AN APPLICATION OF STRUCTURAL FAMILY THERAPY

By

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ABSTRACT

Inherent to the life of the family are the inevitable challenges related to transitions in its normal development over time as well as to possible idiosyncratic stressors such as divorce, remarriage, chronic illness, or domestic violence. Demands both internal and external to the family can impede its ability to adapt to these various types of stress. A family's failure to adapt will hinder its function of nurturing the growth of individual family members. The goal of the structural therapist is to join the family in a therapeutic system and to restructure it in such a way that family members will be set free to try new, more functional patterns of interacting.

This practicum report reviews the theoretical constructs of structural family therapy and describes the application of the model in work with families in a practice setting. Common themes arising from this practice are considered.

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INTRODUCTION AND OVERVIEW

The objectives of this practicum were to work with families in accordance with the structural family therapy model and to evaluate its effectiveness. This theoretical model has been recognized for its suitability for training student therapists because of its "relative simplicity, concreteness, and directness" (Figley & Nelson, 1990, p. 226). It attracted me for these reasons as well for the "visual" qualities of its constructs. My learning goals were to increase my knowledge of the dynamics of various family compositions, to understand how the chosen theoretical model can produce functional change in families, and to develop my clinical skills as an agent of change in the context of the family.

This practicum report is divided into three parts. The literature review in Part One provides a theoretical foundation. A brief historical overview of structural family therapy is followed by a discussion of the model's theoretical assumptions and goals, and more specifically, its theoretical constructs. The section dealing with structural family therapy processes addresses assessment and intervention theory in general terms, thereby setting the stage for Chapter Two which examines the model's applicability to families in various configurations and settings, and to specific presenting problems. Chapter Three serves to complete the literature review in examining empirical data from outcome studies in structural family therapy and it briefly summarizes various critiques of the model as found in the literature.

Part Two is given to the practicum itself. It describes the parameters and logistics of practice followed by three case studies and their evaluations. Part Three comprises a discussion of common themes which were uncovered through practice, analysis, and reflection on the practicum process, and concludes with a summary focusing on my experience in applying this theoretical model to practice.

PART ONE: THE THEORETICAL MODEL

CHAPTER 1

LITERATURE REVIEW

Section One: Historical Overview of Structural Family Therapy

Family therapy was developed in the second half of the twentieth century. It provided therapists with a new way of understanding and addressing human problems which had previously been located in the individual and defined as psychopathology, having roots in early childhood experiences (Barker, 1992). With an increased interest in larger systems, particularly in the physical sciences, psychoanalytically trained psychiatrists came to understand individual behaviour in the context of the larger social systems in their clients' environments, especially their families. What evolved were new assumptions about human behaviour and human interaction, and within this evolution there emerged major schools of family therapy.

Systems therapists flourished in the 1960's when community programs were generously funded to address the psychosocial problems of the urban poor (Hoffman, 1981). A major figure to emerge in the United States during this period was Salvador Minuchin, a native of Argentina, who together with a team of therapists and researchers, including Braulio Montalvo, his "most influential teacher" (Minuchin, 1974b, p. vii), started a research project to study and work with families of delinquent boys at the Wiltwyck School for Boys in New York City. Minuchin's innovative approach presented an alternative to the limitations of treatment methods of that time for this particular population in that his therapeutic interventions recognized the influence of the familial social context on an isolated problem. The resulting work was published as *Families of the Slums* (Minuchin, Guerney, Rosman, & Schummer, 1967). Minuchin was

subsequently appointed director of the Philadelphia Child Guidance Clinic, where he was given the opportunity to intervene with working-class and middle-class families. Braulio Montalvo from Wiltwyck and Jay Haley (1976) from California helped in training the staff and contributed considerably to Minuchin's thinking (Minuchin, 1974b). Also on his staff were Lynn Hoffman (1981), Harry Aponte (1981), Lester Baker (1975), and Ronald Liebman (1974). His theories on how families are organized developed into what was termed the 'structural' school of family therapy, its classic form being set out in *Families and Family Therapy* (Minuchin, 1974b). Together with the introduction of these theoretical innovations in therapy, Minuchin advocated for innovations in practice such as the one-way observation screen allowing colleagues to observe each other inoperation.

Because the Philadelphia Child Guidance Clinic was affiliated with the Children's Hospital of Philadelphia, a joint study of children with psychosomatic disorders and their families was facilitated (Barker, 1992), and led to the book *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin, Rosman, & Baker, 1978). In the 1980's, Minuchin's views of the contemporary family and how they could be helped were described in *Family Kaleidoscope* (Minuchin, 1984). The scope of structural strategies for helping underorganized families has been broadened through the mobilization of extended family and social network resources (Aponte & Van Deusen, 1981). More recently, Minuchin has become interested in how the skills of systems therapists can be applied in larger institutions (Simon, 1996). The structural approach continues to be well regarded by family therapists, perhaps due to its clear and succinct theory.

Section Two: Theoretical Assumptions

Structural family therapy approaches human beings in their social context, in the here-and-now, and is based on changing the organization of the family. The theory underlying the therapy is based on the understanding that individual behaviour does not occur in a void, but rather in the individual's circumstantial reality. Thus, an identified problem is located both inside and outside the person, and the subsequent goal of the

individual is to achieve both a sense of separateness as well as belonging (Minuchin, 1974a). Structural therapists, while focusing on the family-as-a-whole, address both the differentiation and integration of family members (Melito, 1988) with the understanding that changes in context produce changes in the individual, and that therapists, when working with the family, become a part of the context (Napoliello & Sweet, 1992).

The Functional Family

Minuchin provides a conceptual schema of family functioning (Minuchin, 1974b). It is based on viewing the family as a system operating in specific social contexts and having three components: 1) the structure of the family is that of an open sociocultural system in transformation; 2) the family undergoes development, moving through a number of stages that require restructuring; and 3) the family adapts to changed circumstances so as to maintain continuity and enhance the psychosocial growth of each member (Hansen & L'Abate, 1982).

Subsystems

Minuchin (1974a) provides a framework in which to set goals toward family reorganization in describing his notion of what the ideal structure of the family should be. He believes that the family is an evolving, hierarchical organization responsible for the essential functions of support, nurturance, and socialization of its members. The tasks associated with these functions are carried out by the family's spousal, parental, and sibling subsystems according to rules or transactional patterns for interacting across and within subsystems (Fish & Piercy, 1987), and in the context of the family's place in a circular, self-generating, model of family development which begins with birth, and continues into childhood, adolescence, leaving one's family of origin, and coupling in order to continue the cycle into the next generation (Okun & Rappaport, 1980).

Spousal Subsystem

The spousal subsystem performs tasks that are essential to the family's functioning. This requires the couple to support each other through mutual

accommodation as well as complementarity in which each partner contributes to a mutual interdependence in a symmetrical fashion (Minuchin, 1974). These tasks can nurture and support the characteristics of the other, or they can trigger the negative characteristics of the other when one partner disqualifies the other by wanting to improve or save the other, or when one partner remains dependent on the other in order to protect the other's role of protector. The couple functions well when their "patterned transactions" are mutually supportive--for example, they must decide who will do what, and how and when it will be done (Okun & Rappaport, 1980). For the spouse subsystem to function smoothly it requires protection from interference from other systems and subsystems by a boundary which is neither too loose or too rigid.

Parental Subsystem

With the addition of a child, the spouse subsystem makes a transition to a three-person system which requires the parents/spouses to renegotiate and redefine their functions as they relate to the rearing of children around issues of nurturance, guidance, and discipline. They must adjust to the addition of parent-child subsystems, while simultaneously protecting the spouse subsystem in order to prevent the child from being drawn into spousal problems.

The addition of the child also marks the establishment of a parent-child subsystem, which, in order to function effectively, is hierarchical. The parents are in a place of authority over their dependent children in the sense of leadership and protection. As the children age, the parenting process changes in order to adapt to a new stage in the family life cycle. While nurturing functions predominate with the very young, guidance and control become equally important later on. During adolescence, the demands of the child and the parents may conflict as the adolescent negotiates new degrees of autonomy.

For parents to carry out their functions of nurture, guidance, and control, they require the power to do so. It is a weak parental subsystem that must resort to restrictive

control which becomes excessive when it is ineffective. The parent-child subsystems must learn to negotiate with and accommodate to each other (Minuchin, 1974b).

Sibling Subsystem

Minuchin describes the sibling subsystem as "the first social laboratory in which children can experiment with peer relationships"(Minuchin, 1974, p. 59). The sibling subsystem also requires a boundary to protect it from adult interference, albeit in accordance with the children's developmental stages. Children are entitled to privacy, to pursue their own interests, and to explore and develop new skills.

The Role of Extrafamilial Systems

Structural considerations reach beyond the demarcation of familial subsystems to include extended family members as well as external systems affecting individual family members such as the school system, social agencies, friends, and other therapists (Fishman, 1988). Stabalizing these extrafamilial players becomes a key component in an effective restructuring process.

Therapeutic Goals

When a family fails to restructure and fails to adapt to the stressors related to development, family dysfunction occurs. The assumption underlying the therapeutic process is that a symptom is the product of a dysfunctional family system, that is, the family is stuck in rigid transactional patterns, and that as the family's organization approaches "normal", the symptom will disappear (Hoffman, 1981). With a normative model of a functional family in mind, the therapist goes about redesigning the organization of the family to more closely approximate this ideal.

The goal of restructuring the family's organization is to support the family's ability to resolve the presenting problem and master relevant and essential tasks within family life (Fish & Piercy, 1987). Through the process, families as a whole, and their individual members, will acquire greater flexibility in accepting alternative rules of behaviour and more functional roles.

Section Three: Theoretical Constructs

The arrangements that govern a family's transactions form the structure of the family. While Minuchin's conceptual framework owes much to systems theory, his language seems to derive from organization theory and role theory, using metaphors such as boundary, mapping, territory, structure, and role (Hoffman, 1981). These theoretical constructs are representations of reality, or "verbal conveniences" for the therapist in their application in assessment (Nelson & Utesch, 1990, p. 233). According to Nelson and Utesch (1990), structural family therapy constructs can be placed on a continuum from concrete to abstract, where a concrete concept can be assessed with observational data and an abstract concept is assessed with inferences from data. The authors suggest that concrete constructs lend themselves better to concise interventions, and abstract constructs afford greater flexibility in defining the normal family and in designing suitable interventions. The following descriptions of Minuchin's (1974b) structural family therapy constructs are conceptualized in accordance with Nelson and Utesch's (1990) concrete/abstract continuum.

Cohesion

Olson, Russell, and Sprenkle (1979) refer to cohesion as the emotional bonding within a family. Minuchin (1974b) described the theoretical poles of the cohesion continuum, namely enmeshment and disengagement. Enmeshed families have diffuse boundaries, where one member's behaviour has an immediate effect on the others in the family. Disengaged families have rigid boundaries and require a high degree of stress in order for members to activate the family's supportive systems. In these examples, degrees of cohesion describe quantitative differences. A family's place on the continuum can also describe processes within the system. For example, enmeshment and disengagement refer to a transactional style in keeping with a family's life cycle stage, the amount and kind of stress experienced, and family-of-origin rules about different issues (Nelson & Utesch, 1990). Operations at the extremes would indicate possible problem areas (Minuchin,

1974b). Nelson and Utesch (1990) suggest that cohesion is one of the more abstract structural family therapy constructs, and not easily assessed through behavioural observation.

Boundary

Boundaries correlate with family cohesion in that they define the rules and roles of the family and its subsystems. These subsystems include individuals, dyads such as husband-wife or parent-child, and those formed by generation, by sex, by interest, or by function (Minuchin, 1974b). Each individual family member belongs to various subsystems each of which requires different skills and levels of power in keeping with a particular relationship. Boundaries protect the differentiation of the subsystem by defining what functions are carried out by whom.

Clear boundaries allow subsystem members to carry out their functions without interference but allow for communication across subsystems. Rigid boundaries do not allow for this communication, thereby compromising the protective functions of the family. Diffuse boundaries, at the opposite extreme, result in confusion about which system an individual is a part of.

Boundaries can also be defined between individual families and their larger societal suprasystem. For example, a family with rigid boundaries has little contact with those outside of it, and may be threatened by outside associations. The permeability of boundaries indicates the type of cohesion in a family. Nelson and Utesch (1990) suggest that the concept of boundaries is fairly concrete and therefore more easily assessed from behavioural data than other structural concepts.

Power/Hierarchy

Power deals with the relative influence each family member has on behavioural outcomes in family processes. Hierarchy defines a family's power structure, namely the executive subsystem which carries out parental functions, and the sibling subsystem. A clear hierarchy functions by consistent rules about who is in charge of what, and that

parents are in charge of their children. The hierarchical boundaries are maintained by the carrying out of system-appropriate responsibilities and behaviours. Hierarchy is one of the more concrete constructs (Nelson & Utesch, 1990) and can be readily assessed through observation of seating arrangements, and the process and content of conversation between family members. While hierarchy may be readily assessed, the power dynamics within and between subsystems can be complex in nature and difficult to assess, particularly the transactions of power within a differentiated spousal subsystem.

Proximity

Proximity, or the degree to which family members are close or separate from one another, refers to both physical and psychological dimensions. Before making judgements about the family's functional level, the therapist should be aware that proximity is a norm and can, therefore, be culture-bound. Concern is primarily with the comfort level of the family's proximity, rather than with the degree of proximity that is observed or reported. Nelson and Utesch (1990) suggest the following questions as examples: Which parent does the teenager sit more closely to? Where do the parents sit in relation to each other? Does a younger child sit on the lap of an older child? Do people turn away from each other when discussing certain issues? (p. 237).

Alignment

Alignment refers to the way in which subsystems relate to each other relative to other subsystems. Alignments comprise coalitions and alliances. A **coalition** or a **collusion** occurs when two or more members join together against another member or members to the exclusion of others. A coalition is more overt than a collusion and can be assessed through observation, for example when two family members discuss a third member while that third person is present. In a collusion, however, two family members would not openly admit their problem with the third member in the session, but would talk about it in private later on. A collusion is, therefore, less concrete than a coalition and might not manifest itself in the session.

An **alliance** or an **affiliation** refers to an alignment between two family members in order to provide emotional and/or physical support, and is marked by a boundary (Nelson & Utesch, 1990), not necessarily to the exclusion of others. While alliances and affiliations have identical functions, they are distinct in their communication. Alliances are typically more easily observed in the session through gestures such as, touching, eye contact, affection, and conversation. Affiliations are more likely to be described verbally by family members during the session.

Triangulation

Bowen (1978) describes triangulation as a coalition which involves a third person in order to give the system stability. A pattern whereby the same person is consistently pulled in is dysfunctional. For instance, a dysfunctional marriage might have one parent forming a coalition with a child against the other parent. Triangulation is a somewhat abstract construct inferred from evidence of collusions, hierarchy, and boundaries (Nelson & Utesch, 1990). Evidence of triangulation is occasionally found in a child's somatic, social, or emotional problem (Bowen, 1978) as each parent is demanding the child's loyalty.

Detouring

Detouring refers to a process in which conflict between two members can be avoided by involving a third family member. It is most often defined specifically in situations involving parents and their child when parents rely on the deviant behaviour of their child to avoid spousal conflict. By detouring stresses of the spousal subsystem through the child, an illusion of harmony can be maintained. Spousal problems remain submerged as the child is blamed for family problems. In these situations, the boundary between the parents is diffuse and the boundary between the generations is rigid (Nelson & Utesch, 1990). Nelson and Utesch (1990) suggest that detouring is an abstract construct inferred from both observation and assessment of boundaries, hierarchy, and alignment.

They give an example in which parents claim that they have a good marriage and a wonderful family, except that everything the child does is problematic.

Complementarity

The individual is part of a whole (the family) and is affected by the behaviour and experience of the other members. Complementarity describes the nature of interpersonal behaviour as balanced and reciprocal. In a well-functioning spousal relationship, each partner supports the other's functioning in many areas by cooperating in their reciprocal roles. A complementary pattern can also become dysfunctional when spouses activate the negative aspects of the other, thereby inhibiting the growth of the other such as in patterns of leader-follower, victim-rescuer, or pursuer-distancer. In these cases the complementarity must be challenged by changing the nature of the hierarchical relationship.

Section Four: Structural Family Therapy Processes

The processes in structural assessment and intervention are inseparable because of their interactional nature. The following descriptions of the separate functions of joining, assessment, and restructuring serve to highlight their specific operations, yet in actual practice, they are intertwined.

Joining

The therapist's assessment of the family's structure is achieved by experientially joining the family (Minuchin, 1974b) in order to experience reality as the family members do--to feel the stress and pain that they feel, without becoming absorbed into their system. Becoming an integral and active participant in the family process requires the therapist to accommodate or adapt to the family in order to adjust to its cultural uniqueness. A therapeutic system of therapist and family is formed making possible an assessment of the therapist's experiences of the family's interaction in the present. Many accommodation techniques are spontaneous, reflecting the individuality of the therapist. Others are deliberately designed to support subsystems as they are challenged in the restructuring

process. Minuchin (1974b) describes three accommodation techniques which facilitate movement toward therapeutic goals:

Maintenance is a technique which acknowledges and supports the family structure or specific subsystems. For example the therapist may chose to temporarily accept the family's definition of the problem or a couple's definition of complementarity. Confirming an individual's strengths is a form of maintenance designed to expand perceptions of competence in achieving new skills. By supporting one subsystem, the therapist challenges the other parts of the family system to accommodate to it.

Tracking is an accommodation technique whereby the therapist encourages the family to continue its communications and behaviour by asking for clarification or by making approving comments. By allowing the family members to take the lead by telling their story, the therapist communicates acceptance of them, and by eliciting further information regarding their home environment, the family's structure emerges. More specifically, it uncovers explicitly and in detail the family's pattern of behaviour, thinking, or feeling in its systemic context (Sherman & Fredman, 1986). The therapist can track a "symptom, an action, a communication, an interest, a family theme or a nonverbal metaphor" (p. 120), thereby uncovering a sequence of the repetitive pattern which constitutes a self-reinforcing feedback loop. Tracking can be done by systematic questioning or by asking the family to enact a specific event. Tracking techniques are nonjudgmental, and the subsequent feedback is usually "reframed in positive terms in order to validate each person and the system and create a friendly, cooperative atmosphere" (p. 121).

Nimesis is the implicit and explicit accommodation to the family's particular style, for example its affective range or its way of communicating. It may include the therapist's highlighting common experiences with the family or copying certain gestures or movements of the client as an act of "increased kinship."

While accommodation and restructuring processes are differentiated in order to analyze them, they work in tandem with each other. An act of accommodation can be used as a restructuring strategy in that supporting one subsystem opens new possibilities in other subsystems.

Assessment

As a result of having "joined" the family, the impact of this process on the members provides the therapist with data for assessment. The assessment of family interactions focuses on six major areas as set out in *Families and Family Therapy* (Minuchin, 1974). They are as follows:

1) The family **structure**, its preferred transactional patterns, and available alternatives: The therapist tries to ascertain the power hierarchy, the complementarity of functions (role distinctives within subsystems such as tasks performed by father being different than those performed by mother), any idiosyncratic features of the family that organizes the ways in which members interact (verbal communication patterns and affective expression), and the boundaries of the family's functional subsystems as being on a continuum from rigid to diffuse (Levant, 1984).

2) The family's **flexibility** and capacity for restructuring: The therapist assesses the family's capacity for change. Does the family have alternative transactional patterns? How much deviance from preferred patterns is allowed? How much tolerance is there for changes in the power hierarchy or subsystems? (Levant, 1984).

3) The family system's **cohesion** or **resonance**: The degree to which the family is sensitive to the actions of individual members is the extent to which they are enmeshed or disengaged with each other.

4) The family's **life context**: The family's sources of support and stress in its ecological context are considered.

5) The family's **developmental stage** and its performance of stage-appropriate tasks: Problematic behaviour can develop as a response to the stress associated with life

transitions such as the birth of a child, the marriage of a child, or the death of a family member. The therapist determines the resulting strain on the family's functional structure in order to help it evolve.

6) The **role of the symptom bearer**: The ways in which the identified person's symptom is used for the maintenance of the family's preferred transactional patterns are examined. For example, does it diffuse conflict or does it protect another family member? (Levant, 1984).

A family **map** evolves from the assessment process which identifies existing structural problems and implies appropriate therapeutic goals. The therapist redefines the presenting problem for the family, establishes treatment goals, and together they establish a therapeutic contract.

Restructuring the Family

The therapist then begins the **restructuring** operations which will lead the family toward its therapeutic goals. The therapist assumes a leadership role in order to dissolve dysfunctional family transactions by reacting, challenging, and probing from within the family system. A therapist can use a large number of restructuring techniques, the selection of which depends on individual therapeutic style and the specific situation (Minuchin & Fishman, 1981).

Minuchin (1974b) describes seven categories of restructuring operations:

1) **Enactment** is a technique whereby the therapist helps the family transact their normal dysfunctional patterns in the session in order to restructure them. Members are directed to interact with each other, intrafamilial communication is facilitated, and physical space is manipulated in order to encourage dialogue between specific members.

2) Through **boundary-making,** the therapist helps the family form permeable boundaries by modifying interactional processes across existing boundaries between individuals and subsystems. Rules about who is included how, when, and in what functions are clarified. Boundary-making separates responsibilities between subsystems

and recognizes differences between generations. Communicational rules are imposed such as who should talk when. Boundaries that are too rigid are reduced to allow more sharing and cooperation (Sherman & Fredman, 1986). Subsystem boundaries can be strengthened by manipulating the space within the session.

