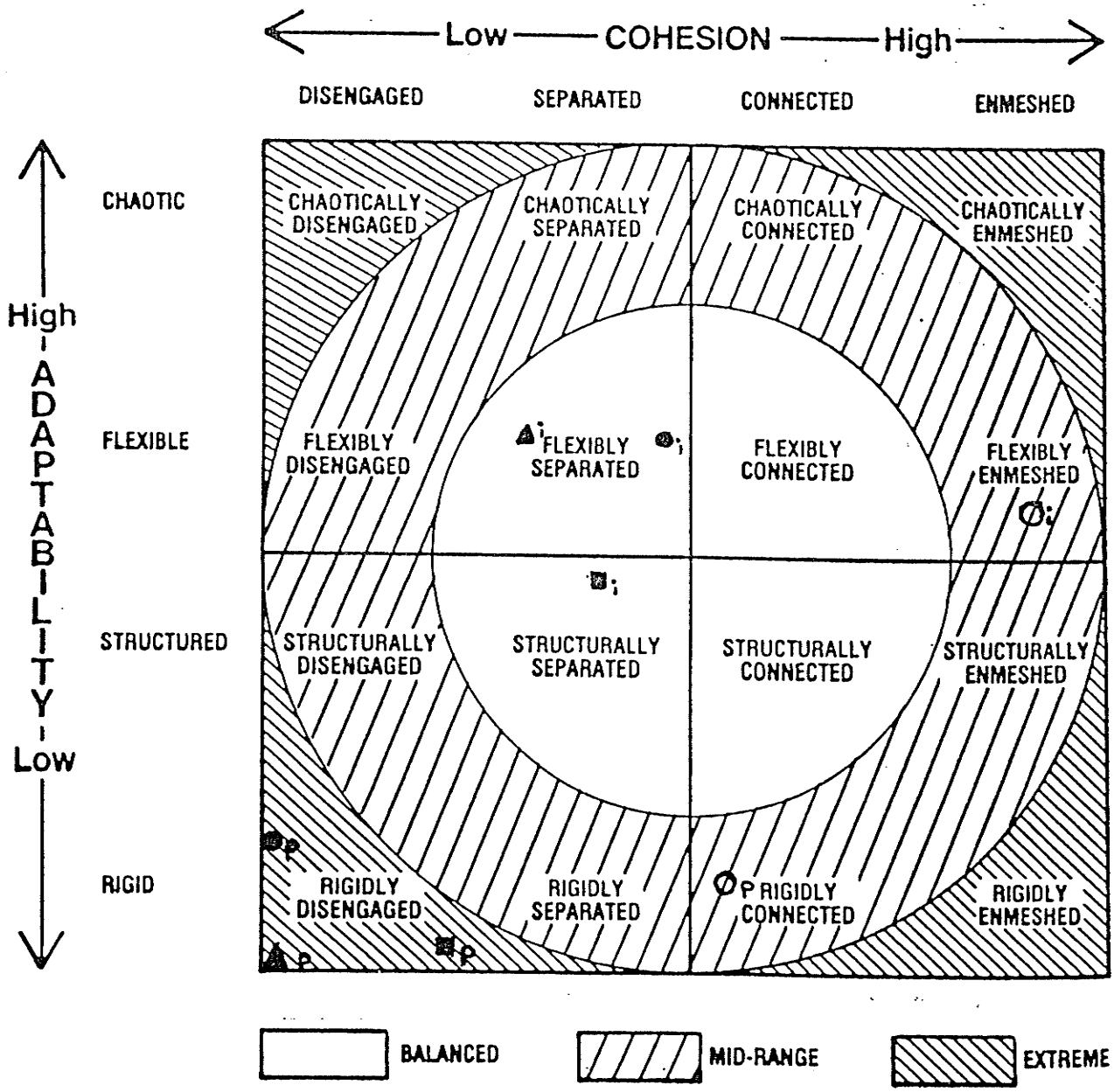
No new issues or incidents occurred during this time, and parental complaints decreased. Termination was mutually agreed upon in session eighteen.

