

THE UNIVERSITY OF MANITOBA

A PRACTICUM IN FAMILY THERAPY

UTILIZING A COMBINATION OF APPROACHES

BY



JUDITH A. BAKER

A Practicum Report submitted to
The Faculty of Graduate Studies
In Partial Fulfillment of the Requirements of the
Degree of Master of Social Work

June, 1988

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ABSTRACT

The purpose of this practicum was to apply a combination of approaches to the practice of family therapy. The four approaches utilized when intervening with the families were ecological, structural, strategic and family developmental life cycle approach. Eight families were seen with widely varying demographic characteristics, at various stages of the family life cycle. The evaluation measure utilized was the Family Concern Form administered pre- and post-intervention which indicated increased satisfaction with family functioning following the intervention. The combination of approaches provided a sound basis for assessment and intervention and facilitated skill development.

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CHAPTER I

INTRODUCTION

The purpose of this practicum was not only to develop clinical skill in family therapy but to achieve an understanding of theory in its application to assessment and intervention with families. The theories examined here include: ecological, structural, strategic and family life cycle.

Discussed in considerable detail in Chapter Two, the ecological approach goes beyond the context of the family to consider the outside systems which interface with the family. The openness of this approach in exploring external systems as well as the internal family system lends itself to revealing many possibilities for intervention, one of which is family therapy.

The structural approach also views the individual and his/her problem within a social context, rather than viewing the problem as being inherent within the individual. Assessment of the family's organization on the dimensions of hierarchy and distance are integral components of this approach. When family members are unable to negotiate their roles and functions as circumstances demand both inside and outside the family, then they are assessed as dysfunctional.

The focus of strategic theory is not on family structure or the family system per se but rather on the ways the family has developed to handle the problems inherent in everyday life. Strategic therapy is based on the premise that families perpetuate their problems by the means they employ to remedy them.

Therapeutic change is directed at this ineffective solution in the form of interrupting or blocking the pattern of behavior that perpetuates the problem.

The family life cycle model postulates that all families in the course of their development face certain major events which entail different tasks. The completion of these tasks enables the family to better meet the needs of its members. The timing of the various events or stages of the life cycle is important as the family experiences disorganization and has to adjust to changes. Difficulties arise when the developmental tasks of one stage are not successfully completed before moving on to the next stage.

After an examination of the theories applicable to the practice of family therapy, I sought an appropriate setting to further enhance my clinical skills.

Children's Home of Winnipeg had recently set up a family therapy program and I was fortunate to be able to participate in the family therapy training group which began in September, 1983. The course of the practicum was January until June 1984. Supervision was provided on site by Shar Reid and Vicki Harrison and overall supervision and case consultation by my advisor Dr. Kathryn McCannell. A further description of the practicum experience including setting, clients and case examples is found in Chapter Three.

The final section of the practicum report provides a discussion on the evaluation instruments and procedures, considering their reliability, validity and limitations. The families rated themselves on a five-point scale of satisfaction in various areas of family functioning. A comparison is made of the pre- and post-intervention scores, which can be found in Chapter Four.

CHAPTER II

LITERATURE REVIEW

This literature review is devoted to discussing four different approaches - the ecological approach, and the structural, strategic and life cycle models. These approaches provided a theoretical framework from which I could practice family therapy. The ecological approach utilizes a style of thinking and a way of operating that goes beyond the context of the family to consider the outside systems which interface with the family. It will be discussed here first, along with several issues considered pertinent to this practicum, which included families from various cultural backgrounds and the core area of Winnipeg.

The Ecological Approach

The ecological approach distinguishes itself from other approaches by the amount of time and effort which

goes into the ordering of data within a selected framework. Auerswald (1968) considers this the most important step of the practice sequence, as it is here that the decision is made regarding what data is important and, therefore, what interventions are attempted. The ecological approach goes beyond the individual or the family to collect data on the broader systems which interface with the client. Auerswald (1968) illustrates this clearly in the case material he presents where the "explorer" psychiatrist becomes involved with helping a mother discover the whereabouts of her runaway adolescent daughter. As part of the process of collecting data, the psychiatrist utilizes a systems view, obtaining information from people outside the family involved with the girl (i.e., social worker, teacher, guidance counsellor, group worker) and from inside the family (i.e., mother, sister, grandparents). The openness of this approach in exploring external systems as well as the internal family system may reveal resources or factors that would not be considered with more traditional approaches.

It is this emphasis on context that distinguishes the

ecological approach and renders it particularly useful when incorporating the role of culture. Spiegel (1982), when applying this model to ethnic families, views a person's behavior in the context of the ecological niche or, in his words, "transactional field". The transactional field as delineated by Spiegel is composed of six foci, namely universal, soma, psyche, group, society and culture. It is organized in a circular fashion to demonstrate how the processes of each focus are in transaction with the others directly preceding and following it. The family as a "group" does not exist in isolation, rather its form and function is influenced by the larger network of a social system called "society". Society is composed of families and other social institutions (i.e., religious, educational, economic, legal, governmental, recreational and voluntary). It is through these social institutions that society expresses its beliefs and values regarding human existence which can be identified as "culture".

Germain (1981) presents a comparable ecological framework whereby the physical and social environments are divided into layers which act on each other. she sees the physical environment as including two layers -

the "natural" world and the "built" world as well as two textures of time and space. The social environment is divided into various layers positioned according to their level of social organization. Social networks of relatives, friends, neighbours and work associates are seen as comprising one layer. The next layer includes organizations and institutions providing services and resources on a public and private basis. The final layering of the social environment consists of the value systems of the culture, the political and economic structures and the environment of law statutes and policy. The textures of social space and social cycles of time are present in the social environment. Both the physical and the social environments interact with each other against the backdrop of the broader cultural context.

There are several commonalities among the approaches advocated by these three authors. First, each sees the ecological perspective as providing a comprehensive frame for assessment of person-in-family-in-environment. Second, such a model suggests many possibilities for intervention within the "transactional field", family therapy being only one possible alternative. Finally,

the approach emphasizes the importance of recognizing strengths and building on these as part of the intervention plan.

Ethnicity and Family Therapy

The therapeutic implications of these approaches would suggest that the focus of culture be a starting point for families undergoing acculturation. As Spiegel notes, the conflict inherent in differing cultural norms must be dealt with in therapy. The therapist can acquaint her/himself with the differences in cultures by comparing value orientations. Spiegel (1982), in comparing the preferred value orientations of American, middle class, Italian and Irish families, identified several dimensions useful in understanding differences. These dimensions included orientation to time, (past/present/future), activity, relationships, and interaction between nature and humans. Such a checklist provides a helpful tool in recognizing differences when working with families from cultures foreign to the therapist.

The therapist needs to be aware of how his or her

values differ from the values of non middle-class, non Canadian/American families and be able to reconcile these differences. In order to understand and accommodate these differences, the therapist needs to be knowledgeable of the dominant values of the client's particular ethnic group.

Poverty and Family Therapy

The ecological approach also lends itself to application with families living in poverty. The "total field" of the problem for the therapist working with poor families can involve other professionals and their agencies, institutions such as welfare, the extended family and other community figures. Auerswald proposed the idea of conferences for multiproblem families; by involving all family members and the professionals working with them, services could then be coordinated (Hoffman, 1981). It is important to note, he is proposing the family be present at such meetings unlike the traditional "case conference".

This coordination of services for the problem poverty family becomes more important when one recognizes the

impact of the behavior of external systems on the internal operations of the family. Janzen and Harris (1980) state that in order to improve the functioning of a poverty family, a change is necessary in the poverty status as well as in the family's functioning. This change can only come about if there are adequate external system supports, of which agency commitments are a part.

The problem poverty family is experiencing limitations in the support given by external systems. The poor family has an inadequate financial base. This could be due to limitations of the economic system (unable to provide employment opportunities), the social system (public attitudes and policy may limit provision of an adequate level of income or services), the personal system (i.e., lack of skills), or any interaction among these three. The consequences of a family unable to provide for itself materially are evidenced in the diminished status and roles of its members.

External systems can exert a negative influence on the poverty family. For example, negative attitudes held by public agencies and workers can diminish the self esteem of family members. Agency policies set up to

provide service and support only under certain conditions and only to specific members of the family tend to divide families. The family under pressure to conform to agency policy may become less of a separate entity and increasingly more dependent on the agency system. When faced with conflicting demands from several agencies, the family's structures or boundaries may respond by collapsing (Hoffman and Long, 1969).

The extended family can be a source of support provided the members are in a more stable position, financially and psychologically. Another possibility involves a relationship with the extended family where they seek to control and direct the actions of the poverty family and lean heavily on them for support. This being the case, the family system is further taxed, rather than being strengthened.

Poverty families may have limited connections with the outside world. They may have few or no friends. The institutions they have been in contact with (i.e., school, church, health services) may not be readily approached because of negative associations.

The poverty family may be operating in relative isolation from the outside world and possible sources of support, self-esteem and connectedness. Saulnier and Rowland (1985) found an average network size of 10 among a sample of 32 mothers of children at risk of out-of-home placement. This is considerably smaller than network sizes reported for the general population. Further, it was found that a low degree of community interaction was associated with greater probability of placement. Without this necessary input, the family becomes more dependent on its members and consequently may lack the knowledge and skills needed for productive interaction with the external systems.

The negative impact or lack of contact with external systems causes the poverty family to turn in on itself for gratification, thus placing considerable stress on internal family operations. The family's response to the stress may be to develop unsatisfactory patterns which will endure until change is made in the behaviors of either the family or the external systems or both (Janzen and Harris, 1980).

Family therapy with problem poverty families may

involve an advocacy component to change external systems. The family may need help to respond appropriately to the new information and resources made available to them. The therapist, by operating in the "here-and-now", can teach the family new behaviors which they can try out at the time.

The internal functioning of problem poverty families will be described according to the following three aspects; boundaries, rules and communications, which relate to the family's integration, solidarity and sense of identity.

In two parent problem poverty families, Janzen and Harris suggest that the adults are often unable to form a strong marital bond, which adversely affects their relationship satisfaction as well as their ability to support each other. Janzen and Harris describe the relationship between the adults as being characterized by distance, conflict and transiency (1980, p. 84).

Partner withdrawal or conflict are common reactions to an unsatisfactory relationship. When withdrawing from the spousal role, the parental function may be given up

as well. This can result in the adult assuming a child position and crossing generational boundaries. When conflict escalates beyond the marital unit, a parent may attempt to form an alliance with a child. In this way, the generational boundaries are again violated.

The child can react to this boundary breakdown by becoming an ally to one parent and isolating him/herself from the support of the other parent. S/he may attempt to mediate the parental differences or take on the parental functions. Both these courses of action place the child more in the parental generation. As a response to an uncomfortable position, the child may develop emotional, physical or behavioral symptoms (Minuchin, 1974; Janzen and Harris, 1980).

