THE UNIVERSITY OF MANITOBA

School of Social Work

STRUCTURAL FAMILY THERAPY:

A Social Work Practicum Integrating Theory, Practice, and Evaluation

By

Victoria Louise Harrison Frankel

A Practicum report submitted to the Faculty of Graduate Studies in partial fulfillment of the requirements for the degree of Master of Social Work

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CHAPTER I

INTRODUCTION

At the outset of the practicum the objectives of the student were primarily two-fold. The student hoped to demonstrate that Structural Family Therapy is a useful therapeutic tool in understanding and intervening in family systems, and that it therefore has an important contribution to make to social work practice. The student also hoped to acquire and demonstrate a fairly advanced level of skill in Structural Family Therapy so that as a social work professional she would be better able to provide service to individuals and families.

The student planned to meet these objectives in two ways: 1) to review the relevant literature 2) to complete a practicum in a setting that supports the practice of family therapy in Social Work.

The following presentation is a report of what the student learned as she set out to meet these objectives. The report has been completed in a way that attempted to integrate theory and practice rather than treating them as separate entities. It begins with an overview of the historical development of family therapy and then a description of current theories in family therapy. This is followed by a description of the practicum. In this last section it was the student's goal to conceptualize theory and evaluation as an integral part of practice: hence theory and evaluation were presented in the context of case illustrations. The final part of the report is

devoted to a discussion of the contribution of Structural Family Therapy, as well as its possible limitations, in social work practice.

CHAPTER II

HISTORICAL DEVELOPMENT OF FAMILY THERAPY

In this section the writer intends to present a brief summary of the early beginnings of family therapy. While it is not within the scope of this report to provide a comprehensive review of this subject, a historical perspective does provide a context in which to further understand the development of structural family therapy.

Nathan Ackerman has been referred to as the "grandfather" of family therapy (Okun and Rappaport, 1980, p.50.) (Guerin, 1976, p. 12). A psychoanalyst and child psychiatrist, he became interested in the external conditions affecting the family and in 1938 wrote a paper entitled "The Family as a Social and Emotional Unit". He continued to treat and write about his treatment of individual patients and their families in the 1940's and 1950's. In 1960 Ackerman founded the Family Institute and there continued to develop his theory about the individual's psychological identity within the family system.

In the mid 1940's Carl Whitaker began adding family members to sessions with the identified patient. He was especially interested in the study of families with a schizophrenic member (Guerin, 1976, p. 10). Later he also became interested in the role of the extended family in the therapeutic process.

Meanwhile in 1952 Gregory Bateson, an anthropologist, received a grant to study paradoxical communication styles of animals and humans (Okun and Rappaport, 1980, p. 42). Bateson did much of the work in the early application of systems thinking to human behavior. Haley, Weakland and Jackson were his research assistants and they went on to study communication styles of schizophrenic patients. A

major concept that evolved from the work of this group was the notion of the "double bind". Another important concept that emerged from this group was the idea of family homeostasis (Okun and Rappaport, 1980, p. 43 ff.). In 1956 Bateson et al. published an important paper "Toward a Theory of Schizophrenia" which explained the group's theory of the set of conditions in a family situation that lead to schizophrenic communication. Out of later research (1958) studying the process of family therapy with schizophrenic patients Jackson and Haley began to explore power and conflict by analyzing and intervening in communication processes in families. Haley later joined Minuchin in Philadelphia where he continued this work.

Bowen and his group began their investigation on schizophrenics and their families in the early 1950's (Guerin, 1976, p. 9) (Okun and Rappaport, 1980, p.45). By the mid-50's Bowen began to hospitalize whole families for observation and research. He became interested in the idea of the degree of fusion or differentiation of feelings and intellect, and of the early triangulation of the child in the marital subsystem.

In the early to mid 1960's Ross Speck and Carolyn Attneave contributed to the family therapy movement by suggesting network intervention as a method of "ministering to the accumulated ills of the family" (Guerin, 1976 p. 11).

In the early 1960's Minuchin and his colleagues began a research project to study the families of delinquent boys. In 1965 he went to The Philadelphia Child Guidance Clinic where, along with

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other therapists including several social workers, he attempted to apply family therapy constructs to working class families and to develop cross-cultural family systems interventions.

The above is by no means an exhaustive description of the early work in family therapy. There were other theorists, researchers and clinicians working along side these, as well as those who independently contributed to the field. Of note is John E. Bell (Bell, 1967, pp 254-263) who in 1951 began to use family group therapy as the sole method of treatment. These early pioneers and others have very much influenced current practices in family therapy.

It is also argued that the impetus of the family therapy movement had some of its origins in other disciplines, especially Social Work. Ruth Rachlis (Rachlis, 1974, pp 5 - 7) argues that as early as the 1870's welfare workers were concerned with the adjustment of the family to its environment. She also writes that by 1901 Mary Richmond was central to the development of the view that took into account the various forces that impinged on and acted within the family. In addition, in 1920 the National Association of Family Social Workers began publishing The Family, a journal intended exclusively for problems of the family. However while acknowledging the contribution of the Social Work profession to the present acceptance of the family as a 'system', Rachlis concludes that social work's contribution to family therapy was not unique and that family therapy as a discipline signalled the coming together of various disciplines and streams of knowledge.

Adele Brodkin (Brodkin, 1980, pp 4-17) argues that family therapy theory has been borrowed from various aspects of science as

well as other disciplines. She includes the behavioral sciences, physical sciences and psychological theory as all contributing to the emergence of family therapy. As well Brodkin states that family therapy developed simultaneously in separate areas and that its roots were well established in these quite separate areas, that each made significant contributions to family therapy theory. Gisela Konapka has responded to what she considers Brodkin's narrow view of history that does not sufficiently credit social work for its contribution to family practice long before psychology and psychiatry made family therapy 'fashionable'. Robert Tomberg, a social worker with Ackerman, addressed this issue in 1958 (Gomberg, 1958). He wrote that while social work has long attempted to include social and family factors in diagnosis, there was still the absence of a diagnostic or conceptual system by which to describe, assess or classify the family configuration. Gomberg wrote as late as 1958 that while social workers had long worked with and planned for families, nonetheless theory and diagnostic formulations were still framed in terms of the individual and lacked a systematic way to conceptualize family dynamics and family interaction (Gomberg, 1958, p 152). He states that we must not confuse our <u>efforts</u> to understand the interaction and interdependence between the individual and family diagnosis with having <u>arrived</u> at a conceptual system (Gomberg, 1958, p 157). This student would agree with all these writers. Social work's unique contribution to family therapy has undoubtedly been that social workers have long understood the need to examine familial and other social factors, and to support family functioning, while it was left to the interdisciplinary family therapy movement to conceptualize the family

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interactive system and develop diagnostic formulations. Nonetheless Siporin (1980) is quite correct when he argues that " ... marriage therapy and family therapy are traditional and basic social work services".

In the context of this report it is perhaps noteworthy to examine more closely Minuchin's work in the early 1960's. The Wiltwyck Research Project is described by Minuchin et al. in Families of the Slums. The research is important in terms of the ideas and theory about families that developed out of it as well as how Minuchin conceptualized working with families by using a non-medical model. In particular one can begin to see the attractiveness of Minuchin's work to the social work practitioner.

The purpose of the Wiltwyck project was to explore the structure and dynamics of the disadvantaged, disorganized families of delinquent children and to study interventions that could best 'reach' these families (Minuchin, 1967, p 9.). The research team was composed of three psychiatrists, two psychiatric social workers and two clinical psychologists.

The research enabled Minuchin and his team to draw certain conclusions about the characteristics of these families, including the extended family. He began to describe disengagement and enmeshment, as well as the communication and interactional styles of these families. He then went on to develop methods of intervening in the family system or structure. These methods were refined in later years and are described elsewhere in this report.

Of particular importance to social work practice was the exploration of the social surroundings of the families in the Wiltwyck

project (Minuchin, 1967, p 272 ff.). Minuchin et al. made particular reference to the existence of "natural and steady networks" that are to be considered in the planning of the therapeutic intervention. They refer to linking disengaged families into "workable social networks which can surround and support the family", and state that in working with the disadvantaged population one must consider the relationship between the larger social system and the family system. They write that the development of large scale interventive programs requires knowledge not only of social structure and processes but also knowledge derived from intensive clinical work with a small number of people, and he refers to the further need for coordination of work within the family with community approaches (Minuchin, 1967, p 370). He states that:

> The boundaries between intrafamilial and extra-familial systems can, after all, become open or closed both ways. To open them both ways, the reactions of the change-agents interacting with the poor must be as earnestly studied as the reactions of the poor themselves. Our unprecise knowledge of family patterns might then resolve into more identifiable and precise knowledge of the patterns through which resources in the social system interlock or not with the needs of particular families." (Minuchin, 1967, p. 377).

CHAPTER III

CURRENT THEORIES OF FAMILY THERAPY

There are currently a number of schools or theories of family therapy that have developed out of the earlier thinking about families and how change occurs in families. For the purpose of this report these theories have been divided into three areas: (1) psychodynamic theory (2) extended family and network theory (3) communication theory. The next part of the report is a brief discussion of each of these theories so that the reader might begin to develop some ideas about where Structural Family Therapy fits amongst other theories. The writer intends to choose in each area a therapist considered to be representative of that theory and to discuss the therapy of that person along several general dimensions: (1) central concepts (2) theory of change (3) techniques or strategies. Structural Family Therapy will be included here, but will be discussed in much more depth in another part of this report.

