STRUCTURAL/STRATEGIC FAMILY THERAPY WITH CHILD AS PRESENTING PROBLEM

BY

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submitted in partial fulfillment of the

requirements for the degree of

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CHAPTER 1 - INTRODUCTION

At the outset of the Practicum, the student had planned to meet the following three objectives.

1. To develop expertise in working with families where the child is the presenting problem.
2. To employ structural/strategic techniques and to develop skills and a conceptual knowledge base in this area.
3. To develop skills in evaluating outcome of structural/strategic interventions and to explore the usefulness of a specific evaluative tool in clinical work.

The student attempted to meet these objectives by:

1. Reviewing the literature in this area.
2. Completing practical work in a setting which maintains a family orientation to solving children's problems.

The following report is a presentation of what the student has learned in the process of completing her Practicum. The initial chapters consist of a literature review, while the final chapters discuss various aspects of the Practicum itself. The literature review is intended to cover three major areas: a historical overview of family therapy leading to the development of the structural/strategic model; a description of the conceptual framework

which underlies the model; and the application of the model to families which present their child as the problem. The chapters on the Practicum attempt to integrate the theoretical concepts with the clinical work. The setting for the Practicum and procedures is described, along with the problems and strengths of the setting for the student. Her cases are reviewed and the personal learning experience of the student is discussed. The evaluation model used is described and analyzed and the findings on the treatment outcome are presented. The final chapter provides an evaluation of the Practicum as a whole, and of the structural/ strategic model - its limitations and contributions to Social Work Practise.

CHAPTER 2 - HISTORICAL OVERVIEW OF FAMILY THERAPY

A brief historical overview of the family therapy field is presented here in an attempt to place the development of structural/strategic family therapy in context. Its' roots are traced from the very early thinkers in the family movement to the pivotal Bateson project (Foley, 1974) and finally to those practitioners responsible for conceptualizing the structural and strategic approaches as we know it today. In addition, the predominant approaches of the most reputable structural/strategic therapists are presented. The purpose of the historical overview is to introduce some of the concepts presented in later chapters and give an orientation to the major practitioners whose methods and thoughts will be referred to in future pages.

This chapter is organized in three phases. Phase one presents some of the major pioneers in the field of family therapy in whose ideas can be traced the crude beginnings of structural/strategic notions. Phase two presents the work of the Bateson group and the individual contributions of its' members. The result of this work was to form the foundation on which structural and strategic ideas were based. Phase three will present the major proponents of the structural and strategic therapies as well as those practitioners presently engaged in structural/strategic family therapy.

PHASE 1 - EARLY THINKERS (1940-1960)

General systems theory, one could argue, underpins all family therapy. As early as 1945, Ludwig Von Bertalanffly, a biologist, applied systems theory to psychiatry. He described families as an open system containing properties of wholeness, relationship, and equifinity. He viewed feedback in the system in cybernetic terms; that is, rather than "a" affects "b" affects "c" as in the linear model, Bertalanffly used the circular model -- "c" leads back to "a". In this paradigm, pathology is derived from a "failure of the system to function properly because of lack of information" (Foley, 1974, p.43). Treatment then, consists of altering the feedback mechanism by correcting the information gap (Foley, 1974, p. 39-44).[1]

In the same decade a number of psychiatrists were attempting to understand schizophrenia in a broader context. In 1948 Lyman Wynne tried to "develop a psychodynamic interpretation of schizophrenia that takes into conceptual account the social organization of the family as a whole" (Foley, 1974, p. 18). Wynne described a "rubber fence" as the boundary surrounding the family which expands and contracts as is necessary to keep the schizophrenic member inside. His terms "pseudohostility" and "pseudomutuality"

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[1] For further discussion of system theory consult Foley (1974, p. 39).

are used to describe the alignment and the lack of differentiation of the schizophrenic in his family (Hoffman, 1980, p. 35). Wynne's thoughts become apparent in Minuchin's later structural concepts of boundaries, coalitions and enmeshment.

In the 1950's, Theodore Lidz, a Yale psychiatrist, related disturbed communication patterns in the marital relationship to the development of schizophrenia. He saw the importance of clear role definitions, particularly in the distinct generational boundaries between parents and their children. The structural/strategic ideas of hierarchy and cross-generational boundaries are foreshadowed by Lidz.

Murray Bowen, a child psychiatrist in the 1950's was one of the early pioneers of family therapy. (Brodkin, 1980, p. 13). Bowen viewed the patient in terms of his extended family, conceptualizing him as part of "interlocking triangles" from which the identified patient must differentiate and detriangulate in order to function well (Okun & Rappaport, 1980, p. 117). The structural/strategic conception of triangulation and triadic interaction can be found in Bowen's theories.

An overview of the pioneers in family therapy could not be complete without including the contributions of Nathan Akerman. Akerman, a psychoanalyst and child psychiatrist, did much to legitimize the family therapy movement. He embraced botth the analytic and systems approach.

Akerman saw pathology of the individual as reflecting an emotional distortion in the family (Okun & Rappaport, 1980, p. 50). As early as 1938, he wrote "The Family as a Social and Emotional Unit" and he has often been referred to as the "grandfather" of family therapy (Guerin, 1976, p. 12).

PHASE 2 - THE BATESON GROUP AND THE DOUBLE BIND THEORY

The 10-year Bateson project (1952-1962) in which language and communication patterns of schizophrenics (among other things) were studied, laid the groundwork for the development of the structural/strategic model of family therapy. Each of the six members who worked on the project (Bateson, Haley, Weakland, Fry, Jackson, Satir) have since achieved prominence in their own right. The results of the first phase of research were published in 1956 in the classic paper "Toward a Theory of Schizophrenia" which expounds the double bind theory.

"Double bind" describes a context of habitual communication impasses that persons in a relationship system impose on one another. "Under some circumstances these impasses seem to elicit the responses known in their aggregate as schizophrenia" (Hoffman, 1980, p. 20). The double bind is a message in which the overt demand at one level is covertly nullified at another level. "Be spontaneous!" is an example of a double bind message. If one obeys the directive to be spontaneous, it is in direct contradiction to the spontaneity because it is simply a response to the command. The communication is paradoxical and the only response can be either to say it is impossible to respond adequately to the message, or to leave the field. When neither of these options is possible and this type of communication becomes habitual, the result can be schizophrenia

(Hoffman, 1980, p.20).

The original work was later qualified to include more than two-person interactions. Bateson used the expression "the infinite dance of shifting coalitions" to describe the interaction of the schizophrenic family (Hoffman, 1980, p. 25).

The project leader, Gregory Bateson, an eminent anthropologist, had studied communication patterns among tribes in New Guinea and was interested in systems and cybernetics. Jay Haley, John Weakland, and William Fry were the first to join Bateson. Weakland and Haley are currently leaders in the strategic therapy field.

Virginia Satir joined the project in 1959. One of Satir's major contributions was in using her charismatic style of presentation to popularize the movement (Broderick & Schrader, 1981, p. 25). A communications therapist, Satir helped families develop clearer communication through focusing on feelings, growth, and the development of self-esteem (Okun & Rappaport, 1980, p. 96).

Psychiatrist Don D. Jackson joined the Bateson project in 1954 as the clinical director, and was the first to introduce the idea of "family homestasis" to the group. Jackson maintained that families under stress developed certain interactional patterns designed to maintain their equilibrium. He claimed that for a disturbed family to retain its stability, one member was needed to develop a

mental illness. Jackson observed that when the patient improved, the family equilibrium was upset and would only be restored when the patient relapsed or another family member became ill. Jackson saw the therapist's role as disturbing the homeostasis in order to create room for change. He employed what later became known as strategic techniques including paradoxical injunctions and relabelling. (These techniques will be described in detail in Chapter 4) (Okun & Rappaport, 1980, p. 84).

In 1959 Jackson established and became director of the Mental Research Institute (MRI). The MRI spawned a great number of research projects, publications, books and creative experiments in the clinical field of family practise. A number of offshoots of MRI were established to study various specific problem groups and techniques in working with them. The most notable of these, for the purposes of this report, is the Brief Therapy Centre.

PHASE 3 - PRACTITIONERS

The Brief Therapy Centre was established to explore what could be done with a variety of problems in a short time. The therapists, Richard Fisch, Paul Watzwalick, John Weakland and Arthur Bodin, are considered by some to be pure strategic therapists. They do not focus on changing the family organization, but plan strategies to eliminate the symptom. Their orientation views strategic family therapy as a theory of change. They view problems being created by the mishandling of everyday life difficulties. Their concern is what works to change the way people handle their problems. (Watzlawick et al, 1974)

Conditions for treatment are fairly rigid. These include a ten-session maximum with very active intervention. Focus is strictly on the presenting problem, ignoring other areas of dysfunction. Therapists use a repertoire of strategic techniques such as "reframing" and "paradoxical injunctions", however, their techniques are somewhat distinctive in the way they work with resistance, avoiding confrontation with the family. The Brief Therapy Centre bases its thinking on the works of Jackson and Haley (Bodin, 1981, p. 291). (Parodoxes, what they are and how they work will be dealt with in Chapter 4)

Jay Haley is a major proponent of strategic family therapy and some may credit him with its original inception. Haley's thinking seems to have evolved through a number of phases "Zigzagging...from process to form" (Hoffman, 1980, p. 280). His early work with Bateson was primarily con-

cerned with communication as a means of defining power in a relationship. "Strategies of Psychotherapy" (1963) focuses on the process of defining oneself in a power position and how one can apply this to therapy.

Concurrently, Bateson introduced Haley to Milton Erikson, the famous hypnotist and innovative therapist. Assigned to study paradoxical communication in hypnosis, Haley became fascinated with Erikson's unusual, directive way of working with patients. Erikson was a master of using paradoxical injunctions to overcome his patient's resistance. Although he did treat individuals, Erikson had a family-life cycle orientation. He viewed his patients as getting stuck in a particular developmental stage, needing to pass through it to the next stage. Haley published a number of papers and books about Erikson's techniques, most notably "Uncommon Therapy" (Haley, 1973). Haley credits Erikson with providing him the key ideas of the strategic family therapy approach (Haley, 1976, p. x, preface).

Haley's next phase of development began in 1967, when he joined the Philadelphia Child Guidance Clinic at a time when structural family therapy was being formulated and refined. His now classic book, "Problem Solving Therapy" (1976), demonstrates Haley's concern for family organization which he terms hierarchical structure. He shows how problems can be assessed by looking at those organizational sequences which surround and maintain the problem (Hoffman, 1980, p. 280).

Haley's recent book, "Leaving Home (1980), describing the treatment of "mad young people" (p. 7) and their families, marks yet another major contribution he has made to the field. Haley defines the "eccentric" or "mad" young person as triangulated between conflicted parents who cannot allow their daughter/son to assume adult responsibilities and leave home, for fear of confronting their own relationship. Haley describes the overall social control system in terms of hierarchy and power, with insight into the undermining effect it may have in therapy with young adults labelled schizophrenic.

The common thread throughout Haley's work is the persistant philosophy of non-pathology. Haley will not label people by ascribing pathology to an individual; he defines problems as involving at least three people and generally sees working through them in stages.

Cloe Madanes has added the notion of "incongruous hierarchies" (Madanes, 1981, p. 27) to Haley's theories, describing in organizational terms the effect of the symptom bearer on the family system. She sees the identified patient as "protecting" the family and employs "pretending" with families in an original way to work on problems. Her recent book, "Strategic Family Therapy" (1981), articulates strategic ideas in an extremely lucid manner. Madanes, like Haley, is now considered a strategic therapist, how-

ever, she has had her original training in structural family therapy working together with Salvador Minuchin.

Minuchin is the major proponent of structural family therapy. His initial work took place in the early 1960's at the Wiltwick School for Boys. There Minuchin worked with underorganized and socially disadvantaged families who had at least two delinquent children. Minuchin found that abstract psychoanalytic insight-based therapies were frustrating to this group. They needed to see visible behaviour change and concrete solutions to their problems (Aponte, 1981, p. 310). "Families of the Slums" (1967), which documents this work, presents the implications for interventions which later develop into structural family therapy.

Minuchin became the director of the Philadelphia Child Guidance Clinic in 1965, refining and developing the structural approach with his colleagues. The outcome was a present-orientated therapy in which problems were enacted in the therapy room rather than simply discussed. In this situation, the therapist becomes actively involved in re-structuring the family organization in the interview itself.

Briefly, Minuchin views the family in terms of its organization and demarcation of subsystems. The therapist's task is to first join with the family system and then intervene to clarify boundaries and encourage appropriate

distances between subsystems.

Structural and strategic ideas will be expanded upon in the following chapter. However, the divergence in their approaches may become clearer by comparing Minuchin's focus with that of the Milan group, who, like the Brief Therapy Centre, are considered to be pure strategic therapists. The Milan group consists of Mara Palazzoli-Selvini, Luigi Boscolo, Gianfranco Cecchin and Guiliana Prata. They began as analysts and currently use a variety of creative, strategic techniques, many of them paradoxical. These are outlined in their book, "Paradox and Counter Paradox" (1978). A number of features makes this group unique in their contributions to the field, most importantly, their rigidly structured format for working with families. Some of their conditions are:

1. There are a maximum of 10 appointments scheduled, one month apart. In most instances they will refuse to treat a family more frequently than once a month. The month-long interval gives the family time to react to and cope with the crisis brought about by their assigned perscription (Palozzoli-Selvini, M., 1980(b))
2. There is always at least one therapist observing behind the one-way mirror.
3. After some time is given to observe the family, the therapist leaves the room and discusses the family interaction with his colleagues who collaboratively

design an oral or written prescription to present to the family. In these collaborative sessions, the Milan group share each others expertise in formulating an assessment of the families'problem. Problems will be defined in terms of interaction between family members rather than ascribing pathology to individuals.

4. The wording of the prescription is meticulously arranged and may take hours to compose. These prescriptions are designed to attack dysfunctional family interactions often by using paradoxical methods. (Paradoxical Interventions described in Chapter 4). True to the strategic tradition, changes are expected to occur at home rather than in the interview as a result of the prescrition given. After the first interview, which is primarily diagnostic, sessions focus mainly on the family members reaction to the assigned prescription.

Based on the feedback obtained, another powerful prescription is designed. The group will abandon a technique if it is not working, and consequently will design a new strategy to attack the family problem.

In recent years, they have begun to screen out all but the most difficult family problems for research purposes. Considering the usual degree of hopelessness felt by helping professions, the Milan group has achieved an extraordinary measure of success with families of schizophrenics (Palazzoli, et al, 1978).

Structural and strategic therapists tend to borrow intervention techniques from one another. They seem to be natural complements in therapy because of the basic conceptual framework which they share. This is an outcome of the collaborative efforts of Haley and Minuchin in the 1960's.

Maurizo Andolfi and Duncan Stanton are perhaps the most well-known therapists who draw from the structural/strategic model. They both work with an extremely difficult population group (addicts and schizophrenics) and find they select a more structural or strategic orientation depending on the situation.

Andolfi (et al, 1980 (b)) and his group in Rome, Italy, are structural/strategic therapists. They have designed a model for working with families of schizophrenics who tend to be highly resistant to treatment and change. Their model outlines when it is appropriate to use strategic techniques and when structural techniques need to be employed. (The model is presented in Chapter 4)

Briefly, Andolfi will approach a very disturbed family with a strategic orientation, responding to their paradoxical messages with paradoxical replies. For example, a family says it wants help, yet views the identified patient as incurable. Andolfi will stress the dangers of change, yet consistently projects his view that the identified patient is normal and his behaviour logical and voluntary.

Only when the family has proven it wants to change will Andolfi stop the strategic, paradoxical techniques and start to work directly and structurally to restructure the families' organization. In the termination phase, when the family asserts it can make it on its own, Andolfi will revert to a strategic approach by sending them off with a warning to "watch out", implying, once again, the dangers of change (Stanton, 1981, (c), p. 389). Paradoxically, by warning the family about the dangers of change, Andolfi expects to induce it. By validating and even exaggerating the families' fear of changing, the family will paradoxically become less fearful and be more inclined to change.

Stanton and Todd (1982) also use a structural/strategic approach successfully with the families of drug addicts. Stanton conceptualizes the addict's addiction as resulting from a family dysfunction where, like Haley's schizophrenic young people, they are unable to "leave home". The families of drug addicts tend to be a very defensive and resistant group, generally with multiple problems.

Stanton suggests using well-thought out strategies if and when the family is demonstrating resistance. When the therapist senses the family's co-operation, Stanton advocates reverting to a structural orientation. He uses the classically strategic technique of "positive connotation", i.e., "ascribing the most noble intentions to their actions" (Stanton, 1981, (c), p. 389) throughout, to gain the family's

co-operation. In the recruitment stage (when families of addicts display greatest resistance to family treatment) Stanton will have a strategic orientation in designing unique strategies tailored to motivate individual families. Lasting changes however, are affected by altering underlying family structures which Stanton views a necessary to allow the addict to freely leave his family.

CHAPTER 3 - STRUCTURAL/STRATEGIC CONCEPTUAL FRAMEWORK

A. INTRODUCTION

Structural/strategic family therapy is an amalgamation of Minuchin's structural approach to family therapy with the strategic approaches pioneered by Haley and others (see Chapter 2). Haley was instrumental in developing structural family therapy and consequently, these two approaches are in many ways quite compatible. Although there exists a distinct difference in focus, both approaches share notions of how problems develop and how families are organized. While this common base exists, there is a difference in perspective in conceptualizing the family system and hence, the consequent intervention strategies.

The structural approach is primarily form-oriented; it views the family through its forms, structures, and organization. The structural therapist will intervene with the goal of manipulating dysfunctional family structures.

The strategic therapist is process-oriented. He will view the system in terms of how its problems were formed and how they may be resolved. His intervention attempts to change the way people have been dealing with their problems.

In spite of different orientations, both approaches are intertwined. The structuralist must gain a deep understanding of the family interaction, the process of relation which maintains the dysfunctional structures. The strategist needs to know who is involved in the problem and how the

problem manifests itself in the structure of family interaction. Both therapists search for behavioural interactions which are dysfunctional. Hoffman (1980) states that "structuralists need to admit their knowledge of process and the strategists need to admit to their knowledge of forms" (p. 278).

Structural family therapy has been called a "theory of family" (Minuchin, 1974) in contrast to strategic family therapy which has been called a "theory of change". (Watzlawick et al, 1974). A theory of family attempts to understand family functioning in this case, by analyzing and evaluating the structures and organization which allow the family to carry out its functions. A theory of change focuses on how change occurs, how problems are formulated, and how they are resolved. This student attempts to view the structural/strategic approach as a cohesive model which studies how one effects change within a family structure. Within this framework, the therapist's point of intervention will vary with the situation, applying strategic and structural techniques selectively, over time, to different situations even within the same family.

The following chapters of the literative review are in fact a synthesis of the conceptual model and diagnostic and interventive techniques which the student ulitized in her clinical work with families. The student drew from numerous diverse sources in the structural and strategic family therapy literature in order to present the basic tenets of structural/strategic family therapy as a cohesive model. This model was particularly appropriate for the student because of its

application to families presented with a variety of child problems.

B. CONCEPTUAL FRAMEWORK - STRUCTURAL/STRATEGIC MODEL

The structural/strategic model views the individual and his problems within his social context. The individual's most basic unit of social context is the family, and therefore, is chosen as the unit of intervention when problems arise. The family is conceptualized as a living system which utilizes transactions between individuals in order to carry out its various roles and functions. Over time, these transactions create a structure which determines how family members will relate to one another. Because of the complexity of (its) roles and functions, each family will have developed a repertoire of structures which is uniquely its own. Some of the structures become dominant while others are subordinate. The dominant structures touch many facets of family functioning (Aponte, 1981, p. 312).

