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Structural Family Therapy: An Integration of Theory, Practice and Research

by

G. Sharolyn Reid

A Practicum Report

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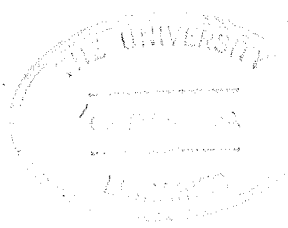

STRUCTURAL FAMILY THERAPY:

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G. SHAROLYN REID

A practicum submitted to the Faculty of Graduate Studies of the University of Manitoba in partial fulfillment of the requirements of the degree of

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I would like to thank my principle advisor, Professor Ruth Rachlis and Dr. Barry Trute for their support and assistance. As well, a special thanks to George Enns and Joyce Tremmel for their great encouragement, support and challenge while I worked at McNeill Clinic, struggling to integrate practice and theory, and wondered if it were possible. Finally, an appreciation to my husband, Joe, who has been my editor and my supporter.

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CHAPTER I

INTRODUCTION

The purpose of the practicum experience was not only to develop advanced clinical skill in structural family therapy but also to develop an understanding and a competency in the transfer of theory and clinical skills utilized in structural family therapy to larger social systems. It is imperative for a social worker to have a framework which, while specific, is sufficiently broad to encompass the problems encountered in practice at the individual, family and community level.

Later, the practicum report will describe in greater detail the theory and practice of structural family therapy. At this point, I will explain why this particular model of intervention was selected. The structural model of intervention was chosen because it views the individual and his/her problems within a social context, rather than viewing problems as primarily inherent within the individual. The epistomological shift from lineal thinking to viewing human problems as interactional provides the clinician with many more options for intervention at different levels. As well, structuralists are very interested in the family's organization. They assess the family's organization on two dimensions, hierarchy and closeness - distance. Family organization is assessed as being dysfunctional when the family members are unable to negotiate their functions and roles as circumstances demand within and without the family unit. Unlike other models, this model looks at a child's symptomology as an outcome of dysfunctional family organization or as a result of a family structure which supports the unacceptable behavior. In this model of intervention, the individual is acknowledged, the family's organizational structure, and transactional patterns are

taken into account, and an assessment scheme is used which places the individual in family context. Not only does this model provide an understanding of the formulation and maintenance of a human problem, it also provides clear and specific ways to do treatment, especially with child-oriented problems. It provides the novice family therapist with a map of how to do this treatment. Further elaboration of the structural model will be provided in Chapter Three.

The core premises underlying structural family therapy are interesting from both a theoretical and practical point of view. For this reason, a practicum setting was sought to allow me to practice in a way to test the theory and to develop skill in this model of intervention.

I was able to contract for a clinical placement at MacNeill Clinic, from January 1 to April 30, 1982, in Saskatoon, under the direct supervision of George Enns, the Director of the Family Therapy Program. Further details of the placement, setting and clients, will be in Chapter Four. There were two reasons for choosing this setting. Firstly, I had the opportunity to receive intensive supervision from an expert family therapist trained in Structural Family Therapy. Secondly, the setting is a community based agency whose clients are primarily children, who could be seen in the context of their families and their school settings.

The practicum report will follow the following format. Chapter Two will provide a history of the family therapy movement. Chapter Three will briefly describe General Systems Theory while the Structural Family Therapy model will be described in detail. Chapter Four will include the description of the practicum setting, its procedures, and the clients, as well as, a case example demonstrating theory and practice. Chapter Five will discuss the evaluation process and provide and interpret the clinical profiles of the families scored. The last chapter will provide the conclusion of the practicum experience.

CHAPTER 2

HISTORICAL PERSPECTIVE

It is the writer's intent to provide a historical perspective to the origins of family therapy through to the late sixties. This will provide a context for structural family therapy. The writer does not pretend that this review will be exhaustive but hopefully it will be informative.

At the turn of the century there were the beginnings of four independent movements; social work, social psychiatry, sexology and family-life education. Boundaries of these origins are blurred when the professions of psychiatry, social work, marriage and family counselling, and the home economics deal with family relationships. The writer will briefly summarize what each of these four movements contributed to the field of family work.

From the beginning, the social work movement has been inextricably interwoven with the history of marriage and family therapy. Cited in Gurman and Knishern (1981), Broderick & Schrader (1981) concluded that the social workers have been the most daring pioneers and the most passive "Johnny come lately's" in the parade of professionals. As early as 1877 the first city-wide charity organization in Buffalo was concerned not with the individual, but the family. Though Zilpha D. Smith, cited by Gurman & Knishern (1981), stressed the importance of the family, it was Mary Richmond who set a new standard of family-oriented case record keeping among social workers in her influential book, Social Diagnosis. She was a clear advocate of not confining one's therapeutic efforts to the individual alone, but of including those who live with the person. According to Rachlis (1974, p. 5), Richmond could be credited with formulating modern concepts of systems in relationship to each other

since she designated the family and its network of personal, neighborhood and civic focus as well as the private and public resources available. In 1920, the National Association of Family Social Workers published The Family, a journal intended for exclusive problems of the family. Broderick & Schrader (1981), cited in Gurman & Knishern (1981), conclude that social work had strong beginnings and could well have developed the fields of marriage and family counselling as subspecialities within the broader field of family casework. There is no question that family work was present from the very beginning of social work. There seems to be two reasons why the field of social work is not credited for its actual contribution. One is that the approach seemed to be taken for granted and seldom seemed worthy of note in print. Secondly, the development of the American Orthopsychiatric Association in the 1930's all but submerged the nascent family therapy of social work of the 1920's. It became commonplace for the psychiatrist to treat the child, the psychologist to do the testing, the social worker to see the mother, and no one to pay attention to the father (Olson, 1970).

Erick Fromm and Harry Stack Sullivan influenced social psychiatry. Fromm emphasized the interaction between man and his society. His work was the forerunner to Bowen's work on the importance of differentiation from the family. Sullivan was the most interpersonally orientated of the American analysts. He had been heavily influenced by Mead and Cooley. He strongly believed that the child's development was a response to his/her shifting social situation and that the child's concept of self was shaped by the parts of one's behavior to which others respond either negatively or positively.

Broderick and Schrader report that Sullivan's work provided important precedents and foundation to the family therapy movement (1981). He first demonstrated that schizophrenia could be treated through psychotherapy. He was a practical person who was not impressed with theoretical dogma; he was more interested in how it could be demonstrated pragmatically.

In the third movement, the early sexologists, Havelock Ellis of Great Britain and Magnus Hirschfeld of Germany, were physicians. Havelock Ellis was raised in the Victorian Era. He reacted to the moralistic and puritanical view of sex which led him to spare others the ignorance and discomfort of sexual matters he had experienced as a young man. What he did was to write seven volumes containing almost every imaginable aspect of sexual behavior as well as to work clinically, mostly with women, about their sexual fears.

Hirschfeld founded the Institute of Sexual Science in 1918 and together with Ellis and August Favel founded the World League for Sexual Reform. Five international meetings were held between 1921 - 1932 which brought thousands of physicians to Herschfeld's Institute. His Institute provided counselling on sex education. By 1930 Herschfeld had published five volumes on sex education based on analysis of 10,000 questionnaires filled out by the men and women visiting him. Through Herschfield's influence there was a proliferation of centres for sexual advice in Germany and all Europe. These centres, like Hirschfeld's Institute emphasized contraception, psychological and relationship counselling. With the advent of Nazism and its racism, the character of the German clinics changed dramatically. The emphasis became the betterment of the biological stock. The marital counselling service con-

cerned itself with the biological improvement of its people. Though Herschfeld's concepts did not survive in Germany, they did in America and Europe.

The last important movement was the Family Life Education Movement. Americans are great believers in education as a vehicle for addressing social problems. Back in 1883, mothers' groups had been established to discuss parenting concerns. However, the Constitutional Convention of the American Home Economics Association in 1908, provided the impetus to establish courses in high school and colleges to improve American home-making as well as the relationship aspects of a married woman's role. During the 1930's, Popenoe, a biologist turned eugenics activist, conducted numerous workshops on home, marriage and sex and had become a household name through his writings in the Ladies Home Journal. Ernest Groves was the first person to institute "functional" marriage and family relations courses for college credit. His functional course differed from the traditional in that it was eclectic, practical in that students needs were taken into account, and, finally, remedial in that the course intended to improve the courtship and marriage of the students involved. Instructors teaching the functional courses soon found themselves doing pre-marital and marital counselling with the students.

The main contribution of the four movements are as follows: social work from its inception advocated the importance of seeing the troubled individual within the social context. This could mean that seeing the family, friends and/or intervening in the community were appropriate. Social psychiatry's major influence was its break with Freudian principles which basically suggested that symptoms arose from trauma and conflict in the past and were relegated to the unconscious. Instead, Adler, Jung,

Fromm and Sullivan suggested that the individual's social environment influenced and affected how the individual relates to his/her environment. The earlier sexologists emphasized the normalcy of sex and acknowledged the need for people to discuss their problems in atmosphere of acceptance. As well, they provided contraceptive counselling. The family life education programs were the forerunners of marital and family courses in universities which discussed marriage in "functional" terms as opposed to traditional approaches emphasizing status, position and obedience.

THE EARLY FAMILY THERAPY MOVEMENT

Having identified four independent movements which have influenced the emergence of family therapy, it is now the writers intent to discuss its development to the early seventies.

The historians of the family therapy movement note that it began in a dozen places at once by independently minded clinicians and researchers. By the 1950's, these individuals were exchanging papers and visits. They were beginning to take major steps toward establishing family conjoint therapy as an approach of treatment. By 1961, the pioneers were wanting to establish a journal which would be a vehicle whereby clinicians could exchange ideas, discuss advances in theory formulation, describe clinical practice in a formal way, and which would be disseminated to family practitioners. In order to do so the Mental Research Institute in California, directed by Jackson, and The Family Institute, directed by Ackerman, drew up an agreement to co-sponsor the founding of the journal, Family Process, which first appeared in 1962. The first editor of Family Process was Jay Haley, while the pioneers like Lidz, Ackerman, Jackson and Whitaker were involved on the first editorial board.

The writer will describe the pioneers of the family therapy movement

by geographic location, their roots and their contribution to contemporary family therapy.

It is fitting to begin with John Bell whom many claim as the father of family therapy. His profession was psychology and he practiced in Massachusetts. His contribution was the notion that he could see his individual patients in their family unit. He took this innovative step accidentally because of a misunderstanding of information he received while visiting Dr. Sutherland at the Tavistock Clinic in London in 1951. In 1953 he reported to a group of fellow psychologists, describing the successful new family approach with nine of his cases which otherwise would have been seen in individual psychotherapy.

The East Coast Pioneers

Nathan Ackerman was trained in child psychiatry, but he was greatly influenced by Moreno's work (sociometry) and by the effects of the Holocaust. He began to contemplate the relationship of social contexts and the fate of individual persons. Prior to this time, he viewed the relatives of patients as irrelevant, only useful when an autopsy was needed to check the connection between brain pathology and mental illness. As he became convinced that emotional problems could be generated by the immediate environment as well as by the dynamics of the psyche, he joined the Menninger Clinic in Topeka. During this time, he adopted the orthopsychiatric viewpoint, wherein the psychiatrist saw the patient and the social worker saw the mother. However, by the mid 1940's, there was a growing flexibility in the field and a single therapist would see the family unit. Ackerman began to experiment with this procedure in his private practice and concluded that there was a relationship between a child's illness and the mothering and fathering received by the child. His ultimate

contribution to family therapy was his view of the family as the unit of diagnosis and treatment. He valued home visits to study the family. Eventually he developed his own institute in New York, then called The Family Institute, now renamed The Ackerman Institute.

Theodore Lidz was a trained analyst at Yale in the early 1950's. He and his co-workers were attempting to map out the interior workings of the family of the schizophrenic (Hoffman, 1981, p. 67). Lidz met Wynne at this time as both men were attempting to compare the communication patterns of normal families with those which had disturbed offspring. Lidz observed that the members of the schizophrenic family were symbolically bound so that it appeared almost impossible for the parents and the hospitalized young adult to separate and become autonomous individuals. His main focus remained on the understanding and treatment of schizophrenic disorders. He and his co-workers were probably the first, or among the first, to treat families, treating the parents and siblings along with the hospitalized schizophrenic patient. Lidz's observations and thoughts correspond, and link to some degree, to Bowen's work which is discussed below. Lyman Wynne was trained as a physician but he pursued a Ph.D. in the field of social relations at Harvard. While at Harvard he met Talcott Parsons and Erich Lindeman both of whom influenced his view of family structure. He joined the National Institute of Mental Health at Bethesda and gradually began to work intensively with families which had a schizophrenic member. Wynne's contribution to understanding these families was to note the unreal quality of both positive and negative emotions. He used the term "pseudomutality" and "pseudohostility" to describe the emotional field, by which family members intensely wish for mutual relatedness in a way which excludes the toleration of distance or difference. He also

commented upon what he thought was the peculiar boundary around the family, an apparently yielding, but actually imperviousness to outsiders (especially therapists). Wynne called it the "rubber fence", a boundary that supports the illusion of mutuality which protects the family from new information or potential change. Hence, children in these kinds of families are caught in a dilemma for if they attempt to disengage or differentiate from the other family members, there are expectations of disaster for the family.