Psychodynamic

The school of psycho dynamic family therapy has developed directly out of traditional psychodynamic individual therapy (Madanes, 1981, p 8). There is an emphasis on the past in terms of the cause of a symptom and of the means to change it. It is assumed that symptoms are present due to past repressed experiences. The role of the

therapist is to focus on the past in order to bring these experiences into present awareness. The methods used are aimed at helping the family become aware of past and present behaviors and the connections between them.

Nathan Ackerman, stated that therapeutic healing must be expanded to include "sources of pathogenic influence" within the environment as well as the individual (Erickson, 1972, p 172 ff.). He believed that family therapy provides an expanded context in which to understand illness. It highlights emotional contagion in family relationships as well as the process by which pathogenic conflict and coping are transmitted from one generation to the next. It provides an understanding of the relationship between individual development and events in the family life cycle. Ackerman's model of family therapy conceptualizes individual illness or symptoms as a struggle between the family's defence of its continuity, identity and functions and individual defence against anxiety. The whole family is therefore invited to come in and discuss the problems around the identified patient. Ackerman stated that it is the therapist's task to stir interaction between family members and to bring about a meaningful emotional exchange. He believed that as family members come in touch with the therapist they come into better touch with themselves. The therapist uses a variety of interventions to undermine the family's pathogenic patterns of coping and scapegoating, and openly places the underlying conflict to its place of origin in the family. Through use of self he shifts family alliances toward improved complementarity of needs. The therapist does this by becoming a parent figure and

offering emotional support to family members on a selective basis. By use of various techniques the therapist stirs up family members so that finally they find healthier ways of living.

Extended Family and Network

Murray Bowen has been credited with much of the original work in the extended family (Okun and Rappaport, 1980, p 114 ff.). The Bowen theory is built around two variables: (1) degree of anxiety and (2) degree of integration and differentiation of self. Briefly, how family systems handle tension produced by chronic anxiety determines whether members of the family system remain symptom free. Furthermore, the person in whom emotion and intellect are differentiated is better able to respond in a manner based more on choice. Bowen sees individual and system maturity hinging on the degree of fusion or differentiation achieved between emotionality and the intellect. People with low levels of differentiation are unable to separate themselves from their families of origin whereas people with higher levels of differentiation are able to function effectively, independent of their family of origin. Bowen further believes that the fusion of a child with the emotional relationship system of a family triangle inhibits the child's normal process of differentiation of intellect and emotion: the child's needs are subordinated to the system's need to maintain its present level of functioning. At some

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later point in time the child lacks the degree of emotional differentiation required to become independent of the family system. As the child attempts to leave home and function independently, he may emerge as the identified patient in the family. The Bowen theory considers schizophrenia to be the consequence of several generations of this process. A goal of therapy then is to begin a differentiation or detriangulation of self from the extended family. Change in the family occurs when interlocking triangles change. Since triangles are interlocked, one can change the entire emotional system by modifying the functioning of a single triangle. Bowen uses four techniques to achieve this: (1) defining and clarifying the relationship between spouses (2) keeping self detriangulated from the family emotional system (3) teaching the function of emotional systems (4) demonstrating differentiation by taking "I position" stands during the course of therapy (Foley, 1974, p 117).

A final note is required on Bowen's theory that he considers essential. Unless the therapist has undergone the process of effectively working on his own triangle in his own family system, he can be too easily triangulated into a client family's emotional system (Okun and Rappaport, 1980, p 125).

In Social Networks as the Unit of Intervention, Carolyn Attneave (Attneave, 1976, p 220) describes the use of family networks as the unit of intervention in family therapy. This model presumes that in addition to the family, people have natural social relationships which can be mobilized as natural support systems. Family

Sessions include persons from all areas and relationships in the client's life. The therapist's role is to define the problems and needs of the family and then to mobilize the natural social resources and supports of the family to resolve these needs and problems. The therapist's goal then is to restore the natural support system of the family rather than have a professional assume control and responsibility.

Communication Theorists

Virginia Satir is a communication theorist who places special emphasis on affect. She represents the human potential model in communication theory. She intervenes in a way that allows communicators to become aware of the real feelings underlying their communications so that a certain congruency results (Okun, Rappaport, 1980, p 90 ff.). The concept of maturation is central to this viewpoint. Mature choices and decisions are made by mature persons who have been able to differentiate from their families. Maturity is also seen as closely related to self-esteem. Communications within a family system reflect the self-esteem of the individuals within the family system. Satir believes that the emotional system of the family is expressed through communications. Dysfunction occurs when communication is incongruent. Thus the goal of therapy is improving the family's method of communication in three areas: (1) Each member should be able to report congruently, completely, and obviously on what he or she sees and hears, feels and thinks about himself or herself and others in the

presence of others (2) Each person should be related to in his or her uniqueness so that decisions are made in terms of exploration and negotiation, rather than in terms of power. (3) Differentness should be openly acknowledged and used for growth (Satir, 1967, p 93).

In Satir's model, the therapist uses himself as a vehicle of therapeutic change. He becomes a model of communication to family members in terms of their relationship to him and to each other. The therapist joins the family and responds to its pain, observes the interaction that underlies family rules, and then helps the family clarify its value and change its rules so that family members can learn to communicate openly and directly with each other and with the therapist.

In terms of strategy Satir pays attention to the ways each family member handles the differentness of other family members, focuses on the roles people play and how this relates to position in the family, and examines the congruency and incongruency between each family member's feelings, thoughts, and behaviors.

Jay Haley and Cloe Madanes represent the strategic school of communication theory. Like Satir, Haley believes that relationships are defined by communications and that communications possess different levels of meanings. However Haley places special emphasis on the power struggle that defines relationships (Okun and Rappaport, 1980, p 99). Central to his theory are the notions that a family is a system that involves power relationships, and that a power struggle

between two people is essentially a matter of who controls the defining of the relationship and by what maneuvers.

A further aspect of power has to do with hierarchy and organization in the family. Symptomatic behavior is seen as occurring in an organizational structure with an incongruous hierarchy (Madannes, 1981, p 225). It is assumed that a symptom expresses a problem as well as an unsatisfactory solution for the people involved. Strategic family therapy looks at symptoms then in terms of how they maintain or challenge power struggles within the system (Okun and Rappaport, 1980, p 98).

In strategic therapy the responsibility for change belongs to the therapist who actively joins with the family to form a social unit, and who must possess the skills and expertise needed to give directives that will result in change in the ways in which people relate to each other and to the therapist (Okun and Rappaport, 1980, p 101).

Strategic therapy requires the therapist to set clear goals which always include solving the presenting problem (Madannes, 1981, p 19 ff.). Therapy is planned in stages to achieve these goals. The therapist first decides who is involved in the presenting problem and in what way. Then he decides on an intervention that will shift the family organization so that the presenting problem is not necessary. Usually change is planned in stages, so that a change in one situation or one set of relationships will lead to another change in another relationship and then to yet another until the whole situation changes. Directives may be straightforward or paradoxical but are chosen to bring about change toward the desired goal.

For many therapists, especially the beginning therapist, it may be difficult to clearly grasp the difference between the strategic model of Haley and Madanes, and the structural model of Minuchin. It should be remembered that Haley worked at the Philadelphia Child Guidance Centre for a number of years alongside Minuchin who was the director. Similarly Minuchin provided Madanes with her first job in the U.S.A. at Philadelphia and she subsequently did much of her learning with him. Thus these therapists worked together over a number of years and developed very many similar ideas about the organization of families, family dysfunction, and how change occurs in families. Essentially their present models are comparable as they have retained many of their early ideas. Differences between them are more in emphasis which Minuchin attempts to describe in his most recent publication (Minuchin, 1981, pp 65-67).

Minuchin states that in strategic therapy the identified patient is seen as carrying the symptom to protect the family. At the same time the symptom is maintained by a family organization in which the family members occupy incongruous hierarchies. For instance, the identified patient is in an inferior position in relation to the family members who take care of him but he is in a superior position by not improving under their care. The therapeutic techniques are directed to challenging the heart of the dysfunctional structure: the organization of the symptom. Haley and Madanes have done a great deal of work with severely disturbed young adults in which the central idea of their techniques is the redistribution of clearly allocated powers in the family (Haley, 1980).

Through the structural approach Minuchin sees the family as an organism, a complex system that is underfunctioning (Minuchin, 1980, p 67). The therapist attempts to undermine the existing homeostasis, to create crisis that moves the system toward the development of a better functioning organization. Like the strategist, the structuralist realigns significant organizations to produce change in the entire system. However, while the strategic school develops goals that will redistribute power, the structuralist school has developed other techniques to challenge the organization of the family. The theory and techniques of structural family therapy are described in detail further on in this report.

In this Chapter the writer has briefly examined a number of current theories of family therapy. The theories described are in three distinct areas and each was examined in order to determine its central concepts, its theory of how change occurs, and the strategies developed to bring about that change. The writer's intent was to demonstrate where Structural Family Therapy 'fits' in current theories as well as to indicate to the reader that there are, in fact, a large number of well recognized and accepted theories of family therapy.