"The family system differentiates and carries out its functions through subsystems. Subsystems can be formed by generation, by sex, by interest or by function" (Minuchin, 1974, p. 52). Every individual belongs to a number of subsystems where he has different functions, makes contact with different people, and learns different skills. The major subsystems in most families are the spouse, the parental-child, and the sibling. (These will be described in greater detail in Chapter 4.)

The structural/strategic view diverges from general systems theory in that "systems theory" sees each element of the system as equal, i.e., having an equivalent status and power to one another (Foley, 1974, p. 40). The structural/strategic perspective views the family as organizing itself in a hierarchy with a differentiated power arrangement. Universally, the natural hierarchy in a family has parents higher than children and grandparents higher than parents. There are three major ways in which a family organizes its subsystems to perform their duties: boundary, alignment, and power.

"The boundaries of a subsystem define who participates and how" (Minuchin, 1974, p. 53). Boundaries serve to monitor the amount of contact with and intrusion from other subsystems. An overly permeable and diffuse boundary would indicate that members of the subsystem are too involved, unable to differentiate from one another, with the result that members may be included in functions inappropriate for them. If this type of boundary is the dominant one, the family would be called "enmeshed".

At the opposite extreme is the "disengaged" family, with highly rigid boundaries. Consequently, there is too much distance and autonomy of the subsystems operating. All families are seen to fall somewhere on the continuum from disengaged to enmeshed (Minuchin, 1974, p.54).

Boundaries are expected to change appropriately with the developmental stage in the family life cycle. For

example, a mother is expected to be enmeshed with her newborn child. When the child grows to adolescence however, the boundaries must allow it more distance so that a measure of autonomy can develop. Problems often relate to a family becoming 'stuck' in a particular developmental stage; the family structure lacks the flexibility to reorganize successfully and to allow new structures to generate themselves.

Alignment refers to one member joining with another in opposition to a third or more members. In a healthy family, members can shift alignments flexibly and appropriately to the situation at hand. In a dysfunctional family, two members may collude consistently regardless of the situation. This is called a "stable coalition". If two people collude and appoint another person as the 'problem', this is called "detouring". Two persons may also attempt to collude with a third against each other. This is called "triangulation" (Aponte, 1981, p. 114). Haley details coalitions which span two or three generations. He finds that the problem is most severe when these cross-generational coalitions are denied or concealed (Haley, 1976, p. 109).

Power alludes to the amount of influence one family member has in relation to another on the outcome of an activity. A function can only be completed successfully if the subsystem has more power than those who oppose it. If, for example, a stable coalition which opposes a parent exists, the parent may have little power or influence in his role.

The structural/strategic model sees problem formation and resolution as a key concept to understanding how a therapist affects change. The MRI group have done extensive work in this area, viewing problem creation as the result of mishandling in everyday life difficulties. When people persist in an attempted solution, despite the evidence that this proposed solution is not working, they inadvertently prolong and maintain the problem. Everyday life difficulties have solutions although they may require an expenditure of time, effort, money, and/or emotional pain. Persistent mishandling exasperates the problem to the point that the participant is paralyzed and must seek outside help (Bodin, 1981, p. 283).

In a family, the meta-rules, or rules about changing rules, must be clearly established. If a family has no implicit mechanism which allows its members to acknowledge, agree upon, or adopt necessary revisions, a paradoxical situation is created where no solution can be found. Change in this situation can best occur by employing paradoxical methods necessary to respond to the paradoxical problem (Bodin, 1981, p. 283). (Specific paradoxical techniques will be dealt with in Chapter 4)

Therefore, changing the rules is not sufficient. Meta-change or second order change [2] is required in order to change family meta rules.

C. STRUCTURAL/STRATEGIC THERAPY

The structural/strategic therapist must identify and intervene in those dysfunctional behavioural sequences which generate and maintain dysfunctional family structure. Because those sequences are currently operative, this approach is present-oriented with no formal attempt at collecting a history (Stanton, 1981, (c), p. 372). The assumption here is that a past trauma did not cause the present behaviour problem, rather the current situation is causal to the problem. (The present-orientation and brevity of therapy will be viewed critically in Chapter 7.)

The therapist may choose to interrupt the sequence in a variety of ways. He may require the family to enact the interaction in the therapy room or he may assign "homework", a task specifically tailored to the family's unique

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[2] First order change and second order change are terms coined by the B.T.C. to differentiate between change on various meta levels. First order change refers to the logical common-sense way of changing a situation to solve a problem. Second order change refers to a counter-inuitive change made which although seemingly illogical may clear the way to spontoneous change thus solving the problem. For example, the insomniac who tries harder to make himself sleep (first order change) is likely, because of anxiety about the problem, to perpetuate his insomnia. To solve the problem, a therapist would forbid him to sleep (second order change) with the expectation that he will eventually become tired and spontoneously fall asleep.

interaction. The task may be direct -- such as advising parents who are over-involved with their children to take a vacation. Or the task may be paradoxical, such as requiring a couple with marital problems to rise daily at 6:00 a.m. for a prescribed session of fighting. (Tasks and other techniques will be dealt with in detail in Chapter 4).

Therapy is conducted in stages, with the major goal and measure of success being the solution of the presenting problem. The goal of structural/strategic therapeutic interventions is to change family organization or the dysfunctional aspects (boundaries, alignments, power structure) so that the presenting problem is unnecessary (Madanes, 1981, p. 22). The family is asked to define its goals in concrete, measurable, and realistic terms so that subsequent therapy can focus on reaching those goals as quickly as possible.

The student sees defining concrete measurable goals as an important process for client and therapist involved in any type of therapy. Haley (1976) talks of therapy in terms of "fair exchange" comparable to a business transaction (p. 195). The client should know in explicit terms why he/she is receiving service (help) and what constitutes completion of the therapy. The problem solving approach could be contrasted to a growth orientation where the goal is to evolve and self actualize to a greater degree. (These positions will be contrasted in Chapter 7).

If the presenting problem has not been resolved, therapy has failed, the therapist is held responsible. He is expected to be active and direct, always maintaining therapeutic control. This requires planning on the therapist's part and a thorough understanding of the dysfunctional sequences and structures which preserve the problem.

Strategic, paradoxical techniques will be employed with difficult families until resistance is overcome and a commitment to work is obtained. At this stage, the therapist will shift to a structural approach where the family works to change dysfunctional structures.

CHAPTER 4 - STRUCTURAL/STRATEGIC FAMILY THERAPY WHEN THE CHILD IS THE PRESENTING PROBLEM

This chapter of the Practicum report will attempt to present the application of the structural/strategic model to the specific population of families who present with their child as the problem. This approach has been used by Haley, Minuchin, Andolfi, Stanton and others in working with psychosomatic children, delinquents, drug addicts, schizophrenic young adults and a host of other child problems ranging from fear of dogs to "messing pants" (Haley 1973, (b)).

A. HEALTHY AND DYSFUNTIONAL FAMILY -- HOW CHILD PROBLEMS ARE SEEN TO DEVELOP FROM A STRUCTURAL/STRATEGIC PERSPECTIVE

This section will begin by describing how a healthy family is organized and expected to function. It will then be explained how a child may develop symptoms as a result of dysfunctional family interaction. The meaning of the child's symptom will be examined in its context.

According to this model, if a family has subsystems which are fulfilling their expected roles, the boundaries around each subsystem and the family system are clear and unambiguous, there are no unhealthy alignments, and the power hierarchy is intact, then it is unlikely a child will have problems.

In a well-functioning family, the spouse, the parent-child, and the sibling subsystems fulfill certain functions, each being endowed with the power to execute

their role. Ideally, the spouse subsystem should serve as a refuge from external stress and as a matrix for contact with other social systems. It should foster creativity, growth and interdependence and support. There needs to be a boundary around the spouse subsystem shielding it from excessive demands and intrusions from the children (Minuchin, 1974, p. 56).

The main function of the parent-child subsystem is to socialize, nurture and guide the children. The parents must not set rigid controls, yet limits and authority must be maintained in relation to their children. The boundary around the parent-child subsystem should allow children access to both parents, yet exclude the children from spouse functions (Minuchin, 1974, p. 57).

The role of the sibling subsystem is to provide a social laboratory, where children can learn to negotiate, co-operate and compete with their peers. The boundary around this subsystem should allow the children to apply their skills in the outside world and to bring extrafamilial experiences back into their sibling world (Minuchin, 1974, p. 59).

The boundary around the whole, well-functioning family should be clear, with a "partial door open to the extended family" (Bodin, 1981, p. 275) and openness to non-family and community members. The structures of a healthy family should be "adequate to and harmonious with the functions of individual members, its subgroups and the social

environment of which it is part" (Aponte & Van Deusen, 1981, p. 313).

The relationship to the nuclear family to its extended family and to the community may vary according to cultural background, such as native or third world families or family structure such as single parent families. The usefulness of the structural/strategic model in these cases will be examined in Chapter 7.

Child problems cannot be fully understood unless one also takes into account two basic ideas: that of behavioural sequences and hierarchy. Haley (1976) states that "to be organized means to follow patterned redundant ways of behaving and to exist in a hierarchy" (p. 101).

The natural hierarchical arrangement in the Western world is that parents are higher than, or in charge of their children. When the hierarchical arrangement is confused, the individual displays symptoms. Madanes (1981) sees symptom development as an attempt to change hierarchical arrangements by rebalancing the power relationships (p. 30). Haley (1976) states that the hierarchy can be confused in two ways: one way is through ambiguity, so that no one knows who is his superior and who is his peer (p.102). The second way confusion can occur is when one member of a hierarchical level consistently forms a coalition against a peer with a member of another hierarchical level, thus violating basic rules of organization. An example of this would be a mother

who consistently colludes with her son against the father.

By observing the behavioral sequences that occur in a family, one can map out a hierarchy. Rigid, repetitive sequences of a narrow range define pathology. Therapeutic change is designed to bring more complexity into relationships, allowing for a greater number of alternative ways for people to interact with one another (Haley, 1976, p. 104-5).

Child problems must be conceptualized in terms of at least three steps in a sequence, and three levels of a hierarchy (Haley, 1976, p. 108). For example, the therapist can conceptualize the three-step sequence as: child does 'x' in reaction to mother, who reacted to father who reacted to child and mother doing 'y'. The hierarchy refers to the participants in the sequence by their generational level, that is, their different order in the power hierarchy. A three-generation conflict could for example, be, a grandmother who colludes with a grandson against his mother.

A typical example of a two-generation conflict will illustrate how sequence and hierarchy are integral to understanding and conceptualizing a child problem. Mother is overly involved with her son, and deals with him by a combination of affection and exasperation. The son's symptomatic behaviour becomes more pronounced. The mother, or son, call on the father to help resolve the difficulty. The father steps in to take charge and deal with the son. The mother then reacts against the father, insisting that he is not handling the situation properly. She reacts with

an attack on the father. Father withdraws, giving up on the attempt to disengage mother and child. Mother and child continue to interact until an impasse is reached in which the sequence is repeated. In the above behavioural sequence, mother has crossed the generational boundary and sided with her child against the father (Haley, 1976, p. 115).

Child problems viewed from this perspective, see the child's symptomatic behaviour as a communication vehicle for the parents. The child metaphorically expresses what is happening in the marital relationship. Put another way, the child becomes the stabilizing force in the marriage (Haley, 1976, p. 116). Madanes (1981) sees the child as "protecting" the parents. She explains that the child "provides respite from the parents' own troubles and a reason to overcome their own difficulties...by focusing their parental concern on him (the child)" (p. 66). According to Madanes, this protection gives the child too much power. "Incongruous hierarchies" is the term she uses to denote parents and child simultaneously occupying two different power levels. Parents who are naturally in a superior position in the hierarchy, by virtue of being the parents of their child, are simultaneously in an inferior position because they need the child's protection. The child is also caught in an incongruous hierarchy; he is in an inferior position as a child, but a superior position as the protector of his parents.

Prior to discussing therapeutic intervention in the system to effect change, a final comment is needed concerning the development of child problems in the context of the family life cycle. As children, parents, and grandparents age and mature, hierarchies and sequences change. There occurs an extraordinary reversal of hierarchical structures in the family life cycle. Children shift from being the object of parental care, to becoming their parents' peers upon reaching adulthood, to taking care of parents in their old age. Natural developmental changes take place over the course of time. However, when families do not change and develop over time but become fixated in a specific dysfunctional interactional sequence of behaviour, the therapist is required to intervene and introduce changes that the natural process has been unable to facilitate (Haley, 1976, p. 128). The assumption here is that a developmental crisis could be the cause of problems. This idea supports the notion that problems are not rooted in past trauma, but rather in current interactions and therefore taking a history is not relevent to discovering the cause of family difficulties.

B. GOALS OF INTERVENTION

The following section will focus on what structural/strategic family therapy sees as the goals for work when a child is presented as the problem. First, there will be an examination of:

i. General therapeutic goals and how one uses the presenting problem. Then the stages of therapy where primary

and secondary goals are established will be applied to work with special cases. Finally,

ii. A review of the assessment process is covered.

i. GOAL SETTING

The goal of intervention can be seen from two vantage points -- how the therapist views the goal and, what is presented to the family as the goal of therapy. The therapist sees his goal as intervening in the dysfunctional behaviour sequences in such a way as to effect change. When there are children problems, the therapist will try to change the dysfunctional sequences by preventing coalitions across generational boundaries. The therapist achieves this goal by strategically aligning with individuals or coalitions while simultaneously remaining neutral (Haley, 1976, p. 119).

Greater co-operation from the family will result if the therapist uses the presenting problem (that which bothers the family most) as the ostensible therapeutic goal. From the family's viewpoint, the child is the problem, and the family will probably not even understand why it is being invited to the interview. It is not crucial for the family to understand that the scope of the presenting problem encompasses the entire family unit. It is however, necessary to enlist their co-operation in doing whatever the therapist requests in order to overcome the presenting problem (Haley, 1976, p. 130). (The issue of how much information a therapist can ethically conceal from a family is discussed in Chapter 7).

In fact, therapy is only considered successful if the presenting problem is either eliminated, reduced or the family's perception of the problem has changed to the extent that it no longer causes them distress. The MRI group present the rationale for focusing on the presenting problem. "The presenting problem offers in one package what the patient is ready to work on, a concentrated manifestation of whatever is wrong and a concrete index of any progress made" (Weakland et al, 1974, p. 147).

In summation, the major goal of intervention in a family with child problems is to eliminate the presating problem by changing the dysfunctional sequence which maintains it.

Dysfunctional sequences are changed in steps. The first step is to identify the sequence which maintains the problem. The second step is to establish a goal based on what and how they are involved in the sequence. Nevertheless, the goal is always to draw a generational line and prevent consistent coalitions across this line. This means that the adults should be involved with each other and disengaged from the child, who can and should have greater involvement with his peers. For example, if the sequence is identified as grandmother consistently joining child against mother, the goal would be to have mother retain charge of the child while grandmother is relegated to an advisory position. The third step is to create a different abnormal

situation replacing the original one. This is based on the premise that therapy must progress through stages, that a system cannot go from dysfunctional to 'cured' in one step (Haley, 1976, p. 120).

Thus changing the dysfunctional sequence which maintains the presenting problem can be regarded as a primary goal; however, to reach this goal, the family must first progress through a number of intermediate goals.

The first intermediate goal is the creation of a new abnormal situation or hierarchy. The new arrangement, although it is abnormal and not the final one, is necessary in order that the shift to a more reasonable hierarchy can take place. The second intermediate goal may be either the creation of another abnormal situation or a more normal one. The third and final stage of therapy occurs when a generational boundary has been drawn and the primary goal has been reached, since the presenting problem is no longer evident or distressing. Two examples illustrate the point. In the case of the grandmother consistently colluding with the child against the mother, the therapist may place the grandmother in complete charge of the child, rather than immediately directing her into an advisory position to the mother (which is the intended primary goal). The therapist will later put the mother in complete charge of her child. In the final stage, the grandmother is relegated to the position of being the mother's advisor (Haley, 1976, p. 123).

Another example will be drawn from Haley's early thoughts on the subject written in his article "Strategic Therapy When a Child is Presented as the Problem" (1973 (b)). He writes of a situation where the mother is overly-involved with the son, and the father is on the periphery. Haley views three stages before the primary goal is reached:

1. In the first stage father and son and therapist become involved in an activity together, while mother is shifted to the periphery.

2. In the second stage, mother and father and therapist are intensely involved, while the child drops out of the adult struggle and is free to join his peers.

3. In the third stage, the therapist must disengage and get out, leaving the parents involved with each other and the boy involved with friends. (p. 647)

While the first two stages are abnormal situations, they lead up to the final stage which is a normal situation. Hoffman (1980) states that Haley's two ideas, the "tracking of organizational sequences in assessing the problem and going through stages in the process of changing it are perhaps Haley's most distinctive contributions to theory of therapy" (p. 281).

Creating a new abnormal situation may also be accomplished by redefining the presenting problem in "solvable" terms. Thus one may redefine a psychiatric problem as a "misbehavior" problem. For example, a depressed child may be redefined as "irresponsible", or an "anorexic" child may be redefined as "rebellious".

There are obvious advantages to defining a problem in solvable terms. Classic psychiatric diagnostic labels such as "paranoid schizophrenic" present a rather hopeless view of the child, with the implication that the child is locked into a fixed condition. "This view is one which totally handicaps both therapist and parents and leads to helpless apathy in everyone" (Haley, 1980, p. 266). It is far more productive for the family and therapist if the problem is conceptualized in terms of what can be solved, rather than what is wrong. One can view the problem in terms of the functions being disrupted. For example, a paranoid schizophrenic could be relabelled as "having difficulty in holding a job" (Madanes, 1981, p. 20). By restating the problem, the therapist and parents not only have hope towards a solution, but a direction in which to work. With the redefined context, parents could focus on helping their child hold a job while therapy concentrates on concrete means of achieving that end. The student sees defining a problem in solvable terms as relevant to any goal-oriented therapy.

Andolfi (1979) also describes the need to redefine the context of therapy, that is, the affective atmosphere in which therapy occurs. "The context must allow the family to rediscover unexpressed areas and relationships so that the identified patient can abandon his role and the family can become its own therapist" (p. 52). He states

that the family may come to therapy oriented towards the identified patient as needing protection, as mad, or as responsible for all the trouble in the family. The therapeutic relationship must be redefined in such a way that the family is required to assume responsibility for solving its own problems as they become clarified in therapy. In fact, Andolfi believes there is a direct correlation between the extent to which this redefinition occurs and the degree to which therapy will transform (p. 52).

ii. ASSESSMENT

Negotiating a solvable problem with the family and discovering what social situation makes the problem necessary are the basic tasks which first confront the therapist. In order for a therapist to evaluate the severity of dysfunction within the family and to identify those dysfunctional behavioral sequences which currently maintain the problem, he must examine the problem in such a way that the family interaction becomes apparent. The structural/strategic approach advocates that diagnosis and intervention begin from the first moment of contact.

In his article "Diagnosis in Family Therapy" (1979), Aponte describes the diagnostic process in a typical structural interview as a type of quasi-exoerimental procedure which involves six steps. Initially, the therapist determines what issues are to be the focus of the session. Next, he gathers all data relevant to the issue. Third,

he formulates a tentative hypothesis about the significance of the current transactional sequence to the nature of the problem, its locus, and its sustaining structure. Fourth, the therapist determines immediate goals for the intervention which is to follow, congruent with the long range goals. Fifth, intervention on the basis of the immediate goals occurs in order to effect change in the patterns of transactional sequences among the family members. Finally, the therapist observes the reaction of family members to his intervention and continues the process, returning to step two to refine his working hypothesis.

