A STRUCTURAL FAMILY THERAPY APPROACH TO WORKING WITH COUPLES AND FAMILIES

BY

PAM ROSEN

A Practicum Report Submitted to the Faculty of Graduate Studies in the Partial Fulfillment of the Requirements for the Degree of

MASTER OF SOCIAL WORK

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ABSTRACT

Families are impacted by a variety of life stressors and challenges as they grow and develop over time. At times these changes and transitions will exceed the families' abilities to cope and manage the adaptations that are required. Structural family therapy is an approach that aims to restructure the family system, increase the flexibility of family interactions, and ultimately improve overall family functioning. This practicum report reviews the literature on structural family therapy, and describes the application of the approach to three couples and six families. This report examines the assessment, intervention, and evaluation process and also considers common themes arising from practice.

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Introduction

This practicum involved the application of a structural family therapy approach to working with families experiencing difficulties. My learning goals were to enhance my clinical social work skills with regards to assessment, intervention, termination and evaluation, strengthen my theoretical and practical knowledge of family therapy and apply it to families in a respectful way and to gain greater experience in family-centered practice with a diverse client population.

This report is divided into four sections. The first section is a literature review which provides both a historical overview of structural family therapy as well as an outline and description of major theoretical constructs and techniques utilized in structural family therapy. This section also provides a critique of the model and an evaluation of the model's effectiveness. The second section provides a brief description of my practicum including the parameters of the practicum, where it took place, and the families with whom I worked .

The third section of the report provides two in-depth case studies taken from the sample of families with whom I worked. For each case study, I provide a description and analysis of the assessment, intervention, and evaluation process. The fourth section deals with practice and learning themes that emerged from my practicum, such as single parent families, families involved with other systems and family strengths.

Finally, the report concludes with a review and reflection of my learning goals and objectives as well as some recommendations based on my experience.

RELEVANCE TO SOCIAL WORK PRACTICE

It is important to address the relevance of structural family therapy as it relates to social work practice. Moreover, it is important to look at the historical relevance of family practice as it relates to the field of family therapy. Indeed, many of the central values and beliefs in social work practice are reflected in the values of structural family therapy.

Based on systems theory, structural family therapy views the individual as being part of a network of larger systems, such as part of a family, community, and culture. For this reason, structural family therapy operates from an approach in which the individual is not to be treated in isolation of her surroundings. Although the concept of the "identified patient" exists as a construct in structural family therapy, it is not viewed as a means to locate the problem primarily in one individual, but rather as a vehicle for engaging other parts of the system in the therapeutic process.

Historically, the relationship between family and social work practice has been of central importance. Indeed, early social workers in mental health and health care settings sought to work with patient's families as a means of alleviating symptomology (Hartman, 1981). Moreover, it was recognized early on by child guidance workers and social workers alike that working with families to help reduce stress in their ecological environment went a long way towards strengthening families' resources and coping skills.

As the practice of social work evolved, it is important to examine the relationship of the profession with that of the family system. While the 1950's were marked by the unification of the profession, the 1960's appeared to focus mainly on generic social work practice. However, by the early 1970's onward, social work practice became more specialized with practitioners opting to direct their energies towards more specific areas of practice (Hartman, 1981). While this appears to have been a natural progression in the field, concerns have been raised around social work's changing conceptualization of the family as it moves more towards the family as a unit of practice, rather than that of an enduring institution (Hartman, 1981).

This conceptualization tends to negate the fact that families continue to be the primary providers of counseling, healthcare, and help to individuals. Furthermore, families are the preferred source of advice and problem-solving for many individuals and the mental health of some individuals is deeply implicated in the functioning of the whole family system (Hartman, 1981). For these reasons, it is both useful and appropriate for clinical social work practice to incorporate a greater understanding and awareness of the various roles families play in providing service to its members.

Family therapy has flourished over the past thirty years as a specialized means of providing mental health services to the family system (Amer, 1980). Structural family therapy is an action-based therapy that sees the entire family as "patient" and seeks to organize, assess, and understand family relationships and interactions. In this way, structural family therapy can be seen as congruent with social work practice as it strives to work with the entire family system and values the input and resources families provide in therapy. Furthermore, this model is not unlike traditional social work approaches

where workers visited the homes of families thus involving the entire family system in problem-solving efforts (Hartman, 1981). In addition, structural family therapy can be seen as a collaborative process in which the therapist and family join together to effect change in the family system and its surrounding environment. At times the therapist may take a more active or directive role in this process, however, the client and therapist ultimately work towards the client's goals together.

However, while structural family therapy is congruent with many of the purposes of social work practice, there are some areas that appear incongruent. Specifically, the "expert" role that structural family therapists are required to take may be seen as undermining and possibly overwhelming the family system. Second, while the structural family therapist helps to facilitate positive interactions between family members, it is less typical for therapists to facilitate positive interactions between the family and other significant systems. In this way, clinical social work practice can be seen as only one of the various strands of social work practice, with areas such as education, advocacy, and community development being equally if not more important.

This practicum is relevant to the development of my skills as a social worker in several ways. First, engaging in family therapy practice allowed me to conceptualize problems that families face in a broader way. It allowed me to gain greater exposure to issues such as poverty, family violence, and the child welfare system, and in turn make decisions about ethical and fair treatment. Second, this practicum allowed me to further develop my skills by way of helping to empower clients. Through the practice of both noticing and actively highlighting families' strengths and resources I was able to strengthen this skill as a social worker, as well as empower families to direct their own

healing process. Finally, this practicum is relevant to my skill-development as a social worker as it reminded me at every turn the importance of treating each family with patience and respect as they shared personal details of their lives and situations.

Overall, many important aspects of structural family therapy are congruent with the practice of social work. Values such as viewing the individual as part of a complex network of other systems, not treating the individual in isolation, treating families with respect and as important resources, and increasing emphasis on collaboration and sharing is consistent with social work values.

SECTION ONE: LITERATURE REVIEW

Introduction

The family is a complex social system that contains diversity and structure. In this way, the family is more than a collection of separate individuals; it is an organic whole with members mutually influencing each other. Family difficulties may be especially challenging because they are embedded in powerful unseen structures (Nichols & Schwartz, 1998). From a systemic point of view, as changes in the system occur, change will also occur at the individual level. These ideas serve as a basis for family therapy, and specifically, structural family therapy.

This paper will provide a review of the literature on structural family therapy. Through an examination of both the theoretical and empirical literature the reader will gain an understanding of basic assumptions, theoretical processes, and techniques central to structural family therapy. In addition, outcome studies assessing the relevance and effectiveness of structural family therapy will be addressed along with a discussion of the model's limitations. Finally, implications for ways in which structural family therapy may benefit from incorporating other therapeutic models such as feminist theory and strengths based practice are highlighted.

Historical Overview of Structural Family Therapy

Family therapy has evolved from the traditions of individual psychotherapy over the second half of the twentieth century. It provided therapists with a new way of

conceptualizing and understanding human problems that had previously been explained as individual pathology (Okun & Rappaport, 1980). In this way, the 1950's were marked by an orientation to family-oriented theory and research. As more theorists began to look at the entire family as the "patient" a need to develop new concepts and terminology to describe the family process was discovered (Okun & Rappaport, 1980). Within this evolution, major schools of family therapy developed.

By the 1960's systems ideas began to dominate theories and practice for understanding and working with families. At this time Philadelphia became a center for a significant amount of family therapy work (Hoffman, 1981). A major figure to emerge in Philadelphia at this time was Salvador Minuchin. His unique approach to working with economically disadvantaged families recognized the influence of the family social context, and provided an alternative to the limited treatment methods available to this population group. The resulting work was published in *Families of the Slums* (Minuchin, Guerney, Rosman, & Schummer, 1967). Later, in his work at the Philadelphia Child Guidance Clinic, Minuchin began to practice with middle and working class families (Levant, 1984).

Several other important figures contributed to Minuchin's thinking and learning. These included Braulio Montalvo from the Wiltwyck School for Boys project, and Jay Haley (1976) from California. Other important individuals such as Lynn Hoffman (1981), Lester Baker (1975), Ronald Liebman (1974) and Harry Aponte (1981) served as both staff and trainers at the Philadelphia Child Guidance Clinic which was founded by Minuchin. Minuchin's theories, which were directed towards changing the organization of the family, became termed "structural" family therapy. These

theories were further solidified in his classic book *Families and Family Therapy* (Minuchin, 1974).

Later work by Minuchin included a joint study of children with psychosomatic disorders and their families with particular interest in families with children suffering from anorexia nervosa (Levant, 1984). This work led to the book *Psychosomatic Families: Anorexia Nervosa in Context* (Minuchin, Rosman, & Baker, 1978). Subsequently, in the 1980's Minuchin produced another book called Family *Kaleidoscope* (Minuchin, 1984) in which structural views on working with contemporary families were presented. More recently, Minuchin has become interested in working with diverse family structures (Minuchin, Colapinto, & Minuchin, 1998) as well as issues within the therapist/trainee relationship (Minuchin, Lee, & Simon, 1996). The structural approach to family therapy continues to be used today both in pure and integrated forms, and is regarded as an excellent model for training student therapists because of its simplicity and directness (Figley & Nelson, 1990).

Theoretical Assumptions

Structural family therapy consists as a body of theory and techniques that approach the individual in her social context (Minuchin, 1974). Therapy based on a structural theoretical framework looks at changing or transforming the organization of the family. An underlying theoretical assumption of structural family therapy is that as positions in the family are altered, each individual's experience changes (Minuchin, 1974).

The theory of family therapy is based upon the notion that individuals do not exist in isolation of each other. Rather, individuals represent members of various groups where action and reaction occur. In contrast to some of the more traditional psychotherapeutic approaches which focus exclusively on the individual apart from her surroundings, therapists working from a structural family therapy perspective necessitate a broader focus.

The structural family therapy school focuses on the present family context while viewing the therapeutic task as one of directed behavior change (Levant, 1984). However, while the structural approach contains definite elements of communication approaches such as Haley (1976), it can also be seen as a holistic approach. This is evident both through Minuchin's (1974) attention to a family's organizational structure, his emphasis on the internal experience of the family and the family's experience and interaction with broader systems, as well as the recognition of the influence a therapist's evolving assessment may have on a member's responses.

Structural family therapy is an action therapy (Minuchin, 1974). Thus, the therapist's role is to be an active member in the therapeutic sessions. Essentially, through joining with the family, the therapist uses herself as an agent of change in order to modify positions of family members and enact changes within the system. The assumption here is that once a shift in family organization occurs it will continue to be perpetuated by a family's self-regulating properties (Minuchin, 1974).

The Family Defined

Structural family therapy defines the family as a social unit that faces a series of developmental tasks. It is important to note that a normal or functional family cannot be distinguished from an abnormal family by the absence of problems. Rather, a functional family is defined by its ability to fulfill its functions and respond to developmental changes as necessary (Minuchin, 1974). Accordingly, the family undergoes different modes of development, moving through a number of changes that require re-structuring. If the family is able to successfully adapt to these changes and maintain continuity, the psychosocial growth of each member is nurtured.

It is important to recognize that views of normality and health are socially constructed and in turn influence clinical assessment and goals for healthy family functioning (Walsh, 1993). Walsh (1998) examines two powerful myths that have perpetuated a bleak view of most families.

One myth is that normal healthy families are problem-free. By defining normality and health in families as the absence of problems, attention is focused away from what contributes to positive healthy functions in families. More importantly, it leads to the faulty assumption that any problem is symptomatic, and most likely caused by a dysfunctional, abnormal family. This belief has tended to pathologize families attempting to cope with ordinary stresses and disruptive changes that are part of life (Minuchin, 1974).

A second myth is the belief that the idealized, traditional, white, middle-class nuclear family is the only possible model for a healthy family. In this way, families that don't conform to this often-unattainable standard are stigmatized and

pathologized by assumptions that alternate family forms are inherently damaging to children. More recently, structural family therapists are beginning to contend that it is not the family form, but rather family processes that matter most for healthy family functioning and resilience (Walsh, 1998).

Nonetheless, Minuchin (1974) identifies the formation of a "typical" family in stages. From this view, the formation of a family begins with the joining of the couple. The initial task for the couple is to separate from their families of origin and begin to negotiate different relationships with parents, siblings, and in-laws. In other words, the new couple must begin to shift their loyalties from their families of origin to their marriage. In turn, the families of origin are required to accept and support this break. Likewise, new transactional patterns are developed in order to form a set of complementary demands that help to regulate the new family situation.

The birth of a child distinguishes the next major organizational change in the family system. With new constraints on the parents' time, the couple must learn to negotiate and balance the infant's needs for care and time with the couple's need for intimacy. This will require a change in the spouses' transactional patterns. If and when additional children are added to the family, new sets of subsystems appear with children and parents having different functions. This period will likely require a renegotiation of boundaries both within and between the couple subsystem and the children as well as between extended or extrafamilial subsystems who may enter to help guide or support the family. In addition, other developmental stages such as launching the children and moving on, as well as the family in later life are

acknowledged as developmental life cycle changes that also necessitate shifts in family structure.

Thus, at different periods of development the family is required to adapt and restructure. Continual accommodation is required to support changes in strength, roles, and productivity of family members. In addition, the family must learn to meet the challenges of internal and external change while nurturing members' growth and adapting to a society continuously in transition (Minuchin, 1974).

According to Minuchin (1974) the family provides its members with a sense of identity both by offering belonging as well as a sense of being separate. The family structure is developed through repeated transactional patterns. These transactional patterns regulate family members' behavior determining when and how and with whom members relate. Transactional patterns involve power hierarchies in which parents and children have different levels of authority, as well as complementary functions. In this way, mutual expectations are formed between members through both implicit and explicit negotiations. Structural family therapy maintains that it is through these transactional patterns that the family maintains its equilibrium. The system will offer resistance to change up to a certain point, by adhering to the preferred patterns of transaction as long as possible. The continued maintenance of the family as a system depends upon the availability of alternative transactional patterns as well as the flexibility to mobilize them when necessary (Minuchin, 1974).

Theoretical Constructs:

Subsystems, Hierarchy and Boundaries

The structural family therapy model identifies subsystems as units of socialization and development through which members carry out various tasks. Individuals may be seen as subsystems within a family as are dyads such as husband-wife, or mother-child. Subsystems may exist around gender, age, interest, or function (Minuchin, 1974). Within each subsystem, differing levels of power and authority exist.

The distribution of power and hierarchy in a family is expressed by rules that prescribe differential degrees of decision-making power for various individuals and subsystems (Colapinto, 1991). While structural family therapists believe that some form of hierarchy is necessary for family functioning, it is acknowledged that families can function with different kinds of hierarchy. Generally, however, parent(s) are hierarchically positioned above their children in the sense that they provide protection and leadership. In single parent families a functional hierarchical leadership may include the role of a parental child when his or her clearly defined responsibilities help contribute to the overall coping capabilities of the family (Colapinto, 1991).

The boundaries of a subsystem are described as the rules that define who participates and how (Minuchin, 1974). The function of the boundaries is to protect

the differentiation of the system. To ensure proper family functioning, the boundaries of its subsystems must be clear. Clarity of boundaries within a family system is of primary importance in the assessment stage of structural family therapy. In this way, all families can be seen as operating along a continuum in which the two extremes are diffuse boundaries and overly rigid boundaries (Hansen & L'Abate, 1982).

Enmeshment and disengagement refer to a transactional style, or preference for a type of interaction (Minuchin, 1974). Typically, enmeshment refers to overly diffuse boundaries between subsystems while disengagement focuses on excessively rigid boundaries. These terms are not meant to connote a qualitative difference between functional and dysfunctional families. Indeed, most families contain both enmeshed and disengaged subsystems. For this reason it is important to look at enmeshment and disengagement as possessing both positive and negative qualities. For example, enmeshed subsystems may offer a heightened sense of mutual support, but at times this may be at the expense of independence and autonomy. On the other hand, rigid boundaries that are overly restrictive and do not permit much contact with outside subsystems may result in disengagement. While this may foster autonomy, growth, and independence in some individuals, it may also result in isolation (Nichols & Schwartz, 1998).

