

**A STRUCTURAL FAMILY THERAPY APPROACH
TO COUNSELLING FAMILIES**

BY

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

MASTER OF SOCIAL WORK

Faculty of Social Work
University of Manitoba
Winnipeg, Manitoba

August, 2000

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A Structural Family Therapy Approach to Counselling Families

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Karin Hadfield

**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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TABLE OF CONTENTS

LIST OF FIGURES	iii
ABSTRACT.....	iv
ACKNOWLEDGMENTS	v
 INTRODUCTION	 1
 SECTION ONE: LITERATURE REVIEW	
STRUCTURAL FAMILY THERAPY	
Overview of Structural Family Therapy.....	2
Key Concepts	8
Key Techniques.....	16
Application of Structural Family Therapy.....	22
Research on Structural Family Therapy	24
Critique	28
 SECTION TWO: PRACTICUM SETTING AND PROCEDURES	
Setting	33
Clients	33
Procedures.....	33
The Families	35
Supervision	40
Learning Objectives	40
Evaluation	41
 SECTION THREE: CASE SUMMARIES	
Introduction	43
THE A FAMILY	
Presenting Problem.....	45
Assessment.....	45
Intervention.....	51
Evaluation.....	55
Conclusion.....	57
 THE B FAMILY	
Presenting Problem	58
Assessment.....	60
Intervention.....	67
Evaluation.....	71
Conclusion.....	74
 SECTION FOUR: ANALYSIS	
Introduction	75
Single-Parent Families	75

Step-Families	80
Assessment	83
Focusing on Strengths	86
CONCLUSION	89
REFERENCES	95
APPENDIX.....	100

FIGURES

Figure 1	A Family Genogram.....	44
Figure 2	A Family FAM Profiles	56
Figure 3	B Family Genogram.....	59
Figure 4	B Family FAM Profiles	72

ABSTRACT

Families are living systems that grow and change over time. Families must be able to adapt to changes or else the viability of the family and its individual members is threatened. Structural family therapy is a therapeutic approach that recognizes that families possess many strengths and it attempts to move families beyond dysfunctional patterns of interaction. This practicum report describes the application of the structural family therapy model to eight families. This analysis will consider the processes of assessment, intervention, and evaluation, and as well, the overall effectiveness of the structural family therapy model.

ACKNOWLEDGMENTS

I would like to acknowledge a number of people who contributed to the completion of this work. Firstly, I am grateful to the families who made this work possible and demonstrated to me the strength and resilience of families. I am also thankful to my advisor, Diane Hiebert-Murphy, for her assistance, support and constant encouragement. I also appreciate the support of my committee members Kathy Levine and Linda Perry.

Most importantly, I am appreciative of a wonderful family who supported and inspired me through this work. I am especially thankful for the help of my older sister, Jacqueline, who was an invaluable source of aid. I am grateful for the support of my husband who made many sacrifices for this to be completed and was always a source of encouragement and comfort. As well, I am thankful for my daughter, Jordyn, who was very understanding when I had to work instead of play.

INTRODUCTION

This practicum involved the application of structural family therapy to families experiencing difficulties functioning. My learning objectives consisted of the following: to familiarize myself with the structural family therapy model, to develop my clinical social work skills and to acquire a solid foundation in family therapy.

This report is divided into four sections. The first section contains a review of the literature on structural family therapy, outlining the major precepts and techniques utilized in this model. This section also provides a review of some of the research on the effectiveness of structural family therapy, as well as a critique of this model. The second section describes the practical aspects of my practicum, including setting, procedures and a general description of the clients with whom I worked.

The third section of this report provides an in-depth case analysis of two of the families I counseled. In particular, a description of the assessment, intervention and evaluation of each case is provided. The fourth and final section includes a discussion of some of the prevalent themes in my practicum, such as step-families, remarried families, subsystems and the need to focus on strengths. I conclude this section by providing an overall analysis of my practicum and its general results.

SECTION ONE: LITERATURE REVIEW

Introduction

The family unit is one example of a system that forms a natural social grouping. Family members regulate the responses that each member has to internal and external inputs (Minuchin, 1974). Therefore, from a systemic viewpoint, the family as a whole and the individuals that make up the family are mutually influencing. As such, a change in the family system affects the individual just as a change in the individual member affects the family as a whole. With these ideas in mind, this report sets out to examine family therapy, and specifically, structural family therapy.

To that end, this report will discuss the structural family therapy approach and its basic tenets. The applicability of this model will be addressed in addition to some of its limitations. Although this model was initially developed in the 1960s, we will see that this approach has evolved and maintains some useful concepts that are still of value today. As well, it will become evident that some of the shortcomings of structural family therapy could be avoided by incorporating other therapeutic models, such as feminism and a strengths perspective.

Overview of Structural Family Therapy

Salvador Minuchin is the founder of structural family therapy, which has been a leading model in family therapy since its inception. Drawing from the systemic model, structural family therapy emerged in the 1960s and 1970s as a new model which contained practical ideas that were easily transferable to the

therapy setting (Nichols & Schwartz, 1998). Of great importance were the constructs that Minuchin formulated and expanded upon. Today, structural family therapy is still one of the most widely used models for family therapy (Powell & Dosser, 1992).

Structural family therapy focuses upon the person within the family system, rather than solely on the individual (Colapinto, 1982; Minuchin, 1974). The major thesis of this approach is that “an individual’s symptoms are best understood when examined in the context of family interactional patterns” (Gladding, 1998a, p. 210). This idea reflected the shift that occurred in family therapy during the 1980s which was very different from the prevailing traditional mental health model which focused upon individual pathologies. Structural family therapy recognizes that “man is not an isolate” (Minuchin, 1974, p. 2). Therefore, within the family system, each member affects the other members. This holds true for the larger society as well. People become who they are through their transactions with their environment (Minuchin, 1974).

Structural family therapy is an approach that is founded upon the notion of the “interrelationship of the whole” (Napoliello & Sweet, 1992, p. 156). The individual, while a separate being, is also a part of the whole family. As well, the influence of each person’s behaviour within the family cannot be separated from other family members’ behaviours. The concept of complementarity encapsulates this idea that behaviour is circular in the sense that it is sustained by each member of the family (Minuchin et al., 1998). In other words, any behaviour is contingent on someone else’s behaviour (Colapinto, 1982).

Colapinto (1991) states that “family members mutually accommodate in such a way that one develops selective aspects of himself or herself, while the other develops a complementary trait” (p. 422). For example, a husband who complains that his wife never listens to him also has a set of behaviours that reinforces his wife not listening. This concept can be emphasized in therapy sessions by asking family members to help each other change and then congratulating the other members for changing (Nichols & Schwartz, 1998). This underscores the interrelatedness of the family.

Structural family therapy is also unique in that it focuses on the present rather than on the past (Colapinto, 1982). The rationale behind this idea is that past dysfunctions are manifest in current functioning, hence a change in current functioning could alter embedded dysfunctional behaviour (Minuchin, 1974). Therefore, therapy sessions center around current problems rather than past concerns. History is examined only insofar as it affects the present (Aponte, 1992).

Structural family therapy attributes problems to dysfunctional family structures and the rigidity that results from these structures. A solution is sought in the modification of the family structure. According to Colapinto (1982), altering that structure requires a change in the position of family members. For example, a family may have a situation in which the father and daughter are extremely close and frequently side against the mother. In order to change this pattern, the father and mother must re-establish the boundary around their parental subsystem. Colapinto (1988) describes change as an “increase in the complexity

of the structure - an increment in the availability of alternative ways of transacting" (p.19). Thus, the goal is to make the family more flexible in its patterns of interacting and responding. Minuchin and Nichols (1993) describe the family as being naturally inclined to continue with familiar patterns of interacting, even though developmental changes have made these patterns less functional. The therapist must undermine this homeostasis and move the system towards better functioning (Minuchin & Fishman, 1981). Accordingly, change is regarded as being necessary for growth.

Powell and Dosser (1992) highlight two important ways in which the assumptions of structural family therapy are different from other family therapy approaches. These are:

(1) families possess the skills to solve their own problems, but for some reason or other do not utilize them. For this reason, a family may require a therapist to help turn its attention to, and assist in maturing, these skills; and

(2) family members generally act with good intentions; sometimes it is in carrying out these good intentions that problems may result. As such, there is no blame to be laid and no accusations to be made.

Both of these concepts emphasize the focus that structural family therapy places on the strengths of the family.

Structural family therapy is also influenced by the life cycle model (Nichols & Schwartz, 1998). The family is seen as changing with the different demands that are placed on it. McGoldrick (1989) observes that the family moves through developmental stages, each one requiring restructuring. Gladding states that "it

is crucial not to mistake normal family development and growing pains for pathological patterns” (Gladding, 1998a, p. 214). For example, as a child matures, his or her parents must adapt their parenting style to accommodate their child’s growth. The same style will not work for both a three year old and a twenty year old. Problems occur when the family fails to “readjust its structure at one of life’s turning points” (Nichols & Schwartz, 1998, p. 125). Hence, it is not the presence of conflict that defines a family in crisis, it is the family’s failure to accommodate change as required.

Minuchin and Fishman (1981) identify four main developmental stages that the family progresses through. The first stage is *couple formation*. In this stage a new system is formed and new roles and rules must be established. *Families with young children* is the second stage. This stage entails developing specific functions for each spouse to perform and a rearrangement of family relationships with the birth of a child. The third stage is called *families with school-age or adolescent children* and this stage is characterized by a need for the family to relate to other systems. *Families with grown children* is the final stage. During this period the family re-negotiates its roles and learns to relate to each other as adults. As well, the parents become a couple again.

Nichols and Minuchin (1999) state that structural family therapy is an aggressive intervention because it challenges families. Using this approach requires a therapist who is willing to “challenge families bluntly enough to push them past habit and avoidance but sympathetically enough for them to accept challenge” (Nichols & Minuchin, 1999, p. 131). This requires that the therapist

move beyond the discussion of problems and focus on clarifying what things families want to change. Colapinto (1991) describes the therapist as taking an active stance in the therapy process, although he or she does vary the intensity of his or her involvement over the course of therapy. Interestingly, structural family therapy is viewed as more appropriate for a single therapist because the techniques used are difficult to coordinate with another therapist (Colapinto, 1991).

Friesen (1995) outlines five goals of structural family therapy. These are:

(1) Creating an effective hierarchical structure in the family.

(2) Helping parents to complement each other in their roles as parents in order to be an effective parental subsystem.

(3) Aiding the children to become a subsystem of peers.

(4) Increasing the frequency of interactions and nurturance, if the family is disengaged.

(5) The differentiation of family members, if the family is enmeshed.

The significance of each of these goals will become apparent throughout this section.

Due to its practical application, structural family therapy has been very important to the field of family therapy. For instance, it has introduced the methods of one way mirror and videotaping (Nichols & Schwartz, 1998), techniques that remain widely used today. Aponte (1992) even goes so far as to state that training a family therapist hinges on live supervision. Furthermore, this approach is often used in the training of family therapists (Aponte & VanDeusen,

1981). Accordingly, it is apparent that structural family therapy has changed the field of family therapy in some substantial ways.

Key Concepts

Structural family therapy utilizes many concepts to organize and understand the family. Of particular importance are structure, subsystems, boundaries, enmeshment, disengagement, power, alignment and coalition. Each of these concepts will be explored in the following section.

Structure: One of the most important tenets of structural family therapy is that every family has a structure (Nichols & Schwartz, 1998). This phrase refers to how a family organizes itself (Nichols & Schwartz, 1998). Minuchin uses the term structure to indicate that families have behavioural patterns, which he describes as conservative but changeable (Minuchin & Nichols, 1993). A healthy family structure is one in which there are clear boundaries around the system and its subsystems. Changing a dysfunctional structure means that therapy is directed towards altering the current structure of the family (Minuchin, 1974). The goal of therapy is to increase the flexibility of the family structure (Minuchin & Nichols, 1993).

Colapinto (1988) found that the family structure is governed by two principles. First, families have a hierarchical structure in which parents have greater authority than children. Families that are described as functional are believed to have a clear hierarchy with “consistent rules about who is in charge of what” (Nelson & Utesch, 1990, p. 236). Hierarchical boundaries are maintained by the rules surrounding each family member’s role (Nelson &

Utesch, 1990). Discerning the hierarchical structure of a family can be done by observing the family and seeing which of its members take charge. Colapinto's second principle is that each family has its own distinct nature. Every family is unique and each of its members develop ways of interacting with each other that are distinctive. This idea refers to the belief of structural family therapists that each family functions in its own way and that every family possesses the skills to move beyond dysfunction.

Families with either a well-organized structure or a disorganized structure will still contend with stress and experience various crises. It is significant however, that families with a clear and organized structure will recover more quickly and will function better in the long term than those families that have dysfunctional structures (Gladding, 1998a). Accordingly, while an appropriate family structure will not help a family avoid crises, it may help in its recovery from such crises.

Subsystems: Minuchin built upon systemic theory by postulating that the family system can be further divided into subsystems (Lester, 1997).

Subsystems are "smaller units of the system as a whole" (Gladding, 1998a, p. 212), and consist of one or more individuals. It is through these subsystems that families negotiate which members will carry out what functions (Jones, 1980). Relationships between subsystems are governed by spoken and unspoken rules (Minuchin et al., 1998). The broad categories of subsystems that are typical in a family are the parental subsystem, the spousal subsystem, the parent-child subsystem and the sibling subsystem. In addition to these common subsystems,

it should be noted that each family may also create its own particular subsystems (Karpel & Strauss, 1983). An example of this could be a family that organized the sibling subsystems according to gender instead of age.

A family begins when two people join for the purpose of forming a family (Minuchin & Fishman, 1981). These two people form a spousal subsystem. They will negotiate roles and a structure will develop underlying their transactions (Minuchin & Fishman, 1981). The spousal subsystem works best when the spouses accept their interdependency (Gladding, 1998a). One of the most important tasks for the spouses is to develop a boundary around their subsystem. Minuchin and Fishman (1981) state that the development of this boundary is crucial to the viability of the family structure, as it is from the spousal subsystem that children learn about intimate relationships. Any dysfunction in this subsystem will be evident in the family system (Minuchin & Fishman, 1981).

As the couple has children, the couple forms a parental subsystem. In some families, the parental subsystem may consist of extended family or single parents. Again, for a child, this is the basis for how she or he views authority and relates to people who have greater strength and power (Minuchin, 1981). Children learn whether their needs will be met in their family and develop a sense of who they are from their parental subsystem. As the child grows, the parental subsystem must change and grow as well (Minuchin, 1981). While the adults in this subsystem have the responsibility of providing for the needs of their child(ren), they also have rights (Minuchin, 1981). For instance, parents may choose what school their child will go to and can determine rules that provide for

the safety of each family member. As Karpel and Strauss (1983) point out, a distinction needs to be made between the spousal and parental subsystems because each role demands something different and is considered essential to the family system.

The sibling subsystem is also important. This unit contains family members who are of the same generation. This subsystem also forms the child's first peer group (Minuchin, 1981). It is within this subsystem that children learn how to get along, how to negotiate and how to deal with conflict. These lessons will impact a child's functioning in school and with his or her peers. In large families, siblings may organize themselves into subsystems according to developmental stages (Minuchin, 1981; Minuchin et al., 1998). It is important however, that the parental subsystem allow the sibling subsystem to function without too much interference.