In the structural/strategic model, the therapist will note the amount of resistance the family mobilizes when reacting to his interventions. If the family is highly resistant, a more strategic approach will be incorporated into the therapist's plan. Throughout therapy there is a continual process of formulating and reformulating hypotheses based on interventions until the immediate goals begin to approximate the long range objectives.

Diagnosis then, is an ongoing process throughout the duration of therapy. Stanton, (1981 (c)) states that "every therapeutic intervention has some diagnostic value, while every diagnostic move has therapeutic potential" (p. 366). However, the initial interview with the family is specifically designed to elicit information about the problem. This information is used in formulating long range goals and an overall family assessment. Considerable attention

has been given to the initial interview in the relevant literature.

The Milan group (1978), the MRI group (1966, 1974), Andolfi (1979), Stanton and Todd (1982), and Haley (1976) have all recounted their methods of interviewing in the first session, revealing varying degrees of structural rigidity, and differences in therapeutic orientation and target population. For the purposes of this Practicum report, Haley's initial interview approach best depicts the type of interview structure, therapeutic presentation, and target population the student used in her work; thus his approach is reviewed.

The initial interview, as stated earlier, is a major diagnostic tool. At the end of this interview, the therapist should: (1) establish a rapport with the family, (2) have observed and identified the dysfunctional sequence and hierarchical arrangement which maintains the child problem, (3) have defined the problem in a concrete and solvable manner, (4) negotiate a therapeutic contract with the family to work on the specified goals.

Haley (1976) partitions the first interview into four stages which need not be rigidly adhered to once the therapist gains experience. These stages are: (1) a social stage in which the family is greeted and made comfortable, (2) a problem stage in which the inquiry is made about the presenting problem, (3) an interaction stage in which the family members are asked to talk with each other, (4) a goal setting stage where the family is asked to specify just what changes they seek" (p. 15). (Refer to Appendix 1 for further

description of each stage of the initial interview.)

What the first interview should accomplish is to clarify the family structure for the therapist and yield some common agreement among all concerned regarding the nature of the problem and the goals of therapy (Haley, 1976, p. 44). Revisions of hypotheses are ongoing, however the initial interview is when the therapist engages almost exclusively in assessment.

C. INTERVENTIONS

Now that it is clear how the problem is formulated, we must examine how the problem is to be solved.

However, before the discussion of specific interventions takes place, it is important to review the available points of intervention; that is, in organizational terms, through which subsystems the therapist can gain access to the family system.

In his early article, "Strategic Therapy When a Child is Presented as the Problem", Haley (1973 (b)) saw three appropriate points of intervention for the therapist. Based on his early idea, child problems always concerned an over-involved parent, usually the mother, with the father acting on the periphery. One method of intervention is through the father (the peripheral parent). The therapist attempts to shift the mother (the over-involved parent) to the periphery while trying to bring the father and child closer. The second point of intervention would intervene directly between the over-involved dyad, attempting to divert

their attentions from each other. The focus would be on mother developing her own interests and the child doing likewise. The third point of entry is through the parents' different perceptions of the child's problem until he eventually focuses on marital issues. (Haleys later thinking would modify this last point; he would not focus directly on marital issues unless a new contract with the couple was negotiated after the child problem was eliminated.) The structural/strategic model does concern itself with points of intervention, however, much of the literature focuses on the type of interventions used to effect child problems. In this section the types of interventions reviewed will be structural techniques, paradoxical interventions, and tasks of directives.

Minuchin's latest book "Techniques of Family Therapy" (1981), divides structural interventions into three major categories: challenging the symptom, challenging the family structure, and challenging the family reality. These categories of technique represent different ways of restructuring the family organization. Each of these will be described in detail. Before challenging or restructuring the family can occur however, it is first necessary to "let the family know that the therapist understands them and is working with and for them" (Minuchin & Fishman, 1981, p. 31).

In other words, it is necessary to "join" with the family.

Joining is referred to as the "glue that holds the therapeutic system together" (Minuchin & Fishman, 1981, p. 32). Minuchin sees joining more as an attitude rather than technique, being reaffirmed continually throughout the process of therapy. Joining is most deliberate in the initial contact. The therapist must feel and experience the family's affective stance, and understand its values and style of communication. His personal reactions to the family will deepen his understanding of them and help in judging how best to challenge and motivate them. Aponte (1981) states, "The therapist's private personal reactions become the plate upon which the family leaves its imprint for the therapist to read and decipher." (p. 327). Minuchin (1974) stresses the importance in adopting the family's language, values, life themes, manner of speech, body language, and tempo to join the family system thus facilitating easier intervention. Therefore, with a jovial family, he will become jovial, and with the restricted-style family, his communications will become sparse (p. 128). Once a therapist is firmly joined to the family, the challenging of their world view, family structure and symptom can begin. The student is aware that joining does take place on numerous different levels depending on the type of therapy used.

Challenging the symptom is a way of telling the family that it is not only the child who bears the symptom, but that all the family members are involved with generating

and maintaining it. In challenging the family's definition of the problem, its members are pushed to search for new responses to it.

The specific techniques used to challenge the symptom are enactment, focusing and achieving intensity (Minuchin & Fishman, 1981, p. 68).

Enactment, as the word implies, is a technique whereby family members act out a transaction during a session. The therapist may choose to observe the transaction (as in the interaction stage of the initial interview), or he may become actively engaged by coaching one person or another. The therapist decides who to involve with whom, what the topic of discussion will be, and the physical placement of participants. For example, he may have a five-year old boy sit on his peripheral father's lap while they discuss a weekly allowance.

Focusing is the collection of data which concentrates on areas which need changing rather than a psychosocial history. Thus rather than following the plot of a story, the therapist may persist in focusing on the diffuse boundaries he has noted by asking questions or creating enactments around this issue. Focusing in a session should yield a map of the boundaries, complementary functions, strengths and problem areas (Minuchin & Fishman, 1981, p. 98).

Intensity is a technique used in getting a family to hear and integrate what the therapist is trying to communicate to them. This may be accomplished by lengthening the time and/or changing the distance between people involved in a transaction, and by repeating a message. When family members signal that they have reached their limit of what is emotionally acceptable, the therapist must learn to ignore this message and intensify the interaction (Minuchin & Fishman, 1981, p. 117).

The second group of techniques is directed at challenging the family structure through boundary-making, unbalancing, and teaching complementarity. These techniques, which serve to monitor proximity and distance, are designed to balance under and over-affiliation between various family members and/or subsystems. They also challenge the family members' delineation of roles and functions by shifting people's positions through work in alternative subsystems (Minuchin & Fishman, 1981, p. 69).

Boundary-making aims at changing family subsystem membership or changing the distance between subsystems. The technique can be directed at psychological distances between family members and at the duration of interaction within a significant subsystem. For example, parents of a triagulated child may be encouraged to work together at controlling the child with a specific task in this area. This is an attempt to thwart the collusion of the parents with the child, bringing mother and father into an interaction for a longer period of time than is usual (Minuchin & Fishman, 1981, p. 146-8).

Unbalancing techniques are designed to challenge the hierarchy and alter the power allocation in the family. With child problems, the goal is always generational demarcation. As the most powerful member of the hierarchy in the therapeutic system, the therapist may achieve this by affiliating with certain family members, ignoring particular members or entering into a coalition with some members against others. For example, in the case where mom colludes with son against father, the therapist may enter a coalition with mother and father against son to realign the hierarchical structure (Minuchin & Fishman, 1981, p. 161-3).

Complementarity aims at having family members experience their interrelatedness and responsibility for maintaining and changing the child's problem. The therapist must subtly challenge the family's certainty that there is one identified patient controlling the system, rather than each member serving as a contextual cue for the others to respond. An adjunct to this is demonstrating a chain, rather than compartmentalization of events, by introducing an expanded time frame which can reveal how each family member's behavior is part of an extended whole. Minuchin & Fishman's (1981) work with an enmeshed family is an effective example here: A daughter sneezes, the mother gives the father a kleenex to give to the daughter, while the sister rummages in her purse for a handkerchief. Minuchin pointed out, "My goodness, look how one sneeze activates everybody. This is a family that makes helpful people", implying of course, that everyone is involved in the problem (p. 198).

The third group of techniques, aimed at challenging the family's world view, is very similiar to techniques relating to paradoxical directives and reframing. Stanton (1981 (c)) claims that the following techniques, tasks or "directives are the cornerstone of the strategic approach" (p. 372).

In the structural/strategic model, tasks are used in the session and as homework assignments to affect change in both the therapy sessions and the intervals between sessions.(Haley, 1976) points out three reasons for assigning tasks: 1) Tasks get the family to initiate new behaviors and new ways of communicating with different members. 2) They intensify the family's relationship with the therapist; the family must invest time and effort in deciding whether to do the task or not and in speculating on the therapist's reaction to their decision, regardless of the outcome. 3) Directives provide an additional source of important interactional data about the family's structural rigidity and the ease or difficulty in changing it (p. 49).

The art in giving a directive lies in motivating the family to carry it out or in "selling the task", particularly if the task seems illogical. Fisch, et al (1982) suggests that the task must be framed with regard to the client's emotional needs and values to be accepted. For example, if a child is angry with his mother, the therapist will promise the child that this task will drive her crazy,

describing the task in those terms. In another instance, a mother perceiving herself as a martyr can have the task framed as a means of extending herself in helping her child. When couched in the patient's language, it is more likely that the task will be attempted (p. 118).

If family members have different goals, Haley (1976) suggests finding some gains for each of them. For example, the therapist can point out that the mother wants to be sure her daughter behaves properly, the daughter wants to avoid constant arguing, while the father does not want to be called in as a referee all the time, therefore they should do the task (p. 55). "Selling" a task may be considered manipulative by some. (Honesty vs manipulation will be dealt with in Chapter 7).

Haley (1976) advises that the task be given in clear, precise terms, specifying when, where, with whom, anticipating difficulties, and getting the family to review the directive to make sure it is clear to everyone involved. If the family has later completed the task, they are congratulated and the interview continues. If they have failed to complete the task without a valid excuse, the therapist should not let them off lightly. His reaction should confirm their failure and a missed opportunity which will never return. The therapist must convey that his directives are to be taken seriously if the family expects improvements. Later in the interview when the family raises its problems, the therapist can mournfully recall opportunities the family chose not to pursue, hence the unsolved problems (p. 57-65).

Effective tasks require planning and an understanding of the major dysfunctional sequences in the family. The most effective tasks involve all family members and address the sequence which is to be changed by focusing on the presenting problem. Some examples of tasks from Haley (1976) are presented in Appendix 2.

There are many different types of tasks, with different types of designs. The Milan group sometimes spend hours designing one powerful family prescription and then send it special delivery to the family to be read at home (Palazzoli et al, 1978). Milton Erikson (Haley, 1973) specialized in metaphorical tasks, while many strategic therapists almost exclusively use paradoxical injunctions.

Paradoxical tasks have been given a tremendous amount of attention in the strategic family therapy literature. They are the mainstay of the Milan group, the Brief Therapy Centre group, and Andolfi (in his initial contacts). A paradoxical intervention is defined by Hare Mustin (1976) as "those which appear absurd because they exhibit an apparently contradictory nature, such as requiring the patient to do in fact what they have been doing, rather than requiring that they change, which is what everyone else is demanding" (p. 128). The rationale for using paradoxical interventions is based on the assumption that families naturally resist change by engaging the therapist into their way of behaving. Attempts by the therapist to directly intervene in family patterns risk arousing even greater family resistance. Paradoxical interventions give the therapist the option of

creating change indirectly. (The student did use a number of paradoxical techniques in her clinical work. These will be mentioned in Chapter 5 when her cases are reviewed. The following paradoxical techniques have been singled out because of their usefulness to the student). Three major categories of paradoxical interventions have been described by Rahrbaugh et al (1977): prescribing, restraining, and positioning.

Prescribing tasks require the family to engage in the behavior they are trying to eliminate. For example, a bedwetting child may be required to wet his bed in his father's presence every night before going to sleep. A therapeutic bind is thus created where the family cannot be resistant. Either the therapist is obeyed and the problem continues or the therapist is disobeyed and the problem is eliminated. The task may be presented to the family in terms of 'gaining control of the symptom' or 'understanding it better' (Stanton, 1981 (c), p. 374).

Restraining tasks have the therapist discouraging and restraining change or improvement. The family may be told to 'go slow', or that improvement is progressing too fast, or even to cease improvement altogether for a week. The family may be asked to spend one week contemplating the disadvantages of the child losing his symptom. If things are proceeding too well, the therapist may predict or prescribe a relapse, a return to the presymptomatic state.

Weakland et al (1974) describe predicting a relapse as "framing any step backwards as a step forward" (p. 160). This task addresses the family's ambivalent and apprehensive feelings which may accompany improvements and change. The resistant family will try to foil the therapist by disobeying him and thus improving more rapidly. When this occurs however, it is important for the therapist to appear doubtful and express concern over the dangers of this improvement. (Issues of honesty and manipulation will be dealt with in Chapter 7).

The technique of positioning refers to a task in which the dysfunctional behaviors which maintain the child's symptom are exaggerated beyond the point of tolerance. The rationale is that by exaggerating the frequency and/or intensity of the symptom, the cure becomes less cumbersome than maintaining the symptom. An example of positioning from Andolfi's (1979) work with the family of a schizophrenic youngster is illustrative. The sequences around the youngster were that motherand father were constantly hovering around the boy, while he chose to go out infrequently. Andolfi required the boy to stay home for two weeks; he was not allowed out under any conditions. The parents were to monitor any abnormal behavior, and jot down detailed notes to be brought to the following session. Naturally no one followed the rules completely; the boy wanted to go out while the parents were anxious to be relieved of the obligation to write everything down.

Madanes (1981) has developed a unique paradoxical technique in a particularly appropriate communication modality for children called pretending. Pretending can be practiced in the session or as a directive at home. There are two pretending strategies; one has the symptomatic child feign the symptom while the child's parents can be encouraged to feign assistance in that situation. The second pretending technique reverses the situation with the parents feigning the solicitation of help from the child, and the child pretending to help the parents (p. 90).

When the child pretends to have his symptom, then the meaning of that symptom has changed. The symptom has become a "metaphor of a metaphor and no longer expresses what it originally denoted" (Madanes, 1981, p. 92). The therapist attempts to confuse and thereby eliminate the reality of the child's symptom, changing the interactive system upon which the reality is based. When a child is required to feign his "real" symptom, it becomes unclear whether that symptom is real or a pretense. It will be increasingly difficult for the child to go back to really having the symptom after he has pretended to have it over a period of time (Madanes, 1981, p. 94).

Sometimes Madanes has the family critique the child's performance, making sure the portrayal is realistic. The more critical the family is the greater the implication that the symptom does not come easily to the child and will therefore be easier to remove.

Having the parents feign the symptom and the child feign assistance is an indirect way of confronting the analogic communication that exists between parents and child. In actuality, the child's symptom is thought to be a metaphor for the parents' relationship, and the child is thought to be helping his parents by having the symptom. Since the parents are pretending to have the symptom, the mask of reality is removed and yet they are allowed to remain unexposed beneath the guise of make-believe. When the pretense is over, the family will abandon the game played together and the symptom will cease to exist. Madanes claims that pretend directives have been successful with families of diverse ethnic backgrounds and socioeconomic classes, because the playfulness and flexibility help bypass resistance.

Palazzoli (1978) of the Milan group, has earned the title "the magician" for her paradoxical tasks (p. 150). Nonetheless, the skill required to master the art of designing and delivering paradoxical tasks is enormous. Beginning therapists are warned not to attempt them and experienced practitioners are advised that a supervisor in this area be available for consultation. One needs both skill in identifying the key dysfunctional behavioral sequences and creativity in designing a task custom-tailored to the family's values. The therapist must frame the task properly and convey sincerity in its presentation. The task must be related to the context of the family interaction and presented so the family can perceive its benefits. If the paradoxical

prescription has hit the mark, it is often powerful enough to precipitate a family crisis. The therapist must then be prepared to handle the crisis without backtracking. (The student's experience with paradoxical techniques will be reviewed in chapter 7). The Brief Therapy Centre group (1982) and the Milan group (1978) have documented a wealth of paradoxical interventions from the "Devil's pact" and "benevolent sabotage" to suit many of the difficulties arising in therapy.

The mastery of paradoxical techniques is an important ingredient in becoming a good structural/strategic therapist. Peggy Papp, who reflects the student's viewpoint, strongly recommends that the therapist attempt to intervene directly, reserving paradoxical interventions for those "covert, long-standing, repetitious patterns of interaction that do not respond to direct interventions such as logical explanations or rational suggestions" (Minuchin & Fishman, 1981, p. 245).

The other major structural/strategic technique is positive connotation, or as Watzlawick et al (1974) called it, "the gentle art of reframing" (p. 97). This technique requires the therapist to project a new definition onto familiar circumstances, allowing the family to view the situation from a new frame of reference. Wittgenstein says "reframing does not draw the attention to anything -- does not produce insight -- but teaches a different game, making

the old one obsolete" (Watzlawick et al, 1974, P. 104). Reframing is used in this approach to attribute positive motives to problematic or resistant behaviors. A "hostile" father may be relabelled as "wanting the best for his family". Haley (1980) reframes the adolescent's "mad" behavior as "trying to better his lot and the lot of his family" (p. 43). Positive connotations may also be ascribed to a family interaction; for example, overly concerned and protective parents could be relabelled as "very close and caring". Reframing positively, the therapist flows with the resistance of the family rather than engaging in a power struggle with them. Under a positive label, destructive behavior patterns can be brought into the open without ensuing denials and in a manner where problems can be dealt with. Stanton & Todd (1982) attribute their success in recruiting drug addicts' families into therapy to the way in which the rationale was presented to them. "If the family were to oppose it, they would have to state openly that they want their son to remain symptomatic" (p. 92). Positive connotation may be sprinkled into every session with every family, but is most helpful with resistant families. Stanton (1981 (c)) states "what positive interpretation seems to do is address, in a respectful way, the resistance and ambivalence which the family feels toward change. The therapist recognizes and acknowledges the functional and desirable aspects of the symptom" (p. 377).

The final aspect of interventions to be addressed is the area of termination. The structural/strategic model advocates "brief intense involvement and rapid disengagement" when the presenting problem is solved (Haley, 1976, p. 150). Failure in therapy is considered to be the therapist's fault (rather than poor motivation of the family) and is totally his responsibility. However, success in therapy is credited overtly to the family to increase their feeling of competence, thereby increasing the probability of their coping in the future. In the case of families who are worriers or resistant types, a relapse may be predicted so that any future resistant tactics are covered (Fisch et al, 1982, p. 176).

Specific interventions were reviewed in this section; however, to close this chapter it is appropriate to present Andolfi's and Stanton's models as representative of the overall therapeutic process in the structural/strategic approaches when working with resistant families.

