

STRUCTURAL FAMILY THERAPY: A SOCIAL WORK PRACTICUM

BY

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in Partial Fulfilment of the Requirements
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MASTER OF SOCIAL WORK

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Marie Caners

**A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University
of Manitoba in partial fulfillment of the requirements of the degree
of
Master of Social Work**

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ABSTRACT

Structural family therapy has persisted over the years and its core constructs are still taught and utilized. Understanding and acquiring a solid grasp of the concepts of boundaries, subsystems and hierarchy are important first steps in the practice of family therapy. It is a useful framework for a broad range of therapeutic techniques, whether structural or otherwise. This practicum offers an extensive literature review on the model and this forms the base from which the writer explores the use of the model with diverse families.

The writer provides a detail analysis with two of the seven families seen as part of the practicum experience. The analysis is based on an assessment model taken from the structural family therapy literature which includes a review of the following areas: the family structure, flexibility of the system, where the family falls along the continuum of enmeshed-disengaged, family's sources of support and stress, the family's developmental stage and ways the identified patient's symptoms are used for maintaining the family's transactional patterns. Evaluation of the practicum is based on the use of the FAM III, a client satisfaction questionnaire and the therapist's observations. The writer further examines emerging themes. The use of the family life cycle framework and how it complements structural family therapy, the use of a strengths based model and aspects to consider in working with stepfamilies are areas explored in the common themes chapter. In conclusion the writer reflects on her learning experience.

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I would also like to express my appreciation to all the families and young people I have worked with through this practicum and through my places of employment. By sharing your stories and allowing me to work with you, you have provided me with the opportunity to expand on my knowledge and skills as a therapist and grow emotionally and mentally as a person.

To my many colleagues and peers (there are too many to mention) your interest in my work willingness to listen and give me critical feedback, has also enriched my learning in immeasurable ways. I thank-you for your support.

This list of acknowledgments would not be complete without mentioning my family. Studying and working with families has given me the wisdom to appreciate all that you are and all that you have given me. To my nieces and nephews, without knowing it you have helped me recognize and appreciate the simple things in life. This is a gift that I carry with me in my work and in life. You are all "gems"!

DEDICATION

This practicum report is dedicated to my husband, Theo whose tremendous support assisted me in being able to reach my goal of completing my Master of Social Work. Theo, you provided me with the inspiration to work hard. Your unselfishness and words of encouragement gave me the drive that I needed to trudge along and complete my Masters. Many sacrifices were made so that I could reach this goal and I am appreciative of your understanding and patience. As we prepare to launch ourselves into a new life cycle and become parents for the first time, I look forward in learning about and adjusting to our new roles as parents with you.

Introduction and Overview

Structural family therapy is a model of family therapy that has gained wide acceptance since its inception. It is also a model from which other family therapy models have evolved. The model provides an excellent blueprint from which family dynamics can be understood and analyzed. Understanding and acquiring a solid grasp of the concepts of boundaries, subsystems and hierarchy are important first steps in the practice of family therapy. My goal in completing this practicum was to gain knowledge and skills in family therapy. Given that my experience in family therapy was limited, I choose to focus on the structural family therapy model to gain a solid base in family therapy which I could continue to build on following the completion of the practicum.

The report is divided into five chapters. Chapter one presents an overview of the literature on structural family therapy that formed my knowledge base. The practicum is described in chapter two and includes my learning objectives, a description of the setting where the practicum occurred, a brief summary of the clients seen, the procedures followed with each case, an outline of the supervision received and an overview of the evaluation tools administered in each case. In chapter three, the case analysis chapter, I present a more in depth review of my work with two stepfamilies at different family life cycle stages and at different phases of stepfamily integration. Chapter four, examines themes that emerged from the therapy process. As a conclusion in chapter five, I focus on my learning process. This includes a review of my experience in supervision and a personal critique of the structural family therapy model, the FAM III as a measure of family functioning and the client satisfaction questionnaire.

CHAPTER 1

Structural Family Therapy

This chapter is a compilation of the literature on structural family therapy. The first section explores the development of the model, in essence its history. Following is a definition of the family as described by structuralists, the basic concepts of the model (subsystems, hierarchy and boundaries) and a description of dysfunctional family structures. The goal of structural family therapy is defined, along with the elements needed to create a therapeutic environment and the techniques commonly associated with the model. The section on the applications of structural family therapy identifies family types and issues to which the model has been applied. It also includes a review of outcome studies and a critique of the model.

Development of the model

In the 1960s working with family systems, rather than focusing on individuals, was gaining wider acceptance in the therapeutic community. One of the theories that emerged was structural family therapy. Salvador Minuchin, a psychiatrist of Argentinian descent, is credited with its inception. He pioneered the therapeutic approach in his early work at the Wiltwyck School for Boys, in New York City and further developed it at the Philadelphia Child Guidance Clinic, where he became director. By the 1970s, structural family therapy had emerged as one of the most influential approaches in the field of family therapy (Nichols & Schwartz, 1994).

In Minuchin's earliest work, *Families of the Slums* (Minuchin, Montalvo, Guerney, Rosman, & Schummer, 1967), his early research on theories and techniques of

working with families are published. Aided by a grant from the federal government. Minuchin and his colleagues at Wiltwyck developed a research project to reach the disadvantaged, unorganized and impoverished families of the Wiltwyck youth, who were not responding to "the usual channels of psychotherapy, care, attention and interest" (Minuchin et al., 1967, p. 6). The gains the children made while at Wiltwyck dissipated once they returned to their families. The purpose of their research was twofold: to explore the structure and dynamics of families and to study the types of techniques and interventions to reach these families. From Minuchin's early work with impoverished families, he and one of his colleagues, Braulio Montalvo moved to the Philadelphia Child Guidance Clinic and expanded their family therapy approach to middle class families and psychosomatic families. Although Minuchin is credited with much of the early research on structural family therapy, others have also contributed to the development of the theory. They include: Braulio Montalvo, Jay Haley, Bernice Rossman, Harry Aponte, Carter Umbarger, Marianne Walters, Charles Fishman and Cloe Madanes (Nichols & Schwartz, 1994).

Structural family therapy was developed as a child orientated therapy method and in working with the socially disadvantaged. It was subsequently expanded to other socioeconomic groups (Aponte & Van Deusen, 1981). Structural family therapy's strength is its ability to describe the organizational pattern of families from which guidelines for diagnosis and treatment can be drawn. The premise of structural family therapy is that families are stuck in patterns of relating and the purpose of therapy is to "unfreeze" them from their rigid habits, leaving room for new family structures to emerge

(Nichols & Schwartz, 1994). The theory and techniques of structural family therapy approach the individual in his/her social context. Minuchin (1974) writes "man is not an isolate...He is an acting and reacting member of social groups...Man is influenced by his social context, which he also influences" (p. 2). Viewing the person as part of a social group broadens the view of pathology and increases the possibilities for intervention. Although the systems concept was not new, applying it to mental health issues was.

Structural family therapy is based on three assumptions. First, the individual influences his/her context and in turn is influenced by it. The individual is a member of a family to which s/he must adapt and in turn his/her actions are influenced by the characteristics of the system. Secondly, structural family therapy operates under the assumption that changes in the family structure will "contribute to changes in behavior and inner psychic processes of the members of that system" (Minuchin, 1974, p. 9). Thirdly, the therapist's behavior in the therapeutic setting is a significant factor in procuring change in the family structure. The therapist's role is thus to be an active participant in the therapeutic sessions. In essence the structural family therapist's role is to join with the family, use him/herself to change the system and by changing the position of the family members, their experiences within that system change. Structural family therapy is therapy in action. The aim is to modify the present circumstances of the individuals through organizational change of their context, not to explore or interpret the past. The structural family therapy model also relies on three properties of families. First, a transformation in the family's structure will open the possibility for future change. Second, given that the family is organized around its role to support, regulate, nurture and

socialize its members. the role of the therapist is to modify or repair the family's ability to meet these needs better. not to educate or socialize the family. Third, the family has self-perpetuating properties, which means that once a shift in organization occurs, it will continue to be maintained by the family's self-regulating mechanisms (Minuchin, 1974).

The family defined

Structuralists define the family as "a social unit that faces a series of developmental tasks" (Minuchin, 1974, p. 16). It is a living organism, constantly developing and adapting to a changing environment. Normality is defined broadly, accepting a wide variety of family forms. A functional family is defined by its ability to fulfill its functions and respond to developmental changes, which in turn depends on the structure and adaptability of the family.

Minuchin (1974) identifies that the formation of a family typically begins with the joining of a couple. The initial task of the couple is for each spouse to separate from his/her family of origin and negotiate a different relationship with parents, siblings and in-laws. In short, the couple must shift their loyalties from their families of origin to their relationship to their spouse. In turn, their families of origin must support and accept this break. The couple develops a set of transactional patterns, which form a set of complementary demands that regulate family situations. The couple must not only decide how the demands of the outside world will be allowed to permeate the new family, but they must also accommodate to each other's needs and demands. Each spouse brings with him/her a familiar or preferred transactional pattern, which s/he may be more or less flexible in adapting to the "newly formed" family. The couple through an

accommodation and assimilating process. develop a way of relating to one another. A boundary is formed and strengthens the couple subsystem.

The next major change in the family organization occurs at the birth of the first child. Family members must negotiate their functions to meet the needs of the infant. They also need to renegotiate aspects of the spousal subsystem. The demands of an infant not only place constraints on the time allotted to the couple, but parenting can also bring to the surface unresolved conflicts of the couple. The family undergoes a number of developmental phases throughout the lifetime of its members other than the formation of a couple and the introduction of the first child. Transactional patterns shift at these different periods of development of the family or with the introduction of new members. The family is required to adapt and restructure at these times.

The family provides the individual with both a sense of identity by belonging to a family unit and the sense of separateness and individuation by participating in different family subsystems and extrafamilial groups. The family structure is developed through repeating transactional patterns. Within a family, patterns are established, regulating family members' behavior including how, when, and to whom to relate. Transactional patterns involve the establishment of a hierarchy of power and the development of mutual expectations (Minuchin, 1974). Hierarchy of power establishes the different levels of authority in a family, such as between a child and parents, but also includes equal level of power such as between spouses. Mutual expectations are formed through implicit and explicit negotiations among family members. Structural family therapy theory perceives these transactional patterns, based on hierarchy and mutual expectations as the main

elements that maintain the equilibrium in the family system. The family resists change as long as possible and when disequilibrium occurs, the system attempts to reestablish the same level of tolerated transactions. A family system that is able to meet the demands of developmental changes, requires a wide range of alternative transactional patterns and needs to be flexible enough to mobilize them when needed.

Subsystems, hierarchy and boundaries

Structural family therapy has progressed over the years, but the main components of the theory have remained constant. They include the notions of subsystems, hierarchy and boundaries.

The structural model identifies various subgroups in a family system, through which the family's different functions are carried out. Subsystems are formed by generation, gender, interest and function. Each individual belongs to different subsystems where he/she has different levels of power and learns different skills. The husband and wife belong to the spouse and to the parental subsystems. The function of the spouse subsystem is to provide mutual support, but when dysfunctional, it can also be an area of invalidation of the individuals. Children are members of sibling subsystems. The sibling group forms the children's first peer group and where they learn to support, share, form alliances and scapegoat.

The distribution of power and the development of a hierarchy within a family system are crucial tasks in the development of the family. Hierarchical structures in a family that are excessively weak or ineffective or excessively rigid and arbitrary create family patterns that hamper individual growth and individualization. A cross-

generational coalition is a specific type of hierarchical dysfunction and occurs when spouses argue their conflict through a child and attempt to attain the child's support against the other. Chronic cross-generational coalitions have been associated with families with psychosomatic illnesses and addiction problems (Colapinto, 1983).

The boundaries of a subsystem define the rules of who participates and how. The function of the boundaries is to protect the differentiation of a subsystem from the remainder of the system. The clarity of the boundaries within a family is an assessment tool used by the structural model to evaluate family functioning. Minuchin and colleagues developed two typologies of families with dysfunctional structures based on their boundaries, now known as the disengagement/enmeshment continuum (Colapinto, 1983). An enmeshed family's boundaries between subsystems are weak and there is little differentiation and autonomy among individuals. Typical examples identified by Minuchin (1978) of enmeshment include when the parents of a diabetic adolescent know better than she/he does when she/he needs insulin and when the differences between a parent and child are mediated by the other parent, or siblings always have their arguments interrupted by the parents. The disengaged family's boundaries are overly rigid and family members are emotionally distant from one another. Families on the extreme end of the disengaged continuum have not developed their protective and nurturing functions, have failed to be mutually supportive to one another and are tolerant to deviant behavior. Members lack feelings of belonging and loyalty to the family system.

Colapinto (1982) points out that most families include both elements of enmeshment and disengagement as they are reciprocal. When an enmeshed subsystem is

created in a family, it disengages another subsystem. For example, when one parent is enmeshed with the children, the parental subsystem is disengaged. Different levels of enmeshment and disengagement are present in a family depending on where they are at in the developmental life cycle of the family.

Dysfunctional family structures

Families have pressures originating from developmental changes of their own members and from the social institutions that impact on each individual of the family system and on the family system as a whole. Families also face other stresses from such sources as an illness of a member, a move to a new community or the demands of a developmentally challenged child. Every family structure has some inherent weaknesses and it is when the family's coping mechanisms are exhausted that these parts give way (Minuchin, 1974).

Dysfunction is explained using a number of variables. The family may lack the capacity to challenge and modify patterns of transaction that are no longer meeting the needs of its members. Such an example is the family with a child reaching adolescence who needs increasing autonomy and the parents continue to deal with her/him as though s/he is a young child. Family members may be unaware of alternate ways of relating to one another or see the need to do so. Another possibility is that family members may be afraid to change or avoid conflict. Disengagement and enmeshment are two strategies of conflict avoidance. In the disengaged family, the members avoid contact and in the enmeshed family conflict is denied (Colapinto, 1983). A couple who constantly argues, but do not reach a resolution, is also engaging in conflict avoidance. Cross-generational

coalitions, where a child is used by the couple to argue their conflict through him/her, is an example of hierarchical dysfunction. The family structure in and of itself can promote symptoms. From Minuchin's work with psychosomatic families specific family structures were identified as creating categories of symptoms. Apart from the three forms of dysfunction mentioned, disengaged, enmeshed and cross-generational coalitions, he adds the family encouraging recurrent behaviors. In these families, the symptom has a regulatory role in the family. The symptom bearer is determined through the years of alliances and coalitions developed through the pattern of transactions from the family formation process. Other factors may also play an equal or stronger role in determining who the identified patient will be, such as whether a member has a chronic illness, a learning disability or circumstantial events such as a child having a bad year in school.

Minuchin (1974) highlights that in families with chronic boundary problems, triads result. Three forms of triads are recognized: triangulation, detouring and cross-generational coalitions. Triangulation results when a child is asked to side with each parent against the other. The child is in a no win situation, if s/he sides with either parent, s/he is seen as attacking the other. The second form of triad is named detouring. In detouring, the spouses reinforce the deviant behavior in the child to detour from problems in the spouse subsystem, to difficulties in parenting. This form of triad may take the form of defining the child as the source of the problem or that s/he is sick or weak and therefore the parents need to unite to protect him/her. The third form of triad involves a cross-generational coalition, where one parent joins with the child in a rigidly bound coalition against the other parent. The goal is to restructure the subsystems according to a

hierarchy where there is a clear boundary between the parental and child subsystems (Minuchin, 1974).

Goals of structural family therapy

Since structural family therapy's premise is that problems are maintained by dysfunctional family structures, therapy is directed at altering these structures. The long term goal is to facilitate growth in the family system, so that the family itself can resolve symptoms and encourage growth in individuals, while also preserving the mutual support of the family. The short term goals are to alleviate life threatening symptoms through the use of behavioral techniques, suggestions or manipulations to provide temporary relief (Nichols & Schwartz, 1994). Unless structural changes occur, the symptom resolution will be short-lived. Although every family is different, there are common problems and typical structural goals that have been identified by structuralists.

In most families, one member is identified as the problem or symptom bearer (Minuchin, 1974). The person's symptoms can be assumed to maintain the system. The symptom is reinforced by the system itself. A common goal of structural family therapy is for the parental subsystem to function as a cohesive executive subsystem. It is important that an effective hierarchy is present in a family system. Parents need to be in charge. The process of therapy takes a family that is "frozen" at a particular developmental stage and creates "a crisis that will push the family in the direction of their own evolution" (Minuchin, 1981, p. 27).

Therapy does not need to necessarily create new family structures: the family may already have developed the necessary relational patterns, but they may be dormant. If the

patterns are functional. through repetition they will be reinforced and family structure will be transformed. People change when the following three circumstances occur: their perception of reality is challenged, they are given alternative possibilities that make sense to them, and once alternative transactional patterns are tried out, these new relationships are self-reinforcing (Minuchin, 1974).

Creating a therapeutic environment

Who is involved in the therapeutic sessions depends on who shares the problem and which members of the family's ecosystem have the resources to assist the family in solving the problem (Aponte & VanDeusen, 1981). The therapist needs to strategize at every stage of treatment who to take into consideration of the family's ecosystem that could be a resource to them, as she/he disrupts, maintains and creates new structures. The therapist can decide who to work with at different times in therapy. Aponte and VanDeusen (1981) describe three types of sessions: joint, concurrent and sequential. Initially it is the rule of thumb in structural family therapy that a joint session occurs, involving all those with the problem. This allows them the opportunity to be equally aware of what is happening. The therapist may also choose to work with subgroups of the system and periodically reconvene with the whole group. Concurrent sessions are interviews the therapist conducts separately with the different subgroupings of the family and its ecosystem. The therapist meets with different group of family members, because they may not be able to negotiate directly with each other. The purpose is to assist the specific grouping to negotiate with the others, with the goal of bringing the issues forth in a joint session. Sequential sessions have to do with phases in the treatment process that

need to be resolved with one subsystem before continuing on with the entire group.

The theory allows flexibility in terms of the number of therapists on one case, which family members to include and the location, length and frequency of sessions. The length of sessions and duration of treatment needs to take into account that most structural family therapy has been undertaken with families where a child was the symptom bearer. Aponte and VanDuesen (1981) underscore that the number of sessions can vary between six to twenty, with the length of time in treatment varying from two and a half months to over a year. A significant drop out rate by families in family therapy was noted after twenty sessions or five months of therapy. The length of therapy sessions has not been reported on a regular basis, but it appears that the average length of the sessions has been one hour (Aponte & VanDeusen, 1981). Therapy is considered completed when the family "autonomously maintains the functional, restructured relational patterns" and the problem they were seeking help for has been resolved (Aponte & VanDeusen, 1981, p. 328).

The need for co-therapy in structural family therapy grew out of working with multigenerational families who were predominantly underorganized and were riddled with several problematic issues within and outside of the family system. The use of co-therapy has however diminished considerably, primarily due to the move to working with middle class nuclear families. Co-therapy has also become more rare due to the complexities of coordinating the structural family therapists' hypotheses and structural moves in therapy (Aponte & VanDeusen, 1981). When co-therapy has been practiced, there is an understanding between the therapists, that one will take the lead. Another

option is to assign primary responsibility for a subsystem to a particular therapist.

Creating a functional therapeutic environment is consistent with the concepts that are related to functional families. In a functional family, subsystems have clearly defined roles, boundaries are permeable allowing flexibility in membership that are consistent with the functions of the subsystem, transactional patterns are allowed to shift to meet the needs of the individuals and the family system at different developmental periods. Similarly therapy will allow flexibility in membership of who is involved in sessions depending on the need of the individuals and the family system. The therapist engages in different ways and enlists different techniques depending on where the family is at in the therapeutic relationship.

In *Family Therapy Techniques*, Minuchin and Fishman (1981) write that therapists need to be spontaneous in their approach with families. Spontaneity involves a knowledge of the theoretical schema of families and family transformation, but equally important is the therapist developing his or her own style. Techniques are only a guide. Therapists need to combine knowledge about families with their emotional experience and then therapy becomes healing. The theoretical constructs are learned from a deductive process, while specific skills are transmitted inductively, through an apprenticeship process.

Structural family therapy techniques

The techniques involved in structural family therapy are categorized either as joining or accommodating and restructuring. Joining and accommodation are prerequisites to restructuring. The therapist must first understand the problem from the

family's point of view and only then can the therapist reframe the family's formulation based on his/her knowledge and understanding of family structure. However joining and accommodating occur throughout therapy and are interwoven in the restructuring process. Assessment of the family structure and testing of the hypotheses occur after a period of joining but also occur throughout the therapeutic encounter.

Joining and Accommodating

Joining involves the therapist directly relating to family members or the family system. The therapist in the joining process takes the role of leader. It is an important initial first step to therapy but is also necessary throughout the therapeutic process. If the therapist has not successfully joined with the family, it will be difficult for him/her to challenge the family, while maintaining the role of leader and the family's continued participation in therapy. Accommodation is the therapist's adjustments in order to successfully join with the family and involves accommodating to the family's tempo and style. The therapist's role is to join and accommodate to the family, but s/he must also be able to disjoin and then rejoin in a different way. The joining process is described as an attitude rather than a technique. Therapy involves the therapist using different levels of involvement depending on her/his personal characteristics and the characteristics of the family. This use of self is a powerful tool in changing families and the therapist must be knowledgeable of her/his repertoire of joining. Minuchin (1974) describes three techniques of joining: close, median and disengaged positions. The therapist uses these three positions in the joining process to support the family's reality or to construct an expanded view that will allow flexibility and change.

In the close position, the therapist searches out positives and recognizes and rewards them. S/he becomes a source of self-esteem to family members. She/he also acknowledges areas of pain, difficulty and stress. The therapist's comments are an acknowledgment of her/his understanding of the family's message. Developing a close position with the family gives the therapist leverage in the therapeutic process. She/he can withdraw her/his approval if clients are not following her/his lead. In the median position the therapist joins as an active, neutral listener. The therapist listens to and encourages members to make contributions and asks for clarifications and expansions. Through the means of the tracking technique, where the therapist follows the content and the process, she/he obtains information about the family structure. Do family members communicate without interrupting each other? Do they act in age appropriate ways? Do they organize each other's behaviors? How does the family deal with conflict and do they avoid it? What alliances do they form and with whom? The structural therapist takes note of the nonverbal interaction that takes place within the session to form an assessment of the family structure. Tracking is known as an accommodation technique, where the therapist asks clarifying questions, makes approving comments or elicits amplification of a point (Minuchin, 1974).

In the disengaged position, the therapist uses her/his stance as an expert to create a therapeutic context that brings a sense of competence and hope. The therapist as the expert, monitors the family's world view. She/he may accept and support some of their values, but others she/he will ignore or avoid. In the disengaged position the therapist acts as a director. Observing family patterns, the therapist creates scenarios and

facilitates enactments of familiar and novel family interactions to force the family to engage in different ways.

In his work, *Families and Family Therapy*, Minuchin (1974) identifies two additional accommodation techniques other than tracking: maintenance and mimesis. Maintenance is providing planned support to a family structure while the therapist analyzes it. It involves confirming and supporting an individual's strength and potential or highlighting a member's position in the family. Mimesis refers to the therapist adopting the family's style and affective range. If a family speaks softly and with many pauses, the therapist will adopt that family's style of communication, by also speaking softly and allowing for pauses. These techniques, tracking, maintenance and mimesis are not only used in the accommodation and joining process, but can also be used as a restructuring strategy. Joining occurs throughout the therapeutic process and the therapist can in fact join over and over again in the therapy session. However as time goes on, the joining process is not as deliberate a process as in the initial phases of therapy.

Assessment

From the initial data that is available about a family, the therapist begins to hypothesize about the family's structure and form, based on the knowledge that families respond to stresses in predictable ways, depending on their structure. Hypotheses are derived from the family's structure, presenting problem, family composition and developmental stage. Strain is placed on a family as its members move through different developmental stages and transitions occur.

Minuchin (1974) identifies six areas of family interaction to assess and from

which a working hypothesis is derived. They are as follows:

- 1- Family structure, which includes the preferred transactional patterns and alternatives available.
- 2- Flexibility of the system is assessed by reshuffling the system's alliances, coalitions and the subsystems' responses to changed circumstances. Assessing the system's flexibility involves assessing the family's capacity for change.
- 3- Evaluation of where the family falls along the continuum of enmeshed-disengaged.
- 4- Review of the family's sources of support and stress in its ecological context.
- 5- Examination of the family's developmental stage and how the family is performing at the tasks appropriate to that stage.
- 6- Exploration of the ways in which the identified patient's symptoms are used for maintaining the family's transactional patterns.