Boundaries: As pertaining to subsystems, Minuchin suggests that boundaries are the rules which define "who participates and how much" (1974, p. 53). Gladding (1998a) states that boundaries are "the physical and psychological factors that separate people from one another and organize them" (p. 213). Therefore, boundaries are the invisible barriers that govern the contact that subsystems have with other subsystems and are necessary for a healthy family structure (Minuchin & Fishman, 1981). Some boundaries may be more concrete (Karpel & Strauss, 1983). For instance, a door with a lock on it that closes off the parents' bedroom is one example of a boundary between a couple and sibling subsystem. Accordingly, boundaries allow the subsystem to perform its functions

without interference from other subsystems (Minuchin, 1974). In order to function well, boundaries must be clear and not too rigid (Minuchin, 1974). For each of the family subsystems described above, there needs to be clear boundaries around the subsystem to allow the flow of energy to and from the subsystem.

Families can have boundaries that vary in their rigidity according to the particular family (Minuchin et al., 1998). For example, one family may expect its children to eat quietly at the table. Another family may allow its children to be noisy and participate in the dinner conversation. The importance of boundaries is that they must go through developmentally appropriate changes as the family progresses through the family life cycle (Minuchin et al., 1998). Thus, a father may intervene when his two young children are fighting, but he would expect them to work out their differences when they became adults.

Boundaries also exist around the family system as a whole. A family is expected to have a boundary around it that separates it from other systems (Karpel & Strauss, 1983). For example physically, many nuclear families live in single-dwelling homes. Another important boundary is the one that separates the nuclear family from the extended family (Karpel & Strauss, 1983). It is important to stress the uniqueness of each family here, and recognize that each family may have its own variations of appropriate boundaries.

The ideal boundaries are ones that are clear. These boundaries consist of rules and habits that allow family members to develop better relationships by encouraging dialogue (Gladding, 1998a). Family members are able to “freely

exchange information and give and receive corrective feedback” (Gladding, 1998a, p. 213). Clear boundaries allow family members to feel connected to the family system, while still maintaining their individuality and autonomy (Karpel & Strauss, 1983). Sometimes families do not have clear boundaries, but are characterized by boundaries that are too rigid or too diffuse. This is discussed below.

Enmeshment: Families with boundaries that are diffuse are described as enmeshed. This is a state in which the boundaries are too permeable and thus there becomes a sacrificing of autonomy in order to maintain the greater sense of belonging to the family system (Minuchin, 1974). Dependence is encouraged and family members tend to stay close to home, expecting to have all of their needs met by the family (Gladding, 1998a). These members are hesitant to form close relationships outside of the family (Karpel & Strauss, 1983). This system lacks the necessary resources to change under stressful conditions (Minuchin, 1974). An example of an enmeshed family is one that has no doors on the rooms in their home. This would not allow the family members the privacy they need and would make it difficult to distinguish where the family ended and the individual began.

Nichols and Minuchin (1999) find that one symptom of enmeshment is when families come to therapy with relatively minor complaints about the children. This could include a family that comes to therapy because one child is talking back and not participating in household activities. While some families might see this as typical behaviour, an enmeshed family would feel that this

“individuality” is threatening to the family system.

Disengagement: Disengagement occurs when families have boundaries that are overly rigid (Minuchin, 1974). Inflexible boundaries serve to keep people separated from each other. Members have significant independence but little interdependence exists within the family system and there is little communication between the subsystems (Minuchin, 1974). As a result, family members have difficulty relating to each other in an intimate way and become disconnected from other family members (Gladding, 1998a). To illustrate this concept, one could think of a family in which the members are unaware of the important events in the other member’s lives. Karpel and Strauss (1983) state that the therapist may be amazed at the way in which a disengaged family can tolerate deviance or pain without concern or interference.

Power: The concept of power refers to the level of influence that each family member has on the outcome of an activity (Aponte & VanDeusen, 1981). It is the ability to get something done. Power can vary according to the setting (for example, a parent’s power is different at home than at school) and it is generated by the way in which family members react (for example, a father’s power may depend on the response from his wife and children, either reinforcing or negating his power) (Aponte & VanDeusen, 1981).

Power is also related to structure, in that there is a hierarchy of power evident in the family structure (Minuchin et al., 1998). This hierarchy defines who makes the decisions in the family and also who controls the behaviours of family members. As with other aspects of family functioning, power is subject to change

as family members grow and develop (Minuchin et al., 1998). For example, children are normally given more power at sixteen years of age than at three years of age.

Alignment: An alignment refers to the way in which “family members as individuals and as parts of subsystems relate to each other relative to other family members and subsystems” (Nelson & Utesch, 1990, p. 237). Alignments can include both joining or opposing one member or subsystem over another (Aponte & VanDeusen, 1981). Within the family system there may exist different patterns of joining or opposition. For instance, a mother may disagree with her husband’s method of disciplining their children and consequently may side with the children. While an alignment can include the joining of two people for a common interest (frequently called an alliance) it can also include the joining of two people actively excluding a third person (called a coalition).

Coalition: A coalition is an alignment between two people in a system which excludes a third person. There is a rigid boundary around the coalition. Coalitions are frequently short-lived and may be quite benign (Minuchin et al., 1998). Children deciding to join together to demand pizza for supper instead of chicken, is one example of a coalition. Coalitions that are stable however, sometimes can be more harmful. An example is a coalition that involves a mother and daughter who frequently side against a brother, resulting in a very distant relationship with him.

Of particular importance is a cross-generational coalition. This is defined as an “inappropriate family alliance that contains members of two different

generations" (Gladding, 1998a, p. 473). This could include parents who argue through a child or grandparents who argue through their grandchild. Colapinto (1991) indicates that chronic cross-generational coalitions are structurally associated with psychosomatic illness and addiction.

Nelson and Utesch (1990) find that coalitions are typically overt and can be identified by direct observation. One way to identify a coalition is when two people are talking about a third person in his or her presence (Nelson & Utesch, 1990). Coalitions can also be formed when the therapist joins to form a coalition against one or more family members (Minuchin & Fishman, 1981). One result of this type of coalition is the stress placed on the family members who are on the inside or outside of this coalition. Care must be taken to ensure that there are no repercussions outside of the therapy session for the person with whom the therapist was in a coalition (Minuchin & Fishman, 1981).

Key Techniques

The structural family therapy model employs a number of techniques including: joining, boundary making, enactment, restructuring and reframing. Each of these procedures will be discussed in the following section.

Joining: For the structural family therapist this is a very important concept, as it highlights the need for the therapist to develop an empathetic relationship with the family in order to modify the family's current functioning (Minuchin, 1974). It is necessary to establish this bond during the assessment phase, as joining is a "pre-requisite" to restructuring (Minuchin, 1993). Joining is an ongoing process though, as the therapeutic relationship must be maintained throughout

therapy (Colapinto, 1982). Part of the joining process requires the therapist to reflect back an understanding of the family's problems (Minuchin et al., 1998). This makes the family feel that they are being heard and understood. Another important aspect of joining is looking for strengths in the family. Highlighting the positives will give the family confidence that they possess useful skills and that they are capable of using these skills to solve their problems. Nichols and Schwartz remind us that structural therapists should "avoid doing things for family members that they're capable of doing themselves" (1998, p. 262).

Colapinto (1982) further elaborates on this concept by asserting that the process of joining involves not only being accepted by the family, it involves being accepted by the family in the role *as a therapist*. This is crucial in order for the therapist to advocate changes in the family system from a position of authority. Minuchin (1993) finds that families are resistant to change when the members feel that they are not understood and accepted by the therapist. Therefore, joining involves becoming a part of the family, without losing sight of the role of therapist.

Joining a family is more complicated than it may seem. Minuchin (1993) observes that the process of joining happens on different levels. For example, he finds that he adopts the language style of the people with whom he works. With adolescents he is idealistic and with religious people he is spiritual (Minuchin, 1993). He also finds that it is necessary to mimic some behavioural patterns. For instance, he is affectionate with the families that are comfortable with physical closeness (Minuchin, 1993).

Another way of joining a family is through accommodation. By accommodation the therapist “makes personal adjustments in order to achieve a therapeutic alliance “ (Gladding, 1998a). Therefore, a therapist must make some personal adjustments in order to connect with a family. The therapist, while he or she is “accommodating” a family, must be non-judgmental (Napoliello & Sweet, 1992). An example of accommodation is a therapist who takes off her jacket in the session because she notices that the family is wearing short sleeves (Gladding, 1998a). Colapinto (1982) notes that “excessive accommodation is not good joining” (p. 125). This is because the therapist must maintain some distance and not be enveloped by family rules.

Boundary making: As stated previously, maintaining clear boundaries around the subsystems is crucial for healthy family functioning. In a family where the boundaries are too rigid or too flexible, the therapist would try to create, within the family, boundaries that are autonomous and yet interdependent enough to allow for the growth of the family members (Jones, 1980). Boundary making involves restructuring the family because it changes the rules within which the family functions (Colapinto, 1982).

The therapist defines which interactions are open to some members of the family but closed to others (Colapinto, 1982). This can be done in one of two ways, that is, physically or verbally. With physical boundary making, the therapist may rearrange seating, use hand gestures to silence other family members or may use his or her own body to block conversations (Minuchin & Fishman, 1981). Some verbal boundary making includes giving specific instructions to the

family and giving verbal reminders to prohibit interruptions (Minuchin & Fishman, 1981). Hence, if a therapist wants to block a son from making decisions that should be made by his father, this could be done verbally, for example by stating "I see you like making decisions for your father, how about if you let him make this one?" or physically, for example asking the son to sit in a chair on the other side of the room, opposite of his two parents or through a combination of both.

Enactment: This concept refers to the way in which the family therapist "constructs an interpersonal scenario in the session in which dysfunctional transactions among family members are played out" (Minuchin & Fishman, 1981, p. 79). This can occur spontaneously or be contrived by the therapist. The rationale for using an enactment is the belief of the therapist that by making changes in the transactions between family members in the therapy session, changes will occur in their transactions outside of the therapy session (Aponte, 1992). Hearing about dysfunctional family transactions may be somewhat helpful but may be of limited use, as the therapist is limited to experiences that have been filtered by the family's perceptions. This is why the therapist uses enactments.

Effective enactments empower the family by allowing it to communicate its typical way of functioning and to explore new behaviours (Minuchin et al., 1998). Enactments also allow the therapist to interrupt the existing patterns of transactions (Colapinto, 1982). This requires some skill on the part of the therapist because he or she must maintain his or her leadership role while still

allowing the enactment to progress without too many interruptions (Minuchin et al., 1998). The purpose of an enactment is to provide the family with a different experience of reality.

Nichols and Minuchin (1999) state that the way to begin an enactment is to have one family member respond to something another family member has said. They find that enactments in the first few sessions are best used for assessment and should have very little interference by the therapist. As therapy progresses, the therapist may be able to become more involved by offering suggestions that would help the family to communicate better (Nichols & Minuchin, 1999).

Enactments can illustrate many things about the family's structure (Nichols & Schwartz, 1998). For example, can the adults discuss an issue without bringing the children into the argument? Can two family members talk without being interrupted? Enactments allow the therapist to observe what roles each family member performs and demonstrate enmeshment or disengagement. This is very useful information for the therapist to incorporate into his or her assessment.

Restructuring: The process of restructuring is important in structural family therapy as the goal of this approach is structural change (Gladding, 1998a). Short range goals may be to alleviate symptoms but the overall goal of therapy is to alter family structure (Nichols & Schwartz, 1998). Restructuring simply means changing the structure of the family. Some of the techniques mentioned above are used to make the family more functional by "altering the existing hierarchy

and interaction patterns so that problems are not maintained" (Gladding, 1998a, p. 219).

There are two broad types of structural problems, as pointed out by Aponte and VanDeusen (1981). The first is system conflict. This is when problems arise due to the competing needs of the family system or subsystems. An example is a lonely son who relies on his mother to meet his social needs, but the mother needs to socialize with her spouse. The second structural problem is that of structural insufficiency. This refers to the problems that arise due to a lack of structural resources to meet the demands of the system. An illustration is a single father who is trying to raise five children by himself and is too overwhelmed to meet their needs. Intervention for these two types of problems includes reorganizing structures for the families dealing with system conflict and creating new structures or reinforcing current structures for families experiencing structural insufficiency (Aponte & VanDeusen, 1981).

Reframing: Reframing involves examining a situation from a new perspective so that the meaning is changed. The therapist may interpret the family's concerns in a different way than the family and this is valuable to give the family an "outside" view (Karpel & Strauss, 1983). Reframing allows the therapist and the family to focus on the positives and also challenge the negatives (Minuchin et al., 1998). A therapist

must become adept at reframing that behavior in more positive terms-not because it is more true but because it is *equally* true, and because it helps people who feel defeated and self-critical mobilize some other, stronger,

part of themselves. (Minuchin et al., 1998, p. 50)

In this way the therapist can change the narrative of the family.

The intended effect of reframing is to make the situation more workable (Colapinto, 1982). By pointing out how each person is contributing to the problem, solutions can be offered. Reframing highlights the complementarity of behaviours (Colapinto, 1991). For example, if a mother and son came to therapy because the mother is too involved in her son's daily decisions and the therapist said to her that her mothering illustrates how much she loves her son, she would be able to see that her actions demonstrate her love. She would also be able to see that the solution may lie in what the therapist calls her "mothering".

An Analysis of the Application of Structural Family Therapy

Structural family therapy is a type of therapy that is ideal for short-term therapy situations (Jones, 1980). Structural family therapy is still one of the most frequently taught models in the United States among family therapists (Figley & Nelson, 1990). This model is ideally suited to the practice of family therapy due to its focus on the entire family rather than individuals. It remains true today that we need to look at "man in his social context" (Minuchin, 1974, p. 4). As Powell and Dosser (1992) point out, almost every family therapist today uses some elements of structural family therapy in his or her practice.

Structural family therapy developed in the 1960s when Minuchin was working with delinquent children from inner-city families (Nichols & Schwartz, 1998). Work with these children had previously been unsuccessful and so Minuchin took the novel approach of looking at these children in the context of

their families (Colapinto, 1982). Although they seemed to have success with these boys, in later years Minuchin reflects that the success may not have been lasting because they may not have been able to transcend the reality of the social conditions facing these families (Minuchin, 1982; Minuchin & Fishman, 1981).

In the 1970s Minuchin and his colleagues applied their developing therapy model to psychosomatic illnesses, including anorexia and asthma (Colapinto, 1982). Again, focusing on the entire family, and not solely the individual, was seen as a new approach. The team found that certain characteristics were common among the families that were being seen, for example, enmeshment and overprotectiveness (Colapinto, 1981). Using this model proved successful in the treatment of psychosomatic illnesses and after books were published on these new found techniques, structural family therapy gained widespread attention (Colapinto, 1981). It is interesting to note that McGoldrick (1989) reports that most of the ideas that developed about addictive disorders are from Minuchin's work with anorectic and psychosomatic families.

Following these events, Minuchin devoted more time to teaching his model of family therapy which has been used successfully in the field of family therapy since the 1970s (Nichols & Schwartz, 1989). As stated above, structural family therapy has had, and continues to have, an important effect on the field of family therapy. Powell and Dosser (1992) find that structural family therapy provides a foundation for "helping" and allows the family to change while still retaining its autonomy.