Andolfi (1980 (b)) theorizes that families have a tendancy toward homeostatis (H) and a tendancy towards transformation (T). (See Figure 3.) He sees therapy progressing through five major stages where the balance between the homeostatic and transformative tendancy changes in relation to the therapist's stance. In phase 1, the therapist generally approaches the family with a desire to transform them and the family is heavily resistant to change. In

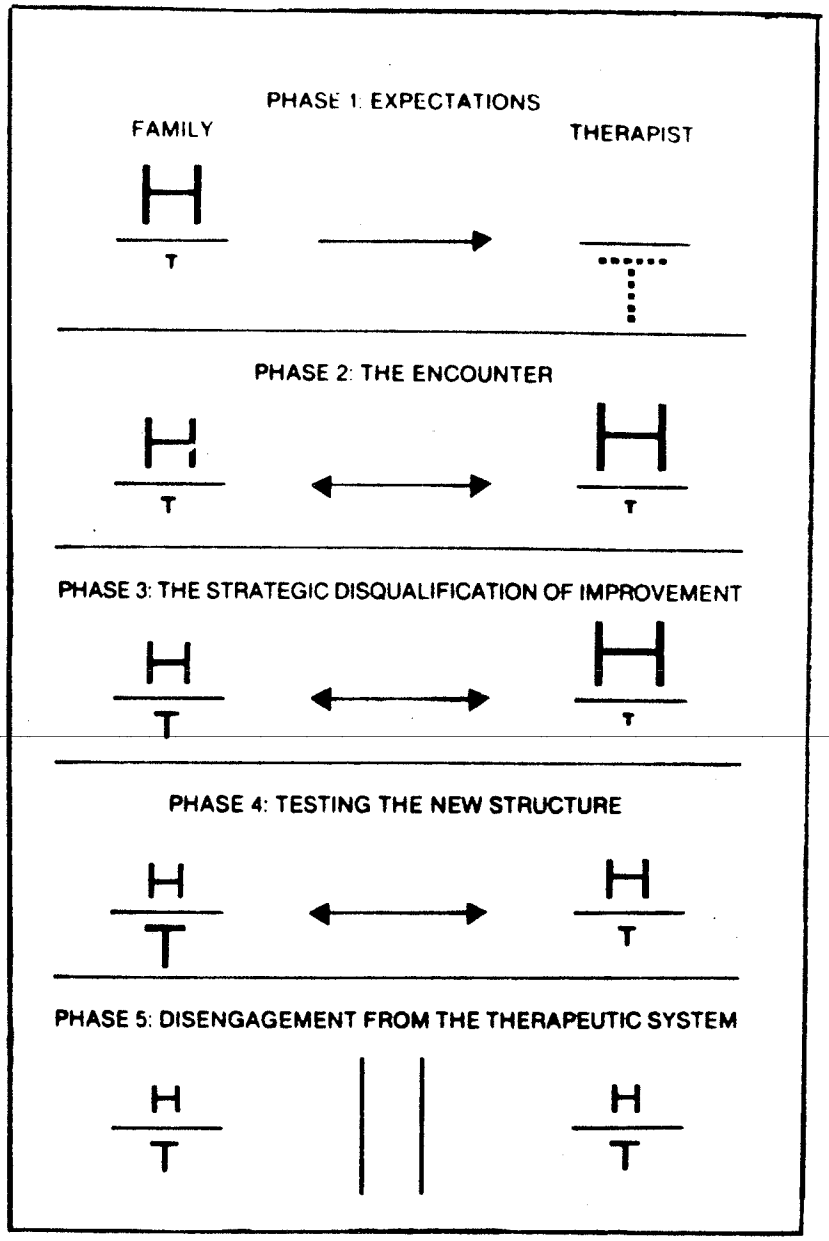

PHASE 1: EXPECTATIONS
FAMILY
THERAPIST
H
T
PHASE 2: THE ENCOUNTER
PHASE 3: THE STRATEGIC DISQUALIFICATION OF IMPROVEMENT
PHASE 4: TESTING THE NEW STRUCTURE
PHASE 5: DISENGAGEMENT FROM THE THERAPEUTIC SYSTEM

Figure 3

phase 2, the therapist employs the strategic technique of being more homeostatic than the family, warning them not to make improvements under any circumstances and prescribing an exaggeration of the child's symptoms. In phase 3, when the family then begins to display improvement, the therapist disqualifies it until the family can prove to him that improvements are indeed considerable and lasting. In phase 4, when the family is ready to take the initiative for transformation, the therapist begins to employ structural techniques in orderto modify and manipulate dysfunctional family structures. In phase 5, the family structure has changed, the symptom has disappeared, and the therapist disengages from the therapeutic system.

Stanton's (1981(a)) model also focuses on the interplay between the structural and strategic approaches. From his perspective it is "possible to apply either a structural or strategic tack seperately or to use the two concurrently and contrapuntally" (p. 431). Stanton specifies three general rules indicating which task to take when. Rule #1 is: to initially deal with a family through a structural approach. The rationale for this is that it can be as effective with some families as the strategic approach and is less complicated and therefore easier for the average therapist to execute. Rule #2 is: to switch to a predominantly strategic approach when "structural" techniques either are not working or unlikely to succeed. The switch can take

place in three circumstances: (1) if the therapist notes that resistance is mounting as he employs structural techniques (2) if the pre-therapy information indicates a very resistant family such as a long history of unsuccessful treatment or a severely dysfunctional member (3) if the therapist is confused and unsure of what is occuring with the family -- he then ceases to focus on content and instead observes the process of interaction. Strategic disengagement is the technique that Stanton may use in extreme cases where the therapist distances himself from family entanglement by abdicating responsibility for change. He may declare "total incompetence" (Selvini-Palazzoli et al, 1978) or simply withdraw by a statement concerning the problem like "Yes, it's a tough one." Rule #3 states that he should return once again to the structural approach once success has been achieved with strategic techniques and the family has become differentiated enough to modify boundaries and make use of other structural techniques. Stanton generally advocates the liberal use of positive connotation throughout to lower family resistance.

There are similarities and divergences in the two structural/strategic masters approaches. Both Andolfi and Stanton advocate using a strategic approach initially, later shifting to a more structural stance when family resistance is overcome. Andolfi, however, employs a strategic orientation routinely when starting with a different family, whereas in the initial stages, Stanton may try to intervene structurally. Andolfi's model is presented in terms of its theoretical

underpinnings - the tendancy to homeostatis and to transformation. Stanton in contrast, presents rules to follow with no theoretical rationale. Stanton also promotes greater use of positive connotation than does Andolfi. Stanton & Todd (1982) have the unique experience of applying the structural/strategic model to families of drug addicts. They have subsequently developed a variety of strategic techniques designed to recruit resistant families into therapy.

In conclusion, it should be reiterated what the criterian was for the inclusion or rejection of material from either the structural or strategic literature. The student attempted in the literature review to reconstruct the model from which she worked clinically. She drew from the literature the conceptual framework which she employed when encountering families and attempting to understand their dynamics and the source of the family dysfunction. The goal setting and assessment techniques described in the literature review are identical to those the student utilized. The section on intervention required perhaps the greatest demand for selection. The student chose a sample of the basic intervention strategies to serve as an overview of the model's techniques. These were also the basic strategies from which the student drew in her clinical work.

The following chapter with a case review should demonstrate the application of structural/strategic family therapy. In summary, the literature review of the structural/strategic model included both a comprehensive overview of the model and a description of the student's working model in her Practicum.

D. OUTCOME RESEARCH FINDINGS

The effectiveness of the structural/strategic approach to family therapy has not yet been conclusively determined, however, there are some positive indications from the family therapy research literature. To date, Gurman and Kniskern have made one of the most extensive reviews of general family therapy research findings in their article "Family Therapy Outcome Research: Knowns and Unknown" (1981). For the purposes of this report a brief presentation of the major findings in structural and strategic therapy will be extracted from this chapter, including a summary of the research in the area.

Aponte and Van Deusen (1981) provide a useful summary of the major structural therapy outcome research. Structural family therapy was described as effective in 73% of 201 families treated in available studies (Minuchin et al, 1967, 1975; Leibman et al, 1976 Berger et al, 1977; Leibman et al, 1977; Minuchin et al, 1978; Zeigler - Driscoll 1977/79; Stanton et al, 1979) (p. 341-358). Effectiveness

was measured in terms of symptom and psychosocial change in the IP. Highest rates of success appeared among thepsycho-somatic families (i.e. families with a psychosomatic member) and low success rates occured in the low socio-economic and addict families. Gurman and Kniskern (1981) state "at the moment, structural family therapy should be considered the treatment of choice for...childhood psychosomatic conditions".(p.780)

Research in strategic therapy is generally considered to be the most well-designed in the family therapy field. It most often employs control and/or comparison groups. Stanton (1981) reviewed the six major research studies in this area and concluded that a strategic family orientation either showed considerably better results or at least a great deal of promise when compared with other treatment approaches, particularly in terms of cost-effectiveness. Some interesting results are:

1. Langsley et al (1971) in their investigation of 300 cases involving family crisis therapy as a means of averting hospitalization, noted that the cost of family crisis therapy was 1/6 that of hospitalization.
2. Alexander and Parsons (1973) found in their study in comparative approaches in the treatment of delinquency that recidivism was cut in half for the systems treatment group.
3. Weakland et al (1974) studied 97 cases involving a range of problems and found that 72% were either successful

or significantly improved.

4. Stanton et al (1978) provided objective, experimental support for the idea that changes in the symptom area related to changed in the family interaction pattern (p. 392-397).

CHAPTER 5 - THE PRACTICUM

I. DESCRIPTION OF THE SETTING AND PROCEDURES

The student completed her Practicum at the Jewish Child and Family Service (JCFS). Supervision was provided by Harvy Frankel, Supervisor of Family Services at JCFS. The student's 20-hour per week Practicum was from May 1, 1982 until October 30, 1982. On November 15, 1982 the student was hired by the JCFS and continued to carry three cases.

The Jewish Child and Family Service is a non-profit organization which serves children and their families of both Jewish and non-Jewish faith mainly in the city of Winnipeg and its suburbs. The Agency was established in its present form in 1952 and is governed under a Board of 36 Directors who are elected from the Jewish community. It is funded by the United Way of Winnipeg, the Winnipeg Jewish Community Council, the Province of Manitoba and the Jewish Immigrant Aid Society of Canada. As the Agency has a Child Welfare Mandate, it is constituted as a Children's Aid Society under the statutes of Manitoba and performs all related functions. Accordingly, the Agency is divided into two major areas: Child Welfare Services and Family Services.

Family Services has several programs: the Elderly, Newcomers, Volunteer Services, and Family, Marriage and Individual Counselling. The Child Welfare programs consist of Adoptions and Child Protection and Placement, and two residential group homes the JCFS administers for permanent and temporary child placement.

Referrals come from the schools, community professionals, two private Jewish schools (Joseph Wolinsky Collegiate and Ramah) which have had a JCFS social worker in the past, and through self-referral. Proceedurally, the intake worker takes a brief summary intake either over the phone or in person, referring the case to the appropriate supervisor. Mr. Frankel generally assigned family cases with a child presented as the problem to the student.

The student received one to two hours of supervision weekly, bi-weekly peer supervision, and live supervision via television monitor when feasible. The JCFS did not receive their video equipment or one-way mirror until late October, therefore the student arranged to borrow equipment from the Department of Social Work, University of Manitoba.

The student would like to make some remarks on the Practicum setting. On one hand, Mr. Frankel's expertise in the area of structural/strategic family therapy made the JCFS an excellent learning opportunity for the student. The Executive Director of the Agency, Mr. Barney Yellen, also has a systems orientation. This similarity in perspective provided the consistency necessary for the student to follow through on structural/strategic methods with Agency support.

However, the technical difficulties experienced by the student in arranging for the video equipment undermined some of the benefits which could have been gained.

Without going into minute detail, video equipment seemed to be in constant demand, hence availability was not always consistant with the student's needs. With little or no advance notice given to the student on numerous cases, the family in question could not be taped and opportunities for live supervision were lost. In addition, the student had to learn the various technical idiosyncrasies of video equipment the hard way; a number of cases were not recorded due to minor adjustments such as not knowing that the memory button must be in the off position prior to recording. The amount of energy expended in arranging for and transporting the equipment (particularly in the no-parking area around the Agency) combined with other equipment-related problems was the single most frustrating aspect of the Practicum.

Records were made according to the Agency's requirements and the student's additional needs. The general format was:

1. who is in the family
2. referral source and presenting problem
3. structural assessment of the family
4. goals of therapy
5. strategies employed
6. notes on each session
7. termination - case summary

II. DESCRIPTION OF CLIENTS

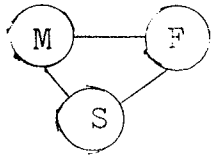
A total of nine families were seen by the student and eight of these will be used for the Practicum write up (the "child" in the ninth family is 48 years old and it was felt that his problems and needs would be exceptional for the purposes of this report). Two families are presently

in treatment, five families terminated in a planned manner, and one family did not want to continue treatment, hence termination. The eight families were seen for a total of 46 sessions, averaging 5.75 sessions each.

Four of the eight families were single parent families, four were two-parent families. Six families had teenage children, two had children who were six years old.

All of these families were middle-class, ranging from lower-middle to upper-middle class. Occupation of head of the households were: accountant, hotel owner, nurse, businessman, legal secretary, payroll supervisor, delivery man, and receptionist. Among the two-parent families, only one wife was at home while the remaining three worked as research assistant, nurse, and receptionist.

What follows will reveal the student's attempt to integrate theory with the practise. A brief description of each family is given with the intention of showing how the student applied structural/strategic assessment and techniques to a variety of child problems. The description includes: (a) the presenting problem and referral source, (b) a brief psychosocial history leading to the problem, (c) a structural assessment of the family including a structural map indicating hierarchical structure. The member on the top is considered to be the highest in the hierarchy. For example:



M(mother) and F (father) are in a higher hierarchical position than S (son)

The lines joining the family members will be defined if they are meant to indicate a particular type of relationship. (d) treatment goals, including a map of the student's goals for the family. (not necessarily the ideal family relationship), (e) strategies employed to reach those goals, (f) a summary of the sessions, and (g) a brief report of the student's personal learning experience with each individual family (first person will be used in this section for readability).

III. CASE REVIEW

Family (1)

A) The presenting problem and referral source:

The B. family consisted of mother, a single parent, age 32, and T. (IP) age 6. Mother called extremely upset about her son T. who was talking of not wanting to live, repeatedly saying he was stupid. She thought the problem might be related to visits with the father, and difficulties with French Immersion in school. They were seen for three sessions.

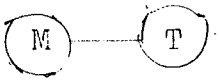
B) Psycho-social history:

I discovered that the week of the first appointment happened to follow the week of the mother's divorce coming through (after a four year separation). Mother is French, father is not. Father is very involved with T., seeing him during the week and every other weekend. He has taken mother to court several times to prove her incompetence in order to

gain child custody. Mother and Father will often fight when dropping T. off. T. was placed in the French Immersion class in Grade I, not taking it in kindergarten like the other children. Although T. was the poorest student in the class, I observed that he was a very creative and bright child. During the first interview it emerged that T.'s sadness was due to talk of selling their dog because the family was planning to move.

C) The structural assessment:

(1) Mother and T. are on the same hierarchical level. Father's questioning of her ability as a mother has caused her to feel insecure about her competence. She gives in to T. because of fear that he will like father better and want to live with him. T. exploits this, playing both parents off against each other to get his way.



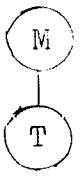
M - Mother
T - IP

(2) The symptom, T.'s suicidal feelings, it seems was metaphorically related to mother's feelings about the finalization of the divorce. Mother's sudden idea to move (no objective reason given) and sell the dog was a way of expressing her feelings connected with a change in developmental stage (divorce). When I asked if anything significant happened that week to cause T.'s sadness, mother never mentioned the divorce, however, the connection was fairly obvious.

(3) A talk with T.'s teacher revealed that because he doesn't know French, she thinks he is stupid. This teacher's feelings were probably conveyed to him in some form. Additionally, because mother is French and father is not, T. was having trouble knowing if his lack of success in French indicates that he sides with father.

D) The goals of therapy:

(1) To give mother more power; helping her realize that because she is the head of the family and has custody, she should be exerting the most power. Her general feelings of competence as a mother had to also be increased.



(2) To normalize T.'s feelings and ease the adjustment through this stage (divorce) by talking to mother through T.

(3) To help mother improve T.'s grades in school, thus increasing her feelings of competence and filling a real need for T.

E) Strategies used:

(1) To give mother more power:

In the session I got mother to tell T. that she makes the decision where he'll live, not father or T. Support was given to mother on the excellent job she is doing and what a bright and sensitive child she has.

(2) To normalize T.'s feelings:

Depression and suicidal feelings were reframed as "sadness" or "very, very sad". A reframing that was later employed was "sadness is different that disobedience", implying that T. is disobedient and manipulative at times.

(3) To help mother improve T.'s grades:

Home tasks included mother's being strict about T.'s doing his homework every day. Mother was also to tutor T. in French and converse in that language at home.

F) Summary of sessions:

Mother however, cancelled the last appointment and we re-scheduled it for two weeks later. Mother said she cancelled because there had been a great improvement in T. She reported joining Emotions Anonymous and feeling very happy. Mysteriously, T. brightened up about the same time. The French tutorials were helping and T. was doing much better in school. I warned mother to continue being firm with T. and not let him manipulate her.

G) Report of the student's learning experience:

This was my first family case. I learned how to talk and communicate to young children. I was asking T. open-ended questions initially, later learning to direct concrete, specific queries instead. Mother told me she though my attitude about T. relaxed her. This made me wonder about the effect a psychiatric diagnostic label would have had on the mother and child; if the child was not seen from an inter-

actional viewpoint, the amount of time and energy invested in therapy would have been prodigious.

Family (2)

A) The presenting problem and referral source:

The M. family consisted of a single mother, age 44, and her son K. (IP) age 14. The mother's boyfriend, who lived with them for the last three months, also attended interviews. The family was referred by the school which stated that K. had missed 49 days during the last four months, leaving everyone at an impasse. I saw the family for four sessions and then terminated because they refused further treatment.

B) Psychosocial history:

K.'s behaviour began in December, about the same time that his mother met her boyfriend. At that time K. moved his furniture and belongings downstairs without his mother's help or knowledge. K. stays out late and remains away from home for long periods of time. The principal noted however, that K. is attending school for tests and will probably pass the year.

C) The structural assessment:

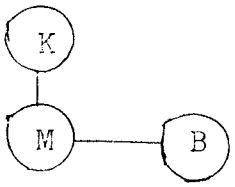
This family has a confused hierarchy. K. is in control of the family. Before the boyfriend came, K. was

on an equal level to mother, but now the boyfriend has usurped K.'s role. K. was very angry about this, expressing it through misbehaviour. The boyfriend did not know how or where he fits in -- he is not a father, yet someone needs to control K.

Before Boyfriend Came

M - mother
B - boyfriend
K - IP

After Boyfriend Came

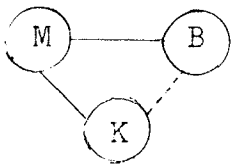


D) The goals of therapy:

(1) To put mother back in charge of K. -- this would be demonstrated by K. attending school and following house rules.

(2) To have K. feel that his position gives him an adequate amount of control.

(3) To find a role for the boyfriend.



--- Not father/son relationship but some relationship

E) Strategies used:

(1) To put mother in charge of K.

a) Task was assigned to be done at home - K. was woken up for school with ice water.

b) Positive connotation was used by reframing mother

as "soft", and the boyfriend "tough" in the way they express their "love and concern" for K.

c) In order to undercut K.'s inordinate amount of control, resistance and sullenness were dealt with by employing paradoxical strategies. K.'s silences were responded to by comments such as "This is too upsetting for K., he'll probably want to remain silent." Or when K. didn't arrive at an appointment as arranged, a note was sent home to him thanking him for giving me the opportunity to talk with mother and boyfriend alone.

