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**Does Structural Family Therapy Really Change the Family Structure?  
An Examination of Process Variables**

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**Does Structural Family Therapy Really Change the Family Structure?**

**An Examination of Process Variables**

**by**

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## **Dedication**

This dissertation is dedicated with love to my wife, Nora.

# **Does Structural Family Therapy Really Change the Family Structure?**

## **An Examination of Process Variables**

Publication No. \_\_\_\_\_

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One important deficiency in the current body of family therapy literature is a paucity of studies examining process variables in treatment efficacy. The current study examined whether the effectiveness of structural family therapy varied depending upon the structural interventions employed by a therapist. The study compared pre and post intervention data gathered from approximately 100 families who participated in a university sponsored family intervention project.

This study hypothesized that when a therapist focused on elevating the status of a scapegoated child in at least half of all sessions, the parents would report greater improvement in child behavior than when the therapist did not maintain this focus in at least half of all sessions. Specifically, more positive changes would be observed from pretest to posttest on problem behaviors on the Achenbach Child Behavior Checklist (CBCL). The results of the study did not support this hypothesis. Improvements were found from pretest to posttest in terms of observed problem behaviors on the CBCL, but

such improvements did not vary depending upon how often the therapist focused on elevating a scapegoated child.

This study also hypothesized that when the therapist focused on increasing parental power in at least half of all sessions, a more positive change in family organization and control would be observed than when the therapist did not maintain this focus in at least half of all sessions. This would be evident by more positive change scores on the Control and Organization scales of the Family Environment Scale (FES), 3<sup>rd</sup> edition.

This study found that parental reports of family control changed in a more positive direction when the therapist focused on enhancing parental power in at least half of all sessions than when the therapist did not maintain this focus in at least half of all sessions. This study did not find differences between groups in the degree of change in scores on the FES Organization scale.

This study contributes to a small body of research examining process variables in structural family therapy. Replication using larger sample sizes, more experienced therapists, and randomly assigned groups would be useful for substantiating these findings.

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## Chapter 1

### Introduction

Since the middle of the 20<sup>th</sup> century, family therapy has become an increasingly popular tool for treating the psychological and behavioral problems of children and adolescents. The origins of family therapy are generally attributed to the “systems thinking” of Gregory Bateson in the 1950’s (Beels, 2002; Cottrell & Boston, 2002). This work paved the way for a shift in emphasis among many mental health practitioners. Clinicians developed a greater recognition of the role of social context on the development and maintenance of behavior (Carlson, 1987). Since many theorists believe that the family is one of the most important social forces for influencing behavior, they developed competing models for how to change family dynamics.

Family therapy clinicians and researchers recognize the importance of improving the body of knowledge that exists about how their therapy works, but family therapy provides some unique research challenges. Unlike other forms of therapy, family therapy involves multiple clients, each of whom might have competing goals in therapy. This makes the task of determining measures that best define “successful” family therapy more difficult (Cottrell & Boston, 2002). In addition, there are fewer manualized interventions for family therapy than there are for individual therapy (Shadish et al., 1995), so it is sometimes quite difficult to perform research in which the specific therapeutic processes used are similar across the families in a study. As a result, there is a limited base of knowledge about the specific processes that make family therapy successful.

To date, most of the research supporting the effectiveness of family therapy examines its success in changing the observed behaviors of an identified child patient (Boyle, Offord, Racine, et al., 1997). For instance, family therapy has been shown to be effective in reducing the behavioral problems of middle school youths in school (Franklin, Beaver, Moore, et al., 2001), in improving the nutritional state of anorexic girls (Eisler, Dare, Hodes, et al., 2000), in reducing the self reported rates of drug abuse of adolescents (Lewis, Piercey, Sprenkle, & Trepper, 1990; Joanning, Quinn, & Mullen, 1992), and in alleviating symptoms of intractable asthma for youths who had previously been spending considerable time in hospitals (Liebman, Minuchin, & Baker, 1974). In addition, family therapy has been found to be an effective means of reducing recidivism of juvenile offenders when it is the only treatment (Gordon, Arbuthnot, Gustafson, & McGreen, 1988), or part of a multisystemic intervention (Henggeler, Melton, & Smith, 1992). The current body of literature, then, makes a compelling case that family therapy can help lead to change in a child's behavior.

The current literature does not provide a clear understanding of what specific processes within therapy produce such change in clients (Horne, 1999; Hohmann-Marriott, 2001). The paucity of studies that examine process variables in treatment has considerable practical consequences. Without research on process variables, clinicians are limited in their ability to tailor therapy for specific clients, and those who train therapists do not have empirical evidence to support decisions about what skills are most important for therapists to learn (Horne, 1999; Zaken-Greenberg & Neimeyer, 1986).

This study will address the lack of process variable research in the field of family therapy. Specifically, this study will examine whether the effectiveness of structural

family therapy varies depending upon the structural hypotheses and interventions developed by the therapist. These hypotheses are described below.

One of the most common structural problems viewed in families is the blaming, or “scapegoating” of many family problems on one child (Minuchin, 1974). When this is observed by the structural family therapist, elevating the child’s position in the family is often the recommended intervention. This can be done by reframing the behaviors of the child so that they are not seen as “negative”, but rather as a product of normal development for his or her age. A structural therapist might also seek to elevate the youth’s position by pointing out to the parent when the child is behaving in a positive manner in session (Minuchin & Fishman, 1981). This form of treatment is provided on the basis of theory and clinical experience. To date, no study has ever examined whether attempts to elevate the scapegoated child are the part of therapy that produce the desired results. For this study, it is hypothesized that parents will report greater improvements in their child’s behavior if the therapist focuses on elevating the status of the scapegoated child.

Another common structural problem viewed in families is a weak parental system (Minuchin, 1974). This might mean that only one of two parents is involved in setting rules for the child, or it could mean that the two parents have conflicting expectations for the child. This problem can also occur in single parent families if the parent does not have enough separation from his or her children to be able to set rules for the family. When this is observed by a structural family therapist, the most common intervention is to help the parent or parents become more powerful players in the family. This is often done in session by directing the two parents to discuss and agree on a plan together while

the child is in the room (Minuchin and Fishman, 1984), or by purposefully excluding children while the parent or parents decide on rules with the therapist. The goal in such interventions is to establish the parent or parents as the members of the family who have the power to establish rules and order in the family. Structural family therapy hypothesizes that this intervention leads to greater family organization and control. Again, no study has specifically examined whether such interventions work as planned. In this study, if the therapist focuses on improving parental power, the parents will report a greater improvement in family organization, closeness, and control.

To date, many researchers have examined whether structural family therapy helps change a child's behavior, but few studies have tested to determine what therapeutic processes help produce such change. This study is designed to assess whether specific interventions in structural therapy lead to the intended results for families who have been referred due to problematic behavior in the school or at home. It would be an important contribution to the literature because it would provide insight into how structural family therapy really works.

## Chapter 2

### Literature Review

This integrative analysis presents a discussion of the history of family therapy, followed by a description of the most influential contemporary models of treatment. A more detailed account of the theory and practice of structural family therapy will be provided, as it is the form of therapy that will be used in this study. A discussion of the current state of research in family therapy in general will follow. Next, the state of research in structural family therapy will be described. Finally, a rationale for the current study will be proposed.

#### *History of Family Therapy*

Before the 1950s, psychological treatment was limited almost completely to treatment via individual psychoanalysis (Beels, 2002). One of the central premises underlying individual psychoanalysis was that an individual's behavioral or psychological difficulties were rooted in his or her own internal psychic conflicts. A confluence of social, anthropological, and medical forces came together in the middle of the 20<sup>th</sup> century and forced people to look at an individual's behavior in the context of the environment in which they lived (Beels, 2002; Cottrell & Boston, 2002). Some of the ideas that helped pave the way for family therapy came from John Bowlby, who noted that the attachment between mother and child could be worked on with both family members at the same time (Bell, 1967); from Nathan Ackerman (Ackerman, 1956), a child psychoanalyst who saw families of children in his New York practice in the 1930s; and from Murray Bowen, who worked with families of schizophrenic research subjects in the 1950s (Bowen, 1966).

While the roots of family therapy derive from the ideas of many people, Gregory Bateson is often identified as the “father” of modern family therapy (Beels 2002; Cottrell & Boston, 2002). Bateson was a British anthropologist who was awarded a grant to investigate the communication patterns families who had a member being treated for schizophrenia at a California hospital. Bateson hired a psychoanalyst, a communication expert, and another anthropologist as members of his team. Together, they developed a theory of schizophrenia that had its roots in the way family members communicated with the patient (Bateson, Jackson, Haley, & Weakland, 1963). Their work served as a blueprint for descriptions of family pathology and methods of treatment. Several members of Bateson’s team went on to found the Mental Research Institute (MRI) in Palo Alto, where they developed a brief family therapy model that they contrasted with the long drawn-out treatments offered by psychoanalysts of the time.

In the 1960s, another psychoanalyst, Salvador Minuchin, began to break away from traditional individual treatment. His client base consisted primarily of inner city families with children with behavioral difficulties and conduct disorders (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967). Minuchin’s view was that healthy families had clear interpersonal boundaries, and his interventions were aimed at helping to create such boundaries in dysfunctional families. Minuchin’s work was not immediately greeted with acclaim by the psychiatric community. In fact, he wrote that the Philadelphia Child Guidance Clinic, of which Minuchin was the training director, nearly lost its license in the 1970s because it did not adhere to traditional psychodynamic methods of treatment (Minuchin, 1982). Since that time, however, family therapy has



flourished, with a number of competing models of treatment espoused. These different models will be examined below.

### *Models of Family Therapy*

This section will briefly outline some of the more common and influential models of family therapy today. Each model is influenced by the development of systems thinking described in the previous section, and operates under the premise that changing the environment can alter an individual's behavior. The means of changing behavior vary for each model, as do the behaviors that are targeted. In practice, most clinicians use some combination of theories and techniques (Beels, 2002; Kazdin, 1997), but many training programs first teach clinicians to perform therapy in a way that more strictly follows a particular model so that they can effectively learn the techniques of that treatment model. The list of theoretical models below is not intended to be exhaustive, but it includes what are believed to be the most prominent contemporary strands of family therapy (Cottrell and Boston, 2002).

#### *Psychoanalytic Family Therapy*

In most cases, psychoanalytic therapy remains true to its individual client-therapist roots, but several practitioners have advocated psychodynamic “object relations” family therapy (Zinner, 1976; Langs, 1977, Melito, 1988) in response to the growing recognition of context on the individual. In this model of treatment, it is believed that many of the difficulties families face are due to a process called “projective identification”. Zinner (1976) describes the characteristics of such a relationship in this way:

- 1) The subject perceives the object as if the object contained elements of the subject's personality; 2) the subject can evoke behaviors or feelings in the object that conform with the subject's perceptions; 3) the subject can experience vicariously the activity and feelings of the object; and 4) participants in close relationships are often in collusion with one another to sustain mutual projections... (p.295).

According to this theory, when projective identification is a part of the relationship, one individual often projects unacceptable parts of him or herself onto other members of the family (Melito, 1988). Such projections tend to remain stable because the individual behaves in a way that elicits behaviors that support the projected identity of the other. For example, if a wife projects a disengaged identity toward her husband, she may behave in a way that encourages the husband to isolate himself from the wife, thus serving to support the projected identity. In such cases, the therapist helps individual family members become aware of their unconscious expectations of other family members and "work through" toward a more integrated and realistic perspective.

#### *Milan and Post-Milan Therapies*

The original Milan Therapy arose out of the work based in the Mental Research Institute (MRI) in Palo Alto, California, on systems theory. Four Italian therapists developed these concepts into a school of family therapy that suggested that families seek to maintain certain problems in order to keep stability in their lives (Palazzoli, Boscolo, Cecchin, & Prata, 1980). In other words, systems have a tendency to work to resist change. Therapeutic intervention takes place by helping family members see how they

are maintaining the problem, and helping them see that this is an understandable response given environmental pressures. Once family members see how they maintain a problem, they become motivated and empowered to drop some of their resistance to change.

In post-Milan therapy, the emphasis is placed on the relationship between beliefs and behaviors in the family (Cecchin, 1987). Therapy deals with posing new questions that encourage family members to develop a wider assortment of explanations for each other's behaviors. Although Milan and Post-Milan therapies are well suited for some families, they have been criticized because they depend on abstract conceptual abilities that are difficult for young children or less educated families to grasp, and because they are not directive enough to quickly stop abuse in a family (Cottrell & Boston, 2002).

#### *Brief Solution Focused Therapy*

Solution focused therapy was first developed at the Brief Family Therapy Center in Milwaukee, Wisconsin, by Steve de Shazer (de Shazer, 1985). This form of therapy differs from the ones described above because it focuses on the strengths of a family, and seeks to reinforce the aspects of the family that are positive. Rather than focusing on past negative behaviors, solution focused behavior is used to bring families together to agree on goals that they will work toward. A distinctive feature of this model of therapy is its focus on the language of the therapist—who uses consistently positive messages to help the family focus on the image of a positive, problem-free future. This mode of therapy works on the premise that every family has inherent strengths, and by focusing on these strengths, they will build toward goals that are positive for all of its members (Berg & de Shazer, 1993).