Structural family therapy is unique because it was generated from work with the poor, unlike many other theories that were based upon work with the middle class and then generalized to the poor (Colapinto, 1981). This acknowledgment of social context and its impact on the dysfunction that was manifest in families was quite significant (although it rarely translated into therapy, as noted below).

Structural family therapy is an approach with many strengths. For instance, it is a favorable model because of its “relative simplicity, concreteness and directness” (Figley & Nelson, 1990, p. 226). For these reasons, it is a model that forms a good basis for the practitioner of family therapy. Simon (1995) states that structural family therapy is a very teachable model in that it takes something as abstract as the family and organizes it using concepts like boundaries and hierarchy. As well, structural family therapy tries to retain a focus on the strengths of the family. Further, this approach is versatile, and to this end, it has been successful in the treatment of families experiencing various difficulties, as will be seen next.

Research on Structural Family Therapy

Structural family therapy has been applied to many different populations. Although a preponderance of the research is based on case studies, there have still been some worthwhile results. Of particular importance has been the work Minuchin and his colleagues have done with delinquent boys and psychosomatic families. This section will examine some of the research studies that have been conducted on this model.

Minuchin's first examination of structural family therapy occurred in the 1960s when he was working with delinquent boys and their families. He evaluated eleven families and found that about 50% to 55% of the cases improved after treatment (Aponte & VanDeusen, 1981). Interestingly, Minuchin found that the families described as disengaged did not improve after treatment. While this study had some methodological concerns, such as, a small sample size and no control group, it did provide the first confirmation that structural family therapy was effective to some extent.

In the 1970s research shifted to studying psychosomatic families. In the published studies, treatment results with anorectic, asthmatic and diabetic cases appeared to be very positive (Minuchin, Rosman, & Baker, 1978). Data reported by Minuchin et al. (1978) found that 86% of anorectics recovered. They also found that 88% of individuals with labile diabetes recovered and 82% of the individuals with asthma recovered. When the authors compared this study to similar studies using different treatment methods they found that structural family therapy yielded the best results. These findings seemed to confirm that structural family therapy was an effective intervention that was superior to other methods.

Stanton and Todd (1979) studied the effectiveness of structural family therapy in the treatment of drug addicts and their families. They compared structural family therapy with two other conditions. They found that the level of positive change was more than double that achieved in the other conditions. Specifically, these researchers found that post-treatment addict families displayed better boundaries between subsystems. These results were

maintained at follow-up.

In another study, Szapocznik, Murray, Scopetta, Hervis, Rio, Cohen, Rivas-Vazquez, Posada, and Kurtines (1989) compared structural family therapy, psychodynamic child therapy and a control condition in the treatment of sixty-nine Hispanic boys. They found that both treatment conditions were essentially equivalent in reducing behavioural and emotional problems. The important difference was that structural family therapy improved the family's functioning, while only treating the child resulted in a deterioration in the family's functioning.

As structural family therapy became more accepted in the field of family therapy, it became a method that was taught to therapists in training. Studies subsequently emerged about the effectiveness of this model as a training tool. For example, in their study on the effectiveness of structural family therapy training, Zaken-Greenberg and Neimeyer (1986) found that trainees in structural family therapy showed higher levels of conceptual and executive skills than the control group. Earlier studies also showed that this approach was effective in training students in the field of family therapy (Aponte & VanDeusen, 1981).

When examining the constructs used in structural family therapy some results are evident. Kog, Vertommen and Vandereycken (1987) found that some terms lacked convergent and discriminant validity, for example, overprotectiveness. They did find empirical evidence for other terms, such as boundaries and conflict. They conclude that it is important to use terms that can be measured empirically with behavioural methods. Nelson and Utesch (1990)

studied the concepts of structural family therapy and found that the more concrete the concept, the more easily it can be assessed directly. They found concepts such as boundary and hierarchy to be more concrete than terms like alignment and cohesion. Concepts that were more abstract required greater inference to interpret them. They point out that this must be taken into account when using these terms for assessment and intervention.

Roy and Frankel (1995) summarize the available research on structural family therapy and conclude that many of the early studies done by Minuchin and his colleagues lack methodological rigor. More specifically, they indicate that there is a paucity of research on the application of a family therapy model to psychosomatic and medical disorders. Roy and Frankel (1995) state that in this area the studies on the structural model often yielded conflicting results. As well, they argue that the results Minuchin obtained when working with individuals with anorexia nervosa have not been substantiated by subsequent research (Roy & Frankel, 1995).

The structural family therapy model appears to be an effective model for a variety of client issues. Nevertheless, there are a few qualifications to these findings. Firstly, as Colapinto (1991) points out, most of the studies on this model have been based on children and adolescents, and there is a scarcity of evidence on the effectiveness of this model with an adult population. Secondly, as stated above, many of the remarkable results reported by Minuchin and his colleagues have not been replicated (Gurman, Kniskern, & Pinsof, 1986; Roy & Frankel, 1995). Lastly, many of the outcome studies on the effectiveness of

structural family therapy are quite dated, leaving the reader to question the applicability of these findings today.

Critique

Structural family therapy is a model that has some clear strengths and has had an unquestionable impact on the field of family therapy. Nevertheless, this model also has some inherent weaknesses, which will now be addressed. One shortcoming of structural family therapy is the lack of a feminist analysis. While structural family therapy looks at the family within its social context, there is no such assessment for women. Looking at the structure of the family fails to take into account the significance of gender and the power differentials inherent in it. The increasingly significant societal demands on women in the home goes unrecognized. Further, concepts such as “enmeshed” and “disengaged” have been frequently applied to women (i.e. mothers) (see, for example, Nichols and Schwartz, 1998), even though these terms are merely constructs and have no absolute reality. Jones (1980) reminds us that operational definitions of these constructs are difficult to obtain because these concepts are quite vague.

McGoldrick (1989) provides a feminist analysis of structural family therapy, pointing out the irony of the clear distinction that Minuchin makes between generations but not between genders. She stresses that gender is a “structural relationship variable” and not just an individual characteristic (McGoldrick, 1989, p. 27). In analyzing the structure of the family, structural family therapy also fails to take into account the power hierarchy that is inherent in being male and female. The assumption of structural family therapy is that the

optimal family hierarchy is that of a two parent system with the male holding the position of power and authority (McGoldrick, 1989). One final criticism McGoldrick (1989) makes is that there is no analysis of how cultural stereotypes and society's norms affect the roles of women and mothers.

The notion of complementarity is also somewhat disturbing. Critics point out that Minuchin expects women to fulfill expressive roles and men to fulfill executive roles (Gladding, 1998a). Recognizing that behaviour occurs in circular patterns can serve to undermine the responsibility of some family members. Although Minuchin et al. (1998) are quick to point out that in severe cases (such as abuse) some behaviours are unacceptable and the therapist needs to take an ethical stand, they are not clear about placing the responsibility for these actions solely on the perpetrator. Claiming that two people contribute to behaviours has some undertones of victim blaming, which is not acceptable today. If one considers the example of a man who frequently demeans his wife, it would seem absurd to blame her for his actions.

There is also a lack of cultural awareness inherent in some of the terms used in structural family therapy. Again, concepts such as "enmeshment" and "disengagement" fail to consider the different parenting techniques utilized by people in different cultures. For example, Napoliello and Sweet (1992) state that the concept of enmeshment would have a different meaning in the Native American culture than it would have in mainstream American culture. As well, the concept of healthy boundaries may be problematic for cultures that have a less distinct delineation of the boundaries within the family and between generations.

For these reasons it is important to remember that these terms are merely constructs which may or may not have universal application.

There has also been the criticism that structural family therapy simply involves restructuring. Critics argue that this approach is solely focused on techniques utilized in the restructuring process. Simon (1995) responds to this by asserting that the "popular view" of structural family therapy has focused exclusively on structural diagnoses and therefore has completely missed the very important assumptions of competence and uniqueness that are at the heart of structural family therapy. These two qualities highlight the capacity that families possess to utilize alternative behaviours in dealing with their current situations by focusing on the uniqueness of the family and acknowledging that there is no single solution to each problem.

Wetchler (1995), in his response to Simon's article, insists that the concepts of competence and uniqueness have always been crucial to this theory and adds his own opinion as to what the central concepts are. The importance of these articles is that they are moving structural family therapy beyond a theory which assesses structural patterns evident in a family, to a theory that is more optimistic and strengths oriented. Emphasizing these concepts reiterates the importance of the relationship between the therapist and the family in structural family therapy and places the family's strengths at the forefront.

As discussed above, structural family therapy was revolutionary in its acknowledgment of the impact of social context on the family's dysfunction. While it is important to recognize the impact of social context, structural family

therapy never went beyond this. Terms such as enmeshment and disengagement are used to describe the family and tend to place very little emphasis on the larger social environment. Pathologies are said to be found in the family structure and in its patterns of interaction, which again, overlooks outside influences.

Structural family therapy is also criticized for being an approach that does not have a very strong theoretical foundation (Gladding, 1998a). This approach is action-oriented, with a focus on the present rather than the past. While there are some useful concepts applied by this approach, there really is no analysis of some of the more complex issues pertaining to family life, such as violence and abuse (Gladding, 1998a). Sometimes a family is more complex than boundaries and hierarchy can discern.

Structural family therapy is also a model that is not very applicable to specific individual syndromes (Colapinto, 1991). As discussed earlier, this theory posits that dysfunctions are due to interactions based on a faulty family structure. Accordingly, by this theory, altering a family structure would not have much effect on a person dealing with a character disorder (such as psychosis) (Colapinto, 1991).

One final critique of structural family therapy is that it can be disempowering for clients (Gladding, 1998a). The therapist is always in control of the process. It is the therapist who decides if the family structure is dysfunctional and then it is he or she that attempts to restructure the family. The client is not a co-creator in the process. If a therapist is seeing a family in which the parents

have little power, it does not seem very helpful if the therapist controls the power and replays the same situation the parents are facing at home.

Conclusion

Structural family therapy offers therapists a model that is active and clearly defined. It is suitable in a variety of cases and it is an approach that focuses on restructuring the family to eliminate dysfunctional interactions. Structural family therapy also makes some assumptions about what constitutes a healthy family, for example clear boundaries and a discernible hierarchy. Although it is said to focus on strengths, some of the terms used are clearly derogatory and imply very little strength.

Structural family therapy however, is an approach that should be taught to family therapists in order to give them a good foundation in family therapy. While this approach may not espouse a collaborative relationship between client and therapist, the practical nature of this model makes it appealing to many practitioners. As discussed previously, the fact that many therapists continue to use this approach today is evidence of its popularity as a family therapy model.

SECTION TWO: PRACTICUM SETTING AND PROCEDURES

Setting

The setting for my practicum was the Elizabeth Hill Counselling Centre (EHCC). The EHCC is located in downtown Winnipeg and provides a no-fee service to people from all areas of the city. Professional referrals to the centre are not required; individuals can refer themselves. The EHCC is operated by the University of Manitoba and serves as a training facility for students from the Faculty of Social Work and the Department of Psychology.

Clients

The clients who participated in my practicum were all referred to the EHCC for family therapy. Two of the families were participants in a child therapy project conducted by the EHCC and were referred to me through Linda Perry, a therapist at the centre. The remaining six families were chosen from the general wait list. Of the eight families I worked with, two terminated prematurely. The remaining six attended a minimum of six sessions each. Although the “family” was the population I chose to work with, one client family consisted solely of a single parent due to the fact that her child was unwilling to participate in the sessions.

Procedures

The procedures that I followed throughout my practicum were consistent with the procedures employed by the EHCC. My clients were informed about the therapeutic process, as well as the fact that I was a student training in social

work. Intake reports, case notes and termination reports were written in accordance with the requirements of the EHCC.

Weekly therapy sessions were videotaped to enhance my learning experience. Taping the sessions allowed both myself and my supervisor the opportunity to review the sessions. Clients were informed of this procedure at the outset and were asked to provide their written authorization to videotape. All of the tapes were erased at the conclusion of my practicum.

All of the families that I worked with were counseled at the EHCC. The first session was mainly spent joining with the family and gathering some information about the family. The assessment process included an analysis of family structure, subsystems, boundaries, developmental stage and overall family functioning. The clients were administered a pre-test Family Assessment Measure (FAM III) (Skinner, Steinhauer, & Santa-Barbara, 1983) during our second or third session together, which also helped in the assessment process.

Once the initial assessment was complete, usually by the second or third session, I spoke with the family about what intervention I felt was appropriate and they were asked for their input. A verbal contract was usually made concerning approximate number of sessions and the intervention plan. We then began the intervention. As was often the case, assessments shifted and developed throughout the intervention process, illustrating the need for flexibility. During our termination session the FAM III measure was again administered as a post-test. In addition, clients were asked to fill out a client satisfaction questionnaire during our last session. Although formal arrangements were not

made with respect to the number of counselling sessions each family would have, periodic progress evaluations were conducted and termination was mutually agreed upon.

The Families

The A family, discussed in greater detail in section three, was referred to the EHCC through a school counselor. This family consists of a divorced mother and her two sons. The presenting issue for this family was the difficulties that Ms. A's eldest son was having at school. Following the assessment process I became aware that Ms. A was not experiencing these concerns at home and that the problems were occurring solely in the school system. Further, I speculated that Ms. A was not appropriately situated in the hierarchy that existed between her and the teachers at her son's school. Restructuring by creating clear boundaries around Ms. A as a parental subsystem became the focus of intervention and this proved to be most helpful. This family was seen for twelve sessions, including nine sessions with Ms. A alone, two with her children present and one session with Ms. A and school personnel.

The B family, which will also be discussed in section three, includes a mother, her fiancé and her daughter. They were referred through their family physician. Although this family was initially referred because of the physical complaints of Ms. B's daughter, it appeared that there was conflict between the adults in this family, specifically Ms. B, her fiancé and her ex-partner Mr. Y and his new wife. I hypothesized that the adults were experiencing some benefits to maintaining this conflict, given that Ms. B and Mr. Y had been separated for

approximately nine years and still were in an intense relationship. Intervention was directed towards the adults in these families and included restructuring and a strengthening of boundaries around each of the families. This family system attended sixteen sessions including two sessions with Ms. B's daughter; two sessions with Ms. B, her fiancé and her daughter; six sessions with Ms. B and her fiancé; one session with Ms. B alone; three sessions with Mr. Y and his wife; and two sessions with all the adults in this system.

The C family was referred to me through the child therapy project at the EHCC. Ms. C has three sons. Her partner, Mr. P, also attended some sessions. The family came to the EHCC for help with their communication as well as to seek resolution regarding whether Mr. P would continue to be involved with the family. After having a few sessions with all of the family members present, it became apparent that the couple issues could not be addressed until Mr. P received help for violence and addictions. In this respect, furthering a therapeutic relationship with Mr. P present could endanger Ms. C and thus it was suggested to him that he seek individual help before their couple issues could be addressed. Unfortunately, Mr. P was not willing to do this. As Ms. C was also interested in receiving some individual help around parenting and communication issues, I continued individual therapy with her.