Bowen was trained as a psychiatrist who, like Ackerman, Lidz and Wynne, began with a specialized interest in treating psychotically ill children. Like Ackerman he began to see families while working at Menninger. Initially, he thought that the mother should be required to stay with the psychotic child. As he developed his ideas and clinical expertise, it became clear to him that the father was an important part of the treatment unit. He had begun to think that schizophrenia was a sign of a larger pathology in the whole family and tried to include as many family members to live in the hospital ward during treatment. Bowen moved from Menniger to the National Institute of Mental Health, Washington, D.C. to conduct a research project which involved having families of schizophrenic youngsters come and live in the hospital. Initially, the project provided separate therapists for each family member but this changed to the family being seen as a unit with a single therapist.

Bowen's major contributions to family therapy are his ideas about the importance of family triangles, the notion of the multi-generational transmission of emotional illness, the importance of working with the family of origin, and the concept of differentiation (Hoffman, 1981, p. 29). Bowen, like Haley and Minuchin (who will be addressed later), emphasized

the importance played by triangles in family interaction and in social groups. Triangulation is a process that involves two forming to exclude or be against a third party.

Whitaker is another East Coaster, trained in traditional psychiatry, who was quick to risk violating its conventions. By 1944, he was bringing spouses and children into sessions with his patients. Eventually he shifted his emphasis to schizophrenics and their families. He is now known for his finely honed therapy of the absurd - a therapy in which he seems to drive the family sane by appearing more mad than they. Whitaker's contribution has been to extend the clinical definition of family to include grandparents as well as collateral kin. He has also emphasized the importance of having a co-therapist for the provision of emotional equilibrium to each other.

The Philadelphia group organized by Ivan Boszorminyi-Nagy, Gerald Zuk and James Framo were trained psychiatrists. They, like others already discussed, were interested in the psychotic individual and their families. One of their contributions was to see the value in co-therapists, much as Whitaker saw the value of a co-therapist. Though they subscribed to an interpretive model with schizophrenics, they also demanded a particular strategic change in the family's activities, thus acknowledging the need for the therapist to be active and insistant, not just interpretive. Lastly, this group was the first to organize family training programs in Europe.

Before moving to the West Coasters, the last person to be mentioned on the Eastern seaboard is Minuchin. He grew up and was trained as a traditional psychiatrist in Argentina and continued in the tradition until the early 1960's when he was asked to take part in the Wiltwyck Research

Project, New York. Its purpose was to explore the structure and dynamics of the disadvantaged, disorganized families of delinquent children, and to study interventions that could "reach" these families (Minuchin, 1967). The research team was composed of three psychiatrists, two psychiatric social workers and two clinical psychologists.

Minuchin's work was a shift from the work of the Palo Alto Group (to be discussed next) and from Wynne, Lidz, Bowen and Whitaker, who had been focusing on communication patterns in psychotic families. Minuchin, Montalvo and Auerswald were the three psychiatrists on the interdisciplinary team who began to think that organizational features produced problem members in poor and disadvantaged families. The problem people in these families had less trouble with "what is real" than with "what is right" according to the mores of the larger society (Hoffman, 1981, p. 71). It was here that Minuchin began to formulate his ideas on family structures, the importance of the social context and on different transactional styles seen in families (enmeshed and disengaged). His notions of "enmeshed" are similar to Bowen's concept of "undifferentiated family ego mass" and Wynne's idea of "pseudomutality". The concept of triangulation discussed by Bowen is similar to Minuchin's in that when a twosome joins against a third party over a period of time, it could cause problems in the family.

From Wiltwyck, Minuchin went to Philadelphia to the Child Guidance Clinic persuading Jay Haley and Montalvo to join him. It is here that Minuchin more fully developed his ideas, concepts and clinical practice of structural family therapy (discussed later). As well, Haley, Montalvo and Minuchin developed an innovative training model which took local black community members and trained them to act as para-professional family therapists. Their training model introduced the use of one-way

mirrors, video taping and a bug-in-the-ear for live supervision.

The West Coast Group

The group this refers to is the Palo Alto Group, which included Gregory Bateson, Jay Haley, John Weakland, Don D. Jackson and Virginia Satir. Bateson's background was in anthropology and philosophy, Haley's in communication theory, Weakland's in chemical engineering, later turning to anthropology, Jackson in psychiatry and Satir in social work. This group at this time (1950's) were thought of as "system purists". Their major contribution to the family therapy field was based on communication theories developed from Bateson's work in general systems theory and on the notion of human groups organizing in a hierarchical fashion with some members having more status and power than others.

During the mid-fifties and the sixties, Jackson, Haley, Weakland and Bateson contributed to the family therapy field by publishing their understanding of the schizophrenic family in classic papers, "Toward a Theory of a Schizophrenia" (1956) and "Note on the Double Bind" (1963). Besides the contribution to viewing the schizophrenic process in a new way, Haley started to describe a new way of viewing all psychopathology. He suggested that the minimal unit of observation must be the triad, rather than a unit of one or two. He hypothized that a pathological system occurred when two features were present in the unit. First one member belonged to a different generation (different order in power hierarchy) from the other two and two members from different generations are in a coalition against the third person. Secondly, the coalition is covert and denied. Jackson's focus was slightly different than Haley's, although the emphasis on the relational aspect and social context was

similar. Jackson suggested that a family is a rule-governed system, that it's members behaye among themselves is an organized, repetitive manner, and that patterning of behaviors can be abstracted as a governing principle of family life. He suggested that these rules govern the relationships in the family and, hence, are predictable. If understood and identified, they could be influenced and changed to more productive patterns.

Satir was part of the family therapy demonstration project at Palo Alto. During the early 1960's she developed her own unique style of being able to expose the families "discrepancies" in communication. According to Hoffman (1981, p. 221), she was an expert at being able to disentangle people from the mystifying communication traps which are the trade mark of families with a psychotic member. She thought that clarification of the communication patterns helped to free the psychotic member. By the mid-sixties, she disengaged herself from the Mental Research Institute as she became more interested in the human potential movement. She, more than any other founder, helped to popularize family therapy as she was able to draw on her charismatic style and her ability to demonstrate her concepts clearly in a non-technical manner.

The early family therapists have been placed by geographic location. Their individual contributions have been highlighted and their commonalities have been noted. The next chapter will briefly describe the theoretical underpinnings os systemic theory, followed by a detailed description of the Structural Family Therapy model on which this practicum was based.

CHAPTER 3

GENERAL SYSTEMS THEORY/STRUCTURAL FRAMEWORK

General Systems Theory

General systems theory is the theoretical rationale underlying structure family therapy. The shift from individually orientated theory and techniques to systemic orientated ideas was dramatic for the helping professions (Olson, 1970). This shift from the traditional perspective demands a new way of viewing human functioning. The basic assumptions to systemic relationship-orientated ideas arises out of the work of Von Bertalanff (1945), a biologist, who developed general systems theory.

Theoretical Rationale

Of the demands for a way to view human functioning, Haley (1969) says that the problem is to change the living situation of a person, not to pluck him from his situation and try to change him. As stated above, the basic assumptions to relationship-orientated ideas grew out of the work of Von Bertalanff. Essentially, a system is composed of interdependent elements whose inter-relationships holds the system together (Walrond-Skinner, 1976). Structurally, these interdependent elements form a complex network of subsystems within the larger system. Relationships are thought to develop among the subsystems themselves and between the subsystem and system itself. These relationships are maintained and controlled by rules and regulations (Walrond-Skinner, 1976). The system strives to maintain itself, adapt and survive, and, therefore, has its own goals and needs which may be at odds with the components of the system. Through the system's structure, and its cybernetic principles of communication between the elements, the component parts are maintained in order that the system's

needs can be met. The paradigm provides a way of seeing a new pattern and thus a new reality even though the pieces of the picture remain the same. Thus, to view pathology from a systemic perspective provides the viewer with a different reality.

In addition, to the basic tenets of systems theory, namely, the structure and the cybernetic pattern of communication, there are four properties of an open system (Paolino and McCrady, 1978). These properties are wholeness, relationships, equifinality, and feedback.

Wholeness implies the relationship between the components and total system. The components influence each other and are influenced by the system as the system influences the individual components. Because of this reciprocal process, it is assumed that the whole is greater than the parts. Thus, if only the individual components of the system are viewed, the systems gestalt cannot be fully appreciated due to the non-summativity. Family therapists believe it is essential to see the family as a unit; however, this might not always occur.

Another property is relationship. The structuralist insist that there are basic patterns so that what might seem widely divergent is, in fact, similar to, as well as transformations of, each other. In practice this translates into a concept labelled "redundancies". It is assumed that no matter what the context, the therapist will be able to isolate communication patterns and sequences which are the underlying causes for the social organization to be dysfunctional. Thus, no matter what context is provided, the therapist will intervene in a planful way to alter the system at the structural and interactive level.

The third property of the system is equifinality. This means that no matter where one begins, the conclusion will be the same thing. This means that it is not important to find the origin of events, rather,

what is important are the transactions occurring in the system and how these transactions maintain the problem.

The last property is feedback. This refers to how the elements within the system relate to each other. Feedback is not undirectional, therefore linear cause and effect is not possible. Rather, causality is circular in that each action is the cause of and is caused by other actions. Thus, feedback has no beginning or ending. The response of the stimulus "X" triggers a response "Y" which in turn becomes the stimulus for another response, at the same time the original stimulus might be affected. Clinically, this feedback loop can be seen in the role of the "identified patient" and the family. For example, when the relationship becomes particularly tense between the mother and father and appears to be threatening the family system with disintegration, the "identified patient" acts out. This enables the mother and father to unite once again, to stay together for the "sake of the children" and, of course, the family system is saved. This is called a negative feedback loop.

This negative feedback loop is the system's way of maintaining homeostasis. The system is a self-sustaining, rule-governed entity which wants to maintain its stability and to balance the demands of the system's elements and the environmental forces upon it. Heomeostatic mechanisms which are used to restore and maintain the system are like defenses in traditional psychotherapy. These processes become dysfunctional when the system becomes rigid and inflexible. The earlier example demonstrates the usefulness of the symptomatic behaviour to restore homeostasis. The "symptom bearer" serves to divert the attention away from the real source of stress that threatens to disintegrate the system. Haley (1976),

Minuchin (1967), and Satir (1967) see the "real" source of stress in the marital subsystem which is the foundation of family interactions.

Positive feedback, on the other hand, can destroy the system. Methods of intervention are based on this idea. When the intervention is successful, the family members are unable to return to old ways. The dysfunctional pattern has become untenable; hence, the family engages in a struggle to behave and interact in a new way. Using the preceeding information as the theoretical underpinnings, a detailed description of structural family therapy will be undertaken.

Theoretical Model

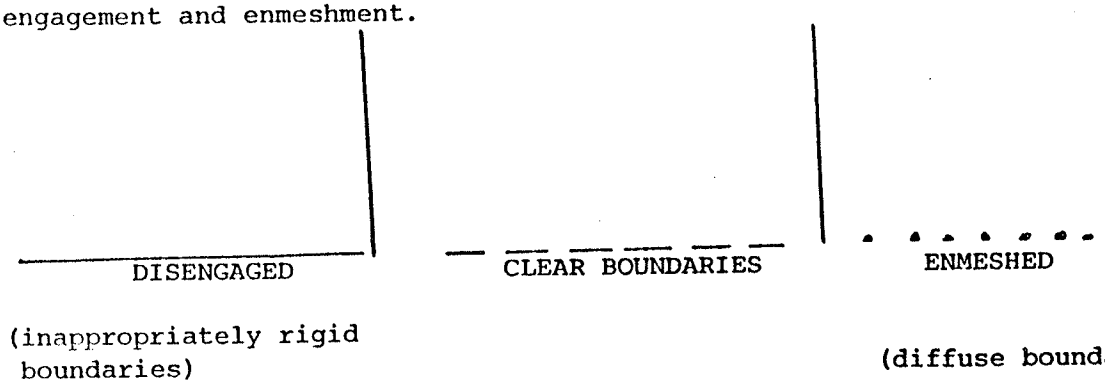
Structural family therapy was first articulated in Minuchin's, Families and Family Therapy, 1974. Since that time there has been a proliferation of information on structural family therapy by various other writers. How families are organized is of most importance to Minuchin. He describes family structures as invisible sets of functional demands that organize the ways in which family members interact (Minuchin, 1974, p. 51). This social structure provides the operational patterns through which the family members carry out their relationships in accordance with the requirements of each operation/function. These repeated transactions establish patterns of how, when, and to whom to relate and are the patterns underpining the family system. The family transactional patterns form the matrix of psychological growth (Minuchin, 1978, p. 52).