Appropriate boundaries can be developed by allying with a subsystem in order to disrupt coalitions and form new alliances. For example, in a parent-child coalition, the child is removed as an ally and stopped from interfering in the interaction between the parents. The parents can then work in cooperation with each other to agree on parenting matters and their implementation (Sherman & Fredman, 1986).

3) **Unbalancing** is a technique designed to escalate stress within the family whose usual patterns of handling stress involve its detour or denial (Levant, 1984). In order to help the family explore alternative relationship patterns, the therapist uses a new stressful situation to provide the family and the therapist an appreciation of the system's ability to restructure and grow (Fishman, 1988; Minuchin, 1974). Minuchin (1974b) describes four ways of accomplishing this, namely, blocking transactional patterns, emphasizing differences that the family has been minimizing or ignoring, developing implicit conflict in situations where conflict has been diffused, and by joining in an alliance or coalition with a family member or subsystem.

Temporarily allying with various subsystems creates a shift in the distribution of power, increasing the weight of one relative to the others to overcome inequities or break oppositional deadlocks (Sherman & Fredman, 1986). For example, in an enmeshed family, the therapist can affiliate with one member of a subsystem, such as a parent, to form a temporary coalition in order to help the parent in his/her role as rule-setter to confront a teenager. Allying with the children to gain their parents' respect and more responsibility is another example of a power shift (Sherman & Fredman, 1986). This technique is also used when a spouse appears to dominate the other, or when a grandparent is more dominant than the parent. The underlying goal is for family members

to transact in a new way, establishing new, more functional boundaries. This technique is useful only if the family implicitly understands that the coalition is a temporary step, and that the therapist is allied with the whole family.

4) **Tasks** are assigned by the therapist in order to provide a new framework for the family members. They can be assigned in the session as directives for communication between members or in manipulating seating arrangements. Homework can also be assigned and is aimed at both the presenting problem and the underlying structural problem. The therapist gives specific instructions as to how the family must transact outside the session. By assigning tasks, the therapist focuses on new possibilities for restructuring the family. The family's response to the tasks provides further information regarding the assessment.

5) When the presenting problem is particularly painful or dangerous, restructuring operations may call for the therapist to **utilize the symptom**. In potentially life-threatening situations (e.g., anorexia nervosa), the symptom takes priority, with the understanding that the individual member's symptom is expressed in the family context and maintained by its transactional patterns. Minuchin (1974b) breaks this restructuring operation down into six distinct categories: 1) focusing on the symptom, 2) exaggerating the symptom, 3) de-emphasizing the symptom, 4) moving to a new symptom, 5) relabeling the symptom, and 6) changing the symptom's affect.

When *focusing on the symptom*, the therapist does not challenge the family's presentation of the problem, but engages it in helping the individual member with the problem. For example, the therapist might have the family enact a particular conflict around a symptom followed by the restructuring of subsystems. As the symptom disappears, the therapist moves to the underlying problem. The therapist may choose to *exaggerate the symptom* in order to increase its intensity and illicit a response from the executive subsystem. In certain situations, it would be better advised to *de-emphasize a symptom* by using the symptom to introduce the family to its larger context. Minuchin

(1974b) offers an example de-emphasizing the symptom by having lunch with an anorexic patient and his or her family. A strong interpersonal conflict is created which takes priority over the child's refusal to eat.

The therapist may choose to shift the focus to another family member by *moving to a new symptom*, thereby revealing the larger function of the particular symptom for the family. By *relabelling the symptom*, the family is given the opportunity to see it from a different perspective, and to change accordingly. For example, anorexia can be redefined as disobedience or as making parents incompetent (Minuchin, 1974b). It may be useful to *change the symptom's affect* by encouraging the family to interact in a new way around the problem. For example, to replace an emotional and reactionary response of a parent to a child's fire-setting, the parent is asked to educate a child about fire-setting in a competent and rational way, thereby rendering the symptom unnecessary (Minuchin, 1974b).

6) By **manipulating the family's affect** the therapist carries out a restructuring maneuver. This is achieved by either exaggerating a particular style in order to induce the client's reaction against it, modeling an alternative mood, or relabelling a predominant affect.

7) Joining operations such as **support**, **education**, and **guidance** can play a role in restructuring a family. Supportive services can be seen as an integral part of treatment .

Sherman and Fredman (1986) describe several additional structural techniques designed to trigger a shift in the family's organization by creating movement for families who typically feel stuck in their present positions:

1) Family members can **discover new aspects of themselves**. They are given the opportunity to try out new behaviours and discover new personal dimensions. For example, role reversals may allow a serious, rigid partner to become more flexible by

planning family activities, while the more relaxed partner tries out new behaviours in keeping with the organization of work-related tasks.

2) The therapist may chose to **normalize the family's experience of being in a particular place**. Sherman and Fredman suggest that a therapeutic response to people who sometimes feel bad, unworthy, or powerless in occupying a certain place in the system might say, "If I were in your shoes I would be depressed too"; or "People in a position like yours generally will do or feel similar things"; or "What are the advantages in this position?" (p. 118).

3) A therapist's **reframing** of a family's situation can trigger an organizational shift. This technique involves the introduction of alternative realities for the family in order for them to experience themselves and each other in a new way. For example, the eldest child's complaint of his/her burdens could be reframed as essential in his/her training for leadership and role modeling.

4) The family system can be changed while **working with one individual**. This technique is based on the systemic assumption that changes in a subsystem will trigger a reorganization of the larger system. By encouraging and supporting one family member in assuming a new role, the others are forced to adapt. This technique can also be strategic. A key person can be extricated from a "circular, self-reinforcing pattern of dysfunctional behaviour" (p. 133). By suggesting new behaviours for this person in private, an element of surprise is introduced, freeing the reciprocal members to respond in new ways.

5) Another structural move is to **send a member of the family on vacation**. The goal is to create more appropriate boundaries by disengaging the dominant or overactive member whose behaviour forces an enmeshed interaction process and a power imbalance which maintains the symptom. The therapist expresses concern for the dominant enmeshed member, suggesting that he/she deserves a rest from their usual responsibilities and involvements. The vacation is used to address symptoms such as "nagging others to

do things, protecting other family members, doing for others and serving them, disciplining the children, working continuously to provide for the family but being uninvolved with the members" (p. 138). The therapist stresses that it will be difficult for the member to remain on "vacation" and solicits the help of the others by asking them how they could assist.

6) The therapist can **challenge the family's complementarity**. This is achieved by shifting the balance in the reciprocal nature of interpersonal behaviour. Complementarities can include leader/follower, victim/rescuer, pursuer/distancer. The therapist encourages each member to change his/her reciprocal role. For example, when one member ceases to be a pursuer, the other no longer needs to be a distancer.

Techniques used by structural family therapists are as numerous as the therapist is creative (Jung, 1984). The approach can be very imaginative, providing that the values of the family are respected.

Section Five: A Critique of Structural Family Therapy as Found in the Literature

Structural family therapy has been criticized for its tendencies to be pathologizing, judgmental, and controlling (Anderson & Goolishian,1990; Hoffmann, 1985). Alternative therapeutic approaches have been presented to address these criticisms and have enriched the field of family therapy (Hoffman, 1985). Simon (1995) suggests that the description of these new approaches as being irreconcilable with traditional family therapy is unfortunate. It is Simon's view that structural family therapy is anything but pathologizing when taking into account its fundamental assumption of a family's competence which views families and individuals as essentially sound and resourceful. Inherent in the notion of restructuring is that, rather than being dysfunctional, the family is simply using an outdated structure to deal with a new problem (Wetchler, 1995). Furthermore, assessment viewed through the lens of a family's competence and uniqueness brings to bear an ecological-developmental perspective rather than a pathological one (Simon, 1995).

As for the model being judgmental and controlling, Simon (1995) asserts that its

assumption of the family's uniqueness ensures that families are at the center of the therapeutic space and are given the right and responsibility to shape the outcome of the therapeutic process. Rather than being controlling, the therapist is directive and active in helping family members become "unstuck" as they explore alternative ways of interacting.

Fundamental to this process is the enactment in which the interdependence between the therapist and family implies that the therapist shares power with a client in a transaction (Aponte, 1992). Minuchin states that the therapist's questions invite families to re-examine the meanings and values that have been "normal" for them and which support conflict, in order to produce specific, targeted changes in the family (Simon, 1996). Minuchin's fundamental message to his clients that "You are more complex than you realize" (Minuchin & Nichols, 1993, p. 47), implies a role of empowering rather than one of control. The structural family therapist becomes an "authoritative coach" helping families "discover, rehearse, and celebrate" their strengths, thereby facilitating their coping skills and their autonomy (Powell, 1991, p. 244). The intervention serves primarily a heuristic function, reserving for the family its "right, responsibility, and competence to determine the specifics of change" (Wetchler, 1995, p. 21). Minuchin views the family therapist as an instrument of change, and believes that "noninterventionist, restrained" therapists restrict themselves to operating only in a "collaborative, symmetrical posture," and therefore, remain as "distant, respectful questioners" (Simon, 1996, p. 52).

Feminists have been critical of family therapy for their exclusive adherence to systems theory in treating families. They maintain that the cultural, historical, and political context of the family must be as thoroughly assessed as its familial context. Feminists assert that, until recently, the subject of power and its unequal distribution in the family and in society has been ignored (Goodrich, 1991). Chaney and Piercy (1988) suggest that traditional family therapy may "inadvertently give priority to the good of the family or relationship over the needs of the individuals--often the women" (p. 306).

Goodrich (1991) states that family therapy which idealizes the conventional model of family, with its gendered division of labour and its hierarchy of privilege and power, makes it complicit with society in keeping women oppressed. The structural construct of complementarity in the spousal relationship, by assuming an equal distribution of power, serves to obscure a power dynamic and the potential abuse of that power. Goodrich (1991) not only challenges the accepted hierarchical relation of husband and wife, but that of parent(s) to child, asserting that "this arrangement of power-over is taken for granted as right, proper, and necessary, despite research demonstrating that a family can function well in an arrangement of consensus" (p. 22). In the areas of wife-battering and incest, Goodrich (1991) believes that family therapy's commitment to patriarchy has lead to the most devastating consequences, clearly because it cannot deal with the principle of power and the abuse of that power.

Feminist theories of power and the abuse of power have been incorporated into family therapy constructs in order to address the limitations on individuals derived from socially sanctioned, outmoded sex role constraints (Chaney & Piercy, 1988). A gender-sensitive approach to treating the family is designed to support women's empowerment. Feminist-informed family therapists recognize that despite the irrefutable concerns regarding the political aspects of the abuse of power in the family, family therapy itself can provide one of the most effective ways to address these concerns because of its access to the family system that maintains the status quo (Barrett, Trepper, & Fish, 1990). Cole (1992) suggests that when working with incest perpetrators, family-oriented therapy makes possible the direct challenging of inappropriate power imbalances, abuses of authority, and dysfunctional boundaries in families in the presence of all family members, thereby offering the opportunity to empower the victim, remove the victim's guilt, and shift responsibility to the perpetrator. The task of equalizing the power base in the parental subsystem can be accomplished through enactments, whereby an enacted family sequence can be interrupted with a sequence of new, more egalitarian

and functional behaviour (Barrett et al., 1990). For example, a powerful father who is resistant to giving up his domineering and aggressive style in individual sessions, may be less resistant when other family members stop responding to him in fear and submission in a family session (Barrett et al., 1990). Barrett, Trepper, and Fish (1990) state that in their work with incestuous families, they "know of no families who have *successfully* completed family therapy who maintain rigid traditional sex roles" (p. 157).

When looking at the power heirarchy in the child-parent(s) subsystem, the feminist assertion of its inappropriateness (Goodrich, 1991) cannot be ignored. In this regard, Minuchin's concept of hierarchy warrants further examination. Minuchin states that "the unquestioned authority in the patriarchal model of the parental subsystem has faded, to be replaced by a concept of flexible, rational authority" (Minuchin, 1974b). The parenting process, he suggests, must be responsive to the children's developmental stage. Nurturing functions predominate for the very young, and change as the children mature into adolescence to functions of control and guidance, with the understanding that their need to grow more autonomous increases with age. Minuchin (1974b) recognizes that the therapist's support of the parental subsystem may be in conflict with a therapeutic goal of supporting a child's autonomy, but points out that "only a weak parental subsystem establishes restrictive control, and that excessive control occurs mostly when the control is ineffective" (p. 59). Minuchin (1974b) agrees with those families and therapists who suggest that an ideal family is a democracy, however, he points out that a democratic society's essential ingredient is effective leadership. Understanding the structural therapist's task as one of helping subsystems negotiate with and accommodate to each other, opens new possibilities for incorporating feminist egalitarian values and feminist concerns regarding patriarchal parenting into gender-sensitive family therapy.

Minuchin's theory regarding family systems and structure has been criticized for not adequately addressing the theory of change or addressing the area misnamed "resistance" especially in cases involving "enmeshed" families (Hoffman, 1981, p. 270).

Structural family therapy does indeed operate on the basis of a set of assumptions about change based on the structural family dynamics as described by Colapinto (1991). Change is a natural process of growth in response to developmental and environmental demands, which in some families, can be either suppressed or arrested. Resistance to change is, therefore, the inability to adapt to these demands, and is expressed by adhesion to existing family rules. Structural family therapy has two major advantages in addressing resistance to change, namely, "harnessing the power of the family on behalf of the individual, and attending in vivo to the reverberations of change in the family" (p. 441). Resistance to change is circumvented through the use of enactments (particularly useful for disengaged families where contact is curtailed) or directly challenged through crisis induction (particularly useful for enmeshed families who deny disagreement or difference). These concrete experiences may also induce behavioural and cognitive change (Colapinto,1991).

Although structural family therapy does take into account the impact of a family's social context, as in Minuchin's *Families of the Slums*, the focus for change remains within the context of the family to the exclusion of broader ecological forces. One of the goals of intervention is to help underorganized families cope better in the face of ecological stressors such as poverty, but the model cannot cure these particular social ills. Even though structural family therapists are now looking beyond the boundaries of the family, and recognizing the impact of the larger culture (Simon, 1996), their parameters of practice do not necessarily allow for their effecting change in larger social systems outside the family.

This practice limitation does not, however, necessitate the separation of units of intervention, namely the family and the environment, or the intervention goals of inducing change in the family and inducing change in the environment, but rather allows for the interdependence of clinical family practice and social policy. The model of

structural family therapy was, after all, created by Minuchin, a very politically involved person with a concern for the "underdog" and a desire for social justice (Minuchin & Nichols, 1993). For the last decade Minuchin has focused not only on the problems inside families but also on the destructive power of institutions that control their lives such as "protective services" which in effect, often destroy families they set out to protect (p. 34). Just as he once challenged mental health workers to assess individuals as players in the context of the family, family therapists are now being challenged to incorporate their knowledge regarding environmental press on individual families, and to bring their knowledge to bear on those who can create change at a policy level.

CHAPTER TWO

APPLICABILITY OF STRUCTURAL FAMILY THERAPY

Structural family therapy is by definition a family approach with broad applicability to various socioeconomic groups and presenting problems (Jung, 1984). With its emphasis on the social context in which families live, and on the joining process, it is an approach also suited to cross-cultural settings. Jung (1984) suggests that the model's attention to appropriate generational boundaries, problem-solving, focusing on strengths, and to the therapist as an authority figure and change agent, allows for its wide application. If the presenting problem lends itself to an interactional reframe, the structural model can be applied successfully (Colapinto, 1991). Limits to the applicability of the model are determined by the therapist's style rather than the family's.

The Multi-Problem Family

Structural family therapy was first applied by Minuchin to lower-socioeconomic-status disorganized families with delinquent offspring. He described these families as units wherein parents provide little or no leadership, where boundaries frequently shift, and transactional patterns are random, producing an unpredictable environment (Minuchin et al., 1967). They function at either extreme of the enmeshment-disengagement axis, or fluctuate between the two poles. As a result, the children cannot experience a sense of their own competence in effecting change. Techniques designed to work with multi-problem families are directed at changing their communication patterns, their structure, and their affective system.

The Psychosomatic Family

Minuchin later applied his structural theory of family therapy to psychosomatic and anorectic families (Minuchin et al., 1978). These families are assessed as being enmeshed, overprotective, and rigid. Their transactional patterns do not fully

acknowledge conflict, leaving it unresolved. A rigid triad exists with one child and the parents in a stable or an unstable coalition. Treatment involves the short-range goal of symptom remission through a combination of behaviour modification and family therapy, often in a hospital setting. The family therapy component may involve a lunch session in which the family enacts its core transactional patterns, the goal being to change the definition of the problem from that of a sick child to that of a dysfunctional family. The long-term goal is then to change these dysfunctional patterns by joining and restructuring the system.

Because of the family's conflict-avoidance patterns, the family may give appearances of cooperation, when in fact they are resisting the therapist's directives. Minuchin suggests that moves of "high intensity" are required to deal with this type of resistance (Minuchin et al., 1978). The therapist induces conflict as a restructuring operation in order that the family must confront the conflict and develop new ways of managing it and resolving it.

The Couple

Although couple therapy is often regarded as a concept separate from family therapy, the structural model conceptualizes the couple as a subsystem for which assessment and intervention follow the same guidelines that apply to the family (Colapinto, 1991). Differences might lie in the choice of techniques. For example, because couples generally perceive their problem as being interactional, reframing it as such would become unnecessary. What could be changed is the definition of what kind of interactional problem it is. As well, working on issues related to subsystem boundaries would be of lesser importance than applying techniques such as enactment and working on complementarity within the couple subsystem (Colapinto, 1991, p. 441). Fishman (1988) suggests that the most powerful therapeutic technique when working with couples is unbalancing the system by temporarily siding with and distancing from one or the other spouse. This creates an experience for the couple in which they are forced to rethink and

reevaluate customary perceptions. Working with the executive subsystem does not preclude a recognition of the impact of other family subsystems such as children, and the effect that the parenting roles of mother and father have on the couple.

The Violent Couple

In his book *Family Healing* (1993) Minuchin describes his experience with couples whose relationships are punctuated with physical violence. He addresses the concern which many experts have that treating violence as a family problem tends to excuse it and may even perpetuate it. He agrees that those who commit violence must take responsibility for it and must be held accountable. Although brutal violence must be punished and the victim protected, Minuchin states that "domestic violence is commonly experienced on a more restrained scale such as shoving and slapping, as an outcome of a relationship fraught with emotionally destructive behaviour" (p. 66). Couples may want to stay together but are "locked in a cycle of mutual provocation that leads to violence" (p. 74). Those who commit violence in families often perceive themselves as victims rather than abusers (Fishman, 1988), responding to the other person's baiting (Minuchin, 1984). It is in cases such as this, where the structural model can uncover destructive patterns of interaction, and help couples "discover their individuality, their power, and their responsibility" (p. 66).

Fishman (1988) contends that violence in families is a problem of invaded boundaries, and that the intrusion of boundaries lead to "helplessness, fear, anger, and confusion, and ultimately to violent expression" (Fishman, 1988, p. 82).

Understanding the predictable nature of a spiraling escalation of emotions in violent couples, Minuchin initially discourages interaction and encourages the couple to take turns speaking to him in specific, concrete details, moving the discussion from a "feelings" level to a "thinking" level. The first priority is to control the perpetrator's attacks but also to "challenge the victim's sense of helplessness by focusing on her competence and supporting her in being assertive" (p. 74).

Fishman (1988) asserts that intervention with violent families must be directed toward the creating and strengthening of personal boundaries and subsequently reorganizing family rules within these established functional boundaries. Establishing these functional boundaries in the therapy room, increases the potential of the family's success outside the therapeutic context. Fishman (1988) suggests that the therapist must seek answers to the following questions at the outset of therapy: 1) How is the family's context making them helpless? 2) What maintains the problem? 3) What are the sources of stress that have the family resorting to violence?

Critics of systemic formulations in the treatment of spousal violence, suggest that while the theories help explain the chronicity and redundancy of battering sequences, the inherent gender bias and power inequality in a normative structure of marriage inadvertently sanction violence against women and ignore the social conditions in which it occurs (Bograd, 1984), and as a consequence, cannot detect it (Aldarondo & Straus, 1994). The description of an abusive man and a battered woman in a complementary relationship in which violence acts as a homeostatic mechanism is based on systemic assumptions that the battering is the product of an interactional context, wife-battering marital systems are characterized by certain relationship structures, and violence may serve a functional role in maintaining the system (Bograd, 1984). The author asserts that these assumptions make the emotional and physical realities of violence invisible, make both partners equally responsible for the violent incident, ignore the restricted freedom of the wife whose husband controls the physical and material resources, and ignore the broader social, economic, and political environment (Bograd, 1984). "The goodness of our clients, their capacity for change, and the possibility of healing and forgiveness in human relationships" (Bograd, 1992, p. 246) may blind family therapists to the violent and destructive patterns in clients' lives (Aldarondo & Straus, 1994).

Bograd (1984) suggests that therapists, while thinking systemically, should rule out conjoint therapy in favour of individual therapy for couples who experience violence

in order to protect the abused. They must also make violence the primary treatment issue and contract a no violence agreement as a prerequisite to therapy, with the complete cessation of violence their primary goal of intervention. In conjoint treatment models a structured separation as a crucial initial stage is advised (Cook & Frantz-Cook, 1984; Libow et al., 1982). Standardized instruments (Aldarondo & Straus, 1994) can be utilized to detect violence with the "intuitive and experience-based inquiry characteristic of good family therapy" (p. 434), thereby helping family therapists fulfill their ethical obligations to their clients.