Alignment, Triangulation, and Complementarity

Alignment refers to the joining or opposition of one member of a system in relation to another (Aponte & Van Deusen, 1981). Alignments comprise both coalitions and alliances. A coalition or collusion occurs when two or more members

join together against another member or members to the exclusion of others. Unlike collusion, a coalition is usually more overt in that it can be assessed through observation. Collusion, on the other hand is more subtle and may not manifest itself in the therapy session per se, but rather in a situation where two family members may discuss another member in private (Minuchin, 1974).

An alliance or an affiliation refers to a situation where a subsystem may share a common interest that is not shared by a third person but is not intended to purposely exclude others (Aponte & VanDeusen, 1981). While alliances and affiliations hold similar functions, alliances are typically more easily observable in family therapy sessions, and are illustrated through body language, physical contact, and gestures. Affiliations on the other hand, are more likely to be described verbally by family members during sessions (Minuchin, 1974).

The concept of triangles or triangulation was developed by Murray Bowen (1978) and refers to a coalition which involves a third party with its function being the maintenance of system stability. Similarly, Minuchin emphasizes that in families with chronic boundary problems triads result. An example of this is when a child is asked to side with one parent against another. This places the child in a no-win situation whereby whenever the child sides with one parent she is automatically defined as attacking the other (Minuchin, 1974).

Another form of triangulation is called detouring. This refers to a process whereby conflict between two members can be avoided by involving a third family member. An example of detouring is illustrated in situations where a spousal subsystem may rely on the disruptive behavior of their child to avoid couple conflict.

By detouring stress in the spousal subsystem through the child, the illusion of harmony in the couple relationship can be maintained. In this way, spousal problems remain below the surface, while the child is blamed for family difficulties (Minuchin, 1974).

Complementarity describes the nature of interpersonal behavior as being balanced and reciprocal (Nichols & Schwartz, 1998). Complementarity also refers to patterns of mutual accommodation and support that help members nurture and enhance selective aspects of him or herself. This concept is likened to a jigsaw puzzle where the irregular borders of the various pieces fit – or compliment each other (Colapinto, 1991). However, exaggerated complementary roles can detract from and even be harmful to individual growth. For example, traditional sex role stereotypes may allow couples to achieve complementarity at the expense of fully rounded functioning for each spouse. For women this may result in lack of autonomy and independence (Nichols & Schwartz, 1998).

Goals of Structural Family Therapy

Structural family therapy is driven by the assumption that families are competent and should be respected (Nichols & Schwartz, 1998). Structural family therapists believe that problems are maintained by dysfunctional family structures, thereby making the alteration of family structure a primary goal. While problem solving definitely occurs as a by-product, the goal of therapy is structural change.

Symptomatic change and enhanced family functioning are seen as two inextricably linked goals (Nichols & Schwartz, 1998). A change in symptoms is facilitated by a change in the family patterns that maintain them. Structural family

therapists view an effectively functioning family as a family that nurtures and supports its members. An overarching goal of this therapy is to aid and encourage growth in individual members while at the same time preserving mutual support within the family.

The goals for each family are dictated by the problems they present and at times may vary considerably. However, although each family is unique there are some common problems and typical structural goals. Minuchin (1974) sees the development of an effective hierarchical structure as essential. In this way, parent(s) are expected to be in charge of their children and not relate to them as equals. A frequent goal is to help parent(s) function together as a cohesive executive subsystem (Nichols & Schwartz, 1998). In the case of a single parent family, one of the older children may be encouraged to assist the parent with executive functions, providing that this does not compromise the needs of the child.

The goals for working with enmeshed families is to differentiate individuals and subsystems by strengthening the boundaries around them (Nichols & Schwartz, 1998). Likewise, the goal for disengaged families is to increase interaction by making boundaries more permeable. While it has been argued by some that emphasis on family typologies such as enmeshment and engagement has diminished as the structural model evolves, a great deal of significance is still placed on connectedness and differentiation (Colapinto, 1991).

Structural Family Therapy Processes

The processes of assessment and intervention in structural family therapy are interactional, ongoing, and often inter-twined. Central to the effectiveness of assessment and intervention is the creation of a positive and safe therapeutic environment. While the formation and structure of who is included in each session may vary, separate functions such as joining, assessment, and restructuring serve to highlight integral processes in structural family therapy.

Joining

Minuchin and Fishman (1981) describe joining as the process between a therapist and a family in which the therapist lets the family know that she understands them and is working with and for them. Structural family therapists believe that joining is the glue that holds the therapeutic system together, and that it is only under this "protection" that a family can begin to explore alternatives, and begin to change (Minuchin & Fishman, 1981).

In order for a therapist to become an integral and active participant in the family process, she must accommodate and adapt to the family. Accommodation techniques may be either spontaneous or deliberate depending upon both the individuality of the therapist and the uniqueness of the family. In this way, the joining process can also be viewed as more of an attitude than a technique. Nonetheless, Minuchin (1974) describes three techniques of joining: close, median, and disengaged positions.

In the close position, the therapist searches out positives and makes a point of recognizing and rewarding them (Minuchin & Fishman, 1981). Although the therapist will identify and acknowledge areas of stress, difficulty, and pain, she will not avoid

them, but make a point of responding with sensitivity and empathy. In this way, a sense of proximity is achieved. By functioning in proximity a therapist is able to achieve intensity, as well as gain leverage in the therapeutic process.

In the median position the therapist joins as an active, neutral listener (Minuchin & Fishman, 1981). Through the means of tracking, the therapist is able to obtain information about the family structure by following the content and process of the family's story. By listening to and encouraging members to contribute, clarify, and expand on ideas or opinions, additional assessment information becomes available to the therapist. Also, the technique of tracking can be a useful self-reflexive process for the therapist in observing her own way of tracking family processes and what this may or may not indicate about pressures in the family via the therapist's own pressure to organize her questions and behavior.

The therapist can also join with a family from a disengaged position. In this instance, the therapist uses her stance as "expert" to create therapeutic situations where family members are able to experience competence and hope for change (Minuchin & Fishman, 1981). From this position, the therapist functions less as a participant, and more as a leader. By observing family patterns, the therapist enacts familiar family scenarios in order to invite the system to engage differently.

Two additional therapeutic techniques that involve accommodation are maintenance and mimesis. Maintenance involves providing planned support to a family structure or specific subsystems while the therapist analyzes it. An example of maintenance is supporting and validating an individual's strengths in order to expand perceptions of confidence in achieving new skills (Minuchin, 1974). Mimesis refers

to the therapist, either implicitly or explicitly, adopting the family's affective style and range of communication. For example, if a family speaks loudly and uses a lot of physical gesturing, the therapist will adopt a similar communication style.

While techniques such as tracking, maintenance, and mimesis are used in the accommodation and joining process, they can also be part of a restructuring process. In this way, joining cannot really be separated from changing a family because ultimately, the mere act of the therapist joining the system changes things. Joining occurs throughout the therapeutic process and may occur many times during the course of a session and throughout the course of therapy.

Assessment

Upon having joined with a family, the therapist is provided with information in which to form an assessment. Minuchin (1974) identifies six major areas of focus to assess family interaction patterns. They are as follows:

1) Family structure – which includes the family's preferred transactional patterns as well as the alternatives available.
2) Flexibility of the system is evaluated as well as its capacity for elaboration and re-structuring. This is ultimately revealed by reshuffling the system's alliances, coalitions, and subsystems and assessing the family's capacity for change.
3) An examination of where the family falls on the enmeshment-disengagement continuum.
4) A review of the family's ecological life context to evaluate sources of stress and support.

5) An examination of the family's developmental stage as well as attention to how the family is performing and coping with tasks appropriate at that stage.

6) An exploration of ways in which the identified patient's symptoms are being used for maintenance of the family's preferred transactional patterns.

From the information gathered in the assessment process, a structural map is formed. A structural map is a visual representation of a family's organization and problematic areas and can also serve to identify therapeutic goals. From here, the therapist begins to redefine or reframe the existing problem(s), establish treatment goals, and work with the family to create a therapeutic contract.

Restructuring

Restructuring operations are the therapeutic interventions that challenge and confront a family to bring about therapeutic change (Minuchin, 1974). Through the use of restructuring techniques, it is the therapist's task to challenge the current family situation and convince members that their current reality can be both expanded and modified. In *Families and Family Therapy*, Minuchin (1974) identifies seven categories of restructuring operations: actualizing family transactional patterns; marking boundaries; escalating stress; assigning tasks; utilizing symptoms; manipulating the mood; and support, education, and guidance.

Actualizing a family's transactional patterns involves moving beyond verbal descriptions of how family members may think they interact with each other, and incorporating observations of non-verbal cues that may support or contradict what the family is telling the therapist. This can be accomplished through enactments, recreating communication channels, and manipulating space.

Enactments are a helpful way of allowing the therapist to experience and observe the ways in which the family naturally resolves conflict, support each other, enter into alliances or coalitions, and diffuse stress. Although the therapist's presence is certainly a modifying factor, enactments can provide the therapist with opportunities to both assess the rules that govern family transactions as well as intervene in unusual patterns. Enactments involve the creation of family scenarios in which certain family members may be instructed by the therapist to interact with other members in clearly delineated ways. By experiencing the family in action, information is gathered about the system's flexibility as well as its capacity for change.

In recreating communication channels, the therapist encourages communication between family members by insisting that members talk with each other, rather than directing all communication towards the therapist. This enables the therapist to pay more attention to the patterned transactions within a family, rather than just the content. Observations gathered from observing family communication may lay the groundwork for future intervention.

Manipulating space and positioning is a technique that encourages dialogue as well as works on boundaries. In this way, geographical positions of family members in a session can provide important clues about alliances, coalitions, closeness, and distance. An example of manipulating space would involve the therapist directing members of a subsystem to move their chairs to the center of the room while other family members move their chairs back so that they can observe and not interrupt.

Marking Boundaries

Boundary making techniques regulate the permeability of boundaries (Minuchin & Fishman, 1981). This is accomplished by modifying interactional processes across existing boundaries between individuals and subsystems. In highly enmeshed families, the therapist's interventions are designed to strengthen boundaries between subsystems and to increase the independence of individuals (Nichols & Schwartz, 1998). Examples include family members being urged to speak for themselves, blocking interruptions, and helping dyads to finish conversations without the interruption of others.

Since disengaged families tend to avoid or detour conflict by minimizing interaction, the therapist may intervene to challenge conflict avoidance in order to help disengaged members increase contact with each other (Nichols & Schwartz, 1998). In this way, the therapist creates boundaries in the session that allow family members to discuss their conflicts without escape or avoidance so that disagreements can be resolved.

Escalating Stress

Through producing stress in different parts of the family system, the therapist can gain a sense of the family's capability of restructuring when circumstances change. Techniques for escalating stress include blocking transactional patterns, emphasizing differences, developing implicit conflict, and joining in alliance or coalition.

Blocking transactional patterns involves suppressing the usual flow of communication. An example of this would be the therapist instructing a child not to interrupt her mother when she usually does. Emphasizing differences involves the therapist highlighting differences that the family members may be ignoring or deliberately not paying attention to. By developing implicit conflict the therapist may force a couple or family members to have conflict in a situation where conflict would usually be avoided. An example of this would be a child becoming disruptive whenever his parents begin to enter conflict. In this case, the therapist would work to block the child's interference in parental conflict in order to allow the couple to communicate. Finally, the therapist can produce stress by temporarily joining one family member or subsystem. This impact will often challenge accustomed ways of communicating as well as preferred ways of negotiating or avoiding conflict. This technique requires careful planning as well as ability on the part of the therapist to be able to disengage.

Assigning Tasks

Tasks draw attention to new possibilities for restructuring the family. By creating a framework within which the family members must interact, the therapist can use tasks to explore new ways of functioning for the family. Tasks assigned within a session may simply indicate how and to whom members should communicate. Tasks can also take the form of homework assignments. This gives the family an opportunity to test out new transactional patterns and exercise them in a natural setting.

The use of tasks has many advantages. By focusing on tasks the therapist is able to deal with family structure and transactional patterns rather than particular characteristics of individual members. Also, tasks can be a valuable means of testing family flexibility. Observing the results of an assigned task can provide clues toward discovering alternative transactional patterns.

Utilizing Symptoms

When a family's presenting problem is particularly painful or dangerous (such as a "patient" suffering from anorexia nervosa) the therapist may decide to focus on the symptom by making it a priority. Minuchin (1974) outlines six restructuring techniques that utilize the symptom: focusing on the symptom, exaggerating the symptom, de-emphasizing the symptom, moving to a new symptom, relabeling the symptom, and changing the symptom's affect.

Focusing on the symptom may represent the quickest way to detect and change dysfunctional family transactional patterns. By recognizing that the identified patient's symptoms represent the family's ways of handling stress, the therapist can begin to work with the family to change the way they are handling the symptoms. A therapist can also use her leadership role to exaggerate the symptom. This is done by reinforcing the identified patient's symptom, thereby increasing intensity. The goal of this maneuver is to exaggerate the symptom to such a point that it becomes extremely unpleasant, thus prompting members to respond in a different way.

At times it is also possible to use the symptom as an avenue to turn attention away from the identified patient. In de-emphasizing the symptom the therapist attempts to focus on other areas that need attention but don't usually take precedence

over those of the identified patient. Moving to a new symptom is another technique that alters the system's concept of the function of a symptom by temporarily moving the focus of therapeutic concentration to another family member. Similarly, relabeling the symptom can bring about new meaning conceptually, resulting in a different way of looking at the problem. Finally, changing the symptom's affect by encouraging family members to interact differently around the problem can be another powerful way of utilizing the symptom as a restructuring technique.

Manipulating Mood

Many families demonstrate a particular kind of affect. In this way, predominant family affect can be seen as a clue as to what is allowable within the family. While taking on the family's affect is a joining technique employed by the therapist, it can also be seen as a restructuring technique. The therapist can accomplish this by using an exaggerated imitation of the family's communicational style, by modeling more appropriate affect, or by using affective components to manipulate distance between members or subsystems in which boundaries are too rigid.

Support, Education, and Guidance

Support, education, and guidance can be seen as both important joining as well as restructuring procedures. The ability of a family to help nurture, heal, and support its members should be recognized and encouraged as vital to the maintenance of the family system. In some instances, the therapist may need to teach members how to interact differently with each other. In working with families that come into contact with multiple societal agencies, the task of the therapist may also be to support and aid the family in mediating and handling them.

Outcome Studies

Outcome studies explore the many influences both in and out of therapy that may help to account for or attribute change to the family system. In this way, outcome studies are designed to assess the effectiveness of a particular therapy, provide statistical information such as the percentage of families that have improved as a result of therapy, and seek to find out which family therapy approaches are most effective. In general, three methodologies of outcome research exist: (1) uncontrolled, single-group studies of the effects of family therapy intervention; (2) comparisons between family therapy as an intervention and no formal treatment; and (3) comparisons between family therapy as an intervention and an alternative treatment modality (Okun & Rappaport, 1980).

Importantly, there are a number of methodological problems that exist within family therapy outcome studies generally. Criticisms include but are not limited to a lack of controlled studies, failure to describe the treatment techniques, inadequate research design, poor data analyses, incongruity between treatment techniques and theoretical framework, the use of outcome measures lacking in reliability and validity, and an absence of effort to replicate positive outcome (Roy & Frankel, 1995).

