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Structural Family Therapy:

An Application of the Model

by

Marlene Richert

A Practicum Report

submitted to

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In Partial Fulfillment of the Requirements

for the Degree of Master of Social Work

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INTRODUCTION

The learning objectives of this practicum are to demonstrate that the student has developed advanced clinical skills using the Structural Family Therapy Model and to present her understanding of the theory to its application and intervention in family systems. The student also proposed to examine the application of this method to family situations.

The intervention objectives were to (1) review the relevant literature and (2) to complete a practicum in a setting that is supportive of family therapy.

The identified problem in all of the families seen by the student were one or more of the children in these families. The child or children of these families were described as out of control or a behaviour problem in some other ways. The student engaged these families with a view to providing the best possible service to these families utilizing all available resources within the practicum setting. Additionally, these families were invaluable as teachers to the student, in most cases tolerant to the student's errors.

The following report is the compilation of what the student learned as she set out to meet these objectives.

Chapter two, the Literature review involves two sections. Section 2A, provides a historical perspective with an overview of the origin and evolution of family therapy to its present day application in many social service settings. The second section, 2B, involves a discussion of General Systems Theory particularly its development towards Structural

Family Therapy, the chosen therapy by this student for her practicum.

In Chapter Three, the Structural Family Therapy Model is presented. This presentation describes the theoretical evolution of Structural Family Therapy, general discussion of major concepts and its adaptability to changing needs of families.

Chapter Four presents Training Issues in Teaching Structural Family Therapy. As a student involved in family therapy training, the student developed an interest in understanding training issues of family therapy. The chapter involves the following presentations, understanding and commitment to theory and practice of family therapy; supportive settings; supervision; methods of learning; support groups; special issues of women training as family therapists; inherent risks and drawbacks of learning new skills and conclusions.

Chapter Five, Methods, involves a description of the student's practicum experience including the setting and procedures used, a description of the client population used.

The evaluation model as well as the major theoretical and practical components of the model, The Family Assessment Measure III, are in this chapter. The significance of a sound evaluation model and procedures cannot be undervalued and constitute a central component of this student's practicum.

In Chapter Six, The Application of Structural Family Therapy, the student presents three case examples with detailed discussion demonstrating the integration of theory and practice. This discussion also includes the

evaluation model, FAM III, with a presentation and interpretation of the clinical profiles obtained from the three families scored.

Chapter Seven, Synthesis and Conclusion, is the final chapter of the practicum report. As the heading implies, it draws major conclusions from the practicum experience and synthesizes signifcant components with a view to solidifying an understanding of what the student learned in her practicum experience.

The remaining cases of the practicum experience are available for examination in the Appendices section of this Practicum Report.

CHAPTER TWO

LITERATURE REVIEW

CHAPTER 2 A: HISTORICAL PERSPECTIVE

A brief historical overview of the family therapy field is presented here in an attempt to place the development of the Structural Family Therapy Model in context. The purpose of the historical overview is to introduce some of the concepts presented in later chapters and give an orientation to the major practitioners whose methods developed the beginning of the structural model.

The therapist oriented to individual therapy tends to see the individual as the cite of the pathology and together data that can be obtained from or about the individual. Family therapy, on the other hand, is a treatment approach that views dysfunctional or pathological behaviour as more a result of the struggles between persons as opposed to the conflicting forces within an individual. (Haley, 1963). The theories of family therapy are predominantly based on the fact that individuals are acting and reacting members of social groups.

The three major historical schools of family therapy are the psychodynamic, the multigenerational and the intergenerational. They all conceptualize family dysfunction and dynamics in historical terms.

Although the three schools describe their theories in several ways, they generally agree that the problems evident in any family fundamentally reside in a lack of maturity or ego development of its marital partners. This is seen as a function of the continued attachment to, lack of differentiation from, or an unsettled loyalty resulting in a fixed unbalance in their relationships with their parents. The result of unsuccessful attempts to deal with life's problems can be symptoms in one of the partners, in the marital relationship or in one or more of the children. In as much as the three schools agree to a substantial

degree in their conceptualization of family dysfunction and dynamics, they also believe therapy should be long term, deal with more fundamental problems of lack of maturity of the partners and its function of previous relationships in their families of origin. Dysfunction is generally viewed as resulting from unresolved issues in the family of origin which result in behaviours and beliefs which are projected onto members of the individual's current family. (Anderson & Stewart, 1983, p. 14). This family dysfunction or dysfunctional sets (Minuchin, 1974) are non-problem-solving reactions to stress that perpetuate the problem rather than allowing change to occur. Aponte and Van Duesen (1981) state that "whatever the history of the problem, the dynamics that maintain it are currently active in the structure of the system, manifesting themselves in the transactional sequences of the family". (p.315)

The growth of family therapy is attributed to other factors such as the increased influence of child psychiatry (Okun and Rappaport, 1980). There was a move away from traditional psychoanalysis due to its rigor, length and the growth of scientific knowledge. Traditional individual therapy also had the major drawback that if one family member was cured in treatment, the other family members would often react negatively to this change, forcing the person back to their previous behaviour. The implications of this would bring into question the long term effects of therapy and difficulty demonstrating that real change had occurred.

The first half of the century, however, concentrated most treatment approaches, the very popular psychotherapy modalities, only on the individuals. However, in 1952, Gregory Bateson, (Foley, 1974) a British anthropologist, was watching monkeys at play. Through his

observations he concluded that there were two types of communication, those that were to be taken at face level and the more subtle signals that modify them. Bateson extrapolated from the monkey's behaviour, the phrase "double bind" theorizing that schizophrencics could not distinguish among the various levels of meaning that exist in most human interactions. (Okun and Rappaport, 1980).

He further speculated that most schizophrenics had received contradictory messages since birth. His contribution to the field of psychiatry has been described as immeasurable. Bateson's double bind, later developed into paradoxical communication theory, continued to remain central to family therapy theory.

Paradoxical communication theory maintains that disturbed families are unable to let go of its members who chance by marrying, leaving home, giving birth or dying. (Papp - 1983, p. 33-35).
These families seek to preserve their unhealthy but comfortable balance. Crises arise in these families because they have to accommodate their needs for change as well as those needs for safety and security.

Over the past twenty years, family therapy has become an increasingly popular mode of treatment. It has been accepted and incorporated by many fields including psychiatry, mental health, and family medicine. Its training curricula has grown and a significant amount of research has also appeared.

John Bell, considered one of the first family therapists, contributed the notion that he could see his individual patients in the family units.

He originally worked with disturbed children and their families and began to refocus definitions of the problems from that of the child's to one of parental conflict. Other noteworthy theorists included Lyman Wynne, Theodore Lidz, Murray Bowen and Nathan Ackerman.

Wynne tried to develop a "psychodynamic interpretation of schizophrenia that takes into conceptual account the social organization of the family as a whole". (Foley, 1974, p. 18). Wynne used the pseudonym of a "rubber fence" to describe the boundaries surrounding the family which expands and contracts as is necessary to keep the schizophrenic member inside. The terms Wynne used, "pseudomutuality" and "pseudohostility" describe lack of differentiation and the alignment in the families of schizophrenics. Minuchin (1974) later developed the structural concepts of boundaries, coalitions, enmeshment and disengagement from Wynne's earlier works.

In the 1950's the works of Lidz, Bowen and Ackerman did much to legitimize the family therapy movement. (Okun and Rappaport, 1980). Lidz stressed the importance of clear role definitions, describing the need for distinct generational boundaries between parents and children. (Okun and Rappaport, 1980).

Bowen viewed his patients with their extended families in the context of conceptualizing the identified patient as part of "interlocking triangles". (Okun and Rappaport, 1980).

Ackerman, sometimes referred to as the "grandfather" of family therapy saw the family as a social/emotional unit. He theorized that his patients individual pathology reflected the emotional distortion of their families. (Okun and Rappaport, 1980, p.50).

CHAPTER 2 B: GENERAL SYSTEMS THEORY

Bateson's work in general systems theory further developed into communication theories with Satir, Haley, Weakland and Jackson later developed into the Structural Family Therapy Model by Minuchin.

These approaches are generally concerned with the current patterns of interactions of families and with the relationships of these patterns to the presenting problems of the identified patient. Although the variations in how the interactional patterns are viewed are broad, they differ from the previously discussed historical approaches by dismissing history taking, overinterpreting or uncovering in the treatment process and by not focusing on the psychology of the individual. The therapeutic approaches generally involve reordering the family system in order to remove the dysfunctional elements that produced or maintain the system. Because of their deemphasis of history and interpretation, the entire process of therapy is much shorter in these theories than in the historical approaches.

Buckley (1967) provides an elaborate definition of a system "...a complex of elements or components directly related in a casual network, such that each component is related to at least some others in a more or less stable way within any particular period of time... The particular kinds of more or less stable interrelationships of components that becomes established at any time constitute the particular structure of the system at that time thus achieving a kind of 'whole' with some degree of continuity and boundary" (p. 41).

Based on this, the family can be viewed as a complex organism composed of

mutually dependent parts and processes which are mutually interactive. In a family system then, a member who is the identified patient is seen as the one who expresses the disturbances within the family. Problems are viewed as developing from the family not from the individual. The treatment in this view then is aimed at changing the structure and interactions of the entire family rather than just changing the I.P.'s symptoms. (Okun and Rappaport, 1980).

Systems theory increases the choices a practitioner has in selecting a criteria for treatment while at the same time enabling conclusions to become more sophisticated. Family therapy is just one choice of a number of treatment modalities for those who adopt a systems approach to problem-solving and decision-making.

General Systems Theory had a direct theoretical impact on the development of the following representative schools of family therapy; Communication Systems (Jackson); Problem-solving (Haley); Brief Therapy (Watzlawick); Paradoxical (Polozzali); Problem-Centered Systems (Epstein); Strategic (Rabkin, et. al.); Structural-Stategic (Stanton, Andolfi); Behavioral (Patterson, et. al.) and Structural (Minuchin).

The communications systems theory grew out of Bateson's research project and was based at the Mental Research Institute (M.R.I.) under the leadership of Jackson in 1959. Originally, the group consisted of Weakland, Haley, Watzlawick and Satir.

Goldstein (1973) recognized the dual part played by General Systems Theory in increasing the complexity of a problem's order and in its problem-solving, "...a system's orientation reveals the nature of the larger social problem as well as its impact on the specific persons or groups of persons

in relation. Conversely it elucidates the system, persons and behaviours which tend to perpetuate the problem and thereby identifies the points in the complex of systems where the most effective intervention is possible". (p. 110).

Although many social workers involve the treatment of the family system, they do not do family therapy which is a distinct treatment modality. The contract between a therapist and the family is much more narrowly defined and specially for family therapy than a more general casework service. (Walrond-Skinner, 1976).

In General Systems Theory, the system can be described as a "whole" and that its components and their characteristics can be understood as functions of the total system. The components of a system and their attributes must be understood in terms of the transactional processes that take place between them. In observing the family is therapy, the therapist creates a therapeutic system or wholeness by combining the whole family and herself. The actions of its individual members are not viewed in isolation of the whole family.

The system's identity is determined by the boundaries of the system. Without a clear awareness of these boundaries it would be difficult to treat the system as a whole. Once the boundaries of the system are determined, the therapist can begin to work with the subsystems.

Systems are further identified as open or closed. Minuchin (1974) expands on these concepts in his theory on Structural Family Therapy and describes two broad family types as "disengaged" and "enmeshed". The extreme points of both categories are described in Structural Family Therapy Theory as dysfunctional. (Minuchin, 1974). (This will be further

discussed in Chapter 3).

General Systems Theory was criticized early on for its limited concept of homeostasis which critics believed could not adequately demonstrate more complex phenomena of family systems such as growth, change and creativity.

Homeostasis is a self-correcting mechanism and is essentially concerned with the preservation of the system. (Watzlawick, et. al., 1974). All functional family systems need some measure of homeostasis so that not all homeostatic functions are dysfunctional. The basic premises of this theory have been expanded on by theorists such as Watzlawick, Haley, Satir and Jackson.

General Systems Theory is concerned with communication. It observes feedback which is considered to be positive or negative. Positive feedback leads to the upset of homeostasis and the movement towards change and growth. Negative feedback triggers off its homeostasis which can decrease the system's movement towards change.

According to this theory, families enter into therapy because they are experiencing some form of breakdown in its usual feedback processes. This breakdown can be between family members (internal) or with the outside systems (external). As the communication becomes blocked or damaged, breakdown or dysfunction occurs. Even though a family may find these dysfunctional patterns painful, they will often cling to them rather than fear extinction as a family.

The therapist in General Systems Theory is goal oriented and purposeful as social systems are naturally. She would join a family in order to

assist them towards its own goals and purpose.

The next section will focus on the theory of the student's practicum experience: Structural Family Therapy.

CHAPTER THREE

STRUCTURAL FAMILY THERAPY

CHAPTER 3: STRUCTURAL FAMILY THERAPY

Origins of Structural Family Therapy

Salvador Minuchin and his colleagues developed Structural Family Therapy beginning at the Wiltwyck School for Boys where Minuchin worked with delinquent boys from New York. At that time, Minuchin was interested in studying "the structure and process of disorganized, low socioeconomic families that had each produced more than one acting out child; and hoped to experiment with and develop further therapeutic approaches designed for such families". (Minuchin, et. al., 1967, p. ix).

Minuchin later studied families with a child suffering from anorexia nervosa. (Minuchin, Rosman and Baker, 1978). During this period at the Philadelphia Child Guidance Clinic, his colleagues included Haley, Aponte, Montalvo as well as Lynn Hoffman, Lester Baker and Ronald Liebman.

Today, the Structural Family Therapy Model has evolved into a widely practiced and highly respected method of family therapy. Structural Family Therapy involves looking at families geometrically. The therapist is trained not to see individuals but larger systems composed of sub-systems with individuals. Three generations of families are concurrently examined. Families are also viewed as exhibiting many triangles or triangular relationships which may discourage growth by affording no solid footing. The therapist views the family in therapy as having many "too close" ties and attempts are made to channel communication into effective family patterns. The techniques for moving families are described in more detail later. Minuchin, a master at family therapy has many methods and techniques for challenging his families. He uses humour, hostility and trickery as well as others to broaden the possible entry points whereby he can work at the interface of the family and

societal system.

Families in Therapy

In family therapy "the family is recognized as a self-perpetuating system. The processes which the therapist has initiated may be perpetuated in his absence". (Minuchin, typed handout, p. 3).

Families usually enter into therapy because one of its members has been identified or labelled as the problem/patient. The family therapist initially transforms this individual label into a diagnosis which includes the whole family.

The family is viewed as being composed of a variety of sets or patterns which direct what occurs in families. Dysfunctional patterns are reactions of family members to stress which are repeated in families in conflict of crises without modifications. The entire family can become involved in these patterns and mechanisms for change can become blocked which could help restore the family system back to a functional equilibrium. Families with dysfunctional patterns are different from families with functional patterns in that families with dysfunctional patterns tend to repeat those patterns when stressed whereas families with functional patterns can change and resolve or reduce stress for its family members.

Assessment and Intervention

Minuchin (1974) attributes 20th Century philosophy and technology to the broadening focus of a diagnosis to an evolving and broader description of relevant sequences. The diagnosis is no longer merely a description but includes implications for therapeutic interventions and is achieved by

therapeutic strategy.

The therapist using the Structural Family Therapy Model designs a treatment plan to change a variety of aspects of the family's structure. This plan is based on an evaluation of the four major concepts of the family. These include family structure, the concept of subsystems, boundaries and the concept of stresses affecting the family and how the family adapts to situations of stress.

Family Structure

Family structure is a key concept of the Structural Family Therapy Model and a clear understanding of a family's structure is necessary in order for interventions made in therapy to be relevant to the family in treatment. The structure consists of transactional patterns with both verbal and non-verbal components that determine the pattern of behaviour of the system. These transactions regulate behaviour by representing a power hierarchy in families and through mutual expactations developed over long periods of repetitions. Minuchin describes family structure as "the invisible set of functional demands that organizes the ways in which family members interact". (Minuchin, 1974, p. 51). An individual's behaviour can be significantly changed by altering the structure of the family, therefore most of the therapist's energy is directed towards the structure of the family.

Subsystems

There are three forms of subsystems identified by Minuchin as the spouse, parental and sibling subsystems (Minuchin 1974, p. 56-60). These are primary mechanisms of the family used to differentiate and perform its

functions. Members belong to a variety of subsystems wherein individuals learn to communicate, negotiate and co-operate with one another to develop a personality and group identity.

Subsystems in families carry out functions so that individuals can move in and out of subsystems without threatening the total family.

The spouse subsystem is formed when a couple is joined in marital like union. It is only open to the spouses because of the specific functions only performed by the couple.

The parental subsystem, usually formed after a child is born, is responsible for the primary tasks of nurturing, socialization and authority.

The sibling subsystem is "the first social laboratory in which children can experiment with peer relationships". (Minuchin 1974, p. 59). It is as important to the health and well-being of a family as are other subsystems.

Boundaries

Boundaries within the subsystem "are the rules defining who participates, and how". (Minuchin 1974, p. 53). In families functioning efficiently, these rules are clearly defined and all family members understand them so that subsystem functions can be accomplished. The lines of responsibility and authority are clear yet the boundaries are flexible to allow members input from each other's subsystems.

Minuchin (1974) depicts three types of boundaries in families and sees them falling somewhere along a continuum of the two extremes of disengaged or rigid and enmeshed or diffuse boundaries. Clear boundaries

are within the normal range wherein most families fall. (Minuchin, 1974, p.54).

Mapping is a very significant method of describing a family and boundaries due are depicted in the following ways: Rigid boundaries are seen as straight unbroken lines. In families with rigid boundaries, individuals are often isolated and forced to function autonomously because communication is a major problem. As a result of this, an individual may not have opportunities to share supportive functions of daily living resulting in disengaged subsystems that may only respond to one another in crisis situations.

On the other end of the continuum are families described as enmeshed with diffuse subsystem boundaries. These families function with increased levels of involvement and dependency. Problem solving is usually random and confused where the behaviour of one member has an immediate effect on other members and no one is sure who is responsible for what and how tasks are to be accomplished. Diffuse boundaries are mapped as broken lines.

Concept of Stresses

Finally, the concept of stresses affecting the family and how the family adapts to situations of stress is examined. As there are many stresses imposed on the family by outside forces, the family itself is subject to internal stress eminating from developmental stages of its own members and subsystems. Minuchin (1974) identifies four sources of stress which can directly affect families and develop a different level of homeostasis. These four include, (1) stressful contact with one member with extrafamilial forces, (2) stressful contact with the whole family with extrafamilial forces, (3) stress at transitional points in the family and, (4) stress

around idiosyncratic problems. The first two sources may be caused by outside agents not related to the family structure and the latter two are internal problems affecting all or several family members. As Minuchin has a very strong belief that families want to preserve themselves, he sees that families deal with stress by attempts to preserve their structure. Whereas healthy families use stress as means for growth and development, unhealthy families utilize old and inappropriate methods of dealing with stress which stifles growth and development. (Minuchin, 1974, p. 63-66).

Once the therapist has assessed the structure of the family in therapy and has a beginning understanding of the family's organizational composition, the therapist can derive a family map which assists the therapist in organizing information and hypothesis formulation about dysfunctional and functional aspects of the family. In obtaining a structural assessment, the therapist must further assess the intrafamilial and extrafamilial coalitions and alliances in the family determine whether transactional patterns are enmeshed or disengaged. (Minuchin, 1974, pp. 89-109).

Three Main Strategies

Structural Family Therapy utilizes three main strategies, each composed of a variety of techniques. (Minuchin and Fischman, 1981). The first strategy, "challenging the symptom" is a means of challenging a family's definition of a problem and the way they respond to that problem. (Minuchin and Fischman, 1981, p. 67).

The techniques specific to this strategy include: 1) enactments, where interpersonal scenarios are enacted in therapy in order to highlight dysfunction and introduce alternative ways of functioning, 2) focusing

whereby the therapist organizes information into a meaningful framework. A theme for work can thereby be developed, and 3) intensity, whereby the therapist gives messages to the family in ways which are opposite to their established rules. The therapist has a lot of opportunity for movement within this framework.

The family structure is challenged by the following techniques of boundary marking, unbalancing and teaching complementarity. (Minuchin and Fischman, 1981, p. 146-206). The family must be led to see that the dysfunctional patterns they have, impact on individual members and that the development of new ways of dealing with one another can create healthier family systems.

Finally, techniques of challenging the world view of families include cognitive constructs, paradoxical interventions and highlighting strengths. In cognitive constructs, the goal of the technique is to show family members that symptoms are not necessary and that family members can be flexible and grow.

Paradoxes are methods of interventions primarily used by skilled therapists in dealing with resistance and power struggles between therapist and family in therapy. Opposite responses are produced by interventions than appears at face value.

The strengths of families must also be observed when challenging their world view. Minuchin sees the family as a balanced growth system or an "open sociocultural system in transformation" (Minuchin, 1974, p. 51). The family maintains itself but is also able to adapt to changing circumstances. The family is "able to transform itself in ways that meet new circumstances without losing the continuity that provides a frame

of reference for its members" (Minuchin, 1974, p. 52).

Summary

Minuchin recognizes the everchanging needs of society but also that change always occurs in the larger system (society) first then in the family. Although many believe the family will cease to exist because of a variety of changes in society, Minuchin believes that the family will survive, albeit in a changed form because it is the best human unit for a society that is rapidly changing and requires flexibility and adaptiveness from its members. (Minuchin, 1974, p. 50).

The Structural Family Therapy Model provides the practitioner interested in family work with a variety of methods and maneuvers based on a sound theoretical model developed by Minuchin. This approach is comprehensive and has allowed this beginning therapist to advance her learning through the use of clearly presented and sensitive guidelines. The full repertory of interventions take the therapist from beginnings moves, through therapeutic goals and interventions and to the achievement and identification of more effective family functioning.

In order to become an effective therapist many skills must be understood and successfully applied to families in treatment. The theoretical component of the model stresses understanding of families, joining and planning therapeutic moves. The practical component of the models allows for mastering skills of changing boundaries, between family members, unbalancing relationships to create room for more effective patterns and methods of reinforcing areas of harmony.

More specific skills of intervention include paradoxical interventions, the constructing of alternate realities for families as well as an emphasis on strengths, rather than focusing on the negative patterns of families in treatment. The student would highly recommend this model not only as an affective model for intervention but as a means of exploring the complicated and fascinating web of families.

This concludes the student's discussion of the Structural Family Therapy Model, her chosen method for her practicum. The next chapter will discuss training issues in Structural Family Therapy.

CHAPTER FOUR

TRAINING ISSUES

CHAPTER 4: TRAINING ISSUES

In this chapter the student will discuss issues in training beginning therapists in family therapy with specific references to the Structural Family Therapy Model.

These issues include; understanding and commitment to theory and practice of family therapy; supportive settings; supervision; methods of learning; support groups; special issues of women training as family therapists; inherent risks and drawbacks of learning new skills. Although the thorough analysis of all of these issues is beyond the scope of this report, the student hopes that the attempt made to discuss briefly, these issues will raise the awareness of the reader to the necessity of considering more than just theory or practice when learning and teaching Structural Family Therapy.

Commitment to Theory and Practice of Family Therapy

A commitment to theory should occur at a beginning stage of learning family therapy. The integration of practice and theory can only occur when a student has started training with an overview of theory and opportunities to observe practical applications that is being taught. (Minuchin and Fischman, 1981, p. 9).

One's personal style is developed as the learning continues which can allow further skill development and commitment to theory.

Trainees need to learn therapeutic techniques to bring about structural change in families but they also need to learn their own ways of using these techniques (Minuchin and Fischman, 1981, p. 6).

Beginning therapists often become frustrated if the "rules" of the model are so ambiguous that only advanced clinicians can integrate them. The trainee, committed to the Structural Family Therapy Model can develop the skills necessary to effectively practice it, yet remain open to considering new developments in other theories which, when properly applied, can enrich the effectiveness of the clinician.

The use of self is also an important component of a commitment to family therapy. Whereas other models of individual or group therapies focus on the therapist as observer, the family therapist becomes part of the therapy. This is particularly true in Structural Family Therapy where the therapist uses her own personality during the course of treatment. Minuchin (1981) describes this use of self as involving the dual role of participant and observer vis a vis the family system, moving in and out of these two roles in accordance with the therapeutic needs of the family. The therapist must be able to move freely, emotionally within the family, the ability to use the caring, nurturing parts of her personality as well as the tougher, controlling parts appropriately. This can only be achieved by an understanding and commitment to theory and practice.

Supportive Settings

The need for beginning therapists (and advanced therapists) to have a supportive setting can be easily understood by most clinicians.

Although family therapy is becoming more popular and accepted among many clinicians and settings, most clinicians were trained in other individually oriented modalities and maintain loyalities to these. Family therapy is often viewed with apprehension and skepticism because it is in direct

opposition to most individual approaches. (see Chapter 2: Historical Overview). The family therapy trainee can experience this lack of support or resistance from co-workers or supervisors which can rapidly lead to feelings of alienation, exhaustion and undermine feelings of self-esteem as a member of a treatment team.

Anderson and Stewart (1983) discuss family therapy in administrations that continue to maintain more traditional approaches that have been previously successful. Family therapists (and trainees) may feel frustrated and undervalued by the administration's continuation of an individual focus. The therapist may simply incorporate their family therapy model into their existing structure rather than adjust accordingly for a family oriented treatment.

Anderson and Stewart (1983) suggest that family therapists and trainees who find themselves faced with such setting's situations, incorporate the following strategies which are similar to those used in dealing with resistance in families. These include; enter the system through the existing power structure; avoid power struggles; offer help to other staff; bring up family issues at every opportunity; avoid the use of family therapy jargon; present cases utilizing family therapy to demonstrate effectiveness and avoid evangelism. Anderson and Stewart (1983) explain that clinical staff are likely to respond with resistance to the over zealous family therapist and other clinicians must be approached sensitively. Anderson and Stewart (1983) further state that family therapists and trainees must take an active role if administrative responsibilities are to occur. They must strive to maintain a fairly high profile if policy changes can occur. The more active the family therapist

and trainees are, the more hope for change there will be.

Supervision

Supervision must emphasize the importance of theory, technique and the trainees' own experiences when teaching the Structural Family Therapy Model. In Structural Family Therapy supervision, "the supervisor operates as a director systemmatically leading the supervisee in the planning and application of interventions that reestablish the appropriate structure". (McDaniel, et al. 1983, p. 498).

McDaniel (1983) recommends the Structural Family Therapy Model as the most helpful for the beginning family therapist because it has a straightforward approach to the teaching of family structure, the application of basic and concrete techniques and where the supervisor serves as the director in actively leading the trainee. This allows the trainee to obtain a clear picture of what the model perports thereby enabling her to decide whether this model in "pure form" is necessarily what she can believe in.

Supervision of trainees using the Structural Family Therapy Model can also be described in structural terms. As the trainee becomes more competent and confident in her work, the supervisor takes on a different role with the trainee, yet maintaining ultimate responsibility for what goes on in the session. "Shifts resulting from the supervisee's maturation and individuation are handled like the structural shifts in a well functioning family with adolescents". (McDaniel, et. al., 1983, p. 493). If a healthy trusting relationship has been developed between the supervisor and the trainee, the trainee can begin to challenge the supervisor in ways which strengthen her skills yet allow for continued

direction by the supervisor. If a trainee is made to feel she is dependent on the supervisor for all direction and ideas, her development may be slower. In the extreme, it may develop into one of anger and rebellion against the supervisor which further limits growth and competence.

McDaniel (1983) describes the essential work of the supervisor as helping the therapist stay focused on and able to change the dysfunctional interactions as they develop in the session. "The supervisor directs the therapist who directs the parents who direct the children". (McDaniel et. al. 1983, p. 492). The supervisor - trainee subsystem is essential for the resolution of transactional problems which can assist the family in therapy. Boundaries established between the supervisor and trainee are clear as there is often a mirror separating them (see next section on methods of learning). The interventions directed by the supervisor to the trainee can additionally force a hierarchy between the supervisor and trainee which maintains clear boundaries between the supervisor - the trainee - and family.

The role of the supervisor cannot be undervalued. Good supervision can lead to clear transmission of theoretical concepts into practice resulting in competent and compassionate family therapists. This can only result in improved services to families.

There are a number of implications of all of this for the student's practicum. The student was committed to learning Structural Family Therapy as a method of working with families. She was also fortunate to have located a supportive setting as well as a skilled supervisor. The student as a trainee, in a training group, was involved with a number of fellow students who were not working in similar situations in other agencies. There were discrepancies between what was being learned theoretically and what could

be applied to other agency settings that were not supportive of Structural Family Therapy. Fellow students were in fact, struggling with settings and supervisors committed to an individual and/or child focus of treatment. These supervisors reportedly saw family work as one of many methods a social worker could use in their daily work. Many of the trainees became frustrated with their limiting situations yet believed they were unable to affect any change in their settings.

The leaders of the training groups encouraged the trainees to learn new skills which could be applied in their various settings. These skills would ultimately demonstrate the effectiveness of a family focus as opposed to an individual focus.

It was very apparent that the supervision available to this student in her practicum experience and training group led to clear transmission of theoretical concepts into practical methods. The nature of the model was helpful in its straightforward approach to the teaching of family structure as well as its basic and concrete techniques.

As the student became more confident and competent, the amount of direction in supervision was reduced and this allowed for a helpful exchange of ideas between the student and the supervisor. The student also obtained supervision from various therapists trained in Structural Family Therapy. While this was a necessary experience which tested the student's flexibility and adaptability, it also demonstrated to the student that the techniques developed from a Structural Family Therapy Model are clear and concrete applicable in a variety of situations.

Methods of Learning

Although there are many methods of learning family therapy available to the student, the student recommends a combination of methods. These primarily involve methods recommended by Minuchin (1981) and supplemented by "family of origin focus in therapy" based on Murray Bowen's early work which was particularly important in understanding of the extended family. (Munson, 1984). Braverman (1984) also recommends family therapy training utilizing "family of origin" work in training.

Kerr (1984) presents the basic theoretical assumption based on Bowen's theory of family of origin, that "every person has some degree of unresolved emotional attachment to their parental family" (p. 8). This premise must be understood by clinicians as the concept of differentiation, both as something which occurs within people and the way people function in relationships. These differentiations can only be understood on a continuum with the most undifferentiated and the most differentiated at opposite ends.

This differentiation refers to an individual's awareness of their intellectual and emotional determination as well as the degree to which they have some choice over their own behaviour.

Additionally, Braverman (1984) recommends that family of origin work not become part of therapy but rather be used as a training resource. She has found it helpful in teaching family therapy as well as part of the supervision process. The trainee must be allotted time to learn from the supervisor as well as be motivated to learn.(p. 70).

In addition to these are the methods described by Minuchin (1981). He recommends videotaping sessions, small training groups and live supervision as necessary methods of training therapists. Although there are many methods available, a combination of supportive yet challenging maneuvers on the part of the supervisor in addition to a sufficient number of treatment families must be available to the student.

Since the acquisition of expertise may take years, it may be very difficult to obtain the training necessary to achieve a high level of competence. Agencies may be open to allow family therapy practises in their settings but not the available resources to train them further or allow them training elsewhere.

On the other hand, agencies may have competent qualified staff but not the ability to provide adequate time allottments to trainees. The costs of training may also be so high that students have difficulty acquiring the funds needed to pay for training.

In summary, family of origin work in addition to basic structural methods of learning family therapy may be very helpful for beginning family therapists. Although Braverman (1984) has had difficulty evaluating the effectiveness of family of origin work in training, she has found it invaluable in her experience as a trainer. She recommends that it be purposeful, focused, time limited and that the supervisor and trainee must have a high level of trust between them (as well as the group if available) and, the supervisor be available to discuss any problems that may arise during the process. (p. 47)

Support Groups

Initially many of the difficulties of learning and using family therapy can be reduced if the beginning family therapist is involved in a congenial support group. This group can be made up of peers within the agency or a group of professionals with similar learning and practice goals. Working as a 'loner' without a support group can be unproductive and emotionally costly. Minuchin (1981) recommends small groups in training of five to eight (p. 5) but larger groups may be formed with clinicians who have had previous training and experience and may not need as high levels of support and direction as beginning therapists. (Heath, 1982 p. 189). Heath (1982) presents a team concept in family therapy training and can be utilized as similar to the purposes of support groups. "The goal of the team model of family therapy are to maximize the opportunity for learning conceptual and executive therapy skills and to provide therapy for families" (p. 189). Because of the high degree of emotional involvement demanded in family therapy, and because of the complexity of some of the problems which confront the therapist, support is necessary for most therapists.

The student was involved in a support group, and among the experiences previously discussed, she believes the opportunity to participate in a support group was invaluable for her own learning.

The opportunity allowed for the exchange of ideas, information and concerns which were likely common to all trainees. Mistakes made in practice were seen as "normal" and the group supported its members to try again. Successful maneuvers or strategies were also noted by group members which further encouraged its members to continue trying.

Special Issues of Women Training as Family Therapists

Caust, et.al. (1981) examined several problem areas for training women as family therapists including issues of authority, counter-transference, boundaries and the sexual politics of supervision. They determined that women family therapists are attracted to the effectiveness of the structural/strategic model because it offers them challenges to function in active, flexible and orchestrative roles. (p. 439) Traditionally, women have a history of problems in sex role training, expectations by clients and administrators as well as inherent difficulties in patriarchal institutions which impose certain limits and expectations on women.

The demands of present day family therapy require women to engage in activities of the treatment process and utilize overt and active therapeutic maneuvers. This may be in direct opposition to the ways women have been socialized to behave both in their families and in their professional lives. Caust (1981) recommends that family therapy training requires particular awareness and emphasis of issues essential to female trainees. This allows for the opportunity of women to assist in reaching their full professional and personal potential (p. 446)

Further research and exploration of women's issues are necessary in order to enhance the professional development and effectiveness of women in the field of family therapy.

The student was very aware of the impact her own socialization had on her practice. Theoretically she was aware of what possible effects there may be, but only fully realized this when in the therapy room with a family. Her own family of origin values women as homemakers and primary caregivers.

Conflict avoidance and suppression of overt demonstrations of anger continue to be major obstacles for the student to overcome.

The student believes that women can continue to be valuable as homemakers and caregivers as well as learn to be effective as family therapists without compromising either roles.

Inherent Risks and Drawbacks of Learning New Skills

As in any process of learning new ideas a move to an extreme position of acceptance is sometimes necessary before the "old" and the "new" can be integrated. (Caust, et. al. 1981) Beginning therapists can sometimes concentrate so much on new ideas and methods that the necessary skills that therapists learned long ago become temporarily repressed. Although a loyalty to two beliefs is rejected by the beginning therapist, she may need the support of her colleagues who may not be aware that her new skills are repressing her old skills. Co-workers, invested in a previous model, not supportive of family therapy, may see these beginning therapists as incompetent and needing to go back to their "old model".

In addition to the inherent difficulties created in the effort to incorporate any new skills, the student may be challenged to examine her own family of origin. This method of working in family therapy confronts the worker with the unresolved difficulties which she may experience in relation to both her family of origin and her current family. (Munson, 1984).

The student can verify the discomfort occasionally experienced in a therapy session where the family attempts to hook the therapist or get her off track. The method they use may trigger a memory or a response not easily ignored by the therapist. The use of "self" in structural

family therapy is very powerful but has also made this student aware of unresolved issues within her own family.

Additionally, workers may idealize family therapy and become immobilized by their fears and anxieties. Previously competent workers may question their skills and ability to work with families. This lack of confidence may make it difficult for the beginning family therapist to be assertive in making demands upon the family during the course of treatment. (Minuchin and Fischman, 1981 p. 5). The worker may be feeling that she has no right to ask the family to organize all family members together and come in to see her; this message can be easily transmitted to the family causing them to react in the very way the therapist is afraid they may. Then, if the family has been moved into treatment, the beginning therapist may get caught in the family's dysfunctional patterns whereby the family devises rules to ensure that the system is maintained. The beginning therapist may also be anxious not to upset anyone or the system thereby not challenging member to look at new method of interacting but rather reinforce already dysfunctional patterns.

These early drawbacks inherent in learning the new skills of family therapy can lead many students to return to previously well established (if ineffective) methods of working with families.

All of the previously discussed components of training must be utilized to assist beginning therapists to overcome the initial or early drawbacks of learning family therapy skills.