From the information gathered a structural map is drawn which identifies problematic areas in the family's organization and identifies therapeutic goals. The therapist reframes the presenting problem, and establishes treatment goals and a therapeutic contract with the family. The family's frame of reality is different than the therapist's. The family's frame of reality is based on the familiar and on the maintenance of the status quo. The therapist's frame of reality is of moving the family toward a more differentiated and competent way of dealing with dysfunctional ways of coping with the demands of its members.

Reframing

Reframing is also known as relabeling (L'Abate, Ganahl, & Hansen, 1986). The

strategy involved in reframing is to alter the conceptual and/or emotional setting or viewpoint in which a situation is experienced, by offering an alternate frame and changing its meaning to those involved. The therapist provides a different frame from which a situation is perceived. Reframing impacts on the client's perception or on their construct of reality. Once clients have been given an alternative, they cannot return to their original view, as alternatives to their situation have been increased. Reframing is based on the principle that reality is based on our frames and labels of a situation: if the frame or label is changed it alters our view of reality and consequently our view of our problems. Providing alternative views of a problem increases the possibilities for solutions. By providing alternative solutions, reframing also provides the client with an increase in control in the situation and lessens the emotions associated with the situation. Reframes are a different way to account for the facts which the client presents. They are also ways to highlight or add additional facts to the client's experience. Reframes are equally applicable to individuals, couples and families (L'Abate et al., 1986). Negative connotations are as useful and helpful as positives ones. The important factor in a reframe is how useful it is to the client and what alternatives it provides to the client.

Restructuring

When faced with periods of stress or crisis, the family will continue to use its best known strategies, regardless of whether they are ineffective or dysfunctional. It is the therapist's task to challenge the family frame and convince members that the reality they have mapped for themselves can be expanded or modified. This is achieved through restructuring techniques. In *Families and Family Therapy*, Minuchin (1974) identifies

seven categories of restructuring operations: actualizing family transactional patterns, marking boundaries, escalating stress, assigning tasks, utilizing symptoms, manipulating the mood, and support, education, and guidance.

Actualizing family transactional patterns. Actualizing family transactional patterns refers to not only relying on the family's verbal description of how they think they interact but also includes moving beyond verbal descriptions. This can be achieved through enactments, recreating communication channels and manipulating space.

Enactments within a therapeutic session are a method for the therapist to observe the transactional patterns with the same intensity as outside of the therapy sessions. By observing the family's transactions, the therapist is able to assess the rules that govern transactions in the family. Enactments also give the therapist control and the opportunity to intervene in the usual patterns. By increasing the intensity, involving other family members or the therapist her/himself, indicating alternative transactions and introducing experimental probes, information is gathered about the system's flexibility and the system's capacity for change.

Enactments facilitate the formation of a therapeutic environment as they offer an opportunity for the therapist and the family members to engage in a meaningful way. The therapist is not only an observer but can also be a participant. The process of engaging in an enactment, draws the family away from the identified patient and redefines the problem and focuses on the family in a dysfunctional situation. Enactments offer families a context to experiment with transactions. Enactments can also be used by the therapist as a tool to disengage from the family system. As the family members are involved with

each other. the therapist can distance her/himself. observe and regain therapeutic leverage.

Enactments can occur in three different ways. The therapist can simply observe the spontaneous transactions of the family and decide which dysfunctional areas to highlight. The therapist can introduce a scenario and the family engages in transactions based on this scenario. The therapist can also suggest alternative ways of transacting and allow the family an opportunity to try them out within the therapeutic session. This technique provides the family hope and provides an assessment of how flexible and how capable the family can change. Minuchin (1974) suggests that enactments become part of the spontaneous therapist and are not only to be used in rare moments of therapy. rather they should be used as small interventions that are repeated over the course of the therapeutic involvement.

Recreating communication channels and manipulating space are other techniques used to actualize family transactions. In recreating communication channels. intrafamilial communication is encouraged in a session by insisting that the family talk to one other and by the therapist refusing to respond when addressed. to avoid being drawn in. Manipulating space and positioning is also a technique to encourage dialogue and work on boundaries. For example the therapist can ask the parents to look at each other when speaking or the therapist can move the two people to the middle of the room. This creates an image of alternate family transactions. Manipulating space is also a technique to delineate boundaries.

Marking boundaries. Marking boundaries is an important method of restructuring

family transactions, since hierarchy is an important element in functional families. The goal of marking boundaries is to obtain the correct degree of permeability among subsystems, depending on the developmental stage of the family (Minuchin, 1974). The different developmental stages of the family require that the system balance the notions of individualization or autonomy with interdependency. Individual boundaries are delineated by setting rules of communication. For example the therapist establishes the rule that family members should talk to each other and not about each other.

Subsystem boundaries need to be established to protect each subsystem's function in the family. The parental subsystem needs to have authority and needs to be the one that sets limits. To complete this function, the boundaries between the parental and child subsystems must be clear, identifying that the parental unit has control, while still allowing the child room to become independent and autonomous depending on the child's developmental stage. The sibling subsystem meanwhile needs to have autonomy from the parental unit, to allow the individuals the opportunity to fully take advantage of their first peer group.

Boundary marking intervenes with triangulations and cross-generational coalitions. Through manipulating space within the therapeutic session, the therapist creates new boundaries. Altering the duration of the interaction among members of a subsystem intensifies the message of who should be involved in what issues. To ensure that the family will continue with the new behaviors beyond the session, the therapist may choose to assign homework. The opportunity would therefore be created where the family could practice the unaccustomed transactions in their natural setting. The task

should be clearly defined and include a time limit. Another technique to create boundaries in over involved dyads is to use paradoxical tasks. By directing an increase in proximity of family members the aim of the paradoxical task is to increase conflict with the goal of increasing distance. Boundary making techniques either change the membership in subsystems or the distance between them.

Escalating stress. The family system can also be restructured through techniques that escalate stress. By creating stress in different parts of the system, an assessment can be drawn of the family's capacity to restructure when circumstances change. Several techniques fall within this category. The therapist can create stress by blocking usual transactional patterns. For example the therapist can tell the child not to interrupt her/his parents when she/he usually does. The therapist can emphasize differences that the family is not paying attention to. The therapist can develop implicit conflict, so that when the family usually avoids conflict, the therapist forces the couple or family members to have contact so that conflict does occur. The therapist can also align her/himself temporarily in a coalition with a subsystem or individual. These techniques escalate the stress in the family, by altering the usual transactional patterns of the family and the family must therefore respond to the changed circumstances.

Assigning tasks. Assigning tasks creates a framework within which the family must interact. Tasks can be used to focus on an area that the therapist wants to further explore, that may not have come out naturally of the sessions or they may be used to highlight an area that the family needs to work on. They take the form of the therapist manipulating space or dramatizing transactions and suggesting changes. The therapist, by

assigning tasks within the session, emphasizes her/his position as the leader and rule setter. Tasks that are given as homework give the family the opportunity to take the changed transactional patterns home and to exercise them in their natural setting. In this situation the therapist becomes rule maker beyond the structure of the therapeutic session. Assigning tasks is advantageous in testing the family's flexibility and in providing further information about the family should they follow through. By assigning tasks the therapist deals with the family structure and transactional patterns and the completion of the tasks focuses on new possibilities of restructuring the family.

Utilizing the symptom. The presenting problem or symptoms in some cases may be life threatening or so overwhelming that the therapist needs to utilize the symptom in the restructuring process. The family may be unable to contract about anything but the presenting symptom. In these situations, for example anorexia nervosa, the presenting problem takes priority, while still understanding that the symptoms are an expression of the family context and are maintained by transactional patterns.

Minuchin (1974) outlines six restructuring techniques that utilize the symptom. By focusing on the symptom, the therapist recognizes that this may be the quickest way to diagnose and change the family's dysfunctional patterns. The symptoms of the identified patient are a symbolic representation of the family's way of handling stress. Therefore, if the therapist works with the family to change the way they are handling the identified patient's symptoms, family structure and habitual transactions will also be altered. The therapist by using her/his position of power in the family can reinforce or exaggerate the identified patient's symptoms. By increasing the intensity of the symptoms, the goal is

that the members will find the situation so unbearable that they will respond in a different way. In de-emphasizing the symptom, the purpose is to draw attention away from the symptom to the areas that need attention. For example, in a situation with an anorectic patient, the therapist de-emphasizes the symptom by conducting family therapy over lunch (Rosman, Minuchin, & Liebman, 1975). This technique creates strong interpersonal conflict, which then takes precedence over eating. In moving to a new symptom, the therapist shifts the focus from the identified patient to another family member who is also exhibiting problems. In relabeling the symptom, the technique redefines the symptom in an interpersonal way with the goal of opening new pathways for change. For example a girl's anorexia is relabeled as disobedience and it redirects the issue as an issue of parental control (Minuchin, 1974). Changing the symptom's affect by encouraging the family members to interact in a different way around the problem, is another way of utilizing the symptom as a restructuring technique. For example encouraging a parent to interact with her/his child in an educative role, rather than responding in an emotional and reactionary way, changes the symptom's affect.

Manipulating the mood. In a therapeutic session the therapist can manipulate the family's mood. Most families adhere to a preferred affect. Some are predominantly depressed or apathetic while others are constantly joking and teasing. The therapist can take on the family's affect either as a joining manoeuvre or as a restructuring technique. Restructuring can take several forms: the family's mood can be exaggerated inducing the client to react against it, an alternative mood can be modeled, or the predominant affect can be relabeled.

Support, education and guidance. Support, education and guidance are equally important ways of restructuring families, as they are joining procedures. The therapist needs to be aware of the importance of nurturing, healing and supporting functions the family provides to its members. The therapist can teach the family how to respond differently to each other. For example the therapist may teach the parental subsystem how to take on a leadership role, by taking over that role and then move out so that the parents can take over. The therapist may teach a child how to get along in school or teach a family how to handle the social agencies with which they are involved.

Application of structural family therapy

Structural family therapy was originally developed in the context of troubled adolescents and their families (Minuchin, 1979). Over the years this model of family therapy has been applied to various types of families and families at different developmental life cycles. Today there are numerous publications citing the use of a structural family therapy model or citing the use of the main constructs (boundaries, hierarchy and subsystems) in their therapeutic encounters with clients. The model has been primarily applied in clinical settings where children and adolescents are the identified patient. Less documentation exists on its application to the treatment of adults, however Colapinto (1991) suggests it can be used where there is a strong family involvement in the adult's life. If the problem is related to an interactional reframe, the model is more likely to be successful. Structural family therapy has gained support in cross cultural settings, given it is a versatile and spontaneous approach. Its effectiveness depends more on the therapist's behavior and style, than on the actual techniques or the

family's style (Colapinto, 1991; Gurman & Kniskern, 1978).

Types of families

Minuchin (1981) cites a wide variety of family types to which structural family therapy can be applied to: "pas de deux" families, three generation families, "shoe" families, "accordion" families, "fluctuating" families, foster families, step families, families with a ghost, and out of control families. The "pas de deux" family type consists of two people and includes such examples as a mother and child, or an older couple whose children have left home. The two family members may rely a great deal on each other, therefore the result may be an intense style of relating creating mutual dependence and mutual resentment at the same time. The two person family creates the possibility for the individuals to become symbiotically dependent on each other, thus the members become overinvolved with each other.

Included in the "pas de deux" family type are couples. Separate concepts or techniques have not been developed for the treatment of couples (Colapinto, 1991). The couple may be the subsystem that becomes the focus of treatment in the family or they may be the ones requesting counseling. Colapinto (1991) states that assessment and treatment follow the same guidelines that apply to the family as a whole, with some differences in the choice and emphasis of techniques. For example the therapist may not need to reframe the problem as interactional, since couples are more likely to already perceive their problems as relating to their transactions, but the therapist may need to reframe the type of interactional problem it is. Techniques in working with couples focus less on boundary making and more on using enactments and working on issues of

complementarity. Couple therapy must also take into consideration the impact of this subsystem on the remainder of the family.

Three generation families are composed of various generations living close together and is probably the most common type of family found worldwide. Examples of this type of family range from the single parent, grandparent and child combination to the complex network of entire kinship systems. A possible weakness of the three generation family is the hierarchical organization, however at the same time the extended family may be influential on the nuclear family.

“Shoe families” as termed by Minuchin (1981) are large families with many children. This family type is not as predominant in the western world as it once was. In such a large family, usually responsibility for the younger children and authority is delegated to the older children. This works well as long as the responsibilities are clearly defined by the parents and are appropriate for the parental child.

“Accordion families” are families where one member is away for a prolonged periods of time, such as military families. This requires that parental functions are concentrated in one person for part of the cycle, thus functioning as a single parent family for part of the time, but having to readjust to a two parent family when the other spouse is around.

“Fluctuating families” are families who are always moving and therefore the family loses its context through relocating and they are depleted of their competency to deal with crises. Foster families have a family member who is only part of the family for a short period of time and the expectation is that the family not become too attached to

the foster child. However, the child may become attached to the family and vice versa. Attention is drawn to the possibility that the child develops symptoms that may not necessarily be the product of his/her experiences prior to entering into care, but they may be a result of the stresses within the family.

Stepparent families have multiple adjustments to make. The stepparent goes through a process of integration with the children. The family must go through the same steps as when they first became a family, through the joining of a couple with no children. Minuchin and Nichols (1993) state that stepfamilies are prone to triangulation and that they err in trying to model themselves on the traditional nuclear family model. Furthermore, stepfamilies are susceptible to competition, conflict, jealousy and resentment. Loyalty issues are at the forefront and family members need to honor prior claims of loyalty between parents and children.

Families who have experienced the death of one of its members or the desertion of a member have to reassign the tasks of the missing person. This family form is known as families with a "ghost".

"Out of control families" are families where one of the members presents symptoms related to control. This includes families with delinquent children and families with issues of child abuse. Issues of delinquent children vary with the developmental stage of the family members. Minuchin (1981) states that in families where the young child terrorizes the remainder of the family, the parents are not working as a functional parental unit and instead disqualifying each other. The goal from a structural point of view is to reorganize the family so that the parents are cooperating with each other and

have authority over the child. In families with adolescents, the control issues may be related to the parents' inability to alter their role vis a vis the adolescent. The old patterns of relating are not allowing the emerging adolescent room to develop new skills and perform new tasks appropriate for her/his age. The structure of these families requires the physical presence of the parents for authority to be upheld. Communication patterns are chaotic in these families, where members are not expected to be heard and the content is less important than the message conveyed by the relationship. In families with child abuse, the second type of out of control family, the system is not capable of controlling the parents' destructive responses to children. The parents have little support outside of the immediate family and the child is seen as a continuation of themselves.

Types of presenting problems

Literature abounds on the use of structural family therapy with families with a wide range of presenting problems. Some of the most notable include multi-problem families, psychosomatic issues, substance abuse and family violence.

Structural family therapy was first applied by Minuchin to lower-socioeconomic-status disorganized families with delinquent adolescents. These families were characterized with multi-problems, which included a lack of leadership by the parental subsystem, diffuse boundaries between children and parent and random transactional patterns. Parents in these families use control tactics with little success in gaining cooperation from their children. The delinquent adolescent boys studied by Minuchin in *Families of the Slums* (1967) were predominantly from families where a father figure was absent. These families fluctuated at the extremes of the enmeshed-disengaged

continuum. Intervention with these types of families is directed at altering their communication patterns, their structure and their affective response to each other. Enmeshed families appear to be more successful at altering their transactional patterns in comparison to families on the disengaged end of the continuum (Aponte & VanDeusen, 1981).

Structural family therapy with psychosomatic families was first introduced by Minuchin and colleagues at the Philadelphia Child Guidance Clinic (Minuchin et al., 1978). Psychosomatic families are families where one of its members is identified as having a psychosomatic problem such as anorexia nervosa, diabetes or asthma. The family appears to function best when someone is sick. The characteristics of such families include overprotection, enmeshment or overinvolvement of family members with each other, an inability to resolve conflicts, a tremendous concern for the maintenance of peace or avoidance of conflict and an extreme rigidity. These families present as the normal family and tend to be very likeable. A systemic model to these life threatening illnesses has provided an important contribution in the understanding of the role of family dynamics in the etiology and the perpetuation of the illness when the traditional medical model failed to provide an adequate answer. The evidence that family dynamics plays a part in the etiology of medical and psychosomatic conditions is controversial (Roy & Frankel, 1995). The controversy is related to the lack of methodological rigor in Minuchin's study on psychosomatic families (1978) and also on the fact that his outcomes were never replicated with the same degree of success (Roy & Frankel, 1995). However, several authors, (Bryant-Waugh, Knibbs, Fosson, Kaminski, & Lask, 1988:

Gurman & Kniskern, 1980; Russell, Olson, Sprenkle, & Atilano, 1987; Stierlin & Weber, 1989) have demonstrated that although it is difficult to determine if family therapy alone would effectively treat psychosomatic illnesses, it should not be negated. Furthermore, Gurman and Kniskern (1980) state that "at the moment, structural therapy should be considered the family therapy treatment of choice for these childhood psychosomatic (anorexia nervosa, diabetes, asthma) conditions" (p. 750). Colapinto (1991) identified that of the three syndromes treated by Minuchin and his colleagues, anorexia nervosa was the best suited to a family focused approach.

Structural family therapy has also been utilized in working with families with substance abusing adolescents. These families have disturbed interactional boundaries and rigid or chaotic patterns of adaptability. Coleman and Davis (1978) and Stanton, Todd and associates (1982) linked structural family factors to the genesis and maintenance of drug dependence. Three common beliefs are that (a) the addiction is a manifestation of an overall family problem; (b) secondly, that drug dependence serves a definite function within the family; and (c) thirdly, that if the drug dependent member improves or abstains, the remainder of the family members may attempt to sabotage her/his progress, so that the family homeostasis returns to a prior state, including the individual becoming readdicted. The involvement of the family is therefore seen as an important factor in the rehabilitation of the addict. When the family is involved in the treatment process, the system can be changed toward helping the addicted member overcome her/his addiction rather than being a force that attempts to maintain it. The use of a structural family therapy approach has been reported as an effective means of

reducing drug abuse among adolescents and of improving family functioning by several authors (Joaning, Quinn, Thomas, & Mullen, 1992; Stanton et al., 1982; Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban, & Hervis, 1988). Stanton et al. (1982) advocate that although their model of structural-strategic family therapy was developed for drug addicts that it can be applied to other kinds of family problems and types of addictions.

Structural family therapy has been applied to violent couples. Minuchin and Nichols (1993) acknowledge that there has been controversy in the use of a systemic approach to violent couples. Therapists need to become aware of the special nature of battering and the necessity in most such cases to separate the couple for individual or segregated group treatment in the initial phases. However, it is also equally important that a systemic model not be ignored as there are some couples who want to stay together and the marital and family system have a powerful influence on maintaining the recurrent cycle of violence (Cook & Frantz-Cook, 1984; Minuchin & Nichols, 1993).

Couples develop complementarity patterns such as pursuer - distancer, active - passive and dominant - submissive. These patterns become problematic when they are exaggerated or when they fail to shift to accommodate to changing circumstances in the couple's life. A battering couple is seen as locked into a complementary system where there is little room for negotiation. Violence erupts when the homeostasis of the couple is challenged. Violence is therefore seen as a response to stress as the couple struggles for control over the functional rules of the relationship. Weitzman and Dreen (1982) identify six major control themes around which violent episodes may erupt in couples: distance

and intimacy, jealousy and loyalty, dependence and independence, rejection and unconditional acceptance, adequacy and inadequacy, control, power and powerlessness.

Minuchin and Nichols (1993) suggest that with violent couples some of the techniques of structural family therapy be altered. For instance it is suggested that the therapist remain distant and in control of the nature of the communication in exploring patterns of communication. While in the traditional form of structural family therapy the therapist would encourage dialogue among family members, in violent families the therapist discourages interaction, promoting instead that the couple talk, each taking his/her turn. The therapist slows down dialogue and encourages the couple to think rather than feel. The therapist's role is to challenge the violent spouse in her/his actions and behaviors, but also to challenge the other spouse's sense of helplessness and encourage her/him to be assertive. History of the relationship is not taken at the beginning of therapy as Minuchin and Nichols (1993) state that historical facts change, depending on the context and on the trust level with the therapist (p. 78). Historical facts of the relationship will flow throughout the therapeutic encounter with the couple.

Structural family therapy is seen as a therapeutic model that is applicable cross-culturally. Jung (1984) defines structural family therapy in the following way: "... an approach with a broad applicability to various socioeconomic groups and presenting problems and with an emphasis on the social context in which families live, on appropriate generational boundaries, on the joining process, on problem-solving, on focusing on strengths and on the therapist as an authority figure and change agent". (p.366)

Furthermore structural family therapy is seen as an open system that takes into account the person in relation to her/his environment and to her/his family.

This therapy model has proven to be adaptable and useful to many social classes and to a range of racial and ethnic groups. Structural family therapists have had to be flexible, perceptive and sensitive to the class and cultural norms of these groups. Jung (1984) writes that the family approach of structural family therapy fits with the Chinese perception that the individual cannot be seen apart from his/her family: seeing the individual separately may further alienate her/him from her/his family. The Chinese family is highly structured with clearly defined generational boundaries and roles for everyone. This fits with the structural model's constructs of hierarchy, boundaries and subsystems. Jung (1984) further points out that immigrant Chinese families may need help to make more flexible the rigid boundaries between parents and children to adapt to the western world. The joining technique of structural family therapy lends itself not only to the Chinese culture, but also to the Native Americans (Napoliello & Sweet, 1992). Through the joining technique the therapist becomes aware of and takes into consideration the cultural values of each member. Involving the client in the therapeutic process and viewing family members as active participants in their own healing is similar to the Native American view of healing. This premise of structural family therapy allows the individuals to chart their own goals and to apply their own cultural norms to the therapeutic context. Another similarity is the trust and emotional rapport between the healer and the patient in the medicine man and the structural family therapist.

Outcome studies on structural family therapy

Although structural family therapy concepts are commonly utilized in family therapy and much has been written about the application of the model, there are few outcome studies that evaluate the effectiveness of the structural approach.

Outcome studies are designed to answer one or more of the following areas: the effectiveness of the particular therapy, the percentage of families that improve and which family therapy models are most effective. There exists a number of methodological problems with family therapy outcome studies that potentially invalidate the existing studies and make it difficult to identify the ones that have utilized structural family therapy interventions (Gurman & Kniskern, 1978; Stierlin & Weber, 1989).

Therapeutic sessions almost never follow a pure application of a given therapy model and since in most outcome study reports, the therapeutic maneuvers are rarely described in detail it is difficult to determine which specific interventions were utilized. Other difficulties emerge in untangling treatment effects from the therapist effects. Would similar results have been achieved with the same therapist utilizing a different approach? Inadequate follow up, which includes a short follow up period, a high failure to trace period, indirect methods of evaluation, a poorly defined outcome criteria and a failure to employ multiple outcome measures, put into question whether the changes seen at the end of therapy are long lasting (Stierlin & Weber, 1989).

There are few outcome studies that have been conducted where structural family therapy was identified as the intervention of choice. Most family therapy interventions are eclectic or are a combined approach utilizing a structural family therapy approach

with some other method. Roy and Frankel (1995) provide a comprehensive review of the outcome literature on the effectiveness of family therapy. Their work assists in identifying the studies which evaluate the effectiveness of structural family therapy.

In the area of attention deficit hyperactive deficit (ADHD) two outcome studies on structural family therapy have been identified. Ritterman (1978) completed a study on the value of structural family therapy to treat hyperactive children. The study compared four groups receiving a different combination of treatment. The ritalin only treatment group consistently showed less improvement and the family therapy alone group had either a neutral or negative effect, whereas the family therapy and placebo and the family therapy plus the ritalin groups showed an improvement in family functioning. Barkley, Guevremont, Anastopoulos, and Fletcher (1992) also studied the outcome of structural family therapy with ADHD youth. The therapeutic models included problem-solving communication training, behavior management training and structural family therapy. Results indicated that there were no significant differences between the different treatment models. All three approaches demonstrated equally significant improvements in parent-adolescent communication, number of conflicts, intensity of anger, parent-reported school adjustment of the adolescent, parent and self-reported adolescent externalizing and internalizing symptoms and maternal depression. In all three approaches, consumer satisfaction ratings were high and all improvements were maintained at a three month follow-up. Given these results, all three models are seen as more effective than no treatment. However, family functioning was not significantly changed and the results may be more indicative of a change in the family's attitude and

perceptions and in stress being alleviated than a structural change in the family.