Critics of this method of treatment have suggested that the emphasis on positive talk reduces the opportunity for empathy or consideration of the parts of the relationship that are not positive (Cottrell & Boston, 2002). Feminist critics contend that women are particularly vulnerable to therapist unspoken encouragements to sweep their concerns under a rug in order to maintain the family's happy front (Gilligan, 1982; Vatcher & Bogo, 2001). Despite such criticisms, clinicians have found this method to be an effective and time-efficient method of treatment, and research has begun to show signs of the usefulness of solution based therapy for a variety of clients (Franklin, Biever, Moore, et al., 2001; DeJong & Hopwood, 1996; McKeel, 1996).

### *Narrative Therapy*

Narrative therapy is most closely identified with Michael White and David Epston. It tends to take a social-political stance about mental health that makes it quite controversial (Cottrell & Boston, 2002). It operates under the premise that a person's life is influenced in large measure by the stories that communities of people associate with the person. In other words, individuals internalize the problematic stories that other people believe about them. Narrative therapy assists people in resolving such problems by helping them see exceptions the problematic story that is connected to them so that they can create a new story about themselves (White, 1986). This new story can be created by writing letters supporting this new version of the self or by exposure to specific others who have conquered similar issues. This form of therapy suggests that as the more positive account of the individual emerges, the problem recedes in importance (White & Epston, 1990). Critics of this therapy suggest that this intervention can be naïve or harmful for those who have serious mental health problems, and there is also

some question whether it is family therapy at all, but rather individual therapy in the presence of family members (Cottrell & Boston, 2002).

### *Feminist/Emotion Focused Family Therapy*

Feminist and Emotion focused therapies, as described by Vatcher and Bogo (2001), are actually two distinct theories of therapy that are easily integrated in practice. Emotion focused therapy introduces systemic and emotional perspectives as they relate to couples' presenting problems (Johnson & Talitman, 1997). It emphasizes that the "problem" in families is a lack of connection between members. Emotion focused therapy then tries to help members of the family articulate the feelings that are impeding healthy interdependence with those they care about.

The emotion focused therapy fits well with a feminist viewpoint because many feminist critics have suggested that traditional therapies tend to pathologize women's ways of being in a relationship by glorifying male models of independent existence (Gilligan, 1982; Vatcher and Bogo, 2001). Feminist family therapy would go one step further, however, by directly raising the cultural and societal issues that cause women to feel a lack of power in marital relationships. For example, if the wife feels that she is doing all of the cleaning in a household, and the husband states that he just doesn't care about the house being clean, the therapist would bring up the fact that society expects women to be the housecleaners, and will more likely hold the wife to blame if the house isn't in good order (Vatcher and Bogo, 2001).

### *Structural Family Therapy*

Structural family therapy is one of the oldest and most widely used forms of therapy. According to this theory, the basic source of problems for an individual is often

derived from a poor family structure or organization (Minuchin, 1974; Minuchin and Fishman, 1981). The structural therapist sees the family in terms of spatial relationships. Those relationships can be too close (or “enmeshed”) or too distant (“disengaged”). The aim of therapy is to redesign the structure so that there are boundaries between parents and children, yet both parents are supportive of each other and their children. In order to accomplish this task, the therapist first observes the family to find clues to develop hypotheses. Clues can be gathered, for instance, by tracking who sits close to one another in session, who sits apart from the family, who speaks with authority, and who answers questions directed toward other members of the family (Minuchin, 1974). Unlike traditional psychoanalysis, the therapist then takes a directive role in therapy, asking family members to change seating arrangements or practice modes of transaction that differ from their normal patterns. Simon (1995) contends that what distinguishes the practice of structural family therapy from other models is that family members do not merely talk about what they would like to change. Instead, they are directed to begin changing communication patterns with one another-- live, in the middle of the session.

Contemporary criticisms of structural family therapy suggest that Minuchin’s model is not well-suited for many modern families that differ from the traditional, western, two parent family (Cottrell & Boston, 2002). They also contend the directive approach taken by the therapist can lead the family to change in ways that the therapist wants, but may not be in the best interest of the family. Feminist theorists, for instance, suggest that traditional structural therapy does not take into account the differences in power that society gives to men and women, and may be complicit in encouraging women to remain with husbands who are abusive (Hare-Mustin, 1986). As a

consequence, several clinicians and researchers have sought to make adjustments to traditional structural family therapy so that it takes the needs of women and “non-traditional” families into account (Vetere, 1992). Since structural family therapy is the mode of treatment used in this study, a more detailed description of how it is applied is provided below.

### *Structural Family Therapy: Tenets and Techniques*

As noted earlier, this study will examine some of the process variables in structural family therapy. Structural family therapy is one of the oldest, most widely used and taught forms of family therapy, and it has a well developed body of research on effectiveness (Figley and Nelson, 1990; Aponte, 1992, Henry, 1983). In this section, a more complete description of family structure is provided, as well as some of the techniques designed to change family structure.

#### *Defining Family Structure*

Structural therapists operate under the premise that every organization has an invisible set of rules that govern the interactions between persons in any social system; including the school, work, or family (Carlson, 1987). In the family, structure is organized by cultural norms and by the idiosyncratic expectations of its members. Structure can be observed by watching the repeated transactions that occur within the family, and between the family and outside systems. Aponte & Van Deusen (1981) describe three important elements of the structure: boundaries, alignment, and power.

The boundaries of a family determine who communicates with whom, and they set up the roles of each member. Ideal boundaries allow for a clear understanding of roles, while allowing open communication and nurturance. As Minuchin (1974) stated,

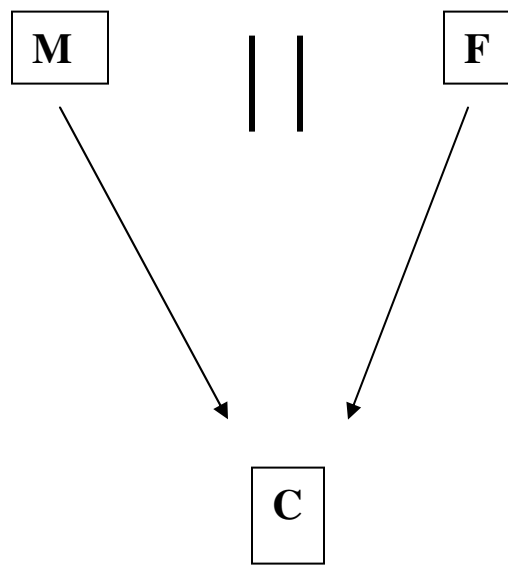
“A family must protect the integrity of the total system and the functional autonomy of its parts” (p.143). Problematic families have boundaries that are either too open (diffuse) or too closed (rigid). When the boundaries between individuals are too diffuse, the individuals are not given the opportunity to communicate for themselves, or have ownership of their own ideas. When boundaries are too rigid, family members feel disengaged from one another and do not experience the warmth that they seek from a family member.

Alignment refers to the joining of two members of a family to carry out an operation (Carlson, 1987). Dysfunctional alignments can be the product of concealed parental conflict, and can place unusual pressure on a child. Figure 1 offers a visual depiction of one example of a dysfunctional alignment. In this case, two parents have a conflict with one another but do not communicate this conflict with each other. Instead they direct this conflict toward a scapegoated child. Dysfunctional alignments have been shown to be correlated with a number of externalizing and internalizing disorders in children (Abelsohn and Saayman, 1991; Raymond, Friedlander, Heatherington, et al., 1993).

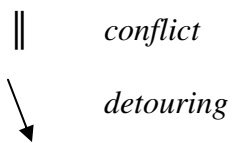
Power refers to the level of influence a particular member of the family has in establishing boundaries and alignments (Aponte & Van Deusen, 1981). In an ideal family structure, the parent or parents have enough authority to implement order in the family. A common example of a family that has a dysfunctional power hierarchy occurs when the children are more powerful than their caretakers, which can lead to behavioral disorders on the part of children. This is referred to as an “inverted” hierarchy, because the power structure is the opposite of what is considered ideal.



Figure 1. Diagram of Dysfunctional Alignment: Detouring Conflict to Scapegoated Child



Key to Figure 1



### *Changing the Structure*

A typical structural family intervention occurs over five to twelve sessions. Treatment begins with an initial joining and assessment stage, and flows into challenges to the family's reality and structure. This subsection will describe ways in which the therapist joins with, and challenges the family in therapy.

The structural family therapist must take a position of leadership from the beginning of therapy (Minuchin & Fishman, 1981). The therapist will often see the source of a problem differently than will the members of the family. At the beginning, however, the therapist is engaged in active listening, exploration, and observation of the family patterns of communication, but does not challenge the family's manner of interacting too greatly. During this phase, the therapist must make family members comfortable with being in therapy and sharing their story with the therapist. The therapist is also probing to find out what structural patterns could be supporting the referral problem, and is gathering information about what influences are shaping this structure. This period of therapy is considered very important because it is the time when hypotheses are developed and interventions planned. Equally important, it is a time when the therapist is gaining the leverage and trust necessary to challenge the beliefs and the structure of the family (Minuchin, 1974). This model suggests that a family will not allow a therapist to challenge their views until they believe that the therapist understands their views.

When trying to make changes in a family, there are two broad types of structural interventions: "restructuring" and "redefinition" (Minuchin & Fishman, 1981; Aponte & Van Deusen, 1981). Restructuring interventions alter the family organization. One

important manner of restructuring occurs through changing family boundaries. One example of restructuring would be to direct disengaged family members to talk to each other directly, without consulting another party. Restructuring can also be aided by physical means—such as asking an enmeshed dyad in a family to sit apart from each other. Sometimes restructuring can occur when the therapist shares a simple observation, such as noting that when one person is asked a question, the question gets answered by another person (Minuchin, 1974; Minuchin & Fishman, 1981). A redefinition intervention, or “reframing”, seeks to change the perceptions of a family about a given reality. Families already have a definition that is stable, but the therapist tries to change the perception of that reality so that they will respond in a more positive manner. For instance, if the family has a view of a child that he or she is “bad” or “poorly behaved”, they are likely to look for behaviors that support that view and consistently relay that view to the child. On the other hand, if the parents view the same child as “naïve”, they might respond to the same behaviors of the child in a very different manner. Altering the parental affect in this way is often sufficient to reveal to parents that the child needs concrete instruction about acceptable behaviors, rather than punishment for misbehavior. At the same time the parents may develop a more positive emotional response to the child’s behavior.

During all structural interventions, the therapist does not suggest that any particular intervention is the only possible answer to the family’s problem, but influences them to try out new patterns of interaction or ways of looking at their reality. The intervention can take place in the office, during session, or sometimes with homework assignments between sessions (Minuchin & Fishman, 1981).

## *Family Therapy Research*

This section will examine the state of research in the various models of family therapy. It will begin with a look at the unique challenges of family therapy research. This will be followed by a review of important findings that have been made, particularly with the successes of symptom reduction for identified child patients.

### *Challenges of Family Therapy Research*

While the practice of family therapy in the community has been common for over a quarter of a century, empirical research in the area has lagged compared to that of individual therapy (Hohmann-Marriott, 2001). Hohmann-Marriott suggests that one important challenge is the presence of multiple family members in treatment. This forces the researcher to make difficult decisions about appropriate indicators of effectiveness. The perceived effectiveness of an intervention could vary greatly depending on the indicator studied. For example, if a child who was the referral problem for a family improves his or her behavior at the end of therapy, but the parents report less satisfaction in their marriage, “effectiveness” would depend on the variable measured. Fonagy, Target, Cottrell, et al., (2002) describe five possible domains for evaluating family therapy: symptomatic or diagnostic change, change in the family’s ability to adapt to a problem, change in family transactions, and use/satisfaction with therapy services. Fonagay and colleagues suggest that there is currently more precise assessment of symptom change than for the other domains.

### *Gaps in Literature*

While family therapy research has increased in recent years, progress must still be made to overcome the actual and perceived methodological difficulties inherent in

evaluating complex systems (Raymond et al., 1993; Horne, 1999; Cottrell & Boston, 2002). This section will examine some of the areas of research that still need to be explored.

Family therapy research lags behind individual therapy research in terms of making its treatment groups homogenous in the age and qualities of the subjects (Horne, 1999; Shadish, Montgomery, Wilson, et al., 1995). This might be influenced by the fact that it is more difficult to find large numbers of family clients to participate in studies (Shadish et al., 1995; Cottrell & Boston, 2002), or because there is less consensus about the proper “diagnosis” of a family compared to that of individuals (O’Sullivan, Berger, & Foster, 1984). In addition, family therapy also has a difficulty in that there are fewer manualised family interventions than individual interventions, so it is more difficult to ensure treatment integrity (Shadish et al., 1995; Horne, 1999).

Another weakness of the family therapy research base is that some theoretical assumptions of therapy models have not been challenged through empirical study. For example, Horne (1999) examined the research available concerning the importance of the “self” of the therapist in family therapy. She found that there was only marginal empirical evidence that a therapist’s intra-psychic health was related to the outcome of family therapy, even though this is a widely held tenet of many therapeutic models.

It has been argued that if family therapists believe that their work is helpful for their clients, it is their ethical duty to work with researchers to attempt to measure that benefit (Cottrell & Boston, 2002; Hohmann-Marriott, 2001). To date, there are a number of theoretical assumptions about interventions that have not been empirically validated. The current study will attempt to examine some untested theoretical beliefs.

## *Structural Family Therapy Research*

*Studies of Symptom Change.* Despite the challenges faced in conducting family therapy research, researchers have begun to establish promising support for structural family therapy. Structural family therapy has perhaps a fully developed body of research than all other models of family therapy research (Raymond, Friedlander, Heatherington, et al., 1993). Research supporting the effectiveness of family therapy is greatest in terms of its ability to effect change in the symptoms of a referred child patient. Some of the studies describing symptom change in the identified child patient are described below.

