

A FOLLOW-UP STUDY OF FAMILY GROUP THERAPY

The case study method was used to follow-up eighteen families who had experienced treatment at the Burnaby Mental Health Centre, Burnaby, B.C. from April 1, 1964 to March 31, 1965

by

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### ABSTRACT

Family Group Therapy has in the past ten years gained much notice in the field of Mental Health, especially in the treatment of children. However, despite the fact that much family group therapy has been done, little research into the results or lasting effects has been carried on. This study hoped to explore some of the effects of family group therapy on a particular group of families from which a random sample was taken. They were seen at the Burnaby Mental Health Centre, over a period of one year.

In family group therapy the approach is radically different from that of individual therapy with an identified patient. The whole family is seen together with an emphasis on total family functioning. Therefore, in our follow-up study we designed our questionnaires and data analysis to include the entire family equally with no emphasis on any particular member.

In designing our questionnaire we chose the six areas of family functioning considered most important, both by the therapists and the theorists, in the field of family group therapy. In each of these areas changes in the families' perception of their own functioning was elicited. To determine the reliability of our results a reliability test originally designed by Kerckhoft was used in the areas of husband-wife task sharing and role relationships.

We then compared the results of our questionnaire and Kerckhoft reliability test with four independent variables. These variables including socio-economic class, family type, number of interviews, and therapists' impressions.

In two variables particularly, the socio-economic class and the number of interviews, we found a relationship between the results of our questionnaire and the variables.

We experienced difficulties in obtaining a suitable sample to interview. Only eighteen families agreed to be interviewed for the purposes of this study, from a total of fifty-four families contacted. For that reason a superficial study is also done of those families who refused to be interviewed.

As our sample was found to be not really representative of all families seen in family group therapy it is rather premature to draw any real conclusions from our study. However, it is possible to say that family group therapy did seem to effect changes in a number of the families interviewed.

### ACKNOWLEDGEMENTS

Through the good offices of the agency Director, Dr. Kenneth Davies, and the Supervisor of Social Service, Mr. Donald Ricketts, the full resources of the Burnaby Mental Health Centre were made available to this research project. Arrangements were made so that we were given full access to any file information we needed. Dr. K. Davies and Mr. D. Ricketts were of further assistance to the researchers by sending a letter to our whole sample notifying the families that they would be contacted. Many of the staff, both professional and clerical, displayed a concern about and interest in the goals and method of this project.

The staff not only co-operated fully and willingly, but offered many useful suggestions which were subsequently incorporated in the study.

Special gratitude is hereby expressed to Dr. Richard Davis, Mr. Angelo Tessaro, and Mr. Sonny Zimmerman, the therapists from whose caseload we drew our full sample, and without whose co-operation the study could not have taken place. They also contributed their time in supplying us with their impressions on all the cases we studied.

Mrs. Vivian Ellis, Casework Supervisor at the Burnaby Mental Health Centre, who is in the process of conducting a longitudinal study of families seen by the same therapists, gave the researchers her added support.

We would also like to express our gratitude to Miss Margaret Towers, Public Health Nurse on the family group therapy team, for her work in gathering together the names which made up our sample and to Mr. Robert McCallum, Burnaby Mental Health Centre Business Manager for his co-operation.

We would also like to acknowledge the special interest and co-operation expressed in our project by the Intake Team of the Children's Clinic at the Burnaby Mental Health Centre.

We also acknowledge the eighteen families who gave of their time to take part in this study.

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## CHAPTER I

### THE PROBLEM

#### Areas of Inquiry.

A review of the literature on family group therapy indicates that very little research has been carried on theoretically or practically.<sup>1</sup> First, there is a lack of systematized surveys investigating the general validity of family group therapy as a treatment process (i.e. follow-up studies, comparative studies, etc.). In other words the question remains - does family group therapy in fact attain the treatment goals or aims which its theorists and practitioners establish for this approach? Secondly, what are the immediate or long term results in family behaviour produced on the part of the therapist? If there are immediate changes noticeable, are the changes of any real or permanent significance?<sup>2</sup> In other words, to what degree can changes be effected, for how long? In addition, what happens to other members of the family when one member improves or when the family homeostasis is upset?<sup>3</sup>

The investigation of more specific questions could help the practitioner in treatment planning. For example,

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<sup>1</sup>Weakland, John H. "Family Therapy as a Research Arena," Family Process, Vol. 1, No. 1, March, 1962, pp.63-68.

<sup>2</sup>Ibid., p. 68.

<sup>3</sup>Ibid., p. 68.

are there certain instances in which family group therapy can be used in various combinations with other forms of treatment, such as milieu therapy, individual treatment, play therapy, multiple impact therapy, and so forth?

Another way of examining treatment combinations would be to determine the desirability of having the parents remain in treatment after the child terminates or vice versa.

In relation to these questions, what is the relative effectiveness of family group therapy with regard to crisis-intervention, long term treatment goals, symptomatic relief, or basic behaviour pattern changes? Related to this, is information for the practitioner with regard to the determination of the optimal point of closure in treatment, and the desirability for follow-up.<sup>1</sup> There is also a need to inquire into controversial issues regarding techniques of treatment. Of the various "schools of family group therapy," which techniques or combinations of techniques prove more successful for specific problems?<sup>2</sup>

The above questions are all focused on the nature of

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<sup>1</sup>In discussion with Mr. S. Zimmerman, Mr. A. Tessaro, and Dr. D. Davis, members of a family group therapy treatment team at the Burnaby Mental Health Centre, it was revealed that there is some question as to what constitutes criteria for the optimal time of closure. One member of this team favours using this treatment method for crisis intervention, and holding subsequent follow-up sessions at the client's own initiative. Others strive to help the family achieve a certain level of awareness of family processes.

<sup>2</sup>In discussion with above mentioned treatment team it was determined that each member leaned toward a different school of practice. One member followed the "Bell school" almost exclusively, while the others practised different variations of orientations tending to rely a little more heavily on the "Satir method" of Conjoint Family Therapy.



the treatment. There are further important factors to be learned about attributes of the family members which are relevant for treatment success. Some of these attributes include category of diagnosed pathology, family structure, socio-cultural classification, family size, and age range of family members.<sup>1</sup> It is generally considered a tendency that lower class families do not communicate verbally as freely as higher classes and that they are more authoritarian. Would this imply that they would be in greater need of this type of treatment which stresses freer flow of communications on a relatively democratic basis, or does it mean that these families would not respond as well to this form of treatment? There have been some impressions by practitioners that multi-problem families, families with an older delinquent, families with schizophrenic members, and families with a foster child may not respond as well to treatment as do families whose identified problem is of a different nature.<sup>2</sup> Similarly, as in other forms of treatment there is the question of the characteristics of the therapist's personality which effect the treatment process.