Other studies have focused on families in which the identified patient was a child with behavioral difficulties. Szapocznik, Rio, Murray, Cohen, Rivas-Vazquez, and Posada (1989) compared structural family therapy to individual psychodynamic child therapy in problematic Hispanic boys. Their results demonstrated that the control group was less effective than the treatment groups, however the group of children receiving structural family therapy showed symptomatic improvement with no change or improvement in the family's functioning. The children in the individual psychodynamic group also showed improvement while their families showed deterioration in their general functioning. The study invalidated the basic assumption that family therapy would improve family functioning, but did eliminate the presenting symptoms. Although the treatment groups did not improve as hypothesized, to only treat the child at the exclusion of the family was seen as ineffective.

Structural family therapy has gained support in treating families with medical illnesses (Roy & Frankel, 1995). Minuchin, Baker, Rosman, Liebman, Milman, and Todd (1975) reported their findings of using a structural approach with children who have diabetes. They based their hypothesis on the theory that family dynamics account for the child's unresponsiveness to conventional treatment and proneness to episodes of ketoacidosis. Their study was based on a small sample of children with psychosomatic diabetes and two control groups with other types of diabetes. The study demonstrated that the family intervention approach decreased the number of ketiacidosis episodes in the group with psychosomatic diabetes.

In the treatment of anorexia nervosa one of the most well known studies is Minuchin, Rosman, and Baker's study (1978). In this study the authors identified certain patterns of family behavior which exacerbate anorexia nervosa. They include enmeshment, rigidity, overprotectiveness and lack of conflict resolution. The majority of Minuchin's approach in this study of anorexic patients and their families consisted of a structural family therapy approach, with the goal of altering the dysfunctional regulatory transactions. It also included a short-term behavioral modification program. Throughout the family therapy phase of treatment the patients remained under pediatric supervision. Minuchin et al. (1978) reported on the outcome of 53 patients. Outcome was evaluated on the basis of medical improvements regarding the remission of the anorexia symptoms (weight gain) and a clinical assessment of psychosocial functioning in relation to home, school and peers. Follow-up of patients occurred over a two year period. The results indicate that 86% of the patients recovered, 4% were rated as fair, 6% as unimproved and 4% relapsed. Furthermore, Minuchin et al. concluded that recovery was more likely if treatment occurred within a year of the onset of the disease.

Stierlin and Weber (1989) replicated a similar study with anorexic patients and their families and observed an 85% success rate. Russell, Olson, Sprenkle, and Atilano (1987) found that patients receiving family therapy in comparison to individual supportive psychotherapy, improved more significantly. They also corroborated Minuchin's conclusion that family therapy is most beneficial with younger patients whose illness was of relatively recent onset, while Bryant-Waugh et al. (1988) in their seven year follow-up, concluded that the age of onset combined with disturbed family life was a poor

predictor of outcome. At this time, the research favors a structural therapy approach with anorexia nervosa, although further research is needed to test structural family therapy in controlled situations to answer whether structural family therapy by itself is effective.

Structural family therapy has been identified as a possible model in working with a variety of presenting problems other than the ones identified above. They include youth with a history of involvement with the law (Alexander & Parson, 1982; Duckro, 1977; Druckman, 1979; Gruher, 1979; Johnson, 1977; Klein, Alexander, & Parsons, 1977; Michaels & Green, 1979; Ostensen, 1981;) and adolescent drug use (Coleman & Davis, 1978; Joaning, Quinn, Thomas & Mullen, 1992; Stanton & Todd, 1982; Szapocznik, Perez-Vidal, Brickman, Foote, Santisteban & Hervis, 1988). Outcome studies on these presenting issues have focused on evaluating family therapy versus individual or group approaches or of evaluating the effectiveness of a combined approach to family therapy. These studies do not evaluate the effectiveness of structural family therapy and are not helpful in identifying whether it is an effective model of intervention.

In the areas that have been studied, structural family therapy appears to be the most effective with psychosomatic families, in particular anorexia nervosa and children with hyperactive disorders. Interestingly, the result of Szapocznik's (1989) study with children with behavioral difficulties, indicates success in addressing the presenting problem, but that family therapy did not necessarily address the family's dysfunctional transactions. It is therefore questionable as to whether structural family therapy is an effective model for altering family dynamics. The lack of outcome studies on structural family therapy as a model of intervention on its own, limits the degree of confidence that

this model can be applied to the range of presenting problems that were previously noted.

Critique of structural family therapy

Limitations of the model

The structural family therapy model, although it appears simple enough to teach, is seen by some as difficult to learn (Hoffman, 1981). It is difficult for a beginning therapist to recognize the analogic behaviors that the experts in structural family therapy easily recognize, such as the invisible patterns in family transactions. Hoffman further points to the need for students to see many families to be able to recognize these patterns and experience extensive live supervision. Structural family therapy is more than mere techniques, it depends on being learned as a "therapeutic stance" (Colapinto, 1983, p. 421).

A serious problem, identified by Hoffman (1981) is that the original structural family therapy model makes no provision for paradoxical techniques, although subsequent therapists have used the strategies of symptom prescription and paradoxical interventions. The model does not contain a comprehensive enough theory of change to deal with resistant families and strategies to deal with enmeshed families.

Although, the model offers much flexibility in selecting who will be involved in therapy sessions, they require at least two people since the model relies on observing the interaction between family members. At least three people are required in session to observe the boundaries in place, including coalitions, detours and triangulations. The therapy sessions include all those who are part of the problem, but also those who will play a role in opening the avenues of change and/or obstructing others. They represent an

important resource that the therapist can access within sessions. This model of family therapy is therefore geared towards families and not in working with an individual.

Structural family therapy is a child orientated therapy model, where the identified target of intervention are children and adolescents. It was developed and gained popularity in working with children with behavioral problems and with psychosomatic families. Given its roots and subsequent success with anorexia nervosa, the model is not seen as the intervention of choice in working with couples and individual adults. The structural model has not developed a separate set of concepts or techniques to work with couples. The guidelines suggested are to follow the same basic concepts and theoretical constructs as applied with families, with a few special considerations (Colapinto, 1983). For example, in couple work it may not be necessary to reframe the problem as an interactional one, but to reframe what kind of interactional problem it is. The focus on the one subsystem would not focus on differentiating between subsystems, but on working with the interactional patterns within the subsystem. Structural family therapy would also pay attention to the couple vis a vis other subsystems. Despite the guidelines offered by Colapinto (1983) there exists little evidence that structural family therapy is effective with couples or with individual adults, as reviewed in the outcome section.

There are problem areas to which structural family therapy definitely does not apply, such as individual syndromes including character disorders (Colapinto, 1983). These problems cannot be reframed as an interaction between family members and are therefore not as relevant to the principles of structural family therapy.

The structural family therapy model is limited by the lack of outcome studies

evaluating the effectiveness of the structural model on its own. There is evidence that the model is effective with psychosomatic families (Bryant-Waugh et al., 1988; Minuchin et al., 1978; Russell, Olson, Sprenkle & Atilano, 1987; Stierlin & Weber, 1989) and in addressing behavioral difficulties in children (Barkley et al., 1992; Ritterman, 1978; Szapocznik et al., 1989) however there lacks evidence that structural family therapy is effective in altering family dynamics. Outcome studies that evaluate the effectiveness of the model and take into account the therapist effects are needed to continue to have confidence in the model.

Application of the model to family violence

Minuchin and Nichols (1993) advocate that structural family therapy is a viable model with violent families and couples. They note that there has been some controversy in its application and the strongest criticism comes from the feminist literature. Feminists' critique of the use of a systemic approach with family violence can be applied to structural family therapy since it is a systemic model. Furthermore, Goodrich (1991) argues that any therapy or model needs to be measured as to how it deals with violence, because if it cannot adequately deal with the abuse of power then it is inadequate to deal with power and the inequality of power. It is in the family that women's oppression and men's power is enacted most plainly and personally (Goodrich, 1991).

Systems theory is seen as providing a coherent account of family phenomenon while excluding significant variables such as power, gender and the link between the two. Bogard (1992) states that systemic theories and interventions were not originally conceived to address the coercive, terrifying and sometimes fatal reality of male violence

against women. Violence qualitatively changes the context of family life and therefore also the context of therapy. Furthermore, Bogard (1992) charges that systems theories implicate the battered woman or diffuse the male's responsibility for the violence, despite the evidence that the abuser produces his own behavior through self-talk and self-created arousal patterns. By applying a systems theoretical orientation to violence, it becomes more manageable and reframes the situation to render the client treatable as well as makes the therapist competent. However such a reframe has the potential of minimizing responsibility of family violence.

There are three ways that systemic theories account for family violence. First, family violence is the product of an interactional context where the violence occurs due to the repeated transactional behavior. Second, the use of violence in intimate relationships is the sign of dysfunctional relationship structures involving enmeshment, rigidity and the regulation of distance. Third, violence serves a functional role in the maintenance of the marital system. These assumptions of the systemic model help explain the chronicity and redundancy of the battering sequence, but feminists charge that those same theories inadvertently sanction violence against women and/or deflect attention away from the social conditions that perpetuate violence. The concept of circularity masks power imbalance and the consequences of the abuse of power, by promoting the idea that responsibility is equally shared (Goodrich, 1991). Redefining the issue of family violence in clinical terms, minimizes the power dynamics and the human brutality involved in these situations (Bogard, 1984). Taking a neutral stance and allowing the individuals to tell their stories while remaining nonjudgmental is ineffective for issues of

violence in therapeutic settings. A passive and indirect role by the therapist ignores the issue of power in violence and the silence about our values on family violence may be interpreted as consent for these actions.

Bogard (1984, 1992) advocates for a therapeutic model that not only provides intrapsychic or intrafamilial explanations of the women's exploitation and the man's control and violence, but also includes the larger cultural belief system as a cause. By not including social factors, family therapists reduce the possible causes of family violence to intrafamilial factors. This narrow view places full responsibility on family members and minimizes the impact of the historical cultural traditions and the current social institutions that maintain patriarchy.

The systemic models assume that both partners in the relationship are equally able to tell their story and are willing to do so in a therapeutic atmosphere. Bogard (1992) contends that not all truths are told in therapy. Abusive partners underestimate or distort the actual physical details and the emotional and interpersonal consequences of their violent acts. Furthermore abused women may not feel free to tell their story, not only because they may fear angering their partner but also because they may have been profoundly psychologically and interpersonally hurt. Effective change requires that therapists work together with the other systems, as there is evidence that the inclusion of legal and social consequences for battering strengthens the therapeutic interventions (Bogard, 1992). Feminists also charge family therapists as placing more importance on the survival of the relationship over the woman's safety (Bogard, 1992). The use of transactional descriptions in the structural therapy model does not place all the blame on

the battered woman for the violence. but feminists charge that "...transactional descriptions are not exempt from biases against women, since they can be punctuated in subtle ways that implicate the battered woman" (Bogard, 1984, p. 561). The notion that violence serves as a homeostatic function in the marriage. further places blame on the victim. In this context violence is seen as an attempt by the batterer to regain his "rightful" place in the marriage. This implies that the victim could and should control the husband's feelings and actions, minimizes the batterer's responsibility for his actions. ignores the physical differences between men and women and denies that the violence is due to the husband's characteristics and is not only the result of the transactional patterns developed in the relationship.

Furthermore feminists charge that the language used in systemic models biases against women or the victim (Bogard, 1984). "The terms "violent couples" or "battering system" hide the gender specific nature of battering" (Bogard, 1984, p. 562). The statements that "violence acts homeostatically to reestablish complementarity" (Bogard, 1984, p. 562) minimizes the batterer's responsibility for the violent acts. The popular formulation of the "overadequate battered woman/underadequate abusive male" has negative connotations for women. It can be interpreted that because the woman has bettered her husband in terms of status level, then she is to blame for the abuse.

Some feminist clinicians strongly advocate against couple therapy. They state that this approach compromises the therapeutic alliance within therapy, increases danger for the woman and highlights interventions that blame the victim and reduce leverage on the batterer. Bogard's (1992) position is that to follow a feminist-informed practice, the

issue is not whether the couple should be seen together or not, but rather the emphasis should be on what issues are addressed in couple and individual work, how the man is approached, his view on the violence, and his commitment to not only ending the violence but also reconstructing a relationship without coercion or control on his part.

Systemic approaches to family violence may perpetuate the processes and structures that help maintain male power over women with or without physical violence. These approaches minimize the issue of family violence to a mental health problem, rather than answering the larger question of gender-based inequality. Cook and Frantz-Cook (1984) argue that the problem identified with systemic approaches by feminism does not lie in the approach to couple counseling per se. They are supportive of the feminist view that family therapists need to be aware of the issues of family violence and the need to separate the couple for individual or group treatment in the initial phases. However these authors contend that we must not automatically reject a systemic approach to marital therapy, as there is a powerful influence within the marital and family system that serves to maintain the recurrent cycle of violence. Cook and Frantz-Cook (1984) point out that treatment approaches based on the view that the man is fully responsible for the battering and the systemic view that the couple is 'stuck' in a recurrent cycle of violence are equally important and call for a blending of both approaches. Interventions are needed that focus on controlling individual behavior and that help break the homeostatic cycle that maintains the violence.

The structural family therapy model advocates that the therapist not impose his/her preferred sociocultural arrangement on the family. However this can be

interpreted that arrangements that are oppressive to women should not be challenged (Ault-Riche, 1986). Minuchin's notion of complementarity in a couple, basically that individuals complement each other in a significant relationship, fails to acknowledge that women and children may not have enough power to easily leave. It also implies that women are equal participants in their oppression and the violence against them. Women have many constraints, whether it be financial and/or psychological which keeps them from asserting themselves, confronting other family members and having the freedom to leave (Ault-Riche, 1986). The structural family therapy model was developed at a time when what was good for the family must also be good for the individual (Ault-Riche, 1986). Its focus on the family as a whole presents limitations in its application to the issue of family violence.

Strengths of the model

Structural family therapy has persisted through the years and its core constructs are still taught and utilized. Although there are limitations and its application to family violence has been questioned, structural family therapy has many strengths.

The model presents some basic ideas and techniques that continue to be useful. It provides "a blueprint to analyze the process of family dynamics" (Nichols & Schwartz, 1994, p. 212). It is a useful framework for a broad range of therapeutic techniques, whether structural or otherwise. Wetchler (1995) states that according to the assumption of structural family therapy that families are unique, the model encourages the use of diverse types of techniques whether they are structural or not. Therefore paradoxical interventions and other techniques such as reframes and the use of genograms not

traditional to the model, can all be used within structural family therapy.

The structural family therapy model is based on family competence and uniqueness (Simon, 1995). Simon contends that structural family therapy has been incorrectly portrayed as pathologizing and controlling. The core of structural family therapy is not the structural diagnosis of the family, rather it is through the process of joining, also central to structural family therapy, that the family's uniqueness and competence is uncovered (Wetchler, 1995). Families in structural family therapy theory are viewed as being "stuck" using transactional patterns that no longer fit. "Stuck with a structure whose time has passed and stuck with a story that does not work" (Minuchin & Nichols, 1993, p. 43). The assumption of competence relates to the idea that families possess alternatives and the role of the family therapist is to assist families to explore unused possibilities, to risk the uncertainty of searching for alternatives that they are already in possession. Families are seen as resourceful and fundamentally sound (Simon, 1995). Therapists need to believe that a family is competent to solve its problems, or else all attempts at restructuring will fail (Wetchler, 1995). It is through the assumption of competence that the therapist can challenge the family to explore new transactional patterns.

Although families share similar characteristics, they are believed to be fundamentally unique. Therefore the therapist cannot assume that she/he knows the family's story. Therapists need to be willing to allow families to educate them. Structural family therapy is far from being controlling, as the family is allowed to contract which specific changes they would like to see happen. Furthermore the assessment of the

family needs to be particularized to the idiosyncracies of each family and to the history and subjective experience of each member. Assessments are much more than a structural diagnosis of the family's adjustment to the developmental demands. "Instead, structural diagnosis should be viewed as the construction of a description of the current state of affairs in the ongoing dialogue between the client system and its context..." (Simon, 1995, p. 22). Interventions are derived from the family's uniqueness. Although the technique of enactment has been associated with structural family therapy, this model of family therapy uses many other techniques that are equally important in restructuring families. They include marking boundaries, raising and lowering the intensity around a problem and unbalancing the system. The therapist can utilize whichever technique or combination that would assist the family in moving forward.

While some therapy models view the therapist as the expert telling parents what they should do, what to think and what values they should uphold, structural family therapy is seen as an empowering model (Powell & Dosser, 1992). Empowering in helping relationships is defined as "a help giver takes pride in and derives rewards from seeing others become more competent and self-sustaining"(p. 256). Structural family therapy's goal is to empower families. "...structural family theory is based upon changing family structure or patterns that are limiting, restricting and restraining while empowering family members to discover and nurture healthier more fulfilling interactional structures" (Powell & Dosser, 1992, p. 246).

The joining process, key to the structural family therapy model, is in and of itself empowering. Joining allows the therapist to develop a relationship with the client, to

better understand how families think and behave and is a base to encourage families to change and grow. Structural family therapy is distinguished from other family therapy approaches in two ways. First families are viewed as competent (Powell & Dosser, 1992; Simon, 1995). Families already possess the ability to relate in positive and growth producing ways, but they are not necessarily using the resources they possess to solve their problems. Second, their actions towards each other are based on goodwill and it is not their intentions that are wrong, but their misguided helpfulness (Powell & Dosser, 1992). Structural family therapy aims at creating contexts in which families can have experiences that challenge their way of thinking and behaving. These experiences then provide opportunities for the families to practice alternate and more functional ways of feeling and behaving. "A goal of structural family therapy is to empower families by: (1) increasing the present quantity, quality, complexity and availability of families' responsive repertory and (2) helping families sense that they can discover-on their own- new patterns of response in the future" (Powell & Dosser, 1992, p. 245). Through their experiences in therapy, the family begins to see themselves, their relationships and their family differently. Over time these repeated experiences challenge the family's stereotypical views and behavior and new transactional patterns emerge. These structural changes reorganize the family. They become more flexible, gain greater understanding of their members and gain coping skills to solve future problems. Through this process they become empowered.

The structural family therapy model allows for the therapist's own style, spontaneity and flexibility (Minuchin, 1981). Minuchin advises that techniques are only a

guide and that therapists need to combine knowledge with their own life experiences. The model is therefore seen as a guide and allows the therapist to develop his/her own therapeutic style. It permits the therapist to borrow theoretical constructs and techniques from other models. The structural family therapy model can therefore be adapted to changes in society.

The flexibility of the model allows for much variability in sessions and to be applied to various family types and presenting issues. This includes who to include in sessions at which time, whether more than one therapist is included, the length and frequency of sessions. The therapeutic contract can therefore be tailored to each family's needs. The model's application to various family types and presenting issues as detailed by Minuchin (1981) are a strength and evidence to structural family therapy's popularity.

Structural family therapy appears to fit well with other models, such as strategic (Stanton, 1981) and behavioral (Rosenberg, 1978) approaches. Fish and Piercy (1987) identify that the major similarities between structural and strategic approaches is the emphasis placed on eliminating the presenting problem. Other similarities include that both models are change rather than insight orientated, view problems in their relational context, are goal directed and both agree that change occurs when dysfunctional, repetitive patterns are interrupted. In this way, structural and strategic approaches blend well.

Structural family therapy lends itself to be integrated with behavioral interventions (Rosenberg, 1978). Once an assessment has been completed on the family structure, behavioral interventions can be implemented to bring out the desired changes. A change

in relational patterns will bring about positive feedback to family members and be reinforced. Through the reinforced relational patterns family members will adopt the changed structure.

The cross-cultural application of the model as highlighted by Jung (1984) and Napoliello and Sweet (1992) are additional strengths of the model. This increases the appropriateness of the model with the Chinese and Native American populations at the very least. It shows promise in being appropriate with other cultures.

Simon (1995) points out that the popularity of the structural family therapy model is attributed in large part to being "an eminently teachable model of family therapy" (p. 23). What is particularly simple to teach is the structural diagnosis of families, although he cautions that by only focusing on the notions of family functioning, namely the notions of boundaries, subsystems and hierarchy, the trainee runs the risk of becoming a pathologizing therapist. It is important for the trainee to confirm and challenge his/her values while deepening his/her understanding of the assumptions of competence and uniqueness in a family.

CHAPTER 2

Practicum Description

Learning Objectives

My objectives in completing this practicum were the following:

1. Gain knowledge and expertise in family therapy, therefore further developing my clinical skills.
2. Increase my working knowledge of structural family therapy, by applying structural interventions to families and couples within a therapeutic relationship.
3. Gain supervised experience in family therapy with families presenting with various issues.

Setting

For the purpose of this practicum all families were seen at the Elizabeth Hill Counselling Centre (EHCC). The EHCC is a counselling clinic in Winnipeg's inner city affiliated with the University of Manitoba. Its mandate is to provide training and supervision to students in the Faculty of Social Work and the Department of Psychology. The EHCC is located at 321 McDermot Avenue and is committed to serving inner-city families and children. Services are provided at no fee to clients. Clients may self-refer or they may be referred by social services and community agencies.

Clients

All clients were identified from the EHCC waiting list. Since the primary purpose of this practicum was to develop my skills and gain more knowledge in family therapy, I selected clients who were seeking either couple or family therapy. Seven client systems

were seen during the course of a twelve month period. The number of sessions ranged from four to seventeen.

All seven families were self-referred to EHCC. They had found out about EHCC as a resource from a collateral agency, through word of mouth from previous clients or had previously been EHCC clients. They were all initially seeking family therapy, although through the course of their involvement in therapy two cases were redefined as couple therapy and in one case an individual of the family system was seen.

Two of the families seen as part of my practicum will be analyzed in the following chapter, the remaining five families are summarized below. Each of these summaries will include a description of the presenting problem, the number of sessions the family was seen, the goals of therapy and what I learned from working with the family. (For a summary of all seven families see Appendix A.) Note that names have been altered to maintain the confidentiality of the families involved.

The Q family

The Q family is a single parent family with three children ranging in age from six to fifteen years of age. The presenting problem was identified as the eldest daughter's (April) conflict in the home with her mother (Linda) and the physical anger directed at her younger sisters. Some of the areas identified as problematic included swearing in the home, challenging of rules and April's anger.

The family was seen for a total of ten sessions over a five month period. The family as a unit was seen for two assessment sessions at intake and for the termination session. The remaining seven sessions involved April and Linda only as it was assessed

that this dyad needed to work on issues without the interruptions of the two younger siblings.

The overall goal of therapy was to assist the family in transitioning to a family with an adolescent and understand each other's needs. The specific goals for intervention included the following:

1. Normalize the family's struggles as April engages in adolescent behavior and Linda worries for her daughter.
2. Draw a clearer boundary between April and Linda, as April attempts to make decisions for herself and Linda learns to accept her daughter's need for independence.
3. Assist April in understanding her feelings and learn to express her anger in constructive ways.
4. Provide opportunities in session for April and Linda to problem solve and communicate in a constructive and effective way.
5. Highlight family and individual strengths and utilize these strengths to build strategies for how they will problem solve and build on their relationship beyond therapy.

Since this was a family where the identified problem was adolescent-parent conflict and the structural family therapy model was developed with problem adolescents, the framework immediately seemed appropriate. The experience of working with family Q solidified my opinion of the applicability of the model with this family type. I learned to assess when it may be necessary to work with a dyad, rather than the entire family.

This approach benefitted the family and the feedback received from the client satisfaction questionnaire corroborated my observations in this regard. The interesting aspect of this family was how resourceful they were in providing the children with opportunities for personal growth and development of skills on a limited budget. I reinforced my skills of working with adolescents and built on my skills of working with families where the presenting problem is adolescent-parent conflict.

The J family

Amy, a single mother of a newborn, self-referred to EHCC following a breakdown in communication with her biological mother, Louise. Amy had reconnected with her mother during her pregnancy following a ten year absence of any contact. Conflict between Amy and Louise dates back to when Amy was an adolescent and as a young adult she and her mother lost contact with one another. The presenting problem was identified by Amy as her mother avoiding contact with her daughter and grandson following a series of conflictual episodes. Amy was seeking a more adult type of relationship with her mother. She was also seeking to understand herself better and not replicate the dysfunctional patterns of relating with her son.