The possibility of the child becoming a "parental child" seems more likely in problem poverty families (Janzen and Harris, 1980, p. 86). The parental function of providing clear leadership is often offset in these families by their tenuous position with the outside world. As many of these families are single parent families, there is a tendency to rely more on children. This may be functional if boundaries are clearly defined.

A child may learn to behave in a responsible independent manner, however, it is imperative that the boundary defining the parental subsystem be demarcated in such a way that the child is free to meet his/her developmental needs.

These structural deficits; a lack of generational boundaries and diminished parental leadership, are associated with a lack of clear and consistent rules. In problem poverty families, parents are often unable to set clear and consistent limits on their children's behavior, which results in the child's inability to learn and internalize appropriate responsible behavior. A situation develops where the presence of parents is needed to regulate the child's behavior and neither are allowed the time and space necessary for their own growth and self differentiation. Goldsmith (1982) notes that a "guilt-anger bind" may develop in response to the heavy demands of parenting. The parent feels angry about having to fulfill the parental role, yet guilty about not doing so; at the same time, a child may feel guilty about asking and angry about not getting. Such a pattern is particularly likely to emerge in the one-parent family.

When clear and consistent rules for behavior are not enacted by parents, then communication conducive to family stability and problem-solving is not likely to be present. Janzen and Harris (1980) cite several patterns of dysfunctional communication they have observed in their work with poverty families. This includes communication characterized by interruptions, simultaneous talking, topic changes and unclear meanings. Messages may not be heard or responded to, which results in a great deal of noise pertaining to affect rather than content.

The structural and communication deficits found in the problem poverty family would adversely affect how the family perceives itself. The development of family cohesion would be impeded by the lack of problem-solving skills, relationship ability and limited resources. Rabinowitz (1969) refers to the Wiltwyck study of delinquent boys and their families noting the lack of a sense of belonging which was observed in the ways the families related. Family members seemed to distance themselves from each other, rarely engaging in conversation. Participation in the family and its relationships was distinguished by a lack of a

pleasurable aspect or positive valuing.

Intervention with problem poverty families is in most situations aimed at the external systems as well as the internal structure and communications of the family. Thus, the value of an ecological approach in assessment and intervention is clear.

Harry Aponte, who worked with Minuchin during his early years as director of the Philadelphia Child Guidance Clinic, has continued to focus on poor families. He has developed an approach to working with these families which combines the ecological framework with the structural model. In his article "Underorganization in the Poor Family", Aponte (1976) describes the structural organization of the poor family as being "deficient in the degree of constancy, differentiation and flexibility" (Aponte, 1976, p.433). He defines the structural issues of alignment, force and boundary and applies them to the poor family. The poor of our society are depicted as being "not effectively integrated within their ecological set and lacking alignments with other units in their society to help them achieve their social goals. They are short on the force to exert their portion of control over the actions taken

in their social context that affect them. They also find themselves outside many of the operations of their society that are meant to enrich the units within that system" (Aponte, 1976, p.434). Thus, the poor family is hampered in its attempts to attain outside aid, and has limited autonomy to regulate its functioning from within. These conditions contribute to the poor family being relegated to an inferior position in relation to the larger society.

In another article, Aponte utilizes the eco-structural approach with a family school problem. The ecological context of the child is delineated clearly as his personality, his family, the school and the community with its sociopolitical character (1976, p. 310). All these systems are considered in the therapeutic intervention and their significant representatives are included in the family/school interview. By including the child, the family and school staff in the interview, the therapists are able to observe the interaction and the participants are able to see how their relations with one another affect the child. During the interview, the therapists construct hypotheses related to the nature of the problem and identify the structures of the family and school that

lead to the difficulties. The hypotheses are tested by considering each system separately and then the relationships that exist between them. These initial hypotheses lead to others which form the basis for the treatment goals. Movement towards these goals is begun in the interview when the therapists facilitate interaction within and between the systems. At the conclusion of the interview, tasks are given which incorporate the structural changes identified in the initial hypotheses and goals.

This assignment of tasks to various components of the system, after first meeting together is similar to a network approach described by Erickson, Rachlis and Tobin (1974). In delineating various modes of network intervention, Erickson identifies four possibilities: network as resource grouping, network as mitigator of multiple agency involvement, network as curative grouping and network as interpreter of help seeking behavior. The network as mitigator of multiagency involvement is particularly applicable with problem poverty families.

Before turning to a fuller discussion of the structural approach, it is important to note that many of these poor families are headed by women (Statistics

Canada, 1981). This indicates that in many situations, the therapist will be dealing with single-parent families and with the particular needs of women in the life cycle.

The Structural Approach

The structural approach to family therapy as put forth by Salvador Minuchin will be considered next. A description of Minuchin's early work can be found in the book Families of the Slums. This work was done at the Wiltwyck School for Boys, a private residential treatment centre for delinquent boys aged eight to twelve years. The boys' families were disadvantaged and disorganized. They came from minority ethnic backgrounds (Negro, Puerto Rican) and lived in the ghettos of New York City. The Wiltwyck Research Project was set up to explore the structure and dynamics of these families and to study the therapeutic techniques and interventions that could best "reach" them (1976, p. 9).

The research conducted by Minuchin et al (1967) utilized a sample of 22 families; 12 delinquent producing families and 10 comparable control families without delinquents. The delinquent producing families were seen for thirty 90-minute sessions. One result of

this research was the delineation of two types of family structure; "disengaged" and "enmeshed".

A distinguishing feature of the disengaged family is the lack of connection between its members. Family members are described as operating within an atomistic field, isolated within their own orbits. This lack of contact and a slowness to respond are prevalent forms of family interaction. Minuchin describes the mother in such families as being apathetic, overwhelmed and depressed. She is unable to assume the parental role of guiding and controlling the children's behavior. Faced with a non-functioning parent, a parental child will attempt to fill the position. Family members demonstrate little involvement or interest in each other. The mother is often isolated from the outside world and sources of support. The family history may reveal a lack of stability in relationships and employment. The social agencies may be the family's only outside contact to which the mother's relationship is usually one of passivity and dependence.

It must be noted at this point that the structural view of family dysfunction has definite overtones of "mother blaming", and does not acknowledge the influence

of sex roles on patterns of family life.

In contrast to the disengaged family, the enmeshed family is characterized by the connectedness of its members. The tight interlocking quality of the system quickly resists any attempts by its members to bring about change. The distinguishing feature of this family's interaction is its immediate reactivity. The mother's style of relating is consistently enmeshed, however the children display a range of interactions from immediate responsiveness to engaged or disengaged passivity. The family's strategy is the continuous engagement of its members. The mother is quick to exert her control over the children's unruly behavior which serves to further activate their behavior. Caught in a continuous exchange of rebellious and counterreactive control responses power conflicts frequently occur.

Enmeshed families are usually able to connect with and utilize the resources of social agencies. However, their perceptions of the agencies are affected by their own powerlessness and lack of identity within the larger society. Helping agencies are sometimes viewed as resources to be exploited and manipulated. Police and the courts which represent authority are to be avoided.

The enmeshed and disengaged family patterns are the two extremes on the continuum of proximity and distance. The boundaries which determine "who participates and how in the family" are diffuse in enmeshed families and overly rigid in disengaged families (Minuchin, 1974, p. 53). It is the clarity of boundaries that indicates proper family functioning. The structural approach sees the family as a system functioning through the support of four subsystems: parental (the "executive" subsystem), spousal, parent-child and the sibling subsystem. Subsystem boundaries should be well-defined, enabling the members to fulfill their functions without interference, at the same time being flexible enough to allow for contact with other subsystems. In order to parent effectively, the parental subsystem boundary needs to be clear but permeable enough to allow access to the children.

Minuchin defines family structure as "the invisible set of functional demands that organizes the ways in which family members interact" (Minuchin, 1974, p. 51). How the family operates can be seen in the repetition of transactional patterns, which define relationships and regulate behavior. Transactional patterns are maintained

by two systems of constraints. The first, generic constraints, refer to the universal rules which govern the family organization. A hierarchy needs to exist in the family giving more authority to the parents than the children. There should be a complementarity of functions which allows for the husband and wife to operate both independently and as a team. The second system of constraints, the idiosyncratic, are the expectations and intentions of each family member, which contribute to the explicit or implicit formation of patterns. These patterns may continue for years after the reason for their emergence has been forgotten. The family system is maintained by utilizing preferred transactional patterns and by resisting change beyond a certain limit. A functional family has a repertoire of alternative patterns which enables it to adapt to the stresses of internal (developmental) changes and external (environmental) demands (Walsh, 1982, p. 12).

According to Minuchin, the family is a social system in transition. He considers the impact of changing situations of the family and its members and the ensuing stress of accommodating to them. This orientation leads Minuchin to state that "many more families who enter therapy should be seen and treated as average families in

transitional situations suffering the pains of accommodating to new circumstances" (1974, p. 60). The idea of helping families and their members adapt to the stresses of life or developmental transitions gives the therapeutic process a sense of normalcy and acceptability. The therapist intervening with an average family would strive to motivate their resources. However, when a family's reaction to stress is to become more rigid in terms of their boundaries and transactional patterns, the therapist needs to play a more active role in the family scenario. This could include entering coalitions in order to skew the system with the consequence of the family developing a different level of homeostasis (Minuchin, 1974, p. 60).

The structural therapist enters the family system in a leadership position. The family has usually identified a certain member as the problem which they would like the therapist to fix. In family therapy, this person is seen only as the "symptom bearer"; the cause of the problem is seen to be dysfunctional family transactions. During the therapeutic process, these transactions will change and the family system will be moved to a more complex form of organization. The general goals devised by the therapist and the family would be to relieve the symptom

bearer of symptoms, to alleviate conflict and stress for the whole family, and to learn alternative ways of coping (Minuchin, 1981, p. 29).

Minuchin refers to "joining" as the means by which the therapist creates a positive therapeutic relationship with the family members. He sees it not as a particular technique, but rather an attitude and/or a climate which the therapist generates. It is through effective joining that the therapist can inspire the confidence necessary for the family to explore and enact alternatives which enable it to change.

The therapist can join the family from three positions; a close position, a median position or a disengaged position. In a close position, the therapist forms an alliance or a coalition with one or more family members against the others. The therapist confirms and supports certain members by emphasizing positions and responding sensitively to difficult or painful areas. When joining the family from a median position, the therapist takes on the role of neutral listener. By actively "tracking" (following) the family, the therapist is able to obtain information and be aware of family process. Finally, the therapist can join the family from

the disengaged position of expert. The family is directed by the therapist to enact familiar scenarios or to try out different transactions. The therapist supports, avoids or ignores the family's world view expressed in their values, myths and communication patterns according to whether s/he wants to reinforce the family reality or expand their world view to allow for flexibility and change.

Minuchin identifies three main strategies of structural family therapy, each of which are implemented through the use of several techniques. These strategies are challenging the symptom, challenging the family structure and challenging the family reality.