There are few outcome studies that have been conducted that employ structural family therapy as the primary or central intervention. The first treatment studies conducted by Minuchin and his colleagues during the early stages of family therapy

development took place at the Wiltwyck School for boys and involved research with low socioeconomic families (Minuchin et al., 1967). Later, Minuchin went on to treat and conduct research with psychosomatic families (Minuchin et al., 1978). In the 1967 study, a global evaluation of therapy outcome was conducted with eleven families. Seven were judged by the therapist to be improved after sessions lasting six to twelve months, and four families were rated unimproved. No control group was used in this study comparing conventional treatment at Wiltwyck (Aponte & VanDeusen, 1981).

Minuchin also achieved a great measure of success in the treatment of anorexia nervosa in the family context. Minuchin and his colleagues showed positive results in family therapy with anoretic, asthmatic, and diabetic clients with most psychosomatic patients improving both in regards to symptom as well as family interactions and transactions (Minuchin et al., 1978). After a two to seven year follow-up period, Minuchin et al.'s study showed an 86 percent recovery rate for patients both in terms of symptomology and psychosocial functioning. Although some authors (Aponte & VanDeusen, 1981) feel that these treatment outcomes provide a great deal of support for the efficacy of structural family therapy with psychosomatic families, others caution against how these results are interpreted.

For example, Okun and Rappaport (1980) point out that closer examination of the study's results reveal that structural family therapy was in fact paired with learning theory and the specific application of behavior modification techniques. These authors also illustrate that although the behavioral component is described fully by Liebman, Minuchin, and Baker (1974), it is hardly mentioned at all by Minuchin

(1974). In this way, outcome studies that purport to validate structural family therapy as a sole intervention, may be more accurately viewed as a strong argument for structural family analyses (Okun & Rappaport, 1980).

Stierlin and Weber (1989) conducted a similar study to Minuchin et al. (1978) with adolescents with anorexia and their families and reported a similar success rate at around 85 percent. In addition, Russell, Olson, Sprenkle, and Atilano (1987) implemented a controlled trial comparing family therapy based on the structural model and individual supportive psychotherapy with anorexic clients. Results illustrated that the family therapy group showed significantly greater improvement over the individual therapy patients.

Roy and Frankel (1995) provide a comprehensive review of the outcome literature on the effectiveness of structural family therapy. Their work helps to identify studies in which structural family therapy was used and include work with children, adolescents, and adults.

Ritterman (1978) conducted a study with children diagnosed with attention deficit hyperactive disorder (ADHD) comparing the use of structural family therapy with other treatments. In this study, forty children were randomly assigned to one of four treatment groups: (1) family therapy based on a structural model; (2) combined family therapy and Ritalin; (3) family therapy and placebo; and (4) Ritalin alone. Results showed that Ritalin treatment alone showed the least improvement, while family therapy alone had either a neutral or negative effect. Another key finding was that family therapy and placebo as well as family therapy and Ritalin used together showed most significant improvements.

Further research has pointed to the effectiveness of structural family therapy with specific clinical populations. Stanton and Todd (1982) used structural family therapy in two of their comparison groups for their study of male heroin addicts. The study employed four treatment groups, three of which included the families of the addicts during treatment. The treatment groups consisted of: (1) paid family therapy; (2) unpaid family therapy; (3) family movie treatment; and (4) nonfamily (methadone and individual counseling) treatment. Success was measured in terms of "days free" of drug use. Results showed that the paid family therapy group had a greater average percentage of days free, while the non-family treatment group had the lowest average percentage of days free from heroin.

Szapocznik et al. (1989) studied the effectiveness of structural family therapy versus individual psychodynamic child therapy with Hispanic boys aged six to twelve labeled as problematic. Children were randomly assigned to one of three treatment groups: structural family therapy, individual psychodynamic therapy, and a recreational control group. Results showed that the control group was significantly less effective than treatment. However, both treatment conditions were almost equivalent in their effectiveness on almost all measures. Also, while the children in the structural family therapy group showed improvement in symptoms, there was no parallel change in family functioning. Furthermore, while children in the individual psychodynamic group also showed improvement, general deterioration in family functioning was visible, especially at follow up. In effect, these results refute one of the basic assumptions of structural family therapy – that improved family functioning causes the elimination of symptamology (Roy & Frankel, 1995).

Many studies have also examined the effectiveness of family therapy with adolescents (Aponte & VanDeusen, 1981; Colapinto, 1991). Recent studies include Guldner (1990), who compared the effectiveness of structural family therapy with family therapy using psychodramatic techniques and Stern and Reid's (1999) examination of the relationship between problem and systems change in family therapy. Guldner's (1990) study revealed that, in some categories of families, work with adolescents in a family therapy setting were more conducive to action and activity oriented methods such as psychodramatic therapy, rather than verbal approaches used in traditional structural therapy. One reason for this might be that activity is seen as a function of adolescence and the use of action methods within the therapy process may facilitate engagement more easily in families with adolescents (Carter & McGoldrick, 1980).

Stern and Reid's (1999) study used a multiple tracking design for evaluating problem and systems change in family therapy. The model demonstrates the methods of simultaneously investigating the contribution of family systems processes to problem maintenance and change and the role of treatment in affecting both family processes and problems. Although the authors' utilization of a single case study design does not permit generalization, the multiple tracking time series design used in this study offers considerable insight into the complexity of family and individual change as well as the interrelationships.

Although the structural family therapy model has not developed a separate set of concepts or techniques for working with couples, it is still viewed by structural family therapists as a subsystem, and assessment and intervention generally follow the same

guidelines (Colapinto, 1991). While differences may exist both in emphasis in the choice and application of techniques, the structural family therapy approach to working with couples pays close attention to the context of the couple and the relationship to other subsystems. To date, little to no outcome studies exist offering measures of effectiveness of structural family therapy as a central intervention for doing work with couples. However, a growing body of literature examines and discusses the use of systems based therapy for working with couples with special attention given to issues of gender, race, class, and sexuality (Goodrich et al., 1988; Boyd-Franklin & Franklin, 1998; Crohn, 1998; Bok-Lim, 1998; Johnson & Keren, 1998; McGoldrick, 1989; Papp, 2000, Sanders, 2000; Marvin & Miller, 2000).

Finally, while to date there does not seem to be much in the literature that evaluates structural family therapy from a qualitative perspective, qualitative research in the area of marriage and family therapy is gaining popularity. Largely through the influences of social constructivist and feminist approaches to family therapy, qualitative research challenges the traditional scientist/practitioner model of knowledge generation (Kleist & Gompertz, 1997). According to Denzin and Lincoln (1994), the word qualitative implies an emphasis on processes and meanings that are not rigorously examined or measured in terms of quantity, amount, intensity, or frequency. Examples of couple and family therapy studies using qualitative research as its primary method of analysis include examinations of couple and therapist experiences in reflecting teams, client and therapist perceptions of therapy effectiveness, an exploration of family therapist's perspectives on home-based family preservation services, and an examination of married couples' construction of gender

through work and family decisions (Christensen, 1995; Friedlander et al., 1994; Sells et al., 1996, 1994; Zvonkovic et al., 1996). These studies provide an important beginning and help to pave the way for further emphasis on qualitative research in the area of family therapy in general and structural family therapy in particular.

Critique of Structural Family Therapy

Structural family therapy has been criticized for pathologizing, ignoring the relationship between social context and family dysfunction, and ignoring the political dimensions of family therapy (Myers Avis, 1988). Feminist family therapy, which evolved initially as a critique of family systems theory and family therapy examines how gender roles and stereotyping affect (1) each individual in the family, (2) relationships between individuals in the family, (3) relationships between the family and society, and (4) relationships between the family and the therapist (Goodrich, Rampage, Ellman, & Halstead, 1988). In this way, feminist family therapy provides a link not often found in traditional family therapy, between interactions of family members to the larger social system.

Feminists have also been critical of the language of structural family therapy. Bograd (1988) argues that the terms "enmeshment" and "fusion" are family systems terms that many family therapists regardless of their theoretical preference use as descriptions of dysfunctional family structures and processes. Although enmeshment was defined by Minuchin (1974, 1981) to objectively describe systems, Bograd (1988) argues that in practice it contains biases against women. These biases may in fact serve to pathologize women's differential development, incorrectly determine family

relations that have broader social meanings, and minimize consequences of male/female inequality.

This danger is exemplified in structural approaches to family based practice with single parent families, and its tendency towards judging and pathologizing these families (Myers Avis, 1996). While structural family therapy purports not to view any family as inherently normal or abnormal (Minuchin, 1974), many of the intervention goals and strategies typical to structural family therapy can be seen as treating the single parent family unit as a deficit model (Kissman, 1991). Examples of this include viewing the alternative structure of one-parent households as having dysfunctional boundaries, either diffuse or rigid.

Another example in which structural family therapy serves to portray the single parent system as being inadequate is in the case of the parental child. Although Minuchin (1974) gives brief mention to circumstances in which a parentified child need not be seen as unhealthy, far more attention is paid in the literature to highlighting problems that arise from this situation (Howard & Johnson, 1985, Kissman, 1991). Feminist family therapy operates from the assumption that children who are the product of single parent households are often more autonomous and self-sufficient than are those from "unimpaired" families, and that this can be seen as one of the strengths of one parent units. Furthermore, feminist family theorists contend that increased responsibilities on the part of the sibling subsystem does not necessarily lead to disengagement, nor does the subsystem's boundary diffusion lead to problematic enmeshment (Kissman, 1991).

In addition, research has shown that mother blaming is a pervasive issue that dominates the field of structural family therapy (Myers Avis, 1996). While this criticism has extended beyond structural family therapy theory and practice to other types of psycho-therapeutic practice and intervention, it has been well noted both in the literature that the assumption of women's primary responsibility for child care frequently results in a parallel assumption of their primary responsibility for causing problems with their children. Glaring examples such as Fulmer's (1983) article entitled "A Structural Approach to Unresolved Mourning in Single Parent Family Systems" illustrates this phenomenon. In his study, the author contends that the six year old's temper tantrums were "the result of his mother's depression due to unresolved mourning", and that because of her own uncompleted grief she "restrained her son's expressions of sadness and at the same time refused to take over part of the father's role of effective disciplinarian" (Fulmer, 1983, p. 260).

Structural family therapy has also come under quite a bit of criticism for its way of interpreting family violence and intervention. Although Minuchin and Nichols (1993) state that structural family therapy is an effective model for dealing with violent families and couples, some feminists disagree. Through an examination of specific systems theory constructs such as complementarity, circularity, and neutrality, Goodrich et al. (1988) argues that therapists concern themselves only with the internal functioning of families without altering power differences and ultimately collude in keeping women oppressed.

Goodrich et al. (1988) argue that the intended blamelessness of constructs such as circularity, complementarity, and neutrality actually serve to mask a bias against

women, especially when applied to situations of wife battering. Bograd (1992) states that since systemic theories and interventions were not originally intended to address male violence against women, they fall short in this area. Furthermore, Bograd (1992) argues that applying a systems theoretical orientation to family violence has the dangerous effect of implicating the battered woman and/or diffusing the male's responsibility for the violence. Indeed, tensions exist between feminists who warn against the dangers of co-responsibility which inevitably detract from male responsibility and accountability and those that believe that the task for family therapists is to care about what the family cares about – the whole unit of relationship (Controneo, 1988).

Feminist-informed therapists argue that despite valid and irrefutable concerns about power and abuse within the family and the political dimensions this holds for women, family therapy can be an effective means of treatment because it provides access to the family system. Similarly, the possibility of couple therapy may influence perpetrators who are resistant to treatment to accept services (Trute, 1998).

A pro-feminist approach to couple and family therapy involves the use of systemic interventions that emphasize sensitivity to the gender context of relationships (Trute, 1998). In this model, safety of victims is paramount and successful outcome is defined by this variable and not in terms of whether or not the couple relationship remains intact. It is important to note that this approach views family therapy as a valid option only when violence in the relationship has ceased and not as an approach that is appropriate for stopping violence (Hiebert-Murphy & Trute, 1998). Included in this approach is a recognition that conjoint therapy may be indicated in situations

where women want to stop the violence in their relationship but do not necessarily want the relationship to terminate. Furthermore, this approach to couple and family therapy acknowledges the need for flexibility, employing both individual and conjoint sessions as needed. In addition, since the abuse of women is often correlated with the abuse of children either directly or indirectly, expanding the range of services for couples and families who have experienced violence can also serve to better help respond to the needs of children who have witnessed violence (Hiebert-Murphy & Trute, 1998).

Structural family therapy has also been criticized for being disempowering to clients (Gladding, 1998). This is often illustrated by the expert role assumed by therapists in therapy. Since the structural model advocates that the therapist be in charge of the therapeutic process, this can have important implications for how family dysfunction is identified as well as ways in which family health and normality is defined.

Although the ecological perspective in social work and family therapy has resulted in a broadened view of family interaction with the external environment, structural family therapy tends to focus mostly on internal dynamics within families. While Minuchin (1967, 1974, 1993) offers brief mention to the role of therapist as social advocate, little attention is paid to concrete strategies to put these ideas into action. A predominant criticism by feminists of structural family therapy is its lack of recognition that the personal is political and that change and intervention must occur both at the practice and policy level (Goodrich et al., 1988). More recently, Minuchin has begun to focus not only on the problems that reside within the family system, but

also on the systems that families interact with in the broader social environment, specifically multi-problem families. In this way, greater attention is being paid to advocacy as well as coordination of intervention and services, with structural family therapy being only one of these (Minuchin, Colapinto, & Minuchin, 1998).

Finally, it is important to note that while structural family therapy possesses some significant limitations in terms of offering a feminist analysis, the model also contains many strengths. For instance, structural family therapy offers therapists a model which is action-oriented and clearly defined. This makes it an ideal approach for beginning family therapists as it offers a solid foundation in family therapy concepts and techniques (Figley & Nelson, 1990). Structural family therapy is seen as a highly teachable model for the reason that it takes something as abstract as the family and organizes it into concepts like boundaries and hierarchy (Simon, 1995).

Structural family therapy has and continues to have a major impact on the field of family therapy in general. The model is unique in that it was developed from work with financially disadvantaged families, with an emphasis on family social context. In this way, structural family therapy can be seen as approach that both recognizes and builds on family strengths, although this is not necessarily true in every case. Primarily, structural family therapy focuses on restructuring the family to eliminate dysfunctional interactions. While there has been some criticism that structural family therapy solely involves restructuring, Wetchler (1995) argues that the model contains important qualities such as an emphasis on family competence and uniqueness. These qualities focus on family strengths by acknowledging a family's capacity to find alternate solutions to dealing with their problems.

Conclusion

Structural family therapy has evolved considerably over the years, but has retained several basic concepts. These include attention to boundaries, roles and rules, families as systems and subsystems, hierarchy, and issues of power. In this way, structural family therapy can be seen as a useful model for beginning family therapists. Clearly, structural family therapy makes some assumptions about family health and normality, and may be seen by some as fostering an expert rather than collaborative approach. Structural family therapy is suitable in a variety of cases as demonstrated in the empirical literature, and continues to be used today as popular family therapy model.

Although, structural family therapy has been criticized by feminists for its lack of attention to issues of gender and power, examples of pro- feminist approaches to structural and systems-based family therapy as mentioned earlier are beginning to emerge in the literature. While this approach exists today in a variety of integrated forms, structural family therapy is still viewed by many practitioners as a popular and useful tool for both teaching and conducting family therapy.

SECTION TWO: PRACTICUM SETTING AND PROCEDURES

SETTING

The setting for my practicum was the Elizabeth Hill Counselling Centre (EHCC). The EHCC is located in downtown Winnipeg and provides free services to couples, families, and individuals in all areas of Winnipeg. Professional referrals to the centre are not required, however many referrals from schools, health care professionals, and Child and Family Services are seen at EHCC. The EHCC is operated by the University of Manitoba and serves as a training facility for students from the Faculty of Social Work and the Department of Psychology.