CHAPTER IV

THE PRACTICUM

Description of Setting and Procedures:

The writer did a practicum at The MacNeill Clinic for Child Psychiatry in Saskatoon. The practicum was done under the supervision of George Enns, Director of Family Therapy at MacNeill Clinic. The student completed the practicum at MacNeill from February 16, 1981 to June 5, 1981.

The MacNeill Clinic provides psychiatric services to children and their families within the Saskatoon Mental Health Region of the Department of Psychiatric Services. The Clinic offers a variety of services under several departments: Psychiatry, Psychology, Social Work, Family Therapy, Reading, Speech Therapy. Each of these services has a department head who reports directly to the Regional Director of the Saskatoon Mental Health Region. Each department and individual staff members within each department receive direct referrals from other professionals in the community (school system, family physicians) as well as self-referrals. General referrals to the Clinic are reviewed weekly at an Admissions & Discharge Committee that assigns referrals to the appropriate department.

The student would like to comment on the practicum setting. On the one hand, the setting was ideal for the student due to the extensive training, knowledge, and skills of the Director of Family Therapy, and especially his willingness and ability to supervise and teach the student. On the other hand, the student found the practice

of separating family therapy from social work at the Clinic rather questionable. Since both Family Therapists are trained social workers it is difficult to understand the distinction. Historically social workers have always provided service to families in a variety of ways -- family therapy is more often thought of as one social work activity or specialty. Also, this student was never able to understand the rationale by which it was decided if families would be seen by Family Therapy or Social Work.

The Family Therapy department has two full time staff. The director and the other therapist receive most of their intake directly from the community. The program usually has a waiting list of persons requesting family therapy.

The writer saw families assigned by the Director of Family Therapy. The writer then contacted the family and set up an initial family session. Most sessions were video-taped so that the student could review work and receive specific supervision and instruction from the Director. As well the student was able to bring these video tapes to Winnipeg in order to receive supervision from her Advisor. The Director also gave the student live supervision for specific sessions as agreed to between the Director and the student. The student normally received a minimum of approximately 4 - 6 hours per week of supervision. In addition the student received approximately 2 - 3 hours a week supervision from the other therapist in the department.

Records were made by the student of each family and session as required by the Director and the Clinic. Recording generally

included the following: 1) Initial Assessment, including referral source and statement of problem, who was present in the first session, what went on in the first session, 2) Structural Assessment of the family, 3) Stated goals of Therapy, 4) progress note on each treatment session, 5) termination or transfer summary.

Description of Clients:

A total of fourteen families were seen by the student during the practicum. Three of the 14 families chose not to return after one session. The student chose to terminate with one family after two sessions. One family was seen in co-therapy with the Director of Family Therapy and will continue to be seen by him after June 5. Three families began therapy and terminated in a planned way prior to the end of the practicum. Six families began in therapy with the student and were transferred to another therapist when the student left the practicum.

A total of 8 of the fourteen families were formally evaluated using the MOOS FES Scale.

In those families where the FES was used there were 4 single parent and 4 two-parent families. The average age of all these parents was 35, and the average number of children per family was 2.5.

Five of the 8 families had children in the teenage years. Two of the families had children in the 6 - 12 years age range. One family had all pre-school age children. In terms of occupation and income these families were in the middle class range. The occupation of the head of the households were as follows: loan officer, chemical operator, manager/supervisor, welder (2), theology student, self-employed electrician, secretary. In all of the two-parent families the female parent identified her occupation as "at home".

The 14 families were seen for a total of 57 sessions. Those families the student terminated with in a planned way averaged 5.5

sessions, while those families transferred to another therapist when the practicum was over were seen an average of 4.2 sessions by the student.

The remainder of the families seen included 2 single parent and 4 two-parent families. In terms of demographic description these families were similar to the sample group. There was almost no difference in the areas of age, occupation or numbers of children in the family. However 3 of the families in this group dropped out after one session, and the student terminated with a fourth family after two sessions. The remaining two families were seen for a total of 10 sessions.

Theoretical Model:

In FAMILIES & FAMILY THERAPY, Salvador Minuchin first described the theoretical framework of structural family therapy. Since then others have also described the clinical application of this model.

Minuchin states that family structure is the invisible set of functional demands that organizes the way in which family members interact (Minuchin, 1974, p 51). A family is a system that operates through transactional patterns. Repeated transactions establish patterns of how, when and to whom to relate, and these patterns underpin the system.

The family system differentiates and carries out its functions through subsystems (Minuchin, 1974, p 52). Individuals are subsystems within a family and dyads are also subsystems. Subsystems can be formed by generation, by sex, by interest, or by function. Each individual belongs to different subsystems in which he has different levels of power and where he learns differentiated skills and in which he enters into different complementary relationships.

The boundaries of a subsystem are the rules defining who participates and how (Minuchin, 1974, p 53). The function of boundaries is to protect the differentiation of the system. The development of individual interpersonal skills is very much dependent on each subsystem's freedom from interference or intrusion by other subsystems.

For proper family functioning the boundaries of subsystems must be clear (Minuchin, 1974, p 54). They must be defined well enough to allow subsystem members to carry out their functions without undue

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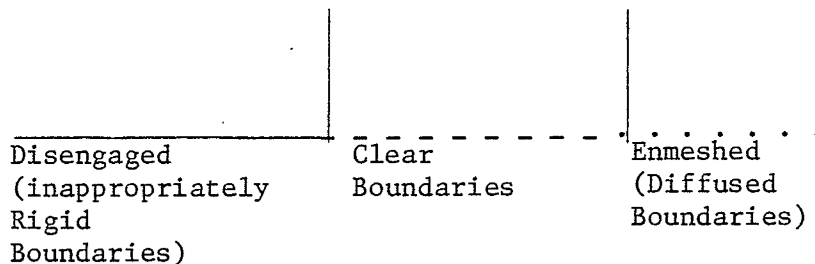
interference, but they must allow contact between the members of the subsystem and others. The clarity of boundaries within a family is one way of evaluating family functioning - boundaries define structure.

In describing disengaged families Minuchin states that they develop overly rigid boundaries (Minuchin, 1974, p 54). Communication across subsystems becomes difficult, and the protective functions of the family are handicapped. Enmeshed families turn upon themselves to develop their own microcosm, with a consequent increase of communication and concern among family members. As a result distance decreases and boundaries are blurred. Such a system may become overloaded and lack the resources necessary to adapt and change under stressful circumstances.



(Minuchin, 1974, p 54)

A therapist's role, according to this model, is to establish boundaries, clarifying diffuse boundaries and opening inappropriately rigid boundaries. Thus the therapist's assessment of family subsystems and boundary functioning provides a diagnosis or structure of the family that determines therapeutic interventions toward the goal of therapy.

It is the symptom of one family member that usually brings the family into therapy. The symptom may have arisen for several reasons, but what is important is that on some level the symptom is being reinforced by the family system. The therapist regards the identified patient as the family member who is expressing in the most visible way a problem affecting the entire system. Minuchin states that selecting one person to be the problem is a simple method of maintaining a rigid, inadequate family structure. The therapist's function is to join with the family and identify its structure, and then to create circumstances that will allow the transformation of this structure. This transformation changes the experience of all family members within the family, and especially for the identified patient who can give up his symptoms. Transformation or restructuring leads to change in the way that family members relate to one another.

When the therapist joins the family he must assess the structure, develop goals based on that assessment, and then intervene in ways that facilitate restructuring in the direction of these goals. The target of intervention is the family system.

The therapist must be well-joined to the family and establish a therapeutic unit before any restructuring can occur. The goals and strategies of the therapist are all dependent on his joining. Joining moves may involve confirmation and support of family subsystems, or confirming and supporting an individual's strength and potential. While joining and restructuring are most often not separable in therapy,

until the therapist is joined with the family restructuring cannot be successful.

Through the interactional process of joining with the family the therapist begins to form a diagnosis of the family. As the therapist joins, he probes the system and elicits material from the family that begins to provide a map of the family transactional patterns. He forms a hypothesis about the family structure and then tests it out as he continues to interact with the family. He establishes a goal in therapy, forms a therapeutic contract with the family, and then begins to plan interventions that will bring about restructuring in the direction of the therapeutic goal.

Minuchin suggests that joining holds the therapeutic system together, while restructuring occurs (Minuchin and Fishman, 1981, p 31). Joining occurs mostly through the therapist's attitude. It is the way she uses herself to let the family know she understands and is working with and for them. In joining, the therapist uses aspects of herself that are congruent with aspects of the family in order to build a common ground with the family. She will do this in a way that requires mutual accomodation between herself and the family. The therapist joins many times throughout therapy while restructuring ocurs.

Minuchin describes three main strategies that each bring about change through a group of techniques. The three strategies are challenging the symptom, challenging the family structure, and challenging the family reality or world view (Minuchin and Fishman, 1981, p 67).

The structural therapist sees the symptom bearer as defending the family homeostasis (Munichin and Fishman, 1981, p 68). The therapist's task is to challenge the family's definition of the problem and the nature of its responses. The goal of challenging is to change or reframe the family's view of the problem, pushing its members to find new responses. The techniques involved in challenging the symptom are enactment, focusing and achieving intensity.