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<sup>1</sup>Dr. J. E. Bell, while addressing a symposium at the BMHC in 1964, stated that the lower age limit for children taking part in family group therapy effectively was generally around ten years of age. In addition, Dr. Bell implied that this form of treatment may be effective in a wide range of pathology.

<sup>2</sup>In discussing this matter with the family group therapy team at the BMHC it was found that impressions differed as to which family types were more difficult to treat. One member felt he had better success than other practitioners with one parent families, while another felt he could deal more effectively with families with an older delinquent. However, all members felt that multi-problem families and families with schizophrenic members were most difficult to treat.

What are the effects of the therapists age, appearance, sex, and/or behavioural mannerisms, on the dynamics of interaction in therapy?<sup>1</sup>

Extended research in this field would hopefully aid the therapist in refining his techniques. How best can the interview structure benefit the treatment process? This would include such questions as home versus office interviews,<sup>2</sup> the use of co-therapists,<sup>3</sup> and various other interview aids. An example of the latter would be the use of tape-recordings. It has been suggested by some practitioners that allowing families to listen to play-backs of their interviews on tape provides them with the opportunity to recognize certain communication patterns they would not recognize while the immediacy of their interaction is ego-syntonic. The scope for research on techniques is infinite. Such practical questions arise as; degree of the use of interaction between family members, the degree of therapist participation, the use of confrontation, and so on.

Finally, research findings are not limited to

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<sup>1</sup>In discussion with the family group therapy team it was speculated that the therapist must be sufficiently aggressive but not hostile, see Frances L. Beatman, Sanford N. Sherman, and Arthur L. Leader, "Current Issues in Family Treatment," Social Casework, Vol. 47, No. 2, February, 1966, p. 79.

<sup>2</sup>Home visits are thought by the treatment team to be useful with resistant patients, but they have the disadvantage of interruptions by phone calls, small children, and so on. In general it was felt the office interview was superior because the practitioner's role of authority in that setting affords him more control of the interview.

<sup>3</sup>The treatment team finds that co-therapists help with the more difficult families, but as a rule they preferred interviewing alone.

practical applications. The advancement of theory with regard to etiology of pathology often benefits from 'post posteriori' deductions derived from observations of interaction and change agents in behaviour. For example, in the etiology of schizophrenia there has been the theoretical assumption that certain forms of communication patterns in the family ("double-bind" messages, and so on) bring about schizophrenic responses. It would logically follow then that methods of correcting these faulty communication patterns could alleviate or prevent the condition of schizophrenia. Failure to do so would cast some doubt on theory of causation, bringing about modifications in theory.

Research in family group therapy has wide implications for social welfare policy. Community policy makers may use the preliminary research findings as indicators for the direction of more comprehensive and extensive studies. One such agency to undertake research is the Community Chest and Council, but in addition, government sponsored agencies might employ more full-time researchers to initiate and direct specific projects.<sup>1</sup> At present, research is a secondary consideration being left locally mainly to students completing their social work training. Through governmental sponsoring, larger, more longitudinal studies can be organized and initiated in this area.

Should this treatment technique prove effective, then the question would arise as to whether there is a need to

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<sup>1</sup>Mr. D. Ricketts, Director of Social Service at BMHC, was most helpful for his co-operation in discussing policy and administrative procedures.

determine the quality of workers trained in family group treatment to be employed by social welfare agencies. Thus, opportunities may need to be provided through agency sponsored institutes and/or in-service training. (To the researcher's knowledge this has already been initiated by the Provincial Probation Service, Burnaby Mental Health Clinic, and Vancouver Family Service Agency). In relation to the nature and extent of required training, policy may have to be revised to incorporate the appropriate programs in Schools of Social Work curricula. Is the responsibility then to rest with the agencies, with the provincial government, or with the School of Social Work? This leads into another question having to do with the staffing of agencies. Because of the specialized nature of these skills, it may be imperative to upgrade incentive. One such proposal has been made to the provincial government to provide a new category of senior practitioner. For example, smaller agencies will not have supervisors qualified to oversee family therapists' work. In addition, the latter's greater degree of specialized training may warrant higher incentives.

Agency policy makers could use information gained through further investigation of this form of treatment. First, knowledge of the effectiveness of family group therapy would help in decision-making with regard to the intake process of an agency. Thus, disposition of incoming cases could be made more efficient, utilizing the maximum effectiveness of the practitioner's use of time. There have been some impressions by practitioners that in certain cases,

these techniques require a shorter stay in treatment. Secondly, agency staffing will require knowledge of training requirements in recruitment of personnel. The agency will need to be aware of the training specifications most effective for their particular program. Certain schools of family group therapy may seem more desirable than others for a particular agency orientation, for certain clientele, and for particular problems dealt with.

If firmly established principles can be derived from ongoing studies, the community at large would benefit from educational programs derived from the knowledge gained. Doctors, education counsellors, clergy, lawyers, social agencies and a host of other referral agents could be made aware of the critical factors in family functioning which would require attention at an agency offering family group therapy as a treatment program. Similarly, widespread knowledge of this form of treatment could be communicated to potential client groups in the community. There are some indications that at the onset of treatment in family group therapy the family is alienated by their unfamiliarity with this approach. Possibly this negative "interviewee set" may explain why drop-outs are particularly high during the initial stages of treatment.<sup>1</sup> Particularly sound knowledge would be needed before an educational program of this

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<sup>1</sup>In discussion with Mr. D. Ricketts, Social Service Director of the BMHC, it was speculated that the alleged "ego assaultive" elements of family group therapy may be in fact due to familiarity the client has with traditional techniques associated with individual psychotherapy. These impressions can be gained through movies, television, literature, heresay, and so on.

type is inaugurated, in order to avoid misconceptions built around a "mystique" associated with half-truths about family group therapy as seems to have been the case with psycho-analysis. Hence, if agencies specializing in family group therapy were set up within the community or if treatment units within other community services were to offer this treatment, families who recognize that they have a problem treatable by these techniques could apply for treatment directly, as people now do for marital counselling.

Finally, we can speculate that research within this area could benefit other disciplines using these techniques. Questions raised by Social Work research in family interaction can be of some use to communications theorists studying communications patterns; it could be used by social psychologists and sociologists studying small group interactions; it may be useful to psychiatrists concerned with pathological process; educators interested in the effects of family relationships on learning behaviour; psychologists in furthering personality theory, and so forth. The above indicates the many ramifications of this basic problem. The next task is to focus this research project on those aspects to which it is addressed.