Szapocznik and colleagues (1989) compared structural family therapy to control groups in terms of treating the behavior of children with conduct disorders. They found that the parents of children who participated in structural family therapy rated greater improvement in their children than did those who were placed in a control group. This effect was present in the short term and at a one-year follow up (Szapocznik, Rio, Murray, et al., 1989).

Barkley, Guavremont, Anastopolous, and Fletcher (1992) found that children with attention deficit hyperactivity disorder made significant improvements for internalizing symptoms, externalizing symptoms, school adjustment, and conflict after being placed in a structural family therapy program. These differences were found immediately after treatment, and at 3 month follow up. While such improvements were found, there was so significant difference between structural family and behavior management training, and it is unclear whether medication was a covariable that influenced this improvement.

Szapocznik and colleagues (1988) found that structural family therapy was positively correlated with families ensuring that their drug-abusing adolescents

completed drug treatment. Their treatment model also included visits and phone calls to the home, and these additional interventions may have played a role in the positive results of the study.

One of the earliest empirical studies of structural therapy found that it was helpful in alleviating symptoms of intractable asthma for youths who had previously been spending considerable time in hospitals (Liebman, Minuchin, & Baker, 1974). The authors found that in many cases, the child's illness served the purpose of helping the family avoid conflict, so the child was unknowingly encouraged to develop a psychosomatic version of the illness. Structural therapy helped the families communicate conflict directly, rather than detour their conflict through the child's illness, resulting in fewer hospital stays for the youth.

Henggeler et al., (1992) found that structural family therapy could play a major role in reducing rates of re-offending among juvenile offenders. The treatment program in this study also added other interventions, such as parent training, social skills training, and marital therapy. It is not clear whether the positive results found in this study would have occurred through structural family therapy alone.

The above studies, combined with anecdotal or case reports of improvements for a wide variety of children through family therapy (Minuchin, 1974; Minuchin & Fishman, 1981; Simon, 1995; Fulmer, Cohen & Monaco, 1985; Heard, 1978; Jung, 1984), have made structural therapy a treatment of choice for a wide variety of families. The current body of literature makes a compelling case that family therapy can help lead to change in a child's behavior. It does not, however, provide a clear understanding of what specific processes within therapy produce such changes.

*Structural Family Therapy Process Studies.* As noted earlier, research concerning the individual processes of change in family therapy has lagged behind studies that show evidence of general relief of symptoms. Over the last 10-15 years however, structural family researchers have conducted several studies that have attempted to improve knowledge of how process variables affect the success of structural family therapy. These studies are discussed below.

Laird & Van de Kemp (1987) explored the level of family-therapist complementarity shown in videotapes of Minuchin working with a family during a successful course of treatment by coding each interaction during a session. Complementarity is an interpersonal concept that suggests that a person tends to react to others in a way that is expected given the behavior of others in a system. In therapy, for instance, a therapist who behaves in a dominant manner with a submissive client is showing high complementarity because he or she is adopting the client's normal pattern of interaction. Laird & Van de Kemp found that Minuchin had a high level of complementarity at the beginning of therapy, but then changed his manner of interacting in the middle stages of therapy. At that time, he began to challenge the family's view of the world and each other. The authors found that the family changed its ways of interacting when Minuchin changed his own methods of interacting. This lent support to Minuchin's model of joining with the family at the beginning of therapy, and then working to restructure or redefine the family's structure or communication later in treatment.

Raymond, Friedlander, Heatherington, et al., (1993) coded the communication processes evident in the therapy sessions of a family with a chronic anorexic adolescent.



Similar to the findings of Laird & Vande Kemp (1987), complementarity was higher at the beginning of therapy than during the middle, when the therapist challenged the family members to change their behaviors and interaction styles. This study found that the therapist intervened to stop enmeshment or intergenerational boundaries, spurred greater involvement on the part of the father, and encouraged the husband and wife to share concerns with one another. Many structural goals were accomplished in the course of treatment: the father became more involved in interacting with the daughter, the mother-daughter coalition became less rigid, the parents focused less negative attention on their daughter, and the parents confronted marital issues with one another.

Zaken-Greenberg and Neimeyer (1986) examined the impact of structural family therapy training on student therapists. Students in this study were assessed during videotaped therapy simulation. They found that students provided a greater number of structural interventions at the end of the training than they did at the beginning. Examples of structural interventions included attempts to alter the family's boundaries or alliances by physical repositioning, "detriangling" family interactions, or providing power directives for the adult. These results suggested that student therapists enrolled in a structural family course do learn to implement structural interventions—though this does not imply anything about whether the interventions work when used with actual clients.

Abelsohn & Saayman (1991) examined the relationship between structural constructs and adolescent behavior problems in families after a divorce. They found a significant correlation between enmeshment or disengagement, as reported by the adolescent; and poor social relationships, as measured by the parents. They also found

that less stability in the family was correlated with higher levels of internalizing, externalizing, and total behavior problems in the adolescent. The study found that a control group of recently divorced families tended to have boundaries that were clear, but flexible. This study lent support to one of the basic hypotheses of structural family therapy—a family with an appropriate structure is less likely to have children with significant behavioral disorders.

O’Sullivan, Berger, & Foster (1984) tested whether practicing structural family therapists who viewed videotapes of an initial family interview would consistently agree on hypotheses of structural difficulties. They found that there was relatively low (20%) inter-rater reliability of entire structural maps of the presenting problem—with all of the dyadic codes of a triangle in agreement. On the other hand, much higher inter-rater reliability (.72) was found for ratings of the individual dyads. This study suggested that clinicians can reliably rate the relationships of specific dyads.

#### *Summary and Rationale*

The use of family therapy in clinical settings is flourishing (Cottrell and Boston, 2002; Kazdin, 1997). At the same time, research in the area of family therapy process variables is in its early stages (Laird & Van de Kemp, 1987; Raymond, Friedlander, Heatherington, et al., 1993, Zaken-Greenberg & Neimeyer, 1986). As a result, a number of family therapy interventions are implemented based on theory and clinical judgment, but lack empirical support for their use. In order for clinicians to make responsible decisions about how to intervene, they should use treatments that have proven empirically to produce the effects that were expected (Rosenthal, 2000; Horne, 1999, Hohmann-Marriott, 2001). Process research can also be helpful in providing family

therapy instructors with more information about the specific techniques that create change in the family.

Structural family therapy is one of the most common models of family therapy treatment (Figley & Nelson, 1990; Aponte, 1992; Henry, 1983), and is used with families with a vast array of difficulties. A fair amount of research has indicated that this treatment can help alleviate the symptoms of the child that causes the family to come to therapy. This form of therapy has been shown to be effective in helping to treat children with conduct disorders (Szapocznik, Rio, Murray, et al., 1989), attention deficit hyperactivity disorder (Barkley, Guavremont, Anastopolous, and Fletcher, 1992), and intractable asthma (Liebman, Minuchin, & Baker, 1974). It has also been found to be helpful in reducing recidivism in juvenile offenders, (Henggeler, et al., 1992) and in helping families keep drug-abusing adolescents in treatment programs (Szapocznik et al., 1988).

Structural family therapy utilizes a variety of techniques and intervention strategies that are based on the therapist's hypothesis of the family structure. O'Sullivan, Berger, & Foster (1984) showed that family therapists have a relatively high degrees of inter-rater reliability when they are asked to rate the interactions of individual dyads. Little is known, however, about whether interventions aimed at changing the transaction patterns of that dyad succeed in their goal, or whether it is those particular interventions that produce changes in the symptoms of an identified child.

One common problem in families, from a structural point of view, is that families tend to blame all or most of their problems on one identified "problem" child (Minuchin, 1974). Minuchin refers to this phenomenon as "scapegoating", and he recommends

certain techniques to change this transaction pattern. In general terms, the therapist attempts to change the way the family sees that child—by reframing behaviors as “normal” or by pointing out to the family occasions when the child is acting out in a way that is contrary to the bad reputation. The theory behind such an approach is that when the family changes its view of the child, the child will feel encouraged to pursue positive behavior, and the family will help the child change because they have a more positive opinion of him or her. To date, however, this treatment is pursued based on theoretical principle and case reports of its effectiveness. There has been no empirical test of whether the number of sessions aimed at elevating the scapegoated child is correlated with more positive parent-child interactions.

Another problem that structural family therapists often find is an inappropriate power structure (Minuchin, 1974). This occurs if the parent or parents do not have show an ability to set rules for the children, and is called an “inverted hierarchy”, because the family’s power is not where it should be. There are several root causes of this problem. If two parents are present in the home, but they have different rules for children or subvert each other’s attempts at creating structure, the children get the idea that the rules are not valid. In this case, the therapist intervenes by promoting greater cooperation between the two parents. This is often done by encouraging parents to sit next to one another and discuss a plan for parenting without interruption from the children. Structural family theory suggests that if the two parents present a united front to their children, the children will learn to obey rules and show greater respect for each parent (Minuchin, 1974; Minuchin & Fishman, 1981).

An inverted hierarchy can also occur if the parent or parents do not differentiate themselves from the children enough to establish that they are highest in the hierarchy of familial power. In this case, the children do not learn to follow rules set forth by others. In such cases, the therapist may purposefully speak to the parent(s) about rules, and ask them to exclude the children from such an “adult” discussion. Once rules are decided, the therapist encourages the parent or parents explain the rules, their rationale, and the consequences for failing to comply with the rules to the children. Such interventions are designed to help parents understand that they must be actively in charge of family rules, and to help children understand that their role is to follow parental rules. Structural family therapy theory suggests that this will lead to greater family organization and control. To date, no empirical tests have been made to determine whether the number of sessions focused on improving parental power is correlated with family closeness, organization, or control.

Knowledge of the process variables of family therapy is vital for clinicians who wish to provide the best possible treatment for their clients. To date, there are significant gaps in the research on some of the most widely used family therapy interventions. This study will attempt to address this gap by examining questions about the processes involved in structural family therapy. Specifically, do attempts by a therapist to elevate the status of a scapegoated child actually alter the way the child is viewed or treated? Do interventions aimed at promoting parental power change parental reports of family organization, and control? These questions will be investigated in the current study described next.

## Chapter 3

### Statement of the Problem

When families enter treatment with a structural family therapist, the therapist begins by assessing the structure and transaction patterns of the family. The therapist develops hypotheses about the family and strategies for making changes in the family (Minuchin, 1974; Minuchin & Fishman, 1981). Currently, much of the therapist's strategy is based on theory and clinical judgment, because empirical testing of family therapy processes is lacking. This study will address the paucity of research on process variables in family therapy.

The current study examines whether structural family therapy interventions that were provided for over 100 families produced the theoretically predicted changes. All families were asked to complete pre- and post- intervention measures. Parents completed ratings of their child's behavior, as well as family organization and control.

### *Research Questions and Hypotheses*

Each research question addresses the general topic of whether the effectiveness of structural family therapy is correlated with the proportion of sessions in which the therapist addresses specific structural goals. Each question seeks to ascertain whether therapy is accomplishing what is predicted based on structural family theory.

#### *Research Question 1*

Do parents report greater improvement on measures of their child's negative behaviors when the family therapist focuses on elevating the status of a scapegoated child?

### *Hypothesis 1*

Parents will report a more positive change in their child's level of negative behavior when the therapist focuses on elevating the status of the scapegoated child in at least half of all sessions than they will when the therapist does not focus on elevating the scapegoated child in at least half of all sessions.

### *Rationale*

Structural family theorists have suggested that families (or other human systems) sometimes develop a homeostatic system in which one individual is blamed for any conflict or stress in the family. For example, two parents who are experiencing conflict with one another may not address that conflict directly—instead choosing to focus on the imperfections of a child, thereby maintaining an illusory state of harmony (Minuchin and Fishman, 1981). According to family therapy theory, one way to address this situation is to challenge the notion that the scapegoated child is really as bad as the family perceives him/her, or to suggest that the child's misbehavior might be a reaction to the behaviors of other family members. If this strategy works as the theory predicts, then one would expect a therapist's focus on elevating the scapegoated child to lead to improvements in how the family perceives the child's behavior.

### *Research Question 2*

Will parents report a greater improvement in family organization and control if the therapist focuses on increasing parental power within the family?

### *Hypothesis 2*

Parents will report a more positive change in family organization and control when the therapist focuses on improving parental power in at least half of all sessions

than they will when the therapist does not focus on improving parental power in at least half of all sessions

*Rationale*

Structural family therapy theorists suggest that one cause of stress in families occurs when one or both parents do not feel that they have an appropriate amount of authority in the home. When this occurs, families are more likely to report a lack of organization or control—the rules and expectations of family members are unclear because at least one parent is ineffective within the household (Minuchin & Fishman, 1981). Structural family theory suggests that one way to treat this situation is to empower parents by pointing out their strengths and helping them to see how they can change their children's behavior by asserting their authority within the home. If such interventions are working in the way structural family theory predicts, one would expect that a focus on increasing parental power would lead to an increase in their ratings of family organization and control.



## Chapter 4

### Methods

The purpose of this study is to evaluate whether structural family therapy makes a differential impact on families depending upon the focus of the structural interventions. This section provides a description of the project from which family intervention data were obtained, a description of the participants who were included in the study, the instrumentation, and the procedure of the study.

#### *Description of Family Intervention Project*

Information for this study is based on data gathered since 1990 by the Family Intervention Project at the University of Texas at Austin. The Family Intervention Program is an ongoing family therapy program at the University of Texas at Austin that is supervised by Dr. Cindy Carlson. The goal of the program is to provide training for doctorate level graduate students in structural family therapy. A summary of the course of treatment through the Family Intervention Project is provided in Table 1.