Minuchin describes _enactment_ as that technique by which the therapist has family members enact a transaction (Minuchin and Fishman, 1981, p 79). He states that the assumption underlying this technique is that the family structure becomes manifest in these transactions and that the therapist will therefore catch a glimpse of the rules that govern transactional patterns in the family. In this way problems as well as alternatives become available to the therapist in the present.

Focusing is the technique by which the therapist will select and organize clinical data from the family into some framework for meaning (Minuchin and Fishman, 1981, p 98). The therapist must organize the facts in a way that has therapeutic relevance and that facilitates change. Focusing refers to collecting data that relates to the process of change, not to family history and description. Out of this data the therapist develops a theme or schema that includes a structural goal, and a strategy for achieving that goal.

Minuchin states that it is frequently necessary to build _intensity_ before a family really hears and integrates what the therapist is trying to communicate through her interventions (Minuchin and Fishman, 1981, p 117). When family members show that they have reached the limit of what is emotionally acceptable and signal their need to

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return to a lower level of affective intensity, the therapist must learn to do exactly the opposite and intensify his message. The techniques by which the therapist can increase intensity may include repetition of the message, changing the time in which people are involved in a transaction, changing the distance between people involved in a transaction, and resisting the pull of a family transactional pattern.

A second technique or strategy of change is directed at challenging the family structure (Minuchin and Fishman, 1981, p 69). Minuchin describes the areas of dysfunction in a family as frequently involving overaffiliation or underaffiliation and therapy then becomes, in part, a process of monitoring proximity and distance. The therapist is in a position to challenge family members' own delineation of their roles and functions. The techniques involved in challenging the family structure are boundary making, unbalancing and teaching complementarity.

Boundary making techniques regulate the permeability of boundaries separating subsystems (Minuchin and Fishman, 1981, p 146). These techniques aim at changing family subsystem membership, or at changing the distance between subsystems. Boundary making techniques can be aimed at the psychological distance between family members and at the duration of interaction within a significant subsystem. Changing the psychological distance is one way of creating new boundaries. The therapist may use cognitive constructs or concrete maneuvers to change psychological distance. Or the therapist may decide to lengthen the process of interaction between family members in order to create

boundaries and thereby facilitate structural change. Tasks may be assigned to increase proximity within a particular subsystem or to bring about some distancing.

In unbalancing, the therapist's goal is to change the hierarchical relationship of the members of a subsystem, that is, to challenge and change the family power allocation (Minuchin and Fishman, 1981, p 161). The therapist may achieve this by affiliating with one family member, by ignoring family members, or by entering into a coalition with some family members against others. Unbalancing the system in these ways can produce significant changes as family members experiment with expanded roles and functions in interpersonal contexts.

Through complementarity family members experience their belonging to an entity that is larger than the individual self. They begin to experience their interdependence (Minuchin and Fishman, 1981, p 193). In order to achieve this the therapist challenges the problem (the family's certainty that there is one identified patient), challenges the linear notion that one family member is controlling the system (rather than each member serving as a context of the other), and challenges the family's punctuation of events (introducing an expanded time frame which teaches family members to see their behavior as part of a larger whole). In challenging the problem the therapist simply blocks the family's routine response to the identified patient as if he were an autonomous entity. In order to create a challenge to linear control the therapist may describe the behavior of one family

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member and assign responsibility for that behavior to another. Family members receive the subtle message that they can help to change the identified patient by changing each of themselves as they relate to him. Or the therapist may choose to frame individual behavior as part of a larger whole. The therapist may help the individual to expand his universe so that he can see how his behavior is part of an interactional context or a larger family pattern.

Minuchin describes the third strategy of change as a set of techniques aimed at challenging the family reality or world view (Minuchin and Fishman, 1981, p 71). Transactional patterns depend on and contain the way people experience reality. To change the way family members look at reality requires the development of new ways of interacting in the family. The therapist takes the data that the family offers and reorganizes or reframes it in a way that allows family members to experience themselves and one another differently so that there is a potential for change. The techniques used in this strategy are cognitive constructs, paradoxical interventions, and emphasizing strength. These are techniques with which to challenge the way a family legitimizes its structure.

The therapist becomes a constructor of realities by giving the family the message that they have more alternatives available to them than their usual ways of transacting (Minuchin and Fishman, 1981, p 214). He may present his interventions as if supported by an institution or concensus larger than the family. Or he may select metaphors from the family's own culture that symbolize their narrowed

reality, and use them to label the family reality and suggest the direction of change. In this way the therapist is challenging the family's own truths by choosing metaphors that also have the possibility of new truths. Peggy Papp describes the use of paradox as a clinical tool used primarily for dealing with resistance and circumventing a power struggle between the family and the therapist (Minuchin and Fishman, 1981, p 244). She states that she used this tool mainly in treating families with symptomatic children, and then only for covert, long-standing, repetitious patterns of interaction that do not respond to other kinds of direct interventions. Paradox is used as an intervention to accomplish the opposite of what it is seemingly intended to accomplish. The success of a paradoxical intervention depends on the family defying the therapist's instructions or following them to the point of absurdity and recoiling. The target of systemic paradox is some hidden interaction in the system that results in the family resisting the usual compliance-based interventions and that expresses itself in a symptom. While paradoxical interventions can certainly bring about change in very resistant families, they need to be used with caution. Paradox is usually inappropriate in certain crisis situations. The therapist needs to understand paradox thoroughly and the therapeutic impact. Papp states that a prerequisite for using paradox is an accurate knowledge of the relation between the symptom and the system and the manner in which they activate one another (Minuchin and Fishman, 1981, p 246). A beginning therapist would be advised not to use

paradoxical interventions.

The last technique that Minuchin describes as a way to challenge family structure is to begin to explore and focus on family strengths rather than deficits. The therapist focuses on the healing capacities of the family. The therapist may challenge the family's response to the identified patient by beginning to relate to the strengths and areas of competence in the identified patient that the family has lost sight of. Or the therapist believing the family has the potential for more complex functioning than they are presenting at the moment, may question the dysfunctional transactions as the family presents them, and go on to encourage members to explore unused alternatives.

In the final part of this section on the theory of structural family therapy, the writer will present two families seen during the practicum. These case descriptions will be used to illustrate the integration of theory and practice.

Theory and Practice: Case Illustrations

Family "3" consisted of a widowed single parent in her mid-forties with two sons, the identified patient (age 14) and his brother (age 18). The family was referred by the school due to the mother's difficulties in managing the identified patient. The family was seen for five sessions.

In the first session the therapist first took some time to join with family members. The mother was asked about her career and was given recognition for her obvious competence in this area. The therapist also joined with her by enquiring about the circumstances of her husband's death and again acknowledging and giving recognition to the difficulty in raising two sons alone while also managing a successful career. The therapist joined with the elder and then the younger son in a similar way by inquiring and showing interest in their present school work and career plans.

The therapist asked mother and then the sons to talk about their concerns and what they would like help changing in their family. Mother began by directing her concerns about the identified patient to the therapist but was then gently asked to direct her statements to the identified patient. As family members continued to discuss their concerns the therapist encouraged them to interact with one another. The therapist observed that mother worried a great deal about the identified patient as she talked to him about his involvement with an older peer group, his use of alcohol and drugs and his involvement in thefts. The mother's overinvolvement with this son was evident in the

way she continued to worry and protect him instead of making him become responsible for himself. By not being held responsible, the identified patient continued to stay in trouble, and the mother and identified patient were in constant conflict as she continued to worry about him. At times mother pulled her elder son into an alliance with her out of her frustration to control the identified patient.

The therapist's structural assessment was that there were no clear generational boundaries in this family which resulted in mother's overinvolvement with the identified patient and her inappropriate alliance with the 18 year old son. The goal of therapy then was to establish mother in a clear hierarchical position in this family. The mother would then be in a position to have the identified patient behave responsibly for his age and the 18 year old would be free to begin to take hold of his own life since mother would be able to parent the identified patient without him.

The therapist's initial intervention was to challenge the family's world view. The mother expressed serious doubts about herself as a parent. The identified patient saw himself as wielding a great deal of control that also kept mother feeling more helpless. The 18 year old had a similar view of his mother and his young brother, and played into this view by helping mother when she signalled him. In fact the 18 year old stated that the present dilemma in the family was due to the absence of a father or adult male since that is the person who is usually capable of effective discipline in a family.

The therapist challenged the family's reality by raising some doubt based on her past experience with families. The therapist went on to talk about a family she had recently worked with that had two parents, and a teenager very much out of control. The therapist explained how she saw the family for some time but the father continued to be ineffective in managing his son. Finally the therapist had mother take over and she was able to take charge of her son immediately and make him accept responsibility. The therapist then concluded by stating while it is usually preferable to have two parents, it is often the mother who is the main disciplinarian in any case. At this point in the session the mother sat up in her chair, leaned toward the identified patient and began to get very angry with him for his behavior and to state she would no longer tolerate it. Therapist gave her support for this, blocking the 18 year old. The therapist then joined again with the identified patient, asked him how it made him feel when his mother worried so much, then directed him to talk to his mother about this. The therapist then turned to the mother and stated that her worrying was not very helpful and that instead she needed to help him grow up by giving him a more realistic view of life. She was given support to clarify rules for the identified patient as well as consequences. She was also assigned the task of reviewing all the monthly household bills with the identified patient before the next session in order to give him a more realistic view of life. The 18 year old was asked to assist the identified patient as an older brother if the identified patient asked for

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his help. In this session then there was considerable clarification of boundaries and the beginning of a hierarchy in this family.