The Single-Parent Family

The single-parent family has become a norm--an intact family unit, however, the therapist is called upon to use his/her self in a special way when treating such a family (Fishman, 1988). Fishman (1988) outlines three general principles to follow when working with the single-parent family:

1) The therapist must confirm the parent's sense of self by focusing first on the parent as an individual, confirming and strengthening the parent's self-respect. Only then is it possible to establish his/her effective role in the family.

2) The therapist's use of self to support the parent is particularly important when working with single-parent families. The therapist provides corroboration or support for the adult views of the parent, by confirming his/her sense of reality and providing support and options. This creates a therapeutic and generational subsystem, a process which adds to the parent's more limited options and resources.

3) Because of the temporary nature of this therapeutic subsystem, it is essential for the therapist to link the single-parent family to other individuals and community resources that can provide a continuity of support following termination of therapy.

Stepfamilies

Minuchin describes stepfamilies as "rich with possibility--for competition and conflict, jealousy and resentment, and for love reborn" (Minuchin, 1993, p. 198). A

stepfamily is a new family organism, and when experiencing crises, they should be seen as normal (Minuchin, 1981).

Although they may be normal, stepfamilies differ from biological families in the ways they are structured (Visher & Visher,1979). Visher and Visher highlight six structural distinctives of stepfamilies (p. 336):

1) All stepfamily members have experienced important losses.

2) All members come with past family histories.

3) Parent-child bond predate the new couple relationship.

4) There is a biological parent elsewhere, either living or deceased.

5) Children often are members of two households.

6) No legal relationship exists between stepparent and stepchild.

These structural variables impact the developmental stages and tasks that stepfamilies face. Visher and Visher suggest four tasks requiring the family's immediate attention (p. 343):

1) Mourning of losses.

2) Negotiation and development of new traditions.

3) Formation of new alliances and preservation of old alliances that are still important.

4) Stepfamily integration.

When assessing and treating a stepfamily the therapist must take into account a more complex structure due to the increased number of subsystems and an increase of boundary ambiguity and fluctuation. They family's hierarchy requires renegotiation, often being challenged by power struggles between pre-existing subsystems. When bringing together children of previous marriages, the formation of stepparent triangles due to rivalries between stepparents and stepchildren, and stepsisters and stepbrothers, can be the family's downfall. Distinct subgroups need time to adapt to new relationships while respecting previous loyalties (Minuchin, 1993). These complicating dimensions of

stepfamilies underscore the importance of a strong couple bond to ensure its successful functioning (Visher & Visher, 1979).

Family Therapy as a Treatment for the Delinquent Adolescent

Common among families with delinquent adolescents is a weakened parental subsystem (Fishman, 1988). This can be the result of absent parents, chronic disagreement between parents, or a disabling split between caregivers (including social agencies and the court). The resulting ineffective authority leaves adolescents having to resort to less appropriate individuals and activities for guidance. Studies have demonstrated that when a family is treated as a unit, the role of the adolescent in the family can be changed due to the increased warmth and affection that develop (Henggeler, 1986).

Fishman (1988) presents five general principals to follow when treating a family with a delinquent adolescent member:

1) The therapist must address the deterioration of the adolescent's sense of self as it has developed. Underlying the delinquent behaviour is the premise that the adolescent is not affected by the breaking of rules but by being a failure at breaking the rules, i.e., getting caught.

2) More functional premises for behaviour must be structured to transform the delinquency, rather than merely interrupting or suppressing it. The therapist can help the adolescent tap into his/her nascent good self that can make choices and exercise competence outside the peer community. This may require the therapist to work with the adolescent's family of peers in order to observe the source of vitality and excitement that prolongs the absence of the individual's competence.

3) The parents must be prevented from being defeated. The parent/parents must continue to function in their role of executive, but must also nurture and support their child in feeling more competent. The therapist must help strengthen the parental hierarchy in order to balance the pull from peers, and at the same time, help strengthen the

adolescent's competent "good self" in the context of peers and reintroducing it into the family. This may require the therapist to generate intensity in the family in order for dysfunctional patterns to surface, or it may require the therapist to support the parents in resisting their involvement in their child's problem in order to shatter the adolescent's illusion that parents will automatically bail them out of difficult circumstances.

4) The therapist must act quickly to interrupt the delinquency before it becomes entrenched by creating a therapeutic crisis as soon as possible in the course of therapy. All essential members of the delinquent system, both inside and outside the family must be included at the outset in order to help the parents evaluate the influence of peers in the larger context.

5) The adolescent must be confirmed in areas of competence in order to make the "good self" an alternative when experimenting with delinquency. Productive situations must be found that can maintain the "good self" and confirm competency in a nondelinquent group of peers.

Working in Cross-Cultural Settings

The structural model is applicable to many cross-cultural settings. Jung (1984) describes the model's usefulness in working with traditional Chinese families in the American context, because of its emphasis on family rather than the individual, on cultural context and structure, and on interactional patterns. In their research study of Hispanic boys with behavioural and emotional problems, Szapocznik et al. (1989) found structural family therapy well-suited for Hispanic families because it targeted intergenerational conflict and culturally determined behavioural conflicts prevalent in Hispanic families.

Structural family therapy is also applicable to Aboriginal Americans (Napoliello & Sweet, 1992). It can be blended with traditional ways due to its "existential, cultural, and philosophical foundations" (p. 163). The authors state that processes such as

complementarity, joining, spontaneity (i.e., using different aspects of "self" in response to different social situations), are particularly transferable to aboriginal culture. Traditionalists would expect the therapist to play an assertive leadership role (traditional healing methods involve a charismatic leader), deal with practical problems, and to be "honest, natural, and spontaneous" (p. 163). Suggestibility, trust, and hope are important factors in the outcome of the therapeutic encounter (p. 161). The concept of "enmeshment" may not be as readily applicable to Aboriginal culture, however, because it may pathologize a culturally-appropriate kind of intimacy required to maintain the interdependence of the larger tribal group.

Since its wide acceptance by family therapists, the structural model has demonstrated its adaptability and usefulness to many classes of racial and ethnic groups where the therapist has been flexible, perceptive, and sensitive to the class and cultural norms of those groups, without imposing his or her own values (Jung, 1984).

The Model's Inapplicability

Structural family therapy has been applied primarily where children have been identified with the presenting problem. There is little documentation of its application to therapy with adults, but reports suggest the applicability of the model when the individual is very involved with his/her family, i.e., the problem must lend itself to an interactional reframe for its successful application (Colapinto, 1991). The model does not apply to phenomena of a psychotic or organic nature, but is applicable to their interactional consequences.

Feminists assert that a models based in systems theory are not suitable for families in which relationships are punctuated by violence because they ignore or obscure power in their theoretical framework and are, therefore, ill-equipped to deal with issues of coercion and violence (Bograd, 1992). Other family systems therapists, while agreeing with the critique, call for an increased awareness of the prominent role of physical violence in couple relationships, and advocate for the incorporation of self-report

measures of marital violence in order to enhance their ability to detect it, thereby fulfilling their obligations to insure the well-being and safety of their clients (Aldarondo & Straus, 1994).

Summary

Structural family therapy's broad scope of application rests on the assumption that the presenting problem is reinforced by the family structure and its repetitive patterns, allowing the therapist to focus on family dynamics that reinforce the problem as well as the presenting problem itself. As such, structural family therapy can be applied to most problems brought to a mental health or family service agency, whether that be anorexia, a phobia, thought disorder, alcoholism, drug abuse, parent-child conflict, school problem, or child abuse (Jung, 1984), and can be used in various cross-cultural settings.

Structural family therapy is contraindicated when the nature of the problem is defined as organic or psychotic in nature, and according to some researchers and clinicians, when family situations involve violence.

CHAPTER THREE

OUTCOME STUDIES

The first treatment studies conducted by Minuchin and his colleagues during family therapy's fledgling period, continue to be instructive in evaluating the structural therapy model. The efficacy attributed to the model is based on early research conducted with low socioeconomic families (Minuchin et al., 1967) and with psychosomatic families (Minuchin et al., 1978). In the 1967 study a link between treatment effect and measure of cohesion was made. Three of the eleven families described as disengaged did not improve after treatment, the authors making reference to the difficulty in keeping this type of family in therapy (Aponte & Van Deusen, 1981).

Minuchin's success in the treatment of anorexia nervosa attracted therapists to the structural model (Colapinto, 1991). Results of therapy with anorectic, asthmatic and diabetic cases were very positive, with most psychosomatic patients improving in both symptom and psychosocial behaviours after treatment (Minuchin et al.,1978). Within a two to seven-year follow-up of the 1978 study of families with adolescents, 86 percent of the adolescent patients not only were symptom free but were functioning well in terms of their psychosocial status (Fishman, 1988). The authors of the study suggest their results are superior to others utilizing behavioural and analytic psychotherapies with similar patients. These treatment outcomes provide a substantial degree of support for the efficacy of structural theory and therapy with psychosomatic families (Aponte & VanDeusen, 1981).

Although the results from these early studies have generally been accepted to indicate the effectiveness of treating both underorganized poor families and overorganized psychosomatic families using structural therapy techniques (Colapinto, 1991), they have come under closer scrutiny to uncover numerous methodological

shortcomings, including the lack of control groups, thus rendering Minuchin's empirical validations as tenuous (Roy & Frankel, 1995).

Michaels and Green (1979) evaluated the efficacy of family therapy with status offenders using a combination of problem-solving (Haley, 1976) and structural family therapy and compared their group to families who had been treated according to other models in the past. Those who received this treatment were found to outperform the comparison group in that it reduced placements in detention homes and reduced court processing.

Aponte and van Deusen's (1981) synthesis of outcome studies of structural family therapy indicates that there is no consistent evidence in favor of short- vs. long-term, or inpatient vs. outpatient formats, or for therapist-family matching (e.g., ethnicity, sex), and that highest success rates appear in the psychosomatic studies. Lower rates of success occurred in the treatment of low socioeconomic and addict families. Aponte and van Deusen (1981) speculate that sources of poorer success in outcome studies are the single-parent structure of low socioeconomic families, adult age of addict patients, therapist-family racial differences, and therapist level of experience.

Gustaffson, Kjellman, and Cederblad (1986) tested the relationship between family dysfunction and childhood asthma using Minuchin's concept of psychosomatic families in a controlled study. The treatment focused on enmeshment, rigidity, and lack of conflict-resolution as maintainers of this medical condition. The twelve children who received family therapy improved significantly as measured by a reduction of asthma symptoms. The problem with this study, as with many others, is the small sample size and its failure to link the reduction of psychosomatic symptoms with an improvement of family functioning (Roy & Frankel, 1995).

Further research has pointed to the efficacy of structural family therapy for specific clinical populations. Szapocznik et al. (1989) conducted a study examining the effects of structural family therapy, individual therapy, and recreational/no formal therapy

in 69 Hispanic boys with behavioural and emotional problems. Family therapy had a positive effect on reducing the number of problem behaviours in adolescent boys, and seemed to be more effective than individual therapy according to the parents. The researchers found that structural family therapy was well-suited for Hispanic families because it targeted intergenerational conflict and culturally determined behavioural conflicts prevalent in Hispanic families.

Chamberlain and Rosicky's (1995) review of recent (1988-1994) studies with families of adolescents provides evidence of the effectiveness of structural family therapy as a component in both prevention and treatment programs, but also points to the acknowledgment of researchers that a substantial number of families experience less than favourable outcomes from family therapy, especially families with multiple stressors (Chamberlain & Rosicky, 1995). Their review indicates that "many families drop out of treatment, do not initially engage, show high levels of in-session resistance, and/or do not maintain treatment gains over time" (p. 448).

Chamberlain and Rosicky's (1995) review identifies three family-related factors associated with differential effectiveness: 1) attrition, 2) lower educational status, and 3) lower income. Szapocznik et al. (1988) identified family resistance to initial engagement as a service barrier, but found that the application of strategic/structural family systems engagement strategies significantly improved initial engagement rates. Family stress and lack of social support also appear to influence attrition (Webster-Stratton, 1985). Child-specific factors such as age have shown to influence treatment outcome. For example, family therapy has been difficult to implement with adolescent populations from multi-stressed families, and while a strongly indicated component of treatment, is not sufficient to produce clinically significant behaviour change (Chamberlain & Rosicky, 1995).

Minuchin's structural model was utilized in a family preservation program to evaluate its effectiveness in preventing adolescents' out-of-home placement (Schwartz,

Auclaire, & Harris, 1991). Those individuals who were eligible for treatment but not yet assigned to a unit in the experimental program received the usual placement services and constituted the comparison group. An analysis after a follow-up period, showed that forty-four percent did not experience placement, forty-five percent of those placed reported only one episode, and fifty-five percent experienced multiple placements. Findings suggested the importance of engaging families in treatment in that the proportion of placement days was linked to the extent and quality of family participation in the program.

Outcome research in systems-based family therapy as a whole has improved significantly in the last two decades in both quality and quantity by addressing problems such as the combining of schools and models under study, outcome measured as symptom resolution with no link to family functioning, and the lack of control groups (Roy & Frankel, 1995). Despite this concession, Roy and Frankel (1995) call for the application of a more rigorous methodology in family therapy research if this form of psychotherapy is to "go beyond the stage of being a mere act of faith" (p. 21).

More studies are needed to test the efficacy of structural family therapy versus alternative family therapies. Results point to the model's success, but not necessarily to why it is successful, or more precisely, why this particular technique results in a "happier" or "better adjusted" individual and family (Hansen & L'Abate,1982). Research also needs to cross another important line of inquiry. With the growing literature on feminist-informed family therapy, more outcome studies are needed to test the efficacy of the structural approach as one component of a multi-modal treatment program in cases involving spousal violence, child abuse, and incest. The debate over the suitability of a systems approach to family violence (Aldarondo & Straus, 1994) is important and requires more research to bring it to a resolution.

Despite the cumulative research record on structural family therapy, more empirical support is needed to substantiate the theory and to make therapists aware of the

strengths and weaknesses of the model in order to better serve their clients (Hansen & L'Abate, 1982). Research carried out in broader variety of contexts, with more clinical populations, and within more diverse practice settings could make this possible.

PART TWO: THE PRACTICUM

CHAPTER FOUR

PRACTICUM DESCRIPTION

Setting

The practicum was carried out at the Elizabeth Hill Counselling Centre (EHCC), a counselling clinic in Winnipeg's inner city affiliated with the Psychological Service Centre of the University of Manitoba, whose mandate is the training and supervision of students in the Faculty of Social Work and the Department of Psychology.

EHCC provides therapy and counselling free of charge to adults, children, adolescents, couples, families, and groups. It also delivers education workshops and seminars. Clients may request service directly or may be referred by social services and community agencies, doctors, teachers, counsellors, and former clients.

Clients

From EHCC's waiting list, I identified potential families and couples that would provide a wide range of profiles and problem areas. I completed intake interviews with six families, all of which subsequently engaged in therapy. Formal termination processes were completed with four of the six cases, two choosing self-termination. My caseload consisted of two step-families, three single-parent families, and one living-as-married couple. Detailed analyses of three of these cases are presented in Chapter Five.

Procedures

Initial contact was made with each family by telephone, at which time I became informed of any changes that may have transpired since their referral and, if necessary, reevaluated their suitability for family therapy based on new information. I provided a brief description of the process of therapy for clients participating in a student practicum,

and upon the client's verbal consent, we scheduled the first appointment. At the first session I further clarified their role as clients and my role as a student clinician. Upon their written consent, I proceeded with the intake and assessment.

All written recording was completed in accordance with EHCC procedures in order to document assessment, intervention, client progress, and outcome. Therapy sessions were video-taped for supervision purposes (with the exclusion of in-home sessions). Personal notes and reflections relating to the cases and the intervention process were kept for evaluation and report-writing purposes.

Three of the six families were seen in the office, two families were seen both at the centre and in their home, and one family, due to extenuating circumstances, requested in-home sessions only. Clients were seen over a seven-month period. I administered the pre-intervention FAM III during the second or third session with all six families and the post-intervention FAM III and Client Feedback Form at termination with four families. I did not contract to meet with families for a specific number of sessions, but rather gave them a time-frame during which assessment and evaluation would occur on an on-going basis. Termination was mutually agreed upon on the basis of outcome and/or with the completion of my practicum.

Supervision

Dr. Diane Hiebert-Murphy, my Faculty Advisor was the Chairperson of the Practicum Committee, and provided primary supervision. The committee, comprising two additional members, David Charabin from the Faculty of Social Work and Coordinator of the Elizabeth Hill Counselling Centre, and Linda Perry from the Elizabeth Hill Counselling Centre, approved the practicum proposal, and examined the completed practicum report.

Two-hour supervision meetings were held on a weekly basis at which time Dr. Hiebert-Murphy advised me regarding specific interventions, and monitored and evaluated my progress.

Learning Objectives

My learning goals for this practicum were threefold: 1) to increase my knowledge of the dynamics of various family compositions; 2) to increase my knowledge of the structural model of family therapy; and 3) to develop my clinical skills in working with families.

Evaluation

An evaluation of the practicum was conducted from the perspective of myself, my supervisor, and the client. Dimensions evaluated included my conceptual knowledge of the structural family therapy model, my technical skills, and the outcomes of the families being treated. Educational benefits which I accrued, namely, theoretical knowledge and practice skills, were measured through weekly clinical supervision and evaluation, as well as through ongoing personal reading, journaling, and reflection on practice experience.

Outcomes were measured using the Family Assessment Measure III. A pre- and post-intervention assessment was administered to evaluate the effectiveness of intervention by measuring the family's ability to carry out its functions of support and nurturance. This, in part, determined to what degree my interventions had resulted in positive changes in family functioning. A Client Feedback Form (Appendix A) provided a qualitative measure of my professional growth and development. It solicited clients' opinions about their experience, including their satisfaction with the therapist and a self-assessment of the benefits of therapy.

Family Assessment Measure III

The scale was developed by Skinner, Steinhauer, and Santa-Barbara (1983). It is a self-report measure based on Canadian norms, originally developed to provide an operational definition of the constructs in the Process Model of Family Functioning (Skinner et al., 1983). The model emphasizes the understanding of family dynamics, making it possible to integrate different approaches to family therapy and research.

The model focuses on family functions and defines the processes by which families

operate. The basic concepts assessed by FAM III include the accomplishment of developmental and crisis tasks (the family's overriding goal), role performance (the allocation and assuming of roles), communication, affective expression (a vital element of communication), affective involvement (the cohesion continuum), control (characterizing boundaries), and values and norms (the influence of family norms and cultural context).

FAM was standardized with respect to a heterogeneous sample of clinical and nonclinical families. The scores were normalized to give each subscale a mean of 50 and a standard deviation of 10. The majority of scores for nonclinical families should fall between 40 and 60. Scores below this range indicate healthy functioning and above this range indicate considerable disturbance.

The measurement consists of three scales: l) the General Scale which focuses on the family system, 2) the Dyadic Relationships Scale which examines relationships between specific pairs, and 3) the Self-Rating Scale which measures the individual's perceptions of his/her functioning in the family. For the purposes of this practicum, the General Scale and the Dyadic Relationships Scale were used to measure outcome following the course of therapy.

The General Scale provides an overall rating of family functioning from a systems perspective. It comprises fifty items, divided into nine subscales (seven as outlined above). The eighth and ninth subscales measure response style including social desirability and denial.

The Dyadic Relationships Scale focuses on relationships among specific pairs in the family. An overall rating of functioning is provided using forty-two items and seven subscales relating to the constructs of the Process Model. It does not include the two additional subscales found in the General Scale that measure social desirability and denial.

The FAM III has good internal consistency (ranging from .65 to .87 for adults, and from .60 to .87 for children) and reliability (.93 for adults and .94 for children). It

discriminates between clinical and non-clinical families (Skinner et al., 1983) and is easy to administer and score.

The FAM-III may be completed by individuals at least ten to twelve years of age. The profiles cannot identify which critical aspects of each construct are a strength or a weakness, and are, therefore, not intended as a substitute for a clinical assessment but rather as a complement to it by either verifying the assessment, alerting the family therapist to potential problem areas, or by providing a baseline for a quantitative evaluation of therapy.

Client Feedback Form

The Client Feedback Form (see appendix A) was administered following the conclusion of therapy.

CHAPTER FIVE

THE FAMILIES

Introduction

This chapter provides case studies of three of the six client families who constituted my practicum. Each of the three families are unique in their configuration, their presenting problem, their development, and their ecological context. Pseudonyms are used to ensure their confidentiality.