The therapist challenges the symptom by not accepting the family's definition of the problem -- one family member is not viewed as the problem; rather all members are equally symptomatic. The symptom is conceptualized as the family's reaction to stress. The family has developed certain dysfunctional transactional patterns to cope with their situation. By observing how the family has organized itself around the symptom and the symptom bearer, the therapist is able to discover the family's preferred responses. In order to change the nature of

these responses and the family's definition of the problem the therapist may decide to challenge the family directly, being explicit and straightforward, or indirectly, being implicit and paradoxical. The techniques utilized to achieve the goals of reframing the problem for the family and compelling them to examine alternative responses are enactment, focusing and achieving intensity (Minuchin, 1981, p. 68).

Challenging the family structure involves the therapist determining the position of family members -- their closeness and distance to one another. When the therapist joins the family system, s/he observes the transactions and forms a tentative diagnosis of the family functioning. The structure of the family is mapped to indicate the coalitions, affiliations, explicit and implicit conflicts and the ways family members group themselves in conflict resolutions. The roles of family members are also represented as "detourers of conflict, switchboards, nurturers and scapegoaters" (p. 69). The delineation of boundaries between the subsystems reveals their flexibility and suggests possible areas of strength and dysfunction.

Dysfunction can occur with subsystem members who are

over or under involved. The therapist can monitor the proximity and distance between the members which gives them the freedom to participate in different ways. The techniques involved in challenging the family members' own delineation of their roles and functions are boundary marking, unbalancing and teaching complementarity (Minuchin, 1981, p. 69).

The final strategy described by Minuchin is challenging the family reality. Families coming into therapy are there because their construct of reality is not working. The transactional patterns developed by the family contain and perpetuate their view of reality. Consequently in order to change the family's reality, the therapist needs to introduce new ways of interacting into the family. The techniques employed in reframing the family's reality are cognitive constructs, paradoxical interventions and emphasizing strengths (Minuchin, 1981, p. 71).

Strategic Approach

The strategic approach as represented by Jay Haley is any therapy where the interventions are designed to fit the problem (Hoffman, 1981, p. 271). Weakland,

Watzlawick and Fisch described a similar approach in their writings "Brief Therapy: Focused Problem Resolution" (1974) and Change: Principles of Problem Formation and Problem Resolution (1974).

The focus of these strategic theorists is not family structure or the family system per se, but rather the ways the family has developed to handle the problems inherent in everyday life. Strategic therapy is based on the premise that families perpetuate their problems by the means they employ to remedy them. The family develops a cycle or sequence of behavior as a possible solution to their problem. Therapeutic change is directed at this ineffective solution in the form of interrupting or blocking this pattern of behavior that functions to maintain the symptom or the problem (Hoffman, 1981; Walsh, 1982).

The strategic therapist follows a specific procedure for the first interview which incorporates five stages. First is the social stage where each family member introduces him/herself and is greeted and made comfortable by the therapist. The second stage is devoted to inquiring into the nature of the problem. The therapist wants to get everyone's view of the problem.

S/he needs to take into account the phrasing of the questions, so as not to limit response, and to whom the questions are addressed first, in recognition of the family hierarchy. In the interaction stage, the therapist encourages family members to talk to each other about the problem, beginning with a dyad and adding a member until everyone is involved. In the next stage, the therapist seeks to obtain a clear idea of the changes desired by everyone in the family. Goals are formulated which provide the basis for a contract and therapeutic focus. The interview concludes with arrangements for the next appointment. This might involve negotiation around the inclusion of an absent family member, whose participation the therapist views as beneficial. The therapist may have formulated a directive to be given at the end of the interview or s/he may choose to assign homework in the form of a simple task (Haley, 1976).

The variables that Haley has identified as being important in therapy are power and organization. He views the family as an organization with a shared history and a future, which has evolved repetitive behavior patterns and established a hierarchy. The hierarchy existing in a family would include members of different generations, different incomes and different degrees of

intelligence and skills. The complexity of hierarchical lines is determined by the different functions performed by the family. The generation line which exists when parents nurture and discipline children is the simplest level of hierarchy. The three generations usually present in a family can be conceptualized as three levels of power. In a nuclear family, often the parents hold the primary position in regards to power, the grandparents the secondary position and the children have the least status. According to Haley, it is necessary for all families to organize a hierarchy and to negotiate rules for the establishment of the power positions. When families have not incorporated a clear hierarchy, symptoms can appear in family members (Haley, 1976; Minuchin, 1981). Coalitions across levels of a hierarchy can also cause dysfunction in the family particularly when the coalitions are covert and the transactional sequences become organized and repetitive (Walsh, 1982, p. 16). When a parent-child coalition is formed against the other parent, organizational rules are violated which cause distress.

Haley proposes that the hierarchy in the family can be discerned by observing the interactional sequences. Sequences are repetitive patterns that occur as part of a

cycle where one event or step leads to another and back to the beginning. If the sequence is a father consistently joining with a child against mother, there would be a number of ways to intervene. First, the therapist could encourage the father to become more involved, with the expectation that a distancing would occur to compensate for the lack of personal space. Second, the therapist could displace the triangulated child by focusing on the parental dyad and highlighting their differences in regards to the child's behavior. Finally, the therapist could engage the peripheral parent with the child by assigning child management or activity tasks, which serve to disrupt the coalition between the child and the overinvolved parent. A common feature of the last two tactics is that the child is relieved of his/her role as deflector of conflict in the marital dyad.

Family Life Cycle Model

The next section of the review will consider the family life cycle as an additional framework useful in family therapy. All families in the course of their development face certain major events which entail different tasks. The completion of these tasks enables

the family to better meet the needs of its members. The timing of the major life events has been defined historically, biologically and socially. Thus, it has been argued that there is an appropriate time for the family to encounter the various events or stages of the life cycle (i.e., marriage, parenthood, children leaving home, retirement and old age) (Neugarten, 1976).

The family experiences disorganization during these turning points in the life cycle and has to adjust to the changes in identity and self-concept (Neugarten, 1976). Difficulties arise for families when the developmental tasks of one stage are not successfully completed before moving on to the next stage. Haley (1973) attributes symptoms in family members to a disruption of the family life cycle. As the developmental needs of family members change, a corresponding change is required in the family structure.

The family life cycle model incorporates a transgenerational view of the family whereby the major life events of one generation are believed to be an influence on the functioning of the generation preceding and following (McCullough, 1980). The developmental achievements of the individual or generation are also

thought to be related to the achievements or failures and unresolved issues of other generations. This model than considers the immediate family in the context of three generations.

Carter and McGoldrick (1980) describe the flow of anxiety in the family as following vertical and horizontal lines. The vertical flow is attributed to the patterns of relating and functioning that have been passed down through the generations in a family. This includes family attitudes, taboos and expectations. The horizontal flow refers to the anxiety that is produced as the family moves through the stages of the life cycle and copes with the accompanying changes and transitions. The degree of anxiety that results from the intersection of the vertical and horizontal lines will determine how effectively the family copes with transitions. Thus, in the family where the mother has given birth to a mentally-retarded child, the daughter, when pregnant, may experience more than the usual amount of anxiety about the normalcy of the expected child.

Many of the authors writing about the family life cycle are referring to the developmental stages of American middle class families (Duvall, 1971, Carter and

McGoldrick, 1980). These stages and their associated tasks may need to be adjusted when dealing with families from different cultures or socioeconomic groups. The life cycle stages are delineated according to the presence of children. However, Carter and McGoldrick contend that most phases of the life cycle are relevant to family members who do not marry or have children. These people, in relating to their families and social networks; are required to face issues common to all families. They may experience difficulty in shifting their status in the family due to family expectations about age appropriate behaviors. Recognizing that individuals as well as cultures and socioeconomic groups present differently with regards to the stages and tasks of the life cycle, the life cycle model still remains a viable and productive way to approach families.

Carter and McGoldrick (1980) have described a six stage model of the family life cycle, incorporating major life events and the significant issues embodied in the works of other authors, such as, Duvall (1971), Haley (1973) and Solomon (1973). The six stages in the Carter and McGoldrick model are: the unattached young adult, the newly married couple, the family with young children, the family with adolescents, launching children and the

family in later life. Rather than outline the issues characteristic of each stage of this model, I will focus on three of the six stages considered relevant to this practicum, namely, the family with young children, the family with adolescents and launching the children.

The Family with Young Children

There are a number of developmental tasks associated with this stage as the family adjusts itself to the presence of children. The marital dyad must open and adjust to accommodate a third member. The couple in assuming the role of parents now have to acquire parenting skills and negotiate the division of responsibilities. At the same time there needs to occur a realignment of relationships with the extended family to include parenting and grandparenting roles (Carter and McGoldrick, 1980).

The birth of a child can precipitate a crisis for the family. In a study done by Le Masters (1957) 85% of the couples interviewed reported "extensive" or "severe" crisis in adjusting to their first child. This response was related not to how the couples perceived their marriage or to whether the child was wanted but, rather

to a lack of preparation for parenting and unrealistic expectations of the parenting role. Some of the adjustments noted by the mothers were: loss of sleep, chronic tiredness, extensive confinement to home, giving up satisfactions and income of outside employment, guilt at not being a "better" mother, the long hours and seven day week necessary in infant care, decline in housekeeping standards, and worry over appearance. The new fathers reported many of these adjustments and included a few of their own; decline in wife's sexual response, economic pressure, interference with social life and worry about a second pregnancy. The results of another study done in the 1960's by Dyer (1963) indicated less couples experiencing a crisis but still a majority (53% of his sample). Dyers found that the severity of the crisis was related to the state of the marriage, attendance at marriage preparation courses, the number of years married (3 years or more having experienced less crisis) and planned parenthood (less crisis experienced by those who had planned and followed their plan). The crisis seemed to be more evident during the first six months and to subside by twelve months.

Hobbs, in the late 1960's did several studies on new parents and found lower levels of crisis than Le Masters

or Dyer. This difference can be attributed to his focusing on reactions to the changes rather than on the changes themselves. He agreed that the behavioral changes were quite extensive but found that most new parents were only mildly bothered by them and that many reported gratifications as well.

A more recent study published in 1980 by Miller and Sollie indicated an increase in perceived personal stress for both mothers and fathers. Their subjects found the transition to parenthood brought with it slightly increased feelings of being "tied down" and a sense that "life is hard not easy". Mothers appeared to be under greater stress, having more of these feelings and perceiving an increase in marital stress not indicated by fathers. Miller and Sollie conclude that romantic conceptions about having children are declining and couples are developing a more realistic view of the impact children will have on their marriages and personal lives. This increased awareness of the advantages and disadvantages of parenthood may be reflected in some couples' decisions to delay pregnancy or remain childless.

The arrival of a child then can represent a crisis

for the couple which seems to be more acute during the early months. The transition to parenthood is viewed as a time of increased stress particularly for the mother who also perceives marital stress. In our society females are given primary responsibility for "mother work", a job which is characterized by high levels of stress and demand (Rosenberg, 19). Women who work outside the home may experience additional stress if they feel ambivalence about combining motherhood and paid employment.