Initial feelings of incompetence, loss of previously acquired skills, confusion, fear and desire to return to previous, comfortable methods are

an acceptable, normal process of learning Structural Family Therapy. Colapinto (1984) states that, "confusion may be a legitimate moment in learning. Some degree of disruption in thought processes is necessary in taking the leap to a new paradigm". (p.21)

Conclusion

As therapists continue to challenge families to grow and explore alternate ways of interacting, the improvement of their lives is always the goal. These should also be among the goals of learning and teaching family therapy. Students should be challenged yet supported, directed yet given freedom to explore, if growth can occur. As these requirements are met, the therapists trained with awareness of their own needs can only become more effective therapists for the families they serve.

CHAPTER FIVE

METHODS

CHAPTER 5: METHODS

Description of Setting

The practicum was conducted at Children's Home of Winnipeg (C.H.O.W.). Supervision was provided by Vicki Harrison, M.S.W., Assistant Director of Clinical Services at C.H.O.W..

The Family Therapy Department at "C.H.O.W." is supportive of family therapy and is part of a multifaceted agency offering a continuum of services to children and families.

The practical part of the practicum took approximately 10 hours per week from September 1, 1984 to May 31, 1985. The student was involved in the practicum in addition to her full time employment as a Family Worker in Project CHANCE, from September, 1984 to March, 1985, a specialized fostering program offered within the mandate of "C.H.O.W.".

As part of the practicum, the student was also involved in a bi-weekly family therapy training group in which sessions emphasized theory and practice with opportunities for group support and live supervision. The instructor was Shar Reid, M.S.W., Family Therapist at C.H.O.W.. Her knowledge and support were invaluable to the student's learning.

Further, the student utilized opportunities to view training tapes from the Philadelphia Child Guidance Clinic as well as observe live and taped sessions conducted by trained and experienced family therapists.

In addition to the resources for training available at C.H.O.W., the student attended several workshops during the practicum period

including, (1) a two-day workshop in Winnipeg with George Enns, M.S.W., Director of the Family Therapy Training Program at the MacNeill Clinic in Saskatoon. Highlights of this workshop included the student's opportunity for live supervision from George while seeing a practicum family.(discussed further in Chapter 6) and (2) a two-day workshop in Saskatoon with Gillian Walker, M.S.W. of the Ackerman Institute presenting on, brief therapy with single parent, divorced and blended families. Both of these opportunities enhanced the student's learning.

The Family Therapy Department at C.H.O.W. practices family therapy utilizing the structural family therapy model. Its referrals come from schools, community professionals, families themselves as well as internally from other services available at C.H.O.W., e.g. families of children in CHOW residential group homes or families involved with Resources for Adolescent Parents.

Procedurally, all incoming cases are presented and assigned at the weekly intake meeting according to factors including therapist caseloads and urgency of referral. Those not assigned are placed on a waiting list which is reviewed weekly for disposition. Referrals to the Family Therapy Department have increased making a waiting list unavoidable.

The student received one to three hours of supervision bi-weekly, many opportunities for consultation and discussion and live supervision via one-way mirror, bug-in-the-ear, and videotaping equipment. The Family Therapy Department has excellent equipment available which greatly aided the student's learning. Most of the student's sessions with

families were videotaped which enriched the student's opportunities to learn from observing her own work as well as eliminating the necessity of notekeeping during sessions.

The difficulties encountered by the student in her setting revolved primarily around the booking of rooms and time availability of clients. As the number of families available to come in during the day is always fewer than those available and/or willing to come in evenings, the student had occasional difficulty booking rooms to see clients in the evening. This problem has been greatly reduced by the addition of another family therapy room (without videotaping equipment and one-way mirror, however).

Recording of cases seen by the student were made according to the agency's requirements and the student's additional needs. The general format involved; a face sheet, initial assessment form and client contacts. Additional progress notes were compiled on all families which assisted in planning for consultation, supervision, and evaluation.

Description of Clients

A total of nine families were seen by the student. Two of the families received the pre-test and the post-test and seven of the families received the pre-test only.

Three families remained in treatment, one family was discharged from treatment, one family withdrew voluntarily but has expressed the desire to become reinvolved in therapy when the student returns from leave, and four families withdrew from therapy voluntarily.

Of the nine families, three were single parent families, three were blended families and three were natural two parent families family units (with the exception of one where the identified problem was an adopted 14 year old boy). All nine families were seen initially as a family. As therapy continued with one family however, outside agencies intervened and removed the I.P. from the family which eventually led to the deterioration of the family system and their withdrawal from therapy.

The nine families were seen for a total of 34 sessions, averaging 5 sessions each.

All of the families were working class to upper-middle class. This was determined by information obtained from the face sheet all families complete when entering therapy. The occupations of the household heads included; a bartender, a theology student, a physiotherapist, two electrical tradespersons, a nurse's aid, an insurance adjustor, an unemployed factory worker and a contractor. Among the two-parent families, two of the women stayed at home while the remaining four worked outside of their homes as, a greenhouse attendant, sales clerk, tax accountant clerk, and a leather worker.

Evaluation Model

The instrument used as part of the practicum experience was designed to provide quantitative indicator of strengths and weaknesses of families. The Family Assessment Measure developed by Harvey A. Skinner, Paul D. Steinhauer and Jack Santa-Barbara, is an assessment measure based on a process model of family functioning developed from a variety of approaches to family therapy and research. (Skinner 1983, p.91.)

There are three scales which are components of the FAM III. These are; (1) the General Scale, designed to view the family in a systems way, (2) the Dyadic Relationship Scale, designed to look at the relationships between pairs within the family system, and (3) Self-rating Scale, designed to discover how an individual views their own functioning within their family. Since each of these scales view differing perspectives on family functioning, the overall picture can be used as a clinical diagnostic tool, as an outcome measure of family therapy or as a basic research instrument on family processes.

FAM III assesses the following basic concepts: task accomplishment, role performance, communication, affective expression, involvement, control, values and norms. (Additional information obtained in writing from Harvey A. Skinner of the Addiction Research Foundation in Toronto).

The student will provide a synopsis of the various key concepts of the process model of functioning. It should be noted that FAM III is not to be used as a model of family therapy but rather as a model which emphasizes family dynamics.

FAM III**

(1) TASK ACCOMPLISHMENT: This involves a process whereby tasks are accomplished including; a) identification of problem or task, b) exploring alternative solutions, c) implementing the selected approach and d) evaluation of the effects of the approach.

** reference to written material received from Harvey A. Skinner describing the process model of family functioning and article "The Family Assessment Measure" in Canadian Journal of Community Mental Health Vol. 2. No. 2 September, 1983

(2) ROLE PERFORMANCE: Task accomplishment can only be successful if the differentiation and performance of roles is performed. The components of this process involve, a) each family member receiving specific assignments of activities, b) their agreement to perform these roles and c) actually performing their assigned roles.

(3) COMMUNICATION: This is essential to the performance of roles and task accomplishment. The goal of effective communication is to achieve mutual understanding whereby the receiver obtains the correct message sent. The message can be distorted by the reader therefore the receiver must also be willing to be open to the receiving of a message.

(4) AFFECTIVE EXPRESSION: A necessary component of the communication process which has the ability to aid or hinder a variety of aspects of task accomplishment and role performance. Stress can have an impact on affective expression which components include intensity, content and timing of involved feelings.

(5) INVOLVEMENT(AFFECTIVE): This can also impact on the way in which family members accomplish tasks. Since family members have a variety of degrees to which they are involved with each other, these are seen to involve the following five types; the uninvolved family, the narcissistic family, the family which expresses interest in one another without feelings, the emphatic family and the enmeshed family.

Family members also need to be available to one another for support of emotions and expression of individual thoughts.

(6) CONTROL: All family members influence one another and have some control of the means by which this occurs. The four prototype styles

of control are; flexible, rigid, laissez-faire, and chaotic. These are made up of aspects of control which include the degree to which styles of family members are consistent, constructive, and responsible.

(7) NORMS AND VALUES: These determine the extent to which a family defines tasks and how they are to be accomplished. All basic processes must be considered in terms of the values and norms they reflect.

The FAM III was administered to all nine families. Of those nine, seven families were unavailable or unwilling to complete the post-tests, therefore the two groups will be discussed separately.

The FAM III generally takes 30 minutes to complete. Some of the families completed the FAM III in that time but most families used an additional 10 to 15 minutes. There did not seem to be any negative responses by the parents of families to completing FAM III. The complaints came primarily from teenagers who said they did not understand some of the questions. One teenager refused to fill in the forms saying he felt he should not have to be here (in therapy) anyway. Several of the adults commented on the limited range (in their opinion) of choices in responding to statements made in the questionnaires. They indicated that a range of "strongly agree" to "strongly disagree" was not enough. They would have liked to answer "no comment" or "sometimes" to a number of the questions. Although the student requested that the families complete the questions with the one response available that most accurately describes their beliefs, there was one parent that circled more than one answer on a number of questions thereby seriously threatening the validity of the questionnaire.

Overall, the families completed the pretest with minimal problems. Although all of the familes were stressed at the time of entry into therapy, none were in crisis which could affect the consistency and reliability of FAM III administered to families (Skinner et. al. 1983, p. 97).

Although the student administered the pretest to all of the family members 12 years of age and older, she would recommend that the age limit could easily be raised to 15 or 16 years of age, given the reported difficulty by the younger teenager in completing questionnaires.

The student herself was also uncomfortable (in some cases) administering the pretests. Although she initially told families at the point of making the first appointment, that the first session would take longer, the student found that the 30 - 40 minutes for filling out the questionnaire in addition to an initial interview of (on the average) 1½ to 2 hours was very emotionally exhausting to both therapist and families.

The student admits that some of this discomfort was also related to the additional stresses of the VTR, one-way mirror and live supervision mechanisms. Although the student's discomfort diminished over time, this must still be recognized as a concern for families and beginning therapists.

The post-tests were administered to two families. Two of these families completed them after the last session (not necessarily at the conclusion of therapy). One family terminated therapy but indicated willingness to complete the tests although they did not do so.

In sum, the FAM III was valuable as an assessment tool for the student. She did not utilize the scores as an indication for the direction of therapy rather as an indicator of strengths and weaknesses in families and also as an indicator of change, that may or may not have been as a result of the interventions made in therapy.

In the following chapter 6, the student will attempt to integrate theory with practice.

CHAPTER SIX

STRUCTURAL FAMILY THERAPY APPLIED

CHAPTER 6: THE APPLICATION OF STRUCTURAL FAMILY THERAPY

A brief description of three families will ensue with the intention of demonstrating how the student applied structural assessment and intervention techniques to a variety of child related problems. The description includes; (1) the presenting problem: (2) a brief report on the etiology of the problem: (3) a structural assessment of the family: (4) the goals of therapy: (5) the interventions: (6) the pre-test and post-test scores (when available) highlighting its correlation to practice and (7) the termination and evaluation of therapy.

Family "A"

(1) Presenting Problem: Family "A" consisted of a young two parent family, the mother 22 and the father 25 with two young boys, 3 and 2 years of age. Their baby son had died of S.I.D. (Sudden Infant Death) Syndrome several months previously at nine months of age. The family was requesting therapy to help them deal with the baby's death which had until this point caused the family to experience a lot of stress. According to the couple, this was causing a lot of problems within the family. The father felt he was dealing with the loss effectively but believed his wife was not coping well. She was crying alot and was taking less control over the children at home. The mother supported this view of the problem and added that she felt her husband was becoming impatient with her grief, resulting in her doing most of her grieving alone in her room.

(2) Etiology of the Problem: The couple have known each other since they were very young. They attended the same high school. The couple relinquished their first child for adoption when they were 15 and 17

years old. Their relationship continued and several years later they conceived another child, this time choosing to marry and parent the child. They had three children very close together. All of their children are boys.

Both parents are very involved with their families of origin. His family is strong Catholic, her family is not religious. They both spend a lot of time with family members and report most of their social activities are with their families as a family. The father works outside of the home and the mother is at home as primary care-giver. The children were unusually active for their age during the sessions and reportedly very active at home as well.

The couple reported a very good marital relationship prior to the death of their baby. Since that time they have had increased difficulty communicating and enjoying family life. They both reported their families as being very supportive. The grandparents assisted the couple to sell and subsequently buy another home immediately after the baby's death. Both parents reported an increased movement toward seeking support from their families of origin and less from each other as a couple.

(3) Structural Assessment: The therapist believed the couple was relatively close usually but the way they were individually dealing with the death of their child had created dysfunctional patterns in the family. They were both dealing with the crisis in different ways, getting support from each other's parents. The husband turned more to his religious background and frequently spoke to his wife about it believing it would also help her. Whereas the wife did not outright object to his religious beliefs she could not accept them as a solution to her problem. She therefore felt he was

becoming impatient towards her forcing her to grieve in private and build resentment towards him because he appeared to be coping so well. They had previously fought about religion. Therefore religion became a solution/problem as discussed by Watzlawick. "...a symptom analogically, or metaphorically, expresses a problem and is also a solution, although usually an unsatisfactory one, for the people involved." (Madanes, 1981, p. 21). Changing the analogies or metaphors are often a focus of therapy as part of the goals of therapy which are to help families select more effective patterns of interaction and prevent the repetition of dysfunctional patterns.

The boundaries in this family had become diffuse. It may have been due to the fact that this couple had become parents at such an early age not allowing for a strong marital system to develop. The crisis of the baby's death had brought this into the foreground making resolution of the problem difficult.

(4) Goals of Therapy:

1. Strengthen the marital boundaries so they could deal directly with each other.
2. Pull together as a couple as a primary system and use their families of origin as a secondary system.
3. A secondary treatment goal would be used for the mother to manage her children better. This would happen after first goals were achieved.

(5) Interventions: In the first session the therapist spent a lot of time joining with the couple as the mother in particular was very anxious and cried easily. The father spoke at length and this had to be limited

in order to move on to other items. The couple answered for and interrupted each other frequently, both as a means of protecting each other and preventing each other from resolving painful issues.

The therapist encouraged the couple to talk with each other about the child's death and gently helped them to allow each other freedom to speak without interruption. Once given this opportunity, the couple freely spoke to each other about their feelings and expressed relief at the opportunity to do so. As it seemed quickly apparent that the couple had not spent any time alone together the therapist asked them to arrange to spend some time alone together as a task for the following week.

The couple was asked to come alone to the second session. This session involved a review of the assigned task which the couple had not done.

The therapist encouraged the couple to talk more about the child's death, again intervening to allow them freedom to speak with minimal interruptions.

Religion became a major issue of the session. When the husband raised religion, the therapist supported the wife to tell her husband what she needed from him was support and understanding not lectures on religion. The therapist then supported the husband to ask his wife for her help and support as he also needed it. The couple shared easily with each other and it was moving to see them adapt to help each other. The therapist asked them to continue this during the week by asking the wife to let her husband comfort her when she cried and for him not to talk with her about religion at those times. Additionally, the therapist asked the husband to let his wife know what he needed from her when he came home from work each evening, if he had a difficult day, etc. They agreed to do this.

The third session began with a discussion of the previous week's task which the couple had utilized at several opportunities during the week. The couple reported a major improvement in their family life and indeed the couple appeared to be happier and more relaxed. Their children did not attend the session but stayed in the waiting room where they were observed to be much more manageable and settled than previously noted.

The therapist intervened to enable the couple to discuss several additional issues not yet dealt with, visiting the child's grave and developing several rolls of film from Christmas which were of the last pictures taken of the baby before he died. The couple set a date to visit the grave and agreed to develop the pictures and have the husband look at them alone and for the wife to look at them soon after either alone or with her husband, as they decided. The couple additionally began to discuss plans to go away together for a weekend as a couple since they had recently received their tax returns giving them some funds with which to plan a holiday.

The final plan for this session was to terminate therapy as the therapist was going on leave and to set a follow-up interview upon her return to recontract for further therapy if necessary.

(6) The Pre- and Post-Test Scores: Family "A" was given the pre-test just prior to the first interview on April 18, 1985 and the post-test following the third interview on May 27, 1985. As the couple was seen for three sessions prior to the student going on leave, as well as noted improvement in family functioning, it appeared to be worthwhile to test the family for any measurable changes utilizing the student's chosen evaluation method.

As previously described in Chapter 5 - Methods, scores in the FAM profile are normalized such that each subscale has a mean of 50 and a standard deviation of 10. As the majority of scores should fall between 40 and 60, scores below 40 can indicate very healthy family functioning and scores above 60 can indicate disturbances in family functioning. Therefore, according to Skinner (1984) the further a score is from 50, the more there is an indication of something unusual relative to the sample of normal families used by the author in the construction of the Tables.

In reviewing Family "A", the student noted the following;
In examining the Dyadic Relationship Scale completed by the husband and wife of Family "A", (see Figures A_1 and A_2), the husband rated the wife with an overall rating of 56.5 in the pre-test and 53.5 in the post-test. Although the changes were minimal, the changes noted an overall movement of scores well into the normal range from the ranges which could indicate family problems.

The wife rated the husband with an overall rating of 43.3 in the pre-test and 42.2 in the post-test. Although this indicated an overall move towards the area of family strength, one must note the continued discrepancies between the ratings of the husband and those of the wife. This could indicate a likelihood of marital discord which continues although both the therapist and the family have noted overall improvement in family functioning. This may not necessarily be the case as they still fall within the normal range.

FIGURE A_1

DYADIC RELATIONSHIP SCALE

FAM PROFILE

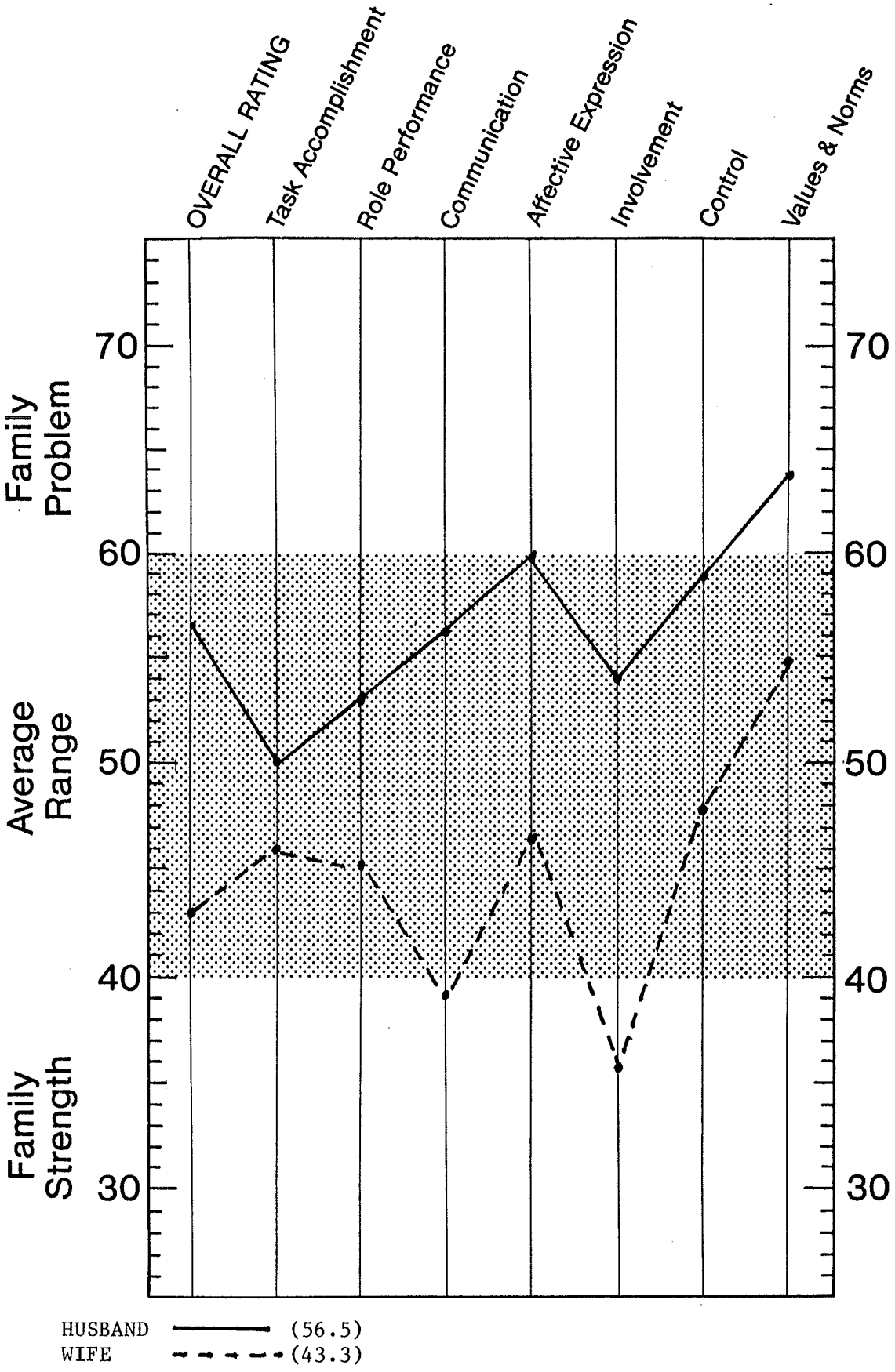
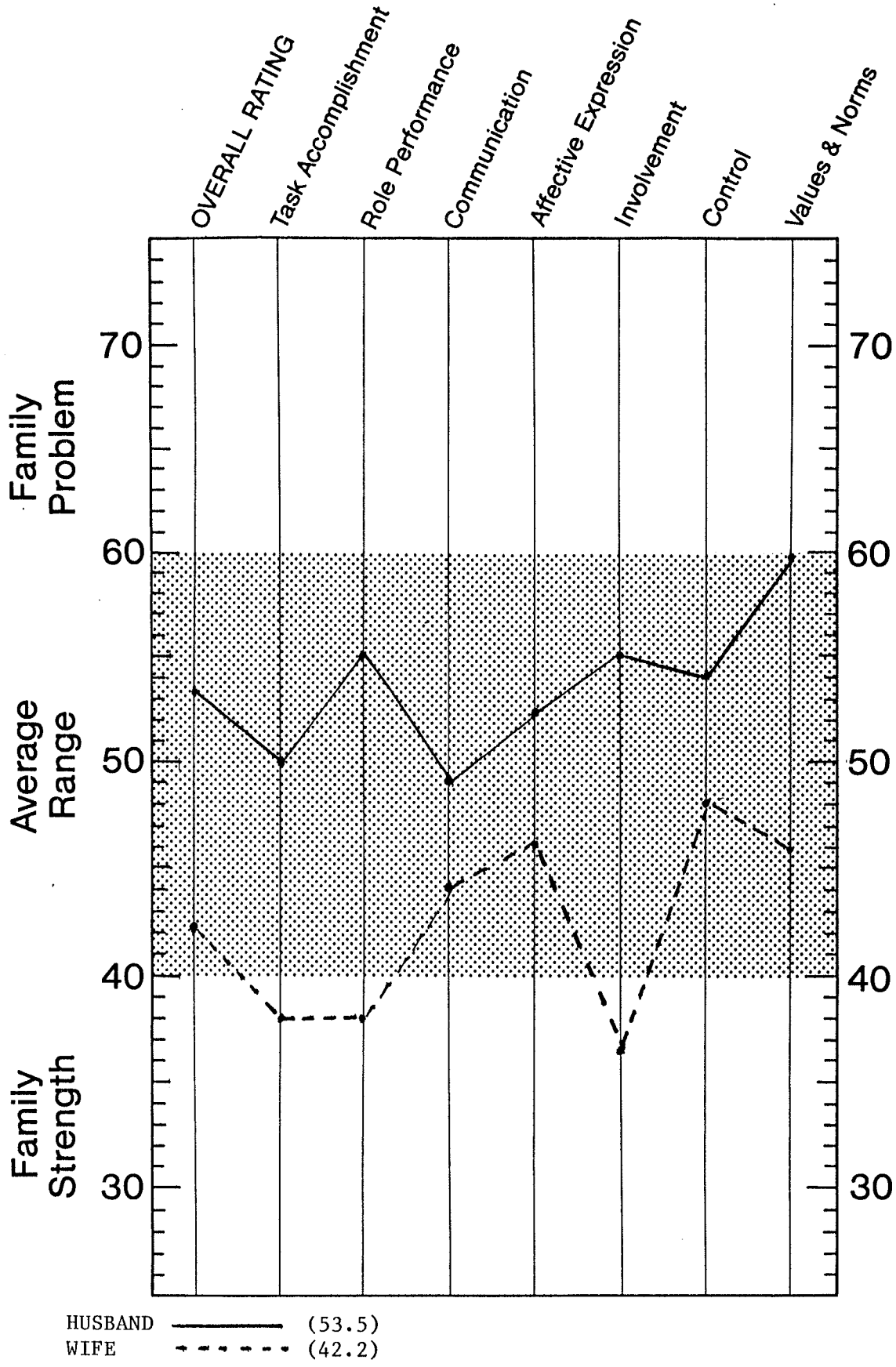


FIGURE A_2

DYADIC RELATIONSHIP SCALE

FAM PROFILE



A noteworthy change observed in therapy was the couple dealing with the solution/problem of religion. This change was also observed in the Values and Norms Scale. This has been demonstrated in Table 1 and 2 utilizing the Dyadic Relationship Scale developed by Skinner et. al. (1984). The husband indicated a move to view the values and norms of his wife from the area of family problem to within the normal range. The wife indicated a move to view the values and norms of her husband from the high average range to the low average range which could indicate a change in her perception of his values and norms towards the area of family strength. As the student also observed these changes in therapy there also seem to be similar changes demonstrated in the Values and Norms Scale of the FAM III.

With reference to the Self-Rating Scale demonstrated in Figures A_3 and A_4, the student noted dramatic changes in the pre-post-test subscales of Task Accomplishment, Role Performance, Communication, Involvement, Control and Values and Norms. With the exception of subscale "Control", the student was pleased to note an increase in congruency between the couple, clearly observed in therapy, also observed in the changing pre- and post-test scores.

Finally in observing the General Scale, pre- and post-tests, demonstrated in Figures A_5 and A_6, there were also noteworthy changes in the scores obtained from the family. The scores indicated overall increased congruency in the subscales of Task Accomplishment, Role Performance, Communication, Involvement, Control, Values and Norms and Defensiveness. Again these changes were also observed in the therapy and can indicate the effectiveness of the identified assessment, goals and interventions of therapy.

PRE-TEST

FAMILY "A"

TABLE 1

DYADIC RELATIONSHIPS GRID

FOR VALUES AND NORMS

TARGET RELATIONSHIP

RATER	HUSBAND	WIFE
HUSBAND	(58.4)	64
WIFE	55	(44.1)
	55	64

RECEPTION SCORES

FAMILY "A"

POST-TEST

TABLE 2

DYADIC RELATIONSHIPS GRID

FOR VALUES AND NORMS

TARGET RELATIONSHIP

RATER	HUSBAND	WIFE
HUSBAND	(51)	59
WIFE	45	(57)
	45	59.