Amy attempted to have her mother join her in therapy, however Louise never responded to Amy's requests. Amy was seen individually for seven sessions over a period of four months.

The goal of therapy was to focus on Amy's relationship with her mother and explore informal support networks. In this context, the specific goals of intervention were the following:

1. Normalize Amy's yearning for a relationship with her mother, as she enters the life stage of becoming a parent herself.
2. Assist Amy in naming her feelings of rejection and hurt.
3. Assist Amy in exploring and locating an informal support network.

This case presented me with the unique challenge of working on family issues with only one family member present. I had to reframe the goal of therapy to accurately reflect what could be accomplished given that Louise never responded to Amy's request for family therapy. The concepts of the structural family therapy model were not useful in this case and I relied on the family life cycle model to identify the goals of therapy and interventions. I found interesting and educational that although this single parent was in her late thirties, because she and her mother had not adequately dealt with the life cycle stage of leaving your family or origin, they were "stuck" at the developmental life cycle stage of launching children and moving on. Amy had not resolved how to differentiate herself from her family of origin, in particular her mother.

The M family

The M family was initially seeking family therapy. Marshall and Monica were experiencing difficulty with their youngest son, J.P. who was fifteen years of age and had run away from home.

The presenting problem upon intake was identified as parent-child conflict. Given that J.P. continued to be absent from the home at intake and that the couple identified that they were struggling with prematurely going through the launching children stage in the family life cycle, the couple and I contracted to engage in couple sessions. The couple

was seen for a total of six sessions and a further three phone calls were made to them over a four month period.

The focus of the therapeutic involvement was to redefine the presenting issue from family therapy to couple therapy and to assess the treatment direction the couple needed to take. An assessment of the couple's relationship revealed issues of physical violence, emotional abuse, conflict avoidance and a lack of intimacy and affection. Given the ongoing violence in the couple relationship, the recommendation for Monica and Marshall was to deal with the issues of violence at an individual level and to take part in an educational group prior to beginning couple therapy. The purpose of the group was for the couple to gain knowledge on the issue of violence and to begin to share their experience. The interventions focused on to achieve this goal were the following.

1. Assisting the couple in identifying short and long term goals in relation to their marital relationship.
2. Interviewing each partner individually to assess the level of risk for abuse.
3. Developing safety plans with each individually.
4. Ensuring each was aware of crisis services available.
5. Emphasizing how violence has been part of their relationship and is one of the core issues they need to address first individually and in a group setting prior to engaging in couple work.
6. Identifying risks to making a referral for and engaging in individual and group work.
7. Providing the couple with information on options for the individual, group work

and future couple counselling.

8. Assisting the couple in identifying when they may be ready to self-refer for couple counselling.

The M family provided me the opportunity to work with a couple subsystem. In this case I learned to redefine family therapy to couple therapy, therefore solidifying how to do so in a supportive way with families. In particular this case taught me to look at the issue of relationship violence and assess and strategize how best to meet their needs. The structural model was not a good fit with this case. Focusing on issues of hierarchy, subsystems and boundaries was not helpful in identifying the direction that was needed with this couple system. I also learned to recognize the different levels of readiness for change and depending on where a person is at, what strategies and interventions to use to motivate individuals. In this couple, the partners were at different stages of readiness for change.

The U family

The U family, consisting of Helen, a single mother, and Jodi, her fourteen year old adolescent daughter, self-referred for family therapy following a recommendation from the local crisis team. Helen had reached out to the crisis team following a physical altercation between herself and her daughter. The presenting issue was parent-child conflict. The identified issues were Jodi's non compliance with her mother's expectations, Jodi hanging around negative peers, thefts from the family home by Jodi's new peers and a deterioration in her school grades.

The family was seen for a total of six sessions over a three month period. Helen's

father was invited to join a session following the assessment session. He was identified by both Jodi and Helen as an influential person in their family. This proved to be a useful strategy in assisting the nuclear family unit of Helen and Jodi in defining their goal for therapy.

The family's goal in attending family therapy was to regain control of family dynamics. This included Jodi and her mother communicating effectively, Jodi sharing with her family her struggles with peers and teachers, Jodi following through on Helen's expectation of not allowing peers to hang out in their home without Helen's permission and Jodi making positive choices about who she associates with. My goal in therapy was to assist the family in transitioning to a family with an adolescent. The objectives focused on to achieve this goal were the following.

1. Normalize Jodi and Helen's struggles in transitioning to a family with an adolescent and Helen's concerns for her daughter.
2. Strengthen the boundary between Jodi and Helen, as Jodi attempts to make decisions for herself and Helen learns to accept her daughter's need for independence.
3. Assist Jodi in relying on her positive peer network, explore ways she can involve herself in positive activities and distance herself from negative peers.
4. Facilitate opportunities for Jodi and Helen to problem solve in a constructive and effective way school issues and household expectations.
5. Highlight the family's and individuals' strengths.

The main learning that I experienced in working with this family was recognizing

the importance of involving an extended family member. It taught me how the timing of this intervention could benefit a family and assist them in becoming “unstuck”. What Ze provided for this family would have taken much more time for me to accomplish, as he was already a trusted and respected authority figure in the family. Again this was another case where the presenting problem was adolescent-parent conflict and where structural family therapy was an appropriate model.

The R family

Lucy self-referred her family for therapy following a separation from her husband of twenty years. The children, Mitchell, Tammy, Carl and Russell ranged from nineteen to nine years of age. Lucy had kept care and control of the children and they were residing in the family home. The presenting problem was identified as the family struggling to adjust to the parents’ separation. Carl, the middle child, was described as having the most difficulty with the separation and the one Lucy was the most concerned about.

Lucy and the three younger children attended therapy. They were seen for four sessions which included two sessions with the family unit as a whole and separate sessions with the parental and sibling subsystems. In addition I had two telephone conversations with Lucy and therapeutic letters were sent to each family member that attended therapy following agreement to terminate therapy prematurely.

The goal of therapy was to assist the family in transitioning to a separated family. The objectives focused on to achieve this goal were the following.

1. Normalize the family’s reactions and struggles to the separation and transition in

becoming a single parent family.

2. Assist the children in being able to express their concerns and worries.
3. Strengthen the hierarchy between the adults and children and distinguish between adult and child issues.
4. Assist the children in building their assertiveness skills when caught in the middle of their parents.
5. Recommend that the parents seek mediation services to assist them in resolving conflicts involving the care of their children, with the goal of lessening the reliance on the children to be the go between and for the parents to take an active role in addressing visitation and other parenting issues.

The R family was the first family I saw as part of this practicum, therefore I experienced a steep learning curve at that time. I learned how to engage a whole family system and the need to provide immediate feedback on my assessment. This was the only family I saw that was experiencing a separation, however through my work with this family and the additional readings I did on divorcing families I learned about the tasks they needed to accomplish. It provided me with a good example of how children become entangled in parental conflict and become the "go between". I learned the importance of respecting where families are at and their needs. I respected Lucy and the children's need to not return to therapy and work out new patterns of relating on their own. This case left me questioning how different therapy would have looked like if the ex-husband had been involved with the family seeking and/or attending therapy.

Procedures

The process of therapy with each family followed a similar sequence. Once identified from the wait list, the families were called to schedule an intake session. In my first telephone contact with the family, I explained to them that EHCC was a training facility and that I was a student therapist. I further explained that all sessions would be supervised by a faculty member and that all sessions are videotaped as part of the supervisory/learning process. After having obtained updated information on the presenting problem, the intake session was scheduled with relevant family members.

The intake session served to orient the family to EHCC, obtain the necessary written consents, further explain to all family members their participation in the practicum, videotaping and the supervisory process, and gain a preliminary understanding of the presenting problem and what they hoped to accomplish in therapy. During the course of the first few sessions I completed an assessment which included an understanding of the family's structure which contributed to family difficulties. Other tasks that were accomplished by the second session included the completion of the Family Assessment Measure III (Skinner, Steinhauser, & Santa-Barbara, 1983). As part of the assessment, I provided family with feedback on the evaluation of the family and contracted to meet for further sessions.

All therapy sessions were recorded as required by EHCC protocol. File recordings included an intake report, process notes on each session and a termination summary for each family seen.

Supervision

Dr. Diane Hiebert-Murphy as my faculty advisor provided primary supervision on five of the seven families. Clinical supervision was held on a weekly basis whereby Dr. Hiebert-Murphy provided direction and consultation in regards to developing hypotheses and planning interventions and provided feedback on clinical skills.

Dr. Harvy Frankel, professor from the Faculty of Social Work and practicum committee member provided live supervision on two cases. Live supervision is defined as observing my work via a two-way mirror and in a few sessions with a "bug in the ear", whereby the supervisor makes suggestions and requests to the student in session. Clinical supervision was also provided before and after sessions. Similarly to the supervision received from Dr. Hiebert-Murphy, Dr. Frankel provided direction in developing hypotheses, planning interventions, formulating tasks and skill development.

The third member of my practicum committee was David Charabin, director of EHCC.

Evaluation

The Family Assessment Measure III (FAM III) (Skinner et al. 1983) was used as the primary outcome measure. It was administered both pre and post therapy. As well a client satisfaction rating scale which I devised was administered upon termination, see Appendix B.

The Family Assessment Measure III

The measure was developed by Skinner, Steinhauser and Santa-Barbara (1983) and is based on a process model of family functioning, allowing the measure to integrate

different family therapy or research approaches. It is versatile as it can be used in “clinical and research settings as a diagnostic tool, as a measure of therapy process and outcome and as an instrument for basic research on family processes” (Skinner et al., 1983, p. 92). The FAM III is a self-report measure, is based on Canadian norms and measures family strengths and weaknesses from three perspectives: the family as a system, dyadic relationships and individual family members. The FAM III takes thirty minutes to complete and is administered to family members who are at least 10 - 12 years of age.

The FAM III assesses family functioning on the basis of seven concepts: 1 - *Task accomplishment* is the family’s ability to achieve a variety of basic, developmental and crisis tasks. The process of task accomplishment involves a process by which the family identifies a problem or task, explores alternatives, implements alternative solutions and evaluates the effects. It is the most basic activity of the family which allows the continued development of its members, provides safety and security, and ensures cohesion as a unit and that it functions as an effective part of society. 2 - *Role performance* is defined as the allocation, acceptance and actual enactment of roles. 3 - *Communication* is important in task accomplishment and role performance. It is effective when the message received is the message intended. 4 - *Affective expression* is a vital element of communication. It includes the content, intensity and timing of feelings involved in communicating a message. 5 - *Affective involvement* includes the degree and quality of family members’ interest in one another, as well as the family’s ability to meet the emotional and security needs of its members and the flexibility in supporting

individuals' autonomy of thought and function. 6 - *Control* is defined as the family members' ability to influence one another. How well is the family able to maintain ongoing functions while adapting to shifting demands? 7 - *Values and norms* of the family itself and the society in which the family lives are included as both influence its functioning.

The FAM III's norms are based on a heterogeneous sample of 475 clinical and non-clinical families. Normalized FAM III scores for each subscale have a mean of 50 and a standard deviation of 10. Scores 40 or below indicate a very healthy functioning family and a score of 60 and above indicate a problem.

The measure includes three scales: the general scale, dyadic relationships scale and the self-rating scale. The general scale provides an overall rating of family functioning based on fifty items divided into nine subscales. Seven of the subscales are based on the concepts of family functioning as outlined previously and the eighth and seventh scales measure social desirability and defensiveness. The dyadic relationships scale focuses on the relationships between specific pairs in the family. It includes 42 items on seven subscales relating to the concepts of family functioning. The self-rating scale focuses on the individual's perception of his/her functioning in the family and is also comprised of 42 items on seven subscales. The scales can be used together or separately.

The FAM III has demonstrated internal consistency and reliability (Skinner et al., 1983). FAM III has a coefficient alpha of .93 for adults and .94 for children which demonstrates strong internal consistency between subscales. It distinguishes between

clinical and non-clinical families.

The FAM III does not identify which critical aspects of each construct are a strength or weakness, but it does give an overview of family functioning. In this aspect it cannot be used as a substitute for a clinical assessment but it can complement it by verifying the assessment, alerting the therapist to problematic areas and by providing a baseline for quantitative evaluation of therapy.

Client Satisfaction Rating Scale

At the final session with families, I administered a qualitative consumer satisfaction questionnaire (Appendix B). The purpose of the client satisfaction rating scale was to obtain the clients' perceptions of their progress in therapy, and to give feedback to the therapist as to what they found the most helpful about the therapeutic process and their overall satisfaction with EHCC.

CHAPTER 3

Case Analysis

Introduction

For the purpose of this practicum report, I will present an indepth summary of the therapy process with two of the seven families seen. These two families were chosen because although both were stepfamilies and had similar presenting issues, the assessment and subsequent interventions varied significantly.

The following case discussions are organized in the following way: reason for referral, a general understanding of family functioning from a structural family therapy perspective, initial or tentative hypotheses, goals and interventions and the impact therapy had on the family system. The evaluation of therapy will include a summary of the results of the pre and post therapy FAM III and the client satisfaction questionnaire. At the end of each case I will also provide a brief overview of what I learned from working with the family.

The N family

The family was seen for a total of seventeen sessions over a period of nine months. Of those seventeen sessions, four included the couple and the children and the remaining thirteen sessions focused on the couple as the unit of intervention.

Reason for Referral

The N family consists of two teenage children (Luke and Candace), biological mother (Renata) and stepfather (Isodore). Isodore called EHCC to refer his family for family therapy. The family was seeking family therapy to address the current conflict in

the home, created by the recent reintegration of the family as a unit.

The couple has been married for nine years and was in a relationship for four years preceding the marriage. The family has experienced multiple separations during their thirteen year relationship, with the most recent separation having occurred in the past year. Some of the separations were geographic and at other times they were attributed to relationship difficulties. The couple attributes the geographic separations to Isodore's work. The family was geographically separated for the past year and reunited a month prior to attending therapy. Renata and the children moved to join Isodore. Although Isodore visited the family in their previous home on a regular basis, the family spent little time together as a unit. The presenting problem was described as the family having a difficult time with the transition back together as a unit. It was also stated as part of the referral that Isodore did not feel supported by Renata in regards to the rules and expectations of the children.

General understanding of family functioning from a structural perspective

The N family is most closely described by what Minuchin (1981) would call an accordion family. This type of family typically has one of the spouses away for a length of time and then returns. The spouses must accommodate their roles every time the spouse leaves and returns. Every time Isodore's work has taken him away from the family, they have had to adjust to Renata being the main caregiver and then attempt to readjust to being a two parent family when Isodore returns.

This is also a remarried or stepfamily, where both children are Renata's biological children from a previous marriage. Minuchin (1981) states that a remarried family goes

through the same steps of establishing themselves as in a first marriage. Beginning with the joining of the couple, the couple must negotiate the rules in their relationship and their preferred transactional pattern. Isodore being the stepparent had to go through a process of integration when he first became part of the family unit and has had to go through a similar process each time the family is separated. At the time of referral, with the family having recently been reunited, the couple was having to renegotiate the rules and preferred transactional pattern of their relationship while at the same time Isodore had to renegotiate a parental role with the children.

Minuchin (1974) identifies six areas of family interaction from which a working hypothesis is derived. They are summarized in the following categories: developmental stage of the family, family structure, flexibility of the system, evaluation of where the family falls along the continuum of enmeshed-disengaged, the family's sources of support and stress in its ecological context and the ways in which the identified patient's symptoms are used to maintain the family's transactional patterns.

Developmental stage of the family. This family is at two developmental stages. First, the members having experienced a lengthy separation are back together again and are at the beginning stage of family formation where the couple is attempting to develop a way of relating to one another. Second, they are also a family with adolescent children, preparing to launch the children into adulthood. The children are both seeking more independence and autonomy, while the parents are still negotiating parental responsibilities. Isodore is trying to figure out how to be a father figure to the children. He has attempted to set rules in the home in regards to the children's curfew and they

have openly defied him, returning home much later. The children expressed that Isodore is their mother's husband and not their father.

Family structure. Evaluating the structure of a family involves identifying the family's preferred transactional patterns. In this section I also will be identifying the subsystems, hierarchy and boundaries of the family system.

Minuchin and Nichols (1993) state that stepfamilies are prone to triangulation. Triangulation occurs where boundaries between subsystems are diffuse and usually involves the children siding with one parent against the other. In the N family, Renata and the children have formed a triad, in which Isodore has not been allowed to participate as an equal parent. The boundaries between Renata and her children were initially assessed as diffuse. Renata would discuss difficulties she and Isodore were experiencing with the children. The mother and daughter appear closely linked and their relationship at times more like two friends, than mother and daughter. Renata and the children are able to communicate using non verbal language, which Isodore is left out of. Renata has made decisions about the children's health without Isodore's input. This triad creates a disengaged parental subsystem. Renata clearly has defined her role as the sole parental figure to the children. The children listen to the rules and expectations that she sets out. This is reinforced by the fact that she is their biological mother and the children remained in her care during the family's many separations. Isodore is frustrated by his lack of authority in the home and lack of support from Renata.

The parental subsystem is fragmented with the parents fighting against each other rather than functioning as a cohesive unit. An ineffective parental unit is created by the

lack of support the parents show one another in attempting to set limits, their lack of communication as to what should occur for the family unit and the lack of clear boundaries between the parental and children subsystems. The ineffectiveness of the parental subsystem is linked to the relationship between the two adults or the couple subsystem. The couple's ongoing pattern of conflict resolution is to temporarily leave the relationship and return without addressing the source of conflict. Colapinto (1983) identifies this as a type of conflict avoidance. The couple who constantly argues but never reaches a resolution is avoiding conflict. It is hypothesized that by arguing about the care of the children the couple is avoiding their relational difficulties. The sources of stress identified by Renata and Isodore in the couple subsystem include commitment, communication, trust and affection.

The couple's commitment to each other is derived from their belief that marriage is a life long commitment. Isodore is not deeply religious, by his own definition, but derives his commitment to his wife according to religious norms. Renata does not share Isodore's religious beliefs, but demonstrates her commitment by following her husband on his many moves.

Communication is a main source of identified stress by the couple. They are engaged in a pattern of avoiding conflict, making assumptions about their partner and giving unclear messages. The couple does not clearly communicate their message to each other and make assumptions that they will know what they want even though they give a verbal message indicating the opposite of what they really want. This leads to confusion and conflict. Renata felt that Isodore should know what she wants, although she has told

him the opposite. Isodore's style of communication was to not allow Renata the opportunity to complete her thoughts or express her opinion, leaving Renata frustrated. The couple's early attempts to establish trust was by promising to give up part of their individuality. Isodore gave up his passion for playing rugby and Renata gave up some of her early friendships that were problematic for her husband. These were difficult sacrifices to make and when reneged upon, the other interpreted it as betrayal.

Affection was an area that both felt was lacking in their relationship. Renata described that she had a difficult time being affectionate to Isodore, although she felt quite at ease being affectionate and playful with her children. Renata's perception is that Isodore is emotionally distant and does not understand her as a person.

The sibling subsystem of Candace and Luke has a clear boundary from the remainder of the family. They are a support to one another and this bond between siblings was strengthened during the family's moves. Being only a few years apart in age, the children relied on one another to get integrated into their new communities. They demonstrated their support in session, by bailing one another out when questioned by me. For example when Luke was asked about his thoughts on a subject matter, Candace jumped in and told me what her brother was thinking.

Flexibility of the system. Assessing the system's flexibility involves assessing the family's capacity for change. Given the number of moves and separations the family has endured one might suspect that the family is very skilled at adapting to changes. In assessing the family, what we see is that certain subsystems have adapted to the changing needs of family members, while the couple subsystem is less flexible. The sibling

subsystem and the subsystem of Renata and her two children have adapted to the changing needs of the children as they entered adolescence. Renata has given the children more responsibility and has allowed them to make choices for themselves. The sibling subsystem has adjusted to the needs of the two siblings to associate with each other's new acquaintances following a move.

The couple subsystem was having a difficult time readjusting to both Renata and Isodore being present in the home. Isodore was seeking to become more involved in the children's lives and to rebuild a couple relationship with Renata. Renata struggled with what this meant for her and her interest was in establishing relationships outside of the marriage and in seeking employment. The couple demonstrated their capacity for change towards the end of therapy and were making strides to relate differently to each other.

In the first half of the sessions with the couple subsystem, Isodore was the one who exerted more influence on his wife. By the termination of therapy, the tables had turned somewhat, allowing Renata to have the floor and Isodore to hear her out. Isodore was most uncomfortable with this new transactional pattern, while Renata became more comfortable expressing her feelings to her husband and ensuring she had been heard. This subsystem although not incapable of change, struggled with the new demands placed on it each time Isodore's work took him away from the family.

Where does the family fall along the continuum of enmeshed-disengaged. The terms enmeshed and disengaged refer to the permeability of the system's boundaries. In an enmeshed family, the boundaries between subsystems are weak and there is little differentiation and autonomy among individuals (Minuchin, 1978). In a disengaged

family, the boundaries are overly rigid and family members are emotionally distant from one another. In most families, as is the case for the N family, both elements of enmeshment and disengagement are present (Colapinto, 1982).

Renata and her children present features of an enmeshed relationship. Renata has shared information with the children about her disagreements with her husband. The children, in particular Candace, are quite protective of their mother and interfere in the parental unit's disagreements. The children will quickly side with their mother and both Renata and the children have developed transactional patterns that exclude Isodore. The boundary between the parental subsystem and the children is somewhat diffuse, although not extremely problematic as the parents responded in agreement to my suggestion that family therapy move to couple therapy. The couple were directing therapy towards couple therapy early on in their involvement. Renata and Isodore were wanting to be a couple and had taken opportunities to spend time alone without the children.

Family's sources of support and stress in its ecological context. The family's sources of support in the geographic area around their current residence is limited to the friends that Isodore has been connected to through work. The closest extended family and former friends of the couple and children are beyond a four hour radius of their current residence. The children have had to form friendships within a peer group already well established and at an age that is not customary for young people to be attempting to reestablish a peer network. Renata is not currently employed and therefore has limited opportunity for social contact. She is largely reliant on the acquaintances and friendships that Isodore had already established prior to the remainder of the family's arrival.

The maternal grandmother had previously been a source of support to the family, in particular to Renata and the children. During the course of the family's therapeutic involvement with EHCC they returned to visit her and she came out to visit the family in their new home. Other extended family are described as less important to the family, but nonetheless the family has maintained contact to varying degrees. Of significant support to Isodore is his younger brother with whom he shares his passion for rugby.

An additional source of stress for the family is Renata's lack of employment outside of the home. She is attempting to secure employment but is having a difficult time. This is also a financial stressor on the family. At termination of therapy, she had yet to find employment.

To their advantage, this is a family who appears to be able to forge new friendships in their new community with relative ease. Both of the children and Renata have positive social skills which will help facilitate the growth of friendships. They are also a resourceful family as evidenced by them seeking out the help they needed by self-referring to EHCC for family therapy. In addition they have also explored and accessed leisure and entertainment opportunities.

Exploration of ways in which the identified patient's symptoms are used to maintain the family's transactional patterns. In this family it is not clear who the identified patient is or whether there is one identified. This depends on how the therapist views the family.

The family self-referred to family therapy with the presenting problem as the family system as a whole unit having a difficult time readjusting to the family being

together again. I could assess that in this family system there is no one particular identified as the identified patient or I could argue that Isodore is the identified patient although it is not as obvious as in other family systems where the presenting problem is an acting out child. The other family members are wanting him to accept the way things have been in the family prior to his return. By viewing him as the problem and the problem as his inability to adjust, the couple is kept from addressing their relational difficulties. For the remainder of the family having Isodore as the identified problem, removes responsibility from the remainder of the family members. They are attempting to protect a way of family life that they are accustomed to and maintain the current homeostatis of the relationships in the family.

I could also assess that Renata is the identified patient. In couple therapy, both Renata and Isodore identified that Renata's lack of self-esteem and past relationship with her father as the problem that was impacting on their marital relationship. Depending on how the family is viewed by the therapist depends as to who will be defined as the identified patient. I chose to approach this area in the assessment with caution as to not pathologize any one family member and assess that there is no one family member who is the identified patient.