#### The Problem for Research.

As can be seen from the foregoing discussion there are several possible research problems growing out of the use of family group therapy as a treatment technique in social work practise.

We felt that a major problem for research at this

point was the evaluation of the extent to which family group therapy does or does not result in improved (bring about a change) family functioning. In an area where little or no research exists, the question of whether or not family group therapy is effective in producing change seems of vital importance (as a first step in research).

The most conclusive way to answer this question would be to conduct a full-scale experimentally designed study, using a control group, and rating the groups as to "family functioning" before, during, and after treatment. We felt this was not possible, for at least two reasons: (1) the time and facilities at our disposal do not permit us to conduct a study of this kind; (2) a field which as yet has had limited development is not prepared for elaborate experimental designs to test abstract hypotheses.<sup>1</sup> For these reasons we have chosen to do a follow-up study of an exploratory (formulative) nature, in which we have explored the client's own perceptions of change, or no change in family functioning following family group therapy, and the extent to which changes, if any, are associated in the client's mind with their having received family group therapy. These perceptions we have compared with: (1) the family group therapists' perceptions and rating of change at the time of case closing; and (2) our own impressions of family functioning at the time of our follow-up interviews.

We feel there are some advantages to this kind of approach, and that the study will have something to contribute

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<sup>1</sup>Polansky, N. A. (ed.), Social Work Research, University of Chicago Press, Chicago; 1960, p. 51.

to the understanding of the social work problem.

On a broad basis, we feel that our study points up the whole question of the feasibility of a follow-up study in the area of family group therapy. The discussion of practical problems with which we have had to deal, such as: (1) the attitudes of clients towards participating in a follow-up study; (2) the reliability of the information obtained; (3) the amount of planning and preparation needed to conduct the study; and (4) the problem of who to include in the study, (e.g. whether to include those who have had only one interview), should be helpful to persons who are considering similar studies. Knowledge of potential difficulties in follow-up studies of family group therapy should also prove useful to practitioners in deciding whether or not families who may be contacted for follow-up purposes at a future date should be prepared for this possibility at the time of termination.

The study provides some preliminary information on three of the key problems relating to family group therapy which should be useful to practitioners, agencies, and future researchers. Firstly, it provides preliminary information upon what aspects of family life family group therapy has an effect. Secondly, with regard to the problem of whose criteria should be given the most weight in assessing outcome: (1) those of the therapist; (2) the recipients of the service; or (3) others in the community, this study will provide information on how the first two agree. The third key problem on which it provides some preliminary



information is that of the "drop out" rate. We have concerned ourselves with the question as to whether change occurs less often in the families who "drop out" of treatment as planned. Along these same lines, we have also concerned ourselves with exploring whether a relationship appears to exist between the number of therapy sessions participated in and the degree of changes which take place.

Introduction to theoretical concepts Section:

As family group therapy is a comparatively new field of study there are as yet not many authors on the subject. For our development of the theoretical framework on family group therapy it was decided to confine our discussion to those authors who had the greatest influence on family group therapy as it was practised at the Mental Health Centre. These authors have all participated in developing both the theoretical and treatment aspects of family group therapy and have also worked with a significant number of families. The many other recent authors in the field of family group therapy have not really influenced therapy at the Mental Health Centre to the degree of Satir, Bell, Rabkin, and Hayley have and will therefore only be included in an annotated bibliography.

Virginia Satir<sup>1</sup> has become recognized in the last five years as one of the foremost authorities on family group therapy. She developed, used, and now teaches her own particular form of family group therapy. Although the sample

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<sup>1</sup>Satir, Virginia, Conjoint Family Therapy, Science and Behaviour Books, Inc., Palo Alto, California; 1964.

that we are studying in this project was treated before the publication of Satir's book, she had written several papers and articles which had an influence on family group therapists at the Mental Health Centre. Personal visits of the therapists to Satir and by her to the clinic have strongly re-inforced her influence.

#### Conjoint Family Therapy:

A guide to theory and techniques by Virginia Satir is a point by point compilation of her conceptual approach to family group therapy as well as the actual treatment. The purpose of the book was to present a strong argument about the importance of family group therapy. The book is an impressionistic writing based on the author's personal experiences. She suggests that all types of mental illness may be treated by her method. Satir, to substantiate her claim, puts forth a rationale for family group therapy. Firstly, she feels that the unhappiness or pain felt by one family member is rejected and reacted against by all family members. There is a tendency in this reaction to perpetuate the identified patient's symptoms. The family attempts to achieve some balance and for this concept Satir relies on Don Jackson's term "family homeostasis". This balance is difficult to maintain and requires effort all round. A particular family homeostasis is in the most part characterized by the quality of the marital relationship. The identified patient is the family member who is reacting most obviously to the dysfunctioning marital relationship. As the patient's symptoms do play an important role in

preserving even the pathological family balance it is necessary to treat the whole family as a unit so that along with improvement in symptoms of the identified patient a new family balance can be achieved.

Satir feels that the basic problem lies behind the marital pair. Each enters the marriage hoping to gain something from the other but feeling that they have nothing to give. When the reality of twenty-four hour marriage occurs both partners feel they have nothing to give, therefore get nothing either. As they are getting nothing, disagreement results and communication becomes obscured. Children are unable to react without symptoms to a very confusing situation. Virginia Satir bases much of her therapy on regaining this communication.

She devotes an entire two chapters in her book to communication theory. Communication is the process of giving and getting information but in the process of transmission this information can become very distorted. The goal throughout therapy is to realign the communication so that family members are receiving, sending, and comprehending the total content of any message. Satir, very painstakingly, dissects the verbal injections of each person and clarifies each word and injection as it is said until gradually family members become more aware of the areas of feeling and confusion.

The actual treatment in family group therapy does not actually begin in all cases with all family members present. Usually an assessment of the adults is made first. In this, Virginia Satir differs from J. E. Bell who sees the

family only in a complete group. If the family is assessed and found suitable for family group therapy, then the first one or two interviews usually consists of history taking. The children, through this process, begin to see their parents as people who existed with their own personalities before they were born. After this process she usually begins her study of the families' communication patterns. The re-establishment of meaningful communication plus an increase in feelings of self-esteem are the goals of Satir's work. Through the use of clear communication by family members with high self-esteem, most external and internal crises can be dealt with.

John Elderkin Bell is the most prominent of the early family group therapists in the United States. He was discouraged with the lack of success of individual treatment methods used with adolescents. Dr. Bell's interest in family group therapy stems from Dr. Bowlby's work with adolescents and their families at London's Tavistock Clinic. From this fleeting contact with Dr. Bowlby he developed family group therapy as he practices it today. Bell's methods, developed earlier than Satir's, are different in many respects. However, the basic goal is the same and that is to treat the family not as an assembly of individuals but as a recognized biological and social unit. There are not individual problems (as Satir allows) but only family problems. In "conferences", as Bell calls treatment sessions, the therapist relates to the family and resists any effort on the part of individuals to relate to him as an individual.