CLIENTS

The clients who participated in my practicum consisted of both self-referred families and families referred for therapy through a professional agency. Three of the families were referred through Child and Family Services, and one family was referred through another community treatment agency. The remaining five families were chosen from the general waitlist. Of the nine families I worked with, two terminated prematurely. The remaining seven families attended a minimum of three sessions, with sessions ranging from three to ten sessions. Although the "family" was

the population I chose to work with, family was defined broadly and included three couples, and four single parent families.

PROCEDURES

The procedures that I followed throughout my practicum were consistent with the procedures followed at EHCC. All of my clients were informed that I was completing my Masters in Social Work, and that their participation was part of a Masters practicum. All of my clients were ensured confidentiality and encouraged to ask questions about the therapeutic process. Consent forms, intake reports, case notes, and termination reports were written in accordance with the requirements at EHCC.

In addition, weekly therapy sessions were videotaped to enhance my learning as well as to provide my supervisor with an opportunity to review my sessions. Clients were informed about this procedure prior to intake and were asked to provide their written authorization. One family expressed extreme discomfort around videotaping procedures and as a result videotaping did not occur. All of the tapes were erased at the conclusion of my practicum.

The process of therapy with each couple or family followed similar procedures. Once identified from the waitlist, the families were called to book an intake session. After explaining the procedures at EHCC regarding supervision and confidentiality, the family was asked to offer a brief description and update on the presenting problem. Once this information was obtained an intake session was scheduled and all relevant family members were invited to attend.

All of the families that I worked with were counselled at EHCC. The purpose of the intake session was to orient the family to EHCC, join with them, and gather more information about the family situation. The assessment process included an analysis of family structure, subsystems, boundaries, developmental stage, and overall family functioning. In addition, during the first or second session, the families were administered a pre-test Family Assessment Measure III which helped contribute to the assessment process.

SUPERVISION

Dr. Diane Hiebert-Murphy provided primary supervision for all of my families. Clinical supervision was held on a weekly basis whereby Dr. Hiebert-Murphy would meet with me for approximately two hours to review my cases, provide consultation and feedback in regards to developing hypotheses and planning interventions, and critically evaluate my progress.

David Charabin is the Director of EHCC and served as the second committee member on my practicum. He provided supervisory duties in Dr. Hiebert-Murphy's absence. My final committee member was Kathy Levine of the Child Guidance Clinic. She too, provided guidance and support throughout the process.

THE FAMILIES

Families that participated in this practicum were drawn from the EHCC general waitlist and the Child and Family Services waitlist at EHCC. Since the primary purpose of this practicum was to enhance my clinical skills and knowledge of family

therapy, I chose clients who were seeking either couple or family therapy. Altogether, three couples and six families were seen for the purposes of this practicum with number of sessions ranging from one to ten.

The A couple, discussed in greater detail in section three, self-referred to EHCC. The system consists of a young man and woman with no children who were engaged to be married. The presenting issues for this couple were communication difficulties, increased fighting, and a fear on the female partner's part that the relationship was falling apart. During the assessment, it became apparent that each partner struggled with issues related to family of origin, and that these struggles were causing considerable tension in the couple relationship. In addition, it was evident that the system was stuck in some negative interactional patterns which served to contribute to increased arguing. Restructuring by drawing clear boundaries between the couple relationship and each partner's family of origin became a central intervention, as well as the reprocessing of emotions underlying each partner's interactional position in order to create new and more effective interactional patterns. The couple was seen for ten sessions, including two with Ms. A alone, one with Mr. A alone, and seven conjoint sessions.

The B family, which will also be discussed further in section three, consists of a single mother and her eleven year old daughter. This family was referred through Child and Family Services. The presenting issue for this family was difficulties surrounding Ms. B's daughter's behavior which included not following the family rules, staying out all night and not calling home, and on one occasion coming home high. Although this family was initially referred because of complaints about Ms. B's

daughter, once therapy began it became evident that a certain amount of distance existed between Ms. B and her daughter, and also, that Ms. B was experiencing a significant amount of grief and trauma related to an abusive past, the death of her brother, as well as the recent apprehension of her younger children. Intervention was directed at re-structuring the relationship between mother and daughter and empowering Ms. B in her parental role, as well as fostering new and more effective communication both between mother and daughter and outside systems. The B family was seen for a total of five sessions including one session with Ms. B's daughter, one session with Ms. B, and three sessions with Ms. B and her daughter together.

The C family consists of a single mother and son aged twelve, who self-referred to EHCC. The family came to EHCC for help regarding Ms. C's son's behavioral problems. Behavioral difficulties included problems with anger such as swearing at his mother, shouting, slamming doors, and stealing. In addition Ms. C's son had difficulty completing homework assignments which had resulted in failing grade six the previous year. After assessing the family, it appeared that Ms. C was not always appropriately situated in the hierarchy that existed between parent and child. In fact, at times the relationship appeared to be more like one of peers or even partners. Further, difficulties in communication appeared to exist between Ms. C and her son's school, with Ms. C often feeling left out or uninformed about her son's progress within this system.

Restructuring, by creating clearer boundaries between the parent-child relationship served as an important intervention for this family. In addition, empowering Ms. C in her parental role proved helpful in fostering more open

communication between Ms. C and her son's teachers. This family was seen for four sessions including two with Ms. C and her son, one with Ms. C's son, and one with Ms. C.

The D couple self-referred to EHCC. The system consists of a common-law couple living together approximately one year. Although the initial referral for therapy was a non-violent couple referral, it became apparent at the onset of conjoint therapy that violence and jealousy were issues in the relationship. As a result, the couple was referred to the Couples project, a counselling program at EHCC for couples where violence has been an issue in the relationship, and myself and a male co-therapist continued to see the couple. The presenting issue for the D couple was Mr. D's jealousy and insecurity in the relationship and the negative impact this was having on both Ms. D and the relationship. In addition, escalating arguments which usually occurred during times when Mr. D was using alcohol were also seen to be a problem.

The focus of therapeutic involvement included a thorough assessment in which Mr. and Ms. D. were seen separately for several sessions in order to determine suitability for conjoint work. Interventions were focussed on interviewing each partner individually to assess level and risk of abuse, developing a safety plan with Ms. D, ensuring that each partner was aware of available community resources and crisis services, and a recommendation that Mr. D attend an educational group to deal with his use of violence at an individual level prior to beginning couple therapy. In total, this couple was seen for ten sessions at EHCC: two conjoint, four sessions with Ms. D, and four sessions with Mr. D.

The E family consists of a foster mother and six year old son. This family was referred to EHCC through a community agency. I worked exclusively with Ms. E and later referred Ms. E and her foster child to the parent-child program at EHCC. The presenting issue for the E family was chronic stress experienced by Ms. E as a result of severe behavioral difficulties on the part of Ms. E's foster son. Ms. E indicated feeling overwhelmed and questioned how much longer she would be able to sustain her foster child in her home. Intervention focussed on highlighting Ms. E's strengths as a parent, exploring her support networks and problem-solving around ways to build up this network, referring Ms. E and her son for theraplay to help deal with Ms. E's son's attachment difficulties, and organizing a systems meeting in which workers from various agencies collaborated and shared information to ensure the best possible coordination of service delivery for the family. Ms. E was seen for four sessions, three of which were with Ms. E alone and one which was a systems meeting.

The F family consists of a mother and a fourteen year old son. The referral for therapy was made through Child and Family Services, although Mrs. F made the phone call to EHCC herself. The presenting issue for the F family was anger on the part of Mrs. F's son. According to Mrs. F her son harbored a great deal of anger and aggression and sometimes took it out on his younger siblings. In one instance, Mrs. F reported that her son had lashed out and punched her. Mrs. F requested assistance with handling her son's anger and also hoped that counselling would provide a space for her son to talk about his feelings.

Therapy with the F family focussed on joining with the client system and exploring the presenting problem. Therapeutic efforts involved assessing family

structure, exploring relational issues between subsystems through the use of a genogram, and exploring ways to strengthen the parent-child relationship. This was facilitated through a discussion about rules and regulations in the household as well as an examination of Mrs. F's role as mother to her children as well as wife to her new husband. In addition, ways in which Mrs. F and her son could engage in conversations about his experience in foster care were explored. Therapy was framed as an opportunity for Mrs. F and her son to spend one-on-one time together, since Mrs. F was often overwhelmed by the demands of her five younger children. The F family was seen for a total of three sessions, two with Mrs. F alone, and one with Mrs. F's son. Mrs. F.'s son refused to attend counselling with his mother.

The G couple consists of a common-law couple with two preschool children. The referral for therapy was made through Child and Family Services. The presenting issues for the G couple were Mrs. G's difficulty trusting Mr. G., communication problems between the two partners, and a difference in parenting styles.

Following the assessment process it became apparent that Ms. G was experiencing grief and mistrust from an affair that had happened in the relationship a few years ago. Although the couple were now considering marriage, Ms. G felt it was important to resolve these issues first. Before the onset of conjoint therapy an assessment took place to screen for issues of violence or abuse in the couple relationship. This was seen as an important intervention as Mr. G had a past history of violence in his couple relationships. The assessment indicated that violence and abuse were not issues for this couple and conjoint therapy ensued.

Therapy focussed on exploring and reprocessing emotional experiences, building and repairing trust in the relationship, facilitating healing from past hurts and strengthening communication in the couple relationship. The G couple were seen for a total of eight sessions, two with Mr. G alone, one with Ms. G, and five conjoint sessions.

The H family consists of a single parent mother and her two children age twenty and seventeen. Ms. H self-referred to EHCC for assistance dealing with difficult behavior on the part of her seventeen year old son. Presenting problems included difficulty handling her son's angry outbursts, swearing, and disregard for household rules. Initial assessment also revealed that Ms. H was experiencing some unresolved grief as a result of a suicide attempt made by her daughter one year earlier. Ms. H was seen alone for a total of one session at EHCC as her son refused to attend therapy.

The I family consists of a single parent mother and her two daughters age twelve and ten. Ms. I also has three other children who are currently in care. Presenting issues for the I family included increased fighting in the family, lack of adherence to household rules on the part of both of her daughters, and a strong emotion on the part of Ms I that her children did not respect her. The I family was seen for one session at EHCC.

EVALUATION

Evaluation was completed using a pre-test post-test design. The FAM III (1983) general scale was used before and after intervention with each family in order to assess the effectiveness of treatment. Clients also completed a qualitative

questionnaire at the end of therapy to assess the family's level of satisfaction with the therapeutic experience.

The FAM III was developed by Skinner, Steinhauer, and Santa-Barbara (1983). This scale utilizes a systemic perspective to measure levels of health and family functioning. The FAM III (general scale) is a self-report measure comprised of fifty items based on a four point Likert scale. The measure contains nine subscales that evaluate family functioning in the areas of task accomplishment, role performance, communication, affective expression, involvement, control, values and norms, and two subscales that identify response bias (Skinner et al., 1983).

The FAM III (dyadic scale) was used to evaluate the couples that participated in this practicum. The dyadic scales are most useful for detecting areas of conflict or tension as perceived by each of the partners (Skinner et al., 1995). Elevated scores indicated areas of overt conflict or tension, while discrepancies in the partners' perceptions of their relationships often suggested difficulties in problem solving and/or covert marital conflict. Similar to the general scale, the FAM III dyadic scale contains nine subscales, including two subscales that identify response bias.

The FAM III has demonstrated good internal consistency and reliability (Skinner et al., 1983). With a coefficient alpha of .93 for adults and .94 for children, the FAM III shows significant internal consistency between subscales and distinguishes between clinical and non-clinical families. There have been no test-retest reliability coefficients reported for this measure. Although the FAM III should not be used as a substitute for clinical assessment, it can serve as a complement as it provides a good overview of family functioning, and may also alert the therapist to problematic areas.

The client feedback form consisted of five questions. Clients were either asked to fill out this form after the last session or had the forms mailed out to them. Two of the questions were based on a four point likert-type scale, and the other three were designed to elicit a more qualitative response.

SECTION THREE: CASE STUDIES

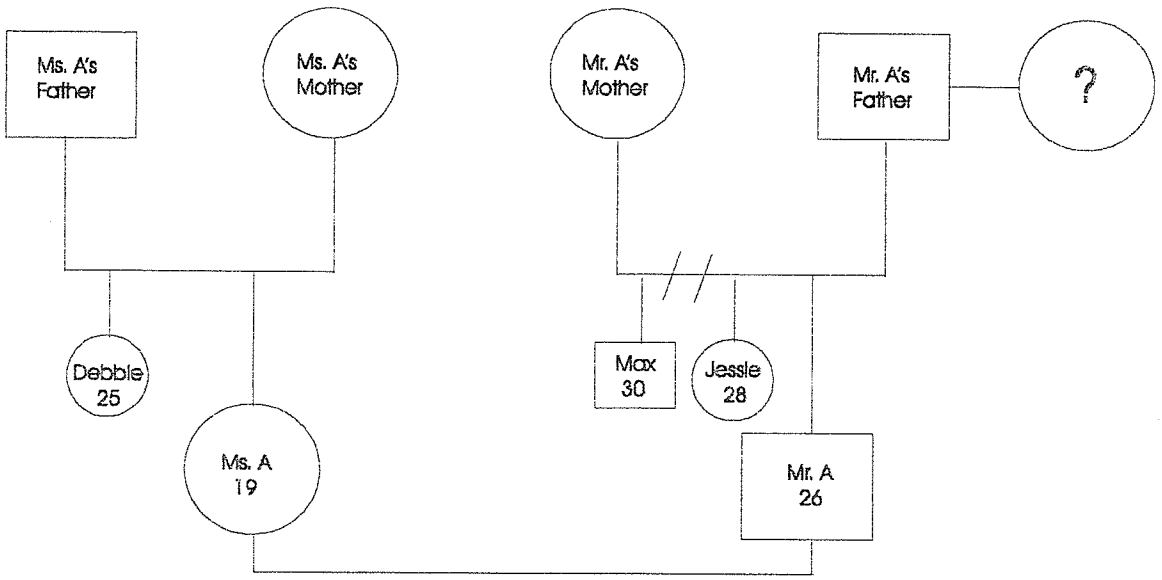
Introduction

This chapter provides case studies of two of the nine families that participated in my practicum. Since this practicum involved both couple and family work, I have selected one couple and one family to use as case studies. My analysis and description of the following two cases involves a structural family therapy approach, but also illustrates the need for flexibility which at times may include assisting families from a variety of counseling perspectives to best fit their needs. While still unique, these two cases are representative of some of the broader issues that faced many of the clients with whom I worked. This section will include a discussion of the presenting problem, an assessment, a description of the intervention(s), and evaluation. Families will be assigned pseudonyms to protect confidentiality.

THE A FAMILY

The A family consists of a young couple with no children who are engaged to be married (see Figure 1). The couple has been together approximately one and a half years with neither partner having been married previously. Both Ms. A and Mr. A grew up in the same small town, and to some extent were familiar with each other's families. Prior to the couple's relationship, Ms. A had been involved in a series of negative relationships with boys from her high school and reported being sexually assaulted by a friend's family member in early adolecence. While Ms. A indicated that she had reported the incident to police, she described not being believed by her

Figure 1 : Genogram
The A Couple



parents and a general lack of support from her home community. Ms. A indicated that she had received prior counselling on this issue, but admitted that she still struggled with issues around clinical depression, post traumatic stress, and anxiety, and that these issues significantly effected her abilities to experience trust in her relationship.

Mr. A became involved with Ms. A shortly after completing a one year residential treatment program for drug and alcohol addictions. Mr. A reported being clean for almost two years, and indicated that his relationship with Ms. A had played a central role in his recovery process. Mr. A described feeling stigmatized in his home community as well as disliked by Ms. A's family. Mr. A also reported feeling somewhat disengaged from his family of origin, with the exception of his mother who currently lives in another province.