According to Minuchin the family has two major functions. One is internal - the psychosocial protection of its members; the other is external, the accommodation to, and the transmission of, a culture. Two

characteristics which are vital to human identity are belonging and separateness. How the individual achieves this mix occurs through participation in difficult family subsystems, in different family contexts and with extra familial groups. As stated earlier, transactional patterns regulate family members' behavior. The family structure must be able to adapt when circumstances require it. The family system differentiates and carries out its functions according to subsystems. The subsystems are marked by boundaries. The boundaries of a subsystem are the rule defining who participates and how. These subsystems can be formed by generation, by sex, by interest, or by function. They may include one member, a dyad (such as a spouse subsystem), or more members (such as a sibling subsystem). There are four enduring subsystems typical of the western family which have particular relevance to the child's growth: the spouse, the parental, the sibling, and the individual (Minuchin, 1978, p. 54). Individuals enter into these different subsystems with different levels of power. To reiterate, boundaries are a basic structural concept. They define who participates and how. The function of boundaries is to protect the differentiations of the system. However, each subsystem has its specific function and makes specific demands of its members. The development of interpersonal skills within the subsystem depends on the subsystem being free of interference from other subsystems. Likewise, the development of negotiating skill with peers, learning how to get along with siblings, requires non-interference from parents. Boundaries with other subsystems must be clear as well as flexible. In this way roles, functions, responsibilities and power can be fairly well differentiated. If the boundaries are confused, rigid or too flexible,

the family members use their energy to disentangle the confusion in the family rather than grow and develop. The family becomes burdened and stressed.

Minuchin described the extremes of boundary functioning as disengagement and enmeshment.



These terms refer to a transactional style. Families with enmeshed subsystems tend to develop their own microcosm which heightens belonging and discourages differentiation so that distance is reduced and the boundaries are blurred. Disengaged families, on the other hand, develop rigid boundaries so that communication across subsystems becomes difficult and the protective functions of the family are handicapped due to a shelved sense of independence (Minuchin, 1974, p. 54, 55).

The therapist's first task is to assess the family's structure and to begin to understand the family's organization. The therapist analyzes the transactional field in which she and the family are meeting in order to make a structural diagnosis. To make a diagnosis, the worker participates by making observations and by asking probing questions which confirm or deny her/his hypotheses about which patterns are functional and which dysfunctional. She/he then begins to derive a family map which allows her/him to organize diverse information. The structural map is a tool which allows her/him to formulate hypotheses about areas in which the

family functions well and those that may be dysfunctional (Minuchin, 1974, p. 90). This structural assessment helps her/him to determine therapeutic goals which provide direction in restructing. The process of assessment, hypothesis building, probing, goal setting and forming a treatment direction is a dynamic not a static process.

One last point on structure. As the writer indicated earlier, boundary marking and boundary functioning are basic concepts in understanding structural family therapy. The boundaries, and hence the structure's formation, are also influenced by alliances and coalitions.

It is important to distinguish between coalitions and alliances. While coalition always involves two parties in opposition to, or to the exclusion of, a third party, alliances are simply teaming up of two parties "based on common interests" with no third party involved (Hoffman, 1981, p. 108). Haley (1967) and Minuchin (1974) describe coalitions , whether cross generational (perverse triangles) or not, as indicative of underlying systemic conflicts which create and perpetuate problems. Minuchin (1978, p. 33) identified three conflict-avoidance patterns of involvement: triangulation, parent-child coalition and detouring. Triangulation occurs when the child is openly pressed to become an ally with one parent against another. In the parent child coalition, the child tends to be in a stable coalition with one parent against another. In detouring, the spouse dyad appears united demonstrating a close relationship whilst all the while submerging their conflict with each other. Their conflict is hidden as they are joined together in a posture of overprotection and concern or of blame and anger towards their sick child.

Hence, not only must the assessment include the steps of the tran-

sactional pattern (disengaged or enmeshed) but it must also assess the intrafamilial and extrafamilial alignments.

To this point, the writer has presented the structuralist's view of the organization of the family, the importance of boundaries and alignments, and the elements to be included in an assessment of a client group in individual, couples, family, or community agencies. Now, the writer will describe how symptoms are viewed in the context of structural family therapy, how the therapist uses herself/himself, and the techniques utilized when intervening structurally.

It is the symptom of one family member that usually brings the family into treatment. The structural approach sees the family as an organism: a complex system that is underfunctioning; the symptom is understood as an expression of a contexual problem from an organism under stress (Minuchin, 1974, p. 152). The therapist's job is to undermine the existing homeostasis by creating a crisis which jars the system toward the development of a better functioning organization which will free the 'symptom bearer'.

Minuchin (1978) describes three main strategies of structural family therapy each of which is served by a group of techniques. The three strategies are challenging the symptom, challenging the family structure, and challenging the family reality. Minuchin & Fischman (1981,p.67) clearly point out that the word 'challenge' is not to be misunderstood as simply implying harsh manoeuvres or confrontation but rather a way of describing the therapeutic process between therapist and therapeutic system.

To challenge the symptom means to challenge the family's definition of the problem and the nature of their response. The identified

patient's symptoms can be an expression of a family dysfunction or may have arisen in the individual family member because of his/her particular life circumstances which has been supported by the family system (Minuchin, 1974, p. 110).

> Challenge can be direct or indirect, explicit or implicit, straightforward or paradoxical. The goal is to change or reframe the family's view of the problem, pushing its members to search for alternative behavioral, cognitive, and affective responses. (Minuchin & Fischman, 1981, p. 68)

Challenging the family structure refers to the family's organization. Areas of family dysfunction frequently involve either overaffiliation or underaffiliation. If there is overinvolvement, the members freedom to function is restricted; if there is underinvolvement, the members may be isolated and lack support. In challenging the family's structure, the therapeutic process is one of monitoring distance and closeness. The therapist, being an outsider, has more mobility even though still constrained by the system's demands. Nevertheless, the therapist works in alternative subsystems challenging the members' overdelineation of their roles and functions. Modifying the context, the family experiences a change.

Challenging the family's reality means to challenge how the family views their world. Structuralists postulate that transactional patterns depend on, and constrain, the way people experience reality. To change the way family members look at reality requires the development of new ways of interacting in the family. The therapist takes the data offered by the family and reorganizes it so that the conflictual and stereotyped reality of the family is reframed in a new way which allows the family new possibilities for change.

For transformation to occur, the therapist must use herself/himself creatively to "join" with the family. Minuchin clearly states that joining is an attitude, not a technique, and it is the umbrella under which all therapeutic transactions occur (Minuchin, 1981, p. 31). Joining with a family lets the members know that the therapist understands them and is working with and for them. It is important that the therapist is able to provide protection and security so that the family members feel secure in exploring alternatives, doing the unusual and changing. "Joining is the glue that holds the therapeutic system together" (Minuchin & Fischman, 1981, p. 32).

When the therapist joins the family, she/he assumes the leadership of the therapeutic system. This means that she/he assumes responsibility for what happens. The target of her/his interventions are to facilitate the transformation of the family system towards its goals. It is the family that is the matrix for healing and growth of its members.

It is through joining that family members feel respected, supported and confirmed even when they are being challenged in their dysfunctional manoeuvers. Joining is more than support; it is helping the family members to have hope; it is knowing the impact of the therapy, being able to assess the life circumstances in the family, and being available to support. To use one's self fully, the therapist must be knowledgable about the range of her/his joining repertoire and how these resources can best be used. Once the therapist learns to be an expert at reading family feedback, the therapist will develop a confidence in how she/he uses herself/himself knowing that her/his behavior will fall within the therapeutic system's acceptable range.

One last comment about joining. It continues throughout the

therapeutic process. The therapist needs to join in each session and throughout. However, the deliberateness decreases as the therapy continues. Joining is an operation which functions in counterpoint to every therapeutic intervention. Joining and challenging are the basis for therapeutic change to occur. But first and always, the therapist must be well joined otherwise the family will not go down the path with her/him.

When Minuchin described the three main strategies of structural family therapy, he linked the strategies to specific techniques. The techniques for challenging the symptom are enactment, focusing and intensity.

Minuchin describes enactment as asking the family members to enact an interpersonal scenario in the session. By asking for the enactment, the therapist quickly sees the dysfunctional structure and begins to understand the rules by which this family has organized itself. Enactment can be regarded as a three step process. In the first step, the therapist observes the spontaneous transactions and decides which dysfunctional area to highlight. Secondly, the therapist highlights an interpersonal scenario which is changed and, finally, the therapist suggests alternate way of getting it to happen in the room.

Focusing means to decide what will be 'figure' and what will be 'ground'. The therapist will select and organize the information into some framework for meaning. However the organization of the data must have therapeutic relevance. To accomplish the skill of focusing, the therapist must select a focus and then develop a theme for work. The data-gathering refers to the process of change (transactions) not to content-

related issues. Through the data-gathering, the therapist will devise a framework which will include structural goals and a strategy for achieving that goal.

Intensity refers to the therapist's message. "Families differ in degree to which they demand loyalty to the family reality, and a therapist's intensity of message will need to vary according to what is being challenged" (Minuchin and Fishman, 1981, p. 117). The therapist, like the family, follows implicit rules about how to behave in situations in which people transact with people. It is imperative that the therapist maintains the required intensity even when the family members show within the session that they have reached their emotional limit. The therapist must train herself/himself to behave in ways opposite to the family's rules. To increase intensity the following techniques can be used: repetition of the message, changing the time in which people are involved in the transaction, changing the distance between people involved in the transaction, and resisting the pull of a family transactional pattern.

To challenge the family structure, the following techniques are employed, boundary marking, unbalancing and teaching complimentarity.

Boundary marking regulates the permeability of boundaries separating subsystems (Minuchin and Fishman, 1981, p. 146). It has to do with membership of subsystems and changing the distance between them as well as affecting the deviation of the interaction within significant subsystems. Changing the boundary can be accomplished by using cognitive constructs which will delineate a boundary between two people or by expanding the definition of the over-involved dyad to include the under-involved person. Different subsystems may do different tasks so that boundaries can be

changed in the direction of the therapeutic goal. As well, the therapist can use concrete spatial manoeuvres to change the proximity between family members. The goal in marking boundaries is either to increase or decrease space between individuals and their subsystems in order to change subsystem membership.

Unbalancing is aimed at changing the hierarchical relationship of the members of a subsystem and thus the power relationships (Minuchin and Fishman, 1981, p. 161). As soon as the therapist enters the system as the leader, the family power structure changes. What the therapist will do to unbalance the system is to affiliate with family members, perhaps ignore a family member, or perhaps enter into a coalition with some family members against others. Unbalancing is a power technique and may produce significant changes when individuals have the opportunities to explore new possibilities and think of new options within their interpersonal context.

Complementarity refers to the individual as intrinsic and as a part of a whole. One of the therapist's goals is to help family members experience belonging to an entity that is larger than the individual self (Minuchin and Fishman, 1981, p. 193). Complimentarity means to assist the family members to see their interdependence. To do this, the therapist challenges the problem. This is accomplished by: challenging the family's certainty that there is one identified patient, challenging the notion that one family member is controlling the system rather than each member serving as a context of the other and, finally, challenging the family's understanding of events which introduces an expanded time frame to teach family members to see their behavior as part of a larger

whole (Minuchin and Fishman, 1981, p. 194). This notion of complimentarity is critical for it is this technique which helps the family members to recognize the impact they have on each other. For transformation to occur, each needs to develop new ways of punctuating the dysfunctional transactional patterns.

To challenge the world view, the following techniques are used: cognitive constructs, paradoxical interventions, and emphasizing strengths.