Initial/tentative hypotheses

The initial hypothesis derived from the first session was that the family is in transition and they were having a difficult time readjusting their expectations of each other and how to relate to one another. They are a family that has just been reunited as a unit and is attempting to adjust to the presence of two parents. The family had been

accustomed to Renata being in charge, while Isodore occasionally came to visit. Now the family is once again living under the same roof. Given that this is a reconstituted family Isodore does not have equal status with Renata, as he might have if he had been the biological parent to Renata's two children. It is hypothesized that in this reconstituted family Isodore is not an equal parent to the two children given that he was also the last one to join the family. Now that the family is reunited and Isodore has a job, he perceives it as his opportunity to become the type of father he has always wanted to be. Isodore's attempt to be an equal parent to the children is creating conflict for the family.

They are a newly reformed family and a family in the developmental life cycle of having adolescents. The children were not keen about making such a big move when they had an already established peer group and identity in another town. It is hypothesized that the children are demanding more independence and are creating stress on the parental subsystem. Renata has responded with some sensitivity to the children's different needs while Isodore is still trying to establish himself as an authority figure in the home. The parental subsystem's incongruity of how to respond to the children's needs creates stress on the system.

Goals and Interventions

The goal of therapy was to strengthen the couple relationship, with the secondary goal of creating a cohesive parental unit. It was contracted with the couple following the second session that they be seen together as a unit. They responded to this recommendation with eagerness. The children were excused from attending subsequent sessions. As therapy progressed, it continued to focus on the couple as a unit and the

children were invited to rejoin therapy only at the termination session.

A therapeutic environment was created by initially joining equally with all family members, paying attention to allowing the quietest family members an opportunity to express themselves. I maintained a therapeutic environment by using different levels of involvement within sessions. The purpose was to create and maintain an environment that would allow the family to be able to address their issues, while challenging them to view their situation in a different way. I would point out to the family their strengths and when they progressed in ways that support each other. At times of duress and when the couple felt hopeless that change would occur, I provided them with hope and support. Joining also occurred by adopting the family's style, referred to by Minuchin (1974) as mimesis. Although the family saw their issues as serious, they had a pleasant and at times humorous approach. I joined with the family by engaging in a similar style.

Initially the focus was on developing a clearer understanding of the couple's transactional process and facilitating the opportunity for the couple to experience a different way of relating. Space was manipulated by having the couple change the seating arrangement in the room so that they faced each other rather than me. The purpose was to have the couple speak to each other rather than to me. The intervention was successful, producing the desired effect. The couple continued to sit in this seating arrangement in subsequent sessions and were more apt to speak to one another without prompting. Communication channels were also recreated marking that Isodore was the most vocal partner and often speaking for his wife. By providing Renata the opportunity to speak I assisted the couple in being able to put issues on the table and in changing patterns of

relating in the relationship. Isodore was clearly uncomfortable when his wife expressed her feelings and challenged him on things he does that bother her . She had not openly addressed these issues with him in the past. The shift in balance of roles presented a different relational pattern and left Isodore struggling with his role. He could no longer attempt to solve his wife`s problems, but now was now in the position of having to listen to her.

Family transactional patterns were actualized using a number of other strategies. When the couple in the initial sessions were more apt to discuss issues concerning the children, this was seen by me as a way of avoiding couple issues. I intervened by pointing out to them that they are really good at detouring, particularly Isodore, and directed them to discuss couple issues. I framed this to the couple in a number of ways which included directly pointing out to Isodore that he was going off topic, by asking my question again or reminding the couple what was being discussed and by pointing out that they were in session to look at couple issues and that we needed to get back on track. Eventually the couple would catch themselves going off on a tangent and would readdress the topic at hand. This intervention also helped create a serious atmosphere and respect that the couple was present to address their issues and not to waste their time. At times I took a challenging approach by pushing the couple to be uncomfortable and highlighting difficult issues between them. When the couple`s comfort level was disrupted they sought different ways of relating and expanded their repertoire of dealing with issues. The couple was also praised when they related in a way that allowed each partner the opportunity to get his/her point across. As sessions progressed the atmosphere created

was being maintained by the couple, with less effort by me. The couple was participating in discussions about issues while I took on more of a role of observer, rather than director. The couple's comfort level in therapy increased as they perceived it as a safe place and felt respected. They were bringing couple issues to therapy sessions with little prompting. They also reported that they were discussing issues on their own, outside of therapy sessions.

Tasks were assigned to the couple at the end of each session and were reviewed in the following session. The couple, although responding to task assignment with eagerness, did not complete many tasks as they had been assigned. Whether they completed them or not it provided the opportunity to learn more about the couple's transactional patterns. The times the couple followed through on the tasks provided them the opportunity to take the changed transactional patterns home and exercise them in their natural setting.

Reframing and the use of metaphors was useful in providing the couple with information about their relational pattern and what they needed to be doing and assisted the couple in being able to predict changes. I reframed that a relationship needs to be in balance, much like a catamaran, that crew members need to alter their moves on the boat in synchronicity with their partner. As one partner relates in one way, the other needs to respond in a way to balance the relationship and keep it floating. The issue of infidelity arose in session. It was revealed that an affair that Isodore had early on in their relationship continued to affect their relationship. A reframe that was helpful for the couple involved thinking about how the issues of infidelity has been dragging them down

for a long time. To personify their struggle I used the analogy of the couple dragging their past issues with them with the bag getting too heavy for them to keep carrying. To assist the couple in being able to perceive that the infidelity will become less important in their relationship and that they will find a way to forgive at intellectual and emotional levels. I used a metaphor involving mountain climbing.

I related how mountain climbing requires a team effort, and how at times the team has to surmount difficult obstacles. Although work is difficult at times, now and then they are able to enjoy each other's company and celebrate their achievements by sitting in a meadow and enjoying a picnic. The mountain climbing and "picnic" metaphors were subsequently commented on by the couple as they recalled that some of their friends had given them a picnic basket. They made plans to use the picnic basket. One way to interpret this statement was to think that the couple was celebrating their achievements in therapy by taking the time to have a relationship and enjoy each other's company.

Metaphors require a different level of communication than simply stating the issue. With this couple the use of a metaphor in session provided them with a different frame of their situation and different ways of living their relationship. The idea of having a picnic flourished in the couple looking at other ways to spend time together and enjoy each other's company. The use of the mountain climbing metaphor was also used to assist the couple predict the future of their relationship. I asked them what they would see when they reached the top and what would they do when they reached their destination. Finding a recipe for forgiveness was another metaphor used in session. It was framed that Renata needed to find the right recipe for forgiveness that worked for

her. Reframes and metaphors were useful in assisting the family to see their situation differently, providing a way of predicting the future, and for me to relay to the couple that I understood where they were at.

Upon exploration with the couple they identified the affair as a pivotal moment in their relationship. Renata had not understood why Isodore had chosen to have an affair and although Isodore had shared with her that he had the affair, Renata continued to have questions about it. Her trust in Isodore and her self-confidence were shaken when years following the affair the woman called him. Renata questioned herself and her relationship. A relationship pattern followed where due to her lack of trust in her husband she drew herself away from her husband and kept him at a distance. Isodore, wanting to be included, responded by questioning her and in response Renata continued to not share with him details of her and the children's lives. Renata disclosed the affair following discussions of trust and commitment. I had given them the task to do three things to entice each other, however Renata had not completed the task. Renata displayed much anxiety over having not completed the task and Isodore showed his disappointment that she did not do anything to entice him. I speculate that the affair was revealed at that time as the couple needed a reason to explain why Renata was not able to complete the task.

Outlining and emphasizing the family's strengths was another favored intervention. Working with the family strengths allows the therapist to join with the couple. Minuchin (1974) categorizes this strategy in the close position of joining. I reframed the couple's different parenting styles as complementary noting that the children

could benefit from this. One is objective and rational while the other parent's strengths with the children is her ability to develop relationships with the children. Rather than perceiving their differences as weaknesses, it was reframed as positive and that they could learn from each other. This reframe provided a different perspective on their differences and directed them to capitalize on their differences rather than be frustrated by them.

I also provided feedback to the couple about where they are at developmentally as a family. I gave Isodore the information that he is in the early parenting stage and is protective of the children. The children, being adolescents, are at the developmental stage of needing more freedom to make decisions. Since Renata has been able to adjust to the differing needs of the family, she was directed to give Isodore feedback on how to build a relationship with the children and to complement her husband on what he did well as a parent.

The couple was able to identify that the husband was left out of decisions and of participating in outings. They also identified that the lack of trust was a major issue in their relationship. Renata felt that her husband did not trust her and Isodore disagreed with this comment. He commented that he wanted to be included in the family life and in her life. The majority of the latter sessions with the couple was spent working on their relationship as a couple.

Making generalizations about relationships, where the therapist imposes "supposed" facts about relationships, is utilized when a therapist is adopting the role of an expert. I shared my expertise on relationships stating to the couple that the real fight is about their relationship and not the content of their disagreement. They are fighting about

trust and inclusion or commitment. My strategy was to name and exaggerate the issue. The issue of trust and inclusion was escalated by naming it a number of times over the length of time that the couple was in therapy. The purpose of this strategy was to have the couple own the problem as a couple, not as individuals, so that they can make changes as a couple. I directed the couple to move from individual responsibility to looking at the process of reciprocity in their relationship. How they relate to each other affects how their partner responds. I shared my view that the couple's relational pattern was based on how trust and inclusion are related to their way of approaching one another. I provided them with an explanation of how relational patterns are circular in nature. When one partner does not feel trusted, she does not want to be close and when the other does not feel included he attempts to be included by asking questions of what is happening. This circular pattern of relating continues when the other spouse excludes the other even more when he questions her on where she is going. She sees it as intrusive, not being allowed to be her own person, and not being trusted. I emphasized that this way of relating is driving each away from the other.

I commented that it is not uncommon for a couple "to get stuck" in a relational pattern. The intervention I chose at that point was to slow the couple down, rather than move on to a solution right away. I directed the couple to first explore whether they were prepared to commit to make some changes. When it was expressed by one of the spouses that they were unsure whether change could happen, I provided hope that change can happen and that I have seen couples stuck in relational patterns move on. The couple was directed to identify the risks of getting closer. Naming the risks allows them to be

acknowledged and heard by each spouse. I directed the couple to stop asking questions, being inquisitive, convincing their partner that they trust them, and to stop attempting to include the other person. The purpose was to direct the couple to relate differently. If they stopped these behaviors, other relational patterns would be able to surface.

I moved on to have the couple explore how they keep each other interested and engaged as a couple. The couple struggled to remember what they did to entice each other. They had an easier time remembering what each partner did for them that they appreciated. Since the couple was indicating that they wanted to be a couple, but their current experience as a couple did not indicate how they were nurturing their relationship, I decided to assign the couple the task of having to do three things to entice each other. The task followed by telling them that they were not to tell each other when and what they were doing to entice each other. This task proved to be interesting when reviewed with the couple at the next session. The partners were asked to comment on what their partner did to entice them since last session. The couple pointed out things that the other had not purposely set out to be enticing and engaging. Renata reported that she had not done anything to entice her husband. She showed discomfort with the task.

At that point in therapy, I hypothesized that she may be wanting to leave the relationship but had not yet declared herself. At the very least something was getting in the way of Renata becoming emotionally closer to her husband. The direction in therapy was to escalate the stress in the relationship, so as to provide the opportunity for the couple to bring to light what was keeping them from becoming closer. The couple revealed an unresolved affair. The affair had taken place many years previous and they

had attempted to put it behind them and move on in their relationship. I hypothesized that the feelings associated with the affair were unresolved for Renata and that the affair was the pivotal point in their relationship. For the couple to move on they needed to address it in therapy. The issues of trust, inclusion and commitment all related to the infidelity.

Several strategies were employed in session to assist the couple in dealing with the infidelity. I educated them about the two levels of forgiveness, intellectual and emotional. I cautioned the couple about change and emphasized that there may be some valid reasons why they may not want to change. This intervention opened the door for the couple to be able to acknowledge each other's concerns. I felt it was also important to instill hope that similar to other couples who have had to deal with this issue, they too could succeed in achieving forgiveness.

The couple was unsure of how to achieve a level of forgiveness where the infidelity would become less important in their relationship. I assisted the couple in identifying a forgiveness ritual, highlighting that Isodore's guilt was not enough. He needed to give the message to Renata that he understood how the affair had impacted on her. I externalized the infidelity to help the couple see it as something they both needed to work on rather than continue to drag around. The issue of infidelity was renamed injustice. Since injustice is a feeling, they were able to develop a plan or recipe for how to deal with it.

The couple was able to identify what the future would look like for them as a couple and even commented that they were being more affectionate to each other. They

identified affection as one ingredient in their recipe to forgiveness. The therapist directed the couple to hold hands. The purpose was to have the couple live in session what they were relaying about the return of affection in their relationship. Once given permission, they continued to hold hands throughout the session.

At termination the couple had made significant changes in how they related to one another. Renata stated and Isodore confirmed that she was not dragging up the past in their arguments. The couple was making conscious decisions about their role in their relationship and focusing on having a relationship. They were investing in their relationship, by making time for each other, supporting one another and making plans for their future as a couple.

As a last session I invited Candace and Luke to the session with Renata and Isodore. Since the therapy had initially been defined as family therapy and the family unit had been seen together, prior to redefining therapy as couple therapy, I felt it was important to include the children in the termination session. Having the children give feedback on how the family was currently functioning, confirmed that the changes experienced by the couple subsystem, had a positive impact on the functioning of the family system as a whole.

Impact of therapy on client system

There was an "equaling out" between the couple as therapy progressed. Once in couple therapy, Renata attempted to take the majority of the blame for the relational difficulties. Through the process of redefining their difficulties to their relational pattern, the infidelity issue arose and dominated therapy. Renata was able to let go of her feelings

that she was responsible for the couple's difficulties. While initially Isodore was the most vocal in the relationship, as couple therapy progressed, Renata became more vocal and assertive. Where she had been unable to express her feelings to her husband, she became more confident. Isodore's discomfort increased as his wife's confidence increased.

Therapy served to educate the couple on their relational and communication patterns. Once aware, the couple recognized their role in maintaining these patterns and were able to change them. Space was manipulated in therapy, with the couple directed to face each other and talk to each other rather than through the therapist. Interestingly once the couple was directed to face one another in session, in subsequent sessions they positioned themselves and their chairs to face one another.

Therapy provided a safe place for this couple to address some difficult feelings and issues. The support and direction provided by the therapy sessions allowed the couple to perceive that change was possible and that they could move on from the debilitating effects of an affair.

Evaluation

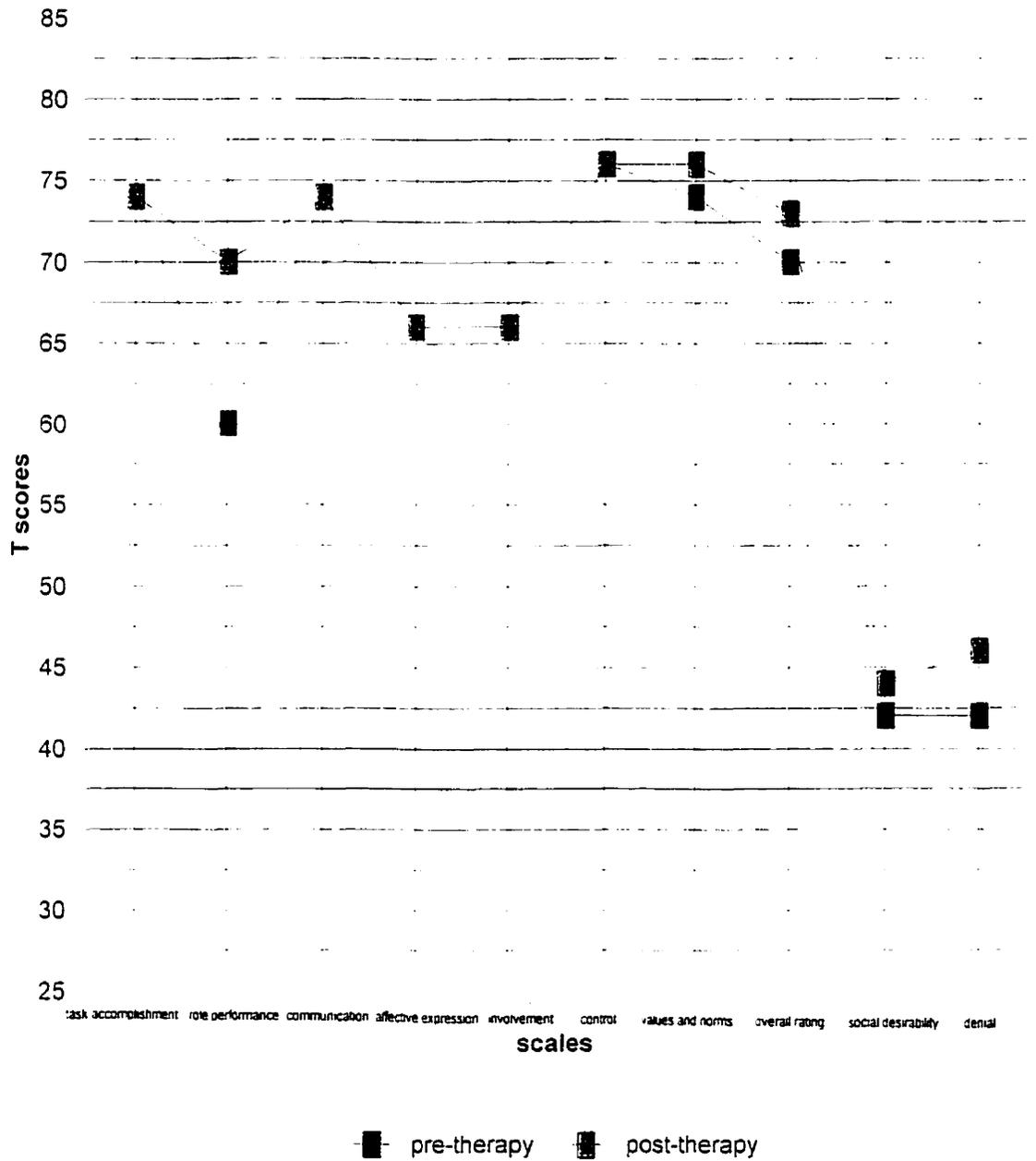
FAM III Profiles. The FAM III general scale was administered at pre and post therapy to all family members.

In the pre therapy profiles it was noted that Renata consistently scored in the problematic range. See Figure 1. Her scores are more elevated than the other family members. This may mean that she was distressed at the time of testing. Based on my clinical observations, Renata was the most anxious in therapy and had difficulty initially stating the issues that she was concerned about.

Figure 1

FAM-III General Scale

Family N - Renata



In comparing the couple's scores they were most similar in the communication scale. Renata scored 74 and Isodore scored 70. See Figure 2. Their profiles are more dissimilar than similar, with Isodore scoring lower than his wife on all scales with the exception of the role performance scale. Renata scored 60 while Isodore scored 66. The discrepancy between Isodore and Renata's profiles indicates that they do not agree on the severity of the problem and points to marital difficulties. The couple's scores in the communication and control scales are most dissimilar.

Isodore scored below the 4th percentile on the social desirability and denial scales (scores of 32 and 24 respectively), possibly indicating that there may be a validity problem with his scores. Isodore may have wanted to favorably portray the family's functioning.

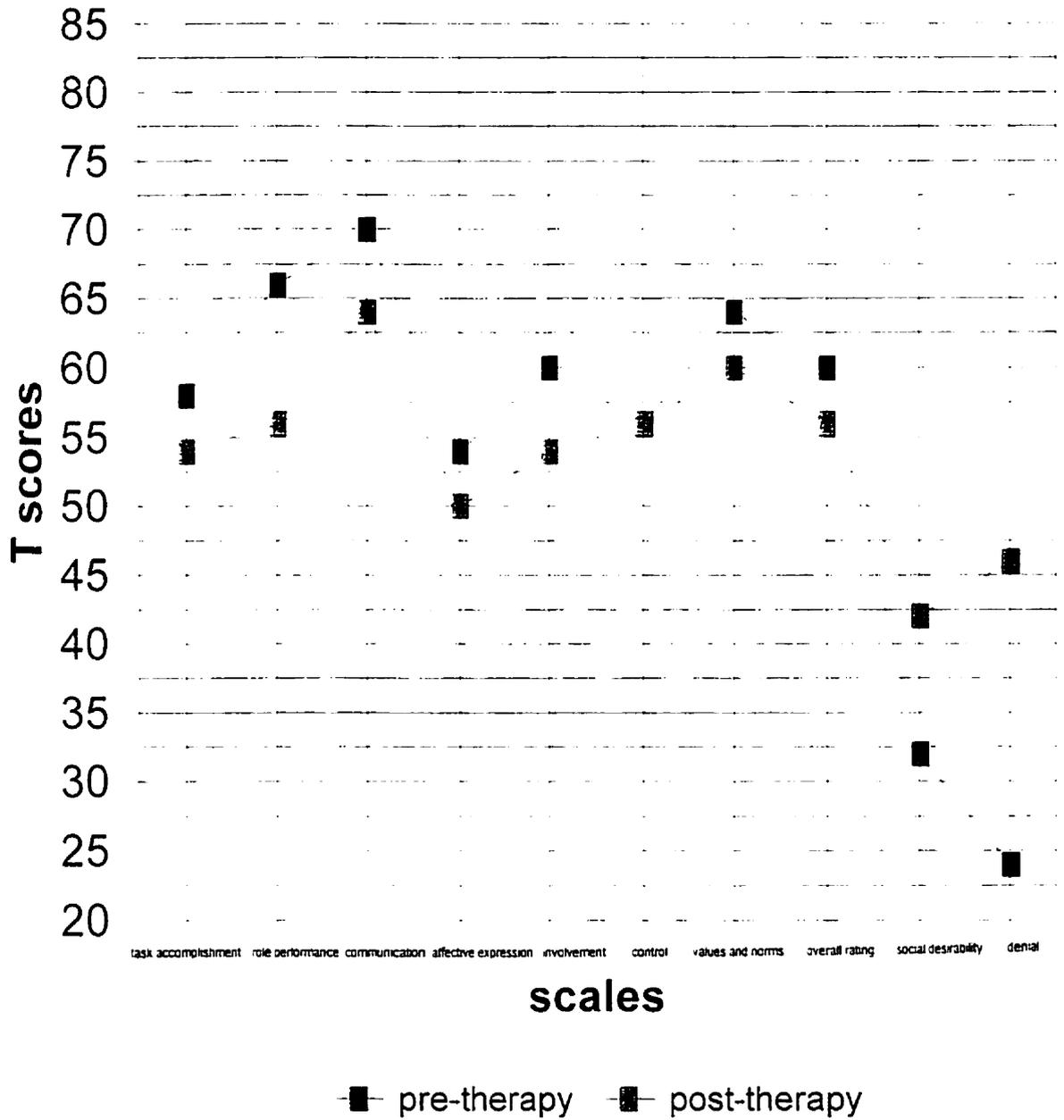
Most scores for all family members are in the family problem range (above 60) indicating that the family problems are generalized across all family members. Isodore and Luke's profiles (See Figure 3) are similar in comparison to the other two family members, while all of Candace (See Figure 4) and Renata's scores are in the problematic range (falling at 60 or higher). This indicates that they perceive family problems as more severe than Isodore and Luke.

