STRUCTURAL/STRATEGIC FAMILY THERAPY IN THE COMMUNITY MENTAL HEALTH SETTING

A PRACTICUM REPORT

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by
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MASTER OF SOCIAL WORK

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This is not the end, nor is it the beginning,
It is the beginning of the end . . . B. J. B.

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Introduction

This practicum was undertaken in the town of Stonewall, Manitoba at the Community Health Centre. This writer chose to adopt a Structural/Strategic model of therapy which is consistent with the notion of "Community Mental Health" and far removed from the traditional approach to psychiatric problems. Two thousand years of cultural and social development have led us to the concept of "madness as an illness", and indeed mental illness has come to be defined as a medical problem in Western society; a disease of the individual, and the popularity of the medical ideology remains today (Conrad & Schneider, 1980; Langsley et. al., 1968).

The disease metaphor was borrowed from the medical profession and is used to conceptualize behaviour disorders. This model holds that diseases can be caused by the invasion of micro-organisms on the body. Likewise it is assumed that behavior disorders follow the same linear pattern. That is, an individual who is displaying symptoms of mental illness is viewed as if they were physically ill, despite the absence of any known etiology. When this linear, cause and effect type notion is assigned to the mentally ill, the problem is largely defined as one that resides within the individual. The focus of treatment is then primarily on the individual with

little or secondary consideration given to significant relationships or outside forces impinging on the person (Conrad & Schneider, 1980).

Most recently in the mental health field, the ecological perspective has gained in recognition. This perspective emphasizes the "transactions between people and environment that, on the one hand, promote or inhibit growth, development, and release human potential and on the other hand, promote or inhibit the capacity of environments to support the diversity of human potential" (Germain, 1981, p. 325). The individual may be observed operating within the context of the family, which is observed operating within the context of the larger community. It is assumed that all individuals affect their environment and in turn are affected by it. It follows then that when "mental illness" occurs it must be systematically assessed within the context of the human-environmental interface in which it occurs. It is with this premise that this writer pursued this practicum.

Chapter one opens with an explanation of systemic theory and concludes with a discussion of family therapy as an interventive strategy. This is the theoretical base upon which this practicum was undertaken. Chapters two and three provide a detailed review of the structural and strategic models of

therapy. Chapter three closes with consideration of the intergration of the structural and strategic approaches and reviews the empirical research on this model completed to date. The fourth chapter explores transactional patterns and the utilization of the Circular Pattern Diagram as an assessment tool. A case example of its application is provided. The report then moves away from theoretical material and into the description of the practicum undertaken by this writer. Chapter five describes the practicum setting, subjects and the three evaluation measures that were used, which include the Family Assessment Measure III, the Family Adaptability and Cohesion Evaluation Scale, and the Checklist of Family Concerns. Chapter six presents the case study results and offers an evaluation of the assessment measures. The seventh and final chapter closes with this writer's concluding remarks.

Chapter One

General Systems Theory

The ecological paradigm has its roots in social systems theory (Auerswald, 1968). By definition, "a social system is a model of a social organization that possesses a distinctive total unit beyond its component parts, that is distinguished from its environment by a clearly defined boundary, and whose sub-units are at least partially interrelated within relatively stable patterns of social order" (As quoted from Olson, 1968; in Anderson & Carter, 1978, p. 10). Von Bertalanffy (1934), a biological scientist, was a pioneer of general systems theory. It was from Von Bertalanffy's study of organisms that the early formulations of systems theory came to be (Hartman & Laird, 1983). He observed organisms to have self-regulative capacities and to be intrinsically active. All organism's motivation for behaviour resided within the organism itself (Okun & Rappaport, 1980). Von Bertalanffy identified the general principles of organization and operation that all systems share. The notion of a family as a system was generated when social scientists generalized the principles identified by Von Bertalanffy to human system interactional patterns.

From a systemic perspective the family is conceptualized as an organizational structure composed of a set of interdependent parts (Okun & Rappaport, 1980; Hartman & Laird, 1983). The focal assumptions of a systems model that relate to the functioning of the family include:

1. The parts of the family are interrelated.
2. One part of the family cannot be understood in isolation from the rest of the system.
3. Family functioning cannot be fully understood by simply understanding each of the parts.
4. A family's structure and organization are important factors determining the behavior of family members.
5. Transactional patterns of the family system shape the behavior of family members (Epstein & Bishop, 1981, p. 447).

The above five assumptions derive from four general system properties that may be illustrated within the family system. These properties are that of equifinality, wholeness, homeostasis and feedback (Okun & Rappaport, 1980).

Equifinality is that property that speaks to the interactions among the parts of the system. It is most likely that the interactional sequences of the subsystems will produce the same results, regardless of the origin. For example if one family member is typically identified as the trouble maker or

problem, the family will probably identify that person as the culprit regardless of who actually initiated the escalation of the problem. Observation of the current family interactional process will uncover the interactional patterns that determine the results, (i.e., the behaviors) of the system.

Wholeness addresses the relationship between the system and its parts. The total system is greater than the sum of its parts; that is, the system is more than the composite of the individual components. A family consisting of father, mother, son and daughter is something other than the absolute of the four members. Each member is a unique entity but the total system includes all interactional processes and patterns that sustain the family system. Given that all parts are interrelated, a change in one part or subsystem may cause a change in one or more other subsystems. For example, if father is successful at abstaining from alcohol after several years of drinking to intoxication daily, this change will reverberate throughout the system. A change in his behavior will subsequently change the interactional patterns of other family members towards him and each other. Following through with the property of wholeness the entire family system may be changed in a way that is greater than the sum of the individual changes. Thus a system cannot be fully comprehended or represented by the summation of its

subsystems (Okun & Rappaport, 1980).

The feedback process involves the interactional exchanges among the parts of the system. It is through feedback that the components of the system relate to one another. The principle of feedback comes to us from the study of cybernetics: a scientific discipline devoted to the study of communication and control in both mechanical and living systems. Earlier scientific explanations of the world assumed linear cause and effect process; a systemic approach incorporating the cybernetic process assumes a circular relationship. The difference between the two, is as simple as understanding the difference between a line and a circle. The circular process was understood as feedback and observed in what was termed feedback loops. Feedback means that part of the system's output is reintroduced into the system as information about the output. Or put another way by Anderson and Carter, (1978), feedback includes the echo and the adjustment made to the echo. It is a simultaneous process where one event influences a second event which stimulates a third and successive event that may impact on either the first or second event or trigger an alternate but related response cycle. Often the example of a home heating unit is used. A drop in the room temperature (A) stimulates the thermostat (B), which activates the furnace (C), which produces heat

(D), that raises the temperature in the room (A) where upon the feedback process will repeat the sequence. The feedback loop that brings (D) circling back to (A) makes a continuous line or event impossible (Penn, 1982), therefore the concept of a beginning or end does not exist.

Feedback mechanisms maintain the regular patterns and structure of the system necessary for its survival (Nichols, 1984; Hartman & Laird, 1983). There are two types of feedback, positive and negative. Positive feedback takes place when the consequences of an output serve to increase the same output (Tomm, 1982). For example if spanking a crying child intensifies the crying, positive feedback has occurred. Negative feedback occurs when the monitored consequences of a particular action result in a decrease in that output (Tomm, 1982). Using the example above, if the spanking serves to stop the child's crying, negative feedback has occurred. Positive feedback causes an "escalation" whereas negative feedback serves to decrease the output and maintain a homeostatic or steady state (Tomm, 1982). In this context the regulatory patterns that are described possess a different meaning from the typical notion of negative feedback as criticism and positive feedback as praise.

Positive feedback alters the system to accommodate change.

All families must possess positive feedback mechanisms if they are to adapt the system to accommodate new information. The maintenance of the system via its feedback mechanisms is termed homeostasis (Okun & Rappaport, 1980). The term denotes the dynamic balance of the system. Family rules or regulations governing interaction function to preserve family homeostasis. It is the homeostatic mechanisms that assist a family to regain an acceptable behavioral balance when disruption occurs, thus serving to resist change. This raises an interesting point in regards to a client's or family's "resistance" to therapy. As Hoffmann points out:

> The idea that the client is "resistant", or that the family "homeostasis" causes it to resist, is totally linear. As Dell says, "the system does not 'resist', it only behaves in accordance with its own coherence" (1981, p. 347).

Thus it is not that the family resists change, but struggles to maintain homeostasis--that which comes naturally. Our task as therapist is to devise interventive tactics that will establish a new homeostasis within the family system. The chief merit of systems theory as noted by Haley (1980), is that it allows the therapist to recognize repetitive behaviour sequences and to subsequently make predictions and plan interventions. However, on the other hand Haley remarks on the irony of systemic theory, in that the "demerit of the theory for therapeutic purposes is that it is not a theory of

change, but a theory of stability" (1980, p. 15). This model that attempts to change families was developed within the theoretical realms of how family systems remain stable. Therapists often observe family members who are helplessly caught up in sequences which repeatedly repeat themselves, despite their wishes and attempts to change. As interesting and insightful as systemic theory may be for explaining human behavior, it is not a simple guide as to what to do in therapy (Haley, 1980).

Nevertheless, the growing awareness of systemic theory has resulted in a marked increase in the practice of conjoint family therapy. In the last two decades, those in the helping professions have observed an expanding interest and acceptance of family therapy (Madanes & Haley, 1977; Hartman & Laird, 1983; Nicholas, 1984). Subsequently it has become an increasingly popular interventive strategy.

When this theory is put into clinical practice the therapist conceptualizes the "problem" very differently than a more traditionally oriented psychotherapist. For example, we can examine the case of a schizophrenic adolescent, and compare the treatment implementation based on a traditional perspective as contrasted with a systems perspective of the situation. In a more traditional approach, the identified

patient is labelled schizophrenic and it is believed that the problem resides within the individual (Okun & Rappaport, 1981). No other people or object relationships are considered. Treatment will typically involve an admission to a psychiatric hospital with an intrapsychic focus, and drug therapy to relieve the symptoms. If utilizing a system approach the child's problems are examined within the context of his or her family, and it is reframed as one that involves all family members. The part each family member plays in the maintenance of the symptom is tracked. The focus is on the communication and interactional patterns of the family and the "problem" is explored in the context of the larger environment.

As previously discussed, revolutionary steps were taken when those working in the field of cybernetics, which incorporated a number of seminal ideas in systems and communication theory, made application to the family system (Hoffman, 1981; Nichols, 1984; and Stanton, 1981b). As Hoffman (1981) indicates, the advent of the one-way screen, which clinicians and researchers have used since the 1950's to observe live family interviews, was analogous to the discovery of the microscope. Just as the microscope allowed the scientist to examine the structure of a chosen specimen with enhanced vigor and precision, so too did the move towards direct observation and

the use of audio and video tape equipment allow the therapist to examine the family unit from a different perspective. Seeing things differently made it possible to think differently. Altered comprehension highlighted the social situation focusing on the interactional patterns, rather than the person as the "problem", which gave prominence to the individual and their historical mishaps, neglecting the importance of the "here and now", person-environment transactions. It became evident that there were options to the more traditional approach that emphasized the individual psyche. The insight gained into system dynamics brought forth alternative explanations of human misfortune, stimulated further innovative techniques for family-oriented therapies and created a new interest and perspective of clinical evaluation and behavioural research (Hoffman, 1981; Nichols, 1984).

The following two chapters discuss in detail two family oriented models whose underlying theoretical bases are derived from systems theory. These orientations, known as the structural and strategic models, are considered to fall under the ecological paradigm. Both approaches focus on the family as the target system, and can be combined allowing the therapist to incorporate techniques from either approach in response to the presenting situation. It was this interventive strategy that this writer chose to adopt. Chapter three

closes with a discussion of an integrated structural/ strategic approach and a review of the research evaluation of these models completed to date.

Chapter Two

Structural Family Therapy

The structural school is one of several that postulates the predominance of environmental factors as determinants of behavior; the basic tenet being that individual growth and development is very much influenced by society (Minuchin, 1974; Aponte & Van Deusen, 1981; Okun & Rappaport, 1980). Emphasis is placed on the transactions between people and the environment in which they exist. The focal system is that of the family, as it is primarily within the context of the family that its members are provided nurturance and socialization occurs. In the 1970's structural family therapy emerged as one of the most popular approaches in the field, as the model clearly describes the underlying structure or organization of the family in terms that provide useful guidelines for assessment and treatment (Nichols, 1984). The concept of the "structure" of the social system is fundamental to this model (Walsh, 1980). "The structure refers to the regulating codes as manifested in the operational patterns through which people relate to one another in order to carry out functions" (Aponte & VanDeusen, 1981, p. 312). The family structure allows the therapist to describe predictable patterns or sequences of behavior. A set of covert

rules which govern transactions exists in all family structures. The structure is shaped by the individual histories each member brings to the family and the constraints placed on the family by the larger society. Every structure with its diversities is unique to each family, but possesses a degree of universality. Patterns of interaction are a manifestation of the dominant family structure with its implicit and explicit rules and regulations that govern individual behavior (Hoffman, 1981).

Historical Background

The structural approach to family therapy is most closely identified with the work of Salvador Minuchin (Aponte, & Van Deusen, 1981; Nichols, 1984). Minuchin was born and raised in Argentina where he obtained a medical degree. He served as a physician in the Israeli army before coming to the United States, where he trained in child psychiatry at the Jewish Board of Guardians in New York City and studied psychoanalysis at the William Alanson White Institute. He returned to Israel for a time and then came back to the United States where he took a job at the Wiltwyck School for delinquent boys. It was here that Minuchin suggested to his colleagues that they start seeing families. Other family approaches at the time, developed by Nathan Ackerman and Don

Jackson were applicable to middle-class families and were not suitable for working with the multi-problem, poor families at Wiltwyck. Minuchin was prompted to develop new concepts and techniques for these New York ghetto families. In their work Minuchin and his colleagues emphasized the communication aspect (who speaks to whom; when; how; and in regards to what) between family members. Thus it has often been labelled a "communication approach" (Stanton, 1981b). This therapeutic approach was founded on the immediacy of the present reality and focussed on problem solving given the context of the social situation (Aponte & Van Deusen, 1981). The work at the school by Minuchin and his colleagues, Montalvo, Guerney, Rosman and Schumer, led to the writing of the book, Families of the Slums (1967). This marked the first attempt at a demonstration of structural techniques. Minuchin's reputation grew, and he became the Director of the Philadelphia Child Guidance Clinic in 1965. Among Minuchin's colleagues were Braulio Montalvo, Jay Haley, Bernice Rosman, Harry Aponte, Marianne Walters, and Stephen Greenstein, all of whom played a role in the development of this approach (Nichols, 1984). By the late 1970's, structural family therapy had become one of the most influential and widely practiced of all family system therapies (Nichols, 1984). Presently practitioners from this school are adapting the therapeutic techniques to other socioeconomic strata.

Basic Theoretical Concepts

The structural dimensions of transaction most often identified by structural theorists are: boundary, alignment, and power (Aponte, VanDeusen, 1981). All interaction contains these three forementioned structural dimensions. The therapist must decide which aspect(s) of the interchange may have more relevance given the issue addressed. The boundaries of a subsystem as defined by Minuchin (1974) are the rules defining who participates, and how. They are invisible boundaries which surround individuals and subsystems that dictate the amount of contact with others. They function to protect the separateness and autonomy of the family, its subsystems and individuals. Parents, for example, have roles in relation to their children that they choose for themselves and that are defined by the larger culture which determines the exchange between parent and child.

Interpersonal boundaries extend along a continuum from being rigid to diffuse (Minuchin, 1974). The concept of enmeshment indicates that the boundaries are relatively undifferentiated, permeable and fluid. Family members function as if they are one. There is a heightened sense of mutual support at the expense of individual independence and autonomy. Enmeshed parents are loving and caring and their lives re-

volve around their children. The children may become over-dependent on their parents and as a result may be less comfortable with themselves and relating to people outside the family. Within a disengaged family, boundaries are firmly delineated, impermeable and rigid. Family members are detached and tend to go their own way with little overt dependence on one another for their functioning. This may force children to develop their own resources and become independent. It may also produce a relatively sterile environment where warmth, affection and nurturance are lacking. Disengaged families must be under extreme stress before they are willing to mobilize mutual support. If parents keep their children at a distance it becomes difficult to determine when the child needs support and guidance. A third common dysfunctional structure related to boundary is the violation of functional boundaries. Often there is inappropriate intrusion of family members into functions that are not consistent with healthy growth and development. The "parental child" is a classic example where the child takes on responsibilities typically reserved for the parental domain.

The concept of alignment involves one member of the system joining or opposing another member of the system in carrying out an operation (Minuchin, 1974). Individuals may form an alliance where two people share a common interest not shared

by a third. The parental subsystem forms a natural alliance. A coalition is formed when two or more people join together against a third. Common types of coalitions formed within family units include: a stable coalition, where interactional patterns become dominant and inflexible; a detouring coalition which occurs when an alliance is formed to diffuse stress between members of another coalition, for example, Haley's (1980) "sacrificial" adolescent; and formation of a triangle where each opposing partner seeks to join with the same person against the other. When coalitions become dominant patterns and depending on the issue, family members are unable to demonstrate flexibility in their alignments, dysfunction occurs.

Power is an issue that exists in any relationship and can be demonstrated in numerous ways (Minuchin, 1974). When a small child throws a tantrum in the supermarket and is successful at manipulating the parent into buying the desired chocolate bar, the child holds the power at that moment in time. In families different members hold power in relation to other members which may vary over time and space. The execution of power is dependent on who is active or passive, willing or unwilling, accommodating or able to compromise, in any given context. The fundamental structural problem with power is the lack of functional power in the system. Dysfunction occurs

when individuals are not able or allowed to exercise the force necessary to carry out functions within the system. A common occurrence is the presence of a weak executive system in which parents are unable to direct and control their children through appropriate means.

Many families have the resources to continue from day to day without seeking professional help, but "normal" family life is neither static or problem free. All families face situations that stress the system (McGoldrick & Carter, 1982; Golan, 1978). A crisis may be related to disruption in the developmental process that individuals and families go through over time such as leaving home, marriage, birth of a child, death, etc. (Haley, 1973). It may revolve around a life transition such as divorce, relocation, job change; or a natural or man-made disaster such as war, flood or earthquake (Golan, 1978). The crisis is the individual or group's reaction to the event, not the event itself. Various situations will induce a crisis state for different individuals, but each will have a unique but somewhat predictable reaction (Puryear, 1978). In such situations the family must modify its structure to adapt to new situations, which "depends on the degree to which the family structure is well defined, elaborated, flexible and cohesive" (Aponte & VanDeusen, 1981, p. 315). It is not possible to define the "normal"

family as opposed to the "abnormal" family, but it is possible to say that the normal family tends to modify its structure to accommodate changed circumstances, and the pathological family tends to increase the rigidity of its structure which will eventually lead to dysfunction if there is no adaptation (Nichols, 1984; McGoldrick and Carter, 1982).