Witnessing the interactions that took place between Ms. C and her children made it clear that her oldest son frequently took over her parenting role, thus disempowering her as a mother. The structure of the family was such that both Mr. P and Ms. C's eldest son were more powerful than Ms. C. As well, there

was an alignment between Mr. P and the oldest son. Accordingly, intervention focused upon strengthening Ms. C's position in the family and helping her to regain her position as the primary care giver in the family. We also worked on developing a safety plan for Ms. C and her children. In total, this family was counseled on six occasions, including two sessions with Ms. C and Mr. P; one session with all the family members present; one session with Ms. C and her sons; and two sessions with Ms. C.

The D family is comprised of a mother and her twin daughters. This family was self referred to the EHCC for family therapy. Issues identified during assessment included parent-child conflict and unresolved anger experienced by each family member. After assessing the family, it seemed that Ms. D frequently expected her daughters to make parental decisions and act as if they were the adults in the family. This was exacerbated by a coalition between the two daughters, in which they often joined with each other to overrule their mother. This family also seemed to possess quite diffuse boundaries between the parental and sibling subsystem. Accordingly, intervention focused on creating stronger boundaries around these subsystems and elevating Ms. D in her position as the parent. The coalition between the two daughters was minimized by having Ms. D sit between the two girls, thus making it physically harder for the "two against one" situation to occur. Upon evaluation, Ms. D indicated that she felt more "in control" and felt more comfortable exerting her authority. This family was seen for six sessions.

The E family includes a father, his new wife Ms. E, and Mr. E's son, as

well as Ms. E's three daughters from a previous marriage (who did not attend counseling). This family was referred to the EHCC by the son's school counselor. The identified concerns included the son stealing, lying and not going to school. As well, the family was experiencing some difficulty as they were trying to establish themselves as a newly blended family. After the initial intake session, Mr. and Ms. E decided that their concerns with Mr. E's son were too great to overcome, and that they were going to place him in foster care. They did not want to continue with therapy to aid in this transition and so they were only seen once at the EHCC.

The F family was referred through the child therapy project at the EHCC. Ms. F has one daughter. She had previously miscarried a child and was referred to the EHCC because she had recently had another child die. Child and Family Services (CFS) was involved with this family and had encouraged Ms. F to seek treatment. The presenting issues for this family included Ms. F's inability to continue to be a functional parent to her daughter and her use of large amounts of alcohol to cope with her recent loss. Ms. F was seen twice at the EHCC and missed two subsequent appointments. She indicated that she felt pressured by CFS to attend therapy and that she did not want to receive help at this point in time.

The G family includes a mother and her two daughters. They self-referred to the EHCC following an incident in which the oldest daughter intentionally injured herself (although this type of incident never occurred again). The daughter stated that she was expressing her anger over her parents' impending

divorce. The presenting issues for this family included helping them adjust to the change in structure that was a result of Ms. G's recent separation from her husband and helping Ms. G to communicate more with her daughters. Through assessment it became apparent that Ms. G had developed rigid boundaries around the parental subsystem, primarily because she was afraid of involving the girls in the details of the divorce. It was hypothesized that through her intention to not involve the girls in the divorce, she had communicated to them that they were not allowed to talk about the divorce.

Intervention focused on facilitating a greater degree of open communication between Ms. G and her children. Ms. G was encouraged to develop boundaries that were clear but flexible. She also had to continue in her role as parent, despite the changing structure of this family. In addition, the family was helped in their transition from a two-parent to a single-parent family. This family attended 13 sessions, 5 of which were with Ms. G alone. Upon termination, the family was communicating better as was evidenced by the daughters asking their mother questions they were previously apprehensive about asking.

The H family consists of a mother and her son. This family was referred to the EHCC through a friend of Ms. H's. The identified concern was mother-son conflict. This family had previously sought help from another agency but terminated there prematurely. With this family I worked exclusively with Ms. H; her son did not attend any sessions. After assessing the family it became apparent that this family was extremely close and could be described as

enmeshed. I also realized that Ms. H was not willing to change this pattern, although she was unaware that she was having this type of relationship with her son by choice. Intervention focused on emphasizing the power that Ms. H held as a parent. Essentially, it was helpful to reframe her relationship with her son as a choice she had made. We also focused on some of the developmental issues that were occurring. As her son was moving into the young adulthood stage we explored how each of their roles would change and how they could accommodate these changes. Ms. H was seen for thirteen sessions. Her evaluation indicated that her relationship had improved with her son and that she no longer felt pressured to do what others thought was best for him.

Supervision

Over the course of my practicum I was supervised by two members of my practicum committee, Dr. Diane Hiebert-Murphy and Kathy Levine. Dr. Diane Hiebert-Murphy was my advisor and is the chairperson of my committee. She provided supervision on a weekly basis. We would meet for approximately two hours each week to review the cases, plan future sessions and critically evaluate my progress. Kathy Levine is with the Faculty of Social Work. She assumed supervisory duties in Dr. Hiebert-Murphy's absence. My final committee member was Linda Perry who is a therapist at the EHCC.

Learning Objectives

The goals that I wanted to achieve through this practicum process included (1) to familiarize myself with the structural family therapy model such that I would be able to use it in a way that is beneficial for my clients; (2) to

develop my clinical social work skills; and (3) to develop a solid foundation in family therapy.

Evaluation

Evaluation was completed by using a pre-test post-test design. The families completed the FAM III before and after intervention in order to guide me in the assessment process and enable me to assess the effectiveness of their treatment. As well, I had my clients complete a general client satisfaction questionnaire at the end of therapy sessions, which assessed their overall experience in therapy (see Appendix). The results of this questionnaire provided me with constructive feedback on my skills as a therapist.

The FAM III was created by Skinner, Steinhauer and Santa-Barbara (1983) and is based upon a Canadian population. Using a systemic perspective, it measures the level of health or pathology in a family's functioning. The FAM III contains nine subscales which each contain equal numbers of healthy and pathology keyed responses (Tutty, 1995). What is unique about this measure is that it contains two subscales that identify response bias.

The FAM III (general scale) is a self-report measure comprised of fifty items based on a four point Likert scale. The subscales evaluate family functioning in the areas of task accomplishment, role performance, communication, affective expression, involvement, control, values and norms and the response styles of social desirability and defensiveness (Skinner et al., 1983). The FAM III can be completed in under 30 minutes and family members must be at least ten to twelve years of age to complete it (Skinner et al., 1983).

The internal consistency reliability for the FAM III is quite high with a coefficient alpha reported at .93 for adults and .94 for children (Tutty, 1995). There have been no test-retest reliability coefficients reported for this measure. The construct validity for this scale is also good, indicating that the scale discriminates between problem and nonproblem families (Skinner et al., 1983). The FAM III is based on standardized norms, in which most of the non-clinical families should have a T-score in the range of 40-60. A higher number (i.e. over 60) indicates a weakness in that particular area, whereas a lower number (i.e. less than 40) indicates a strength (Skinner et al., 1983).

The client satisfaction questionnaire consists of six questions. Clients were asked to fill out this form on their own during our final session. Two of the questions in this questionnaire were likert-type. The remaining four questions were open-ended and were designed to elicit a more qualitative response.

SECTION THREE: CASE STUDIES

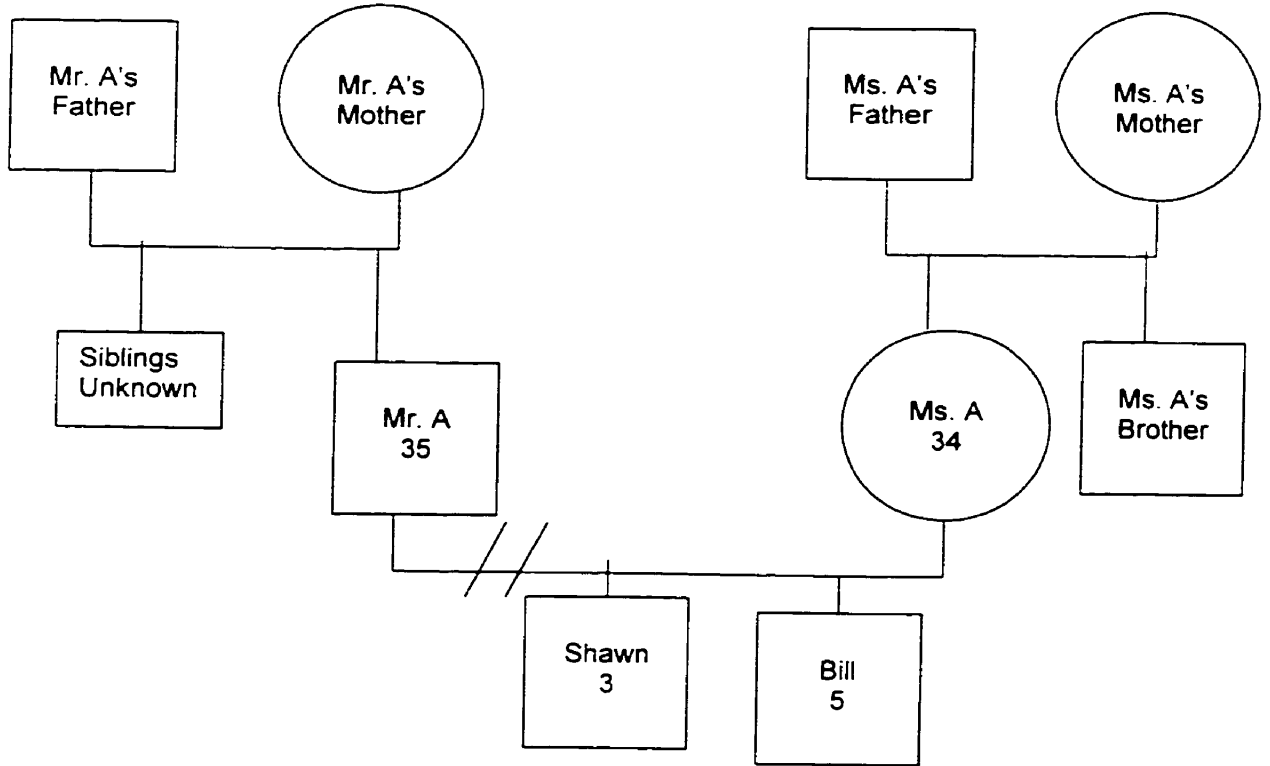
Introduction

This section describes two of the eight families that were participants in my practicum. My analysis of these cases illustrates the application of a structural family therapy approach, but also exemplifies the necessity of recognizing the uniqueness of each family. In addition, these two cases are representative of some of the broader concerns that were evident in many of the families with whom I worked. This analysis includes a discussion of the presenting problem, an assessment, a description of the intervention and an evaluation. To protect their identities and to ensure confidentiality, the families will be assigned pseudonyms.

The A family

As indicated previously, the A family consists of a divorced mother (age 34 years) and her two sons, Bill (age 5 years) and Shawn (age 3 years)(see Figure 1). Ms. A has been divorced for three years. Prior to her divorce, Ms. A was involved in an abusive relationship with her husband. Her children witnessed some of this violence. Her ex-husband lives in another province and Bill and Shawn only see their father about twice a year. Ms. A works full-time and her children attend both school and daycare during the day. Ms. A was referred to therapy through a counselor at the school that her son, Bill, attends.

Figure 1: Genogram
The A family



Presenting Problem

The primary reason that the A family was referred to therapy was because of Bill's behaviour at school. Two months into kindergarten Bill's teacher reported that Bill was making unprovoked attacks on other children in his class. She also reported that he appeared to be lacking in social skills and was reluctant to participate in some of the activities in which the other children were involved. This behaviour appeared to be restricted to the school setting, as Bill's daycare reported that he was not having similar problems in that setting. Further, Ms. A indicated that he was not engaging in these behaviours at home.

Assessment

Structure

Ms. A was trying to adjust to the many recent changes that her family had undergone. The structure of the family appeared to be organized and flexible enough to adapt to the changes following the divorce of Ms. A and her ex-husband. Within her new family hierarchical structure, Ms. A wielded the most power. She appeared to be appropriately placed in terms of her position in the family, which became evident to me in the sessions her sons attended. They appeared to respect her authority as parent. For example, when she asked them to do something they generally did what she asked. Ms. A indicated that she felt comfortable setting limits and would use discipline if and when necessary, which again suggests that she holds power.

The structure of this family as it relates to the external environment is somewhat problematic. Specifically, with the school system the A family has

developed a pattern of interacting that has undermined the power and authority of Ms. A. For instance, Ms. A was chastised by the school teacher in front of her son. Within the school setting, it appeared that Ms. A had been relegated to the same level of power as her son. Both of them are expected to respect the schoolteacher and they are also expected to comply with the teacher's demands.

The flexibility of the A family was such that the members of this family appeared to be adapting to the many changes they had been confronted with. For instance, Ms. A managed the household as a single-parent and supported the family with her income. Both Bill and Shawn attended daycare and appeared to be adjusting to the absence of their father. Bill also seemed to be getting accustomed to the routine of school. Ms. A often stated that she anticipated that the adjustments following the divorce would take time, and that therefore, some behavioural difficulties would resurface when her sons returned from their yearly visit with their father.

Subsystems and Boundaries

Ms. A seemed to possess good boundaries around her parental subsystem. She was careful to not involve her children in the power struggles that sometimes arose with her ex-husband. Ms. A seemed to have boundaries around her parental subsystem that were clear but flexible. For example, when Bill was continually asking for something she was firm in her answer but still considered his thoughts.

In terms of the sibling subsystem, Bill and Shawn appeared to enjoy a

typical sibling relationship. During the two sessions in which the children were present they seemed to play well together. The sibling subsystem appeared to function without too much interference from Ms. A. As individuals, they each appeared to function well and seemed able to engage in their own activities. Within the family system, the boundaries appeared clear but flexible, indicating that the family was neither enmeshed nor disengaged.

The parental subsystem consisting of Ms. A and her ex-husband can be described as disengaged, given that Mr. A lives in another province and rarely sees his sons or has input into decisions affecting his sons. This affected the family because Mr. and Ms. A were not able to act as a unified parental subsystem and consequently, the boys felt divided loyalties. Ms. A tried to respect the parent-child boundary that existed between her sons and their father, in that she gave them time alone to phone him and she protected them from any conflict she may have had with their father. The relationship between Ms. A and Mr. A was conflictual and Ms. A stated that she tried to avoid engaging in disagreements with him.

Although Ms. A maintained a boundary around her role as parent within the home, outside of the home she often had others define her role as mother. Ms. A stated that she felt intimidated by the "experts" from the school who were involved with her son, and did not feel that she had the knowledge and authority to challenge them. She described herself as feeling "disempowered" in her dealings with the school system. Ms. A was also concerned that her son was being labeled a troublemaker so that the kindergarten class could receive

additional funding for an aid in the classroom. When I was contacted by the school teacher a number of times, I also found that she tended to dismiss the opinions of Ms. A.

Life Context

Ms. A was trying to reestablish herself following her divorce and subsequent move. Ms. A indicated that she has some sources of support. She relies on her mother for most of her emotional support and for help with the children. Ms. A stated that she is also close with her father. Ms. A has one brother, but he lives in another province and she rarely has contact with him. Ms. A also indicated that her relationship with Mr. A's parents is conflictual, as she feels that they are constantly criticizing her. They will occasionally visit the children, but Ms. A does not consider them a source of support. Ms. A also has some friends whom she considers support systems.