The scores between pre and post therapy for the couple showed little change. Renata's pre and post test profiles are very similar, differing only in the role performance scale. In the pre test she scored 60 and in the post test she scored 70, possibly indicating that Renata is seeing her family has having a difficult time adjusting to the roles of family

FAM-III General Scale

Figure 2

Family N - Isodore



FAM-III General Scale

Figure 3

Family N - Luke

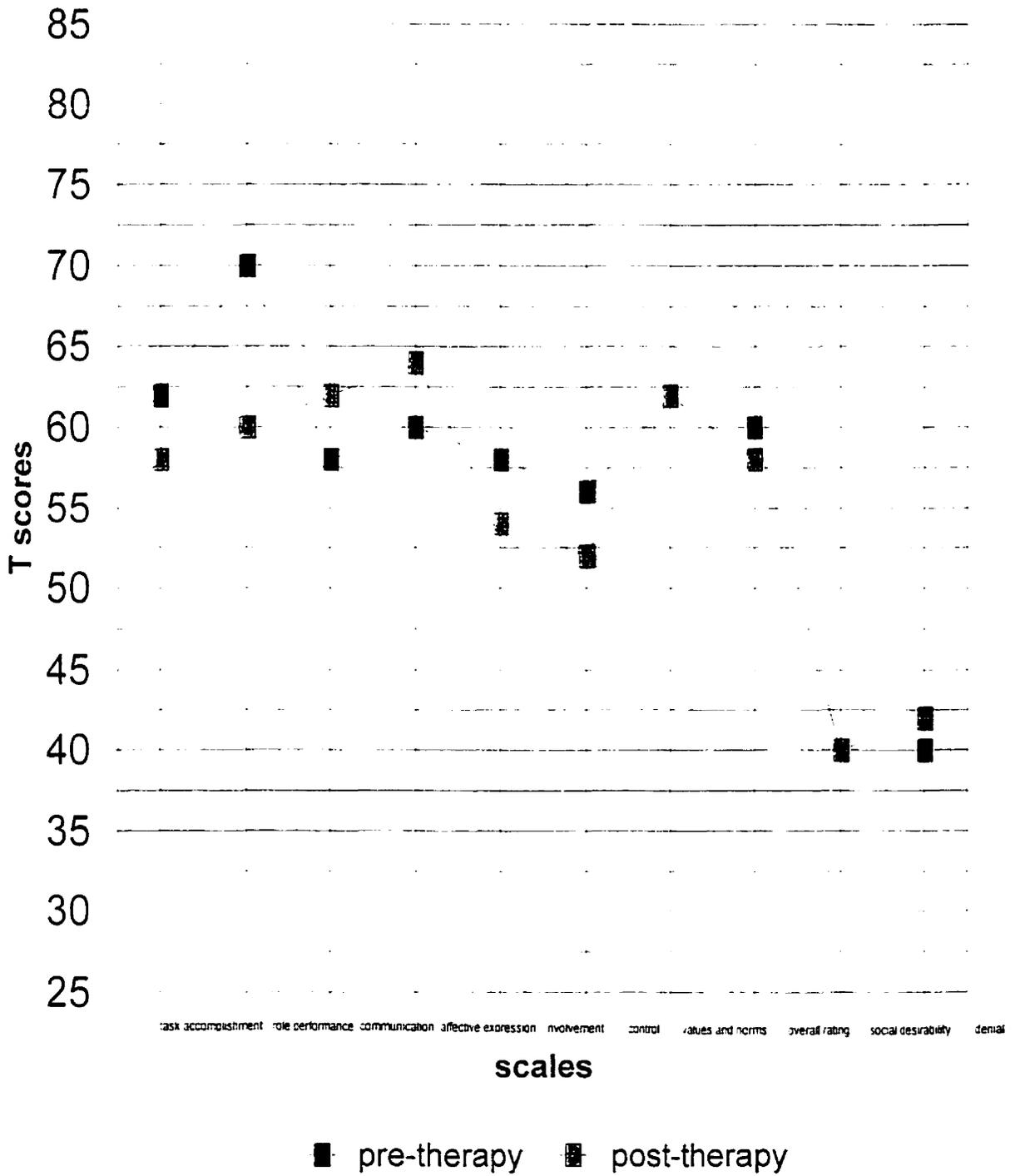
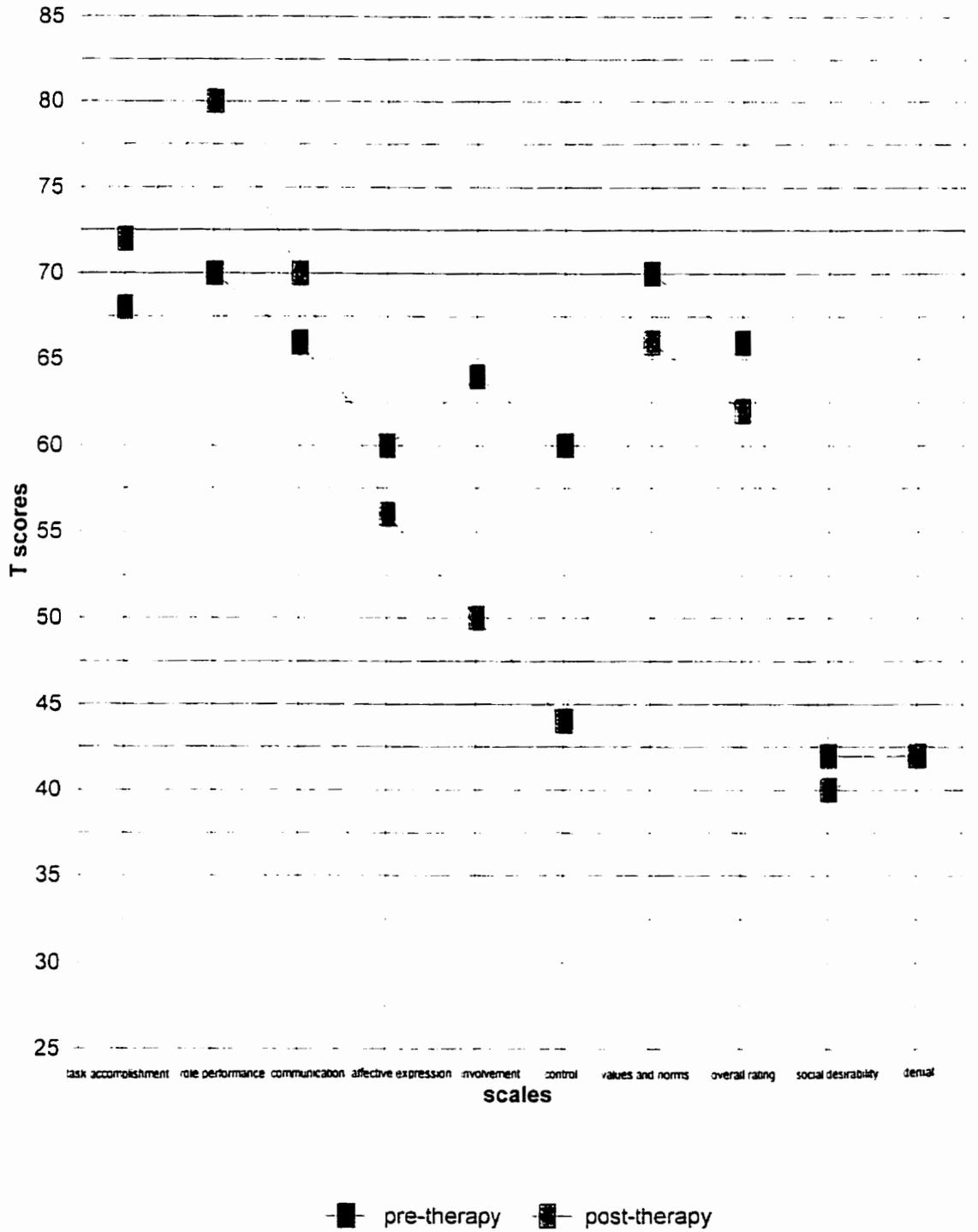


Figure 4

FAM-III General Scale

Family N - Candace



members, following therapy.

On the post test, Isodore's scores in the social desirability and denial scales meet the requirement to be considered valid. Isodore scores are primarily in the average range with the exception of the communication scale, where his profile score is 64. Isodore's elevated score in this area possibly indicates that family members are not consistently effective in exchanging necessary information. In comparison, Renata's scores all fall in the problematic range. The differences in profiles indicate that the couple has different perceptions of family functioning. Renata's highest score is in the control scale indicating that from her perception, the family engages in power struggles over who is right or who wins.

Candance's pre and post therapy profiles are quite different. While her pre test profile is in the 60 to 70 range on all scales, her post test profile varies from 80 on the role performance scale to 44 on the control scale. Her profile is the most dissimilar in comparison to the other family members. She perceives that her family has made gains in the affective expression, involvement, control and values and norms scales, but has more difficulties with task accomplishment and role performance.

Luke's post therapy profile scores are lower than his pre therapy scores, on most scales with the exception of the communication and affective expression scales. On his pre therapy scale Luke scored 58 on the communication scale and 60 on the affective involvement scale. On his post therapy scale Luke scored 62 and 64 respectively.

The changes in Luke and Candance's pre and post therapy profile indicate that some aspects of family functioning have improved over the course of the time that the

family was seen in therapy. However, the FAM III general was not the most useful in demonstrating the changes observed and reported by the couple at termination. Given that therapy was redefined as couple therapy, it would have been useful to have the couple also complete the dyadic scales of the FAM. The dyadic scales may have revealed more of the changes observed in sessions in the couple dyad.

It is difficult to predict what I could expect to happen in the next year for the family given that the family will continue to face new challenges as Candace and Luke grow closer to becoming young adults. I could however predict that Isodore and Renata's scores on the FAM III profiles will become more similar as they continue to grow as a couple and become a more cohesive parental unit. In regards to Candace's scores, I predict that they will either remain elevated and in the problematic range as she struggles to gain more independence and defines a role for herself outside of the family system. Luke's scores, I predict, will probably remain the same, in the average range.

Client satisfaction questionnaire. All four family members filled out a client satisfaction questionnaire. All four family members saw changes in the way the couple related to one another. The couple reported that they are able to be more open about their feelings, are more laid back and express appreciation for one another. The children commented that the couple has fewer fights and are more openly affectionate to one another in the home. I observed that Renata in particular was able to be more open with her feelings through the course of therapy. They also expressed their affection for one another more readily as therapy progressed, often with Renata taking the lead. Upon termination, the couple presented as a more cohesive unit and supported one another's

decisions in the presence of the children. While at the beginning of therapy the couple was reluctant to share feelings and would avoid problematic areas, by termination the couple became aware of their relational patterns and was making a conscious effort to not fall into the same destructive patterns.

What did I learn from this family?

Working with this family provided me with the opportunity to work with a couple subsystem and marital issues. I learned that a family may initially identify or frame an issue as a family problem, but that the focus of intervention may need to rest with a subsystem. I have gained experience in how to reframe family therapy to couple therapy and how to move the couple in this direction. The experience has taught me to pay attention to how subsystems are functioning and how marital problems can impact on the functioning of the family as a whole. An unhealthy executive subsystem in a family impacts on the how the family can meet the needs of the individuals.

I had to supplement my knowledge on family therapy by reading materials specific to marital therapy as the literature on structural family therapy did not adequately provide me with sufficient knowledge in working with couples. Being able to apply the knowledge I gained in the additional readings strengthened my skills. Overall it provided me with a more diverse practicum experience.

The E family

The E family consists of a pre-adolescent girl, Zoe, her biological mother, Susan and Susan's common law husband, Paul. The family was seen for a total of seven sessions over the course of six months. Three sessions were held with the family as a unit

and four sessions were held with the parental subsystem. In addition the therapist had three telephone conversations with Susan. The initial two sessions focused on gaining a better understanding of the family and involved all three family members. Initially I spent some time joining with each family member, paying attention that Zoe was engaged, given her young age. Zoe presented as fairly assertive and was attentive during sessions. She engaged in discussions eagerly and at times I drew a boundary between Zoe and the parental unit to highlight that Zoe was not the center of attention.

Reason for referral

This is a newly formed family. Susan and Paul had been dating for six months before deciding that Susan and Zoe would move in with him. The decision of who would move was made easier by the fact that Paul owned his home, while Susan rented. The family had moved in together three months prior to being seen in family therapy. This meant a new family structure, new home, new community, new school and new peer group for Zoe.

Susan was separated from Zoe's biological father for two years prior to meeting Paul. Zoe visits with her father every second weekend and spends the occasional school holiday with him. He is also in a new relationship and Zoe rarely spends time alone with her father when she visits. Paul was also previously married and has two adolescent boys from this union. Given the geographic distance, Paul sees his boys infrequently. When they come for a visit it is usually for a number of weeks at a time.

The presenting problem was Zoe's anger, expression of feelings and disrespect for Susan. Zoe was also experiencing behavioral difficulties at school and on the bus.

despite being an average to above average student. At home her anger was characterized as stomping to her room, throwing her belongings and telling her mother she hates her. At school, Zoe was described as uncooperative and refusing to participate in classroom activities. She was described as a bright and creative student, who speeds through her work. There was no concern at the time of referral of Zoe not passing her grade. Susan's goal was to better understand her daughter and why she gets so angry. Paul wanted Zoe to handle her anger and not escalate so quickly.

General understanding of family functioning from a structural perspective

Developmental stage of the family. This family is at two developmental stages. First, since they are a newly formed family they are at the beginning stage of family formation where the couple is attempting to establish the couple subsystem. They are also at the developmental stage of a family with a pre-adolescent child. At the same time that the couple is attempting to establish themselves the family also needs to adapt to having a pre-adolescent girl in the home. Zoe is at a developmental stage where she needs parental involvement in her life and structure, however her peers are gaining importance in her life.

Family structure. The E family is in transition and attempting to establish themselves as a family. Paul and Susan bring to this union two different parenting approaches. Susan is the nurturer in the family and her parenting style is to respond "from the heart" to her daughter, while Paul's parenting style is to be more analytic and concrete. Although initially Paul's role with Zoe was determined by the couple that he would be just a friend, it became clearer in sessions that Paul takes on an active parenting

role and is involved in the day to day decision making.

Zoe and her mother lived predominantly alone from the time of her birth, given that even when Susan and her ex-husband were married he spent very little time at home. Susan's experience was to parent as a single parent. Now that Paul is part of the family, he is attempting to take part in parenting Zoe. This is a change for Susan and Zoe. The adults are struggling with which approach to take with Zoe and how best to parent her. They had not spent time exploring their differences or planning how best to deal with her and therefore they are not a cohesive parenting subsystem.

The boundaries between the parental subsystem and Zoe as the child subsystem is unclear. Susan and Paul's expectations of Zoe are that she behave a lot older than what she is. They expect her to handle her feelings like an adult. They want her to verbalize her feelings, know when she will get angry, remove herself from a conflictual situation and deal with the stresses of the recent changes in her life. Paul is currently co-parenting at a distance his two teenage sons and his parenting style with his boys is to give them explanations of what his expectations are and the reason for them. The expectation is that the boys will follow through on their father's wishes, a parenting style he is attempting to replicate with Zoe. He is frustrated with the emotional intensity that parenting Zoe presents. Paul is not taking into consideration that Zoe is a different person than his sons and at a different developmental level. In addition she is still in transition with both her mother and her biological father and trying to figure out her role, given that the family composition has been altered in both families. She used to be the center of attention at both her mother's and father's home and now has to share her parents with their new

partners.

Flexibility of the system. Assessing a system's flexibility involves assessing the system's capacity for change. The couple was very interested in trying to address the difficulties they were experiencing as a family. There is a strong commitment on Susan's part to her daughter and Paul appears to have taken an active interest in his step-daughter's well being. Both partners attended therapy and readily engaged in the therapeutic process. Both partners were able to hear each other's thoughts. Zoe had not always been a difficult child and the family identified times that they were able to relate in a positive way without feeling frustrated.

Where does the family fall on the continuum of enmeshed-disengaged? The family's boundaries fall closer to the enmeshed side of the continuum, where there is little differentiation between family members. Enmeshment exists in the dyad of Susan and Zoe. Susan reported feeling that her daughter was engaging in tantrums purposely to upset her. Zoe and Susan lived alone for a number of years without another adult present in their lives. Zoe figured out how to push her mother's "buttons" to get what she wants. With Paul in the picture, Zoe has been displaced as the main person in her mother's life. He also brings with him a different view of family life, therefore unbalancing the mother daughter unit. Zoe is expected to behave much older than her age. The parents have leaned towards the expectation the Zoe know how to handle her feelings and that if they explain to her the behavior they expect that she will be able to follow through.

Family's sources of support and stress in its ecological context. There are a number of sources of stress for the E family. Susan and Zoe moved in with Paul, which

resulted in a new community, new home and new daily routines for all of them. Susan used to be able to take the transit system to work, however now must rely on Paul to drive her to work every morning, as she does not have a vehicle nor does she have a valid driver's license. The move meant that Zoe had to change schools and leave her peer group behind. She is now attempting to reestablish herself in a peer group and acquaint herself with a different school. Zoe was a young person that was well liked in her previous school by peers and excelled in school. She is having to reestablish a reputation in her new school. Her mother's and Paul's work schedule and distance from work has meant that Zoe has had to get up much earlier than previously and attend before and after school care. Also due to the adult's work commitments and Zoe's visitation schedule with her father, she spends limited time at home with her new family unit.

Zoe's biological father is another source of stress for the family. He is inconsistent in providing maintenance for Zoe and is not interested in having Zoe spend more time with him than the scheduled weekend visits. He and Susan continue to share an antagonistic relationship. They rarely speak and Zoe is the one informing each parent of what is happening for her in the respective homes. She is the intermediary between her biological parents. The biological father has rarely been interested in what Zoe is doing at school or in extra-curricular activities, which frustrates Susan.

Exploration of ways in which the identified patient's symptoms are used to maintain the family's transactional patterns. The identified patient was Zoe. Upon intake Susan contented that there had to be something wrong with her daughter and that she was the one who needed help. Zoe's behavior in and outside of the home was an indicator

that the family was struggling with the changes brought on by the new partners in her biological parent's lives.

Initial/tentative hypothesis

The initial hypothesis derived was that this is a family transitioning from a single parent to a two parent family. The family is struggling to blend their two parenting approaches at the same time that Zoe is struggling to find her place in both her mother's and biological father's homes. It was hypothesized that Susan and Paul were not functioning as a cohesive parental unit. They are at an early stage of family formation and need to establish rules of relating as a couple subsystem at the same time that they are having to negotiate how they will parent.

Both partners are entering into the relationship with a history of parenting. Susan has been parenting Zoe mostly as a single parent, without having to negotiate with a partner how she will parent. Paul has parented his two boys in partnership with his ex-wife for a number of years before they separated and now co-parents them at a distance. Paul's boys are in their later years as adolescents and therefore presenting different parenting needs than Zoe. Keeping their history of parenting in mind, it was thought that the couple subsystem needs to negotiate their parenting role vis a vis Zoe in this newly created family system.

Zoe was seen as struggling with the changes that occurred in her life in the past few months. She required guidance and support from the parental figures in her life of how to manage her feelings and to create some predictability in her everyday life.

Goals and interventions

The goal of therapy was to empower the parental subsystem to assist Zoe in her struggles with the transitions in family composition and in her new environment. Following two assessment sessions I contracted with the family to see the parental subsystem in therapy for a series of sessions without Zoe. The objectives derived from the assessment were to strengthen the boundary between the parental and child subsystems, assist the family in defining its role as a newly created stepfamily and Paul's role as stepparent, normalize Zoe's reactions in response to the struggles she is experiencing and help the parental subsystem to learn to recognize Zoe's needs and feelings and respond in helpful ways to her. An additional objective was for the parental subsystem to create a family life that balances structure and nurturance.

I utilized the median position in joining with the family, where I joined in with the family as an active, neutral listener. The purpose was to allow the family members to describe their view of what was happening for them as a family and to gain an understanding of the intensity of the problem. I further gained an understanding of the family structure by having the family describe a typical day. Tracking, where the therapist asks clarifying questions, makes approving comments or elicits amplification of a point, was utilized in the assessment phase of the therapy sessions. This approach was successful in finding out that the family spends little time as a family unit. Zoe spends considerable time over at a peer's house before and after school. The adult's work schedule, her school schedule and the fact that she visits with her biological father every second weekend leaves her very little time with her primary family. The family had noticed that her behavior is less problematic the more successive days she spent at home

with them. It was hypothesized that the family was struggling to find meaningful time together. They feel like they are "fighting" with Zoe most of the time they are together leaving them exasperated.

Although the adults stated they wanted Zoe to spend more time at home, they would leave it up to Zoe to make that decision. I used my tone of voice to amplify how the adults needed to provide the structure to have this happen and that to ensure that this would occur they would need to take charge as the parental figures to restructure Zoe's time spend outside of their home.

I was conscious of joining with Zoe and attempting to have her participate in session by providing her point of view of the problem. At times however Zoe was purposely excluded as an active participant in discussion and directed to listen to what her mother and Paul had to say. The family system's structure was altered by purposely drawing a boundary between the parental and child subsystems. Zoe was skilled at answering questions that were directed at her mother. A boundary was drawn between the two subsystems by redirecting the question to Susan and directing Zoe that the question was meant for Susan. Boundaries were further marked between Paul and Susan since they had identified that Susan was Zoe's parent and Paul's role was identified as being her "friend". I therefore focused on Susan as the expert on her daughter and directed parenting questions towards Susan. My approach was to differentiate roles within the system.

In sessions Paul was much more involved in parenting Zoe than the couple had verbally expressed. I hypothesized that the parental subsystem had not made the time to

explore and understand each other's approach and merits of both. They were functioning independent of each other and possibly against each other. I chose to reframe these differences as strengths and the potential for mutual support. Therapy served as an opportunity for the couple to express individual point of views on parenting.

I continued to join with the family by identifying strengths in their daughter, with the purpose of reframing their perception of Zoe. I highlighted that I saw Zoe as a bright child and her assertive nature was a strength. Examples of their strengths as parents and how they demonstrate their care for Zoe include the following: (a) they really care about her well being, (b) they do things for each other and nurture her, (c) they have a bedtime ritual that involves hugs, (d) they praise their daughter, (e) in making the commitment to attend therapy they are demonstrating their commitment to their new family, and (e) as a family, they have a number of neat ideas of how they see things happening in their family and are accepting of their daughter's opinion. I also normalized Zoe's need to adjust to the changes that had occurred by them moving in together. Zoe was not only having to adjust to changes in her primary family but also the changes in relationships with her father and this home. I established my expertise by sharing that it usually takes on average a year for children to settle into a new environment. By the start of her second year in the same school, Zoe and the family were reportedly more settled.

Tasks were assigned in therapeutic sessions to concretely have the couple transfer some of the work they did in sessions to their home. Tasks were purposeful in strengthening the parental subsystem's role of making decisions and following through on them once home. When the family did not complete an assigned task, the risks and

benefits of the task were explored in session. This allowed family members the opportunity to voice their concerns and open the possibility of the family addressing these concerns. When the family completed a task they were praised for their seriousness of wanting to make changes in their family life. In session the family looked at how to effectively have chores completed in the home. The adults were given the task of designing a system to make this occur and to keep it going. Zoe's role was to remind her parents of the task. The goal of the task was for the parents to communicate about parenting issues beyond the therapy session. The purpose of giving Zoe a role in the task was for her to have an investment in the task and increase the opportunity that she would cooperate with the parents when they figured out how to make it happen.

Zoe's anger was reframed from being a behavior problem to needing to learn what to do with her feelings. Susan felt strongly that her daughter needed to see a therapist for individual therapy. To alleviate her concerns I saw Zoe in an individual session. The one on one session with Zoe also served the purpose to assess whether there was any issues for Zoe that she may not have wanted to share with her parents in the room. None were indicated. My approach was to involve the parental system in assisting her in learning what to do with her anger and feelings in general. The parent's role was reframed as that of a coach. A coach helps develop skills in a person by breaking down the steps that are needed to build that skill. In this case the skill is helping Zoe express her feelings in healthy ways. In addition the people who live with her are in the best situation to coach her on a daily basis. Talking in coaching terms helped the parental subsystem to begin to look at the process of how they were going to achieve the task of helping Zoe develop the

skills needed to express her feelings.

A session with the parental subsystem focused on developing the coaching skills in the parents to be able to transfer them back to Zoe. The parental unit was given the task of observing her affect for a week. The purpose of the task was to make the obvious more obvious. Taking note of her affect at all times not only when she does not deal well with her feelings would help highlight when she is coping well and what occurs when this happens. This would provide the parents with a more balanced view of their daughter as well as give them insight under what circumstances she respond in an appropriate manner. In the session following the assignment of the task of observing Zoe's affect the adults reported that Zoe had been happy all week and that they were able to set limits without Zoe throwing a tantrum or being angry in an exaggerated way. Affect was further explored in session with the adults and exploring what their daughter is attempting to communicate through her expression of feelings. The couple identified that when Zoe is angry she is expressing her disagreement and telling them to back off, she needs time and space. Identifying the meaning behind the expression of feelings redefined how they perceived Zoe's behavior and gave them new ideas of how to respond to her. The couple also identified that they may not always be sure of why Zoe is responding in a certain way therefore they planned to ask her directly. I directed the couple to think about how they handle their feelings and how they could apply this to assisting Zoe in her expression of affect.