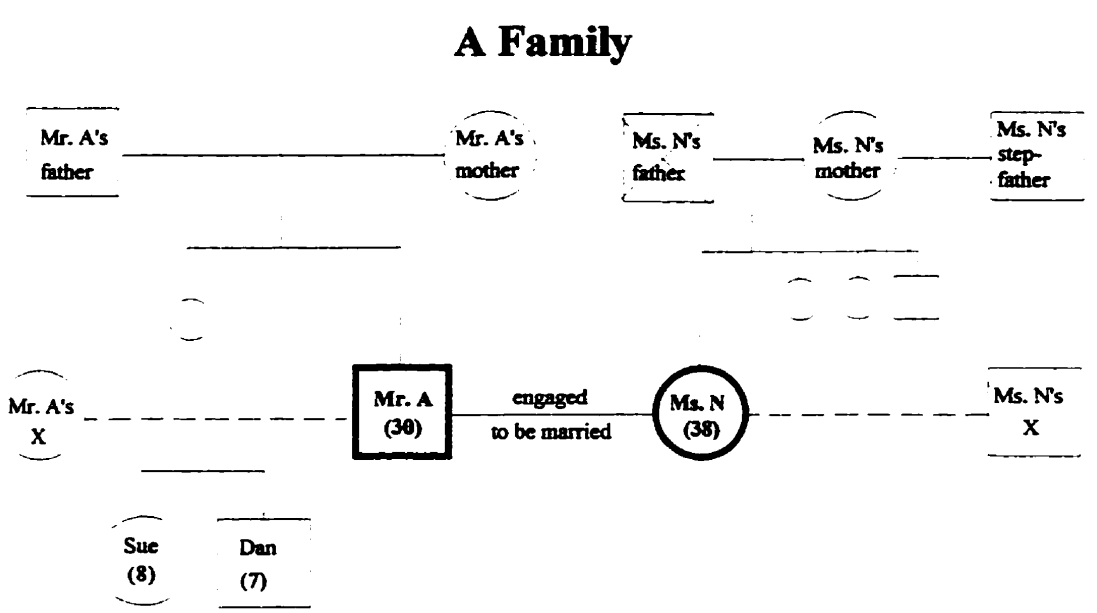
Each case study includes the precipitating factors leading up to the referral, a structural assessment which also takes into account the family's life context and developmental stage, the FAM III pre-test results, and a tentative hypothesis. A discussion follows highlighting specific interventions, an analysis of the process, and an evaluation of the family's therapy, including the results of the FAM III post-test and the Client Satisfaction Survey.

The A Family

The A family consists of a divorced father (31) and his two biological children from his previous marriage, Dan (7) and Sue (8) (Figure 1). He is engaged to be married to Ms. N (38), divorced with no children. A court-ordered home assessment has recently been completed, on which a revised custody and access agreement is pending. Mr. A currently has full custody of the children due to their mother's alleged abusive and neglectful behaviour. Ms. N is centrally involved in the family, as she has been since the couple met two years ago.

Mr. A has a full-time job. Since the initial referral, Ms. N has taken a part-time position out-of-town, and spends the weekends in Winnipeg. She spends day-time hours with Mr. A and the children, and night-time hours in the home of her mother and step-father located just a few doors away.

Figure 1: Genogram



Presenting Problem

The family was referred by their pediatrician. Mr. A stated that the children's behaviour is very difficult, particularly following visits with their mother. He was concerned that the family's instability is jeopardizing his relationship with Ms. N who had recently broken off their engagement until "things settle down". The couple was seeking help in dealing with the children.

Assessment

Structure

Mr. A and Ms. N, together with the children, constitute a remarried family, even though they are not yet legally married. A rigid boundary exists between the couple and the children's mother who continues to be a prominent and challenging player in the family's life. The boundary between the children and their mother is ambiguous. The children express that they like their mother but appear confused about how to relate to her.

Mr. A, a mild-mannered and reserved individual, is now sharing the parenting role and the housekeeping tasks with Ms. N, an active and goal-oriented woman, who has taken on these functions very willingly and capably. The boundaries between them appear ambiguous relating to home maintenance and child rearing. Ms. N feels that Mr. A is not maintaining the home efficiently or parenting effectively while she's away. A power struggle has consequently developed in a dysfunctional pattern of complementarity in which Ms. N is generally active and Mr. A is passive. She also struggles with feelings of frustration in her inability to intervene with medical and legal professionals on behalf of the children because she has no legal rights to do so, and because she is now living a significant distance away from the family during the week. Mr. A, although he welcomes and appreciates Ms. N's involvement, resents her ongoing critique of his performance as father and housekeeper. Regular long-distance telephone calls result in Ms. N questioning Mr. A about what he has or hasn't done, and Mr. A giving information only if it asked

for. The children's psychological and medical problems are characteristically identified by Ms. N as urgent and requiring immediate attention, with Mr. A agreeing, yet not following through on her advice regarding contacting the doctors or teachers.

The power imbalance in the couple subsystem clearly has an impact on them as a spousal subsystem. The couple spends most of their time together with the children, and only in the evenings after the children are in bed, do they have privacy. Their limited private time together as a couple together with their lack of observable verbal or physical affection for each other suggest that at an affective level, the boundaries between them are rigid. Adding to the tension is the possible alignment between Ms. N and her mother, two doors down. Ms. N spends the nights in her mother's home and feels it necessary to spend evening hours there as well.

Boundaries between the sibling and parental subsystems appear clear and suggest a parent-child hierarchy. Mr. A appears to have a good rapport with his children. Although he has a limited affective range, he speaks with authority when he feels the need. Communication of affection towards the children, both verbal and physical, appears somewhat limited. Ms. N's involvement with the children has evidently earned their trust. She engages in regular recreational activities with them individually, and as siblings. She appears to take the leadership role with the children in organizing their activities and in discipline when they are together as a family, suggesting that power resides chiefly with her.

Dan and Sue appear to get along well. During the two sessions in which they were included, they engaged each other in play with only a few minor upsets. Their individual activities also suggest their differentiation as individual subsystems. Many of their activities are individualized and they play with their own peers in the neighbourhood.

Flexibility

Undoubtedly, all subsystems in this family have been confronted with enormous changes. Both Mr. A and Ms. N have joined in a new quasi spousal relationship. Mr. A has become a part-time co-parent with Ms. N, while simultaneously working through parental legalities with his children's mother. Ms. N has taken on the role of parent even though her legal rights as one are limited. The children have a new mother figure, as well as new grandparent figures.

All four family members appear to be adapting at some levels, yet lack the flexibility to adapt at others. For example, Mr. A continues to earn an income and support the family. He has managed a household as a single-parent. Ms. N was able to find new work when suddenly finding herself unemployed. She has organized the children into various recreational and physical activities which they enjoy. Even though Ms. N lives apart from the family on weekdays, they have managed to incorporate a sense of continuity within this schedule.

On the other hand, Mr. A and Ms. N, as the executive subsystem, are inflexible in their ability to negotiate their new roles and are stuck in a rigid pattern of complementarity of overinvolvement and underinvolvement. Ms. N is very critical of Mr. A's lack of initiative and Mr. A is grateful for and at the same time resentful of Ms. N's involvement.

The children are confused about their biological mother. They have not been seeing her as often and, and when they do, signs of emotional trauma are evidenced. They are both enuretic and Dan is also encopretic. Dan has been diagnosed with ADHD and Sue reportedly, may receive a similar diagnosis.

Cohesion

The couple subsystem is somewhat disengaged at an affective level. They are emotionally distanced from each other but find common ground in their focus on the children. At a functional level, however, they struggle with ambiguity, lacking clear

boundaries of involvement. Age-appropriate cohesion exists between parental and child subsystems as observed by the clear hierarchical boundaries, as well as between siblings as observed by their mutual play activity.

Life Context

Mr. A comes to this new relationship with a reported history of having been verbally and psychologically abused by his former wife, who voluntarily gave up the children when she left him. A custody dispute was triggered when Ms. N became involved and is the cause of ongoing tension in the home. A family assessment has recently been completed on which a revised settlement will be based. Ms. N's previous marriage was short-lived and no contact remains between the two parties.

The A family has several sources of support. Although Mr. A's parents live out-of-town, they have been and continue to be instrumental in caring for the children. If Mr. A's work takes him away from Winnipeg for a few days at a time, they either come to Winnipeg to stay with them, or they take the children home with them. Mr. A's sister is available for occasional child care.

Ms. N has three siblings with families in Winnipeg. She describes them as a close family. Although her father, who was alcoholic, died when she was eleven, she now expresses love and caring concern for her step-father. Ms. N's mother provides before-school and lunch-time supervision of Dan and Sue. She also provides Ms. N with financial assistance when necessary, such as the purchase of the house which Mr. A now rents, and a newer car in order to make the regular weekend trips. A live-in foreign student provides after-school child supervision. The family attends the neighbourhood church at which Ms. N is a member.

Mr. A and Ms. N have not developed many mutual friendships, and the few they have are out-of-province.

Developmental Stage

This family unit is developmentally in transition to a remarried family as they conceptualize and plan a new marriage and family. The developmental issues salient to this stage in development require a "recommitment to marriage and to forming a family with readiness to deal with complexity and ambiguity" (Carter & McGoldrick, 1988, p. 24). Mr. A and Ms. N are faced with developmental tasks uniquely associated with a remarried family (Visher & Visher, 1979). They have been plunged into new roles that can be complex, conflicting, and ambiguous. Ms. N, who has no children of her own, has instantly become a stepmother of two children. The relationship between the children and Ms. N needs to be defined and worked out with consideration given to the children's ages, their primary residence, the circumstances of the divorce, and the desires of all concerned (McGoldrick & Carter, 1988).

Complex boundaries must be negotiated as they redefine family membership, personal space, authority, and the allotment of time with children. Although remarried families function best when boundaries around the members of different households are permeable for the sake of the child access, exceptions to the rule apply to the A family in view of the fact that the children's mother reportedly has a mental illness, has a history of family violence and/or child abuse and neglect, and irreconcilable disagreements about child rearing exist between the parents (McGoldrick & Carter, 1988).

Problems of an affective nature need to be addressed including intense conflictual feelings or their denial (McGoldrick & Carter, 1988). For Mr. A and Ms. N, these feelings are compounded by extenuating legal complications which have constrained them emotionally and financially, as well as their part-time approach to functioning as a two-parent family as necessitated by Ms. N's need to seek employment at a distance, and their decision not to spend their nights together until they are married. These arrangements are necessary for them at the present time but add to their conflictual feelings.

Mr. A and Ms. N are at different life cycle phases as individuals and are in the process of learning to function in each of them simultaneously (McGoldrick & Carter, 1988). Whereas Mr. A is younger than Ms. N, he has raised two children while Ms. N has not. Ms. N has lived with her parents since her divorce from her first husband. As a 38-year-old woman, she is now anxious to settle down and have a family of her own. The couple is also at different stages in terms of career development. Although Mr. A's employment is secure, he is feeling unfulfilled and is hoping to return to university next year. While Ms. N is satisfied with her career, her part-time contract position expires at the end of June and she has no further job prospects.

The lives of Dan and Sue, both school-age children now, have been in constant flux since their parent's separation at ages three years and four months, respectively. They are both involved with medical practitioners to address behavioural and psychosomatic complaints. Aside from the issues of abuse and neglect by their mother, as part of a remarried family they will need to work through issues of loss, divided loyalties, and belonging. The presence of Ms. N in the life of the family has added a measure of stability for them. Their schooling also contributes to their stability. Academically, they are functioning at an average level.

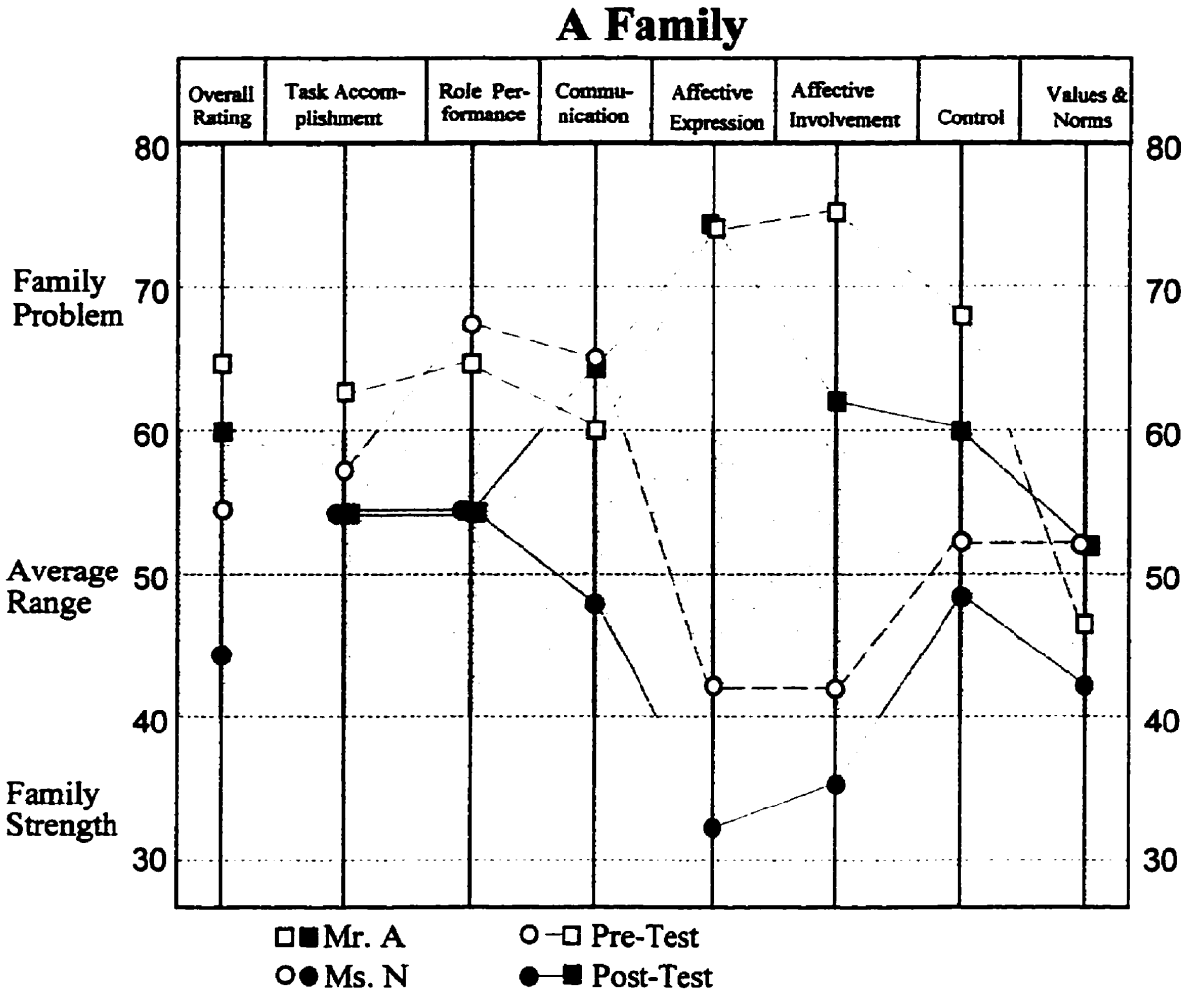
Role of the Symptom Bearer

The children's difficult behaviour has played a role in Mr. A's readily accepting Ms. N as a parental partner, and her involvement has given Ms. N a sense of purpose. While detouring their relational problems onto the children has given them a focus on which to build their union, the children's escalating behavioural problems are now threatening their stability as a couple subsystem.

FAM III Pre-Test Profile

The overall ratings of the completed Dyadic Relationships Scale (Figure 2) confirmed that problems existed. Only the Values and Norms dimension fell within the average range for both Mr. A and Ms. N. The couple's similarly high scores in Task

Figure 2: FAM Profile (Dyadic Relationships Scale)



Accomplishment, Role Performance, and Communication suggest their agreement on problems in these areas, namely an inability to respond appropriately to changes in the family life cycle, problems in task identification, lack of agreement regarding role definitions, and a lack of mutual understanding. Clearly evident was their disagreement in Affective Expression, Affective Involvement, and Control, suggesting a high degree of overall conflict. This corroborated my clinical findings that Ms. N perceives her level of involvement and control in the family as right and natural whereas Mr. A perceives Ms. N as overinvolved and too much in control.

Tentative Hypotheses

The development of the couple subsystem is being constrained by its pre-mature overlap with the development of a new family system, resulting in overly rigid boundaries between the couple at an affective level. The family's hierarchy requires renegotiation as it moves from a single-parent household to one with two parents. The necessity to fluctuate between these two family forms from weekdays to weekends, and Ms. N's shifting identities in three different households, has resulted in blurred boundaries and confusion of roles within the parental subsystem. The couple is struggling with issues of complementarity in which Ms. N has become overinvolved and Mr. A underinvolved. This has resulted in a power struggle between the two in which Ms. N's efforts to organize the family system is being stymied by Mr. A's choosing not to follow through on her directives. Due to Ms. N's alliance with her mother and her mother's relationship with Mr. A's children, this intergenerational boundary between the couple subsystem and the in-laws is blurred.

Goals

Two goals of intervention were indicated:

1) To strengthen the couple bond to protect it from other subsystems, namely Mr. A's children, the children's mother, and Ms. N's mother.

2) To challenge the couple's complementarity, and help them negotiate functional roles within the family system.

Interventions

Although the couple's original request for service was intended to include both of them, Ms. N's employment out-of-town now necessitated her exclusion from the sessions. Mr. A indicated his desire to proceed with therapy despite this, stating that Ms. N regretted her absence but was in agreement that therapy proceed. Mr. A attended with his two children for the first two sessions, and individually for the third. It soon became clear that the family's problem was located in the couple subsystem and would be difficult to address if Ms. N were not included in therapy. In order to make her inclusion possible, we contracted to meet in Mr. A's home on Saturdays approximately once a month to work on issues related to the couple subsystem. A total of ten sessions were held with the family; two sessions with Mr. A and the children at EHCC, one conjoint session with Mr. A and Ms. N at EHCC, one individual session for both Mr. A. and Ms. N, and five conjoint sessions in their home.

Because of the unusual nature of this situation at the start of therapy, the joining process began with a number of challenges. Ms. N's initial absence necessitated my joining with Mr. A individually, resulting in the creation of a therapeutic system without the involvement of a key player. I wanted to guard against the perception of my "taking sides" with Mr. A, yet at the same time I needed to show empathy with Mr. A, letting him know that I heard and understood what he was describing. In joining with him I searched for his competencies, citing his ability to have raised two very young children on his own prior to Ms. N's involvement and reframing this as an accomplishment, despite Mr. A's reports of her harsh criticism of his parenting and organizational skills . Knowing that I had successfully joined with Mr. A after three sessions, I faced the challenge of joining with Ms. N with the knowledge that if I could not do so, therapy would be unsuccessful. With the awareness that she was the couple's spokesperson, I invited her to share her

perspective of the family's problems. To my discomfort, my attempts at tracking developed into a rather lengthy diatribe of Mr. A's shortcomings as he quietly sat by and observed. I felt caught between the need to give Ms. N the "air time" she was entitled to in order to join with her, and the need to ally with Mr. A in what clearly had the appearance of a one-down position. As it turned out, joining with Mr. A prior to this conjoint session by emphasizing his personal strengths as an individual and parent, proved to be of critical importance in not losing him during this phase and it prepared the groundwork for the joining process with Ms. N. Despite my discomfort in allowing the temporary imbalance of power at the outset of this first conjoint session, it proved necessary in successfully getting Ms. N "on board".

What became almost immediately apparent in the first conjoint session was Mr. A's decreased involvement when compared with his individual sessions. I hypothesized that fear was driving the couple's dynamics and felt compelled to explore this further. Why was Mr. A afraid to assert himself in Ms. N's presence? Why did Ms. N appear so threatened by his passivity? By further exploring these questions, the couple was given the opportunity to verbally communicate to each other what was at stake if the relationship were to dissolve and what could be gained by nurturing its further development. It became clear that Mr. A felt it necessary to avoid conflict in order to keep Ms. N happy. Her unhappiness would, in his mind, trigger her departure and result in the loss of a good and capable partner and mother figure for his children. Ms. N explained that she was at this point very invested in this family, both emotionally and financially, and if she continued to feel dissatisfied with Mr. A and break off the relationship, she would lose this investment as well as the opportunity for a new chance at being a family and to bear her own children, something she very much aspired to. The couple's ability to verbalize these fears paved the way for the work that was required in getting them unstuck in their interactional pattern of complimentarity. To create

movement out of this entrenched pattern proved to be the working goal that defined the process in every subsequent session.

Even though their complimentarity was clearly a primary problem, I felt that in order to address it, the couple had to have an understanding of how their developmental stage was impacting on their ability to reorganize themselves into a new family system, and that the difficulties they were experiencing were normal for families in similar situations. I made the observation that they appeared very focused on parenting issues and paid little attention to each other. I encouraged them to focus on their relationship as a couple apart from their need to be a co-parents, helping them understand that a solid marital relationship is the key to a well-functioning family. We explored the nature of their social network, low-cost evening activities they could enjoy, and possible childcare options. Although it was a matter of many months before progress on this score became evident, they did show a desire to pursue activities without the children.

As a way to challenge the complimentarity, I reframed Ms. N's role as one of helper. I acknowledged the very important role she had with the children and the many positive results of her involvement with them, and that she was now deserving of a "vacation" from her parental responsibilities, adding that the geographic distance from the family during the week further added to her level of stress and frustration. She stated that this would be difficult for her to do, and I agreed, suggesting that Mr. A help her with this. I directed Mr. A to act on his authority as the children's biological father by taking primary responsibility for them. I encouraged him to articulate what the problems of the children were, what the possible solutions were, and then to act on these decisions. To facilitate Ms. N's "vacation" and Mr. A's more active involvement, we clarified new boundaries related to parenting by contracting to meet individually with Mr. A in the office to address parenting issues and his communication of those to Ms. N, and to continue to meet conjointly on weekends in the home to address their relationship, including their role as parents. They readily agreed to this, particularly Ms. N, who was

under the misguided assumption (until my correction of it) that I would help Mr. A become more organized, this being her primary goal for him.