Presenting Problem

Mr. and Ms. A self-referred to EHCC for counselling. Although initially Ms. A indicated that she was also seeking individual counselling she stated that couple therapy was her primary concern at this time. Ms. A indicated that in the past few months, since the couple had moved in together, difficulties had begun to arise. Ms. A reported that fighting had increased and that Mr. A would often go out after work with his friends and stay out very late without informing Ms. A of his whereabouts. Ms. A stated that no violence existed in the couple's relationship, however arguing had become increasingly escalated with the couple's communication involving much yelling and screaming with long periods of not speaking to each other at all.

Assessment

Structure:

Mr. A and Ms. A, living together with no children, constituted a newly married couple, even though they are not yet legally married. A rigid boundary existed between Ms. A and her family of origin with Ms. A's mother appearing to be a prominent player in the couple's life. At times the boundaries between Ms. A and her family (especially her mother) appeared ambivalent and seem to alternate between being enmeshed and disengaged. Ms. A expressed love and concern for her family and at other times stated that she wanted nothing to do with them. Ms. A's style of relating with her mother appeared to signify a deep enmeshment, as well as some difficulty on the part of Ms. A to differentiate herself from her family of origin.

Mr. A, a laid-back and quiet individual sometimes appeared quite immature. The boundaries between Ms. A and Mr. A appeared quite rigid, with Ms. A attempting to control Mr. A's recreation time as well as his interaction with his family of origin. A somewhat enmeshed relationship existed between Mr. A and his mother with Mr. A describing nightly phone conversations with his mother as well as an acknowledgement that he is his mother's favorite child. Ms. A had attempted to develop a relationship with Mr. A's mother and reported a chilly reception. The tension between Ms. A and Mr. A's mother affected the relational patterns between the couple in that Ms. A feels envious of the time and energy Mr. A puts into his relationship with his mother. Consequently, a power struggle has ensued between Ms. A and Mr. A's mother creating dysfunctional and complementary interactional

patterns in which Ms. A is generally active and pursuant of Mr. A and Mr. A is generally passive and distant. This pattern is further illustrated by Ms. A's increasing demands to spend more time together, with Mr. A feeling smothered and overwhelmed.

A power imbalance in the couple subsystem clearly existed. Ms. A appeared to have few if any friends or close relationships outside of Mr. A. Ms. A appeared to resent social and recreational time that Mr. A spent with friends or colleagues. In addition, both Mr. and Ms. A work full-time with each of their jobs requiring shift work that is often opposite to each other's schedule. Their limited private time together as a couple combined with Ms. A's lack of social supports has contributed to rigid boundaries around the couple relationship.

Flexibility:

The flexibility of the A family appeared adaptive at some levels but lacked flexibility at others. For instance, both Mr. and Ms. A earned income and contributed to household finances and functioning. Upon moving in together, the couple easily established a pattern of mutual complementarity in which Ms. A organized and paid household bills while Mr. A was in charge of groceries and general household maintenance. Despite Mr. and Ms. A working opposite schedules, a routine pattern had developed on which each partner could rely.

On the other hand, Mr. and Ms. A appeared inflexible in their ability to negotiate rules around intra and extrafamilial relationships. This appeared to have resulted in a rigid pattern of closeness and distance between the couple depending upon Ms. A's perception of time and attention focussed on the relationship by Mr. A.

Ms. A was very critical of time or attention spent by Mr. A with peers, and Mr. A alternated between being resentful of Ms. A's overinvolvement in his life and also being flattered and appreciative.

Cohesion:

The couple subsystem appeared somewhat disengaged at the affective level. At times, Mr. and Ms. A appeared emotionally distant from each other, while at other times they exhibited caring and nurturance appropriate for a newly engaged couple. The couple appeared to struggle with ambiguity surrounding rules, regulations, and roles within their newly formed relationship and lacked clear boundaries of involvement. An example of this was when during the space of one session Ms. A threatened to call off the wedding if Mr. A continued to stay out all night with his friends, then later in the session became affectionate and merely requested that Mr. A call and let her know he'd be late.

Cohesion between each partner and their respective families of origin seemed tenuous, with Mr. A displaying an over-involvement with his mother that is not age-appropriate. Ms. A, on the other hand, appeared to be struggling with both over and under involvement with her family of origin, specifically her mother.

Life Context:

Mr. A came to this relationship with a reported history of drug abuse. He reportedly spent one year in a residential treatment facility but did not graduate from the treatment program as a result of his decision to move in with Ms. A. Mr. A stated that he no longer receives support from this facility due to the organization's religious

orientation and Mr. A's perception that the organization disapproved of the fact that Mr. and Ms. A are living common-law. Mr. A cited his own strength and resilience as well as the love and encouragement of Ms. A as important sources of support in his life.

Ms. A came to this relationship with a past history of sexual abuse and self-harming behaviors. Although Ms. A had received several different forms of counselling and therapeutic services to deal with past trauma, she had not received any support around these issues from family members or friends. Ms. A reported that as a result of her past experiences, her ability to trust and form close and intimate relationships has been impaired. Ms. A cited Mr. A as an important source of support to her and stated that at times she has been able to share feelings about her past with Mr. A.

Mr. and Ms. A have not developed many mutual friendships, with Mr. A primarily spending his leisure time participating in sports and recreational activities with community members or peers at work. Ms. A reported having difficulty forming friendships with women her own age, and cited one close friendship with an older women who lives outside the province.

Developmental Stage:

This system is developmentally at the life cycle stage of joining as a couple and becoming a new family. Several developmental issues are salient to this stage and they include renegotiating issues that have previously been defined individually; renegotiating relationships with parents, siblings, and friends; and forming a close

relationship with one's partner based on intimacy rather than fusion (McGoldrick, 1989).

These issues were especially relevant for Ms. A and Mr. A as they attempted to resolve tensions stemming from each other's parent and sibling relationships and plan a wedding that will ultimately mark the change in status of family members and shift the family organization. In this stage, pre-marital counselling can be seen as an important intervention to help couples negotiate the transition and develop preventative strategies for dealing with extended family and other subsystems in the future (McGoldrick, 1989).

A common difficulty at this stage of the developmental cycle is the confusion between intimacy and fusion. Indeed, there "is a vast difference between forming an intimate relationship with another separate person and using a couple relationship to complete one's self and improve one's self-esteem" (McGoldrick, 1989, p. 213). Since gender differences also exist in the way fusion and intimacy are experienced, it is not surprising that Ms. A appeared to place greater importance on emotional intimacy in the couple relationship to the point where she felt she was "losing herself". In contrast, Mr. A appeared to experience Ms. A's desire for closeness and intimacy as frightening. This pattern closely resembles Bowen systems theory (1978) which relates a partner's ability to complete him/herself in the partner to the degree that s/he has failed to resolve his/her relationships with his/her parents.

Role of the Symptom Bearer:

Increased fighting in the couple relationship had forced Mr. and Ms. A to closely examine their upcoming decision to marry and commit to each other in a more permanent way. In addition, each partner brought to the union relational difficulties with family of origin as well as past histories which are potentially frightening to the other partner. These concerns were being detoured through the couple's struggle for closeness and distance in the relationship causing negative interactional patterns between the couple and threatening the stability of their relationship.

Hypotheses:

The development of the couple subsystem was constrained by loyalties and relational ties to each partners family of origin making it difficult to develop a new family system. Boundaries around the couple relationship as well as intra and extra-familial relationships needed to be renegotiated as each partner transitioned from his/her role as a young single adult to that of a married couple. The need to find a balance between each partner's role as daughter/wife and son/husband required a shifting in identities as well as a clear yet flexible definition of boundaries between the couple subsystem and that of their families of origin. The couple also struggled with issues of complementarity in which Ms. A is overinvolved and pursuant of Mr. A and Mr. A is underinvolved and distant. This has resulted in a power struggle in which Ms. A has become overly controlling of Mr. A's relationships and leisure time, with Mr. A refusing to take responsibility for his part in the relationship. In addition, each partner felt threatened by the other's past, and this too was played out through

controlling behaviors. Finally, Ms. A needed to increase her network of social support in order to address her needs for friendship and connection, decrease social isolation, and apply less pressure on the couple relationship.

Goals:

Four goals of Intervention were identified:

1) To identify and alter negative interactional patterns that contributed to tension in the couple relationship such as the distancer/pursuer pattern.
2) To address issues around each partner's past that were perceived as threatening to the couple subsystem.
3) To strengthen the couple bond and protect it from other subsystems, mainly each partner's family of origin.
4) To expand Ms. A's formal and informal social support network.

Interventions:

Although the couple's original request for therapy was intended to include both partners, Mr. A was not available to attend the initial session. For this reason, Ms. A attended the first session on her own, with much of the first session spent getting to know Ms. A and her view of the situation. Mr. A attended subsequent sessions with Ms. A and was also seen for an individual session later in the process as a means of balancing the process. A total of ten sessions were held with the A couple: two sessions with Ms. A alone, one session with Mr. A alone, and seven conjoint sessions.

The process of joining with Ms. A and Mr. A was a central part of the intervention. This was seen as especially important with Mr. A as Ms. A attended the

first therapy session on her own thereby creating a bit of a power imbalance at the outset. In joining with Ms. A during the first session I played the role of supportive listener. I expressed empathy for Ms. A by reflecting back the difficulties she was experiencing and letting her know that I understood what she was describing. Throughout the session I listened for areas of strength and competency and made a point of highlighting these areas for Ms. A.

Joining with Mr. A presented a slight challenge since Ms. A and I were already acquainted with each other from the first session. To guard against feelings of discomfort or secrecy after introducing myself to Mr. A, I invited Ms. A to provide a recap of what we had discussed during the first session. This intervention served to include Mr. A in the session that was missed as well as create an opportunity for Ms. A to speak directly to Mr. A rather than to me. In addition, I invited Mr. A to share his perspective of the couple's problems. During this session I attempted to provide Mr. A with extra air-time in order to join with him and create an atmosphere in which each partner felt his/her views were respected. The process of joining proved to be extremely important as it paved the way for further interventions.

Upon gathering more information from Ms. A and Mr. A as well as observing the dialogue that took place in our sessions, it became apparent that the couple frequently engaged in negative interactional patterns whereby Ms. A would become highly emotional and blaming towards Mr. A and Mr. A would become quiet and distant. At times it became necessary to align myself with Mr. A to balance out the therapeutic system. In structural terms, this alliance was important in order to ensure Mr. A's views and ideas were heard in session. In addition, my occasional alignment

with Mr. A created a therapetic triangle, which allowed the system to maintain relative stability while the couple addressed issues that would normally be too threatening. Though at times I felt discomfort as an ally to Mr. A, I attempted on many occasions to balance this by emphasizing Ms. A's strengths both as a woman and a partner and this appeared to offset any imbalance of power that may have been created by these temporary alliances.

Identifying this negative interactional pattern for the couple proved to be an important intervention. Pointing out and illustrating for Ms. A and Mr. A the ways in which their behaviors and actions served to compliment each other but at the same time caused difficulties in their relationship provided an opportunity to examine new ways of interacting. Several useful questions became important to explore: What made it difficult for Mr. A to assert himself and/or provide Ms. A with the nurturance and support she needed? What caused Ms. A to push Mr. A harder when her needs were unmet and eventually led her to withdraw? By exploring these and other questions the couple was able to verbalize feelings that were underlying these interactions such as fear and insecurity on Ms. A's part and loneliness and inadequacy on Mr. A's part.

Another important intervention used was designed to address areas about each partner's past that the other perceived as threatening. To achieve this, an emotionally focussed approach to counselling couples was also used in therapy sessions (Johnson, 1996). In this way, intervention focussed on accessing unacknowledged emotions that were underlying negative interactional sequences. For example, Ms. A explained that part of the reason she behaved so restrictively about Mr. A's leisure time was because

she feared Mr. A would start spending time with friends who abused drugs and alcohol thereby creating opportunities for Mr. A to "fall off the wagon." Conversely, Mr. A expressed feeling the need to distance himself from Ms. A, finding the intensity of her feelings at times to be overwhelming as well as feeling pressure to "fix" her past problems. The couple's ability to verbalize these fears and my efforts to reframe the problem in terms of underlying emotions proved to be somewhat successful.

Another intervention that proved significant for this couple involved the marking of boundaries between the couple and other subsystems. This was facilitated by the drawing of a genogram illustrating each partner's family of origin. This proved to be a practical and useful tool for understanding family patterns as well as educating each partner about his/her family history and relationships. Through the use of different colors and symbols difficult or negative relationships became distinguished from warm and close ones. In essence the genogram provided an excellent means of both assessment and intervention as it created dialogue between the couple and allowed the therapeutic system to explore ways in which the couple relationship might be "protected" from outside interference. Boundaries between the couple relationship and outside relationships were marked by the establishment of a set time each week in which the couple would spend time together alone without interference from each other's families. Boundaries were drawn around issues that were seen as inappropriate for Mr. A to discuss with his mother about the couple's relationship. In addition, during a subsequent individual session with Ms. A an exploration of ways that Ms. A could draw clear yet flexible boundaries between her role as daughter and

sister and that of wife to Mr. A took place. Ms. A and Mr. A appeared to respond well to this approach, with both partners citing time alone together to be very valuable.

Finally, the task of expanding Ms. A's formal and informal social support network was seen as an important intervention. This was facilitated by providing Ms. A with information and phone numbers of relevant support groups and couselling services to address some of her individual issues. Between sessions, homework tasks helped Ms. A to record thoughts and feelings in her journal as well as document the frequency and intensity of her emotions. Personal safety and self-care plans were developed and information about crisis services were reviewed. Ms. A was encouraged to practice positive coping skills that she had learned both in past and present therapy such as calling a friend to talk when feeling sad or lonely, going for coffee with a co-worker, or going for a walk. Though Ms. A did need constant support and encouragement to reach out to others, she indicated feeling positive and less isolated when she spent time with peers.

Evaluation:

The FAM-III Dyadic Relationship scale was administered to Ms. A and Mr. A as both a pre-test and a post-test (see Figure 2). The results indicate that the couple possessed many strengths. Areas in which the couple showed competence included values and norms, task accomplishment, role performance, and communication. Areas in which the couple showed possible confusion or conflict were control, involvement, and affective expression. This was indicated most significantly in the area of involvement where there was a large discrepancy in scores between Mr. A and Ms. A. This was consistent with my clinical observations that emotional distance existed

FIGURE 2

DYADIC RELATIONSHIP SCALE

T-SCORES

	Ms. A Pre-Test	Ms. A. Post-Test	Mr. A Pre-Test	Mr. A Post-Test
Over-all Rating	48	48	58	55
Task Accomplishment	54	52	58	56
Role Performance	46	46	54	56
Communication	40	44	52	52
Affective Expression	56	54	60	56
Involvement	26	32	58	56
Control	60	58	68	60
Values and Norms	52	52	56	52

T-SCORES	LOW	HIGH
Family Strength	20	40
Average Range	40	60
Family Problem	60	80

between Mr. A and Ms. A in the area of involvement with Ms. A often being overinvolved and Mr. A being underinvolved.

While the pre-test and post-test scores appeared somewhat similar, a slight change was noted in the areas of affective expression and control. Though scores were still elevated close to a T-score of 60 (which normally indicates a greater likelihood of disturbance) in the area of affective expression, the post-test indicated greater congruence between scores. This suggests both improvement and a greater degree of agreement about how the couple expresses both the content and intensity of their feelings. As well, scores were less elevated in the area of control at post-test indicating that struggles for control had lessened somewhat.

The FAM-III dyadic measure was supplemented by a client feedback form (see appendix A) at the termination of therapy. This questionnaire elicited a more qualitative response to the couple's experience of the therapeutic process. Both Ms. A and Mr. A indicated that much improvement in their relationship had occurred as a result of therapy. Ms. A cited "understanding each other better" and "less fighting" as helpful aspects of therapy and Mr. A cited "getting to know my wife better" as particularly helpful.