Parenthood with its accompanying stresses and demands may leave little time and energy to be put into the marital relationship (Duvall, 1971; Haley, 1973; Bradt, 1980). The couple then must take steps to actively maintain and promote a sense of intimacy in their marriage relationship. Intimacy between the parents assures the child of the space necessary for his/her own growth and development. If the bond between the parents involves more fusion than intimacy or if the parents are emotionally distant there is a real danger of the child being triangulated (Bowen, 1978, Bradt, 1980).

The extended family may be in a position to offer help to the nuclear family and to become a resource.

Even when geographically distant the extended family has an impact on the nuclear family so that it reacts to nodal events regardless of its being close, distant or cut off (Bradt, 1980). The addition of a grandchild usually means increased involvement with the extended family and especially the grandparents (Duvall, 1971). Consequently relationships with the extended family need to be realigned to include the new roles of parent and grandparent in a way that is supportive of the marital relationship and recognizes the nuclear family's need for autonomy (Bradt, 1980).

Saulnier (1983) found that network variables were very important in mediating difficulty in adjusting to first time motherhood. In her study of 40 first time mothers, the value of being part of a circle of other parenting adults with whom concerns and anxieties were shared was confirmed. Interestingly, perception of support received was more important than actual quantity of help received. Thus, women who were satisfied with the assistance they received from network services tended to report less difficulty.

The Family with Adolescents

The key principal of the transition process for this stage is to increase the flexibility of the family boundaries to accommodate the children's independence. The developmental tasks associated with this stage include: shifting of parent-child relationships to permit the adolescents free movement in and out of the system, refocusing of the parents on midlife issues concerning marriage and career, and increasing involvement of the parents in the concerns of the older generation (Carter & McGoldrick, 1980).

Adolescence represents a special nodal point for the family. The family is challenged by the adolescent who is continually introducing new ideas, displaying changeable behavior and offering new values. In addition the adolescent is also bringing new people into the family which poses more of a threat. The family is reminded of the adolescent's eventual leaving and the end of the family as they have known it. This new input compels the family to reevaluate its long established boundaries and relationships (Ackerman, 1980). The adolescent's need for individuation and separation may disturb the balance of the family's interactions. The

intensity of the marital relationship may increase as there is less involvement in the parent child relationship. Threatened by the focus on their marital relationship the parents may try to increase their hold on the adolescent by maintaining his/her dependency or in a more extreme way by triangulating the child. The child may develop an incapacitating problem which allows him or her to remain in the family system and to maintain the parents' relationship (Haley, 1973).

Launching the Children and Moving On

This developmental stage begins with the launching of the children and continues until retirement or approximately age 65. The duration of this stage can be lengthy as a result of two 20th century trends, the mother being younger when the last child is born and our greater life expectancy. Two other important changes that influence this stage are the decrease in the average number of children in a family and the greater employment of women (McCullough, 1980).

The greatest changes in family membership occur within this stage. The key principle of the transition process is the acceptance of the various exits and

entrances of family members.

The children leaving home begins this shift in membership which may be followed by marriage and giving birth to offspring of their own. A later development is the death of the members of the older generation. A number of developmental tasks are associated with these changes in family membership. The marital partners need to renegotiate their marital relationship as a dyad and create new ways of relating as parents to adult children. A realignment of family relationships needs to occur to include in-laws and grandchildren. Parents are required to deal with the disabilities and death of their parents and other family members who belong to the older generation (Carter & McGoldrick, 1980).

The tasks of the middle generation are of particular concern in this stage. The parents are required to decrease their investment in the caretaking role and accept the child's independent pursuits. As the parents are relinquishing the gratifications inherent in the parental role the marital relationship has to be stable. If the parents are unable to cope with the increased intensity on the marriage, there is a tendency to hold on to the children or the last child (Solomon, 1973). As

couples today maybe spending a lengthy time together after the launching of the children it is important that they reinvest in the marriage or perhaps change some of its basic traits. This period can be a creative and productive time where marital satisfaction increases, new interests are pursued and a fuller perception of oneself and life in general can develop (Duvall 1971; Neugarten, 1976; Walsh, 1980; McGoldrick & Carter, 1982). Alternatively, it may be a time when resentments and conflicts surface, as the focus on the marital relationship may yield disappointment.

Having outlined the basic tenets of the four theories which guided my involvement with families, this report now turns to a description of the practicum itself.

CHAPTER III
PRACTICUM EXPERIENCE

Description of Setting

The practicum was conducted at Children's Home of Winnipeg. Children's Home of Winnipeg is a multifaceted agency offering a continuum of services such as residential treatment, foster care, professional parenting, family therapy, independent living and psychological services. The underlying philosophy of the agency can be summarized as that of keeping the child in the home--providing the necessary services to support the client in his or her own environment, and should this fail, providing alternative resources (Jordan, 1984).

Dr. Kathryn McCannell as my advisor had the primary responsibility for overall supervision of the cases. At Children's Home, Dr. Cynthia Jordan, as director of clinical services, was responsible for the administration of the family therapy program. Vicki Harrison and Shar Reid, both family therapists in the program, provided supervision for some of my cases. Supervision took the

form of assessment and planning sessions as well as direct supervision through the use of the one-way mirror or via video recording/monitoring devices. Members of the committee, Dr. Kathryn McCannell, Dr. Barry Trute and Shar Reid had access to audio/video tapes and written material. Ongoing consultation was provided by Dr. Kathryn McCannell.

The duration of the clinical component of the practicum was six months; from January, 1984 until June, 1984. Various other activities were viewed as important components of the practicum. The literature review, considered an ongoing endeavour, was begun in August, 1983. This allowed me the opportunity to thoroughly explore a variety of models in the family therapy literature. In order to familiarize myself with the agency, its objectives, services and policies, I elected to attend an orientation day for students in September, 1983 and to be present at several intake meetings.

An additional feature of the practicum was my participation in a family therapy training group. Two family therapy groups were convened in September, 1983 at Children's Home. Under the direction of Vicki Harrison and Shar Reid, the groups were composed of Children's Aid

Society workers, agency people and native community workers. The purpose of the groups was to educate and train helping professionals to utilize a structural/strategic approach to working with families. The seminar format was comparable to a full course at the university, meeting on a weekly basis for three hours over eight months. Group meetings involved theoretical presentations, video viewing, case discussion, and experiential learning via role plays and live supervision. The groups culminated in April with a two-day workshop conducted by George Enns, family therapist from the McNeill Clinic in Saskatoon.

Recording was done in a manner consistent with that used by the family therapists at Children's Home. A face sheet, initial assessment form and progress notes were compiled on each family. For the purposes of this practicum the assessment process was augmented by a health and history form completed by a parent (see APPENDIX I).

Description of Clients

The families I worked with in this practicum were referred to the family therapy program at Children's Home

of Winnipeg. The family therapy program was set up to help families whose parenting was in question. The families eligible for the program included those with documented evidence of abuse or neglect and families who had a child temporarily withdrawn or who face that prospect should no viable alternative become available. Referrals for the program came from the families themselves, from educational authorities, pediatricians and medical personnel (Children's Home of Winnipeg, 1983).

Eight families comprising a total of 30 people were seen in this practicum. The different types of families represented were single parent families, a blended family and a traditional family unit. The majority of the families, six of the eight, were single parent families. The families came from a variety of ethnic backgrounds.

There was a range of family incomes or social classes evident in this practicum. Four of the single parent families were receiving social assistance. One single parent was receiving unemployment insurance benefits while another was employed full time with a work training program. Of the families with two parents both husbands were employed full-time and the wives were employed

part-time. Two single parents were looking for work. Nine parents had high school education ranging from Grade 9 to Grade 12 and some had additional vocational training. One parent had not attended high school.

The length of marriage of the spouses currently together ranged from less than a year to 25 years. Of the single parents, five had been separated or divorced from less than a year to five years.

Case Examples

In the next section three cases, which exemplify the theories reviewed, will be presented.

Intervention with a Male Single Parent Family

The D. family was a single parent family headed by a male and the identified client a boy, four years old. The father had separated from his wife in the fall of 1982. This occurred after a move from Thompson to Winnipeg earlier in the year. Apparently the move to Winnipeg was precipitated by the wife's unhappiness living in the north. Both parents were originally from Winnipeg and had resided in the city before going to

Thompson. The father after having been employed with a prominent firm in Thompson had been unable to find work in Winnipeg.

The initial family therapy sessions were devoted to joining with the family, assessing and forming a contract with the family. The therapist was interested in determining the family's network - sources of support, the stresses on the family, the family's developmental stage and its performance of tasks appropriate to the stages. The effect of the individual member's behavior on the family system was also considered. The individual member's symptoms would need to be understood as a way of maintaining the family's preferred transactional patterns.

In the first session the therapist spent time joining with the family, listening to family members and tracking (following the content of the family members communication and behavior and encouraging them to continue). The father, Mr. D. expressed some concern about the frequency of his son's visits with his mom, which occurred about once every two months. He stated a preference for the visits to happen more often. He recognized that his son was a slow talker, only having

started to talk at two and a half years, one month after the separation.

The presenting problem was the child awakening early in the morning and emptying the contents of the kitchen cupboards. The father and child would sometimes engage in a contest to determine bedtime. He was being seen by a speech therapist and the day care had incorporated a type of speech program.

The one serious problem the father identified was that his son slept an hour less than he did. The father could not go to sleep before his son which meant he was up until 11:00 p.m. His son would get up between 5 and 6 a.m. and turn off his father's alarm. The father described his activities during this time as vandalism whereby he would dump food out of cupboards and fridge. He had responded to this behavior by making these areas inaccessible to the boy, e.g., tying cupboards closed and locking the bathroom and bedroom. The father was not totally happy with this solution.

In the second interview the therapist joined with Mr. D. around the demands of parenting, nursing a sick child, not being able to go out, the inconvenience of

babysitting arrangements. A difficulty in the past week was the child soiling his pants three times. Mr. D. had consulted his ex-wife about the behavior and acknowledged that he did this whenever there was a problem. At times when frustrated and undecided about what action to take Mr. D. would call his ex-wife. Parenting decisions were also shared with his son who was asked if punishment was warranted. Mr. D. appeared unable to take charge as a parent and the boundaries between parent and child were not at all clear. An incident that was considered more serious by the father occurred after a night of seeing who could stay up the longest. The boy awoke, dressed in outdoor apparel and was looking for the keys to the door when discovered by his father. Mr. D. had put a lock on the door as a result of this incident. Although he did not like to have so many locks in the house (the child only had access to the living room) he did not know of any other solutions.

The therapist attempted to reframe the child's activities as being that of a bright curious child. In this session the boy drew a picture of himself with his mother, placing dad, grandma and grandpa off to the side. In asking about the separation it emerged that Mr. D. had not discussed the separation with his son. He explained

his reluctance to do this in terms of his son not being able to understand with his limited speech and vocabulary. He reported that his son did not believe his mother was going to have a baby with her new partner.