Only one session was held with Mr. A individually. He painted a very positive picture of their home life, and the session was generally unproductive. It was becoming clear that the couple had not made significant progress and that I would have to "turn on the heat" in order to create movement by temporarily unbalancing the system by allying with Mr. A. I did this by challenging Ms. N's appearance of invulnerability and by challenging Mr. A's need to avoid conflict. While being supportive, I made reference to Ms. N's biological time clock and how much she needed Mr. A to fulfill her own personal dreams and desires of bearing her own children in the context of a traditional family. This in turn, empowered him to accept my suggestion that he was perhaps tired of having a "boss" and that he wanted some autonomy. This resulted in a heated dialogue between them, in which Mr. A raised his voice and for the first time vented his anger towards her over what he perceived as her overinvolvement. The session ended in Mr. A declaring that their problem lay in their confusion over their respective roles with the children and with household tasks. I felt that we had experienced a measure of success in creating movement, but I was concerned that the risk I had taken could backfire, creating an even deeper wedge between them. This fear proved unfounded when after a lengthier break due to the Christmas holidays, they informed me that they were once again formally engaged and were planning a June wedding. Mr. A stated that he was talking more and that they were enjoying each other's presence more. The children's biological mother had not been seeing the children in accordance with a new court order, and their behaviour was reportedly more manageable as a result. A good measure of dissatisfaction was still evident with Ms. N, however, so it was agreed that an individual session with her would be useful to explore her insecurity with lack of order, her personal fears and her vulnerabilities.

Ms. N described her family of origin with an alcoholic father and a mother who "always told everybody what to do". She acknowledged her similarities with her mother and stated that she found this "scary" and that she had to learn to "let go". But she was convinced that if she were to do this, the children would not receive the professional help they needed medically and educationally. She felt that Mr. A would not change in this regard and I attempted to help her understand that it was not her role to try to change him into a mirror image of herself but to accept him for his strengths and to nurture those, just as it was his role to do the same with her. This discussion was continued in the following conjoint sessions as I encouraged the couple to discover new aspects of themselves and each other. Because they were both involved in athletics, I used the analogy of the sports team in helping them understand how their relationship might function at its best. I challenged their competitive stance with each other by suggesting that they were not on opposing teams but rather on the *same* team, playing different positions, each depending on the other to create a winning play. They seemed to resonate with this image and it helped create an air of levity when it was needed.

Towards the end of the course of therapy, they appeared more reconciled to the need for flexibility and the mood in the house was noticeably less electric. A June wedding was being planned, Mr. A was pursuing acceptance into a professional faculty at the university, Ms. N had applied for a new position in town, and they were planning the children's baptism. Despite this increased stability, extrafamilial stressors would continue to challenge their adaptability. What if Ms. N did not find a job? Should Mr. A postpone his studies if she could not find stable employment? Serious behavioural problems persisted with Dan, despite professional involvement. How would they manage this as a couple? They recognized and acknowledged the serious hurdles ahead, but evidently felt equipped to meet the challenge.

Evaluation

In retrospect, several complicating factors at the outset of therapy with this family proved to be serendipitous. Considering the degree to which this couple was stuck in their pattern of complementarity, meeting monthly on a long-term basis was indicated from a treatment perspective and was also necessary from a practical perspective in order to accommodate their living arrangement. This contracting of time-frames proved to be ideal. Our need to meet in their home assisted me in my ongoing assessment while at the same time enhancing our joining together as a therapeutic system. Having joined with Mr. A prior to Ms. N's involvement proved to be a useful intervention in that it started a shift in the distribution of power between them. My alliance with him prepared Mr. A to assert his needs with Ms. N in subsequent sessions.

The couple bond had grown stronger during the course of therapy. The high degree of defensiveness observed initially was less evident. Their decision to get married was an indicator of the progress they had made, particularly considering that they had once before exercised their will to call off the engagement.

FAM Post-Test Profile

Positive change is indicated in the couple's post-test results (Figure 2). Mr. A's post-test results reflect an improvement in Task Accomplishment and Role Performance in decreasing from above average (weakness) to normal. Communication remained somewhat the same with a slight decline. Affective Expression remained the same in the post-test indicating a need to further address the couple's inadequate affective communication. The improvement in the Affective Involvement score is perhaps the most noteworthy. Its shift from the most problematic dimension in the pre-test to almost average in the post-test indicates either a significant improvement in the couple's complementarity or in Mr. A's acceptance of it. The Control score showed improvement, now falling within the average range, reflecting his perception of more

flexibility and fewer power struggles. Values and Norms remained relatively stable as the strongest dimension.

Ms. N's post-test results are noteworthy in that all the scores fell within the average to below average (strength) range. Improvement is indicated in every dimension, with the most positive change indicated in Role Performance and Communication, the two areas of Ms. N's strongest complaint at the outset of therapy.

The most obvious discrepancy in the couple's scores lies in the areas of Affective Expression and Affective Involvement, with Mr. A indicating these as the weakest dimensions and Ms. N indicating these as the strongest, suggesting that while Ms. N's needs in these areas are being met, Mr. A's are not, and that a rigid complementarity in this regard still exists.

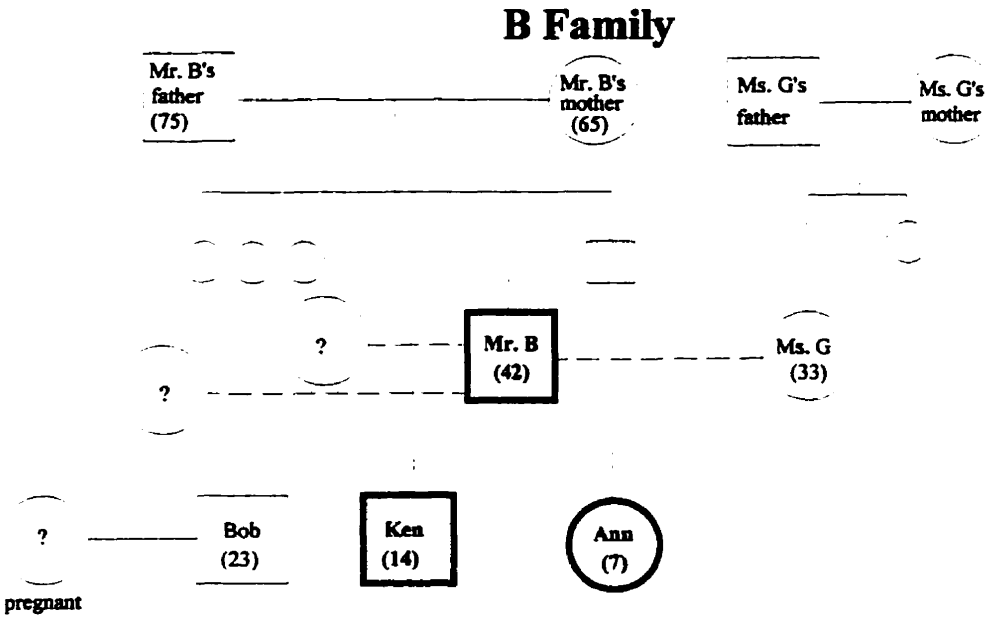
Client Feedback Form

Both Mr. A and Ms. N expressed satisfaction with the help they had received and both indicated some improvement as a result. The most notable change for Mr. A was in his ability to more effectively communicate and to "express my dissatisfaction without fear of abandonment". Most helpful for him was the role of mediator that the therapist could play and the confidence this gave him in speaking up. Ms. N indicated the most notable change for her was in her ability to let go of the "little things" which decreased the tension in the house as a result. Most helpful to her was her new-found ability to look at herself differently. Both indicated no specific problems with the help they had received and reported their willingness to recommend their therapist to others.

The B Family

The B's are a single-parent, middle-class family (Figure 3). Mr. B (42) recently left his common-law wife of eleven years, taking with him his two younger children, Ken (13) and Ann (7). His oldest son, Bob (23) lives independently with his girlfriend. Mr. B and Ms. G reportedly had a difficult relationship. Mr. B and the children were allegedly

Figure 3: Genogram



subjected to emotional abuse by Ms. G. An escalation of physical violence towards the children prompted Mr. B to remove himself and the children from the family home and make a report to Child and Family Services (CFS). Ms. G was subsequently charged on three counts of assault causing bodily harm. At the time of the first intake interview, Mr. B had been granted primary care and control of the children and the family home, but all further legal dispositions were pending.

Presenting Problem

Mr. B was referred by a CFS worker for family therapy. Ken had a history of behaviour problems (diagnosed ADHD and on Ritalin until two years ago), and was beginning to "act out" at home and at school. His grades were falling behind. The fighting between Ken and Ann was increasing in frequency and severity. Mr. B was feeling out of control with his children, but was also concerned about the psychological damage that may have resulted from the abuse as well as from the marriage break-up.

Assessment

The initial assessment was completed after five sessions, each with different subsystems--Mr. B individually, Mr. B and Ann, and Mr. B, Ann, and Ken. Two factors prolonged the information-gathering phase: 1) Mr. B's need (as requested by him) for individual sessions during this time, and 2) Ken's reluctance to attend sessions.

Structure

The B's are a single-parent family with many subsystems. Each of the three children stem from a different relationship, yet Mr. B has had sole custody of Bob (as a child) and Ken, and for the interim, of Ann. Bob is estranged from his mother (whom he met this past summer for the first time since infancy), and Ken spends every second week-end with his mother, who is remarried with a 17-year-old son. Ann would welcome some contact with her mother, however, Ms. G is currently legally prohibited from communicating with her. A rigid boundary exists within the parental subsystem. Due to the very high degree of marital conflict, no direct contact exists between Mr. B and Ms.

G, which could likely jeopardize their ability to establish a workable parenting relationship with regards to Ann when this becomes legally possible.

Each family member, as an individual subsystem, is experiencing stress. Mr. B, who had initiated the family's dissolution, appears overwhelmed and discouraged, yet has shown a measure of strength in reaching out for help. Not only has his role within the family system expanded, but roles with extra-familial systems have been added, including the children's schools, CFS, the police, the legal system, and the family therapist. Ken, although relieved that his step-mother has been removed from his system, feels anger towards her, and feels the pain and lack of self-esteem of having been her victim. Ann is feeling the confusion of having been hurt by her mother, yet at the same time, having been physically separated from a parent who also took care of her. Added to this trauma is the child's inability to know when she will see her mother again or what will happen to her.

The family system as a whole has suddenly been thrown into a new living arrangement where the former unwritten rules and the former hierarchy no longer apply. Although Mr. B is attempting to establish rules consistent with a parent-child hierarchy, he finds it difficult to exert his parental role as authority figure, making the boundaries between himself and the children unclear. The children appear to be testing the boundaries by creating a power struggle, as evidenced in their unwillingness to cooperate in household chores and the constant fighting between Ann and Ken. Mr. B's ability to be nurturing and resourceful, and to express affection and concern, and to organize recreational activities is clearly evident. The boundary of the family system as a whole has been opened up to the scrutiny of many other formal systems (as mentioned earlier), thereby complicating their ability to adapt to a new family structure.

The sibling subsystem is under stress and the boundaries between them slightly rigid. Because Ken felt unequal treatment from Ann's mother, he feels a resentment towards his sister. Ann teases her brother, yet admires him and shows affection for him.

Ken identifies some of Ann's character traits as similar to her mother, yet hesitates to admit it openly. Ken has often helped Ann with her homework, but recently has shown less interest in this, to Ann's disappointment. Bob, who moved out three years ago, reportedly has a good relationship with both Ken and Ann. Both are quick to state that they like him and enjoy his occasional visits.

The parent-child subsystems are distinct, each having a separate history. Ken resents having been subjected to abuse by his stepmother and Mr. B feels guilt for not having "rescued" Ken sooner. This guilt adds to Mr. B's feelings of powerlessness with Ken, consequently jeopardizing his ability to set limits for Ken. Ann, a precocious child, is testing the boundary with her father by regularly insisting on her own way. She also plays the role of problem-solver when Mr. B and Ken get into an argument. This evidence points to a power hierarchy which is currently under duress. Whereas Mr. B is attempting to establish his authority, the children's inordinate amount of power is making this difficult to achieve.

Clear cross-generational boundaries are evident. Mr. B's parents, who live in the neighbourhood, have taken on a more central role with the family since the marriage separation by helping out with the instrumental tasks around caregiving. For instance, they provide supervision for Ann during the lunch hour, and are available on weekends and evenings for childcare, and have the family over for meals. There is no evidence to suggest role confusion between Mr. B and his parents. They appear to respect his rightful place as the children's parent. Mr. B's sister, who lives two blocks away, provides social contact as does her seventeen-year-old son. Mr. B reports having a good relationship with all of his siblings.

Flexibility

The B family system is in the process of reorganizing itself after a long period of reported chaos and ultimate crisis. The family configuration is new, making existing behaviours and patterns of interaction open to suggestion and change. Mr. B is pursuing

help for his family (as he has in the past for himself and for Ken) in order to prevent more negative fallout from their previous chaotic family life. Unfinished legal business challenges the family subsystem to be ready for the unexpected as the process unfolds regarding criminal charges against the children's mother/stepmother and custody and access issues between the parents.

Cohesion

Even though the family and its subsystems have undergone undue stress and a resultant crisis, an emotional attachment between members is clearly evident. Mr. B's attachment is different with each of his children in keeping with their developmental stage, but also in keeping with their distinctive needs with respect to the departed family member. Ann, being younger, more dependent, and physically separated from her biological mother, requires a stronger connectedness with her father. Because Ken's relationship with his biological mother remains unchanged, and he is beginning to test his autonomy as a teenager, the resonance of his relationship with his father differs from that of Ann's to reflect the stability of his relationship with his mother and his growing need for more independence.

Life Context

The B's, after having been a remarried family for eleven years, are suddenly a one-parent family set adrift in a legal battlefield in two courts of law--criminal and family. Their environment includes both sources of support and stress. The sources of support include Mr. B's parents, his oldest son, Bob, and his girl friend, a friend of Mr. B's who is a police officer, the children's teachers, and the therapeutic system. This support helps alleviate the stress induced by the ongoing legal proceedings. Although Mr. B has work contracts (which provide financial support), the external stressors, with their intendant obligations, constrain his work time, this in turn, causing more financial stress in the face of mounting legal fees. Extensive home renovations begun prior to the separation are at a standstill, adding a degree of physical discomfort to daily living and increased pressure on

Mr. B to complete these projects. Mr. B's estranged wife is a source of stress when she tries to communicate with Ann through her own parents who phone the house to try to speak to her.

Developmental Stage

The B family is in transitional crisis related to the break-down of a common-law marriage. Major individual adjustments must be made at the emotional level as it adjusts to the upheaval of the separation, and at a practical level as it deals with problems associated with adjustment to a new lifestyle (Stern-Peck & Manocherian, 1988). The household and parenting tasks once carried out by Ms. G must now be carried out by Mr. B and the children in age-appropriate ways. These adjustments have interrupted the family's developmental tasks and have resulted in chaos and disequilibrium in the entire family system (Carter & McGoldrick, 1988).

The dissolution of the family has taken place during its adolescent phase of development, with Ken experiencing the physical, psychological and relational changes normal for a fourteen-year-old which move him towards solidifying an identity and establishing autonomy from the family (Garcia-Preto, 1988). The B family must redefine the terms of the parent-child relationship regarding issues of Ken's autonomy, responsibility, and control. This will require the flexibility of family boundaries and a change in Mr. B's parental authority to permit Ken greater independence and developmental growth (Garcia-Preto, 1988). Mr. B's task at this stage is to retain control while at the same time "being objective, supportive, and democratic" (p. 263), a task that he is finding very difficult.

The strengthening of the boundaries between Mr. B and Ken, a structural change fundamental to this stage of development, must also be considered in the context of the abuse Ken experienced by his stepmother. The developmental task of separation could be perceived by Mr. B as Ken distancing himself out of anger towards him for not having rescued him sooner, while Mr. B is wanting emotional closeness as reasurrance that

everything is OK. On the other hand, the task of separation might have been made easier by the departure of Ken's stepmother whose abusive parenting would have interfered with his development. In this sense, Ken is experiencing a sense of closure rather than the need to grieve the loss of a parent like his sister is.

Ann is grieving the loss of her mother from the family home. She has also been hurt by her, but unlike Ken, continues to feel a sense of loyalty towards her. She finds herself in the middle of her parents' bitter conflict, and may be feeling a sense of guilt for having given a statement to police regarding her mother's abusive behaviour. The confused feeling of loyalty and betrayal of trust would further compromise Ann's ability to adjust to the new family structure.

Elementary school-age children like Ann benefit from time given to processing the idea of their parent's separation (Stern-Peck & Manocherian, 1988). Because of the family's hasty departure from the home and the chaotic circumstances surrounding it, preparing for the event was not possible. Adding to this confusion is her fear for her mother's well-being and the fear related to not being allowed to see her or talk to her at the present time.

Mr. B's developmental task is to resolve the emotional attachment he had for Ms. G. This process began well before the physical separation, but the intense ongoing conflict, illustrated by his inability to talk with her, will require resolution for the sake of Ann's adjustment. Mr. B must retrieve a sense of self that will enable him to carry on as a single-parent (Stern-Peck & Manocherian, 1988).

Role of the Symptom Bearer

Several interpretations of the children's role as symptom bearers present themselves. The children's difficult behaviour may play a role in maintaining the family's transactional patterns that they have grown accustomed to. Even though these patterns were abusive, they are familiar to them. Ken's escalating behaviour problems may be serving his need for his father's attention, in view of his having felt disbelieved by his

father about the abuse he suffered from Ms. G. His misbehaviour could also help to diffuse any conflict between Mr. B and Ann as a result of the separation between Ann and her mother by deflecting attention onto himself. Ann, by testing her father's control over her, may be inviting her father to prove himself as a capable father--as capable as her mother was in controlling her. By focusing on the children's need for a therapeutic response to their having been harmed physically, emotionally, and psychologically by their mother/step-mother, Mr. B is detouring his own needs as an individual who has also been victimized. His focus on the children's needs may afford him a measure of protection from self-examination of his own role in the troubled family.

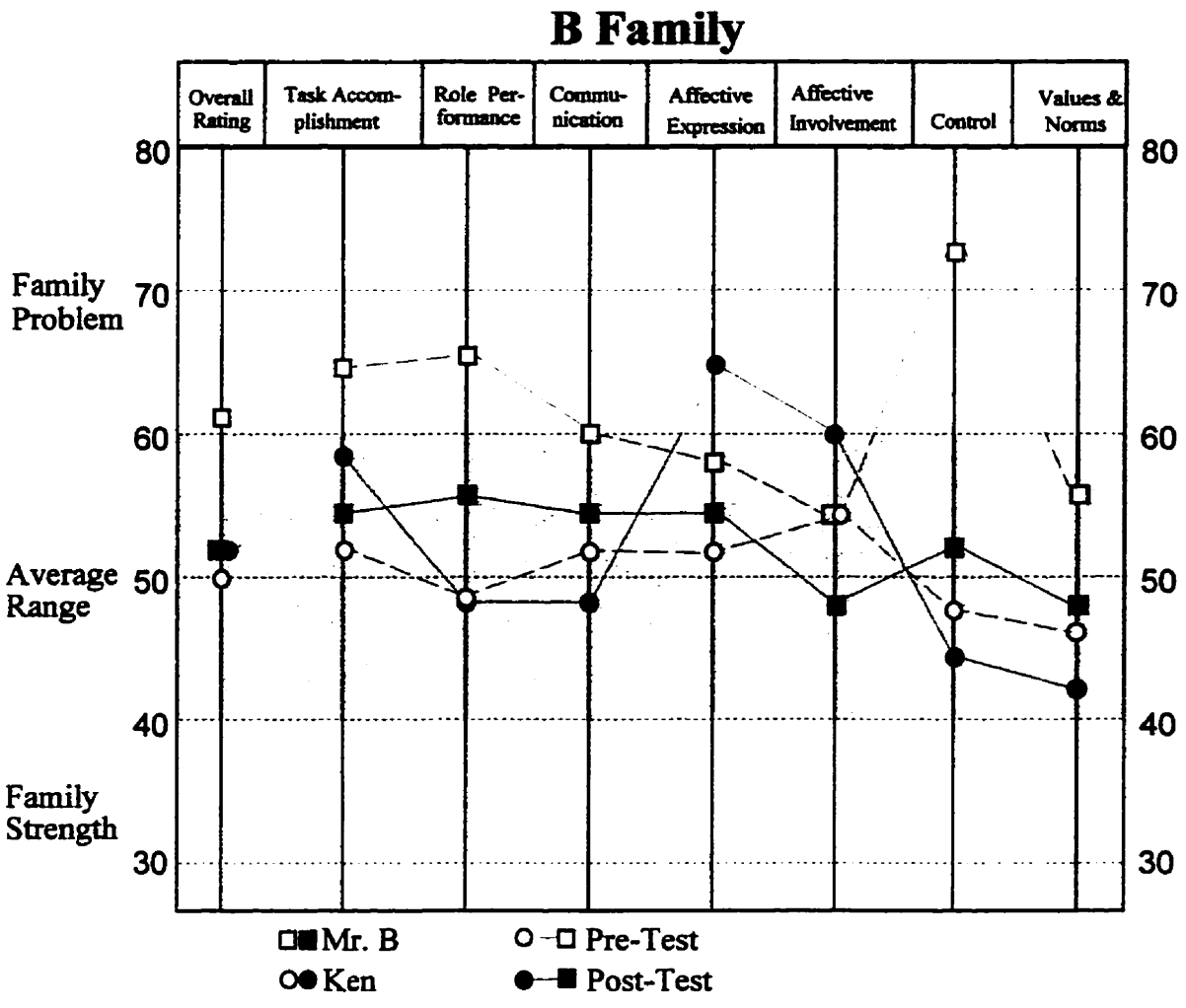
FAM III Pre-Test

The General Scale was administered to Mr. B and Ken (Figure 4). Ann was excluded from completing this measure due to her young age. All of Ken's scores fell well within the average range. His results indicated his satisfaction with the way the family related to each other, however, his inability as an adolescent to recognize how his behaviour impacts other family members should be considered, as should his almost certain comparison with his pre-separation familial experience. His Social Desirability score, slightly above average at 54 (not shown) could point to a problem with validity whereas his Defensiveness score of 50 (not shown) does not. Mr. B's results indicated problems in the areas of Control, Role Performance, and Task Accomplishment. The discrepancy between the results pointed to possible discord between father and son. These findings corroborated my clinical assessment. His Social Desirability and Defensiveness scores of 42 and 40 respectively (not shown), suggest the results are valid.