Evaluation and Case Conclusions

Figure 3 depicts the pre-therapy Faces II profile. It is immediately apparent from the perceived scores that everyone in the family shared the perception that the family was rigid in terms of adaptation. This was consistent with the therapist's observations. In particular, it was noted that the family was rigid in terms of role structure and rule negotiations, and there was a low tolerance for deviation or change.

In terms of cohesion, Mrs. B and Tracy scored in the extreme range of disengagement. Mrs. B scored particularly low, at 39, 17.9 points

FIGURE 3 CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



Mr B
Mrs B
Tracy
Rudy
Perceived
Ideal

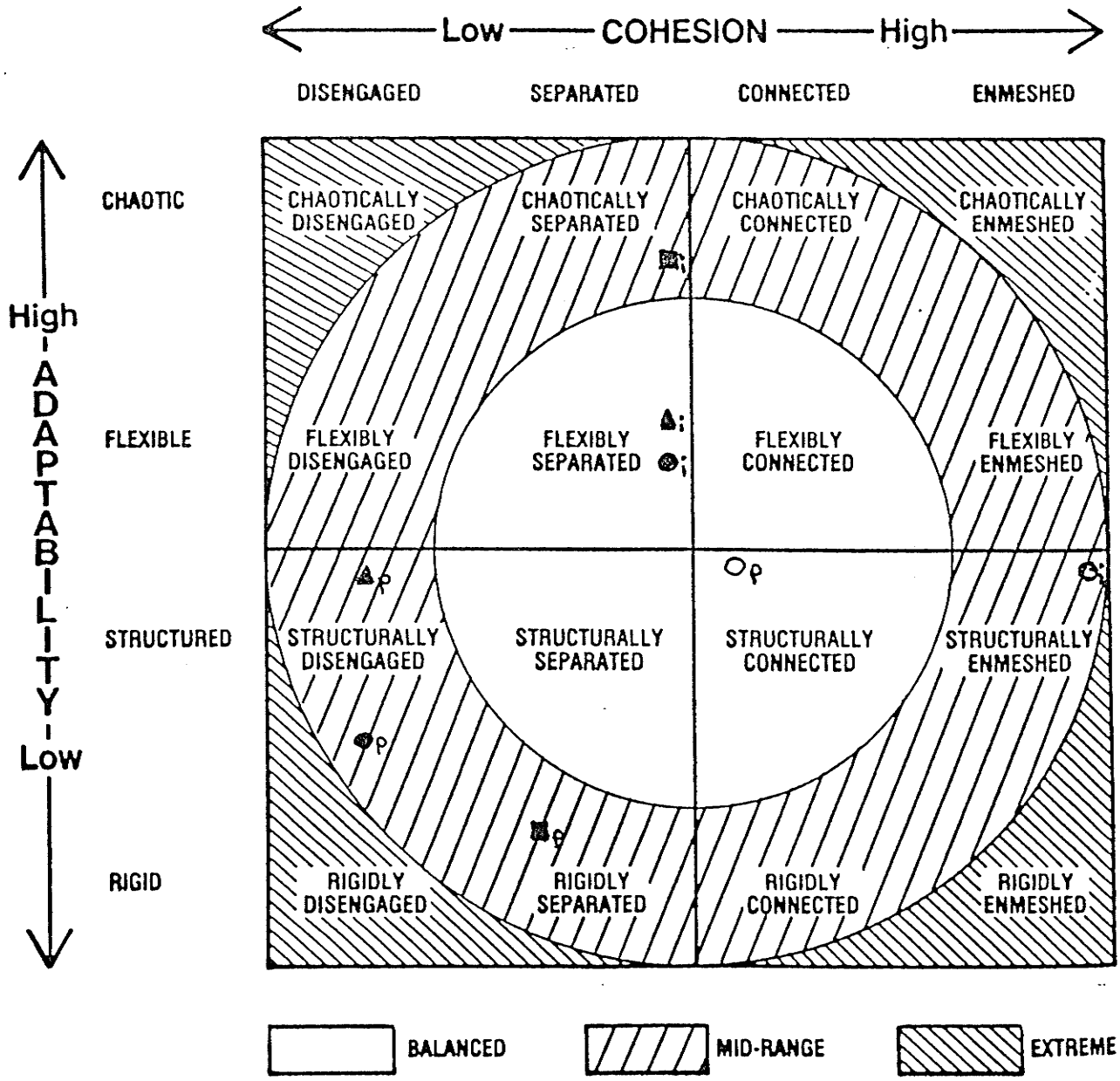
below the adult cut-off point for disengagement. Tracy's score was slightly less extreme in relation to the cut-off point (47.9 or below) at 36. Father scored at the lower cut-off point for connected at 57, an identical score to Rudy's. The lower adolescent norms placed Rudy in the connected range.