Conclusion:

My experience counselling Ms. A and Mr. A provided me with my first opportunity to practice couple therapy. Emotionally focussed interventions proved to be particularly valuable in working with this couple. In particular, emotionally focused therapy provided me with tools and ideas around re-processing emotions that

the couple was experiencing. At times this involved helping the couple to access and describe unacknowledged emotions such as fear, insecurity, and vulnerability. Emotionally focused therapy provided guidance and direction with re-framing relational problems the couple experienced in terms of underlying emotions and needs. In this way, emotionally focused therapy provided me with a means to address emotions associated with negative interactional patterns in a way that structural family therapy did not.

Structural family therapy also provided a useful paradigm for working with this couple. Concepts such as developmental stage of the family were especially significant as it allowed for an in-depth exploration of each partner's family of origin issues as well as relationships between subsystems. In this way, the structural family therapy model provided me with a framework for change that allowed the couple to both identify and explore relational patterns and draw clear yet flexible boundaries around their relationship and other family relationships to create greater harmony.

In addition, structural family therapy provided me with important tools for both assessment and intervention in working with the A couple. In this instance, joining with Ms. A and Mr. A proved crucial as it laid the groundwork for trust and risk-taking in future sessions. Tracking the couple's interactional patterns and later identifying and reframing these interactions for the couple proved to be appropriate interventions as later evidenced at the outcome of therapy. As well, the use of homework tasks proved beneficial for Ms. A as it served as an impetus for her to gain greater insight into her feelings as well as form relationships with others and build a stronger support system.

Finally, although the structural family therapy model may not always be the most effective model for working with couples, it may certainly appear advantageous with young couples who are in the process of joining together for the first time and separating from their families of origin. Certainly, challenges exist in terms of meeting the needs of the individual partner within the couple relationship, but can be adequately addressed within the structural family therapy model through the use of boundaries. This was illustrated in working with the A couple by conducting individual sessions with Ms. A as needed to assist her in addressing personal issues related to her past that did not directly concern the couple relationship. In this way, separate sessions with Ms. A proved helpful, as it allowed her to explore and address personal issues she felt she needed to deal with, while at the same time it created a boundary around individual and couple issues. Over the course of therapy, the couple was given the opportunity to explore and learn about each other's family of origin, identify and alter negative interactional patterns of communication, and gain a greater degree of insight into emotions underlying these patterns. Couple work was complimented by a few individual sessions which served to lengthen the process of therapy but enhanced and provided opportunity for individual support and growth.

Limitations of the model centered around structural family therapy's focus solely on the problem and dysfunctional interactional patterns supporting the problem. Significantly, in work with couples I found it helpful and indeed necessary to enhance the couple's communication patterns through the use of insight and emotions. Since structural family therapy is not geared towards insight and understanding of the problem, but rather towards shifting negative patterns of interaction through structural

change, I found it to be limiting in this area. Further, structural family therapy was limited in its analysis of gender and its impact on family and couple relationships. Specifically, in working with couples, I found it impossible not to address gender role patterns in the relationship and examine the ways in which these patterns helped or hindered difficulties the couple experienced. However, applied together with other approaches such as emotionally focused therapy, and feminist therapy, the structural family therapy model proved quite effective when working with this couple.

The B Family

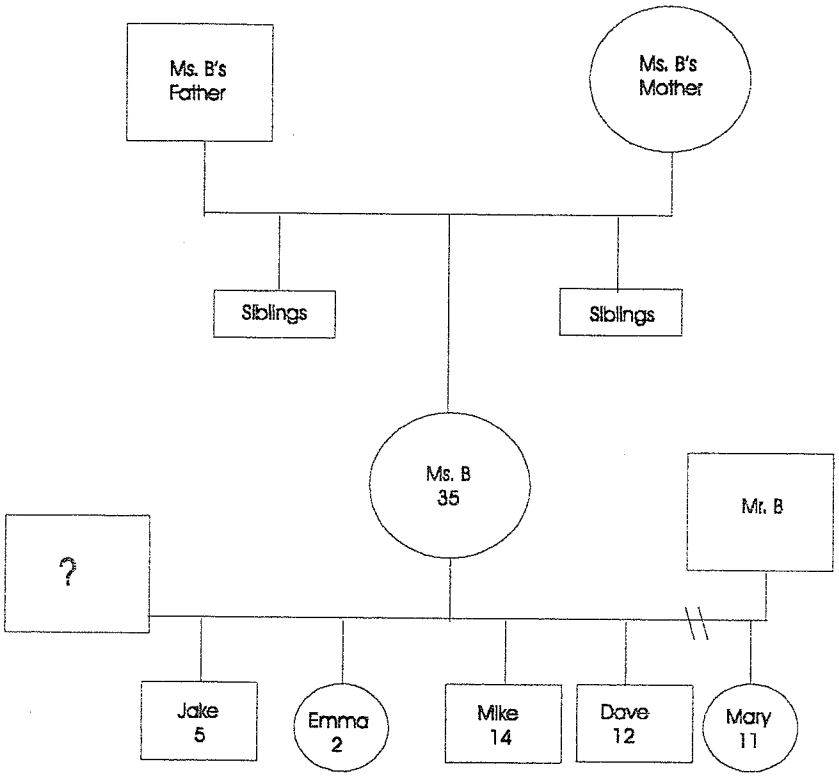
The B family consists of a thirty-five year old single parent mother and her eleven year old daughter Mary. Ms. B also has four other children aged two to fourteen years of age (see Figure 3). At the time of therapy, the younger two children were in foster care with the older three residing at home with Ms. B. Ms. B had no contact with the children's father Mr. B who had resided in prison for the past year and a half. Ms. B was unemployed and on social assistance. In addition, as a result of previous trauma, Ms. B was experiencing stress related health concerns.

Mary was attending grade six at an elementary school in her community. She was the eldest daughter in the family and was frequently responsible for looking after the younger two children prior to them entering care. Although Mary stated that she was not involved in a gang, many of the children in Mary's neighborhood are gang-involved including Mary's older brother. In the past few months, Mary had become increasingly involved with peers in her community that had encouraged her to steal, try drugs, and stay out late at night.

Presenting Problem

The B family was referred to EHCC through Child and Family Services. At the time, Ms. B cited problems with her daughter Mary as being a major concern. According to Ms. B, Mary had been skipping school, staying out all night, and not letting Ms. B know of her whereabouts. On one occasion, Mary had come home high. In

Figure 3: Genogram
The B Family



addition, Ms. B reported that Mary was a quiet child and that at times this caused worry and concern for Ms. B.

Assessment

Structure:

Ms. B along with her five children function as a single parent family living in poverty. Ms. B has sole custody of the older three children and her younger two were in foster care. The children had little or no involvement with their father, although Mary indicated that she would like some contact with him. Ms. B was rigidly opposed to Mary having contact with her father since he used to abuse both Ms. B and the older two boys.

The assessment, which was completed after the initial few sessions, revealed a family structure that was somewhat chaotic. The family system as a whole had been thrown into a new living arrangement several times throughout the course of therapy. This was a result of the family being evicted from their dwelling on two separate occasions with the family having to split up and stay at different households until a more permanent living space could be arranged. Although Ms. B stated that she would attempt to set up rules and regulations at each household this proved difficult at times since the family was living in others' homes.

The hierarchy of the B family appeared ambivalent. At times, it appeared as though Ms. B held authority and would set clear rules and regulations for her children. At other times it appeared as though Mary was in control and Ms. B would appear powerless to do anything about it. Since it appeared that Ms. B found it difficult at times to exercise her parental authority, boundaries between Ms. B and her daughter appeared unclear.

Although Ms. B was encouraged to include her older two children in some of our sessions, Ms. B seemed vested in isolating the problems to Mary. As a result, it was difficult to assess the sibling subsystems in depth. Mary indicated feeling closest to her younger two siblings that were currently in care. This is relevant as it appeared as though Mary took on a somewhat parental role in caring for her younger brother and sister when her mother was unable prior to them entering care.

The parent-child subsystem could be described as somewhat disengaged. Mary and her mother rarely spent time together and during the process of therapy preferred to interact directly with me rather than each other. For example, when I would direct Ms. B to ask a question of her daughter, she would begin talking with me. Although, Ms. B appeared to have great level of concern for her daughter's safety, she seemed to have difficulty expressing that concern directly. Instead it came out in negative ways such as threatening to send her daughter to residential care.

The boundaries surrounding the B family could be characterized as rigid. Ms. B appeared somewhat caught up in many of her own personal difficulties. As a result she was largely unavailable to Mary both emotionally and physically. Communication between mother and daughter was infrequent and inconsistent with Mary often making her own meals and eating alone.

The B family was involved with multiple formal systems including the school system, recreational systems, and most notably CFS. The boundary between the family and CFS was seen as problematic as it was both rigid and diffuse. The boundary between Ms. B and CFS was rigid in that she felt a great deal of disdain for the system and indeed experienced significant levels of stress as a result of the agency's involvement in her

family's life. On the other hand, diffuse boundaries existed between CFS and the B family in that Ms. B received several different services from this system and therefore had become dependent on them to resolve family issues. Ironically, this had contributed to an extreme lack of privacy for Ms. B which she resented very much.

Flexibility:

The B family was in a constant state of re-organization throughout the process of therapy. Though the family structure remained the same, family members were sometimes required to live at different residences temporarily until Ms. B could locate housing appropriate for the whole family. Interestingly, while this arrangement certainly appeared stressful at times to the B family, it was also somewhat normal. Due to multiple changes in living arrangements and family configuration, behavior changes and patterns of interaction became flexible out of necessity. In this way, depending upon where Ms. B and her daughter were living, specific patterns of mother-daughter interactions were no longer functional. For example, Mary, who was used to preparing and eating her meals alone began to ask Ms. B to eat with her when they were staying at a friend's home. Mary's ability to reach out to her mother in strange or unusual circumstances and Ms. B.'s ability to respond positively to a change in pattern indicated that flexibility existed in the relationship.

Cohesion:

Even though Ms. B appeared somewhat disengaged from her children, an emotional attachment existed. This was evidenced by Ms. B's distinct interest in her children's safety. Mary required protection from the possibilities of sexual assault, prostitution, and early pregnancy, and Ms. B appeared fierce in her resolve to teach Mary

some important lessons about being a woman. Because Mary was on the verge of entering adolescence, Ms. B appeared torn between her responsibility to protect Mary from making poor choices and her tendency to rationalize Mary's poor choices as part of becoming a teenager and asserting her independence.

Life Context:

The B family had been involved with the child welfare system for several years. Paradoxically, this system provided the family with sources of support as well as stress. The sources of support included help with finding food, shelter, and schools for the children to attend, especially since the family tended to move frequently. Ms. B acknowledged that during the past year she had experienced a great deal of personal difficulties and had found it a "relief" to not have to look after the little ones during those times. CFS had helped link Mary up with a big sister as well as a support worker that came into the family home twice a week. Respite was provided for Ms. B to enable her to get out and run necessary errands.

On the other hand, the role of Child Welfare contributed to a great deal of stress for the B family. Ms. B. often complained about a lack of privacy, and the constant feeling of "being watched." In addition, Ms. B felt that help received through this system was not always culturally appropriate and that deficits in her parenting were often attributed to her unfairly. Stress was compounded by Ms. B's health problems, which she believed constrained her ability to show CFS that she indeed was a fit parent.

The B family experienced substantial stress due to their financial situation. Living in poverty, the B family had limited access to resources and social supports. For example, Mary stated on more than one occasion that she would like her family to move

out of their inner city neighborhood for purposes of safety. However, due to the fact that the family was poor, their choice in housing was limited to what the family could afford. Conversely, Mary and her siblings felt increasingly pressured to join a gang in order to feel "protected." Furthermore, Ms. B identified that many of her family members and sources of support lived up north on her reserve. As a result, living in the city in an urban area further increased Ms. B's sense of social isolation.

Developmental Stage:

The B family was in a relatively consistent state of crisis, transition, and poverty. Moore Hines (1989) observed four distinguishing characteristics in the life cycle of poor minority families: (1) their life cycle seems more truncated than that of middle-class families, and transitions are not clearly delineated; (2) households are frequently female-headed; (3) their life cycle is punctuated by numerous unpredictable life events and the associated stresses they engender; and (4) they have few resources available to assist them with these stresses and as a result must rely on governmental institutions to meet basic needs.

Ms. B and her family represented a female-headed single parent household containing both adolescent and pre-school children. The household and developmental tasks of middle-class families at this stage may not correspond to those of multiproblem families living in poverty and therefore will be defined differently. Some suggested developmental tasks for families at this developmental stage include: differentiation of self, development of intimate peer relationships, taking on parental roles, and realignment of relationships.

The first two developmental tasks are especially significant to Mary who was attempting to fend for herself both in and outside the home yet at the same time still required concrete assistance from her family. Not yet a teenager, Mary had little time to develop skills associated with successful intimate relationships, yet is already at a stage where sexual experimentation is a reality in her peer group. Ms. B., having become a parent at a very young age, felt the need to protect her daughter from the burdens of early parental responsibility but at the same time identified positively with motherhood and indicated that she did not regret having children at a young age.

The final two tasks, taking on parental roles and realignment of relationships were especially significant to the B family. Since Mr. B had never been involved in the children's lives in a consistent or meaningful way, Ms. B had been forced to take on the organizing and central role in the family. Ms. B, who suffers from stress-related health problems, often relied on her daughter Mary to provide care and nurturance for the two younger children. In this way, Mary can be seen as a "parental child" as she attempted to assist her mother with parental tasks. As well, the addition of new children to the family system created a need for a realignment and adjustment of roles and relationship patterns creating generational boundaries between Ms. B and Mary that at times were unclear.

Role of the Symptom Bearer:

Mary's role as the symptom bearer may have two purposes. First, Mary's out of control behavior may have been an attempt to get her mother to notice her needs for parenting and attention. Since Ms. B's energies for the past year had been focussed on trying to get her younger two children back, she has had little emotional energy left over for her older three children. Mary may in fact have been testing her mother to see if she

was capable of controlling and protecting her. The second role of Mary as symptom bearer may be to deflect attention away from Ms. B. By focussing on Mary's bad behavior, Ms. B was able to refrain from having to examine her own role as parent, thereby maintaining family homeostasis.

Hypotheses:

The B family structure was such that no consistent parental authority existed in the parent subsystem. Mary's behavior may be reflecting this ineffective power hierarchy as she attempted to test the often unclear boundaries within the household. This was compounded by the fact that the family was in a constant state of crisis and transition thereby making it difficult to set clear guidelines and regulations as the family is constantly reacting to the stress of each new crisis. These transitions were further complicated by Mary's entrance into the adolescent phase of her life replete with its own adjustments.

Goals:

The goals for the B family were threefold:

1) To strengthen the parent-child relationship.
2) To facilitate improved communication between Ms. B and Mary by creating clear boundaries between the parent and child subsystems.
3) To support and empower Ms. B in her role as parent in order to strengthen her ability to deal with stress and crises related to outside systems and ultimately enable her to be a source of strength and support to her family.

Interventions

Before any interventions took place with the B family, it was of central importance to join adequately with the family and gain trust. This was seen as especially significant as the B family entered therapy with a certain amount of suspicion and discomfort at the outset since they were referred to EHCC through Child and Family Services. In order to develop a relationship with the B family, it was necessary to have an in-depth discussion about confidentiality (as well as the limits). This allowed the B family an opportunity to have their concerns listened to and reflected back and ultimately resulted in a decision to refrain from videotaping therapy sessions.

Joining with the B family was a somewhat erratic process. This was influenced by a lack of continuity between sessions ranging from one to five weeks at a time. Despite these barriers, I came to realize that the B family's ability to continue in therapy over a fairly chaotic four month period illustrated a great deal of strength and resilience. Joining with Ms. B was considered my first priority as she was the adult in the family, and therefore in charge of bringing the family to sessions. For this reason, the initial session was spent gathering a detailed description of Ms. B's view of the presenting problem(s). Through active listening, empathizing, and asking non-intrusive questions, I was able to develop a certain level of comfort for Ms. B and Mary.