Ms. A has a good relationship with her son's daycare provider. She feels that they have an open relationship and that the daycare workers respect her. Unfortunately, she does not feel that she has the same relationship with the school Bill attends. She had developed a positive relationship with the school principal, but he recently left this position. Ms. A's biggest source of stress is when Bill's teacher suspends him. This is for the reason that Bill's daycare is located at the school and he is not allowed to attend daycare when he is suspended. Ms. A does not have the resources to take time off work and so it becomes very difficult for her to arrange for childcare on these occasions.

Triangles

Both Ms. A and Bill appeared to be in powerless positions in dealing with Bill's school. This put them at risk of aligning with each other against the school system and it sometimes appeared that this alliance had formed. Such an alignment would empower Bill, therefore our intervention sought to eliminate this alignment and in addition, create a new alliance between Ms. A and Bill's school.

There also existed other triangles in this family system. Ms. A and her mother were in a coalition against Mr. A, which helped Ms. A to feel supported in her decision to leave the marriage. It also appeared that there was a coalition between Mr. A and his family against Ms. A. Bill and Shawn appeared to align with their mother, as they would frequently refuse to talk to their father. These triangles did not appear to be especially problematic for the family members involved in them.

Developmental Stage

While Ms. A has been divorced for three years, she was still adjusting to being a single parent. It is not uncommon for this adjustment to take up to three years (Carter & McGoldrick, 1999). This transition is significant because Ms. A has had to adapt her way of parenting to accommodate the fact that she is the sole parent in the home. Also, because her ex-husband lives in another province and rarely has contact with their children, Ms. A's isolation as a parent is compounded.

Some of the tasks associated with becoming a single parent include developing a visitation schedule with the ex-partner, maintaining financial

responsibilities and rebuilding one's social network (Carter & McGoldrick, 1999). Although her relationship with her ex-partner has been somewhat conflictual, Ms. A has managed to develop a visitation schedule with him. She has also begun to rebuild her financial resources, although this has not progressed as well as she would like. In addition, Ms. A has started to create a new social support system, but has not yet worked out her relationship with her ex-husband's family.

Despite Bill's tender age, he appeared to have been affected by the change in their family structure. The effects of divorce are known to have an impact on the functioning of pre-schoolers (Carter & McGoldrick, 1999). This supports Ms. A's belief that her divorce has contributed to, or is in part the cause of, Bill's social difficulties.

Role of the Symptom Bearer

Bill's behavioural difficulties in the classroom have given his teacher a student to focus on in order to obtain funding for a teacher's aide. Bill's teacher suggested that she was overworked and had to exaggerate Bill's behaviours in order to obtain help. Within the family system, Bill's problems with the school have joined Ms. A and Bill together to fight against a shared concern. Therefore, these concerns have served to unite Bill and his mother.

Hypothesis

My original hypothesis was that Ms. A did not have clear boundaries around her role as parent within the home. I hypothesized that her lack of authority in the home was one reason for Bill's behaviour in the school system.

As I witnessed the interactions between Ms. A and her sons and when Ms. A described how her family was at home, I realized that the home was not the source of Bill's problematic behaviour. In fact, it became apparent that Ms. A was functioning well in her role as parent within the home. Through more assessment of the external environment, I hypothesized that the problems that the A family were experiencing were a result of the lack of power Ms. A was experiencing outside of the home. Consequently, intervention would need to focus on restructuring the relationship between Ms. A and the school. More specifically, Ms. A needed to be empowered in her role as Bill's parent so that she could take a more active role in addressing his difficulties at school. It also seemed that Bill's social skills were lacking and that this was contributing to his difficulties at school. Indeed, it appeared that developmentally Bill was somewhat behind his peers.

Goals

Given that most of Bill's difficult or anti-social behaviour occurred at school, this seemed to be the most appropriate place on which to focus. Specifically, the primary goal was to situate Ms. A in a greater position of power relative to the school teachers. Ms. A was also encouraged to work on some of the developmental issues pertinent to Bill (for example, developing his social skills), although it was recognized that this was a long-term goal.

Intervention

After two sessions with Ms. A and Bill it became apparent that Ms. A was appropriately situated in her family hierarchy, i.e. she wielded the most power in

that family system. For instance, her children would do a task that she asked them to do even though they did not want to. Accordingly, it appeared unnecessary to focus on her parenting skills as a place for intervention. Once the focus was shifted from the interactions within the family to the interactions with the external systems, Ms. A felt more competent as a parent and this was empowering in itself.

The process of joining with Ms. A and her children became an integral part of the intervention, as I was able to approach intervention from a trusted and empathetic position. Communicating to Ms. A that I was there to help her family and not assign blame was both a relief and a strength to her. Given that her interactions with the school system had been quite blame-ridden, Ms. A found that my support enabled her to take action and become more pro-active. Ms. A was able to let go of the guilt she felt regarding Bill's behaviour and start to focus on solving the problem. Although joining was especially important during our first sessions, it was also important to maintain our relationship throughout therapy. The bond that we had developed as a therapeutic team was evidenced by our mixed feelings when it was time for termination.

Upon eliciting further information from both Ms. A and the school system, it became apparent that the structure of the interactions between the two systems was such that Ms. A had access to very little power and seemed to be on a level equal to that of her son. Specifically, Ms. A did not feel that Bill's teachers listened to or respected her opinions. To address this issue we developed a plan to have Ms. A meet with Bill's educators and start to exert her

authority as Bill's parent. Thus, we were restructuring the relationship and the hierarchy between Ms. A's family and the school system.

Transactional patterns between Ms. A and the school system revealed that Ms. A was in a powerless position. She indicated that she was not called upon to offer her reasons for Bill's behaviour and she was rarely contacted to offer solutions for his behaviour. As well, the school teacher decided it was necessary to send Bill home each day with a list of his misbehaviours and would often suggest things that Ms. A should be doing in the home to stop these behaviours. While the school was focusing on the home for solutions, we shifted the focus back to the school. To this end, Ms. A began to hold the school accountable by asking them how they were going to deal with Bill's behavioural problems, which seemed to occur solely in that setting.

Counselling sessions leading up to the meeting with the school were spent developing Ms. A's confidence with respect to her dealings with Bill's school teachers. This was approached on the basis that Ms. A, as Bill's parent, knows what is best for her son and therefore her views should not be discounted. My role in these sessions was to coach Ms. A and facilitate the restructuring process. This was done by clearly delineating a boundary around what was her responsibility and what was the school's responsibility. Ms. A also found it helpful to rehearse with me what she wanted to say to the teachers.

Reframing was also a helpful technique. Rather than pronounce that Bill was a bad child, we said that Bill was not functioning well in his school environment. Bill benefited from this because he no longer had to accept all of

the blame when things were not going well at school. This also helped Ms. A to externalize the problem and accept that she was not solely responsible for Bill's behaviour at school.

Between session homework tasks helped the process of change. Ms. A was unhappy with the daily reports of negative behaviour so she was encouraged to come up with an alternative form of communication about Bill's behaviour. She did this by having the school record Bill's positive and negative behaviours for each day. In addition, for one week Ms. A went to Bill's school fifteen minutes earlier each day and spent the time talking with Bill's teacher and discussing parenting strategies that had been successfully applied at home.

The meeting with the school involved both Ms. A and myself as well as the teachers primarily involved with Bill's schooling. My presence and perceived alignment with Ms. A served to unbalance the hierarchy between the school and Ms. A. During this meeting Ms. A was able to express her concerns and offer her own solutions for Bill's behavioural problems in the school, demonstrating her growth and confidence in her role as Bill's parent. Throughout the meeting Ms. A became increasingly assertive about her role. She frequently overrode ideas presented by school staff. Boundaries were being strengthened around this parental subsystem as she was exerting her authority as Bill's parent. Although Bill's teachers were unreceptive to Ms. A's suggestions, Ms. A was able to realize this and as a result was able to take alternate approaches in her subsequent dealings with the school. For example, when she had a school-related concern she approached the vice-principal when Bill's teacher was

unresponsive.

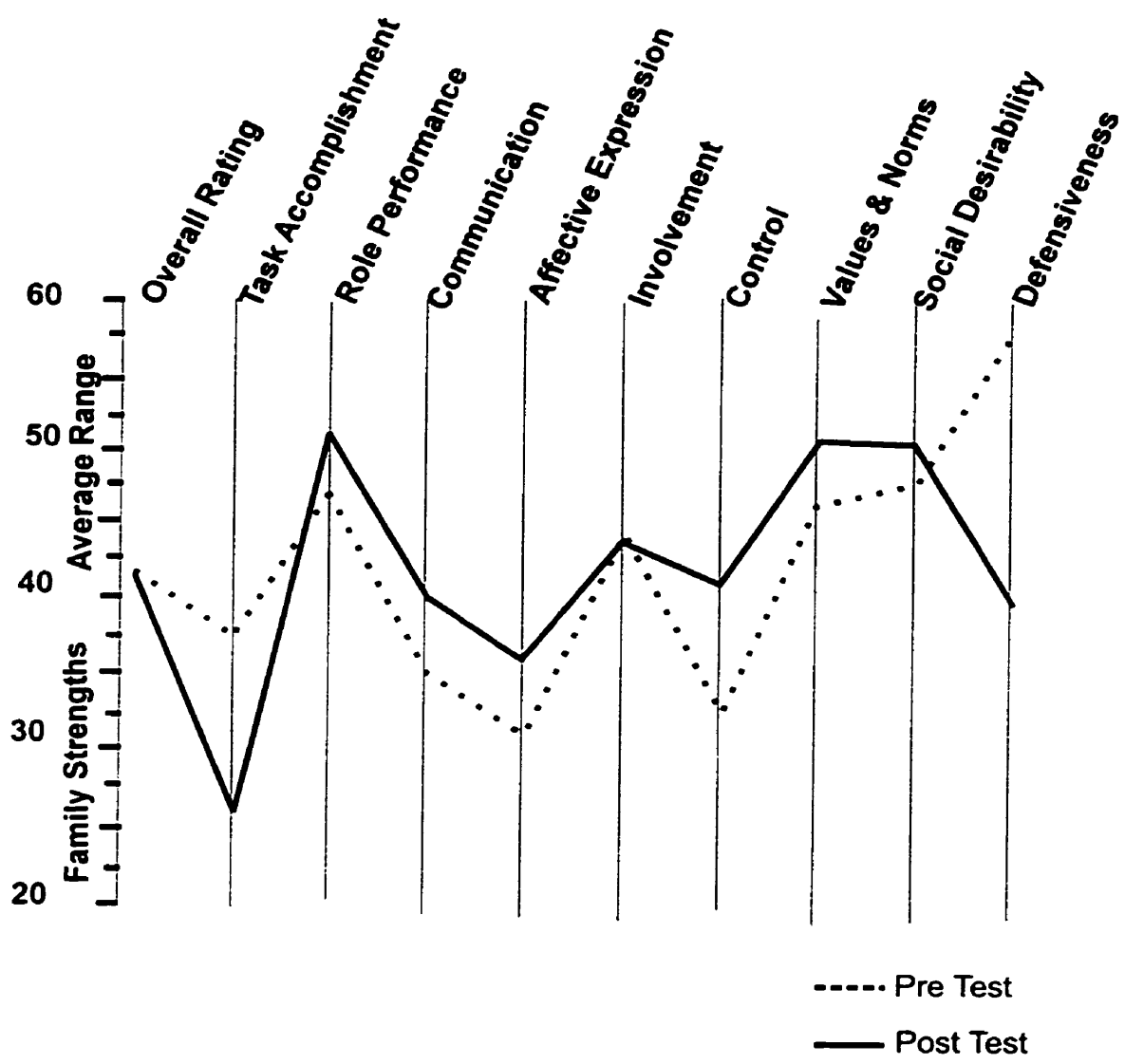
Following this meeting, it appeared that a boundary had been defined, distinguishing between Ms. A's role and the school's role with respect to Bill. Ms. A no longer assumed sole responsibility for Bill's behaviour at school. As well, Ms. A expected the school to deal with Bill's behaviour within the school setting and not within her home. Follow-up sessions indicated that Bill's behaviour in school showed marked improvement, which seemed to confirm my hypothesis and intervention.

Evaluation

The FAM-III General Scale was administered to Ms. A as both a pre-test and a post-test (see Figure 2). The results indicate that she possesses many strengths. In all categories her perceived level of functioning was in the strength or average range. This is consistent with my clinical observations in which she demonstrated her strengths as a parent. The control and affective expression categories seemed to be areas in which she appeared to be particularly strong, which again was confirmed by my clinical observations. The pre-test and post-test overall T-score for Ms. A remained the same at 43.

While the pre-test and post-test measures of the FAM III showed little deviation, this measure was supplemented with a client satisfaction questionnaire which indicated that Ms. A felt that she had experienced great improvement with her presenting concern. When asked what the most helpful aspect of therapy was she stated that it was "gaining back the confidence to be an assertive mother."

Figure 2
FAM III General Scale
"A" Family



Conclusion

My experience counselling the A family provided me with a unique learning opportunity. I recognized that families cannot be examined in isolation of the larger systems with which they interact. Similar to the outlook of Minuchin, I saw that "successful intervention at the level of the family can be dissipated by the inertia and power of the larger social system" (1982, p. 660).

The concepts outlined in structural family therapy proved to be of great use in the assessment and intervention with this family as they provided me with a constructive framework. Specifically, assessing the B family's life context was crucial in the development of my hypothesis (and subsequent intervention). As well, the structural model provided ways of restructuring the hierarchy that existed between the school and Ms. A. Indeed, unbalancing and altering the power hierarchy proved to be the appropriate intervention for this family and demonstrated the efficacy of the structural paradigm.

Finally, this family was not representative of a "typical" family therapy intervention because the focus was on the relationship between the family and the external environment, rather than on the relationships within the family. The effectiveness of my application of this model is indicative of the versatility of the structural family therapy model.