The FACES II scores were consistent with the writer's system assessment with one exception. Mrs. B's in-session behavior frequently suggested enmeshment with Tracy. As indicated in the system assessment, an alliance based on their perceived lack of emotional connection and sex differences may have also included overinvolvement. Unfortunately, the FACES II scale measures the family as a whole, and does not identify dyadic differences.

With the exception of Rudy, the rest of the family scored in the balanced range of flexibly separated in their ideal scores, indicating dissatisfaction with its functioning and a balanced view of how it would prefer to function.

The post-therapy profile is depicted in Figure 4. Changes were most evident on both dimensions for Tracy and Mrs. B. Tracy indicated a slight increase on the cohesion dimension, up to 40 from her pre-therapy score of 36. Mrs. B showed a large increase on cohesion , up to 46 from her pre-therapy score of 39. Both still had scores about 10 points below their respective cut-off levels for disengagement. On the dimension of adaptability Mrs. B showed a small change, up to 44 from 40. Tracy showed a dramatic change in her rating of adaptability, up 13 points (44 post-therapy, vs. 31 pre-therapy). Mr. B reported a small increase in cohesion (60 post, 57 pre-therapy) and a slightly larger increase on adaptability (42 post, 37 pre-therapy). Rudy reported

FIGURE 4 CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



Mr B
Mrs B
Tracy
Rudy
Perceived
Ideal

identical perceived scores pre and post-therapy (cohesion 57, adaptability 34).

The most significant overall changes were increases in adaptability for Tracy and cohesion for Mrs. B. Moderate changes were noted for Tracy on cohesion and for Mr. and Mrs. B on adaptability. The changes made were consistent with the therapeutic targets and changes noted in the therapist's observations. The direction of the changes were as desired. The magnitude of the changes was moderate for the most part, with several large changes noted, particularly cohesion for Mrs. B and adaptability for Tracy. It should be noted however, that the pre-therapy scores were in the extreme levels, and remained outside of balanced levels at termination.

It is interesting to note that the ideal scores for Mr. and Mrs. B at termination showed substantial elevations in adaptability, into the chaotic range. It may be that the therapy focus on issues relating to the adaptability dimension may have produced the desired cognitive change without corresponding behavioral change. Relative to their current functioning they may have perceived larger changes than necessary in order to achieve their ideal for healthy functioning.

Clinical observations of the family's progress concurred with the FACES II results. Overall, the family was in the extreme range at the time they entered therapy. The changes which occurred were moderate, but their functioning at the time of termination was still fairly rigid and disengaged. The magnitude of the changes reported by Brook on adaptability and Mrs. B on cohesion were larger than what the writer's clinical observations would have suggested. This may have been due to the extended period of time which he saw them and the discrepancy

between his goals and the family's level of functioning. Owing to the gradual nature of the changes it may be that they were not detected as being as significant as they were. Given this possibility, it would have been beneficial to get a measure of any such marital changes which may have taken place. Likewise, although strengthening of the sibling subsystem and generational boundaries were therapeutic targets, the effectiveness of those interventions could not be quantified using the FACES II scale.