Many families seek help at the transitional life stages of family development. As a therapist is is essential that we are aware of the family developmental cycle and sensitive to expectant critical periods. It is also important that we do not mistake family growing pains for pathology (Minuchin, 1974). With any disruption, regardless of the precipitating factors, the family must modify its structure to fit the extended environment and possess the ability to adapt and change to meet the basic needs of individual family members.

Assessment Framework

Structural therapists maintain that family problems are a result of a dysfunctional family structure and/or its ecosystem (Minuchin, 1974). Therefore therapy is directed at altering the cyclic patterns of interaction so that the family can learn to solve its own problems in relation to the

larger environment. The ultimate goal of therapy is structural change (Minuchin, 1974; Okun & Rappaport, 1980, Nichols, 1984). Once the desired structural changes have been accomplished the system will move towards a healthier state of functioning. The therapist directs the family to engage in alternative patterns of interaction which will modify family structure and therefore organization. They are taught new transactional patterns that if regularly repeated will enhance family functioning. Both within and outside the session, via homework assignments, the therapist assumes an active role in providing the family with direction, influencing selected aspects of their transactions.

In order to assess family dynamics the therapist must possess an adequate understanding of structural theory and must observe family members interacting (Minuchin, 1974). Self report from family members is not enough. The therapist must have the opportunity to observe the family in action to determine structural dynamics. Given that the purpose of structural theory is to describe the organizational relationships of the parts to the whole in the social ecosystem (Aponte & VanDeusen, 1981) it is preferable that all members of the nuclear family be included in the assessment phase. This may also involve those people who appear to share in the problem such as extended family, friends, colleagues, or

other helping professionals. The assessment process includes identifying the problem, determining its locus in the ecosystem, and defining the system's structures that sustain the problem (Aponte & Van Deusen, 1981). Problem identification involves determining where in the operationalization of the structure, system dysfunction occurs. It is the act of identifying the cyclic behaviour sequences that in fact maintain the interactional exchanges that the family insists they want to change. The family becomes locked in a cyclic interchange and may or may not be aware of how one's action and reaction affects the other. Individuals or subsystems are believed to be "stuck" in a mutually reinforcing relationship.

Problem identification also demands investigation beyond the realm of the family system. Problems do not occur in isolation. Although the family system level remains the primary focus both theoretically and in practice, the therapists must be attuned to environmental factors that impinge on the family system (Auerswald, 1968).

The above is related to determining the locus of the problem. In view of the fact that the therapist conceptualizes the individual operating within a family within a community, this is not a simple task. The therapist may attend to one or more levels at any given time, none of which is independent

of the other (Okun & Rappaport, 1980). The primary locus consists of those systems engaged in a mutually reciprocating relationship that generates the problem for all or some of those systems. The concern is for whom the problem is an issue presently and not at its time of origin, because the locus of the problem relates to the sustaining structure and not necessarily to the initial structure to the problem. In the final analysis the therapist must ascertain what and where the problem is in relation to how the system is organized given its sustaining structures and unique history, such that the dysfunction is generated and maintained.

Process of Structural Family Therapy

Several techniques or strategies are utilized within the process of structural therapy. In reviewing these, one needs to take into consideration what the different moves are intended to accomplish. Within this model, techniques are interjected to create transactions; undertaken so the therapist can join in the transaction, or are an effort to restructure the transaction (Aponte & VanDeusen, 1981).

In the initial stage of treatment the therapist sets the stage, so to speak, and joins the family as a leader. The therapist's opening moves are of critical importance as he or

she must gain the family's acceptance while maintaining their respect (Minuchin, 1974). The family possesses a firmly established homeostatic pattern. At times it will be necessary for the therapist to confront and challenge family members. He or she must establish the necessary leverage to work with the family. Just as initial meetings leave lasting impressions, so too do the first few minutes of the initial session (Haley, 1976). If the therapist has any information about the family prior to the session, this can be used to hypothesize about the family's dynamics and strategize for the first meeting. Questions such as: who the therapist should speak to first; who has the family identified as the patient; is there anyone the family has neglected to bring, but may be important for the therapy process, go through the therapist's mind. The therapist must also be sagaciously attuned to the body language of each individual. It's as if the therapist is a director who has just walked onto the stage. The immediate task is to assess very quickly the characters with whom the work is to be done and to begin directing the movement. There is a significant amount of mental preparation and thought that is necessary just prior to meeting the family and within the first few minutes of the session.

As the therapist works toward structuring the therapeutic

system he/she must also actively attempt to join with or accommodate the family system. Joining is the act of relating personally to the family for professional purposes (Aponte & VanDeusen, 1981; Haley, 1976). The therapist typically engages each member of the family and demonstrates an empathetic understanding and acceptance of each. It is essential that the therapist obtain some degree of rapport with each member as restructuring requires compliance from the family system. Minuchin (1974) describes three styles of accommodating: 1) maintenance, in which the therapist initially supports the existing dysfunctional family structure; 2) tracking, in which the therapist actively attends to the family's language, symbols and behavior patterns; and 3) mimesis, where the therapist joins the family by becoming like the family in manner or content of his or her communication (Okun & Rappaport, 1980).

The therapist engages the family without being overly critical or offering value judgements. The intent of the initial stage is to stimulate and observe the family system's interactional pattern so that an assessment can be made of the family's structural organization (Minuchin, 1974). Six different aspects of the family's structure are examined:

1. The family structure in terms of its major subsystems.

2. The system's flexibility and its capacity for elaboration and restructuring, as revealed by the reshuffling of the alliances, coalitions, and subsystems in response to changing circumstances.

3. The system's resonance, its sensitivity to individual members' action.

4. The system's context, its life-support systems and sources of stress in its extrafamilial environment.

5. The family's developmental stage and its performance of tasks appropriate to that stage.

6. The ways in which the identified patient's symptoms are used to maintain the current transactional patterns (Okun & Rappaport, 1980, p. 147).

Techniques

Once the assessment is made the therapist can contract with the family to work on the agreed upon problem. The therapist then begins to restructure the family system. Several techniques may be employed which include: 1) actualizing transactional patterns; 2) boundary making; 3) escalating stress; 4) assigning tasks; 5) utilizing symptoms; 6) manipulating mood; and 7) providing support, education, and guidance (Okun & Rappaport, 1980, p. 147).

Actualizing of transactional patterns involves manipulation of communication and behavior by the therapist. He/she may encourage family members to talk to one another within the session, thereby creating a different sequence of interaction. For example, an adolescent may blurt out "She doesn't want me anyway!". The therapist may intervene by turning to the mother and saying "Your son believes you don't care for him. I know that you do. Can you talk to him now about what has happened to make him feel this way." The therapist may have other family members listen and defer interruption. He/she may also encourage a family member to do the thing that has been identified as a problem. For example he may have a young child light a fire in a garbage can, or request that a depressed husband demonstrate how he behaves when he is depressed (Munuchin, 1974). If the husband complains that he has no control over his depression, yet can spontaneously bring on his symptoms within the session, then he does indeed control that which he claims not to.

The therapist actively works to restructure the system by way of marking boundaries and adjusting family alliances (Munuchin, 1974). This may occur within the session by asking people to change seats or as a homework assignment by suggesting the parents spend a weekend away without the

children. Other interventions that function to restructure the family subsystems may include rule changes in the home. For example, in an enmeshed family where boundaries are not clearly defined a beginning step might be to have family members close their bedroom doors at night and no longer allow the children to come into their parents' room to sleep.

The therapist may attempt to move the family by escalating stress (Munuchin, 1974). A common tactic is to intensify the emotion within the session. This manoeuvre demands great skill and competence as the therapist may lose control along with the family's confidence and they may not return.

The assignment of tasks can be extremely beneficial to the therapeutic process. They require ingenuity, planning and comprehensive direction to be effective. The therapist can give a directive within the session or assign a task to be completed as homework before the next session (Minuchin, 1974). The therapist may choose to utilize the symptom, to the family's advantage. There are several options available to the therapist, dependent upon what structural modification is desired. The therapist can de-emphasize the symptom or request that the symptom be exaggerated (having the bulimic client throw-up a specified number of times a day). He/she may choose to introduce a new symptom or relabel the stated

problem (depression becomes laziness, jealousy becomes an expression of affection). Finally the therapist may define the problem in such a way that the effect of the symptom is altered (the "out of control" son is helping his parents to demonstrate what good parents they are). Whatever the technique used, all interventions are designed to modify the structure and boundaries within the context of the family and its extended ecosystem.

This concludes the discussion on structural theory. The following chapter examines strategic theory and its application to therapy.

Chapter Three

Strategic Family Therapy

The Strategic school also has its foundation in general system theory, with an added emphasis on cybernetic theory. Developing from a communications model of family systems, strategic therapists focus their attention on repeated sequences of behavior patterns of communicaiton (Nichols, 1984). The model is problem focused and method-oriented, and may also be termed problem-solving therapy, brief therapy, or systemic therapy (Nichols, 1984). The therapist takes direct responsibility for change without attempting to instill insight or awareness upon the family. Simply put by Hoffman (1981), if insight was all that was required, families would not present themselves to the therapist with the variety and chronicity of problems that they do. Jay Haley (1973) coined the term "strategic therapy" when describing the much admired work of Milton Erickson. Erickson became renowned for his brilliant interventive strategies. Unlike the structural therapist, who takes a much wider scope, the strategic therapist works from the inside out (Munichin, 1974). Thus there is a concentrated interest on the details of the symptom and less concern for the family and their overall growth and welfare (Nichols, 1984). Therapy goals are specific and clearly

set with the purpose of resolving the presenting problem (Stanton, 1981a). Interventions are astutely pragmatic, and their design is the primary task of the strategic therapist. The popularity of this model grew rapidly in the 1970's and as one of the most recent developments of family therapy, it is also one of the most exciting.

Historical Background

There are several prominent figures that are identified as strategic therapists, Jay Haley being the most notable (Stanton, 1981a, 1981b). There are several variations to the approach. None the less all possess a common theoretical background in systems and communication theory, and the therapeutic intention revolves around interrupting repetitive patterns of interaction in which the problem is embedded (Nichols, 1984). The approach itself has its beginnings in the work of Gregory Bateson and Milton Erickson (Hartman & Laird, 1983; Stanton, 1981b). Bateson, an anthropolgist, worked towards the advancement of the field of cybernetics. In 1952 he was joined by Jay Haley, John Weakland and William Fry at the Palo Alto VA Hospital. At the same time, Don Jackson started working with schizophrenics in a familial context. He was developing the concept of homeostasis at the same hospital, and joined the Bateson group as a consultant

in 1954. The revelations devised by this group from their work with schizophrenic families, tied together with communications and cybernetic systems theory; and the studies by Haley and Weakland of Milton Erickson's hypnotic and therapeutic techniques formed the basis for the strategic approach (Stanton, 1981b). Haley gives much credit to Erickson with his innovative therapeutic interventions including hypnosis and paradoxical instruction. His methods significantly influenced the development of this school. In 1967 Haley joined Minuchin and Montalvo at the Philadelphia Child Guidance Clinic, after spending time at the Mental Research Institute with Don Jackson. For the next ten years Haley was the Director of Family Research at the clinic. In 1976 Haley moved to Washington, D.C. where he joined the faculty of the University of Maryland Medical School, and established his own family therapy clinic, The Family Therapy Institute, with his wife Cloe Madanes. Others who have significantly contributed to the strategic school include Gerald Zuk of the Eastern Pennsylvania Psychiatric Institute in Philadelphia; the Milan group at the Institute for Family Studies in Milan, Italy, consisting of four psychiatrists: Mara Selvini Palazzoli, Luigi Boscolo, Gianfranco Cecchin, and Guiliana Prata; Lynn Hoffman and her colleagues at the Ackerman Institute; Richard Rabkin and members of the Brief Therapy Center of Mental Research Institute (MRI) in Palo Alto,

including Richard Fisch, John Weakland, Paul Watzlawick, Arthur Bodin and Carlos Sluzki (Stanton, 1981b).

Basic Theoretical Concepts

The strategic approach is oriented towards solving the problem, and less concerned with understanding the family system or its structure, per se, (Hoffman, 1981; Stanton, 1981a). As the theoretical underpinnings of this approach come from general systems theory and cybernetic theory, the emphasis is on communication. The basic assumption is that the family system and organziation can be understood by studying communicaiton, both verbal and non-verbal (Okun & Rappaport, 1981). The therapist zeros in at the most specific level, questioning the family about the presenting problem, with the intention of observing the current interactional patterns within the family system.

Human interaction and the act of communication is extremely complex. There is nothing simple about receiving a message, processing the information and responding. The following are axioms of the communication theorists (Okun & Rappaport, 1981, p. 78):

1. All behavior is communicative. It is impossible not to communicate, since silence or

withdrawal indicates something about the relationship between two people.

2. Every communication has a content/report and relationship/command aspect. The content is the message given by the words spoken. The relationship/command is the non-verbal message about the message. The tone of voice, and body language used by the sender may or may not be congruent with the spoken words to the listener. It is the meta communication that places a demand on the recipient.

3. Relationships are defined by the command messages and are dependent upon the punctuation of the communicational sequences between the communications. Misunderstandings can result when communicators are unaware of the commands they are giving, receiving, or obeying. Often there is a perceived inconsistency between the message and the meta communicaiton. If the listener does not receive the sender's command message--the punctuational sequence has been ineffective.

4. Human beings communicate digitally (verbally) and analogically (nonverbally). The verbal communication is the content/report of the message; the nonverbal communication is the relationship/command aspect. There is concern not only for the message, but what it implies about the relationship between the communicators.

5. All communicational interchanges are either symmetrical (equal and parallel where either can lead) or complementary (where one leads and the other follows). Interactions are based on equality or on differences and enable the observer to learn about the nature of the relationship between the communicators (what are the implicit and explicit rules; who holds the power and has control).

Flowing from these principles is the assumption that relationships can be understood by analyzing the communicational and metacommunicational aspects of interaction.

The strategic therapist conceptualizes the family's interpersonal system as analogous to other cybernetic systems. It is therefore circular, as opposed to linear, with complex interlocking feedback mechanisms and patterns of behaviour that are repeated in regular sequences involving three or more persons (Nichols, 1984; Hartman & Laird, 1983). It was Murray Bowen (1966) who first described the triangulation within family systems. As tension escalates between two people, one of them moves towards a third to form a triangle. Triangulation of a third person functions to stabilize the relationship but serves to maintain the problem. Most strategic therapists, but not all, emphasize the triadic problem-maintaining sequence of the family system (Nichols, 1984). Often a child, friend or therapist becomes the triangulated member of a marital dyad (Fogarty, 1976).

Several concepts are fundamental to the strategic school, these include the ideas of homeostasis, hierarchy and symptoms (Haley, 1976; Stanton 1981b; Nichols, 1984; Okun & Rappaport, 1981). Homeostasis as already discussed is the dynamic equilibrium that is established as the family evolves. As in the structural model, this concept is of key importance to the strategic school. There is also an emphasis placed on the hierarchical structure in the family. Haley (1976) in particular adopts this view. Functional

families are believed to be organized hierarchically, according to generations. He maintains that symptom free families respect generational boundaries and avoid covert, cross-generational coalitions. Conflicts can cut across several levels in the familial hierarchy and Haley further posits that "an individual is more disturbed in direct proportion to the number of malfunctioning hierarchies in which he is embedded" (1976, p. 117). Other strategic therapists stress the need for open acknowledgement of family alliances (Selvini & Palazzoli, et al., 1978) but do not stress the importance of cross-generational coalitions or attribute the pathology to them as Haley does (Nichols, 1984).

Symptoms develop as misguided attempts to solve existing problems and are purposeful within the family. They further serve as homeostatic mechanisms which regulate the familial system. Efforts to relieve tension in a symptomatic family become the very thing that maintains the problem. The symptom functions as a homeostatic mechanism regulating the organizational structure of the system (Hoffman, 1981).

Repeatedly playing out habitual games to maintain a fixed homeostasis is exactly that which causes dysfunction. "The crux of the difference between normal and pathological families is that normal families tolerate and admit differences,

alliances, and even power struggles; pathological families on the contrary, conceal and mystify any circumstance that runs counter to prevailing family myths" (Nichols, 1984, p. 436). As is premised by the structural school, families that develop problems are those who are unable to adapt their organizational structure to fit changing circumstances. Abnormal families are limited to their rigid repetitive sequences that constrict the range of behaviour available to them.

A distinction must be made here between first-order change and second-order change (Watzlawick, Weakland and Fisch, 1974). First order change is characterised by a minor shift within the system. Second order change is characterised by a major adjustment that requires an alteration in the system. Returning to the earlier example of the home heating unit, automatic shifts to keep the room at the set temperature are first order changes. A second order change would be exemplified by a substantial drop in the external temperature that required the householder to adjust the thermostat accordingly. Families who are only capable of making first order changes develop symptomatic members (Stanton, 1981b). It is then the therapist's task to strategically intervene to create second order changes.

Typically families present themselves at transitional points in the life-cycle (Haley, 1980; McGoldrick & Carter, 1982), when they have become "stuck" and the system's homeostatic mechanisms do not allow adaptation to the required changes. In sum, the strategic approach assumes that: symptoms can be viewed as particular types of behaviour functioning as homeostatic mechanisms which regulate family transactions; problems in an identified patient cannot be conceptualized apart from the context in which they occur and the functions which they serve; an individual cannot be expected to change unless the family system changes; and insight is not necessary for change to occur (Stanton; 1981b).

Assessment Framework

Unlike the structural therapist who gathers information related to the present structure of the family, the strategic therapist possesses a persistent preoccupation with the problem and its manifestation. There is much greater concern with the current behaviour patterns that maintain the problem than with its etiology (Haley, 1976; Stanton, 1981a). The therapist works to uncover the cycle, which entails gathering information related to the management of the condition and not the condition itself (Hoffman, 1981). With the emphasis on the problem the strategic therapist proceeds to go to

battle with the forces that maintain the problem, not the family structure as emphasized within the structural model; although they may be one and the same. Individuals or family subsystems may be seen separately, perhaps even setting one against the other (Haley, 1976). It is not viewed as necessary to bring the family unit together as emphasized by the structural school.

Where the structural therapist actively works to repattern relationships in the room, the strategic therapist appears strangely inactive. The therapist proceeds by asking detailed questions about the problem, and pays little or no heed to affective involvement (Haley, 1976; Hoffman, 1981). Therapy becomes a technical matter. The primary goal is to solve the presenting problem. Change is sought by observing the family organization, then strategically planning to alter these sequences. For the strategic therapist "the key to change is the art with which they can reframe the client's perception of the context of his behavior" (Hoffman, 1981, p. 277). The primary interventive task is one of changing the perceived reality of those involved, so that different behaviors become possible. This requires extensive therapeutic expertise and is by no means an easy feat.