(2) To give K. some feeling of control:

a) Some in-session moves were reframing K.'s behaviour in ways that gave him permission to be "independent". This was done by complimenting him on moving out. K. was made into a "boarder" instead of a son.

b) A homework task was given to K. He was asked to show a sign if he wanted to get back into the family or not.

(3) To find a role for the boyfriend:

An attempt to clarify and validate the boyfriend's role in the family was made by references to the akwardness experienced by all families in this situation, and by allowing K. to openly discuss his feelings of acceptance or non-acceptance of the boyfriend.

F) Summary of sessions:

After two sessions, K. showed great improvement. He was attending scool regularly, with the only remaining complaint

that he was coming ten minutes late for 8:00 a.m. detentions. He showed signs that he wanted to rejoin the family and even stated openly that he would try to accept the boyfriend. Due to my inexperience, I was elated. Rather than expect and predict a relapse, I transmitted my enthusiasm for a rosy future. In the next and final session, mother insisted on placing K. in a foster home and refused further treatment. She had been very disappointed in K.'s behavior in-between sessions. After an hour of unsuccessfully trying to persuade mother not to place K., I told her that I could not recommend placement, but if she insisted she could call the Children's Aid Society. Unwittingly, my intervention had brought out mother's determination to place K., with the result that K. became terribly frightened that this would occur. After the interview, K. begged mother to let him stay home, swearing he would behave. Summer holidays were imminent and the family refused further treatment.

G) Report of the student's learning experience:

This family provided an excellent but painful learning experience because I committed so many errors. My major mistake was allowing the family to dictate what happens in therapy, and when it happens. I allowed myself to be robbed of therapeutic control within the first five minutes of our meeting and never regained it (this refers to mother's comment when we first met, "No one else could help us, prove that you can." This was an opportunity to create therapeutic manoeverability through a comment such as, "If no one else could

help you, what makes you think I can?", thus placing the initiative for change on them and relieving me of the responsibility to prove myself. In future cases, similiar issues of therapeutic control arose which I was able to maintain due to the awareness and experienced gained with this family.

Family (3)

A) The presenting problem and referral source:

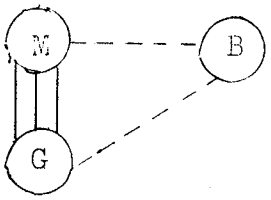
The Sc. family consisted of a single 34 year old mother, her son, G. (IP) age 11, and boyfriend/fiance. They were referred by the Child Guidance Clinic because mother felt that G. was having trouble adjusting to her impending marriage. The family was seen for four interviews.

B) Psychsocial history:

This group of individuals was articulate, with good communication and the appearance of a very open relationship with one another. G. was not overly concerned with mother's marriage and seemed like an exceptionally well-adjusted child with good marks, many friends, and a relaxed disposition. When pressed, mother finally said she was worried about G. having unexpressed, pent-up feelings about all the "changes". She is certain he cries in his room although when she goes to check, he claims her hasn't been crying.

C) The structural assessment:

(1) Mother is highly enmeshed with G. The impending marriage, which has caused a need for reorganization, has given mother the excuse she needs to get G. checked out.

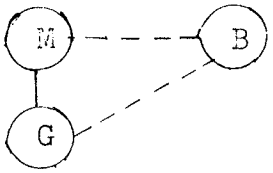


M - Mother
B - Boyfriend
G - IP
lll - Overinvolvement
--- Appropriate but tentative relationship

(2) Metaphorically, G. is probably expressing his mother's fear of the impending marriage and her reaction to all the "changes".

D) The goal of therapy:

To provide more distance between mother and G.; specifically, to give G. the right to his own feelings and privacy concerning them.



E) Strategies used

(1) To provide more distance between mother & G. and validate G.'s right to privacy concerning his feelings.

Reframing the problem was used by saying that G. did not have enough time "to mourn after his father left". I told the family they are moving "too fast" for G. -- adults may adapt

quickly but not kids. The assignment homework was for G. to mourn alone for 15 minutes everyday about all the things he lost and will lose if his mother remarries. Mother was not to disturb him or ask anything about it. She was assigned to the task of being in charge of G.'s happiness. She had to spend a half hour daily talking with him about happy things.

After the final meeting, G. was going to be leaving on a trip to visit his father. Mother was worried that G. would get upset by his father. Positive connotations were continually given about how close they are; this lead up to saying they are like one person so that G. doesn't know if his feelings beling to him or his mother. I reframed this process as G. wanting to be responsible for his own feelings, not needing mother to take care of them.

F) Summary of the sessions:

In a follow-up call concerning questionnaires, mother said that G. expressed his anger for the first time and simultaneously, she didn't take it upon herself for the first time. I complimented her.

G) Report of the student's learning experience:

In this case, I learned how one well designed prescription can solve a problem. I was very surprised that they accepted my rationale about the mourning. It appears

that intelligence is not related to a family "buying" the rationale. If it is an accurate one, "sold" properly, most people accept it regardless of their intellectual level. (refer to selling task P. .)

Family (4)

A) The presenting problem and referral source:

The B. family consisted of mother, age 34, father, 42, A. (IP) 13, and her brother, 16. A. was referred by the Child Guidance Clinic at the onset of summer break because her social worker was going on holiday and felt it would be best for someone to work with A. during that period. A. failed the year in school. The family was seen for ten sessions during three months.

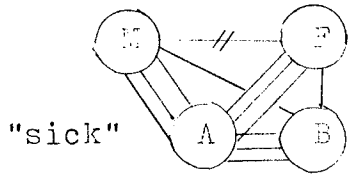
B) Psychosocial history:

In the first session, A.'s presentation was that of a mentally handicapped child. When filling out the questionnaires, she and everyone else in the family remarked on her slowness, bringing her to the verge of tears throughout the interview. (In actuality, A. completed the questionnaire in the same amount of time as her 16 year old brother.) The brother and parents were both successful and articulate by contrast. A. has had "help" since grade one when Child Guidance Clinic first intervened. In the last year, the parents had tried to pressure A. into doing her school work

and she received less than 20% in most areas. She lied, threw tantrums, and ran away from home daily.

C) The structural assessment:

(1) Everyone in the family was enmeshed around A.'s problem and needed to have her in a handicapped status in order to protect the marriage. There appeared to be some marital difficulties which I intentionally did not deal with.



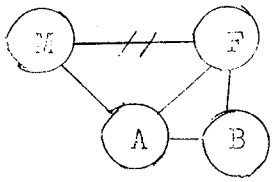
M - Mother
F - Father
A - IP
B - Brother
lll - Overinvolvement
// - Conflict

(2) Generational boundaries were intact in this family as the parents were able to maintain control of their children.

(3) The brother, who was the "good" son, was invested with keeping A. "sick".

D) The goals of therapy:

(1) To challenge the family's view of A. as handicapped.



(2) To get A. to take more responsibility for herself.

E) Strategies used:

(1) To challenge family's view of A. as sick.

a) The family interaction was reframed as "too helpful" to A. and consequently the homework task was to be "less helpful" to her.

b) The family was told that they have a myth that A. is not capable.

(2) To get A. to take more responsibility for herself.

a) A.'s behaviour was reframed as "disobedient".

b) The problem we concentrated to work on was to get A. to act like a 13-year old and her parents to treat her like one. A. was given the task to give a sign if she wants to be 13 or not.

c) In the following sessions time was spent helping A. to negotiate fair rules for herself. In about the sixth session, A. was refusing to take responsibility for herself. I then pressed the parents to treat her like a 3-year old. This created a crisis where A. went to the hospital and reported her mother falsely for abuse, however noticeable improvement took place after that incident.

d) During a later session I had A. pretend to throw a tantrum in order to demonstrate her control over it. I also had her schedule her tantrums on certain days of the week.

F) Summary of sessions:

By the last session, which was held after the second week of school, A. was a changed person. She was attractive, confident, happy, joking with her parents and taking responsibility **in** school. She brought her notebook to show me how she had meticulously organized it (A. has been diagnosed as having an "organizational disability"). Her parents were allowing her more age-appropriate activities and were enrolling her in an acting course in order to channel her imagination.

By the last number of sessions her parents were referring to her as an "extremely bright child".
A follow-up call reveals A. is doing well at school and in her acting course.

G) Report of the student's learning experience:

This family was satisfying to work with because they were all articulate, intelligent and had a very good sense of humour. The major learning experience for me, besides having an opportunity to employ a large range of techniques, was bringing on a crisis. Essentially, When A. refused to co-operate, I aligned with her parents against her. Beneath the calm exterior I presented to them, this created a crisis which shook me up. I am now more prepared for the possibility of a crisis and can better maintain my balance when it occurs.

Family (5)

A) The presenting problem and referral source:

The Gu. family consists of mother, in her mid-50's, and father, late 50's, both Holocaust survivors. There are four children, a sister, age 28, single and living in her own apartment, a son living in Ontario, but here for the summer, and S., age 16. The oldest daughter is married and did not come to sessions. The parents called the Agency to have S. placed in an Agency group home. They had called the police

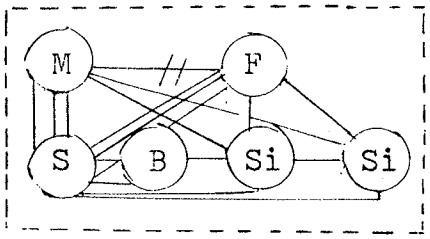
on him because they claimed he tried to attack them. Initially, I saw them two times a week. There were 9 sessions altogether.

B) Psychosocial history:

The claims made against S. were too numerous to mention. The parents claimed that he stole from them, gave away their expensive articles, attacked them, went out of control and even tried to run them over with a car. The parents were wealthy and appeared to be rigidly controlling types who had tried a variety of treatments for S. with no success. Their mood was always very tense and this was only heightened by father's serious heart condition which caused him to grab his heart when S. misbehaved in the sessions. When their claims were explored, it appeared that there existed an incredible confusion concerning the actual ownership of the articles in question. For example, the parents bought a stereo, when S. lent it to a friend, the parents called this "stealing" because they saw the stereo as theirs. One of the tasks I assigned to the parents reinforced the perception that S. had no real possessions that were indisputably his. I asked them to list S.'s own possessions. They complied and gave me a list of objects each with a question mark beside it indicating that the ownership was unclear.

C) The structual assessment:

The parents in this family were very enmeshed with the IP. They do not know where they end and S. begins.



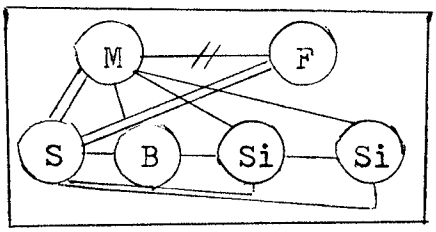
M - mother
F - father
B - brother
Si - sister
S - IP
-//- - conflict
___ - clear boundary
111 - overinvolvement
--- - diffuse boundary around family to other systems

A classic "leaving home" syndrome is demonstrated where the other children have left home, mother and father's relationship seems to be stagnant and S. protects them by remaining a failure so that they can avoid being alone with each other.

D) The goals of therapy:

(1) To keep S. in his parents' custody and help them overcome a crisis without resorting to outside agents of social control (police, group home, etc.).

(2) There was an attempt to provide distance between S. and his parents, to reinforce the disengagement process which needs to take place within the next 2 - 4 years. Marital difficulties were apparent but I intentionally did not deal with them.



11 - less over-involvement
___ - clear boundary around the family and other systems

E) Strategies Used:

(1) To keep S. in parents custody and avoid using outside agents of social control:

a) Because I was aware of the tremendous power this family had, I maintained a very controlled stance and conducted very structured interviews focusing on concrete issues. The first major issue was whether or not S. was to be apprehended by the Agency. Positive connotation was employed, commenting on what "caring" parents they are. I implied that they would be neglectful if they let us have custody and that parents are always the best people to care for their child because they "care the most". Because of their value system, this approach was very effective. We made ground rules for three days at a time and S. was kept at home. At another crisis point, S. moved to his sister's apartment. Sessions were spent focusing on concrete issues such as where S. was going to be staying and when he would return to school.

b) Since one of the goals of therapy was to prevent the introduction of outside agencies, the parents were asked to explicitly state what boundaries S. would have to violate in order to be thrown out of their home.

(2) To provide distance between S. and parents thus reinforcing the disengagement process:

a) A technique I frequently used was positioning, where I exaggerated their "controlling" stance to the point of absurdity, causing them to modify their original position. They said he steals. I strongly suggested they should have

locks on all the doors until they admitted S. really isn't that bad.

b) I stressed that the family only has two short years with him before he becomes a legal adult. This was done to reinforce the disengagement process.

F) Summary of the sessions:

When S. moved in with his sister the situation appeared to relax. By the final session, S. was attending school, living at his sister's, but still in his parents' custody, visiting home once a week (usually creating havoc at these visits) and generally appearing more talkative. The family mood in the last meeting was incredibly light, where members joked with one another. I reinforced their competence by referring to their wisdom in keeping his custody and coping with the situation. The final message I gave was "school will be the real test", which is vague enough to cover most situations or relapses.

They called me two months later to say that S. is not behaving himself at the sister's and they wanted names of special schools for him. Mother's reaction was very different than in the past. She seemed in control and was not over-reacting or hysterical. Most important, she was not abdicating control by calling in the police or other agencies to come for S.

G) Report of the student's learning experience:

I learned a great deal from this case. Because they would not agree to video taping I was pressed to describe them well in order to get appropriate supervision. I learned that one must focus and ignore to maintain therapeutic control. This family was a cesspool of problems and without a focus and total control, the therapist would be lost. This family provided me with the opportunity to employ positive connotation. With the technique of positioning, I was reluctant to press them although when I did, positive results were obtained. Because this family was so controlling, I was forced to cope with their resistance by consistently using paradoxical techniques to avoid overt power struggle.

Family (6)

A) The presenting problem and referral source:

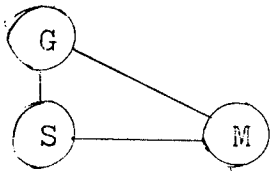
The Gi. family consists of mother in her 30's and her daughter S. (IP), age 5, who was having temper tantrums. I had seen the mother and father concerning their recent seperation and mother felt S.'s behavior was related. I met with the parents twice, with S. and her mother once, and once together with her parents.

B) Psychosocial history:

Mother and S. moved into mother's house after the seperation. Father had a very explosive personality. Mother feared S.'s tantrums were related to both father's intimidating behavior and the seperation. S.'s behavior was new and becoming more frequent since the seperation occured. It seemed that grandmother and an elderly aunt would eventually give in to S. on any issue particularly if she threatened a tantrum. Mother worked on 12-hour shifts as a nurse and saw herself as under grandmother's control while living in her house.

C) The structual assessment:

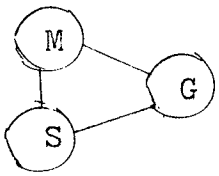
The assessment was that there is a hierarchical confusion with grandmother being in a more powerful position than mother in relation to S.



G - grandmother
M - mother
S - IP

D) The goals of therapy:

(1) To restore mother's natural hierarchical position as mother and reinforce her feeling of competence with S.



(2) The problem was situational and it was felt that over concern would aggravate it. The goal was to make mother aware of the situational nature.

E) Strategies used:

(1) To replace grandmother with mother as head of family:

a) In the session, we explored ways in which mother could share methods of coping with S. with her grandmother.

b) I supported mother in taking charge of the situation as much as possible.

(2) To make mother aware of situational nature of problem:

a) I predicted that when mother moves to her own place it would be easier for her to take control and S.'s symptoms would disappear.

b) Making only one appointment which gave her the message that S. is not deeply disturbed.

F) Summary of sessions:

In the following session with the parents, mother reported less frequent tantrums and announced her plans to move away from grandmother.

G) Report of student's learning experience:

This was the only case I had which involved a third generation. Seeing them once sharpened my assessment skills and taught me that change could occur from one intervention.

Family (7)

A) The presenting problem and referral source:

The W. family consists of a single mother, age 50, and three daughters, age 16, 15, and 13. B., age 15, is the IP. The mother called the Agency about B. who is uncontrollable and throws temper tantrums. I am currently seeing them and at time of this writing, I have seen them for five interviews.

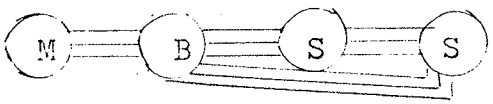
B) Psychosocial history:

The three daughters, who are very close in age, were continually bickering, sharing clothes and becoming involved in each other's fights. Mother, who worked full-time, tried to settle the fights, became entangled in them and consequently vented her anger on B. who was often the instigator. She finds B. generally unco-operative and two or three times a week is embroiled in some battle with her.

C) The structural assessment:

(1) Mother did not occupy a power position in the hierarchy.

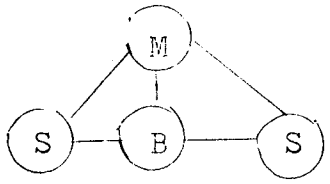
(2) The family was enmeshed. The girls were overly-involved in each other and the mother overly-involved in the children's relationship.



M-mother
B-IP
S-sister
S-sister
lll-overinvolvement

(3) Mother was overly concerned about her daughters outbursts, fearing they indicate a deep disturbance.

D) The goal of therapy:



(1) Mother has to maintain distance, gain more power in the hierarchy, and be supported in keeping control.

(2) To disentangle mother from her children, enabling her to leave when the children fight.

(3) Normalize B.'s behavior.

E) Strategies used:

(1) To help mother gain more power and maintain control: The problem was redefined as "mother needing space". I colluded with mother against the girls in establishing rules which forced them to follow through on their responsibilities, thus allowing mother more uninterrupted time. This strategy seemed to be the right one.

(2) To disentangle mother from her children when they fight:

The problematic transactions were enacted in the session in order to imply that the behavior is not uncontrollable.

(3) To normalize B.'s behavior:

B.'s behavior was reframed as that of a "typical teenager" and concern was expressed over the oldest daughter who per-

haps was not "normal" because she was very co-operative. Later B.'s conflict with her mother was reframed as "B. teaching her family how to cope with a real teenager".

b) None of these strategies seemed particularly effective and a new tact was taken.

F) Summary of sessions:

Rather than continually being singled out as the troublemaker, B. blended into the sibling subsystem and mother established herself as head of the family. Mother's needs were asserted and validated and measures were taken in the family to meet them. Mother was restored to her natural hierarchical position and therefore maintained the distance necessary to avoid entanglements in her children's problems.

G) Report of the student's learning experience:

This family became a difficult one for me and thus I was able to learn a great deal. I found myself becoming entangled in family conflicts and probably experiencing the same feelings of exhaustion and frustration as mother. Because the family is a pleasant one, my defences were down and I did not exert heavy therapeutic control, causing me to become enmeshed in their difficulties. The other interesting aspect of working with this family was the process of experimenting with what "works". When they did not seem to respond to one line of attack, another was enforced until an effective one was discovered.

Family (8)

A) The presenting problem and source of referral:

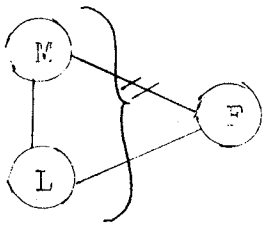
The Sm. family consists of mother, age 53, father, age 56, and adopted son L. (IP), age 13. When the mother called, she was very upset, and requested placement for her son whom she felt was uncontrollable. At the time of this writing, I have seen them for five meetings and family treatment has been discontinued for reasons which will be explained.