Tentative Hypotheses

The B family structure is in transition from a remarried family to a single-parent family. Each subsystem (individual, parental, parent-child, and sibling) is being challenged to adapt to new roles and new transactional patterns. The psychological trauma resulting from abuse and separation, and the subsequent legal proceedings, are

Figure 4: FAM Profile (General Scale)



compromising the system's ability to adapt to the new structural context. The children's escalating behaviour problems are symptomatic of an ineffective power hierarchy, lacking adequate authority in the parental subsystem and too much power in the sibling subsystem. The structural disruptions of moving to a single-parent household are overlapping with the adolescent phase in the family life cycle, further complicating the family's ability to readjust.

Goals

The goals of therapy for the B family were fourfold:

1) To create clear boundaries between the parent and child subsystems.

2) To help Mr. B exert his authoritative role as parent.

3) To strengthen the sibling subsystem.

4) To support each member in processing issues related to family violence and separation in order to strengthen their ability to adjust to a new family structure.

Interventions

I met with the B family for a total of 18 sessions between October and May. An element that set this case apart from the others during the assessment phase was my difficulty in contracting with Mr. B. I came to realize through reflection and supervision that this clinical dilemma on my part reflected the multiple levels of chaos that the client was experiencing and the urgency with which he desired change for himself, his children, and the family as a whole. It was after my recognizing the confusion with the various layers of work required, that I was able to explore this with him and deliberately contract to engage in family subsystem work.

Joining with the B's was a gradual process. Meeting with Mr. B individually for the first two sessions gave us time to develop an understanding for each other and gave him time to develop his trust in me as their potential helper. I was given the opportunity to empathize with his situation and ask sensitive questions which would have been

inappropriate in the children's presence. From an assessment perspective, his requesting several individual sessions at the beginning indicated healthy parent-child boundaries.

These individual sessions also provided the opportunity to confirm Mr. B's sense of self as a single parent, understanding that his role in the family would be strengthened if his self-respect was confirmed (Fishman, 1988). Even though he had taken the step to remove himself and the children from a bad situation, he was now faced with increasing stresses of a different sort. By my reframing his move as a courageous act, he was able to see himself in a different light and felt bolstered during bouts of feeling defeated. My corroboration and support of him as the single-parent were a defense against the occasional doubts he had about what was correct or appropriate.

A good portion of our time during individual sessions was also spent on issues related to the difficult and complex overlap between criminal and family law. Ms. G had been charged with three counts of assault, and while these criminal charges were pending, the family court was proceeding with determining visitation rights. Feeling disempowered by the legal system, Mr. B would find a measure of relief in venting his frustrations in our sessions. Simultaneously undergoing a court-ordered family assessment, added to his burden of meeting more scheduled appointments and opening up wounds yet again. Added to this was the pressure of maintaining his and the children's best appearances under the scrutiny of an impartial party.

When Mr. B began to request Ann's participation in therapy, followed by Ken, it indicated to me that our joining process had been successful. A limited amount of work was directed at acknowledging and dealing with the abuse that the children had experienced, and took place in Mr. B's presence. Ann required much sensitivity on my part in eliciting her expression of conflicting emotions about the marriage break-up and her mother's criminal charges. My engaging her in drawing and writing out her responses on paper also served to model a communication technique for Mr. B who was very concerned that she was not talking about these things. The "Nurturing Game" was a

good joining tool for Ann but also proved to be a valuable communication tool in a later session with all family members. Acknowledging the abuse that Ken had experienced was essential in beginning my work with him. I arranged for this to take place in Ann's absence in order to relieve him of his need to protect her. Knowing that he had received psychotherapy in the past to address these issues, and that my focus of attention was the family as a whole, I dealt with the impact of the abuse on family relationships. Ken responded well to humour, and although Mr. B had been skeptical that Ken would agree to participate in family therapy, he cooperated fully in the session. In joining with Ken I explored his personal interests and competencies in an effort to build on his sense of self-worth. Although he did not attend further sessions at EHCC, he responded positively to several in-home sessions that were introduced several months later.

Normalizing the family's experience was necessary to alleviate the initial tension. I directed normalizing statements to each of them individually. To Mr. B, I stated that considering the upheaval and emotional torment that he had come through, his feelings of stress, frustration, guilt, and exhaustion could certainly be understood. Ken's testing the boundaries of behaviour by acting out was normalized by defining this as both age-appropriate and not uncommon among adolescents who have experienced abuse. Ann's inability to talk about her experiences was normalized for her by helping her communicate in age-appropriate ways and by helping her understand that having "mixed-up feelings" about her mom was O.K. I reassured them that a measure of general chaos could be expected after the dissolution of a firmly established family pattern, even though that family pattern had also been chaotic.

At approximately the midpoint of the course of therapy, I had seen Ken only once together with Mr. B and Ann and it was unlikely that he would return even though he had reportedly been satisfied with the session. I offered Mr. B the opportunity of in-home sessions in order that Ken could be included and in order to effect more immediate

change from within the family's environment. His openness to this idea resulted in family sessions in the home and his individual sessions in the office.

Allying with Mr. B as a parent was the common intervention in all family sessions. This was a structural maneuver aimed at shifting the distribution of power from the children to the parent. This included backing up Mr. B in his role as rule setter during family sessions by inviting him to speak authoritatively and explicitly with his children, and by providing parenting education during our individual sessions.

Time was given to clarifying boundaries between and among subsystems. The issues of who would do what, when, and how were made even more critical when Mr. B's oldest son, Bob, moved into the family home with his girlfriend. A family session around the kitchen table facilitated this very well. Each member was supported in finding their age-appropriate, functional place in the system and in communicating both their emotional and instrumental needs to each other. It was clarified that Mr. B's position as leader of the household did not change even though there now were two additional adults in the family home who were occasionally called upon to be in charge during his absence.

Family members were given the opportunity to discover new aspects of themselves. I nurtured this by helping each individual see the successes they were experiencing--Mr. B as a person and a parent, Ken as a son, brother, grandson, friend, and student, and Ann as a daughter, sister, granddaughter, friend, and student. An in-home session which included Mr. B's mother gave evidence of their movement towards positive change. "Grandma" stated that she had observed great improvement in the way the children cooperated with her and with each other during times when she was put in charge. Mr. B, in turn, agreed that there had been a fifty-percent improvement and that he was expecting that to increase to eighty-percent. They were evidently changing their perspectives from that of being a chaotic family with problematic children to that of being not only a family experiencing a measure of success, but of being capable of much more. For the children to hear this was most likely a pivotal moment for them.

I manipulated the family's affect as a technique on two occasions each of which were intended to shift power to the parental subsystem. The children were accusing their father and their grandmother of being "mean" when carrying out executive tasks such as assigning responsibilities to Ken or instructing Ann in the outdoor clothing she needed to wear. The children's tactic was paralyzing Mr. B and his mother in fear that the children would perceive them the way they had perceived their mother and step-mother or that they would arrive at school in an emotional upset, thereby putting them in a bad light as caregivers. I utilized this dynamic by becoming playful and exaggerating the children's accusations, all the while knowing that they were bluffing. Amid their smiles, I invited the children to express how they really felt about their father and grandmother--that they were in fact kind, caring, and generous individuals. Mr. B expressed to me in a later session how freeing it had been for him to understand how the children were "playing" him, and that he could now exert his rightful authority with more self-confidence and with a lessened preoccupation with making a bad impression with the school.

Tension between family members had eased noticeably by March. They were not arguing as much with each other, and Mr. B's complaints about the children's resistance to household tasks diminished. Stabilizing the family system gave them the ability to better cope with the stress generated within extrafamilial systems which became more complex with time. For example, Mr. B expressed increased dissatisfaction with his legal counsel, Ms. G appeared to be "gathering her forces" and devising new tactics for the custody dispute, and the parental supervisor's inability to stay within the boundaries of her role during visits between Ms. G and Ann aroused Mr. B's suspicions and anxiety. His sense of needing to be ever vigilant and on guard took a heavy emotional toll.

Although a measure of progress had been made, closing with the B family felt premature for them and for me. They had come a considerable distance in their shift to a new family arrangement, but we were aware of the enormous challenges that lay ahead for them. Mr. B's request for referrals for both himself and Ann testified to his

determination to build on the growth they had come to experience. He registered for a general parenting course through CFS and expressed interest in attending a course relating specifically to adolescents as well. I informed him of a support group for abused men which he promptly contacted, requesting that his name be placed on a waiting list. A primary concern of his continued to be Ann's need to talk to a counsellor around issues of being in the middle of a parental dispute, anticipation of her mother's trial, and the complicated visits with her mother. He also wanted Ken to receive therapy with respect to his abuse history and was hoping to connect him with the psychologist he had seen in the past. I provided him with names of several agencies that could meet these needs.

Evaluation

I had observed considerable positive movement within this family over the seven-month course of therapy. There was less tension in the home, instrumental tasks were better organized, Mr. B had attained increased respect from his children in his role as parent, and the children's fighting had decreased. Mr. B presented as generally more self-confident than he had at the outset. Perhaps his comment that family life sometimes felt very natural now--as if "it had always been this way," was the best indicator of improved family functioning. Ken continued to experience difficulty at school, with the possibility of having to repeat the school year, however, it was Mr. B's feeling that "he would be OK".

FAM Post-Test Results

The General Scale was administered at termination with Ken and Mr. B (Figure 4). Whereas Ken's results had initially been well within the strength area, and possibly distorted to a degree, they now reflected a more realistic picture, yet still within the average range with the exception of Affective Expression, an indication of inadequate or overly intense affective expression. His Social Desirability and Defensiveness scores (not shown) each increased by two points to 54 and 56 respectively, suggesting a slight distortion, although still within the average range. Mr. B's results showed improvement

in all categories, but most importantly in the Control dimension which was initially the most problematic. There was little discrepancy between the dyadic scores, and the overall ratings were identical at 52, indicating a symmetry in their perception of their family's functioning. His Social Desirability score (not shown) increased from 42 to 48 and Defensiveness score (not shown) increased from 40 to 50. The increases still fall within the normal range and therefore do not call into question the validity of his results.

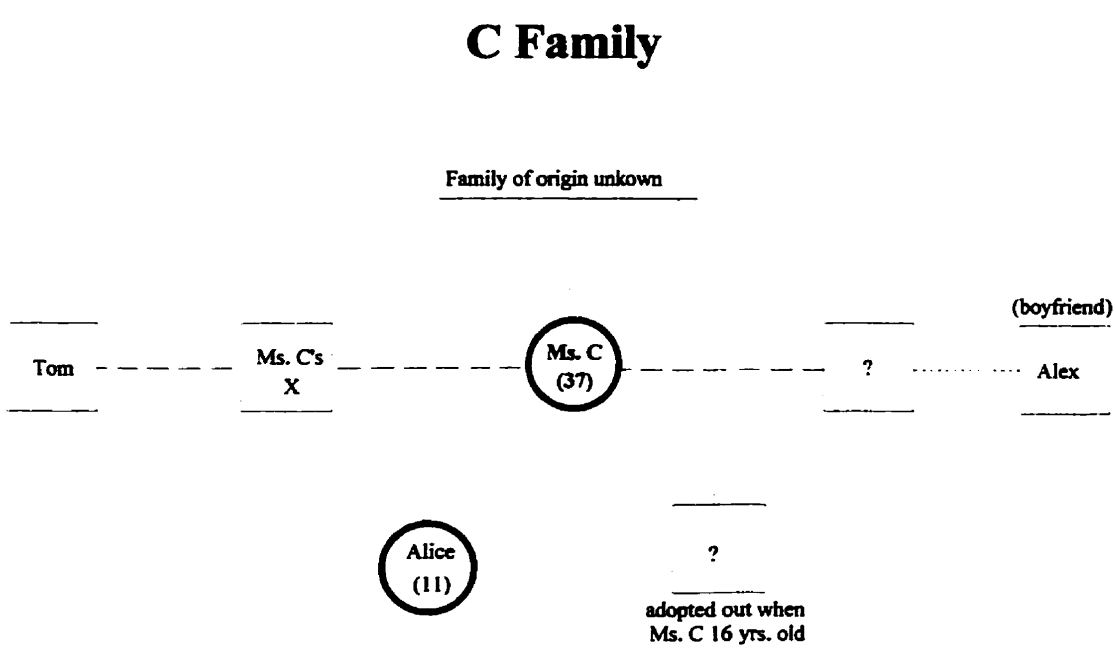
Client Feedback Form

Mr. B completed the Client Feedback Form in which he indicated being very satisfied with the therapy he and his family had received. He noted very much improvement in their situation as a result, the biggest change being their ability to understand each other better, to take time to listen to each other, and generally "get along better". Mr. B stated that the most helpful aspect of therapy was for his children to come to understand that talking to a therapist can help them solve their problems. He appreciated the "caring and respectful" way that all three of them had been dealt with, particularly knowing how difficult it had been for the children to participate at the outset.

The C Family

The C family consists of a mother (37) and her daughter Alice (11) (Figure 5). Until three months prior to the referral, they had lived for eight years with Ms. C's common-law husband, Tom, a man addicted to alcohol and, reportedly, both verbally and emotionally abusive toward them. Ms. C's first husband, and the father to Alice, left the family soon after her birth and has since had limited and inconsistent contact with Alice. Ms. C is employed six days a week in a low-wage job which keeps her away from home until 7:00 in the evening. She had received help from the school social worker who in turn involved Child and Family Services. The CFS worker referred Ms. C to the Elizabeth Hill Counselling Centre for family therapy after their attempt to provide an in-home support worker for Ms. C proved unsuccessful.

Figure 5: Genogram



Presenting Problem

Since moving out on their own, Alice's behaviour had become very difficult at home, at school, and in the neighbourhood. She was easily triggered to lash out physically at other children, the most recent incidents at school resulting in four weeks of suspension. Being unsupervised at home, she had several run-ins with a group of adolescents who had entered the family home, threatening Alice and trashing the apartment. Alice had spent occasional nights elsewhere without her mother knowing her whereabouts. Ms. C felt incapable of handling Alice and feared that her stress level was impacting her work and that she may ultimately lose her job.

Assessment

Structure

The family system consists of a single parent and daughter dyad. The system is in chaos with very few rules governing its transactions. Absence of a parent-child hierarchy is evident. The boundary between Ms. C and Alice is blurred resulting in a skewed system of an ineffective parent and a powerful child. Alice refuses any directives from her mother and Ms. C feels incapable of controlling her daughter's behaviour. A pattern of complementarity is evident in their ability to accomplish tasks, i.e., Ms. C does everything and Alice does nothing to contribute to household maintenance. Verbal communication patterns fluctuate between intense anger and loving concern from hour to hour and day to day. Verbal fights are an increasing problem but are tempered by regular physical acts of affection by Alice towards her mother. Mother and daughter write loving notes to each other every morning as a way of connecting after Ms. C has left for work. Despite the occasional show of affection, there is evidence of a complementary pattern of victim (Ms. C) and abuser (Alice).

Ms. C is in a relationship with Alex, a man she befriended while still living with Tom. He spends every weekend and occasional evenings during the week with them. Ms. C admires Alex and questions why he would be interested in her. He does not get

involved in the parenting directly, yet reportedly encourages Ms. C to be more authoritative with Alice. Alice, on the other hand, resents Alex's presence and blames him for Ms. C's limited time with her. Alex, however, likes Alice as evidenced by his reported patience with her and his gifts to her. Despite Alex's overtures and demands for more of her time and attention, Ms. C is not ready to commit herself to this relationship and is attempting to maintain as much independence as possible, but finding it difficult to maintain a clear boundary between the family system and Alex. Because Ms. C feels the pressure to defer to the needs of both Alice and Alex, she lacks sufficient differentiation to constitute herself alone as a functional subsystem. Both Alex and Alice are invading her personal boundaries.

A rigid boundary exists within the father-daughter subsystem. Being alcoholic and involved with another family unit, Alice's biological father is unavailable to her, a reality which Alice finds very hurtful. A rigid boundary exists between the parents. Communication between Ms. C and Alice's father is infrequent and conflictual, further complicating the parents' ability to arrange visits. Ms. C knows how much these visits mean to Alice, but would just as soon not have them take place due to the reported negative influence her father has on her.

The family system is involved with multiple formal systems. The boundary between family and school is rigid. The boundary between family and CFS is flexible yet problematic in that Ms. C's expectations of help are not being met. The boundary between Ms. C and her employer are rigid and possibly tenuous as family stress jeopardizes her ability to perform her job effectively.

Flexibility

The system is currently underorganized. The family's premorbid patterns of mother-daughter interaction are no longer functional in this new system. Because Ms. C and Alice were both controlled by Tom until their separation, Ms. C has never learned to exert parental authority, nor has Alice experienced her mother in this role. Ms. C claims

an inability to assert herself with Alice but is reaching out for help with this. Alice's tolerance for having her mother in charge is limited. Her insolent behaviour with her mother and her violent outbursts at school are a recent phenomenon. Her ability to show a sense of caring and affection, however, suggests that positive change is possible.

Cohesion

The boundaries between Ms. C and Alice are enmeshed as a result of having lived under Tom's power and control for eight years. They have been each other's only source of love and affection and have developed a relationship resembling a sibling subsystem. Alice claims that her mother tells her everything. Ms. C's involvement with Alex is, therefore, putting stress on this sibling-like system.

Life Context

Ms. C's own history is fraught with separations and losses. She was fostered in multiple homes since birth and gave up a child for adoption at the age of sixteen. She met one of her biological sisters a few years ago, but they reportedly have little in common and contact is infrequent. Ms. C has occasional contact with Alice's father and his family but this is usually of a stressful nature. Child support payments are minimal (approximately $150.00/month) and inconsistent. Ms. C is still on speaking terms with Tom, who lends her his vacuum cleaner when she needs it. A girlfriend lives a block away but she is not an instrumental or emotional resource for her. Ms. C and Alice spend a lot of time at the neighbour's where they often eat or simply "hang out". Alex provides the most consistent support, yet Ms. C complains of being "smothered" by him at times.

Ms. C's work, while it does provide an income, is a source of much stress. The hours are long, the shifts are split, the wages are low and do not cover her living costs. She uses the bus for transportation which adds to her hours away from home. Ms. C has insomnia which can last for days, compromising her ability to cope at home and at work.

Developmental Stage

The C family is in a transitional crisis related to the dissolution of a common-law relationship. Ms. C and Alice are beginning a life apart from Tom, an alcoholic man who has kept them on a "short leash". They are experiencing freedom from this former reality at an emotional level, while simultaneously attempting to make adjustments at a practical level (Stern-Peck & Manocherian, 1988) in terms of reduced income, new housing, and new responsibilities associated with parenting. They are experiencing chaos and disequilibrium as a result (Carter & McGoldrick, 1988). New rules pertaining to who will do what and when have not yet been established. Alice runs away at times to escape the conflicts at home.

This transitional crisis is interrupting the tasks associated with the family's adolescent phase of development. Alice is at a stage marked by her growing definition of her individuality and her desire to establish her autonomy by spending more time in social activity outside the home with peers (Carter & McGoldrick, 1988; Garcia-Preto, 1988). What makes her development somewhat unique is that her sense of autonomy has been triggered very suddenly rather than developing gradually with time. The absence of Tom, a step-parent who had tight control over her, has given Alice a sense of unguarded freedom to test the boundaries with her mother, school authorities, and school mates. Ms. C's expectations of Alice also require a natural evolution in keeping with her increased autonomy, however, she is unable to determine how much accountability to demand or what her expectations of Alice should be, a task made even more difficult by her history with Tom. Unlike the stages of normal family development, Ms. C must learn how to exert parental control (a new task for her) while at the same time, incorporating more flexible boundaries.

Ms. C, in her development as a single parent, must retrieve a sense of self that will enable her to carry on as a single-parent (Stern-Peck, 1988). This task is complicated by the trauma she endured from the psychological abuse over many years.

Lacking a network of peers, she is now leaning inappropriately on Alice for emotional support (Stern-Peck & Manocherian, 1988). Her parental tolerance is also low because Ms. C was never able to experience emotional autonomy from her own parents, having been raised in foster homes as a child and group homes as an adolescent and teenager (Garcia-Preto, 1988).