THE C FAMILY - LESLIE

Leslie was a self-referral, coming on the advice of her mother. The presenting problems related to what leslie's mother referred to as mood swings. Leslie frequently felt that her emotions were out of control, and was afraid that her mood swings might jeopardize her relationship with her boyfriend Peter. She and Peter had been serious enough in their relationship to be discussing marriage.

Background and Etiology

Leslie was a twenty-two year old and divorced. Leslie had married Fred at the age of nineteen, against her parents' wishes. Fred and Leslie were the same age. Leslie and Fred had moved to a remote northern community right after their marriage, to find work for Fred. The marriage was characterized by chronic hostility and withdrawal, lack of support and frequent absences on Fred's part during alcohol and drug benders. The marriage lasted a year and a half. Leslie described the last six months of their relationship as being characterized by total apathy and disengagement.

Leslie returned to her home town of Carman a year prior to coming to the mental health service for help. She was employed as a clerk and shared a house with several friends. At the time she came for counselling she had been dating Peter for six months, and maintained a fairly independent life from her family of origin. She visited with her mother at least one night a week with regularity.

In terms of family of origin, Leslie was the oldest child in an intact two parent family. Leslie's parents were both in their fifties. She had two siblings, a sister Rebecca who was a year younger than

herself and a thirteen year old brother, Ed. Rebecca, pregnant at the age of seventeen, was currently separated and living with her parents, along with her child. Rebecca and father had always been in open conflict with each other.

Father had always been peripheral while Leslie was growing up. Leslie's outbursts toward father had been labelled as mood swings at the age of eleven. They were most frequently directed toward father. Mother was described by Leslie as the "emotional centre" of the home. There was a history of psychiatric problems in mother's family of origin, with one uncle having committed suicide and another being under psychiatric hospitalization. Following termination of therapy with Leslie mother referred another uncle for counselling. Mother also appeared to be the "family psychiatrist."

Assessment of System Dysfunction

It was hypothesized that Leslie had not fully differentiated from her family of origin, that she was still triangulated by the family projection process. Leslie's anger outbursts toward father served to detour the conflict between mother and father, voicing mother's anxiety and frustration about father's disengagement. They also served to regulate distance between mother and father. The family mythology that Leslie had "mood swings" served to keep the coalition between mother and Leslie covert. In turn, this legitimized the triangulation and enabled Leslie to continue voicing mother's anger without an obvious generational violation. The family myth also served to maintain the enmeshment between mother and Leslie. Over time, Leslie became increasingly dependent on mother to validate her feelings, as she could

not trust her own perceptions.

At the personal level, Leslie was caught in a self-defeating cycle. She was tentative about any conflictual feeling expression, and as a result often overlooked what she considered to be personal transgressions against her. Eventually her frustration would build to the point where she would ventilate her frustrations. Following that she would disqualify her feelings and attribute them to mood swings.

Goals.

1. To facilitate a healthy emotional cut-off, detriangulating Leslie from the parental and family conflict.

2. To challenge the family script Leslie carried as someone with mood swings.

3. To legitimize feeling expression for Leslie and to coach her to identify and express her feelings in a healthy manner.

4. To support and validate Leslie to enable her to strengthen her personal boundaries, accept new definitions of herself, and accept responsibility for her own thoughts, feelings, and behavior.

In conjunction with Mr. MacDonald it was decided to see Leslie individually at the outset, reinforcing the limited independence which she demonstrated. If strategically working with her individually was not effective, family sessions would be initiated.

Interventions

Much of the first session was spent joining with Leslie, gathering information and validating Leslie's feelings of hurt. Leslie went through an outpouring of emotion, particularly about her feelings of being uncared for in her marriage and family of origin. Having validated her feelings, the therapist normalized her feeling expressions in the session as natural for someone who felt so unloved.

The therapist claimed some confusion regarding her mood swings, whether they were in fact mood swings or expressions of anger and feeling uncared for. Leslie was given the assignment to track her mood swings with greater detail in the next week. She was to take note of the triggers to them, with reference to when they occurred, with whom, about what, and any other such details. She was also requested to think about past patterns of her mood swings, to get a better picture of what they were about. A contract was made to work with Leslie on the mood swings for five sessions.