B) Psychosocial history:

L. was expelled from school because he reported drunk on one occassion and had missed too many days. He refused to attend other schools in which the parents tried to enroll him. The parents claimed this behavior began only 4 months ago and blamed it on his school friends. The Agency was reluctant to apprehend the child. However, after our first meeting the father abused L. for misbehavior and the Children's Aid Society became involved. At this point we agreed to shelter L. but only under a TCP, a temporary contract placement agreement. This is a co-operative arrangement between parents and child and can be cancelled any time by either party where parents retain legal guardianship and the Agency has temporary custody.

(C) The structural assessment:

(1) Mother and L. colluded against father who was peripheral.



F - Father
M - Mother
L - IP
{ - Collusion
// - Conflict

Serious marital difficulties were evident and L. told the child care staff of wife abuse and of his mother's desire to leave.

(2) L. is metaphorically expressing his mother's ambivalent feelings towards leaving her home by his running away and then sneaking back home.

The developmental stage of this family, (L. is reaching adolescence) is particularly relevant since the child is adopted. Because this stage is difficult for the parents to adjust to, they seemed to think that they could perhaps return the child to the Agency which had placed him. (JCFS placed this child originally.)

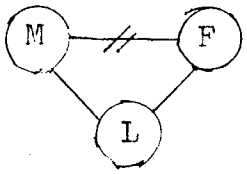
(D) The goals of therapy:

The original goals with this family were to:

(1) To keep or return L. home.

(2) To involve the parents with one another rather than using L. to detour conflict.

(3) to prevent collusion between mother and L. against father.



The goals at the time of this writing are to involve the parents in family treatment with another more experienced therapist, and ultimately return L. home.

(E) Strategies used:

The strategies I used were not successful. The possible reasons will be discussed in the following section. The strategies I did use were related to keep L. at home and give the parents maximum control of the situation. They are recorded here.

In the first meeting, placing L. was discouraged as a poor solution to their problems. I implied that they could handle the situation themselves. When placement was made, the TCP was chosen in order to give the parents maximum power and control of the situation. The final strategy which eventually led to a confrontation, was to allow L. to return home for breakfast every morning. This was done for two reasons: First, to render the need for L. to sneak home obsolete and second, to give L. the feeling he is living at home.

(F) Summary of sessions:

Immediately after L.'s placement, problems arose with the parents' not following through on agreements made with them. For example, we arranged that if L. came home

the parents would contact us immediately. L. returned home a number of times and the family did not report it then or at later opportunities. We never reached a point of agreeing upon a therapeutic contract and father was expressing mounting frustration. Father felt that he was not receiving what he wanted from the interviews, L. was not improving under our care, and they, as parents, were denied control of L. A confrontation occured after a member of "Tough Love" (a self help group) was refused entry into the interviews and a homework task I assigned the family led to a flare up between L. and his parents. Among other things the family refused further treatment but also did not want their son back home. The flare up occured on one of L.'s breakfast visits. L. stole $6.00 from his mother and within a few days the arrangement broke down. L. is presently living in the group home, attending school regularly and doing well there.

(G) Report of the student's learning experience:

Obviously, there were some serious errors made with this family. This family introduced me to the inconsistencies of the Child Welfare model and the Family Therapy approach. (This is detailed in Conclusions, Chapter 7)

Some of the problems resulted from the confusion in the levels of hierarchy in the child welfare system and my unfamiliarity with the system. I was dependent on the child welfare supervisor for Agency decisions concerning the

child, my own supervisor for clinical advice, and a psychiatrist who saw L. separately. Group home staff (who tend to be child centered) often did not work in a way consistent with family goals. Because of the various types of conflicting input, it became very difficult to maintain therapeutic control.

The family was a difficult one because their statements were generally made with no context. When I interpreted what the statement meant, the family would later return and claim a different meaning. They would complain of too much control and too little contact with L. within the same interview. According to the structural/strategic model, failure is always the therapist's responsibility rather than the resistance of the family. A more experienced therapist perhaps could have addressed some of their paradoxical demands by apparently giving them control and appearing to move quickly while in actuality maintaining all the control and moving very slowly.

Dealing with issues of adoption, abuse and child placement were new to me. Learning took place from trying to retrace my steps to discover where I could have chosen to use more appropriate approaches.

CHAPTER 6 - RESEARCH

The student has three basic aims by including an evaluative component to the Practicum:

(1) To gain facility in using evaluative tools in clinical work.

(2) To receive meaningful feedback concerning the effectiveness of structural/strategic therapy and the student's effectiveness as a therapist.

(3) To test the usefulness of the newly developed questionnaire, the "Structural Family Interaction Scale" (SFIS) as applied to this type of family therapy.

I. EVALUATIVE MODEL

Three methods of evaluation were employed to measure treatment outcome with the assumption that multiple instruments supplement each other and provide greater outcome validity. The three instuments employed were:

1. The Structural Family Interaction Scale (Perosa, 1981) pretest - post-test questionnaire concerning changes in family structure:
2. The elimination or reduction of the presenting problem as an indicator of therapeutic success or failure:
3. Self Report which is based on:

a) self report of family members

b) Three-month follow-up procedure where families report on the maintenance of improved behaviors in cases where

families were unable to complete the pre or post-test.

The three instruments are described in terms of their strengths and weaknesses as well as my recommendations when necessary.

1. THE STRUCTURAL FAMILY INTERACTION SCALE

The Structural Family Interaction Scale (SFIS) consists of a group of 105 questions designed to evaluate family interaction in structural terms. Sandra and Linda Perosa (1981) developed the instrument and are now in the process of testing its usefulness in evaluating treatment outcome. Because the research on the questionnaire is still in progress, the reliability and validity figures are incomplete.

However, this evaluation tool was chosen among a number of other tools for its adherence to structural principles and the relatively easy-to-administer paper and pencil format. Other options were:

1. Moos' Scale of Family Functioning - although far more established than Perosa's scales, Moos' sub-scales are not based on structural concepts. This means one would have to translate each of the concepts into structural terms which creates threats to construct validity.

2. Family Interaction Task (FIT) - originally designed by Minuchin and modified by Stanton. The FIT consists of a number of tasks which a family completes by listening to a recording of the directions. They are video taped and a

number of raters rate the family interactions. The rating itself takes five hours and at the time of this writing the student had no access to a one-way mirror. This tool is far too complex and impractical.

3. Madanes' Family Hierarchy Scales - this tool is apparently very easy to administer and quite powerful. Unfortunately, the student was informed that it is unavailable.

The questionnaire takes an adult about a half hour to complete and can be administered to children only over the age of 12. The questions are generally phrased in terms of the individual parent's relationship to the child and to each other. (IP) (See Appendix 3) SFIS is designed to give ratings in the following areas:

> enmeshment, disengagement, mother overprotection, mother neglect, father neglect, rigidity, flexibility, parent conflict avoidance, mother-child conflict avoidance, father-child conflict avoidance, parent conflict expression without resolution, mother-child conflict resolution, father-child conflict resolution, parent conflict resolution, parent management, triangulation, parent child coalition, detouring.

These concepts are developed along Minuchin's structural model of family functioning and therefore utilize exclusively structural concepts.

A summary of the reliability and validity of this instrument indicates that:

Reliability

> Most of the primary subscales other than neglect, and the majority of the secondary scales, other than mother overprotection, parent conflict, avoidance, parent-child conflict avoidance and parent-child expression without resolution, have met the alpha criterion for internal consistency reliability. Figures for test-retest reliability are not yet available. (Perosa, 1981)

Validity

> Efforts have been made to determine content and construct validity. Six family therapists were given construct definitions, questionnaire items and directions to rate the fit between the two. The overall interjudge reliability for the content of items was .950. Most promising in terms of construct validity is the fact that the inter-scale correlations do fall into patterns predicted by Minuchin. The instrument does appear to be tapping into concepts illuminated by his theory...Future research will focus on establishing criterion validity (Perosa, 1981).

The student's goals in using this tool were two-fold:

1. To test the SFIS's usefulness in evaluating outcome.
2. To evaluate the student's treatment outcome.

These two goals were met only in a minimal way. When the student discovered this, (with her committee's permission) she developed instrument #3. The follow-up procedure in order to evaluate the treatment outcomes of her cases where a post-test was not taken. The major problem was in administering the questionnaires. Of the 8 cases, only 3 families completed a pre and post-test, and only 5 of the 8 completed a pre-test. The other 3 families were in crisis and it was not possible to administer the pre-test, precluding a post-test. Therefore, as far as testing the instrument's usefulness, it is very difficult to make any substansive statement based on 3 families. Some comments however, will be made, based on the results of the findings with the knowledge that any statements are at best tentative.

The major advantage of this instrument was as a diagnostic tool. It yielded a description of every family member's perception of the interaction around the IP. Another advantage mentioned earlier, and the major attraction for the student, was the conceptualization in structural terms, providing the student with hints as to which hypotheses need further investigating.

The disadvantages were numerous. Most families commented on the repetitiveness of the questionnaire. A twelve-year old child needs some assistance in filling out the questionnaire and in vocabulary comprehension.

If the evaluative tool demanded only five or ten minutes of people's time, more accurate results may have been obtained. Upon meeting the family, the student also gave them a three page face sheet to fill out for the questionnaire, the video consent form to sign, the eight page questionnaire itself, and then proceeded with an explanation about the supervision and the video taping. This whole process took almost one hour and was a hindrance to developing the proper rapport with the family at the beginning.

The final disadvantage was the use of the terms "mother" and "father" in the questions. Although half of my families were single mothers, one-third of the questions concerned fathers' reactions to various situations. Perosa sent instructions for single mother families to fill out father questions as either the real father or as mother's serious boyfriend. In the case of a single mother with no boyfriend, this was an unpleasant experience to have to recall her ex-husband's would-be reactions to situations. In the case where a boyfriend exists, it was very akward considering him a father when he is <u>not</u> a father, but only a boyfriend.

2. <u>ELIMINATION OR REDUCTION OF THE PRESENTING PROBLEM</u>

The student chose this method of outcome evaluation based on Haley's (1976) belief that the elimination or

reduction of the presenting problem expressed in behavioral terms is a major indicator of therapeutic success. In most cases the student negotiated the therapeutic contract with the family based on what the family perceived as the major problem, and subsequent goals to its elimination. In some cases it was inappropriate to share the goals of therapy with the family, nonetheless, goals were based on the family's presenting complaint and were parallel with the family's goals.

The advantage of this method is that it is clear if success is completely, partially, or not at all reached. The method is unobstructive and takes no time away from the ongoing therapeutic process. It also forces the therapist and the family to define what indicates success and/or failure.

The disadvantage of this method of evaluation is that it is somewhat subjective and individualized. It is possible that problems are defined in a way which makes them simple to achieve. The skill of the therapist and the degree to which the problem has been clearly defined will affect the clarity of the results. It is also possible that the presenting problem could be eliminated without the underlying structures being affected. Another problem different in form may arise from the intact dysfunctional structure to affect the original IP or another family member. Thus, Haley's measure of success in his standard for evaluations does not account for all possibilities. Although elimination of the presenting problem can be an indication of

therapeutic success, it can also represent a superficial symptom change rather than a deeper lasting change within the family structure.

3. SELF-REPORT

The Self-Report relates to: (a) the family's perception concerning the success of therapy and changes that have evolved, and (b) the follow-up. Self-Report is the standard method for evaluating treatment in clinical practise. The disadvantage of this method is obviously the subjectivity of the findings. Self-Report is normally transmitted to the therapist alone, in which case the recording is done by a biased person who has a stake in the report. This is to some extent offset by the video recording and use of a supervisor. The client's responses may not be truthful, but rather a reflection of the relationship he has with the therapist. The therapist is part of the therapeutic system and it is difficult for him to be objective. The student offset this to some extent, by having her supervisor view the tapes of family interviews thus increasing reliability. However, the supervisor in this model is thought to be responsible for therapy and may also be considered in some way to be invested in the results and unable to be completely objective.

The Follow-Up Report consists of phoning families who did not complete a pre and post-test and making inquiries concerning the behavioral changes of the IP. This pro-

cedure was developed in order to compensate for the lack of post-test responses and to indicate the effectiveness of the therapy over time.

The advantages of this evaluative tool are that it incorporates a follow-up for most families and short-lived changes seen at the end of therapy are scrutinized for long-term effectiveness. It is thought that because the student does not inquire directly as to the effectiveness of the approach or as to her personal effectiveness, more honest answers will be obtained. It is important to note that in the structural/strategic model, credit for change is given to the family to reinforce their feelings of competence, therefore it would be antithetical to ask the family directly about the effectiveness of the therapy or the therapist.

The disadvantage of this tool is the obvious lack of objectivity. Although the student does not inquire directly about her personal performance, the family response may be guarded as to not reflect negatively on the inquirer. The student may also ask leading questions, convey emotions, or interpret responses which are consistent with her own view of the situation, rather than an objective view.

Another disadvantage and contradiction to the structural/strategic model, is the inquiry made from only one family member, usually the mother. The interaction between all family members was observed throughout therapy and each person's perceptions were weighed against the others

in the system. In this case only one member's idea about the whole situation is heard, which may differ from the IP's or other family members' perceptions.

However, the three methods of evaluation are seen to complement and balance each other, hopefully yielding a somewhat consistent and accurate outcome evaluation.[3]

II. OUTCOME FINDINGS

The findings will be presented by reviewing the results of treatment on each family and then compiling them to get an overall view of the findings.

Family (1)

(1) SFIS scores: (See Appendix 4)

The pre and post-test score revealed differences consistent with goals of therapy. The results showed a reduction in enmeshment, mother overprotection and detouring. An increase was shown in mother-child (child refers to the IP) conflict resolution and parent management. Surprisingly, the SFIS showed changed in the ex-husband's relationship with the child as perceived by mother. Scores indicate a decrease

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[3] It is not within the scope of this paper to relate causal effects of treatment outcome to therapeutic intervention. The term "success" in outcome is meant to indicate the student's impression of therapeutic goals being met rather than implying that her intervention was the sole cause of change.

in father overprotection as well as parent conflict avoidance. Perhaps mother's general feeling of greater competence caused her to perceive father's role differently.

(2) Elimination of the presenting problem:

The IP's mood had improved and he was doing better in school. The presenting problems then were significantly reduced.

(3) Self report:

The Self-Report indicated that the presenting problem was eliminated and the therapist's observations confirmed positive changes. Therapy with this family is considered successful.

Family (2)

(1) SFTS scores:

A pre-test was completed, but a post-test was not due to the unplanned termination, therefore outcome could not be measured.

(2) Elimination of the presenting problem:

The presenting problem was reduced significantly at the end of therapy, i.e., the IP was attending school whereas beforehand he was regularly absent. However, the therapy was not completed and therefore did not likely affect structural changes in the family. The final session where mother insisted on placing her son scared the IP into behaving, however, upon speaking to the mother a number of months later, it appeared that the situation had become once again very difficult.

(3) Self-report:

(a) The Self-Report indicated that therapy was unsuccessful and not useful to the family.

(b) The follow-up report done seven months after treatment, showed that the IP's negative behavior has been eliminated almost completely. He is attending school and being fairly obedient to his mother. The mother attributes the change in her son to the new guidance counsellor.

Although the presenting problem was eliminated and the change was sustained over time, the therapy was incomplete and cannot be considered successful.

Family (3)

(1) SFIS scores:

Only a pre-test had been completed without a protest therefore, outcome could not be measured.

(2) Elimination of the presenting problem:

The presenting problem which was mother's concern over her son's moods was significantly reduced. At the end of therapy mother tended to view his moods as a healthy reaction rather than a sign of disturbance.

(3) Self-report:

The self-Report indicated that therapy was successful and observations by both the student and supervisor confirmed this. The student spoke to mother two months following treatment and apparently the positive changes in the IP had been maintained.

Therapy with this family can be considered successful.

Family (4)

(1) SFIS scores: (See Appendix 4)

The pre-test and post-test indicated changes which were not always consistent with the goals of therapy, but did indicate some of the changes which occured. The changes in scores were surprisingly consistent amongst the four family members, especially considering that in the pre-test scores, the parent perceived the situation very differently than their children. Each individual family member's result will be presented seperately. In the post-test result, mother scored lower in mother and father overprotection and parents conflict expression without resolution. She scored an increase in parents conflict resolution and father-child conflict resolution. Father scored lower in both parent conflict expression without resolution and father-child conflict expression without resolution. He scored an increase in mother-child conflict resolution and father-child conflict resolution. The brother (he said his post-test was inaccurate because he rushed through it) scored an increase in mother and father overprotection and mother-child conflict expression without resolution, father-child conflict avoidance and mother-child conflict resolution.

The IP scored lower in father overprotection, father-child conflict expression without resolution and mother-child conflict resolution. She (IP) scored higher in parent conflict avoidance, mother-child conflict avoidance, mother-child conflict expression without resolution and parent conflict expression without resolution. She marked a very great increase in father-child conflict avoidance, parents conflict resolution and father-child conflict resolution.

Cumulatively, the scores seem to indicate an improvement in the father/IP relationship and a corresponding decrease in the parents' need to overprotect her. There seems to be some indication that although father and the IP have increased their ability to resolve conflicts, mother and the IP are in greater conflict. This change may be inevitable as the IP gets closer to father. There were some contradictory scores which cannot be accounted for and may indicate either a weakness in the test itself or a lack of thought on the part of the respondent. Overall, the SFIS did indicate structural changes within the family which were consistent with goals of therapy.

(2) Elimination of the presenting problem:
The problem defined by the therapist with the family was the IP's inability to act her age. By the end of therapy this was significantly reduced, although there was a way to go.

(3) Self-report:

The self-report indicated partial improvements. The student's observation saw marked positive changes in the IP and how the family related to her. This was confirmed by a colleague who had seen only the first and last sessions and by the student's supervisor. A follow-up report indicated that improvements were increasing, however, there were occassional relapses to the "old" behavior.

Therapy with this family can be considered successful.

Family (5)

(1) SFIS scores:

This family did not complete a pre or post-test. They refused to have any conditions placed upon them.

(2) Elimination of the presenting problem:

In this case the student's goals for the family were met, however the family had somewhat unrealistic (in this student's view) expectations and those were unfulfilled. The family came in requesting placement for the IP. The student's goal was to avoid placement and encourage the family to cope with their son without the involvement of outside agencies. The family expected the Agency to transform their son and to get him to behave respectfully and obediently. Placement was avoided. The IP moved in with his sister. While the parents retained custody, the separation allowed everyone to relax, although when the IP came

home, conflicts with parents always arose. Because of these conflicts, the parents felt that their goal for their son in therapy were not met.

(3) Self-report:

a) The self-report indicated satisfaction with treatment and the student's observation confirmed positive changes in the IP and the family's relationship to him.

b) The family called the student three months after treatment, wanting to find a suitable private school for him, because the IP needed to leave his sister's residence.

Although this relapse could be considered a failure in therapy, the student noted that the way in which the mother dealt with the crisis was far different from previous instances. In earlier crises with the IP she had been hysterical, demanding and overwhelmed. In the follow-up she was fairly relaxed and gave the message that she was competent and in control of the situation. Mother did not consider placement as an option. The student therefore felt her primary goal for the family was met in that the inevitable tempestuous family interactions were handled within the family unit.

Therapy with this family can be considered at least partially successful.

Family (6)

(1) SFIS scores:

A pre and post-test were not completed as the family was in crisis at the time.

(2) Elimination of the presenting problem:

The IP's tantrums, the presenting problem, were significantly reduced. The student's goal for the mother which was to restore her as hierarchical head of the family was also maintained according to the follow-up report.