#### *Pre-Intervention Steps*

Most participants were referred to the program by school personnel, such as teachers, counselors, or principals. Other participants were self-referred or sought participation based on the recommendation of family, friends, or other agencies. All families who participated in the Family Intervention Program did so on a voluntary basis, and therapy was provided at no cost. Written consent was obtained from all parents and assents from children were obtained for all children of at least 7 years of age before the family was accepted into the Family Intervention Program. See Appendix for copies of consent and assent letters.

Table 1

Summary of Family Therapy Treatment

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Pre-Intervention Steps

Step 1: Family is referred to Family Intervention Project; typically by school personnel

Step 2: Dr. Carlson contacts family

Step 3: Student therapist contacts family; sets up initial appointment

Step 4: First meeting; family signs consent forms, completes pre-intervention data, and completes interaction tasks

Step 5: Therapist prepares diagnostic report by looking at pre-intervention data and developing therapy goals

Intervention Steps

Step 6: Therapist develops treatment plan for first session, along with predicted results

Step 7: Therapist conducts first family therapy session

Step 8: Therapist writes down results of session

Step 9: Repeat steps 6 to 8 until termination

Post-Intervention Steps

Step 10: Termination session; family completes post-intervention measures

Step 11: Therapist completes family therapy report, which describes course of treatment and final results. He or she places report in family therapy notebook along with pre and post intervention data and all therapist notes

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During the family's first contact with Dr. Cindy Carlson, Program Director, the family was given basic information regarding the program. Each family was then assigned to one doctoral student therapist, to be supervised by Dr. Carlson. Each student therapist had completed a course on family therapy theory the previous semester, but in most cases this family was the therapist's first client in structural family therapy.

The therapist contacted the family to set up the initial session. At this session, the family was informed of confidentiality issues, informed that they would be videotaped and viewed behind a one way mirror by Dr. Carlson and the students in the Family Intervention Program. If consent was obtained, all families that participated in the Project were then given a number of objective pre-intervention measures. These measures were used to help establish goals for treatment, and would also be compared with post-intervention measures to assess the efficacy of treatment.

Each parent was asked to complete the following objective measures: the Family Environment Scales, 3<sup>rd</sup> edition (FES) (Moos and Moos, 1994), the Family Assessment Measures-III Dyadic Relationship Scale (FAM-III) (Skinner, Steinhauer, & Santa Barbara, 1995), the Child Behavior Checklist (CBCL) (Achenbach, 1991), and the Parenting Stress Index, Short Form (PSI-SF) (Abidin, 1995). Each child who was at least 11 years old was given the FES, the Parent Perception Inventory (PPI) (Hazzard, Christensen, & Margolin, 1983), and a Kinetic Family Drawing. Next, a Family Genogram was also completed with all family members in order to obtain a family history. Finally, the family was asked to perform a series of three interaction tasks to help the student obtain a better understanding of family dynamics. These interaction

tasks were to discuss a recent family argument, to plan a day together as a family, and to discuss the family's strengths. The family was given 3-5 minutes to complete the task, and their responses were observed and videotaped from behind a one-way mirror.

Based on the data gathered above, the student developed diagnostic hypotheses about the family processes underlying the family's identified problems. These hypotheses are based on the tenets of structural family therapy, as developed by Salvador Minuchin (Minuchin, 1974; Minuchin & Fishman, 1981). There are a number of possible diagnostic hypotheses that could be developed. Figure 2 provides examples of two possible diagnostic hypotheses.

Example one depicts a family in which it is hypothesized that one child has equal power with the mother, while the other children are lower in power. This family structure is not always problematic, but the family can run into difficulty if the mother abdicates her role in guidance and control and the parental child is given power and responsibility that he or she cannot adequately manage.

In this example, it is hypothesized that the mother and father do not communicate with one another when they have a conflict. Instead, they use the child to detour their own conflict. According to structural family theory, this is often done in order to help the parents maintain a state of illusory harmony (Minuchin, 1974). Rather than be in conflict, the parents unite in their criticism of the scapegoated child.

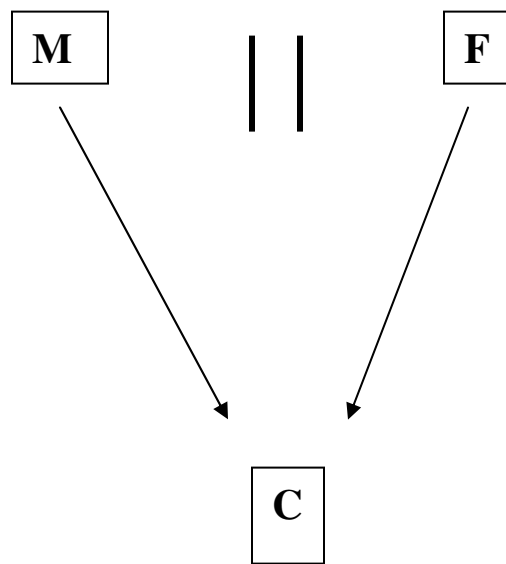
After the student developed diagnostic hypotheses, he or she developed a treatment plan and described the expected results of such treatment. Before each therapy session, the student completed a worksheet that described the plans for intervention for that session. Again, the treatment plan was designed based on the principles of structural

Figure 2. Sample Diagnostic Hypotheses

*Example 1: The Single Mother Family with a Parental Child*



*Example 2: Mother and Father Detour Conflict to a Scapegoated Child*



---

*Key to Figure 2*

- ||      *conflict*
- ↓      *detouring*
- *rigid boundary*

family therapy. For the family cited in example 1, for instance, the therapist might develop a treatment plan that focuses on making clear boundaries between the mother and the parental child, and might seek to reduce the degree of power and responsibility of the parental child in relation to the mother. The therapist then writes out a diagram depicting the predicted results of the intervention. Below is an example of the expected results that could have been predicted after treating the family depicted in the structural hypothesis of example 1.

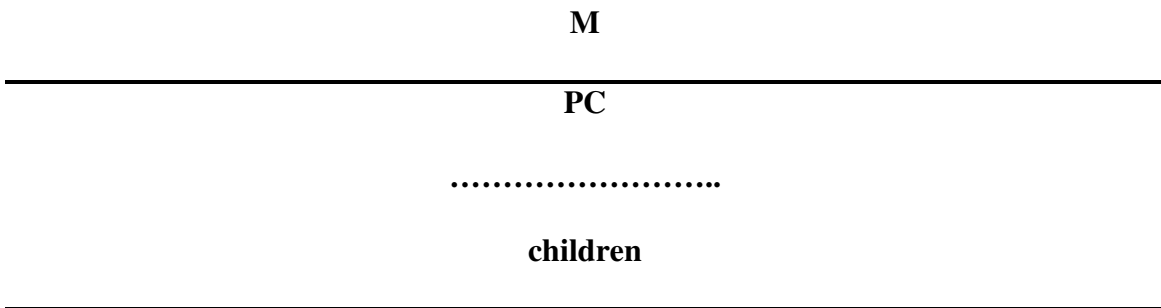
Figure 3 depicts a family with a changed structure. The mother is now at the top of the hierarchy, clearly separated from the parental child. The parental child continues to have a higher level of power and responsibility than the other children, but the distinction is not as rigid as the distinction between mother and children. This is a possible structural goal for this family.

### *Intervention Steps*

Each therapy session lasted for one hour. During the session, the therapist attempted to implement structural interventions that were based on the structural hypotheses that were developed before the session. Halfway through each session, the student therapist left the room to consult with Dr. Carlson or appointed teaching assistant and a consulting team made up of other student therapists. The supervisor and consulting team helped to make sure that the therapist was pursuing the interventions and structural goals that were delineated before the session, and provided guidance for how to maintain that focus. After this consultation, the therapist returned to complete the session with the family. After each session, the therapist described the intervention and its result. The treatment plan for each session, as well as the therapist's discussion of the results of each

session, was placed in a family therapy notebook. This process was repeated throughout the course of therapy, which lasted for the length of a school semester, or until the family decided to drop out of treatment.

3 Figure. Expected Results of Treatment



*Key to Figure 3*

\_\_\_\_\_ *rigid boundary*

..... *Diffuse boundary*

*Description of Post Intervention Steps*

For most families, the last session was a termination session that included a family post-assessment data collection. Approximately one third of the families terminated without coming in for a final termination session, so family post-assessment data are not available for those families. For family members that did complete post-assessment measures, an attempt was made to give each family member the same measures as in pre-assessment in order to assess treatment efficacy. Each family member was also asked to complete ratings of satisfaction with the therapist and with the therapy

service offered. As part of the course requirement, student therapists completed a Data Summary Sheet for each family and placed them in family therapy notebooks. It should be noted that completion of all of the family rating forms is quite time consuming, and there were a number of families who did not complete all post-intervention measures.

The final course assignment for the therapists was to complete a family therapy report. The family therapy report consisted of 1) Identifying Data, 2) Reason for referral, 3) Developmental Context of Family—which includes life cycle stages, ethnicity and SES, environmental stressors and resources, 4) System History, 5) Pre-Assessment of Family Members' Objective Measures, described above 6) Pre-Intervention Assessment of Process-- which describes how families interacted when given three separate interaction tasks, 7) Diagnostic Synthesis-- which includes the diagnostic hypotheses generated by the graduate student therapist, 8) Treatment Plan and Expected Results, 9) Description of course of treatment, 10) Post-Intervention Assessment: Objective Measures, 11) Post-Intervention Assessment of Process, 12) Discussion.

Data for the current study were gathered from the final therapy report, pre-intervention and post-intervention measures given to each family, as well as progress notes the therapist wrote about each session.

### *Participants*

The sample for this study was drawn from the population of families who participated in the Family Intervention Project between 1990 and 2002. During that time, 115 families participated in the Family Intervention Program. Data are unavailable or were not collected for 8 families, leaving 107 families for this study. Of those 107 families, however, many did not complete all of the relevant pre and post intervention



Table 2.  
*Characteristics of Participants in Study*

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<u>Age of Identified Child Patient (ICP)</u>	<u>Percentage (N=107)</u>
0-4	4% (n=4)
5-11	64% (n=68)
12-17	32% (n=34)
18 or older	1% (n=1)
 <u>Gender of IP</u>	
Male	51% (n=55)
Female	49% (n=52)
 <u>Type of Family</u>	
Intact	24% (n=26)
Single/Divorce/Widow	44% (n=47)
Remarried	26% (n=28)
Cohabiting	6% (n=6)
 <u>Family Ethnicity</u>	
White (Non-Hispanic)	74% (n=78)
Hispanic	17% (n=18)
African American	1% (n=1)
Other (including mixed)	9% (n=9)
 <u>Number of Treatment Sessions</u>	
0-4	28% (n=30)
5-8	55% (n=59)
9 or more	17% (n=18)
 <u>Therapist Gender</u>	
Male	18% (n=19)
Female	82% (n=88)
 <u>Reason for Referral</u>	
IP Emotional/Behavioral Difficulty <sup>a</sup>	90% (n=96)
Family Adjustment <sup>b</sup>	10% (n=11)

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<sup>a</sup> Such as ADHD, Anxiety, School Behavior Problem

<sup>b</sup> Such as recent divorce or death in family

data. For example, 44 families completed pre and post intervention data for the Achenbach Child Behavior Checklist (CBCL), while 62 completed pre and post intervention data for the Family Environment Scales (FES), 3<sup>rd</sup> edition. Characteristics of the IP's and their families in terms of sex, age, grade, ethnicity, number of siblings, and family type are presented in Table 2. The presenting problem in most of the families was misbehavior in school or at home by a particular child. For each family in the study, the child who was considered to be the primary source of family concern was labeled as the Identified Patient (IP). In some cases, the IP had an identified psychiatric disorder, including Depression, Attention Deficit/ Hyperactivity Disorder (ADHD), or Pervasive Developmental Disorder (PDD), and others. Families often indicated that the child was having difficulty adjusting to a recent change, such as divorce, separation, remarriage, a move, or death in the family. Age of IP ranged from 3 to 18, and a wide range of ethnicities were included in the study. Socioeconomic data are not available for the participants, but due to the fact that the therapy was free, the program appeared to draw a socioeconomically diverse group of participants.

### *Instrumentation*

#### *Description of Child Behavior Checklist (CBCL)*

The dependent variable for the first research question is the change score on the Total Problems Scale of the Child Behavior Checklist (CBCL) (Achenbach, 1991). A description of all of the scales on the CBCL is provided on Table 3. The Total Problems Scale of the CBCL was chosen because it provides a global measure of how difficult the parent perceives the child's behavior to be as compared to how other parents perceive their child. If a therapist is successful in an attempt to elevate the scapegoated child, one

Table 3

*Syndrome Scales of the Child Behavior Checklist*

---

<u>Scale</u>	<u>What is measured</u>
1. Withdrawn	Degree to which child seeks to remove self from others
2. Somatic Complaints	Degree to which child complains of physical injury or illness
<u>Scale</u>	<u>What is measured</u>
3. Anxious/Depressed	Child's feelings of nervousness and sadness
4. Social Problems	Degree to which child has difficulties interacting with peers
5. Thought Problems	Degree to which child has obsessive, compulsive, or atypical thoughts
6. Attention Problems	Degree to which child has difficulty maintaining concentration
7. Aggressive Behavior	Amount of physically aggressive behavior displayed by child
8. Delinquent Behavior	Degree to which child deviates from social norms and parental rules
9. Internalizing Problems	Child's concerns that are perceived within the child
10. Externalizing Problems	Concerns about the child as perceived by others
11. Total Problems	Global score of Internalizing and Externalizing problems
12. Activities Competence	Child's abilities in sports, hobbies, chores, and other activities
13. Social Competence	Child's ability to positively interact with others
14. School Competence	Child's ability to succeed academically
15. Total Competence	Global score of Activities, Social, and School Competencies

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Note. Adapted from Achenbach (1991)

would expect that the parent would rate their child in a less negative manner. If a focus on elevating the scapegoated child is the process that leads to such change, one would expect that the group of families for which the therapist implements this focus in at least half of all sessions would show greater improvement on the CBCL total problems scale than for families in which the therapist does not focus at least half of all sessions on elevating a scapegoated child.