During one session the adults identified a teacher at Zoe's school who they admired as being able to maintain a sense of order in the classroom while at the same

time able to be able to foster the students' interest in learning. I took this opportunity to draw parallels from teaching to parenting. In exploring the qualities they admired in this teacher and the strategies this teacher employed to get the result they perceived as successful. Susan and Paul were able to identify how they could replicate some of the same ideas within their own home. One of the main themes for this family was how much time Zoe spends away from their household and how this presents as a challenge in maintaining a sense of structure in their home and build a relationship with Zoe. The intervention utilized was to highlight the importance of keeping a balanced approach in their parenting. I hypothesized that the family was focusing on structuring Zoe's life and wanting to maintain a structured set of expectations and were not balancing this out with building a relationship with Zoe. The couple was aided in exploring how they could meet a balance of the nurturing and setting structure in their daughter's life. The family was also assigned tasks in this area to transfer their thoughts and plans into action in their home.

I guided the parental unit to problem solve as a team and to help each other out. This was done while keeping in mind that the primary parent is Susan and delineating boundaries between them. since Paul had been identified as taking on the role of being Zoe's friend and not an active parent. To delineate boundaries I assigned parenting tasks to Susan. Using the reframe of coaching Zoe. I focused on Susan being the coach and Paul being the assistant coach. Susan's role as the parental figure in her daughter's life was reinforced.

Boundaries continued to be marked between the parental subsystem and the child

subsystem by intensifying the message that Susan is the parent and Zoe is the child in this family and Susan makes the decisions of when a friend comes over and how long she stays. Susan presented as ambivalent over how much limit setting she should do and how many decisions should she allow her daughter to make for herself. I gave Susan permission to set limits and stated that this was part of her role as a parent.

I continued to join with the parental subsystem throughout the time they were in therapy by giving them positive feedback. I reinforced that Susan had done a good job parenting her daughter. Other positives included giving feedback that Zoe is a resilient young person and reinforcing the positives steps the family was taking in establishing a sense of predictability in their home. The purpose of these statements was also to build the parents' confidence in their abilities as parents. I reframed Zoe's defiance of their expectations and argumentative nature as a strength in that she would not be easily led by peers. Towards the end of therapy, both Susan and Paul were able to identify strengths in Zoe and were able to see that the qualities about her that they had struggled with could be positives in helping her cope through life and in particular in adolescence. They moved towards enjoying their daughter and nurturing her. For example, prior to termination, the couple identified how they both took some time off of work to bring her to her first day back to school after the summer break.

Susan expressed her frustration with Zoe's biological father and over not knowing what was happening for her daughter during their visits. Her frustration was accentuated by watching how Paul parents his own boys and the interest he takes in their upbringing despite the geographic distance between them. Susan identified that she had been

reaching out for support from coworkers and that this had been helpful in reinforcing that her daughter is similar to other children in stepfamilies.

Impact of therapy on client system

At termination the parental subsystem was functioning as a more cohesive unit and they had a more realistic set of expectations of Zoe. The parent's confidence about their ability as parental figures to respond to her different needs increased. They were able to see positives in their daughter and were appreciating her uniqueness as an individual.

Within the parental subsystem, Susan was taking the lead in making decisions about her daughter and felt positively about this. She received some criticism from Paul, but demonstrated that she could defend her position. In the end Paul demonstrated that he could back up Susan.

Zoe was reportedly more settled at home and at school. Termination of therapy occurred following the beginning of a new school year and she was reportedly finding her own place among her "new" peer group. There was also evidence that Zoe was coping better with visits with her biological father, although communication between Susan and her ex-husband continue to be sporadic.

The E family reported upon termination that they was a decrease in problematic situations and that they as a family unit were happier. Susan and Paul expressed some anxiety over Zoe reaching adolescence, however they were open to the idea of learning more on how to parent an adolescent. I recommended they explore parenting support groups on parenting adolescents and they were provided with the name of resources

within their community.

Therapy provided the couple with the opportunity to express their views and plan how they would approach Zoe. Therapy served as an opportunity for the family to view their situation as normal and created the hope that they could survive as a family. It was also a place of affirmation that individual members of the family had strengths and were capable of change.

Evaluation

FAM III Profiles. The FAM III general scale was administered at pre and post therapy to Susan (See Figure 5) and Paul (See Figure 6). The results of the pre therapy FAM III profiles suggest that the E family falls within the problematic to average range on most dimensions of family functioning. Paul scored higher on all scales with the exception of the task accomplishment dimension where both he and Susan had the same score (56). This observed difference corroborates the assessment that this is a relatively new family still attempting to adjust as a family unit and define their roles. Between the two adults there is a difference in the assessment of role performance. Where Paul's profile is elevated in this area, Susan's dips in comparison to the remainder of her profile. Paul scored a 66 and Susan 48. These results possibly indicate that Paul is struggling with his role as stepparent to Zoe and common law husband to Susan.

The post therapy FAM III profiles corroborate my observations and the report from the family. Both Susan and Paul's profiles mirror each other and fall within the average to typical range. This indicates that the couple is in agreement in how they perceive their family functioning.

Figure 5

FAM-III General Scale

Family E - Susan

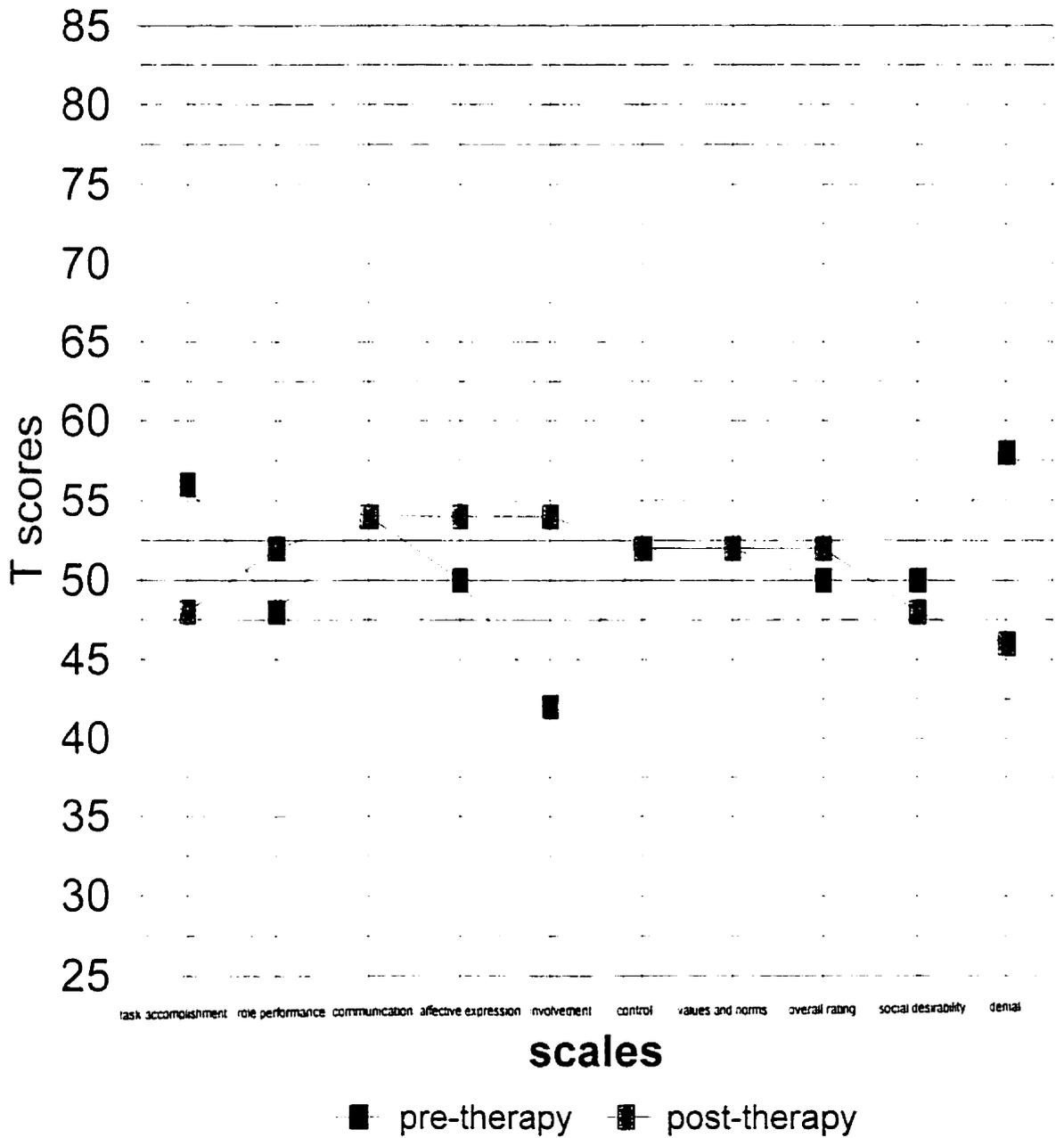
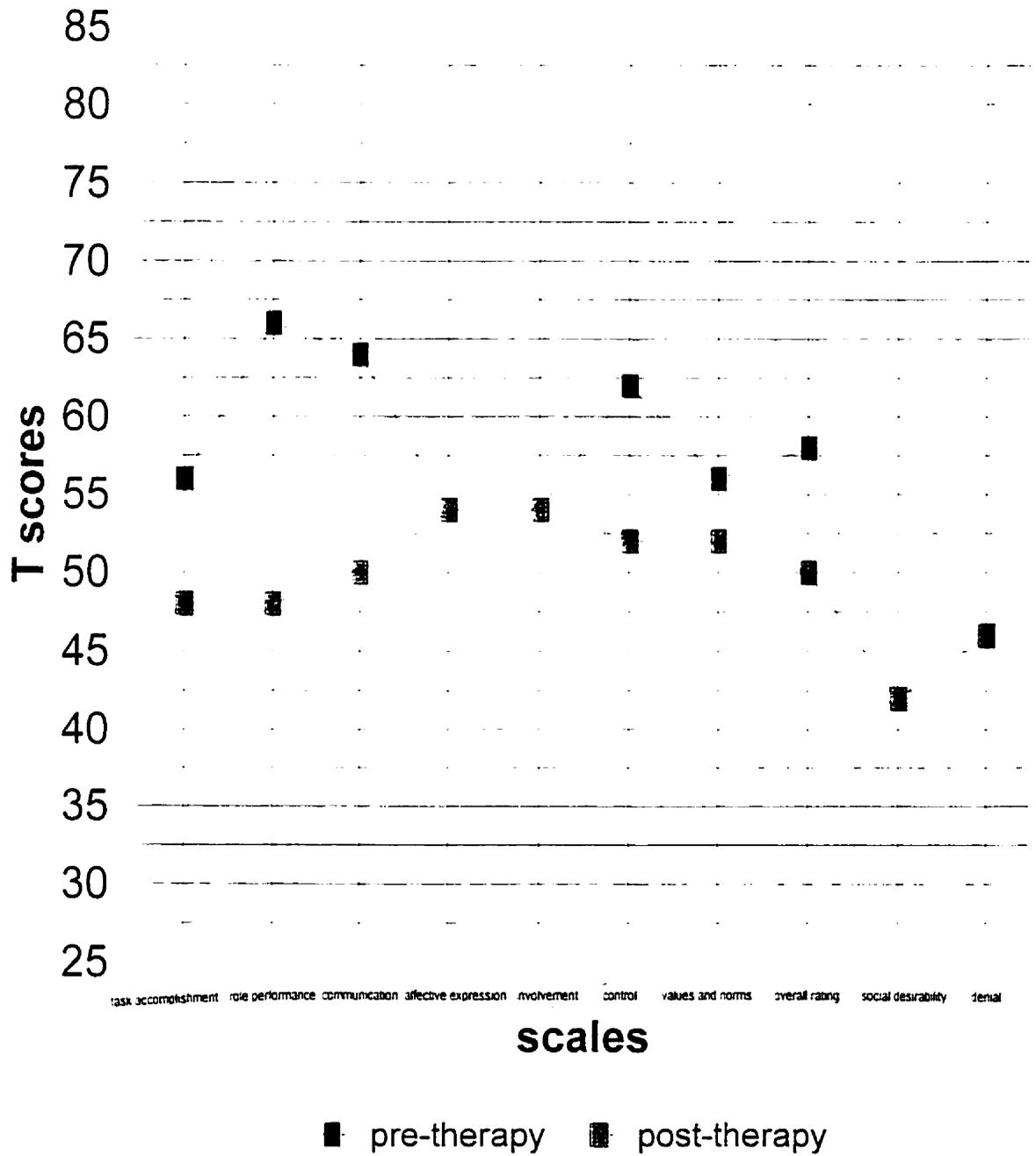


Figure 6

FAM-III General Scale

Family E - Paul



By comparing the pre and post therapy FAM profiles, Susan's scores overall remained constant, with the exception of her score in the affective involvement and task accomplishment scales. Her score on the affective involvement scale went from 42 at pre therapy to 54 at post test while her score on the task accomplishment scale went from 58 at pre therapy to 48 at post therapy. Although all scores still fall in the average range, this fluctuation possibly means that following therapy Susan is more clearly understanding the needs of her family and the need for additional information on parenting a preadolescent. Both partners' scores on task accomplishment decreased. Both were at 58 at pre therapy and decreased to 48 at post therapy, corroborating my clinical observations that the family is moving towards better problem solving and the ability to respond to the family life cycle changes. Paul's score in the role performance scale decreased from 66 at pre therapy to 52 at post therapy indicating that he perceives the family having been able to adapt to the new roles required by their new family. Similar changes have also occurred in the communication and control scales, indicating that Paul's perception of the family is that they are able to respond to the needs of their family unit in a positive way.

Client satisfaction questionnaire. Susan and Paul filled out a client satisfaction questionnaire at the termination session. Both felt positively about their involvement. They reported that they are working as a family unit and in the process are understanding their daughter better. They have changed their expectations of her and they are happy with where their family is at. Susan reported that the most helpful aspect of therapy was "understanding you have to all help out in making a family (new one) work out". She also reported that "we like being a family".

What did I learn from this family?

From the additional readings on stepfamilies I strengthened my knowledge of interventions for stepfamilies. For example I learned to be more flexible than the structural family therapy model suggests about boundaries and hierarchy. It is normal that in some stepfamilies the stepparent will have a different role than had if he/she been a biological parent. I learned that stepfamilies, in particular newly created stepfamilies, may require an educational model of intervention. They need information about what to expect and what is normal. The other piece about stepfamilies that was reinforced in working with this family was the need for the family to feel hopeful. In this case the use of identifying strengths, as is part of the structural family therapy model was beneficial for the family. A significant learning in this case was the need to focus on a few issues and have faith that by the family making changes in a few aspects of their lives it will impact on other areas. This case helped me build on my skills in working with younger children in a family therapy setting and learn how to engage them in therapy.

CHAPTER 4

Common Themes

Through the application of structural family therapy as a model, I found it useful to look at the developmental stage of the family and how families were meeting the tasks of that family life cycle stage. I also found it useful to consider the family's strengths and sources of stress. Recognizing that modifications are needed to the structural family therapy model to adequately address the needs of stepfamilies, I found it necessary to build on my knowledge base of this family type. Specifically in this chapter I will further explore the following: a) the use of the family life cycle framework and how it complements structural family therapy, b) the use of a strengths based model and how it assisted families in viewing themselves as capable of moving forward, and c) aspects to consider in working with stepfamilies and how I applied these to the two stepfamilies seen as part of this practicum.

The use of the family life cycle framework

A functional family is defined by its ability to fulfill its functions and respond to developmental changes. Including an assessment of where the family was at developmentally and including information from the family life cycle framework benefitted my practice and therapy with the families seen in this practicum. The family life cycle framework (Carter & McGoldrick, 1989) helped me assess families, form hypotheses, clarify goals for intervention, and understand the family at a particular point in time and how the structure of the family needs to change over time. The model helped me to provide information to families of what is normal for the developmental stage they

are at and what they can expect in the future.

As identified in the case analysis chapter, family N was assessed at two developmental stages. Having experienced a lengthy separation they are reunited. The couple subsystem is at the beginning stage of family formation and they need to renegotiate ways of relating to one another. They are also a family with adolescent children. Incorporating the life cycle model helped me understand where this couple was at and explore their transactional patterns of relating. The information gathered then assisted in identifying goals for interventions, in particular altering their way of relating.

Families Q and U are families with adolescents. Looking at the tasks of a family with adolescents, I identified that these two families needed to cope with the increasing needs of their young persons to be more independent and the need for boundaries within the family system to be more flexible to allow individuation from the family. The goals therefore developed around this issue were similar for both. They included normalizing the family's struggle as they transition to a family with an adolescent, strengthening boundaries between parent(s) and the adolescent that allow the young person to differentiate from his/her family of origin and assisting the family to constructively problem solve in a way that validates both the parent(s) and the young person's view of the world while reinforcing the parental role of providing age appropriate structure and expectations. By framing adolescent-parent conflict within a developmental framework, the family was able to understand that what they were experiencing was a normal transition of family life. This helped to reinforce a message of hope to the families that their difficulties were surmountable.

The family life cycle framework was also helpful both in understanding Amy's (family J) needs as a new parent and in developing therapy goals. Amy was transitioning from a single person with no children to being a single mother of a newborn. This life cycle stage not only meant that Amy had to readjust her life to meet the needs of her son, but it also meant a realignment of relationships with extended family members. Amy was seeking therapy to reconcile her relationship with her biological mother, Louise. The life cycle model also helped identify that the family system consisting of Louise and Amy was stuck at the family life cycle stage of launching children and moving on. Louise choose not to respond to Amy's request for them to attend family therapy. The goal of therapy was to then focus on Amy's needs by normalizing her yearning for a relationship with her mother and the need for her mother to regard her as an adult, and to assist Amy to seek her needs for an informal support network through other avenues. The model helped identify what Amy needed and by presenting this to her, it empowered her to seek out alternatives.

At the time of referral the M family was in the family life cycle stage of launching the last of their three children and was renegotiating the marital subsystem without the presence of children. The life cycle model helped me hypothesize that Monica and Marshall were forced to identify the resources and limitations of their marital relationship and their lives as individuals. The violence and emotional abuse in the relationship was an issue they could no longer avoid. To move in their relationship as a couple and as a family unit these issues had to be addressed. Based on this hypothesis therapy was redefined as couple therapy and I negotiated with the couple a plan of how they were

going to first address the issue of violence and emotional abuse.

Given that the majority of the families were non traditional families, I sought out variations on the family life cycle framework that Minuchin (1974) describes, as is outlined in chapter one. Carter and McGoldrick (1989) describe additional tasks that families experiencing divorce and remarriage must deal with in addition to the family life cycle. Carter and McGoldrick's family life cycle for families experiencing divorce and remarriage was of interest to me given that two of the seven families seen for the purposes of this practicum were stepfamilies (families E and N) and a third family (family R) came to therapy following the separation of the couple and pending divorce. One of the premises of structural family therapy is that a change in family structure creates changes for the individuals in that system. Remarriage and separations create change in family structure and therefore the family system must respond to those changes while continuing to meet the needs of the individuals. It is important for the family to respond to and deal with the tasks associated with separation and remarriage.

For the purpose of understanding how Carter and McGoldrick's (1989) model helped me work with remarried and separated families the following is a brief overview of the model. Carter and McGoldrick (1989) conceptualize divorce as an interruption in the traditional family life cycle, whereby the family experiences changes in relationship status and the need for family members to complete important emotional tasks in order to proceed developmentally as a family. The authors identify four emotional phases a divorcing family experiences. The first phase is the decision to divorce where there is an acceptance of being unable to resolve marital tensions to continue the relationship. The

developmental issue at this phase is coming to accept one's own part in the failure of the marriage. The second phase is phrased "planning the break up of the system" (p. 22). This phase involves working on the issues of custody, visitation and finances as well as dealing with extended family about the divorce. The third phase is the actual separation. The task for the family is to figure out a way of continuing a cooperative co-parental relationship and working on the resolution of attachment to the spouse. These emotional peaks are experienced by all divorcing families, not necessarily in the given order. The family may re-experience these emotional phases more than once.

Family R was between phase two and three. While Lucy and her exhusband had gone through the first phase, making the decision to divorce, and had already separated as occurs in phase three, they had some unresolved issues that fit with a family at phase two. They were still working through the issues of custody, visitation and finances. As well, they were still dealing with the extended family about the divorce. The next emotional phases the family will experience will be related to being a post divorce family whether as the single custodial or noncustodial parent. At the time that family R was in therapy they were just beginning to sort out issues of custody, visitation, support and the like. Carter and McGoldrick's (1989) model was helpful in being able to put into perspective for Lucy and her children what they were experiencing as a newly separated family and assisting them to focus on the tasks they needed to accomplish at the time they were seen in therapy. The model also helped define that Lucy and her husband must move towards a cooperative relationship. This was the basis of my recommendation to Lucy that she and her exhusband seek mediation services to assist them in resolving conflicts involving

the care of their children. I provided Lucy with the knowledge that separations and divorces can be emotionally difficult, but that the divorcing spouses need to be able to relate as cooperative parents for the benefit of their children.

Family N and E were both remarried families, but at different family life cycle stages and at different phases in the development tasks with remarriage. Carter and McGoldrick (1989) offer a developmental outline for remarried families that was useful to understand where both of these families were at and was incorporated in the assessment of the families. The first step involves entering the new relationship, having adequately dealt with the emotional loss of the first marriage. The second step is termed conceptualizing and planning the new marriage and family. This step involves accepting one's own fears, the spouse's and the children's about remarriage and forming a stepfamily. The second step also involves adjusting to the complexity and ambiguity of new roles, boundaries and affective issues such as guilt, loyalty conflicts and unresolvable past hurts. The third step, remarriage and reconstitution of the family, involves an acceptance of a different family model with permeable boundaries that allow for the inclusion of the new spouse and stepparent, the realignment of relationships within subsystems, and room for relationships with all children and extended families. Reviewing these steps gave me a better understanding of the families. In turn the knowledge acquired assisted me in forming hypotheses and clarifying goals for intervention.

Family E is somewhere between the first and second steps of the remarried family life cycle. I hypothesized that roles, boundaries and affective issues all need to be

negotiated. Goals for intervention were to assist the family in defining roles, boundaries and affective issues. Within the therapy sessions the parental subsystem began to look at those issues and determine a way of structuring their family life to address these concerns. Given that they were at the beginning of stepfamily formation, I purposely drew boundaries between Susan as the biological mother and Paul as the stepfather. In time the family will have to adjust to being a two parent family and it may be possible that for this family Paul take on a more active role in parenting Zoe. The family was well engaged in developing ways of sharing memories and histories, through daily rituals and through sharing time at the family's cottage. In therapy I reinforced the need for the family to share positive, nurturing times together as a family.

Family N was predominantly in step three of remarried family formation. The family's ability to establish boundaries between spouses that included the new spouse or stepparent was hampered by the family's multiple separations, due both to relationship difficulties and work demands. With the help of this model, it was assessed that the spouses had relational issues to deal with, that impacted on their ability to move through the steps of a remarried family. Therapy was therefore redefined as couple therapy, with the goal of addressing the relational difficulties in the couple subsystem.

Structural family therapy as a strength based model

The assessment framework proposed by Minuchin (1974) and utilized in the case analysis chapter of this practicum report includes an assessment of the family's sources of support and stress. When reviewing the literature on structural family therapy it appealed to me that this model was based on the assumption of family competence. This practicum

reinforced that it is a valid way of assisting families in overcoming the difficulties they are experiencing. Working from the assumption of competence, encouraged families to perceive their reality differently and empowered them to use their own resources to assist them in moving on rather than totally relying on the therapist as the expert. Approaching my work with families on the basis that each family had strengths, I purposely sought and utilized the families' strengths as interventions. Families needed to have their concerns validated, but also needed to hear that they were not all "bad".