(3) Self-report:

a) The self-report indicated that the mother was helped by treatment.

b) The student had hoped to lower the mother's anxiety concerning her child's problem and the mother's self-report confirmed the achievement of the goal. In a follow-up report five months later, mother said that the IP's tantrums had not increased in frequency from the time of treatment and were no longer a major problem. She also claimed that because of her initiative, the grandmother and elderly aunt were handling the IP in a consistent way.

Therapy was considered successful.

Family (7)

(1) SFIS scores:

a) The family is continuing in treatment and the post-test was administered following one of the sessions.

b) Because the overall therapeutic process was interrupted in order to administer the post-test, it became necessary to introduce an intermediate goal. The intermediate goal in this family is to support mother in her role as head of the hierarchy, while the next stage of therapy should theoretically achieve the elimination of the presenting problem (i.e. improvement in the relationship of mother and the IP). The pre and post-test results were expected to confirm these changes. This family was instructed to leave questions concerning father or parental conflict blank because he has had no contact with the family for five years and mother has no boyfriend. This involved over 1/3 of the questions. Because scores were fairly consistent, the culmative scores will be presented. All family members saw a decrease in mother-child conflict without resolution. The IP and the eldest daughter (who is in some conflict with mother) scored an increase in mother's rigidity and a corresponding decrease in her flexibility. These results were consistent with the student's observations. Mother has become more rigid at this stage and conflict may be increased as a result. However, it is felt that this is a necessary stage which will hopefully lead to resolution of the mother-child conflict.

(2) Elimination of the presenting problem:

Because therapy is as yet incomplete, the presenting problem is not expected to be eliminated at this point. There has been little change in the presenting problem - IP's behavior. However, as mentioned earlier (in 1. SFIS scores)

the intermediate goal for the family has thus far been achieved.

(3) Self-report:

The self-report indicates that there is as yet little change in the presenting problem. Mother, however, reports general success in enforcing rules and seems to be more able to assert her need for privacy. The therapist's observations confirm mother's growing confidence in her ability to head the family, but she has not yet seen a significant change in mother's relationship to the IP.

At this point in time one can only speculate on the chances for therapeutic success.

Family (8)

(1) SFIS scores:

The family was in crisis and neither a pre or a post-test was completed.

(2) Elimination of the presenting problem:

a) The presenting problem, the boy's truancy in school, has been resolved and attendance is now regular. However, the dysfunctional family structure has not been altered. It seems that the family's need to detour its conflict occurs via the Agency rather than the child, since their child has been removed from their home.

b) From the student's viewpoint and according to her goals for the family, therapy was unsuccessful. The family came requesting placement for their son. The student's goal was to present outside intervention in the handling of the problem, keeping the parents in charge of the situation. The child is presently placed in a residential treatment home and will probably be apprehended in the near future.

(3) Self-report:

The self-report indicates that therapy was unsuccessful.

Therapy with this family can be considered unsuccessful.

An overall summation shows that with five of the eight families, treatment was successful. Although the presenting problem was resolved with two families, their underlying structures were unchanged, therefore, therapy is considered unsuccessful. In one family still in treatment, success is not yet evident, but is expected.

SFIS as an evaluative tool for measurement of treatment outcome cannot really be judged by its use in two or three families. However, because it did indicate changes which were consistent with therapeutic goals and with changes observed by the student, there is some evidence that this instrument warrants further investigation and experimentation. The limitations discussed earlier require some strategies designed to modify them.

III. EDUCATIONAL BENEFITS TO STUDENT

The student found the evaluative aspect of the Practicum an asset in her clinical development. In spite of the difficulties encountered, it was a valuable experience to attempt to apply objective tools in the evaluation of her work. The process of evaluating a particular type of intervention as well as her own performance has increased the student's appreciation of the need for some measure of evaluation in clinical work. Ideally, however, the evaluative tool in family therapy would be one which is both congruent with the theoretical approach (in this case Structural/Strategic Family Therapy), short enough to be administered in a non-intrusive way, and accessible to young children.

CHAPTER 7 - CONCLUSION

I. INTRODUCTION

The Practicum afforded the student the opportunity to meet her planned learning goals. She was able, by the completion of the Practicum, to effectively utilize structural/strategic interventions when working with families where the child is the presenting problem. Reviewing the literature has allowed her to develop a conceptual knowledge base from which the model is taken and applied. Finally, the student gained experience in employing a number of evaluative tools in clinical intervention and was given some indication of the usefulness and limitations of these tools. A few comments here should be made about the limitations of the model, as well as its applicability and contribution to Social Work Practise.

II. LIMITATIONS OF THE STRUCTURAL/STRATEGIC MODEL

One of the limitations of the structural/strategic model is its incompatibility with models which are not interactionally based (i.e. problems defined in terms of the interaction between people). Conflicts may arise when the structural/strategic therapist attempts to appy his techniques in a setting oriented towards individual pathology. This may occur in a hospital psychiatric setting; or in wife/child abuse shelters where individuals are isolated and protected from their dysfunctional environment. The conflicts which may arise are not necessarily a result of

the model's inability to deal with this type of problem. Conflicts tend to be between other therapists, the psychiatrist or other relevant workers. This is due to the different orientations in defining and dealing with problems and the subsequent misunderstandings which may result.

In the domain of child problems, the student's Practicum experience has heightened her awareness towards some of the inherant contradictions in the Child Welfare system. The Child Welfare mandate is basically designed to protect children who are neglected or abused by their parents. In practise however, it is used as a partial remedy for parents who find their children uncontrollable and unmanageable. The children are then defined as needing protection because their parents refuse to continue to care for and shelter them. The children are then placed in a group home with temporary (or potentially permanent) custody and/or guardianship of the child becoming the Agencies responsibility. The group home staff care for the child until the parents agree to resume their responsibilities. The assumption underlying this system is that the child needs to be protected or "saved" from his parents, that the parents are a noxious influence on him, and therefore a separation is required for change to occur. The group home staff enact the role of pseudo-parents providing the nuturing and discipline which the child was deprived of at home. This model is essentially individually based, with the child defined as the problem requiring help. The parents are considered to be in a

separate compartment and depending on the agency's approach, varying degrees of involvement with the child may be prescribed.

Madanes (1981) differentiates between different approaches to therapy by counting how many units the therapist uses to define the problem, whether it is one, two, three or more people. The term "family therapy" does not necessarily indicate the child problems are defined interactionally (as interaction between all family members). A psychodynamic family therapist and a growth oriented-experiential family therapist will probably use a one-person focus to define the problem while a behavioral family therapist will use a two-person focus. (He who reinforces the behavior and the person with the problem) (p. 9).

Madanes (1981) states, "The issue here is not how many people are actually involved in a problem or how many people are actually present in the interviews, but how many people are involved in the therapist's way of thinking about the problem. A family of eight can be thought of as eight individuals or as four dyads or as a variety of triangles." (p. 5)

When parents find their child very difficult to manage and wish to place him in a group home, the structural/strategic model would see the child's problems as stemming from a confused hierarchy. The child is seen to be in an inordinately powerful position in relation to his parents and the parents are probably experiencing marital c nflicts

which the child is metaphorically expressing. Excluding life and death situations, where abuse or incest are considered to be at a dangerous level, the general goal would be to reinstate hierarchical order by restoring power to the parents. In order for the therapist to relegate power to the parents, he must be in control of the therapeutic system. That effective control has sometimes proven to be largely incompatible with the existing Child Welfare system.

There are two issues according to the structural/strategic model: the therapist's control of the system and the parent's control of their child are both necessary for restoring the proper hierarchical order. The therapist's control can be undermined by the group home staff, the involved psychiatrist and potentially the Agency who may define the problem soley in terms of the child, using techniques which are inconsistant with the therapist's goals. If the hierarchy among those dealing with the family is confused and it is unclear who is in control, it is virtually impossible for the therapist to relegate control to the parents.

Even assuming the therapist does have the necessary therapeutic control, the parents receive double messages about their own power in the system. While the therapist's goal is to support the parents in being competent, assuming charge of their child, the social system is labelling them as incompetent and irresponsible for their child's well-being. The parents' control has been effectively removed

from daily and long-term decisions concerning the child. The child's visits home thus do not replicate normal family interaction. Because the status of the child has now changed to that of a "guest", parents may feel reluctant to exert their authority and risk an unpleasant situation. Parents are placed in the position of having to "earn" the right to have their child back and may feel their strict demands may alienate the child even further. The parents' feelings of incompetence are increased by their real reduction of power in the situation.

Another basic incompatibility stems from the change in the child's social unit. Structural/strategic family therapy uses everyday shared experiences which create problems as a base for determining changes and goals. Because the child's social unit is the residential treatment setting rather than the parents' home, it becomes extremely difficult to negotiate boundaries and improved ways of communication between persons who do not share a living space or (in some cases) have any contact with one another. Conducting therapy in these situations can easily become an abstract exercise rather than a move to action. The student observed the ambivalent feelings in parents and child when a child is removed from the home. Although all are aware that the existing situation is untenable, parents often experience guilt for abdicating control of their child, and the child generally feels rejected. The student sensed that the families she dealt with wanted help and support to improve

their situations, therefore, therapy under duress was not a major issue. The major issue for the student was being caught between two models of viewing child problems.

In the student's opinion the structural/strategic model provides a superior method for handling a child who is out of control and the placement option is sometimes unfortunate because it provides a convenient exit for responsibility. However, confusion and conflicts arise for the structural/strategic therapist when confronted with child placement and the model does not explain how to proceed in these cases. This is a definite short-coming of the model which needs to be overcome.

The second major area which needs to be examined is in the range of what some claim is the model's limited applicability. There seems to be an implication that the structural/strategic model is tied to the middle-class, North American nuclear family. When the model describes family organization in terms of subsystems - spouse, parental and child, their implication is that there are two parents. The power structure when relating to the extended family also has implications that the grandparents are in a lower position to the parents as depicted by the standard American family, rather than a native or 3rd world family. Research has shown that success with low-income and single-parent families is low. (see Chapter 4 - Outcome Research) The question remains - is there an inherant bias within the model which restricts its applicability to families outside the

middle-class American nuclear family?

Madanes (1981) claims that "there are no contra-indications in terms of patient selection and suitability. The approach has been used with the whole range and all socioeconomic classes..." (p. 27)

The structural approach in fact grew out of and was designed for poor multi-problem families (see Chapter 2). Harry Aponte, (1976) (structural family therapist) calls poor families underorganized and much of his work deals with poor black and Peurto Rican families where different family structures and values are an issue. Stanton's (1982) families of drug addicts were generally from a low socioeconomic standard. Madanes (1981) is Argentian and often deals with varieties of Spanish speaking families.

Froma Walsh (1982) sees the structural and the strategic approaches as taking culture and structural means into account. Minuchin, she says, is more concerned with the clarity of the boundaries than the composition of the subsystems. "A parental subsystem that includes a grandparent or a parental child for example, can function quite well as long as lines of authority and responsibility are clearly drawn." (p. 13)

She also says that the structural approach accounts for cultural norms and gives the example of an enmeshed family, which is typical in many ethnic societies and would not be considered pathological by this model if seen in the context of this ethnic group. Walsh (1982) describes the strategic approach as being sensitive to these issues as well.

She states that Haley observes that in Asia and other cultures the norm is that the power resides with the eldest generation. However, Haley (1976) sees that in a single parent American family, it is normal that grandparents may have more important functions than in two-parent families. "The crucial matter is that whatever the arrangement, every family must deal with the issue if organizing in a hierarchy and must establish clear rules to govern power and status differentials." (p. 16)

In the student's Practicum work, 4 of the 8 families were single parent, and the model was applied to all of them. The model generally worked well with the single-parent families, however, in Family (7), a triadic relationship between the mother and the IP and a third person was not discovered. The mother had no boyfriend or parent living in Canada and there appeared to be no parental child who shared her authority. The student can then conclude on the basis of her clinical work that the model is applicable to most single parent families but there are cases to which the model does not fit.

Haley (1976) brings in a final point which therapists could be aware of when working with poor families, which is our role in the social control of society. Haley, (1976) claims that governments pay therapists to keep segments of the population from making trouble. "When the poor riot, mental health clinics proliferate in the slums." (p. 196) He sees an ethical dilemma occuring from the desire to help the poor and so using government funding, but not wanting to be used by the establishment to keep the

peace and prevent basic social change.

In summary, the question of applicability of structural/strategic model has not been conclusively resolved. Inherent in its design, the model has the flexibility to be applied to a large variety of cultures and family structures, however, research shows lower success rates with some of these groups. A possible explanation is that these groups may be the most difficult families to engage in any type of therapy, or their success rates are low compared with the very high success rates of middle-class psychosomatic families. More research in the field is required to obtain an answer.

A third limitation of the model is the complexity of the techniques and the problem of training therapists. The paradoxical techniques, although potentially effective, are usually too complex for the beginning therapist. Expert supervision in the area of paradoxical injunctions and a good conceptual understanding of the model are required. The ideal way for a student to learn this approach is with live supervision, access to a one-way mirror and video equipment. These facilities, although becoming more prevalent, are often unavailable. Live supervision has many advantages, but it is time consuming and may demand more from most agencies than can be given. Canada has very few resources for training structural/strategic family therapists and training centres in the United States are costly and extremely competative. Because of the complexity of the techniques, proper train-

ing is essential in mastering the structural/strategic model.

The student was very fortunate in having access to live supervision, video equipment and a supervisor who is well versed in the field of structural/strategic therapy. The live supervision enabled the student to experiment with new intervention techniques in different situations because of the option for immediate transmission during the interview itself (as opposed to retrospective analysis). Therapeutic control was enhanced by the presence of an experienced supervisor who would be prepared to intervene if the interview threatened to go awry. The ongoing feedback both during and following the session increased the student's awareness of her own misjudgements and misinterpretations as well as her strengths. Use of the video equipment allowed the student to review her work critically and learn a tremendous amount prior to consultation with the supervisor.

In summary, the student did not suffer personally from the scarcity of good training, but on the contrary, feels that her opportunity was a rare one.

Two final issues will be discussed here with the intention of examining some of the unique elements of the structural/strategic model. The first issue covers the implications of focusing on the presenting problem. The second deals with how much information the therapist should ethically conceal from his clients.

Within this model, the implications of focusin on the presenting problem are that:

1. growth and self actualization are not the priority
2. therapy will be as brief as possible
3. focus will be on the problem's manifestation in the present time frame.

The underlying assumption of this model is that normal families have problems. (Walsh, 1982, p. 11). The goal for therapy therefore is not to eliminate problems or aspire to communicate like the "ideal" family (as in the growth oriented therapies like the psychodynamic or experimental approaches). Rather, the therapists' goal is to intervene for as brief a period as possible to help the family work through a stage in which they are temporarily stuck. Because the problems are seen to be manifested in current interactions, the time involved in the psychodynamic approaches (where one delves into the past with the intent of discovering the roots of a post-trauma), is unnecessary and a focus on the present is maintained. The usefulness of this aspect is discussed in this Chapter, Part III - Contributions to Social Work Practise.

The second area deals with how much information a therapist should ethically conceal from his clients. This touches on issues of how "honest" a therapist should be, how much he should share of his observations and the degree to which he may "manipulate" the family. Haley (1976) sees the directive approach as determining if change will take place as a result of insight (as in psychodynamic approaches)

or because of changes occuring outside the client's awareness as in directive approaches (such as structural/strategic or behavioral therapies). The structural/strategic model sees information as synonomous with boundary, coalition and power.

Because the therapist in this model must maintain therapeutic control and a clear boundary must be drawn between himself and the family, his role is akin to the gatekeeper of information. The power to withhold or reveal information determines the therapist's superior position in the hierarchy of the family system.

The second assumption of this model is that family members in therapy lack ways of resolving their problems but they do not lack understanding of them. Therefore, education and/or interpretations concerning the problem is irrelevant and insight into the problem will not bring about change. If one assumes that the family already understands the therapist is demonstrating courtesy and respect for the family by providing them with a graceful way out of their problem. (Haley, 1976, p. 213)

The third assumption of this approach is that every therapist manipulates, only some do it less consciously than others. "The pretense that sitting with a deadpan expression and responding in mono syllables would not influence a patient's life decisions has been recognized as only a pretense." (Haley, 1976, p. 200)

This model maintains that since all therapy is manipulative, it is best to be aware of one's manipulation and to consciously plan out strategies to manipulate the

clients to the desired directions and goals.

In summary, I adopt Haley's position who sees an overconcern for the so called "moral" behavior and "honesty" of the therapist and much less concern given to whether the therapist cured people of their problems. The act of concealment between therapist and client is seen as essential in defining a boundary between them and individuating them. To impose awareness upon clients and so help them to discover what they already known and would rather not admit, is seen as disrespectful. Finally, Haley (1976) sees therapists as trained experts who should know how to handle a great variety of situations and should take responsibility for directing the family. A therapist's claim that he does not know how to resolve a particular family problem should not be accepted as a valid abnegation of responsibility. As a directive therapist he has an obligation to fulfill his stated shortcomings. (p. 221)

The student experienced some difficulty in maintaining this stance as a beginning family therapist, who in fact did not know how to resolve many situations. However, the student sees the validity of what Haley (1976) calls "fair exchange". (p. 195) A family who is paying for therapy has the right to expect treatment by a competent professional who will take responsibility for change. It is clear to the student that the family need not be privy to the therapist's methods and perceptions in order for positive changes to occur.

III. STRUCTURAL/STRATEGIC FAMILY THERAPY - ITS CONTRIBUTION TO SOCIAL WORK PRACTISE

There are a number of factors which make structural/strategic family therapy compatible with the role of the clinical social worker. A social worker with a predominantly family caseload or one who deals mainly with child problems could find this model a valuable asset in her practise.

This model advocates focusing on the presenting problem which has two major advantages to the social worker. One is that it gives direction for therapy, the other is as an indicator of change. When a social worker encounters a family with many problems, the complexity of the interactions and the tremendous amount of data one could collect from a single family interview can be overwhelming. The social worker can find herself feeling helpless and unsure how to proceed. The structural/strategic model outlines in concrete terms how one conducts the first interview and how one is to proceed in therapy by focusing on the presenting problem until it is solved. Because this is the family's ostensible concern, chances of enlisting their co-operation are increased and a therapeutic contract can be made. By defining the presenting problem in concrete and measurable terms, the social worker has the basis for therapeutic goals and an indicator of change. If there is a change in the presenting problem which is consistent with the therapeutic goals, therapy is con-

sidered to be successful. However, if there is no change, therapy can be considered unsuccessful and the social worker is required to retrace her steps to review her errors. To some extent, having the change in the presenting problem as an indicator for success or failure of therapy can counter the common complaint levelled against clinical social workers about the lack of an evaluative component in their work.

Another contribution of the structural/strategic model is its brief and pragmatic orientation versus an insight and historical one. This model strongly advocates that therapy be as brief as possible, usually not exceeding three to six months. The focus on pragmatic issues is an element in the time factor. In this approach, delving into early childhood experiences and interpretations linking past behavior to the present are considered irrelevant. Therapy focuses instead on issues which are currently in operation and pragmatically explores how to resolve them. Obviously the time involved in this model will be far less than if one must understand the history of each individual as well as problem development. It is not uncommon for structural/strategic therapyto consist of three or four interviews whereas in the psychodynamic approaches this would be highly unlikely. For the social worker, the brief therapy approach allows for service to a greater number of families and greater cost effectiveness (see outcome research findings, Chapter 4). The pragmatic

orientation which focuses on symptoms and presenting problem offers social workers a way to see and appreciate the gains made which are measured in concrete terms rather than abstract ones. Insight, according to this model is not considered to be an end in itself. The primary goal is the achievement of concrete solutions to currently occuring problems. Thus the social worker can, with the average family, establish a clear therapeutic contract based on concrete goals which will be achieved in a minimum number of sessions, probably within three months.