*Reliability and Validity of the CBCL.* The norms for the test were derived from testing over 2,300 children from the 48 contiguous states chosen to be representative in terms of ethnicity, SES, geographical region, and urban-suburban-rural residence (Achenbach, 1991). The test-retest reliability of the CBCL scales are high, and have been tested to be generally above .8 (Achenbach, 1991). Inter-parent reliability coefficients were .985 for Total Problems and .97 for Total Competencies. Reliability coefficients of individual subscales averaged a more modest .66. This suggests that differences in subscale scores should be rated with caution because they are partly influenced by differences in the rater, not just differences in the child. As a result, reviewers have suggested that only the composite scores (Internalizing, Externalizing, Total Problems, Total Competence) should be used to support diagnostic or treatment decisions because are the most stable and best able to discriminate between typical and abnormal behavior problems (Doll, 2001; Furlong & Wood, 2001).

Items were only included in the checklist if they significantly discriminated between typical children and those referred for mental health services because of behavioral disturbances. Higher T scores on these scales indicate that the child has more behaviors in common with behaviorally disordered children. The CBCL does not have

scales to detect social desirability sets or lying, and as such could be vulnerable to those who wish to minimize a child's problems (Furlong & Wood, 2001). Overall, however, the CBCL is considered to be the standard in the field of child psychopathology against which the validity of other instruments is measured (Doll, 2001; Furlong & Wood, 2001; Edelbrock & Costello, 1988).

#### *Description of Family Environment Scales (FES)*

The dependent variable used for the second research question is the change from pre intervention to post intervention on the Organization and Control subscales of the Family Environment Scales, third edition (FES) (Moos and Moos, 1994). The FES is designed to assess family members' perceptions of their social environment. The organization and control subscale of the FES were chosen because they provide measures of family structure that can be compared across time. If increasing parental power is a structural goal of therapy, one would expect family organization and control would improve at the end of treatment. Furthermore, one would expect treatment that focuses on increasing parental power in at least half of all sessions to lead to greater gains in organization and control than treatment where the therapist focuses on increasing parental power in less than half of all sessions.

The FES contains 90 items to which respondents must answer "true" or "false". There are four forms of the FES: Real, Ideal, Expectations, and a Children's version. For this study, the Real and Children's versions were administered to subjects. There are ten subscales for this measure. Table 4 provides a description of each subscale.

The FES is an instrument that is informed by a well developed theoretical context (Mancini, 2001). This theoretical model contends that behavior is best understood as an

interaction between a person's individual characteristics and their environmental influences.

*Reliability and Validity of the FES.* The FES manual (Moos and Moos, 1994) provides information indicating adequate internal consistency across subscales (.60 to .71), test-retest reliability at 2 months (.68 to .86), and at 4 months (.54 to .86). As Mancini (2001) noted, however, the test-retest reliability measures were based on small (n=47 for 2 months and n=35 for 4 months) sample sizes.

Moos and Moos (1994) also provide evidence that the FES shows discriminant validity with large sample sizes between normal (n=1432) and distressed (n=788) families on dimensions such as Cohesion, Expressiveness, Independence, Intellectual and Recreational Orientation, and Conflict. Such findings indicate that the FES can be useful for assessing how well families are coping with their environmental stresses.

### *Procedures*

#### *Coding for Research Question 1: Focus on Elevating a Scapegoated Child*

The independent variable for research question one was whether the therapist focused on elevating the status of a scapegoated child in at least half of all therapy sessions. Coding for this variable occurred in the following manner.

The author obtained the therapy notebooks of families that participated in the Family Intervention Project from 1990 to 2002. He looked at the family therapy reports and focused on the therapist's session-by-session account of the course of treatment and recorded the number of sessions in which the therapist described a treatment of attempting to elevate the status of a scapegoated child. The therapist's account of therapy

Table 4.

*Subscales of the Family Environment Scale, 3<sup>rd</sup> Edition*

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<u>Subscale</u>	<u>What is measured</u>
1. Cohesion	The degree of commitment and support family members provide for one another.
2. Expressiveness	The extent to which family members are encouraged to express their feelings directly.
3. Conflict	The amount of openly expressed anger and conflict among family members.
4. Independence	The extent to which family members are assertive, self sufficient and make their own decisions.
5. Achievement Orientation	How much activities (such as school and work) are cast into an achievement-oriented or competitive framework.
6. Intellectual-Cultural Orientation	The level of interest in political, intellectual, and cultural activities.
7. Active-Recreational Orientation	Amount of participation in social and recreational activities.
8. Moral-Religious Emphasis	The emphasis on ethical and religious issues and values.
9. Organization	The degree of importance of clear organization and structure in planning family activities and responsibilities.
10. Control	How much set rules and procedures are used to run family life.

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Note. Adapted from Moos and Moos (1994)

was in a narrative form, and it was sometimes not clear whether the therapist actually focused on this goal during a given session. In such cases, the author examined the therapist's session notes in order to help to make a decision about whether the therapist addressed elevating a scapegoated child.

The author also trained a graduate student who had completed a course in the theory of family therapy to look at a random selection of 25 notebooks in order to test for inter-rater reliability. This person's group coding was in agreement with the author for 19 of 25 (76%) of the families. Among families that participated in at least 5 sessions, the inter-rater reliability was 15 of 17 (88%). In other words, the two raters coded the family (1=at least half of sessions focused on elevating scapegoat, 2=less than half of sessions focused on elevating scapegoat) in the same manner for 15 of the 17 families that participated in at least 5 sessions.

Data for this research question were not used unless the family completed at least 5 sessions of therapy, and the family completed the Child Behavior Checklist (CBCL) at pre and post intervention. A total of 44 families fit the criterion for use in this research question. A scapegoated child was elevated in at least half of the sessions for 8 of those families, while there were 36 cases in which the therapist did not attempt to elevate a scapegoated child in at least half of the sessions. Reasons for not focusing on elevating a scapegoated child could include a belief that no child is being scapegoated or a belief that the family will resist coming to therapy if the therapist challenges the idea that the scapegoated child is the source of most of the family's problems.



### *Coding for Research Question 2: Focus on Increasing Parental Power*

The independent variable for research question two was whether the therapist focused on elevating increasing parental power in at least half of all therapy sessions. Coding for this variable occurred in the following manner.

The author obtained the therapy notebooks from the Family Intervention Project from 1990 to 2002. He looked at the family therapy reports and focused on the therapist's session by session account of how the course of treatment. He recorded the number of sessions in which the therapist described a treatment of attempting to increase the power of a parent. When it was not clear from the narrative whether the therapist actually focused on this goal during a given session, the author examined the therapist's session notes. Each family was then coded as "3" if the therapist attempted to increase parental power in at least half of all sessions, and as a "4" if the therapist did not attempt to increase parental power in at least half of all sessions.

The author also trained a graduate student who had completed a course in the theory of family therapy to look at a random selection of 25 notebooks in order to test for inter-rater reliability. This person's group coding was in agreement with the author for 20 of 25 (80%) of the families. Among families that participated in at least 5 sessions, the inter-rater reliability was 15 of 17 (88%). In other words, the two raters coded the family (3=at least half of sessions focused on increasing parental power, 4=less than half of sessions focused on increasing parental power) in the same manner for 15 of the 17 families that participated in at least 5 sessions.

Data for this research question were not used unless the family completed at least 5 sessions of therapy, and the family completed the Family Environment Scales, third

edition (FES-III) at pre and post intervention. A total of 62 families fit the criterion for use in this research question. The therapist attempted to increase parental power in half of all sessions for 48 (77%) of those families, while there were 14 cases (23%) in which the therapist did not attempt to increase parental power in at least half of the sessions.

### *Research Design*

Research outcomes for this study were evaluated using a one-way ANOVA to compare the changes in pretest/posttest data between groups based on the structural focus of therapy. It should be emphasized that the research questions described below are concerned with measuring differences in the change scores of groups, not on differences between pretest and posttest within each group. Huck and Jennings (1975) found that a repeated measures ANOVA using pre and post test data is statistically equivalent to using t-scores with change score data.

#### *Research Question 1:*

Do parents report greater improvement on measures of their child's negative behaviors when the therapist focuses on elevating the status of a scapegoated child during therapy?

#### *Null Hypothesis 1:*

There will be no difference between the change in parental reports of the child's level of negative behavior, as measured by the change score of the Total Problems scale of the Child Behavior Checklist (Achenbach, 1991), when the therapist focuses on elevating the status of the scapegoated child in at least half of all sessions than when the therapist does not focus on elevating the scapegoated child in at least half of all sessions.

*Research Question 2:*

Will parents report a greater improvement in family organization and control if the therapist focuses on increasing parental power within the family?

*Null Hypothesis 2*

There will be no difference in the change of parental reports of organization and control, as measured by the Family Environment Scales (Moos and Moos, 1994), when the therapist focuses on improving parental power at least half of all sessions than when the therapist does not focus on improving parental power in at least half of all sessions.

## Chapter 5

### Results

The research findings of the present study are presented in three sections. The first section describes the sample and provides an analysis of the demographic data used in the study. The second section compares the equivalency of groups on pretest measures. The third section provides results of the hypothesis testing.

#### *Test of Group Demographic Equivalency*

##### *Research Question 1: Elevating the Scapegoated Child*

The total pool of participants considered for this study consisted of 107 families who participated in the Family Intervention Project at the University of Texas at Austin from 1990 to 2002. Of those families, there were 44 families that participated in the project for at least 5 sessions and completed post test data on the CBCL. Of those 44 families, there were 8 (18%) cases in Group 1—those cases in which the therapist attempted to elevate the status of a scapegoated child in at least half of all sessions, and 36 (82%) in Group 2—those cases in which the therapist did not attempt to elevate the status of a scapegoated child. Table 6 provides a comparison of the demographic characteristics of groups 1 and 2.

All of the data above were obtained by examining the family therapy notebooks of families that participated in the Family Intervention Project. The focus of treatment was made based solely on the beliefs of the therapist and supervisor about how to best treat the family. As a result, no effort was made to match the two groups in terms of demographic variables. Despite this fact, chi square analyses did not reveal significant

Table 5.

*Demographic Characteristics of Groups for Research Question 1: Effects of Focus on Elevating Scapegoated Child*

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	<u>Group 1: (n=8)</u>	<u>Group 2: (n=36)</u>
<u>Age of IP</u>		
0-4	0% (n=0)	3% (n=1)
5-11	88% (n=7)	64% (n=23)
12-17	13% (n=1)	33% (n=12)
18 +	0% (n=0)	0% (n=0)
<u>Gender of Child</u>		
Male	25% (n=2)	53% (n=19)
Female	75% (n=6)	47% (n=17)
<u>Family Type</u>		
Intact	25% (n=2)	28% (n=10)
Single, Divorced, or Widowed	50% (n=4)	50% (n=18)
Remarried	13% (n=1)	22% (n=8)
Cohabiting	13% (n=1)	0% (n=0)
<u>Family Ethnicity</u>		
White	75% (n=6)	74% (n=26)
Hispanic	13% (n=1)	14% (n=5)
African American	0% (n=0)	3% (n=1)
Other (including mixed race)	13% (n=1)	9% (n=3)
<u># of Sessions</u>		
5-8	63% (n=5)	72% (n=26)
9 or more	38% (n=3)	28% (n=10)
<u>Therapist Gender</u>		
Male	13% (n=1)	14% (n=5)
Female	88% (n=7)	86% (n=31)
<u>Reason for Referral</u>		
ICP emotional or behavioral problems	88% (n=7)	97% (n=35)
Family adjustment	13% (n=1)	3% (n=1)

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Group 1: Therapist focused on elevating scapegoated child in at least 50% of sessions

Group 2: Therapist did not focus on elevating scapegoated child in at least 50% of all sessions

differences between the two groups in terms of Age of Identified Patient (Chi Square=1.61;  $df=2$ ;  $p=.447$ ), Gender of Identified Patient (Chi Square=1.84;  $df=1$ ;  $p=.176$ ), Family Type (Chi Square=4.91;  $df=3$ ;  $p=.178$ ), Ethnicity (Chi Square=.356;  $df=3$ ;  $p=.949$ ), Therapist Gender (Chi Square=.006;  $df=1$ ;  $p=1.00$ ), or Reason for Referral (Chi Square=1.47;  $df=1$ ;  $p=.225$ ). In addition, a one way ANOVA did not reveal any statistical differences between the two groups in terms of the Number of Sessions conducted ( $F=.039$ ;  $df=1$ ;  $p=.844$ ).

*Test of Group Equivalency for Research Question 2: Increasing Parental Power*

For the second research question, there were 62 families that fit the necessary criteria for inclusion in the study—they completed at least 5 sessions and completed post-intervention data on the FES. Of those families, there were 48 (77%) cases in Group 3—those in which the therapist attempted to increase parental power in at least half of all sessions. There were 14 (23%) in Group 4—those in which the therapist did not attempt to increase parental power in at least half of all sessions. Table 7 provides a demographic comparison of the groups in this research question.