The following week Leslie stated that she could not find any pattern to the mood swings as assigned in session one. The therapist tracked Leslie regarding the patterns which might have been occurring in her marriage and family of origin. It gradually emerged that Leslie would become angry about something, get depressed and mad, and after a period of time where the anger churned inside her, would be triggered off by some little incident. Leslie would then make peace by disqualifying herself and whatever issues she had raised.

Leslie then discussed a recent example of how she had blown up at Peter. The therapist highlighted how this was about something she had legitimately been angry about, not a mood swing. Leslie was beginning

to accept the reframing of her mood swings as being legitimate expressions of anger, but usually expressed after a long period of discomfort, long after the initial source of her anger was absent. The right to confront others with her anger was then discussed, laying the groundwork for more appropriately timed assertive behavior.

Leslie's disjointed affect was also confronted by the therapist, highlighting how she attempted to minimize conflict expressions by nervous laughter and becoming overly talkative. It was reinforced that if she were more focussed on her feeling state and did not try to avoid her feelings, that she would find it easier to assert herself in legitimate ways, and people would take her more seriously.

The frame was suggested that Leslie could only get herself to confront strong people, currently her mother and her boyfriend. Leslie was to think about who she could confront and who she couldn't in order to get a clearer picture of what was happening transactionally.

In session three Leslie stated that the frame from the previous session did not seem to fit, that it was only strong people she could confront. Upon further probing Leslie suggested that it was sensitive people she had difficulty confronting. Leslie discussed her fear of hurting others with her anger, saying intractable things. The therapist engaged in reframing Leslie's anger and what it meant to people when she became angry. This was done as a way of challenging her fusion of emotion and intellect, differentiating between her thoughts, feelings, and behavior, and those of others as well.

The therapist distinguished between expressing anger and asserting herself about specific behaviors people were doing which bothered her. She had equated anger with character slander to that point in her life,

presumably due to her weak personal boundaries. The implications of this were explored in terms of her social functioning, boyfriend, and family of origin.

It was of note that Leslie was very quick to pick up on the concepts of differentiation. At this point in therapy she was also much more attuned to her own feelings. As well, her behavioral presentation was much more congruent with her affect than it was previously.

Leslie was given the assignment to identify her anger when she felt it, and to confront specific behaviors that others were engaging in which bothered her. She was coached on how to be precise about the behavior she was confronting and to preface it with the feeling it caused in her. This was assigned to further promote differentiation and strengthen her personal boundaries. Owing to the level of involvement she maintained with her family and boyfriend at the time, it was anticipated that the assignment would involve these systems. The task was left open-ended in terms of content, in order to effect the changes in current situations rather than historical issues.

Leslie presented in a very calm and confident way in session four. In the course of the week she had confronted her sister about some issues which were happily resolved. As well, she had engaged in a discussion with her mother regarding some of the parental dynamics around her mood swings as a child. Leslie was sorting out a lot of family scripting on her own, and was no longer talking about anger in terms of mood swings.

Much of the session revolved around family themes of Leslie's triangulation and family anxiety about differences. Leslie had felt very good about the adult conversation she had with mother, and was

contemplating doing the same with father the next week.

No specific assignment was given in light of the steps Leslie was taking on her own. The themes of differentiation, behavioral specificity in confronting, and not letting anger building up to the point of blowing up were reinforced.

Leslie cancelled her final appointment. She stated that she did not feel the need for further therapy at that time.

Evaluation and Case Conclusions

A target complaint rating scale was used as a pre-post measure of the success of therapy. Leslie reported that her "mood swings" had gone from a rating of 4 (very serious) to a 1 (not very serious). Feeling emotionally out of control went from 3 (fairly serious) to a 1 (not very serious). Feeling insecure about boyfriend dropped from a 3 (fairly serious) rating to 1½ (between somewhat serious and not very serious).