The therapist spent some time exploring the family's network. Other than the paternal grandparents the family seemed to rely on professionals for any help they required. Mr. D. explained he did not know many people in Winnipeg and did not feel comfortable burdening friends with personal problems.

The focus of the next session was to normalize the boy's behavior by informing the father about stages of human development and what could be expected of a four year old. At this age a child has not developed the internal controls necessary to make most decisions, therefore he is dependent on parents and teachers to provide external controls. It was important for the father to incorporate a routine of established bedtimes and provide supervision during the boy's waking hours. After a discussion of how this could be accomplished the task was for the father to establish a routine around a bedtime of 9:00 p.m. so he could get up with the child in the morning.

In consultation with my supervisor Dr. Kathryn McCannell several therapeutic goals were established. It was evident that the father needed to talk with his son about the divorce. This could be done with the aid of books, for example The Parents Book about Divorce by Richard Gardner (1977). It was hypothesized that in order for the boy to get his parents together or to see his mother he would misbehave. This being the case, what needed to be established for the boy was regular predictable contact with his mother.

These therapeutic goals formed the basis of the following three sessions. In session four, the therapist requested the boy to draw his house and his mom's house with their occupants as a way to differentiate the two families. This led into a discussion of his understanding of divorce and why they were here. The therapist had the father explain why they were in therapy and begin to talk about the divorce. A task was given for Mr. D. to take his son to the library to find books on divorce to read to his son. Visiting the library was an activity that father and son had often enjoyed together. The father had incorporated a bedtime routine and was rising with him in the morning.

In session five the task was reviewed. Mr. D. had not done the task. The therapist acknowledge Mr. D.'s uncomfortableness and encouraged him to talk to his son about how it was that he was no longer together with his mom. Although Mr. D. and his ex-wife seemed to be in agreement in most of their decisions about their son, visits were an area where they were not in agreement. Mr. D. agreed to talk to his ex-wife about setting up the visits on a regular basis so that his son and the parents would know when the visits would take place and be able to plan for them. The therapist suggested having his wife come in to discuss this.

In session six Mr. D. spoke of his decision to look for work rather than continuing to work on his grade 12. Apparently over the past several months he had been completing grade 12 courses to meet university entrance requirements. His plan had been to attend university in the fall, obtain student aid and go off welfare. However, in order to continue with assistance from city welfare he was required to look for work eight hours a day. Mr. D. expressed frustration with a system that did not support his decision to further his education or to help him find work (not enough money was allotted to pay for bus fare and day care).

Mr. D. had talked to his wife about the visiting arrangements and visits were to occur every weekend for the next two months. He had not discussed coming to a session with her. Since he and his son had been sick and unable to go outside they had not gone to the library. He had looked at the books previously but did not select any as they depicted women as always having custody and the father as leaving.

The goal of session seven was to discuss termination. Mr. D. was in the process of moving to low rental housing and continuing to look for work. He explained the visits with his ex-wife had not occurred on a scheduled basis because of his difficult living conditions and moving arrangements. He foresaw that in the next month the visits would be easier to schedule as they would be living close to one another. In response to my questions of what he had learned and what things were the same or different, Mr. D. stated that he recognized the importance of order and scheduling both in his son's life and in his own. He was also aware of the importance of sleep. The original problem that of his son emptying the cupboards, no longer occurred, nor did the late nights. The differences noted by Mr. D. were his son going to bed earlier, (bedtime routine was still

in place) an improved diet and his having quit smoking. He was feeling better, his son was happier and with the extra money from not buying cigarettes they were able to have more fun together, e.g., going to a movie. However, he was still not confident about his ability to judge what behavior was normal and acceptable for his son. He had enjoyed sharing his parenting role and feeling accepted by a couple in the neighbourhood whose daughter befriended his son. The therapist recommended a parenting group to Mr. D. as an avenue to develop more confidence in his parenting skills. Since these groups would not be meeting until the fall, I offered to meet once or twice in the summer as follow-up. Mr. D. was amenable to these proposals.

Intervention with a Remarried Family System

The G. family was referred to the family therapy department by Probation Services because of the older daughter's delinquencies. The therapist saw the family four times and termination was based on a mutual decision.

The G. family was composed of a mother, stepfather and two daughters aged 15 and 13 years. The girls'

parents had separated in 1978 and divorced in 1982. The mother had recently remarried and the biological father had been living common-law for the last few years with a woman and her three children.

Mr. G. did not attend the first three sessions because of his employment as an electrician to Northern Indian reserves. The mother was working in a nursing home and taking courses part-time. The girls were both attending grade eight in the same classroom at a junior high school.

In the first session the therapist spent time joining with the family around work, school, their interests and activities. When the family outlined their concerns, the mother's concerns focused on the oldest daughter and included school attendance, not coming in on time and not listening or showing respect to her stepfather. She also mentioned Adrienne's involvement with the courts for theft under \$200 (on probation until December, 1985) and previous suicide attempt. The girls' concerns centered on their stepfather's preferential treatment of his daughter (who visited on weekends) and their friends.

The youngest daughter Amber did not attend the second

session. Mrs. G. spoke in this session of how both girls were disrespectful not only towards their stepfather but with herself and other adults as well. She felt that the paternal grandparents were undermining her role as parent. It became apparent that this was a close family where there was considerable contact with both sets of grandparents. The paternal grandparents were perceived by mother to interfere with the family and undermine her role as parent. They would often give the girls money, thus taking the decision away from her as to whether the family needed something or when they would have it. Adrienne related seeing her paternal grandfather everyday on the way to school and getting money from him. She saw both paternal grandparents every Sunday for supper with her sister. Adrienne was the first granddaughter in a family of sons and was her grandmother's favorite. She had lived with her paternal grandparents for several months the previous year. She had also spent a brief time living with her dad.

Mrs. G. explained that Amber had missed the session due to calling her father and getting his permission to stay home. Apparently he did not know the family was going to family therapy. In an attempt to establish some positive interaction the task given to the family was for

them to do something together that was fun.

Since the initial presenting problems were no longer occurring it was difficult to get a sense of this family's problems. In supervision with Vicki Harrison several issues were discussed. It was decided that the concerns about the stepfather would be difficult to address until he was present in the session. The girls appeared to be worried about their mother and how this new marriage would work. Acknowledging the grandparents involvement with the family it became important to ascertain the clarity of boundaries. The biological father's involvement with the family also needed to be further delineated.

The separation was another area requiring exploration around how it had happened, the feelings it generated and how they were resolved.

The next session began with a discussion of the previously assigned task. The family did attend the same event - the couple's wedding social but did not go out together as a family and have fun.

It was recognized that the family had gone through a

crisis last fall, where Adrienne had not been attending school, coming in on time and had been in trouble with the law. These were no longer issues for the family. Therapy had been part of the contract with the probation officer, whereby it was the probation officer's idea and the family agreed, as their only option to prevent the daughter going into care.

The family's response during this stressful time was for Adrienne to live first with her paternal grandparents and then with her father. When this did not work out Adrienne returned home.

Although the mother and stepfather's relationship had gone on for three years, the girls had difficulty accepting the relationship and would elicit their natural father's input into parenting decisions. In this way the girls' mother and father could continue their relationship and fighting. The girls had difficulty accepting their parents' separation and sharing their pain. It became clear in this session that the adults involved had not sorted out their problems and that they needed to find a way of being father and grandparent that did not interfere with the mother being in charge.

The mother's help was enlisted in identifying the important adults and arranging a time when we could all meet together.

Present at the fourth session were the immediate family, the mother, stepfather, Adrienne and Amber, the father and his spouse and the paternal grandfather and grandmother. After introductions, the therapist recognized the difficulties with Adrienne had passed and that in order to understand what was happening with the family now - the changes, all the important people needed to be involved. The family's concern and caring for Adrienne and Amber was evident in their presence at this meeting.

Beginning with the mother the therapist asked everyone for their view of the problem. The mother explained that a year ago there were a lot of problems and that's when they should have been here. Those problems were straightened out. Now, Adrienne was pregnant. The mother identified the main problem as discipline whereby Adrienne would disobey and go to her father when she did not want to do something. She wanted this to stop out of respect and for her daughter's benefit so they could be brought up properly. The

therapist reiterated the need for everyone to come together and work together so the girls could grow up to be responsible young adults.

The father stated his availability to Adrienne when she was in trouble, she was welcome to come and stay. His responsiveness was prompted by Adrienne's phone calls during a crisis. He agreed that since the girls were in the care of their mother they should do what she tells them.

The stepfather acknowledged his lack of control over Adrienne and her running to other members of the family. Adrienne's ability to organize the family was highlighted by the therapist.

The grandfather stated their aim of trying not to interfere. He admired Adrienne's independence comparing her way of coping or surviving to that of his son.

The grandmother saw Adrienne as the impetus for getting the family involved and together at meetings like this, which helped everyone grow up. The therapist noted that by being the centre of attention she brings everyone together, recognizing that the parents' separation was

hard for her to accept.

After some further adult interaction around the children and their position in the family, the therapist focused on what would need to happen for the girls to stay on track. The adults discussed the plans for Adrienne and her baby. The mother and father expressed differing opinions. Adrienne talked about feeling stuck and the therapist attributed her standing still to not wanting to risk hurting either parent. Her father gave her responsibility for the decision stating that whatever road she took he would support her. Mother reaffirmed that she was not going to get back together with the girls' father. The girls were encouraged to talk to her and their stepfather about what was bothering them.

The patterns in the family which were apparent in the sessions were described by the therapist. The therapist stated her belief that it would be easier for Adrienne when she accepted her father's common-law spouse and children. Also, if the adults felt she was playing one against the other, it was recommended that they talk about it. The session ended with an affirmation by the adults that they were all together in their support of Adrienne as a future parent.

In a further discussion with the immediate family it was agreed that family therapy was no longer necessary.

Intervention with a Family System Challenged by an Adolescent

The P. family was a two parent family composed of a couple in their forties, a son, Michael aged 18 and a daughter, Cheryl aged 14. Both parents were employed, the father at a grain terminal, and the mother at a meat packing plant part-time. Their son was attending first year university and their daughter was in grade eight for the second year. The daughter had been adopted at four weeks of age.

The presenting problems involved the adolescent daughter who had run from home and was having difficulties in school. The mother was feeling overwhelmed with having to make most of the parenting decisions. She was wanting to share this responsibility with her husband, who would disagree. The daughter would go from one parent to the other and maybe get the answer she wanted.

In the second session, the therapist focused on how

it was so difficult for the parents to come together as a team. The mother felt she had to respond to the urgency of the teenagers' requests before the father came home. The father, tired when arriving home, did not want to have to deal with the teenagers' requests immediately. The parents negotiated 20 minutes of relaxation for father, before meeting mother in the bedroom to discuss the parenting decisions. The teenagers were also directed by the therapist to talk about what needed to be different for them to be happier. When Michael asked his sister questions, she felt he was asking for their parents. Cheryl and Michael discussed other ways he could show his interest. The family was given the task of doing something together as a family that was fun.