The B Family

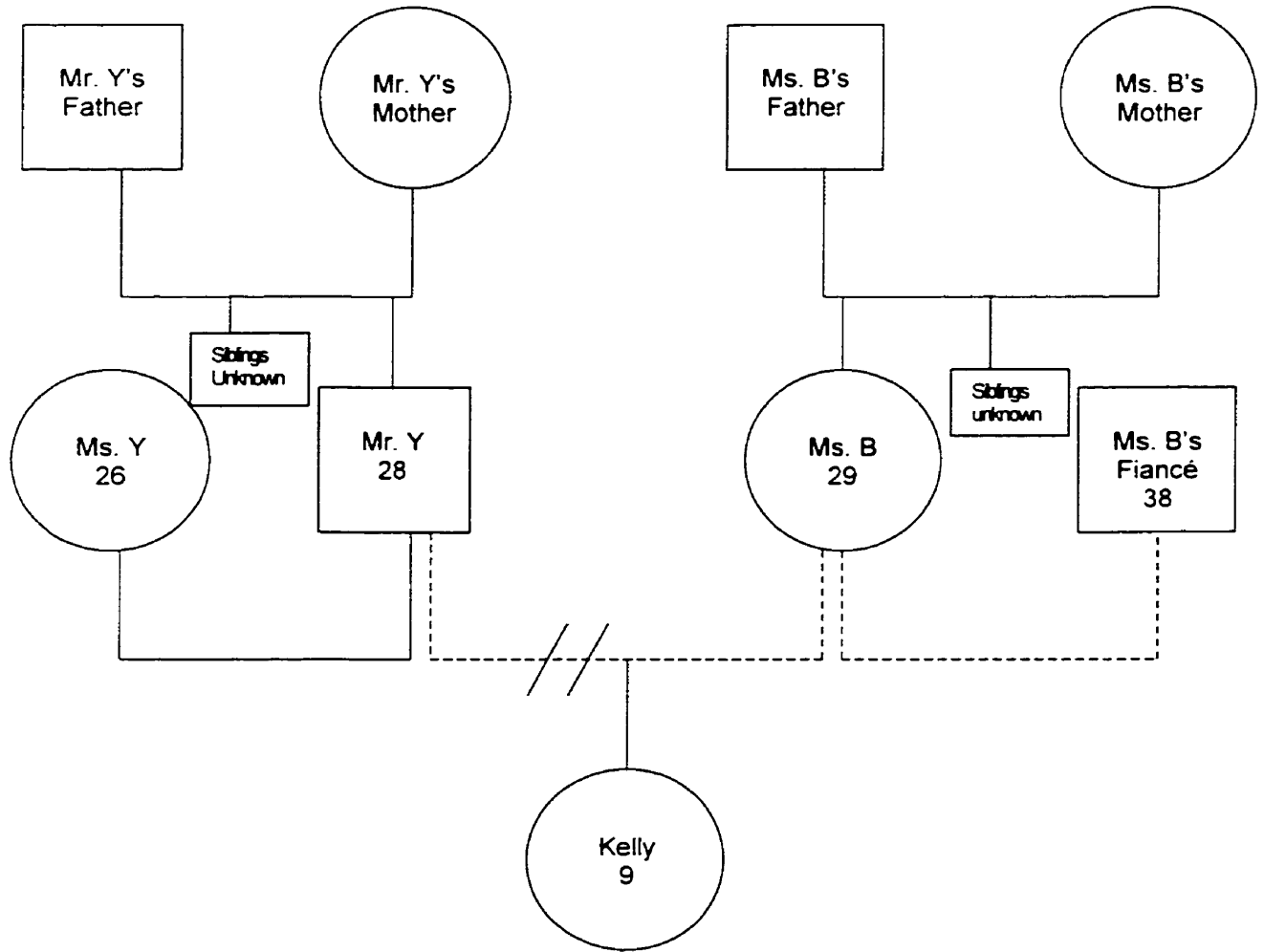
The B family consists of a 29 year old mother who is currently engaged and living with her fiancé. Ms. B has never been married, but has one child, Kelly, aged nine, from a previous relationship with Mr. Y (see Figure 3). Ms. B has been in a relationship with her fiancé for 6 years. She has always maintained primary custody of Kelly. Currently, Mr. Y has Kelly every second weekend. Although the referral for therapy came primarily for the B family, it soon became apparent that treatment would need to involve the Y family as well, as will be discussed in more detail further on.

Recently, Mr. Y married. While Mr. Y and Ms. B have never had a relationship void of conflict, things deteriorated significantly at the time of his engagement to his current wife. Further, Mr. Y's mother and father are very involved with Kelly and there is a particularly intense conflict between Ms. B and Mr. Y's mother. The relationship between Ms. B and Mr. Y has deteriorated to the point that they can no longer resolve issues concerning Kelly between them. Rather, they rely on the court system to resolve any disputes that arise. Shortly after the B family began therapy they were referred to mediation by the Court.

Presenting Problem

The B family was originally referred to the EHCC through Kelly's physician. At the time, Kelly was experiencing various physical ailments with no known physical cause. After examining Kelly, her physician recommended that Ms. B seek out therapy for Kelly. During our initial sessions, Kelly indicated that she was experiencing stomach-aches and sleep disturbances. She also revealed

Figure 3: Genogram
The B Family



that she was very distressed about the relationship between her mother and her biological father.

Assessment

Structure

Ms. B and her fiancé, along with Kelly, function as a remarried family, although they are not legally married. The structure of this family appeared unorganized and problematic. For example, alliances would frequently shift and Kelly would alternate between the roles of confidante and child. During our initial sessions, Ms. B spoke for the entire family, although Kelly would sometimes interrupt to add information. Ms. B's fiancé was not very vocal and tended to defer his answers to Ms. B.

The couple subsystem seemed to display an imbalance in power. It appeared that Ms. B wielded the most power in this subsystem. For example, although this couple had been living together for many years, they only recently became engaged when Ms. B decided the time was right. Pertaining to the conflict with Mr. Y and his new wife, Ms. B's fiancé indicated that he had been suggesting ways to end the conflict but felt that Ms. B was not receptive to his suggestions.

The hierarchy of the B family was such that it was difficult to distinguish a parent-child hierarchy. Interestingly, although the parents in this family thought that they held the most power, it appeared that Kelly was wielding the most power, as she appeared to be fueling the conflict between her biological parents and would often use their disputes to her advantage.

The B family also displayed little flexibility in terms of their capacity for change. When I attempted to shift the focus away from the identified patient (i.e., Kelly), the parents would try to refocus on her. As well, when I initially indicated that it would be helpful to involve Mr. Y and his wife in the counselling sessions, the B family was not receptive to this and was quite reluctant to give me Mr. Y's phone number. This family appeared to tolerate little deviance from their established transactional patterns. For example, when I pushed Ms. B's fiancé to respond to a question Ms. B would say "you don't really feel that way do you"?

Subsystems and Boundaries

Ms. B and her fiancé have been together since Kelly was three and therefore they have functioned as a parental subsystem for as long as she remembers. The boundaries between the parental subsystem and Kelly's place as a child appeared blurred; her mother frequently treated her as a confidante, rather than a child. For instance, when Ms. B was in disagreement with other adults she often confided in Kelly. As well, when a new conflict arose between Ms. B and Mr. Y, Kelly was usually drawn in and expected to choose sides. Therefore, the relationships within the B family could be characterized as enmeshed.

As a couple subsystem, Ms. B and her fiancé did not seem to function well. They indicated that about 90% of their time was spent in conflict with Mr. Y and his family, and that consequently, they rarely had time to focus on their own relationship. The B couple also seemed divided on some important issues and never really communicated how these issues could be resolved. For example,

Ms. B stated that she wanted more children but her fiancé did not. As well, they were not able to agree on when they should get married. By spending all of their time engaged in the conflict with Mr. Y it seemed that the B couple subsystem avoided facing some of the larger issues evident in their own relationship.

The parental subsystem involving Ms. B and Mr. Y could be characterized as disengaged. They rarely contacted each other about parenting issues and frequently had to go to a third party to gain information about Kelly. For example, Mr. Y would contact the school to see how Kelly was doing in that setting. Ms. B and Mr. Y also disagreed about many parenting issues, which again gave Kelly a tremendous amount of power. One illustration was when Kelly knew her mother would not give her something and then Mr. Y, knowing Ms. B disagreed, gave the item to Kelly.

The boundary around the B family system appeared diffuse. Indeed, between the B family and the Y family there was a lack of boundaries as evidenced by their over-involvement in each other's daily affairs. For instance, they would call each other daily and get into arguments or they would send messages through Kelly voicing their disapproval concerning an issue that does not pertain to them. Moreover, the relationship between the B family and Y family can be characterized as enmeshed, for the reason that they seemed unable to disengage from each other.

The boundaries separating the extended families can also be described as diffuse. Both sets of Kelly's grandparents frequently contact each other as

well as Kelly's parents to argue and take sides on issues of concern. In fact, the entire family seemed to be caught up in this conflict. Ms. B indicated that Mr. Y's mother would sometimes call her up to four times a day. This illustrated the intensity and the embedded nature of this conflict.

Life Context

The B family has been embroiled in this battle with the Y family for many years. As they have currently been going to the court system to resolve even minute details about Kelly, this has resulted in court ordered mediation. Both the B family and the Y family indicated that their legal bills were becoming very expensive and that they were not happy resolving issues in this manner. As well, although Kelly was not present during the court sessions, she seemed to know all of the details of the proceedings and this was a source of stress for her.

The B family and the Y family are from small towns. Both families live short distances from their own families of origin. Ms. B feels that her mother is a source of support, although she tends to fuel the conflict between Ms. A and Mr. Y. Ms. B's father is also a source of support for her. Both of these grandparents provide care for Kelly, sometimes on a daily basis. The B family also has many friends with whom they interact. In addition, they have a good relationship with Ms. B's fiancé's parents.

Mr. Y's parents also live in the same area as Ms. B and spend time with Kelly on Mr. Y's weekends. Their close relationship with Kelly is a source of stress for Ms. B as she particularly dislikes Mr. Y's mother. Since Kelly is the only grandchild on both sides of the family, she tends to get a tremendous amount of

attention. When Kelly is with her mother she states that she has a conflictual relationship with her paternal grandmother, but in my individual sessions with her she indicated that they in fact, had a close relationship.

Triangles

The assessment suggested that there were numerous triangles between the family members, indicating the complexity of the relationships in this family. There was a coalition between Mr. Y and Ms. Y against Ms. B, as was evident by their frequently siding with each other and against Ms. B. There was also a coalition between Ms. B and her fiancé, excluding Mr. Y (and his family members). The alignment between Kelly and her biological parents would frequently shift, depending on who she felt closest to at the time. As well, the alignment between Kelly and her grandparents would shift.

Developmental Stage

Although Ms. B and Mr. Y were never formally married, they seemed unable to progress beyond their "divorce"-like separation. The emotional wounds from their relationship, particularly for Ms. B, were still very fresh. As Carter and McGoldrick point out " families in which the emotional issues of a divorce are not adequately resolved can remain stuck emotionally for years" (1999, p. 374). This can be evidenced by the fact that Ms. B has remained engaged for years but has never set a date to be married.

Mr. Y and his new wife, Ms. Y, have also entered a new stage, being that of a remarried family. Similarly, Ms. B and her fiancé have been living as a remarried family and have been doing so for six years. An unresolved divorce

can prevent step-family integration (Carter & McGoldrick, 1999). Some of the tasks that are required at this stage include restructuring family boundaries and realigning relationships (Carter & McGoldrick, 1999). In addition, the family needs to discard their ideals about their family and develop a new model for themselves (McGoldrick & Carter, 1999). Mr. Y and Ms. Y, while still dealing with issues from Mr. Y's previous relationship, had to negotiate these tasks associated with their newly created family. They have begun the process of restructuring family boundaries by trying to disengage from this conflict with Ms. B, although it was recognized that this conflict was providing some benefits for Mr. and Ms. Y. They have also started to resolve some of their concerns about the role of Ms. Y in parenting Kelly. As well, the Y family seems to be developing a family model that is based on their own needs. The unresolved issues between Ms. B and Mr. Y have prevented Ms. B from moving on and taking what she describes as the "next step" in her relationship with her fiancé. She has not been able to let go of her past relationship and develop a new model for her current relationship. As well, she has not been able to restructure the boundaries in her current family.

Role of the Symptom Bearer

By focusing on Kelly as the problem, Ms. B and her fiancé are detouring their own couple issues. As well, Ms. B and Mr. Y are detouring their issues relating to parenting. Because of the lengthy nature of this conflict, the focus on Kelly has retained the family homeostasis.

Hypothesis

Given the intensity and long-standing nature of this conflict, I hypothesized that there were some definite benefits for the family members in continuing this conflict. It seemed that one benefit of maintaining this conflict was that the family homeostasis was not disrupted. For the Y family, the continuation of this conflict seemed to unite them. This family did not recognize the drawbacks of maintaining this conflict. As well, power within the family was usurped by Kelly because of the diffuse boundaries within and around the B family. Moreover, this family could not progress in their own development unless they resolved these past issues that were keeping them 'stuck'. Therefore, the focus of therapy needed to shift to the adults in the family system so that restructuring could occur.

Goals

The first goal of therapy was to clearly delineate a boundary around the parents in this family system that were primarily responsible for Kelly. In addition, I felt that it was necessary to develop boundaries around each of these family systems. Within the B family, I wanted to create a boundary between the parental and child subsystems and shift the power back to the adults in the family. I also wanted to prepare the adults for the court-ordered mediation sessions that they were required to attend. To this end, we agreed that approximately two sessions with each of the four adults present would be necessary.

Intervention

The process of joining with this family was a necessary part of intervention. Through the use of humour I was able to become more comfortable with the B family and develop the relationship that was needed in order for me to encourage the difficult changes that were necessary for this family to make. I also found it necessary to join with Kelly in order to advocate changes for her. When I began sessions with the Y family, I found it especially important to communicate to each family that I was a neutral person in this family conflict.

My first order of priority in counselling was to shift the focus away from Kelly to the adults in the two families. In this way I unbalanced the family by allying with the parental subsystem. To do this, I felt it necessary to make boundaries between the parental subsystems and Kelly. One of the first interventions included having Ms. B and her fiancé attend the sessions together, without Kelly. Although they had agreed to do this, they were somewhat uncomfortable with this shift, often asking when Kelly could return with them. Excluding Kelly from these sessions emphasized the importance of limiting the conflict to the adults.

As Ms. B has had a particularly difficult time letting go of her relationship with Mr. Y, this became the focus of some of our work. It was necessary for her to work through an "emotional divorce" with Mr. Y before she could progress in her relationship with her fiancé. In the individual and couple sessions with Ms. B and her fiancé, we focused on these issues and I encouraged them to resolve some of the couple issues that they had not previously dealt with. Having

sessions alone with this couple also emphasized the importance of the couple subsystem. Often, when I knew that Kelly would be going to her father's house for the weekend, I suggested that the B couple do something different as a couple that weekend. The results of these tasks were generally quite positive, such as a romantic evening for the couple.

We also worked on developing stronger boundaries around the B family system. This was done by defining what interactions were open to whom. One important boundary we made was to exclude the extended family from the counselling sessions. As well, Ms. B decided that she would no longer stay on the phone when Mr. Y's mother called to argue with her. It was also important to create a boundary around the parental subsystem of Ms. B and Mr. Y. We clarified when Mr. Y should be involved in decisions involving Kelly and developed a plan so that he could get weekly updates on her progress.

As therapy progressed, it became evident that Ms. B's fiancé was equally unhappy with the conflict between Ms. B and Mr. Y and it became helpful for me to align with him. By doing this I unbalanced the couple subsystem by allying with the weaker member of the subsystem. Thus, Ms. B's fiancé became an ally for me and often had some constructive suggestions for how the conflict could be lessened. For instance, he had previously been in a situation similar to the one between Ms. B and Mr. Y and I often called upon him to share what he had done to resolve similar concerns. Ms. B's fiancé also recognized his own part in maintaining the conflict and started to take a more neutral stance, leaving Ms. B and Mr. Y to resolve their issues without his interference.

I also recognized the necessity of involving Mr. Y and his wife in the therapy process. Again, this served to delineate a boundary around the parental subsystems. In order to minimize the anxiety that Ms. Y may have had about her husband's role in therapy, I felt it necessary to join with her and treat her as an ally. Similar to McGoldrick and Carter (1999), it seemed most appropriate to coach Mr. Y in the presence of Ms. Y. This turned out to be quite helpful and allowed Ms. Y the opportunity to participate in the process. I recognized that Mr. Y often took a passive role in this conflict and did not take responsibility for his own actions. Accordingly, I realized that reframing would be helpful. In this respect it became necessary to label his inaction as action and point out that he was allowing this conflict to continue to the same extent that Ms. B was. My role was to let Mr. Y take responsibility for his actions and encourage him to become more active. This strategy also minimized the coalition between Mr. Y and Ms. Y because, like Ms. B's fiancé, Ms. Y became more of a neutral bystander in the conflict.