Though Bell's basic goal with a family is to improve functioning he comes into treatment with every family ready to help them develop their own goals from their particular cultural matrix. He feels that "the climate offering freedom for the development of the most satisfactory complex of family roles seems to require consciousness by the family of the impact that each member has on each other member."<sup>1</sup> This is actually much the same concept as adopted by Satir in her attempt to have family members clarify completely what each individual intends in every interaction with every other member. Delineation of family roles and expectations therein should be a result of the clarification of family members impact on each other. It is hoped that stereotyped generalizations will be abandoned and replaced by more accurate recognition of various family members' roles. Another goal in Bell's general theoretical outline of family group therapy is to enable the family to recognize their essential unity and mutual "interdependence on each other and on the family as a whole . . . . While this may be thought of as a consequence of the therapy, since for the most part it is to be found in the final stages, it is also true that it is a factor in bringing about the therapeutic progress."<sup>2</sup> By encouraging the family to verbalize the positives as well as the differences Bell hopes to develop these feelings of the family unit.

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<sup>1</sup>Bell, J. E. Family Group Therapy, Public Health Monograph, No. 64, U. S. Printing Office, 1961, p. 5.

<sup>2</sup>Ibid., p. 6.

Bell's actual therapy sessions differ from Satir's. There is not nearly so great an emphasis on verbalization and much emphasis is on non-verbal communication. He is not so concerned with dissecting communication but more in providing insight into the actual behaviour prompting the communication. Bell begins therapy not with a history given by the parents but after a brief introduction he asks the children what changes they would like to see in the family. No matter what these changes are they are discussed in view of possible implementation. Bell, unlike Satir, never sees any family members individually as he considers it essential that the family always be reacted to as a group.

Both Bell and Satir have basically the same goals and the results of treatment are the same but the techniques used differ. A combination of both of these methods with more emphasis on Bell was used at the Mental Health Centre during the time the sample families were treated.

#### Previous Research:

In surveying the literature searching for previous research relative to family group therapy, it is particularly noticeable that there is a lack of research being done in this area. The writings and articles are descriptive in terms of methodology and rationale for the implementation of family group therapy, however, little could be found centering on a follow-up case study of the benefits, changes, improvements, etc., after having been treated in family group therapy sessions. The treatment of an entire family, interviewed together as a group is a new procedure in

psychiatry, although this has been more common in the practice of social work. There have been questions as to when family group therapy appeared on the scene. It is generally held by most practitioners in social work and psychiatry, that it was about a decade ago. However, Haley points out that just when family therapy originated is difficult to estimate because the movement has largely been a secret one.<sup>1</sup> Only until most recently therapists who treat whole families have not published on their methods, and their studies are relatively rare. The secrecy about family therapy has two sources, according to Haley, which are:

1. "Those using this method have been too uncertain about their techniques and results to commit themselves to print, and,
2. there has been apparently a fear of charges of heresy because the influence of family members has been considered irrelevant to the nature and cure of psychopathology in a patient."<sup>2</sup>

It is only most recently that the family group therapy movement has come to the surface and there are three general arguments offered for treating the family as a whole rather than the individual with symptoms, as postulated by Haley, which are:

- a). "... often individual therapy has failed with a type of patient, or a particular patient, and it is argued that his family environment is preventing change and should be treated,

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<sup>1</sup>Haley, Jay. "Wither Family Therapy," Family Process, Vol. 1, No. 1, March, 1962, p. 69.

<sup>2</sup>Ibid.,

- b). when individual treatment is slow, difficult, and subject to relapses, it is singularly argued that the environment of the patient is inhibiting change, and,
- c). the appearance of distress and symptoms in other family members when the patient improves raises questions about the responsibility of a therapist to other family members."<sup>1</sup>

Haley seems to have taken the lead in developing research relative to family group therapy. One such research report deals with an interactional study whereby the families are observed in conjoint interviews where they are asked standard questions, in family therapy sessions, or they are exposed jointly to a task, such as playing a game together, or giving their impressions of TAT or Rorschach cards. Two sorts of measurements are attempted in these studies: (1) the counting of the responses to the task by frequency or time; and (2) the categorization of the verbal interchange of the family conversation,<sup>2</sup> in order to measure the sequential frequency in family communication patterns.

One of Haley's hypotheses in this study was that,

When a family falls in the disturbed range on the scale of deviation from random behaviour and is treated successfully by family therapy, the family will move towards a normal range.<sup>3</sup>

It is the goal of the family therapy sessions to encourage more equal participation in family discussions by family members. In reference to the hypothesis stated above,

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<sup>1</sup>Haley, loc. cit.

<sup>2</sup>Haley, Jay. "Research on Family Patterns: An Instrument Measurement," Family Process, Vol. 3, No. 1, March, 1964, p. 43.

<sup>3</sup>Ibid., p. 51.



Haley feels that "sufficient data is not yet available to test this hypothesis."<sup>1</sup> Descriptions of six families were reported who were tested before treatment and then were given exactly the same test with the same interviewer six months later. The first four families were treated by training therapists, and their supervisors reported independently that he felt none of these families had undergone any basic change. "The results here support that conclusion: all the families moved toward the normal range of the scale, but only slightly."<sup>2</sup> To determine whether families change with family therapy, it was necessary to consider how normal families change on test and re-test without the intervention of a therapist. At this point six normal families were given a test and subsequently given the same test six months later (TAT). Haley found that the normal families change only slightly less than the group of treated families.<sup>3</sup>

Perhaps Haley's demonstration of the greater use of mechanical recording devices to take the most simple measurements of family interaction will lead to further adoption of this methodology. "In its own way, this admittedly crude measure of family patterns is no more primitive than the kinds of evaluations being carried out by observers whose capacity for apprehending the intricate totality of interaction leaves much to be desired."<sup>4</sup>

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<sup>1</sup>Haley, Family Process, Vol. 3, No. 1, p. 57.

<sup>2</sup>Ibid.

<sup>3</sup>Ibid.

<sup>4</sup>Rabkin, Leslie Y. "The Patient's Family: Research Methods," Family Process, Vol. 4, No. 1, March, 1965, p. 121.