The remaining sessions were used to continue to clarify boundaries and move the family in the same direction. In the second session it turned out mother had reviewed the bills with the identified patient. As well she had him do the grocery shopping and prepare all the lunches and suppers for a week. She was given much support for this as was the identified patient. Mother had set a curfew which he broke once - she had not followed through on consequences. Mother was supported to do this in future and was again directed to discuss with her son how she would follow through on consequences. Therapist supported mother by helping her to decide on effective consequences so that the identified patient could see how serious she was. There were no further reports of mother not following through with consequences after this session and the identified patient rarely missed his curfew. Since the previous session the identified patient had been involved in some minor vandalism at school and mother had made him take responsibility for working this out with the school alone. There were no further reports of vandalism or delinquent behavior during the remaining sessions. At the end of the second session the family was requested to negotiate to do some leisure activities together.

At the third session mother reported her pleasure with the changes at home. She stated she worries much less because she has much more confidence in the identified patient. The identified patient was

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supported also to talk with his mother about his ability to be responsible. Most of this session was used to support this new structure, and to continue to block the 18 year old from intruding. Mother was directed and supported to talk with the 18 year old about how she could parent the identified patient alone. The therapist began to notice the 18 year old becoming somewhat incompetent as his place in the family was threatened. This was the second session he had arrived looking unwell and at times talking in a nonsensical way. As the mother became competent and the identified patient became responsible, the 18 year old began to show signs of failing. He was no longer in night school, and was unable to find employment. Mother responded by showing signs of worry, while he in turn showed less and less maturity. Mother and sons were instructed to plan an activity as a family. When the identified patient refused to be a part of the plans the therapist first joined with the mother to try to pressure the identified patient and this created even more resistance. The therapist then accomodated to the identified patient by stating he should not have to participate if he did not want to and suggested leaving the decision up to him. He then decided to participate.

By the fourth session the identified patient had given up all his symptoms and both he and mother were pleased with the changes. As they talked about these changes the 18 year old intruded on their interaction and mother was supported to block him. The 18 year old was showing signs of improvement. He was given recognition for the efforts

he had made to find a job and therapist joined with him to challenge mother about her worrying over him. Therapist spent some time talking with him about his career plans without allowing mother or the identified patient to intrude in order to increase his sense of personal autonomy.

The plan for the fifth session was to terminate if the reorganization in this family had remained intact. It had been 3 weeks since the last session. Mother was very pleased and feeling in control. The identified patient was happy his mother no longer worried and he continued to behave responsibly. The 18 year old appeared very much better and had found gainful employment. The therapist gave the family a great deal of recognition and support and had them talk about how they had made these changes. Therapy was terminated.

The evaluation of the therapy with this family is cited elsewhere in this report.

Family "9" was a two parent family seen by the student for one session only. The family did not keep further appointments after this session for a number of reasons. The student believes that a serious strategic error was made with this family that largely accounts for their decision not to continue in therapy. The student saw her work with this family as an important learning experience and therefore a valuable part of the practicum to report on.

The 31 year old father in this family was employed as a carpenter. The 30 year old mother was at home full time. The identified patient, a 12 year old boy was doing well in grade 6. There was also

a 5 year old boy and a 1 1/2 year old boy at home. The family was referred by the school as mother had told the principal that they were having a serious problem with the identified patient and needed help urgently. The school was surprised since the identified patient does well in his academic work and with his peers, and so referred the parents for family therapy.

A number of serious errors were made in the first session and as a result the therapist was far too aligned with the identified patient. At the beginning of the session the therapist sat opposite the parents, but beside the identified patient. The therapist spent some time joining with the parents, especially father, early in the session, but then moved too fast into a further alliance with the identified patient. As the parents stated their concerns in a very critical manner about the identified patient, the therapist became somewhat alarmed and annoyed that they ignored the identified patient as he began to weep. In retrospect, it appeared to the therapist that the parents were well aware of this as they saw the therapist attempt to comfort the child.

The therapist's structural assessment of the family was that the mother was extremely overinvolved with her children while father was peripheral to the family. Mother was clearly using the identified patient in order to try and engage her husband. The goal of therapy was to detriangulate the identified patient from the marital subsystem and to strengthen the father-son subsystem.

While the therapist was probably sufficiently joined to each parent, the second error was in assigning tasks to them around managing

the identified patient rather than have them work together to negotiate and plan these tasks with each other. By not having the parents work together to achieve some agreement the identified patient remained even more triangulated and his symptoms increased. Mother became more involved and father more peripheral as mother tried to reach him through her son who accomodated by further increasing his symptoms.

The intervention that should have been used was to have the parents talk with one another about their differences in the way they handle the identified patient. The therapist could then have directed and supported them to make a plan to manage the identified patient until the next session. However while the therapist had several further phone calls with the mother, the family cancelled all further appointments and finally arranged to have their son seen individually by a psychiatrist.

Evaluation Model:

The student's intended goal in evaluation was to see if change had occurred in each family and if so in what direction. The intent was not to use the evaluative data as feedback during therapy, but solely as an objective criteria for measuring change. The student hoped to see if the pre and posttest data yielded information that supported or negated the student's own structural assessment of the family. In other words the data yielded would hopefully give the student an objective measure of her effectiveness as a therapist.

Instruments

The instrument chosen as an objective measure was the Moos Family Environmental Scale (FES). This scale focuses on measurement and description of interpersonal relationships among family members, on the directions of personal growth which are emphasized in the family, and on the basic organizational structure of the family. It includes 90 items that reflect various dimensions of the family across 10 subscales. Table 1 lists the ten subscales and provides a brief description of each.

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Table 1

* FAMILY ENVIRONMENT SCALE SUBSCALE DESCRIPTION

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

* Combined Preliminary Manual, Family, Work and Group Environment Scales, p. 4

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The Cohesion, Expressiveness and Conflict Subscales are conceptualized as Relationship dimensions. They assess the extent to which family members feel that they belong to and are proud of their family, the extent to which there is open expression within the family and the degree to which conflictual interactions are characteristic of the family.

The second group of subscales are conceptualized as Personal Development or Personal Growth dimensions. They measure the emphasis within the family on certain developmental processes which may be fostered by family living. Independence measures the emphasis on autonomy and family members doing things on their own. Achievement Orientation measures the amount of emphasis on academic and competitive concerns. Intellectual Cultural Orientation reflects the degree to which the family is concerned with a variety of intellectual and cultural activities. The Active Recreational Orientation and Moral-Religious Emphasis subscales measure other important dimensions of personal growth.

The subscales of Organization and Control are conceptualized as assessing System Maintenance dimensions. These dimensions are system-oriented in that they obtain information about the structure or organization within the family and about the degree of control which is usually exerted by family members vis-a-vis each other.

Moos describes how the FES was initially constructed as well as the reliability of the scale. An inital 200 item Form A was

administered to over 1000 individuals in a sample of 285 families. Families were recruited from church groups, from a newspaper advertisement and from students at a local high school. These groups included an ethnic minority sample; as well, further data was collected from samples of Black and Mexican-American families. Finally a "clinic" family sample was collected from a psychiatrically oriented family clinic and a parole and probation department. The data from these three samples were used to develop the 90-item ten subscale Form R of the FES.

Means and standard deviations of the Form R subscales are presented in the Moos Manual. He states that these are based on a preliminary normative sample, but a relatively broad and varied one. He also states that the subscale internal consistencies are all in an acceptable range. The item-to-subscale correlations vary from moderate to substantial. The test-retest reliabilities of individual scores on the ten subscales, calculated on 47 family members in 9 families who took the FES twice with an eight week interval are all acceptable. The average subscale intercorrelations indicate that the subscales measure distinct though somewhat related aspects of family social environments. Intercorrelations account for less than 20 percent of the subscale variance.

Clinical Interpretation of Family Scores

As stated above, the items on the FES are grouped into ten subscales. A score is obtained for each subscale by adding up the number of items on the subscale which have been answered in the scored

direction. An average score is then calculated for all the members of each family and family profiles are generated comparing these sub-scale averages with the normative sample. The FES can be used, among other things, to assess changes in family environments over time.

Procedures

The Family Environmental Scale was administered to eight families as a pretest prior to the first session. The posttest was administered to three of these families immediately after the termination session, and to the remaining five families immediately following the last session with the student before continuing with another therapist.

The Scale was administered to all family members present who were 12 years of age and older at the time of the pretest. Written instructions accompanied each form and the student reviewed these with each family prior to both the pre and posttest. The student also clarified the meaning of some statements on the form to family members who had questions.

The student was not able to obtain the Preliminary Manual from the publishers of the FES until after the practicum was completed. Therefore, as it turned out, the data eventually yielded by scoring the FES Forms, was unavailable during the time the student was seeing the families and had no direct influence on the therapist's work with these families.

Educational Benefits to the Student

The evaluation component of the practicum was also of educational benefit to the student beyond the requirement of the practicum.

Evaluation of this kind is not usually done on clinical work outside a research setting. The student was able to have first-hand experience in the evaluation of clinical work. In particular the student was able to understand very clearly the value of this kind of tool in a practice setting and to think about how clinical evaluation could be carried out in her own future practice. In summary, as a result of this experience the student recognizes the value of formal evaluation in practice but would like to suggest that there is a great need to first develop evaluation tools that are more appropriate to social work practice settings.