Throughout the course of therapy, I found it necessary to utilize the symptom. That is, by focusing on Kelly and her physical complaints I was able to appeal to the parent in each of the family members. For instance, when the B family would hesitate about doing something I would say "you do want Kelly to get better, don't you"? To this end, both the B family and the Y family were encouraged through therapy by the thought that they were being good parents.

After having individual sessions with each of the couples, I had two sessions with all four adults present. Again, this served to delineate a boundary

around their parental subsystem and communicate to Kelly that they were in control of this conflict. Reframing each of their roles as that of co-parents was helpful as it allowed them to recognize the need for their cooperation. As well, these sessions allowed the formation of an alliance between Ms. B's fiancé and Ms. Y to encourage their partners to withdraw from this conflict. Before our first meeting together, I assigned each couple the task of writing out concerns that they wanted to raise during the session and possible solutions for their concerns.

Initially, during our first session with all four adults present we marked a boundary around the parental subsystem by clarifying the issues that only Mr. Y and Ms. B could decide on. My role in this session was facilitator, but I also served to keep the adults on topic and focused on the present. When Ms. B and Mr. Y enacted a familiar sequence in their conflict, I used this enactment to change their pattern of relating. For instance, Mr. Y was telling Ms. B that he did not want to do something and Ms. B kept saying he was being selfish. I interrupted her and said "Mr. Y is telling you something important, do you hear what he is telling you"? This stopped their familiar interactional pattern and forced Ms. B to listen to what Mr. Y was saying.

The first session with all of the adults also helped the adults to accommodate each other. Each family had brought in their list of problems and solutions and the couples then negotiated how the solutions would work. I kept track of the content by writing their issues on a large board. I then left it up to the couples to tell me what final solution I should write next to the problem. The flexibility of the families appeared to have changed as Ms. B's fiancé seemed to

agree with Mr. Y on a number of points and this did not threaten Ms. B. When the families left the session, they agreed to a follow-up session.

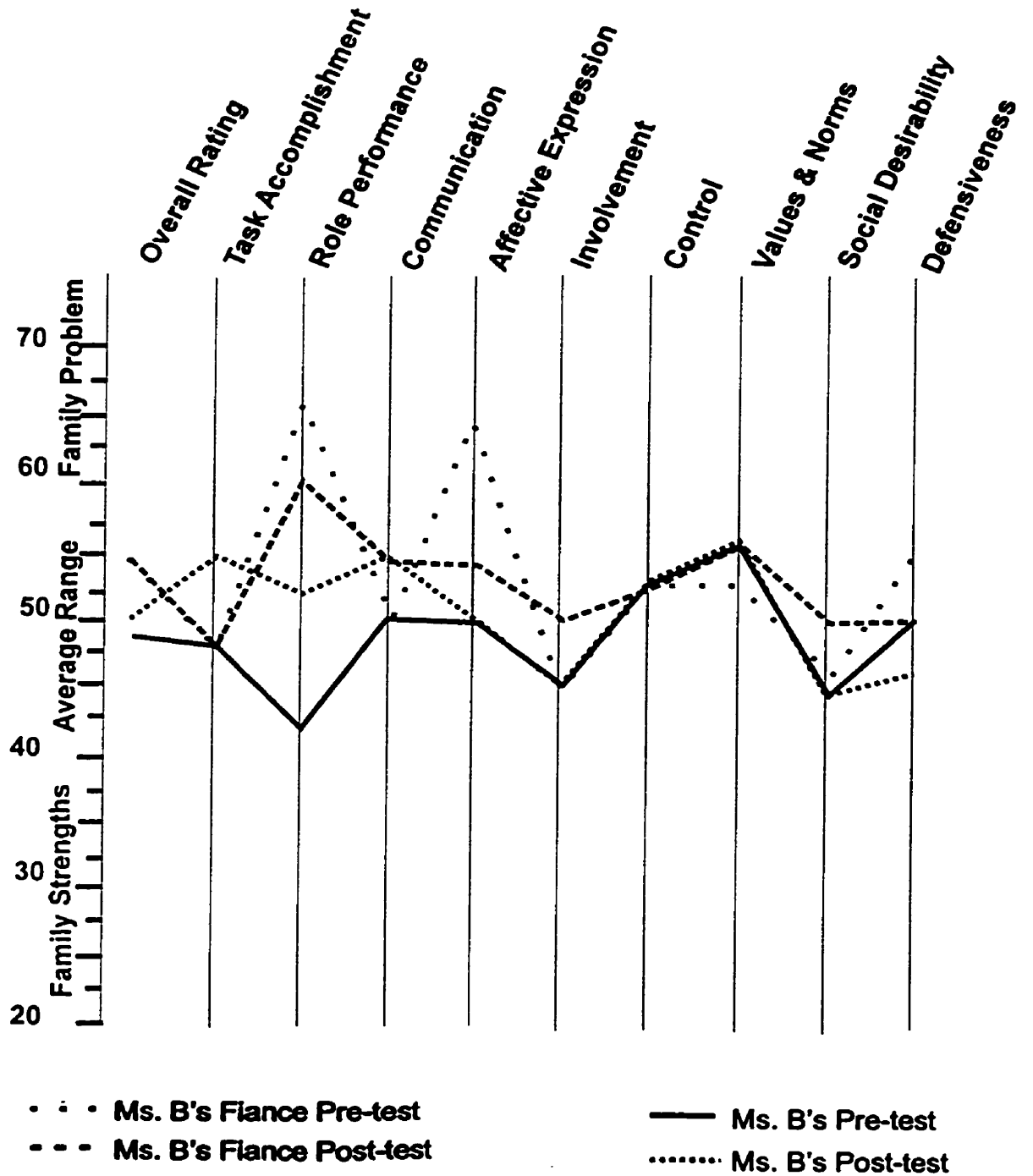
Our second session with the adults took place one month later. During this session the mood was markedly different as the couples seemed more relaxed and even friendly. There was confirmation about the amount of power Kelly was receiving from this conflict as the adults stated that she was acting out in order to regain some of her power. As well, during this session Ms. B and her fiancé reported that they had set a wedding date, which was indicative of the progress in their relationship. Both the B family and Y family pointed out that the changes had been positive, although recent, and that they would need time to work out all the details of their relationship. Because mediation was the next step for these families, I felt that progress had been made and that they would be quite receptive to the mediation process.

The sessions involving the adults clarified the boundaries around the adults in the family. As the boundaries and structure of the family was changed, the power reverted to the parental subsystems. Although it was recognized that this was a step in the family's progression, it was felt that significant progress had been made.

Evaluation

Ms. B and her fiancé completed the FAM III as both a pre-test and a post-test (see Figure 4). Their results indicate that they had some diverging viewpoints on their family's functioning. Specifically, in the areas of role performance and affective expression, Ms. B's fiancé indicated that their

Figure 4
FAM III General Scale
"B" Family



functioning was in the weakness range while Ms. B rated their functioning as average. These scores signaled to me that Ms. B's fiancé felt that there were some concerns about this family's functioning. Given that the concerns he raised related to what Skinner et al. (1983) call "lack of agreement concerning role definitions" and "inhibition of (or overly intense) emotions appropriate to the situation" (p. 101) my clinical findings tended to support the view of Ms. B's fiancé. The B family did not seem to be in agreement over their individual roles and each member appeared to be fulfilling a variety of roles. This was also congruent with the finding that expression of affect is most distorted in times of stress (Skinner et al., 1983). In the post-test these two problem scores fell within the range of normal for Ms. B's fiancé. Other results indicated that their general functioning was within the average range.

The results of the FAM III pre-test were helpful in the assessment process and confirmed that Ms. B did not see her family functioning in a way that was unusual in any dimension, which is what I found clinically. Ms. B tended to deny that her family had any problems in functioning, which was a way of maintaining homeostasis. Her fiancé, though, seemed to be more cognizant of the stress of this conflict as was illustrated by his results. The post-test results showed that there were some improvements in the family's functioning, congruent with what the family indicated to me. In sum, the FAM III seemed to provide results that were in agreement with my clinical observations about the functioning of the B family.

The results from the client satisfaction questionnaire administered to Ms.

B and her fiancé indicated that they both felt that changes were occurring in their family and that these changes were for the better. They indicated that the most helpful aspect of therapy was learning how to communicate with Mr. and Ms. Y. Overall, they reported being very satisfied with the therapy services they received. Lastly, and more importantly, Kelly reported that positive changes had occurred in her family and that she was no longer experiencing physical health problems.

Conclusion

Working with the B family was a challenging, but rewarding experience. This case illustrates the complex issues remarried families must often contend with and highlights the need for a broad assessment of the factors contributing to a presenting problem. This case also demonstrates how easy it is for families to become “stuck” at a certain developmental stage and unable to progress beyond it. I found that a particular strength of structural family therapy was the emphasis it placed on developmental stages and how they impact a family. As well, by examining the structure of the family it became apparent that Kelly’s physical complaints were rooted in a dysfunctional family structure. Thus, another strength of structural family therapy evidenced by this case is in its shift away from individual pathology to an analysis of the individual within the family system.

SECTION FOUR: ANALYSIS

Introduction

Throughout the course of my practicum several clinical themes emerged. These themes form the basis of discussion in this final section and include issues pertaining to single-parent families, step-families, the process of assessment and the importance of focusing on family strengths. These issues are discussed in detail below.

Single-Parent Families

Of the six families that I counseled on a regular basis, four were single-parent families headed by the mother. As these families were dealing with issues specific to their family structure, I had to be cognizant of their uniqueness and the fact that I could not expect them to function like a two-parent household (Gladding, 1998b; Walsh, 1991). Especially important in the treatment of these families was the overall notion that professionals try to strengthen them and empower them (Gladding, 1998b), which was the approach that I took. It was also important to recognize that "divorce" was less a single event than a process.

Minuchin and Nichols (1993) indicate that people still tend to view divorce as a failure of the family and as an end to the family. They suggest that divorce be conceptualized as a stage in the life cycle of many families. Viewed in this way, divorce is a transition that requires that the family change shape (Minuchin & Nichols, 1993), as it shifts from a two-parent to a single-parent household. Attempting to understand divorce in this way can help alleviate some of the guilt

that family members have over the breakup of their family.

Some essential tasks upon the dissolution of a relationship are: resolving the loss of the marriage, assuming new roles and responsibilities, altering relationships with family and friends and developing an agreement with one's ex-partner (Gladding, 1998b). To this end, the family has to restructure itself following the end of a relationship. One single mother that I counseled had been separated from her spouse for approximately a year and they were still clearly trying to negotiate some of these steps. This substantiates the notion that divorce is a process and not merely a single event.

Single-parent households are becoming increasingly common and therefore the strengths and limitations of these households will be examined next. For example, one strength of single-parent households is that they tend to be more democratic than most family forms (Gladding, 1998b). As well, these families tend to be more flexible about what roles and tasks each family member will assume and perform (Anderson, 1999). This appeared to be the case with respect to the families that I counseled. For instance, one family had the teenage daughters preparing dinner each evening while their mother got settled after being at work all day. This departed from the traditional notion that the mother should make dinner.

In addition to its strengths, there are also challenges to single-parent households. For example, such households are not as likely to have two adult caretakers in the home, which puts increased pressure on the single adult care giver in the home (Greif, 1996). All the single-parent families I counseled

identified this as an issue for them. As well, being in a single-parent home can increase the chances of experiencing difficulties with boundaries (Gladding, 1998b; Greif, 1996). This is particularly apparent in the relationships with children and former spouses, where boundaries may become diffuse, resulting in confusion and further difficulties. In this respect, the structural model is particularly adept at re-establishing appropriate boundaries. Interventions aimed at boundary making and restructuring are often used in this regard. One final and significant challenge to single-parent households is the increased likelihood that they will be living in poverty (Gladding, 1998b). Single mothers in particular are the most likely to experience poverty, and this appeared to be the case for all the single mothers with whom I worked.

In addition to the challenges described above, single mothers encounter the following additional difficulties which I believe warrant further discussion in light of the fact that all my single-parent clients were women. As mentioned previously, one of the most immediate concerns that single mothers face is financial. These women have conflicting demands placed on them as they try to meet financial obligations, take care of their homes and raise their children (Walsh, 1991). Ms. A, as well as some of the other single mothers I counseled, found that these demands were very stressful and difficult to fulfill. Post-divorce changes are also especially difficult for women who had previously been full-time homemakers and who now have to find full-time employment in addition to performing their duties in the home. To this end, Carter and McGoldrick (1999) see divorce as an opportunity for both men and women to re-examine their ideas

about gender roles and to develop healthier models. For example, after divorce women may see that they do not need to be financially dependent on men and may develop a sense of competence in this regard. Conversely, men may realize that they need to be more involved with their children and may actively seek to maintain closer relationships with them.

Speaking to the specific model of family therapy that I was using, Gladding (1998b) states that structural family therapy is a popular choice when working with single-parent households. Walsh (1991) indicates that the structural model may be especially useful in reducing behavioural problems and improving parent-child relationships. Although the structural family therapy model does not prescribe a specific way of working with single-parent households, some conclusions may be drawn from its approach.

The idea of a family structure is particularly helpful for single-parent households in that a power hierarchy must exist. The notion of family hierarchy assumes that parents will wield the most power in the family system. Following the dissolution of a relationship, the primary parent must restructure his or her family to maintain parental power. This was evident in the A family as Ms. A was trying to re-establish herself in a position of authority following the end of her relationship. Thus, this family was restructuring itself following the change in its structure.

One of the difficulties facing a newly divorced family concerns boundaries. The parents in the family must accept that there is a boundary separating them, yet they must each maintain a relationship with their children (Nichols &

Schwartz, 1998). Especially following a divorce, it is important for boundaries to be established around the parent-child subsystem. This is so that the child may maintain an individual relationship with each of his or her parents. Boundary making is a structural technique that is helpful for these families. With respect to one family that I saw, the couple had recently separated and were in the process of getting a divorce. The husband and wife were finding it very difficult to let go of their own personal issues and so we developed ways of creating a boundary between them. For instance, they decided to only talk with each other about issues relating to their children, rather than getting into arguments about who was to blame for the divorce. It was also necessary to set up some boundaries around the parent-child subsystems that were flexible but clear. This was done by creating a rule that each parent would not talk about the other in front of their children.

One criticism of the structural model of therapy, particularly as it pertains to single-parent households, is that it tends to assume that two parent households are the norm. For example, the notion of complementarity assumes that fathers and mothers will fulfill different roles within the family (Gladding, 1998a). This model is also lacking in its analysis of how women in particular, face many unique concerns following a divorce. For example, there is no analysis of how women face poverty and conflicting demands based on their role of mother and provider following a divorce. Incorporating a feminist analysis of power issues can help to overcome these weaknesses of the structural model.

Step-Families

Two of the six families I counseled consisted of step-families, another prevalent family form. Again, as with my single-parent families, it was important to be aware of the difficulties in trying to treat step-families as nuclear families (McGoldrick & Carter, 1999). In this respect, it was helpful to encourage the family members to build a model of family that was not based upon the nuclear family model (Minuchin & Nichols, 1993).