RECEPTION SCORES

FIGURE A_3

SELF-RATING SCALE

FAM PROFILE

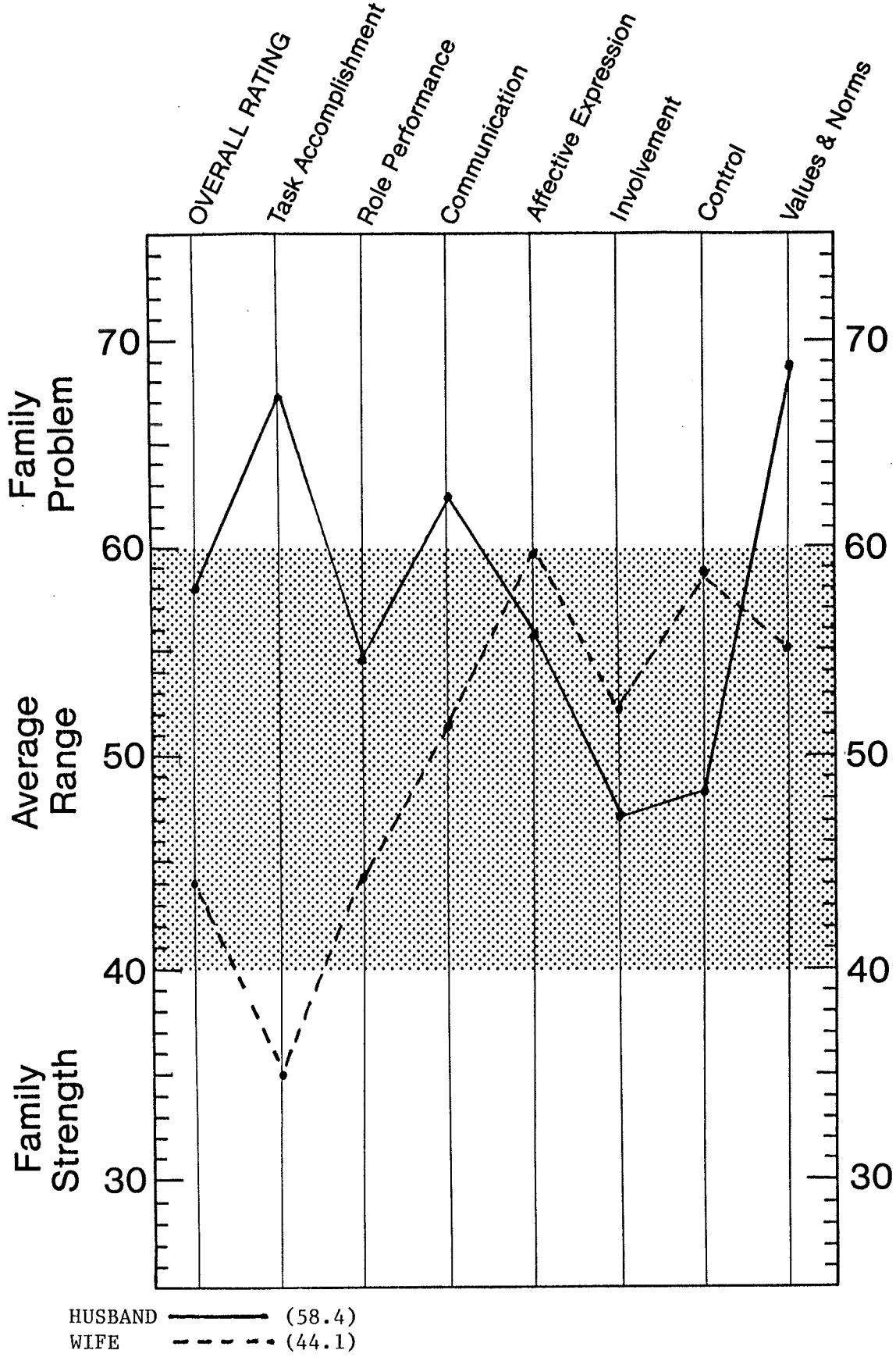


FIGURE A_4

SELF-RATING SCALE

FAM PROFILE

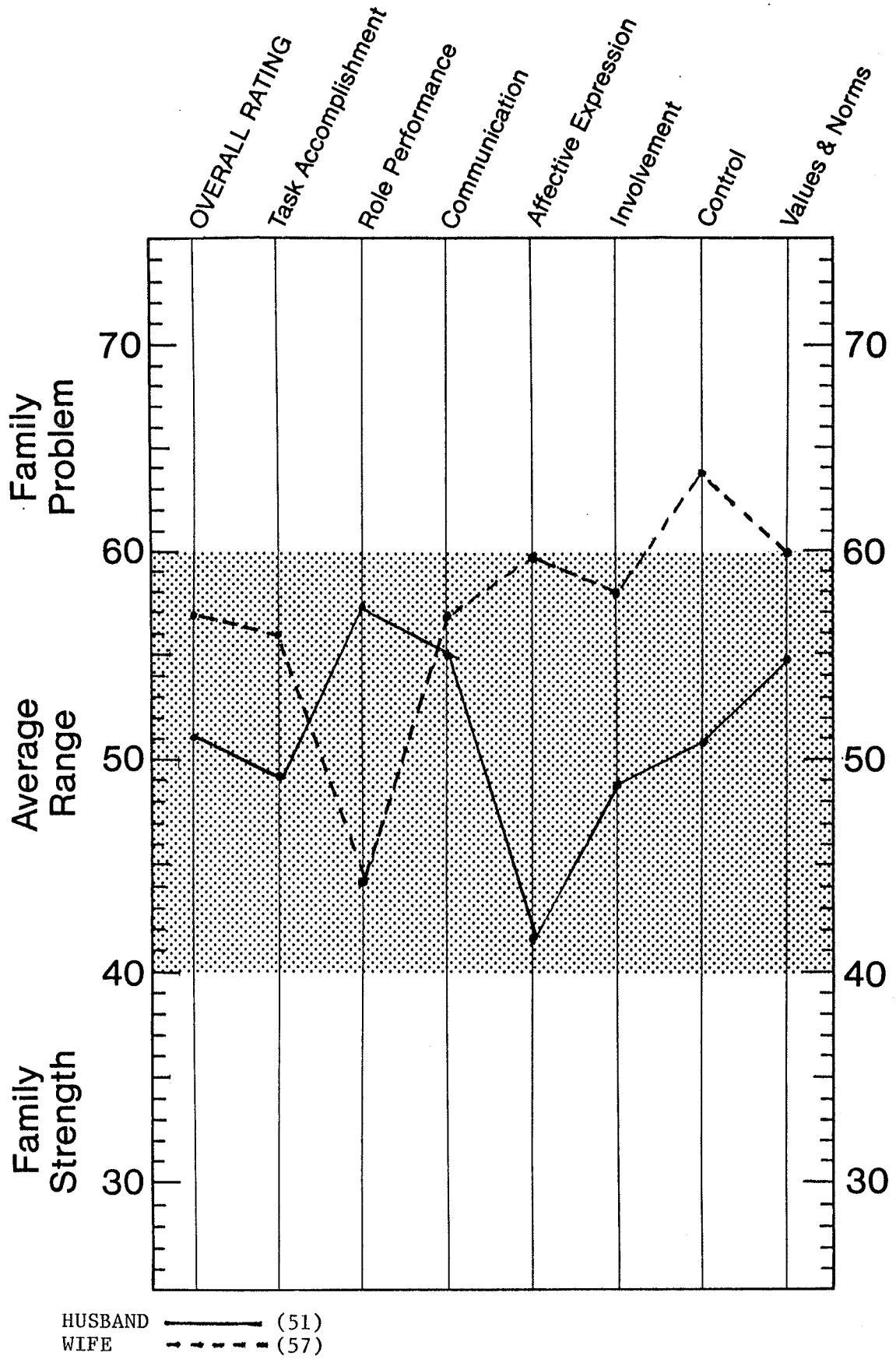


FIGURE A_5

FAM GENERAL SCALE

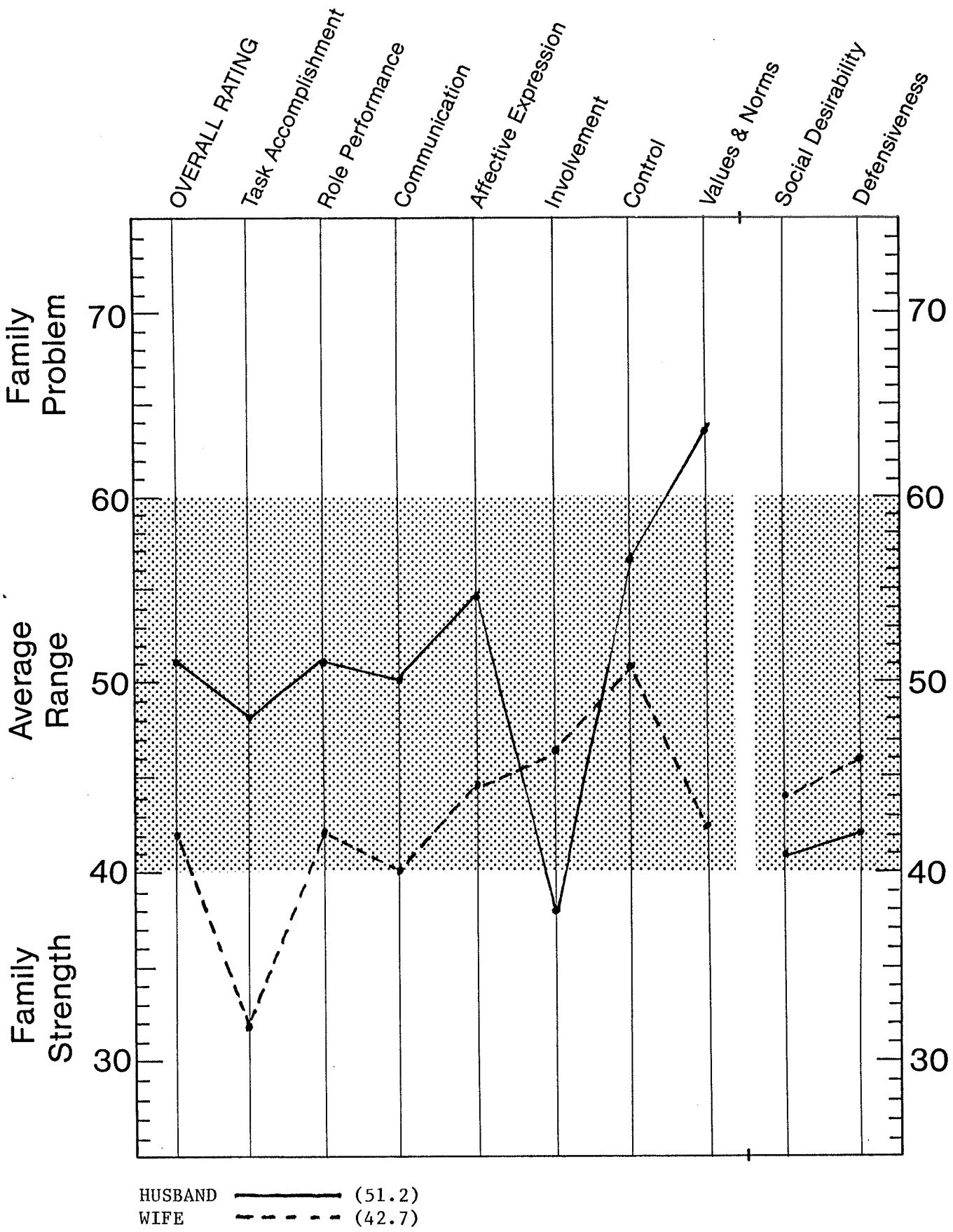
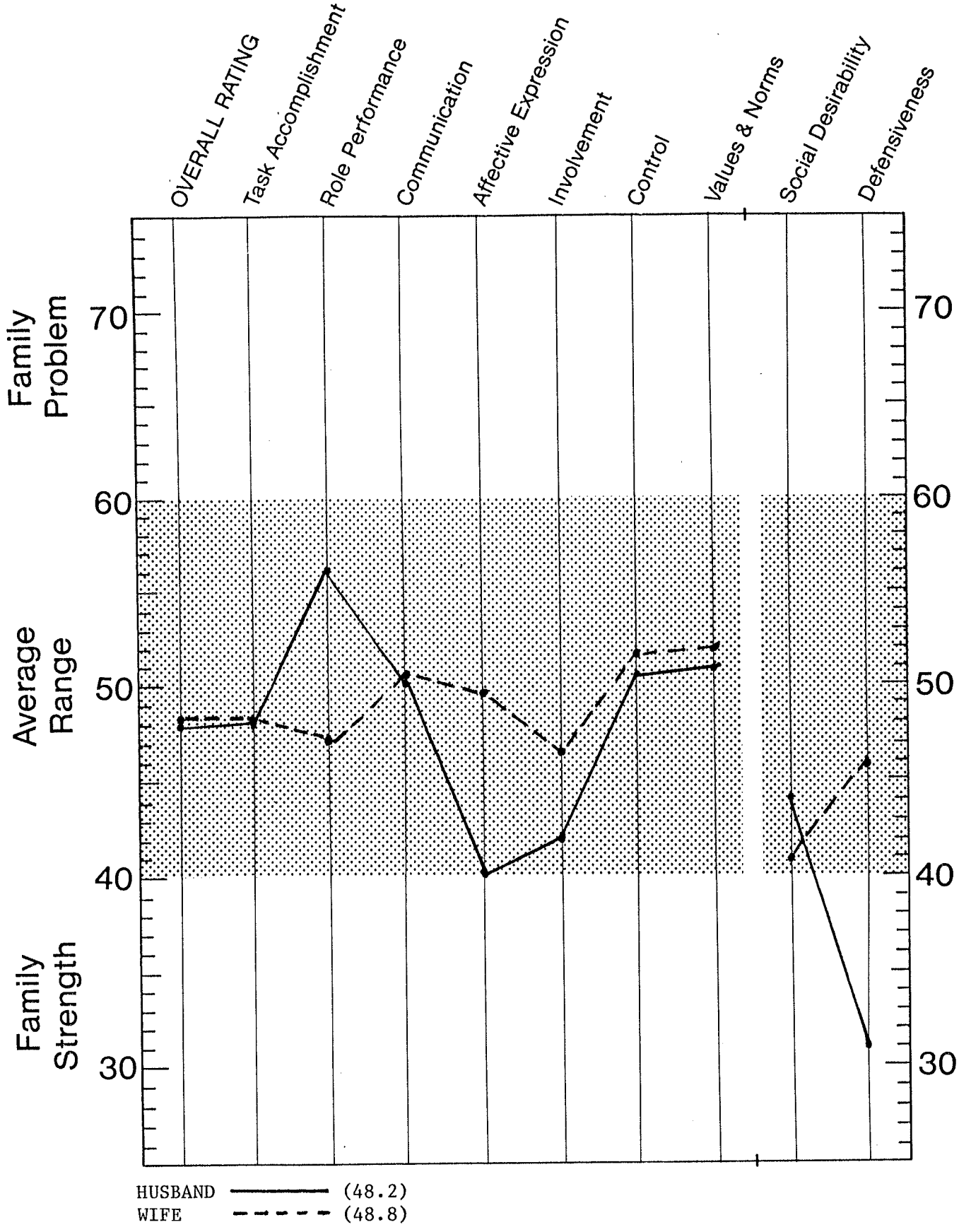


FIGURE A_6

FAM GENERAL SCALE



Overall the student was pleased with both the results of therapy and the demonstrated changes observed in the scores obtained in the pre- and post-tests of Family "A". FAM III helped to illuminate areas of strength and disturbance and was useful as an aid to the clinical assessment of the family.

Family "P"

1. Presenting Problem: Family "P" is a two parent family composed of the father 37, the step-mother 27 and three children; C^1, female, 15 years; C^2, female, 13 years - both the father's children from a previous marriage and C^3, 7 years, a child from this union.

The family was self-referred and was requesting family therapy to help them deal with their 15 year old daughter who was out of control. They described their concerns about her as primarily behavioural and saw her as not listening to them or taking any direction from them. The step-mother/wife had made the referral and was very angry at the daughter, (I.P.). Although the father/husband agreed with the mother's description of the problem, he saw the problems primarily involving the step-mother and daughter (I.P.).

2. Etiology of the Problem: The father was married previously in his early 20's and had two children C^1(15) and C^2(13). His marriage broke up when the children were infants whereupon he maintained custody (and later guardianship) and moved in with his parents. The father (at 27) met the step-mother (at 17). They lived together for several years then married and shortly thereafter had C^3(now 7 years old). They have been married eight years.

The step-mother reports that problems began with C^1 when the couple married. C^1 had difficulty accepting the step-mother and in the past several years has spoken more about and contacted her natural mother. The two children have seen their natural mother on only one occasion since the natural parents were divorced. The current parents disagree on this as an issue. The father does not feel that the natural mother

is an issue at all. The step-mother wants the father to be more involved with the children and explain to them the reasons for their natural parents marriage breakup. The father disagrees. This did not become a major issue in therapy.

Problems in this family began years ago but have worsened in the past year when the I.P. began to act out by staying out at night and reportedly becoming sexually active and involved in drinking and drugs. Whereas the step-mother has become more concerned about these behaviours she wants this to stop and expects her husband to help her. The father feels the situation is serious but not as serious as the mother thereby minimizing her concerns and undermining her attempts to intervene with the I.P.. He sees the problems as a "stage" the I.P. is going through and was not convinced that family therapy was at all necessary. He had difficulty articulating what he felt were the problems and did not know what to do about them. The step-mother was very articulate and frustrated with her situation and the behaviour of the I.P. and her husband's reaction to it.

The children were well behaved during therapy and were co-operative to questions asked by the therapist. C^3 did not appear to be overly affected by the problems in the family.

3. Structural Assessment: The therapist's structural assessment was that there were no clear generational boundaries in this family which resulted in the step-mother's over involvement with the I.P. and the father's inappropriate alliances with the two older daughters against the step-mother. The step-mother was using the identified patient in order to try and engage her husband who was very peripheral. The

dysfunctional pattern that has developed in this family usually involves the I.P. acting out, the step-mother steps in and tries to take action, the father minimizes the mother's concerns, occasionally alligning with the I.P. against the step-mother, resulting in the step-mother's withdrawal. In the past year the pattern has worsened as the I.P. became involved in more serious behaviour and frequently the step-mother withdraws to avoid any confrontation. Consequently all family members feel frustrated and problems worsen as issues do not get resolved.

4. The Goals of Therapy: The goals of therapy included;

(1) to de-triangulate the I.P. from the marital subsystem and to strengthen the (step)-mother-daughter subsystem.

(2) Strengthen the marital subsystem by having the parents begin to work together to set limits and expectations for the I.P. and other children.

(3) An additional goal of therapy was to establish the parents in a clear hierarchical position in the family. This would thus place the parents in a position to have the I.P. behave responsibly for her age thereby freeing up the family members to go on with their lives and allow the I.P. to develop an appropriate behaviour.

5. The Interventions: The family was seen for six sessions, five as a whole family and one with the I.P. only. Additionally the therapist met with the step-mother and I.P. at the I.P.'s school (described later).

In the first session the therapist took some time to join with the family members. The parents were asked about their jobs and given recognition for their additional effort to improve their skills by attending upgrading

programs. The therapist also joined with the three children in a similar way into their present school work and hobbies.

The therapist asked the parents to talk about their concerns and what they would like to see different in their family. The therapist encouraged the father to express his views as the step-mother continued to dominate the discussion. The therapist had difficulty controlling the first session and did not obtain a clear definition of the problem and what the family wanted to begin to work on during this initial interview.

In the second session the therapist rejoined with the family and explored what they did as a family and as a couple as well as about each of their families of origin. The pattern began to emerge in this family as the step-mother described the difficulty with herself and her mother-in-law. She described their relationship as tense with a lot of conflict but the step-mother has minimized the confrontations by withdrawing at the evidence of a beginning argument with the mother-in-law.

It further became clear that the wife withdraws from her husband when she's angry at him because she feels he does not listen to her and does not support her to place limits on the children. This was evident as the parents did not agree on what the expectations were of the children.

The therapist encouraged the parents to discuss the problems with each other in the session and stressed the importance of this as a means of resolving what changes needed to occur.

The therapist reframed the problem of the step-mother withdrawing from confrontations to; validating the step-mother for loving her children very much. She was helped to understand how she was hurting her

children by withdrawing. Her continuation of this would not bring her and the children closer together. The step-mother agreed with this and both the father and step-mother agreed they wanted the step-mother to be closer to the children. The therapist then validated them for their openness and directness and scheduled another appointment.

In the third session the therapist began to deal with curfews and establishing new rules and patterns of interaction. This was meant to achieve the goal of strengthening the marital subsystem by having the parents begin to work together to set limits and expectations for the I.P. and other children.

The therapist encouraged the parents to discuss the curfews of C^1(I.P.) and C^2. It became clear that although there was a curfew it was easily broken and altered. The I.P. was not sure what the consequences were if she broke the curfew. The therapist directed the parents to decide on an acceptable curfew and consequences for the I.P.. This was not established during the session so the therapist assigned the task of the father to be in charge of setting a curfew and for him to enforce it. The step-mother was requested to back him up even if she disagreed with the details.

Additionally, in order to achieve the goal of strengthening the step-mother/daughter subsystem, the therapist requested that the step-mother and the I.P. do something together alone the following week and for the step-mother to plan this event. The family members agreed to do these tasks and an appointment was set for the following week.

The family cancelled several appointments before they attended the fourth interview. The parents were very angry and disappointed with C^1's behaviour over the past several weeks. They had not completed the assigned tasks but had attempted to give C^1 more freedom to make some decisions regarding curfew on her own. As this did not work, C^1 had stayed away from home one night, the parents stated that therapy was not helping and in fact they thought that C^1 needed individual help.

After considerable discussion the therapist discovered that due to C^1's suspected promiscuity and her recent interest in staying out late and drinking, the parents were very concerned that C^1 would become pregnant. The therapist assisted the parents in discussing their concerns with C^1 as well as C^1's reluctance to use oral contraceptives. As it appeared to be at a critical point, resolution of this problem could likely aid the family in continuing therapy and working on their concerns in other areas. The parents were able to discuss their concerns with C^1 and C^1 finally agreed to make a plan to obtain oral contraceptives.

The therapist made an appointment to see C^1 alone following this session as it was unavoidable for C^1 to feel "ganged up on" while the therapist encouraged the parents to work together to come up with a plan.

The therapist and C^1 discussed the content of the previous session and the therapist moved to rejoin with C^1 so that she would return to, and continue to participate in therapy. C^1 reported she had begun taking oral contraceptives following the session and wanted to see her father and step-mother work more closely together. She reported that they had all been becoming further apart prior to therapy and were beginning to

make changes. The therapist also noted C^1's awareness that should the family not resolve problems, C^2 would eventually become the I.P. after C^1 left the family.

During the fifth session, the therapist briefly discussed the previous individual session with C^1 and again organized the session to help the parents work together to set limits and expectations for their children. Following a lengthy session, the parents agreed to a curfew for week days and week-end nights as well as a means by which the children could renegotiate these curfews at a later date. These interventions furthered the goals of detriangulating the I.P. from the marital subsystem as well as strengthening the marital subsystem by having the parents begin to work together to set limits and expectations for the I.P. and their other children.

Prior to the next appointment the family entered a crisis when C^1 did not return home for two nights. The step-mother called the therapist to attend a meeting with the step-mother and C^1 at C^1's school. As the father was unavailable and it appeared that the situation could be remedied, the therapist agreed to go. The step-mother and C^1 were able to discuss the events just prior to C^1 leaving for the two nights and the therapist noted a real improvement in the way the step-mother was able to express her concerns to C^1 and still maintain her openness to listen to C^1. The situation was resolved to the satisfaction of C^1 and the step-mother.

Following this intervention the family was not able to attend any further therapy sessions prior to the student going on leave due to C^3 developing

rheumatic fever and the family undergoing tests for the fever as well. This family has agreed to return for therapy following the student's return from leave.

6. Termination and Evaluation of Therapy: The therapist reports that the goals and interventions of therapy with Family "P" have not been completed but there has been some movement as well as improvement in specific areas of family functioning.

These improvements include an increased strengthening of the marital subsystem and the mother-daughter subsystem. There was a decrease in the coalitions and alliances between the father and the children (C^1 and C^2) against the step-mother. In time this could enable an increase in generational boundaries which would free up the family members to persue their age/socially appropriate activities.

The therapist is confident that although this family has longstanding problems, their willingness to continue therapy will certainly assist in their attempts at problem solving in therapy.

7. Pre-Test and Post-Test Scores:

Family "P" was given the pre-test just prior to the first interview on April 2, 1985 and the post-test following the sixth interview on May 27, 1985.

Since the student had worked with this family fairly consistently over a period of time, she felt that changes taken place in therapy to date may also be reflected in the post-test. Thus the following will be an examination of those scores.

In reviewing family "P" the student noted the following; in the General Scale completed by husband, wife, C^1 and C^2, the student noted generally high scores which could indicate a high level of problem within the family (see Figures P_1 and P_2).

The scores obtained from the husband and wife indicate a slight move towards the family problem area with the overall scores in the pre-test, husband (60), and wife (70) to the post-test, husband (64) and wife (72). C^1 and C^2 however both scored a statistically significant drop in the scores towards the normal range with scores in the pre-test, C^1 (67) and C^2 (55) to the scores in the post-test, C^1 (62.5) and C^2 (50.5). These scores may indicate a change in the family's perception of the problems whereby the parents observe an increase and the children observe a decrease. Taken liberally, this could reflect the movement in therapy from viewing the problems as those of the individual child to those of the family. Increased focus on the marital subsystem may have highlighted awareness of family problems. The children may have observed a decrease in their involvement in the family problems with the focus also moving towards the marital subsystem.

Overall the step-mother's scores seemed consistently higher (70 and 72) which could reflect her higher level of frustration and anxiety with the family situation. (see Figures P_1 and P_2). This was also observable in therapy. Skinner et. al. (1984) also note that if one family member tends to have scores elevated while other family members are clustered near to one another, "these may be acute, generalized conflict between the member with the elevated score and other family members". (p. 9) Conversely C^2's scores tended to be lower, consistently within the normal range, (55 and 50.5). This could have reflected her own interpretation of problems within the family or her limited direct involvement

FIGURE P_1

FAM GENERAL SCALE

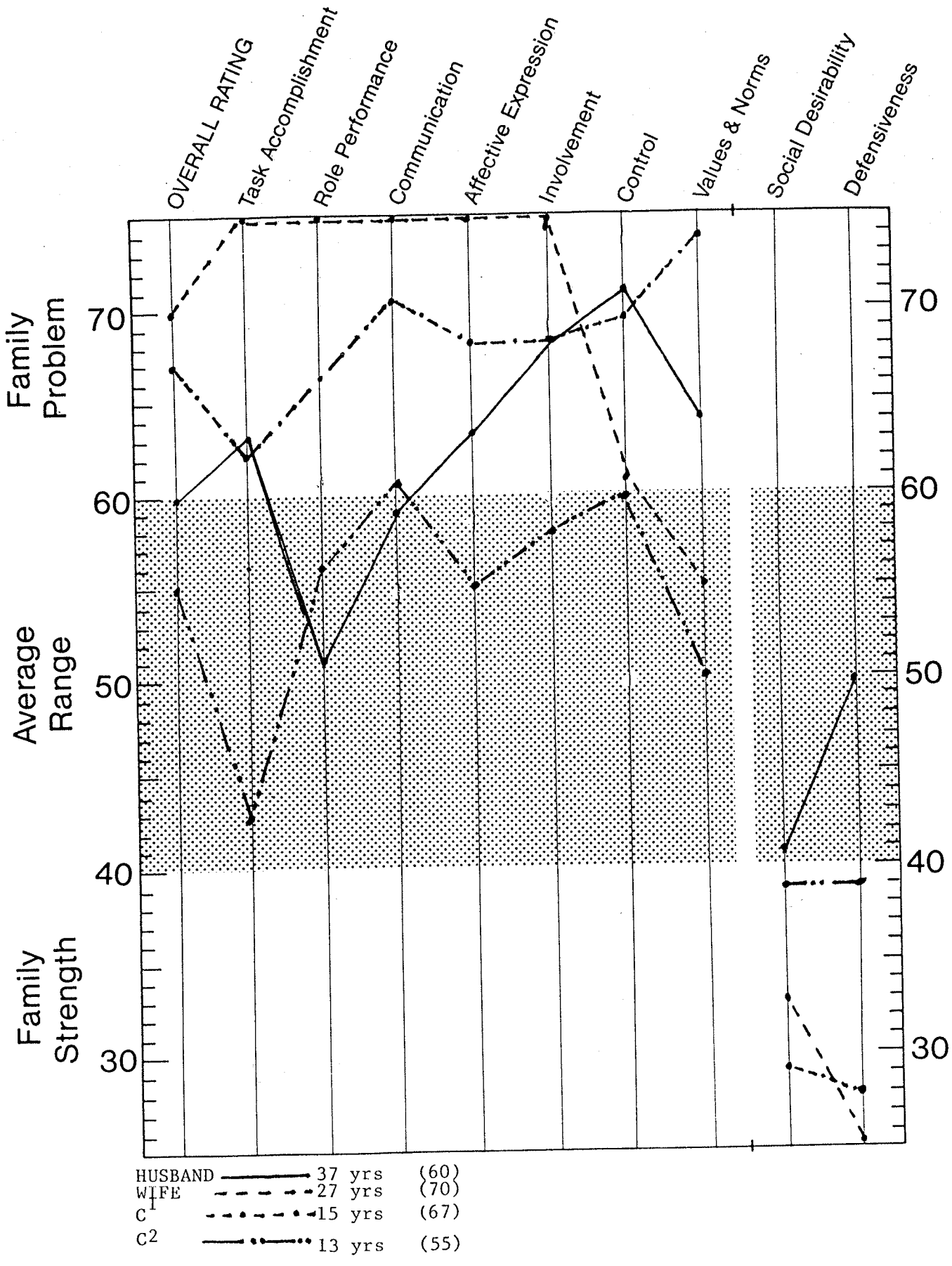
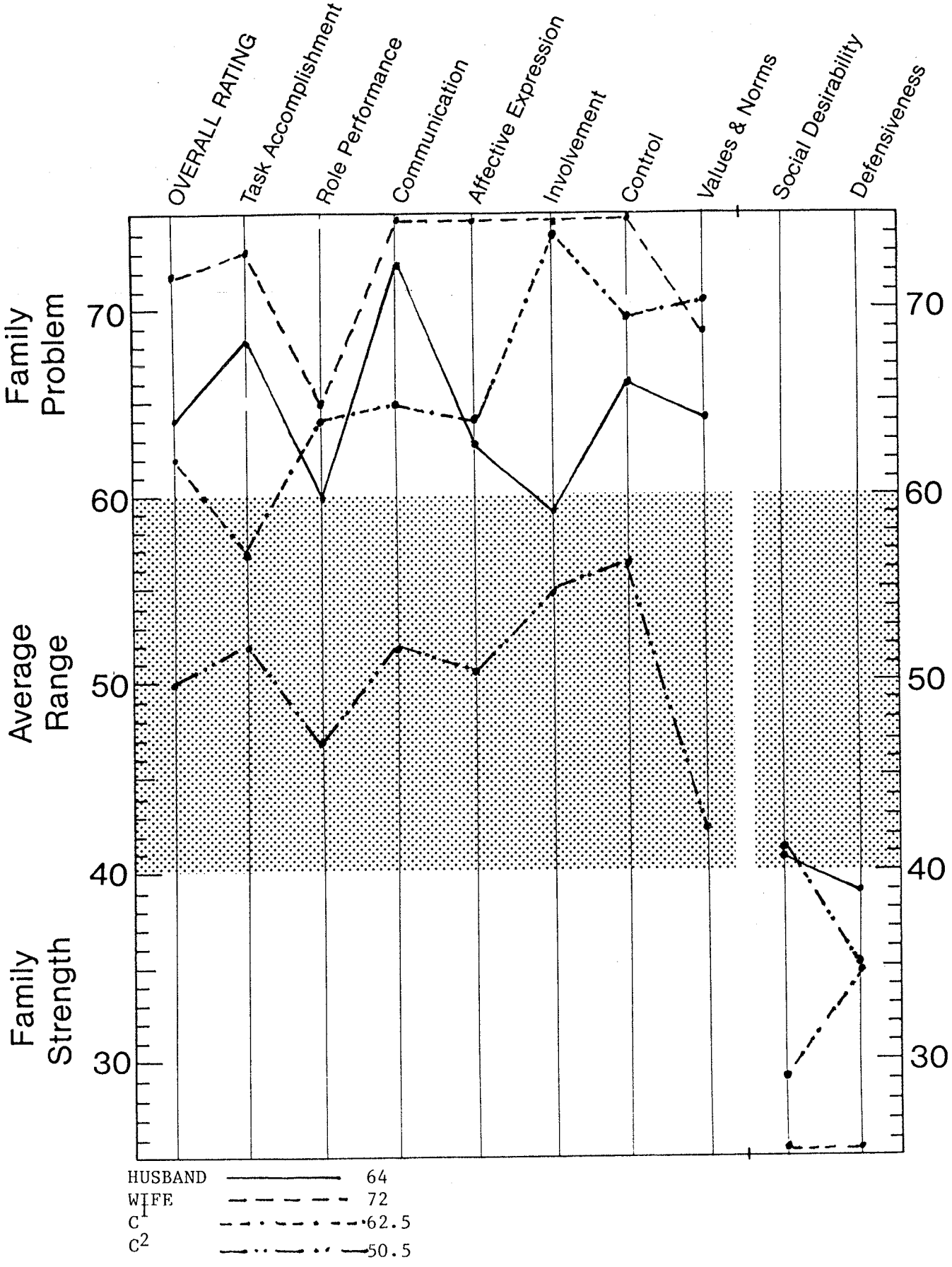


FIGURE P_2

FAM GENERAL SCALE



in a number of the individual situations.

Examining the Self-Rating Scale, scores of the pre-test and post-test, the student again noted overall high scores, of all family members, with overall scores above 60, indicating a greater likelihood of a shared common perception of themselves. (see Figures P_3 and P_4). As there were a number of elevated subscale scores over 60 noted by family members, a severe family pathology seems to be indicated. As Skinner et. al. (1984) notes, "the more family members who indicate an elevated scale score (i.e. 60 or above) in a particular area, the more likely that area is a problem" (p. 7).

The overall scores varied slightly with C^2's scores changing most significantly from pre-test (61.2) to post-test (52.4). The student can only speculate that change may or may not have occurred as a result of therapy. The step-mother's score changed slightly from the pre-test (66.7) to the post-test (63.5) which again may or may not have been a result of therapy. The scores of the father and C^1 remained virtually the same with little change. This was also reflected in therapy.

Examining the scores of the Dyadic Relationship Scales; the student observed the following; the overall ratings of the mother rating the father; pre-test (49.5) and post-test (47.4); the mother rating C^1; pre-test (71.5) and post-test (65.8); the mother rating C^2 pre-test (52.7) and post-test (48.7). (see Figures P_5 and P_6). Whereas the scores reflecting the dyadic relationships between mother and father and mother and C^2 appeared within the normal range, the reported dyadic relationship between mother and C^1 was elevated clearly indicating a disturbance in their relationship. The change in these scores from the

FIGURE P_3

SELF-RATING SCALE

FAM PROFILE

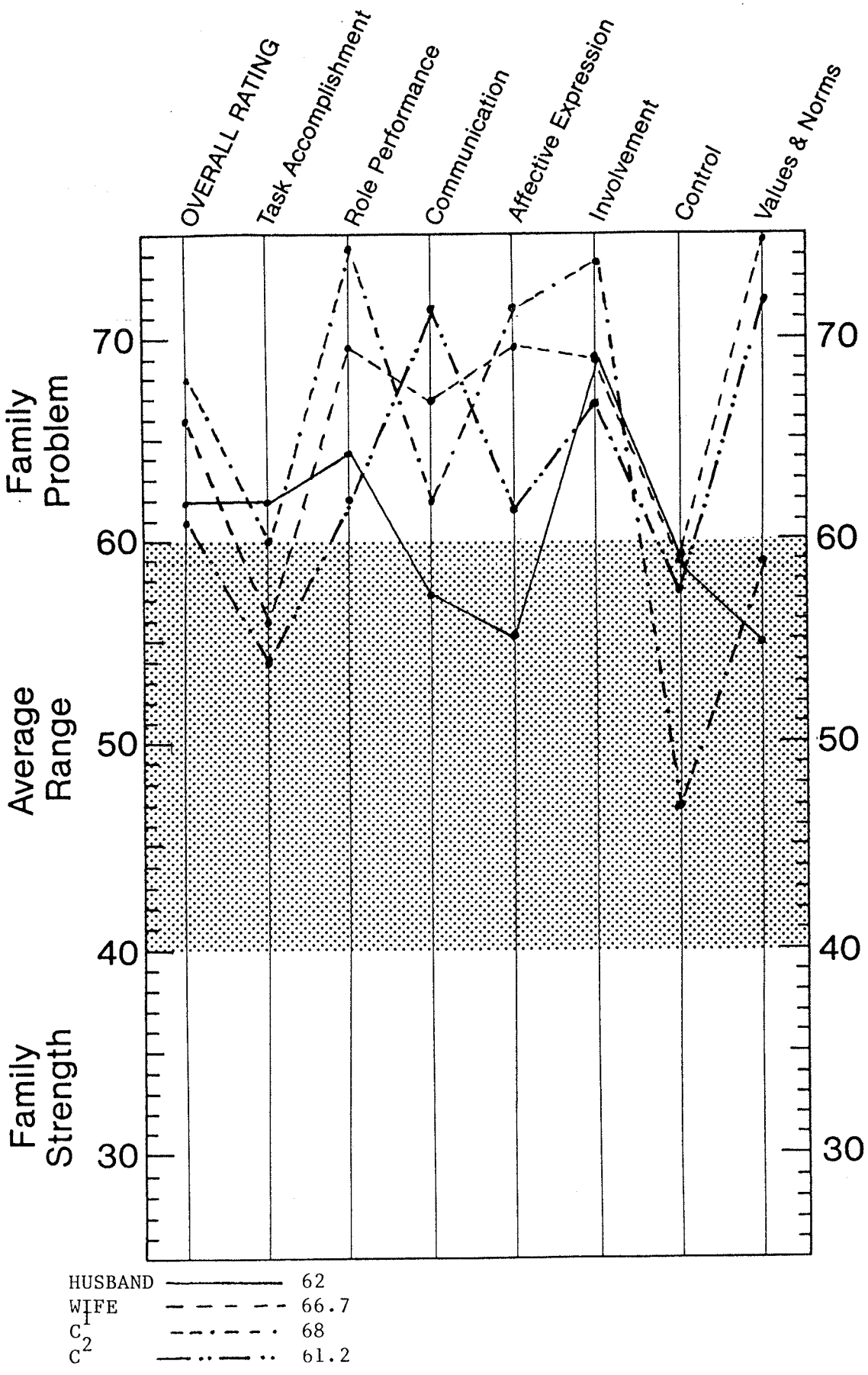


FIGURE P_4

SELF-RATING SCALE

FAM PROFILE

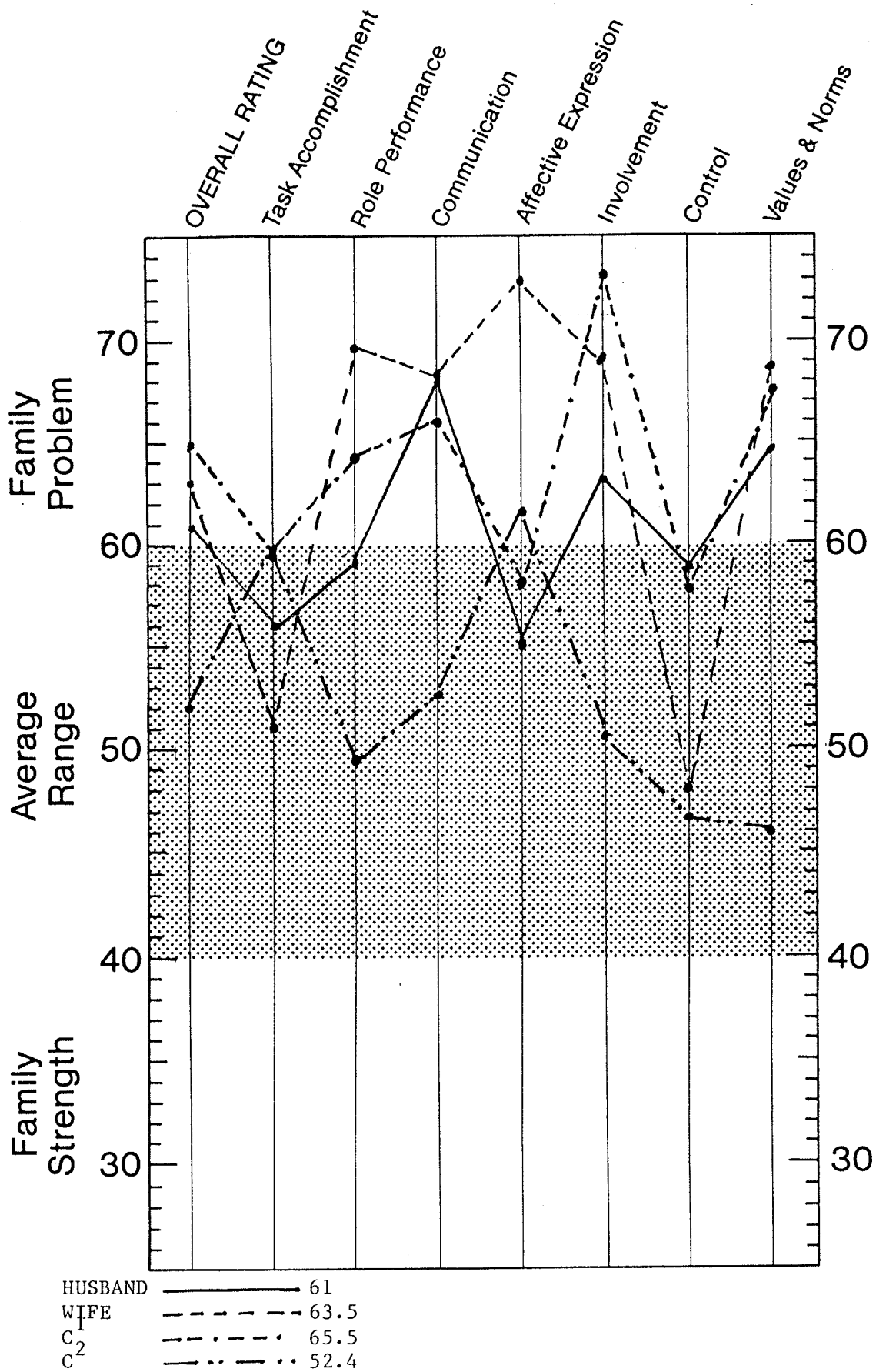


FIGURE P_5

DYADIC RELATIONSHIP SCALE

FAM PROFILE

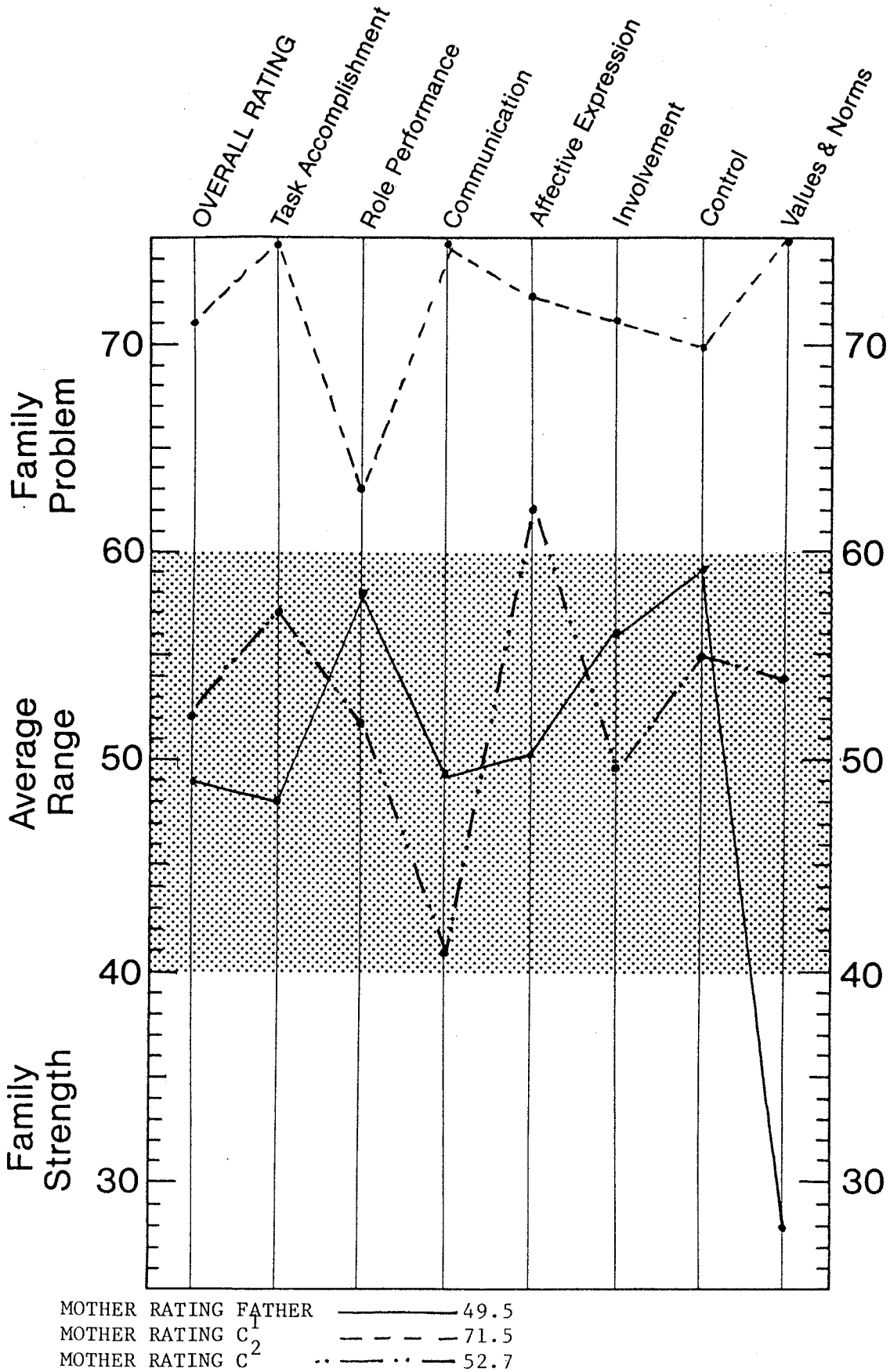
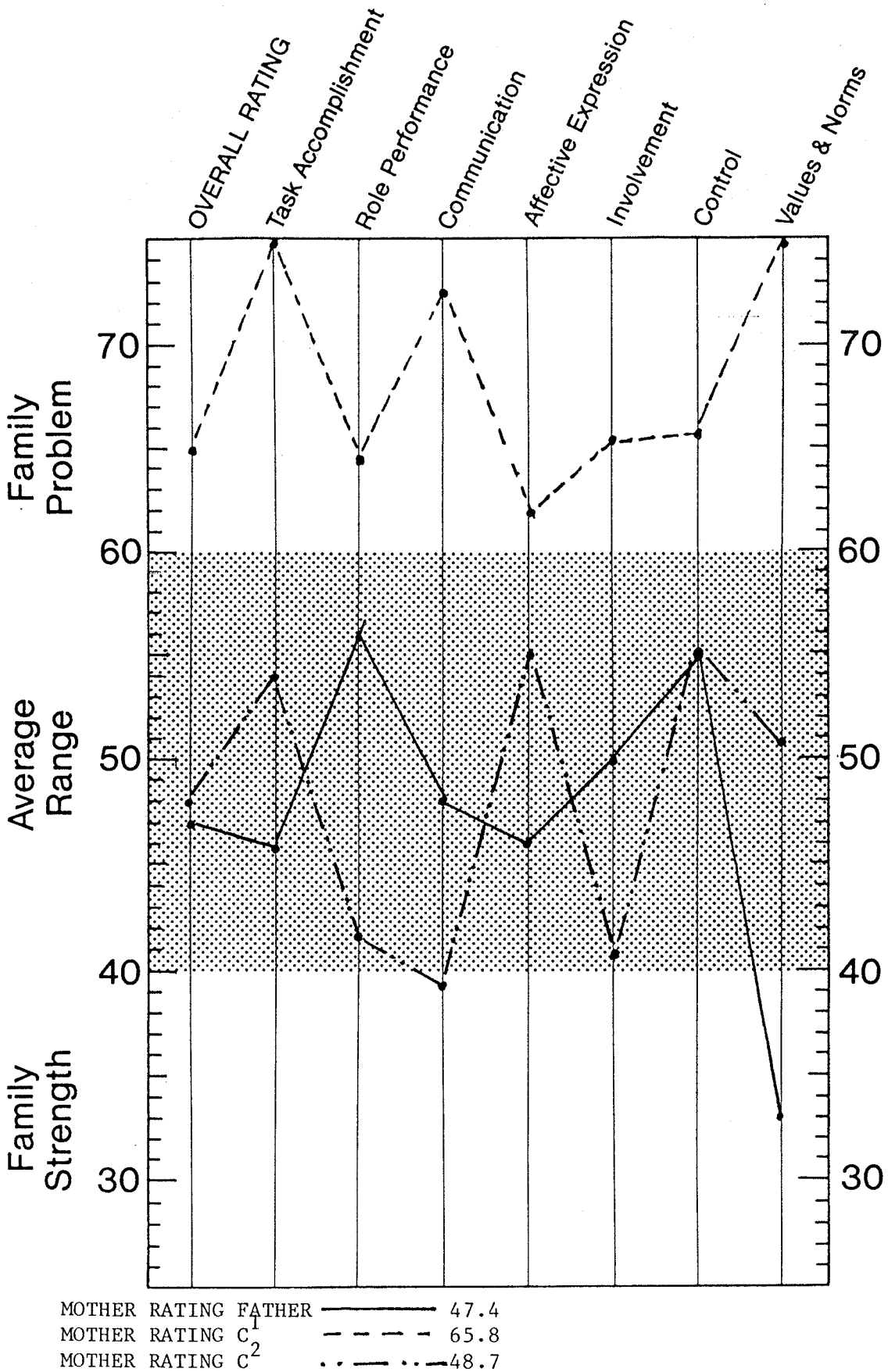


FIGURE P_6

DYADIC RELATIONSHIP SCALE

FAM PROFILE



pre-test (71.5) to the post-test (65.8) indicates a significant move which was also observed in therapy.