Leslie's rating concurred with therapist observations. Leslie in fact no longer saw her mood swings as mood swings at all, but rather as expressions of pent-up frustration. In terms of feeling out of control and insecure with her boyfriend, Leslie had become so unsure of her own feelings owing to family scripts and labels that it is the writer's hypothesis that they were largely a by-product of not trusting her own feelings. She was still experiencing some insecurity about her status with Peter, but it appeared to be greatly diminished.

Session observations suggested that Leslie was acting in a much calmer and confident manner in the course of therapy, in sharp contrast to her emotionally labile manner at the outset. Her affect was more congruent, less distracting, and nervous. Overall, her presentation in

the sessions changed dramatically.

In the writer's view, the most significant intervention in bringing about the changes which occurred involved challenging the labels and scripts which Leslie held about herself and her emotional expressions. Once she accepted those redefinitions and saw her outbursts as legitimate outpouring of pent-up frustration she began to trust her feelings, assert herself, and change her undifferentiated perceptions. The changes which Leslie made in terms of her family appeared to take a quantum leap in terms of a healthy emotional cut-off. Her perceptions of family of origin influences were much more in focus. In many ways, it felt to the writer that the whole process unravelled by itself once the initial reframing was done regarding the mood swing script she carried.

COMPARISON OF EVALUATION INSTRUMENTS

The following discussion examines the respective strengths and weaknesses of the family evaluation instruments utilized in this practicum, FACES II and FAM III. The discussion opens with an examination of some practical issues, followed by discussion of the instruments in terms of diagnostic and evaluative use.

The FACES II Scale is a relatively short instrument consisting of 60 items in total when perceived and ideal ratings are made. The FAM III Scale contains fifty items on the general scale and forty-two items on the self-rating scale. Also, the dyadic scale requires the completion of forty-two additional items for each family member. For a family of three, if all the scales were filled out this would require filling out a total of one hundred and seventy-six items. However, the potential practical constraints of length can be dealt with by differentially administering only one of the levels of the scale at the beginning of therapy. Depending on what is deemed important, the family would only need to complete one of either the general, dyadic, or self-rating scale. Aside from requesting dyadic pairs for a large family, the two scales are fairly comparable in length when FAM III is administered in this way.

It has been suggested in previous practicum reports (Shar Reid 1985, Marlene Rechart, 1985) that completion of the scales at the therapy site immediately preceding the initial interview can be a frustrating experience for parents who have to attend to restless children while the scales are being completed, resulting in less than ideal conditions to begin the interview. If the initial interview is a lengthy one in addition to that, it is conceivable that the emotional

drain experienced by the family by the end of the first contact may set a negative tone for the therapy process.

If the therapist's level of discomfort is high regarding the administration to the scale or with conducting family interviews, the net effect may be doubly disruptive to properly joining with the family and making full use of the interview to set the tone for therapy. It can also signal to the family that scales are disruptive and unrelated to therapy.

In light of the above considerations, pre-therapy scale administration in family therapy may be somewhat more difficult than in other modalities. Several alternatives which have been adopted may be used to minimize these difficulties. Pre-mailing questionaires is one such alternative. The accuracy of reporting may be somewhat affected by pre-mailing, including family anxiety about therapy and failure to understand the instructions. Assigning the completion of the scale as a take-home task is another option. Compliance with completing the scales may be compromised though, as is the case with pre-mailing. Finally, the therapist may have the family complete the forms after the interview, once the therapist has joined with the family. This not only has the advantage of allowing the therapist to observe the family and determine which scales might be the most informative, but also would be expected to have the greatest compliance.

While the practice of family therapy has been popularized by a number of charismatic and skillful advocates, it is this writer's contention that if it is to maintain its acceptance as an effective therapeutic modality, hard evidence of its effectiveness by grass roots practitioners is required. Process measures such as FACES II and FAM III

can quantify the effectiveness of family intervention which this writer suggests is doubly important in the case of systems therapies, as the flexibility in method and attention to process which contributes to their effectiveness also makes them ambiguous to interpret for the sceptic.

Turning to the scales themselves, the writer found both to have their merits. The writer preferred the FAM III Scale primarily for its flexibility and capacity to map the various currents of family process. This is described in greater detail following the discussion of FACES II.