McGoldrick and Carter state that the broad goal when working with step-families is to “establish an open system with workable boundaries” (1999, p. 432). The steps required to achieve this goal include establishing a beneficial co-parenting relationship between ex-partners, completing the divorce emotionally, not relinquishing parental power to children and acknowledging that children will have a variety of feelings for each of their parental figures (McGoldrick & Carter, 1999). The B family illustrates the significance of these steps. You may recall, the B family consisted of a mother, her partner and her daughter, as well as the ex-partner and his new wife. This family lacked clear boundaries and therefore a good deal of work was required on each of the above steps in order to help them develop healthier boundaries. When they first came to therapy the B family had not worked out the details of their co-parenting relationship with Mr. Y and his wife. Indeed, Ms. B and Mr. Y had not yet worked out the issues pertaining to their own emotional divorce from each other. This became a crucial step that we had to resolve in order for each couple to progress in their current relationship. Once they had accepted the reality of the termination of their relationship as it

previously existed, they were willing to sit down and discuss each of their roles as parents in Kelly's life.

Visher and Visher (1994) stress the importance of developing a parenting coalition. This entails having all the relevant parents and step-parents work together rather than compete with each other. This concept is especially pertinent to the B family because each couple was competing for their daughter Kelly's affection. Once they realized that they could be more effective parents by working together, Kelly felt free to openly show affection for all four parents and did not feel that she had to choose between them.

Triangles have commonly been found to be present in remarried families (Walsh, 1991). A triangle is when two people are engaged in a conflict and they draw in a third person (Nichols & Schwartz, 1998). Minuchin and Nichols (1993) find that triangles within step-families are the most troublesome. Some of the more typical triangles are those between the newly formed couple and the ex-partner, the remarried couple and a child, and the remarried couple and their extended family (McGoldrick & Carter, 1999). Each of these variations illustrates the complexity of forming a remarried family. In both of the remarried families that I worked with there existed many triangles, therefore one of the first interventions I facilitated involved dismantling some of these coalitions. As an illustration of this, one family that I worked with included a mother, her sons and her partner. In this family there was an alignment between the mother's partner and her oldest son, and as a result these two tended to wield the most power in the family system. As well, the two youngest sons tended to align with their

mother, which caused some tension with their older brother and their mother's partner.

Minuchin and Nichols (1993) assert that step-mothers may have an especially difficult time in step-families as they are expected to take over their "natural" child rearing roles. They state that biological fathers often immediately relinquish the care of their children to their new wives. This can be very difficult for both the new mother and the children because they do not have strong biological bonds already in place. This was evident in one family that I saw for a brief period of time, in which the biological father was often away and as a result, the step-mother was left to care for his son. The step-mother felt overwhelmed by this and unprepared to raise the teenager and therefore the son was ultimately removed from the home.

The process of combining two families to form a new family implies that the families should be "blended" to form one family. Minuchin and Nichols (1993) recognize that this is misleading and emphasize that the new family should be thought of as new system that has unique features and subsystems. Therefore, it would be natural to expect that a step-family would have boundaries around the biological siblings and also around the parent-child subsystems. The B family was illustrative of this as Ms. B's fiancé was very respectful of the boundary around Ms. B and Kelly and as well the boundary around Kelly and Mr. Y. This made it easier to enlist his help in the restructuring process.

Assessment

The importance of assessing families in a thorough and complete manner was apparent to me throughout my practicum. Assessment is an integral part of structural family therapy. Colapinto (1991) states that assessment is inextricably linked to joining. This is for the reason that a full assessment of family functioning is being conducted while the therapist and family are forming a therapeutic system. Thus, while the family and therapist are joining, the therapist is also assessing the family.

When families typically enter therapy it is generally precipitated by a presenting problem. Often the presenting issue relates to a specific individual in the family. To this end, the structural family therapist must place these individual complaints in a family perspective (Colapinto, 1982). Nichols and Schwartz (1998) point out that families tend to focus on the identified patient so as to disrupt the family homeostasis as little as possible. Minuchin and Nichols (1993) describe the role of the therapist as one who must be

attending to both individuality and connectedness, and knowing how to broaden individual stories by shifting to the family perspective. Once family members stop dwelling on the frustrating behavior of others and begin to see themselves linked together, they discover whole new options for relating. (pp. 285-286)

One family that I counseled came to therapy because of the behaviour of the son. Through assessment, I realized that his behaviour was better examined within the context of a family entering a new developmental stage with a diffuse

boundary between the mother and son. Seen in this way, the family became the focus and the son exhibited far fewer behavioural concerns.

Therapists assessing a family's functioning are not concerned with establishing cause (Colapinto, 1982). In fact, the origin of the presenting problem is irrelevant to the process of therapeutic change (Colapinto, 1982). Aponte and VanDeusen (1981) indicate that one of the distinguishing features of structural family therapy is that it maintains a focus on the problem and is not geared towards insight or an understanding of the problem. This seemed particularly true for the B family. I found that focusing on the structural problems was more suited to this family than developing insight into their problems. For example, when we discussed Ms. B's role in the maintenance of Kelly's physical complaints, Ms. B would immediately focus on Mr. Y's contribution to the problem. It became more helpful to resolve the problem without a detailed analysis of its origin.

Aponte and VanDeusen (1981) conceptualize assessment as consisting of "identifying the problem, determining its locus in the ecosystem, and defining the system's structures that sustain the problem" (p. 316). They describe identifying the problem as viewing the problem in relation to the other issues to which it is structurally connected. This is similar to the previous discussion of examining a presenting issue in the context of the family and their patterns of interaction. Determining the locus of the problem means examining for whom the problem is *currently* an issue (Aponte & VanDeusen, 1981). Defining which structures generate and maintain the problem entails having the therapist

examine the structural relationship between the family and other systems to the problem. Nichols and Schwartz (1998) remind us that we must take into account the presenting problem as well as the structural dynamics of the family.

Minuchin (1974) asserts that there are six areas that must be focused on during an assessment. These include:

(1) The family structure. This includes an assessment of hierarchy and power.

(2) The flexibility of the family system and its ability to restructure.

(3) The cohesion of the family. Families can fall anywhere on the continuum from enmeshed to disengaged and the therapist must assess this.

(4) The family's life context. The therapist examines the sources of stress and support for the family.

(5) Developmental stage. The therapist examines whether the family is performing tasks appropriate to their stage.

(6) The way in which the identified patient's symptoms contribute to homeostasis (i.e. the role of the symptom bearer).

To illustrate the importance of assessing these areas, we will examine one family that I saw that consisted of a mother and her two daughters. The presenting problem for this family was a violent incident involving the oldest daughter. When I assessed the family structure it seemed that the mother was in her appropriate place as the parental figure in the home. The family, however, appeared to be somewhat inflexible and resistant to change. For instance, the family members tended to minimize the fact that changes in structure were required in order for

this family to shift from a two-parent to a single-parent family. The family did not seem to be at either extreme of the enmeshed or disengaged continuum, although the boundaries around the parental subsystem were fairly rigid. For example, there was an unspoken rule that the daughters could not talk about their father in front of their mother. The family, however seemed to possess good support systems. An analysis of the developmental stage of the family revealed that they were in the process of restructuring following the divorce of the two parents. Finally, the symptom bearer seemed to be the family member who was expressing all of the anger the family members felt and this allowed the family members to continue in their familiar patterns. It is evident from this analysis that each area mentioned by Minuchin needs to be examined in order to gain a complete picture of a family's functioning.

Overall, assessment is an integral part of structural family therapy. The necessity of examining the entire family is imperative to the goal of transforming the family in a way that benefits all its members (Nichols & Schwartz, 1998).

Focusing on Strengths

Each of the families that I counseled possessed strengths in some areas of functioning. Bringing attention to, and nurturing these strengths, proved to be an essential part of empowering these families. Minuchin et al. (1998) point out that professional helpers must be attuned to the family and must be able to detect areas of strength. In this respect it is important to remember that a "family always has a broader potential repertoire than appears in its repetitive patterns" (Minuchin et al., 1998, p. 39).

Anderson, in her chapter on single-parent families, stresses the importance of focusing on the strengths of these families (1999). Helping single mothers to mobilize their resources and accept what they have no control over is a first step. In addition, these women need to be supported as mothers and helped to see that they are competent in this role (Anderson, 1999).

While the idea of focusing on family strengths seemed obvious to me, the response that was generated often surprised me. Mothers would break down in tears and one single-mother in particular commented that “you have no idea how much what you just said means to me. No one ever tells me I’m doing a good job.” Emphasizing their positive attributes demonstrated to the single mothers that I saw that they were good parents who were simply “stuck” in some manner.

Ms. A found it particularly difficult to accept praise and credit for her good child-rearing skills. For this reason, I chose to end each of our sessions by commenting on some of the strengths she displayed during the session. As a result, she often indicated that she felt empowered after attending therapy. It is noteworthy that in her evaluation she commented that she was impressed that there was never a “pointing finger” at her during our therapy sessions.

The B family also exhibited many strengths, including their kindness and commitment. In fact, their deep affection for their daughter was the main reason that they continued their therapy, despite the difficulties they had confronting some painful truths. This family also displayed a great sense of humour and this facilitated the joining process.

Overall, by highlighting and focusing on the strengths exhibited by the

families I counseled, they appeared significantly more empowered and less pathologized. Further, by focusing on their strengths my clients were able to recognize the many things that they were doing well with their families.

CONCLUSION

In this final section I provide a review of my learning goals, a critique of the structural family therapy model, a critique of the measure used, and as well, some general conclusions about my practicum.

With respect to my learning goals, upon completing my work at the EHCC I was able to reflect back on my counselling experience and conclude that my learning objectives had indeed been met. Moreover, the more I learned about the structural family therapy model the better able I became at applying its principles into practice. To this end, I found that I was increasingly able to analyze a case using the structural model and provide the appropriate interventions. Further, throughout my practicum I became progressively more comfortable counseling families. Overall, I can state that my practicum experience enabled me to develop basic skills in family therapy.

During my practicum I found that I became more adept at conceptualizing families in a structural way. I found the concepts of structural family therapy, particularly boundaries, structure, subsystems and joining, to be especially useful and because these concepts are relatively concrete, they can be easily applied to a practice setting. I also found it useful to conceptualize families in a structural way as it provided a way of organizing them and proposing interventions.

Through the course of my learning experience I found that I occasionally made assumptions about families with whom I worked. For example, with one particular family I had assumed that the father had wanted to become more

involved with his daughter. When I finally realized that he was telling me he did not want a closer relationship with her, we were able to progress much more quickly. From this I learned that to be an effective therapist I had to listen to what the family was telling me and put aside my preconceptions.

My growth was also evidenced by the fact that my expectations for the families I saw became increasingly realistic. I realized that families must progress at their own rate. As well, it became apparent that many of the families I saw knew best what would work for them. For example, with one family that I counseled I felt that the school-age child appeared quite immature, yet his mother only saw improvements from what his behaviour had been.

As a therapist I learned to become less content focused and more process oriented. Although I had prepared material for each session, I found that families often came with their own "agenda". As a result, I learned to become more flexible. For instance, in one session where I saw a mother with two school-age daughters, we spent the entire session having the youngest daughter struggle through a book I had brought for her mother to read. The results of this session proved to be quite positive as I learned to be more compromising.

Through the course of my practicum I also came to appreciate how beneficial it is to be guided by theory. I felt the comfort of having direction with respect to assessment and intervention. As well, using a structural approach presented a pragmatic way of practicing. Finally, I found that the structural family therapy model lends itself easily to a learning setting, as is indicated in the literature (e.g., Figley & Nelson, 1990).

One of the drawbacks of using the structural family therapy model however, is that it makes certain assumptions about the nature of a healthy family structure. For example, under this model healthy families should possess clear boundaries. In one of my cases this assumption proved problematic in terms of proposing an intervention. While the mother and son could be described as enmeshed and therefore lacking clear boundaries, the mother was unwilling to change this and in fact, was quite content with this arrangement. Throughout the course of therapy we discovered that indeed, this family worked quite well within this structure and therefore it was not necessary to alter it (particularly in light of the fact that an earlier attempt to change the family's structure had failed).

Consistent with the critique of structural family therapy in my literature review, I found that the structural family therapy model failed to address some gender issues that arose. In this respect, the model is deficient in its analysis of what it means to be a woman in a society that appears to place more value on men, as compared to women. Many of my clients were struggling with the discrepancy between societal expectations of mothers and reality; something that structural family therapy does not address. For instance, there is no analysis of why mothers are expected to be the primary care givers of children and how the role of mother can consume their identity as individuals.

The structural approach is also lacking in its dealings with issues of family violence. When I was faced with this issue in one of my cases, I realized that taking a structural approach overlooked the safety concerns that arose. This also

demonstrated to me that structural family therapy is lacking in respect to an analysis of the power inequities between the genders, as McGoldrick (1989) pointed out. I found it helpful to supplement the structural model with a feminist model to compensate for these weaknesses.

I also found the structural approach to be fairly concrete and systematic, while some of my clients favored a less structured approach. For instance, one of my client's was a writer who preferred a story-telling approach to communicating and that my role be one of a listener and thought provoker. Had I taken a more directive approach with her, our therapeutic relationship would not have progressed.

Structural family therapy dictates that the therapist take an expert stance in the therapy session (Gladding, 1998a). This can be contrasted with the more collaborative approaches that are characteristic of some of the post-modern theories. As previously indicated, insight is neither desired nor encouraged using this model (Aponte & VanDeusen, 1981). This is disempowering for clients as they are placed in a position that allows them very little access to power.

With respect to the pre and post measure employed in my practicum, some flaws were apparent. For example, the FAM III is based on norms that are not representative of every family. The families that consisted of two people (mother and child) found it very difficult to answer some of the questions. They indicated that an answer could be completely different depending on whom the question was referring to. For example, if a family was to say whether they felt the rules were fair in the household the mother may say "yes from my point of

view, but not from my son's point of view." These families felt that the questions did not adequately capture what they were trying to express. In addition, many of the families who filled out the form found that they neither agreed nor disagreed with an answer (i.e., they felt quite neutral about a question) but the survey could not accommodate that response. Finally, I found that in general, this measure was insufficient with respect to capturing the complexities evident in some of the families I saw. This included, for instance, when a concern was occurring with the external environment or when family violence was occurring. As Skinner et al. (1983) suggest, the FAM III is not a substitute for a clinical assessment.

Some of the strengths of the FAM III that I found were its ease of use and relatively straightforward questions. I also found that the two subscales measuring response bias were helpful because they allowed me to examine the results in a more critical manner. In addition, I felt more comfortable with this measure because it is based on a Canadian population and captures features unique to Canadians.

Overall, my practicum experience provided me with unique learning opportunities. I was able to expand my knowledge base in relation to the practice of social work and become more familiar with a model that has been part of the foundation of family therapy. I have also witnessed the "inextricable association of family and individual" as I have seen how changes in one individual inevitably affects another (Colapinto, 1991, p. 422). Most importantly, I have been fortunate enough to be a part of these families' lives, be it for a short period of time, and

witness their strength and resilience. This has proved to be the most valuable experience of all.

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Appendix A
Client Feedback Form

Date:

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

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

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

Very Dissatisfied	Dissatisfied	Satisfied	Very Satisfied
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2. Did you family's situation improve as a result of therapy?

Very Much Improvement	Some Improvement	Very Little Improvement	No
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3. What was the most helpful aspect of therapy for you?

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

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

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