The emphasis on solving the problem stems from the rationale

that the family is more likely to be "stuck" than "sick". Interventive tactics are therefore designed to help the family become "unstuck" and make the transition onto the next stage of development. Haley (1980) writes extensively on the period when the young person is preparing to leave home, and believes this to be a particularly difficult time for families. One may express concern about the symptom-focussed, problem solving emphasis of this approach, but the strategic therapist does intend to prevent the repetition of problematic sequences through the introduction of new and alternate behaviour sequences. The family has been given a new order of complexity that will aid them in solving future difficulties.

Process of Strategic Family Therapy

Strategic therapy is strictly pragmatic. Haley (1976) lists three steps for identifying and changing the family's organization. First it is necessary to acquire a moving picture of the families' interactional patterns, in order to pinpoint the behavioral sequence that functions to maintain the problem. Second, a goal for therapy must be negotiated, agreed upon and put in a solvable form (Stanton, 1981a). If the family presents with more than one problem, they are directed to select the most important one. Third, an intervention is designed, typically involving a relabelling of the problem,

and subsequently applied. The strategic therapist works alone, or with a consultant team of one or more colleagues. Ideally the team observes the session from behind a one-way mirror, and may phone in messages or call the therapist out of the interview to strategize. The team meets both before and after sessions helping the therapist to analyze the family's interactional behaviour and carefully plan interventions. A member of the team may enter the room and interrupt a session with the intention to support, confront, confuse, challenge or provoke the family (Haley, 1976), with the therapist free to agree or oppose them; or compose a message to be read to the family at the end of the session (Papp, 1980).

Given that the directives to the family may appear rather bizarre, the team approach functions to enhance the therapist's prestige and identify him or her as the expert. The therapist takes sole responsibility for change. If an intervention is not effective an alternate strategy is designed and a new directive is given to the family. As strategic therapists are much less active in the actual session, most of the work is assigned as homework between sessions (Stanton, 1981a).

In the initial interview, after the therapist has successfully joined with each family member (Haley, 1976) he/she

proceeds to inquire about the presenting problem. The therapist must obtain a clear and specific definition of the major problem, and his/her questions serve to gather this information. Questions such as: What is the problem? Who did what the last time it happened? What is likely to occur? When did it first appear? A careful analysis of these behaviours will reveal that the family's solutions, typically involving a symptom-bearer, have become part of the problem in a self-reinforcing sequence (Hoffman, 1981). Watzlawick, Weakland and Fisch (1974) have attempted to identify those solutions which serve to exacerbate the problem. They fall into three categories. The solution may be to deny the existence of a problem, therefore the family does nothing. For example, the parents refuse family therapy, blaming the child and insist he or she be "locked-up". In the second situation the solution is an effort to solve something which isn't really a problem. For example the parents who deny their teenage daughter the opportunity to interact with peers or go out on dates. Finally, a solution may be an effort to solve a problem within a mind-set that makes the solution impossible. For example parents may inflict corporal punishment on a young baby or an adolescent. Action is taken, but it is not appropriate, and will therefore be ineffective. These three types of solution attempts will only serve to perpetuate the problem in the long term.

Once an agreed upon goal is negotiated with the family, and the therapist has developed an hypothesis about what is maintaining the problem, a specific strategy of intervention is designed to block the symptom maintaining behavior. Several technques may be employed, which include: reframing, giving directives and paradoxical prescriptions (Hoffman, 1981). The therapist is concerned with what works, regardless of how illogical it may appear to the family. Typically the problem is "reframed" such that it is viewed in a different light (Barker, 1981; Hoffman, 1981; Madanes, 1981). Given that the strategic therapist does not attempt to convey insight, one can understand the therapist's emphasis on reframing. This technique is used to restate the situation so that is is perceived in a new way (Hoffman, 1981). Once it is perceived in a new way, the family is more apt to do something different and change. Reframing can be seen as the foundation that paves the way for second order change (Hoffman, 1981). Closely related to reframing is positive connotation, a similar technique where, that which has been regarded as pathological behaviour is reframed as a strength or a good thing (Barker, 1981; Hoffman, 1981).

The primary therapeutic tool of the strategic therapist is the directive or task (Haley, 1976). Ideally they are designed to encourage second order change in the family system.

The "emphasis on directives is the cornerstone of the strategic approach" (Stanton, 1981b, p. 372). Much of the initial discussion with the family is aimed at providing the information and rationale for the design of the directive. Haley (1976) writes extensively about designing directives, and indicates that "the best task is one that uses the presenting problem to make a structural change in the family" (p. 77). For example Haley (1976) describes the case of a young boy who is terrified of dogs and over-involved with his mother. The task was to have the father help the son to find a puppy that was afraid of him, and cure the puppy of his fear. Typically the task is assigned as homework, to be completed between sessions. This can be a method of controlling the therapeutic pace and functions as a means to enhance the generalization effect of what transpires in the session to the natural environment (Stanton, 1981b).

Strategic therapy is most notably associated with the use of paradoxical intervention. The use of this strategy is in part based on the assumption that the family is resistant to change and inadvertantly wanting to induct the therapist into their family system with its unique organizational characteristics (Stanton, 1981b). If the family is successful the therapist becomes part of the system and therefore part of the problem ipso facto. A common therapeutic technique is to

prescribe the symptom, thus placing the family in a therapeutic double bind (Nichols, 1984; Stanton, 1981b; Weeks & L'Abate, 1982; Hoffman, 1981). If the family does as the therapist instructs continuing the prescribed behaviour, they are doing as directed. This places the therapist in control by making the symptom occur at his/her direction. If the family resists they must discontinue the prescribed behaviour and move toward improving. When a paradoxical intervention is used it creates a state of confusion in the family, as it is assumed that they must develop new ways to resist and thus change their organization. At the very least the family is temporarily detached from the problematic behavior (Stanton, 1981b).

The paradoxical directive may be given to the whole family, or to certain members. The family is told that the therapist would like to "try a little experiment". The intervention is positively connoted and the therapist takes care to use the language of the family when assigning the task. The directive may fall into one of three categories: a) a prescribing strategy, where the family is instructed to continue or even increase the symptomatic behaviour; b) a restraining strategy where the therapist indicates to the family that he/she does not believe they have the capacity to change, or have done so too quickly and a relapse is predicted; and c) a positioning

strategy is used where the therapist accepts or exaggerates an assertion the client makes about themself or the problem (Stanton, 1981b). For example, if a family member presents as hopeless, the therapist may join with them and define the situation as even more dismal than believed. If an intervention is prescribed, and proves unsuccessful, that is an obvious setback occurs; this provides valuable data in the form of negative feedback for the therapeutic team (Nichols, 1984). The response is evaluated and the new information is used for further hypothetical deliberation and interview design.

An Intergrated Structural/Strategic Approach

Both these schools are systemic in origin falling within the realm of the ecological paradigm (Hartman & Laird, 1983; Stanton, 1981a). Although both approaches initially developed as a function of interventive techniques aimed at a specific target population, contemporary application has broadened considerably (Nichols, 1984). It is possible for the practitioner either to strictly adhere to one or the other model or adopt an approach that combines the two. In doing so the therapist may alternate from one to the other or use them contrapuntally. This enables the therapist to incorporate the appropriate techniques from each, given the situation at hand.

It is suggested that the therapist initially begin with a structural approach--joining, accommodating, boundary marking and restructuring (Stanton, 1981a). This is primarily due to the fact that the structural approach is less complex, more comprehensible and easier for the therapist to grasp and put into practice than the strategic approach. A move to strategic methods are typically undertaken when structural techniques are not producing change. At times the therapist may note a strong homeostatic tendency on the part of the family, leaving the therapist feeling that resistance is mounting and she and the family have reached a stalemate (Hoffman, 1981). Or perhaps the therapist has information, prior to the initial session that the family has had numerous therapists over an extended period of time. When situations such as the above occur a change in tactics is required. The therapist may choose to revert to a structural approach after sufficient movement is observed in the family system. As a general rule, the therapist selectively determines an orientation depending primarily on the level of resistance or the rigidity of the homeostasis displayed by the family (Stanton, 1981b), and as a function of their own level of competency.

Research and Evaluation of Therapy

Only in the last twenty-five years has family therapy gained

popularity. To date there has been only one study conducted to evaluate the effectiveness of an integrated Structural/ Strategic model (Stanton & Todd, 1979). There have, however, been several descriptive and etiological studies undertaken by structurally-and strategically-based researchers.

As discussed earlier, the structural school stresses the individual within their family, within the community and their interrelationships (Auerswald, 1968). Family studies have all incorporated a focus upon communicative behaviours between family members, an emphasis that is congruent with the transactional tenets of the theory. However, no uniform system of variables has been universal across studies (Stanton, 1981b). This again reflects the early stage of theoretical development and subsequent inquiry, and the lack of collaboration between researchers. Nonetheless, over 200 studies have been documented. Within these studies four types of clinical families have been described: the low socioeconomic family (Minuchin et al., 1967); the psychosomatic family including those that are anorectic, diabetic and asthamtic (Minuchin et al, 1978); the alcoholic family (Davis, Stern & VanDeusen, 1977); and the addict family (Kaufman & Kaufman, 1979; Stanton et al., 1978; Zeigle-Driscoll, 1977, 1979). In relation to these four types of families Minuchin and his colleagues have been particularly

successful when treating psychosomatic asthmatics, and psychosomatic-complicated cases of diabetes (Minuchin, Baker, Rosman, Leibman, Milman, & Todd, 1975), as well as drug addicts and their families (Stanton & Todd, 1979). Minuchin has also demonstrated that families clinically rated as enmeshed were quite often successful in therapy while disengaged families did not evidence change (Minuchin et al., 1967).

One study of important scientific value was undertaken by Minuchin, Rosman, and Baker (1978). Subsequent to prior research studying the relationship between emotional arousal and episodes of ketoacids in children with diabetes, Minuchin and his colleagues intended to verify the hypothesis that the symptom is brought to function as a regulator of the level of stress in interpersonal relationships between family members. The investigators compared three subtypes of diabetic patients: psychosomatic (N = 11), behavioural (N = 7), and normal (N = 8), and their families in terms of their response to a three-stage stress interview. In the baseline interview parents discussed family problems with their children absent. Normal spouses showed the highest levels of confrontation, while psychosomatic spouses exhibited a wide range of conflict avoidance maneuvers. In the second stage a therapist intentionally pressed conflict issues earlier expressed by

the couple, while the patient observed from behind a one-way mirror. Normal couples continued their conflicts at the previous level, while psychosomatic spouses became more direct and expressive than they had been in the first stage, rising to emotional levels approximating those of the normal group. The psychosomatic patient displayed a marked increase in the distress, as indicated by a dramatic upward incline in the free fatty acid (FFA) levels of the blood, a measure which is related to ketoacidosis. In stage three of the interviews, the patient joined the parents. Normal and behaviour-disordered parents continued as before. The behaviour of the psychosomatic families differed in that the parents detoured the conflict, drawing in the child either passively by switching the subject from themselves to the child as the target, or actively by allowing the child to participate in the discussion. Children were observed to enter into alliances, suppress issues and manifest increased stress discomfort. The child's level of FFA continued to rise while the parents' level fell (the "cross-over" phenomenon) mirroring the transactional patterns. On the basis of both physiological and transactional measures, this study provided confirmation of the key role that the psychosomatic child plays, (both conscious and unconscious) in the regulation of familial stress.

These cited examples offer support to the theraputic validity of structural family therapy. The studies consist of several important lines of inquiry and offer evidence in support of the school's major tenets and techniques (Stanton, 1981b). However, the research to date is limited and further examination, clinical application and validation is required.

Strategic family therapists have undertaken several studies demonstrating the effectiveness of this model. There have been at least seven research studies completed which examine the treatment outcome of therapy. The earliest of these was by Langsley and associates (Langsley, Fairbairn, and De Young, 1968; Langsley and Kaplan, 1968; Pittman, Langsley, Flomenhaft, De Young, Machotka, and Kaplan, 1971). This group compared the effectiveness and cost efficiency of home-based treatment (in-patient treatment combined with family-centered, hospital-based out-treatment), and hospital-based treatment (traditional psychiatric client-centered treatment), of individuals requiring immediate in-patient psychiatric treatment. The techniques adopted when intervening in family crises were similar to those employed by both the MRI Brief Therapy Center and Haley's earlier work in this area (Stanton 1981b). The Langley et al. (1968), project involved 300 cases, which were randomly assigned to either group. Results from an eighteen month follow-up indicated that

family crisis therapy was an effective, acceptable and safe alternative to hospital-based treatment (regardless of diagnosis); cost was one-sixth as much, and the number of days home-treatment patients subsequently spent in the hospital was less than half than that of the control group.

In another carefully designed study, Parsons and Alexander (1973) compared a behaviourally-oriented, crisis-centerd family therapy based on strategic techniques and systems theory, an eclectic-dynamic approach, a client-centered family approach, and a no-treatment control group in treating delinquent behaviour. Recidivism of delinquency was cut in half for that group which was treated with the systems approach, in comparison to no significant difference between the other three groups. Furthermore, a three-year follow-up showed that the incidence in the siblings was significantly lower for the family sytems treatment (Klein et al., 1977). Given that this treatment was adopted from the systems approach described by Haley (1963, 1971) and Watzlawick et al. (1967), a strong case is made for the effectiveness of this model as well as its interventive value as a secondary preventative treatment.

Several other studies have been undertaken which include one by the MRI group (Weakland et al., 1974) evaluating the success of treatment for a variety of problems or disorders;

studies by Stanton, Todd and associates (Stanton et al., 1978) assessing the impact of a structural/strategic approach with drug addicts and their families; and several studies initiated by Garrigan and Bambrick (1975, 1977, 1979) entailing a six year research program investigating Zuk's go-between therapy for families with distrubed children or adolescents. In contrast to the average studies of other family therapy approaches, strategically based researchers have been noted for their superior research designs and undertaking of controlled or comparative family therapy research (Stanton, 1981b; Nichols, 1984). In sum, Stanton's inquiries into family therapy research indicate that the strategically oriented family therapists have had encouraging results when compared to other standard forms of treatment (Stanton, 1981b). However, these conclusions have been drawn from a minimum number of studies and there is a need for further research that not only continues to evaluate treatment methods, but begins to categorize and clarify the school's basic tenets and techniques.

Chapter four examines the transactional patterns of human communication. Karl Tomm (1982) and his associates at the University of Calgary concerned themselves with the cybernetic regulatory mechanisms that are observed to perpetuate a pattern. The following chapter explores the use of

Circular Pattern Diagramming as an assessment tool and as a means of developing an interventive strategy.

Chapter Four

Advances in Strategic Family Therapy: Intervening in Transactional Patterns

The theoretical foundation of the strategic therapy model as discussed in the previous chapter is general systems theory. Several key concepts encompassing homeostasis, cybernetic theory and the principles of communication axioms have been incorporated by the system theorists and applied to the functioning of the family unit. For the systems-oriented therapist, "the family is seen as a system that is composed of individuals embedded in a structure of mutual interactional patterns and which function in a collective, goal-oriented manner" (Tomm, 1982, p. 72), which directly relates to the health or pathology of the family. The above is based on the understanding of three concepts described by Papp (1980): "the concept of the family as a self-regulatory system, the concept of the symptom as a mechanism for self-regulation, and the concept of the systemic resistance to change, resulting from the preceding two" (p. 45). Given this the therapist's task becomes one of identifying and clarifying circular patterns that maintain the problematic behavior (Tomm, 1982). At the University of Calgary the notion of cybernetic feedback and circular patterns as observed within the family unit was taken one step further at

the Family Therapy program. They developed a simple conceptual tool--the circular pattern diagram (CPD), which allows the therapist to schematically depict the interactional patterns of the family. "This diagrammatic model has proven helpful in facilitating a shift from linear to circular thinking and in guiding therapeutic action" (Tomm, 1982, p. 70). This chapter reviews the theory of cybernetics and describes how these concepts are applied to the family's interactional patterns.

Circularity

As discussed earlier the systemic model incorporates the notion of cybernetics and the feedback process between systems. This assumes a patterned circular interactional relationship between family members which cannot be punctuated. As described by Prosky and Prosky, (1980):

> Relationship transactions are end-over-end entities, in which each event has a bearing on the next. One striking feature is that there is no way to get back to the first event. There is no first event. There are two people coming together in their first transaction, but even here the transaction is mutually determined, a production of them both, as are all transactions. p. 90.

The behavioural output of one family member provides the communication which becomes the perceptual input of the second and vice versa. The system is self-maintaining and that which is identified as the symptom functions to preserve the homeostatic state.

Circularity, as described by the Milan Associates, is an active ongoing process between the therapist and family, with the therapist assuming the lead. In their article "Hypothesizing, Circularity and Neutrality" (Selvini, Boscolo, Cecchin, & Prata, 1980), they defined circularity as follows, "By circularity we mean the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationship and, therefore about difference and change" (p. 8). This definition delineates an information-producing process between the therapist and the family and includes an epistemological premise about circularity (Penn, 1982).

In an effort to acquire the most accurate observation of the behavioral sequences in the family, the therapist engages in what has been termed circular questioning (Penn, 1982; Selvini, et. al., 1980). Every member of the family is invited to tell the therapist how he/she sees the relationship between two other members of the family (Selvini, et. al., 1980). For example the therapist may ask one daughter "Tell me how your mother and your sister get along", rather than asking the mother directly about her relationship with her daughter. To request a third person comment on the relationship of a dyad breaks a cardinal rule of therapy, that all family members are to speak for themselves. This

move away from a more traditional approach can be extremely informative and effective in overcoming resistance. Resistance is overcome as the third person is more likely to volunteer information about another family member, than if the person was asked directly to describe their relationship with another (Selvini, et. al., 1980). Family members tend to correct inaccurate perceptions provided by the third person, when they disagree with the description given, therefore providing the therapist with a clearer picture of family interaction. This type of questioning also relies on the first axiom of communication--all behavior is communicative. Family members cannot avoid communicating while listening to another member's scenario of family interaction. In fact the Milan Associates in their article "Hypothesizing--Circularity--Neutrality: Three guidelines for the Conductor of the Session" (Selvini, Boscolo, Cecchin & Prata, 1980), have concluded with the question "Can family therapy produce change solely through the negentropic effect of our present method of conducting the interview without the necessity of making a final intervention?" (p. 12). This is a question they hope to answer with future research.