Even though during the initial session Mary did not feel comfortable communicating verbally, effort was made to engage with Mary in other ways. For example, though Mary sat quietly and played with a deck of cards while Ms. B described the problem, it was evident that Mary was listening carefully while her mother spoke. At one point in the session, when Ms. B began to cry, Mary reached over and offered her

mother a kleenex. This was used as an opportunity for me to reflect out loud Mary's desire to comfort her mother and express her caring. This reflection appeared to soften Ms. B towards Mary and provide Mary with some positive attention.

To facilitate all three goals, strengthening the parent-child relationship, empowering Ms. B in her role as parent, and improving communication between Ms. B and Mary, I found it necessary to make clearer boundaries between parent and child. To do this, I requested to see Mary and Ms. B for separate sessions. This served the purpose of allowing Ms. B to discuss more personal, "adult" issues without her daughter present, as well as allow Mary to benefit from one-to-one attention and an opportunity to explore some of the difficulties she was experiencing from her point of view.

The individual session with Ms. B provided the opportunity for Ms. B to "tell her story." This story included a history of grief, loss, violence, and abuse. It also provided me with an opportunity to ally with Ms. B in her efforts to keep Mary safe from harm and allow her to tell her story to an empathic, non-judgmental listener who was able to recognize the trauma and difficulties that Ms. B had survived and reflect back her strengths. By reframing the situation for Ms. B and complimenting her on her ability to persevere and protect her children in the face of adversity, Ms. B was able to see herself as a strong and capable parent, who has managed to overcome many barriers in her life.

The individual session with Mary provided me with an opportunity to join positively with the child as well as gain important assessment information with regards to family structure. For example, the activity of tracking a typical day in Mary's life provided me with important information about what time Mary went to bed at night and woke up in the morning, whether or not she ate her meals alone or with other members of

the family, who prepared meals, how often Mary spent on homework, chores or other school-related tasks, how much time was spent interacting with peers as well as when and how this interaction took place. By engaging Mary in concrete tasks such as making a genogram, drawing pictures, and making lists, communication was enhanced and also provided valuable tools for later family sessions.

After my individual session with Mary, I began the following week's session by meeting with Ms. B alone for the first fifteen minutes to discuss my impressions of Mary. This intervention served to further clarify parent-child boundaries by delineating parent and child roles. During this time, I shared with Ms. B the activities that Mary and I had done in the previous session. I discussed my impressions of Mary, such that she seems to be a somewhat shy, quiet child who may at times have difficulty reaching out, and solicited Ms. B's ideas on how to help Mary with that. Through emphasizing the important role that Ms. B plays in Mary's life, and framing Mary's acting out behavior as a means of getting more time and attention from her mom, Ms. B and I were able to problem-solve around ways in which Mary might receive some of this attention in more positive ways.

Later in the session, Mary was asked to join us and share some of the ideas we had discussed during the previous session. With my help, Mary was able to share some of the pictures and lists we had drawn during our previous session together. This also served as an important intervention as it modeled for Ms. B alternative positive ways of interacting with her daughter and promoted a good deal of dialogue and discussion. In turn, Ms. B added and clarified items on the lists labeled "House Rules" and "Ways to help Mom worry less".

As boundaries between Ms. B and Mary were further clarified, it also became necessary to clarify boundaries around the B family system. This entailed decisions around whether or not to include the B family's social worker in subsequent therapy sessions. As therapy progressed, Ms. B made the decision not to include the family's worker as she felt strong enough to manage the conflict between Mary and herself on her own without the intrusion of outside systems. However, a plan was established in which Ms. B and I determined what information could and could not be shared between myself and the family's worker during infrequent phone conversations.

It was also important to normalize the family's experience in order to intervene appropriately. This meant reassuring and empathizing with Ms. B about the difficult role she had as mother and the considerable stress and frustration she experienced as a result of her life difficulties. By letting Ms. B know that her feelings were understood, and by recognizing how far Ms. B had come in her life, I was able to alleviate some of the defensiveness Ms. B had about her parenting skills. In addition, I normalized much of Mary's behavior as being part of entering adolescence, experiencing peer pressure outside of the home, and testing boundaries within the household. In particular, I focussed on Mary being a female and her need for guidance and direction from her mother with regards to growing up and becoming a woman. By reassuring both mother and daughter that their feelings were normal and that some of the feelings each were experiencing were normal reactions and attempts to cope with chaotic and uncertain circumstances, Ms. B began to assign less blame to Mary.

Allying with Ms. B as a parent proved to be the most central intervention in all family therapy sessions. As Ms. B began to feel more competent and supported in her

role as parent, she began to set more consistent rules and structure within the household. Part of this structure included at least one evening or afternoon each week in which mother and daughter spent time together alone. This idea began as a homework assignment in which Ms. B and Mary were instructed to set aside some time each week doing something they enjoyed together. Mary appeared to really like this idea and devised a list of activities she and her mother could engage in such as going out for lunch, going shopping together, or simply taking a walk. In addition, a discussion was held around ways that Ms. B could teach her daughter important lessons around being a woman and pass down wisdom Ms. B had learned from her own mother, who was now deceased. Mary showed a strong interest in learning about her culture and generations of extended family. The final session was contracted as a session in which Ms. B would share important teachings.

As Ms. B became more competent in her role as parent, the family structure began to change. Both Ms. B and Mary commented that they were getting along much better and that increased time together had helped greatly. In addition, the focus on Ms. B being strong in her role as parent and helping Mary to make positive choices served to frame time alone to talk about "girl stuff" as both important and appropriate. Though significant disruptions in therapy took place throughout the four month period, it was felt by all that substantial progress was made.

Evaluation

Ms. B and Mary completed the FAM-III general scale as both a pre-test and post-test (see Figure 4). The results indicate both similarities and differences in the way family functioning is viewed. In particular, in the area of task accomplishment, Mary's

FIGURE 4

FAM III GENERAL SCALE

T-SCORES

	Ms. B Pre-Test	Ms. B Post-Test	Mary Pre-Test	Mary Post-Test
Over-all Rating				
Task Accomplishment				
Role Performance				
Communication				
Affective Expression				
Involvement				
Control				
Values and Norms				
Social Desirability				
Defensiveness				

T-SCORES	LOW	HIGH
Family Strength	20	40
Average Range	40	60
Family Problem	60	80

scores fell in the weakness range while Ms. B's scores fell in the average-strength range. This is consistent with some of my clinical impressions during assessment related to problems with task identification, generation of potential solutions, and difficulty implementing change. It is quite possible that one of the reasons Ms. B's score indicates a strength in this area is because of her ability to maintain basic task accomplishment even under severe stress. This seemed to signify that Ms. B was used to functioning in a chaotic environment and in fact experienced it as somewhat normal.

Another area of discrepancy in scores was in the category of involvement. Ms. B's score indicated a substantial strength in this area while Mary's score fell in the range of average-weakness. This seemed to signify Mary's need for greater involvement with her mother or at least more one-on-one attention. It is possible that Ms. B's scores indicated a strength in this area because of her strong concern for her daughter's safety and desire to be more involved as a parent in her daughter's choices. It may also serve to indicate that Ms. B was somewhat defensive during the assessment process and may have attempted to portray family functioning in a more positive light.

The administration of the FAM-III in the assessment process was helpful in that it introduced dialogue around family functioning. Indeed many of the questions required explanation and clarification and this provided me with an opportunity to engage further with the family. For example, when statements on the FAM-III such as "My family and I understand each other completely" were responded to negatively by both mother and daughter itgave me an opportunity to clarify responses and facilitate substantial discussion. In particular, the FAM-III was especially useful with Mary, as it gave her an

opportunity to share her ideas and feelings non-verbally. The post-test results showed improvement in all areas of family functioning especially with regards to Mary's scores. This was consistent with sentiments the family expressed to me verbally at the end of therapy.

Unfortunately I was unable to gain further results from the client satisfaction questionnaire as the family did not return it to me. However, both Ms. B and Mary indicated to me verbally that therapy had been helpful and that they were considering the possibility of continuing with sessions after my practicum ended. Ms. B. indicated that she didn't "have any more problems with Mary" and that she wished to further address some of her personal issues in future sessions.

Conclusion

My experience working with the B family provided me with a great opportunity to practice structural family therapy. This case illustrated the structural challenges single parent families face, and how these difficulties can be further compounded by issues of race and class. For example, in addition to the responsibility of being the sole parent to five children, Ms. B. also struggled with difficulties and negative stereotypes associated with being an aboriginal family living in poverty. For this reason, assessment and intervention aimed at assisting the B family needed to take into account the family's cultural background as well as an understanding of how their experiences impacted on their view of the helping process. This case also illustrates the variation in developmental stages among families, and the need to be flexible in our understanding of developmental needs and stages for the many families that do not fit the white, middle-class ideal.

SECTION FOUR: PRACTICE THEMES

Introduction

During the course of my practicum, I worked with several different kinds of families. Though each family possessed unique qualities and characteristics, several common themes emerged. These themes include issues pertaining to single parent families, issues pertaining to families involved with other formal systems, such as child welfare, and the need to focus on family strengths and resilience as a means of intervention in family therapy. These themes will be discussed in detail in the next section.

Single Parent Families

Of the nine families I saw at EHCC for counselling, five were single parent families. All of the single parent families were headed by women. As a result of this family structure, many of the difficulties these families faced can be seen as related to family composition. Since structural family therapy, and family therapy in general, often base intervention strategies on an assumption of a traditional nuclear family structure, it was important for me as a practitioner to examine ways in which structural family therapy could be used effectively when working with this particular population group.

In Canada, ten percent of all families are headed by a female single parent (Status of Women Canada, 1990). Many of these families experience distinct and differing kinds of stress than traditional nuclear families. A number of these families deal with emotional issues and problems that are directly related to their economic and political

positions in society. Although some families headed by women are financially comfortable, the majority, or 60%, have incomes at the poverty level (McCannell et al., 1993). This makes single parent families the type of family with the highest incidence of low income. Indeed, four out of the five single parent families I saw at EHCC were living in poverty. Financial concerns affected the lives of families and individuals in a variety of ways, most notably in terms of access to supports and resources, as well as food, transportation, and access to childcare. Financial concerns played a role in the therapeutic process with two families in particular as families found it difficult to access and pay for childcare in order to attend therapy. This resulted in families having to miss sessions, bring small children with them, or rely on other formal systems for transportation and assistance.

Poverty is related to a wide variety of emotional, psychological, and physical problems in adults and children. In fact, the continual strain of poverty over time, which is often accompanied by reduced access to skill building, insecurity, and humiliation can have major impacts on female single parents and their children (McCannell et al., 1993). Compounded with the fact that many mothers, single or married, carry the primary load in childcare, financial support becomes only one of numerous areas for which women are responsible.

With structural family therapy's orientation towards flexible family structure that operates on a continuum of normality, where exactly do single parent families fit? Most often, structural family therapy portrays single parent families as being in a position of transition and/or loss. Stresses are produced by adaptation to a decreased membership in a family, caused by circumstances such as death of a family member, divorce, or

separation. For example, when a couple separates, new subsystems and lines of differentiation must develop. The unit of two parents and children must now become a unit of one parent and children, with the other parent often excluded (Minuchin, 1974).

It is important to recognize that the problems of single mothers and their families do vary depending on how they became single, as do the feelings of women in relation to motherhood (Hicks & Anderson, 1989). Although little attention has been paid to this population in the literature, it has been suggested that never-married mothers have the greatest amount of difficulty in dealing with the complicated issues of raising children (Hicks & Anderson, 1989). One possible reason for this is that a sizeable proportion of never-married mothers are teenage mothers, who because of their age have less education and thereby less access to good job opportunities. Of the five single parent families I worked with, four were never married to their children's father. In fact, the child in one family had never before met his biological father. This may provide a complex situation, as single mothers may be left to deal with the anger and confusion expressed towards them by their children rather than a father who they may rarely or never see. This issue was relevant for the B and F families. In both cases, the children expressed desires to have relationships with their fathers. However, due to histories of violence and abuse, neither single parent felt comfortable allowing fathers access to their children.

Another common theme among single parent families is the concept of the parental child. The allocation of parental power to a child can be seen as normal in large families, single parent families, or in families where both parents work (Minuchin, 1974). This system can function quite well, and it enables the parental child to develop responsibility and competence. However, a family with a parental child structure can run

into problems if the delegation of authority is not made explicit, or if the child comes to be the only source of guidance and decision-making. In this instance, demands on the parental child may come into direct conflict with his or her own childhood needs and surpass her ability to cope (Minuchin, 1974). In the case of the B family, Mary could be defined as a parental child. Due to Ms. B feeling overwhelmed by the stressors of poverty, childcare, and personal loss, she often relinquished parental authority to Mary with regards to providing care for the younger siblings. Mary, barely twelve years old and a female child, began to take on responsibilities that were not age-appropriate and ultimately started to define her own household rules. The younger children's needs for care and nurturance surpassed Mary's own abilities to cope, and ultimately the younger children were taken into care.

In looking at the C family, Jason, Ms. C's son could also be seen as a parental child. Jason, an only child who grew up never knowing his father, lived alone with his mother for almost twelve years. Although Ms. C appeared to be a highly competent parent, at times the relationship between Ms. C and her son appeared to function more like one of peers. This is not uncommon among single parent families where a decompensation of the executive structure results in increased communication among family members (Howard & Johnson, 1985). As a result, single parents may experience greater intimacy and connection with their children than in two parent families. In some cases, the enormous demands of single parenthood often necessitate that children assume greater responsibility with respect to management of the home. It is important to note that the parental child role is not necessarily negative, and may in fact facilitate a child's growth and development in positive ways (Walsh, 1983). For the purposes of this

practicum it was necessary to assess whether or not family functioning was significantly impaired as a result of having a parentified child such that it adversely impacted the child's growth and development. This determination was usually made in collaboration with the family and included an appreciation of the unique and varied roles children may play in a household with only one parent.

According to a structural point of view in working with single parent families, the first order of priority is to support executive functions and to establish generational boundaries. Approaches to ensure that the executive system functions adequately include: an understanding that the tasks confronting the single mother may appear daunting or indeed be beyond her capabilities, non-exploitive and supportive utilization of the parental child, the assignment of several children to help the mother out with executive functions, and utilization of extended family and friends as well as formalized social services where possible and necessary (Howard & Johnson, 1985).

Once the executive system has been supported and is functioning adequately, the next step is to work on establishing generational boundaries between parent and children. According to Minuchin (1974) effective family functioning necessitates that a power hierarchy exist in which parents and children have differing levels of authority. However, it is important to note that this arrangement can still be flexible in accordance with the parent's capacity and the children's developmental needs.

Approaches to establish generational boundaries might include: identifying certain issues as "off bounds" for children, validating the mother's power over and assertiveness with the children, emphasizing the issues that naturally separate the two generations, and encouraging adult relationships for the mother and peer group

relationships for the children (Howard & Johnson, 1985). Two single mothers that I worked with had difficulty recognizing how specific information or discussion was not appropriate for children to be involved in. In this way, marking generational boundaries proved useful by having the child leave the room in order for mom and myself to discuss "adult" issues.

Single parent families represent an increasing demographic in society and like other systems, contain both strengths and weaknesses. In general, structural family therapy offers some insight and skill when it comes to addressing the needs of single parent families. However, from a more holistic perspective, the model falls short in its lack of attention to the social and economic realities faced by women raising children alone. Structural family therapy could benefit from increased attention to feminist theorizing and critique in family therapy. Indeed, I felt it necessary as a therapist to include feminist strategies and assumptions in my work with these families. Examples of this included viewing single parent families as having substantial strengths, helping women to feel empowered in their role as mother rather than blaming, and providing women with information and education to access resources and services for their family.