Ms. C is feeling overwhelmed and frustrated by the tasks of single-parenting and adolescence and struggles with wanting to give up all responsibility by asking CFS to take control (Garcia-Preto, 1988) by removing Alice from the home.

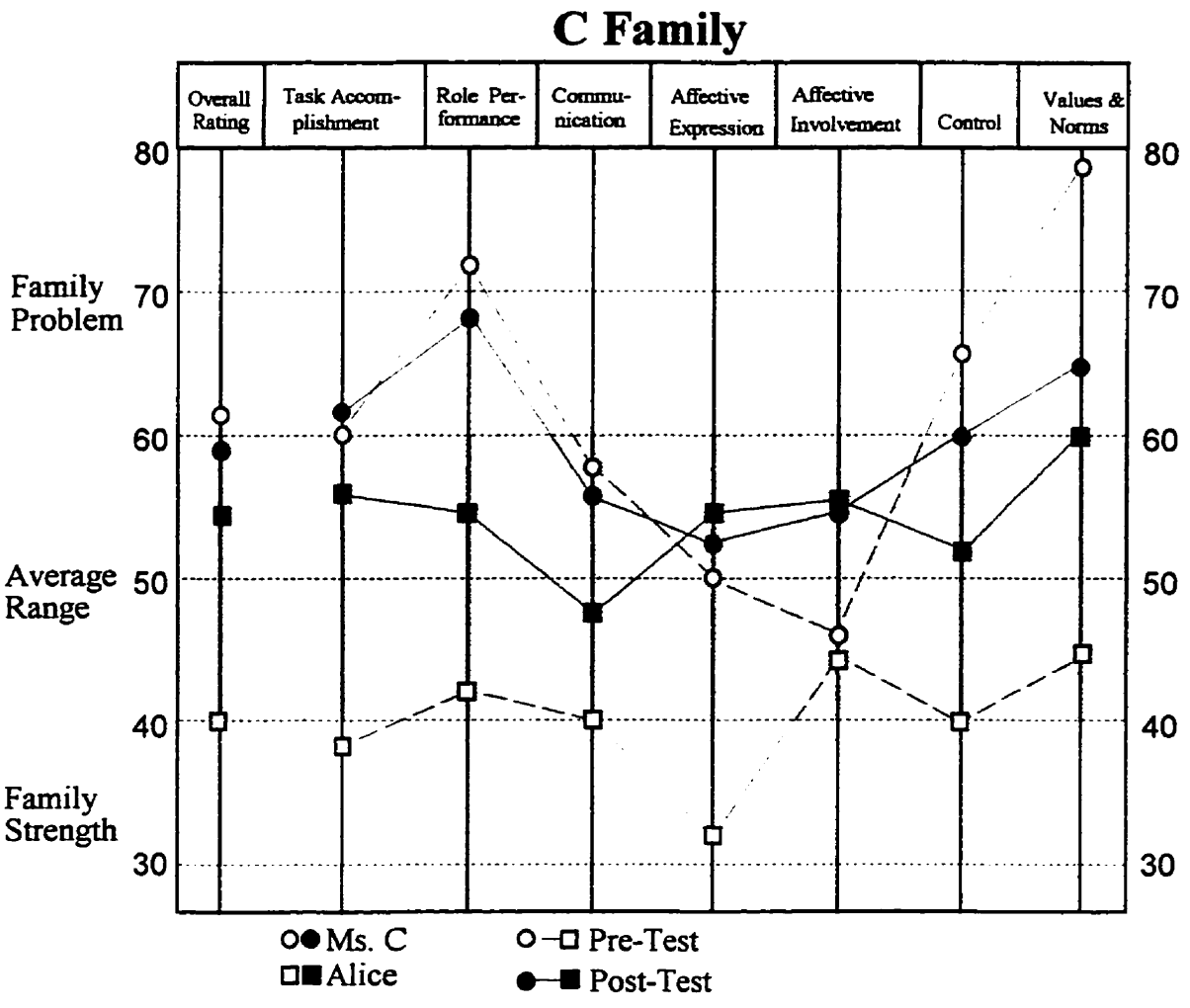
Role of the Symptom Bearer

By focusing on Alice as the problem, Ms. C is detouring her own issues of ineffective parenting. The power that Alice has over her mother, further reinforces her central position in the dyad. Ms. C's capitulation to her, in turn, reinforces her need to detour onto Alice.

FAM III Pre-Test

The results of Ms. C's pre-test using the Dyadic Relationships Scale (Figure 6) indicate problems in the areas of Role Performance, Control, and Values and Norms. This corroborates with my clinical assessment of the lack of an effective power hierarchy resulting in considerable role tension and conflict, lack of parental control, aggressiveness, and a dissonance in the family's value system which causes confusion and tension. Ms. C's scores in Communication, Affective Expression, and Involvement fall within the average range, suggesting her comfort with a high degree of affection and involvement with Alice. Alice's results are noteworthy in that they all fall well within the range of family strengths, underscoring her inability to understand the operations of a functional family structure, and possibly her inability to understand the questions. Because of the absence of the Social Desirability and Defensiveness scales in the Dyadic Relationships Scale, the validity of the scores were not assessed.

Figure 6: FAM Profile (Dyadic Relationships Scale)



Tentative Hypotheses

This is a family fractured by domestic violence. Leaving a bad situation has opened up opportunities for positive change, but also for a compounding of many stressors in all the family's internal and external systems. The inherent structural problems in this mother/daughter dyad impede their ability to cope with the many challenges. Leaving Tom has left a power vacuum. Their enmeshed relationship makes it difficult for them to understand age-appropriate roles and behaviour. Ms. C finds it difficult to exert her parental role, which is causing confusion and anxiety for Alice. These structural difficulties combined with the trauma related to years of psychological abuse from Tom, are contributing to Alice's need to lash out at school, in the community, and at home.

Goals

The goals are directed at several levels:

1) To stabilize the systems involved with the family (CFS, CGC, school administration, and EHCC) in order to streamline interventions for a more effective result.

2) To clarify the boundaries between mother and daughter in order that Ms. C can support the developmental needs of her daughter.

3) To increase Ms. C's ability to exert her parental role in order that Alice be allowed to feel the age-appropriate freedom of childhood without the pressure of pseudo-parental responsibilities.

Interventions

Because Ms. C and Alice constituted a high-risk, multiple needs family, I took particular care in the joining process, knowing that any measure of positive movement on their part would require their trust in me to understand their needs. One of the most immediate and practical joining maneuvers was to accommodate their need for home visits. Our first meeting was in November at which time we contracted to meet at 7:00 in the evening on a weekly basis. These sessions continued until the end of April with only

a few interruptions necessitated by the Christmas break, their move to a new residence, Ms. C's brief stay in hospital, and my two-week vacation. In total, 17 sessions were held with the family, and 3 sessions were held with their formal systems.

The first session set the tone for our ongoing work together. I had a genuine respect for these two individuals, knowing that they had demonstrated a capacity for change in having had the courage to leave Tom. I could recognize their individual competencies and made a point of emphasizing these knowing that Ms. C was feeling particularly defeated and Alice was feeling angry and confused. Thus, our first encounter was defined by naming their strengths rather than their limitations, which in turn gave them a sense of hope and motivation, not to mention a willingness to see me again. By spending time over coffee, or an occasional game at the kitchen table, they not only began to accept me as a trusted partner, but learned how to have a good time as a defense against being caught up in an ever-present crisis.

I soon came to realize that in this family context, despite my repeated attempts at positive reframing and normalizing, assessment was an ongoing process. Developments from one week to the next were completely unpredictable and new information would surface at each session necessitating a reevaluation of their functioning. For example, we were well into the course of therapy when it came to light that Alice had a bedwetting problem or that Ms. C was playing the VLT's between work assignments and was, therefore, unable to meet the rent without Alex's help, or that Ms. C had loaned money to her neighbour with a gambling addiction even though she knew this to be against her better judgment. Ms. C's medical problems were disclosed slowly over time, and her unexpected hospitalization was another one of those "surprises" that I came to expect. I needed to remind myself that what was most important was *their* pace and *their* perception of positive change rather than my adherence to a strict theoretical model and prescribed time frame. The need for multidimensional interventions became apparent, and I began to understand my roles as those of facilitator, advocate, and ally within the

family system as well as their ecological systems, including the school, the Child Guidance Clinic, and Child and Family Services (CFS).

One of my first interventions was to set up a meeting at the school which included Ms. C, the vice-principal, and a school superintendent to discuss Alice's need to be in school, Ms. C's need to feel secure that her daughter was being supervised, the school's need to provide a safe environment for other students, and how these collective needs could be dovetailed most effectively. I took this opportunity to advocate for the family and to facilitate Ms. C's "finding her voice" with the school administration. As a result of this session, the school administration agreed to appoint an aid to supervise Alice for afternoons only upon her return to school following her suspension, and if she could prove herself capable, to attend mornings unsupervised. Alice did prove herself capable of controlling her angry outbursts and attended school regularly for the next three months.

In a subsequent move to stabilize the systems, I contacted the social worker at the Child Guidance Clinic who in turn, set up a joint meeting with the CFS case worker and Alice's newly appointed support worker in order to define and clarify our distinctive roles, to share new and relevant information, and to plan for the future. The support worker was assigned to spend after-school hours with Alice three days a week until Ms. C returned from work. This assignment also proved successful. Alice liked her worker, who helped her with homework, provided recreation outside the home, and modeled consistent and unconditional support. Undergirding these efforts was my ongoing effort to empower the family. I repeatedly communicated to Alice my belief in her ability to prove herself and my admiration for her successes, and invited Ms. C to do the same. This was a restructuring move designed to separate her role as supportive parent from Alice's role of dependent child, but it also demonstrated my multidimensional roles of nurturer, teacher, and role model for the family.

The C's had many concrete needs that required addressing and because of their primary importance, often relegated the other therapeutic goals to a secondary status. In this, I often felt the pull between paralysis and the need to temper possible overinvolvement. For instance, Ms. C's job demanded long hours, split shifts, multiple daily bus rides, and relatively low wages. I could normalize her feelings of despair and exhaustion related to this, but it was up to her to become pro-active in seeking out new work assignments and different employment options, which she then did over the course of time. When her exorbitant rent payments necessitated Ms. C to locate alternative housing, I supported and encouraged her in her search, but did not undertake these responsibilities for her. She did locate a different apartment and she did manage to pack up and move her belongings, even though she had to rely on Tom, the man she left, in order to have these practical needs met. I admired her ability to reach short-term goals through creative problem-solving despite the many obstacles, and did not hesitate to acknowledge her ongoing accomplishments.

This type of nurturing intervention, referred to as "reparenting" (Kaplan & Girard, 1994) was strongly indicated in this case. Ms. C failed to receive the nurturing support of parents as a child, therefore I availed myself as a temporary parent figure in order to decrease her need to depend on Alice in inappropriate ways. In attempting to trigger a structural shift in this way, my hope was that Ms. C would experience a new self-confidence which would, in turn, equip her to respond more effectively and positively toward Alice.

Throughout our time together, a primary intervention strategy was to put Ms. C in charge. For example, by encouraging her to determine working goals and by helping her enact alternative responses to Alice's belligerence, I hoped to convey to them both my belief in Ms. C's competence as a parent. This area continued to be a challenge throughout the therapeutic contract. Having had no positive parenting as a child and having given up the right and responsibility as Alice's parent to Tom until their

separation, Ms. C had little experience in asserting her authority and Alice had little respect for her as an authority figure. When she occasionally did speak with authority when asking Alice to tidy up, and when Alice did oblige, I emphasized their success as reinforcement.

The family's communication patterns were in constant flux. Ms. C was often highly stressed and at times made Alice the target of her frustration. When Alice would respond by mouthing off at her mother, I asked Ms. C to tell Alice that her language was unacceptable and I attempted to facilitate clearer communication between them by helping Ms. C separate what was her responsibility as an adult from Alice's responsibilities. When Alice would respond by refusing to talk or by leaving the room, I would explore the fears which could possibly lie beneath Alice's anger. For example, following Ms. C's hospitalization, she was warned about the ill effects of smoking and was strongly encouraged to quit. Alice's verbal attacks on her mother were on the increase, and after exploring what was behind her anger, she was able to tell her mother how scared she had been during her mother's hospitalization and that her choice to put her health at risk by smoking was frightening her.

Ms. C considered her ineffectiveness in dealing with Alice as another area in which she was a failure. I continually countered this by creating a language of strength and hope, believing that offering them a different view of themselves would help build their self-esteem, thereby maintaining their motivation to change.

Although change was incremental and inconsistent, by mid February Ms. C noted that she was occasionally seeing Alice genuinely happy for the first time in her life. Alice's support worker had also observed positive change, as had the school. The CGC social worker noted that Alice's appearance was taking on a more age-appropriate look. By the end of March several significant changes were evident. Ms. C was parenting with considerably more authority and determination. Her work situation had stabilized and she was no longer playing the VLT's between shifts, her job was located closer to home

allowing her to walk or cycle to work, and she was home by 4:30 which gave her more time with Alice. Ms. C was making plans to begin attending weekly Alanon meetings and a family membership at the Y was being considered. There was less fighting in the home, Alice had stayed in school, and she was registered for a baby-sitting course.

All this suddenly changed when by April the family was again in crisis. They had relocated to more affordable housing, but also, unbeknownst to them, were now neighbouring a group home for adolescent boys. It was only a matter of weeks before Alice became involved with a number of the residents. Her behaviour reflected this new influence. She refused to go to school, and when she did, was sent home due to her refusal to cooperate. She took no responsibility at home, verbally abused her mother, and brought her new friends into the home against her mother's wishes, threatening the family's security with the landlord.

My need to restabilize the systems was once again paramount due not only to the nature of the external forces at work here, but to the fact that I was in the termination process with the family and had hoped to lay the groundwork for a their smooth transition out of our therapeutic system. I feared that all the gains that had been made over the past four months would be lost in a matter of a few weeks.

I contacted Alice's CFS caseworker to apprise her of these developments. We discussed the positive effect a police visit might have on Alice, opportunities for summer camp, and the urgent need for a support worker for Ms. C. We acknowledged the positive changes that had occurred with Ms. C, i.e., her increasing ability to assert herself in her role of parent, even though the results of this were not yet measurable. I called the CGC social worker as part of the termination procedure in order to facilitate his reconnection with the case in a more instrumental way, building on the knowledge that Ms. C had developed a relationship of trust with him prior to my involvement.

Evaluation

Although this family was in perpetual crisis, there did appear to be a slight shift towards its ability to reorganize itself. Ms. C had become a more assertive parent and the intensity and frequency of their verbal fights had decreased. Therapy had provided them with a sense of hope at a very critical period and provided a foundation for the ongoing involvement of their other systems in the future. Joining had been successful. Although they expressed gratitude for my involvement and regret at its termination, they graciously accepted the closure of our relationship.

A poignant symbol of Ms. C's personal growth during this period was her drawing my attention to an excerpt from a parenting book she had on loan from the public library. The following passage had struck a chord with her: "If parents truly love the child and if they show it in a way that the child perceives it, they need not worry about how their child will turn out...the child will be resilient enough to bounce back without damage because the child feels love, accepted, valued" (Sifford, 1989). The fact that she was seeking out this sort of information was an encouragement to me, and the passage itself gave the termination a "silver lining".

FAM III Post-Test

Whereas the pre-test indicated a large discrepancy between their scores (apart from involvement) indicating acute conflict, the post-test results indicated a considerable lessening of this gap (Figure 6). Alice's overall higher scores indicate her more realistic perspective of their situation according to Ms. C. An improvement in Ms. C's perception of Role Performance, Control, and Values and Norms is noteworthy, even though they remain problematic. This is further evidence that Ms. C has become a more authoritative parent with a higher perceived sense of control and a better understanding of her place in the family, although her ability to parent effectively remains a challenge. Ms. C's clear sense of right and wrong and her unhappiness with Alice's behaviour are reflected in Values and Norms. Their perceptions appear to be most consistent in Involvement, again

reflecting the close nature of their ties with each other. As in the pre-test, the validity of the post-test results can not be empirically measured due to the absence of the Social Desirability and Defensiveness dimensions in the Dyadic Relationships Scale.

Client Feed-back Form

Both Ms. C and Alice indicated they were very satisfied with the help they had received, both having experienced some improvement as a result of therapy. The biggest change that Ms. C had noticed was that she and Alice did not argue and shout as much and that Alice respected her curfew. What she found most helpful was the opportunity to share problems with someone who would listen. She expressed being comfortable with me in many different situations. No indication was given of anything not being helpful and she stated that she would recommend me to others.

Alice also noted the biggest change being "not so much fighting" and the most helpful being the opportunity to talk about their problems. What was least helpful to her was "me not being here" referring to her absence on three occasions. She indicated that she would recommend me to others and closed by expressing her gratitude.

Although this case was difficult in that its problems were multiple and crisis oriented, structural family therapy offered a useful framework for assessment and intervention. It took the focus off Alice as the problematic family member and put Ms. C in charge. A unilateral approach simplified the process conceptually, but I found it difficult to adhere to a theoretically clean model considering the complex nature of this family within its ecological system. A multi-modal approach including psychotherapy for both Ms. C and Alice would have given us the opportunity to deal more thoroughly with family of origin, trauma, and abuse issues at an intrapsychic level. Although I occasionally invited her to share her personal history in the few individual sessions I had with Ms. C, this was clearly insufficient for these issues to be addressed effectively. Despite this limitation, the primary importance of the trusting relationship that they

developed with me was central to this intervention. They were able to experience unconditional positive regard, perhaps for the first time.

PART THREE: ANALYSIS AND CONCLUSION

CHAPTER SIX

COMMON THEMES

Introduction

Working within a variety of family compositions with their own unique problems and contexts required specific intervention strategies to meet their individual goals. Despite these dissimilarities across the case studies, common themes were exposed in areas relating to the presenting problems as well as in the process of intervention including family composition, family dynamics, assessment approach, and clinical methods.

The Family in its Larger Context

The premise that social context is a powerful organizer or disorganizer of families and its individual members is one of the cornerstones of structural family therapy (Colapinto, 1991), and was brought to bear on all three families presented in this practicum report. Although each social context was unique, the salience of their respective contexts in the therapeutic process provides the common theme.

The A and B families were similar at a socio-economic level as well as in their ability to avail themselves of social networks. Even though they were economically challenged, they considered this a temporary dilemma and had the consistent support of family and friends when needed. Both families had a sense of cultural identity, particularly the A family who also included a formal religious experience in their social context. These factors enhanced the families' abilities to support structural change.

In contrast to this, the C family was stuck at a low socio-economic level and their social network was severely limited and not always supportive. They had no family members on which to rely, and the individuals they needed to depend on in times of crisis were either unstable themselves or escalated the tension. Having no connection with a family of origin, the C family could not identify with specific cultural group norms and practices. Although Ms. C did express a religious faith and tried to foster this in Alice, there was no formal religious involvement. Their social context severely curtailed the C family's ability to reorganize itself to meet current developmental pressures.

Legal obligations in both the A and B families were often crisis inducing and were experienced by the families as disempowering due to their being ill-informed on issues of process and content, as well as the intimidating nature of the process itself. Adding to this stress was the continued role of ex-spouses as contextual players.

Past Domestic Violence

Domestic violence as a precursor to the family's present context was a similar theme in all three case studies. Although the violence was in the past, and reflected the families' strength in that they exercised their right to live free from destructive relationships, it continued to shape the way in which the family members viewed themselves. Their experience of violence was reflected in the parental subsystem. Each of these parents, having had to defer to their partners in the past, lacked self-confidence in exerting their parental role. Past violence was also reflected in the sibling subsystem. Children in all three families, to a greater or lesser degree, exhibited behavioural problems. Domestic violence, even though it was no longer the presenting problem, shaped their contemporary context and impeded their ability to reorganize themselves.

As a theoretical model, structural family therapy could not address this issue at an intrapsychic level. In order to adequately understand these situations and to intervene effectively, I had to draw on knowledge relating specifically to the impact of domestic abuse. It was occasionally difficult for me to understand how I could intervene with

individuals at an intrapsychic level while simultaneously working to structurally reorganize the family system.

Single-Father Families

All three cases studies involved single parents. Two of these were fathers who reported spousal and child abuse having been perpetrated by their former partners. The male-headed, single-parent family composition thus emerged as a sub-theme. Mr. A had been his children's primary caregiver and had been given sole custody when his youngest was still an infant. Mr. B, the father of three children from three separate relationships, was the custodial parent for each one. What differentiated these cases of female perpetrated violence from that of Ms. C who had been abused by an alcoholic husband, was the fathers' discomfort in recognizing themselves as having been victims at the hands of their wives. While Ms. C was very open to discuss her history of abuse, Mr. A and Mr. B were not. In the case of Mr. A, it was his fiancée, Ms. N, who volunteered the information. Similarly, Mr. B merely alluded to his ex-wife's problematic behaviour towards him but resisted exploring how it may have affected him. His acceptance of a referral to a support group for abused men illustrated movement in his ability to accept the fact that he had been a victim in a cycle of violence from which he now wanted to break free.

What makes this theme particularly noteworthy is the apparent gender-specific role reversal of domestic violence as it is found in the literature. Feminists have brought the subject of violence in the family to the fore with a focus on the abuse of male power in marriage and family (Goodrich, 1991), yet the family's narrative of power abuse and violence appears to be incomplete. A considerable gap in the literature will exist until men like Mr. A and Mr. B add their voices, and further research is conducted on female perpetrated family violence, and the complicated interplay between politics, gender, power, personal history, and socialization that keep inequity in place for some men as well as women.