The FACES II Scale provides a simple, short format for reducing the complex interaction of a family into a manageable form. The dimensions of cohesion and adaptability are useful dimensions clinically, and sample from a number of content areas which from the standpoint of face validity appear useful. The writer found the cohesion dimension in particular a useful anchor, as clinical descriptions of this seemingly simple concept may easily be buried by complex system interactions which mask its true levels. The B family provides a good example of a mother-daughter relationship whose in-session behavior had the appearance of enmeshment while their extra-session behavior suggested disengagement.

Another feature of the FACES II scale which this writer found useful was the use of perceived and ideal functioning. First, it serves to qualify what are essentially subjective responses, assisting the therapists interpretation of perceived scores when there are discrepancies between family members. As well, it may be useful in identifying unrealistic expectations which some family members may hold.

Finally, relating to both of the above, the use of perceived scores may be of use in identifying polarization in the family in the strategic sense. That is, for example, if distance is an issue, extreme scores on the ideal ratings should alert the therapist to the potential that family members will perceive relationship cohesion in significantly distorted ways.

On the negative side, the FACES II Scale measures family functioning as a total system, obscuring the analysis for differentiated functioning at the various subsystems in the family and their interrelationships within the larger system. As illustrated by the B family, marital functioning was not discernable from sibling interaction, nor the individuals involved. The family may function in a disengaged manner but enmeshment may exist between specific pairs, which the scale does not identify. Also, FACES II provides only two major dimensions which are somewhat nebulous, as opposed to FAM III's seven family factors and two response bias scales.

The FAM III Scale does allow for subsystem analysis and identification of dyadic differences within the family context. As illustrated by the short comings of FACES II in the B family, dyadic information is important to gather when subsystem boundaries are a target, as well as subsystem interaction. Marital conflicts may be readily identified, as well as coalitions and triangulation. Whereas family functioning may be characterized as disengaged for example, as with the B family, coalitions or triangulation may be identified by way of the dyadic component of the scale.

Another feature of the FAM III Scale which gained this writer's appreciation was its ability to identify problems at boundary

interfaces, recognizing that the whole is greater than the sum of its parts. As illustrated in the case of the A family , while communication was not in the extreme problem range for Mrs. A when considering either her fiance or son individually, as a family the difficulties were much greater. By measuring family interaction and referencing it to dyadic interaction, problems at the boundary interface are readily apparent.

The Self-Rating Scale provides another means by which different family members ratings can be cross-referenced. It provides a subjective self-perception apart from the other members ratings. Discrepancies alert the therapist to areas of potential resistance and which are incongruent with the rest of the family's perceptions.

The differentiation into subscales is another useful facet of the FAM III Scale. Deficits in functioning may be identified and isolated as specific targets for therapeutic intervention. At the same time the information may be condensed into a simple overall rating for the sake of clarity.

Finally, the social desirability and defensiveness subscales provide a valuable check against misrepresentation on the test. While the example provided by the son in the A family was evident enough to be detected, there may be instances where distortions in reporting may misdirect the therapist into unwarranted conclusions without checks of any type. As well, research efforts need concrete indices such as those provided by these subscales to simplify the criteria for data exclusion.

CHAPTER V REFLECTIONS ON THE PRACTICUM EXPERIENCE

Having concluded the discussion of theory and practice, the writer now turns to a personal reflection of the practicum experience. Before discussing the particulars however, I feel the most fitting comment at this point would be to emphasize my heartfelt sentiment regarding the value of the practicum in developing my family therapy skills. I would like to make note of my good fortune in carrying out this work in the manner it was done, and with professionals with the kind of expertise that I was able to work with.

While many of the systemic writings talk about live supervision, it seems that there are fewer therapeutic settings which are committed to working this way than those who do family therapy. This being the case, I found the committment of the Portage Mental Health unit to "doing family therapy the way it is supposed to be done" a very unique and very positive experience.