Practical Limitations of the FES

Several persons appeared to be displeased with the length of the questionnaire and became somewhat impatient over the time it took to complete. A number of people left questions unanswered on the form.

The student noted that respondents in several families - usually persons under 18 years of age - asked for clarification of the meaning of certain words or phrases. For example several teenagers asked what is meant by "inflexible". In addition one couple was somewhat offended by the word "sin" and on the posttest the husband stroked it and put in "consequences". This man is a theology student.

The student also had concern that there are no instructions as

to an age cut-off for completing the questionnaire. The student chose 12 years of age rather arbitrarily and with the approval of her committee members. In retrospect, it seems that many of the ideas suggested by the questionnaire are conceptually beyond a 12 year old.

A final comment is that the student found the whole process of administrating the pretest and then obtaining written permission to videotape (and sometimes to receive live supervision) rather cumbersome and not conducive to starting therapy 'on the right foot'. Anxious individuals became more anxious with this process, and family members who were already present "reluctantly" seemed to become more annoyed.

Nevertheless no individual refused to complete the form or to be videotaped.

FES as an Objective Measure of Structural Change

The student's intent was to use certain of the subscale scores as an objective measure of structure and structural change. It was hypothesized that cohesion, expressiveness, conflict, independence, organization, and control are dimensions (as defined by Moos) that to some extent measure the degree to which families are structurally disengaged (inappropriately rigid boundaries). Changes across these dimensions would presumably reflect some restructuring.

While completing this report however, the student concluded that these subscale dimensions are features of process but not neces-

sarily of structure.

There are several problems in using these dimensions as objective measures of structure. First, Moos does not operationalize what he means by certain terms when he describes each subscale and several of the descriptions refer to several different notions. For example, in defining COHESION, Moos does not operationalize the terms "concerned", "committed", "helpful", and "supportive". In defining INDEPENDENCE he used words like "assertive" and "self-sufficient" which can refer to related but different ideas.

Second it seemed to this writer that almost all of these dimensions may be present or absent to the same extent in families with quite different structures, as well as in families of similar structures. For example, it is quite possible for both disengaged and enmeshed families to lack cohesion although for quite different reasons. Similarly, an inordinate amount of control may be very much a feature of one enmeshed family but not another.

Therefore it seemed to this writer that changes along these dimensions would likely reflect change in process that results from restructuring interventions made at a process level. Change in process is therefore an indicator of restructuring but not of a specific structure. This being the case the FES scale cannot be used as an objective measure of structure but can be used as an objective measure of change at a process or restructuring level. The key then is to use the difference in scores from T_1 to T_2 across these FES dimensions as an objective measure of direction and degree of change

that might indicate the student's effectiveness as a therapist in intervening toward the desired goal of therapy.

Two further points need mentioning regarding use of the FES as an evaluative tool on the practicum. The student assumed that those families terminated with in a planned way would show a greater degree of change in the desired direction than those that were transferred to another therapist following T_2. As well the student did not expect to see any significant change across the Personal Growth Dimensions (except independence) as these subscales are highly content oriented. A structural therapist is trained to intervene at a process level rather than content as a way to bring about change.

In the final part of this section on evaluation, the writer will present several families seen during the practicum. The purpose will be to illustrate how the student actually used the evaluation component of her practicum as one measure of her effectiveness as a therapist. By describing the families and the outcome of evaluation, the student intends to demonstrate how evaluation can be an important and relevant part of daily clinical work.

Evaluation And Practice: Case descriptions

Family "3" consisted of a single mother (widow) in her mid-forties with two sons, the identified patient (age 14) and his brother (age 18). The family was referred by the school due to mother's concerns that the identified patient was involved with an older peer group, was beyond her control, and was recently involved in vandalism. The entire family was seen for five sessions.

The therapist's assessment of this family was that the mother was very much overinvolved with her sons, especially the identified patient. She tended to worry a great deal about both her sons' behavior but not to hold them responsible. At the beginning of therapy there was considerable conflict between mother and this son.

The goal of therapy was for the mother to use her parental authority to take charge of her son by setting rules and holding him responsible for his behavior. The therapist worked to establish a hierarchy between mother and son, and to further clarify boundaries since the elder son frequently became inappropriately involved in transactions between mother and the identified patient.

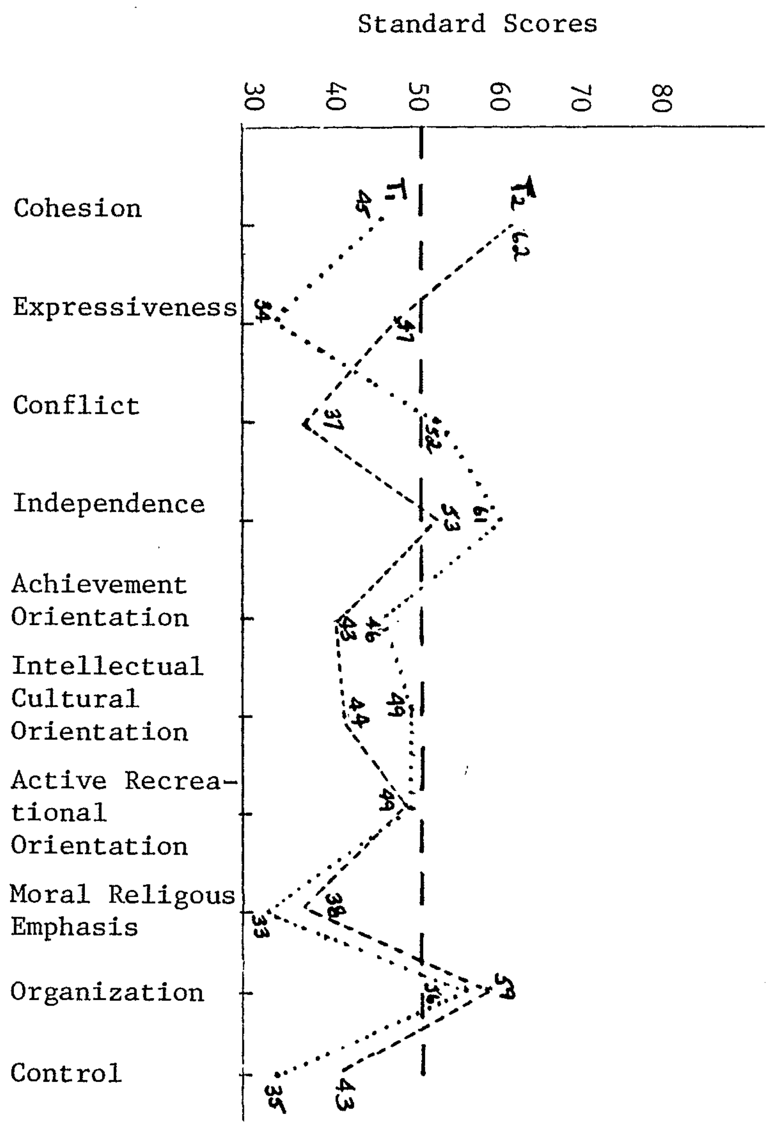

Figure 1.1

Figure 1.1 shows the FES pretest and posttest profiles for family "3" as compared to the average score obtained by all the families in the Moos overall normative group.

At T_1 the family scored slightly above average (56) on organization while at T_2 they scored somewhat higher (59). At T_1 the family scored substantially below average (35) on control and only somewhat below average (43) at T_2. The differences between T_1 and T_2 in these scores suggest that change was occurring in the desired direction as mother was supported to use her executive authority as a parent to clarify and enforce family rules and responsibilities. Not unexpectedly the family cohesion score changed from somewhat below average (45) at T_1 to moderately above average (62) at T_2 as members worked to support one another and the family. Expressiveness changed from substantially below average (34) at T_1 to almost average (47) at T_2, while conflict was slightly above average (52) at T_1 and very much below average (37) at T_2. These scores also indicate that as mother was more clear and direct in negotiating as a parent there was less conflict in the family. The family independence score was moderately above average (61) at T_1 and only slightly above average (53) at T_2, indicating a more reasonable emphasis on personal autonomy vis-a-vis what is best for the family.

These scores tend to indicate that restructuring occurred in this family toward the stated goal of therapy. This is an objective measure of change as well as the fact that the presenting problem disappeared. Mother was in control of her son who became more responsible and no longer involved in acts of vandalism.

Family "8" consisted of a two-parent family (mother, age 27; father, age 31) and four children (ages 10, 10, 7, 5). Parents have lived common law almost 9 years and each is divorced. One of the 10 year old boys was from mother's earlier marriage while the other 10 year old boy was from father's earlier marriage. A 7 year old male and 5 year old female are from the present union.

The family was referred by the school as mother had vague concerns about the 10 year old boys not getting along with one another. The entire family was seen for seven sessions before termination.

The student's structural assessment was that this family was enmeshed resulting in little personal or subsystem differentiation. Boundaries were diffuse which meant that family rules and responsibilities were very unclear, along with an absence of hierarchy in the family. The family was held together by a controlling mother who was required to be central to every transaction in the family. What brought this family into crisis was the father's 10 year old son very recently joining the family and making demands to have a relationship with his father independent of his stepmother. This boy had lived most of his 10 years with his mother and stepfather in another province. The stepfather had died a few months earlier and the mother decided to send her son to live with his natural father. The boy came into his new family and looked to his father for support while he grieved for his stepfather.