Cognitive constructs refers to the therapists ability to shake-up the rigidity of the family's preferred schema. The therapist's is limited by her/his own biography, by the finite reality of the family structure, and by the idiosyncratic way in which the family has developed its structure (Minuchin and Fishman, 1981, p. 214). Always, the goal is to provide the family with a new world view in which symptoms are not needed and in which the horizons of the members are expanded so that this reality is pluralistic.

Paradoxes are a clinical tool for dealing with resistance and circumventing a power struggle between the family and the therapist (Minuchin and Fishman, 1981, p. 244). Paradoxes are not always necessary or desirable and ought not to be employed in crisis situations such as violence, acute grief, attempted suicide and other acute situations where the therapist needs to move quickly to provide structure and control. Papp (1981) says she and her colleagues reserve paradoxical interventions for these covert, longstanding, repetitious patterns of interaction that do not respond to direct interventions such as logical explanations or rational suggestions (Minuchin and Fishman, 1981, p. 245). The paradoxical intervention, if followed, will accomplish the opposite of what it is seemingly intended to accomplish. For it to be successful,

the family must defy the therapist's instructions or follow them to the point of the absurd and then recoil from the absurdity. The target of the systemic paradox is to make obvious the hidden interaction which expresses itself in a symptom. The therapist will connect the symptom to the system through a series of drastic redefinitions so that one part cannot change without the other part. The symptom and the system are interconnected. A word of caution needs to be given to the beginning therapist. Paradoxical techniques are powerful and ought only to be used by those individuals who have an accurate knowledge of the relationship of the symptom to the system and how the system might react if a paradoxical intervention was to be used.

Strengths of the family have been overlooked by the helping professions. Minuchin suggests that "helpers" are trained to be psychological sleuths who are to "search and destroy": pinpoint the psychological disorder, label it and eradicate it (Minuchin and Fishman, 1981, p. 263). The therapist needs to assist the family to focus on their healing capacities which may result in a transformation of the reality that the family understands. The challenge can be related to how the family responds to the individual or how the family uses alternatives. The therapist looks for strengths rather than deficits and assists the family members to use their competencies and capabilities.

This last section concludes the review of the intellectual underpinnings of structural family therapy theory and interventive techniques in Chapter 3. The next chapter describes the setting, the clients and concludes with a case example demonstrating the integration of the practice of structural family therapy with the theory.

CHAPTER 4

PRACTICUM EXPERIENCE

Description of Setting

The practicum was conducted at The MacNeill Clinic for Child Psychiatry in Saskatoon. The practicum was supervised by George Enns, Director of the Family Therapy Program. The placement was from January 4, 1982 to April 30, 1982.

MacNeill Clinic offers psychiatric services to children and their families in the Saskatoon Mental Health Region of the Department of Psychiatric Services. The Clinic provides assessment, counselling and consultation services which are available from psychologists, social workers, psychiatrists, speech therapists, reading therapists, and learning disabilities consultants. Each of these professionals report to a department head who directly reports to the Regional Director of the Saskatoon Mental Health Region. Each of these departments receive referrals. Other than self-referrals, the Clinic receives direct referrals (from police, doctor, school) to a specific professional or from the Admissions and Discharges Committee that assigns general referrals to the appropriate department.

The Family Therapy department had 3 full-time staff including the director. Usually there was a waiting list for Family Therapy. Upon referral, an initial appointment was set up. It was expected that the initial interview would include: (1) who referred and who was present, (2) identification of the problem, (3) structural assessment of problem and (4) goals for treatment. Following the initial interview it was expected that a weekly progress note would be charted. On termination or transfer a summary of what occurred was to be completed before the

file was closed or transferred to the next worker.

Each therapy session was video-taped. The video tapes were viewed by the supervisor in Saskatoon. As well, some segments were shown to the writer's advisor in Winnipeg. At MacNeill, supervision time was divided between the Director and the senior staff member. The writer received two hours of weekly supervision from each for a total of four hours. The supervision time was divided into viewing segments of video-tape, discussing theoretical issues and planning case directions. In addition the writer received two hours weekly of "live" supervision from the supervisor and the senior worker.

Description of Clients

A total of fourteen families were seen. Five of the fourteen families received pre- and post-test, six families received only the pre-test and three families did not receive either the pre-or post-test.

Four of the fourteen families were transferred at the end of the practicum, two families were discharged from treatment and eight families terminated voluntarily. Of those families who voluntarily withdrew from treatment three were seen for one visit, four were seen for three visits and one for four visits. Further explanation of what occurred will be discussed in the evaluation section.

Of the fourteen families there were two single-parent families, four blended families and eight traditional family units. Eleven of the fourteen families were seen in treatment as a family while two of the fourteen were seen as a couple and one seen as an individual. The people seen in treatment were primarily from the working class to middle class.

The best way to illustrate practice theory is to provide a case example which demonstrates the theoretical model of practice described in the previous chapter. This case was transferred from a previous student; hence this case was not measured on the Moos Environmental scale and is not part of the evaluation.

The H. Family had been receiving treatment at MacNeill Clinic for three months prior to the writer's arrival. The family had been referred by the child's school. They were in treatment with a student and had agreed to be transferred to the writer. They had previously been seen six times. The writer saw them twelve times and terminated in a planned way with them.

The H. Family is a two-parent family, the identified client, a boy eight years old and his sister, seven years old. The parents immigrated to Montreal from England approximately ten years ago. In Montreal they adopted the two children more or less at the same time. Their intention was to adopt only the boy but the adopting agencies successfully encouraged them to adopt his sister as well. The boy was two years old and the girl one when adopted. The boy had been physically abused in his natural home. When the parents talked about the adoption time, they stated that they felt pressured to take both children. In this family the mother stays at home, father is a middle manager in business. Apparently their move to Saskatoon was precipitated by the husband being fired due to financial cuts in his firm in Montreal (The wife had given this information to the previous worker but said not to address it directly with her husband. It was the writer's understanding that this event explained some of the husband's rather argumentative behavior in

the interview room). Prior to their move to Saskatoon, the boy had been in individual treatment because of his class room behavior.

The school referred the boy to MacNeill; it was assessed at MacNeill to be a family problem. The writer prepared herself for this family by looking at two previous video tapes, reading the file and discussing the case with the supervisor who was also the previous worker's supervisor. It was thought that although some change had occurred, the structure had not reorganized itself sufficiently to cause symptom withdrawal. In this dysfunctional structure there was a disengaged couple triangulating their son as a way to avoid the conflict between them. Father was very involved with his work and mother was involved with the children; indeed it was hypothesized that she was overinvolved with the boy. However, when mother did attempt to discipline the children, father would undermine her and tell her that her judgement was poor. It seemed that their basic transactional pattern was organized around her anxiety and upset which then provoked his rigidity, making him less available to her. This caused her to become more upset and worried about the boy who then acted out more. The mother would then become more anxious and frightened which, in turn, frustrated and irritated the father prompting even more withdrawal. They were in a vicious cycle. The writer had a fairly clear picture of their structure and pattern prior to meeting with this family. When the writer met with them for the initial interview the therapeutic goal was to join with the family, have them describe what they still found problematic, ask for permission to see the school, and reassess their family structure.

In preparing for this interview, the writer already knew that the

husband was argumentative and that if he began to argue that complimenting him, listening to him and tracking him were important joining manoeuvers (tracking is the therapist following the content of the family members' communication and behavior and encouraging them to continue). It was vital in this initial session to accommodate to the family, to confirm them and to respect what it is that they wanted the writer to hear. Unless the writer could join the family and establish a therapeutic system, restructuring could not occur and therapeutic goals could not be reached. As the writer joined with them, she began to form a therapeutic system so that she could assess and form a contract with the family. The assessment involved testing hypotheses about the structure as well as evaluating the system's flexibility and its capacity to restructure. There was also interest in finding out about their sources of support, the stresses on the family unit, the family's developmental stage and its performance of the tasks appropriate to the stages, and the family system's sensitivity to the individual member's action. The family needed to explore ways to understand how the identified member's symptoms are used for maintenance of the family's preferred transactional patterns.

Another part to be considered in forming the therapeutic system is the contract. Mr. and Mrs. H's complaints fall into three categories, the boy's meaness especially at school, his difficulty in relating to his peers and his hyperactivity. As the writer talked with them about these concerns, it became clear that the husband and the mother saw the difficulties very differently. At this point, it was the writer's therapeutic task to focus the discussion and to separate out what they saw as, and what they thought were, serious problems. They were able to come to agreement that they wanted his bullying and hitting to stop

and for his peer difficulties to improve. At this point, I began to mark the parental subsystem.

It was decided in consultation with the supervisor, George Enns, that the writer needed to connect father and son in some kind of pleasant activity and block mother from this as a way to begin to restructure. Two simple tasks were assigned, one concerning fun and the other to do with father spending time with the son on homework. The fun activity also included his sister.

For session two the writer reviewed the tasks and also included a discussion with mother to see whether she felt excluded. The restructuring needing to occur was the development of a parental subsystem in which the parents could talk directly to one another, support one another in their disciplinary actions with the children. This would permit both children to grow and develop. This was particularly true of the boy as the parents were fighting their battles through him. In session two the writer had the father and son do some talking in the interview while mother and daughter remained silent. This is a skill called enactment. The therapeutic goal was to collect information on how father does talk with son and have the father more directly involved with the boy instead of everything needing to go through mother as though she were a switchboard. Also in this session the writer started to identify the wife's isolation and worries. The goal was to restructure this woman's personal boundaries so that she could begin to take responsibility for her own thoughts, feelings and behaviors and begin to contemplate doing something positive about her isolation. This session ended again with another task. This time father was asked to help his son arrange to have a friend over. The son and father had spoken about the arrangements in the therapy room.

In session three, the parents came in with complaints from the school. When asked whether they had followed through with their agreement on consequences they reported that in part, they had. The goal for this session was to get them to come to some agreement with each other about what needed to occur when their son misbehaves again at school. The father attempted to draw the writer into an argument in the interview while mother was saying that things they do between them as a couple and as parents do affect the boy. The mother in this instance has accepted the concept of complementarity and is beginning to recognize how family members trigger each other. Father still feels very blamed and thinks that the school is to blame. A similar task is set for father and son to plan something for fun and mother to be thinking about how she could do something for herself.

Between the 3rd and 4th interview, the writer visited the school accompanied by the supervisor. The principal was in a state of "uproar" about the boy. Apparently the boy had been playing with matches near the incinerator and chased somebody with scissors and played with the copying machine making a mess. As the supervisor and I gathered information, it became clear that the principal and one teacher were just unable to plan for the boy, whereas the third teacher thought that the boy needed some clear structures with consequences. However, the instances had been reported to the board by another parent so probably the boy would be dismissed. We organized a plan with the school and said that the writer would be working it out with the parents. In a subsequent session with the supervisor, it was thought that the school, to some degree, mirrored the structures and conflicts at home. The principal and the boy's home room teacher seemed unable to develop a consistent plan with consequences. It

seemed that they did not follow through; rather they kept changing their plans. The other teacher said she had had little trouble with the boy and thought that he required clear structures which were connected to consequences. This child had been enrolled since September and seemed to be causing "uproar". The school had neither found a way to manage the uproar nor had the school figured out how to enlist the parents help.

Because of the board's involvement and the principal's own desire to want the boy moved, it seemed likely that the parents would be asked to move the boy. Though the writer thought that this would be disruptive to the boy, it might be best. If the move occurred, it would be to the boy's advantage to be in a structured classroom. Intervening in the school system proved to be no different than intervening in the family system. The principles and concepts called forth were the same.

The overall goal for this session four was to get the parents to take charge of the boy's discipline. This meant getting their son to listen to them (enactment) and then discussing with them whether they followed through on their agreements. If they did not, the goal was to increase the "intensity", especially with the father, about what makes it so hard for him to talk about the seriousness of his son's problem. That session was very intense. Once they had talked about the seriousness of what had happened at school, each talked to the son separately. Again, the focus was upon restructuring and helping the parental subsystem to work together.

Sessions five and six were repeats of session four. The parents were asked to follow through in areas of fun, homework and discipline; they were doing so. It had become much clearer that the boy handled things much better when the structure for him was clear. At about this time he had

psychological testing at the Clinic so he could be transferred (requirement of the school system). The psychological testing and recommendations supported what was being done with the family.

Session seven was spent supporting the parents as the school board had decided to dismiss him from the school prior to the transfer arrangements. The focus of session was on what to do next and how the writer could be helpful. By this time, the parents were reporting things were better at school and according to the father, he seemed to be getting along better with his peers. However, the mother still had concerns about the boy, about his slowness and his irritation of his sister.