Families Involved with Formal Systems:

Five of the nine families I worked with during the course of my practicum were involved with other formal systems, most notably child welfare. These families faced distinct issues and difficulties that directly affected family relationships. Structurally, the presence of a formal system such as Child and Family Services dramatically changes the makeup of the family as well as the way the family functions. While the term foster care

is now commonly used to describe both family-based and congregate care settings, formal foster care is distinguished from informal foster care by the fact that it involves a change in legal custody (VanBergeijk & McGowan, 2001). Although foster care services are developed as a solution to the needs of children who cannot remain with their biological parent(s), inevitably the use of substitute care may create other types of problems.

Since some of the families I worked with were referred for service through Child and Family Services, families often arrived at EHCC with the expectation and assumption that therapy would be directed at "fixing" the child. This appears consistent with families who have experienced intervention by child welfare where emphasis is placed on care and well-being of the child rather than the child's entire family. The B family is a good example of this type of situation. Ms. B and her daughter Mary were referred to EHCC through Child and Family Services. During the initial stages of therapy, Ms B. made it clear that Mary was the "identified patient" and therefore the one requiring intervention. Ms. B agreed to participate in therapy to discuss the ways in which Mary was causing problems, but appeared hesitant to examine her role in the difficulties the family faced. This situation was similar to that of the F family, who were also referred to EHCC through Child and Family Services. Ms. F was very hesitant to attend therapy with her son, the identified patient, and even sent him to EHCC for the first session alone.

A second issue faced by families involved with formal systems is the lack of involvement many parents have had in the planning process for their children. This was evidenced on numerous occasions with families who seemed to have an unclear idea of

the expectations or necessary changes required for their children to return home or for CFS to disengage from their lives. Indeed, this was the case with the G couple who were referred for counselling by CFS to deal with their relationship issues. With this couple, a one year supervision order had been placed on the children as a result of suspicion that Mr. G had been mis-treating the children. In this instance, the reason for referral and the reason(s) the couple was seeking counselling varied considerably. Moreover, neither parent appeared to have a concrete sense about what had brought about the involvement of Child and Family Services in the first place. This issue was further compounded by the fact that in all cases except one, families felt strongly about NOT having their social worker involved in family sessions, with some agreeing to a release of information. This factor, along with the relative ease in which workers tended to share "off the record" information with me created the need for more explicit agreements with families and workers about what information could and could not be shared.

A third issue facing families involved with formal systems is the substantial lack of parental input and relative disempowerement of parents in the decisions made regarding their children. Key to structural family therapy theory is the notion of a parental hierarchy or authority. This concept can become somewhat problematic when parents have had the legal guardianship of their children terminated. Indeed, it was not uncommon to hear stories from parents who had their children taken away and returned years later with no real plan or discussion around how the family might deal with issues that may crop us as a result of re-unification. This issue was salient with the B family as the lack of conversation around family dissolution contributed to anger and sadness on the part of the child and guilt and frustration on the part of the parent. These factors

substantially contributed to Ms. B's ability to act as an authority figure to her children by setting up clear rules and regulations, as she frequently felt guilty enforcing them.

Finally, the tasks of helping children work through loss issues and confront attachment concerns to parents are necessary ones (Martin, 2000). For this reason, an important task facing children and families that have been in care is the act of recognizing and understanding the facts of separation as well as the lessons learned about family relationships as a result of this separation (Martin, 2000). Two of the families that I worked with had experienced having children taken into care and returned years later. In both of these cases, parents acknowledged that upon the return of the children to the biological families, no discussion or conversations had taken place between the children and parents as to what had occurred. In addition, some children who had developed positive and nurturing relationships in their foster families, subsequently had little or no contact with foster parents after returning home.

With these families, intervention focussed on helping parents to explore how having children taken into care had changed their relationships with their children and also to understand what aspects of those relationships remained consistent. In this way a separate session involving Ms.F alone provided a space for discussion where Ms. F could talk about her substantial remorse and sadness surrounding the apprehension of her children as well as an acknowledgement of her own role in the situation. In this session Ms.F was able to plan for a future discussion with her son about his time in care as well as prepare herself for her son's expression of anger and sadness.

Structural family therapy provided a useful model for working with families impacted by other systems, specifically child and family services. Since structural family

therapy focuses so much on family structure and the need for clearly delineated boundaries between parents and children, the model proved especially helpful for working with families who had experienced substantial disorganization as a result of forced separation. In addition, since many of the difficulties faced by these families in therapy centered around the child's inappropriate or disruptive behaviours, structural family therapy provided guidance in working with these families through helping to reframe these behaviours as the normal testing of boundaries between parent and child. Finally, while structural family therapy provided a normative framework in which the family could view themselves, it also provided a context in which parents were encouraged to view themselves as competent and in charge, an experience that was powerful for some parents as it increased the disparity between present and past experiences.

Family Strengths

Identifying strengths and supporting families' capacities for growth are important aspects of the change process. Indeed, empowerment in clinical practice can be seen as "an internal process which is fueled by identification of strengths, encouraged through support from others, and fostered by growing self-esteem through experiencing success in coping with daily living" (Harper Dorton & Herbert, 1999). Each of the families I worked with at EHCC possessed unique strengths and capabilities. Focussing on client strengths proved to be a central part of the intervention process, as it helped families to feel empowered and become more self-directed.

In my practice, an important part of empowering families came from the simple recognition that the family had survived to this point - not without pain and difficulty – and that this in itself was an inherent strength. Certain families, such as the B and F families had become very accustomed to outside judgement and critique of their parenting abilities. Through the simple acknowledgment that these families could not have survived to this point without substantial will and strength, families were able to experience themselves as competent and resilient. In addition, families who had themselves been involved with systems such as child welfare throughout their own childhood were encouraged to draw on what they had learned growing up and how these experiences could help to guide them in solving some of the difficulties faced today.

Another important means of uncovering family strengths was through inquiring about family supports (Saleeby, 1997). For example, with the A couple, through exploring with Ms. A which community supports she found to be particularly valuable, it was discovered that her work with physically and emotionally disabled children was especially meaningful and provided her with a strong sense of pride. By focussing on particular qualities and traits Ms. A possessed in order to work in her field such as kindness, patience, caring, and hope, Ms. A was able to recognize these attributes as sources of energy for working on her relationship with Mr. A.

Noticing exceptions to the problem can also be seen as a potential means of discovering strengths (Saleeby, 1997). This technique was employed with families I saw by inquiring about what had been different in the past when they had experienced their lives as more stable. This line of questioning proved provocative at times and often helped to uncover moments or particular situations in a family's past that were seen as

particularly special. With the C family, this line of questioning served to be quite useful as it uncovered a sense of comfort and security in the child when his mother had been involved in a relationship for several years. This recognition on the part of both Ms. C and her son helped both to reframe her son's behavior in terms of sadness and frustration over the loss of a family relationship, as well as help Ms. C to recognize the substantial support and encouragement she received from her son on a daily basis.

Finally, by focussing on client strengths, I was able to avoid pathologizing families, or making a "diagnosis" (Cowger, 1997). Some families, especially those who had never attended family therapy before, entered therapy expecting a diagnosis, or an explanation for the symptom (usually the child's unacceptable behavior). Understandably, this type of association with the medical model of assessment created fear and dread on the part of the child, and ultimately resulted in one child refusing to attend therapy at all. For this reason, assessing client strengths rather than diagnosing problems or weaknesses, became an important part of the therapeutic process as it enabled families to define the problem situation in terms of their own perspectives and foster the belief that families possess inherent strengths that provide expertise and experience relevant to solving their own difficulties.

Structural family therapy provided a somewhat useful model for focusing on family strengths. First, since structural family therapy was initially developed as a model for working with socially and economically disadvantaged families, in some ways it can be seen as promoting family strengths. For instance, structural family therapy is driven by the assumption that families are competent and should be respected. In this way, the model contains important qualities and focuses on family strengths by acknowledging a

family's ability to find alternate solutions to dealing with their problems. Structural family therapy sees families as possessing a number of resources, and as the model evolves it has shown increasing emphasis on family social and political context.

In contrast, structural family therapy can also be seen as a model that fosters an "expert" approach to treating families. Since the structural model promotes the idea that the therapist is in charge of directing the therapeutic process, some families may experience the process as being disempowering. In addition, this approach can have implications for how family problems are identified as well as ways in which family health and normality may be defined in terms of family dysfunction. For this reason, structural family therapy can only be seen as partially adequate as a model for promoting emphasis on family strengths.

Conclusion

This section will provide a reflection on the intervention used for this practicum, as well as a critique of the structural family therapy model. In addition, I will provide a review of my learning goals and objectives as well as include recommendations based on my experience with this practicum.

I found the structural family therapy model to be a very useful way of both conceptualizing as well as theorizing about families. Concepts such as structure, boundaries, subsystems, hierarchy, and joining were especially relevant, and I found myself applying these concepts to families with whom I worked with relative ease. In particular, these concepts were useful both with families as well as couples. Since most of the therapy consisted of subsystem work, such as parent and child or female and male partner relationships, I was able to witness the ways in which change in one subsystem or relationship can influence and impact the larger system or systems.

I also found it helpful to utilize tasks or assign homework when working with families. This allowed for some source of continuity between sessions and provided a logical place to pick up again even when there were large gaps of time between sessions. It also provided a good indication of the family's flexibility or ability to change depending upon whether or not they had been able to follow through with the assigned task as well as discussion about what the experience had been like for them.

The structural family therapy model was quite useful in working with single parent families. I found the structural analysis, which tends to show the family as focussing on the identified patient as a means of disrupting the family homeostasis as

little as possible, to fit for many of the families with whom I worked. In this way, structural family therapy techniques such as reframing the problem as being related to entering a new developmental stage and clarifying boundaries between parent and child were especially useful. As I became more comfortable and skilled working with families, I found it helpful to have a framework for organizing them as well as a theoretical rationale for my interventions.

Despite the model's effectiveness, I experienced several drawbacks with the intervention that prevented me from using a pure structural family therapy approach. One of these limitations is that structural family therapy maintains a focus on the problem, and is not geared towards insight or an understanding of the problem. While this may prove effective when working with particular families, ultimately I found that a certain degree of insight was needed to move forward with nearly all of the families in which I worked with, especially the couples. With these couples, I found it helpful to implement an emotionally focussed approach to therapy as it allowed couples to enhance their communication patterns by accessing unacknowledged emotions and exploring the ways in which these underlying feelings impacted present difficulties.

I found the use of insight also to be important when working with families where children had previously been in care. For example, with one family, it was necessary for the mother to gain some insight into her son's hurt and anger related to his time spent in care. Further, it was necessary to explore the mother's feelings of guilt and shame in order to help her see herself as linked to the relationship, and ultimately some of the difficulties her son was experiencing.

Another limitation with structural family therapy is the notion that the therapist play the role of expert in therapy. I found this to be a constant challenge during sessions since it went against my own values and assumptions, namely, that clients and families are experts of their own lives and experiences and that the role of therapist is to collaborate and enhance this process, not necessarily direct it. In addition, I found that while there were some families that welcomed and even requested more direction, there were others that preferred my role to be one of listener and supporter, allowing themselves to direct the process.

Finally, the structural family therapy model fails to pay adequate attention to gender and gender differences and the way these differences impact relationships. Considering the fact that all of the single parent families I worked with were headed by women, there is little analysis of the unique difficulties single mothers face relative to being parents. Indeed, structural approaches to family practice tend to focus on mothers' inadequacies and even have a tendency towards mother blaming (Myers Avis, 1996). Often, both in therapy and in the literature, the assumption of women's primary responsibility for child care frequently results in a parallel assumption of their primary responsibility for causing problems with their children. For this reason, I found it necessary to incorporate a feminist approach to working with families and couples in order to support and empower women, acknowledge the integral role women play in maintaining relationships, and recognize that difficulties faced by single parent women are not necessarily related to personal deficit but rather to the social and political contexts in which woman live. In this sense, structural family therapy did not provide

enough direction for addressing life stressors, particularly those specific to being a woman.

My learning goals and objectives for this practicum were met and enhanced by skilled supervision, a supportive learning environment, a knowledgeable committee, and a substantial degree of drive and determination. The wide variety and number of couples and families I worked with enabled me to enhance my clinical social work skills with regards to assessment, intervention, termination, and evaluation. Although I was only able to achieve assessment and/or intervention with some of my cases, I feel that overall I was able to gain experience and knowledge in all four aspects.

The evaluation piece of my practicum included quantitative and qualitative outcome measures as well as clinical observation and judgement. The FAM III was used as both a pre-test and post-test with families and couples involved in this practicum. The utility of the FAM III was definitely positive as an assessment tool, however, I found it to be of limited use as a post-test. One reason for this is that I was unable to terminate formally with some families, and therefore was unable to administer the post-test. Another reason is that in some cases, the post-test did not indicate improvement in family functioning despite client's reports otherwise. One possibility for this occurrence may be related to families feeling more comfortable and honest at the end of therapy and more guarded and defensive during the initial stages of therapy when the pre-test was administered.

Strengths of the FAM III included its ease of use and relative short time to administer. However, although the measure indicates that it is appropriate for children eleven years of age and older, I still found it necessary to go through each question

carefully with some children as it was apparent that questions could be easily misconstrued or misinterpreted. Information provided by the FAM III were complimented by a client feedback form. This form provided clients with an opportunity to offer feedback and provide information about their counselling experience at EHCC. Though information provided was generally positive, this may have been impacted by myself administering the form.

With respect to my second learning goal, I feel that my theoretical and practical knowledge of family therapy was strengthened both by the research and scholarship that went into preparing for this practicum as well as the opportunity to apply the theory and model to actual families with whom I worked. This also enabled me to achieve my third objective, which was to gain family – centered experience with a diverse client population. Although, this practicum did not allow me to work with every type of family configuration, it provided a solid basis in working with a variety of families and couples, each possessing commonalties as well as unique differences.

Based on my practicum experience doing structural family therapy at EHCC, I have two recommendations. First, although at the start of my practicum I outlined a six to eight session parameter as a guideline for working with families, I found this to be unrealistic. As a result, I would advise future students to be more flexible with regards to estimated number of sessions, as this may be difficult to accommodate given the often chaotic nature of family situations. Secondly, I would also recommend that the term "family therapy" be defined more loosely. Early in the practicum, I encountered difficulty in having the entire family attend therapy. More significantly, I encountered situations in which children refused to attend therapy with their parent, and family

therapy became a process of working solely with the parent or seeing the child and parent in separate sessions. Future students may find it helpful to recognize this phenomenon and make adjustments accordingly.

In conclusion, my practicum experience provided me with a wealth of learning opportunities both personally and professionally. Much like the intervention model itself, I learned the need for flexibility and patience as well as the need for each individual to progress at his/her own pace. More importantly, my expectations in terms of what families could achieve as well as my expectations of myself as a beginning therapist provided endless opportunities for self-growth, learning, and reflection.

As a beginning practitioner I learned a great deal about myself. During the course of my practicum I learned much about my own abilities to handle stress and uncertainty, and was conscious about how this affected my work with clients. Moreover, I recognized the importance of both a professional and peer support network in aiding my growth as a practitioner, providing me with opportunities to de-brief difficult therapy sessions, as well as provide perspective on challenging situations faced throughout the process. Finally, I learned that a sense of humour provided me with an invaluable source of energy and means of connecting with families as well as an effective coping strategy for dealing with the ups and downs of my practicum experience.

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APPENDIX A

CLIENT FEEDBACK FORM

Name:

Date:

We are very interested in having your opinion about the services you received here at Elizabeth Hill Counselling Centre. This will help us to provide couples and families with the best possible service in the future.

Please circle the answer that you feel best describes your opinion and comment in the spaces provided.

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

Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied

2. Did your family situation/relationship improve as a result of therapy?

Very Much Improvement	Some Improvement	Little Improvement	No Improvement

3. What was the most helpful aspect of therapy for you?

4. What was the least helpful aspect of therapy for you?

5. Do you have any additional comments or suggestions about the help you received?