The therapist asks several different kinds of questions and interjects at various stages in an effort to obtain an understanding of the family relationships. Peggy Penn in her article "Circular Questioning" (1982), describes nine cate-

gories of questions the therapist poses to the family to unearth the patterned sequences of interaction. In sum, "The aim of circular questioning is to fix the point in the history of the system when important coalitions underwent a shift and the consequent adaptation to that shift became problematic for the family" (Penn, 1982, p. 272). The order of circular questioning (which questions are asked when) can be altered. The intent is to probe family functioning in the past tracking the transformations to the present, or beginning in the present and moving to the past. Penn (1982) describes it conceptually "as though an "arc" were drawn with one point in the present and the other point in the past" (p. 272). The information sought depicts the differences in the relationships before and after the problem began. It is from the responses elicited from the family that the therapist can conceptually diagram the circular patterns of feedback the family has unknowingly demonstrated and described repeatedly in therapy.

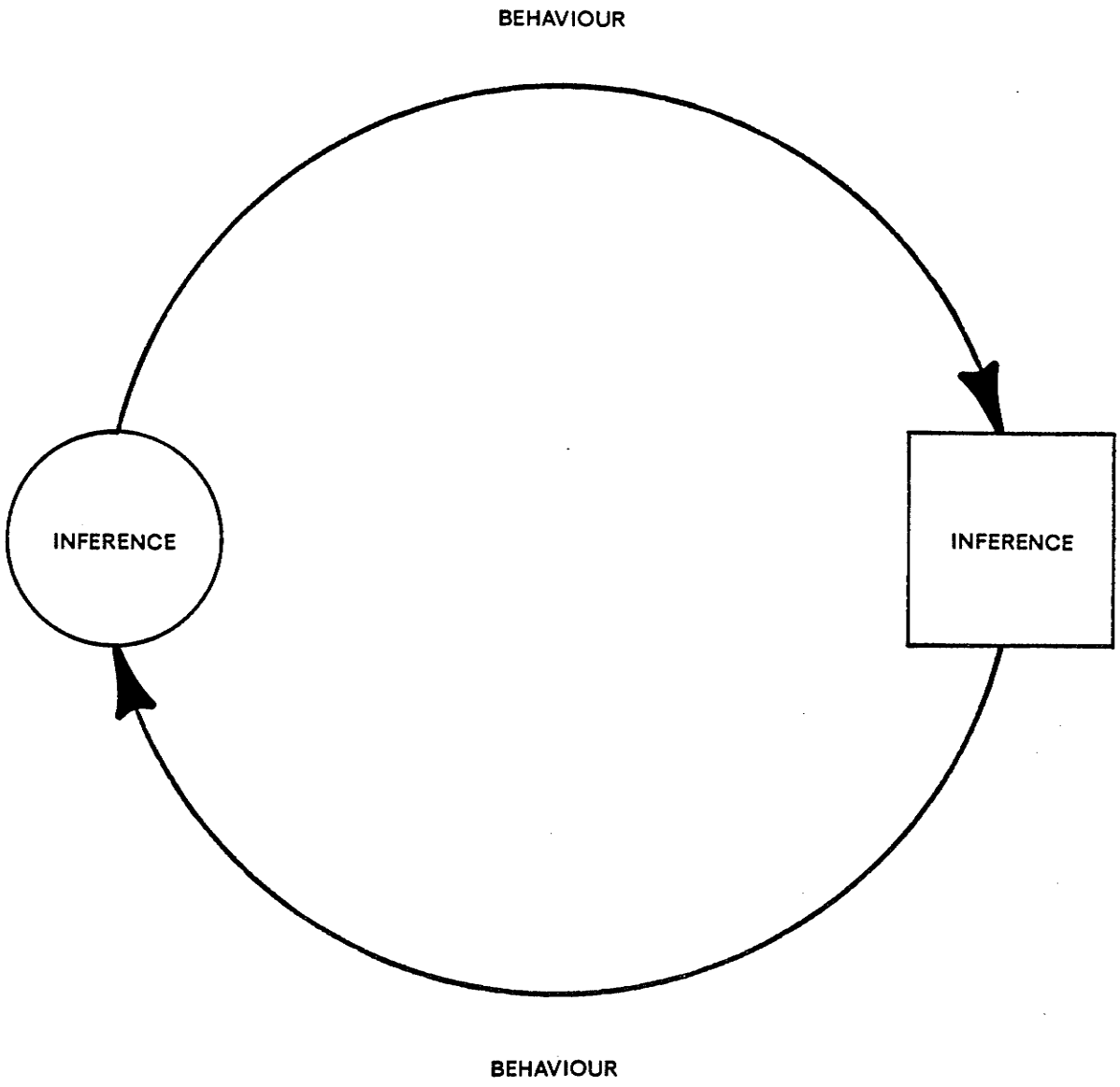
Circular Pattern Diagraming

As therapists we are faced with the ongoing task of processing an inordinate amount of data that comes to us from the family. The circular pattern diagram is a conceptual tool designed to assist the therapist in identifying family inter-

action patterns which summarize and simplify the "organized complexity" of the family system (Tomm, 1982). Because all systems function to maintain homeostasis, family patterns of control tend to become quite stable and predictable (Tomm, 1982). The patterns may develop over weeks, months or even years. The circular diagram represents a certain block of time that contains the repetitive sequence which is conceptually "collapsed" onto a flat plane.

The conceptual model designed by the Calgary program, as described by Tomm, (1982) is most easily applied to the interactional patterns of a dyadic relationship. The simplest circular pattern diagram of the dyadic interaction includes two observable behaviours and two inferences of meaning which affect the subsequent behaviour. Figure 1 (Tomm, 1982, p. 78) diagrams the structural relationsip between these four basic elements. The figures (square = male, circle = female) represent the two people involved. The inference is noted inside the figure depicting the internal process of either individual; that is, what is assessed as going on within the interactant. The external arrows represent the information communicated from one person to the other through their behaviours. The circular delineage assumes that the interactional sequence is a stable, repetitive pattern that is self-regulating (Tomm, 1982).

BASIC ELEMENTS OF A CIRCULAR PATTERN DIAGRAM.



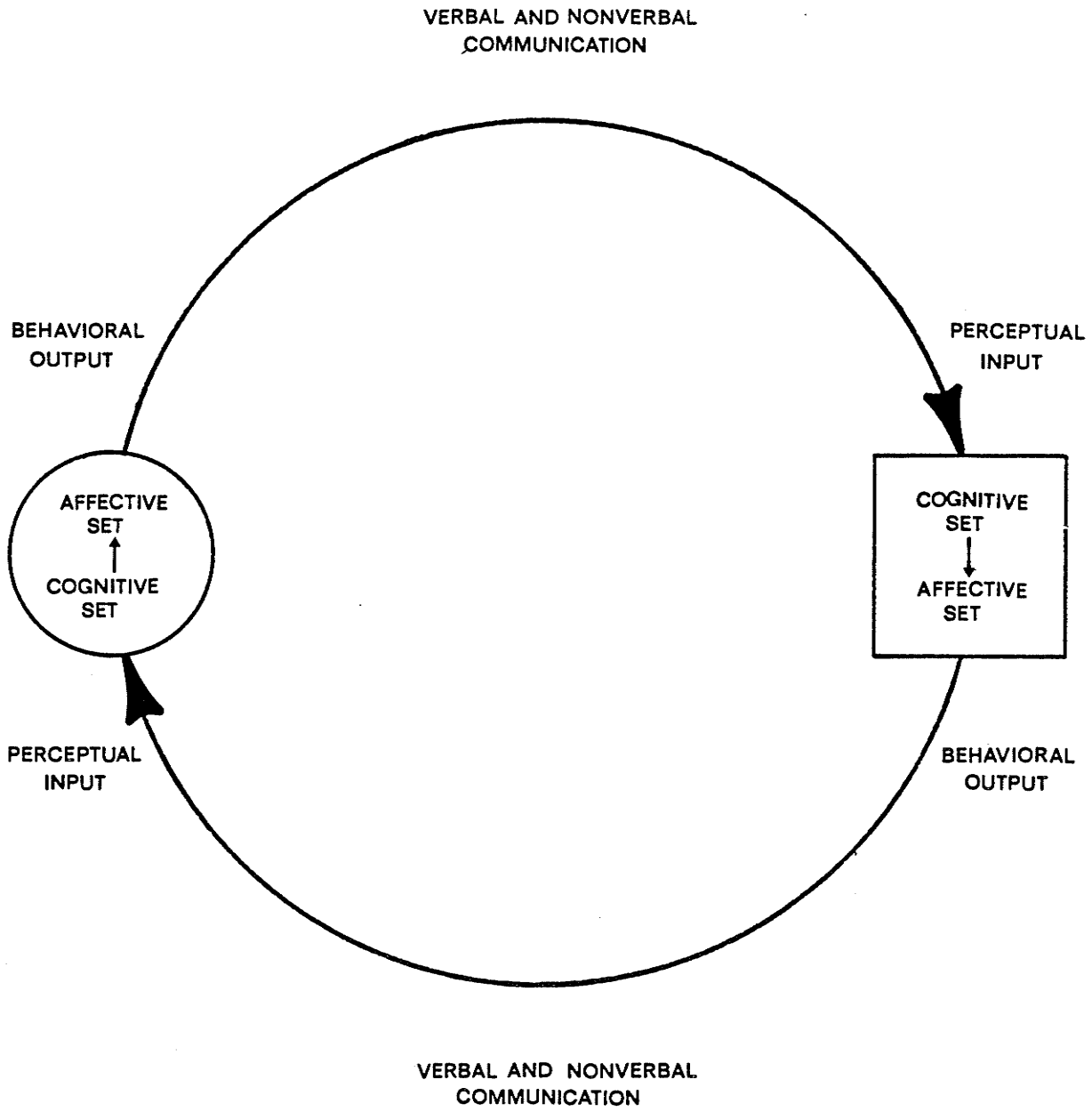
Source: Tomm, K. (1982) Towards a Cybernetic Systems Approach To Family Therapy. In F. W. Kaslow, The International Book of Family Therapy. New York: Brunner/Mazel, p. 78.

fig.1

Figure 2 (Tomm, 1982, p. 78) expands upon the component and connections of the basic model. Described in greater detail the behavioural output of one person provides the communication which becomes the perceptual input of the second peson and vice versa. Two types of inferences are identified, cognitive and affective. According to Tomm (1982) the cognitive inference is what the individual thinks, that is the idea or belief which is used to attribute meaning to the perceptual input and that which subsequently triggers the affective set. The affective inference is what the individual feels, that is the motivational response set which is activated in the individual and which "drives" the behavioural output. As discussed earlier, human communication occurs at various levels, both verbally and non-verbally. Inference cues are derived from all levels of communication. If there is a discrepancy between what is said and what is being conveyed via body language and tone, the inference should be based on the non-verbal data which are less liable to be deceptive (Tomm, 1982).

The circular pattern can be described as symmetrical or complementary. Neither is necessarily adaptive or maladaptive, however the contents and stability may be. Complementary patterns that are maladaptive and rigid are particularly pathogenic (Tomm, 1982), and represent a system that is

BASIC ELEMENTS OF A CIRCULAR PATTERN DIAGRAM.



Source: Tomm, K. (1982) Towards a Cybernetic Systems Approach To Family Therapy. In F. W. Kaslow, The International Book of Family Therapy. New York: Brunner/Mazel, p. 78.

fig·2

"stuck". An example of four common patterns are given in Figure 3 (Tomm, 1982, p. 80).

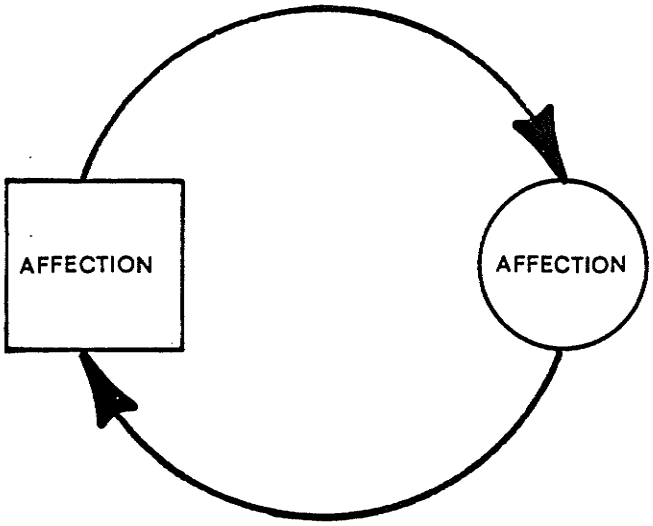
As demonstrated the relationships can be adaptive/symmetrical, maladaptive/symmetrical, adaptive/complementary or maladaptive/complementary. These diagrams are used to depict the observed cybernetic feedback component of a particular ongoing relationship. Human interaction is extremely complex and in no way is it suggested that the CPD can represent complex communicative exchanges in their entirety. However, as pointed out by Tomm (1982) a well developed CPD can often capture a core pattern that is paradigmatic.

The CPD model can also be used to depict a child-parent interaction. For example Figure 4A (Tomm, 1982, p. 83) outlines a pattern that is often identified when a child is presented with a behavioural or emotional problem.

If the mother believes herself to be an inadequate mother and wife (cognitive inference), she may become depressed and resentful (affective inference). The resulting behavior may include being over sensitive and unresponsive. The child, as a result, may perceive him or herself as an unwanted, unlovable person, which generates feelings of anxiety and hurt. These may become a preoccupation resulting in an inability to

A. LOVING RELATIONSHIP

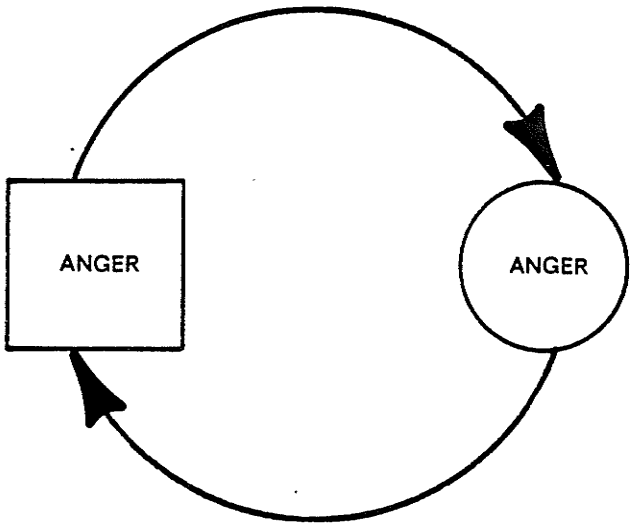
RESPONDS AND GIVES



RESPONDS AND GIVES

B. CIRCULAR ARGUMENT

BLAMES AND THREATENS

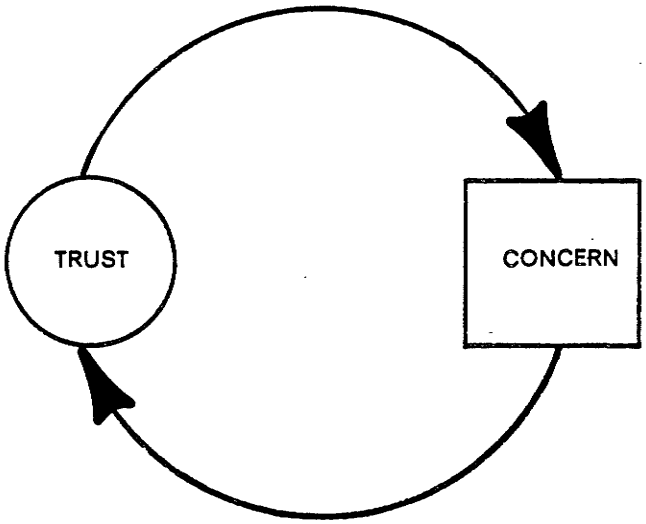


BLAMES AND THREATENS

COMMON CIRCULAR PATTERNS

C. SUPPORTIVE RELATIONSHIP

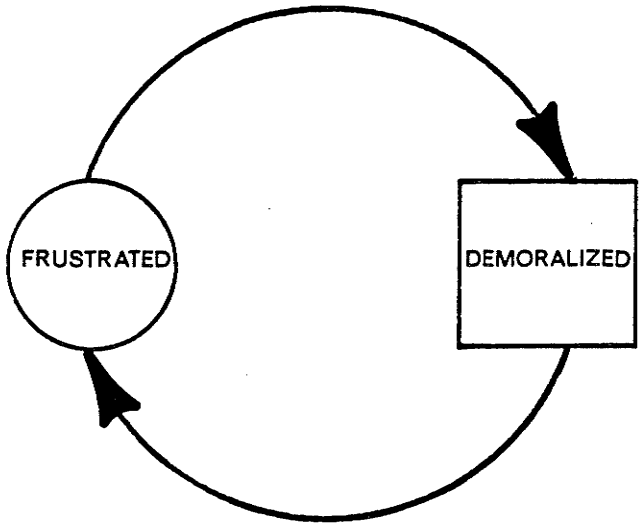
REVEALS NEEDS AND WEAKNESSES



SUSTAINS AND PROTECTS

D. COMPLEMENTARY CONFLICT

REBUKES AND CRITICIZES



COMPLAINS AND PERFORMS POORLY

Source: Tomm, K. (1982) Towards a Cybernetic Systems Approach To Family Therapy. In F. W. Kaslow, The International Book of Family Therapy. New York: Brunner/Mazel, p. 80.

fig. 3

DYADIC AND TRIADIC PARENT-CHILD PATTERNS

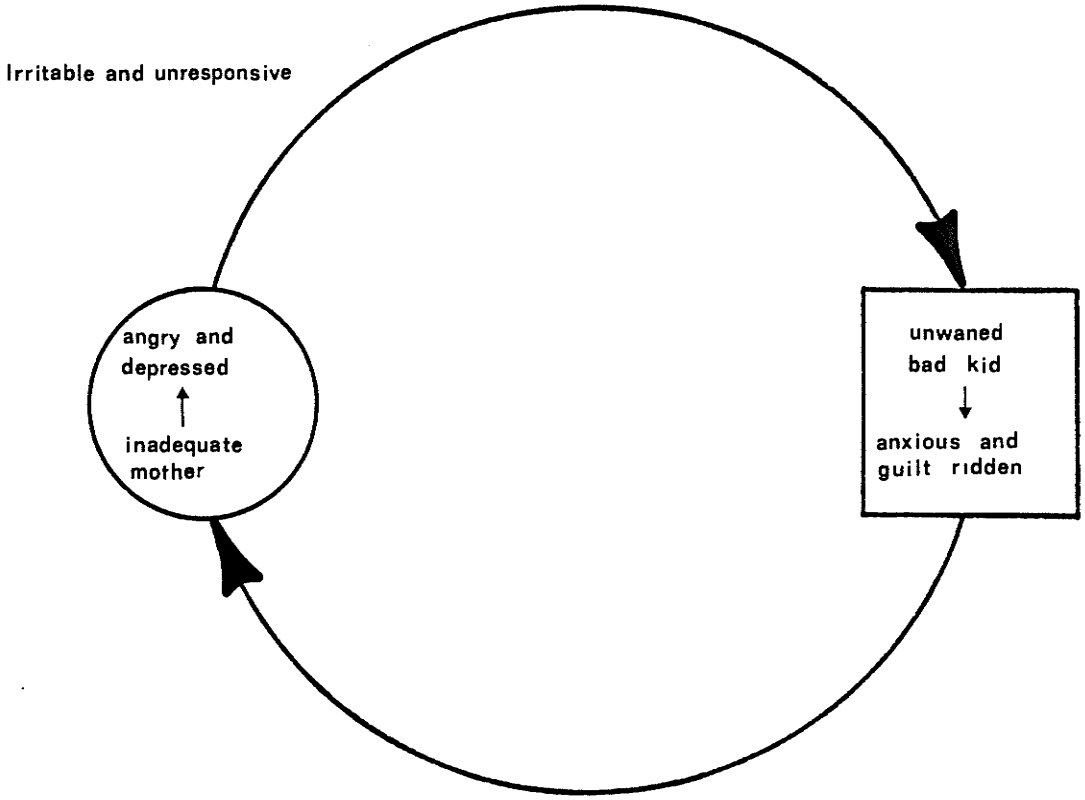
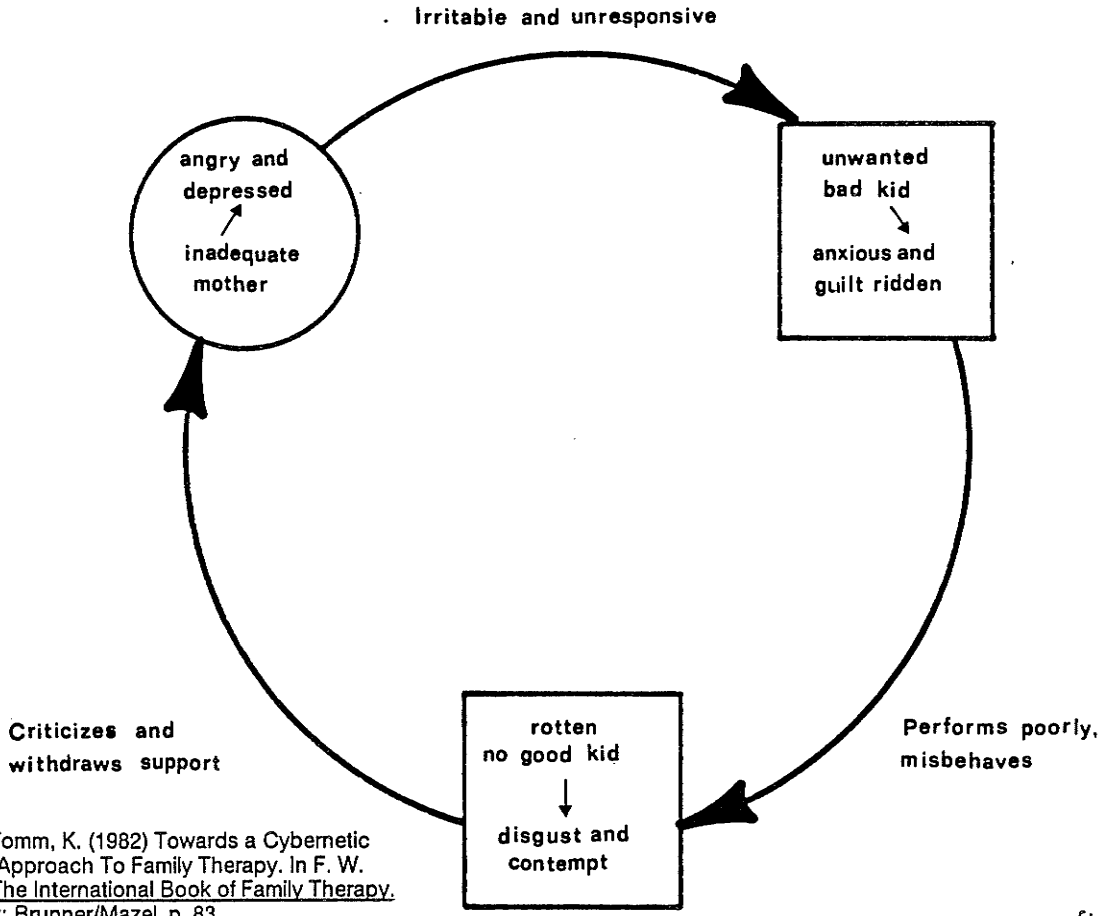


fig 4A



Source: Tomm, K. (1982) Towards a Cybernetic Systems Approach To Family Therapy. In F. W. Kaslow, The International Book of Family Therapy. New York: Brunner/Mazel, p. 83.

fig 4B

perform age appropriate concrete operations and misbehavior as a ploy to gain more attention. The child's poor performance and lack of control serve to legitimize mother's cognitive set of "inadequate mother" thus the pattern becomes self-perpetuating.

In Figure 4B (Tomm, 1982, p. 83), father is included in the interactional sequence. The child's inappropriate behaviour may feed into the father's belief that his son is a failure. This may generate feelings of frustration and disgust on the part of the father towards his wife and son. Behaviourally father may react by openly criticizing his wife for being a "poor mother". Again this response confirms the mother's belief that she is an inadequate mother and wife, thus the maladaptive interactional pattern has gone full circle and is perpetuated. The triadic circle could also be drawn in the opposite direction beginning with father to son to mother, or several interrelated dyadic patterns could be diagrammed. However, when attempting to grasp the three-person relationship structure, the less complex triangle depicted in figure 4B is most appropriate (Tomm, 1982).

Designing Interventive Strategies

The CPD can be extremely useful when designing interventive strategies as the diagram maps several potential points of

entry to alter the sequential interactive pattern of the family system (Tomm, 1982). Given that the diagram clearly depicts the inferences and feedback occurring between family members, the interventions tend to be specific, precise, and carefully planned. To view the symptom as part of a cybernetic circuit means mapping a CPD feedback structure that includes the event which has been identified as the "symptom". Likewise, systematically designed interventions require constructing a cybernetic circuit which includes the intervention as inside the loop (Penn, 1982). Because this model intergrates a number of behavioural, psychodynamic and cognitive concepts, it is the therapist who must determine which techniques will provide the greatest leverage to induce change.

This may include intervening at multiple points utilizing one or more orientations in an effort to alter the interactional patterns of the family. If the therapist or family member is observed to be behaviourally oriented, the strategy may be to alter the communicative behaviour depicted by the connecting arrows. If the therapist is more psychodynamically oriented, the interventive focus becomes one of modifying the affective set or response inference. If one is cognitively oriented, the intervention is directed toward changing the cognitive inferences (Tomm, 1982). Nonetheless,

inevitably all three are used in combination, as a change on one level creates a change at another level. For example, if the therapist chooses to use a behavioural strategy and alter the communicative behaviour of one member of the system, this in turn influences the affective set (how one feels) and response set (how one behaves) of the other person. This in turn will alter the perceptual input of the other person and change their cognitive set, thus impacting on the system at all three levels, behaviourally, affectively and cognitively.

Case Study -- The Wray Family

The Wray family is described in detail in chapter six. The family consisted of husband Ted, age thirty, wife Joanne, age twenty-six, son Christopher, age five and daughter Beckie, age eighteen months. They had been married for six years and lived common-law for two years prior to being married. The presenting problem was categorized as marital, with poor communication and lack of affective involvement identified as critical issues.

Goals for therapy included opening up the lines of communication, and increasing the positive exchanges between this couple. Structurally it was necessary for them to strengthen their marital sub-system and experience a more egalitarian

relationship in which they could once again be supportive and nurturing towards one another. This would serve to disengage Christopher from the marital triangle and allow this couple to work together to complete tasks around the home.

The pathological interactional pattern displayed by this couple encompasses both the communication breakdown and the lack of supportive affective involvement (Figure 5). Entering the sequence at the point where Joanne is displaying her hurt and anger, her behavioural output includes banging dishes around, cueing Ted to the fact that she is angry, but will not discuss her feelings with him. She, as described by Ted "clams up". Ted, aware that Joanne is angry will ask in a sarcastic tone, "What's wrong?" This only functions to increase Joanne's hurt and anger and she responds with "Don't talk to me!" Ted claimed that this was Joanne's favorite line.

Ted's perceptual input is one of confusion as he does not know what has upset Joanne and feels he has made an attempt to console her. This is internalized and Ted's cognitive set includes thoughts of his wife not willing to talk with him, not knowing how to please her, and making the assumption that he is not good enough. This leads to feelings of frustration and inadequacy. As a result Ted withdraws, goes out and

DYADIC INTERACTIONAL PATTERN

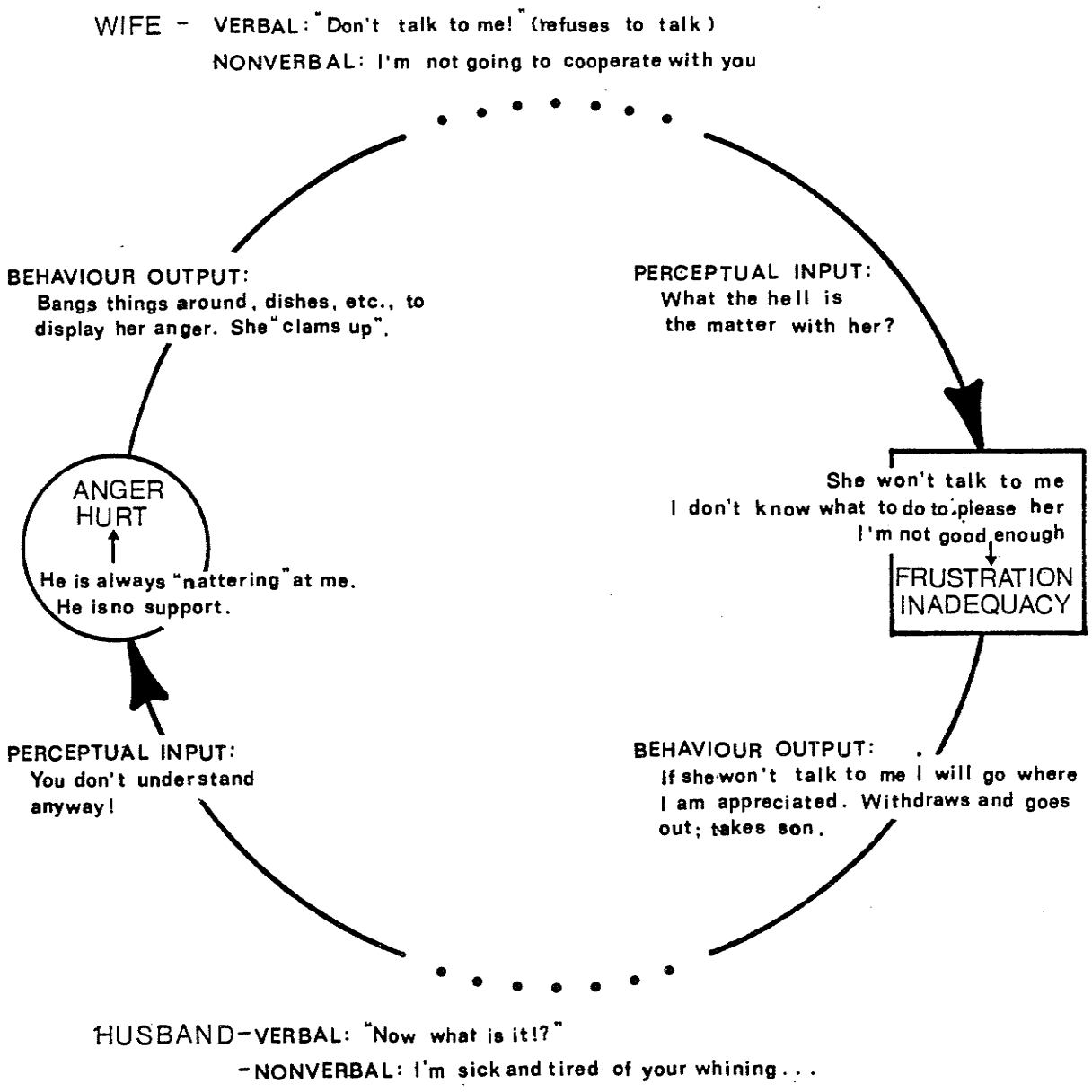


fig. 5

takes his son with him. At the same time Ted expresses his frustration by condemningly questioning Joanne with, "Now what is it!?" Joanne perceives this as a lack of understanding on Ted's part. Internalized her thoughts include making the assumption that Ted is always "nattering" at her and that he is never supportive. Ted's leaving only increased Joanne's hurt and anger and the vicious cycle is perpetuated.

There were several interventive points of entry identified as possible options to "break" the cycle. Two strategies are depicted in Figure 6. In the first instance, Intervention 1, Ted's nattering is reframed as a way of reaching out to his wife and trying to get in touch with her feelings. There, that which has been viewed as negative behavior is relabeled as a strength and given a positive connotation. It is also pointed out to Ted that Joanne must feel he is genuine in his concern and he must not respond with a sarcastic tone. This gives Ted credit and alters Joanne's perceptual input, serving to open up the lines of communication.

Intervention 2 focuses on Joanne and her expression of feelings. Joanne is told that Ted does not have "E.S.P.", legitimizing his confusion over what has upset her and placing responsibility on Joanne to express her feelings more directly through verbal communication. In this way, this couple

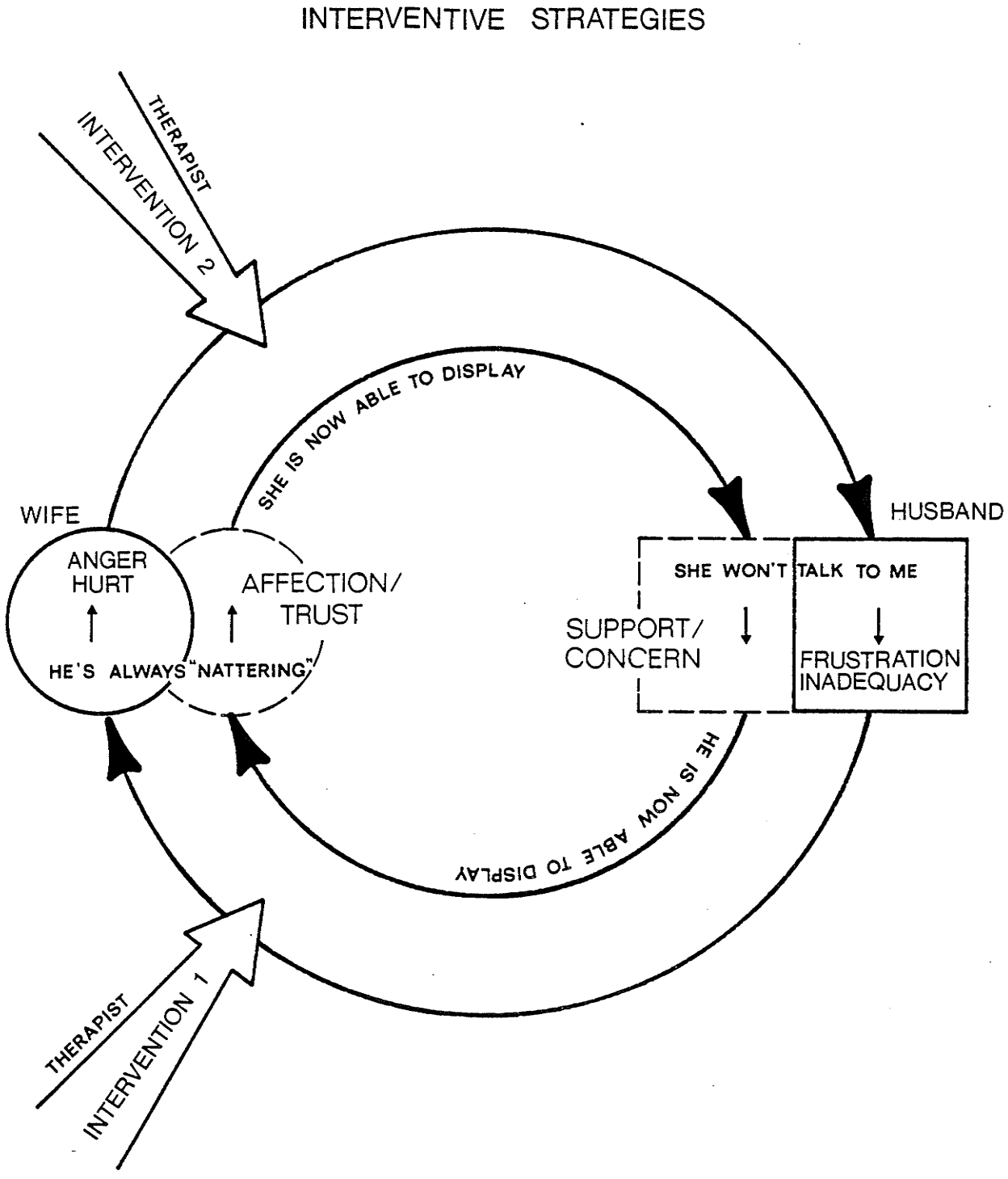

INTERVENTIVE STRATEGIES
THERAPIST
INTERVENTION 2
SHE IS NOW ABLE TO DISPLAY
WIFE
HUSBAND
ANGER
HURT
AFFECTION/
TRUST
HE'S ALWAYS "NATTERING"
SHE WON'T TALK TO ME
SUPPORT/
CONCERN
FRUSTRATION
INADEQUACY
HE IS NOW ABLE TO DISPLAY
THERAPIST
INTERVENTION 1

fig. 6

began to work on more effective ways of expressing feelings and communicating to the other person what it is that they need or want from them. Ted did not realize he was not being supportive of Joanne nor what it was she wanted from him. Joanne did not know she was discrediting Ted. Simply acting as a facilitator and helping this couple to maintain a focus and exhaust certain issues helped them to regain some of the trust and faith that had been lost between them.

The circular pattern diagram was designed on the principle of the cybernetic process encompassing positive and negative feedback loops, and from the notion of homeostasis. Applying these principles to the family system lead to the development of the conceptual tool. The CPD facilitates the shift from a linear to a circular understanding of interpersonal interaction, and is useful when designing interventive strategies. However the complexities of human communication are far too intricate to be reproduced in a one-dimensional diagram. All systems are subject to obscurities when observed and assessed. The CPD represents a simplified, distorted interpretation of a complex process, and the therapist must realize that the diagram is only a tentative hypothesis. Recognizing these limitations the circular pattern diagram can be a valuable conceptual tool used to facilitate the understanding of human interactions and dysfunctioning systems.

Chapter Five

Practicum Description

The Setting

The practicum work was completed at the Stonewall District Health Centre, located about twenty kilometers northwest of Winnipeg in the Interlake Region. The centre includes an eighteen bed hospital, four private physicians' offices, one dentist's office, the Department of Health and Social Services District Office, a thirty bed personal care home, and a senior citizens' home. All the local health and social services are provided within the centre, including: medical, dental, public health, geriatric, mental health, mental retardation, income security, probation, vocational rehabilitation, employment and child welfare. Within the Health and Community Services office, the Department of Health employs one community mental health worker and four public health nurses; the Department of Community Services has two child welfare workers and one mental retardation worker. The catchment area of this district office encompasses the municipalities of Rosser, Rockwood, Woodlands and St. Laurent. The income security, probation, vocational rehabilitation and employment workers are itinerant and based out of Selkirk.

There is also a halftime community psychiatrist available for consultation purposes.

The writer was working in the area of community mental health under the supervision of Community Mental Health Worker, Mr. Kenneth Nattrass, M.S.W. and my primary advisor, Professor Barry Trute, D.S.W., School of Social Work. Professor Kathryn Saulnier, Ph.D. also from the School of Social Work was the third member of this writer's advisory committee.

Case Description

Ten cases were seen in total, including seven families and three couples. The number of sessions ranged from a single consultation to a maximum of ten. Referrals were typically self referrals, or clients acting on the suggestion of their physician and subsequently requesting service. One case requested service at their own initiative; four cases had received counselling at some point in the past and returned requesting further service, and five cases had initially contacted their physician with their difficulties and were then referred for therapy due to the psycho-social nature of the problems.

Description of Evaluation of Therapy Intervention

Three assessment measures were utilized to evaluate family functioning and change; in conjunction with direct observation. These included:

1. The Family Assessment Measure III (FAM III)
2. The Family Adaptability & Cohesion Evaluation Scales (FACES II)
3. Check List of Family Concerns

The purpose of the evaluation measures were twofold. Firstly, the writer intended to evaluate the suitability and practicality of each of the assessment measures, given the clientele and setting; and secondly, to obtain a pre and post therapy measure of the level of health/pathology of the family.

The Family Assessment Measure III

The FAM III, Family Assessment Measure III, was developed by Harvey Skinner, Paul Steinhauer and Jack Santa-Barbara, at the University of Toronto, where these authors are continuing their validation studies. It is a self-report instrument that provides quantitative indices of family strengths and weaknesses. FAM is based on a process model of family func-

tioning, attempting to integrate different approaches to family therapy and research. Seven basic concepts are assessed which include: task accomplishment, role performance, communication, affective expression, involvement, control, and values and norms. Task accomplishment is identified as the most basic activity of any family, and it is through the process of accomplishing tasks that the family attains, or fails to achieve objectives pertinent to its life as a group (Skinner, Steinhauer, Santa-Barbara, 1983). The identified concepts interrelate to determine the level of task accomplishment.

FAM consists of three components:

1. A General Scale which consists of fifty-two items
2. A Dyadic Relationship Scale which consists of forty-two items, and
3. A Self-Rating Scale which also consists of forty-two items.

The General Scale focusses on the family as a system and its level of health/pathology. The scale provides an overall rating of family functioning in relation to the seven measures (subscales) identified in the process model, in addition to a Social Desirability and Denial subscale, making nine subscales in total. The Dyadic Relationship scale examines interaction between specific pairs in the family. For each dyad an overall rating of functioning is given as well as providing seven measures (subscales) of the process model.

The Self-Rating Scale focusses on the individual's perception of his/her functioning within the family unit. Again, an overall index is given along with the seven measures of the process model.

The questionnaire takes approximately twenty to sixty minutes to answer depending on whether all three scales are administered and the number of people in the family. It is designed for all members in the family over the age of 10-12 years. Raw scores are translated into standard scores for each subscale. These are then plotted on a graph providing a profile for each scale. Low scores of forty and below identify a strength. Scores below sixty and above forty are average, and high scores, sixty and above characterize a weakness or family problem.

In addition to the clinical assessment FAM provides the practitioner with an objective tool for further examination of family functioning. It provides an overview of family strengths and weaknesses as related to the constructs of the process model and identifies areas of potential difficulties that require further inquiry. The quantitative data collected at the initial stages of therapy can be used as a baseline measure for evaluating pre and post therapy functioning.

The preliminary analyses conducted to date used a heterogeneous sample of 475 families (N = 933 adults, n = 502 children) that were tested at various health and social service settings in the Toronto area (Skinner, Steinhauer, Santa-Barbara, 1983). Examination of this data has shown that the FAM scales are reliable, and that they significantly differentiate between problem and nonproblem families. With respect to reliability, coefficient alpha provides a lower bound estimate of the population reliability (ratio of true score to observed score variance). The estimates for the overall ratings are: Adults - .93 General Scale, .95 Dyadic Relationships, .89 Self-Rating; Children - .94 General Scale, .94 Dyadic Relationships, .86 Self-Rating. These scores are quite respectable as are the scores for the General (ranging from .60-.87) and Dyadic Relationships (ranging from .59-.82) subscales (Skinner, Steinhauer, Santa-Barbara, 1983). However, further study is required to raise the subscale reliabilities on the Self-Rating Scale, specifically for the Task Accomplishment, Involvement and Control subscales.

Family Adaptability and Cohesion Evaluation Scales

A second tool utilized was the FACES II Family Adaptability and Cohesion Evaluation scales, developed by David Olson, Richard Bell and Joyce Portener (1982) at the University of

Minnesota. It is a thirty item self-report instrument that can be administered to families or couples. All family members over the age of eleven are asked to complete the questionnaire. They answer each of the thirty items twice; once for how they perceive their family currently to be, and again for how they would like their family to be. The ideal and perceived are compared to assess the level of satisfaction with the current family system and this level is compared to the post treatment scores.

FACES II is designed to measure the individual's perception of family cohesion and adaptability; believed to be the two most central dimensions of family behaviour by Olson, Russell and Sprenkle (1979). Family cohesion relates to the emotional bonding family members have to one another, assessing the degree to which family members are separated from or connected to their family. Family adaptability relates to the ability of a marital or family system to change its power structure, role relationships, and relationship rules in response to situational and developmental stress. This dimension assesses the extent to which the family system is flexible and able to change.

Within what has been termed the Circumplex Model, there are four levels of family cohesion ranging from extreme low

(disengaged) to extreme high (enmeshed). The two balance levels of cohesion are termed separated and connected. The four levels of family adaptability range from extreme low (rigid) to extreme high (chaotic). The two balance levels are termed flexible and structured. For each dimension, the balanced levels (moderate) are hypothesized to be most viable for healthy family functioning, and extremes are typically viewed as more problematic.

Sixteen distinct types of family systems are identified by combining the four levels of the cohesion with the four levels of the adaptability dimension. Four of these sixteen types are moderate (balanced types) on both the cohesion and adaptability dimension. Eight types are extreme on one dimension and moderate on the other (mid-range types) and four types are extreme on both dimensions (extreme types). Each family members' converted score is plotted on the Circumplex Model. This assists in understanding the dynamics of the family and planning treatment goals.

The development of the FACES Scales has progressed over the last several years, and requires further testing. As measured by Cronbach's Alpha the figures relating to internal consistency are satisfactory (.90). However the construct validity was determined by way of factor analysis and no

evidence of empirical validity is provided. The factor loadings for the dimensions of family functioning, adaptability and cohesion are less impressive. They range from .34-.61 (averaging .49) for cohesion, and .10-.52 (averaging .37) for adaptability. The test-retest reliability is good, at .84, but is not representative as the test group consisted of 124 university and high school students. Therefore FACES II has its strengths, namely the high internal consistency, but also possesses weaknesses in certain areas, particularly in terms of its empirical validity.

Checklist of Family Concerns

A third measure utilized to assess family functioning was the Check List of Family Concerns.[1] The scale consists of twenty- two items in total. The first twenty questions require the respondent to rate their level of satisfaction in a variety of areas related to the family system. The final two questions address the overall satisfaction with their family and personal self. The questionnaire is appropriate for all family members over the age of twelve and takes approximately

[1]This form was originally designed by the Morrison Centre For Youth and Family Service, 3355 S.E. Powell Blvd., Portland, Oregon, 97202.

five to ten minutes to complete. The Check List provides every family member with the opportunity to highlight their perception of family strengths and weaknesses. This information is then examined in relationship to the other assessment measures and the therapy sessions. The scale can also be used as a pre and post treatment measure highlighting areas of change from the individual's perspective. The information can prove valuable, unfortunately it does not incorporate tests for reliability or validity. Thus results can only lend themselves to the development of hypotheses that provide a direction for therapy.

The following chapter will provide a more detailed discussion of the evaluation measures in context of their application and value as assessment tools.

Chapter Six

Evaluation of Practicum Families

This chapter examines the three assessment measures, The Check List of Family Concerns, The Family Assessment III, and The Family Adaptability & Cohesion Evaluation Scale, utilized by this writer to evaluate family functioning. For each, a case example will be presented, concluding with a brief critique of the measure as an assessment tool. The chapter will close with a more indepth discussion of the suitability of the assessment measures employed for the purpose of this practicum.

The Check List of Family Concerns consists of twenty items. There are two additional questions that require the client to rate the overall satisfaction with their family and indicate the degree to which they feel good about themselves. Used as an intake tool, it was given to family members upon their arrival at the office, typically before the initial session. In some cases it was used as a pre and post measure.

This scale proved to be valuable in the assessment process. It is brief in that it can be completed in five minutes, yet supplies the therapist with important information that may

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feelings about each area.

	Very Dis-satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Making sensible rules					
5. Being able to discuss what is right and wrong					
6. Sharing of responsibilities					
7. Handling anger and frustration					
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline					
11. Use of physical force					
12. The amount of independence you have in the family					
13. Making contact with friends, relatives, church, etc.					
14. Relationship between parents					
15. Relationship between children					
16. Relationship between parents and children					
17. Time family members spend together					
18. Situation at work or school					
19. Family finances					
20. Housing Situation					

21. Overall satisfaction with my family					
Make the last rating for yourself:					
22. Feeling good about myself					

Source: Morrison Centre For Youth and Family Service, 3355 S. E. Powell Blvd., Portland, Oregon, 97202.

NAME: _____ Date: _____

not otherwise come to light. An examination of the completed form with subsequent comparison between family members can provide knowledge in some or all of the following areas:

- a general indication of the family's strengths and weaknesses
- the presenting problems which the family brings to therapy
- an indication of the types of problems, ie. generally affective/communicative as opposed to housing or financial difficulties
- the state of mind and degree of distress felt by each family member
- differences between family members in terms of their perception as to what the family problems are, and the severity of the problem
- a subjective rating by each family member as to the status of a major or minor problem
- pre and post therapy measures
- allowed for comparison to other assessment measures that may have been administered to the family

Although the scale has proven to be a valuable intake tool it is problematic in that some items are vague and may be misinterpreted. For example if a family member indicates that they are very dissatisfied with the handling of anger and frustration, this may be interpreted as a personal difficulty with anger and violent outbursts, or might suggest that

physical violence on the part of one or more other members is viewed as a problem in this family. The Check List can only lend itself to hypothetical interpretation on the part of the therapist. All possibilities that come to mind must be explored further with the family.

The Larson Family--Historical Information

Mrs. Laura Larson telephoned the office requesting to speak to a worker in regards to her twelve year old daughter, Ashley. According to Laura, she and her husband Wilfred were concerned about Ashley as she was described by her mother as "fairly well developed physically" and "growing up too fast". It was decided to meet initially with the parents and an appointment was scheduled at the earliest possible convenience. Laura and Wilfred were living in a nearby rural town with their daughter Ashley. Ashley was the youngest of their four children. Their oldest daughter Janet (age 29), was also living with them as well as her five year old daughter Krystal. Janet returned to live with her parents ten months ago after separating from her second husband. He was presently living in Lethbridge. Janet was taking a legal secretarial course and expected to be finished and move out in four months. Laura and Wilfred reported that it was stressful having Janet and Krystal living with them, and

expressed some guilt for feeling this way. Dan their second oldest (age 27), was married with two children and living in Winnipeg. Cindy, (age 23), was working in Winnipeg and living with two other girlfriends.

This couple had been married for thirty years and had spent the majority of that time apart due to Wilfred's occupation. He was employed by a construction company and had spent extensive periods of time up North away from his family. He was away for as long as three months at a time and would return home for a week or so. Thus Laura has functioned as the primary parent in this family and had become accustomed to a fairly independent life style. Wilfred had been laid off four months ago and had not returned to work. This had not only created a tremendous financial strain on this family, but had demanded some adjustment in their lives given the time they now had to spend with one another.

At our first meeting the parents expressed several concerns. Most of the issues were raised by Laura and she appeared to be noticeably more worried about Ashley than Wilfred. Laura described Ashley as having a "body that doesn't quit--and she knows it". Both parents were concerned at the rate of which Ashley was maturing. Mentally and emotionally she was twelve going on thirteen; physically, she appeared sixteen or older.

According to Laura, Ashley was not popular at school or part of the "in group". However this year she had become an overnight success, had a steady boyfriend and was constantly on the telephone or with her girlfriends. There was concern over how Ashley was handling this and her feelings about her own sexuality. There was also some question as to how Ashley was adjusting to the "new rules" in the home, now her father had returned home.

Parents also spoke of Ashley as their "love child" and felt that she was very special to them. Apparently the three older siblings were "jealous" of Ashley as she received special attention from her parents and had been given privileges that they were not as fortunate to receive. Overall, Laura and Wilfred were very proud of Ashley and indicated that she did well in school, was active in athletics, and they believed her to be open and honest with them.

Assessment of System Dysfunction

Although this family identified Ashley as the concern, this writer expected to hear more about their difficulties adjusting to Wilfred's assimilation back into the family, and the financial strain they were now experiencing. Structurally there appeared to be a sibling split in this family, result-

ing in two different family subsystems. The older sibling group, which includes the three older children, was not given the attention nor did they experience the intimacy Ashley now shared with her parents, particularly her mother. Mother and daughter showed signs of enmeshment which functioned to limit Wilfred's access to his family above and beyond the actual physical separation he had experienced. Laura described Wilfred as withdrawn, shy and unwilling to discuss the family or himself with her or anyone else. Thus this was compounded with the added stress of being unemployed which can quickly overwhelm a person and lead to feelings of inadequacy and worthlessness.

The above information was gathered in the first interview with the parents. It was requested that they fill out the problem Check List before the initial interview. Ashley completed her form the following week before this worker met with her alone.

From the completed forms the following was evident:

- all family members indicated that they were either dissatisfied or very dissatisfied with their own feelings about themselves personally
- all family members indicated that they were very dissatisfied with family finances
- other problems indicated by two or more family members included: sharing feelings like anger, sadness,

hurt, etc.; sharing of responsibilities; handling anger and frustration; making contact with friends, relatives, church, etc; situation at work or school; and housing situation

This information was compared and contrasted to that which the family indicated verbally in the initial interview. This particular family proved to be fairly consistent in their responses; to the twenty-two items, that is, there appeared a general consensus as to the perceived family concerns. This suggested that members had an awareness of the family as a unit, which was important, as well as being able to identify and agree on the problem areas. This was also supported by that which the family indicated they were satisfied with: making sensible rules; being able to discuss what is right and wrong; use of discipline; relationship between parents and children; and the time family members spend together. Problem areas that were clearly identified both on the Check List and verbally included financial and housing difficulties. Although it was evident on the Check List that other problem areas included: affective expression, role performance (sharing of responsibilities) and lack of social engagements and support network for the parents; these difficulties were only hinted at by one family member or another.

The above example demonstrates that the Check List can be a valuable assessment tool. It can provide the therapist with

LARSON FAMILY

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

DAUGHTER

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family			X		
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong.				X	
6. Sharing of responsibilities		X			
7. Handling anger and frustration		X			
8. Dealing with matters concerning sex					X
9. Proper use of alcohol, drugs					X
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church, etc.				X	
14. Relationships between parents			X		
15. Relationships between children				X	
16. Relationships between parents and children				X	
17. Time family members spend together				X	
18. Situation at work or school		X			
19. Family finances	X				
20. Housing situation	X				

21. Overall satisfaction with my family			X		

Make the last rating for yourself:

22. Feeling good about myself		X			

LARSON FAMILY

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

MOTHER

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)		X			
2. Sharing feelings like anger, sadness, hurt, etc.		↑			
3. Sharing problems with the family		X	X		
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong.				X	
6. Sharing of responsibilities		X			
7. Handling anger and frustration	X				
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs				X	
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family			X		
13. Making contact with friends, relatives, church, etc.		X			
14. Relationships between parents					X
15. Relationships between children			↑		
16. Relationships between parents and children				X	
17. Time family members spend together			X	X	
18. Situation at work or school			X		
19. Family finances	X				
20. Housing situation		X at the moment			

21. Overall satisfaction with my family			X		

Make the last rating for yourself:

22. Feeling good about myself	X				

LARSON FAMILY

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing NOW in each area. Put a check (x) in the box that shows your feeling about each area.

WILFRED

	Very Dis-Satisfied	Dis-satisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)				X	
2. Sharing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family				X	
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong.				X	
6. Sharing of responsibilities				X	
7. Handling anger and frustration		X			
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs				X	
10. Use of discipline				X	
11. Use of physical force		X			
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church, etc.		X			
14. Relationships between parents				X	
15. Relationships between children				X	
16. Relationships between parents and children				X	
17. Time family members spend together				X	
18. Situation at work or school	X				
19. Family finances	X				
20. Housing situation	X				

21. Overall satisfaction with my family				X	

Make the last rating for yourself:

22. Feeling good about myself		X			

a key to open up locked closets hiding family skeletons, so to speak. The therapist is given the necessary information to develop hypotheses and can pursue them when the opportunity presents itself.

It is always of great importance to note how the children rate the parental relationship. This child indicated her parent's relationship was "in-between". Although these parents identified their daughter as the concern, the information gathered suggested that the parental dyad may become the primary target system. The presenting problem expressed by parents was the concern for their daughter's adjustment to adolescence with particular emphasis on issues of sexuality. No family member indicated this as a concern on the family check list. This strengthens the hypothesis that although this couple identified their daughter as the problem, it was the marital system that required attention. Further, this was mother's way of engaging her husand in therapy, which is a common occurrence on the part of one spouse. Most couples single out a child as the identified problem and may or may not allow the therapist, in time, to shift from the parenting issues to the marital relationship. It is typical of a wise stragegy to go the path of least resistance and accept the executive system's view of the problem as one of child management, encouraging the parents to work together to solve their difficulties. It may then be

possible to shift the focus onto the marital relationship.

In conclusion, even though the Check List has its weak points, it does provide the therapist with some valuable leads that assist in directing the therapy. It also serves to frame the therapy process by initially giving all family members the message that it is important that they all participate and every person's input and opinion is of value.

The Check List may also be examined in conjunction with the FAM III or FACES II scales. One item on the Check List that is of vital importance is item 22--feeling good about oneself. If the individual rates him or herself as very dissatisfied and also scores below 40 on the FAM III, Social Desirability subscale, then there is a strong possibility that this family member may be anxious, hysterical or depressed at the time of completing the forms (Skinner, Steinhauer, Santa- Barbara, 1983). If so, the validity of the other FAM scales are not guaranteed. This functions as a "red flag" so to speak for the therapist and alerts him or her to the fact that there are other things going on with the family which require immediate attention.

Family Assessment Measure III

The Family Assessment Measure, FAM III, has been designed for

use in clinical and research settings as a diagnostic tool; as a measure of therapy process and outcome; and as an instrument for the examination of family functioning (Skinner, Steinhauer, Santa-Barbara, 1983). The emphasis is placed on the family's process, with the accomplishment of tasks identified as the most basic activity of all families. Who performs what roles, the types of communicative messages exchanged by family members, the affective expression and involvement displayed by family members, the means by which family members control and influence one another, and the underlying values and norms held by each member, all interact and affect the degree to which a family is capable of carrying out the necessary tasks critical to its perpetuation. FAM provides the therapist with indices of family strengths and weaknesses, in relation to the six aforementioned family processes from three perspectives: the family as a system, the dyadic relationships, and the individual's perception of his/her functioning in the family.

The FAM scale can be administered at any time, but is typically done so at the beginning of therapy. It is left to the therapist's discretion as to what scales family members should complete and when. Not all scales need be filled out, and in certain situations all are not applicable. For example, to request that a family with young children, or a

couple, complete the self-rating subscale, does not always make sense as their responses will reflect the dyadic relationship, whereas the questions relate to the individual within the context of their family. In this case, the General Scale and the Dyadic Scale may be all that is required.

The Wray Family--Historical Information

Ted Wray, age thirty years, and his wife Joanne, age twenty-six years, had been married for six years. They lived common-law for two years before they were married. They had two children, Christopher, age five, and Beckie, age eighteen months. They owned their own home in Stonewall, and preferred to live in the rural area. Ted had been employed as a machine mechanic for the last eight years and was quite handy around the house. Joanne worked for a real estate agent as clerical staff. Both worked nine to five with weekends off.

Joanne grew up in Dauphin, and Ted in Stonewall. Most of Ted's extended family still lived in Stonewall. He was the third oldest of five siblings. Joanne's extended family was in Vancouver. She had one older sister. Her parents remained in an unhappy marriage "for the sake of the kids" and divorced when Joanne was in her late teens.

One morning in January, without any forewarning, Joanne went

to her mother-in-law's home to pick up Beckie, and informed her that she and Beckie were leaving for Vancouver. Ted had already left for work and had driven the children to his parents. As both Joanne and Ted work the children were taken to their grandparents' home every day. They took turns dropping the children off each morning. Joanne asked her mother-in-law not to interfere and promised that she would phone Ted from the airport. Ted's sister, Susan, called Ted immediately and he left work to try and stop Joanne at the airport. When Joanne attempted to call Ted from the airport, Ted was already on his way. He was unable to catch Joanne, and she and Beckie flew to Vancouver. Ted was utterly shocked by Joanne's leaving. He was certainly aware that they were having problems, and had been for several years, but never anticipated that Joanne would leave. Joanne stated afterwards that she had to get away and believed this was the only course of action open to her. She felt herself under great emotional strain and said if she had not gone when she did she would have ended up in a mental hospital needing psychiatric care.

This couple was able to negotiate Joanne's return home over the telephone. Originally Joanne wanted them to relocate in Calgary--a midpoint between their extended families. Joanne then agreed to come home if Ted promised not to spend so much

time at his parents' house and help more around the house. Ted agreed and Joanne returned to Stonewall, with Beckie, six weeks later, the middle of February.

Ted had initially requested help four days after Joanne's departure. He came to the office on a walk-in basis wanting to speak to a counsellor. The case was transferred to myself and I saw this couple for the first time a week after Joanne's return to Stonewall.

The following issues and concerns were identified in our first meeting:

1. Joanne's primary complaint was that Ted spent too much time at his parents' home. Gathering data on this point, Ted agreed that he did visit his parents every day. This was in part due to the fact that he (or they together) must pick up the children. But Ted reported that he might spend an hour there because "There's always someone there and they ask you how you are and how your day has been, and I don't get that at home". Joanne feels that his family takes away from their time together. Ted said he has only been going to visit at his parents once a week since Joanne's return.

   An interesting point related to this, was that Ted always took Chris with him when he went out, or would keep him up late while Joanne retired for the evening. Joanne made the statement "I feel my husband is married to my son more than me, and I resent my son and my husband because of it". Most

certainly the son had been triangulated into the marital conflict and served as a buffer between the parents.

2. Joanne's other major complaint was that Ted would not help around the house. She felt that they both work thus should share the household chores. Upon exploring this further it was evident that Ted does help out. The problem was that Joanne had to tell him what to do. For example, if Joanne was going out for the evening and did not get the dishes done, Ted would not take it upon himself to do them. However, if she asked him to do the dishes he would oblige her without argument. Joanne was infuriated by always having to tell Ted what to do. Joanne appeared to be very active, controlling type of person. Ted on the other hand, was very laid-back and easy going. Joanne wanted and expected Ted to take the initiative and be more directing and decisive with her. If she asked him a question he would respond by saying "Whatever you want dear". Joanne felt that she must make all the decisions. She explained on the phone that in her mind Ted had never really grown up and depended on her too much. She at times, felt like she was more of a mother to him than a wife and was resentful because of it. However, she has never expressed these sentiments to Ted. Joanne also stated that Ted does not give her any support (if she has a problem it is "her problem" not "their problem"), nor does he know how to comfort her when she is upset.

3. Ted was concerned over the lack of communication. He said, "We don't really talk that much at all. If we do it's about what T.V. program to watch. If we go out for dinner or something it's uncomfortable because we don't have anything to say to one another . . . We never really get together at all. "You have to make an appointment with Joanne to have a sexual experience with her".

   Ted also stated that when he does have an opinion about something Joanne discredits him while someone else may have the same opinion and Joanne is very supportive of their stance. Ted felt this was emphasized by the fact that Joanne left without even coming to him first to discuss their difficulties.

   It was also pertinent that this couple had not had a vacation together since they were married. Ted claimed that was not much of a holiday as they spent

their time visiting Joanne's family in England. They stayed all but one night at Joanne's grandmother's. Ted said he was unable to take time off work (except for weekends) because they needed the money. Joanne disagreed and said she felt their marriage was more important. Joanne has taken holidays every year without Ted. She typically would visit her family in Vancouver.

4. Ted was also unhappy with the delegation of tasks around the home. He described it as a state of "disorganization" and said that "nothing ever gets done". Both had expectations of what the other should do, but had never formally discussed it. Each just assumed that the other knew what to do when. This resulted in tasks not being completed (i.e. dishes washed, vacuuming, laundry, etc.) and hard feelings towards the other for not doing his or her part.

Assessment of System Dysfunction

Given the above and that which was obtained from the FAM III, Dyadic Relationship subscale in which the family scored in the upper range of family problems, this couple was experiencing serious relationship difficulties. There was no emotional support and little affective involvement. They could not effectively communicate thus issues were left unresolved and problem solving was non-existent. Roles were chaotic and household tasks not completed. The children had been triangulated into the marital conflict and each partner had turned to extended family for support as a result of their ineffectiveness as a couple to resolve their marital difficulties. This had caused hard feelings and had only

created further distance between the two.

Developmentally it was evident that neither Ted nor Joanne has successfully differentiated from their own families of origin. Although they themselves were presently in the life stage of a family with young children, they as individuals married before firmly establishing a sense of independent selfhood. By marrying too soon they sought a substitute for the security of their families of origin and an escape from their fears of being alone. In doing so, they transferred to the new marriage unresolved difficulties experienced in their own families. Both brought to the marriage insecurities and needs, wanting desperately to feel reassured and protected by the other. Since neither could risk rejection, they suppressed their own feelings and unmet needs that threatened to aggravate the other. This may have sufficed for a time, but after several years of marriage they began to feel that something was seriously wrong. Caught in a two-sided dependency, neither was able to give to the other due to their own yearning for nurturance and support. Soon they felt abandoned and alone in their own right and discovered their inabilities to help one another. Their attempts to solicit love and attention from each other only functioned to wedge them further apart. Many couples become as Ted and Joanne did, overwhelmed with anger and hurt, strangers in their own home, simply going through the motions.

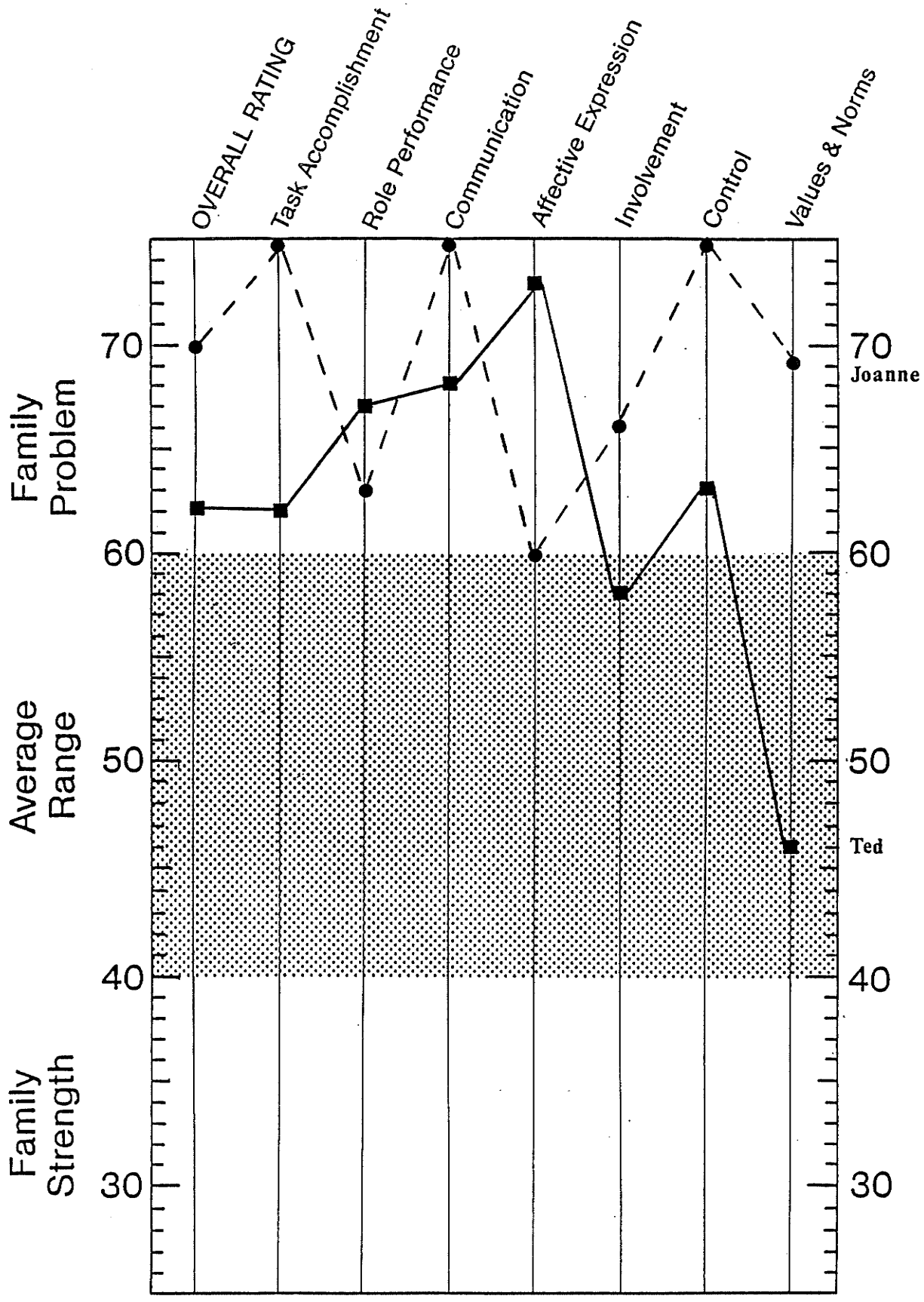
The Wrays were given both the Check List and the Dyadic Scale prior to the initial session and after therapy was completed as pre-/post therapy measures. The following observations were deduced from the dyadic profile:

- Most scores are above 60, measuring in the family problem area. The greater the number of elevated scores the more severe or generalized the family pathology is likely to be.
- The higher the score the greater the likelihood of a disturbance, particularly if indicated by both spouses.

Given these general interpretations of the scores it is evident that this couple is experiencing serious marital discord. Areas of greatest concern include task accomplishment, communication, affective expression, issues of control, and values and norms. One might question the inclusion of values and norms, however, the twenty-three point spread between Joanne's and Ted's profile raises some concerns. Just as the therapist is alerted to elevated scores, likewise, extended differences can be a cue to serious problems, particularly for this subscale. The profile was consistent with the issues and concerns identified by this couple, and as well reflected their mental state. That is, Joanne was observed to be, both verbally and non-verbally more upset and agitated, and expressed these sentiments more so than her husband.

WRAY FAMILY
PRETHERAPY

FAM DYADIC PROFILE

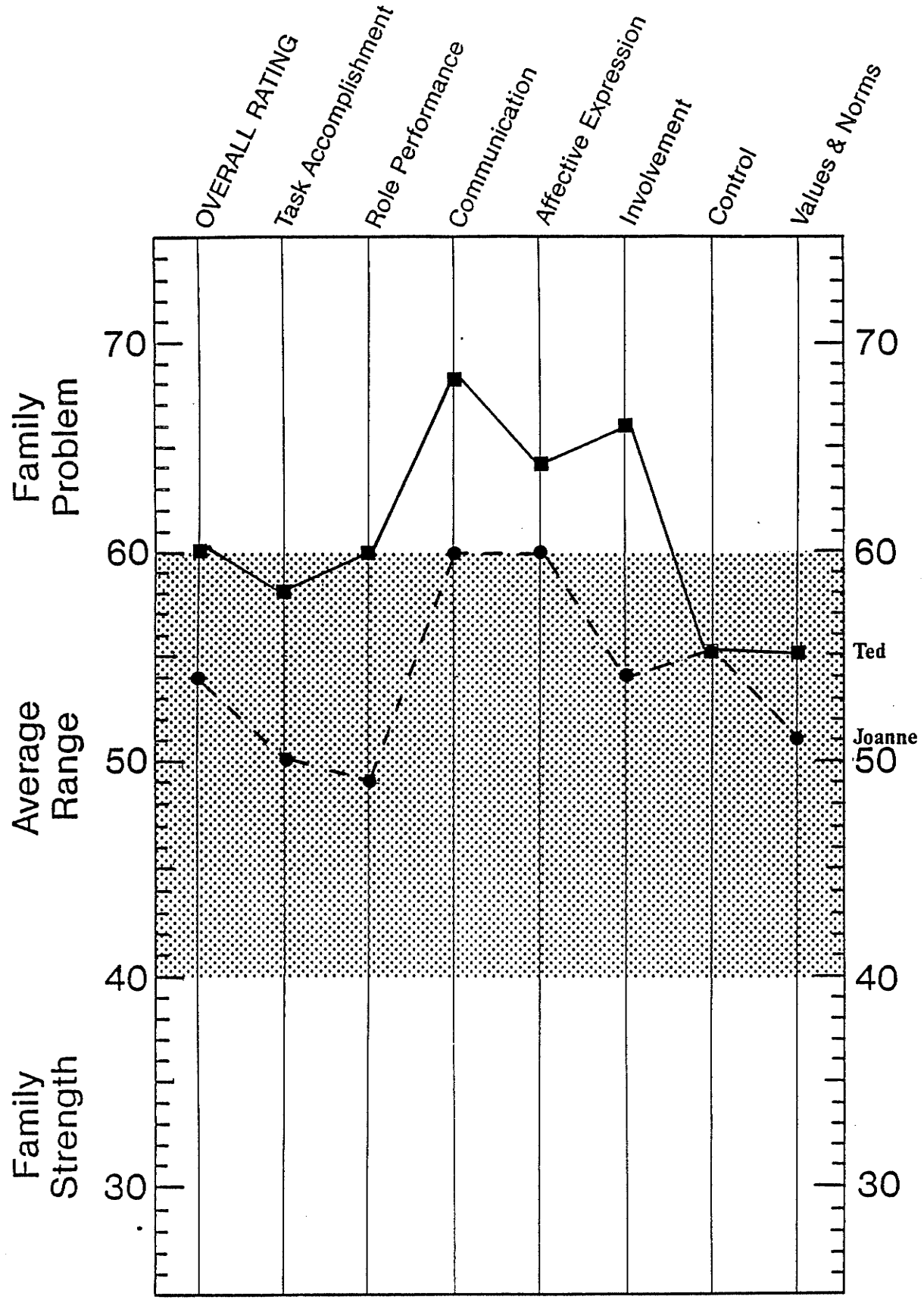


Post Therapy Profile

The post therapy profile, obtained six months later, after the eleventh and final sessions indicated a general improvement in all areas. Throughout the course of therapy this couple was able to reaffirm their commitment to one another and strengthen the boundary around the marital subsystem. The amount of time they spent together and the number of positive exchanges between the two greatly increased. Ted no longer had to tip toe around the bedroom in the morning with the lights off, in the pitch black, attempting to get himself ready for work, as Joanne endeavored to catch an extra twenty minutes of sleep. A sincere concern of Ted's, in the beginning, was that he could never find a pair of socks that matched, as the tension was so great between the two, if he took the liberty to turn on the light, Joanne would attack with an onslaught of verbal obscenities. In time this became a personal joke between the three of us. The children were no longer triangulated into the marital conflict, nor were extended families used as allies. By reworking the commitment to one another, Joanne and Ted were able to overcome their greatest fear of losing one another, and discussed their problems in an open and direct manner with one another. Although Ted was the partner who always maintained that he never wanted to be separated, he was the one who had become

WRAY FAMILY
POST THERAPY

FAM DYADIC PROFILE



untrusting of Joanne. He was very shaken by her leaving, and the concern that she would leave again without any forewarning remained in the back of his mind. It would take more than the six months we had together to reestablish the trust lost between this couple. This hesitation on Ted's part is reflected in the post-therapy profile. The scores on the communication and involvement subscales are still somewhat high. Joanne's profile indicates that there have been some significant changes and she appears to be feeling far more comfortable in her role as wife and mother. Although it was agreed that there remained issues yet to be resolved, this couple felt they now had the skills and confidence to tackle them on their own, knowing that the door was always open for them to return.

Family Adaptability & Cohesion Evaluation Scale

The Family Adaptability & Cohesion Evaluation Scales, FACES II, are designed to measure individual family members' perception of family cohesion and adaptability. This scale includes an alternate questionnaire form designed for couples. The content of the question remains the same, but the pronouns have been changed such that it is directed at the marital relationship. This scale was administered as an alternate to the FAM dyadic scale in two cases.

Wendy Winters and Ken Blackwood--Historical Information

Wendy Winters telephoned the office requesting to see someone, and an appointment was made for her to see me. Wendy was a thirty-seven year old who was presently living common-law with her twenty-four year old boyfriend Ken Blackwood. Wendy became pregnant at age seventeen and was unhappily married to an alcoholic husband for sixteen years. After separating from her husband, three years ago, Wendy moved from the rural area into Winnipeg, where she met Ken four months later. Three months after they had met, they began living together. Wendy was presently employed in a garment factory and Ken had just been laid off from his job as a courier.

Wendy had two children, a daughter Janet, aged twenty and a son David, aged sixteen. Janet too, became pregnant at seventeen and was involved in an unhappy marriage. Wendy had very little contact with her son David, and was told by her daughter that he was getting into a lot of trouble lately.

Wendy was referred by her physician because of what was described as an acute anxiety state. She was extremely tearful throughout the entire interview and reported that she had been that way off and on for about a year. She also had dif-

ficulty eating and sleeping. When it came to my attention that Wendy was living common-law (which was something she did not make obvious at the start) she was requested to return with Ken the following week. Wendy described her relationship as a positive one and said that Ken was very supportive of her. The following week we had our first conjoint meeting. Wendy and Ken were asked to complete the Problem Check List and the FACES questionnaire before the meeting. Ken was very apprehensive about being there as the doctors had told Wendy that he was her problem and she should leave the relationship. Therefore there was some back-tracking to be done and he needed to be reassured that this worker had no intentions of condemning him.

In discussing their relationship with them, it became evident that they were in serious difficulty. When they began living together, Ken moved into Wendy's apartment, and everything in the apartment was owned by Wendy. She took him under her wing, so to speak, primarily in response to her emotional needs. Ken reciprocated primarily in response to his financial needs. Their relationship began as a convenient arrangement three years previous, and developmentally as a couple they had not progressed beyond that point.

Assessment of System Dysfunction

As two individuals joining together to construct a new unit, they had yet to deal with the necessary adjustments when forming a couple system. Wendy still maintained all of the responsibility of running the household. She paid the bills, handled all fiscal matters, did the cleaning, cooking, laundry, and worked full time. They did not have a joint bank account, and if Wendy ran short she would ask Ken for twenty dollars until payday, with the understanding that she would pay him back. Ken did pay half the rent. In the session I had with Wendy alone she played the "poor me, look at all these things I have to do" role, but never had, nor did she think she could, discuss them with Ken. In the joint session Ken reported that he had no idea how unhappy Wendy was, until she had come home last week and informed him that she had been to see this worker and it was requested that he join us at our next meeting.

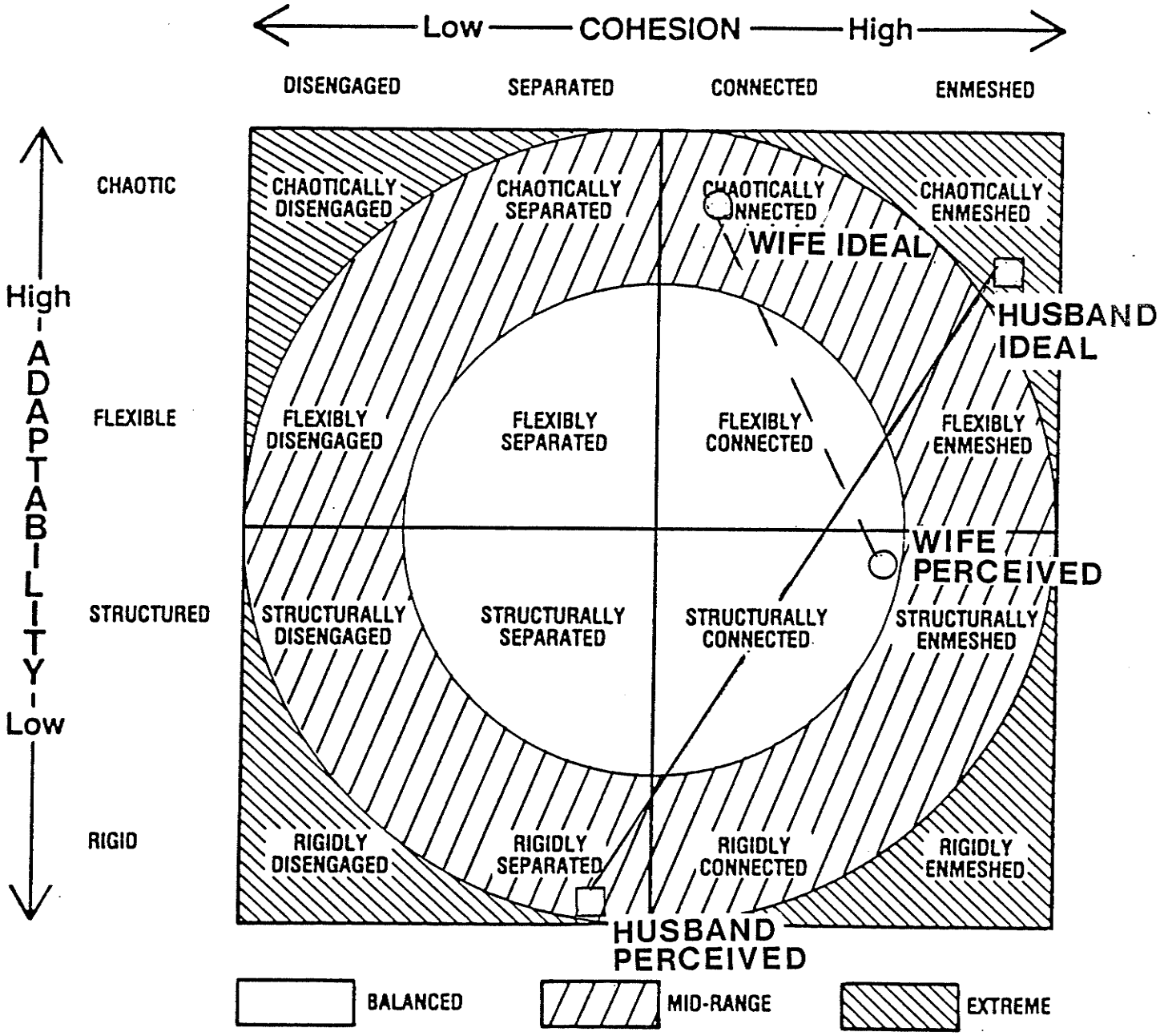
Structurally this pair had never formed a couple system. Wendy carried on as a parent, allowing Ken to be the irresponsible child. Wendy claimed that she was frightened to speak up because she did not want to re-experience the arguing and fighting that went on in her previous marriage. Thus her world view held that conflict was negative and should be avoided at all costs. She was also fearful that

Ken would take offense and withdraw. Ken claimed that he never realized that there was a problem, and simply avoided the issues. It became a never- ending cycle where the more Ken withdrew the more depressive symptoms Wendy developed, and the more depressed Wendy became the more Ken maintained he was unaware of Wendy's sadness.

In response to the FACES questionnaire, Wendy perceived their relationship as structurally-connected whereas Ken defined it as rigidly-separated. This follows from her dependence on him for emotional support, and his reliance on her for financial support. Ken kept his emotional distance as he felt he would have been consumed by Wendy if he allowed her to come too close. He maintained important supports outside their relationship and never perceived their problems to be as serious as Wendy felt they were. This is clearly evident in their responses to the problem Check List.

Wendy's perception of their relationship (structurally connected) more so reflects how she wanted the relationship to be, rather than how it was. Due to her own fear of losing Ken, she chose to blame herself and maintained that this was "her problem" as opposed to believing that the depression she was experiencing was somehow related to the state of their relationship.

CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



I met with this couple seven times before transferring the case as I was leaving. As a paradoxical move, Wendy was encouraged to take all the blame for the difficulties. As a result I was not perceived as a threat to Ken and we were able to establish a working relationship. Wendy quickly retaliated and found it within herself to confront Ken with their relationship problems. We were then able to proceed with therapy. The pace at which we advanced was intentionally very slow given the rigidity of this system. However, Wendy took flight, became more depressed, lost her job and chose to see a psychiatrist. She was then again given the message that Ken was her problem and she should leave the relationship. They had then gone full circle and were right back where they had started. Wendy had been successful in blocking the therapy process and maintaining the homeostasis. Wendy and Ken were given the option of returning to Stonewall to continue therapy as a couple, or for Wendy to see the psychiatrist on an individual basis. They chose to continue as a couple. My last meeting with them was the case transfer conference with my supervisor. When completing a follow-up sometime later I was informed that Wendy and Ken were unable to keep their commitment and discontinued therapy. Therefore, post-therapy data was not obtained.

Assessment of Evaluation Measures

In review, three assessment measures were utilized to evaluate family functioning and change. These included the Check List of Family Concerns, the Family Assessment Measure and the Family Adaptability & Cohesion Evaluation Scales. The rationale behind using three measures was twofold. Firstly, and most importantly it was my intention to evaluate the suitability and practicality of each of the measures; secondly, the scales were used as pre and post therapy measures.

In respect to therapy, the importance of systematically monitoring and evaluating the process cannot be overstated. We are now living in the age of accountability and everywhere there is an emphasis placed on evaluation. Requesting that the family or couple complete a questionnaire such as the Check List of Family Concerns or FAM II, functions to frame the therapy process. The family is given the message that this is a family problem, that each member's opinion and input is necessary and of value, and that no one family member will be blamed or ostracized. Once the assessment has been completed and the therapist has obtained a family profile, she has the option of providing them with an interpretation of their present difficulties and if appropriate, may

further discuss with them their goals for therapy. This tends to enhance motivation and pave the way for positive therapeutic expectations. It may also provide the therapist with the data required to monitor the therapeutic process, thereby revealing the necessity for revision of the treatment program. Related to this, but on a different vein, the accumulated data provides statistical evidence supporting or refuting a particular model or program. Such elevation adds to the present body of knowledge and contributes to the advancement of the profession and to the clients who entrust to the therapist their personal histories when faced with difficult life situations. It is essential that there is some method applied to the madness, and that we as professionals offer our clients more than a subjective interpretation of the problems they present to us.

The Check List of Family Concerns was well worth the time and effort it took to administer. As touched upon previously, this scale proved valuable as an assessment tool. It is quick and easy to complete yet provides the therapist with important information in a variety of areas. However, the Check List must be subjectively interpreted by the therapist and only lends itself to hypothetical speculation that must be explored further with the family.

The FAM III scale also proved to be a valuable assessment

tool. The profiles obtained fit well with the conceptual framework of the structural/strategic model. The questionnaires were not difficult to understand and clients reported few or no problems when completing them. However, if the family is large and two or more of the scales are administered at one sitting, it may take half an hour to an hour to complete, which can prove trying for clients. This can be easily corrected by having the family complete one scale prior to the intake session to ensure they understand the directions, then requesting they take the additional scales home or complete them at the next meeting. As a pre and post therapy measure FAM III also proved useful.

Profile results appeared congruent with the client's self report and the therapist's observations. However, this relates to the level of health and pathology on the six subscales, and does not address specific problem areas.

In comparison, the FACES II measure proved to be more difficult for clients to comprehend and the data obtained was less applicable. Although the FACES scale was shorter and appeared less complex than the FAM scale, clients had more trouble following the directions and completing it properly. They asked more questions while completing the questionnaire and generally appeared to attribute less credibility to this

scale. That is, I sensed that those who completed the FAM scale felt it would be of greater scientific value and more beneficial to the therapeutic process than those who completed the FACES scale. In addition, I found the conversion of the data more difficult and the end results less helpful in the assessment process. I was looking to reveal patterns of interaction. The FAM measure was useful in this endeavor as it functions to disclose the process of interaction whereas the FACES scale focuses on the structure of the system. For myself, the FAM scale provided more of the kind of information that went hand in hand with my personal understanding of family systems and that which is necessary when completing a thorough assessment. I would without question, use the FAM III measure in the future.

There were other problems that presented themselves when using the scales. Most noticeably, the clientele at the Stonewall office did not appear overly enthusiastic about filling out the questionnaires. This was an exercise that had not been undertaken at the Centre before, and was new to both staff and clients. The community health centre was just that, a facility that provided a wide variety of services for the entire local population. I was very much impressed with the positive attitude the people of Stonewall and those in the outlying rural areas held towards the Centre and the staff

that worked in the different areas. There appeared to be both co-ordination and co-operation between the RCMP, the doctors, the public health nurses, the child welfare workers, the mental health workers, the probation workers and the income security workers. This was an informal kind of working relationship that is much more prevalent in the rural setting. Families are much less transient, there is a much greater sense of community and there is a more open and positive attitude towards those in the helping professions that is seldom observed in the urban centers. However, this attitude made my task more difficult for several reasons. Firstly I was introducing something new, and for those clients returning this was an unexpected change which automatically created resistance. Secondly, the fact that I was a Master's student from the University complete with clinically tested assessment measures and excellent supervision/consultation options, did not impress the clientele. I brought to them exactly what they had chosen to leave behind. That is, I had the sense, that with my attachment to the University and my questionnaires I was bringing the city to their rural community. Even though I clearly explained my position and the rationale behind the forms I requested clients complete, I felt an unwillingness on the part of clients to accept that part of what I had to offer. Some families did not put as much effort into filling out the forms as I thought they

might have. One family neglected to return the post therapy questionnaire, even though they had made a commitment to do so, in addition to myself pursuing the matter by telephone and sending out a letter.

Thus, it became evident that which assessment measures the therapist requests the family to complete, how they are introduced to the family as well as the timing of their introductions is of critical importance. Three factors can be identified as to when it is appropriate to introduce assessment questionnaires to the family. The first consideration relates to the therapist's own comfort with introducing the forms and the explanation provided to the family as to why the therapist has requested that they complete the questionaires. If it is explained to family members that the questionnaire will be helpful as it will provide the therapist with a greater understanding of how each individual family member sees themself within their family, and the scientific value of the measure is downplayed, most individuals are comfortable with completing the questionnaire. Emphasis is placed on the importance of each individual's perspective of their place within the family, and time must be taken to answer questions family members may have. Secondly, the complexity of the questionaire, that is, how long it takes to complete, how methodical/informal the ques-

tions will appear to the family members; and how threatened family members may be by the kind of questions they are asked to respond to must be evaluated. The therapist must ask herself, "Is the family at the point where they can answer these questions?" Finally, and related to the above, the more joined the therapist is to the family the more willing the family will be to complete the questionnaire. It follows that the more complex the questionaire the more joined the therapist should be prior to introducing the questionnaire. The Check List of Family Concerns is brief and conventional enough that it can be given to family members at the initial intake meeting. Assessment measures such as FAM III and FACES should be introduced after the therapist is confident that she or he is well joined with the family and the necessary rapport has been established. If not, the therapist runs the risk of the client feeling like a "labratory rat" and being turned off by what appears to be a nonempathetic therapist.

If the above are adhered to when introducing assessment measures the family is more likely to co-operate and feel at ease, and less likely to withdraw from therapy. When the therapist requests family members to complete a questionnaire, the therapist must be cognizant of the fact that this is most likely a new and relatively uncomfortable task for the

family. Each family is unique and the therapist must be prepared to respond to the family's needs and not be overly anxious to proceed with the theraputic agenda.

Chapter Seven

Concluding Remarks

In looking back, this practicum experience was extremely valuable both in terms of professional and personal growth. In regards to the former, I had been working in the City of Winnipeg in the area of child welfare for four years prior to my work in Stonewall. I was pleasantly surprised and very encouraged to find the quality of the services and professional accountability in this particular rural area far superior to what I had experienced in the urban setting. There was an entirely different flavour to working at this location, where on the one hand I felt more at ease and relaxed about the task at hand, yet there was constant pressure to achieve excellence; to learn; and offer to the client the best possible service.

This was also my first experience with clinical assessment measures. It was decided to go with using more than one measure to provide a more varied experience and to allow for a contrast and comparison of the assessment measures selected. This had its advantages and disadvantages. The advantage was that I did have the opportunity to sample two scientifically developed questionnaires and one subject

questionnaire. This was helpful in that it assisted me in deciding which ones were of value to me and useful in the therapy process. I have already stated that I found FAM III more suited to my needs and will use it in my practice in the future, as well as the Check List of Family Concerns. The disadvantage is that by using more than one measure, perhaps I did not allow myself fair exposure to each of the measures to make an accurate assessment of their suitability. However, at this point I have only my subjective opinion, which is that I am satisfied with the route I chose. An important objective was to gain exposure to assessment measures and this goal was achieved.

One final discovery I made in regards to using different measures was that as far as the client is concerned, a scale is a scale, is a scale. Although clients agreed to complete questionnaires, there was always a sense that this was not a comfortable undertaking. Recognizing that it is a difficult decision to request professional help (Gourash, 1978), at times I felt like I was bombarding clients with forms consenting to the use of video equipment, questionnaires, and possibly requesting permission for live supervision. What is second nature to the therapist appears to be an unpleasant experience for the client. I have certainly become more aware of to the client's position, and although the import-

ance of administering questionnaires before the initial session is stressed, the therapist must be sensitive to the family's availability, and proceed carefully. Complex questionnaires should only be introduced when adequate joining has been achieved with the family by the therapist.

Finally, it is my hope that this practicum report will be of benefit to others who are curious to learn more about the Structural/Strategic Model of Family Therapy and perhaps even courageous enough to adopt it as their choice of intervention. Many therapists are now making the shift to a structural approach as there is now an abundance of literature on this model and it is less difficult than the strategic model to put into practice. I will continue to use the Structural/Strategic Model; to learn; and to contribute to the Social Work profession that which I have been given. Indeed, every ending is a new beginning.

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