The focus of treatment was made based solely on the beliefs of the therapist and supervisor about how to best treat the family. As a result, no effort was made to match the two groups in terms of demographic variables. Despite this fact, chi square analyses did not reveal significant differences between groups 3 and 4 in terms of Age of Identified Patient (Chi Square=3.94;  $df=3$ ;  $p=.268$ ), Gender of Identified Patient (Chi Square=.111;  $df=1$ ;  $p=.739$ ), Family Type (Chi Square=4.622;  $df=3$ ;  $p=.202$ ), Ethnicity (Chi Square=1.161;  $df=3$ ;  $p=.762$ ), Therapist Gender (Chi Square=.375;  $df=1$ ;  $p=.54$ ), or Reason for Referral (Chi Square=.026;  $df=1$ ;  $p=.873$ ). In addition, a one way ANOVA

*Table 6. Demographic Characteristics of Families for Research Question 2: Effect of Focus on Increasing Parental Power*

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	<u>Group 3: (n=48)</u>	<u>Group 4: (n=14)</u>
<u>Age of IP</u>		
0-4	2% (n=1)	0% (n=0)
5-11	67% (n =32)	57% (n =8)
12-17	31% (n=15)	36% (n =5)
18 +	0% (n =0)	7% (n =1)
<u>Gender of Child</u>		
Male	48% (n =23)	43% (n =6)
Female	52% (n =25)	57% (n =8)
<u>Family Type</u>		
Intact	31% (n =15)	14% (n =2)
Single/Divorced/Widowed	40% (n =19)	71% (n =10)
Remarried	25% (n =12)	14% (n =2)
Cohabiting	4% (n =2)	0% (n =0)
<u>Family Ethnicity</u>		
White	77% (n=36)	71% (n=10)
Hispanic	15% (n=7)	14% (n=2)
African American	2% (n=1)	0% (n=0)
Other (Including Mixed Race)	6% (n=3)	14% (n=2)
<u>Number of Sessions</u>		
5-8	71% (n=34)	71% (n=10)
9 or more	29% (n=14)	29% (n=4)
<u>Therapist Gender</u>		
Male	15% (n=7)	21% (n=3)
Female	85% (n=41)	79% (n=11)
<u>Reason for Referral</u>		
ICP emotional or behavioral problems	94% (n=45)	93% (n=13)
Family adjustment (such as divorce or death in family)	6% (n=3)	7% (n=1)

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Group 3: Therapist focused on increasing parental power in at least 50% of all sessions

Group 4: Therapist did not focus on increasing power in at least 50% of all sessions

did not reveal any statistical differences between the two groups in terms of the Number of Sessions conducted ( $F=.201$ ;  $df=1$ ;  $p=.656$ ).

#### *Equivalency of Groups on Pretest Measures*

The groups were tested for equivalency on the pretest measures, utilizing independent T-tests. For the first research question, the group for which the therapist attempted to elevate a scapegoated child for at least 50% of sessions (Group 1) was compared to the group in which the therapist did not attempt to elevate a scapegoated child in at least 50% of all sessions (Group 2) in terms of its pre-test score on the CBCL total problems scale.

For the CBCL Total Problems Scale, Group 1 had  $N=8$ ,  $Mean=71.31$ ,  $SD=7.736$ . Group 2 had  $N=36$ ,  $Mean=68.08$ , and  $SD=8.012$ . No significant difference between the two groups was found ( $t=.977$ ;  $df=42$ ;  $p=.334$ ).

Hypothesis two suggests that therapy will have a different impact on the family depending upon how much focus is placed on increasing parental power. For the second research question, the group for which the therapist attempted to increase parental power in at least 50% of all sessions (Group 3) was compared to the group in which the therapist did not attempt to increase parental power in at least 50% of all sessions (Group 4) in terms of its pre-test scores on the FES Organization and Control Subtests.

For the Organization subtest, Group 3 had  $N=48$   $Mean=45.15$ , and  $SD=13.767$ . Group 4 had  $N=14$ ,  $Mean=51.29$ , and  $SD=13.767$ . No significant difference between the two groups was found ( $t=-1.479$ ;  $df=60$ ;  $p=.144$ ).



For the Control subtest, Group 3 had N=48, Mean=56.02, and SD=9.606. Group 4 had an N=14, Mean=57.64, and SD=8.509. No significant difference between the two groups was found ( $t=-.569$ ;  $df=60$ ;  $p=.571$ ).

### *Hypothesis Testing Results*

#### *Analysis 1: Elevating the Scapegoated Child*

A one way ANOVA was conducted to assess the effect of focusing on elevating the status of a scapegoated child on parental reports of their child’s behavior. The group of families for which the therapist focused on elevating the scapegoated child in at least half of all sessions (Group 1) was compared with the group of families for which the therapist did not attempt to elevate the scapegoated child in at least half of all sessions (Group 2) on the Child Behavior Checklist Total Problems change score. The ANOVA procedure in the SPSS statistical package was used to perform this analysis.

*Table 7. ANOVA for Effect of Elevating Scapegoated Child on CBCL Total Problems Change Score*

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<u>Source</u>	<u>SS</u>	<u>df</u>	<u>MS</u>	<u>F</u>	<u>Significance</u>
Between Groups	.081	1	.081	.001	.97
<u>Within Groups</u>	<u>2439.556</u>	<u>42</u>	<u>58.085</u>		
Total	2439.636	43			

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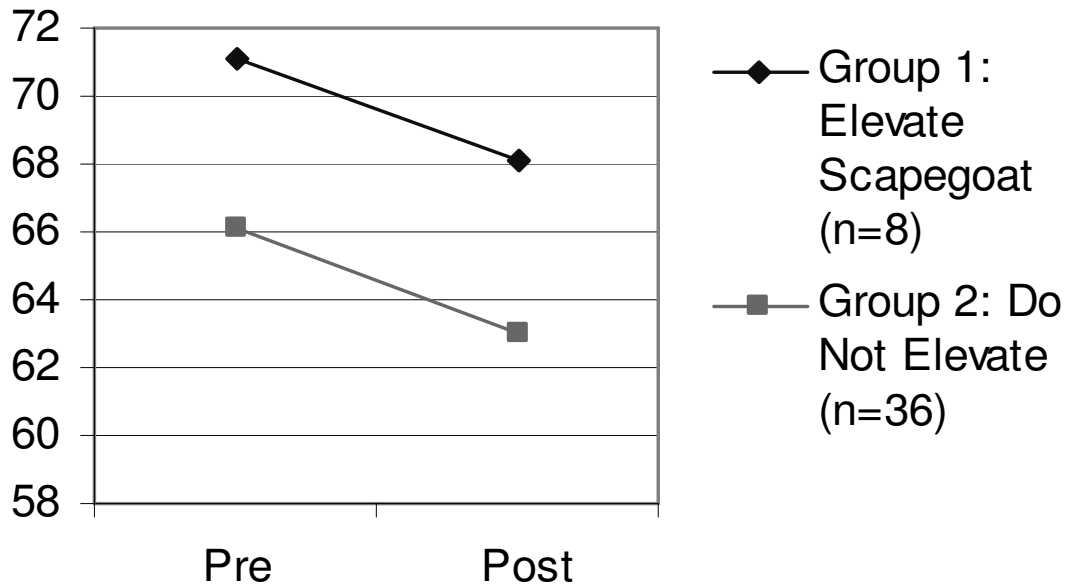
Table 7 does not show a significant interaction between groups on the CBCL Total Problems change score. This means that the two groups did not show significantly different patterns of change from pretest to posttest. This is important because it suggests that improvements in behavior ratings were not related to the proportion of sessions in which the therapist attempted to elevate a scapegoated child. It should be noted that a paired sample T-test revealed that there was a statistically significant overall treatment effect showing that scores on the Total Problems Scale improved from pre test to post test ( $t=4.483$ ;  $df=43$ ,  $p=.000$ ). According to Cohen (1988), this treatment effect had a medium effect size ( $d=.60$ ), but does not meet the criteria for a clinically significant effect size—as suggested by Kendall and Grove (1988), because the mean difference from pretest to posttest (5.11) is less than one standard deviation (10.00).

Figure 4 shows the pattern of change for the two groups. Both groups started at similar pre-test scores and dropped at a similar rate, suggesting that the intervention led to a reduction in parental perceptions of child behavior problems, but a change that did not depend on the therapist's focus on elevating the scapegoated child.

#### *Analysis 2: Increasing Parental Power*

One way ANOVAs were conducted to assess the effect of focusing on increasing parental power on family reports of organization and control. The group of families for which the therapist focused on increasing parental power in at least half of all sessions was compared with the group of families for which the therapist did not attempt to increase parental power in at least half of all sessions on the Organization and Control Scales of the Family Environment Scales (FES). The ANOVA procedure in the SPSS statistical package was used to perform these analyses.

Figure 4. Changes on Total Problems Scale of CBCL (n=44)



Note: Higher scores indicate greater levels of problem behavior

Table 8

*ANOVA for Effect of Increasing Parental Power on FES\_Organization and Control Scale Change Scores (n=62)*

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Source	SS	df	MS	F	p
Organization					
Between Groups	35.841	1	35.841	.407	.526
Within Groups	5289.177	60	88.156		
Total	5325.177	61			
Control					
Between Groups	422.581	1	422.581	4.74	.033*
Within Groups	5348.774	60	89.146		
Total	5771.355	61			

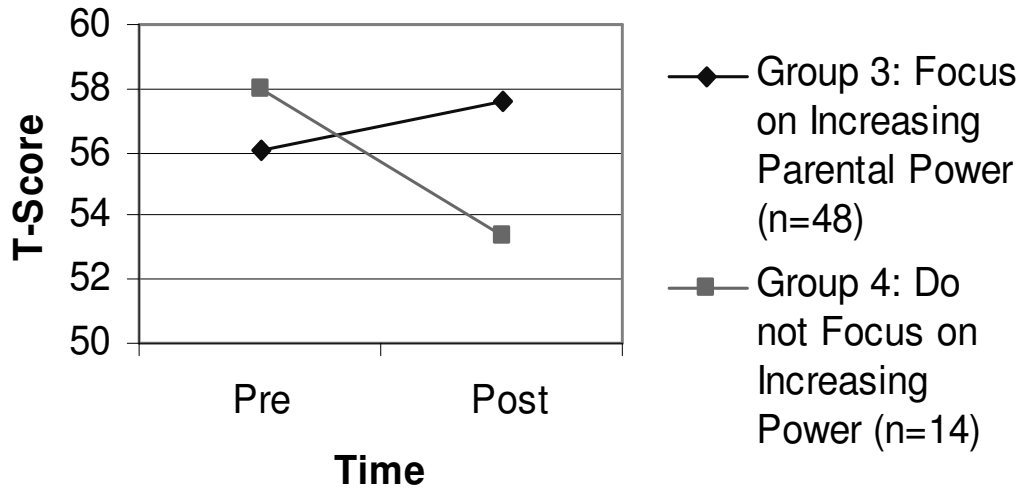
\* significant at  $p < .05$

Table 8 does not show a significant between groups effect when looking at the change score on the FES Organization scale, indicating that the change in the FES Organization scale was not significantly different for the two groups. This means that from pretest to posttest, the two groups did not show statistically significant differences in their patterns of change. This indicates that changes in parental perceptions of family organization did not vary according to the proportion of sessions in which the therapist attempts to increase parental power.

Table 8 shows a significant between groups effect, indicating that the change in the FES Control scale was different for the two groups. This means that from pretest to posttest, the two groups show statistically significant differences in their patterns of change. This is important because it indicates that changes in parental perceptions of family control vary according to the proportion of sessions in which the therapist attempts to increase parental power. Using the Cohen's *d* method of evaluating effect size,  $d=.625$ . According to Cohen (1988), this would indicate that there is a medium sized effect of the proportion of sessions focused on increasing parental power on the change in scores of the Control subscale of the FES. The differences between the two groups are not clinically significant according to Kendall and Grove (1988), because neither group changes as much as one standard deviation (10 points) on the average T-Score.

Figure 5 illustrates the different patterns of change in the FES Control score. Figure 5 shows that the change in T-score for Group 3 was significantly more positive than was the change in T-score for Group 4.