Conversely C^1 was observed to score overall ratings with the step-mother pre-test (64.8) and post-test (62.2); C^1 rating the father, pre-test (59.2) and post-test (56.2); C^1 rating C^2, pre-test (49) and post-test (43). (see Figures P_9 and P_{10}). These overall changes in C^1's view of the dyadic relationships in her family correspond with those also reported by her step-mother. Given the corresponding scores, the likelihood that change has occurred seems to be supportive of the noted changes in therapy.

The scores obtained from the father in the Dyadic Relationship Scale demonstrated a minimal change of the father rating the step-mother, (overall rating, pre-test 62.5 and post-test 61.1) as well as the father rating C^2 (pre-test 58 and post-test 56.5). (see Figures P_7 and P_8). Alternately, the overall rating in the scores obtained from the father rating C^1 were elevated indicating a move towards increased disturbance in their relationship (pre-test 56.2 and post-test 61.7). This also seemed to be reflected in therapy as the parents began to work together, the father became more aware of the concerns previously noted most predominantly by the step-mother.

Finally, scores obtained from C^2 indicated a lowering of overall ratings most significantly between C^2 and the step-mother (pre-test 61.8 to post-test 56.2). (see Figures P_{11} and P_{12}). As the scores indicate a move from the dysfunctional to the normal range in most of the sub-scales, this change was also reported positively by C^2 in therapy. The implications of this are unclear to the therapist as they were not

FIGURE P_7

DYADIC RELATIONSHIP SCALE

FAM PROFILE

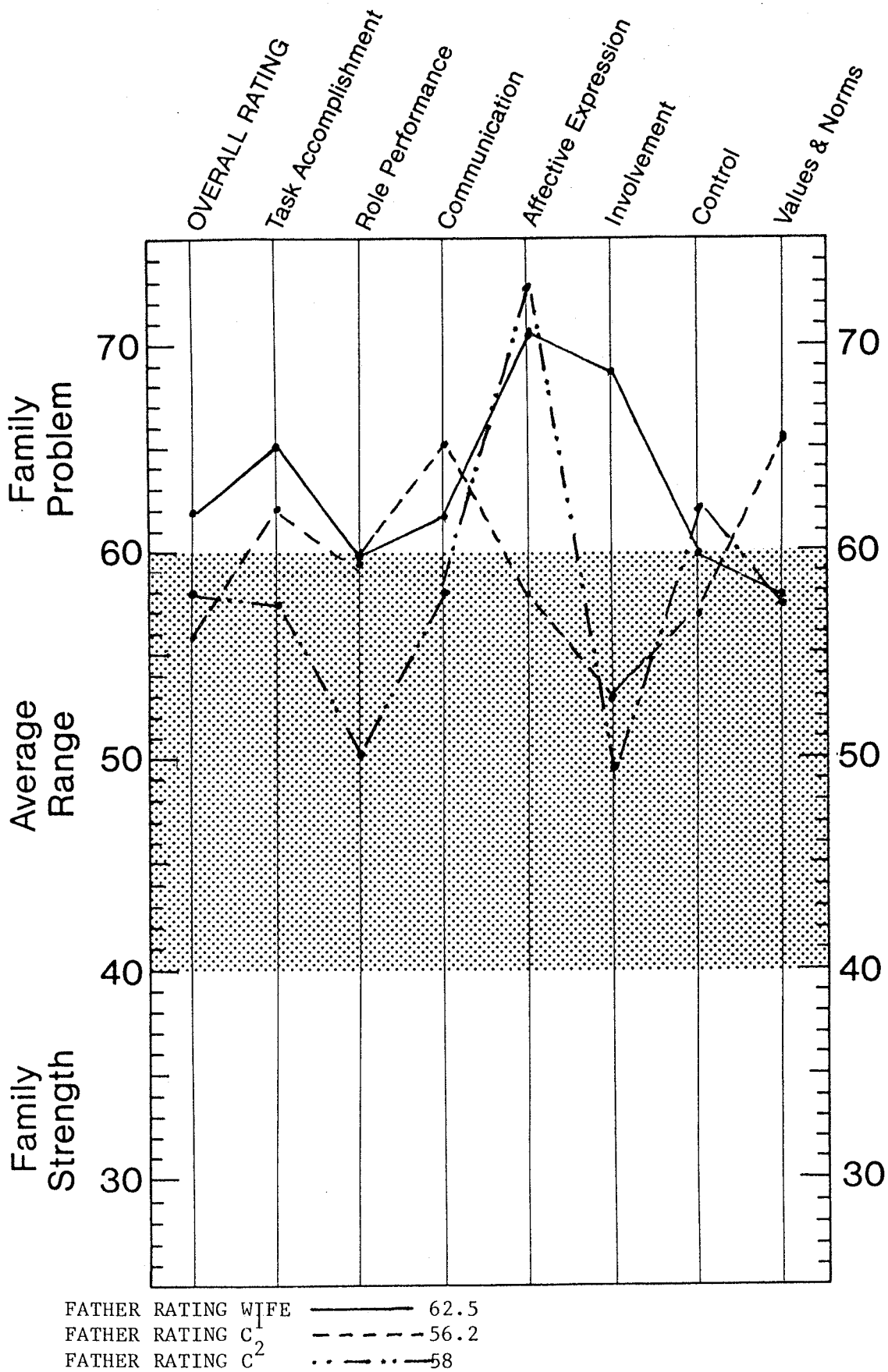


FIGURE P_8

DYADIC RELATIONSHIP SCALE

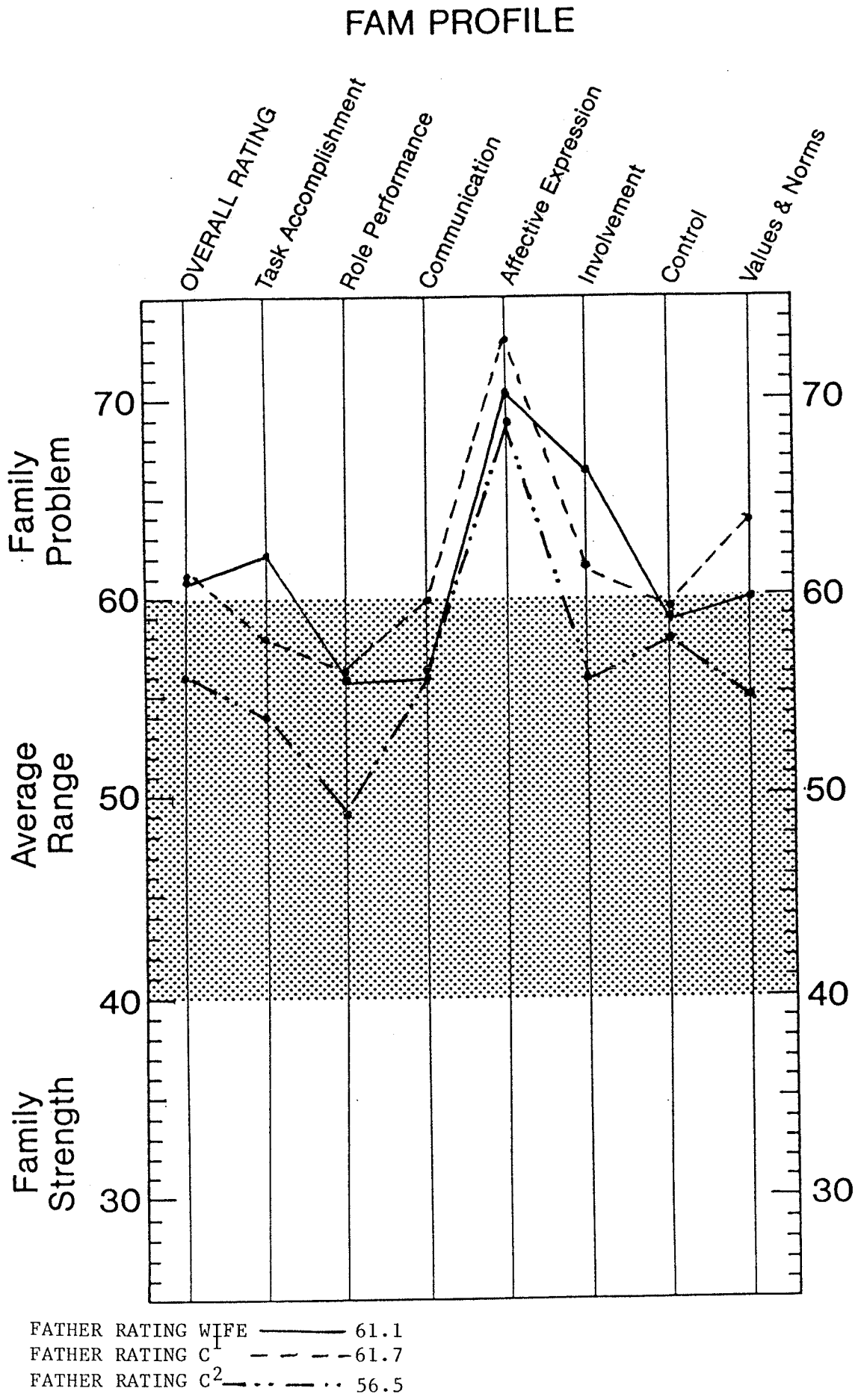


FIGURE P_9

DYADIC RELATIONSHIP SCALE

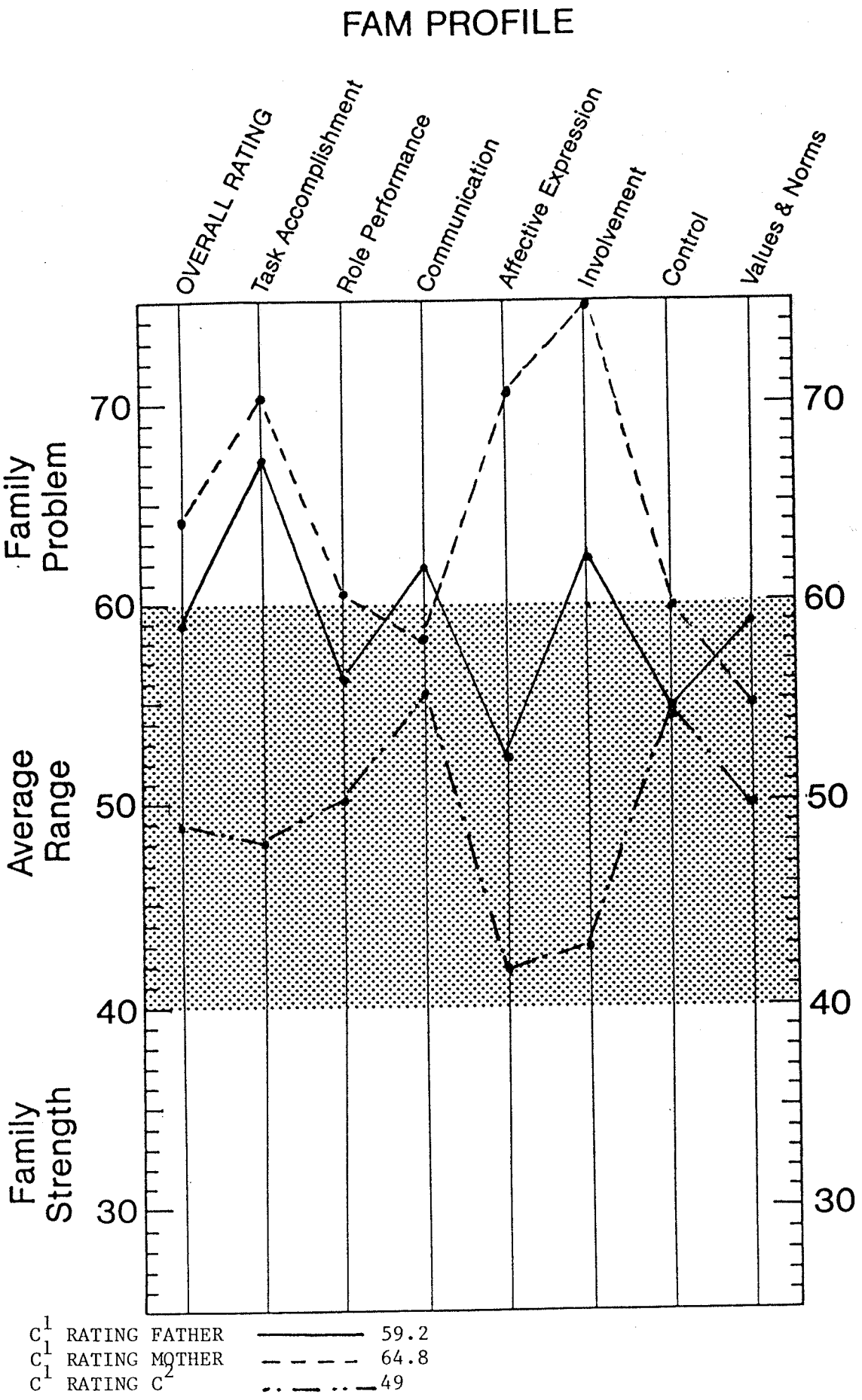


FIGURE P_{10}

DYADIC RELATIONSHIP SCALE

FAM PROFILE

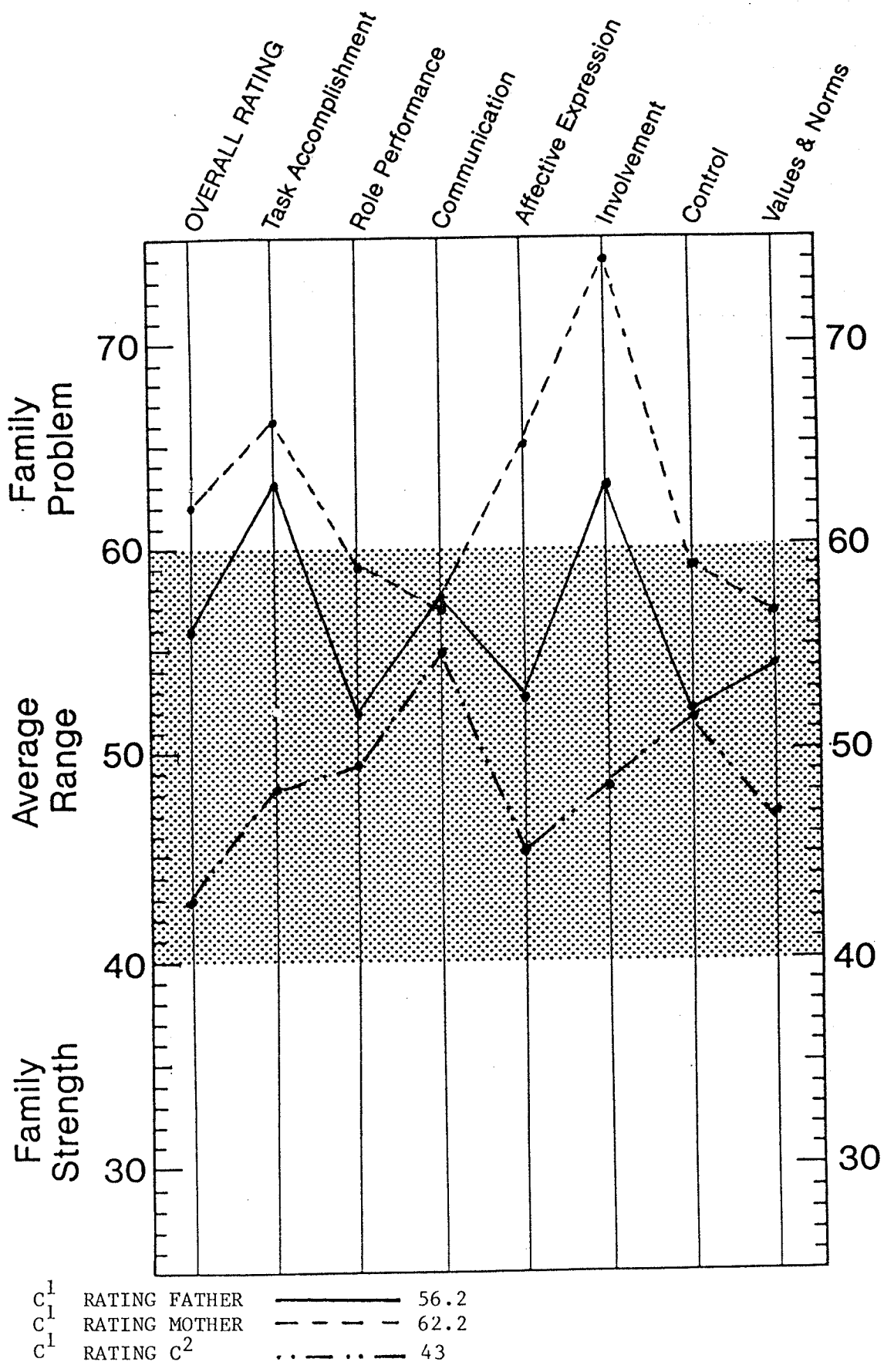


FIGURE P_{11}

DYADIC RELATIONSHIP SCALE

FAM PROFILE

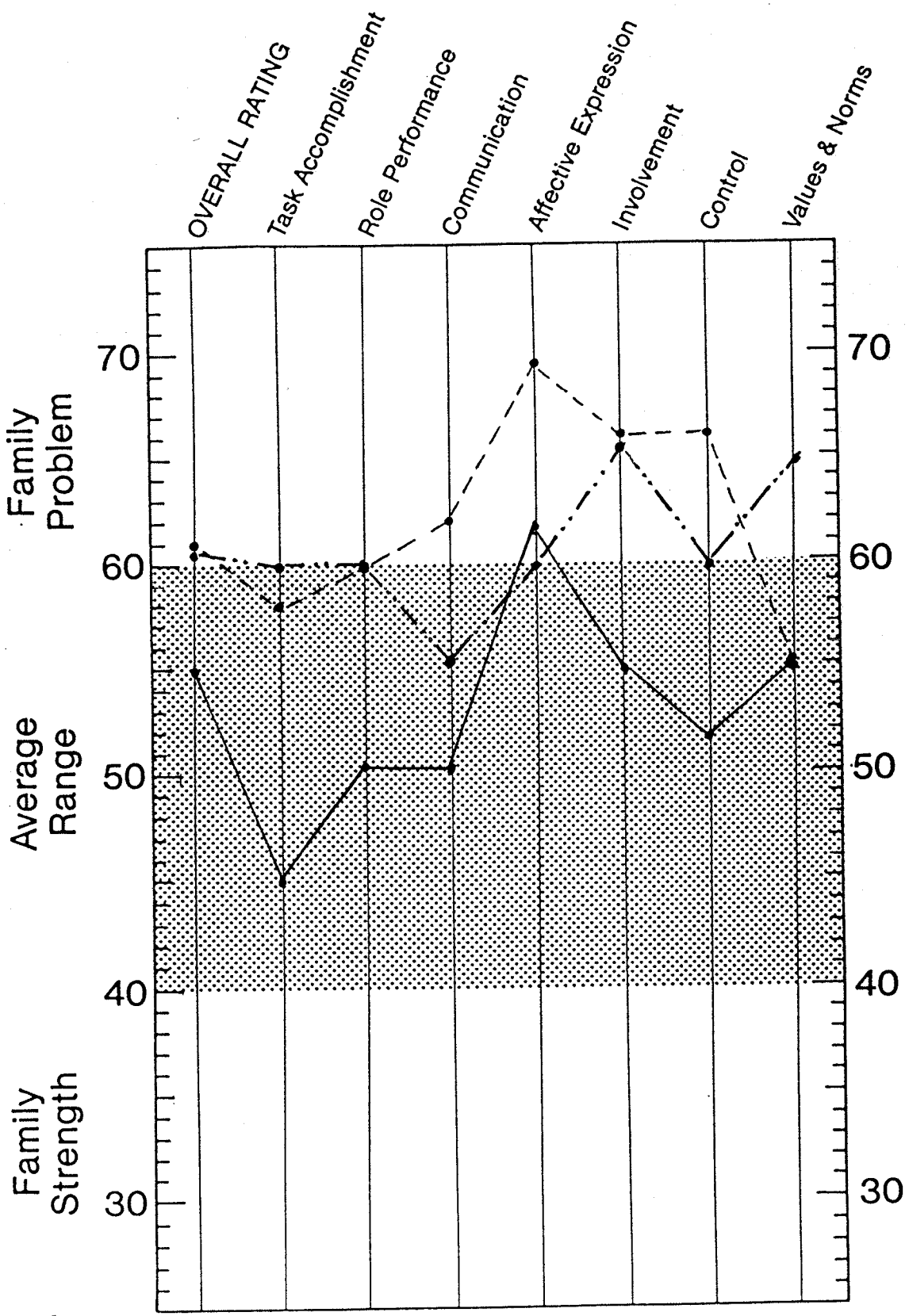
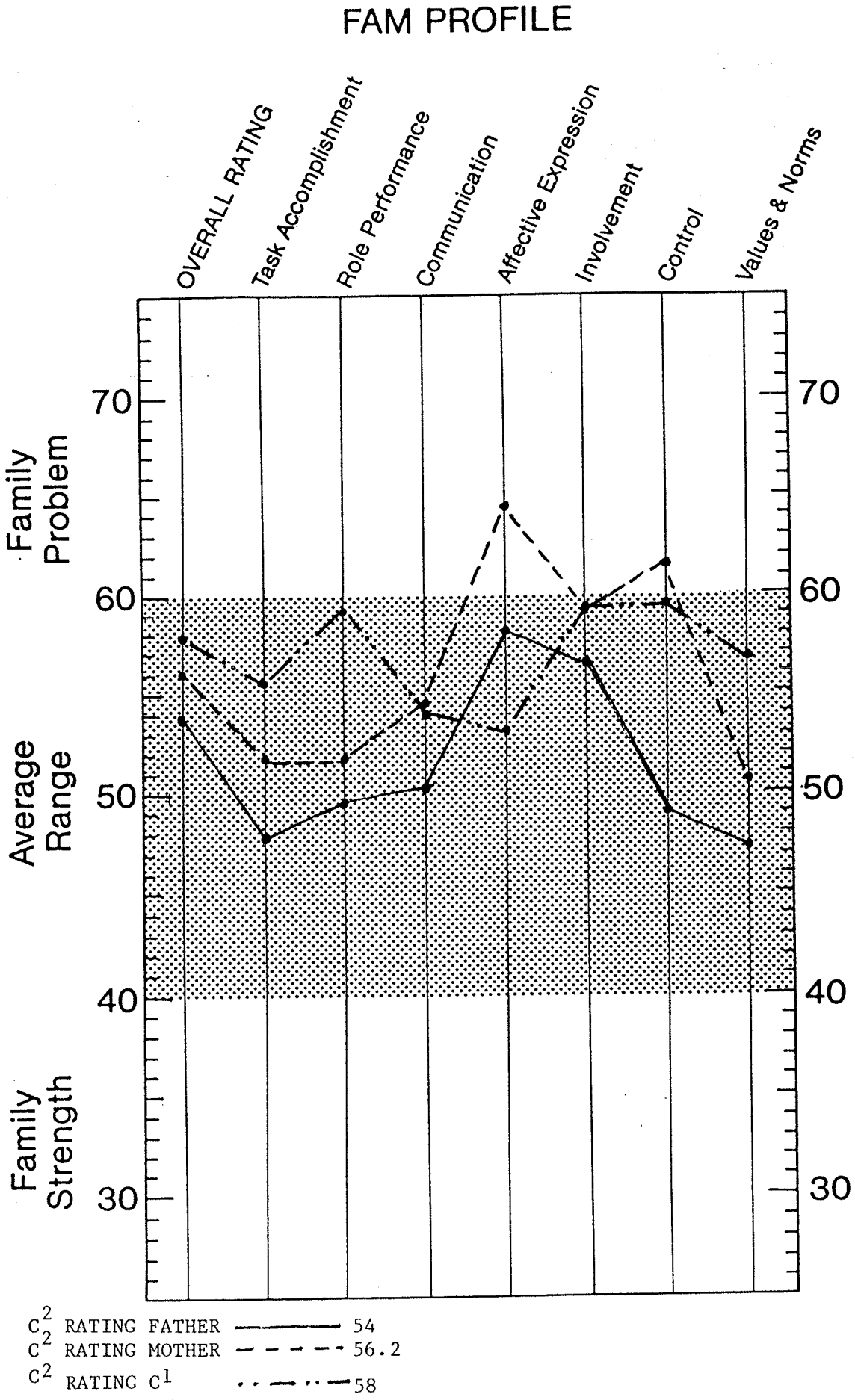


FIGURE P_{12}

DYADIC RELATIONSHIP SCALE



significantly reported by other family members in either the FAM III scores or in therapy.

In summary, the FAM III was valuable in assisting the student's assessment and evaluation of treatment to date. It appears evident that as the student is aware of the continued dysfunctional patterns and problems within the family, these problems are also clearly recognized in the FAM profiles of the family members.

It is beyond the scope of this report to provide a comparative analysis of the basic components of the Structural Family Therapy Model with those of the Family Functioning Model of FAM III. It is however, evident that both the Structural Family Therapy Model and the FAM III can be used in combination to provide additional information to the therapist who would want to provide some measurable evaluation of the therapy provided to families.

Family "M"

1. Presenting Problem: Family "M" was referred for family therapy by a community child welfare agency. This was a two parent family with two children. The I.P. or C^1 was a 13 year old female. She was the mother's child from a previous union. The second child, C^2 was 8 years old from the current relationship.

The family entered therapy at the request of the social worker from the community child welfare agency but clearly believed and stated to the therapist that they (the parents) thought the problems were C^1's and they were only in therapy to help her.

The presenting problem involved C^1's behaviour over the past several months. Three months prior to referral to C.H.O.W. for family therapy, C^1 was removed from her home and placed in a foster home. The precipitating incident involved C^1 acting out and developing a plan to run away from home. The parents, frustrated and unsure what to do next, called the child welfare agency and requested placement. The agency complied and planned to have C^1 return as soon as possible. As this did not result in a clear plan, C^1 remained in care for three months prior to referral for family therapy. Due to a variety of factors common in families who are experiencing stress, once C^1 was removed, stress in the family immediately subsided, thereby solidifying their belief that C^1 was the problem and the only one needing help.

It was immediately apparent to the therapist, that although the parents cared very much about C^1, their commitment to therapy was minimal. The parents were intelligent and able to realize that they could affect change in C^1 by participating in her treatment but this participation was viewed

as a supplement to C^1's treatment not the family's treatment.

Although the therapist clearly explained the nature of therapy, the parents were not committed to "family" therapy therefore a contract to work on issues was never established. The nature of the attempts at therapeutic interventions will be discussed however, with a view to highlight problems inherent in working with resistent families as well as the difficulties in obtaining therapeutic control or contracts for work when a child is in placement outside of the home.

2. Etiology of the Problem: The mother is the oldest of six children in a family which can be described as problematic. The mother left home at 14 and had C^1 at 16 years of age. The mother met the current step-father when C^1 was 1½ years old and they were married shortly thereafter. In the past several years the mother reestablished a relationship with her parents and describes their relationship as close. She maintains contact with only one-sibling, - a sister.

The step-father describes his relationship with both of his parents as close but sees his one male sibling infrequently.

The step-father works outside of the home whereas the mother is at home with primary child caring responsibility. The mother and step-father described their relationship as very good and claimed they rarely argued or disagreed on most issues. They believed in discussing issues and this had been working for them. This did not work well with C^1 as they described C^1 as willful and defiant.

The mother reported that C^1 has always been a difficult child to manage and most traditional parenting methods were ineffective with C^1. The parents describe C^2 as an altogether different child who is very easy to parent. As a family they are very soft-spoken and polite and do not like to display any overt emotions, positive or negative ones. C^1 challenges this by forcing them to alter their methods of communicating. She does this by maintaining silence when asked questions which has then placed the step-father in a position of "bullying" C^1 to get needed information from her. The mother continues to ask questions from a very detached position.

The precipitating incident which led to C^1 coming into care was not singularily significant. Some time prior to that incident, the mother described a similar incident where C^1 "provoked" her resulting in her losing control and physically restraining C^1.

The mother was very upset about this incident which reminded her of her own family history. She was afraid of losing control again and consequently withdrew from her daughter. This withdrawal involved positive as well as negative emotions. Whereas the mother believed C^1 was deliberately forcing her to take extreme measures of control (i.e. losing control), the mother felt that should she display any emotions (i.e. telling her daughter that she loved her), C^1 would only take advantage of those emotions further hurting the mother.

This was a very complex situation where the family members really loved each other but did not display their love for fear of rejection and pain.

3. Structural Assessment: The structure of this family involves a rigid parental system, and a severe dysfunctional relationship between the mother and the I.P.. The step-father has in the past, taken a variety of positions including supporting his wife against C^1 and on occasion, supporting C^1 against his wife. As the latter causes severe stress on the marital relationship, this pattern occurs much less frequently. Resistance on the part of the mother, her fear of being hurt by C^1, caused considerable delays in therapy. The child welfare agency's well meaning but problematic role with this family further solidified their belief that C^1 was the only problem.

4. The Goals of Therapy:

(1) To obtain a clear commitment to participate in therapy with the ultimate goal of C^1 returning home.

(2) Strengthen the parental subsystem to enable it to be more flexible and less rigid.

(3) To work on the dysfunctional parental-child subsystem allowing the mother and C^1 to deal openly with one another and share emotions.

5. Interventions: The family was seen for five sessions, from March 6, 1985 to April 18, 1985.

In the first session the therapist spent considerable time joining with all family members. The therapist concentrated on tracking which occurs by following the content of the family member's communication and behaviour.

The therapist joined with the family and explored the family's sources of support, stresses on the family unit, the family's developmental stage and the family's responses to behaviours of individual members. The therapist further attempted to explore ways to help the family understand how the I.P.'s symptoms were being used to maintain the family's preferred transactional patterns.

In this initial interview it quickly became apparent that the step-father and mother were concerned about C^1 but were not communicating their concerns to each other in a way that could resolve issues. The therapist began to encourage the parents to discuss their concerns with C^1 clearly. As C^1 began to cry and continued to cry for most of the session, the therapist had the step-father and mother sit on either side of the daughter. This would begin to open channels of communication as well as establish a beginning therapeutic intervention to test the hypotheses that the parental subsystem was rigid.

This was certainly verified by the mother's inability to question or comfort her daughter. She maintained physical and emotional distance while the step-father moved in quickly to physically touch and speak to the daughter. Although both parents were unsuccessful in assisting C^1 to speak, the therapist and supervisor, Vicki Harrison became concerned by the degree of closeness apparent between step-father and daughter. (N.B. There had previously been some unsubstantiated accusations by C^1 that she had been sexually abused by someone. The step-father and mother had expressed concerns that C^1 would accuse the step-father of this if she became angry at him. Although these accusations never occurred, the degree of closeness observed between the step-father and C^1 initially led the therapist and the supervisor to believe there may be reasons

for concern.

Following the session, the concerns of the therapist and the supervisor were shared with the social worker from the child welfare agency, and information obtained from the social worker did not indicate any conclusive information to suspect abuse. It was agreed that this issue would be further explored in therapy with the consultation of the social worker and child welfare agency should further information surface.

In the second interview the therapist concentrated on rejoining and further developing a therapeutic system so that further work could occur.