Rabkin points out several difficulties in utilizing the case history study method of research. The first difficulty is that these histories are not gathered for research purposes but are generally part of the clinical evaluation of the patient. "Thus, only certain items tend to get tabulated, those considered by the social worker to be relevant to the etiology of the patient's disorder. This means that certain theoretical notions intrude into what gets recorded."<sup>1</sup>

Another difficulty with the case history study method is that once the records are chosen for analysis, there arises problems of a control group. "There has been an unfortunate tendency to choose control groups, if they have been used at all, more on the basis of their availability rather than their relevance to the study."<sup>2</sup>

#### Guiding Questions for Study.

We have embarked on an exploratory study of the effects of family group therapy on a client-group from the Burnaby Mental Health Centre. Rather than posing an hypothesis, we have formulated specific questions which we have used to guide our exploration of this subject. Since we set out to study the relationship between change in family functioning and family group therapy, our questions are basically trying to get at change, find relationships among various variables, and finally endeavouring to make connection between the six areas of family functioning and improvement

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<sup>1</sup>Rabkin, op. cit., p. 110.

<sup>2</sup>Ibid., p. 111

in family group therapy.

1. What changes in family functioning are reported by family members as being directly related to something that happened in family group therapy? Here we believe that certain criteria must be met for change to take place. We have drawn from the material by Virginia Satir for this section. Some of the criteria included would be improved understanding of what is said by family members, consideration of feelings, participation of all family members in discussions, etc.

2. What changes in the roles of family members are perceived by them to be related to family group therapy? We believe that an important area in family functioning is the matter of roles. We need only turn to the work of the sociologist, Robin M. Williams, Jr.,<sup>1</sup> to be aware of its importance. Thus we will look at the family's role expectations, note perceptions, role performance, etc. It should be noted that the therapists themselves place a great deal of emphasis on changes in this area and this is one area of criteria which they consider in the successful termination of their cases.

3. What changes in the intra-familial relationships within the family are perceived by them to be related to family group therapy? Here again, we have drawn both from the writings of Virginia Satir and the personal experience of the three therapists for the inclusion of this question. We are interested in looking at family alignments and how

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<sup>1</sup>Williams, Robert M. American Society, Alfred A. Knopf, New York; 1951, pp. 55-73.

they were affected by family group therapy. We also include here the question of scapegoating, marital expectations and satisfaction, etc. Information in these areas will help in the answering of this question.

4. What changes in the family's use of available community resources are perceived by them to be related to family group therapy? We have hypothesized that a family which has been extremely active in the community, using resources, will come back into his family if helped by family group therapy. The opposite might also be expected, that is, the family which has been isolated and totally divorced from participation in the community, will go out and become more independent and individualistic.

5. What changes in the occupational and educational situation of the family are perceived by them to be related to family group therapy? We believe that a family helped by family group therapy will find more satisfaction on the job or at school, and his performance may even improve. Our rationale here is that the individual is freed from the burden of worry at home and approaches work with a more relaxed attitude. The therapists believe that father may better himself occupationally and the child will do better at school.

6. What is the relationship, if any, between any change in family functioning and the family's occupation level.<sup>1</sup> Here we are looking at the families in which some change has taken place and we believe that they probably had more

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<sup>1</sup>Hollingshead, August B. & Redlich, G. "Social Stratification and Psychiatric Disorder", American Sociological Review, Vol. XVIII, April, 1953, pp. 163-170.

strengths and more security than those families in which no change took place.

7. What is the relationship between any change in family functioning and the therapists' rating of the case? In effect, what we are trying to get at is the relationship between the therapists' perception of change and the family's perception of change.

8. What is the relationship between any change in family functioning and the family type as diagnosed by the therapists? The therapists have evolved a classification scheme of seven family types<sup>1</sup> and we are interested in learning if there is any particular correlation between change in family functioning and family type.

#### Value Assumptions and Assumptions of Fact.

In undertaking our study, setting up the questionnaire, analyzing the data, and coming to conclusions, we were working under two main value assumptions.<sup>2</sup> Firstly, we made the assumption that the six categories of family functioning should constitute an exhaustive list and that family group therapy should aim for some change in some of these areas. Therefore, a family comes into therapy because one or more of these areas is malfunctioning and is thus causing stress on the other areas. We believe that by effecting a change in one area, the general level of stress will be lessened. Our second value assumption states that the

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<sup>1</sup>See Appendix VI.

<sup>2</sup>These value assumptions were arrived at by the researcher's own thought supplemented by those of the therapists.

therapists ought to set out to promote change and improvement in the six categories: (communication and roles; intra-familial relationships; occupation and education satisfaction; extended family relationship; use of community resources) and that they should measure success by the extent or degree of change achieved by the family in treatment in these areas. In talking to the therapists they listed a number of criteria they look for, including: mother prettier, father more spontaneous, laughter and enjoyment in the family, family listening to each other, better communication between children and parents, and increased social contacts outside the family.

We also made three assumptions of fact. In the first, we assumed the equal competence of the three therapists involved, and that they use the same general criteria of family functioning. We also assume that the ratings they give on each case should be reliable and valid to a satisfactory degree. Although there is one psychiatrist and two social workers on the team, they have all been working on family group therapy for the same period of time and have shared many of their experiences and thus we feel are of equal competence in this field although their individual techniques may vary. It is necessary for us to make this assumption if we are to be able to look at a cross sample of all the cases. However, we should like to note that because of the distinctive personalities of the therapists, we would hesitate to generalize our findings to other situations. Secondly, we make the broad assumption that the respondents' replies should be reasonably accurate and

and truthful. We have given all the married couples a short questionnaire which measures the amount of agreement between them. This we plan to use as a form of reliability test.

We further assume that opinion data from family members who received treatment ought to provide information pertinent to the measurement of outcome.

#### Outline of the Study Report.

This research report is organized in the following way. Chapter II, entitled "Methodology of the Study", describes the level of research design chosen for the study, the sampling procedures used, and the methods of gathering data. Chapter III, entitled "Analysis of the findings" describes the major findings in each of the six sections of data analysis. Chapter IV, entitled, "Summary and Conclusions", contains a summary of the major findings of the study, the conclusions drawn from these findings, and the recommendations for future endeavour in the area of family group therapy.

#### Authorship of Report.

The following list indicates those pages or sections of the text dealt with exclusively by individual members of the group.

C. Akin	pp. 26-29; 54-65.
R. Dlin	pp. 20-25; 29-31; 86-98.
C. Forst	pp. 11-16; 74-79.
K. Levitt	pp. 46-54; 65-73.
C. Smith	pp. 8-11; 98-106.
J. Yee	pp. 16-20; 79-86.

The remainder of the text was the result of collaboration between group members.