In the following sessions the therapist's focus continued to be on getting the family to define themselves in their relationships - for the parents to find ways to come together in their parenting role and for the teenagers to find ways of being a brother or sister to each other. The family did not do the task.

Prior to the fourth session Cheryl had not returned home for two nights. The focus of this session was on the parents making a plan for how they were going to deal

with the behavior. The therapist stressed the importance of their being in agreement on what would happen and following through with their decisions.

In the next session Cheryl was now at home but the parents had not taken charge and laid out any consequences. They had treated her as in the past and done nothing. The therapist proposed another strategy in this session. As the mother was at the end of her rope and unable to get the support she needed from her husband, she was to take a break. The father was put in charge of making the decisions regarding the teenagers and given the task of laying out some rules. The parents formulated some rules in the session, for example, they set a curfew. The tasks given to the family were for mom to stay out of the problems with the teenagers. The teenagers were to go directly to father. If mom did not like what dad did she was not to undermine but talk to him when the kids could not hear. As well mom was to spend 10 minutes each night at bedtime worrying and telling her husband about her anger. He was not to say anything but give her a hug. His wife really needed to know he cared and he should give her a surprise.

The next session was spent tracking the tasks which

the family had done, for the most part. Mother enjoyed the break and stayed out of the teenagers' problems. She expressed her anger and worries to her husband most nights and he gave her a hug. Father took charge and laid out the rules for the teenagers.

Michael recognized that father had not really been tested yet. Cheryl was finding it better. The same tasks were assigned for the next week. How the family operated had become more clear after the last session. This was described to the family in the following message at the end of this session. The wife wants her husband's support and understanding and signals him by being overbearing, flooding and whining. The husband misunderstands the signal and thinks she is just running off again, so rather than sitting her down and finding out what the trouble is he withdraws. At this point, the wife becomes increasingly frustrated and more worried. Her anxiety drives her to become more involved with Cheryl and Michael. Cheryl picks up her mom's anxiety and worries about her and begins to be confused about her worries and fears. Because she cannot separate her worries and fears from her mothers; she acts out by running and failing in school. Cheryl's behavior is a signal to dad to become more involved with mom. On the

other hand Michael is not so direct as his sister in acting out, he displays his frustration by challenging mother in disrespectful ways and helps her out because he's worried - seeing that father is so distant. As well he acts out his frustration by hitting Cheryl because he too, feels caught.

In the seventh session, the therapist tracked what happened during the week to discover that mom was having trouble staying out of the teenagers' affairs. The therapist recognized the importance of her sharing concerns and worries every night with her husband. Father was asked to continue being in charge. Mom was instructed to do something fun with Cheryl.

The next session dealt with the parents' concern around Cheryl's lying. The therapist encouraged dad to talk to Cheryl about how it was she had to lie.

In the ninth session the parents discussed Cheryl's irresponsible behavior. Cheryl missed her midnight curfew, called later and dad directed her to come home. Over the weekend when she did not return the parents tried to find her and on Sunday brought her home together. The therapist directed the parents to discuss

Cheryl's irresponsibility considering if anything had happened to cause the behaviour and what were reasonable consequences. The therapist explained that Cheryl was testing them in a strong way and that it was appropriate for teenagers to test limits. The parents were to continue working together, with the father taking leadership and mother supporting him. The task given to the parents was to read Between Parent and Teenager by Ginott (1969) particularly the mother because father would be more directly involved with Cheryl. It was presented as another step in mother's thinking about how she wanted to treat her daughter. The therapist congratulated mom on being supportive not intrusive and in viewing the situation more realistically and calmly. The father was congratulated on taking leadership, making decisions and being direct.

In the following weeks an individual session was held with the mother who was still having difficulty relaxing and allowing her husband to struggle with the daughter in setting clear consistent limits. These issues were explored and the therapist recognized how difficult it was to change roles, but her tendency to be so protective was getting in the way of her and her husband working together. She needed to be in charge of her own life so

she could be a role model for her daughter.

The other issues that came up in therapy were Cheryl's court appearance as a witness which mom explored with her in a supportive way so she could share her worries and fears.

The mother's worry and upset was getting in the way of Cheryl's talking. The therapist asked the parents how they were going to come together and support each other so their anxiety and worry did not get in the way of what their daughter needed. The husband was to take his wife out on a date and each evening take her mind off problems. Mom was only to engage in pleasant conversations with Cheryl. Cheryl was to keep track of whether they stuck to their agreements.

The twelfth session dealt with the parents' frustration and anger around Cheryl's recent run. Friends had informed the family of Cheryl's whereabouts. Mother was going to get Cheryl as father in his anger had refused. Michael then approached dad because he felt it was his job. When he refused Michael accompanied his mother. Cheryl told the family she wanted some time and space, so arrangements were made for her to stay with

friends.

The father had initiated a discussion about group home placement. In the beginning of therapy the parents had also discussed this possibility. This discussion was a more rational one, where the parents recognized that the supervision would probably be less, workers did not necessarily have special training and Cheryl's behavior could well become worse being exposed to more street wise kids. The parents made an agreement to work together to parent Cheryl. The therapist noted that it would be difficult. There would be more runs which would challenge and test their capabilities as parents. The other agreements made by the parents were reiterated and evaluated. The parents were complimented on the beautiful job they did the last time Cheryl ran, when they decided on a plan together and grounded her. The therapist found it interesting that Cheryl had run not when grounded but when she had freedom.

Last week's task was reviewed and explained as being a way for the parents to indicate to Cheryl they could lead their own lives. Cheryl was sensitive to the confusion in the home and needed to be provided with a united front. The therapist recognized that adolescence

was a difficult time for parents requiring them to give direction, be firm and flexible. the question was raised as to what to do this time. The therapist proposed tinkering with the task whereby mother would handle day to day discipline and rules. Father would give her support at the end of the day and stay out of the fights. The rationale for this was that teenage girls need to learn how to grow up and become women from their mothers. It would be important for mom to do this from a firm place without being pushy or overinvolved.

The next session began with an examination of the task. Mother had been in charge of the day to day discipline. She had been able to get the support she needed from her husband and reported an easy week. The husband had been listening to her at the end of the day and giving her a hug. The therapist recommended they continue with these practices. The focus was then shifted to the unfinished business of the previous week - Cheryl's run where Michael was put in the position of protecting mom. This was explored further to get a clearer picture of what happens in the family. Michael agreed to help his mom when his dad refused. He felt it was his dad's job. Father attributed his behavior to his annoyance and stubbornness. He agreed it was his job and

admitted shirking his duties.

The tasks remained the same for the remaining sessions. Mother was in charge of disciplining the teenagers. Father was not to interfere and support her.

Father did have some difficulty staying out of the fights between mother and daughter. The therapist emphasized the importance of supporting each other and presenting a united front. The family reported no problems for two weeks. Father attributed this to Cheryl having more freedom, staying in the neighbourhood and less policing. Mother related feeling less anxious and not being so controlling. The therapist requested the parents make a plan for dealing with Cheryl's running. The family was accomodating Cheryl's desire for time away from the family by arranging a summer babysitting job with cousins in another city.

Two weeks later the family was expressing some anxiety over Cheryl's lying and attempted run. The parents did come together in grounding her and making the decision to allow her to stay with friends until school was over and her job began.

There were two follow up sessions in August and October. The mother was still feeling anxious, even though there had been no major incidents. In October, Cheryl was doing well in grade nine.

CHAPTER IV

EVALUATION

Evaluation Instruments and Procedures

Two instruments were used to evaluate the effectiveness of the therapy. These instruments were developed at the Morrison Centre for Youth and Family Services in Portland, Oregon. The Family Information Form (F.I.F.) was administered at the end of the first interview, to all family members over the age of ten. The Family Feedback form (F.F.F.) was administered at the termination of therapy (see APPENDIX II). These two instruments are based on client reports of satisfaction/dissatisfaction with various areas of family functioning, such as handling discipline expressing anger and dealing with sexuality issues. Video and case presentations provided another format for evaluation.

The Morrison Centre Family Concern form was chosen for use in this practicum because it was easy to adapt and it had been found to be an effective instrument for measuring clients' satisfaction with aspects of their family's functioning and interaction. The form has been

in use for ten years, although no measures of its reliability are currently available.

As the design and language of the original form was easy to understand and administer, only some of the wording and the name of the agency were changed. The gradation of five responses utilized by the form allows the client to indicate feelings that range from very low to very high satisfaction. The list of concerns is numerous and comprehensive, so that changes can be identified in some areas and not in others. The information gleaned tends to be more specific rather than inferring a general sense of satisfaction or dissatisfaction.

The lack of reliability figures have to be weighed against the form's advantages and utility. The appropriateness of this self-report measure to the purposes of this practicum necessitated its use and as Bloom and Fischer state, "there is little evidence that self-reports are any more or less reliable or valid than many other forms of measurement" (Bloom and Fischer 1982, p. 169).

When considering face and content validity the form tends to conform with the literature on normal family functioning. The content of the form contains elements of family functioning which are considered important indicators of normal family functioning, for example problem solving, communication, roles, affective expression and involvement and behavior control (Epstein, Bishop & Baldwin, 1982).

The weaknesses of the instrument include, as previously mentioned, the lack of data on reliability. As this instrument is a self-report measure, it is an obtrusive measure and may be subject to reactivity. What is measured with the form is client satisfaction with the family functioning not the actual family functioning itself. The therapist has to make inferences from the ratings to the family's functioning. This is augmented by observations of the family's interactions in the sessions.

Evaluation of Outcome

Outcome of the intervention with the families can be evaluated according to two criteria. First, an increase in the clients' satisfaction with family functioning as

indicated in pre - and post - intervention scores on the Family concern form can be considered. Second, clients' reports of improvement in the major areas of concern and expressed satisfaction with the service they received were also a criteria.

Of the cases described here all three families completed both pre - and post - intervention concern forms. Of the remaining families all completed the pre-intervention forms, but few completed the post-intervention forms. This can be mainly attributed to client termination for various reasons, such as moving, illness and no longer feeling a need for the service.

Results of the three families described here, when comparing pre - and post - intervention scores indicated increased satisfaction in some areas and decreased satisfaction in other areas of family functioning. An overall increase in satisfaction in other areas of family functioning. An overall increase in satisfaction was noted for every member of every family (see APPENDIX III).

More specifically, in Family G. all members of the family reported satisfaction in relation to item 10 (making sensible rules). There were no areas where all members reported a decrease in satisfaction. On some items an individual reported increased satisfaction while others reported a decrease or no change.