The parents discussed their relationship with the child welfare agency claiming they were not clear on what agreements had been made between the child welfare agency and the family. They insisted however that C^1 needed a psychological assessment although the purpose of the psychological assessment was unclear.

The therapist attempted to obtain clarity around issues of previously raised concerns. She was unsuccessful in this regard as the parents did not make any clear statements about their concerns. They saw the need for "family" work only in as much as it would be to help C^1 with her problems. C^1 spoke during this session and the therapist suspected that this occurred because there was little focus and minimal structure during this session. This session primarily furnished the therapist with additional demographic information about the family and validated the hypotheses of the rigid parental subsystem and dysfunctional patterns in the family.

In the third session, the therapist had the opportunity to obtain live supervision from family therapist, George Enns, M.S.W. of the MacNeill Clinic in Saskatoon. As there were a number of students observing this session from two family therapy training groups, the session was very lengthy.

After considerable consultation with George, the therapist met with C^1 alone to discuss the alleged abuse incidents. C^1 emphatically denied she had not been abused in any way by either the step-father or anyone else. She was not aware of where these allegations had come from.

The therapist rejoined the family and was directed to challenge the parental subsystem to pull together and take charge of their daughter. This meant getting C^1 to listen to them and answer their questions as C^1 immediately returned to her familiar pattern of maintaining silence as a means of obtaining control and pushing the mother away. The goal was to increase the "intensity" of the session to enable the family members to talk to each other and begin to resolve issues. The mother opted to fight with the therapist by avoiding directives and questioning all moves the therapist made to bring about change.

As a means of diffusing the power struggle developed between the mother and the therapist, C^1's position in the family was described as too powerful, thus enlisting the parents to help their daughter act age appropriate a have the parents take a more powerful position.

The dysfunctional patterns in this family became clearer as the session continued. The daughter desperately wants her mother's love and attention but only receives this attention when the mother is stressed

around issues such as C^1's school, running away and fears of C^1 becoming pregnant. Therefore C^1 has to continue to display overt behaviours such as these in order to keep her mother engaged. Because C^1 is away from home she must do these in ways which the mother will observe. They are all caught in a vicious cycle.

The marital relationship consists of a step-father who is a very dependent person who deals with things emotionally. He needs to connect with someone who is strong and rigid or he'll lose his identity. The mother, conversely is rigid and maintains emotional distance from everyone. Emotional intimacy scares her because of her own history yet she is attracted to someone who is gentle and not demanding of her emotionally. This complementarity may be suitable for a childless couple but the daughter needs emotional intimacy from her mother. Unfortunately the more she attempts to get it in the only way she knows how, the more the mother withdraws by protecting herself from her perceived fear of being "hurt again" by the daughter.

The step-father was aware of this dysfunctional pattern and realizes the mother needs to be more emotionally available to the daughter. The father having his own needs uses the daughter to engage the mother. He wants the daughter home to keep distance from his wife since problems between them have intensified since C^1 left. C^2 was very co-operative and quiet during all of the sessions and did not appear to be very involved with the problems at this time.

Session four was a repeat of session three with the focus on having the parents continue to struggle to obtain control of their daughter and develop a plan for the family to begin to see each other on more

frequent occasions with a goal towards having C^1 return home by the end of the school year. Although the parents did not emphatically agree to this goal, they would not take a stand which would disspell this goal.

The therapist continued to encourage the parents to take charge by having them develop plans to deal with the behaviours of C^1. Although there was some movement in this session, the family reacted much like disengaged people who are concerned with themselves first, observed as a "push and pull". They are always pulling back after they've gotten some intensity.

In the fifth and final session, the therapist entered into a power struggle with the mother.

As it appeared that the parents were attempting to terminate therapy, the supervisor, Ms. Harrison entered the therapy room. As a therapeutic move to end the power struggle she paradoxically declared the mother as the "winner". This would then cause the mother to behave in an opposite (co-operative) manner to disagree with the therapist but alternatively enable the therapist to continue therapy.

This attempt was unsuccessful as the parents' need to discontinue therapy was stronger.

6. Termination and Evaluation of Therapy: Several days later the step-father called the therapist stating their decision to withdraw from therapy. The parents chose to relinquish C^1 on a permanent basis unless C^1 chose to and could demonstrate (unclear how) that she wanted to change and return home. The step-father was aware that they were

potentially separating their family on a permanent basis but was supporting this plan as their only viable option at this time.

The therapist clearly stated the tragedy of this decision, and raised the concern that should issues remain unresolved they may resurface at some point with C^2. The step-father acknowledged that this was a risk they would have to take.

The conclusions and recommendations for this case were documented and forwarded to the social worker at the child welfare agency.

In summary then, the family continued to resist restructuring interventions during the therapy which were highlighted by the family not agreeing to or completing suggested tasks and entering into power struggles with the therapist. The mother's fear of being hurt by C^1 resulted in her turning herself off to attempts made by the therapist to bring them closer. Although the step-father was more willing to consider further interventions, his fear of further damage to his marital relationship as well as worry about his wife's fears, led him to support his wife's position of terminating therapy.

The therapist obtained a considerable amount of live supervision on this case which she believes affected her effectiveness with this family. Although it was valuable given the degree of difficulty, the therapist experienced a considerable amount of stress during this.

As it seems inevitable that students must learn to work with "easy" families as well as "hard" families, there may not have been a way to be more effective with this family without compromising the therapeutic situation. The experience for the student was valuable, however, as she

learned to deal more effectively with resistance as well as with larger systems.

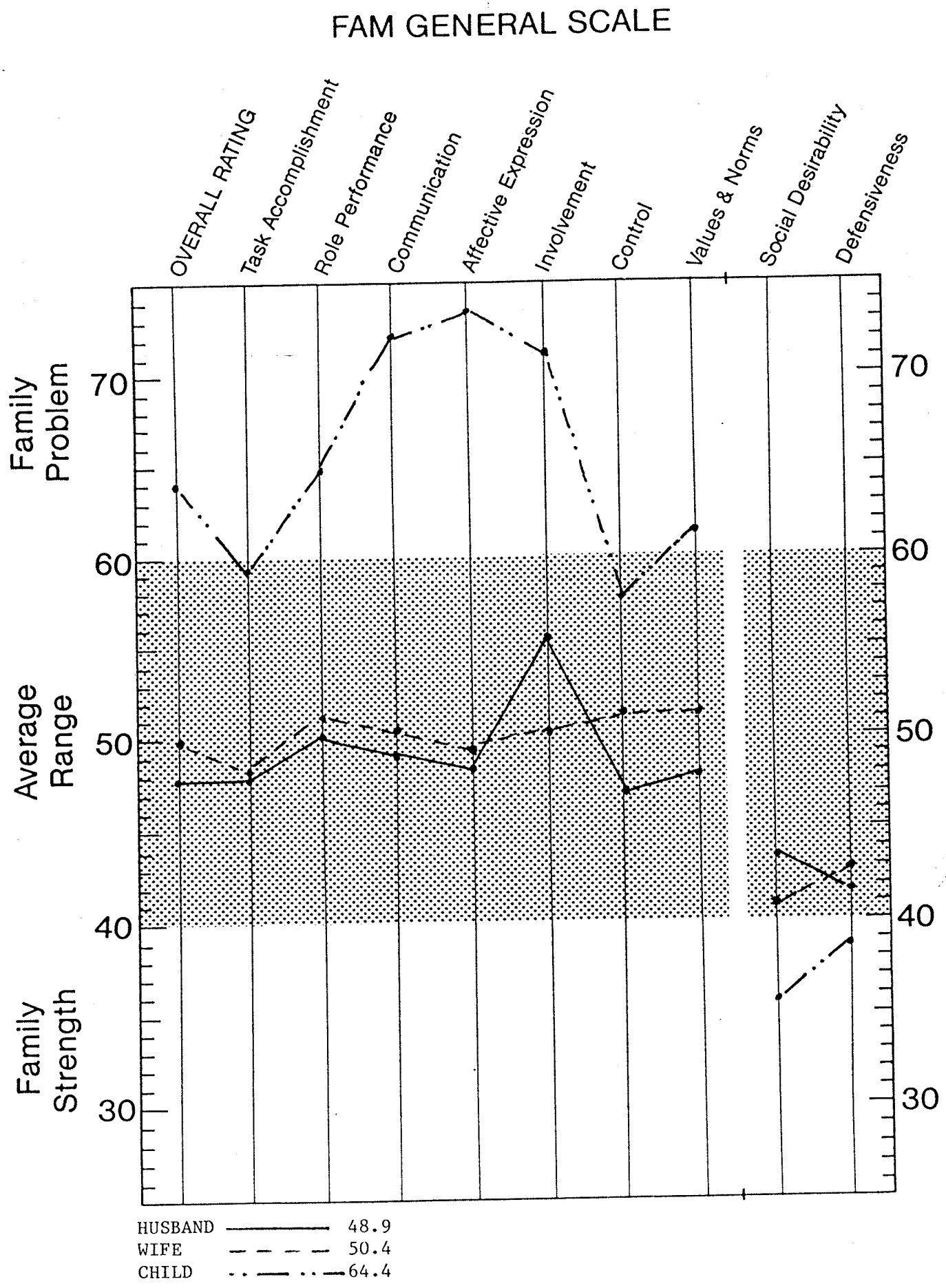
7. Pre-Test and Post-Test Scores: Family "M" was given the pre-test just prior to their first interview on March 6, 1985. Although they agreed to complete the post-test following termination of therapy, they did not do so. It is regretful that this did not occur as it would have provided valuable information from which the student could have learned.

In examining the General Scale (Figure M_1) the discrepancy between C^1 and her parents becomes immediately apparent. C^1 scored all subscales consistently high with the exception of Task Accomplishment and Control which were just within the normal range. Both the husband and the wife scored all subscales similar to one another, well within the normal range. It is noteworthy to relate these reports to the student's observations of therapy whereby the parents insisted that "the family" was not the problem. They clearly entered therapy convinced that C^1 was the problem and may have distorted their responses to the questions to protect their view of the family and C^1 as the I.P.. (see Figure M_1)

In the FAM III, C^1 consistently noted that the family was problematic yet did not speak out in therapy about her beliefs.

Although C^1's responses are not unusual for an adolescent I.P. in a family, the student wonders what would have happened should C^1 have been more open in therapy. The discrepancies in the scores obtained from the parents and C^1 also indicate that there are problematic areas in the family but that family members perceive the problems very differently (Skinner, et. al., 1984, p. 8).

FIGURE M_1


FAM GENERAL SCALE
OVERALL RATING
Task Accomplishment
Role Performance
Communication
Affective Expression
Involvement
Control
Values & Norms
Social Desirability
Defensiveness
Family Problem
Average Range
Family Strength
70
60
50
40
30
HUSBAND 48.9
WIFE 50.4
CHILD 64.4

In examining the Self-Rating Scale there were again discrepancies between scores obtained from the family members. C^1 noted consistently elevated scores on all subscales with the exception of Values and Norms (59). The husband and wife noted relatively similar scores in several areas such as Role Performance, Affective Expression and Values and Norms. The major discrepancy was noted in the scoring of Involvement with Wife (63) and Husband (43). The wife's scores were most similar to C^1's score for Involvement (65). This could reflect a similar view that this is a problematic area for these two family members. The incongruency between the spouses score may indicate a potential area for marital discord. Involvement or lack of involvement was certainly an issue in this family during therapy. (see Figure M_2)

In examining the Dyadic Relationship Scale in this family, there are striking incongruencies in the scores obtained from all family members. (see Figures M_3, M_4 and M_5)
Firstly, the wife rating the husband (overall rating 42.1) was slightly lower than the husband rating the wife (overall rating 37.2).

The wife rating the daughter, C^1 was consistently more elevated into the family problem area (overall rating 63.4) than was the husband rating C^1 (overall rating 57.4) within the normal range. This discrepancy was also reflected in therapy where the wife/mother clearly viewed the daughter as more of a problem than did the husband/step-father.

The daughter, C^1 rated the mother consistently more problematic with an elevated overall score of 70.1 as compared to the rating of the step-father with an overall score of 61.4. This discrepancy was also evident in therapy where C^1 viewed her relationship with her mother as problematic

FIGURE M_2

SELF-RATING SCALE

FAM PROFILE

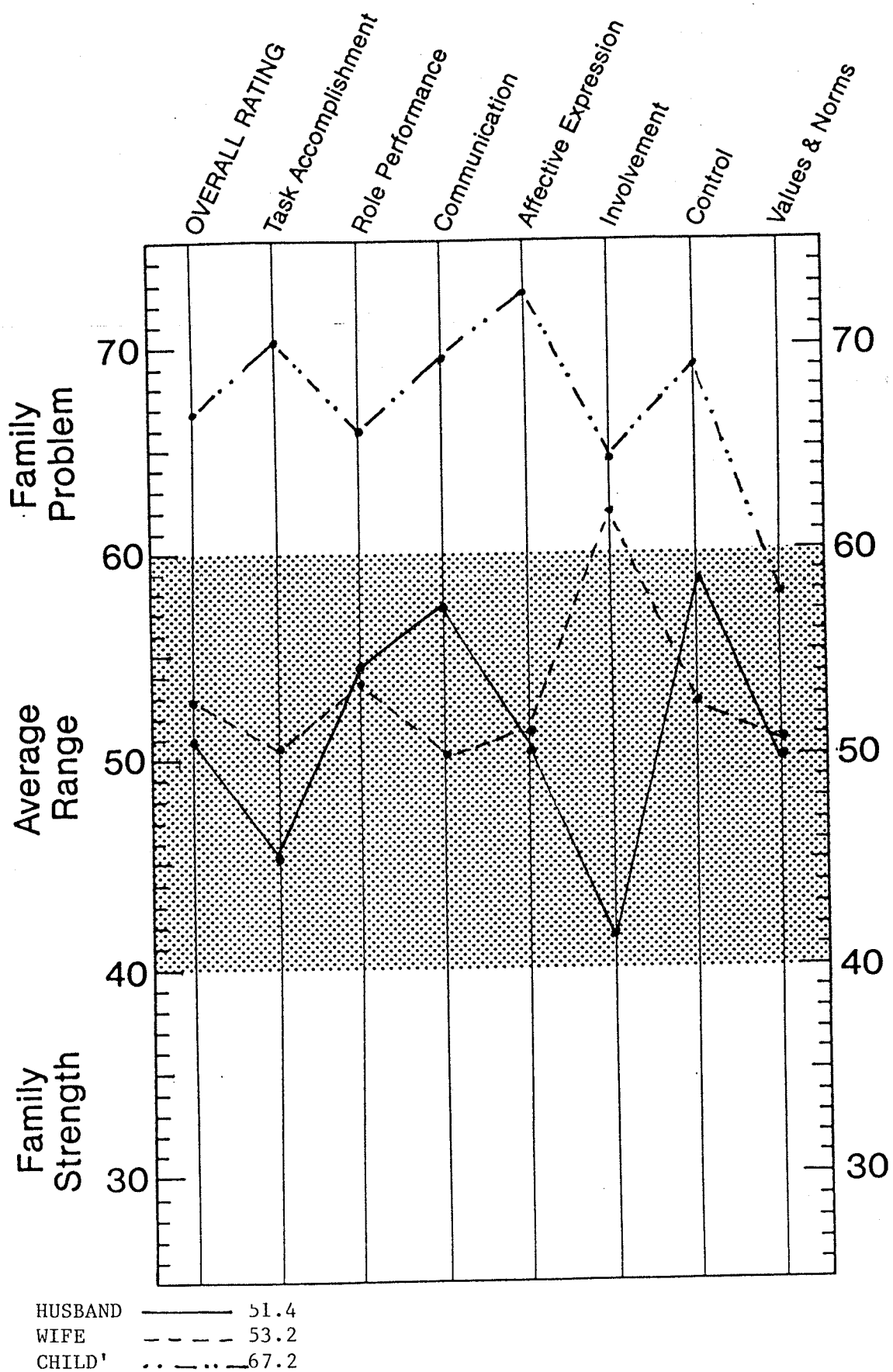
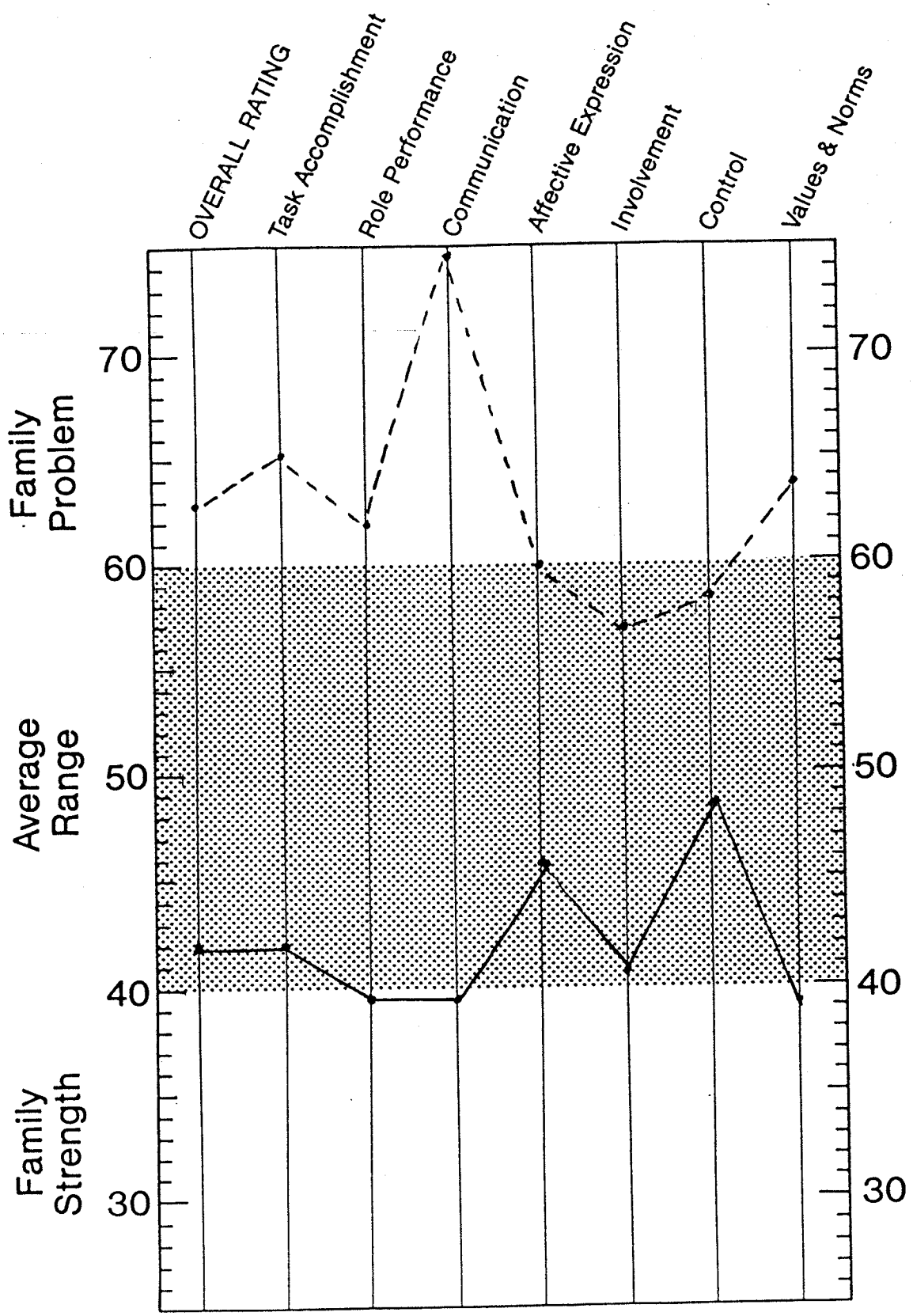


FIGURE M_3

DYADIC RELATIONSHIP SCALE

FAM PROFILE



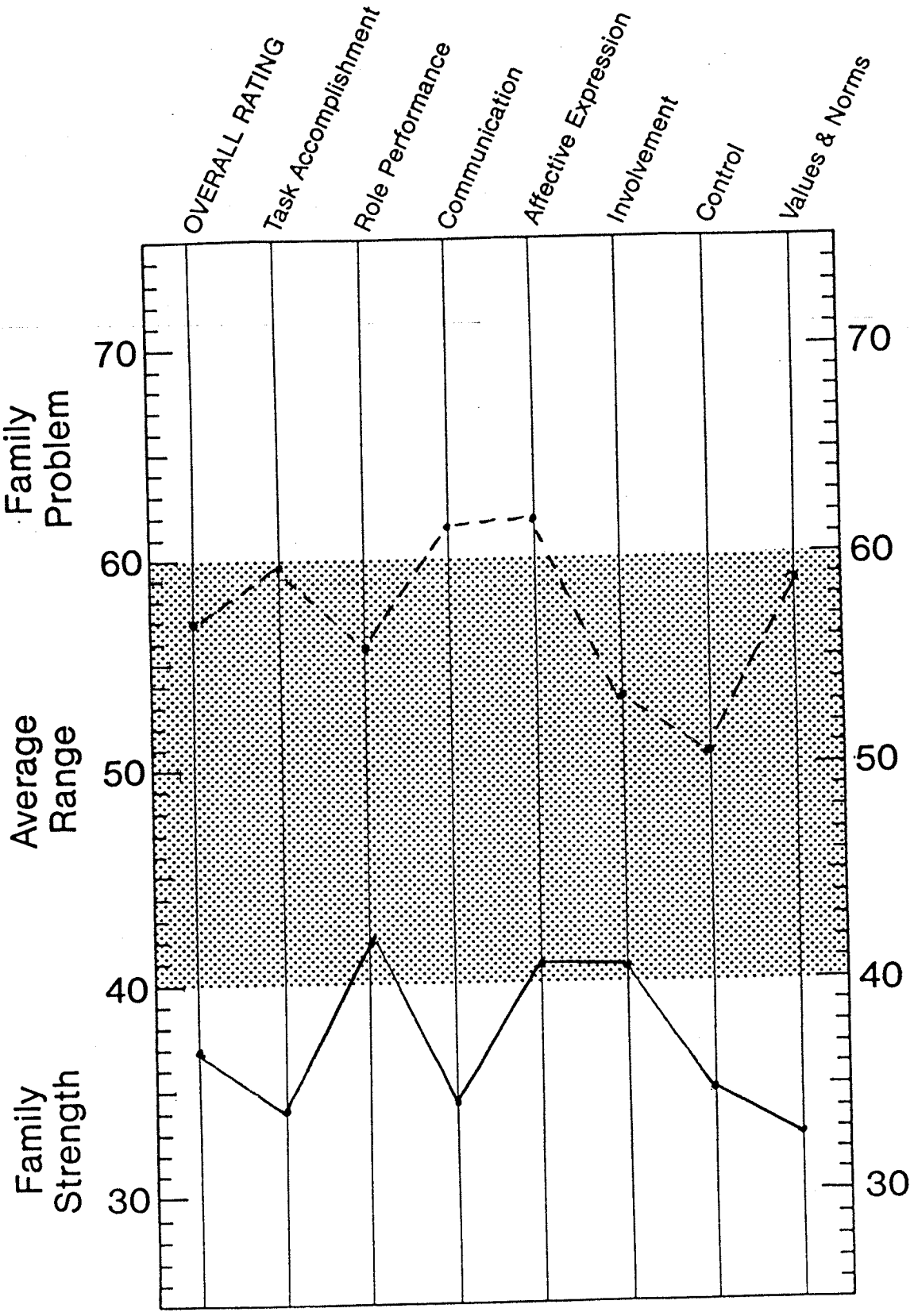
WIFE RATING HUSBAND ——— 42.1

WIFE RATING CHILD' — — — 63.4

FIGURE M_4

DYADIC RELATIONSHIP SCALE

FAM PROFILE



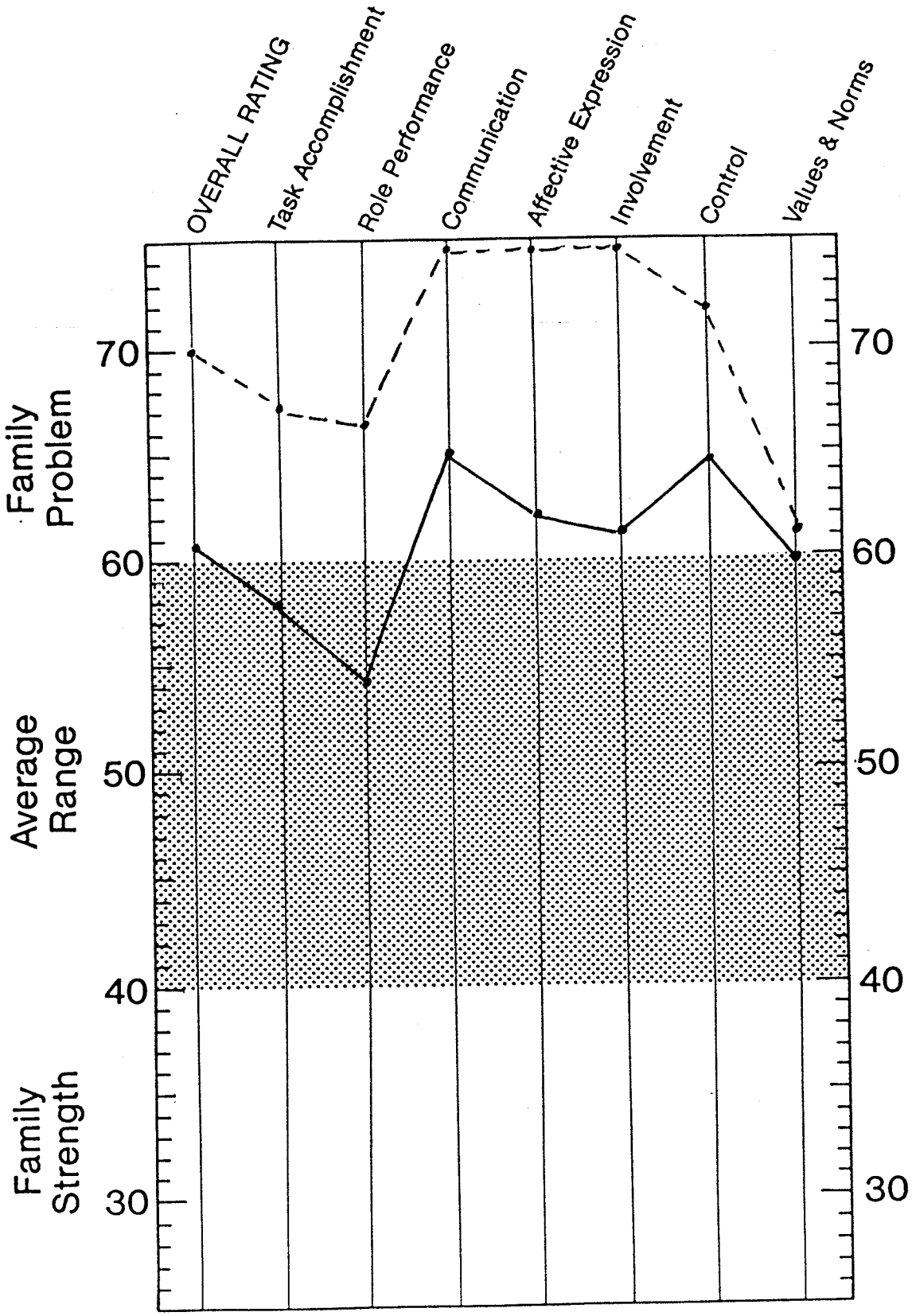
HUSBAND RATING WIFE ——— 37.2

HUSBAND RATING CHILD'- - - 57.4

FIGURE M_5

DYADIC RELATIONSHIP SCALE

FAM PROFILE



CHILD' RATING HUSBAND ——— 61.4

CHILD' RATING WIFE - - - - 70.1

and reported that she had been closer to the step-father. The recent problems with the step-father alligning more often with the mother could be reflected in the elevated scores obtained from C^1 regarding her current relationship with the step-father.

In summary, the pre-test scores were consistent with the student's observations about the family in therapy.

Had circumstances been otherwise it would have been valuable to have obtained post-test scores, as it would also have been desirable to have the family continue in therapy. As these were not possibilities, the FAM III was nonetheless helpful in identifying areas of strength as well as concern that the therapist had also noted in therapy.

CHAPTER SEVEN

SYNTHESIS AND CONCLUSION

CHAPTER 7: SYNTHESIS AND CONCLUSION

During the course of researching, performing and writing this practicum, the student has been amazed by the complexity of individuals, families, and systems as well as the range of tools available for intervening in these systems. The student believes that Structural Family Therapy has increased our understanding of the structure of relationships within families and between families and larger systems. It provides us with an effective tool with which to improve services to families.

There are several comments the student would like to address in this synthesis which are clearly subjective but may be valuable to further students' practicums utilizing Structural Family Therapy.

Firstly, the student must familiarize themselves with structural therapy and other systems theory models prior to embarking on such a practicum. Structural Family Therapy requires a paradigm shift and cannot just become one of many "intervention tools" a social worker may randomly choose to use in a particular setting. The paradigm shift from a linear model to a systemic model involves more than a shift in focus from a child (I.P.) to the parents. Hoffman (1983) describes this shift in thinking from that of studying the science of physical matter, "observed systems" to the study of the science of living forms "observing systems". (p.7)

Structural Family Therapy is not a model designed to be used for only specific "hard" cases. It was a model developed by Minuchin based on research and practice with a wide range of problems and settings. It was originally seen as a model which could be used to work with low socio-economic families and is now used successfully with all economic levels. It has been used successfully in working with families whose children are

identified as the problem, or whose parents are experiencing a variety of psychological problems previously requiring long term individual treatment. Its use of systems enables social workers to intervene more appropriately and successfully in all facets of client life, including larger systems issues which impact of many clients.

The student experienced some difficulty in applying structural terms to previously vaguely defined situations. This initially caused some anxiety and loss of previously acquired skills. Over the period of the practicum, a stronger sense of security in knowledge and skills developed and is now being applied in this student's work with families.

The combination of these experiences can cause a lot of anxiety and error in the early work of beginning therapists.

The association with a supportive family therapy training group can greatly aid the development of therapeutic skills as well as strong qualified supervision (as was available to the student) and a supportive setting.

The evaluation model was valuable to the student and several observations need to be made. Should the student continue to use FAM III she would explain the questionnaires and supervise its completion much more clearly than she did initially. The student was initially uncomfortable giving the families such a "lengthy" questionnaire and was not convinced that an evaluation model was really necessary or valuable for this kind of work. It became clearer to the student that FAM III could in fact be very valuable and was not an unacceptable request to families who were asking for help. It was in fact another tool to aid in their diagnosis

which would only enhance treatment.

FAM III can aid in the diagnosis by providing indications of change of family strengths and weaknesses by examining the family system, the dyadic relationships within the family as well as those of individual family members.

The post-test scores were only obtained from two of a possible nine families. The student should have obtained at least several more of the post-tests by following up more thoroughly with the families and being more convinced herself that this was a worthwhile effort. The need for additional accountability and identification of treating what we believe we are treating is much clearer to the student following her practicum than it was previously.

Another issue this student would like to address has to do with women training as structural family therapists. As previously discussed in Chapter 4, the student can identify personally, with the difficulty women may have in competently practicing Structural Family Therapy when they have been socialized to be passive, submissive, indirect, and to accept limiting stereotypes of both themselves and families experiencing problems. There seems to be a lack of material written on the subject of women's and men's issues in the Structural Family Therapy literature which could greatly enhance the training of family therapists.

The student has learned a great deal from the entire practicum experience and recognizes that although she has moved a great deal from where she was at the beginning, it is still only a beginning. The prospect of continued learning opportunities is a source of excitement.

APPENDICES

APPENDIX (1): OTHER CASES

In this section the student briefly reviewed the remaining six of the nine families engaged in family therapy. The presentations include family composition, presenting problems, sessions attended, highlights of the therapy, termination and reference to the pre-test scores obtained on all of these families available for observation on Profiles included with each case example.

The student would like to note that although not all of the families were "successfully"treated, the student was impressed by the level and number of strengths observed in all families involved in therapy. Their love and concern for each other was remarkable and should not be overlooked by any professional working with families.

Family "B"

The "B" family was a two parent family with two children. C^1 was a 7 year old female from the mother's previous union and C^2 was a 1 year old female from the present union. The family was self-referred requesting family therapy to help them manage the 7 year old child who was described as out of control.

The structural assessment was a disengaged couple with unclear boundaries. The mother and step-father were unable to pull together to set appropriate limits and expectations on the I.P.. Furthermore, the ex-husband (the I.P.'s natural father) was becoming increasingly more involved with the I.P. resulting in increased behavioural problems as he allegedly wanted the child to come to live with him. The therapist believes there are serious unresolved issues between this ex-husband and the mother.

The family was seen for three sessions prior to the student going on leave and at that point, the therapist was well joined with the family, had a clear statement of the problem and what the family wanted to see different. It was also agreed that the next step would be to involve the ex-husband in therapy with the plan to begin to resolve issues between him and his ex-wife which would ultimately enable the present family system to begin to address its own issues to improve family functioning.

The student is very hopeful that this family will return to therapy following her return from leave, as they are clearly wanting help to address their concerns. A return appointment was scheduled.

This family completed a pre-test which is available for observation on Figures B_1 to B_4.