## CHAPTER II

### METHODOLOGY OF THE STUDY

#### Level of Research Design.

In choosing a level of research design the authors will take three factors into consideration. The first, and most vital consideration is that there is no previous research in this area (as mentioned in a previous section). Hence, a design with broad scope will be used, since the nature of this study is primarily exploratory-formulative, in that it seeks to gain insights and generate hypotheses for future studies with narrower foci. For this reason it is thought that the case study method will be more appropriate because it affords the opportunity to study the individual case at greater depth and thoroughness, even though precision and validity of findings must be sacrificed by the smaller sample. In addition, the case study method has been chosen because of its unstructured aspects. Although the authors have devised an interview schedule with focused questions, many of the questions are of an open-ended nature maintaining a broad scope. The design of the interview itself will allow sufficient opportunity for inclusion of the interviewer's impressions.

A second consideration in deciding the design of research is the nature of the sample. The purpose of the study is to provide follow-up information on a group of



cases already treated. Since systematic documentation describing the population of cases was not undertaken at the onset of treatment, the conclusions of our study will have to be drawn on an ex post facto basis. This will reduce the desirability of using a descriptive study because assessment of the changes which may have been brought about by treatment will be largely left to the authors' and to the clients' impressions, and will not be based on firmly observable criteria. Similarly, no control group was drawn at the initiation of treatment therefore observations cannot be made on the basis of comparison.

Finally, consideration must be given to expediency of time utilization. Because the authors are students involved in a curriculum limited to eight months duration and requiring work in other areas, time will allow study of only a small sample. For the same reason, the authors will be unable to familiarize themselves with, and perform more elaborate forms of data analysis, in such a short time. In addition, the eight months time limit on the study obviously will rule out use of a longitudinal study which would require at least one year at the minimum, in the authors' estimation.

#### Control of Interfering Variables.

In the choice of data collection some effort will be made to control for interfering variables. The semi-structured interview schedule will provide a degree of checking reliability. By focusing on general areas of family functioning predetermined by the authors, the effects

of interviewer bias and unreliability of the client's impressions may be somewhat reduced. A test for reliability will also be introduced by the inclusion of a standardized test within the interview schedule.<sup>1</sup> An effort has been made to determine whether there is an "experienced connection" in the client's mind between changes in family functioning and family group therapy. This kind of evidence is useful as shown by Komorovsky and others.<sup>2</sup> This will reduce the likelihood that spurious relationships between changes and the effects of treatment will be accepted although it may increase the possibility of a "honey effect", whereby a client may be encouraged to please the interviewer with a positive response. Contamination will be avoided to a certain degree by allowing the interviewers no knowledge beforehand of the cases to be interviewed, prior to the interview.

#### Plan of Data Analysis.

The form of analysis is simple summarization of the main trends (as seen by the authors) related to each of the study questions. Firstly, the authors intend to compare the therapists' impressions of treatment progress with those of the researcher interviews. Discrepancies or consistencies

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<sup>1</sup>Kerkhoff, Alan C. "Nuclear and Extended Family Relationship" in E. Shanas and C. F. Streits, (ed.), Social Structure and the Family, Prentice Hall, New Jersey; 1965.

<sup>2</sup>Komorovsky, M. "The unemployed Man and his Family," in Paul F. Lazarsfeld, The Language of Social Research: A Reader in the Methodology of Social Research, Glencoe, Illinois; Free Press, 1955.

here may be of some significance. Secondly, attention will be given to the question of how these changes were maintained through time. This will be a pertinent question in providing speculations about the lasting effects of changes produced by family group therapy. Thirdly, the authors intend to examine the specific changes which are suggested as a result of treatment. In other words, information as to what kinds of changes are produced, and in what areas of social functioning they occur, which will be valuable in the production of hypotheses concerning vital areas of social functioning and their relation to treatment.

Analysis will also be focused on the comparison of family attributes with change. Hence family type, family structure, symptom category and so on, can be related to the various changes in order to determine which family attributes are most amenable to treatment. Simple tabular analysis will be made of any tendencies, generalities or typologies which occur in the relationships between the dependent and independent variables.

#### Sampling Procedures.<sup>1</sup>

The population from which our sample was chosen consisted of all those families who were seen and closed between April 1st, 1964 and March 31st, 1965. This consisted only of those cases seen by Team B of the Mental Health Centre. It is interesting to look at how the cases were given to the three therapists from Intake, the only requirement being that the identified patient by over nine

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<sup>1</sup>Polansky, op. cit., chap. 11

years of age. We felt that there were a large number of variables over which we had not control and which we believe affected the population even before it reached the treatment team. The variables included the socio-economic level of the family which we believe would in part determine father's ability to attend therapy. Another would be the distance of the family from the clinic as it has been found that there is a definite concentration of cases from Burnaby and surrounding area. Yet another variable might be the motivation of all family members to attend family group therapy which might in part be connected with the last variable which is the source of referral.

We were given a list of 107 names of people seen between April, 1964 and March, 1965. We decided to set the sample size at 24 which would mean four interviews each, choosing this small a number after considering that the length of our questionnaire could easily run over two hours in its administration. Another reason was our decision to take the case study approach in our thesis.

Since the names were given us arranged over a time sequence, we wanted to avoid skewing our sample in any one time period. Therefore, we arranged the names alphabetically and chose every fourth case, giving us a sample of 25. We then chose every fifth case to make up our reserve list of 18 cases. Each worker was given four names and three reserves to be used if contact was not made or if the families refused to be interviewed.

However, it was at this point that we began to run into a number of difficulties with our sample. Some of the

names given us had not been seen in family therapy and a number had only been seen for one assessment interview. This fact, plus the fact that a large proportion of our sample size refused to be interviewed, forced us into tracing more names than we had originally intended. In fact we finally had to settle on a sample size of 18 cases.

In view of the difficulties we were running into in getting our sample size, we decided to look at those people who had refused to take part in our study and who offered some reason. Thus we had a final list of 54 names, 18 of whom we interviewed and the remaining 36 cases who refused and gave their reasons for doing so. We will thus be able to give some detailed consideration to the refusals and perhaps make a few hypotheses after we examine our findings.

#### Source of Data:

(a) Agency Files - Each case studied had a file set up at the time of opening at the Mental Health Centre. The files varied in completeness but for the most part included an original diagnostic assessment made upon intake. The intake assessment was made in most cases by the psychiatrist and included more psychiatric than social information. Usually a diagnosis of family type was made by the psychiatrist using a nomenclature unique to their particular team.

Each subsequent interview was usually recorded. The length and depth of the recording varied greatly depending on the case and the therapist. In cases where the first diagnostic interview was also the last no other recording

aside from a usually very brief closing summary was made.

Cases which continued over two or more interviews usually contained a closing summary. In the most part the summaries included a very brief note evaluating the outcome of therapy. In some cases closing summaries dealt for the most part with reasons why the therapist felt the family was dropping out.