Power Issues

Power is one of the theoretical constructs of the structural model, and as such plays an integral role in all families. A theme which developed in these case studies, however, was the difficulty in assessing what became a complex dynamic despite its relatively simple conceptualization. Power was also played out differently in various subsystems. It was easier to define and restructure in the hierarchical parent-child subsystems of the B and C families than within the egalitarian executive subsystem of the A family.

Parenting is an act of unilaterally empowering one's children, and to do so effectively requires power. To shift the imbalance of power in the B and C families from the children to the parents was a conceptually uncomplicated goal. Structural techniques such as allying with the parent and clarifying intergenerational boundaries assisted the family in reorganizing the power hierarchy. The families' contexts, however, either enhanced this process (B family) or hindered this process (C family), and these differences were reflected in the outcome measures.

I found that the concept of power in a non-hierarchical couple relationship is exceedingly more complex. In a well-functioning marital relationship, empowering is a mutual process of interaction that enhances the personal power for each individual. This ideal can be difficult to achieve in a couple relationship that is stuck in a power struggle, as was the case in the A family. If power is the relative influence each individual has on the other, it does not follow that one can determine who has more power because power can shift depending on the situation. For example, even though Ms. N exerted significant power in the relationship with Mr. A in her performance of organizational tasks and in her role as spokesperson, Mr. A exercised his power by "staying the course" and resisting to follow through on her initiatives or her directives. Assessing the power construct in this couple was, therefore, not only difficult but ongoing due to its constant fluctuation. I was uncertain whether they were equally powerful as individuals, whether they needed to

achieve a shift in a power imbalance, or whether a shift towards a different type of power was necessary. The latter would require them to give up the type of power which relies on the *dis*empowering of the other and embrace the power which allows for the *em*powering of the other. For a couple attempting an egalitarian relationship, this is a change of belief in addition to a shift in organizational structure. A change in one's belief requires a degree of insight, a concept which is theoretically inconsistent with the structural model. In addition to this theoretical overlap, I was uncertain whether insight would follow from a behavioural restructuring of the couple system.

Noteworthy, however, was that the couple's resistance to change was, in fact, directly challenged through crisis induction using the unbalancing technique which empowered Mr. A to challenge Ms. N assertively rather than passively, and elicited Ms. N's expression of vulnerability. This would suggest that there was in fact a power imbalance of sorts. For a couple as stuck as this one was in a struggle over power, insight alone would not have triggered a change in the power dynamic. The system did indeed require a reorganizational shift as a prerequisite to attitude change.

The connection between power, powerlessness, and human relationships reaches beyond the individuals' personal qualities and resources to include their social contexts and the macro level factors that give shape to these larger ecological systems. When a good fit exists between a family and its environment, the family feels empowered to make choices that enable its members to reach individual and group goals. A poor fit exists, however, when dominant ideologies inherent in social, economic, and political structures create power blocks which limit an individual's choice of alternative solutions (Compton and Galaway, 1989). A paradox arises in that the powerlessness that is created by these structures undermines the very skills necessary for coping with the problems they create (Pinderhughes, 1983).

The A family, despite its problematic past, is supported by its good environmental fit. Mr. A is exempt from power blocks related to race and gender. He is securely

employed, and enjoys the privilege of striving for an even higher level of education and a higher income bracket. Ms. N's primary power block is a lack of job security, despite her educational credentials. If the job market improves, she is well situated to be successful. Even though socio-economic prospects are good for this family, their ability to cope with developmental stressors will be compromised by economic constraints in the short term.

Like the A family, the B family also enjoys the privileges associated with membership in mainstream culture. Mr. B feels empowered by his ability to earn a good income in a male-dominated profession and has the option of being successfully self-employed. His current economic constraints are linked to his separation from his wife. Mr. B and his children were accustomed to a lifestyle that requires a dual family income. These material conditions, combined with his adherence to the societal notion of the nuclear family being the ideal family, kept Mr. B and his children in an abusive home for many years. Although he is now confronted with the economic challenges of single-parenthood and the legal bills that accompany the transition, Mr. B's good fit with his environment protects him against the power blocks associated with race, gender, or social class, and empowers him to make good choices for his family's future.

The C family, like the B family, is feeling the economic constraints of adjusting to one income. What differentiates the C family is their low social status. Whereas the A and B families enjoy the self-worth and the decent standard of living associated with their higher paying jobs (rightly or wrongly), Ms. C suffers the personal indignity and economic consequences of a low-wage, low-status job. Her economic status in a society which emphasizes material success is accompanied by unequal opportunity structures, rendering her powerless in coping with the consequences.

Being uneducated, Ms. C has resorted to domestic work--female work that is undervalued and underpaid. She was economically dependent on her domineering partner until she chose to leave him, and is now wanting to succeed on her own while simultaneously being denied the means to do so. The C family's internal power structure

is, therefore, affected by systemic power blocks associated with gender politics and socioeconomics. Solutions to their personal problems are severely limited as a result. Fortunately, the C family does not have to contend with the added systemic prejudice or discrimination often experienced by racial minorities.

Subsystem Work

Subsystem work is based on the systemic assumption that changes in the subsystem will trigger a reorganization of the larger system. The structural technique of working with one individual or dyad from within the family proved to be an essential and effective ingredient of all three cases, some by design and some not. Where empowering the parent was a goal as in the case of the B and C families, working with them individually allowed me to encourage and support them in a way that was not possible through enactment alone. The premise was that in order to be a self-confident parent, the parent must first be a self-confident individual. This type of intervention was deliberate with Mr. B, whereas in the case of the C family, whose therapy was restricted to home visits, the opportunity for individual sessions was accommodated when Alice chose to forego a therapy session in favour of another activity with her peers (on three different occasions), or when she asked for her mother's permission to leave the session a little early. In both cases, the parents gained considerable confidence in being able to discuss certain issues that would have been inappropriate in the presence of their children.

With the A family couple, subsystem work with Mr. A was initially the result of Ms. N's unavailability due to geographic distance, but a successful joining with Mr. A was, in retrospect, a necessary step in a successful joining with Ms. N later on, when taking into account the power imbalance that existed. A strategic scheduling of an individual session with Ms. N further on in therapy, allowed us to explore her family of origin and helped her recognize how her dysfunctional family history with an alcoholic father was influencing her need for control and her discomfort with disorder. She was

able to see herself from a different perspective which, in turn, allowed her to "let go" of the less important issues.

Home Visits

Although home visits were not an element of therapy I anticipated when designing this practicum, they became a standard feature with three out of the six families (all three cases described in this report). The A family required week-end sessions which could not be accommodated by EHCC, the B family had an adolescent who was resistant to office sessions, and the C family requested home visits as a necessary part of therapy due to environmental constraints. In all three cases it was my choice whether or not to accommodate my clients, and in retrospect, believe I chose well, not just from the client's perspective but also from an educational perspective.

Home visits are an accepted treatment strategy in family therapy, particularly in high-risk, chaotic families (L'Abate et al., 1986; Kaplan & Girard, 1994). In my experience, home visits also enhanced the ongoing assessment process in that situations arose in the families' natural settings (as with social networks) that would not have been visible in the office. The technique of enactment became not so much a technique as the playing out of authentic interactions. Home visits also facilitated a truly client-centered approach to therapy by allowing the client to be host and to give a measure of direction in therapy. These visits enhanced my ability to join with these families because I could take note of and reinforce the positive elements in their environment such as the cleanliness I observed in the B and C households. I could empathize with them in difficult situations as they happened, such as the day Ms. N's step father was suddenly taken ill. The context generally allowed for a more friendly interaction which consequently enabled me to "put on the heat" when necessary in a direct yet supportive way.

Observing Mr. A and Ms. N on Saturday afternoon while in full flight of a week-end routine with the children, enabled me to see them in action as they negotiated parenting tasks (as in ensuring our privacy for the session) and household tasks (role of

host), and availed me the opportunity to intervene with an immediacy based on what I had just observed.

It was helpful for me to see the B family in context. What I saw was a neat and clean house despite its unfinished state of renovation. I observed Mr. B negotiate with Ken about plans with peers and I saw the spontaneous physical affection between Mr. B and Ann. Home visits allowed for an effective family meeting including his "daughter-in-law" around the kitchen table, and the unexpected inclusion of Mr. B's mother at a session in the family's livingroom.

Unlike the other two cases, Ms. C and her daughter Alice were seen exclusively in their home. The benefits of this were similar to those of the others. I saw their affection for each other as well as their heated verbal fights. I met Ms. C's "boyfriend" on one occasion and Alex's brother on another in the family's natural course of events. The advantages of the immediacy of therapy in their home might have, ironically, also been disadvantages. Due to the chaotic and unpredictable nature of the setting at times, a certain degree of order which was impossible in the home, might have been better established at EHCC. Also, if it hadn't been for the time limitations of the practicum, the family's dependence which may have been fostered through home visits, might have been more difficult to avoid. When considering therapy for multiple-needs families such as the C family, it may be advisable to include office sessions as part of the contract in order to address these concerns.

Searching for Competence

"The very idea of family therapy implies confidence in the family as a place for healing" (Fishman, 1988, p. 7). Each family member must, therefore, be seen as a resource to facilitate that healing. Minuchin's fundamental message to his clients was that they were more complex than they realized (Minuchin & Nichols, 1993), implying the therapist's role of empowerment was a search for competence.

People are generally more motivated to change when their strengths are supported (Kaplan & Girard, 1994), thus the search for competence became the underlying feature of my work with families. They typically started therapy feeling defeated and at a loss for a sense of hope. A lesson I quickly learned as a therapist was that in spite of the many problems my clients faced, their competencies were overshadowed by their problems. The clients often understated their strengths or took them for granted. At other times, they required help in discovering what their competencies were in order for me to reinforce them. Each family gave some evidence of how this process enhanced their ability to cope in a difficult situation and to effect change within their family as autonomous individuals.

Mr. A, whose history of having been psychologically abused by his first wife had affected his self-perception, was able to see his past accomplishments as a single father of small children in a new light, which, in turn, empowered him to be more assertive with Ms. N. Ms. N's competencies as an organizer were reinforced in order to give her the confidence to "let go" when necessary.

Mr. B, whose victimization in a cycle of abuse from his previous partner had rendered him powerless, felt validated when his ability to leave a dysfunctional relationship was reframed as an act of courage. He was able to rediscover his competencies as an autonomous individual and as an effective parent. His children were more than willing to hear themselves being described as normal and competent after seven years of negative and conflicting messages from their mother and step-mother.

Ms. C, who had never been admired or validated as a child, and had experienced psychological abuse from two alcoholic partners, was a willing recipient of positive messages. Despite her particularly difficult context, her degree of insight, her social graces, her system of values, and her ability to organize her family in a crisis never ceased to amaze me. By helping her recognize these behaviours as competencies, she was able to rediscover new aspects of herself and, as a consequence, take on a more

assertive parental role with Alice. My emphasizing Alice's ability to be creative, and to be a kind and caring person, made her receptive to supportive confrontation when her behaviours were unacceptable.

The Use of Self in Therapy

The use of self in therapy is emphasized repeatedly in the literature. "The critical component of treatment is not a particular approach or technique; it is the creation of a trusting relationship between worker and family" (Kaplan & Girard, 1994, p. 58). "Together with knowledge and skill, mastery of therapy depends upon the therapist's mastery of self" (Aponte, 1982, p. 46). "It is the therapist's behaviour, rather than the intrinsic efficacy of techniques or prescriptions or the appropriateness of interpretations that helps families change" (Colapinto, 1991, p. 435). As much as the use of one's self can be technical, it is a natural process of human interchange. It is this very process of using one's self as an instrument of change that is of primary importance to therapeutic outcome, yet ironically, it is also a somewhat abstract component of therapy.

My use of self was evident in creating an atmosphere of trust with my clients. Their ability to feel secure and comfortable depended on my ability to create this type of environment, and was accomplished most effectively by being empathic and spontaneous. Although I was "myself" with each family, different aspects of the self were deliberately emphasized as technique. In the A family, my use of self as a neutral mediator, and my ability to increase the intensity without losing them in the process, played a significant role in their ability to reach an understanding. In the B family, my use of self as a friendly, sometimes humorous player, helped ease the tension and made them receptive to change. The C family relied on my ability to be flexible in that an element of surprise awaited me every week. I needed to tolerate considerably intense interactions at times, knowing that an inability to do so would weaken their trust in me as a helper.

Although I attempted to adhere to the unilateral approach of structural family therapy, it was my use of self in combination with specific techniques which rendered my interventions unique from those of other structural therapists.

CHAPTER SEVEN

CONCLUSION

At the conclusion of this practicum I would agree with Figley and Nelson (1990) that structural family therapy is the model of choice for a therapist in training due to its "relative simplicity, concreteness, and directness" (p. 226). My learning goals were met as a result of this sound and well-established theoretical base in combination with several other important factors, these being an ideal learning environment at the Elizabeth Hill Counselling Centre, a suitable number of cases, consistent and skilled supervision, and a supportive and knowledgeable committee.

I found the structural notions of family functioning conceptually clear as defined by boundaries, subsystems, hierarchy, and coalitions. I was able to apply these theoretical constructs and various structural techniques to a number of family configurations presenting with problems specific to their particular dynamics. These families included three couples and three single-parent families. Identified problems included the effects of family violence, divorce, remarriage, ineffective parenting, delinquent behaviour, and complementarity and power issues in couple relationships. Through subsystem work, I could observe how change in individuals or dyads can trigger an organizational shift in the entire family system. The impact of the client's context on their ability to adapt to restructuring became clearly evident. The model's deliberate focus on the clients' competencies as the building blocks of change proved very useful as I tried to avoid the pitfalls of the pathologizing therapist.

Despite the model's usefulness, I experienced several limitations in theory and practice. The model's lack of an adequate explanation of power and the abuse of power, particularly in the context of complementarity in the couple relationship, caused me a

considerable amount of confusion at the assessment and intervention levels. The model's description of complementarity would suggest differentiation within the context of equality and ignores the issue of power as a potential problem. My experience with the A/N couple was that the dysfunctional complementarity could not be challenged without giving consideration to the power imbalance. Another limitation was the model's inability to address psychological trauma resulting from parental and spousal abuse. Structural shifts address relationship issues but cannot address individual dynamics. Since all my clients had been impacted by the trauma of domestic violence, it might have been useful to provide them with family therapy in conjunction with individual psychotherapy in a framework that combines individual psychodynamics with the structural model (Melito, 1988).

In evaluating the effectiveness of my structural interventions, change in family functioning was evidenced in each of the three families presented as case studies in this practicum report. Outcome measures included clinical observation, pre- and post-FAM Profiles, and a Client Feedback Form. Although I anticipated some resistance from clients to completing the FAM Profiles at two separate occasions, this was not the case. They were willing participants in these written assignments. The questions in the FAM were relevant, yet I noticed an answer would occasionally fall between the "agree" and "disagree" categories, indicating that an answer is sometimes situation-specific rather than general. Aside from generating outcome data for the therapist, the measure may have been an intervention tool as well. It likely enhanced the clients' ability to evaluate their own situations more clearly at the outset and to recognize any changes they may have experienced a few months later. A drawback of the Dyadic Relationships Scale (unlike the General Scale) was the absence of the Social Desirability and Defensiveness dimensions which measure the profile's validity.

The Client Feedback Form provided for qualitative and quantitative evaluation, giving clients a fair amount of latitude in their choice of answer and accommodating

varying degrees of written competency. It must be taken into account, however, that the objectivity of their feedback may likely have been compromised to a degree as a result of having administered it myself.

I began to develop clinical skills as a family therapist but soon came to understand that my work symbolized the beginning of learning rather than a completion of a practicum. I came to recognize the central position the clinician holds in the therapeutic relationship, and that if my goal is to apply the "widest possible use of self" (Minuchin & Fishman, 1981), this might well require a lifetime of learning.

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Appendix A

CLIENT FEEDBACK FORM

Date:_____

Your opinion about the service your family received at the Elizabeth Hill Counselling Centre is important. It helps the agency and the therapist provide the best possible service to families in the future.

Please circle the answer that best describes your opinion, and comment in the space provided.

1. How satisfied are you with the help your therapist gave you?

very dissatisfied	dissatisfied	satisfied	very satisfied

2. Did your family's situation improve as a result of therapy?

very much improvement	some improvement	very little improvement	no improvement

3. What, if any, is the biggest change you have noticed in your family?

_____
_____
_____
_____

4. What in therapy was most helpful to you?

_____
_____
_____
_____

5. What in therapy was the least helpful to you?

_____
_____
_____
_____

6. If your friends had problems, would you recommend your therapist to them?

Yes No

7. Do you have any additional comments about the help you received or suggestions for the therapist? (Use the reverse if necessary)

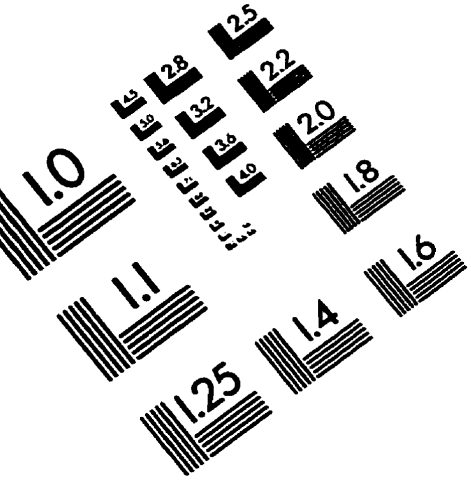
_____

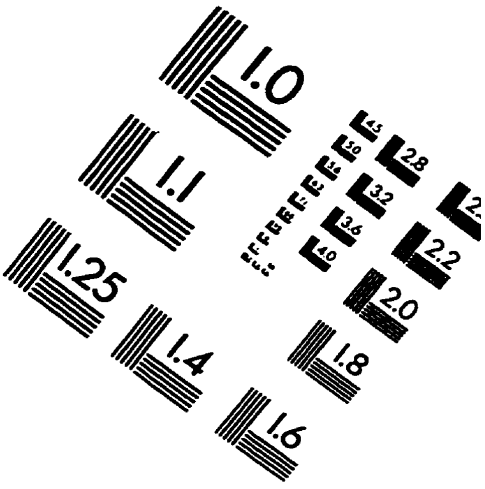
_____

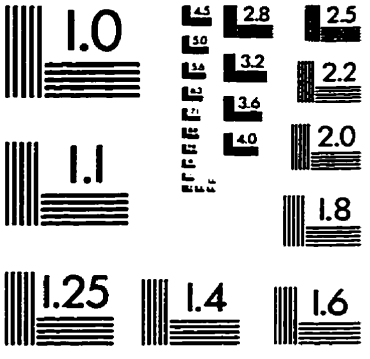
_____

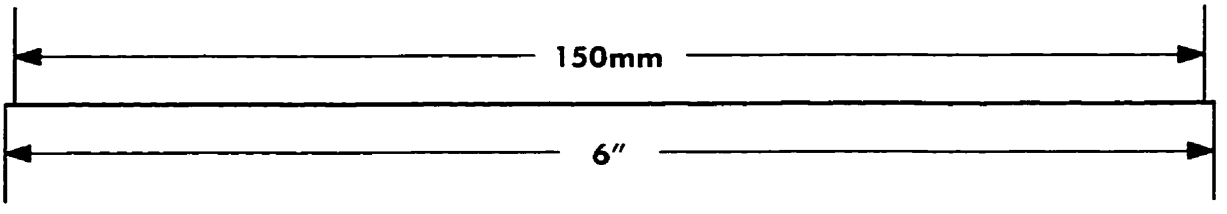
_____

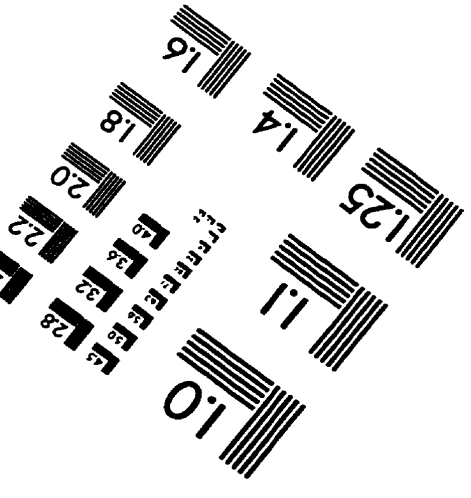
IMAGE EVALUATION TEST TARGET (QA-3)

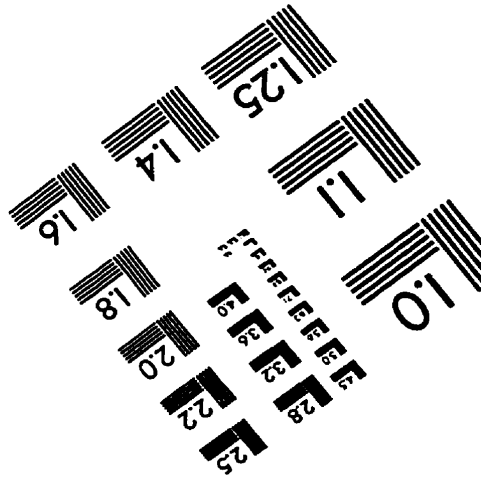












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