FIGURE B$_1$

PRE-TEST

FAM GENERAL SCALE

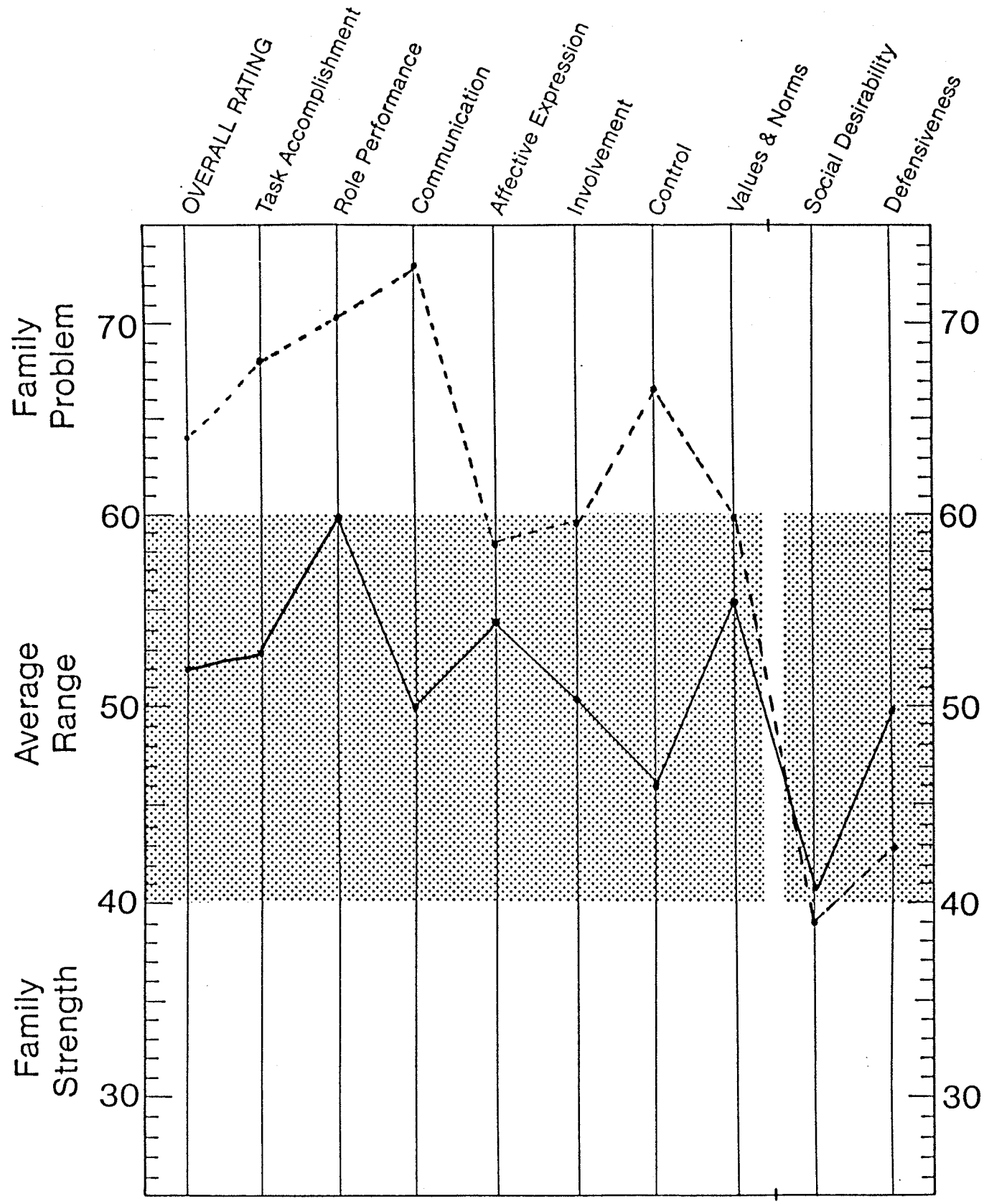
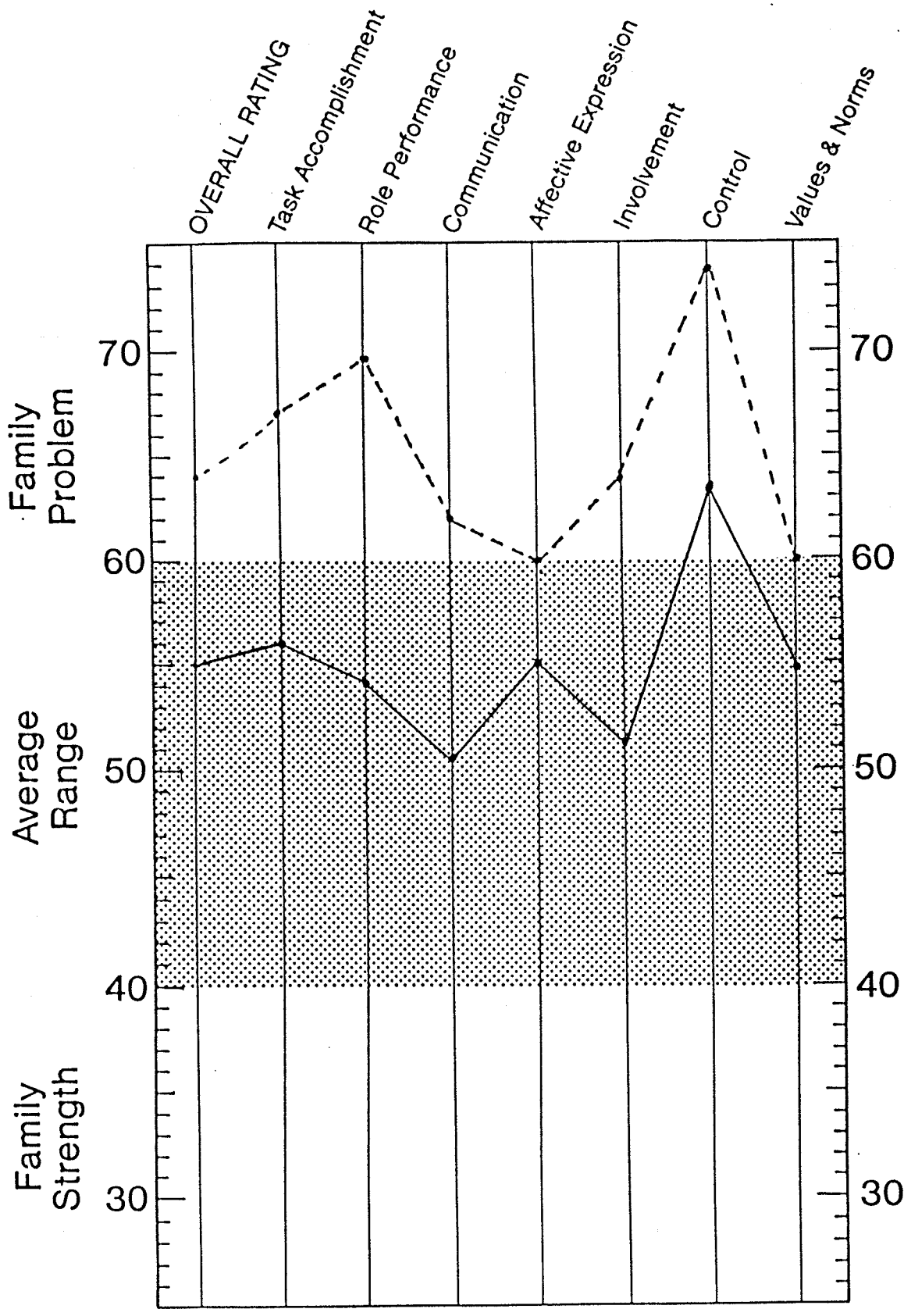


FIGURE B_2

PRE-TEST

SELF-RATING SCALE

FAM PROFILE



HUSBAND ——— (55.2)

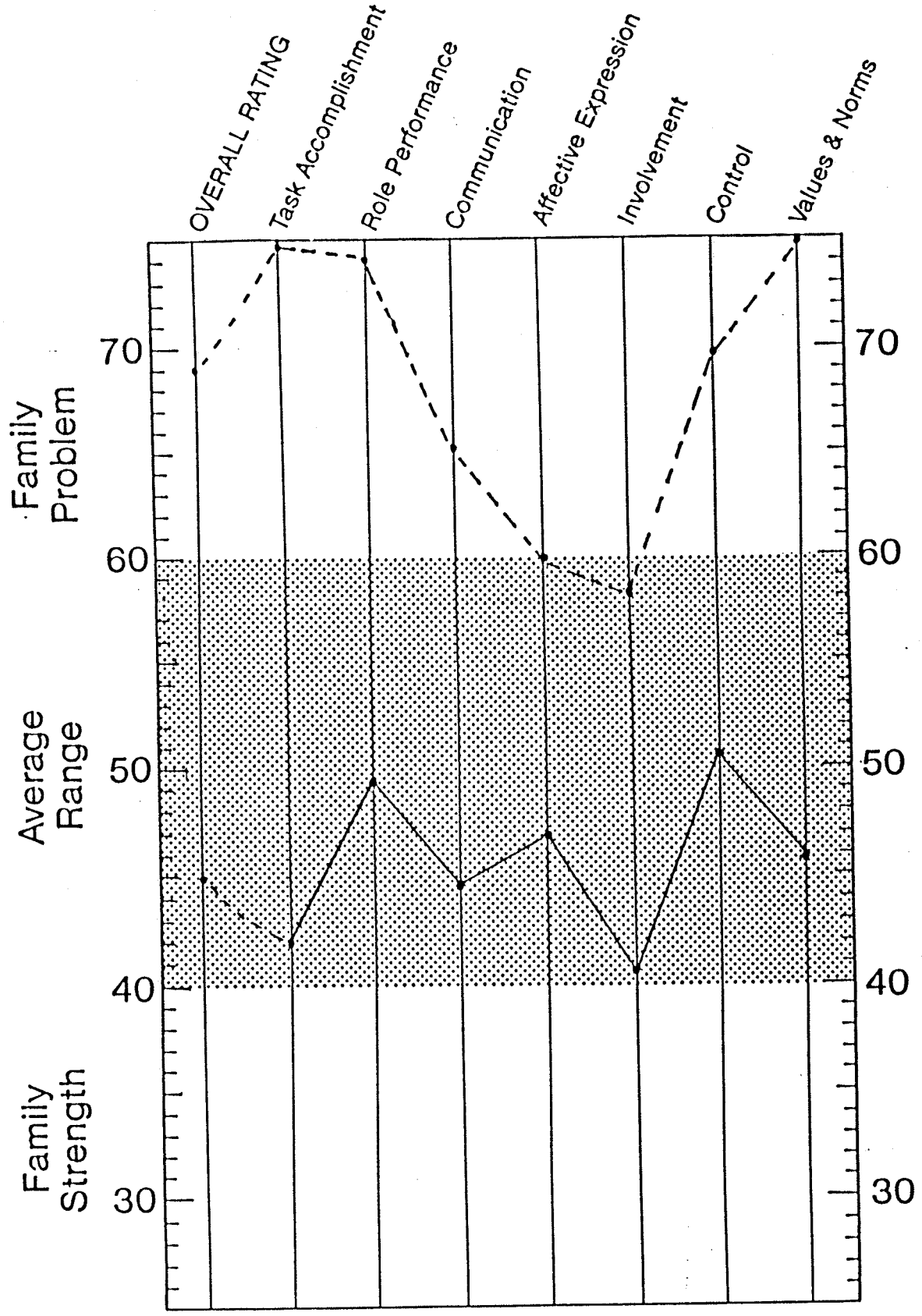
WIFE - - - - - (64.2)

FIGURE B_3

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



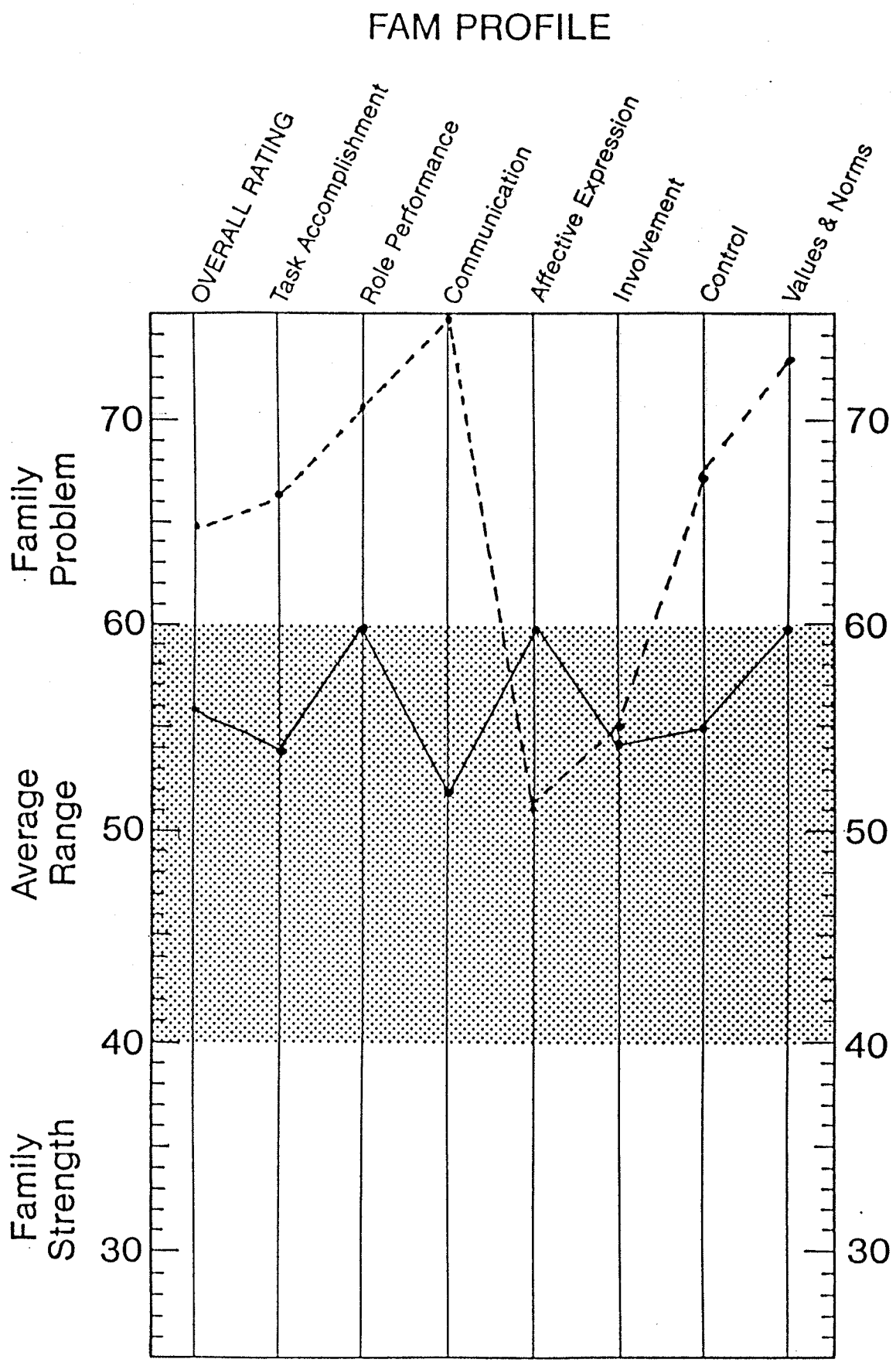
"SBAND rating C' ----- (69.2)

SBAND rating WIFE —— (45.5)

FIGURE B_4

PRE-TEST

DYADIC RELATIONSHIP SCALE



Family "W"

The "W" family was a self-referred two parent family with two children, C^1 male (16 years, (I.P.) and C^2 female, (14 years). The presenting problem involved the father's concern that their son, C^1 was increasingly truant at school and out of control at home.

When the family entered therapy it was clear that the parents had difficulty managing C^1. He continued to be rude in the sessions and his behaviour remained unchallenged by the parents. The father seemed most interested in therapy while the mother did not really want to participate.

The structural assessment was that this family was enmeshed resulting in little personal or subsystem differentiation. Boundaries were diffuse which meant that family rules and responsibilities were unclear. There were also a number of coalitions between the mother and son against the father. This may have been due to the therapist's perception of marital problems between the parents.

The goal of therapy was to create personal and subsystem autonomy in the family and create a hierarchy. The parents would then join together to clarify and enforce family rules and responsibilities. This would lessen the need for coalitions in the family as well as enable C^1 (and C^2 to some extent) to engage in age appropriate behaviour.

The therapist made a number of errors in working with this family. She was not well joined with them and did not maintain a clear leadership position. In addition to this, the mother was reluctant to be in therapy and may have avoided dealing with issues in therapy by activating her son who then became disruptive.

The family terminated therapy after three sessions by not returning for several appointments. It was difficult for the therapist to observe this as it was clear that they had serious problems which could have been dealt with in therapy but just as clearly, the therapy could not continue without a commitment to work.

This family was administered FAM III prior to their first session although C^1 refused to attempt the questionnaires. The scores are available for observation on Figures W_1 to W_5.

FIGURE W_1

PRE-TEST

FAM GENERAL SCALE

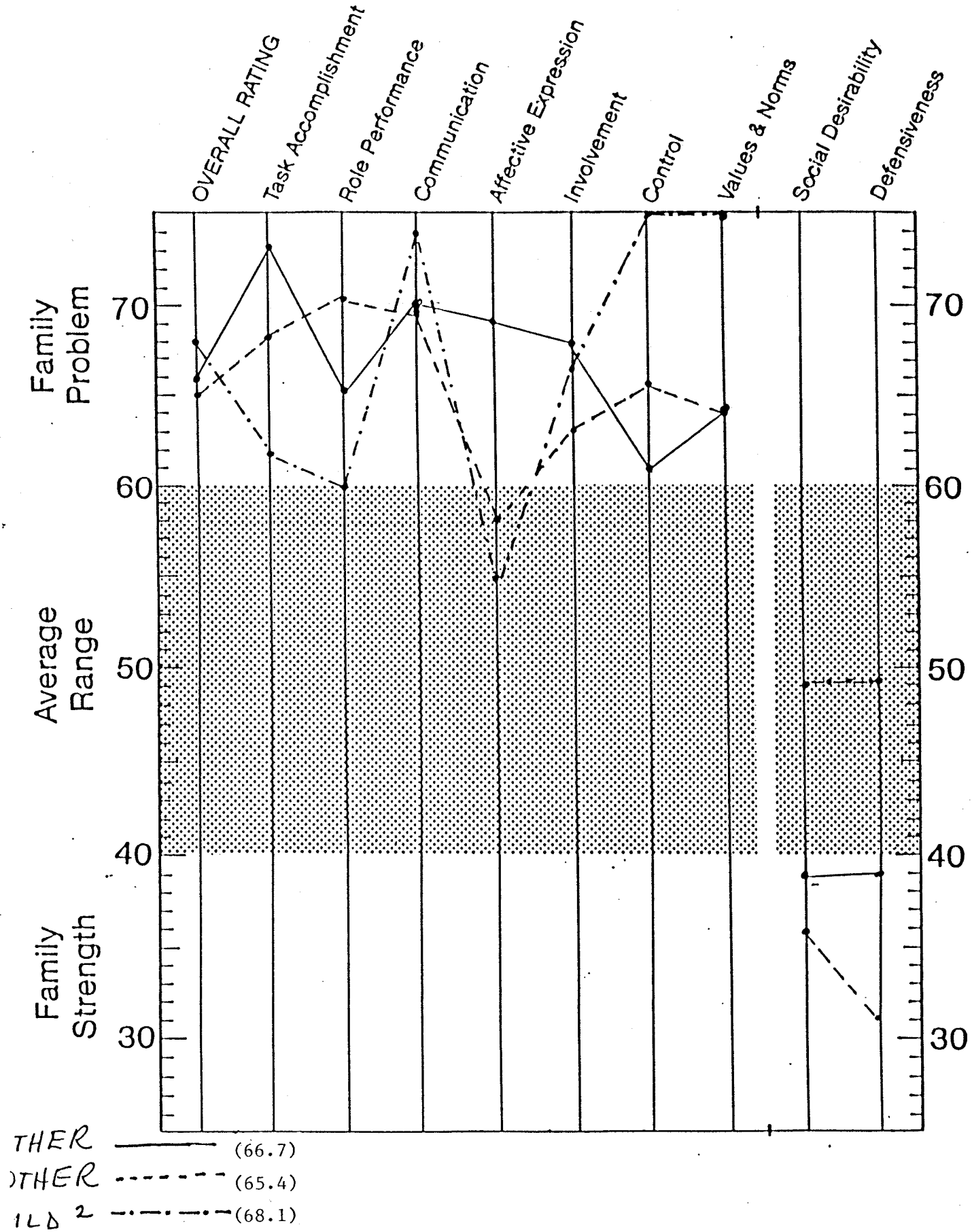
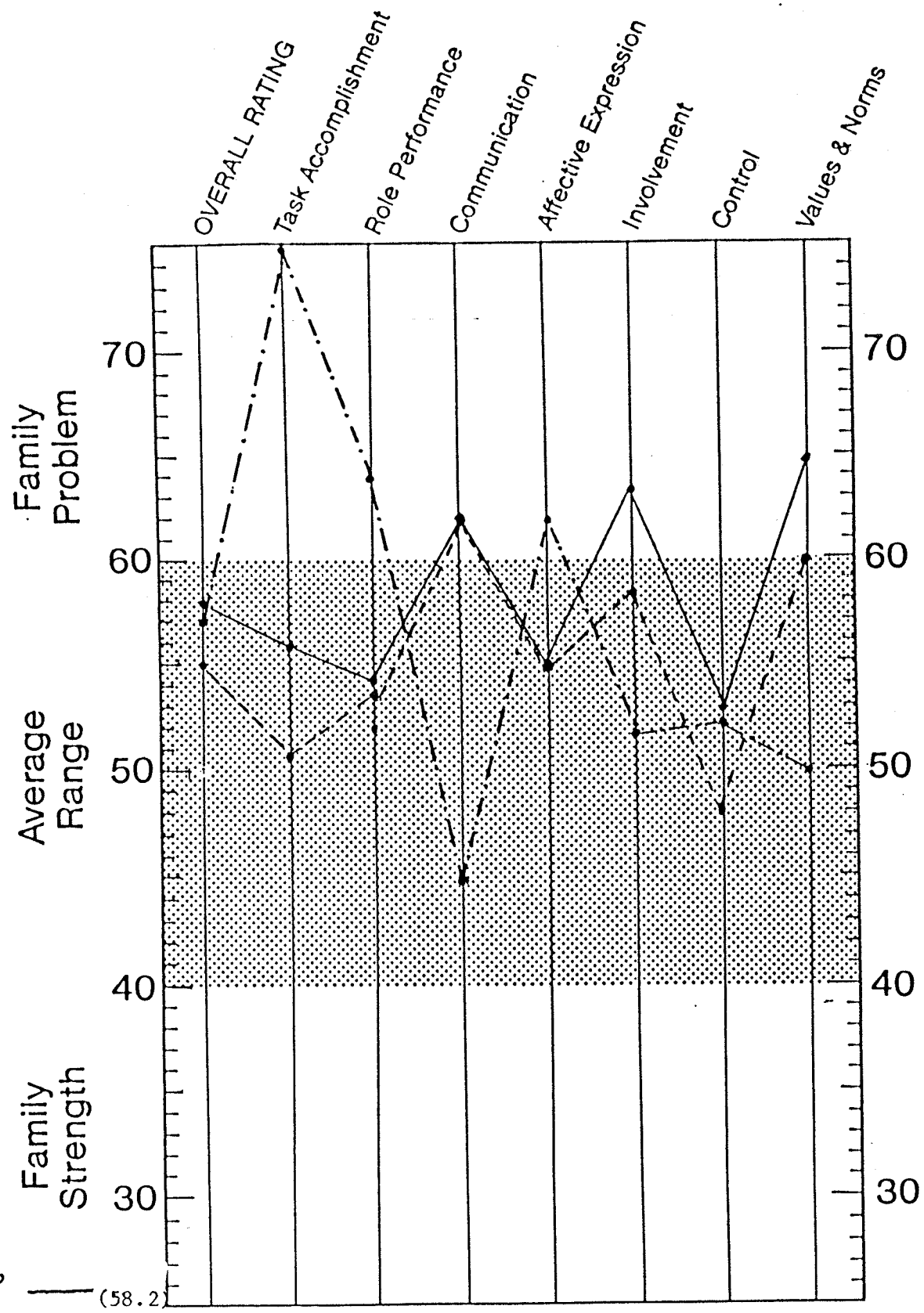


FIGURE W_2

PRE-TEST

SELF-RATING SCALE

FAM PROFILE



THER —— (58.2)

)THER - - - - (55.4)

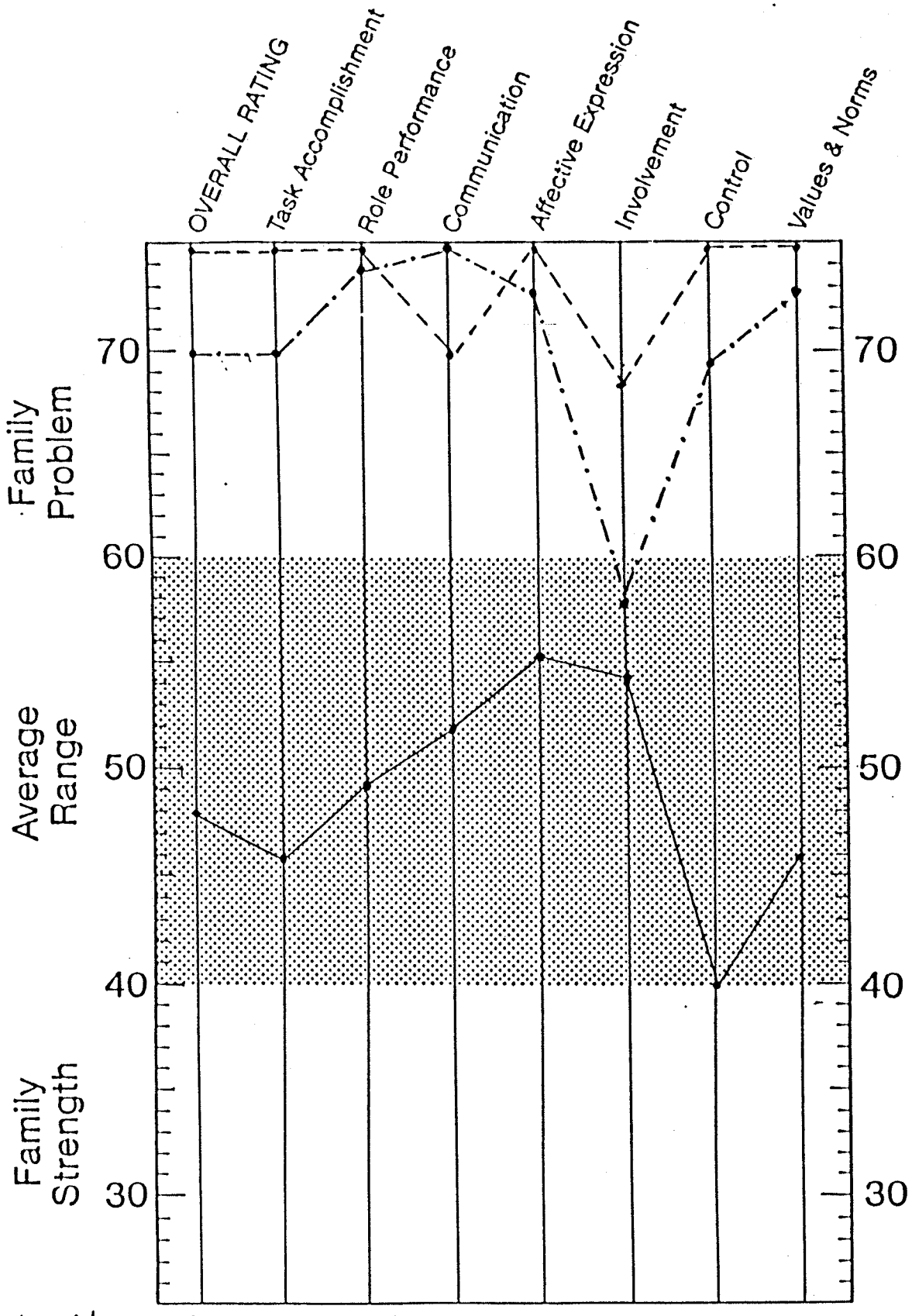
VILD 2 -.-.-.- (57.1)

FIGURE W_3

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



HER rating MOTHER ——— (48.8)

HER rating C' - - - - - - - - (79.4)

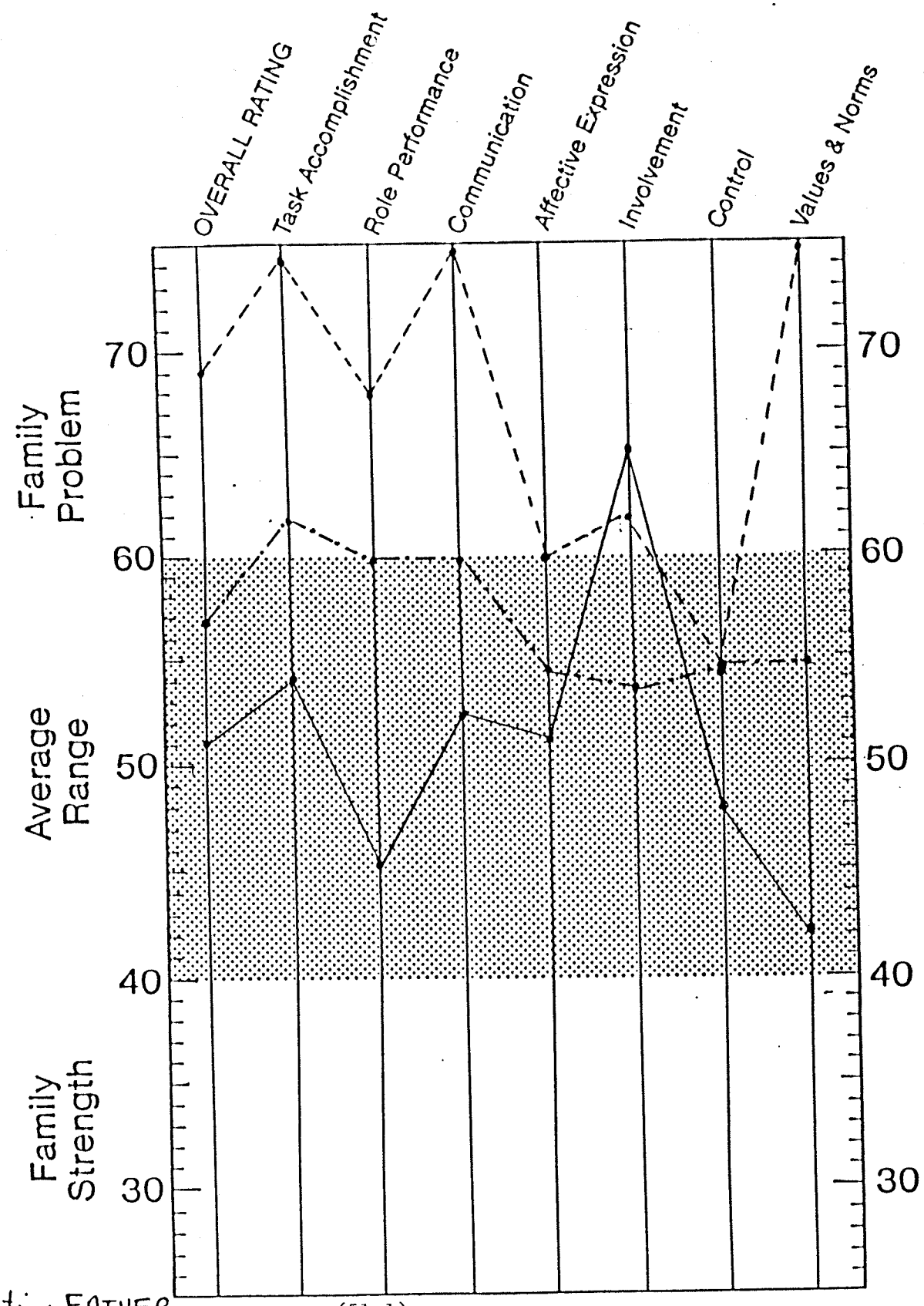
HER rating C2 —·—·—·— (70.7)

FIGURE W_4

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



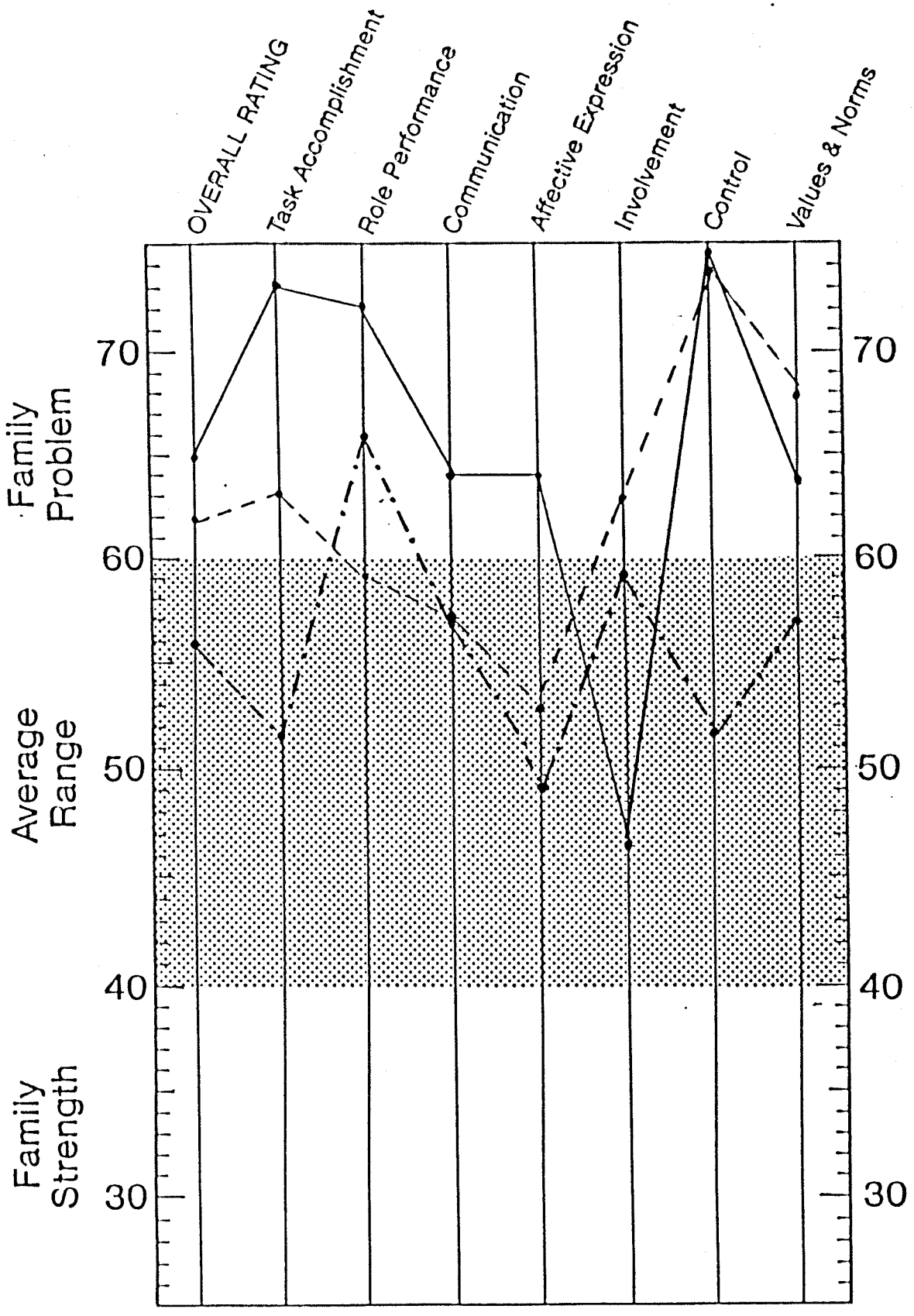
YER rating FATHER ——— (51.1)
YER rating C' - - - - - (69.4)
YER rating C^2 —·—·—·— (57.2)

FIGURE W_5

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



2 rating FATHER ——— (65.8)

2 rating MOTHER - - - - (62.4)

Family "MR"

Family "MR" was a two parent family with one (adopted) child still living at home, the 14 year old male I.P.. They had two older children who were not involved in therapy (with the exception of one interview near termination of therapy where the second oldest a 26 year old daughter attended).

This family entered therapy at the request of a social worker of the child welfare agency in their area. The boy had run away from home on several occasions and had most recently stolen from his parents' home. The boy was in a holding centre and shortly thereafter placed in a group home pending disposition.

The structural assessment of the family was an overinvolved mother and a peripheral father. The son desperately wanted to be closer to the father but the mother would step in between them, resulting in the son becoming more demonstrative in his attempts to engage his father. The mother's family of origin involved a violent father. Although her husband had never become physically violent, he had had a heart attack on one occasion while restraining the boy who was then 4 years old. The father minimized the mother's concern about this but she continued to protect the son from the father and protect the father from the son.

The plan for this family involved family therapy with a view to this child returning home as soon as possible. The family was involved with this agency over a period of nine months. During this time the parents had considerable difficult committing themselves to therapy, the I.P.'s behaviour became increasingly demonstrative and the child welfare agency responded by taking more control and decision making away from the parents in their efforts to help the child. As this situation became increasingly

complex and problematic, the therapist's supervisor did the therapy while the student therapist observed, either in the session or from behind the one-way mirror.

Over time, CHOW was not able to obtain treatment control of this case and as the child's behaviour became more demonstrative (i.e. refusing to attend school and therapy) the child welfare agency responded in ways which further separated the child from his family.