In all cases identifying information from the face sheet was available from agency files.

In order to equalize as much as possible the impressions gained from the interview and to remain objective during the interview we read only identifying information before the interview.

(b) Interviews - All available families included in the sample were interviewed by one of the researchers. The first group of families were approach initially by telephone. Many families felt very negatively toward the caller. They felt that our connection with the Mental Health Centre was not firmly enough established and they resented their names being given out. As so many families were unwilling to co-operate it was felt that a letter of introduction from the Mental Health Centre prior to the call would be most useful. It was subsequently arranged that Mr. Don Ricketts, Social Work Supervisor for the Mental Health Centre, would send all families involved a letter requesting co-operation, (see Appendix I). It was felt by most of the callers that the letter made the explanation of our project much easier and the families

were more willing to co-operate. It is difficult to determine exactly how the percentage of families accepting increased with the letter because of the number of people unavailable for other reasons, however, a decided improvement in co-operation was noted. It is possible that some families were confused over the role of the interviewees but this was not the main reason given.

Each family was interviewed using the questionnaire, (see Appendix II) for structuring after a brief introduction. All family members were encouraged to give their own individual opinion on each question. In reality, however, it appeared that some young children particularly were influenced by parents and other children. However, for the most part families readily answered and commented freely on all questions. The interviews encouraged comments and digressions and recorded everything that was said if at all possible.

The questionnaire was completed with the whole family present except for the last two pages which dealt with the marital relationship. It was felt that the parents would feel freer to verbalize their real feelings if the children were not present. No problems were encountered in this section. Most parents answered freely. Two one parent families were included in our sample and this section was not applicable to them.

After the completion of the main questionnaire an anonymous questionnaire was given to each parent. This questionnaire is Appendix III. This questionnaire along

with the first one are described in detail later.<sup>1</sup> No difficulty was experienced by the parents in answering this questionnaire although some did comment on it or wrote in brief qualifications.

Upon completion of both questionnaires the families were asked if they had any other comments and these were recorded.

The interviews on the average last two to two and one-half hours and proceeded without difficulty.

(c) Therapists' Impressions.

As the therapists' impressions of success were one of the more important independent variables it was decided that the data on the file was too inconsistent and incomplete to be relied upon for the therapists total evaluation of treatment. Therefore only the initial impressions were gained from the file and the therapists' impressions were made in retrospect at the time of this study, (see Appendix IV). Their impressions included an evaluation of the therapy as well as an assessment of the family according to type in cases where this was not included in the original notes on assessment.

An itemized questionnaire was administered to each marital partner and completed separately. This test was an examination of conjugal role relationships to differentiate between joint and segregated roles involving a number of different characteristics. These characteristics were in

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<sup>1</sup>See p. 36, Role Performance.



terms of a division of labour.<sup>1</sup> "A Likert Scale of normative items, called Task Sharing . . . ." <sup>2</sup> was used, (see Appendix III). The first part, containing nine specified items was called "Ideal Task Allocation". We adopted Kerckhoff's behavioural counterpart, as well, which also consisted of nine items. It was entitled "Husband's Participation Index" or who does what specified tasks, (see Appendix III). Scores that were high in "Ideal Task Allocations", ". . . indicated an acceptance of task sharing by husbands and wives and a low score indicated a preference for task segregation and specialization".<sup>3</sup> Again, in scoring actual behaviour a high score on "Husband's Participation Index" indicated a ". . . high degree of household task performance by the husband."<sup>4</sup>

It was assumed that the husband took over some of the responsibility traditionally belonging to the wife. Thus these two measures of conjugal relationship are ". . . measures of normative task sharing and the actual degree of husband's participation in tasks that are traditionally carried out by wives."<sup>5</sup> To the knowledge of the researchers there has not been any extensive degree of validation achieved in previous research other than that

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<sup>1</sup>Herbst, P. G. "Task Differentiation in the Nuclear Family," in N. W. Bell and E. F. Vogel, (ed.), The Family, The Free Press of Glencoe, 1960.

<sup>2</sup>Kerckhoff, op. cit., p. 102.

<sup>3</sup>Ibid.

<sup>4</sup>Ibid., p. 103.

<sup>5</sup>Ibid.

used by Kerckhoff. The researchers employed Kerckhoff's study as a method of validation for the answers given to the questionnaire directed in particular to husband and wife.

Our questionnaire, (see Appendix II) is divided into six parts. Each area represents a factor which the therapists thought was important in family group therapy. They felt that each of the six factors could have been areas which would be influenced by family group therapy. The therapists were interested not only in general changes but more particularly in changes in certain areas. They were also interested in the relationship between change in one area and change in another area. It was felt that an overall evaluation of the whole questionnaire would give a generalized impression of the impact of treatment. Hence a part-by-part analysis would permit a detailed study of family dynamics as they were influenced by family group therapy.

#### Division of Questionnaire:

The factors were divided into two groups. (a) The internal which included communication, role performance and relationship; and (b) externals which included use of community resources, informal socializing, and occupation and education.

Each area was assigned to one researcher to develop questions based on the literature and on the therapists' interests. We shall discuss each area briefly mentioning the sources used. As each individual author will be discussing their own area in detail in the data analysis the description will be very limited here.

### Occupation and Education<sup>1</sup>

The questions in this section were designed to evaluate change in two areas of occupation and education. The first area was the actual performance of tasks either at work or at school. The therapists and researchers concurred in thinking that improved family functioning through family group therapy should have a favourable influence on task performance. This section is designed as one of the objective tests of the extent of carry-over into the external functioning of improved internal family conditions. The second area included in this section was the family members relationships with those in authority and with peers. Here again it was felt that improved family relationships with a resulting increase in feelings of self-worth would carry over into external relationships with employers, school friends, etc. Changes in work roles or the assuming of more tasks and responsibilities were also felt to have some possible connection to strengthening feelings of self worth developed through family group therapy.

### Role Performance

One of the therapists' postulates was that if family group therapy is successful, then role performance of the individual's involved will be enhanced. If the role

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<sup>1</sup>Reiss, A. J. Jr., Occupations and Social Status, The Free Press of Glencoe, Illinois; 1961.

Bendix, Rinehart and Lipsett, Class, Status and Power, The Free Press of Glencoe, Illinois; 1953.