Sessions eight and nine had a similar focus. In the early therapy, one of the tasks that had been set was that the husband should act as a consultant to his wife when she felt burdened and needed advice to deal with their son. This was a strategy to help keep the father engaged. However, this structure now needed to be changed so that mother could reclaim her authority. This was accomplished by enacting a situation in the room and by assigning tasks so that mother and the two children would do things together and separately. As this process occurred the writer had to block the husband's dismissive manner with his wife and help him find a way to express himself in ways that were less damaging for the system.

Session ten was another very important session. The supervisor and the writer made a decision to see the mother and children alone. The children played in the playroom. The focus of this session was to find out more about the mother, and about why it is so difficult for her to get her points across. It was also intended to build her up by confirming

her in every available way. After a forty-five minute interview, the writer consulted with the supervisor (live supervision in progress). It was decided to give her a prescriptive message which described in detail how the boy was sacrificing himself (by using him as the go-between) so that his parents could learn how to argue.

Between the tenth and eleventh session, the boy had been transferred to, and settled in, to the new school. The writer went once in the boy's first week to discuss with the teachers the goals for the boy and his family.

In session eleven the goals were to discuss termination, (for which the parents had been previously prepared) and to find out what if anything had happened as a result of the "message" that had been delivered to the wife in the last session.

It was clear that there had been another shift; the wife was beginning to reclaim her authority in the family and the father said he liked it. The mother was much firmer, more able to define herself and reported that she had had a very frank discussion with her mother long distance. She was very pleased with herself. We terminated by reviewing the changes since we had met and said goodbye. They thought that they did not want more help but if they needed something they would call the supervisor whom they met before they left (joining manoeuver).

In summarizing this case, its obvious that changes in the structure did take place; however, the writer saw the changes as very new and not well entrenched. Father and mother were a little more connected. The boy's behavior was under control at home and school. If he did misbehave, the school and family had a clear structure of how to handle it. The world view used with the parents was that their son needs to learn that

they are there for him, that he can trust them and rebuild his life with them. However, in order to trust he needs to know that they will follow through and that they will take leadership because they care. Mother reported feeling easier with the children, especially the boy, and she was more willing to follow through on her ideas. She had met a neighbour, had decided to take a hair cutting course while she was in treatment, and was being franker. Husband was spending more time with the family rather than at work. Wife and husband had been out for lunch a couple of times. This case was very challenging as the family was so 'rigid' and difficult to impact upon. Also the writer had the opportunity to work with two different school systems.

CHAPTER 5

EVALUATION AND CLINICAL PROFILE

Evaluation Instrument

As part of the practicum experience, the student is expected to use an objective measure which will hopefully provide information on the direction of change in the client population.

The student reviewed two instruments, the Perosa Structural Interaction Scale and the Moos Family Environment Scale (FES). The FES scale was chosen as it has been well tested for validity and reliability whereas the Perosa Scale has just been developed and tested only through a pilot study. The writer hoped that the information obtained through the pre-and post-test measure would indicate whether or not change occurred, and if so, its direction and magnitude.

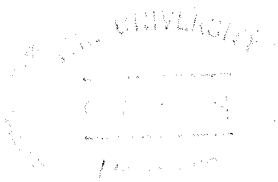


TABLE 1

* FAMILY ENVIRONMENT SCALE SUBSCALE DESCRIPTION

	RELATIONSHIP DIMENSIONS
1. Cohesion	The extent to which family members are concerned and committed to the family and the degree to which family members are helpful and supportive of each other.
2. Expressiveness	The extent to which family members are allowed and encouraged to act openly and to express their feelings directly.
3. Conflict	The extent to which the open expression of anger and aggression and generally conflictual interactions are characteristic of the family.
	PERSONAL GROWTH DIMENSIONS
4. Independence	The extent to which family members are encouraged to be assertive, self-sufficient, to make their own decisions and to think things out for themselfes.
5. Achievement Orientation	The extent to which different types of activities (i.e., school and work) are cast into an achievement oriented or competitive framework.
6. Intellectual Cultural Orientation	The extent to which the family is concerned about political, social, intellectual and cultural activities.
7. Active Recreational Orientation	The extent to which the family participates actively in various kinds of recreational and sporting activities.
8. Moral/ Religious Emphasis	The extent to which the family actively discusses and emphasizes ethical and religious issues and values.
	SYSTEM MAINTENANCE DIMENSIONS
9. Organization	Measures how important order and organization is in the family in terms of structuring the family activities, financial planning and explicitness and clarity in regard to family rules and responsibilities.
10. Control	Assesses the extent to which the family is organized in a hierarchical manner, the rigidity of family rules and procedures and the extent to which family members order each other around.

* Combined Preliminary Manual, Family, Work and Group Environment Scales, p. 2.

INSTRUMENT

Moos Family Environment Scale (FES) had ten subscales which assess three dimensions. These are: The relationship Dimension, Personal Growth Dimension, and the System Maintenance Dimension. The focus of this instrument is on the basic organizationl structure of the family, the direction of personal growth and the nature of the interpersonal relationships among family members. The scale is composed of ninety items which tap the three dimensions. Table 1 lists and describes the ten subscales.

The three subscales on the Relationship Dimension are Cohesion, Expressiveness and Conflict. They assess the degree of commitment, support and closeness family members have for each other, as well as how openly family members relate to one another and express their feelings, especially feelings of irritation, anger and aggression.

On the Personal Growth Dimension there are five subscales. Independence has to do with autonomy and self expression in the family, while achievement has to do with performance at school and at work in the family. Intellectual-cultural and active-recreation are concerned with participation in social, cultural, intellectual and physical activities. The moral-religious subscale emphasizes the family values and ethics.

The System Maintenance Dimension is composed of the organizations and control subscales which assess the degree of structure in the family organization and the rules and regulations which run the family life. Moos describes the development of the scale. (1981). Initially, a 200 item Form A was administered to a sample of over one thousand people in 285 families. The sample included different types of families from different ethnic backgrounds, recruited from churches, newspaper advertisements, and high schools. As well, a group of distressed families was obtained from probation, parole and a psychiatrically-oriented family

clinic. From this original 200 item scale, the 90 item scale was developed into Form R. Moos presents the mean and standard deviations for the 90 items on Form R as the norms established for the sample with which he worked.

The internal consistencies for each of the 10 FES subscales are all within an acceptable range, varying from moderate for independence and achievement orientation to substantial for cohesion, organization, intellectual-cultural orientation and moral-religious emphasis. The ten subscale scores were intercorrelated separately and indicated that they measure distinct though somewhat related aspects of family social environments. Test re-test reliabilities of individual scores for the ten subscales were calculated for 47 family members in 9 families who took Form R twice with an 8 week interval between testings. The test retests are all within an acceptable range, varying from a low of .68 for independence to a high of .86 for cohesion.

TEST ADMINISTRATION

The Form R test items are printed in a re-useable booklet designed to be used with a separate answer sheet. The FES was administered at the initial interview and at the last interview to obtain the pre- and post-test measure.

It was important that the family be made comfortable prior to the administration of the questionnaire. The writer would offer coffee or hot chocolate as a way to demonstrate warmth. Once settled, all family members over 16 were given a clipboard, sharp pencil with eraser, booklet and answer sheet. The writer explained the purposes of the instruction, and then explained how to fill in the form. The writer stayed in the room while the forms were being filled in which provided an opportunity

for clarifications if it was required.

Scoring:

The scoring procedure is simple. The template fits over the answer sheet. The writer counted the number of x's showing through the template in each column and entered the total in the score box. An individual or family average score can be calculated for each subscale and be converted to a standard score which can be compared to the normative sample.

Difficulties Encountered:

Generally families did not seem pleased to fill out the forms, especially the pre-test. The writer attributes this impatience to having to do something which they perceived as having nothing to do with their reason for coming to the Clinic. They seemed to feel restraint and "put off" with the pre-test. The pre-test atmosphere was less favorable than at post-test time. Then, family members appeared more relaxed and took their time to complete the forms.

All but one of the families that were asked to fill out the form did so. In the family which refused, the husband was angry that he could not compare notes with his wife and felt that he could just not answer the questions "true" or "false". This couple did not return after the first interview.

The scoring manual does not indicate a cut-off age for the administration of the test. According to Frankel (1981) who chose 12 as a cut off age, this seemed too young. In discussing this information with the writer's committee, the writer chose the cut off age to be 16. This did not appear to be a problem.

Although the administration of the pre- and post-test was straightforward, the writer thought that the pre-test created a degree of anxiety

especially since the test could not be filled out by younger family members. Their restlessness contributed to their parents upset so much so that the parents sometimes started to get irritated with their children. On one hand, this was helpful assessment material for the writer but, on the other hand, it did not assist the therapist in joining with the members in a positive way. For all these reasons, the pre-test scores may not be highly reliable. Therefore, the writer will use the scores obtained on the measures as suggestive of change but will not regard them as conclusive indicators of same.

The writer was not convinced that meeting people in this way was the most constructive way to begin the family sessions. Besides the FES form, the family members had to be introduced to the VTR procedures and the one-way mirror. To the credit of the families, no one refused to be videotaped.

Clinical Applications:

The investigative aspects are the replication of the work by Frankel (1981) since it was done in the same setting, used the same instrument and used the same theoretical approach. In assessing the instrument, Frankel concluded that dimensions of cohesion, expressiveness, conflict, independence, organization and control (as defined by Moos) would, to some degree, measure the extent to which families are structurally disengaged (inappropriately rigid boundaries). Change across these dimensions would presumably reflect some restructuring. However, she concluded that these dimensions may be present or absent to the same extent in families with quite different as well as similar structures. Her conclusions are consistent with the writer's own experience and observation and, therefore, in this section of the report, the writer will briefly summarize how

Frankel viewed the change scores on the FES.

Frankel describes that change along the dimensions of cohesion, expressiveness, conflict, independence, organization and control reflects change in process that results from restructuring interventions made at a process level. Change in process is therefore an indicator of restructuring but not of a specific structure. Thus, the difference in scores from T_1 T_2 are an objective measure of degree of change and direction of change.

The writer wants to caution the readers about the subscale dimensions mentioned in the previous paragraph (the other Moos dimensions were not measured as they were highly content oriented, thus inappropriate for the writer's purpose). These dimensions are descriptions of relationships in the family and are not to be correlated to Minuchin's structural concepts of enmeshment and disengagement. Nor are these dimensions to be viewed as meaning that a particular structure exists. Another limitation of the scale is that children younger than 16 had difficulty filling it out.

The next part of this report will address two things, initially the writer will briefly describe what occurred to five families who were pre-tested but not post-tested and then will describe the clinical profiles of the other families in structural terms. As indicated in Chapter Three, there were five families who were pre-tested but not post-tested. The following profiles will describe those families.

Family "1" was a blended family. The mother had 7 children, the father had 3 children. They did not have a child of their own at the time they were seen. Four of the mother's children (3 girls and 1 boy) lived with them and a fifth child (girl) came and went. While the

father did have 2 of the 3 children living with them at one time, only one was still with them when they came into treatment. However, this child never came to the sessions. The identified patient (I.P.) was the mother's 16 year old daughter who was missing school.

This family was extremely chaotic. The mother and father were in constant battles over the discipline of the children, the sixteen year old was in a struggle with her step-father, and there was constant rivalry between the siblings, especially between the girls. The mother was clearly overinvolved with her children, especially the sixteen year old. The father seemed to have an alliance with his wife's fourteen year old boy. Each parent had an ally which acted as balancers so that the marital conflict could be avoided and redirected to the children's misbehaviors. Besides the parents' conflict avoidance pattern, the family had a confused hierarchy which was demonstrated by the chaos of the sessions. Since there was a weak executive subsystem, the family had little sense of structures which would have provided rules, guidance and nurturance for the family members. The problem that the family demonstrated was the same problem the writer was having, that is taking leadership and being in charge of the sessions. In order for this family to be moved towards the necessary therapeutic goals, the writer needed to win the battle for structure. If the battle could not be won, the writer then would lose therapeutic maneuverability in the system. Following the fourth session, they did not come back. In reviewing what occurred, it seems that the writer was triangulated between her supervisor and the family. This caused confusion within the sessions as the therapeutic direction was not clear.

The writer did try to re-engage the family but was unable to do so.

The termination was in the form of a letter that was written to all the family members. The purpose of the letter was to prescribe the symptom and how the symptom was maintaining the interactional pattern of the family. The hope in sending the letter was to impact the system by supporting the system in what it was presently doing rather than challenging the system.