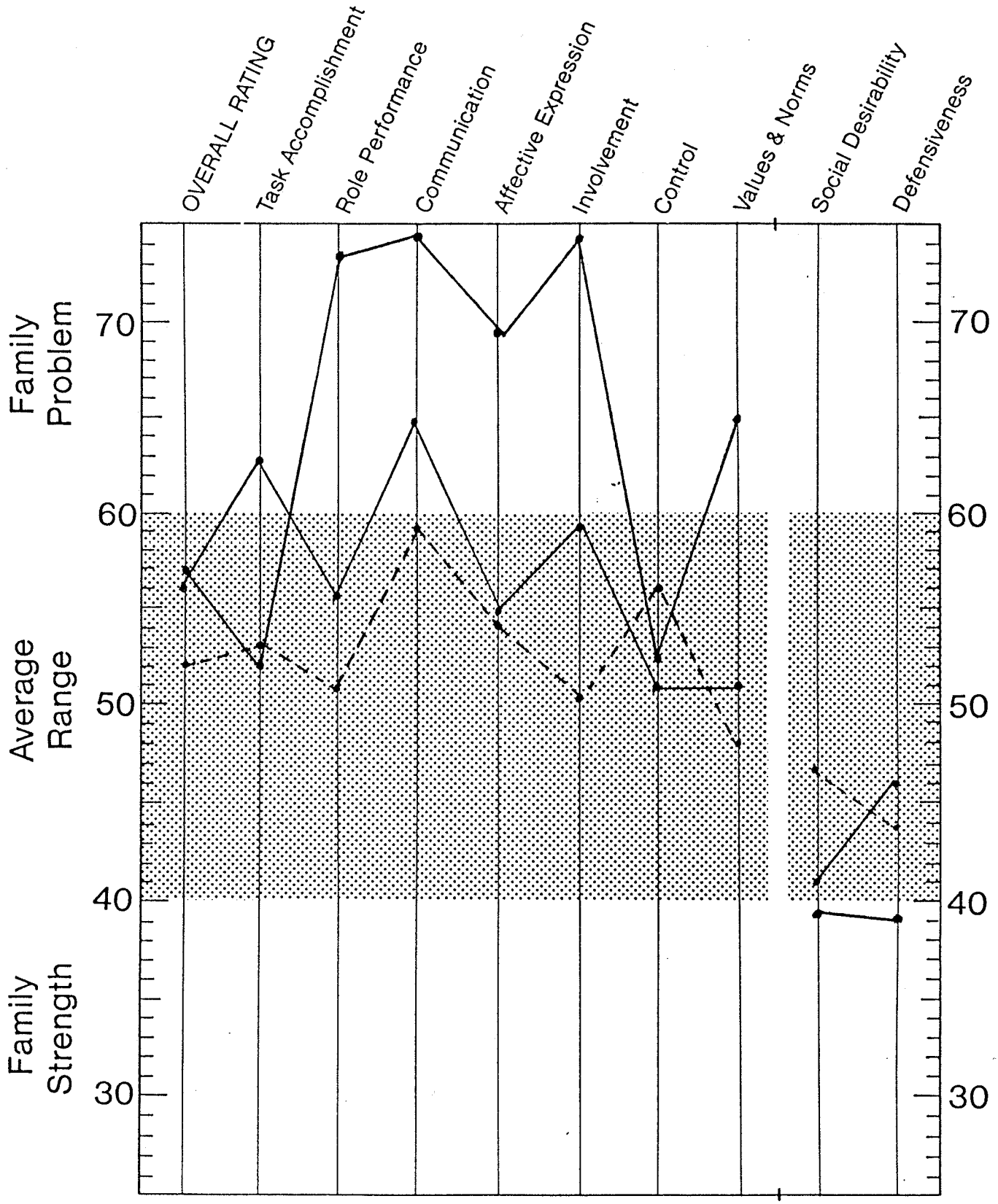
Finally, the child welfare agency decided to permanently separate the child from his family in their attempt to "save" the child. It is the opinion of this writer that this family unit could have been maintained with the support of the child welfare agency. Instead, the damage "larger systems" caused in this family is likely irreparable.

This family was administered the pre-test and those scores are available for reference on Figures MR_1 to MR_5.

FIGURE MR_1

PRE-TEST

FAM GENERAL SCALE



HER —— (52.8)

HER - - - - (56.8)

D —— (57)

FIGURE MR_2

PRE-TEST

SELF-RATING SCALE

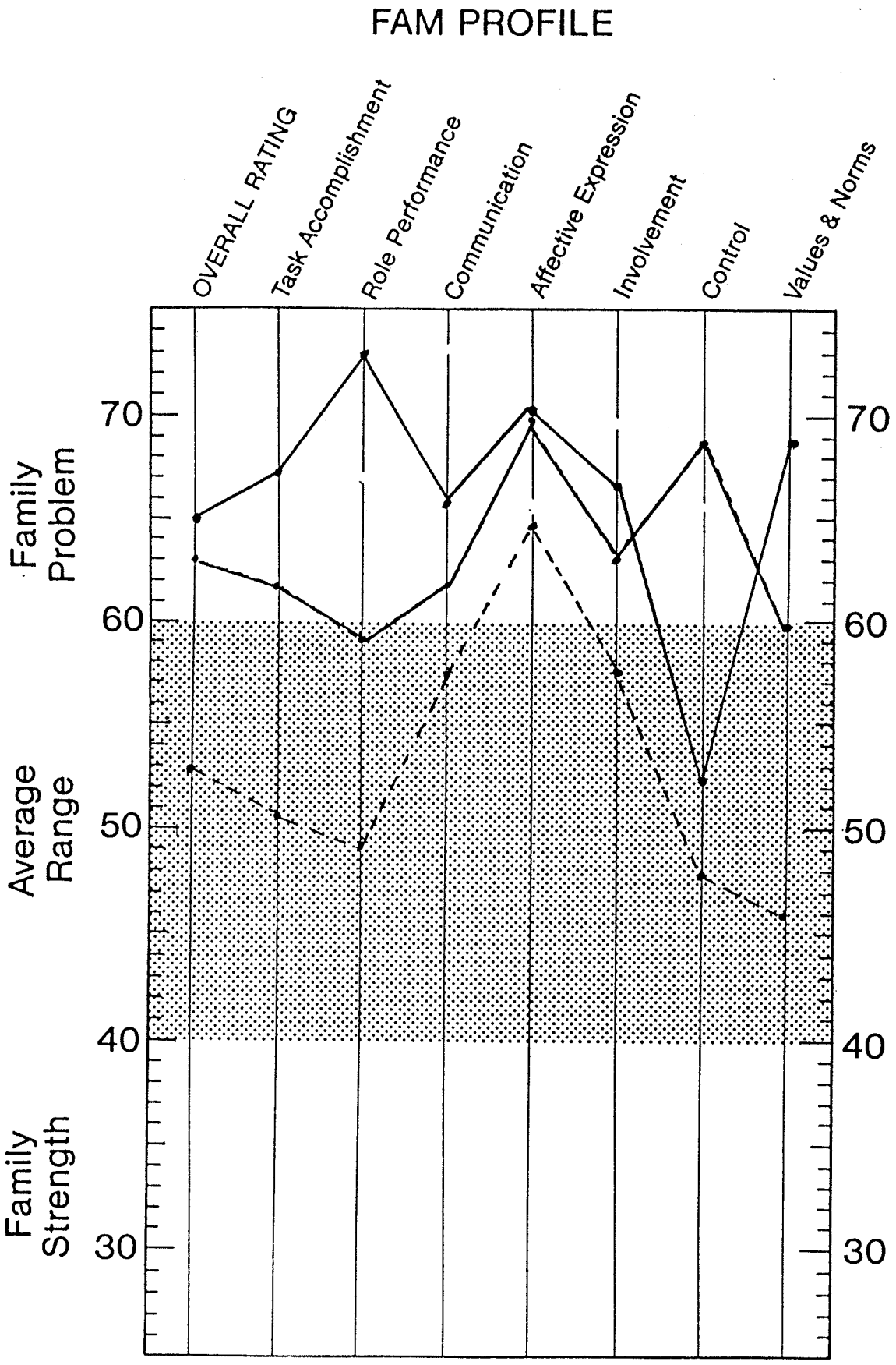
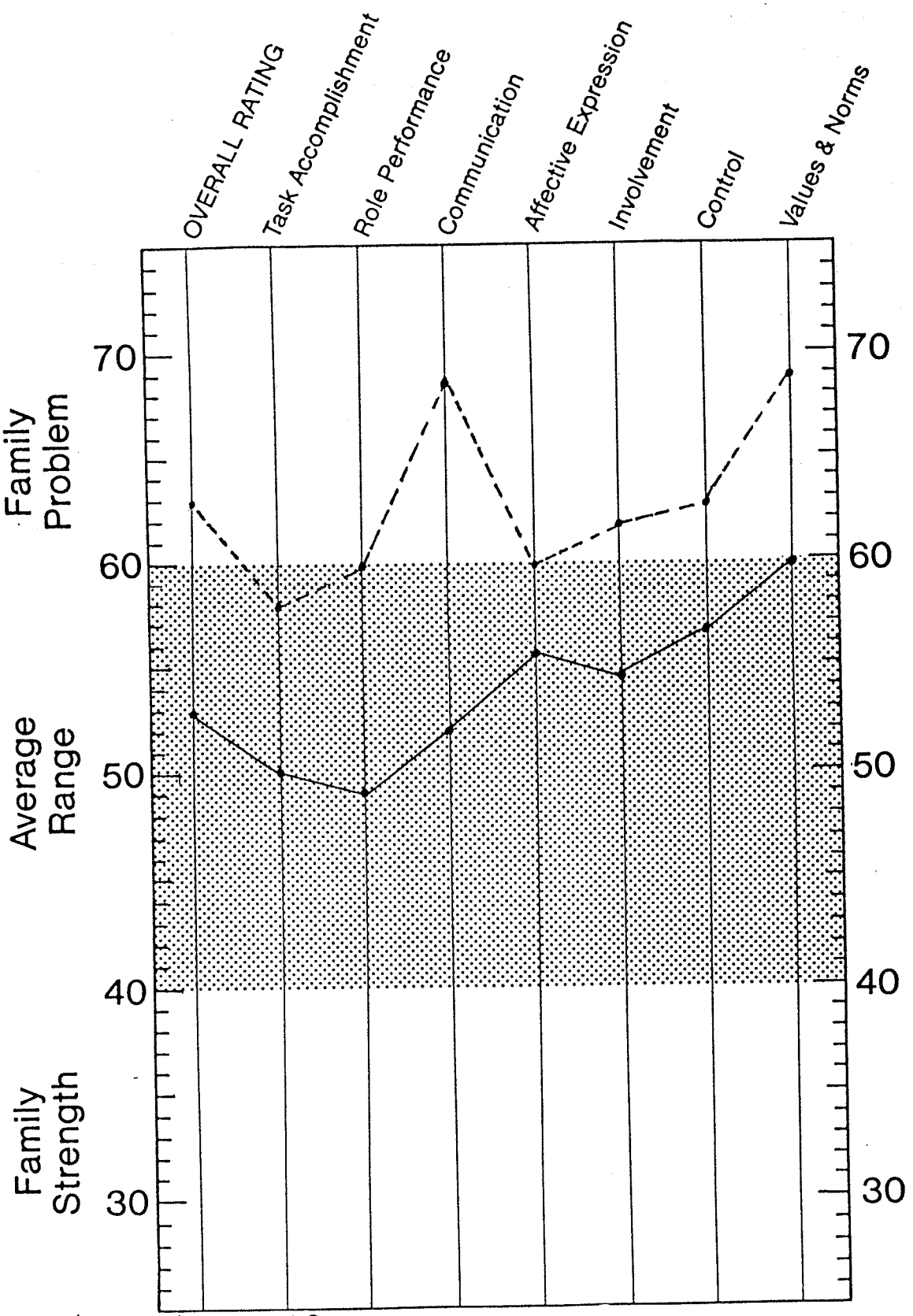


FIGURE MR_3

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



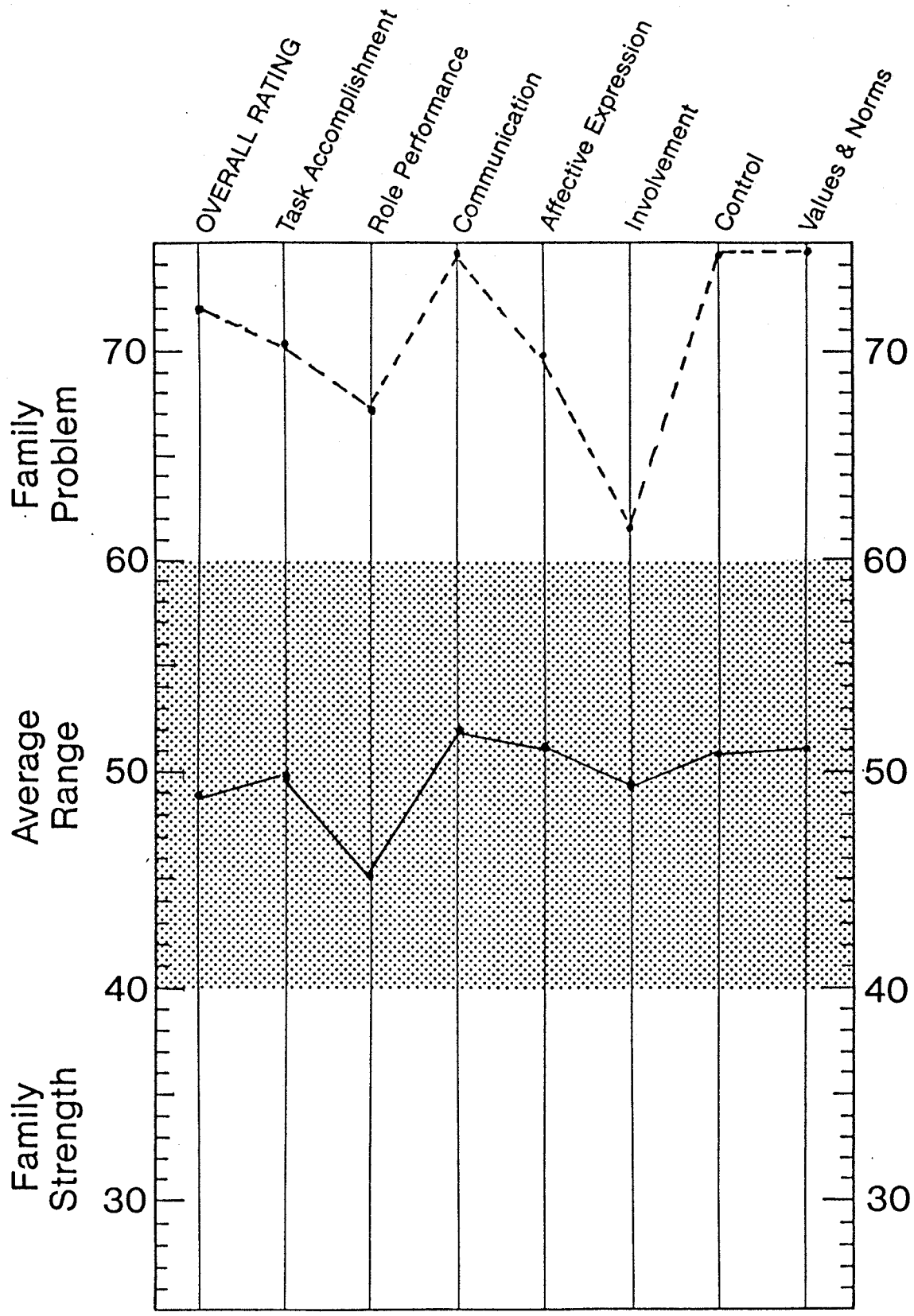
FATHER rating MOTHER ——— (53.8)

FATHER rating CHILD. - - - - - (62.8)

FIGURE MR_4 PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



OTHER rating FATHER ——— (49.8)

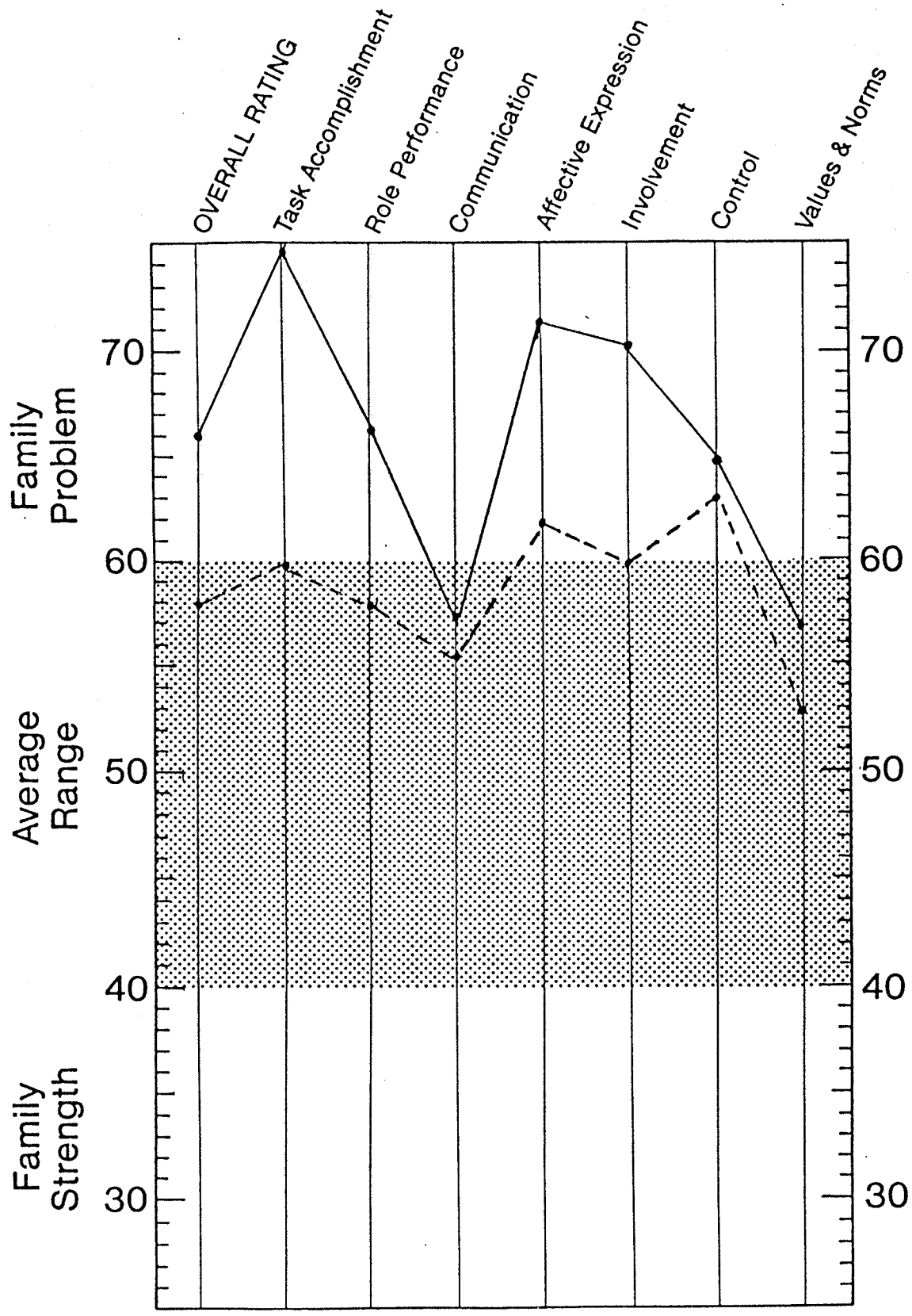
OTHER rating CHILD - - - - - (72.1)

FIGURE MR_5

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



4LD rating MOTHER ——— (66.1)

4LD rating FATHER - - - - - (58.7)

Family "N"

Family "N" was a single mother with two male children, C^1, 11 years old and C^2, 7 years old (I.P.). This family was in the midst of a crisis of family development. The mother was involved in a post-graduate course in Theology and was also planning to marry again. The ex-husband had recently become reinvolved with the family, primarily with the youngest child. C^2 verbalized that he wanted his natural parents to get back together and in fact knew nothing of his mother's plan to remarry. C^1 was not very involved with his natural father and was aware of and supported his mother's decision to remarry.

The structural assessment involves a disengaged mother who divided her time between school work, her children and her boyfriend. She kept them separate and maintained secrets and alliances between herself and C^1. There seemed to be a reverse hierarchy where C^1 shared in the parenting role and was often placed in charge of C^2 so that the mother could study or go out with her boyfriend.

C^1 was clearly labelled the problem and the mother wanted C^2 to get "fixed". Neither the ex-husband nor the boyfriend became involved in therapy.

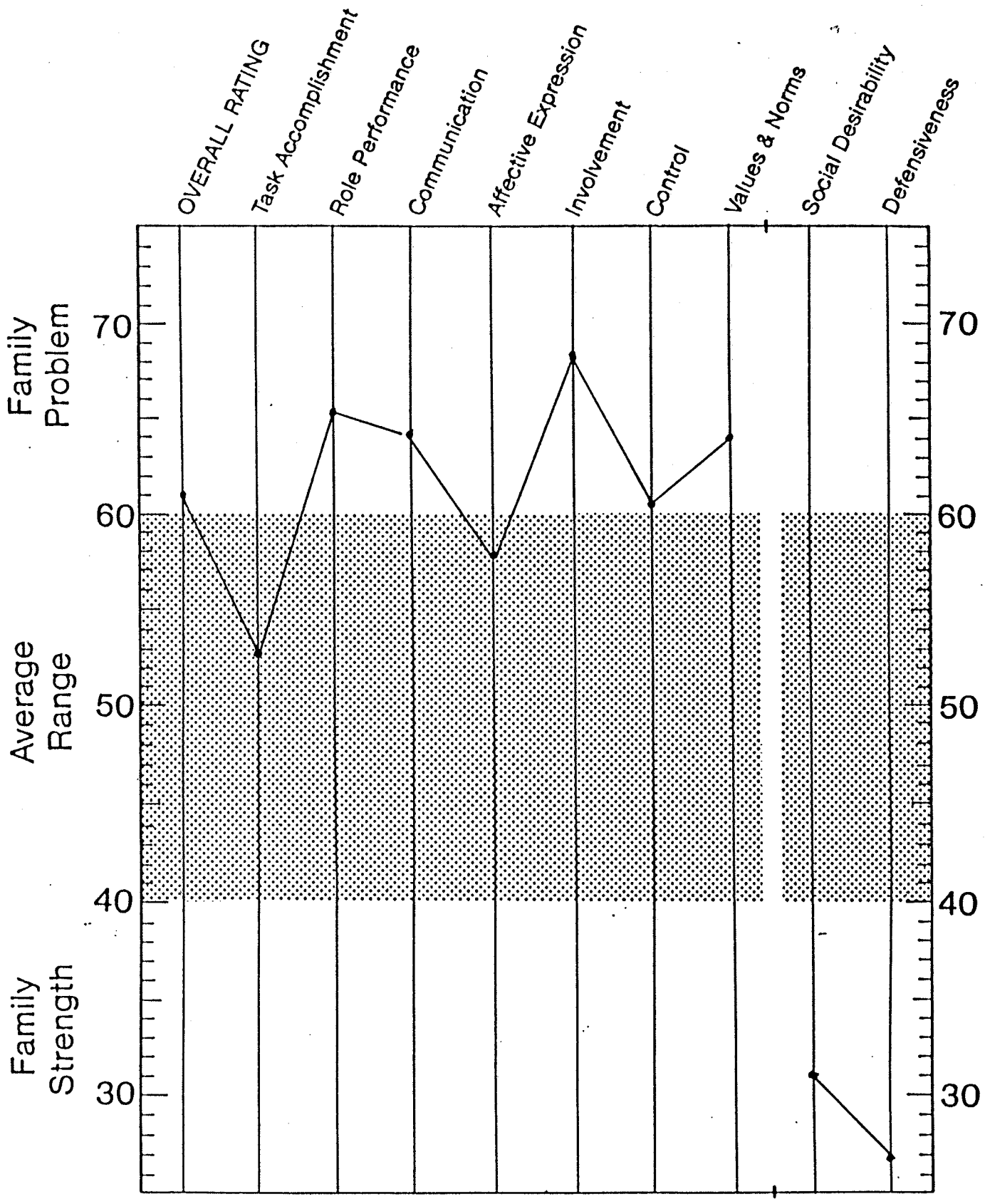
This family was seen for three sessions. Although the therapist made some errors in exploring the problems in this family, both by not taking a clear leadership position in the family and by focusing too much attention on the I.P., the therapist certainly questioned the mother's willingness to continue in therapy. During the final session, the mother revealed her intention to marry and wanted the boy fixed prior to her marrying. Although several return appointments were scheduled

where the student arranged to have live supervision, this family terminated therapy. The student believes this mother is quite resourceful and capable and should problems in this family become critical again, she would contact appropriate resources for therapy as necessary.

The pre-test scores compiled on this family are available for observation on Figures N_1 to N_3.

FIGURE N_1 PRE-TEST

FAM GENERAL SCALE



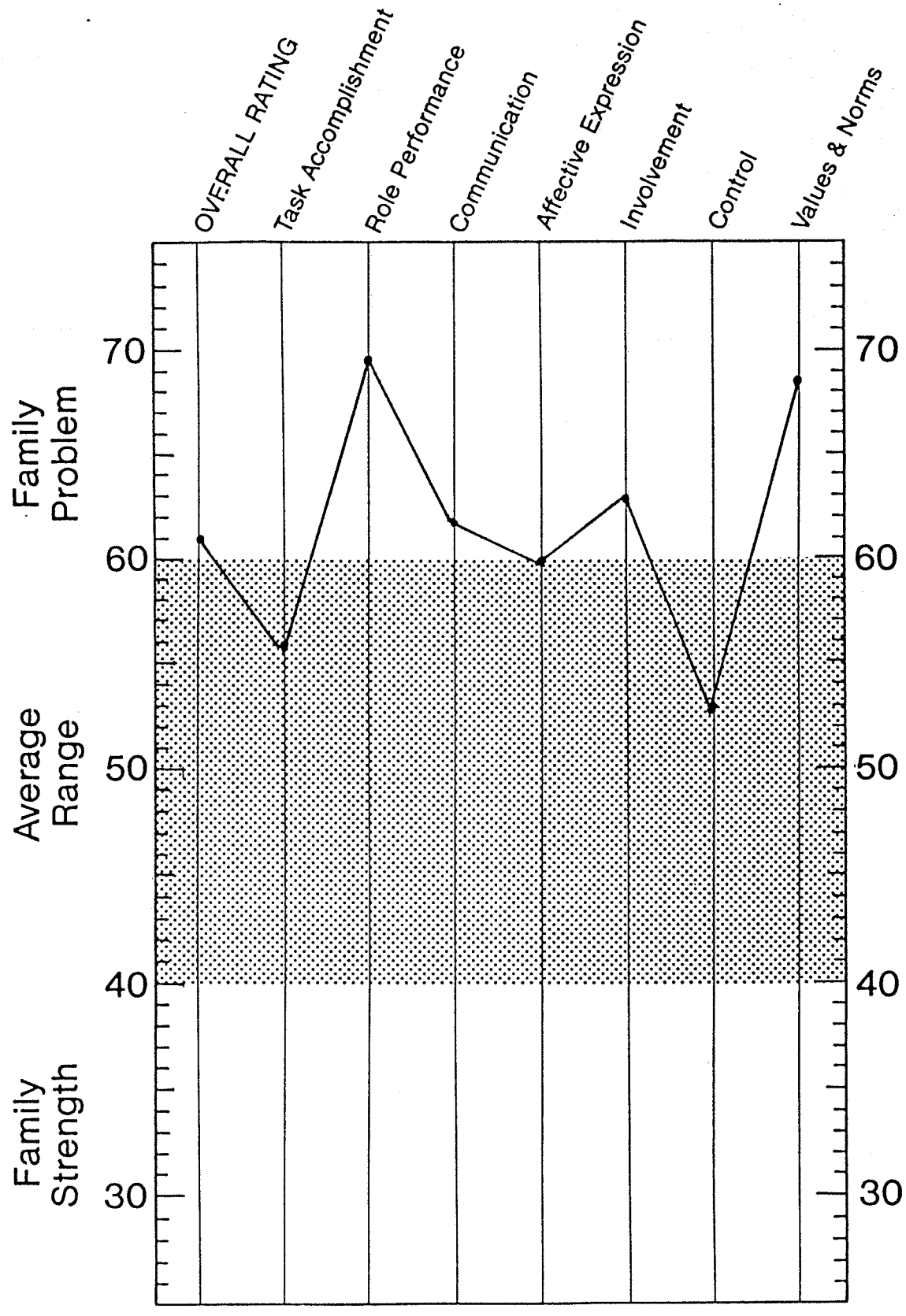
OTHER ——— (61.7)

FIGURE N_2

PRE-TEST

SELF-RATING SCALE

FAM PROFILE



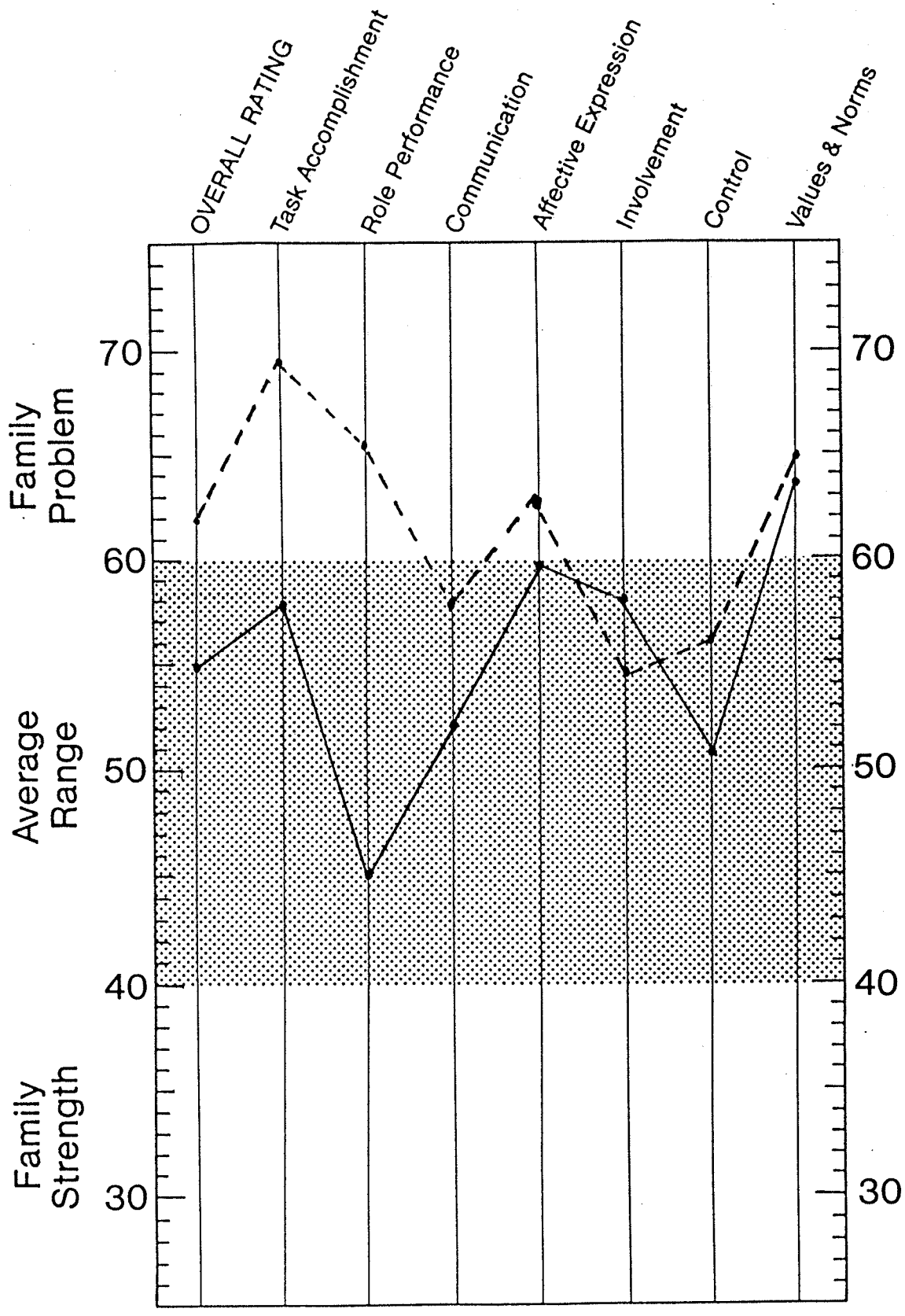
MOTHER ——— (61.7)

FIGURE N 3

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



1OTHER rating C' ——— (55.4)

1OTHER rating C 2 - - - - - (62.2)

Family "D"

This was a single parent family composed of the mother, C^1 (16 years), C^2 (6 years) and C^3 (4 years). C^1, the I.P., was the mother's child from an earlier union, whereas C^2 and C^3 were from the more recent marriage. The parents of C^2 and C^3 were divorced and the ex-husband lived out of the province.

The ex-husband was minimally involved with this family at the time of therapy. Due to his allegedly abusive relationship with both the mother and C^1, he was a significant (if absent) figure in the problems and therapeutic interventions of this family in therapy.

The presenting problems in this family involved a dysfunctional relationship between the mother and C^1. The mother was a full-time physiotherapist and was also taking several courses towards a needed degree in order to continue her practice. The stresses on this family were great and the resultant problems were also of a developmental nature.

The structural assessment involved unclear generational and personal boundaries. The reverse hierarchy in this family, although inconsistent, created serious conflicts between the mother and C^1. On occasion the mother and C^1 shared parenting of C^2 and C^3 and at other times the mother would take this on herself. This led C^1 to become increasingly frustrated and unsure about her role in the family. The younger children were seriously out of control and there were few appropriate boundaries between them and their mother and older sister. The mother was very insecure and emotionally unsure of herself. She believed that to be a good mother she should be at home but as she was the only provider she also needed to

work and to go to school in order to care for her children. This confusion of loyalties was visible in the insecurity and behaviour of all of the children.

Retrospectively, the therapist moved too quickly to reorganize the structure in the family. The family was seen for five sessions and numerous restructuring maneuvers occurred in the sessions so that there would be a clear hierarchy and better boundaries between mother and C^1 as well as between mother and C^2 and C^3.

By the fifth session, the mother appeared to be more confident and purposeful in discussions with the therapist. She reported feeling more capable and validated by the therapist thereby enabling her to take charge of her children.

The therapist does not believe that all of the changes in this family occurred as a direct result of therapy nor that all of the problems in the family were resolved in five sessions. This mother was very intelligent and really capable of making appropriate decisions for her family. With the aid of the therapist, utilizing a lot of supportive and validating moves, this family was able to continue on their own. Therapy terminated mutually.

The pre-test scores are available on this family on Figures D_1 to D_3. It is regretful that the student was unable to obtain post-test scores from this family as it may also have demonstrated noteworthy changes observed in therapy.