In Family P. all family members reported an increase in satisfaction in relation to item 16 (deciding, agreeing upon discipline) item 20 (making family decisions) and item 123 (feeling good about our family). There were no areas where all members reported a decrease in satisfaction. Frequently, in the reports of this family's satisfaction three members indicated an increase in satisfaction (on a total of fifteen items) while one person would indicate no change (on nine items) or a slight decrease (on five items). Data was missing on one of the items, where three members were in agreement.

In Family D. where only one individual was of age to complete the measures, a significant increase in satisfaction (+3) was indicated in three areas of functioning including item 12 (taking on responsibilities) item 14 (use of self-control) and item 17 (being consistent with discipline). On several items

the client indicated a slight decrease in satisfaction (-1). This change usually occurred in a shift from the category of "very satisfied" to "satisfied".

In all families, areas of increased satisfaction included items which were the focus of intervention and items which were not. Similarly, where a decrease in satisfaction was indicated this included items which were the focus of intervention and items which were not. In some instances, it was revealed that individual decreases in satisfaction were the result of intervention activities which stimulated awareness of existing weaknesses in the family system. Decreased satisfaction was also reported because of the client's altered view of what was realistic for the family. In both these situations, decreases in satisfaction were seen as progress. In addition, some decreases in individual satisfaction resulted when the family was assisted to change a dysfunctional pattern which had previously served one member. For example, in Family G. a change was needed in the family's decision making processes - item 20 - and this resulted in the increased satisfaction of one member at the expense of another who had benefited from the original system.

Overall, the results from the Family Concern forms were positive. The changes were not always of a large nature, but generally satisfaction with family functioning did increase. The case study design of the intervention (i.e., the lack of standardized treatment techniques due to the widely varying presenting problems of families and the lack of a control group) do not permit firm conclusions to be drawn regarding the cause (s) of change in family functioning. Several factors may have contributed to the reported changes, including: reactivity of the instrument itself (because as a self-report it is an obtrusive measure), history and maturation.

CHAPTER VCONCLUSION

As cited in the Introduction, the purpose of this practicum was to develop clinical skill in family therapy as well as an understanding of applicable theory which included; ecological, structural, strategic and family life cycle.

Through examination of these various theories and their application in my clinical practice I was able to develop an understanding of the family system, its structure and function as well as the influence of outside systems such as the public school system, legal system and the welfare system. The development of a conceptual framework to guide one's work would seem to be essential to the competent professional. Additional valuable information would be an awareness of ethnic group and class so that differing expectations are taken into account by the therapist.

Two of the case examples appearing in this report are post-divorce family systems. Goldsmith (1982) views the post-divorce family from a systems perspective, recognizing that its structure has changed, with the parents ending their spousal relationship but continuing to some extent their parental relationship. Members of the post-divorced family system are the same and continue to be interdependent. Both post-divorce families cited here, had as a presenting problem the child's symptomatic behaviour which served to keep the non-custodial parent involved.

In one case, Family G, the mother had remarried adding a new member to the original post-divorce family. This forming of a new step-family did not result in the dissolution of the original post-divorce family, rather there was a continuation of the unresolved problems of the original family members into the new step-family. Recognizing these factors, a family session involving all family members (original family, step-family and grandparents) was convened emphasizing the importance of communication between the co-parents and that they work together.

However, in Family D this recognition of communication between former spouses related to co-parenting was not followed up in a session with both parents present. I realize this did not occur because of father's resistance and my resistance as a therapist.

The development of a strong conceptual base was an integral part of my practicum experience. Other aspects of my practicum experience to be discussed here relate to my acquisition of clinical skills.

The family therapy program at Children's Home of Winnipeg was just in its beginning stages in September, 1983. The identified goal of the program was to assist those families experiencing difficulty in parenting. There was also a commitment to providing training opportunities for other social service professionals. Through my timely involvement with the agency I was able to join the group lead by Shar Reid. Selected readings subjected to group discussion furthered my understanding of theoretical concepts. The use of videotapes, role plays and vignettes provided a means for the application of intervention strategies. The supportive peer group provided a safe forum to experiment with new modes of

behaviour and acquire directive skills. Through my participation in the group with Shar Reid I was introduced to the use of a "structural/strategic family systems model which offers clinicians the opportunity to intervene therapeutically in client systems in active, instrumental and nonstereotypic ways". (Caust, Libow and Raskin, 1981, p. 440).

The model of supervision and training within the family therapy department at Children's Home of Winnipeg was live or videotaped supervision. Live supervision was a challenge and certainly stretched my capacity to take risks and make decisions on my feet. The supervision I received during my practicum came from Shar Reid and Vicki Harrison, family therapists at Children's Home of Winnipeg and my advisor, Kathryn McCannell. I feel fortunate to have had the opportunity to work with these competent professional women. Through their shared experience and support my acquisition of family therapy skills was indeed positive.

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APPENDIX I

FAMILY THERAPY FACE SHEET

<u>NAME</u>	<u>MARITAL STATUS</u>		<u>EDUC.</u>	<u>INCOME</u>
	S/M/SEP/ DIV/C.L./W	D.O.B.	1-8/8-12/VOC CERT/ BACH/POST GRAD.	SA/10-15/15-20/ 20-25/25-30/30+
<u>Mother</u>				
<u>Father</u>				

- | <u>CHILDREN</u> | <u>D.O.B.</u> | <u>SCHOOL</u> | <u>GRADE</u> |
|-----------------|---------------|---------------|--------------|
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

ADDRESS (including directions and area of city):

PHONE: Mother _____ (Residence) _____ (Work)
 Father _____ (Residence) _____ (Work)

OTHER SIGNIFICANT PERSONS:

- | <u>NAME</u> | <u>RELATIONSHIP</u> |
|-------------|---------------------|
| 1. | |
| 2. | |
| 3. | |

ETHNIC/RACIAL BACKGROUND, IF RELEVANT:

DATE AND SOURCE OF REFERRAL:

DATE CONTACT INITIATED:

OTHER AGENCIES/PROFESSIONALS INVOLVED:

- 1.
- 2.
- 3.

CHILDREN'S HOME OF WINNIPEG

FAMILY THERAPY DEPARTMENT

INITIAL ASSESSMENT FORMAT

DATE:

REFERRAL SOURCE:

FAMILY THERAPIST:

PEOPLE PRESENT:

PRESENTING PROBLEM:

STRUCTURAL ASSESSMENT:

HYPOTHESIS/attempt to
make sense of symptom
for the function it
serves in each member
of the family.

THERAPEUTIC GOALS:

PLAN:

CHILDREN'S HOME OF WINNIPEG

FAMILY THERAPY DEPARTMENT

ONGOING FORMAT: Brief progress notes which would include an update on how the structural/dysfunctional pattern is changing.

TERMINATION:

Date

HEALTH AND HISTORY FORM

Child's Name Family Name

Form Filled Out By

Please check the box that best describes the current male parent:
Natural Father . Step-father ; Foster Father ; Live-in Boyfriend .
Adoptive Father ; Other ; No Current Male Parent .

Please check the box that best describes the current female parent:
Natural Mother ; Step-mother ; Foster Mother Live-in Girlfriend ;
Adoptive Mother . Other ; No Current Female Parent .

Family History

Rows 1-9: Please put a yes (y) or no (n)
in each box. If you don't have information
on a specific item put a question mark (?).
Rows 10-11: Please fill in each box as
indicated or put a question mark (?).

	Child Client	Other Children	Current Female Parent	Current Male Parent	Natural Mother (if not current)	Natural Father (if not current)
1. Received counseling or therapy before						
2. Been psychologically evaluated before						
3. Attempted suicide before						
4. Mental illness in the family						
5. History of drug or alcohol abuse						
6. History of problems with the law						
7. Long term physical illness or handicap						
8. Separated from parents as a child						
9. Been held in custody by CSD, CPS or Juvenile Detention Hall						
10. Been admitted to a psychiatric hospital (number of times)						
11. Education level (indicate last completed grade level)						

Current length of time the male parent has been living with the child client:
Since the child's birth . Other (years and months) ;
Separated less than 6 months ; Separated 6 months or more .

Current length of time the female parent has been living with the child client:
Since the child's birth . Other (years and months) ;
Separated less than 6 months ; Separated 6 months or more .

Pregnancy: Normal___; Complications___; Birth Weight_____
Delivery: Normal___; Complications___; Premature___.

Describe any difficulties as a newborn or small child:_____

Name of child's doctor_____

List any current medical or health problem or physical complaint your child has:

List any regular medication your child takes and the reason it is taken:

Describe any injuries or surgeries that your child has had:_____

Is any member of your immediate family currently receiving counseling elsewhere?

Who? _____ Where? _____

Please list three of your child's interests:

- 1.
- 2.
- 3.

Please list three things you especially like about your child:

- 1.
- 2.
- 3.

Please list three ways you would like your child or your family to change:

- 1.
- 2.
- 3.

Is there any other information that may enable us to be more helpful to you and your family? Please consider such areas as family background, life style, religious beliefs, employment, behavioral or physical information. Use the back of this form.

APPENDIX II

FAMILY INFORMATION FORM*

Name of Child _____ Date _____ Code _____
 Your Name _____ Therapist _____

Circle your position in the family: MOTHER FATHER DAUGHTER SON

The following questions are designed to assist our staff in evaluation of the services we provide families at Children's Home. This form is focused on your family as a whole. Please circle the answer which best shows your feeling about each question.

1. How much do you expect your work here at Children's Home will help with the problems you want to change? The problems might become:
 MUCH WORSE WORSE NO CHANGE BETTER MUCH BETTER

2. How easy was the therapist to talk with?
 VERY HARD HARD IN BETWEEN EASY VERY EASY

3. At this point in your life, how much of a commitment can you make to attending sessions and following through with the work of therapy at home?
 NO COMMITMENT SOME COMMITMENT IN BETWEEN MUCH COMMITMENT TOTAL COMMITMENT

4. If you are a parent, how satisfied are you with your relationship with your mate, or with being a single adult? If you are a son or daughter, how satisfied do you think your parent or parents are with their relationship?
 VERY DISSATISFIED DISSATISFIED IN BETWEEN SATISFIED VERY SATISFIED

5. How satisfied are you with the amount of time family members spend together?
 VERY DISSATISFIED DISSATISFIED IN BETWEEN SATISFIED VERY SATISFIED

6. If you are a parent, how well do you get along with your children? If you are a child or teenager, how well do you get along with your parent?
 VERY POORLY POORLY IN BETWEEN WELL VERY WELL

7. If you are a parent, how well do your children get along with each other? If you are a child or teenager, how well do you get along with your brothers and sisters (if you have any)?
 VERY POORLY POORLY IN BETWEEN WELL VERY WELL

8. If you are a parent, how satisfied are you with how your child(ren) is doing in school? If you are a child or teenager, how satisfied are you with how you are doing in school?
 VERY DISSATISFIED DISSATISFIED IN BETWEEN SATISFIED VERY SATISFIED

9. If you are a parent, how satisfied are you with your (or your mate's) job?
 VERY DISSATISFIED DISSATISFIED IN BETWEEN SATISFIED VERY SATISFIED

* Developed at the Morrison Center for Youth and Family Services, Portland, Oregon, 3355 S.E. Powell Blvd.