**Figure 5.** Changes on FES Control Scale (n=62)

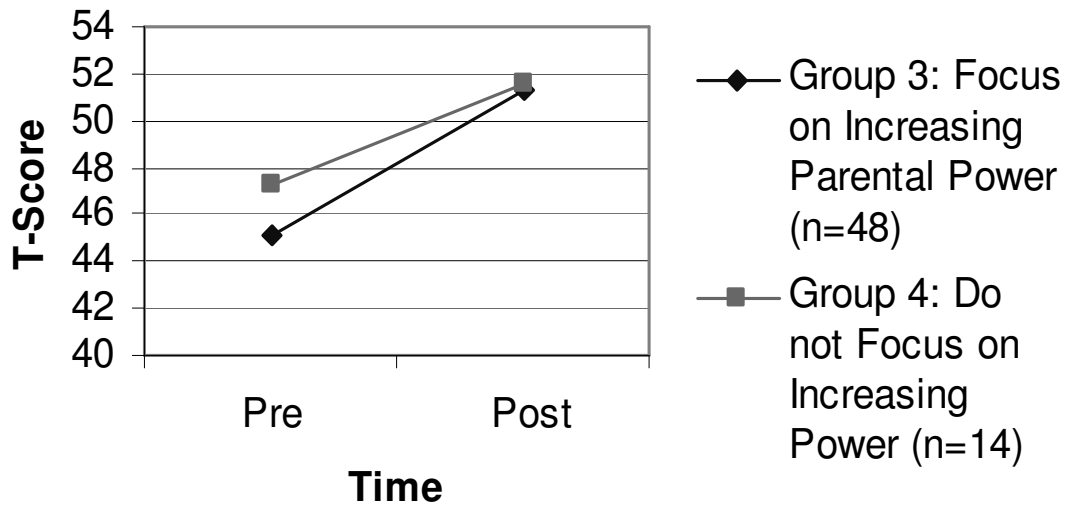


Note: Higher score indicates higher degree of family control

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Figure 6 illustrates the patterns of change for the two groups. It shows that the group of families for whom the therapist attempted to increase parental power in at least 50% of all sessions (Group 3) reported a similar degree of family organization at pretest and posttest than did the group of families for whom the therapist did not attempt to increase parental power in at least 50% of all sessions (Group 4). Paired sample t-tests revealed that neither group made a statistically significant change from pretest to posttest (Group 3:  $t=-1.5$ ,  $df=47$ ,  $p=.14$ ; Group 4:  $t=-.131$ ,  $df=13$ ,  $p=.897$ ), and a oneway ANOVA revealed that their changes were not significantly different from one another ( $F=.407$ ;  $df=1,61$ ;  $p=.526$ ).

**Figure 6.** Changes on FES Organization Scores (n=62)



Note: Higher score indicates higher degree of family organization

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## Chapter 6

### Discussion

The primary purpose of this study was to determine whether the effectiveness of family therapy treatment, as measured by parental perceptions of their children and family, was influenced by the proportion of sessions in which the therapist pursued a particular structural goal. Family therapy research to date has provided evidence that structural family therapy work is helpful for a number of populations (Raymond, et al., 1993; Szapocznik, Rio, Murray, et al., 1989; Barkley, Guavremont, Anastapolous, & Fletcher, 1992; Liebman, Minuchin, & Baker, 1974), but there is a lack of research that examines the questions, “What makes structural family therapy work, and what makes it work better?” (Horne, 1999; Hohmann-Marriott, 2001) The current study addresses a gap in the literature by attempting to connect specific processes with particular therapeutic results.

This discussion will examine how a therapist’s focus on elevating a scapegoated child or increasing parental power influences family therapy effectiveness. It will then examine the limitations of the current study and provide recommendations for future research. Finally, this section will discuss how the current study contributes to family therapy research and practice.

#### *Effects of Elevating Scapegoated Child*

The first research question in the current study looked at whether the effectiveness of family therapy, as measured by parental reports of change in total problems of an identified child, is influenced by the therapist’s focus on attempting to elevate the status of a scapegoated child within the family. It was hypothesized that Group 1, (cases in



which the therapist attempted to elevate the status of a scapegoated child in at least half of all sessions), would show a more positive change in parental reports of a child's total problems than Group 2, (cases in which the therapist did not attempt to elevate the status of a scapegoated child in at least half of all sessions). This study failed to show that there was a statistically significant effect of focusing on elevating the status of a scapegoated child on changes in parental reports of externalizing and internalizing problems. The results showed that parents reported a statistically significant reduction of total problems for their child from pre-test to post-test regardless of whether the therapist attempted to elevate the status of the scapegoated child. These differences were of a medium effect size but not clinically significant. The improvements for Groups 1 and 2 were not statistically different from one another.

There are several possible rationales for the above result. One possibility is that the therapists made wise decisions about when to focus therapy on elevating the status of a scapegoated child. As Aponte (1974) noted, structural therapy should be organized around the family's problems and their structural bases. It may be that for the 8 families in Group 1, the family detoured conflict through the scapegoated child, and it was the focus on elevating the scapegoated child that produced the improvement in behavior. For the 36 families in Group 2, on the other hand, the family may have had very different problems and structural bases for these problems. As a result, the therapist may have appropriately chosen to use another intervention instead—producing similarly successful results.

Another possible rationale for the findings in this study was that structural family therapy is effective in helping to improve parental ratings of their child's total problems,

but the focus on elevating the scapegoated child was not the therapeutic process that caused the change. Instead, there might have been some other process that produced this change. It might be that the child simply responded to greater involvement from the parent or parents. The change also might have been brought about by the fact that the child saw that his or her behavior was a concern for the family. In other words, the presence or absence of a focus on elevating the scapegoated child could have been inconsequential for family therapy effectiveness.

Structural family therapy texts (Minuchin, 1974; Minuchin & Fishman, 1981) and research studies (Raymond, et al., 1993) have provided a number of case studies supporting the idea of restructuring the family so that a scapegoated child is given a new position in the family. Prior to the current study, no research has attempted to test whether a focus on elevating a scapegoated child improves therapeutic effectiveness in a quantitative study.

It is important to empirically examine the effect of a therapist's focus on interventions that elevate a scapegoated child because it is very common for structural family therapists to try to make such changes in the family structure when they feel that a family too rigidly adheres to transaction patterns that focus negative attention on a child (Minuchin, 1974). The process of restructuring a family so that the scapegoated child is provided with more positive interactions is not an easy one, and structural family therapists have indicated that it must be approached with great care (Minuchin & Fishman, 1981; Laird & Van de Kemp, 1987; Raymond, et al., 1993). Minuchin and Fishman (1981) noted that the process of elevating the status of a family member has problems associated with it. One problem is that family members often find this

technique different to accept, and may react negatively to the efforts of the therapist. As a result, the therapist must be able to first develop a strong affiliation with the family before challenging their views about family interactions. The other difficulty associated with elevating a scapegoated child is that it requires a skill that can be very difficult for therapists to master. It requires a therapist to move away from an objective, detached interaction style to one in which the therapist actively supports one family member at the expense of others. Raymond and colleagues (1993) viewed videotaped sessions that illustrated this method of intervening when parents detoured their conflict with one another on to the daughter. The authors found that the co-therapists were more likely to join with the family than challenge them in early therapy sessions, but in later sessions the therapists blocked scapegoating of the child and encouraged the parents to resolve their conflicts with one another, rather than focus their frustration on the daughter. The inexperienced family therapists who participated in the current study may not have been as experienced or skilled in the implementation of this technique as those in the study by Raymond and colleagues, leading to the results found in this study.

Because families and therapists were not randomly assigned to each group, there are other factors that might have differed between Groups 1 and 2. It is unclear from the data, for instance, if the therapists for the 36 families in Group 2 did a better job of joining, or establishing a therapeutic alliance with family members, than did the therapists in Group 1. If this were true, it would mean that elevating a scapegoated child could have been one way to improve ratings of a child's total problems, but there are other processes that could have effected changes in the child.

### *Effect of Increasing Parental Power on Family Control and Organization*

Some of the most influential writings in structural family therapy (Aponte & Van Deusen, 1981; Minuchin, 1974; Minuchin & Fishman, 1981) suggest that many difficulties occur in a family when parents lack the power to maintain authority within the family. This often occurs when one or both parents are disengaged from their roles as authority figures (Minuchin, 1974). Structural family therapists have long argued that parental disengagement can lead to a lack of organization or predictability in family roles or rules (Minuchin, et al., 1967). When structural therapists observe such problems in a family, one of the most common goals in therapy is to encourage greater involvement on the part of the disengaged parent, and to support that parent in their assertion of power within the family (Minuchin, 1974; Minuchin & Fishman, 1981; Aponte & Van Deusen, 1984).

The second research question of the current study looked at whether the effectiveness of family therapy, as measured by change in parental reports of Family Control and Family Organization, was influenced by the therapist's focus on attempting to increase parental power within the family. Family Control, as measured by the FES, was operationally defined as the degree to which set rules and procedures are used to run family life (Moos & Moos, 1994). Family Organization was operationally defined by the FES as the degree of importance of clear organization and structure in planning family activities and responsibilities (Moos & Moos, 1994).

It was hypothesized that there would be a more positive change in parental reports of family control when the therapist focused on increasing parental power within the family than when the therapist did not focus on increasing parental power. Group 3

(cases in which the therapist focused on increasing parental power in at least 50% of all sessions) was compared to Group 4 (cases in which the therapist did not focus on increasing parental power in at least 50% of all sessions) in terms of change from pretest to posttest on the FES Control subscale.

The results of this study provided support for the hypothesis that structural family therapy had a more positive impact on parental reports of family control when the therapist focused on increasing parental power in at least half of the therapy sessions. A more positive change in parental reports of Family Control was found for Group 3 than for Group 4. The difference in the change between the two groups was statistically significant, with a medium effect size. The difference was not found to be clinically significant, however. Such findings provided some support of structural family theorists that recommend supporting disengaged parents in their efforts to become more involved and more directive within the family (Minuchin & Fishman, 1981). One of the goals in such interventions is to help families gain greater predictability in terms of family rules and expectations (Minuchin & Fishman, 1981; Minuchin, 1974). Because the FES Family Control scale was operationally defined as the degree to which set rules and procedures are used to run family life (Moos and Moos, 1994), structural theory would suggest that greater therapeutic focus on increasing parental power would be associated with more positive change in Family Control.

It also was hypothesized that there would be a more positive change in parental reports of Family Organization when the therapist focused on increasing parental power within the family than when the therapist did not focus on increasing parental power. Group 3 (cases in which the therapist focused on increasing parental power in at least

50% of all sessions) was compared to Group 4 (cases in which the therapist did not focus on increasing parental power in at least 50% of all sessions) in terms of change from pretest to posttest on the FES Organization subscale. The findings of this study did not support the hypothesis that structural family therapy had a more positive impact on parental reports of family organization when the therapist focused on increasing parental power in at least half of all sessions. This indicated that changes in parental reports of Family Organization were not related to the proportion of sessions in which the therapist focused on increasing parental power. In fact, this study did not find significant changes in Family Organization from pretest to posttest regardless of whether the therapist focused on increasing parental power in half of all sessions.

The lack of support for the hypothesis that Family Organization would a more positive change when the therapist focused on increasing parental power in at least 50% of sessions was surprising. It is possible that the Family Organization scale of the FES takes longer to change than does the FES Control scale. Because Family Control is the degree to which rules and procedures are used in family life, it may be a matter of time before changes in Family Organization (degree of clear organization and structure is present in planning family activities), is observed. Future research might seek to ascertain whether follow up data show differences in Family Organization as a result of a focus on increasing parental power.

#### *Limitations and Recommendations for Future Research*

This study used clinical data, and it has limitations that are related to the methodological issues typical of data collected in clinical settings. The lack of a control group is an important limiting factor in the validity of any pretest-posttest study of

therapeutic outcome (Shadish, et al., 1995). In this investigation, a control group was not used as a comparison group, and conclusions reached in studies without controls are limited (Donovan, 1992). It is important to test hypotheses using clinical data, however, because most “real world” practice of family therapy occurs in clinical settings. Finding indicators of therapeutic change in the clinical setting is important, but conclusions drawn from the current study could be made with more confidence if they were corroborated by studies using control groups.

A specific limitation that arose from the clinical nature of the data was that the groups were not assigned randomly. As a result, the families in the two groups being compared could have been heterogeneous on a number of important characteristics. While t-tests indicated that the groups were not significantly different in terms of race, family type, age, or gender of identified patient, there were a number of possible group differences that could have been important. Families in Group 3 could have been different from families in group 4 on factors such as socio-economic status, receptiveness to treatment, or previous exposure to family therapy. Any of these variables, since they were not controlled, could have contributed to the differential impact of family therapy on Family Control found in this study. Again, future research that tests the hypotheses that were tested in the current study would be particularly useful if a truly experimental design were implemented that used random group assignment.

The current study shared a difficulty in common with a good deal of family therapy research (Shadish et al., 1995; Horne, 1999) in that there was no treatment manual used in this intervention. This made it more difficult to ensure treatment

integrity, because the lack of manualized treatment allowed each therapist to provide a unique version of structural family therapy.

Another limitation of the study was that no attempt was made to match the therapists in each pair of groups. It is possible that there were therapist variables that contributed to the therapist's choice of whether to elevate a scapegoated child or increase parental power, that were not accounted for in this study. Possible therapist variables might have included—willingness to confront parents, beliefs about the causes of misbehavior in children, or understanding of structural family interventions. These therapist variables could have been better controlled for if the study had randomly assigned a focus of treatment for each therapist.

Another possible limitation of this study was its reliance on student therapists. Zaken-Greenberg and Neimeyer (1986) found that student therapists evidenced a greater degree of conceptual and executive skill at the end of a structural family therapy training seminar than they did at the beginning of training. Although the therapists in this study were supervised, it is possible that they did not develop diagnostic hypotheses about structural problems as accurately as more experienced therapists would have. Even if they did make accurate diagnoses, it is also possible that the inexperienced therapist did not provide interventions as effectively as a more seasoned clinician would have. This limitation could have been especially important for research question one, which examined the effectiveness of focusing on elevating a scapegoated child. This can be a difficult technique to master, because it requires the therapist to challenge some firmly held beliefs about the source of a family's problems. Novice therapists may not have been adept at challenging such entrenched family views. So while this study did not find



that focusing on elevating a scapegoated child was the process that produced significant changes in scores on the CBCL, a study using more experienced therapists might produce different results.

The study also suffered from relatively small group sizes for some groups. Group one consisted of only eight families that fit the necessary criteria while group four consisted of only 14 families. Such small sample sizes limited the power of the study and made it more difficult to find statistically significant results. Future research performed with larger numbers of families that fit the criteria for groups 1 and 4 would be beneficial for helping to understand the influence of therapeutic process in structural family therapy.