Family "2" was a couple who referred themselves to the Clinic. It was decided with the supervisor that the writer could take this case. He supervised the writer live on the initial interview. This couple had been separated because the husband had had an affair. However, they now wanted help in re-uniting.

The tactic the writer took was to get them to define clearly their positions before deciding to work with them. Once the positions were clear and an agreement made, the therapist insisted that the agreement be kept before the next step of therapy continued. They came back for their second appointment but the husband had not kept his agreement. The couple was nicely told by the therapist that they could not be seen until the husband kept his part of the agreement. To have seen them would have once again said "it's O.K., husband and wife, not to keep agreements with each other". It took this couple six weeks to keep their agreement so that when they phoned to continue therapy, the writer was terminating her practicum. They were referred elsewhere. In speaking to the supervisor, his subjective evaluation was that to have kept them "locked in" to a firm agreement and to hold it until the husband followed through was probably a new and beneficial experience for this couple.

Family "3" was a two parent family with a four year old I.P. and a 1 year old. This family was in the midst of a crisis of family

development. Mother had decided to enter dentistry, which meant that the couple had to move to Saskatoon in the fall of 1981. Father was involved as a trouble shooter in business so he travelled the prairie provinces and Ontario. Aside from the crisis caused by the wife attending school, a new baby and an often absent husband, the mother was very worried and overinvolved with the four year old. Structurally it looked as though mother was overinvolved with the four year old, the father being peripheral because of the overinvolvement between mother and the daughter. In the session, father told me that he and his wife did not have agreements about child rearing practices. Minuchin & Fischman (1981) refer to this structure as an "accordian family" due to the father being in and out of the family. He suggests that the therapy include re-education and restructing maneuvers.

In the initial session, mother thought the daughter was being too aggressive at home. She also reported that day care was concerned about her temper tantrums which usually occurred at 3:30 in the afternoon. Father did not express the same concern as mother and thought mother was more worred than she needed to be. Numerous restructuring maneuvers occurred in the initial session so that there would be a clear hierarchy and better boundaries between mother and daughter as well as a stronger wife-husband boundary. As well, the therapist agreed to visit the play-school. This couple was to be seen again when the husband was next in town. However, this did not materialize. Only the wife was seen. She reported positive changes in the four year old. So had the school. Mother was less burdened as she had met some other women and was socializing. She had also begun to talk more freely with her husband by initiating more frequent phone contact when she was lonely and upset. The

therapist set another appointment but the mother cancelled as she had no further complaints.

Family "4" consisted of a grandmother and her granddaughter. The granddaughter was the grandmother's daughter's child. Grandmother sought treatment as she was worried about the granddaughter not going to school and not having a job. In the initial interview, the writer found out that the seventeen year old I.P. had had a horrendous fight with her father and taken refuge at the grandmother's house (there is a family history of feuds and turmoils). It seemed that the grandmother and her daughter were in conflict as was the 16 year old with her mother and father. In this family the grandfather was 20 years older than the grandmother and was very peripheral.

Somehow the granddaughter decided that her grandmother cared more for her than her parents. The 16 year old expressed worry about her youngest sister who was left in the family. The structure was not clear from the initial interview. However, the therapist hypothesized that daughter was in some way triangulated between grandmother and her own mother and that the grandmother undermined her daughter by having developed a strong alliance with her granddaughter. As well, the 16 year old seemed to be triangulated between her mother and father. The hierarchy in this family was confused.

By the third interview, the therapist, in discussion with the supervisor, decided to explore the possibility of the granddaughter bringing her own family into therapy. She seemed receptive to the idea but did not keep her next appointment. In the next month, the therapist attempted to make contact. In phoning the grandmother's house, the

therapist discovered that the girl had moved in with friends and was looking for a job. This in itself seemed to be progress.

Family "5" were referred by a sexologist. Although they had multiple marital problems, the referring source thought that their family problems had become more acute. It was a two-parent family with two boys, ages eight and five. Father was on the road. The structural assessment was a mother overinvolved with the 2 boys and a peripheral father. The couple appeared to be chronically disengaged. Both parents appeared to have little tolerance for frustration. This frustration was being siphoned off onto the 2 boys as the couple did not seem to have good problem-solving skills. It was obvious that father wasn't too sure that he wanted to be involved with the helping process. In the inital session, the therapist's goal was to join with the couple. Retrospectively, the therapist moved too quickly to intervene to reorganize the structure. The family were not well enough joined. What the writer thinks happened was that the mother became frightened and no longer pressured her husband to come home early on Fridays so that the family could be seen. They made a second appointment and cancelled. When phoned, they reported the husband was not able to leave early to get into Saskatoon as he was working in Alberta. The therapist informed the referring source as this family did seem at risk.

The remainder of this chapter describes the clinical profiles which were both pre-and post-tested. The writer described each profile by doing a social thumbnail sketch, a structural assessment and the results of the FES.

Clinical Profiles:

Family "A" consisted of a mother (divorced 2 times) and 3 children. The children were 12, 17 (boys) and 18 (girl) years old. There was not an identified patient as such in this family. Mother called the Clinic late January and asked that someone see her and her family. Her reason for calling was to improve the communication in the family.

The overall structural goal was to elevate mother to an executive position in the hierarchy so that she could take leadership. It was important that the generational boundary be strengthened between mother and her children. Mother related more like an older sibling to the twelve year old son and the daughter. The two teenagers seemed to be providing most of the parental functions. The therapeutic tasks to be accomplished were: to relieve the adolescents of the parental functions, to assist them to become more connected as siblings with the twelve year old, and to free them to deal with their own developmental tasks. These tasks were part of the structural goals of strengthening the generational boundary, the parental subsystem and personal boundaries with mother.

This family was slow to engage. In retrospect, the process of engagement reflected the situation of the family. It took three appointments to assist the mother to take charge and bring the family in. As the therapist saw it, the structure was that mother was overinvolved with the 12 year old boy, with the two older siblings in alliance and in conflict with the 12 year and with mother. It seemed that mother was disengaged from her two adolescents. This particular split was thought by the therapist to reflect mother's two marriages with the two older children being from the first, and the 12 year old from the

second union.

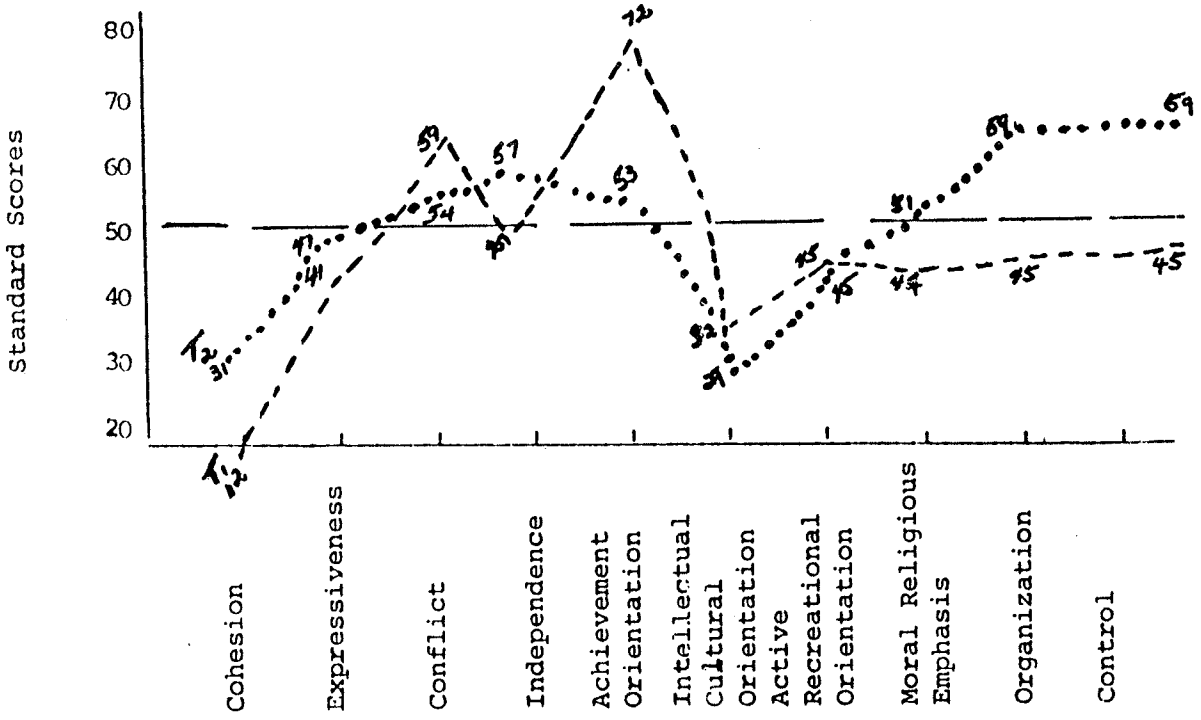
In figure 1.1 shows FES pre-test and post-test profiles for family "A" as compared to the norm obtained by all the families in the Moos overall normative group.

At T_1 the family scored substantially below the average on cohesion (12) while at T_2 they scored (31) which demonstrated an improvement.

My understanding is that the low score at T_1 (12) demonstrates the disengagement between the 3 siblings and,hence, the score at T_2 (31) though still outside the norm was improving in the desired outcome. This improvement suggests that the family was more supportive and feeling more united rather than as a family divided into two camps.

Along with this score, it is of interest to note the change at T_1 for organization (45) and control (45) to T_2 organization (59) and control (59). At T_1, organization and control were in the low end of the normative range while at T_2 there was a shift to the high end of the range. This shift supports that structural change has occurred in the desired direction with mother being seen as more of the executive in the hierarchy. Expressiveness increased slightly from T_1 (41) to T_2 (47) and conflict decreased slightly from T_1 (59) to T_2 (54). These last two scores reflect what was observed by the therapist. As the family sessions proceeded, family members were much more expressive of their sadness and concerns for each other, especially concerns about the mother. As well, mother had been more able to define what she wanted and did not want and then to negotiate that with the three children. The independence score changed T_1 (45) to T_2 (50) which suggests that more personal autonomy was allowed vis-a-vis the family. This had been an

Figure 1.1



Family A

an issue with the two adolescents and mother.

From the scores it appears that this family have changed in the desired direction. Subjectively, the family reported behavioral changes which were congruent with the objective measures.

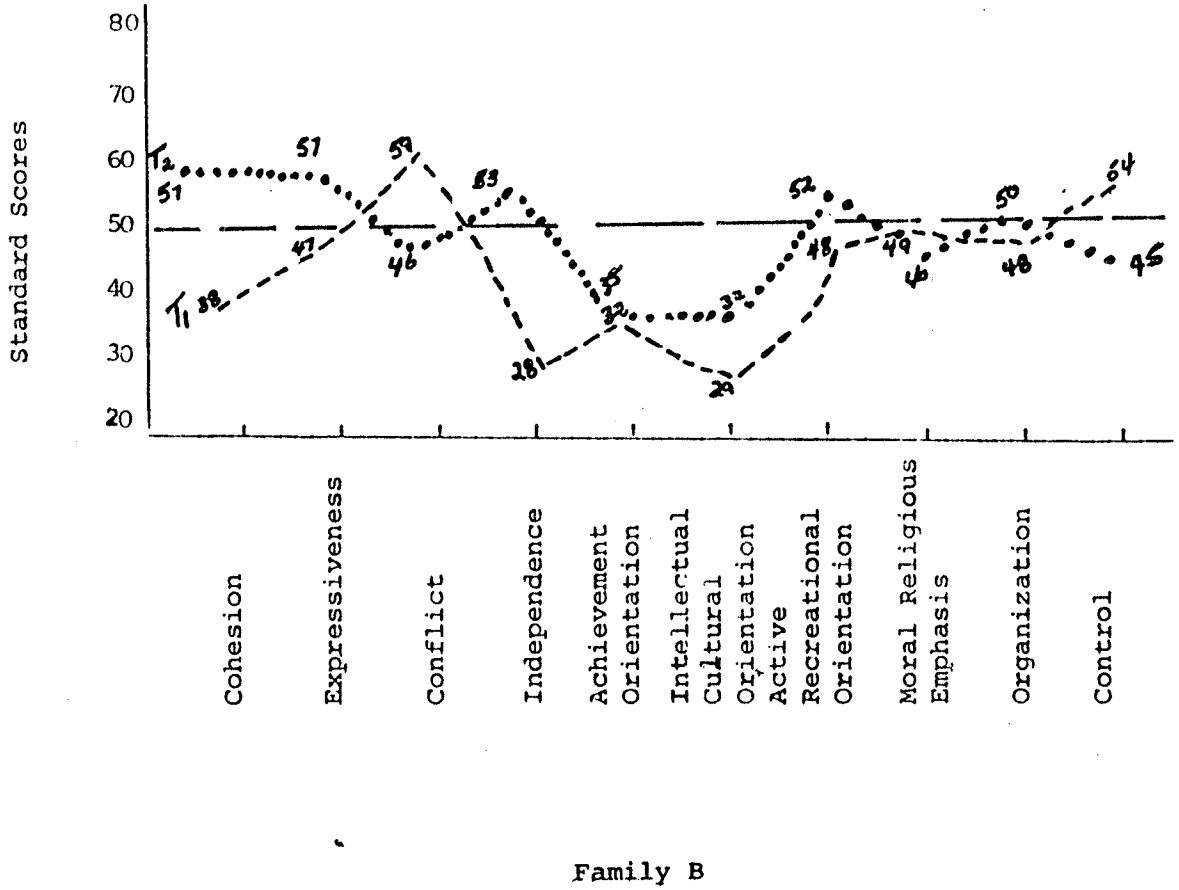
Family "B" consisted of a two -parent family (mother, age 38; father, age 37) and their two children (a boy, age 11, and a girl, 9). The identified member was the 9 year old girl. The parents saw the I.P. as troublesome and not obeying her mother. As well, they reported that she lied. What precipitated the family coming into treatment was the girl's lying. This family referred themselves to the Clinic. They were seen by the writer weekly for six weeks and then transferred to another worker.