The goal of therapy was to create personal and subsystem

autonomy including a hierarchy in the family. Parents would work together to clarify and enforce family rules and responsibilities which would lessen the need for mother to be as controlling.

Figure 1.2 shows the FES pretest and posttest profiles for family "8" as compared to the average score obtained by all the families in the Moos overall normative group.

At T_1 the family was very severely below average (27) on organization while at T_2 the family was average (51). This reflects change in the way parents began to work together to structure activities and clarify family rules and responsibilities. The family score on control was slightly below average (48) at T_1 and dropped slightly at T_2 (46). This difference appears to reflect that change did not occur in the right direction in this area. However the individual scores indicate that as mother became less controlling, father became more involved in a hierarchy. Mother's score on control at T_1 was 62 and at T_2 it was 46, while father's score at T_1 was 35 and at T_2 it was 46. These scores indicate that parents were in fact beginning to work together to form a hierarchy.

As parents began to work together in a way that was more helpful and supportive to one another and their children the family's score on cohesion went from substantially below average (37) at T_1 to moderately above average (62) at T_2. As differentiation began to occur the family expressiveness score went from slightly below average (47) at T_1 to moderately above average (64) at T_2, and the independence score went from substantially below average (36) at T_1 to almost average (49) at T_2.

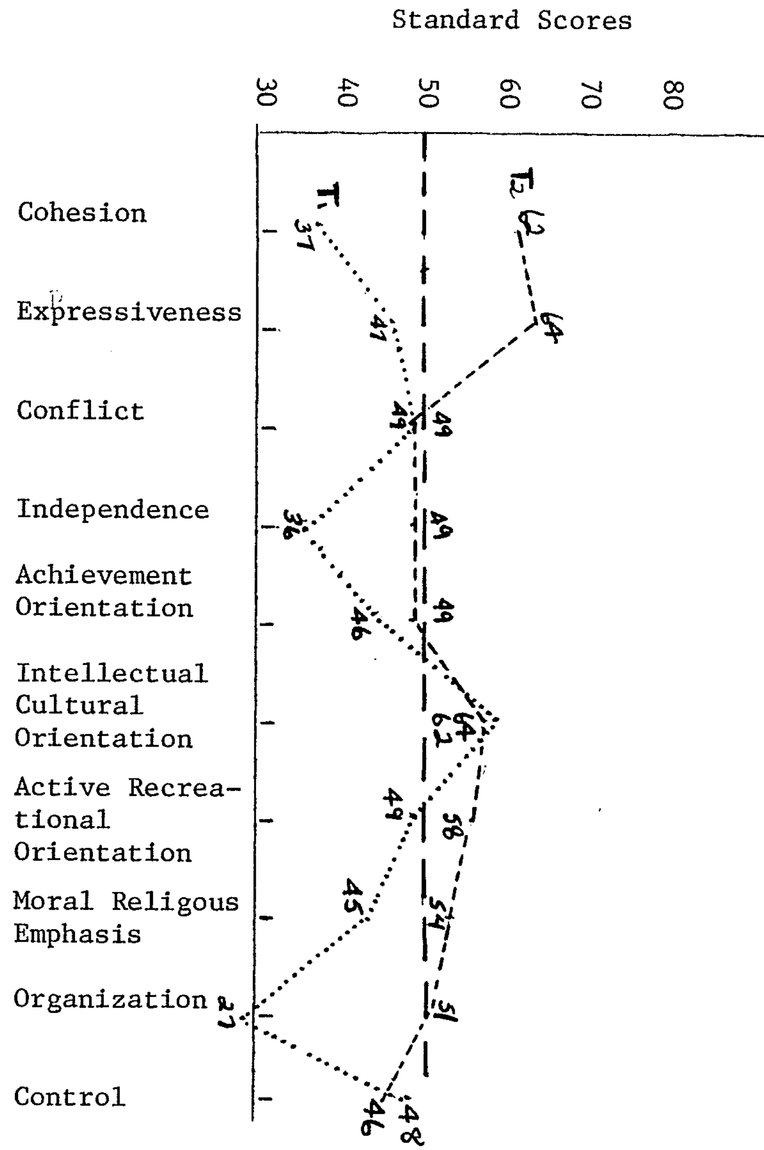

Figure 1.2

These scores indicate that change occurred in the direction of the goal of therapy. In addition, at termination the parents had no further concerns about their sons and the 10 year old who had just joined the family had the support he needed from his father to grieve his stepfather and become a part of his new family.

Family "6" consisted of a two-parent family that was seen for four sessions prior to being transferred to another therapist. The entire family was seen on three occasions, while the parents were seen alone once. The ages of the family members were: father (39), mother (34), son (17), daughter (15).

The family was referred by their physician who stated there was much conflict in the family around the 17 year old son.

The student's structural assessment was that mother was over-involved with her son while father was very peripheral. Conflict between the parents had been detoured through the son since he was a pre-schooler.

The goal of therapy was to detriangulate the son by having parents begin to work together, and for father and son to begin to establish a closer relationship.

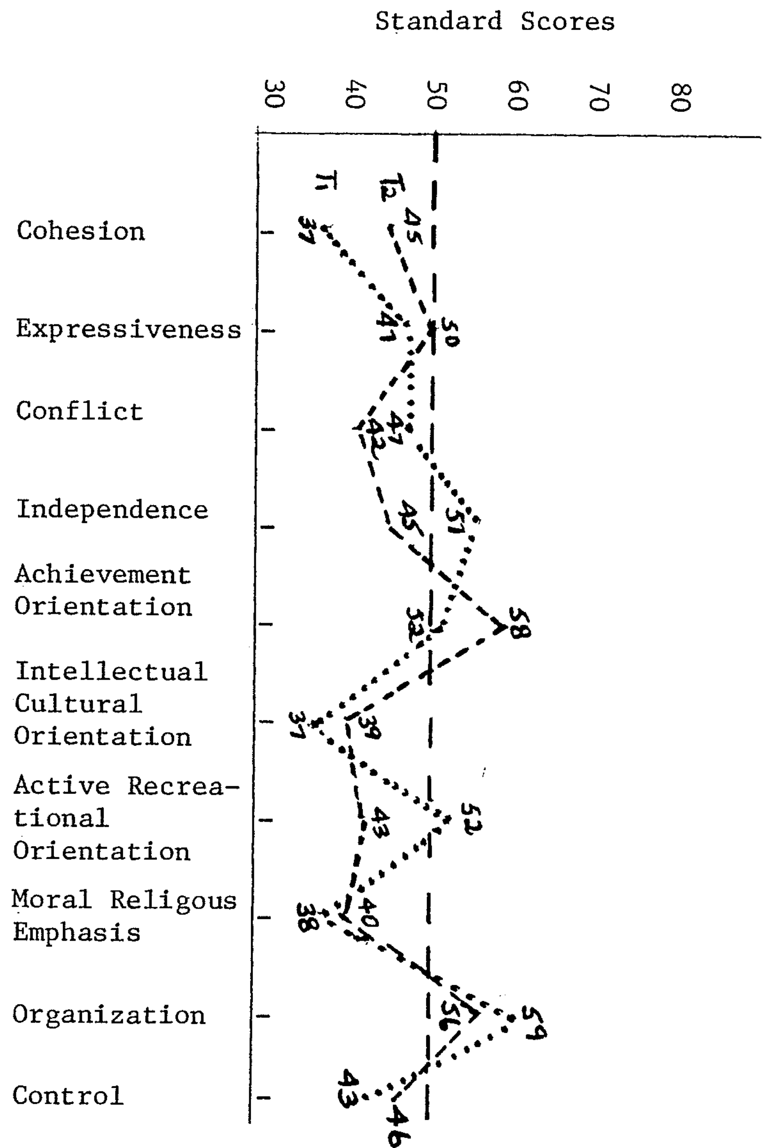

Figure 1.3

Figure 1.3 indicates that change began to occur in the desired direction before the family continued with another therapist.

As the son began to be detriangulated and parents worked directly with one another the family score on control moved closer to average (43 at T_1 and 46 at T_2). That parents began to work together is reflected across several dimensions. The family score on cohesion was substantially below average (37) at T_1 and only somewhat below average (45) at T_2. The expressiveness score moved from slightly below average (47) at T_1 to average (50) at T_2. Conflict dropped from slightly below average (47) at T_1 to moderately below average (42) at T_2. The difference in the identified patient's scores in these areas indicate that he was experiencing a great deal of the change: cohesion (T_1, 43; T_2, 53), expressiveness (T_1, 47; T_2, 61), conflict (T_1, 47; T_2, 37).

These scores are an objective measure that change was beginning to occur toward the goal of therapy. As well there was clearly less conflict around the identified patient as the parents dealt directly with one another, and father also began to be involved with his son in several areas.

Family "1" consisted of a single mother (age 40) with two teenage daughters, age 17, and the identified patient, age 14. The family was seen for four sessions before transfer to another therapist occurred.

The letter of referral from the school stated that the 14 year old identified patient had been drunk at school on several occassions,

that she was dropping academically, and that she had become belligerent and stubborn both at home and at school.