While the use of supervision may greatly enhance the power to create change in families, I believe it does a number of other important things as well. It is one thing to make the shift from linear to systemic thinking, it is another to put it into practice. I believe there are a number of practitioners who are aware of and see systemic influences, but have difficulty putting it into practice. Having the opportunity to observe other practitioners doing it and being supervised by them can be of as much importance in terms of confidence as it is in terms of clinical skills. To anyone sincere in their wish to do family therapy, I could strongly recommend at some point in their practice to "do it the way it is supposed to be done".

Given the nuances and complexity of family process and intervention, I found the use of live supervision invaluable in terms of

my own learning. The fact that I had the opportunity to work with practitioners as experienced and varied as they were made it doubly invaluable.

As a student, this could have been a very threatening experience. Learning complex methods in complex situations with seasoned family therapists either watching or consulting has the potential to raise a lot of anxiety. Without confusing acknowledgements with a statement of my experience, I take my hat off to all those who I worked with on the practicum, for their skills in guiding my development in a helpful and natural way.

I believe that among other things, the chance to participate behind the "one-way mirror" was one of the things which helped to alleviate some of the anxiety. Seeing experienced family therapists at times struggling with a "difficult" family made it a little easier to struggle myself. Observing how to "climb out" of some of those struggles also made it a little easier to "climb out" myself.

The chance to participate in a Milan styled team was an opportunity to observe not only the process of therapy, but the process of supervision as well. The writer had the opportunity to participate this way in cases which were being seen by Mr. MacDonald and Mr. Dunfield, which eased his own anxiety about the process substantially. Somehow reading about condensed versions of classic cases dealt with by the "Masters of family therapy" seems a little less intimidating when one has a chance to see what happens in between the "magic moments" of therapy.

An area which seldom receives mention is the process and skills involved in working in a live supervision format. As stated earlier,

shifting from systemic thinking to systemic intervention requires the development of confidence to do so, in addition to the clinical skills. If one way to assist therapists to becoming more confident and successful in "trying on" systemic intervention is the use supervision, the barriers of anxiety to working with supervision also need to be addressed.

Most therapists are accustomed to doing therapy on their own, behind closed doors. Adding another therapist to the situation means adding another therapeutic dynamic, that between the therapist and supervisor. I was fortunate enough to learn to deal with this by observation and osmosis. For many therapists I'm sure it is not that easy, with the net effect of setting back the process of supervision, and perhaps, giving up on a method of therapy which can be as powerful as it can be confusing. Unless one is anchored, it can be very confusing indeed.

Mr. MacDonald set out a rule at the outset of the practicum: "The supervisor supposes and the therapist disposes". Translated, this meant that the therapist in the room with the family ultimately decides upon direction. This may be a simple rule, but an important one. The writer also noted how this rule worked best when preparation and general direction were worked out prior to sessions, to avoid mid-session stumbling blocks and anxiety.

Much of this discussion has focussed on the live supervision component of the practicum. This is not to minimize what I felt in terms of developing my skills in family therapy or systemic therapy in general. I feel that my learning was substantial. What seemed most significant to me in respect to the learning process of doing systemic

therapy however, was the manner in which the practicum was carried out. Having the opportunity to observe firsthand the triumphs and failures of a team with a combined experience of fifty years or more, working as a team, seemed to me to accelerate my learning tremendously. As well, I think it gave me some "guideposts" on which to judge what I am doing in therapy, to know when my anxiety with a family is rightfully telling me to try something more, and when it is necessary to accept that change does not always come easily.

In conclusion, it is my belief that any therapist endeavouring to practice systemic therapies should, at sometime in their work, use the format of this practicum. As a setting to learn in, I couldn't think of one I would recommend more highly.

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Name _____

TARGET COMPLAINTS

Please rate the amount of difficulty you experience with these problems currently.

Not Very Serious	Somewhat Serious	Fairly Serious	Very Serious	Overwhelming
1	2	3	4	5

Rating

Problem 1:
_____

Problem 2:
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Problem 3:
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Problem 4:
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Problem 5:
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Additional Comments:

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CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS