

STRUCTURAL FAMILY THERAPY,

THEORY, PRACTICE AND EVALUATION

BY

© BARBARA G. DAIEN

A practicum submitted to the
Faculty of Graduate Studies
of the University of Manitoba
in partial fulfillment of the
requirements of the degree

MASTER OF SOCIAL WORK

Winnipeg, Manitoba
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TABLE OF CONTENTS

CHAPTER ONE - Introduction	
Objectives	4
Rationale	5
CHAPTER TWO - Literature Review	
Historical Perspective	7
General Systems Theory	23
Structural Family Therapy	27
CHAPTER THREE - Practicum Site	
Intervention	40
CHAPTER FOUR - Evaluation	
Faces II	43
Case Studies	48
Phillips Family	48
Andreas Family	56
Thomson Family	64
Martin Family	71
Reflections on FACES II	79
CHAPTER FIVE - Conclusions	
Training Issues	82
Implications for Student's	
Practicum	90
Conclusions	91
BIBLIOGRAPHY	
APPENDICES	

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From the first cry at birth to the last words at death, the family surrounds us and finds a place for all ages, roles and relationships for both sexes. Our needs for physical, emotional and intellectual exchange, and for nurturance, control, communication and genital sexuality can all exist side by side and find satisfaction in harmonious relationship to one another. It exists to make itself unnecessary, to release its members into the wider community as separate, autonomous beings only to recreate these images of itself anew. It has enormous creative potential, including that of life itself, and it is not surprising that, when it becomes disordered, it possesses an equal potential for terrible destruction.

A. C. Robin Skynner

Systems of Family and Marital Psychotherapy

CHAPTER ONE - INTRODUCTION

OBJECTIVES

The purpose of this practicum was to study the application of structural family therapy. The goal of this intervention was to assist families to resolve the presenting problems and enable them to function more competently and effectively.

It was expected that in conducting this practicum the student would develop a solid theoretical knowledge base of structural approaches to family therapy. It was also expected that the student would develop therapeutic expertise in the application of this model to clinical families. Further, it was expected that the student would gain knowledge and experience in conducting clinical practice evaluation with families involved in structural family therapy.

RATIONALE

My reasons for selecting the structural approach to family therapy were twofold: rational and intuitive. Rationally, it appeared logical to me to view problems in a family context. As will be elaborated in the literature review, structural family therapy provided an excellent model for understanding the family, its structural organization and the role and function of the symptom. Its techniques were well-defined, its goals were clear and the duration of treatment was brief. Its focus on changing family structure in addition to eliminating the presenting problem appeared to offer greater possibilities of long and pervasive changes within the family. Furthermore this approach was not limited to any particular symptoms because of the breadth of techniques used within its theoretical framework. My experience had not yet presented interpersonal/family problems that would be outside the applicability of the structural approach. Although this did not suggest universal application, it did suggest that the theoretical and technical framework of the approach were broad enough to lend themselves to be applied and tested with the broadest range of problems in all clinical settings.

Intuitively, I was inspired and excited by the field of family therapy. I felt that the structural approach held great promise for effective and efficient change in families that present themselves

clinically with a number of personal and interpersonal problems. This student felt a strong sense of "fit" with this approach in terms of her personal and professional values, knowledge base, skill level and of practice.

CHAPTER TWO - LITERATURE REVIEW

HISTORICAL PERSPECTIVE

The following chapter will discuss the history and the origins of family therapy through to the late sixties. This information is intended to provide a context for structural family therapy.

At the turn of the century there were the beginnings of four independent movements; social work, social psychiatry, sexology and family life education (Broderick and Schrader, 1981 as cited in Gurman and Kniskern). The boundaries of these origins became blurred when the professions of psychiatry, social work, marriage and family counselling, and home economics began to deal with family relationships. Each of these movements and their significant contributions to the field of family work will be highlighted.

From the onset, the social work movement has been interwoven with the history of marriage and family therapy. Broderick and Schrader (1981) suggested that social workers have been the most daring pioneers and the most passive "Johnny come lately's" in the parade of professionals. As early as 1877 the first city-wide charity organization in Buffalo was concerned not with the individual but the family. Though Zilpha D. Smith, cited by Gurman and Kniskern (1981), stressed the importance of the family, it was Mary Richmond who set a new standard of family oriented case record keeping among social workers in her influential book, Social Diagnosis. She was a clear advocate of not confining one's

therapeutic efforts to the individual alone, but of including those with whom the person interacts.

In 1920, The National Association of Family Social Workers published The Family, a journal intended for exclusive problems of the family. Broderick and Schrader (1981) concluded that social work has strong beginnings and could well have developed the fields of marriage and family counselling as sub-specialties within the broader field of family casework. Working with the family is basic to social work from the beginning.

There seem to be two reasons why the field of social work is not credited for its actual contribution. One is that the approach seemed to be taken for granted and seldom seemed worthy of note in print. Secondly, the development of the American Orthopsychiatric Association in the 1930's all but submerged the new field of family therapy of the 1920's. It became common place for the psychiatrist to treat the child, the psychologist to do the testing, the social worker to see the mother, and no one to pay attention to the father (Olson, 1970).

Erick Fromm and Harry Stack Sullivan influenced social psychiatry. Fromm emphasized the interaction between man and his society. His work was the forerunner to Bowen's work on the importance of differentiation from the family. Sullivan was the most interpersonally oriented of the American analysts. He had been heavily influenced by Mead and Cooley (Broderick and Schrader, 1981). He strongly believed that the child's development was a

response to his/her shifting social situation and that the child's concept of self was shaped by the parts of one's behaviour to which others respond either negatively or positively.

Broderick and Schrader report that Sullivan's work provided important precedents and foundation to the family therapy movement (1981). It was Sullivan who first demonstrated that schizophrenia could be treated through psychotherapy. He was interested in the practical aspects of the process.

The third movement, the early sexologists, Havelock Ellis of Great Britain and Magnus Hirschfeld of Germany, were physicians. Havelock Ellis was raised in the Victorian era. He reacted strongly against the moralistic and puritanical view of sex which led him to write seven volumes containing almost every imaginable affect of sexual behaviour, as well as to work clinically to spare others the ignorance and discomfort of sexual matters he had experienced while growing up.

Hirschfeld founded the Institute of Sexual Science in 1918 and together with Ellis and August Tavel founded the World League for Sexual Reform. Five international meetings were held between 1921-1932 which brought thousands of physicians to Hirschfeld's Institute. Counselling was provided on sex education. By 1930 Hirschfeld had published five volumes on sex education based on an analysis of 10,000 questionnaires filled out by patients visiting him. Through Hirschfeld's influence many centres offering sexual advice flourished in Germany and all of Europe. These centres, like

Hirschfeld's concentrated on contraception, psychological and relationship counselling. With the advent of nazism and its racism, the character of the German clinics changed dramatically. Marital counselling began to concern itself with the biological improvement of its people. Although Hirschfeld's concepts did not survive in Germany, they did in America and Europe.

The family life education movement was the last important movement. Americans are great believers in education as a vehicle for addressing social problems. As early as 1883, a mothers group was established to discuss parenting concerns. It was the Constitutional Convention of the American Home Economics Association in 1908, that provided the impetus to establish courses in high school and colleges to improve American home-making as well as the relationship aspects of a married woman's role. In the 1930's Popenol conducted numerous workshops, on home, marriage and sex and had become a household name through his writings in the Ladies Home Journal. In 1936, Ernest Groves was the first person to institute "functional" marriage and family relations courses for college credit (Broderick and Schrader, 1981). His functional course differed from the traditional in that it was eclectic, practical in that students needs were taken into account, and finally, remedial in that the course intended to improve the courtship and marriage of the students involved. Instructors teaching the functional courses soon found themselves doing pre-marital and marital counselling with the students.

In summary, each of these four movements have made significant contributions to the origins of family therapy. Social work from its beginning advocated the importance of seeing the troubled individual within the social context. Interventions including family, friends and the community were considered appropriate. Social psychiatry's major influence was its break with Freudian principles which basically suggested that symptoms arose from trauma and conflict in the past, and were relegated to the unconscious. Alternatively, Adler, Jung, Fromm and Sullivan suggested that the individual's social environment influenced and affected how the individual relates to his/her environment. The earlier sexologists emphasized the normalcy of sex and acknowledged the need for people to discuss their problems in an atmosphere of acceptance. In addition, they also began to provide contraceptive counselling. The family life education programs were the pioneers of marital and family courses in universities which discussed marriage in functional terms as opposed to traditional approaches emphasizing status, position and obedience.

The following section will explore the development of the family therapy movement, the founding decade being 1952-1961.

The historians of the family therapy movement (Broderick and Schrader, 1981) note that it began in a dozen places at once by independently minded clinicians and researchers. By the 1950's it emerged as a connected movement, and these individuals were exchanging papers and visits. They were beginning to take major

steps toward establishing family conjoint therapy as a treatment method. By 1961, the pioneers were wanting to establish a journal which would be a vehicle whereby clinicians could exchange ideas, discuss advances in theory formulation, describe clinical practice in a formal way and which would be disseminated to family practitioners. To do this the Mental Research Institute in California, directed by Jackson, and the Family Institute, directed by Ackerman, drew up an agreement to co-sponsor the founding of the journal, Family Process - which appeared first in 1962. The first editor of Family Process was Jay Haley, while pioneers like Lidz, Ackerman, Jackson, and Whitaker were involved on the first editorial board.

Some of the pioneers of the family therapy movement will be introduced by their roots and their contribution to contemporary family therapy highlighted.

John Bell

It is John Bell who many claim as the "father of family" therapy. His profession was psychology and he practiced in Massachusetts. His contribution was the notion that he could see his individual patients in their family unit. This new approach was taken accidentally because of a misunderstanding of information he received while visiting Dr. Sutherland at the Tavistock Clinic in London in 1951. In 1953 he reported to a group of fellow psychologists, describing the successful new family approach with

nine of his cases which otherwise would have been seen in individual psychotherapy. Among Bell's most respected contribution is his monograph, Family Group Therapy (1961). Together with the 1958 Ackerman volume, it constitutes one of the founding documents of the profession. Its wide circulation, especially in the western part of the United States had an immediate and immense impact. From 1956 to 1961, Bell gave several hundred lectures and workshops on family therapy. To an important degree because of Bell's work, family therapy gained prominence rapidly and was far in advance in the western United States at the end of the founding decade.

Nathan W. Ackerman

Ackerman came to family therapy from the field of child psychiatry. He had also been interested in group psychotherapy and was much influenced by the work of Moreno. Perhaps most important for Ackerman, as for many psychiatrists of his generation, was the experience of the Holocaust and World War II. This had a profound effect, turning his attention to the relationship of social contexts and fate of individual persons. Some appreciation for the distance he came in his career can be gained from his description of his own training. Prior to this time, he viewed the relatives as largely irrelevant, only useful when an autopsy was needed to check the connection between brain pathology and mental illness. He became convinced that emotional difficulties could be generated by the immediate environment as well as by the dynamics of the psyche. As

this new viewpoint emerged, he joined the Menninger Clinic in Topeka. During this time, he adopted the orthopsychiatric viewpoint, wherein the psychiatrist saw the patient and the social worker saw the mother. However, by the mid 1940's there was a growing flexibility in the field and a single therapist would see the family unit. Ackerman began to experiment with this procedure in his private practice and concluded that there was a relationship between a child's illness and the mothering and fathering received by the child. His major contribution to family therapy was his view of the family as the unit of diagnosis and treatment. He valued home visits to study the family.

Theodore Lidz

Lidz was another of the founders who was analytically trained. In the early 40's, while on the staff of John Hopkins University, he became interested in families of schizophrenics. When he moved to Yale in 1951, he sharpened his focus and together with a colleague began studying a group of 17 young hospitalized schizophrenics and their families intensively. Following analytic concepts more closely than some of the others, he became especially concerned with the failure of these families to develop adequate boundaries and with their intense symbiotic needs derived from a parent's need for and inability to differentiate himself or herself from the patient. In some cases the parents were distant and hostile toward each other (the condition labelled "schism"). In others there was a tendency

for the mother to become domineering in a destructive way (the condition he labelled "skew". He felt that the first condition was hardest on male children and the second on females. (Lidz et al, 1957).

Lidz interest remained focused essentially on the understanding and treatment of schizophrenic disorders rather than on the development of family therapy as a discipline. However, reports by the Lidz group are probably the first, or among the first, to convey the concept of family treatment. He treated the parents and siblings of his hospitalized patients in marital pairs and occasionally in conjoint family therapy.

Lyman C. Wynne

Of all the pioneers, none is considered as well trained to become a family researcher and therapist as Lyman Wynne (Broderick and Schrader, 1981). He received his medical training at Harvard, and pursued a Ph.D. in the graduate Department of Social Relations. While at Harvard he became interested in the ideas of Talcott Parsons and Eric Lindemann. These social scientists influenced his ideas on family structure and its role in illness. He joined the National Institute of Mental Health at Bethesda and gradually began to work intensively with families which had a schizophrenic member. Wynne's contribution to understanding these families was to note the unreal quality of both positive and negative emotions. He used the term "pseudo mutuality" and "pseudo hostility" to describe the

emotional climate, by which family members intensely wish for mutual relatedness in a way which excludes the toleration of distance or difference. He also commented upon what he thought was the peculiar boundary around the family, apparently yielding, but actually impervious to outsiders (especially therapists). Wynne called it the "rubber fence" which protects the family from new information or potential change. Thus children in these kinds of families are caught in a dilemma for if they attempt to disengage or differentiate from other family members there are expectations of disaster for the family.

Murray Bowen

Bowen, like the majority of pioneers, was a psychiatrist who specialized in treating psychotic children. Like Ackerman, he started to see families while working at the Menninger Clinic. Initially, he thought that mothers should stay with the psychotic child. As he developed his ideas and clinical expertise, it became clear to him that the father was an important part of the treatment unit. He began to think that schizophrenia was a sign of a larger pathology in the whole family and tried to include as many family members to live in the hospital ward during treatment. Bowen moved from Menninger to the National Institute of Mental Health, Washington, D.C. to conduct a research project which involved families of schizophrenic youngsters who came and lived in the hospital during treatment. Initially, the project provided separate

therapists for each family member but this changed to the family being seen as a unit with a single therapist.

Bowen's research has contributed significantly to the field of family therapy in terms of his notions of the importance of family triangles, the notion of multi-generational transmission of emotional illness, the importance of working with the family of origin and the concept of differentiation (Hoffman, 1981 p.29). Bowen was keenly aware of the importance played by triangles in family interaction. Triangulation is a process that involves two forming to exclude or work against a third party.

Carl A. Whitaker

From the beginning he has been noted as the most irreverent and whimsical of the founding pioneers. In recent years he has developed his approach to defy traditional psychotherapeutic practices . By 1944, he and John Warkentin began bringing spouses and eventually children into sessions with their patients. Eventually he shifted his emphasis to schizophrenics and their families. He is now known for this finely honed therapy of the absurd - a therapy in which he seems to drive the family sane by appearing more outrageous than they. As the family therapy movement developed, Whitaker was part of the central network. The evidence of this rests in the fact that he was on the first board of editors for Family Process. He was one of the first to include grandparents, as well as collateral kin, all of whom he would invite

for weekend workshops around a particular individual's or nuclear family problem. He also focused on the importance of having a co-therapist for the provision of emotional equilibrium to each other (Broderick and Schrader, 1981).

The Philadelphia Group

The Philadelphia group consisted of Ivan Borzorminye-Nagy, Gerald Zuk and James Framo who were trained psychiatrists. They, like several founders of the family therapy movement were interested in therapy of psychotics, and the integration of family therapy with psychotherapy as a whole. They like Whitaker saw the value of co-therapy. Though they supported an integrative model with schizophrenics, they also demanded a particular strategic change in the family's activities, thus acknowledging the need for the therapist to be active and insistent, not just interpretive. This group was first to organize family training programs in Europe (Broderick and Schrader, 1981).

Salvador Minuchin

Salvador Minuchin grew up and was trained as a traditional psychiatrist in Argentina and continued in the tradition until the early 1960's when he was asked to take part in Wiltwyck Research Project, New York (Broderick and Schrader, 1981). Its purpose was to explore the structure and dynamics of the disadvantaged, disorganized families of delinquent boys and to develop a treatment

method to help them. The research team was composed of three psychiatrists, two psychiatric social workers and two clinical psychologists.

Minuchin's work differed from Wynne, Lidz, Bowen and Whitaker whose focus tended to be on patterns of communication in psychotic families. Minuchin and his associates Braulio Montalvo and Edgar Auerswald were the three psychiatrists on the interdisciplinary team who began to believe that organizational aspects produced problem members in poor and disadvantaged families. The problem people in these families had less trouble with what is "real" than with what is "right" according to the mores of the larger society (Hoffman, 1981 p. 77). From his involvement with this research Minuchin began to formulate his ideas on family structure, the importance of the social context and on the different transactional styles (enmeshed and disengaged).

His notions of "enmeshed" are similar to Bowen's concept of "undifferentiated family ego mass" and Wynne's idea of "pseudomutuality". The concept of triangulation as articulated by Bowen is similar to Minuchin's in that when a dyad joins together with a third party over a period of time, it could cause problems in the family.

Minuchin then moved on to the Philadelphia Child Guidance Clinic persuading Jay Haley and Montalvo to join him. It is here that structural family therapy was fully developed in theory and practice. Furthermore an innovative training model which took local

black community members and trained them to act as para-professional family therapists was established. This model incorporated the use of one-way mirrors, taping and bug-in-the-ear methods used extensively today in training facilities.

Palo Alto Group

This group consisted of Gregory Bateson, Jay Haley, John Weakland, Don J. Jackson and Virginia Satir.

Gregory Bateson's background was in anthropology and philosophy, Jay Haley's background was in communication, Weakland's in chemical engineering later developing into anthropology, Don Jackson came from psychiatry and Virginia Satir was in social work.

This group was considered to be "system purists" in the decade of the 1950's. Their major contribution to the field of family therapy was based on communication theories developed from Gregory Bateson's work in general systems theory, and on the notion that human groups organize in a hierarchical fashion in which some members have more status and power than others.

During this era, Jackson, Haley, Weakland and Bateson contributed to the family therapy field by publishing their understanding of the schizophrenic family in classic papers, "Toward a Theory of Schizophrenia" (1956) and "Note on the Double Bind" (1963). These papers generated much discussion in the psychiatric community as they viewed schizophrenia in a new way. Haley began to describe a new way to view all psychopathology.

He suggested that the basic unit of observation must be the triad rather than a unit of one or two. He hypothesized that an unhealthy system existed when A) a member belonged to a different generation (different order in power hierarchy) from the other two and two members from a different generation are in a coalition against the third party, and B) the coalition is covert and denied. Jackson's contribution was similar to Haley in concentrating on the relational tendencies and social context. However, he suggested that a family is a rule governed system, that its members behave among themselves in an organized, repetitive manner, and that the patterns of behaviours can be abstracted as a governing principle of family life. He suggested that these rules govern the family relationships and are therefore predictable. If understood and identified, they could be influenced and changed to more productive patterns.

Virginia Satir was part of the family therapy demonstration project at Palo Alto. During the early 1960's she developed her own unique style of being able to expose the discrepancies and incongruencies in communication. She is considered a master of the art of disentangling people from the mystifying communicational traps that are a particular hallmark of families with a psychotic member. During the mid 60's she gradually disengaged from the MRI as she became more and more involved with the human growth movement. Probably more than anyone else, she has a flair for clear, non-technical explanations and charismatic presentations that lend

her an extremely wide audience through her books and media.

The early family therapists have been discussed. Their individual contributions have been highlighted and their similarities noted.

The following chapter will describe General Systems Theory followed by a detailed description of the Structural Family Therapy Model.

GENERAL SYSTEMS THEORY

General systems theory is the theoretical rationale underlying structural family therapy. The shift from individually oriented theory and technique to systemic oriented ideas was dramatic for the helping professions (Olson, 1970). This shift from linear thinking of causability demands a new way of viewing human behaviour. General systems theory arises out of the work of Von Bertalanffy (1945), a biologist.

In terms of thinking for a way in which to consider human functioning, Haley (1969) says, that the problem is to change the living situation of a person not to pluck him from his situation and try to change him. Essentially, a system is composed of inter-dependent elements whose inter-relationship holds the system together (Walrond-Skinner, 1976). Structurally, these interdependent elements form a complex network of subsystems with the larger system. Relationships develop among the subsystems themselves and between the subsystem and system itself.

These relationships are maintained and controlled by rules and regulations (Walrond-Skinner, 1976). The system strives to maintain itself, adapt and survive and, therefore, has its own goals and needs which may be at odds with the component parts of the system. Through the systems structure, and the cybernetic principles of communication between the elements, the component parts are maintained in order that the systems' needs can be met. This model

provides a way of seeing a new pattern and a new reality even though the contents of the picture remain the same.

To view problems/difficulties from a systems perspective provides the viewer with a different reality. There are four basic properties of an open system - wholeness, relationships, equifinality and feedback, in addition to structure and cybernetic patterns of communication (Watzlawick et al, 1967).

Wholeness, refers to the relationship between the components and the total system. The components influence each other and are influenced by the system as the system influences the individual components. Because of this reciprocal process, it is assumed that the whole is greater than the sum of its parts. Thus, if only the individual components of the system are viewed the system's wholeness can not be fully appreciated. Family Therapists believe it is essential to see the family as a unit; however, this often does not occur.

Relationship - refers to the basic patterns which, though might seem widely divergent is, in fact similar to, as well as transformations, of each other. Thus, patterns repeat themselves, no matter what the context. The therapist will be able to isolate communication patterns and sequences, which are the underpinnings of the dysfunctional social organization, and plan to intervene in a way to alter the system at the structural and interactive level.

Equifinality - This means that no matter where one begins, the conclusion will be the same thing. This suggests that it is not

important to find the origin of events, rather what is important are the transactions occurring in the system and how these transactions maintain the problem.

Feedback - the last property, refers to how elements within the system relate to each other. Feedback is not unidirectional, thus linear cause and effect is not possible. Causality is circular in that each action is the cause of and is caused by other actions. Thus, feedback has no beginning or ending. Clinically, this feedback loop can be seen in the role of the identified patient and the family. For example, when the relationship becomes particularly tense between mother and father and appears to be threatening the family system with disintegration, the identified patient acts out. This enables the mother and father to unite once again, to stay together for the "sake of the children" and of course, the family system is saved. This is called a negative feedback loop.

This negative feedback loop is the system's way of maintaining homeostasis. The system is a self-sustaining, rule governed entity which wants to maintain its stability and to balance the demands of the system's elements and the environmental forces upon it. Homeostatic mechanisms used to restore and maintain the system are like defenses in traditional psychotherapy. These processes become dysfunctional when the system becomes rigid and inflexible. Symptomatic behaviour is useful to restore the homeostasis of the system. The "symptom bearer" serves to divert the attention away from the real source of stress that threatens to disintegrate the

system.

Haley (1976)Minuchin (1967), and Satir (1967) see the "real" source of stress as the marital subsystem which is the foundation of family interaction. Positive feedback, on the other hand, can destroy the system. Methods of intervention are based on this idea. When the intervention is successful, the family members are unable to return to old ways. The dysfunctional pattern has become intolerable, hence the family engages in a struggle to behave and interact in a new way.

STRUCTURAL FAMILY THERAPY

THEORETICAL MODEL

Structural Family Therapy was originally articulated in Families and Family Therapy (1974) by Salvador Minuchin. Since that time much has been written to add and expand on Minuchin's model. The organization of the family is of key importance to Minuchin. He describes family structure as an invisible set of functional demands that organize the ways in which family members interact. (Minuchin, 1974 p.51). This structure provides the day to day patterns through which the family members carry out their relationship in accordance with the requirements of each operation/function. These repeated transactions establish patterns of how, when and to whom to relate and are the patterns underlying the family system. These family transactional patterns form the matrix of psychological growth (Minuchin 1978 p.52). What is the function of the family? According to Minuchin it is the psychosocial protection of its members (an internal function), and the other is external, the accommodation to, and the transmission, of a culture. Two characteristics which are vital to human identity are belonging and separateness. How the individual achieves this mix occurs through participation in difficult family subsystems, in different family contexts and with extra familial groups. These transactional patterns regulate family member's behaviour. The family structure must be able to adapt as the circumstance demands. The family system differentiates and carries out its functions according to

subsystems which are marked by boundaries. The boundaries of a subsystem are the rules defining who participates and how. These subsystems can be formed by generation, by sex, by interest, or by function. They may include one member, a dyad (spousal subsystem), or more members of the family (a sibling subsystem). According to Minuchin there are four enduring subsystems which are representative of the western family of particular relevance to the child's growth: the spouse, the parental, the sibling and the individual. Individuals enter into these different subsystems with different levels of power. Boundaries surround these subsystems and serve to protect the differentiations of the system. However, each subsystem has its specific function and makes requests of its members. Interpersonal skills within the subsystem depends on the subsystem being free of interference from other subsystems. Likewise, the development of negotiating skills with peers, learning how to get along with siblings, requires non-interference from parents. Boundaries with other subsystems must be clear as well as flexible. In this way roles, functions, responsibilities and power can be fairly well differentiated. If the boundaries are confused, rigid, or too flexible the family members use their energy to disentangle the confusion in the family rather than grow and develop. The family then becomes burdened and stressed.

Boundaries are conceptualized by Minuchin in terms of extremes of disengagement and enmeshment.

The terminology refers to the transactional style of the

family. Families with enmeshed subsystems tend to develop their own reality/space which heightens belonging and discourages differentiation so that distance is reduced and the boundaries are blurred. Disengaged families, develop overly rigid boundaries so that communication across subsystems becomes difficult and the protective functions of the family are handicapped due to a skewed sense of independence. Members tend to lack feelings of loyalty and belonging and the capacity for interdependence and for requesting support when needed. All families are conceived of as falling somewhere along a continuum whose poles are the two extremes of diffuse boundaries and overly rigid boundaries (Minuchin, 1974).

The therapist's task is to assess the family's structure and to begin to understand the family's organization. The therapist analyzes the transactional field in which she and the family are meeting in order to make a structural diagnosis. To make a diagnosis, the worker participates by making observations and by asking probing questions which confirm or deny her hypothesis about patterns which are functional and those which are dysfunctional. She then begins to derive a picture which allows her to organize diverse information. The structural map is a tool allowing the therapist to hypothesize about areas in which the family functions well and those that may be dysfunctional (Minuchin, 1974 p.90). This structural assessment helps her to determine therapeutic goals - the impetus for restructuring the family. The process of assessment, hypothesis building, probing, goal setting and forming a

direction for treatment is an active dynamic process. Clarity of boundary marking and boundary functioning are key elements in structural family therapy.

Alliances and coalitions are additional concepts. Coalitions always involve two parties in opposition to or to the exclusion of, a third party, alliances are simply teaming up of two parties "based on common interests" with no third party involved. Hoffman (1981, p.108), Haley (1967) and Minuchin (1974) describe coalitions, whether cross generational (perverse triangles) or not as indicative of underlying systemic conflicts which create and perpetrate difficulties. Three conflict avoidance patterns of involvement have been identified by Minuchin (1978 p.33) triangulation, parent-child coalition and detouring. Triangulation occurs when the child is openly pressed to become an ally with one parent against another. In the parent-child coalition, the child tends to be in a stable coalition with one parent against another. In detouring, the spouse dyad appears united demonstrating a close relationship whilst all the while submerging their conflict with each other. Their conflict is hidden as they are joined together in a posture of overprotection and concern of blame and anger toward their sick child.

Assessment, therefore, includes the aspects of the family transactional patterns (disengaged and enmeshed) in addition to coalitions and alignments within/and outside of the family.

Symptoms - viewed in a structural context

It is the symptom of one family member that usually brings the family into treatment. The structural approach sees the family as an organism, a complex system that is underfunctioning; the symptom is understood as an expression of a contextual problem from an organism under stress (Minuchin, 1974 p.152). The job of the therapist is to undermine the existing status quo by creating a crisis which jars the system toward the development of a better functioning organization which will free the 'symptom bearer'.

Three main strategies comprise the core of structural family therapy. These strategies can be broken down into a series of techniques. The three strategies include challenging the symptom, challenging the family structure and challenging the family reality. "Challenge" referring to a way of describing the therapeutic process between therapist and therapeutic system.

Challenging the symptom refers to challenging the family's definition of the problem and the nature of their response. The identified patient's symptoms can be an expression of a family dysfunction or may have resulted in the individual family member because of her life circumstances which has been supported by the family system (Minuchin 1974, p.110).

Challenge can be direct or indirect, explicit or implicit, straight forward or paradoxical. The goal is to change or reframe the family's view of the problem, pushing its members to search for alternative, behavioural, cognitive and affective responses

(Minuchin and Fishman 1981, p.68).

Challenging the structure of the family refers to the family's organization. Areas of family dysfunction frequently involve either over involvement or under involvement. If there is over involvement, the members freedom to move is restricted, if there is under involvement, the members may be isolated and lack support. In challenging the family's structure, one needs to monitor closeness and distance. The therapist, as an outsider, has more mobility even though still constrained by the system's demands. However, the therapist needs to work back and forth between the subsystems challenging the members definition of their roles and functions. Modifying the context the family experiences a change. Challenging the family's reality means challenging how the family views their world and their place in it. Structural thinkers suggest that transactional patterns depend on and constrain the way people experience reality. Changing the way family members look at reality requires the development of new ways of interacting in the family. The therapist takes the data offered by the family and reorganizes it so that the conflictual and stereotyped reality of the family is reframed in an alternative way which allows the family new possibilities for change.

For change to occur the therapist must use herself actively to join with the family. Joining refers to an "attitude" , not a technique, and it is the underpinning of all therapeutic transactions. Joining with a family lets the members know that the

therapist understands them and is working with and for them. It is important that the therapist is able to provide protection and security so that the family members feel secure in exploring alternatives doing the unusual and changing.

"Joining is the glue that holds the therapeutic system together" (Minuchin/Fishman 1981, p.32).

When the therapist joins the family, she assumes the leadership of the therapeutic system. This means she assumes responsibility for what transpires during the therapy session. Interventions are then designed to facilitate the transformation of the family system towards its goals. It is the family themselves that heals and helps its members grow.

In the process of joining family members feel respected, supported, and confirmed even when they are being challenged in their dysfunctional manoeuvres. Joining is more than support, it is helping the family members to have hope; it is knowing the impact of the therapy; being able to assess the life circumstances in the family, and being available to support. In order to use one's self fully, the therapist must be knowledgeable about the range of his/her joining responses and how these resources can best be utilized. Once the therapist learns to be an expert at reading family feedback, the therapist will develop a confidence in how she uses herself knowing that her behaviour will fall within the acceptable range of the therapeutic's system.

Joining is an integral part of the therapeutic process. The

therapist needs to join in each session and throughout the course of therapy. Joining is an operation that relates to every therapeutic intervention. Joining and challenging are the basis for therapeutic change to occur. But first and always, the therapist must be well joined otherwise the family will not go down the path with her.

The three main strategies of structural family therapy are linked to specific techniques. The techniques for challenging the symptom are enactment, focusing, and intensity.

Minuchin describes enactment as asking the family to enact an interpersonal scenario in the session by requesting and watching the enactment, the therapist quickly sees the dysfunctional structure and begins to understand the rules by which this family has organized itself. Enactment can be seen as a three step process. In the first step, the therapist observes the spontaneous transactions and decides which dysfunctional area to focus on. In the second step, the therapist highlights an interpersonal scenario which is changed and finally the therapist suggests alternate ways of getting it to happen in the room.

Focusing means to decide what to zero in on and what to let pass by. The therapist will select and organize the information into some framework for meaning. However, the organization of the data must be relevant to the therapeutic process. To accomplish the skill of focusing, the therapist must select a target and then develop a theme for work. Data gathering refers to the process of change not to content of issues. Through gathering information, the

therapist will devise a framework closely tied into structural goals and a strategy for achieving that goal.

Intensity refers to the therapist's message. "Families differ in degree to which they demand loyalty to the family reality and a therapist's intensity of message will need to vary according to what is being challenged" (Minuchin and Fishman, 1981 P 117). The therapist like the family, follows implicit rules about how to behave in situations in which people transact with people. It is crucial that the therapist maintains the required intensity even when the family members show within the session that they have reached their emotional limit. The therapist must train herself to behave in ways opposite to the family's rules. To increase the intensity the following techniques can be used: repetition of the message, changing the time in which people are involved in the transaction, changing the distance between people involved in the transaction, and resisting the pull of a family transactional pattern.

Challenging the family structure, involves boundary marking, unbalancing and teaching complementarity. Boundary marking regulates the permeability of boundaries separating subsystems (Minuchin and Fishman, 1981 p.146). It relates to membership of subsystems and changing the distance between them as well as affecting who interacts with whom within significant subsystems. Changing the boundary can be accomplished by using cognitive constructs which will delineate a boundary between two people or by

expanding the definition of the over-involved dyad to include the under-involved person. Different subsystems may do different tasks so that boundaries can be changed in the direction of the therapeutic goal. In addition, the therapist can use concrete spatial manoeuvres to change the proximity between family members. The goal in marking boundaries is either to increase or decrease space between individuals and their subsystems in order to change subsystem membership.

Unbalancing is aimed at challenging the hierarchical relationship of the members of a subsystem and thus the power relationships (Minuchin and Fishman, 1981 P.161). As soon as the therapist enters the system as the leader, the family power structure changes. What the therapist will do to unbalance the system is to affiliate with family members, perhaps ignore a family member, or perhaps enter into a coalition with some family members against others. Unbalancing is a power technique and may produce significant change when individuals have the opportunities to explore new possibilities and think of new options with their interpersonal context.

Complimentarity refers to the individual as intrinsic and as a part of a whole. One of the therapist's goals is to help family members experience belonging to an entity that is larger than the individual self (Minuchin and Fishman, 1981 p.193). Complimentarity means to assist the family member to see their interdependence. To do this the therapist challenges the problem. This is accomplished

by challenging the family's certainty that there is one identified patient, challenging the notion that one family member is controlling the system rather than each member serving as a context of the other, and finally, challenging the family's understanding of events which introduces an expanded time frame to teach family members to see their behaviour as part of a larger whole (Minuchin and Fishman, 1981 p.194). This notion of complementarity is critical for it is the technique which helps the family members to recognize the impact that they have on each other. For change to occur, each needs to develop new ways of punctuating the dysfunctional transactional patterns.

To challenge the world view, the following techniques are used: cognitive constructs, paradoxical interventions and emphasizing strengths.

Cognitive constructs refers to the therapists ability to shake up the rigidity of the family's preferred way of seeing things. The therapist is limited by her own biography, by the finite reality of the family structure, and the idiosyncratic way in which the family has developed its structure (Minuchin and Fishman 1981, p.214). The goal is always to provide the family with a new world view in which symptoms are not needed and in which the members perceptions include new alternatives and dimensions.

Paradoxes are clinical tools used for dealing with resistance and avoiding a power struggle between the family and the therapist (Minuchin and Fishman, 1981 p.244). Paradoxes are not always

necessary or desirable and ought not to be employed in crisis situations such as violence, acute grief, attempted suicide and other acute situations where the therapist needs to move quickly to provide structure and control. Papp (1981) says she and her colleagues reserve paradoxical interventions for these covert, longstanding repetitious patterns of interactions that do not respond to direct intervention such as logical explanations or rational suggestions (Minuchin and Fishman 1981, p.245). The paradoxical intervention, if followed, will accomplish the opposite of what it is seemingly intended to accomplish. For it to be successful, the family must defy the therapist's instructions or follow them to the point of the absurd and then recoil from the absurdity. The target of the systemic paradox is to make obvious the hidden interaction which expresses itself as a symptom. The therapist will connect the symptom to the system through a series of drastic redefinitions so that one part cannot change. The symptom and the system are interconnected. To the beginning therapist, paradoxical techniques are powerful and ought only to be used by those individuals who have an accurate knowledge of the relationship of the symptom to the system and how the system might react if a paradoxical intervention was to be used.

Search for Strength

Strengths of the family have often been overlooked by the helping professions. Minuchin suggests that "helpers" are trained

to be psychological sleuths who are to "search and destroy", pinpoint psychological disorder, label it and eradicate it (Minuchin and Fishman 1981, p.263.)

The therapist needs to assist the family to focus on their strengths - healing capacities which may result in a change in the reality that the family understands. The challenge can be related to how the family responds to the individual or how the family uses alternatives. The therapist looks for strengths rather than deficits and assists the family members to use their own competencies and capabilities.

This section concludes the review of the theoretical model of structural family therapy.

The following chapter describes the practicum setting, clients, evaluation procedures and four case studies demonstrating the integration of the practice of structural family therapy with the theory.

CHAPTER THREE - PRACTICUM SITE

INTERVENTION

Family therapy is a treatment approach based on systems theory and views problems as emanating from the family system and not from inherent weaknesses in any one individual. Treatment is aimed at changes in the family's structure and its pattern of interacting.

As stated earlier, the specific conceptual framework of the practicum intervention is structural family therapy where problems in families are seen as the result of problems in the family structure. The structure is the organizational rules of the family, which direct family functioning and determine how, when, and to whom to relate. These rules are manifested by boundaries which suggest family functioning on a continuum with enmeshment at one end, (diffuse boundaries), and disengagement at the other end (rigid boundaries). Exclusive functioning at either end is seen to jeopardize healthy adaptability to stress, that is, the family's ability to confront issues directly and accommodate change.

Structural Family Therapy is an intervention aimed at modifying boundaries and restructuring the family system in order that the family is better able to adapt to and deal effectively with the stresses it encounters.

A variety of evaluation measures were used to assess the families. These measures provided empirical results concerning changes which occurred. These empirical results are supplemented by clinical observations presented in the form of case studies.

Setting

The families represented in this practicum were seen and evaluated at the Psychological Service Centre of the University of Manitoba. It is an interdisciplinary training facility of the Faculty of Arts and its primary goal is the training of students in the Department of Psychology and the School of Social Work. The Centre provides services to individuals or families who telephone, appear in person or write requesting help. Such services are provided to persons referred by community agencies, physicians, teachers and counselors in the Winnipeg Area. The staff of the Psychological Service Centre includes fully qualified clinical psychologists, social workers, and a consulting psychiatrist as well as other professionals skilled in the mental health field. The centre utilizes the capabilities of advanced students in their respective disciplines.

Subjects

The families seen by the student requested help because of problems surrounding one or more of their children. The families were either self-referred or referred by other involved professionals in the community: physicians, social workers, school principals. As this was a practicum setting the groups of families seen contacted the clinic shortly after the practicum began. The criterion by which the families were assigned to the writer was

informal, the main goal being that a wide range of families be seen at varying life stages with varying problems.

A total of nine families were seen. The children ranged in age from three to sixteen with the average age of seven. The sessions were weekly and were approximately ninety minutes in length conducted over a six month period.

All of the names of the families in this report were altered to preserve confidentiality.

Supervision

Supervision was provided by the members of the writer's committee. Professor Walter Driedger acted as overall supervisor and primary advisor of the student's activities. Dr. Barry Trute supervised the student in the evaluation components of the practicum. Maria Gomori was also available for case consultation, and supervision in the application of the structural model.

George Enns, through his workshops, was invaluable to the writer in facilitating the integration of theory and practice.

CHAPTER FOUR - EVALUATION

FACES II

The purpose of the evaluation was to evaluate the families receiving family therapy during the practicum placement to determine whether change had occurred as a result of the intervention.

The evaluation measures used were:

Family Adaptability and Cohesion Scales

Structural Assessments

Therapists Reports

- These evaluation measures were chosen according to their ability to measure different criteria. They were easy to administer, were time efficient for scoring and interpreting and met recognized standards of validity and reliability.

Faces II Family Adaptability and Family Cohesion Evaluation scale was developed by David Olson, Richard Bell and Joyce Portner (1982) at the University of Minnesota. This is a 30 item self-report instrument designed to measure individual family member's perception of family cohesion and adaptability. Family cohesion assessed the degree to which family members were separated from or connected to their family. Family adaptability assessed the extent to which the family system was flexible and able to change. There were four levels of family cohesion ranging from extreme low (disengaged) to extreme high (enmeshed) and four levels of adaptability ranging from extreme low (rigid) to extreme high (chaotic). The balanced levels (moderate) were hypothesized to be

the most viable for healthy family functioning.

Sixteen distinct types of family systems were identified by combining the four levels of the cohesion dimension (disengaged, separated, connected, enmeshed) and the four levels of the adaptability dimension (rigid, structured, flexible, chaotic). Four of these sixteen types were moderate (balanced types) on both the cohesion and adaptability dimensions. Eight types were extreme on one dimension and moderate on the other (mid-range types) and four types were extreme on both dimensions (extreme types). Scores were obtained for both dimensions and family types were derived from the scores. These were compared pre and post-treatment to assess change (Olson et al., 1982).

Each member of the family over eleven was asked to complete the scale twice, once for how each currently saw their family and secondly, for how each would like their family to be, that is, their ideal. The ideal and perceived were compared to assess the level of satisfaction with the current family system and this level was compared to the post treatment ratings.

A third measure used to evaluate was the diagnosis of the family, the structural assessment. From information obtained in the first interviews, a structural assessment was formed that clarifies and conceptualizes the structure and organization of the family. This pre-intervention measure was used by comparing it with the post intervention assessment to determine changes, that had occurred.

As this is a subjective measure, there was naturally some

question concerning its validity and reliability. But, as it focused on specific, concrete areas of family functioning, the likelihood of screening out subjectivity was increased. It also had the added advantage of providing additional and valuable information about the family. A structured assessment was formulated for each family and, therefore, the post comparison made good use of a measure that was already employed. The structured assessments were discussed with the supervisor and George Enns.

The therapist reports were incorporated as an outcome measure. These provided professional insight into what occurred in the therapy process. They were based on knowledge about the family and an indepth awareness of the therapeutic plan.

In actuality, evaluation was an ongoing process of therapy. The fact that the therapist was a trained observer lended validity to the use of the reports as an evaluation measure. As well, the therapist was best able to understand the context within which the family was operating.

Obviously, the main drawback of the therapist's report was that the therapist had a personal investment in the family improving and therefore the reports would be biased. As well, they were a personal account and thus subject to reactivity. Hopefully, the advantages identified outweighed the limitations.

The Faces II provided information on family status according to the pre and post treatment scores. The scores are then averaged to provide one score for parents and one for adolescents. The changes

which occurred in the family status of the four case families reported appear in Table I (see following page).

The Faces II scale also provided a measure of the family's satisfaction with their perceived functioning as compared to their ideal functioning. By the end of treatment, ideally, the family should move closer to their perceptions of the ideal family.

TABLE I

FACES II DIAGNOSES

NAME	PRETEST PERCEIVED DIAGNOSIS	POST TEST PERCEIVED DIAGNOSIS
PHILLIPS FAMILY	Rigidly Disengaged	Flexibly Separated
ANDREUS FAMILY		
	<u>Parents</u>	
	Rigidly Separated	Structurally Separated
	<u>Adolescents</u>	
	Rigidly Disengaged	Structurally Separated
THOMSON FAMILY	Rigidly Disengaged	Rigidly Disengaged
MARTIN FAMILY	Structurally Connected	Rigidly Separated

CASE STUDIES

THE PHILLIPS FAMILY

Background Information

This young family presented to the Psychological Service Centre on their own. Roman was a 33 year old farmer and grade five school teacher and Colleen was a 32 year old school teacher. They had two children, Rena aged 10 and Joshua aged 7. Joshua was the initial reason for the contact with the clinic. He was experiencing behaviour problems at home and at school (hyperactivity) and it was suggested to the parents to seek counselling. In the initial interview with me, they described themselves as having family difficulties, constant arguments between the two of them and with the children. The parents seemed unable to agree together on routines and values to be followed. They had poor control over their children and experienced tremendous tension between themselves. This family was seen by this student for 12 sessions. They worked hard and made major gains, however, they terminated prematurely due to seasonal demands of the farm. They were encouraged to return in the fall.

Pre-treatment Structural Assessment.

This was a disorganized disengaged family with a lack of clear hierarchical organization. Generational boundaries were weak;

father frequently entered into the sibling subsystem in his lack of commitment to the marriage and the family, and executive functions of the parental subsystem were not carried out.

The marital subsystem boundaries were weak and the conflict between the parents is detoured through the parental subsystem, (through their roles as parents), rather than being dealt with in the marital subsystem where it belongs. This represented itself in the lack of consistency in limit setting because of their own disagreements. This allowed them to avoid dealing with the unresolved tensions between them.

Treatment Goals:

1. To strengthen the executive functions of the parental subsystem by helping the parents establish and follow through on rules and consequences.
2. To strengthen Roman's personal boundaries by validating him as a parent and helping him negotiate on an equal basis with his wife.

Interventions

1. To align with Roman and support him in his efforts to take charge of the children.
2. To reframe for Colleen that she requires a break from disciplining the children.
3. To direct Roman and Colleen to talk to each other forcing

them to continue until they have successfully negotiated agreements.

4. To challenge their dysfunctional pattern in which Colleen attacks and Roman withdraws.
5. To reframe Colleen's pattern of over controlling Roman, as her tremendous mothering instinct.
6. To challenge Roman's pattern of organizing his wife to take over for him.
7. To help parents to see that they must be the leaders of the family, and assure them that following through on rules and regulations will not result in their being disliked by their children.

Brief Summary:

Working with this family was very exciting. The parents were motivated and willing to work hard. Errors on my part resulted from my tendency to move them ahead too quickly, an overload of stress was immediately visible in the children.

Although this couple moved forward a great deal in terms of parenting issues they were not ready to confront their major relationship issues. Roman readily accepted a one down position as he tended to be overpowered and overcontrolled by his wife. They functioned more effectively as equals with relation to parenting, but not yet as partners. The family appeared for treatment at this time because of the concern for Joshua's functioning in addition to

Colleen's desire to add another child to the family.

Post Treatment Structural Assessment:

The family was now more engaged. Roman was re established in the parental subsystem and functioned on an equal basis with his wife around parenting. A clear power hierarchy had been established and there was a great deal more order and structure in their lives. The parents had not yet established clear boundaries around their marital subsystem. Conflict still continued, to a lesser degree, to be detoured through the parental subsystem with Joshua's acting out behaviour at home.

Faces II Scale Scores and Diagnoses

Pretreatment:

Family Diagnosis: Rigidly Disengaged

Scores: Cohesion 56

Adaptability 42

Individual Scores:

Roman - Rigidly Disengaged

Scores: Cohesion 56

Adaptability 38

Colleen - Structurally Disengaged

Scores: Cohesion 56

Adaptability 49

Post Treatment:

Family Diagnosis: Flexibly separated

Scores: Cohesion 63

Adaptability 50

Individual Diagnosis:

Roman - rigidly separated

Scores: Cohesion 60

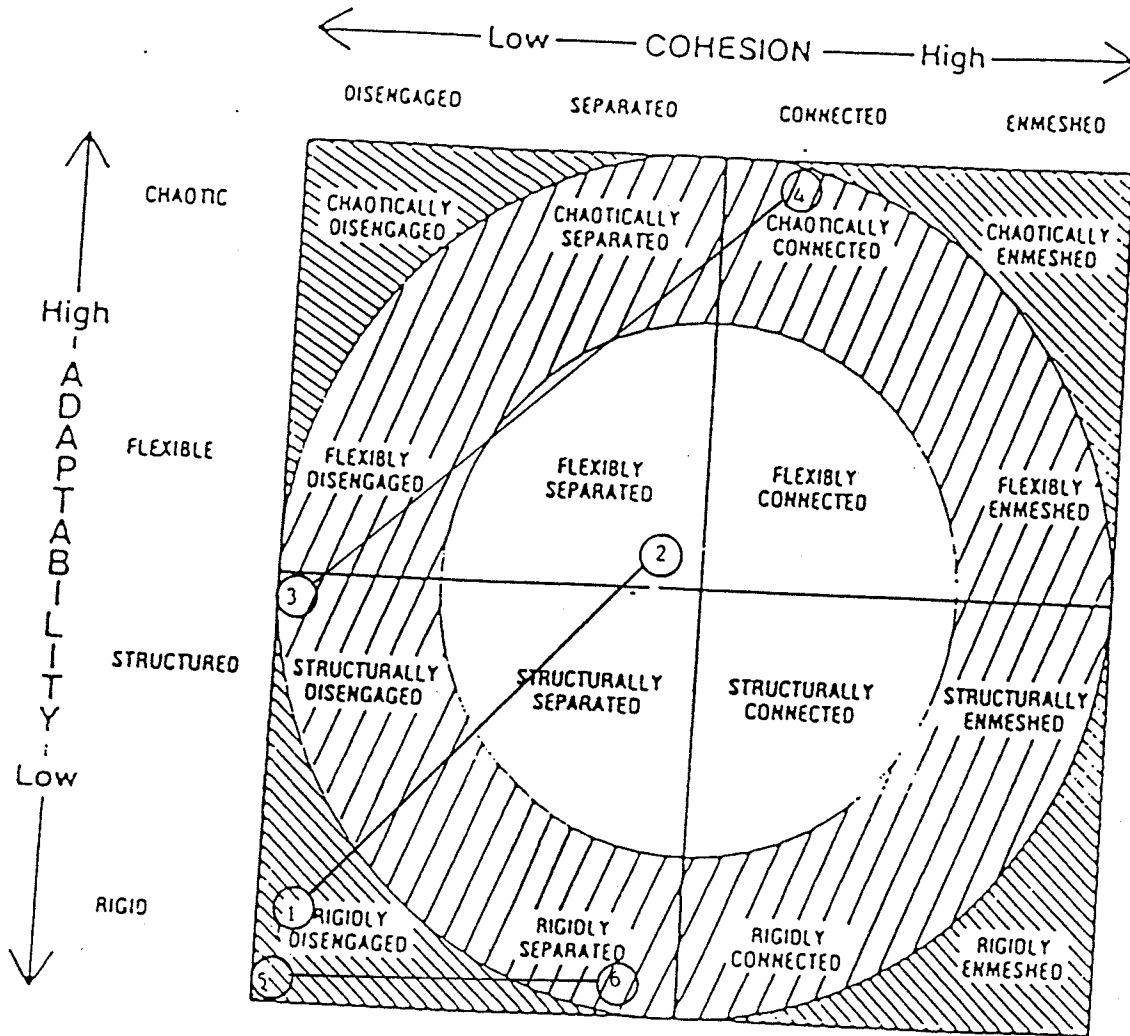
Adaptability 43

Colleen: Chaotically connected

Scores: Cohesion 67

Adaptability 57

FIGURE 1. CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



BALANCED
 MID-RANGE
 EXTREME

FAMILY
 1 - Pretreatment
 2 - Post Treatment

INDIVIDUAL
 3 - Wife - Pretreatment
 4 - Wife - Post Treatment
 5 - Husband - Pretreatment
 6 - Husband - Post Treatment

This family diagnoses indicated change on both dimensions, a much greater ability to adapt to stress and increased connectedness among family members. However, investigation was important with respect to the larger gains in adaptability, moving two levels from their initial position. A closer examination of individual scores in the context of the therapy interventions and the underlying family dynamics helped to explain this.

At the beginning of therapy the dynamics of this couple's relationship was one of the wife in the more powerful position with the husband experiencing himself as one down. Therapy challenged this dynamic supporting the husband to assume a more equal position with his wife. Unfortunately, this couple terminated therapy prematurely and the changes which had occurred in therapy had not stabilized. This was most clearly reflected by their post treatment scores. Colleen perceived the family to be in chaotic range of adaptability, a reflection of a non-traditional, wife dominant power structure (Spreakle and Olson, 1978).

This was likely a reaction to the interventions, a common clinical occurrence, where an attempts are made to return to the status quo before change can be accepted and integrated.

Roman in his non-acceptance of this power structure, as indicated by his rigid (authoritarian, traditional power structure) pre treatment score which he demonstrated by passive withdrawal and lack of involvement, accommodated more readily to the therapy interventions and moved to a less rigid position, being only one

point away from a structured level.

Therefore, this family had not stabilized at a flexible level of adaptability and was still in the process of instability with the major dysfunctional pattern challenged. With respect to the cohesion dimension, Roman demonstrated less movement on this dimension than Colleen.

This was a realistic perception of the difficulties ahead of him in striving for equality in the relationship. Colleen on the other hand, perceived greater emotional closeness. This was likely due to the fact that, in spite of her wish to return to the status quo, she was aware of his increased commitment to the family and the support that offered her. She, therefore, perceived the family as connected.

THE ANDREUS FAMILY

Background Information:

This family of five was referred by the mother because the fourteen year old daughter Georgina became actively involved in a Punk-Rock movement, and drastically altered her appearance. The father, Frank, aged 45 was an insurance agent and the mother, Rhoda, aged 40 was a homemaker and assisted in the insurance company. The other two children were Angela aged 13, and Tara aged 7. I saw this family for 16 sessions. They progressed fairly well throughout the sessions and they felt satisfied with their progress.

Pretreatment Structural Assessment:

In this family father was disengaged and mother was enmeshed with her children. The boundaries between father and children were rigid and diffuse between mother and children. The parental subsystem functions were carried out largely by the mother and as a result she was over burdened. Husband and wife were disengaged and the daughter's symptom (her punk rock activity) was serving to bring father and mother closer together.

Treatment Goals:

1. To bring father in closer to the family to relieve his wife of some of her burdens and to get to know his

children.

2. To strengthen the marital subsystem creating clear boundaries between the parental and sibling subsystems thereby decreasing mother's over involvement and allowing the children to grow up and separate.

Interventions:

1. To enact the transactional patterns between husband and wife getting them to talk until they have successfully negotiated agreements around discipline.
2. To enact transactional patterns between father and daughter getting them to talk in order to engage them and decrease mother's over involvement.
3. To assign father the task of spending time with children one hour per week (i.e., lunch with children before their downtown outing).
4. To block the children's intrusion into the marital subsystem.
5. To assign task of husband and wife spending one hour together talking and sharing.
6. To educate and support the parents by encouraging them to allow their children more autonomy.

Summary of the Treatment Process:

A strong theme of protectiveness existed in this family. This

protectiveness, although resulting from good intentions had the destructive quality of preventing anyone from learning to tolerate and resolve conflict. As a result, conflicts in the family were submerged and successful adaptation to stress was blocked. This family was hard working, motivated and eager to please and as a result they responded well to the interventions. These largely revolved around opening up communication and raising intensity levels such that submerged issues were addressed. This freed the family to reorganize into a healthy structure. The family requested treatment at this particular point in time because of an increase in stress resulting from entering into a new developmental stage - (Carter and McGoldrick, 1980) separation and individuation of the adolescent children. The structural organization of the family and their rigidity at the time of treatment was not conducive to successful negotiation of this stage on their own.

Treatment:

Post Structural Assessment:

The marital subsystem had been strengthened, husband and wife were more supportive of each other and the wife was getting more of her needs appropriately met by her husband instead of her children. This had decreased her over involvement with the children, freeing them to attend to their own developmental needs and to individuate. The generational boundaries were being strengthened.

The daughter's symptoms decreased considerably and the family

was much more able to tolerate conflict and difference of opinion.

Faces II Scale Scores and Diagnoses

Pretreatment:

Family Diagnosis:

Parents - Rigidly separated

Scores: Cohesion 58

Adaptability 43

Adolescents - Rigidly disengaged

Scores: Cohesion: 45

Adaptability: 30

Individual Diagnoses:

Frank: Rigidly separated

Cohesion: 59

Adaptability: 42

Rhoda: Structurally separated

Cohesion: 57

Adaptability: 44

Georgina: Rigidly disengaged

Cohesion: 41

Adaptability: 30

Angela: Rigidly disengaged

Cohesion: 49

Adaptability: 31

Post-treatment:

Family Diagnosis

Parents - Structurally separated

Scores: Cohesion: 60

Adaptability 49

Adolescents - Structurally separated

Scores: Cohesion 50

Adaptability 41

Individual diagnoses:

Frank - Flexibly separated

Cohesion: 59

Adaptability: 55

Rhoda - Structurally separated

Cohesion: 62

Adaptability: 44

Georgina: Structurally Separated

Cohesion: 50

Adaptability: 41

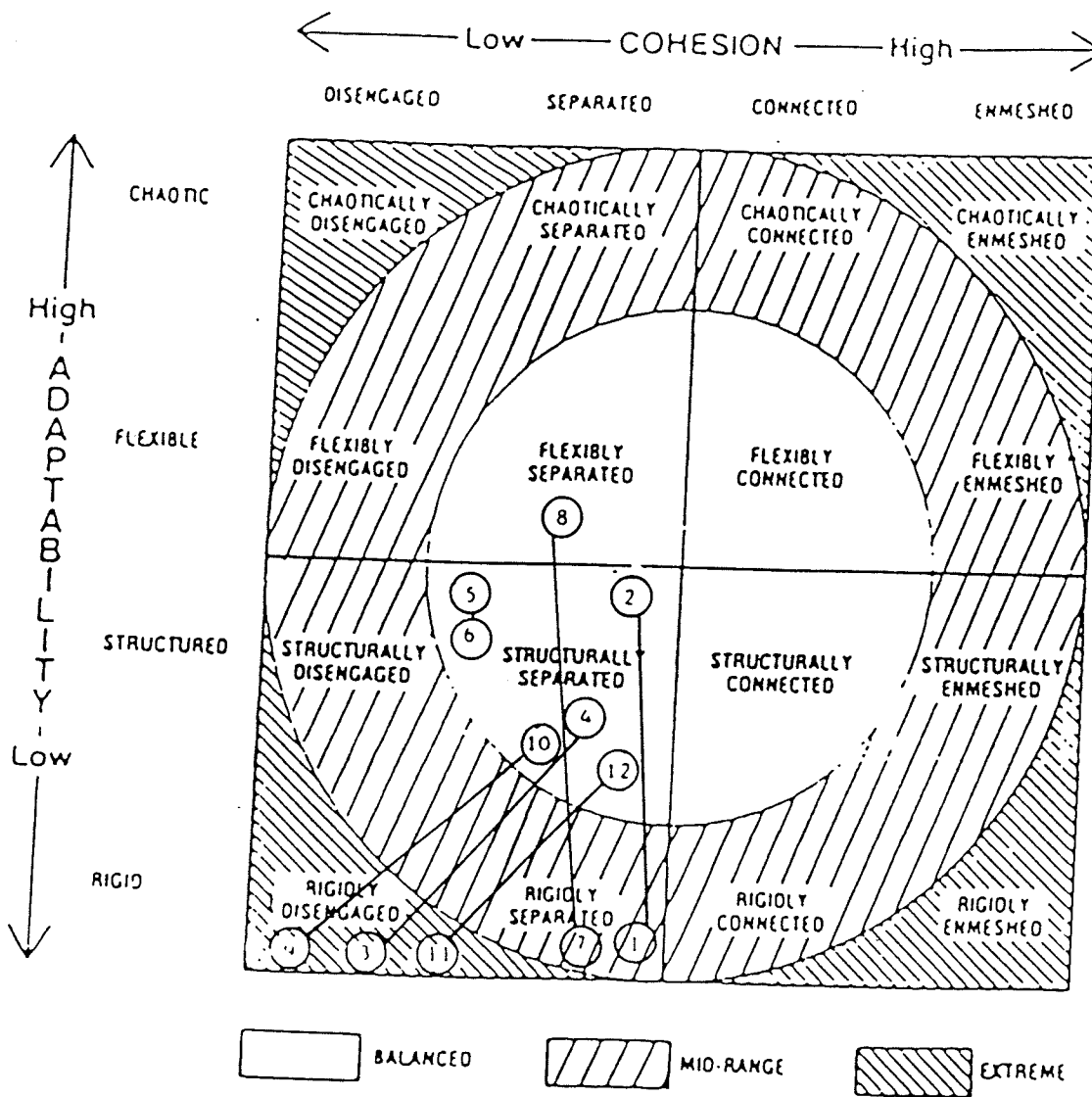
Angela: Structurally Separated

Cohesion: 50

Adaptability: 42

THE ANDREUS FAMILY

FIGURE 1. CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



FAMILY

- 1 - Pretreatment Parents
- 2 - Post Treatment parents
- 3 - Pretreatment Adolescents
- 4 - Post Treatment Adolescents

INDIVIDUALS

- 5 - Wife - Pretreatment
- 6 - Wife - Post Treatment
- 7 - Husband - Pretreatment
- 8 - Husband - Post Treatment
- 9 - Daughter - Pretreatment
- 10 - Daughter - Post Treatment
- 11 - Daughter - Pretreatment
- 12 - Daughter - Post Treatment

This post treatment family diagnosis indicated that the family moved to being more adaptive in their response to stress and were now more closely connected emotionally. The structurally separated diagnosis for both the parents and the adolescent was appropriate given their life stage; the adolescents had moved toward successfully negotiating the separation - individuation.

In reviewing the individual scores it appears that there was a reversal in the parents' perception of adaptability. Pretreatment, the mother was the more flexible of the two; post-treatment, it was the father. Likely this was a result of their teamwork, one balanced the other, as the father increased, the mother decreased.

The large amount of movement the father experienced, moving two levels from rigid to flexible was likely the "pendulum swing effect". As he relaxed, he became more involved with the family and, not being the disciplinarian, he perceived himself as a great deal more flexible. With time he may settle in at a level more congruent with the rest of the family (structured level).

The Faces II Scale diagnoses did not reveal the enmeshed subsystem of mother and children which was revealed in the pretreatment structural assessment.

THE THOMSON FAMILY

Background Information:

This single parent family of three was referred by their physician. The mother Linda, aged 37, had called following up on the physician's referral for counselling. The two children were Erica, aged 9 and Roberta aged 7.

Linda was separated and trying to manage a job and her two daughters on her own. She described herself as nervous and depressed and was experiencing great difficulties with her children. She frequently felt out of control and would end up screaming and swearing at them. She felt the girls had suffered because of her separation and that they needed increased affection, and thus, she was uncomfortable about invoking disciplinary measures. Roberta was having difficulty with her school work and with peers.

I saw this family for seventeen sessions, six of which I met with Linda alone and eleven were held with the children.

Pretreatment Structural Assessment:

This was an enmeshed family with weak generational boundaries. Mother was poorly differentiated with diffuse personal boundaries. She looked to her children for support and saw herself as unable to take leadership and to control them. Her difficulties with her children served the purpose of distracting her from her own difficulties and pain.

Treatment Goals:

1. To strengthen generational boundaries by putting mother in charge of her children.
2. To have Roberta begin to do homework assignments.
3. To have Roberta sleep through the nights.
4. To help Linda strengthen her boundaries and develop a firmer sense of herself by taking ownership of her pain in order that she was able to recognize her competence.
5. To help Linda develop a support system so she was not using her children for support.

Intervention:

1. To support her to take charge of her children in the sessions so she could experience success in this area.
2. To develop a plan to get Roberta to do her homework even if that required supervision in the beginning.
3. To take a problem solving focus around problem behaviours with her children. Help her define rules and consequences.
4. To support her to help Roberta sleep through the night.
5. To give her permission to feel weak and scared and support her in her pain, helping her to take ownership.
6. To assign her the task of doing something for herself with friends to help her develop a support network.

7. To explore how she makes herself feel incompetent and out of control.

Brief Summary of the Treatment Process:

In the early sessions, the focus with this family was on management of the children. As Linda experienced increased success in feeling able to control the girls she became free to enjoy them. As she became more competent with her children, she began to become aware of the conflict and pain in her own life. At this point, the previous contract around behaviour management was redesigned to focus on her personal issues, while the support around her children was continued. She was able to talk quite openly about herself. In the beginning she intellectualized a good deal of the time and was also out of touch with her feelings. She resisted the need to recognize the themes in her life that contributed to her situation.

During the last few sessions, she began to experience increased difficulty with her girls again. It seemed that termination was difficult for her. I reassured her that she could contact the Centre if she felt the need to do so.

Linda's image of herself as incompetent is deeply ingrained. Linda appeared for treatment at this point in time as her separation had become a reality for her and it was clear her husband would not be returning.

Post Treatment Structural Assessment:

Linda was able to take charge of her girls appropriately by strengthening generational boundaries. However, under stress she lost control and described herself as being too lazy or forgetful. She had made a major step in beginning to take ownership for their behaviour and recognized that their acting out was due to her not following through on limits rather than her previously held belief that there was something wrong with them. She had only slightly strengthened her own personal boundaries in spite of demonstrating increased competence in a number of areas. However, she persistently refused to integrate this competency into her self image. To do so was exceptionally frightening as she saw that resulting in her being in charge of her life and therefore, terrifying, alone and separate.

Faces II Scale Scores:

Pretreatment:

Family Diagnosis: Rigidly Disengaged

Scores:

Cohesion: 52

Adaptability: 32

Post-treatment:

Family Diagnosis: Rigidly Disengaged

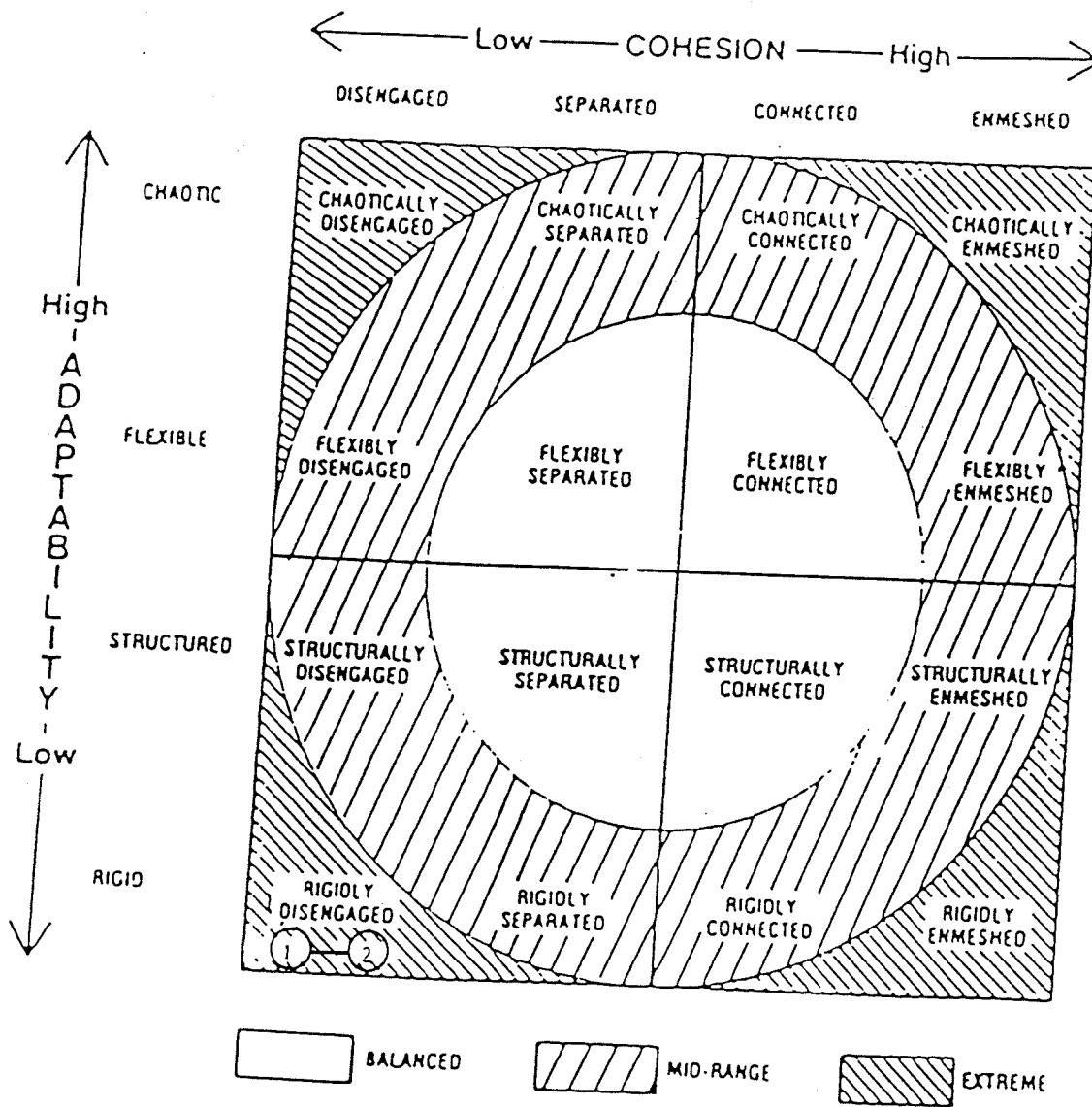
Scores:

Cohesion: 49

Adaptability: 38

THE THOMSON FAMILY

FIGURE 1. CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



FAMILY

- 1 - Pretreatment
- 2 - Post Treatment

The limited change in Linda's scores represented her difficulty with integrating this competency into her sense of herself (while the therapist perceived areas of increased competency). Although the scale indicated Linda as disengaged with her girls she was assessed as enmeshed with her girls because of a tendency to fuse with them due to a lack of personal autonomy.

The fact that Faces II scale is not designed to handle single parent systems may account for this score.

THE MARTIN FAMILY

Background Information

This reconstructed family of four was referred by the mother. At the time of the referral, Mary aged 30 and Paul aged 32 had been living together for one year with Mary's two children, Jonathon and Jeanine. The presenting problem was a difficulty with Mary's son Jonathon. Mary and Paul were concerned about Jonathon's acting out behaviour at home and at school. Mary shared custody of her two children with her exhusband. Mary and Paul both felt this arrangement was destructive for Jonathon because of a lack of discipline at his father's and because Norman involved Jonathon in his fight with Mary. This distressed the boy. Mary and Paul had begun out-of-court negotiations to help limit Norman's access to the children, however, they were unclear about how to handle Jonathon now. I saw this family for five sessions with the children and for the remaining ten sessions with the parents alone. They made slow but significant progress.

Pretreatment Structural Assessment

Jonathon was triangulated in two ways, between Mary and her exhusband Norman, and between Mary and Paul. Mary continued to be angry and through Jonathon she kept the fight going with Norman. The boundaries of the new marital subsystem were weak and the covert conflict between Mary and Paul was detoured through the parental

subsystem. They fought about parenting issues rather than the real issue between them in their marriage. Mary and Paul were aligned in unequal positions, each alternately functioning as parent or child in a circular pattern of interactions; she appeared helpless, he approached and then soon became over controlling, she attacked critically, he withdrew, she begins to appear helpless, he approached and so the vicious circle continued.

Treatment Goals:

1. To help this couple learn to negotiate agreements effectively rather than criticize each other through their parenting. By working out issues with her present relationship, she would be able to separate from her first husband.
2. To strengthen the marital relationship by realigning Mary and Paul in more equal positions.
3. To allow Mary and Jonathon to continue their relationship without Paul's interference.

Interventions:

1. To put Mary in charge of disciplining Jonathon. If she would like assistance she was to ask Paul, but he was to coach and support her only and not step in and take over.
2. To have Paul wait and allow Jonathon to come to him rather than pushing himself on the boy.

3. To reframe their marital problems supporting the love and caring in their relationship while defining their problem as a difficulty with problem solving.
4. To focus on changing the major dysfunctional pattern in which she attacked him and then he withdrew. Align with Paul to support him to stand up to his wife in order that they learned to negotiate and resolve the differences between them.

Brief Summary of the Treatment Process

This couple presented as the perfect loving couple experiencing difficulties only because of Jonathon's father. They rigidly held to this view of themselves and as their conflict began to emerge, they began to come late to sessions and cancel. When I gently confronted them about this, they rationalized their behaviour. It was a painful struggle that they totally denied. Once I reframed their problem as simply a difficulty in problem solving together, they seemed more able to tolerate the stress. Thus, it was important to proceed at a slower safer pace with them. Their extreme difficulty in acknowledging conflict hindered their progress and they only began to make progress once this conflict was acknowledged.

This couple appeared for treatment at this particular point in time because the "halo" of their relationship had begun to wear off

and it became clear to them that they were unable to negotiate together on how best to handle the child.

Post Treatment Structural Assessment

Jonathon was successfully detriangulated and no longer presenting problems.

Mary had established firm boundaries between herself, and her exhusband and was no longer needing to keep the fight going.

The marital subsystem had been strengthened. Mary and Paul were dealing more directly with issues between them. The major dysfunctional pattern remained the same and they would need to continue in treatment to change this and solidfy the gains they had made.

Faces II Scales Scores and Diagnosis

Pretreatment:

Family Diagnosis: Structurally Connected

Scores: Cohesion 70

Adaptability 49

Individual Diagnosis:

Paul - Flexibly Connected

Scores: Cohesion 72

Adaptability 51

Mary - Structurally Separated

Scores: Cohesion 69

Adaptability 48

Post Treatment

Family Diagnosis: Rigidly Separated

Scores: Cohesion 65

Adaptability 42

Individual Diagnosis:

Paul - Structurally Separated

Scores: Cohesion 65

Adaptability 45

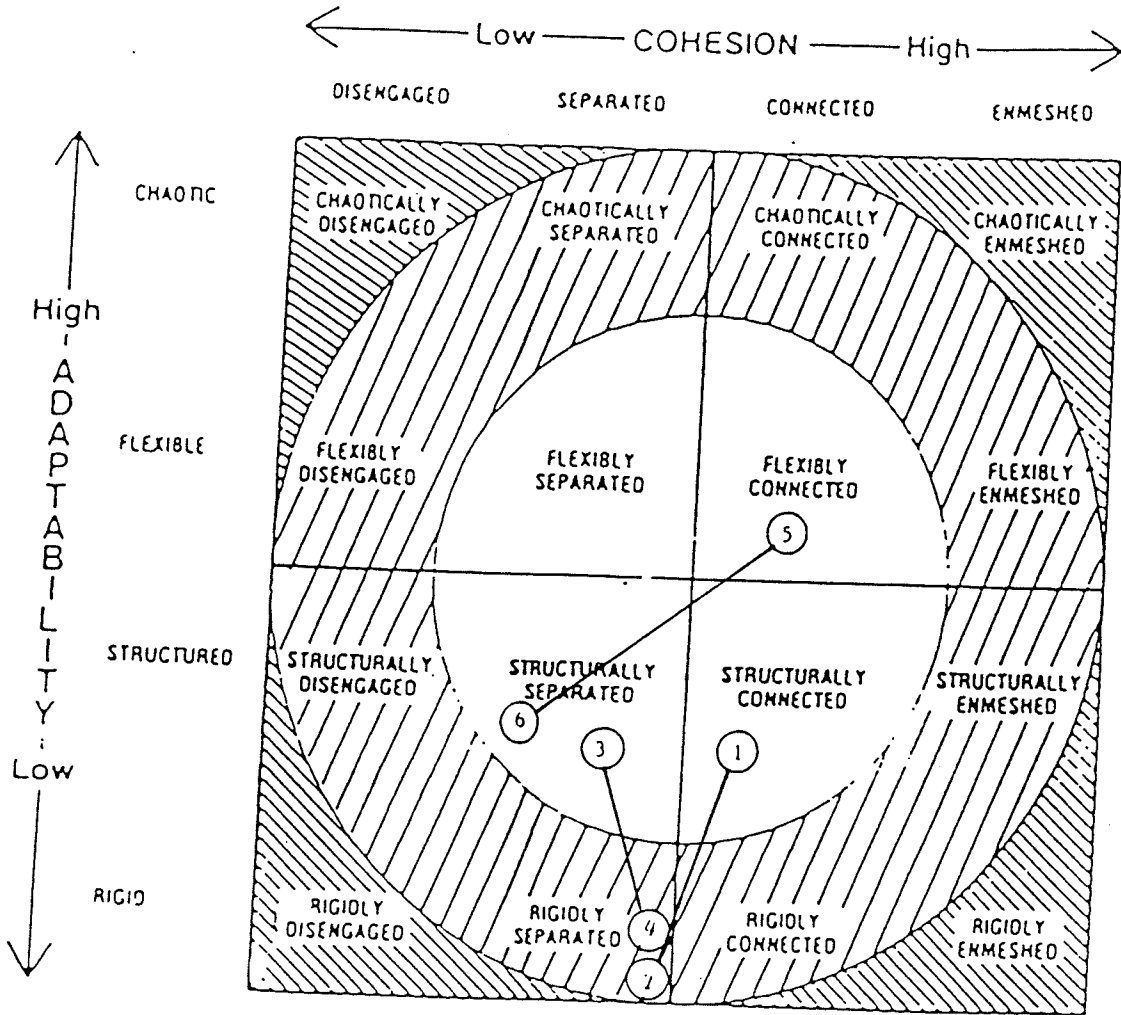
Mary - Rigidly Separated

Scores: Cohesion 65

Adaptability 38

THE MARTIN FAMILY

FIGURE 1. CIRCUMPLEX MODEL: SIXTEEN TYPES OF MARITAL AND FAMILY SYSTEMS



BALANCED
 MID-RANGE
 EXTREME

FAMILY

- 1 - Pretreatment
- 2 - Post Treatment

INDIVIDUALS

- 3 - Wife - Pretreatment
- 4 - Wife - Post Treatment
- 5 - Husband - Pretreatment
- 6 - Husband - Post Treatment

The increased honesty and willingness to face their issues directly likely accounts for the regression on the Faces II Scale. They moved from a pretreatment diagnosis of structurally connected (an idealized account of their functioning), to one which more accurately represented their position - rigidly separated.

Mary described her perception of adaptability as considerably more rigid than Paul at post treatment. This very much characterized Mary, when angry as she was at her husband at post-test, she became increasingly reactive and very rigid.

There were a number of factors explaining the lack of measured positive change in this family. The main factor being that treatment was not complete and further therapy was required. A second factor was that a change in dimension level involved considerably large and considerably stable changes in the family organization. This family had begun to change but the changes were not large enough or permanent enough to be reflected as a positive change in dimension level when the post test was administered. A third reason was that for this family, treatment became largely a process of helping them to work through their denial and defensiveness in order that they were able to acknowledge and hence to work on the difficulties they were experiencing.

Upon fuller acknowledgment and confrontation of the major issues in their family life, this family experienced a regression. This can be understood as an example of a commonly noted clinical phenomenon; that is, the tendency for a high stress period to

follow the lowering of established dysfunctional defenses (Fossum and Mason, 1986).

Reflections on Case Studies

The narrative style of the case studies attempts to portray the uniqueness of each case and qualitatively describe the changes occurring.

They also demonstrate the difficulty in accurately quantifying change through the use of self-report scales. In the writer's opinion, the FACES II scale, as an evaluative measure, did not always accurately reflect the families' functioning on the two dimensions. There was a difficulty with the self-report measure in that it was a general and subjective assessment based on the individual's perception and it was not always equivalent to an objective assessment (Olson et al, 1979). Families often idealized their functioning and as well, social desirability seemed to be a or with families responding in ways that were more socially acceptable than accurate.

Finally, a number of factors appear to be influential in affecting the amount of change experienced by a family. It would appear that therapy over a six-month period does not allow adequate time for sufficient change to occur. Another factor affecting change is the rigidity of the family system, that is, how long the problems have existed and how able the family is at the beginning to develop alternative patterns of functioning. Included in this work

is the family's ability to look at themselves openly and honestly and acknowledge their difficulties. If these are difficult processes, change is delayed. A third factor seems to be related to the strength of the personal boundaries of members in the system.

As a training therapist, the writer was not always able to discern what a family needed, and intervene accordingly. Some families were able to tolerate mistakes made, having better defined personal boundaries whereas others reacted negatively becoming more resistant to the process of therapy. The results from these families do seem to indicate that the intervention of family therapy has an effect in that it produces change in family functioning.

Reflections on FACES II

As an assessment tool during family therapy FACES II scale contained strengths and limitations as an evaluation measure. The FACES II scale was specifically developed to measure the cohesion and adaptability of family members. It also provided individual scores which were averaged to provide a family score which was then plotted on the model to determine the family type. In terms of its strengths the FACES II scale was easy to obtain. The questionnaire form and answer sheet was easy to photocopy to obtain the numbers required. It was also easy to administer, being a paper and pencil test, and time efficient as most respondents completed it within twenty minutes. The wording was simple and easy to understand - even by a twelve year old. It was simple to score and provided a

wealth of information in terms of a score for how families perceived themselves, and a second score for ideally how they would like to be. These scores related to the two dimensions, cohesion and adaptability. It also reflected changes that occurred during treatment in comparing pre and post test scores. Finally, in evaluating the families the scale was systemic in that it focused on and described systems properties of families. The circumplex model, for which the scale was specifically developed, was found to be a useful one for assessing families. It was relatively comprehensive and examined sixteen variables of family functioning. The two core dimensions of cohesion and adaptability appear to be well grounded in family therapy theory as they have been identified from the work of leading family theorists. The model was clear and direct in describing families. However, literature concerning the model was confusing to obtain as it was scattered through a number of various journals and books.

In terms of limitations in the use of the scale, it was time efficient in its administration. However, there were some organizational difficulties arising from the design of the answer sheet and its questioning style which left respondents confused and caused some errors. The respondent's task could be facilitated if the scale contained 60 items of 2 parts in which the wording in Part II was consistent with the wording in Part I, i.e.,

PART I - Family members are able to say what they want, now.

PART II - Ideally, I would like family members to be able to

say what they want.

In addition, with respect to the answer sheet, due to the way the columns were shaped, mistakes were made in that respondents answered vertically rather than horizontally. Perhaps fewer errors could result if the numbers read horizontally, with Part II placed underneath, rather than beside Part I.

Issues of universality of the scale arose, specifically in terms of families with young children as many questions were inappropriate for such families. In addition, it was stated by the authors that the items were not designed to assess single parent systems.

Another limitation was that the scale, while presenting an overall diagnosis of the family system, failed to provide an account of the richness and complexity of the family and all its subsystems. Looking at the individual scores of family members and comparing pre and post-test scores did not adequately accomplish sufficient description of the different subsystems.

Finally, with regard to the structural family therapy intervention, crucial information regarding boundaries (internal and external) and personal autonomy which were key to the system's complexity were not adequately assessed by the scale and thus presented limitations to the trainee using this framework.

TRAINING ISSUES

As this writer is involved in a training capacity in her workplace, issues related to the training of family therapists in structural family therapy were of special significance. Issues to be discussed in this chapter are: commitment to theory and practice of family therapy, supervision, supportive settings, method of learning, special issues of women training as family therapists, inherent risks and drawbacks of learning new skills. It is intended that this chapter will expand the reader's awareness of these issues involved when learning the theory and practice of Structural Family Therapy.

Commitment to Theory and Practice

Essential to the learning of structural family therapy is a commitment to theory in the early stages. Minuchin and Fishman (1981) both agree that integration of practice and theory can only occur when a student has begun learning theory and has the opportunity to observe practical applications. One's own personal style is also developed as the learning continues. This continuity can assist in the commitment to skill development and theory.

Beginning therapists can become frustrated if the rules of the model are so unclear and vague that only advanced clinicians can integrate them. The student committed to structural family therapy model can develop the skills necessary to effectively practice it

while still remaining open to a consideration of new developments and ideas in other theories which when incorporated, can enrich the effectiveness of the clinician.

The use of self is a key component of the commitment to family therapy. Structural family therapy requires that the therapist use her own personality in the dual role of participant and observer vis a vis the family system, moving in and out in accordance with the therapeutic needs of the family. The therapist must be able to move unrestricted emotionally within the family with the ability to use the caring, nurturing parts of her personality as well as the tougher, controlling parts appropriately. This can only be achieved by an understanding and commitment to theory and practice on the part of the trainee.

Supportive Settings:

Most clinicians can understand the need to have a supportive setting. Although family therapy is becoming more popular and accepted among many practitioners and settings, most clinicians trained in individualistic oriented schools of thought maintain loyalties to these areas. There is much apprehension and skepticism about family therapy because it can be considered in direct opposition to most individual approaches. The family therapy trainee can experience this lack of support or resistance from co-workers or supervisors which can rapidly lead to feelings of alienation, exhaustion, and can undermine feelings of self-esteem.

On occasion, this student experienced many of these feelings as she struggled to integrate theory and practice.

Anderson and Stewart (1983) suggest that family therapists and beginning students who find themselves faced with such settings adopt the following strategies in keeping with those used in dealing with resistant families. These include: enter the system through the existing power structure, avoid power struggles, offer help to other staff, bring up family issues at every opportunity, avoid the use of family therapy jargon, present cases utilizing family therapy to demonstrate effectiveness and avoid evangelism. The above authors also suggest that clinical staff are likely to respond with resistance to the over zealous family therapist and must be sensitively approached. A lack of genuine sensitivity to this resistance can seriously impede the students growth and development.

Supervision:

Supervision needs to emphasize the importance of theory, technique and the trainees own experiences when teaching the Structural Family Therapy Model. In supervision, it is the task of the supervisor to act as a director in leading the student in planning and applying interventions that re-establish the appropriate structure (McDaniel et al, 1983). McDaniel suggests that the Structural Family Therapy Model is the most helpful for beginning family therapists because it has a straightforward approach to the teaching of family structure, the application of

basic and concrete techniques and where the supervisor serves as the director in actively leading the trainee. This allows the trainee to obtain a clear picture of what the model holds and how she can apply it.

The supervision of trainees using this model can be described in terms similar to the therapeutic process. As the trainee becomes more competent and confident in her work, the supervisor takes on a different role with the trainee, yet maintaining ultimately responsibility for what goes on in the session.

If a healthy trusting relationship has been developed between the supervisor and the trainee, the trainee can begin to challenge the supervisor in ways which strengthen her skills yet allow for continued direction by the supervisor. If a student is made to feel she is dependent on the supervisor for all direction and ideas, her development may be slower. In the extreme, it may develop into one of anger and rebellion against the supervisor which limits growth and competence.

The essential work of the supervisor is helping the therapist stay focused on and able to change the dysfunctional interactions as they develop in the session.

The subsystem of supervisor and trainee is essential for the resolution of transactional problems which can assist the family in therapy. Clear boundaries are established between the supervisor and student as there is often a mirror or tape separating them. The interventions directed by the supervisor to the trainee can also

create a hierarchy between the supervisor and trainee which works to maintain clear boundaries between the supervisor, the trainee and the family. The role of supervision can not be undervalued as it leads to clear transmission of theoretical concepts resulting in competent and compassionate family therapists which can only result in improved services to families.

Minuchin (1981) recommends video taping sessions, small training groups and live supervision as necessary methods of training therapists. Although there are many methods available, a combination of supportive yet challenging maneuvers on the part of the supervisor, in addition to a sufficient number of treatment families must be available to the student.

In addition a "family of origin focus" based on Murray Bowen's early work in therapy has been recommended by Braverman (1984) and Freeman (1981) as another major learning method. The writer was particularly fortunate to participate in three family of origin workshops by David Freeman focusing on differentiating from one's family of origin during the course of the practicum. This focus is particularly important in the understanding of the extended family. The basic theoretical assumption is that every person has some degree of unresolved emotional attachment to their personal family. This concept must be understood by clinicians as the concept of differentiation, both as something which occurs within people and the way people function in relationships. These differentiations can only be understood on a continuum with the most undifferentiated

and the most differentiated at opposite ends. This differentiation refers to an individual's awareness of their intellectual and emotional determination as well as the degree to which they have some choice over their own behaviour.

The acquisition of expertise may take years and it may be very difficult to obtain the training necessary to achieve a high level of competence. Agencies may be open to allow family therapy practises in their settings but not the available resources to train them further or allow them training elsewhere. The opposite may occur as well where agencies may have competent qualified staff but not the ability to provide adequate time allotments to trainees. The cost of training may also be so high that students have difficulty acquiring the funds needed to pay for training. It is this student's experience that the cost of training in terms of time, energy and funds was high.

Support Groups

Initially many of the difficulties of learning and using family therapy can be reduced if the beginning family therapist is involved in a support group. This group can be made up of peers within the agency or a group of professionals with similar learning and practice goals. Working as a "loner" without a support group can be unproductive and emotionally costly. Minuchin (1981) recommends small groups in training of five to eight, but larger groups may be formed with clinicians who have had previous training and experience

and may not need as high levels of support and direction as beginning therapists. Of key importance in a support group is the maximization of learning conceptual and executive skills.

Because of the high degree of emotional involvement demanded in family therapy and because of the complexity of some of the problems which confront the therapist, support is necessary for most therapists.

This writer was fortunate to participate in a number of separate support groups during the course of this practicum. Of particular value were several workshops that the writer attended which were conducted by George Enns dealing with the theory and practice of structural family therapy. The writer found these experiences to be extremely enriching. Opportunities existed to reinforce theoretical concepts and apply these in a practical setting. In a supportive atmosphere members were encouraged to exchange ideas, information and concerns relative to the use of this model which were common to all. Mistakes were normalized and members were encouraged to continue on in their search for clarity.

Women Training as Family Therapists

A number of issues are particularly relevant to women training as family therapists. These issues include matters of authority, counter-transference, boundaries and sexual politics of supervision.

Caust et al, (1981) determined that women family therapists are attracted to the effectiveness of the structural/strategic model

because it offers them challenges to function in active, flexible and orchestrative roles.

Traditionally, women have had a history of problems in sex role training, expectations by clients and administrators as well as inherent difficulties in patriarchal institutions which impose cultural limits and expectations on women.

Family therapy today requires women to engage in activities of treatment using open and active therapeutic maneuvers. This may be in direct opposition to the way women have been socialized to behave both in their families and in their professional lives. Awareness of these issues is paramount in allowing women the opportunity to reach their full professional and personal potential.

Further research and exploration of women's issues are required in order to enhance the professional development and the effectiveness of women in the field of family therapy.

IMPLICATIONS FOR STUDENT'S PRACTICUM

The student was committed to learning Structural Family Therapy as a method of working with families. She was also fortunate to have located a supportive setting as well as a number of skilled supervisors. The student as a trainee, in a training group, was involved with a number of fellow students who were not working in similar situations in other agencies. There were discrepancies between what was being learned theoretically and what could be applied to other agency settings that were not supportive of structural family therapy. Fellow students were, in fact, struggling with settings with supervisors committed to an individual and/or child focus of treatment.

Trainees were encouraged to learn new skills which could be applied in their various settings. These skills would ultimately demonstrate the effectiveness of a family focus as opposed to an individual focus. It was very apparent that the direction available to this student in her practicum experience and training groups led to clear transmission of theoretical concepts into practical methods. The nature of the model was helpful in its straightforward approach to the teaching of family structure as well as its basic and concrete techniques.

As the student became more confident and competent the amount of direction was reduced and this allowed for a helpful exchange of ideas.

CONCLUSION:

Structural Family Therapy

Structural Family Therapy model provides the practitioner interested in family work with a variety of methods and maneuvers based on a sound theoretical model developed by Minuchin. Human problems are viewed in relationship to the family context. Therefore, the problems are not just reduced to a diagnosis and pre-conceived treatment plan.

This model does not put forth a preconceived treatment package to family problems, rather there is an understanding of hierarchical organizational structure and transactional patterns which provides a way to view any living system.

In addition this model lends itself to empowering the family to do its job rather than giving over its functions of protection, nurturance, and growth to a clinician. Inherent in the model is the belief that the family is a dynamic organism with resources and strengths which are sometimes not available due to the organizational structure of the family. As a result of this belief, the intervention is aimed at the reorganization of the family structure not of one individual.

The task of the therapist is to assist the family members to struggle with their differences and difficulties so that they can grapple with the choices and decisions they have to make as individuals and as members of a family.

This model assists the practitioner in connecting the symptom

with its context and it provides a framework which can be applied to other systems. It provides a way of viewing and assessing what the difficulties might be or how the difficulties are maintained in that structure. In addition, this model examines how the family functions as it interfaces with other systems.

Theoretically structural family therapy is quite straight forward. Once the basic theoretical concepts are learned, it is a matter of translating these concepts into practice by learning the various techniques. There exists a dynamic quality to the model which permits a flexibility when intervening with various systems - individuals, couples and families.

This model is not a doctrine other than to see human problems within a context. Given this, it is up to the practitioner to decide on what combination of subsystems or whole units need to be seen in therapy for the purposes of creating change.

In working with this model over time, the writer began to understand the importance of viewing problems in a systemic way. As there are no villains or victims, just people caught in a vicious circle. With increased skill at assessing the structure and the transactional patterns the model began to make increased sense.

In terms of criticism, this model poorly addresses the family in its larger social, economic and political context. In ignoring these contexts the danger for the practitioner using this model is a tendency to assess the family's structure as problematic when in fact the larger culture supports its organization.

Secondly, this model pays little attention to issues specific to women, specifically issues relating to power, authority and boundaries. This appears to be in keeping with much of the family therapy literature.

People who have difficulties with living have the right to the best possible assistance. Structural Family Therapy asks individuals to struggle with their pain in a context which views human problems as having to do with their context as well as themselves.

"The therapist should be a 'healer', concerned with engaging human beings in a therapeutic relationship that focuses on areas and issues that cause them pain while always retaining great respect for their values, areas of strength and esthetic preferences. In other words, the goal is to transcend technique. Only a person who mastered technique and then contrived to forget can become an expert therapist" (Minuchin and Fishman, 1981).

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FACES II ITEMS

by
David H. Olson, Joyce Portner, and Richard Bell

1. Family members are supportive of each other during difficult times.
2. In our family, it is easy for everyone to express his/her opinion.
3. It is easier to discuss problems with people outside the family than with other family members.
4. Each family members has input in major family decisions.
5. Our family gathers together in the same room.
6. Children have a say in their discipline.
7. Our family does things together.
8. Family members discuss problems and feel good about the solutions.
9. In our family, everyone goes his/her own way.
10. We shift household responsibilities from person to person.
11. Family members know each other's close friends.
12. It is hard to know what the rules are in our family.
13. Family members consult other family members on their decisions.
14. Family members say what they want.
15. We have difficulty thinking of things to do as a family.
16. In solving problems, the children's suggestions are followed.
17. Family members feel very close to each other.
18. Discipline is fair in our family.
19. Family members feel closer to people outside the family than to other family members.
20. Our family tries new ways of dealing with problems.
21. Family members go along with what the family decides to do.
22. In our family, everyone shares responsibilities.
23. Family members like to spend their free time with each other.
24. It is difficult to get a rule changed in our family.
25. Family membes avoid each other at home.
26. When problems arise, we compromise.
27. We approve of each other's friends.
28. Family members are afraid to say what is on their minds.
29. Family members pair up rather than do things as a total family.
30. Family members share interests and hobbies with each other.



FACES II: Cutting Points

C O H E S I O N

DISENGAGED SEPARATED CONNECTED ENMESHED

PARENTS (56.9 or below) PARENTS (57.0-65.0) PARENTS (65.1-73.0) PARENTS (73.1 and above)
 ADOLES. (47.9 or below) ADOLES. (48.0-56.0) ADOLES. (56.1-64.0) ADOLES. (64.1 and above)

ADAPTABILITY

CHAOTIC PARENTS 56.1 or above ADOLES. 52.1 or above				
FLEXIBLE PARENTS 50.1-56.0 ADOLES. 45.1-52.0				
STRUCTURED PARENTS 44.0-50.0 ADOLES. 38.0-45.0				
RIGID PARENTS 43.9 or below ADOLES. 37.9 or below				

In plotting the couple or family's cohesion and adaptability scores into the Circumplex Model, try to mark the specific location within the particular type that most accurately reflects the actual scores.

NAME: _____
 FAMILY MEMBER: _____
 SEX: _____ AGE: _____
 DATE: _____
 EVALUATION: _____
 (Pre/Post/FU)
 TOTAL COHESION: _____
 TOTAL ADAPTABILITY: _____
 FAMILY TYPE: _____

	Parents (n=2,030)		Adolescents (n=416)	
	\bar{X}	SD	\bar{X}	SD
Cohesion	64.9	8.4	56.3	9.2
Adaptability	49.9	6.6	45.4	7.9

Family Cohesion Dimension: Clinical and Research Indicators

	<i>DISENGAGED</i> (Very Low)	<i>SEPARATED</i> (Low to Moderate)	<i>CONNECTED</i> (Moderate to High)	<i>ENMESHED</i> (Very High)
Emotional Bonding	Very Low	Low to Moderate	Moderate to High	Very High
Independence	High independence of family members.	Moderate independence of family members.	Moderate dependence of family members.	High dependence of family members.
Family Boundaries	Open external boundaries. Closed internal boundaries. Rigid generational boundaries.	Semi-open external and internal boundaries. Clear generational boundaries.	Semi-open external boundaries. Open internal boundaries. Clear generational boundaries.	Closed external boundaries. Blurred internal boundaries. Blurred generational boundaries.
Coalitions	Weak coalitions, usually a family scapegoat.	Marital coalition clear.	Marital coalition strong.	Parent-child coalitions.
Time	Time apart from family maximized (physically and/or emotionally).	Time alone and together is important.	Time together is important. Time alone permitted for approved reasons.	Time together maximized. Little time alone permitted.
Space	Separate space both physically and emotionally is maximized.	Private space maintained: some family space.	Family space maximized. Private space minimized.	Little or no private space at home.
Friends	Mainly individual friends seen alone. Few family friends.	Some individual friends. Some family friends.	Some individual friends. Scheduled activities with couple and family friends.	Limited individual friends. Mainly couple or family friends seen together.
Decision-Making	Primarily individual decisions.	Most decisions are individually based, able to make joint decisions on family issues.	Individual decisions are shared. Most decisions made with family in mind.	All decisions, both personal and relationship, must be made by family.
Interests and Recreation	Primarily individual activities done without family. Family not involved.	Some spontaneous family activities. Individual activities supported.	Some scheduled family activities. Family involved in individual interests.	Most or all activities and interests must be shared with family.

Family Adaptability Dimensions: Clinical and Research Indicators

	<i>Assertiveness</i>	<i>Control</i>	<i>Discipline</i>	<i>Negotiation</i>	<i>Roles</i>	<i>Rules</i>	<i>System Feedback</i>
CHAOTIC (Very High)	Passive and Aggressive Styles	Limited leadership	Laissez faire Very lenient	Endless negotiation. Poor problem-solving	Dramatic role shifts	Dramatic rule shifts. Many implicit rules. Few explicit rules. Arbitrarily enforced rules.	Primarily positive loops; few negative loops
FLEXIBLE (High to Moderate)	Generally Assertive	Egalitarian with fluid changes	Democratic: Unpredictable Consequences	Good negotiation; good problem-solving	Role making and sharing. Fluid change of roles	Some rule changes. More implicit rules. Rules often enforced.	More positive than negative loops.
STRUCTURED (Moderate to Low)	Generally Assertive	Democratic with stable leader	Democratic: Predictable Consequences	Structured negotiations, good problem-solving	Some role sharing	Few rule changes. More explicit than implicit rules. Rules usually enforced.	More negative than positive loops.
RIGID (Very Low)	Passive or Aggressive Styles	Authoritarian leadership	Autocratic: Overly strict	Limited negotiations; Poor problem-solving	Role rigidity; Stereotyped roles.	Rigid rules; Many explicit rules. Few implicit rules. Strictly enforced rules.	Primarily negative loops; few positive loops.

FACES II ANSWER SHEET



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INSTRUCTIONS: Complete Part I completely, and then complete Part II. Please answer all questions, using the following scale.

1 ALMOST NEVER 2 ONCE IN A WHILE 3 SOMETIMES 4 FREQUENTLY 5 ALMOST ALWAYS

PART I:

How Would You Describe Your Family Now?

- | | |
|-----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |
| 11. _____ | 12. _____ |
| 13. _____ | 14. _____ |
| 15. _____ | 16. _____ |
| 17. _____ | 18. _____ |
| 19. _____ | 20. _____ |
| 21. _____ | 22. _____ |
| 23. _____ | 24. _____ |
| 25. _____ | 26. _____ |
| 27. _____ | 28. _____ |
| 29. _____ | |
| 30. _____ | |

PART II:

How Would You Like Your Family TO BE?

- | | |
|-----------|-----------|
| 31. _____ | 32. _____ |
| 33. _____ | 34. _____ |
| 35. _____ | 36. _____ |
| 37. _____ | 38. _____ |
| 39. _____ | 40. _____ |
| 41. _____ | 42. _____ |
| 43. _____ | 44. _____ |
| 45. _____ | 46. _____ |
| 47. _____ | 48. _____ |
| 49. _____ | 50. _____ |
| 51. _____ | 52. _____ |
| 53. _____ | 54. _____ |
| 55. _____ | 56. _____ |
| 57. _____ | 58. _____ |
| 59. _____ | |
| 60. _____ | |

36 +
 - Sum 3, 9, 15, 19, 25, 29
 + Sum all other odd numbers plus item 30
 TOTAL COHESION

18 +
 - Sum 12, 24, 28
 + Sum all other even numbers except item 30
 TOTAL ADAPTABILITY

36 +
 - Sum 3, 9, 15, 19, 25, 29
 + Sum all other odd numbers plus item 30
 TOTAL COHESION

18 +
 - Sum 12, 24, 28
 + Sum all other even numbers except item 30
 TOTAL ADAPTABILITY