Another limitation of the study was that the researcher relied on the subjective reports of therapists in order to classify the focus of treatment. The therapists involved in this study may have reported that they focused on increasing parental power or empowering parents, but these reports were not corroborated by an independent observer. O'Sullivan, Berger, and Foster (1984) indicated that it is difficult to use the structural family therapy nomenclature to describe family processes by simply reading case notes about a family. In this study, an outside observer of therapy may have been able to detect sessions where the therapist provided an intervention that the therapist did not put in his or her case notes. Such questions about the validity of the therapist's reports make it more difficult to draw conclusions from the results of this study.

This study also shared a limitation in common with many other family therapy studies, (Horne, 1999) in that the participants were heterogeneous in terms of age, ethnicity, family type, and diagnosis of individual patients. As a result, this study did not shed light upon whether the interventions used were more or less effective due to any of

these variables. Furthermore, the data were collected in the field, by student therapists, over more than 10 years. This led to variance in the data collection, and to missing data. A more persuasive case for the validity of this data could be made with the presence of a more controlled experiment that tests the hypotheses using randomly assigned families and therapists.

Another factor that could be a limitation of the current study is that the wrong variables may have been chosen for study. The processes of elevating a scapegoated child or increasing parental power may cause family changes that are not reflected in the CBCL Problems or FES Organization and Control scales.

Finally, this study lacked information about the quality of interventions. This study would have been more effective in testing structural family hypotheses if assurances were made concerning the quality of therapy provided. There are several ways to address this deficiency in future research studies. Future research could examine whether quality of intervention, as measured by a group of experts, is correlated with treatment efficacy.

#### *Contribution to Family Therapy Research and Practice*

To date, family therapy research has shown that family therapy can improve symptoms of an identified child patient, but there has been little examination of the processes that lead to such improvement (Fonagy, et al., 2002). Obtaining greater information about structural family therapy processes is of vital importance in training new family therapists. There have been calls from researchers and clinicians for emphasis on teaching interventions that have empirical support (Hohmann-Marriott, 2001; Melito, 1988). Process studies such as the current study provide empirical support

not just for the effectiveness of structural family therapy as a whole, but for specific techniques used within family therapy. Process studies can be used to help those who train therapists to better understand what techniques are most useful in teaching structural family therapy, and to help clinicians make better treatment planning decisions.

Despite the limitations noted above, this study makes some important contributions to the small but growing body of literature that focuses on the process of family therapy. This study appears to be among the few to empirically support a link between structural family therapy processes and treatment efficacy (Figley & Nelson, 1990; Laird & Van de Kemp, 1987). Specifically, it suggests that a therapist who is concerned about the degree of control (use of set rules and procedures) within the family should focus on increasing parental power in at least half of all sessions because families changed in a significantly more positive direction when the therapist focused on increasing parental power than when the therapist did not maintain this focus. This has important implications because structural theorists and practitioners have been recommending for several decades that therapists encourage disengaged parents to assert their authority within the family in order to help families gain a greater degree of reliance on rules and procedures within the family (Minuchin et al., 1967, Minuchin, 1974). Such recommendations were based on the belief that greater assertion of parental power was related to a greater sense of predictability and organization in the family (Minuchin, 1974; Minuchin & Fishman, 1981). These theorists have not had an empirical foundation for such recommendations, other than evidence of structural family therapy's overall effectiveness. The current study suggests that a therapist's focus on increasing parental power can have a statistically significant impact on the family's level of control.

Currently, therapists are trained to try to change the family's perception of a child if they are unfairly blaming family problems on the child (Minuchin & Fishman, 1981). This study did not, however, support the theoretical prediction that elevating a scapegoated child is an important factor in improving reports of a child's behavior. As a result, this study challenged a basic supposition of family therapy. It may be that the lack of support for this theory is due to a combination of the methodological limitations described above, but this study suggested that some of the presuppositions of structural family therapy should not go unchallenged. If structural family therapy can lead to improvements in parental reports of their child's behavior without the therapist attempting to elevate the scapegoat, then the wisdom of confronting parental perceptions of their child is not unquestioned. In other words, the reader may look at this study and question whether family therapists should continue the practice of attempting to elevate the position of a scapegoated child within the family unless it is proven that this intervention brings about some benefit for the family that can not be obtained by other means.

The state of structural family therapy research also would be improved by studies that look at how family therapy processes affect other outcome variables. It would be helpful to examine, for instance, whether there are specific interventions in structural family therapy that affect how a husband and wife rate their relationship with each other, or how they view each other's parenting skills. It also would be helpful to pay attention to the way children perceive change within the family, and how this is related to therapeutic process. Future research might also compare the effectiveness of structural

family therapy to other forms of therapy in order to make better decisions about when to choose a particular form of therapeutic intervention.

### *Summary*

This study was unusual in that it addressed the question of how structural family therapy works, not just whether it works. The results provide evidence that a focus on increasing parental power played an important role in how structural family therapy affected a family's perception of control in the family. The study did not provide evidence that a similar focus of therapy played a significant role in changing the family's perception of its level of organization. Finally, the results of this study did not provide evidence that a therapist who focused on elevating a scapegoated child in at least half of all sessions was likely to obtain greater improvements in parental ratings of the child's behavior than would a therapist who did not focus on elevating the status of a scapegoated child. There is evidence that therapy had an overall positive effect on the child's behavior, but this change was not related to the focus on elevating a scapegoated child.

The current study offered clues to help gain a better understanding of the specific therapeutic processes that influenced the effectiveness of family therapy. This is an important endeavor because process research is vital for helping to make therapists more effective in treating their clients. The conclusions that can be drawn from this study, however, are tentative due to the clinical nature of the data and to the limited sample size of some of the groups. Future research concerning therapeutic process will not only enrich existing theory, but will also help children and their families in practical and meaningful ways.

## Appendix A

### FES Protocol

1. Family members really help and support one another.
2. Family members often keep their feelings to themselves.
3. We fight a lot in our family.
4. We don't do things on our own very often in our family.
5. We feel it is important to be the best at whatever you do.
6. We often talk about political and social problems.
7. We spend most weekends and evenings at home.
8. Family members attend church, synagogue, or Sunday School fairly often.
9. Activities in our family are pretty carefully planned.
10. Family members are rarely ordered around.
11. We often seem to be killing time at home.
12. We say anything we want to around home.
13. Family members rarely become openly angry.
14. In our family, we are strongly encouraged to be independent.
15. Getting ahead in life is very important in our family.
16. We rarely go to lectures, plays or concerts.
17. Friends often come over for dinner or to visit.
18. We don't say prayers in our family.
19. We are generally very neat and orderly.
20. There are very few rules to follow in our family.
21. We put a lot of energy into what we do at home.
22. It's hard to "blow off steam" at home without upsetting somebody.
23. Family members sometimes get so angry they throw things.
24. We think things out for ourselves in our family.
25. How much money a person makes is not very important to us.
26. Learning about new and different things is very important in our family.
27. Nobody in our family is active in sports, Little League, bowling, etc.
28. We often talk about the religious meaning of Christmas, Passover, or other holidays.
29. It's often hard to find things when you need them in our household.
30. There is one family member who makes most of the decisions.
31. There is a feeling of togetherness in our family.
32. We tell each other about our personal problems.
33. Family members hardly ever lose their tempers.
34. We come and go as we want to in our family.
35. We believe in competition and "may the best man win."

### FES Protocol

36. We are not that interested in cultural activities.
37. We often go to movies, sports events, camping, etc.
38. We don't believe in heaven or hell.
39. Being on time is very important in our family.
40. There are set ways of doing things at home.
41. We rarely volunteer when something has to be done at home.
42. If we feel like doing something on the spur of the moment we often just pick up and go.
43. Family members often criticize each other.
44. There is very little privacy in our family.
45. We always strive to do things just a little better the next time.
46. We rarely have intellectual discussions.
47. Everyone in our family has a hobby or two.
48. Family members have strict ideas about what is right and wrong.
49. People change their minds often in our family.
50. There is a strong emphasis on following rules in our family.
51. Family members really back each other up.
52. Someone usually gets upset if you complain in our family.
53. Family members sometimes hit each other.
54. Family members almost always rely on themselves when a problem comes up.
55. Family members rarely worry about job promotions, school grades, etc.
56. Someone in our family plays a musical instrument.
57. Family members are not very involved in recreational activities outside work or school.
58. We believe there are some things you just have to take on faith.
59. Family members make sure their rooms are neat.
60. Everyone has an equal say in family decisions.
61. There is very little group spirit in our family.
62. Money and paying bills is openly talked about in our family.
63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace.
64. Family members strongly encourage each other to stand up for their rights.
65. In our family, we don't try that hard to succeed.
66. Family members often go to the library.
67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school).

#### FES Protocol

68. In our family each person has different ideas about what is right and wrong.
69. Each person's duties are clearly defined in our family.
70. We can do whatever we want to in our family.
71. We really get along well with each other.
72. We are usually careful about what we say to each other.
73. Family members often try to one-up or out-do each other.
74. It's hard to be by yourself without hurting someone's feelings in our household.
75. "Work before play" is the rule in our family.
76. Watching T.V. is more important than reading in our family.
77. Family members go out a lot.
78. The Bible is a very important book in our home.
79. Money is not handled very carefully in our family.
80. Rules are pretty inflexible in our household.
81. There is plenty of time and attention for everyone in our family.
82. There are a lot of spontaneous discussions in our family.
83. In our family, we believe you don't ever get anywhere by raising your voice.
84. We are not really encouraged to speak up for ourselves in our family.
85. Family members are often compared with others as to how well they are doing at work or school.
86. Family members really like music, art and literature.
87. Our main form of entertainment is watching T.V. or listening to the radio.
88. Family members believe that if you sin you will be punished.
89. Dishes are usually done immediately after eating.
90. You can't get away with much in our family.

Source: Family Environment Scale Protocol by Moos, R.H., & Moos, B.S. (1986)



Appendix B  
 FES Profile Sheet  
 FES PROFILE

**SOCIAL CLIMATE SCALE PROFILE OF**

CHECK SCALE USED: \_\_\_\_\_

CES WAS \_\_\_\_\_ COPEs \_\_\_\_\_ URES \_\_\_\_\_ CIES \_\_\_\_\_ MEI \_\_\_\_\_ WES \_\_\_\_\_ FES \_\_\_\_\_ GES \_\_\_\_\_

CIRCLE FORM USED: R S E I

NORM GROUP \_\_\_\_\_

DATE \_\_\_\_\_

OTHER \_\_\_\_\_

COMMENTS: \_\_\_\_\_

100																					
90																					
80																					
70																					
60																					
50																					
40																					
30																					
20																					
10																					
S/S																					
Scale																					

Standard Scores

Standard Scores

Scales Developed by Rudolf H. Moos and associates.  
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## Appendix C: Consent Form



COLLEGE OF EDUCATION  
THE UNIVERSITY OF TEXAS AT AUSTIN

Department of Educational Psychology • George I. Sánchez Building 504 • Austin, Texas 78712-1296  
(512) 471-4155 • FAX (512) 471-1288 • E-Mail: [edpsych@uts.cc.utexas.edu](mailto:edpsych@uts.cc.utexas.edu) • Campus Mail Code D5800

### **Notice of Confidentiality**

I understand that the information disclosed by myself or other family members while participating in the Family-School Assessment and Intervention Program will remain strictly confidential. This means anything that is discussed between members of your family and your student therapist will not be shared with persons outside of the Family Intervention class (i.e., Dr. Carlson, the teaching assistant, and enrolled students) without your written consent.

I further understand that the student therapist working with my family is enrolled in a professional training program, and as part of that training pertinent information regarding my family may be shared only with other student therapists in the program as well as with the supervising psychologist, unless I have otherwise authorized.

In addition, I acknowledge that I have been informed that this confidentiality will be violated only under the following conditions:

- 1) If I or other family members disclose information which indicates harm or the intent to harm myself or others.
- 2) If I, other family members, or any other person outside the family (e.g., school personnel) discloses information of alleged child abuse.
- 3) If I or other family members disclose information indicating unethical or illegal behavior on the part of a mental health professional with whom we have had a past or current relationship.

Date: \_\_\_\_\_

Family Members' Signatures

Witness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Appendix D: Exchange of Information Form



COLLEGE OF EDUCATION  
THE UNIVERSITY OF TEXAS AT AUSTIN

*Department of Educational Psychology • George I. Sánchez Building 504 • Austin, Texas 78712-1296  
(512) 471-4155 • FAX (512) 471-1288 • E-Mail: edpsych@uts.cc.utexas.edu • Campus Mail Code D5800*

### EXCHANGE OF INFORMATION AUTHORIZATION

I have agreed to participate in the Family-School Assessment and Intervention Program under the direction of Dr. Cindy Carlson at The University of Texas at Austin in the Department of Educational Psychology. In order to facilitate our participation in the Family Intervention Program, I give my written permission for \_\_\_\_\_ to exchange information regarding my child, \_\_\_\_\_, and family with Dr. Carlson and the training staff of the Family Intervention Program.

I understand that both parties will treat this information in a confidential manner and will not release it to anyone else without my further written permission. I further understand that I may withdraw this authorization at any time by written request, otherwise this permission will expire in 6 months. I also certify that if the above-named person is a minor child, I have the legal right to grant this authorization.

Name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Relationship to Child: \_\_\_\_\_

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## VITA

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