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box (1-5) that shows your feeling about each area.

	Very Dis- satisfied	Dis- satisfied	In between	Satisfied	Very satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8. Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right and wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistent with discipline					
18. Participation in family fun' and recreation					
19. Making individual decisions					
20. Making family decisions					
21. Seeking help for family problems from friends, relatives, church, etc.					
22. Ability to provide help to friends neighbors, relatives, church, etc.					
23. Feeling good about our family					
Make the last rating for yourself:					
24. Feeling good about myself					

FAMILY FEEDBACK FORM *

Name of Child _____ Date _____

Your Name _____ Therapist _____

Circle your position in the family: FATHER MOTHER SON DAUGHTER

The following questions are designed to assist our staff in evaluating the services we provide families at Children's Home. This form is focused on your family as a unit. Circle the statement that shows your feeling.

1. How much change have you noticed in the problem areas that you worked on at Children's Home?

MUCH MORE OF A PROBLEM	MORE OF A PROBLEM	NO IMPROVEMENT	SOME IMPROVEMENT	MUCH IMPROVEMENT
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2. If you noticed improvement, how much would you guess was due to the services you received at Children's Home (as opposed to help from friends, church, physician, self-help, etc.).

VERY LITTLE	LESS THAN HALF	ABOUT HALF	MORE THAN HALF	ALMOST ALL
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3. If improvements occurred in your family since you came to Children's Home, how confident are you that they will last?

VERY DOUBTFUL	NOT CONFIDENT	NOT SURE	FAIRLY CONFIDENT	VERY CONFIDENT
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4. How satisfied have you been with your therapist?

VERY DISSATISFIED	FAIRLY DISSATISFIED	NOT SURE	FAIRLY SATISFIED	VERY SATISFIED
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5. How satisfied were you with the number of sessions in your therapy services?

MUCH FEWER	FEWER	THE SAME	MORE	MUCH MORE
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6. If you are a parent, how satisfied are you with your relationship with your mate or with being a single adult? If you are a son or daughter, how satisfied do you think your parent or parents are with their relationship?

VERY DISSATISFIED	FAIRLY DISSATISFIED	NOT SURE	FAIRLY SATISFIED	VERY SATISFIED
----------------------	------------------------	-------------	---------------------	-------------------

7. How satisfied are you with the amount of time family members spend with each other?

VERY DISSATISFIED	FAIRLY DISSATISFIED	NOT SURE	FAIRLY SATISFIED	VERY SATISFIED
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* Developed at the Morrison Center for Youth and Family Services, Portland, Oregon, 3355 S.E. Powell Blvd.

8. If you are a parent, how well do you get along with your children? If you are a child or teenager, how well do you get along with your parents?
VERY POORLY POORLY ABOUT AVERAGE WELL VERY WELL

9. If you are a parent, how well do your children get along with each other? If you are a child or teenager, how well do you get along with your brothers and sisters?
VERY POORLY POORLY ABOUT AVERAGE WELL VERY WELL

10. If you are a parent, how satisfied are you with how your child(ren) is doing in school? If you are child or teenager, how satisfied are you with how you are doing in school?
VERY FAIRLY NOT FAIRLY VERY
DISSATISFIED DISSATISFIED SURE SATISFIED SATISFIED

11. What is the main reason your family stopped coming to Children's Home for therapy?

12. Would you recommend Children's Home to other families if they had problems similar to those which brought you to Children's Home?
_____ YES _____ MAYBE _____ NO

13. Plax an X on one of the blanks below:
If difficult problems were to occur or reoccur within your family, would you:
1. _____ Recontact Children's Home
2. _____ Contact another mental health agency
3. _____ Deal with the problem yourselves
4. _____ Give up or try to ignore the problem
5. _____ Other (Explain) _____

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a check (x) in the box (1-5) that shows your feeling about each area.

	Very Dis- satisfied	Dis- satisfied	In between	Satisfied	Very satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8. Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right and wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistent with discipline					
18. Participation in family fun and recreation					
19. Making individual decisions					
20. Making family decisions					
21. Seeking help for family problems from friends, relatives, church, etc.					
22. Ability to provide help to friends neighbors, relatives, church, etc.					
23. Feeling good about our family					
Make the last rating for yourself:					
24. Feeling good about myself					

APPENDIX III

An Explanation of the Reporting
of Differences in the Pre and Post
Intervention Scores on the Family Concern Form.

In the following tables, an increase or decrease in satisfaction is represented by a plus (+) or minus (-) sign in front of the number of response categories the item changed over the course of intervention. As there were five possible categories of response on the Family Concern form. The maximum change that was possible on any given item was plus or minus 4 (i.e., from very dissatisfied to very satisfied).

When no change occurred in an item it is indicated by the notation "NC". The notation "- - " indicates missing data or items that were not applicable to a family member.

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

	Very Dis- Satisfied	Dis- satisfied	In between	Satisfied	Very Satisfied
1. Showing good Feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8. Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right and wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistent with discipline					
18. Participation in family fun and recreation					
19. Making individual decisions					
20. Making family decisions					
21. Making contact with friends, relatives, church, etc.					
22. Dealing with stress					
23. Feeling good about our family					
Make the last rating for yourself:					
24. Feeling good about myself					

DIFFERENCES BETWEEN PRE - AND - POST - INTERVENTION SCORES ON THE FAMILY CONCERN FORM
 FAMILY D
 MEMBER 1 - PARENT

1. Showing good feelings (joy, happiness, pleasure, etc.)	NC				
2. Sharing feelings like anger, sadness, hurt, etc.	+ 2				
3. Sharing problems with the family	+ 2				
4. Listening and understanding	- 2				
5. Being patient or calm with others	- 2				
6. Showing care and concern	+ 1				
7. Being positive, saying nice things about others	+ 1				
8. Knowing what behavior to expect at different ages	+ 1				
9. Dealing with matters concerning sex	- 1				
10. Making sensible rules	- 1				
11. Being able to discuss what is right and wrong	NC				
12. Taking on responsibilities	+ 3				
13. Encouraging others to take on responsibilities	- 1				
14. Use of self-control	+ 3				
15. Proper use of alcohol, drugs	- 1				
16. Deciding, agreeing upon discipline	- 1				
17. Being consistent with discipline	+ 3				
18. Participation in family fun' and recreation	- 1				
19. Making individual decisions	- 1				
20. Making family decisions	- 1				
21. Seeking help for family problems from friends, relatives, church, etc.	- 1				
22. Ability to provide help to friends neighbors, relatives, church, etc.	- 1				
23. Feeling good about our family	- 1				
Make the last rating for yourself:					
24. Feeling good about myself	- 1				

DIFFERENCES BETWEEN PRE - AND POST - INTERVENTION SCORES ON THE FAMILY CONCERN FORM

FAMILY G

Family Member 1 Parent Family Member 2 Child Family Member 3 Child

1. Showing good feelings (joy, happiness, pleasure, etc.)	NC	NC	NC		
2. Sharing feelings like anger, sadness, hurt, etc.	NC	+ 2	- 2		
3. Sharing problems with the family	NC	+ 1	NC		
4. Listening and understanding	+ 1	+ 1	NC		
5. Being patient or calm with others	- 1	- 1	+ 1		
6. Showing care and concern	- 1	+ 1	+ 1		
7. Being positive, saying nice things about others	NC	+ 1	NC		
8. Knowing what behavior to expect at different ages	NC	NC	+ 1		
9. Dealing with matters concerning sex	NC	NC	NC		
10. Making sensible rules	+ 2	+ 1	+ 2		
11. Being able to discuss what is right and wrong	+ 2	+ 1	NC		
12. Taking on responsibilities	+ 1	+ 1	NC		
13. Encouraging others to take on responsibilities	+ 2	NC	+ 1		
14. Use of self-control	+ 2	NC	NC		
15. Proper use of alcohol, drugs	NC	+ 1	NC		
16. Deciding, agreeing upon discipline	NC	+ 2	NC		
17. Being consistent with discipline	+ 1	NC	+ 1		
18. Participation in family fun and recreation	+ 1	+ 1			
19. Making individual decisions	+ 1	NC	+ 1		
20. Making family decisions	+ 1	- 1	NC		
21. Seeking help for family problems from friends, relatives, church, etc.	NC	- 1	- 2		
22. Ability to provide help to friends neighbors, relatives, church, etc.	NC	+ 1	+ 1		
23. Feeling good about our family	+ 1	NC	NC		
Make the last rating for yourself:					
24. Feeling good about myself	NC	NC	- 2		

DIFFERENCES BETWEEN PRE - AND - POST - INTERVENTION SCORES ON THE FAMILY CONCERN FORM
FAMILY P.

	Family Member 1 Parent	Family Member 2 Parent	Family Member 3 Child	Family Member 4 Child	
1. Showing good feelings (joy, happiness, pleasure, etc.)	+ 1	+ 3	- 1	NC	
2. Sharing feelings like anger, sadness, hurt, etc.	+ 1	+ 3	- 1	+ 1	
3. Sharing problems with the family	+ 1	+ 2	NC	+ 1	
4. Listening and understanding	+ 1	+ 2	- 1	+ 2	
5. Being patient or calm with others	NC	+ 1	NC	+ 1	
6. Showing care and concern	+ 1	NC	NC	+ 1	
7. Being positive, saying nice things about others	+ 2	NC	+ 1	+ 2	
8. Knowing what behavior to expect at different ages	+ 1	NC	+ 2	NC	
9. Dealing with matters concerning sex	+ 2	+ 2	NC	+ 1	
10. Making sensible rules	+ 1	+ 2	+ 2	NC	
11. Being able to discuss what is right and wrong	+ 2	- 2	+ 1	+ 2	
12. Taking on responsibilities	+ 1	NC	+ 1	+ 1	
13. Encouraging others to take on responsibilities	+ 1	NC	+ 1	NC	
14. Use of self-control	+ 2	NC	+ 1	+ 1	
15. Proper use of alcohol, drugs	+ 1	NC	+ 1	+ 1	
16. Deciding, agreeing upon discipline	+ 1	+ 2	+ 2	+ 1	
17. Being consistent with discipline	+ 2	- -	+ 2	+ 1	
18. Participation in family fun and recreation	+ 2	+ 1	- 1	+ 3	
19. Making individual decisions	+ 2	+ 1	- 1	+ 1	
20. Making family decisions	+ 2	+ 1	+ 1	+ 1	
21. Seeking help for family problems from friends, relatives, church, etc.	+ 1	+ 1	- 1	NC	
22. Ability to provide help to friends neighbors, relatives, church, etc.	+ 2	+ 3	+ 2	NC	
23. Feeling good about our family	+ 2	+ 2	+ 1	+ 1	
Make the last rating for yourself:					
24. Feeling good about myself	+ 1	+ 2	NC	+ 1	