FIGURE D_1

PRE-TEST

FAM GENERAL SCALE

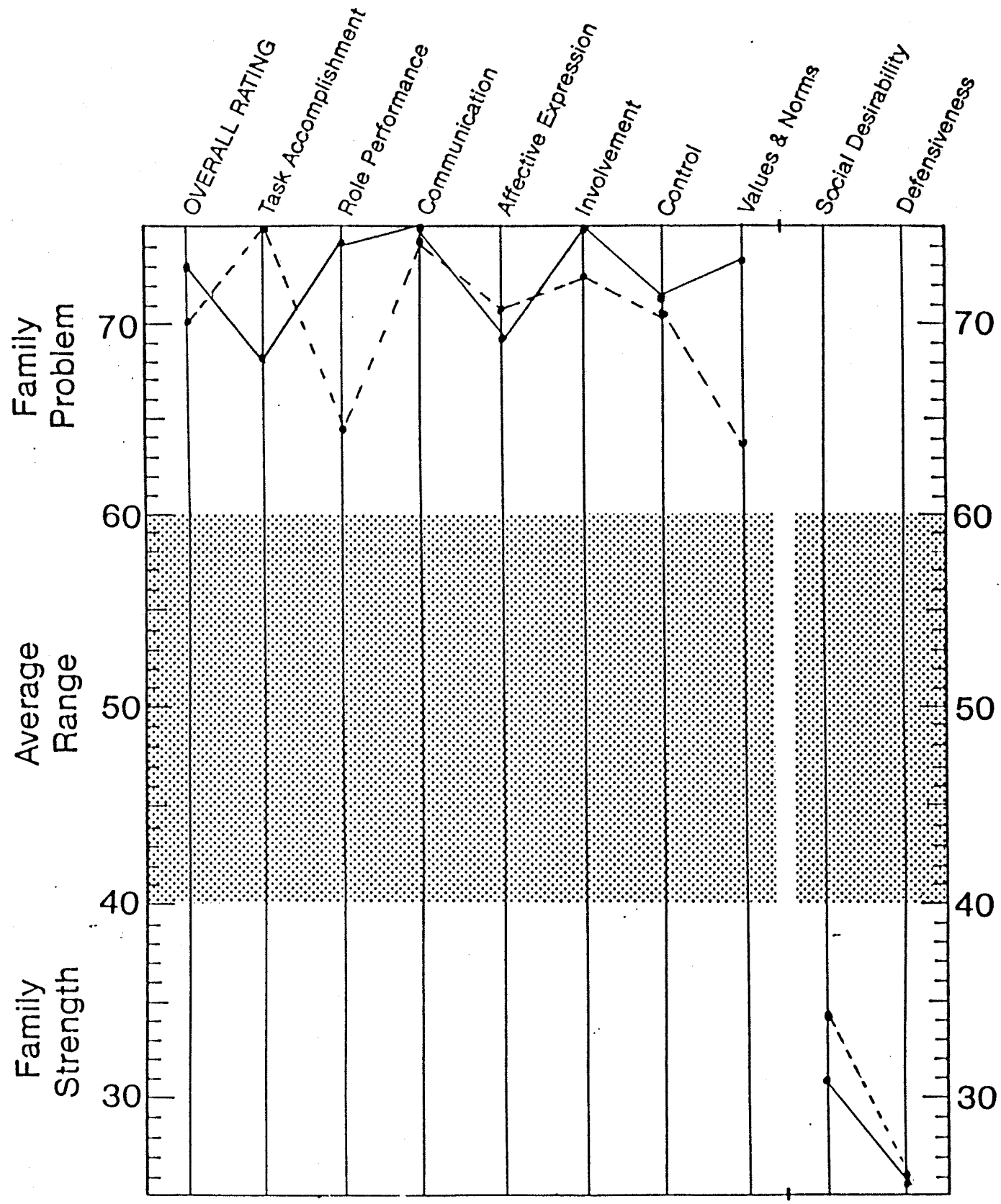
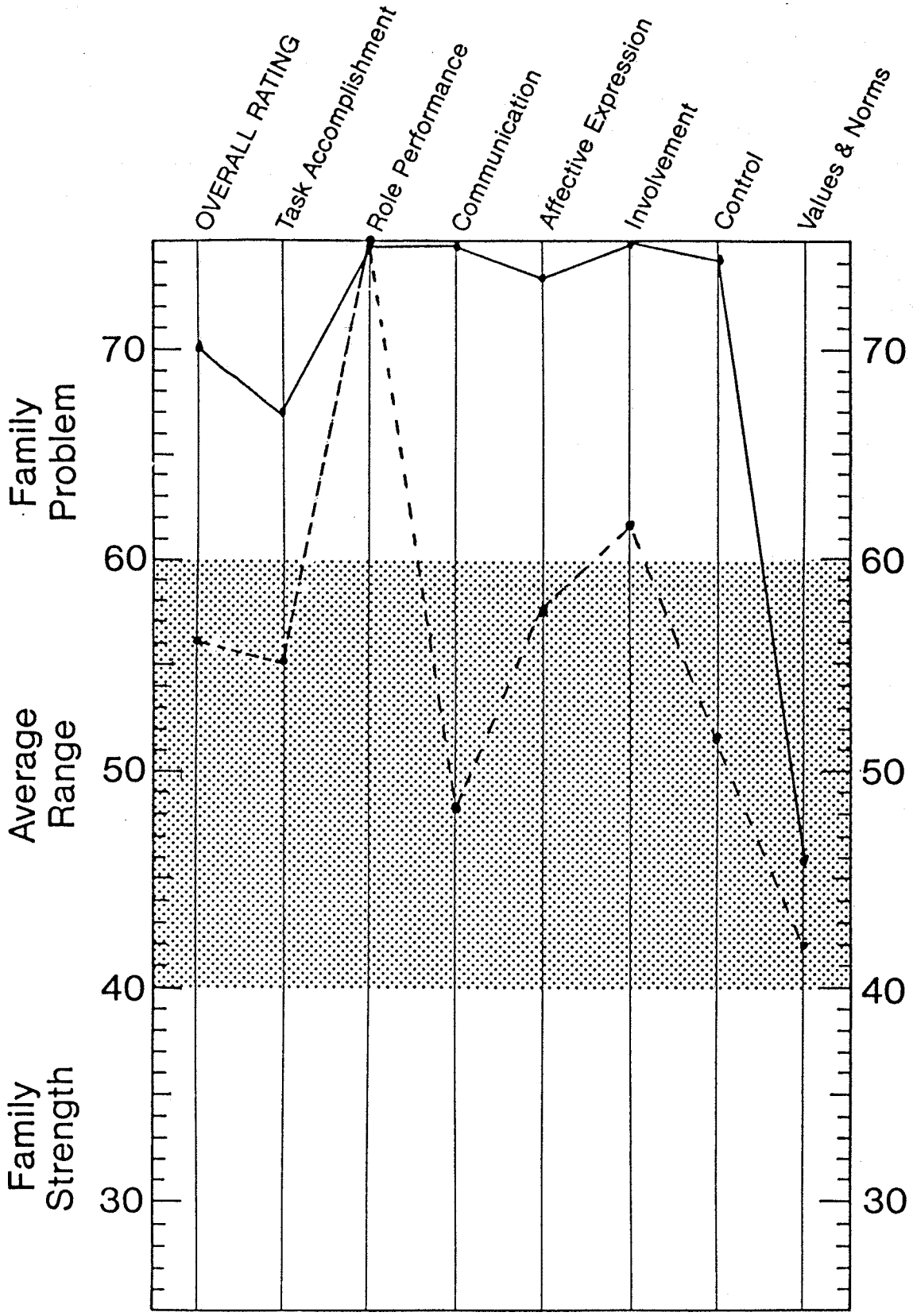


FIGURE D_2

PRE-TEST

SELF-RATING SCALE

FAM PROFILE



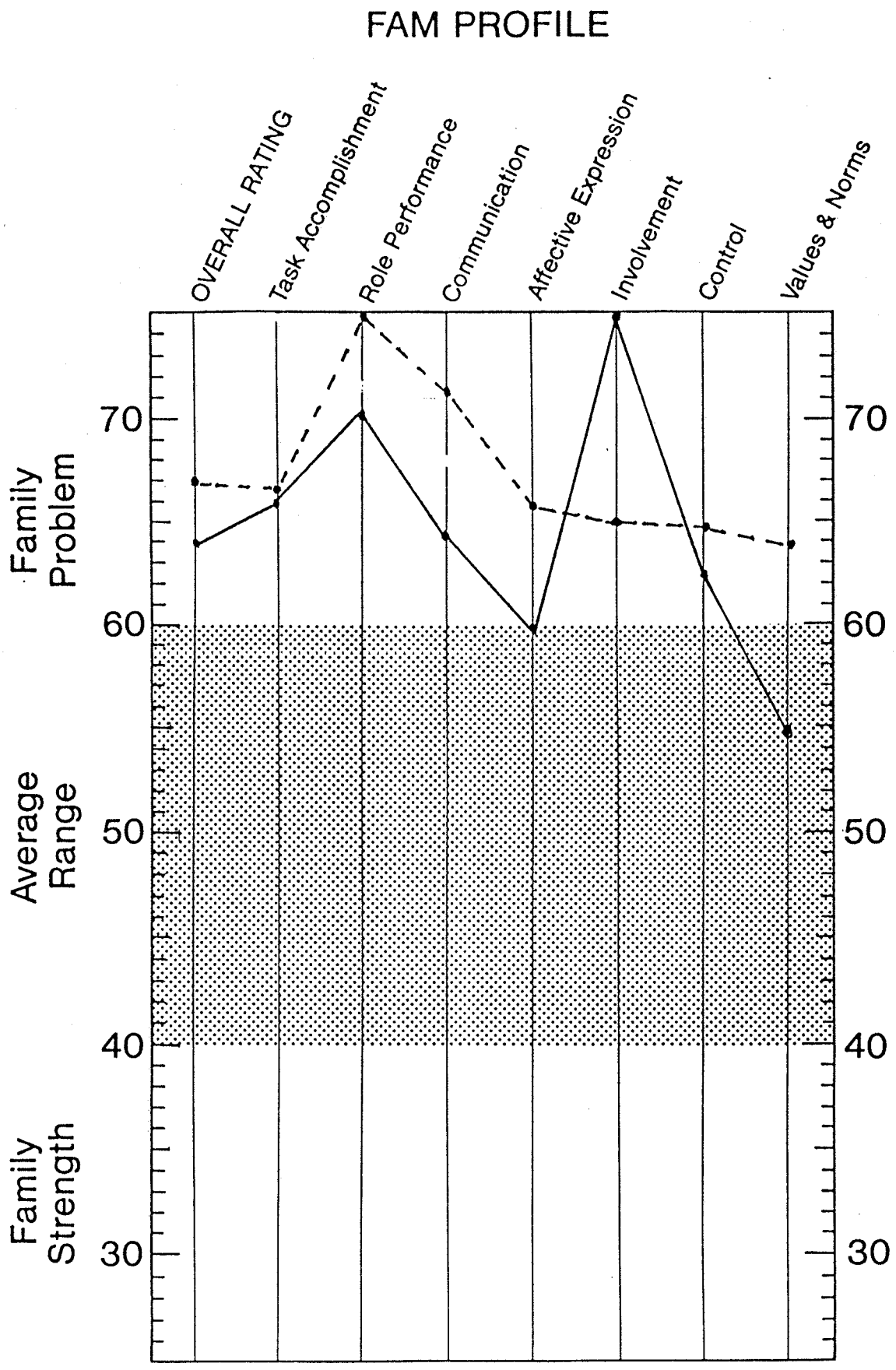
MOTHER ——— (70.7)

CHILD' - - - - - (56.5)

FIGURE D_3

PRE-TEST

DYADIC RELATIONSHIP SCALE



Family "S"

The "S" family was a single parent family with two boys, C^1 (6 years), the I.P., and C^2 (4 years). This family had been referred to the Family Therapy Department by a program for adolescent parents also within CHOW. This family was requesting therapy as a result of C^1's behaviour described as out of control with temper tantrums. The mother was very concerned because C^1 had discussed suicide with her on one occasion. This family was seen for two sessions prior to the writer going on leave and will continue therapy upon her return.

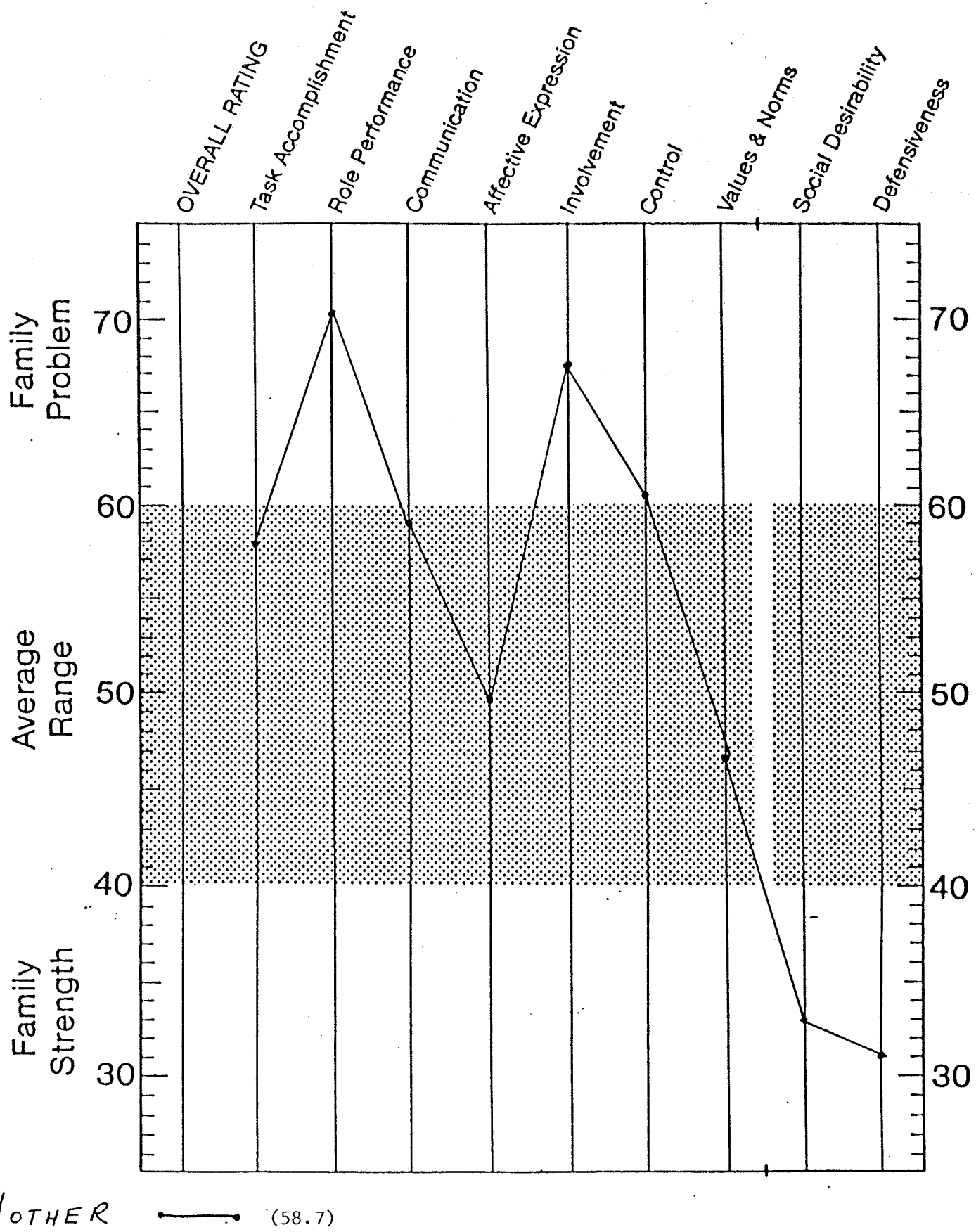
The structural assessment of this family was that the mother was not in a clear hierarchical position in this family. At the beginning of therapy there was considerable conflict between the mother and C^1. The goal of therapy was for the mother to use her parental authority to take charge of her son by setting rules and holding him responsible for some of his behaviour. The therapist worked to establish a hierarchy between mother and son and to further clarify boundaries for both C^1 and C^2 since the children frequently became inappropriately involved in conversations between the mother and the therapist as well as when the mother attempted to speak to one child.

The mother reported an immediate improvement in the children's behaviour resulting in a reduced level of frustration for herself. This was also evident in the second session with this family. In discussing C^1's mention of suicide, the mother reported that she was no longer concerned that C^1 was at risk as she believed he was asking for attention which she was learning to provide for him. Further work needs to occur when this family returns to therapy.

The FAM III was administered to this family prior to the first session and is available for observation on Figures S_1 to S_3.

FIGURE S_1 PRE-TEST

FAM GENERAL SCALE



1 OTHER ——•—— (58.7)

FIGURE S_2

PRE-TEST

SELF-RATING SCALE

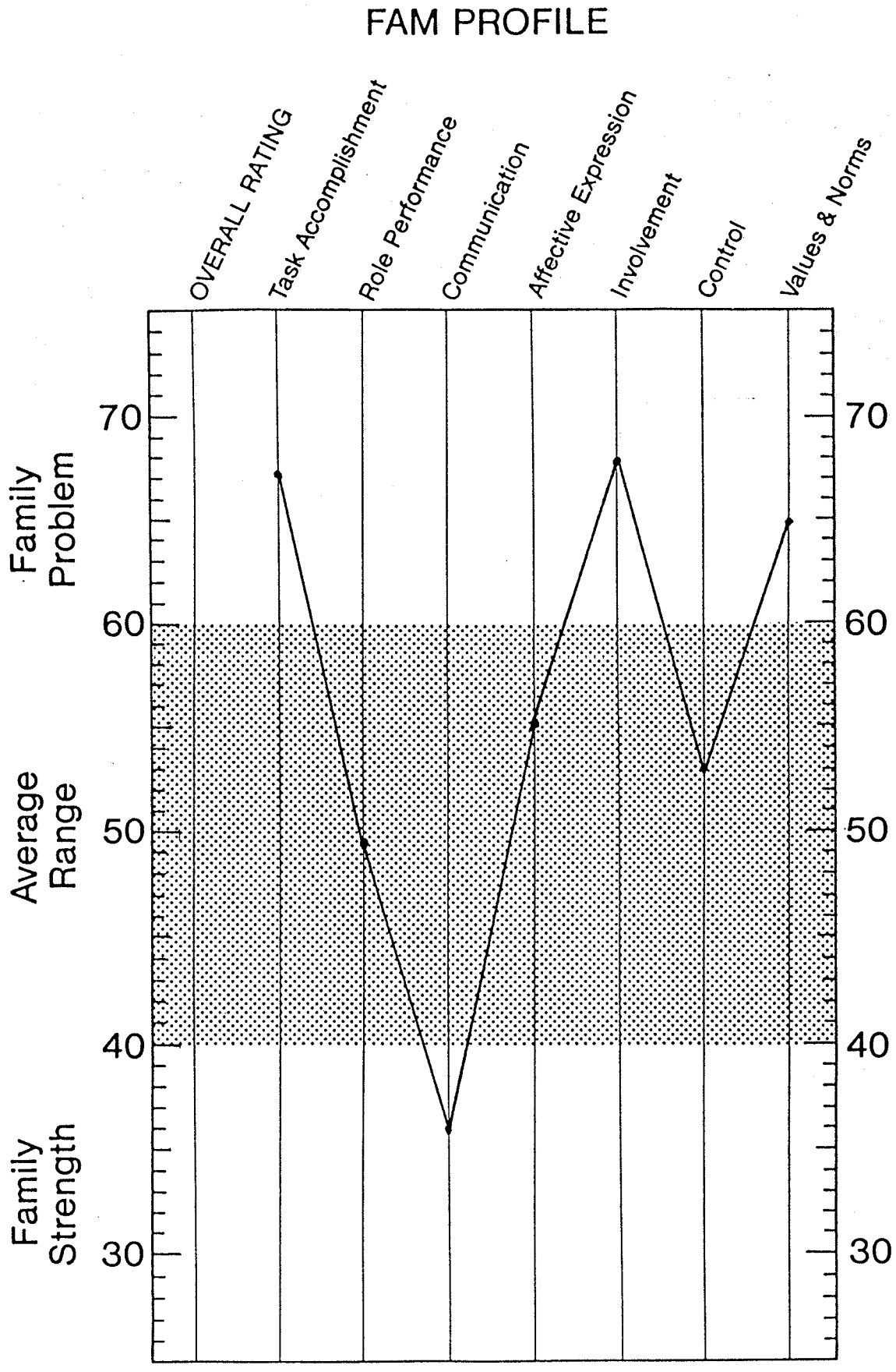
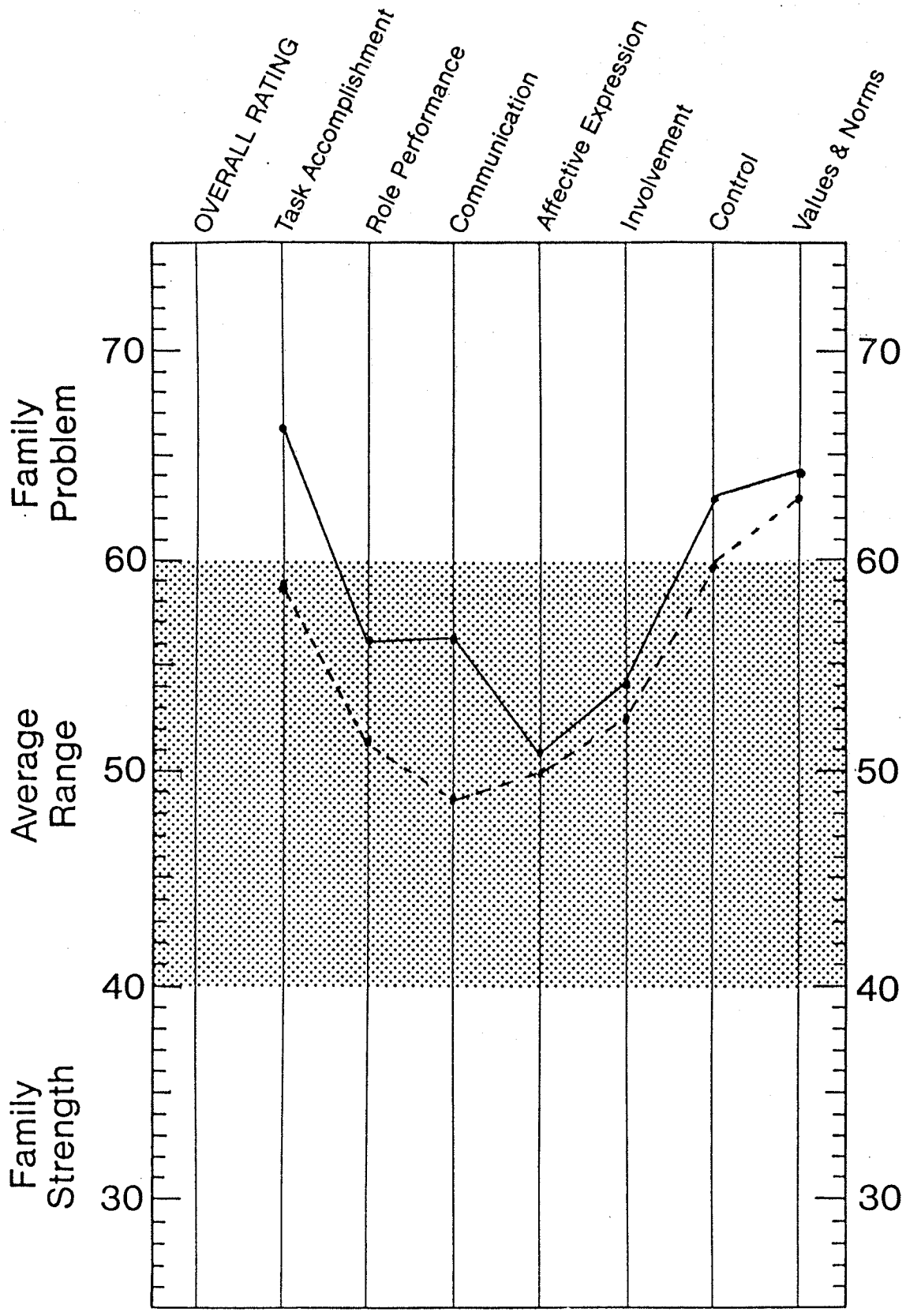


FIGURE S_3

PRE-TEST

DYADIC RELATIONSHIP SCALE

FAM PROFILE



OTHER rating C' —— (58.5)

OTHER rating C 2 - - - - - (54.2)

NOTICE/AVIS

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(1) FAMILY ASSESSMENT MEASURE - GENERAL GUIDE

(2) FAMILY ASSESSMENT MEASURE - DYADIC RELATIONSHIP SCALE

(3) FAMILY ASSESSMENT MEASURE - SELF-RATING SCALE

Family Assessment Measure

GENERAL SCALE

Directions

On the following pages you will find 50 statements about your family as a whole. Please read each statement carefully and decide how well the statement describes your family. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

26. My family tries to run my life.
27. If we do something wrong, we don't get a chance to explain.
28. We argue about how much freedom we should have to make our own decisions.
29. My family and I understand each other completely.
30. We sometimes hurt each others feelings.
31. When things aren't going well it takes too long to work them out.
32. We can't rely on family members to do their part.
33. We take the time to listen to each other.
34. When someone is upset, we don't find out until much later.
35. Sometimes we avoid each other.
36. We feel close to each other.
37. Punishments are fair in our family.
38. The rules in our family don't make sense.
39. Some things about my family don't entirely please me.
40. We never get upset with each other.
41. We deal with our problems even when they're serious.
42. One family member always tries to be the centre of attention.
43. My family lets me have my say, even if they disagree.
44. When our family gets upset, we take too long to get over it.
45. We always admit our mistakes without trying to hide anything.
46. We don't really trust each other.
47. We hardly ever do what is expected of us without being told.
48. We are free to say what we think in our family.
49. My family is not a perfect success.
50. We have never let down another family member in any way.

FAM GENERAL SCALE

Date _____

Name _____

Age _____ years

Sex: M F

Your Family Position

1. ☐ Father/Husband
2. ☐ Mother/Wife
3. ☐ Child
4. ☐ Grandparent
5. ☐ Other,

Specify _____

a = strongly agree
b = agree
c = disagree
d = strongly disagree

1. a b c d	11. a b c d	21. a b c d	31. a b c d	41. a b c d
2. a b c d	12. a b c d	22. a b c d	32. a b c d	42. a b c d
3. a b c d	13. a b c d	23. a b c d	33. a b c d	43. a b c d
4. a b c d	14. a b c d	24. a b c d	34. a b c d	44. a b c d
5. a b c d	15. a b c d	25. a b c d	35. a b c d	45. a b c d
6. a b c d	16. a b c d	26. a b c d	36. a b c d	46. a b c d
7. a b c d	17. a b c d	27. a b c d	37. a b c d	47. a b c d
8. a b c d	18. a b c d	28. a b c d	38. a b c d	48. a b c d
9. a b c d	19. a b c d	29. a b c d	39. a b c d	49. a b c d
10. a b c d	20. a b c d	30. a b c d	40. a b c d	50. a b c d

FAM GENERAL SCALE

Date _____

Name _____

Age _____ years

Sex: M F

Your Family Position

1. ☐ Father/Husband
2. ☐ Mother/Wife
3. ☐ Child
4. ☐ Grandparent
5. ☐ Other,

Specify _____

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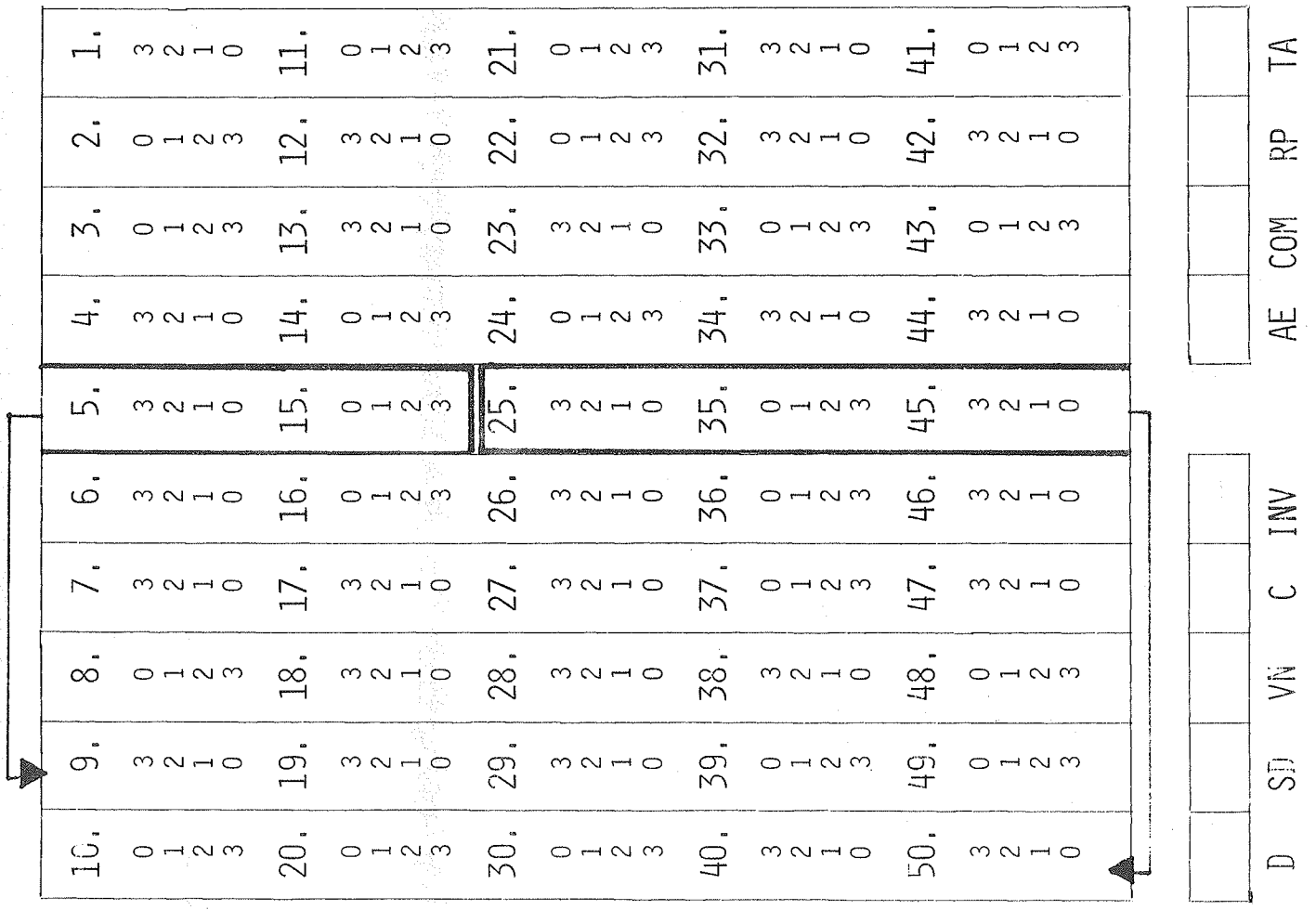

Family Assessment Measure

DYADIC RELATIONSHIP SCALE

Directions

On the following pages you will find 42 statements about the relationship between yourself and another member of the family (age 12 or older). Please read each statement and decide how well the statement describes your relationship with this family member. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this sheet.
Circle your response on the answer sheet.

24. This person is available when I want to talk to him/her.

25. When this person gets angry with me, he/she stays upset for days.

26. This person gets too involved in my affairs.

27. This person gives me a chance to explain when I make a mistake.

28. This person is right about the importance of education.

29. When problems come up between us, this person is all talk and no action.

30. This person expects too much of me.

31. Even if this person disagrees, he/she still listens to my point of view.

32. This person takes it out on me when he/she has had a bad day.

33. This person really trusts me.

34. This person is always on my back.

35. There's a big difference between what this person expects of me and how he/she behaves.

36. I can count on this person to help me in a crisis.

37. This person and I have the same views about who should do what in our family.

38. I often don't know whether to believe what this person says.

39. When this person is upset, he/she tries to get me to take sides.

40. This person worries too much about me.

41. I don't need to remind this person to do his/her share.

42. This person is right about the importance of being successful.

FAM DYADIC SCALE

Date _____

Your Name _____

Age _____ years

Sex: M F

Family Member Being Considered:

Name _____ Age ____ Sex: M F

Relationship to you:

1. ☐ Father/Husband
2. ☐ Mother/Wife
3. ☐ Child
4. ☐ Brother/Sister
5. ☐ Other,

Specify _____

a = strongly agree
b = agree
c = disagree
d = strongly disagree

1.	a b c d	8.	a b c d	15.	a b c d	22.	a b c d	29.	a b c d	36.	a b c d
2.	a b c d	9.	a b c d	16.	a b c d	23.	a b c d	30.	a b c d	37.	a b c d
3.	a b c d	10.	a b c d	17.	a b c d	24.	a b c d	31.	a b c d	38.	a b c d
4.	a b c d	11.	a b c d	18.	a b c d	25.	a b c d	32.	a b c d	39.	a b c d
5.	a b c d	12.	a b c d	19.	a b c d	24.	a b c d	33.	a b c d	40.	a b c d
6.	a b c d	13.	a b c d	20.	a b c d	25.	a b c d	34.	a b c d	41.	a b c d
7.	a b c d	14.	a b c d	21.	a b c d	26.	a b c d	35.	a b c d	42.	a b c d

FAM DYADIC SCALE

Date _____

Your Name _____

Age _____ years

Sex: M F

Family Member Being Considered:

Name _____ Age ____ Sex: M F

Relationship to you:

1. ☐ Father/Husband
2. ☐ Mother/Wife
3. ☐ Child
4. ☐ Brother/Sister
5. ☐ Other,

Specify _____

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1.	3 2 1 0	8.	3 2 1 0	15.	0 1 2 3	21.	0 1 2 3	29.	3 2 1 0	36.	0 1 2 3		TA
2.	0 1 2 3	9.	0 1 2 3	16.	3 2 1 0	23.	3 2 1 0	30.	3 2 1 0	37.	0 1 2 3		RP
3.	0 1 2 3	10.	3 2 1 0	17.	3 2 1 0	24.	0 1 2 3	31.	0 1 2 3	38.	3 2 1 0		COM
4.	0 1 2 3	11.	0 1 2 3	18.	0 1 2 3	25.	3 2 1 0	32.	3 2 1 0	39.	3 2 1 0		AE
5.	3 2 1 0	12.	0 1 2 3	19.	0 1 2 3	26.	3 2 1 0	33.	0 1 2 3	40.	3 2 1 0		INV
6.	0 1 2 3	13.	3 2 1 0	20.	3 2 1 0	27.	0 1 2 3	34.	3 2 1 0	41.	0 1 2 3		CON
7.	0 1 2 3	14.	3 2 1 0	21.	3 2 1 0	28.	0 1 2 3	35.	3 2 1 0	42.	0 1 2 3		VN

Family Assessment Measure

SELF-RATING SCALE

Directions

On the following pages you will find 42 statements about how you are functioning in the family. Please read each statement carefully and decide how well the statement describes you. Then, make your response beside the statement number on the separate answer sheet.

If you STRONGLY AGREE with the statement then circle the letter "a" beside the item number; if you AGREE with the statement then circle the letter "b".

If you DISAGREE with the statement then circle the letter "c"; if you STRONGLY DISAGREE with the statement then circle the letter "d".

Please circle only one letter (response) for each statement. Answer every statement, even if you are not completely sure of your answer.

Please do not write on this page.
Circle your response on the answer sheet.

24. Often I don't say what I would like to because I can't find the words.
25. I am able to let others in the family know how I really feel.
26. I really care about my family.
27. I'm not as responsible as I should be in the family.
28. My family and I have the same views about being successful.
29. When problems come up in my family, I let other people solve them.
30. My family complains that I always try to be the centre of attention.
31. I'm available when others want to talk to me.
32. I take it out on my family when I'm upset.
33. I know I can count on the rest of my family.
34. I don't need to be reminded what I have to do in the family.
35. I argue with my family about how to spend my spare time.
36. My family can depend on me in a crisis.
37. I never argue about who should do what in our family.
38. I listen to what other family members have to say, even when I disagree.
39. When I'm with my family, I get too upset too easily.
40. I worry too much about the rest of my family.
41. I always get my way in our family.
42. My family leaves it to me to decide what's right and wrong.

FAM SELF-RATING SCALE

Date _____ Age _____ years

Name _____ Sex: M F

a = *strongly agree*
b = *agree*
c = *disagree*
d = *strongly disagree*

1.	a b c d	8.	a b c d	15.	a b c d	22.	a b c d	29.	a b c d	36.	a b c d
2.	a b c d	9.	a b c d	16.	a b c d	23.	a b c d	30.	a b c d	37.	a b c d
3.	a b c d	10.	a b c d	17.	a b c d	24.	a b c d	31.	a b c d	38.	a b c d
4.	a b c d	11.	a b c d	18.	a b c d	25.	a b c d	32.	a b c d	39.	a b c d
5.	a b c d	12.	a b c d	19.	a b c d	26.	a b c d	33.	a b c d	40.	a b c d
6.	a b c c	13.	a b c d	20.	a b c d	27.	a b c d	34.	a b c d	41.	a b c d
7.	a b c d	14.	a b c d	21.	a b c d	28.	a b c d	35.	a b c d	42.	a b c d

FAM SELF-RATING SCALE

Date _____ Age _____ years

Name _____ Sex: M F

Note: This instrument is still under development and may not be used without written permission from the authors.

1. 0 1 2 3	8. 3 2 1 0	15. 3 2 1 0	22. 0 1 2 3	29. 3 2 1 0	36. 0 1 2 3	
2. 3 2 1 0	9. 0 1 2 3	16. 0 1 2 3	23. 3 2 1 0	30. 3 2 1 0	37. 0 1 2 3	
3. 0 1 2 3	10. 3 2 1 0	17. 3 2 1 0	24. 3 2 1 0	31. 0 1 2 3	38. 0 1 2 3	
4. 0 1 2 3	11. 3 2 1 0	18. 0 1 2 3	25. 0 1 2 3	32. 3 2 1 0	39. 3 2 1 0	
5. 3 2 1 0	12. 0 1 2 3	19. 3 2 1 0	26. 0 1 2 3	33. 0 1 2 3	40. 3 2 1 0	
6. 0 1 2 3	13. 3 2 1 0	20. 0 1 2 3	27. 3 2 1 0	34. 0 1 2 3	41. 3 2 1 0	
7. 3 2 1 0	14. 3 2 1 0	21. 0 1 2 3	28. 0 1 2 3	35. 3 2 1 0	42. 0 1 2 3	

VN	C	INV	AE	COM	RP	TA

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BIBLIOGRAPHY

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