The direct goal was to strengthen the parental subsystem yet acknowledge that there were differences in their child rearing ideas. Less directly, but extremely important, was to strengthen the marital subsystem so that the mother could get her needs met directly by her husband rather than needing her daughter as a means to gain access to her husband. Finally, the last goal was to strengthen mother's personal boundaries.

The structural assessment in this family was that the mother and father were disengaged with mother being overinvolved with the daughter and son being overconcerned with mother. It almost seemed as though he replaced the peripheral father. The therapist thought that the function of the child's behavior was to help father and mother re-engage.

Figure 1.2 shows the FES pre-test and post-test profiles for family "B" as compared to the normative score obtained by all the families in the Moos group.

Figure 1.2



Family B

At T_1, the family scored on organization (48) and on control (54), at T_2 organization scored at (50) and control (45). These scores are within the normative range. However, the individual scores for the mother at T_1 on organization was (42), at T_2 (53), for father -- T_1 (53) and T_2 (59). The individual scores slightly suggest that mother was more able to be direct in what she wanted and to begin to enforce consequences; likewise, father's score reflected a similar trend. The individual scores on control show mother with some variation and father with none.

In regards to cohesion dimension, there is a marked difference on the individual scores which is to some degree demonstrated in the normative score of the family. Individually, T_1 on cohesion was (23) for the wife and (53) for the husband. The individual T_1 scores reflect the state of the disengagement in the marital subsystem and support the structural assessment that there was marked disengagement with the wife. The husband saw himself as supportive, encouraging and interested in his wife while the wife did not experience him as involved, either as parent or partner. The T_2 individual scores for the wife was (60) and for the husband (53). The combined score at T_1 (38) and at T_2 (57). These results indicate that the wife has changed in the desired direction suggesting that she is feeling more connected to the husband.

On the other two dimensions, expressiveness and conflict, the combined scores are not as dramatic as the individual scores. On expressiveness, T_1 combined (47) and T_2 (57). The husband's pre-and post-test score was the same while the wife's T_1 was (40), T_2 (60) which again suggested that this woman felt more able to express herself. This suggests that she had begun to differentiate herself from her

daughter and husband. On conflict, the combined score on T_1 (59) and T_2 (46) reflects a desired change in that as the wife has been more able to feel connected and supported by her husband and more able to express her needs; she is less in conflict with her daughter as she utilizes her executive function. On the independence dimension, T_1 (28) and T_2 (53) shows a dramatic shift. The quite low score at T_1 (28) reflects the lack of differentiation. Each in his or her own way is passive and has difficulty defining personal thoughts and ideas (weak personal boundaries). T_2 (53) suggests that has been a dramatic shift in the desired direction of increasing the individual's personal boundaries.

From the clinical profile, there appears to be a change in a positive direction.

Mother and father were beginning to connect on parental issues, father was providing his wife support to take charge of their daughter and the sibling system was beginning to re-establish itself. As well, the boy's position changed from a parental child to being a boy with his own problems. The objective changes correspond with the process that was taking place in the sessions.

Family "C" is a native single parent family (mother, age 29) and her 10 year old daughter. The ten year old daughter was the identified person. She was referred to the Clinic in December by the school social worker who reported her as out of control, abusive to other children and disruptive at school. Though this child was known to the Clinic, and had three previous contacts varying in length of time, it was decided that the writer would see the child with the mother. Mother was pleased to come in.

Mother's complaints were similar but different than the school's. She described her daughter as not following her rules, as coming and going as she pleased and as continuously fighting with her mother. She was also not able to keep her friends and she had temper tantrums. The mother had a boy friend but he was in the process of moving out into his own place; hence, he was not included in the treatment. The natural father was not involved at all. The mother and daughter were seen for four months by the writer and then transferred.

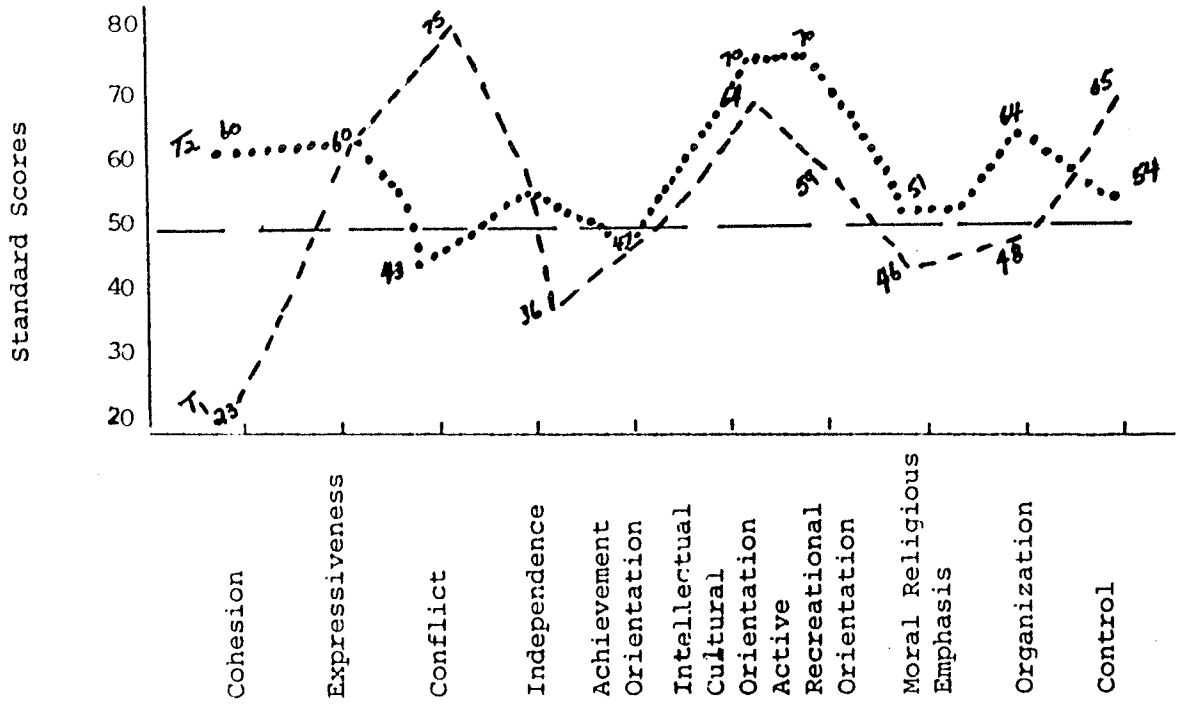
The structural assessment was that there was no hierarchy. The mother-child dyad were terribly overinvolved; in fact, the hierarchy was inverted with the child taking, or wanting to take, care of the mother. It also appeared as though the child was sometimes caught between mother and boy friend and was mother's ally when mother needed one.

The goal of therapy was to create personal and generational boundaries. The mother would learn how to reestablish the executive functions of rules and consequence-setting as well as providing nurturance. Also, each would develop stronger personal boundaries to address their needs for individuation.

Figure 1.3 shows the FES pretest and post-test profile.

The T_1 score for cohesion (23) was at the low end while T_2 (60) was at the high end of the normative range. This is a dramatic swing. When the mother and daughter first came into treatment, they were involved in very volatile fights with little support or helpfulness in either direction. The scores suggested that the mother-child dyad was more cohesive. Mother reported that she "felt better about her daughter" and that they were more able to talk and plan events together.

Figure 1.3



Family C

Expressiveness score did not alter while conflict dimension did, T_1 (75) and T_2 (43). This difference supports the interpretation that mother was much better able to handle conflictual situations and that the conflict was more within normal bounds. The control dimension does not demonstrate the kind of results one would expect, T_1 (65) and T_2 (54). The early score suggests that mother operated from a clear hierarchical structure, one might say rigidly so. The later score suggests a more normal, flexible structure. The only explanation that makes sense is that her hierarchical structure was rigid in its inconsistencies and lack of consequences as well as the inability to be firm. The subjective reporting indicated that the mother changed drastically in how she handled her executive functions. The behavioral change in the child at home and school supported that change had occurred; T_1 organization (48) and T_2 (65) demonstrated a shift. Though the later score is slightly at the high end, it seems appropriate. This mother became much more structured in planning her time, time with child, and time for the child to be with her friends. As well, she began to insist on the child taking certain responsibilities without mother bailing the child out. The change in the independence dimension is quite dramatic T_1 (36) to T_2 (53). Throughout the sessions, this mother was being assisted to develop personal boundaries, to trust her own judgement and her own decisions. The score indicates that she has clearly moved in that direction. This change helps to support the dramatic shift in the conflict dimension. As mother started to doubt herself less, she was freed up to "act" rather than react to the various situations confronting her as a mother and as an individual.

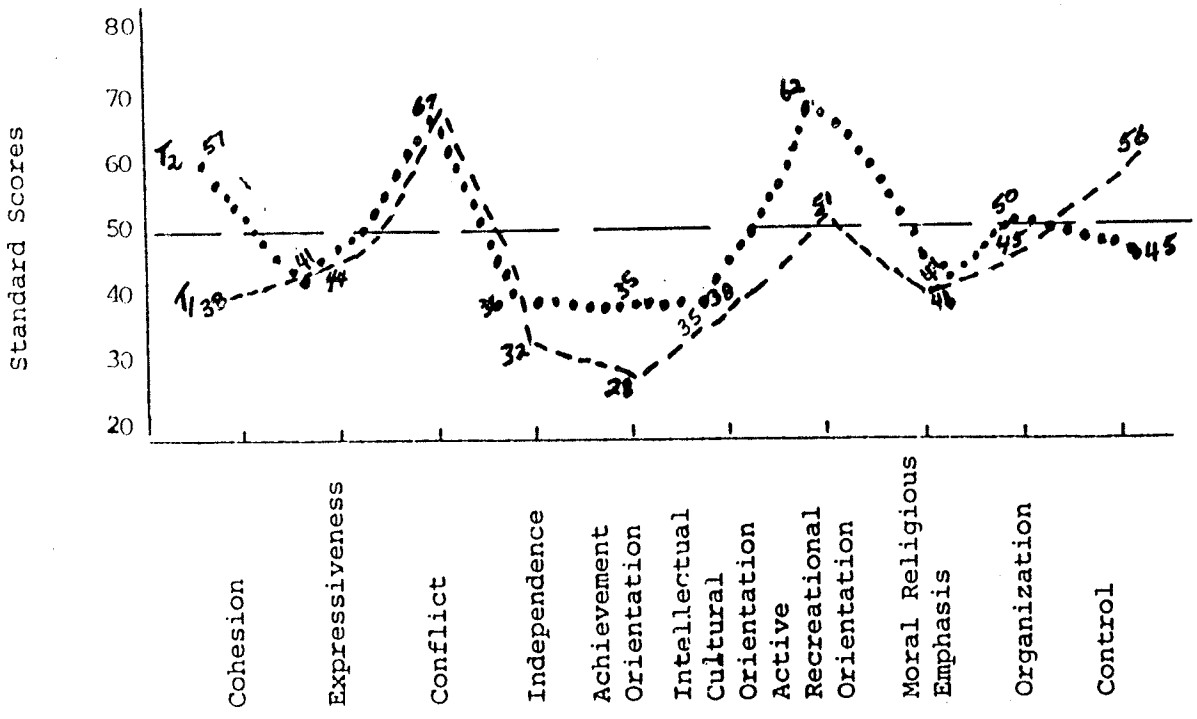
Family "D" consisted of a two parent family (mother age 32; father age 32) and their children (boy age 7; girl age 5). The identified person was the boy. Both parents complained of the boy's temper tantrums; however, it was the mother that was most bothered by the tantrums as they occurred only at home. Both parents clearly stated that they were worn out, very much under stress and they wanted assistance with each other as well as with the boy's temper tantrums. They referred themselves to the Clinic.