The therapist's structural assessment was that there were no clear generational boundaries between mother and daughters, indicating an absence of hierarchy in the family. Mother lacked parental authority by which to manage her daughters. She frequently drew her elder daughter into an inappropriate alliance in order to try to control the identified patient.

The structural goal for this family was to create generational boundaries between mother and daughters. Mother needed to establish parental authority to negotiate with the identified patient without intrusion from the elder daughter.

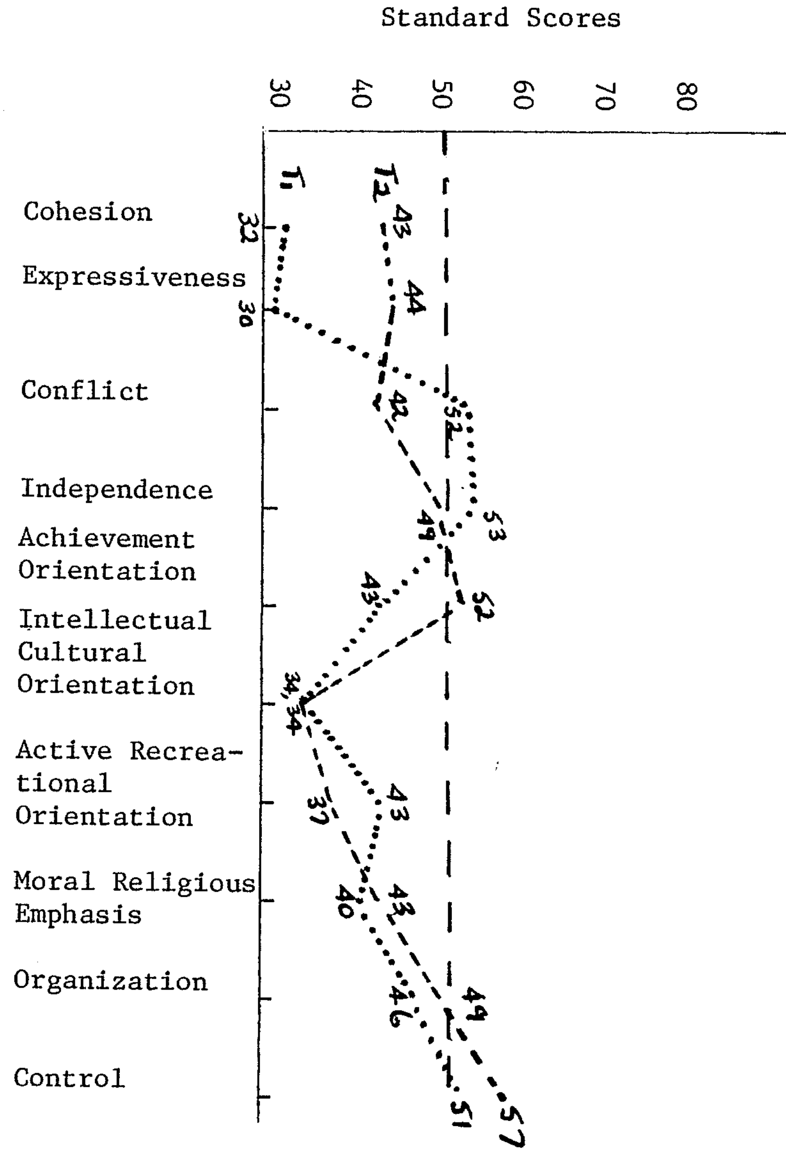

Figure 1.4

The difference between the T_1 and T_2 scores as indicated in Figure 1.4 indicates that change was beginning to occur in the direction of the goal of therapy. At T_1 the family scored average (51) on control and above average (57) at T_2, indicating the beginning of increased hierarchy in the family. On organization the family score at T_1 was below average (46) and almost average (49) at T_2, indicating clearer rules and responsibilities being established. As the mother and daughters began to work together in a more helpful and supportive way, the family cohesion score went from substantially below average (32) at T_1 to somewhat below average (43) at T_2. The extent to which family members became more open with one another is reflected in the expressiveness score. At T_1 expressiveness was substantially below average (30) whereas at T_2 it was only moderately below average (44). As mother took charge and the identified patient became more responsible the family conflict score changed from slightly above average (52) at T_1 to somewhat below average (42) at T_2.

The difference in these scores from T_1 to T_2 are an objective measure that supports that change was occurring in the direction of the goal of therapy. As well the identified patient and her mother reported they felt much closer, and the identified patient began to do better in school and there were no further drinking episodes reported.

Conclusions

The cases presented do in fact suggest that change occurred to some extent in the desired direction. The difference between T_1 and T_2 scores across the six dimensions described support the earlier assumption that change occurred at a process level toward the goal of therapy as stated for each family. What was unexpected in the outcome, however, was the degree or amount of change in most families. The student had anticipated some change in the desired direction in most families. However the Moos Scale outcome data suggested that a number of families in fact experienced much more change than the student had assessed at T_2.

In addition change was reflected more at a process level than a content level as earlier hypothesized. As well there was a greater degree of change with those families terminated with than those transferred to another therapist when the student left the clinic.

In the remaining four families to whom the FES was administered change also occurred at a process level toward the stated goal of therapy.

Finally it is important to note that while the outcome supports the original hypothesis, change could also have occurred for reasons other than the work of the therapist since it was impossible to control for other variables in this setting. For example the very fact of going to therapy is likely to have an immediate cohesive effect on most familes irrespective of the therapist. One might also safely

assume that "expressiveness" would improve in a family in almost any therapeutic setting.

As well it is quite possible that variables outside of therapy had a positive impact on the family. For example, the identified patient in one family (a teenager), was taking a course in family life education at school while the family was in therapy. Another family finally got into the new apartment they had been on a waiting list for, while also in therapy. In yet another family the father obtained another job he had very much wanted.

It is also important to remember that there was virtually no follow-up by the student on any of the families and the last contact was the last session, following which the posttest was administered. Therefore there is no way of knowing how permanent any of these changes were.

CHAPTER V

STRUCTURAL FAMILY THERAPY IN SOCIAL WORK PRACTICE

In this final section the student wishes to limit her comments to two areas which are really opposite sides of the same coin. In considering any therapeutic model of intervention for use in a social work practice setting one needs to have some idea of the possible limits of the model before attempting to put it to use. It is also useful to be able to identify the contributions of a particular model to the discipline and practice of social work.

This writer would like to suggest that whatever limitations might exist with this theory are due to the limitations of the therapist. Whatever biases, lack of experience, incorrect ideas and so forth that a therapist brings to therapy will of course limit the use and effectiveness of any model. The beginning therapist, the young therapist, the therapist whose earlier training was in individual therapy, all run the risk of error. The social worker who wears "blinders" and fails to see families in the context of their larger social environment or ecological systems is limiting his practice by not using this model optimally. Perhaps the limitations of the model are best described by Minuchin: "the road is not the road, the road is how you walk it." (Minuchin, 1974, p. 119).

Minuchin's successor at Philadelphia was Harry Aponte, a social worker whose early training was psychoanalytic. Aponte had worked with Minuchin for a number of years and had also become especially interested in developing better ways of reaching what he has referred to as the "underorganized poor". Aponte worked alongside Minuchin as

the structural model was developed. Since that time he has continued to write about the problems of the poor and has begun to look at ways of intervening in what he refers to as the "ecological structure" (Aponte, 1976, p 303-311).

As a social worker, Aponte has used his structural training to describe the underorganization of the poor (Aponte, 1976, p 448 ff.). He states that this "structural problem refers to the lack of constancy, differentiation, and flexibility in the social organization of the individuals and subgroups in the family system." Aponte further explains that this situation means that poor families are often powerless and excluded from the institutional and community supports necessary for ongoing development. As a structural therapist and a trainer of therapists, Aponte has developed clinical maneuvers to enter the structural dynamics of the family and to use himself to effect change in families who live in nonsupportive social conditions such as poverty.

As a structural clinician Aponte has also contributed to social work practice by describing an "eco-structural approach" to intervening in family/school problems (Aponte, 1976, p 305). He states that one must "conceptualize the child, the family, the school, and the community organization involved in the child's problem as systems-interrelated in an ecological complex over a common issue". He states that their relationships provide the context or structure within which the problem needs to be defined, and he writes that the challenge is to develop methods to intervene at the point where all these systems meet.

Structural family therapy has contributed to the field of social work by furthering our understanding of individuals and families. The theory was developed out of a systems model and is therefore based on generally accepted ideas in the field of social work of how change occurs. Of particular importance to social workers, the model was based on research and practice across a number of very different cultures. As well it was developed as a model that was originally seen as a way to reach low socio-economic families and has since been used equally successfully at all economic levels. Minuchin has used the model to describe a whole range of family constellations many of which are commonly seen by social workers. He has described how to understand and intervene in families where either parents or children are very much out of control, and families with a handicapped child. These are of course the kinds of families that often constitute the majority of the social worker's caseload.

Not only has structural family therapy contributed to our knowledge about individuals and families, it has increased our understanding of the importance of the structure of the relationship between family systems and larger ecological systems, and it has provided us with yet another tool to intervene effectively in these systems. To the extent that all of these things help us to provide better service to families, structural family therapy has contributed in an important way to the social work profession.

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