The other major contribution to social work is the development of paradoxical techniques for dealing with resistant families. Families of drug addicts, schizophrenics and alcoholics were considered almost hopeless. Paradoxical methods have proven effective with a number of them. Paradoxical techniques can be used in a variety of situations and with a majority of families in addition to extremely resistant ones. The techniques are complex and require an investment of time to gain mastery, however the experience is invaluable. When a social worker encounters a very resistant family, paradoxical methods are an asset in the repertoire of effective therapeutic techniques.

Finally, the contextual and interactional focus of the structural/strategic model is another compatible aspect to social work practice. Inherent in the social worker's role is the expectation that she intervene in

the social environment to effect change. Unlike a psychiatrist who is usually required to conduct interviews in his office, a social worker has the flexibility to view the problem in its context, be it the school, the home or street. Aponte (1976) writes an article about how one carries on a structural interview within a school setting. The social worker has access to the context of the occuring problems and if she can define them in interactional terms, her scope on the issues will be considerably widened. The structural/strategic model is one which is contextually based and ideal for the social worker who can intervene within a variety of contexts surrounding the problem.

APPENDIX 1 - STAGES OF THE INITIAL INTERVIEW

1. The goal of the social stage is to put the family at ease. Therefore, they are greeted and seated as one would do with guests in one's own home. The therapist can gather a great deal of valuable information in this stage expressed both verbally and non-verbally. The therapist must keep a sharp eye to observing the family. He can note how the parents organize their children as they enter the therapy room, where family members sit in relation to each other, how the parents generally relate to their children, and the overall mood of the family. The therapist is forming tentative ideas based on these observations, however, neither is ever shared with the family. In this stage, the therapist introduces himself, obtains everyone's name (to indicate that everyone is involved and important), inquires if everyone is living at home, or other significant individuals, are present, and finds out how the interview was presented to the children. This stage may last a few minutes before a purposeful shift is made to the problem stage (Haley, 1976, p. 15-19)

2. In the problem stage, an inquiry about what the problem is conveys to the family that the situation has changed from a social to a therapeutic setting where everyone must get down to business. Before proceeding, the therapist should clarify why he has asked the whole family to come in when only the child has the problem. He may do this by saying "I have some idea what the problem is, but I wanted to get everyone's opinion about it." The therapist must then decide how

to phrase the inquiry and whom first to ask about the problem, keeping in mind what this will represent in the power hierarchy. The inquiry about the problem is best left open-ended and general since this gives the family an opportunity to display their point(s) of view. Haley recommends that the therapist address the inquiry either to the whole group, where the family spokesperson will generally respond first, or to the peripheral adult, who is usually the father in two parent families with child problems. Addressing the peripheral adult first involves him in the process and validates his position as head of the family. The therapist should not start with the problem child since this would only serve to reinforce the inordinate amount of attention he receives. Great respect and concern should be accorded the family member who has the power to bring the family into therapy. The therapist receives everyone's version of the problem, usually getting the child's perspective last (Haley, 1976, p. 19-29).

The therapist will not share his conclusions based on what he observes, but a great deal of interactional information can be gathered at this stage of the interview. The hopefulness of the family can be gauged by how upset they are about the problem and by the degree of credibility given the therapist in his attempt to help.

The first hints concerning the location of the dysfunctional sequence should become evident here. For example, the therapist can note the behavior of other people,

particularly the problem child, when others are talking, and if anyone is particularly proud or happy that the child is being blamed. The therapist begins to conceptualize the child problem in relation to his family by listening to the indirect messages which are the metaphorical meaning of the stated family opinions. Based on the assumption that the child problem reflects or is a performance of the marital problem, the therapist is careful in this stage not to ask questions which are too specific and may limit the expression of the metaphor. In a later stage a more detailed definition of the problem will be sought after, however, in this stage the family should be encouraged to talk while the therapist listens for the different meanings in their statements. It is understood that many things cannot be said directly or there would not be a problem. The therapist listens to each parent discuss their child's problem as though they were simultaneously speaking of their mate and their marriage. The mother who says her child wants to run away may be talking about her husband who wants to run away as well. By remaining sensitive to motivation and interpretations of the child's problems on both the literal and metaphorical levels, the therapist can begin conceptualizing the dysfunction in terms of mother, father and child. The definition can be even broader if greater space is yielded for responses (Haley, 1976, p. 35).

3. When everyone in the family has had an opportunity to give their perspective on the problem, the therapist shift to the interaction stage by encouraging family members to talk to each other about the problem while he sits back to observe. The therapist may use content from the previous stage to get the mother and son discussing their different views on the problem. He will probably want to involve more people in the discussion depending on which tentative hypothesis he is testing. He may, for example, ask Dad to "help them get it straight", thus providing information on how much power father has to oppose the mother and son. If it is appropriate, the therapist will direct the child to act out his problem to see how family members react. This is the stage where family organization and sequences become apparent. It is possible to observe who is overly-involved with the child, who is on the periphery, and how set this pattern is. The over-involved adult will want to intrude either by objecting to the way the other adult handles the child or by simply trying to take over. The more difficult it is for the therapist to stop the intrusion, the more rigid and dysfunctional this pattern of behavior has become (Haley, 1976, p. 36-40).

4. In the final stage of the initial interview, the desired changes are defined and a therapeutic contract is negotiated. As previously mentioned, the problem should be defined in solvable terms; it should also be set up so that results can

be observed, counted and measured. The specific questions of 'how often' and 'when does it come', 'it is expected', and 'what solutions have been tried', are appropriate here. Everyone, including the problem child, should give a clear statement of the changes they would like to see. Only in crisis situations should the therapy shift away from these defined goals, and if possible, the focus should be maintained even if a new situation arises. Haley (1976) provides an example of a family whose concern was with their mentally handicapped daughter who received the news that the father only had a few months to live. Rather than deal with the issue of death directly, the therapist focused on how the wife/mother was able to cope with the daughter alone. The therapist retained focus on the presenting problem but achieved other relevant therapeutic goals as well (p. 40).

APPENDIX (2) - EXAMPLES OF TASKS (Haley, 1976)

1. A father who is siding with his small daughter against the wife may be required to wash the sheets when the daughter wets the bed. This task will tend to disengage the father and daughter or cure the bedwetting.

2. In a case in which the grandmother is siding with the grandchild against the mother (an actual case) the therapist sees mother and her ten-year old daughter together. The grandchild is to do something of a minor nature that would irritate grandmother and the mother is to defend her daughter against the grandmother. This task forces a collaboration between mother and daughter and helps to detach daughter from grandmother.

3. (An in-session task may include:) Father and mother may be directed to talk without including daughter; or in a family in which everyone constantly interrupts, a "speaker's chair" may be set and only the person sitting in it can talk. This is intended to shift the pathways of communication (p. 60-61).

APPENDIX (3) - THE QUESTIONNAIRE

STRUCTURAL FAMILY INTERACTION SCALE

NAME _____

Please Circle: Mother
Father
Child

Fill in: Age ___ Sex ___
Birthday _____ Grade _____

DIRECTIONS: Below are statements describing family interaction patterns. For each statement choose which of the following is most characteristic of that statement as it describes your family.

A - Very true of our family
B - More true than false
C - More false than true
D - Very false

Please circle your answers.	Very True	More true than false	More false than true	Very false
1. There is a strong sense of loyalty in our family.	A	B	C	D
2. In our family parents rarely lose their tempers with each other.	A	B	C	D
3. Father and child seem to be fighting about the same thing again and again.	A	B	C	D
4. In our family mother seldom lets a child do things for himself/herself.	A	B	C	D
5. During a family argument certain members usually can count on the same person's support against another member.	A	B	C	D
6. Family members have an equal say in making many family decisions.	A	B	C	D
7. Father seldom looks after or gives attention to a child in our family.	A	B	C	D
8. Even though parents have different viewpoints they can talk them over without fighting.	A	B	C	D
9. In our family a child feels it is possible to get a rule changed by getting the help of one parent against the other.	A	B	C	D

		Very True	More true than false	More false than true	Very false
10.	People feel alone in our family.	A	B	C	D
11.	A child feels it is necessary to choose a side when parents have a disagreement.	A	B	C	D
12.	Father is afraid to let a child make mistakes.	A	B	C	D
13.	We are flexible enough to adjust to new situations in our family.	A	B	C	D
14.	Mother and child are careful about bringing up touchy topics with each other in our home.	A	B	C	D
15.	When one parent raises an issue, the other one threatens to hit or leave.	A	B	C	D
16.	In our family father and child compromise to settle their differences.	A	B	C	D
17.	In our family mother feels the child "comes second".	A	B	C	D
18.	Father and child won't talk over disagreements with each other.	A	B	C	D
19.	In our family mother and child just end up yelling at each other when they try to discuss issues.	A	B	C	D
20.	There is one child who gets blamed for most of the problems in our family.	A	B	C	D
21.	In our family disagreements between mother child are settled by those two without bringing in the other members.	A	B	C	D
22.	When someone in our family gets hurt or upset we all react.	A	B	C	D
23.	When one parent says something angrily to the other parent, that parent will not argue back.	A	B	C	D
24.	In our family father and child settle their differences by hitting or shoving.	A	B	C	D

	Very True	More true than false	More false than true	Very false
25. Mother is very careful about protecting a child.	A	B	C	D
26. You can predict which two or three people are going to "clash" in our family.	A	B	C	D
27. In our family parents support each other in making and enforcing rules.	A	B	C	D
28. Often father pays no attention to a child who is sick.	A	B	C	D
29. In our family disagreements between parents are resolved by themselves without bringing in the other members.	A	B	C	D
30. One parent and one child have a special relationship in our family.	A	B	C	D
31. There is very little concern for each other in our family.	A	B	C	D
32. When parents disagree about an issue they make a child feel "caught in the middle".	A	B	C	D
33. A child frequently complains of being babied by father in our family.	A	B	C	D
34. As a child grows older parents are flexible enough to give him/her more freedom.	A	B	C	D
35. In our family mother and child rarely lose their tempers with each other.	A	B	C	D
36. Parents seem to be fighting about the same thing again and again.	A	B	C	D
37. Father and child work out disagreements without hurting each others feelings.	A	B	C	D
38. Mother seldom looks after or gives attention to a child in our family.	A	B	C	D
39. In our family father and child seldom openly become angry at each other.	A	B	C	D

		Very true	More true than false	More false than true	Very false
40.	When mother or child tries to bring up an issue, the other one puts off discussing it by saying, "I can't talk about it now".	A	B	C	D
41.	Parents avoid a fight between themselves by blaming someone else in the family.	A	B	C	D
42.	In our family mother and child can talk over their differences and settle them fairly.	A	B	C	D
43.	When someone is hurting in our family the others feel sensitive, too.	A	B	C	D
44.	In our family parents seldom openly become angry at each other.	A	B	C	D
45.	When father or child raises an issue, the other one threatens to hit or leave.	A	B	C	D
46.	In our family mother tells a child exactly how to do his/her work.	A	B	C	D
47.	There are "favorites" in our family.	A	B	C	D
48.	Parents make it clear to the children there are limits to how far they can bend the rules.	A	B	C	D
49.	Father is not there when a child needs him.	A	B	C	D
50.	In our family both parents compromise to settle their differences.	A	B	C	D
51.	In our home a child gets his or her way by getting the help of one parent against the other.	A	B	C	D
52.	We spend very little time together in our family.	A	B	C	D
53.	In our family it's hard for a child not to get involved in disagreements between parents.	A	B	C	D
54.	Father is very careful about protecting a child.	A	B	C	D

		Very true	More true than false	More false than true	Very False
55.	Family members are flexible in who they agree with or side with in family discussions and arguments.	A	B	C	D
56.	When mother or child says something angrily the other one will not argue back.	A	B	C	D
57.	In our family parents just end up yelling at each other when they try to discuss issues.	A	B	C	D
58.	Even though father and child have different viewpoints they can talk them over without fighting.	A	B	C	D
59.	Mother seldom responds when a child needs help or support.	A	B	C	D
60.	Father and child are careful about bringing up touchy topics with each other in our home.	A	B	C	D
61.	In our family mother and child settle their differences by hitting or shoving.	A	B	C	D
62.	One person chiefly is blamed for all our conflicts.	A	B	C	D
63.	Mother and child work out disagreements without hurting each others feelings.	A	B	C	D
64.	We are a "close family".	A	B	C	D
65.	Parents won't talk over disagreements with each other.	A	B	C	D
66.	When father or child tries to bring up an issue the other one puts off discussing it by saying, "I can't talk about it now".	A	B	C	D
67.	A child frequently complains of being babied by mother in our family.	A	B	C	D
68.	Family members seem to "pair off" in the same way around issues in discussions or fights.	A	B	C	D

		Very true	More true than false	More false than true	Very false
69.	Parents are clearly "in charge" in our family.	A	B	C	D
70.	In our family father feels the child "comes second".	A	B	C	D
71.	In our family parents can talk over differences and settle them fairly.	A	B	C	D
72.	In our family there is consistent support between one parent and a child against the other parent on issues.	A	B	C	D
73.	In our family people feel "cut off" from each other.	A	B	C	D
74.	A child feels trapped in between when parents argue.	A	B	C	D
75.	In our family father seldom lets a child do things for himself/herself.	A	B	C	D
76.	Rules are pretty flexible in our house.	A	B	C	D
77.	In our family mother and child seldom openly become angry at each other.	A	B	C	D
78.	When one parent tries to bring up an issue the other parent puts off discussing it by saying, "I'm too busy to talk now".	A	B	C	D
79.	In our family disagreements between father and child are settled by those two without bringing in the other members.	A	B	C	D
80.	Often mother pays no attention to a child who is sick.	A	B	C	D
81.	When father or child says something angrily, the other one will not argue back.	A	B	C	D
82.	When mother or child raises an issue, the other one threatens to hit or leave.	A	B	C	D
83.	Parents avoid a conflict between themselves by giving attention to someone else in the family.	A	B	C	D

		Very true	More true than false	More false than true	Very false
84.	Even though mother and child have different viewpoints they can talk them over without fighting.	A	B	C	D
85.	At home we go out of our way to constantly do things for each other.	A	B	C	D
86.	Parents are careful about bringing up touchy topics with each other in our home.	A	B	C	D
87.	In our family father and child just end up yelling at each other when they try to discuss issues.	A	B	C	D
88.	Mother is afraid to let a child make mistakes.	A	B	C	D
89.	It's hard to break family routine at home.	A	B	C	D
90.	In our family parents support each other in making decisions.	A	B	C	D
91.	Father seldom responds when a child needs help or support.	A	B	C	D
92.	Parents work out disagreements without hurting each others feelings.	A	B	C	D
93.	A child is able to get more attention or support from one parent rather than the other.	A	B	C	D
94.	In our family we lack a feeling of togetherness.	A	B	C	D
95.	When parents disagree over something they try to get a child to take sides.	A	B	C	D
96.	In our family father tells a child exactly how to do his/her work.	A	B	C	D
97.	We are flexible enough to do things on the spur of the moment.	A	B	C	D
98.	Mother and child won't talk over disagreements with each other.	A	B	C	D

		Very true	More true than false	More false than true	Very false
99.	In our family parents settle their differences by hitting or shoving.	A	B	C	D
100.	In our family father and child can talk over differences and settle them fairly.	A	B	C	D
101.	Mother is not there when a child needs her.	A	B	C	D
102.	In our family father and child rarely lose their tempers with each other.	A	B	C	D
103.	Mother and child seem to be fighting about the same thing again and again.	A	B	C	D
104.	When parents have an argument they blame some other family member.	A	B	C	D
105.	In our family mother and child compromise to settle their differences.	A	B	C	D

PPENDIX (4) - QUESTIONNAIRE SCORES

AMILY (1) SFIS (105 Items)

	MOTHER	
	BEFORE	AFTER
nmeshment	18	16
)isengagement	10	10
lother)verprotection	12	7
ather lverprotection	13	11
lother leglect	5	5
ather eglect	7	7
igidity	11	8
lexibility	16	14
arents onflict voidance	13	11
other-Child onflict voidance	12	14
ather-Child onflict voidance	14	14
arents onflict xpression ithout Resolution	10	9
other-Child Conflict xpression Without esolution	9	9
ather-Child Conflict xpression Without esolution	4	5
arents Conflict esolution	13	13

MOTHER

	BEFORE	AFTER
Mother-Child Conflict Resolution	15	17
Father-Child Conflict Resolution	15	15
Parent Management	12	16
Triangulation	13	12
Parent-Child Coalition	14	13
Detouring	11	8

'AMILY (4) SFIS (105 Items)

	FATHER		MOTHER		BROTHER		IP	
	BEFORE	AFTER	BEFORE	AFTER	BEFORE	AFTER	B	A
nmeshment	15	16	16	16	14	13	12	13
isengagement	7	8	9	8	6	7	17	18
lother verprotection	11	12	16	14	12	17	13	13
ather verprotection	14	13	15	11	14	16	16	11
other eglect	6	7	7	6	9	8	7	8
ather eglect	8	7	8	7	11	12	20	19
igidity	12	12	11	11	12	13	14	13
lexibility	14	15	15	16	15	11	9	10
arents onflict voidance	12	11	8	7	7	7	9	12
other-Child onflict voidance	11	12	8	7	6	7	13	15
ather-Child onflict voidance	11	10	6	6	5	10	8	18
arents onflict xpression ithout Resolution	11	9	14	11	12	13	13	18
other-Child Conflict xpression Without esolution	10	9	12	12	11	14	10	15
ather-Child Conflict xpression Without esolution	12	10	12	11	11	12	20	18
arents Conflict esolution	14	14	11	14	10	7	6	15

Mother-Child Conflict Resolution	12	14	11	11	13	15	14	10
Father-Child Conflict Resolution	13	15	10	12	11	9	5	12
Parent Management	17	17	15	15	13	12	14	15
Triangulation	10	10	10	10	9	8	17	17
Parent-Child Coalition	10	10	9	10	14	15	12	8
Detouring	10	11	7	6	11	12	15	16

FAMILY (7)

SFIS (105 Items)

	MOTHER		ELDEST		YOUNGEST		IP	
	BEFORE	AFTER	BEFORE	AFTER	BEFORE	AFTER	B	A
Enmeshment	16	15	19	19	14	15	12	11
Disengagement	5	6	7	7	6	7	12	12
Mother Overprotection	6	5	13	14	7	7	12	11
Father Overprotection	-	-	-	-	-	-	-	-
Mother Neglect	5	6	4	5	8	8	7	8
Father Neglect	-	-	-	-	-	-	-	-
Rigidity	9	10	7	9	13	14	15	18
Flexibility	14	13	13	11	14	13	16	12
Parents Conflict Avoidance	-	-	-	-	-	-	-	-
Mother-Child Conflict Avoidance	8	9	9	9	5	6	13	14
Father-Child Conflict Avoidance	-	-	-	-	-	-	-	-
Parents Conflict Expression Without Resolution	-	-	-	-	-	-	-	-
Mother-Child Conflict Expression Without Resolution	9	12	14	16	15	17	14	13
Father-Child Conflict Expression Without Resolution	-	-	-	-	-	-	-	-
Parents Conflict Resolution	-	-	-	-	-	-	-	-

Mother-Child Conflict Resolution	18	15	12	10	12	9	12	11
Father-Child Conflict Resolution	-	-	-	-	-	-	-	-
Parent Management	17	17	15	14	18	18	17	16
Triangulation	-	-	-	-	-	-	-	-
Parent-Child Coalition	-	-	-	-	-	-	-	-
Detouring	-	-	-	-	-	-	-	-

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