The major difficulty was the triangulation of the boy. The function of the triangulation in this family was to siphon off the tremendous frustration between the parents as each seemed to be conflict avoiders. Mother seemed very much involved with the boy while father just wanted to escape from the situation. The children seemed close to one another.

The goal was to detriangulate the boy and to get the parents involved in working as a team. Thus, the boy would recognize that both parents were involved with him in a meaningful manner. In doing this the parental subsystem would be strengthened. Another goal was to support both parents as individuals, hence strengthening the personal system.

Figure 1.4 shows control T_1 (56) and T_2 (45) and organization T_1 (45) and T_2 (50) reflect little desired change. Over the process of treatment, organization and control were salient issues. In order to have the parents gain control, as a first step in the treatment plan, the parents were rotating the discipline every second night. In this early phase, the parents were not able to work as a team but were able to develop a plan for themselves as individuals. It may be that the lack of objective validation in these dimensions has to do with the short

Figure 1.4



Family D

time span as the parents were able to subjectively identify change. Conflict at T_1 (67) and T_2 (67) is still high, has reduced according to the wife's individual score but not according to the husband's individual score. These results would coincide with their subjective remarks. On the cohesion dimension, T_1 (38) and T_2 (57), there was a marked change. This change was understandable in that the husband and wife were giving each other much more support and encouragement as they worked out their individual plans. They were beginning openly to discuss their tensions ansd difficulties with each other in treatment as well as their individual concerns. While the independence dimension scores T_1 (32) and T_2 (36), were below the normative range, change seemed to be occurring in the desired direction. Each parent was beginning to think more positively of his or her decision and were more able to plan family activities as well as to take independent charge of the son. The scores on the expression subscale were T_1 (44) and T_2 (41).

Overall, this family had begun to change in the desired direction. The subjective remarks were more positive than the test results demonstrate. The boy's temper tantrums had lessened considerably to approximately twice a week; the boy and girl were not fighting as often or to the same degree. Father helped mother after a half-hour free time after work. He helped by occupying the children while mother was free to fix supper (by mutual agreement). Both parents became involved with discipline, not just mother, and were finding this to be working very nicely.

Family "E" is a blended family (father, age 49; mother, 39) and her children (boy, age 15; girl, age 17). The daughter was out of the home; the boy was in the home. This family was seen for three and a

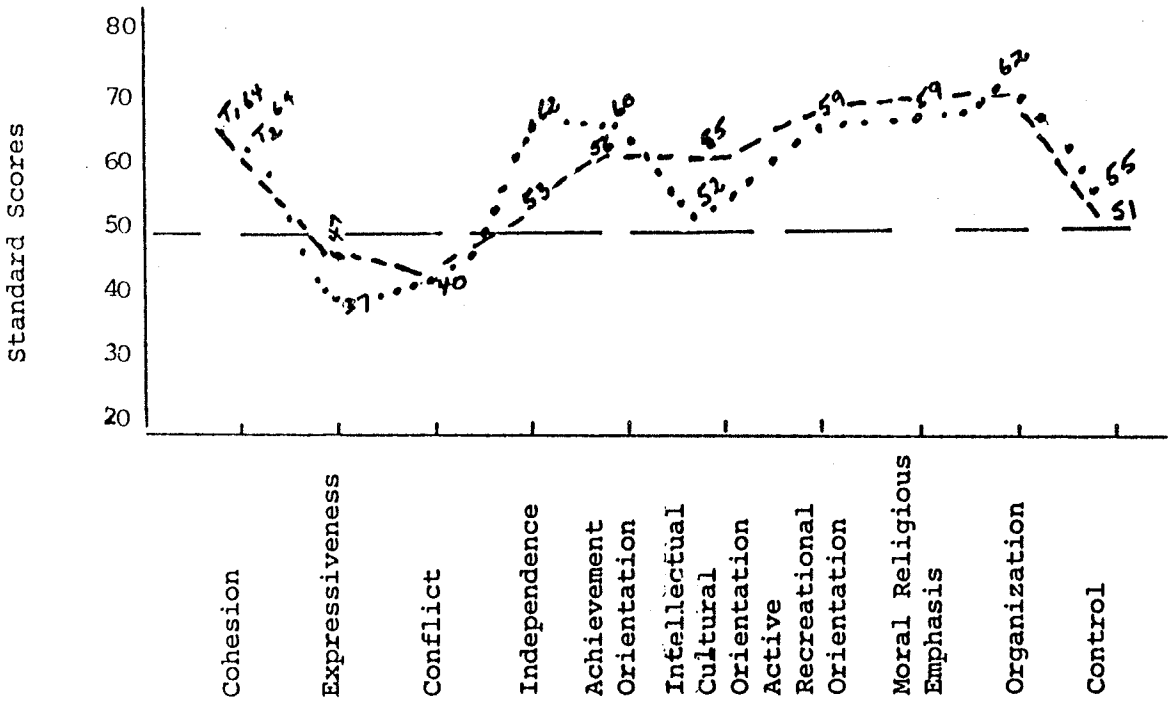
half months, then transferred to another worker. They were a self-referral to the Clinic. This case began as a family treatment but became couple treatment as the boy moved to his own father's home six weeks after treatment commenced. It became couple treatment as the writer was able to detriangulate the boy and then to intervene directly in the marital subsystem.

The structural assessment looked as though there was a coalition between mother and son against father. It appeared that much of the couple's conflict was siphoned off by detouring it through the boy. There was open conflict between the husband and the boy and hidden conflict in the marital pair.

The goal was to strengthen the marital, personal and parental boundaries in such a way that mother would become less smothering of her son, able to encourage him to function more responsibly and autonomously. Another goal was for the step-father and step-son to get to know one another and to develop a positive relationship. A third was for mother and father to resolve conflict in their relationship directly so that they could more appropriately meet their needs.

Scores shown in Figure 1.5 appear to demonstrate little objective change; one immediately notes the tremendous similarity between the pre- and post-test scores. On the dimension of cohesion, T_1 (64) and T_2 (64), have remained the same, somewhat above the norm. This suggests that they are still quite overinvolved with each other. Scores on the independence subscale, T_1 (53) and T_2 (62), show a little change. This change is viewed as just above the norm and suggests that they are more autonomous of each other. Scores on the expressiveness subscale, T_1 (47) and T_2 (37), again suggest that they are more independent and less

Figure 1.5



Family E

likely to be enmeshed with each other on every event. Conflict scores are at T_1 (40) and T_2 (40). While no change is noted, the wife, in particular, was beginning to define herself much more clearly and was willing to disagree openly with her husband in the latter part of treatment. He, in turn, found it hard to accept that they had differences; hence, disagreement was very difficult for him. Scores on the dimension of organization, T_1 (59) and T_2 (61), are at the high end of the norm. Change in the desired direction has not yet occurred. Both of these individuals need to learn how to be less organized and structured yet more able to be more explicit about how each would like the family organized. On the subscale control T_1 (51) and T_2(56), this change in score suggests that the family is organized in a more hierarchial manner which supports the therapy goal of improving parental, marital and individual boundaries. The man and woman had begun to make agreements about money and whether the boy and daughter ought to come home to live.

The objective picture of this family is quite uneven. This could be due to a number of reasons. People do change at varying rates; the resistance to change in people varies from individual to individual and family to family, length of problem and history of previous therapy. In this case, the problem with the boy was presenting before (3 to 4 years) this marriage. As well, both people in this couple had previous therapy in their last marriages so that the degree of resistance to change is probably high.

Subjectively each reported behavioral change. She stated that she felt more autonomous and was more able to trust her own thinking, thus risking expressing different points of view (regarding the children),

to her husband. He reported being less frustrated as he was not personalizing his wife having different ideas and opinions from his. As well, the son did move out to his father's in the sixth week of treatment (which freed him from being "caught" between his mother and step-father); likewise, the couple did not allow their daughter to move back in when she was in desperate financial troubles. The couple recontracted for marital therapy.

Though the FES scores show little indication of change in the desired direction, it seems that the structural goals established in session one were beginning to be met; stronger marital, parental and individual boundaries were evident. This couple was transferred and continued in treatment.

CHAPTER 6

CONCLUSIONS:

In the introductory chapter the writer stated that there were two goals for choosing the structural model of family therapy. First, the writer wanted to develop a working understanding of the theory so as to integrate the theory with clinical practice. Secondly, the writer wanted to develop clinical skills to a higher level.

To evaluate the experience, I will divide the information into three components. The first component will describe the generalizations drawn from the experience using the structural family therapy model.

Using this model allowed the flexibility to conceptualize human problems in a variety of ways. Human problems were viewed in relationship to the family context. Therefore, the complexity of the problem is not reduced to a diagnostic category which often does elicit a preconceived treatment package. In this model there is not a preconceived treatment package; rather, there is an understanding of hierarchical organizational structure and transactional patterns which provides a way to view any living system i.e. individual, couple, family, and community.

As well, this model lends itself to empowering the family to do its job rather than 'giving over' its functions of protection, nurturance and growth to a mental health practitioner. Inherent in this model is the belief that the family is a dynamic organism with resources and strengths which are sometimes not available due to the organizational structure of the family. Because of this belief, the intervention is aimed at the reorganization of the family structure not at one individual.

The clinical work is to assist the family members to struggle with their difficulties and their differences so that they can grapple with the choices and decisions they have to make as individuals and as members to a family.

Besides this model offering the practitioner a way of connecting "symptomology" with the context, it provides a framework which is transferable to other systems. It provides a way of viewing and assessing what the difficulties might be or how the difficulties are maintained in that structure. As well, this model takes into account the interface between the family and the other systems.

The second component is the practice utility of the model. Firstly, the theoretical model is quite straightforward. Once the basic theoretical concepts are learnt, it is a matter of translating those concepts into practice by learning and using various skills. As a practitioner, the writer liked the dynamic quality of the model as well as its flexibility to intervene with individuals, couples, families and larger systems. The model is not doctrine other than to see human problems within a context. Given this, it is up to the practitioner to decide on what combination of subsystems or whole units need to be seen for the purpose of creating change. As the writer worked with this model, the writer began to understand the importance of viewing problems in a systemic manner as there are no villains and victims but rather people caught in vicious cycles. As the writer became more skilled at assessing the structure and the transactional pattern, the model made more sense and did appear to have some objective merit as demonstrated in the preceding chapter.

Finally, the third component to this chapter is to reflect on the shortcomings of this model. The model was initially developed for poor, underorganized families so that the emphasis in the literature is on the family not on larger systems. Because of this, the practitioner must extrapolate from the body of knowledge translating it to fit other circumstances. This is not always easy to do; it appears that the model could be more fully developed on the dimension of intervening in larger systems.

Though the writer does think Minuchin addresses the larger social context as important and needing to be taken into account when assessing what is functional and what is dysfunctional, the writer is not sure that practitioners pay sufficient attention to the political, economic and social contexts within which the family exists. If these contexts are ignored, this model becomes far too limiting because the practitioner may be too willing to assess the family's structure as problematic when in fact the culture supports the family's organization. So the writer is not so sure that it is the model that is lacking; rather, the interpretation of what is stated may be limited. However, the practitioner's limited interpretation may have to do with the fact that the literature addressing structural family therapy does not take social, political and ecomomic context sufficiently into explicit account.

One last criticism has to do with the lack of attention to women and men's issues in this model and whether or not this model can handle these issues. So far these concerns have not really been addressed in the structural family therapy literature.

It seems that people with living difficulties have the right to the best possible assistance. What underlines best, for this practitioner

is working from a framework which asks individuals to struggle with their pain in a context which views human problems as having to do with the context as well as with themselves.

> The therapist should be a healer: a human being concerned with engaging other human beings, therapeutically, around areas and issues that cause them pain, while always retaining great respect for their values, areas of strength, and esthetic preferences. The goal, in other words is to transcend technique. Only a person who has mastered technique and then contrived to forget it can become an expert therapist. (Minuchin & Fischman, 1981, p.1.)

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