In family Q, Linda was feeling frustrated with her adolescent daughter, April and being a single parent she did not have someone else in the home to validate her efforts to raise three children on her own on a limited budget. I took the time to identify strengths in April. I expressed that there were not many fifteen year olds who saw the significance of planning for their future or plan how they could get their money's worth from the clothes they bought. Highlighting these qualities renewed Linda's pride as a mother. It also reinforced that she had done a great job instilling values in her children. I also recognized strengths in Linda. When she acknowledged the need for clearer boundaries between herself and her daughter and not rely on April to be her confidant. I provided her the feedback that she had a good understanding of what she needed to do differently. From this statement Linda identified how she was going to meet her needs without relying on her daughter. Her resourcefulness as a single parent and her consistency in providing a predictable environment for her children were also highlighted. Providing positive feedback to Linda about her daughter, but also about herself, was the encouragement she needed to feel hopeful for the future. I really appreciated this family's

ability to laugh at each other and at their struggles and used it to encourage them to enjoy each other and to plan some time together as mother-daughter. Providing this family with feedback on what I saw as strengths gave the family the energy to tackle the issue of parenting an adolescent and the changes that this brings to a family system. The family recognized that they were the “expert” on their family and experienced positive problem solving on their own.

Being able to name family strengths provided the families with an alternate view and perspective on their family. For example, naming strengths and reframing problematic behavior as a strength gave the E family a new perspective on who their daughter was. Her defiance of parents’ expectations and argumentative nature could be seen as self-assurance and that she would probably not be easily led by peers. Susan and Paul’s perspective on Zoe’s defiance changed; they no longer saw it as a trait they are struggling with but began to appreciate their daughter’s character. I also reframed the parents’ different parenting styles as a strength and guided them to complement each other’s approach. This opened the possibility for each parent to feel they had something to offer in parenting Zoe, rather than focus about the right and wrong way of parenting.

Looking for strengths and reframing positives was also a way of joining with families and establishing my credibility. The children in family R were apprehensive about being in therapy and testing how much they could share. I chose to begin the second session by pointing out how they were a support to one another. This helped me join with the children and helped them perceive therapy as a place where positives are talked about and problems are not the only focus. An atmosphere of respect for the

families and credibility as a therapist was established with families by identifying the aspects of families that have helped them cope with the demands of life. For example with family U, at the end of the first session I purposely summarized the session by identifying the strengths that were observed. I shared with Helen and Jodi that they are a caring family. This is demonstrated by mom and daughter being equally committed to attending therapy and Helen showing she cares by worrying about her daughter. I also highlighted that I was impressed by how clearly Jodi was able to articulate her needs and her positive communication skills.

Identifying strengths in individuals and families modeled for individuals to do the same. In family Q, April recognized the sacrifices her mother had made and how resourceful she was in being able to access community activities for herself and her sisters. I exaggerated her comment and asked her if she was congratulating her mother. April's response was "Oh yeah, definitely!" This comment helped Linda and April reconcile their relationship and build trust.

By helping families identify and name their sources of stress, I was able to encourage them to find solutions or ways of dealing with the stress that fit for them as a family. For example, in therapeutic sessions, Amy (family J) was assisted in identifying her limited support network and that her need to reestablish a relationship with her mother was in part to fill the need for support in her new role as parent. Once the issue was identified, Amy initiated a phone call to an old acquaintance who could meet this need. For Monica and Marshall (family M) identifying the violence and emotional abuse as an issue and identifying a process to address this issue, gave the couple direction for

what they needed to do and assigned them responsibility for their actions and relationship. Upon termination Marshall was prepared to take action in making changes for himself whether his wife chose to follow the directions given by the therapist or not. He went from feeling there was nothing he could do, to feeling empowered.

For the couple, Renata and Isodore by identifying how they drive each other crazy by falling into the same transactional patterns of relating to one another, the couple could no longer relate in the same way. In addition using the metaphor of climbing a mountain and directing them to predict the future, gave the couple hope.

For the U family, inviting Ze (the grandfather and identified source of support) to attend a session was a turning point in therapy. From my assessment, Ze was someone the family trusted and had relied on for support in the past. The one session where he was included assisted Helen and Jodi define their goal for therapy and what they need to take responsibility for in their relationship as mother-daughter. Identifying this relative as a support and further inviting him to a session proved to be a helpful intervention for the family.

Stepfamilies as a family type

A stepfamily is defined as a family which includes children from one or both spouses from a previous relationship (Ransom, Schlesinger, & Derdeyn, 1979). Two of the seven families seen as part of this practicum were stepfamilies (families E and N). I chose to analyze these two families as part of the case analysis chapter, as although both were stepfamilies, the assessment and subsequent interventions differed. The commonality of these two families was that the biological parent of the child(ren) was the

mother and the stepparent was the father figure in the home. They differed in many other aspects, such as where they were at in the family developmental life cycle, where they were at in the steps of integrating the stepparent in the family, and relational issues between the couple.

Although structural family therapy is seen as a viable model to use with stepfamilies, adjustments are needed (Kelley, 1996; Minuchin & Nichols, 1993). To understand these variations and build on my knowledge of stepfamilies I explored the possible differences in approaches and what to include in assessing stepfamilies. The family's history which includes the families of origin of all parents and stepparents, their first marriage, the meaning attributed to the experiences that affect the current family system all need to be taken into consideration in working with stepfamilies. The therapist needs to pay attention to the following issues: resolution of the previous relationship, the influence of the outside parent, the co-parental relationship, the mobility of children between households and the integration of the new partner (Morrison & Stollman, 1995).

A stepfamily has unique variations in the timing of its composition in comparison to most other families. Since children are already part of the system, the couple does not have the same opportunity as in first time marriages with no children to join as a couple. The presence of children means that the couple must simultaneously work on the accommodating and assimilating processes of the couple subsystem and negotiate parental responsibilities. The couples of both family systems were having to balance the needs of the couple subsystem and integrating the parental role. The stepparent is also required to go through an integration process with the children, rather than the stepparent

being part of the child(ren) live(s) from birth. Isodore (family E) had never been in a parenting role prior to joining the family and although he had been part of the family for thirteen years, he was still working on developing a relationship with Candace and Luke.

Stepfamilies are more likely than other family types to have children at different developmental levels and therefore the family must respond to the needs of both. In family E, Paul brought to the family two sons in their late adolescence, while Susan brought Zoe, in preadolescence. How Paul parented his boys was different than parenting Zoe. The children's needs and the parental role with these different age groups differs. The stepparents in this family needed to be able to recognize the difference and also adjust their expectations.

Berger (1998) notes that it is important to understand and judge stepfamilies according to their unique features rather than comparing them to non-stepfamilies. Stepfamilies are different from non-stepfamilies and from one another. Stepfamilies need to come to terms with the loss and changes they experience as a result of the dissolution of the first family and the joining of a new parental figure and stepsiblings. Given that there are no cultural norms for the roles of stepparent, stepson/daughter and stepsibling, the family must adjust to roles that fit for them as a family, while at the same time deal with the unrealistic beliefs set out by society of what a stepfamily looks like. For example, families E and N had different views of how involved the step parent was in parenting the children. Although initially, Paul's (family E) role had been identified as a "friend" to Zoe, he took on more parental responsibilities as time went on. Susan had no objections to this and appeared to appreciate his input. In family N, one of the conflicts

between the couple was Isodore's attempts to take on an authority role with the children and Renata not supporting him.

Therapists need to normalize stepfamilies' experiences and educate them about characteristics and processes that are typical (Berger, 1998; Morrison & Stollman, 1995; Visher & Visher, 1988). An educational approach was utilized with family E, given that they were in the early stages of family formation. I normalized Zoe's response to the changes in her family. I shared with Susan and Paul that Zoe's uncooperative behavior and emotional outbursts were in response to having to adjust to the changes in her life and family dynamics. Therapy therefore focused on how the parental unit could help her adjust with the transition, rather than only see fault with her behavior. I used the metaphor of Susan being a coach and Paul the assistant coach. Through this metaphor the parental unit was given the task of teaching Zoe how to express her feelings in acceptable ways. The family was also educated about what Zoe's needs may be as she attempts to cope with the changes. They were given the task of paying attention to balancing the nurturing and disciplinary aspects of parenting. Normalizing their experiences and providing information on tasks specific to this family type facilitated the family in becoming unstuck, alleviated their anxiety, enabled them to use their strengths effectively and permitted them to plan for how they will deal with the future. I shared with family E to expect that it would take a full year before Zoe and their family had adjusted to their stepfamily.

Giving positive feedback is seen as crucial for all families and couples in family therapy, but is seen as particularly important for stepfamilies (Morrison & Stollman,

1995; Papernow, 1993). Positive feedback provided relief to families and the message that they are doing some things right and should continue doing them. With both stepfamilies, families E and N, I was conscious of giving them positive feedback and reframing their view(s) of their family. In family N, the feedback was related to the couple relationship as this was the unit of intervention, while for family E positive feedback was given about their approach in parenting and sorting out the tasks they needed to accomplish to facilitate adjustment to stepfamily life.

In working with stepfamilies it is important to assist families to establish clear boundaries around the couple as strengthening this bond will build on the family's stability (Berger, 1998; Burt & Burt, 1998). With families E and N, I contracted to meet with the couple subsystem to work on couple and parenting issues. This created a boundary between the parental and children subsystems. For family N it was hypothesized that with an amelioration of couple functioning, the family unit would be strengthened and be able to deal with family issues. Upon termination, my assessment and the family's self-report indicated that there were notable differences in the couple functioning.

Families also need to work on clarifying roles. Clarifying parental roles is seen as a major task for stepfamilies, in the absence of role definition by norms (Berger, 1998). Clarifying roles also assists in rebuilding generational boundaries within the family and with the other biological parent. In my work with family E, I explored with the couple their expectations of Paul as the stepparent. I also explored their different parenting approaches and how they were integrating this in their relationship and with Zoe. In

family N, Renata was comfortable with Isodore's role vis a vis the children, where she was the primary care provider to the children and Isodore was there to support her. Isodore wished for a role that more closely resembled that of a natural father in a non stepfamily. Therapy served to have the couple share their different views on Isodore's role and what they both wanted his role to be. Because of the relationship difficulties they were experiencing, role clarification was examined by addressing their transactional patterns.

Stepfamilies also need assistance in developing skills in communication, negotiation and conflict resolution (Berger, 1998; Burt & Burt, 1998; Visher & Visher, 1988). Stepfamilies need to be given the opportunity to talk, negotiate and communicate about how they will do things. Given the differences that are possible in stepfamilies, family members need to communicate and negotiate rules and expectations. The parental subsystem needs to spend time communicating their views regarding child rearing. Susan and Paul of family E needed to hear each other's stories and points of view first before they could reach consensus of how they were going to parent Zoe. Since they were a newly formed stepfamily, therapy provided them with the opportunity to share their views. Through this process and with the therapist reframing their differences in approaches as a strength, the couple was able to see the benefit of their individual views. Once they had the opportunity to share, disagree and again share their views, Paul and Susan built their confidence in one another and support for one another. For family N, communication was identified as a main theme in the assessment of the couple subsystem. This issue was addressed in therapy by altering the way they communicated

in therapy. By altering their communication within session it impacted on how they communicated outside of therapy.

To further strengthen the couple subsystem, stepfamilies need to develop a couple's history and create "glue" in the couple relationship (Burt & Burt, 1998). The "glue" in a couple relationship is defined as the experiences that hold people together and includes loving gestures, considerate responses and thoughtful actions. I directed Renata and Isodore to live their relationship and share activities as a couple. They initially struggled with this directive, but by termination the couple was planning time away from the children. I also gave the couple the task of doing three things to entice each other. As the couple was talking about being more affectionate with each other in session, I reinforced this and had them move their chairs closer together and hold hands.

Building my knowledge on stepfamilies and the variations in approaches and interventions complemented the application of the structural family therapy model. It provided valuable information to consider in assessing stepfamilies and provided direction for interventions.

CHAPTER 5

Conclusion

In conclusion I have decided to reflect on my learning experience. I will review my experience in supervision, provide reflections on my learning of the structural family therapy model and review the usefulness of the FAM III and the client satisfaction questionnaire.

Supervision of the practicum

The learning process is seen as an interactional process, whereby a student, the learner, plays an important role in his/her own learning (Shulman, 1993). The learning process involves the student owning her/his knowledge, working it over, imposing her/his own order on it and altering it to fit what she/he already has. The supervisor's role is to present ideas and monitor the ways the student relates to them. I saw an opportunity in investing in my learning by participating in different forms of supervision when arranging my practicum.

In addition to my advisor, Diane Hiebert-Murphy, supervising my clinical work, Harvy Frankel, also on my practicum committee was seeking to supervise a student on two cases as part of his requirements for licensing as a clinical supervisor with the American Association of Marriage and Family Therapists. I was presented with the opportunity to receive supervision from two clinicians. The supervision approach that each undertook was slightly different. With Dr. Hiebert-Murphy supervision consisted of meeting once a week to review the current cases I was involved in. We would discuss the cases, my hypotheses, my approach with the families, what I could do differently and

would occasionally review a segment of video tape of my work. Supervision with Dr. Frankel was similar in that we met once a week to review the two cases he supervised and this took on a similar approach to Dr. Hiebert-Murphy's supervision. However, in addition, Dr. Frankel provided live supervision at most sessions. Live supervision consisted of Dr. Frankel supervising the sessions through a two way mirror, at times using "a hug in the ear" All sessions were formatted with a quick break towards the end of a session, whereby I would meet with Dr. Frankel and quickly review the salient points of the session and plan for the remainder of the particular session. The intermission in sessions allowed the supervisor and I to touch base. It also gave me the immediate opportunity to receive feedback and direction.

Having two clinical supervisors delivering different supervision styles provided me with the unique situation to be able to reflect on how supervision styles affected my learning. Shulman (1993) writes that a student needs structured opportunities for using the information that she/he gathers about theories and ways to practice. The doing part strengthens the student's understanding of the content. Furthermore he writes that a student is more likely to learn a new skill if she/he can practice it while it is being taught. The live supervision linked the knowledge and the application within a short period of time. The immediate critical feedback that was part of the live supervision helped strengthen my skills as a therapist. For example, tasks were formulated during the breaks in sessions in the live supervision model and I was able to deliver them immediately to the family. The immediacy of the feedback strengthened my practical skills, however building on my theoretical knowledge occurred in supervision sessions where tapes were

reviewed and the student and supervisor discussed hypotheses and interventions with families. Therefore one style of supervision was not better than the other but each complemented the other.

My work with all families was influenced by both supervision styles. I applied the knowledge and skills I learned from both supervisors to all the families with whom I was working. Experiencing different supervision models helped me meet the learning objectives of the practicum experience, however neither model would have been effective had I not taken an active role in my learning process. I found that by video recording sessions and reviewing the tapes on my own, I was able to have some ongoing means of examining the details of my practice efforts and be critical of my own work.

My practicum work has broadened my understanding of families and reinforced the idea that therapists need to be flexible and spontaneous in their approach. Minuchin (1981) views spontaneity as the therapist developing his/her own style, while having a theoretical schema of families and family transformation. As part of the process of this practicum I acquired the theoretical knowledge of structural family therapy through the extensive literature review that was presented in chapter one. The practical application of the model with the seven families seen, laid into practice the theoretical knowledge learned and helped me develop my own style as a therapist. My style was influenced by both supervisors, my previous and current work history as well as my personality. Supervision served to challenge my thinking and style and stimulated my interest in working as a family therapist.

Structural family therapy as a model of practice

In preparation for this practicum I obtained a knowledge base on structural family therapy by preparing a literature review on the model. I chose to see different family types and not limit my learning experience to just one type of family. I felt that this would provide me with the opportunity to evaluate the effectiveness of the model and diversify my learning experience.

I found the model easiest to apply to families with an adolescent and I struggled the most in applying the model when working with couple subsystems where the identified issue was marital conflict. I sought out additional readings on marital and couple therapy to build on my knowledge base and explore alternative strategies. Structural family therapy's usefulness was enhanced by focusing on the developmental model and the family life cycle framework. I borrowed interventions from the problem solving model, in particular how to organize and deliver directives and assign tasks. Learning to assess a family system based on its structural concepts is a good starting point, however I appreciate that Minuchin's direction was for therapists to develop their own style and to incorporate other interventions in practice. I took Minuchin's advice and explored different ways of complementing my skills and knowledge as a family therapist.

The particular strategy that I found the most helpful in my work with families was the use of reframes. Reframes were helpful in providing different perspectives to families and were helpful in getting families and couples "unstuck" from seeing their family and relationships as dysfunctional and hopeless. They were also helpful in confirming with

the family that I understood what they were saying and experiencing.

The information gathered about the joining process and how joining is interwoven in the therapeutic process was useful information. I was able to then purposely set out and recognize the times in therapy that I needed to pay attention to joining with the family as a whole or with particular individuals. By paying attention to the joining process as directed by the model, I was able to develop a more comprehensive assessment from which goals flowed with ease. It also helped in establishing myself as a credible therapist.

FAM III Measure

The use of the FAM III in pre therapy was useful in corroborating what the family was reporting and my observations. It also provided me with areas to question and further explore when a family scored differently than I had expected. It was helpful in comparing family members' scores to one another and obtain information on how the members' perceptions were similar and dissimilar.

The results of the post therapy scores did not consistently match my observations and/or the family's self-report. Where I would have expected to see a shift in scores from the pre to the post therapy scores, one was not always observed. What did it mean when scores were unchanged, yet family members reported change and I observed shifts in therapy? In retrospect, it would have been helpful to have the families also complete the dyadic scale for each dyad. I judged the instrument too lengthy if I had each family member complete a dyadic scale for each dyad in the family. For example family N was composed of four family members. Had I asked them to also complete the dyadic scales

each family member would have had to complete three additional scales at pre therapy and the same at post therapy.

When I contracted to shift from family to couple therapy with two family units. I did not find the information from the general FAM III scale useful. In retrospect it would have been more useful to use another measure, specifically aimed at marriage and similar dyadic relationships, such as the Dyadic Adjustment Scale (DAS) (Spanier, 1976). This may have helped in detecting problem areas in the relationship that were not detected by FAM III and may have assisted the family in transitioning from focusing on the family and parenting issues to couple issues.

FAM III did not provide me with an assessment of family strengths. I relied on my own observations for this information. If FAM III did take family strengths and sources of support into consideration, would the results of the post therapy scores more accurately reflected the family's self-report and my observations?

Client Satisfaction Questionnaire

The client satisfaction questionnaire provided me with the family members' views of their experience and provided feedback about what was helpful for them.

All families who filled out the questionnaire were positive about their experience in therapy. It was interesting to hear how families' perceptions of themselves had changed over the course of therapy. Because in some families I focused on the couple as the unit of intervention, I did not always have a clear idea of where the children were at. Having them fill out a questionnaire upon termination reinforced that the approach taken had benefitted the family as a whole. In essence, the couple's changes in transactional

patterns. impacted on the dynamics with the children. In cases in which the FAM III post therapy scores were unchanged the questionnaire helped corroborate my clinical observations.

I found the administration of the questionnaire in the last session a logical way of terminating with the client system in addition to reviewing the family's accomplishments during the time they were in therapy.

Conclusion

By coincidence the majority of the families seen as part of the practicum were Caucasian and working class families. I can therefore not draw conclusions as to whether the structural family therapy model is applicable cross-culturally and across different social classes. I have experienced some of the limitations of the model as described in chapter one of the practicum report. In particular I found that although the literature says the model can be applied when working with couples and couple violence, it does not provide clear directions of how to do so. I found myself complementing my knowledge of structural family therapy with readings on marital, couple therapy and family violence to increase my confidence in working with these clients. My practicum experience also confirmed that structural family therapy is not applicable in working with individuals. In my current position as counsellor with the AFM Youth Residential Services, the family component of the program requires that we work therapeutically with family systems of the youth in program, however a large number of families are unable to attend the center in person on a regular basis. I have found that although I can use the concepts of structural family therapy in assessments, it is limited in its application when attempting to

work with families via teleconference.

Through this practicum I have improved my skills in being able to join with families and individuals. I learned the need to join differently with people depending on their age and their perception of me as a therapist. I approach families from the perspective that they are the experts of their families and that I have knowledge and skills to assist them through their current difficulties. With this framework I found that families and individuals were comfortable in being able to share their stories and accepting of my role as therapist. Joining and accommodating with families and individuals are my strengths as a therapist. As is assessing a family's strengths and using those in session to assist the family to move forward.

Reframing and the use of metaphors have become part of my repertoire of clinical skills that I find useful in assisting individuals and families in altering their perception of their situation. Beyond my practicum and how I used reframes and metaphors with the families seen as part of the practicum, I have made use of this technique in my current employment. Since my practicum, I have learned that reframes and metaphors may not always be understood depending on the developmental level of a young person or if they are a concrete thinker. I have learned to alter my style depending on the individual or family.

Through the clinical supervision received as part of the practicum experience I have become more conscious in my therapeutic approach with families and ensuring that contact and sessions with families are purposeful. It has become part of what I naturally do in my therapeutic relationship with clients.

The clinical supervision I received as part of my practicum was invaluable in challenging my thinking and style as a therapist and although having two supervisors was more time consuming given that I met with each individually at different times, it has enriched my learning experience. By having two supervisors I was exposed to two different therapeutic styles, different ways of looking at families and how to apply the structural family therapy model. This combined with the different supervision techniques I found my practicum experience rich with learning opportunities. I would recommend to other students and clinical supervisors that they evaluate how they could incorporate two supervisors and different supervision techniques in their practicum. I would definitely recommend live supervision as an excellent way to receive immediate feedback and supervision. I also believe that students must take an active role in their own learning if they are to benefit from any form of supervision.

My learning objectives in completing the practicum were to gain knowledge in family therapy, further develop my clinical skills, increase my knowledge of structural family therapy and gain supervised experience in family therapy. All of my objectives were met. Through the application of the structural model with various family types and the different supervisory experiences, I have gained both knowledge and skills in family therapy. My confidence in assessing families and in identifying goals for intervention have grown throughout the time that I worked on this practicum. I feel that I have acquired a solid base in working with family systems and structural family therapy.

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Appendix A

CHARACTERISTICS OF THE FAMILIES				
FAMILY NAME	FAMILY TYPE	FAMILY COMPOSITION	NUMBER OF SESSIONS	PRESENTING ISSUE
Family E	stepfamily of thirteen years and accordion type family, where one spouse is absent for periods of time	mother is biological parent of both adolescents, second marriage for mother, first marriage for father, adolescents are 16 and 15 years of age	seventeen sessions (thirteen sessions with the couple and four with the couple and children)	family conflict created by the reintegration of the family unit
Family N	newly created stepfamily	biological mother of preadolescent daughter from previous marriage, father has two adolescent boys from previous marriage that are not currently living with the family, daughter sees her biological father every 2 nd weekend	seven sessions (three sessions with family unit and five with parental subsystem)	preadolescent daughter's anger and parent-child conflict
Family Q	female single parent family with three girls	Never married single female parent, three girls ranging from six to fifteen years of age, the oldest and youngest share the same father and have occasional contact, middle daughter has no contact with her biological father	ten sessions (three sessions with the family unit, seven sessions with the mother-adolescent daughter dyad)	adolescent-parent conflict with oldest daughter and oldest daughter's anger

CHARACTERISTICS OF THE FAMILIES				
Family J	female single parent family with a newborn	first time parent in late 30's, newborn and maternal grandmother	seven sessions (all were with adult daughter)	adult daughter and mother conflict dating back to daughter's adolescent years
Family M	first marriage family	couple with three boys ranging from 15 to 20 years of age, all three boys have left home	six sessions (all were with the couple only)	last son left home prematurely at fifteen years of age: issues of emotional and physical abuse in the marital relationship
Family U	female single mother with adolescent daughter	never married single female parent and 14 year old adolescent girl	six sessions (five sessions with mother-daughter dyad, one session included maternal grandfather)	parent-adolescent conflict
Family R	recently separated family with four children	single female parent, recently separated from husband of 20 years, four children ranging in age from nineteen to nine years of age, all four children currently residing with mother, children have ongoing contact with father	four sessions (two sessions with mother and three youngest children, one session with mother and one with the three youngest children)	family struggling to adjust to parents' separation, especially the middle child

Appendix B - Client Satisfaction Questionnaire

Your opinion about the service you received at the Elizabeth Hill Counselling Centre is important in helping the agency and therapist provide the best possible service to families.

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

1. What was the main reason for coming to therapy?

2. How often did you feel you got the kind of help you needed in therapy sessions?

a) always b) usually c) sometimes d) rarely

3. Was the therapy helpful in providing ways for you to understand your problems better?

a) always b) usually c) sometimes d) rarely

4. What has changed since you came for help?

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

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

7. If you needed help in the future would you come back to the Elizabeth Hill Counselling Centre?

___ Yes ___ No. Please explain.

8. Any additional comments?