Bettelheim, Bruno and Sylvester, Emmy. "Parental Occupations and Children's Symptoms," Bell and Vogel, op. cit., pp. 499-509.

expectations are given in our society,<sup>1</sup> then a new level of performance is a resultant objective of family group therapy. In line with Satir's notion of self-esteem<sup>2</sup> we postulated along with the therapists that his role performance is positively enhanced then, so too will be one's place within his nuclear family. He will be able to perceive a change in terms of how he feels about his place in the family and be able to note changes in terms of how he sees his role in relation to his significant others. Finally, we wished to see, as in each of the other sections, if the subjects saw any change as being brought about by attendance at family group therapy.

#### Formal Community Resources

This section of the questionnaire was originally designed to explore the families feelings about the Mental Health Centre. A general question was asked first so that the families' feelings about community agencies in general could be determined. It was thought that their feelings about other agencies could have some influence on their initial feelings about the Mental Health Centre. The

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<sup>1</sup>Zelditch, Jr. Morris. "Role Differentiation in the Nuclear Family: A Comparative Study," in N. W. Bell and E. F. Vogel, The Family, The Free Press of Glencoe, Illinois; 1960.

Goode, W. The Family, Prentice-Hall, Englewood, New Jersey; 1964, especially chaps. vii and ix.

Williams, Jr., Robin M. op. cit., pp. 55-73.

Allport, G. W. Pattern, Growth and Personality, Holt, Rinehart, & Winston, New York; 1961, p. 184.

Maas, H. Stressful Situations and the Concept of Role Expectation, Unpublished Paper, Berkely.

<sup>2</sup>Satir, Virginia. Conjoint Family Therapy, Science & Behaviour Books, Inc., Palo Alto; 1964, pp. 8-11.

question on change was of course designed to discover attitudes concerning the Mental Health Centre, formed as a result of therapy. Religion was included in this section as another formal community resource. Glueck's study on Juvenile Delinquents and their families concluded that the children whose families were moderately religious and where the children attended church with the parents that there was less chance of delinquency. We felt that this question would evaluate the family's religious participation and see if changes in religion were in any way related to family group therapy and subsequently family health.<sup>1</sup> As the therapists felt that greater community participation and interest was an indication of family growth the last question on organized clubs and groups was included.

External Family Relationships and  
Use of Informal Community Resources

In the area of family visiting it was felt that a change either up or down was not necessarily an indication of family growth except in the families where extended family relationships had been a problem before therapy. Though a quantitative change was not felt to be important it was thought that any change in the family's conflicts in this area would be valuable to measure. As some families in the population had extended family members in the same household, conflicts between generations and changes therein would be measured by these questions.

Question 4 on the use of recreational resources was

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<sup>1</sup>Glueck, Sheldon & Eleanor, Family Environment & Delinquency, Houghton Mifflin Co., Boston; 1962.

intended to measure once again not the quantity of use but the quality. Is the family able to make more effective use of community resources as a result of family group therapy?<sup>1</sup>

### Communication

One of the most critical areas to be studied is that of communication.<sup>2</sup> For Satir,<sup>3</sup> communication is the central theme of her therapy and for Bell<sup>4</sup> it is also important for it is felt that faulty communication leads to family dysfunction.<sup>5</sup> It has been said that man is primarily a communicating animal. People communicate with each other by a great variety of signs, the most obvious of which are the signs systematized in language whether spoken or written. They also communicate by gesture, including the subtle expressive movements of face, eyes, and all the body muscles.<sup>6</sup>

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<sup>1</sup>Goode, op. cit., p. 44.

Kluchholon, Florence. "Variations in the Basic Values of Family Systems" in Bell & Vogel, op. cit., pp. 304-316.

Pitts, Jesse. "The Family and Peer Groups" in Bell & Vogel, op. cit., pp. 266-286.

Alexrod, M. "Urban Structure and Social Participation," American Sociological Review, Vol. XXI, No. 1, February, 1956.

<sup>2</sup>Ruesch, J. Therapeutic Communication, New York; Norton, 1961.

<sup>3</sup>Satir, op. cit., pp. 63-70.

<sup>4</sup>Bell, J. E. Family Group Therapy, U. S. Public Health Service Monograph No. 64, Washington, D.C., U.S. Government Printing Office, 1961.

<sup>5</sup>Fisher, Seymour and Mendell, David. "The Communication of Neurotic Patterns over Two and Three Generations," in Bell & Vogel, op. cit., pp. 616-622.

Giffen, Mary E. et al, "The Transmission of Superego Defects in the Family" in Bell & Vogel, op. cit., pp. 626-627.

<sup>6</sup>Watzlawick, Paul. An Anthology of Human Communication, Palo Alto Medical Research Foundation, Palo Alto, California; 1964.

At this point let us first state three basic premises of the theory of human communication.<sup>1</sup> The first sounds almost too simple for it states that "One cannot Not communicate". Even silence as a response is only one of a number of types of non-verbal communication. As stated in the previous paragraph the study of communication includes the total field of verbal and non-verbal messages. The second premise states that human communication is a multi-level phenomenon, and that communication becomes meaningless when reduced to one level, that is taken out of context.<sup>2</sup> Of prime importance is the presence of understanding, for without understanding you cannot have communication. If we look at the two aspects of communication, we find the content with its information value, and secondly there is the aspect which defines both what the message is about and how its sender conceives of his relationship with the receiver. The latter aspect is referred to by Ruesch as Meta-communication--communication about communication.<sup>3</sup> Virginia Satir takes this concept further by stating that meta-communication conveys the sender's attitude toward the message he just sent, his attitude towards himself, and lastly, the sender's attitude,

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<sup>1</sup>Bryenton, J. G. "Communication with Children," Master of Social Work Thesis, University of British Columbia School of Social Work, 1954, p. 2.

<sup>2</sup>Ibid.

<sup>3</sup>Reusch, J. and Kees, W. Nonverbal Communication: Notes on the Visual Perception of Human Relations, University of California Press, Berkely; 1964, p. 6.

feelings, intentions towards the receiver.<sup>1</sup>

This allows us to move on to the third premise of human communication which states that the message sent is not necessarily the message received.<sup>2</sup> A typical pathology of interaction involved here is the partners' respective blindness for the actual sequence of communications, so that each of them considers his behaviour as a reaction to that of the other, but remains blind to the fact that his behaviour is a stimulus and reinforcement. An important concept in this area is the idea of feedback which refers to the process of correction through incorporation of information about the effects his message achieved. Feedback of information thus becomes a steering device upon which learning and correction of errors and misunderstandings are based.<sup>3</sup>

Since people begin to work out the nature of their relationship the moment they meet, by the time a relationship has developed over several years, a set of rules has come into being. These rules ensure the stability of the system, in our case, the family. Don Jackson introduced the term "family homeostasis" to cover this concept.<sup>4</sup> One of the most frequent complaints made by people who seek help is the feeling of being misunderstood because of lack of, or breakdown in, communication among family members. It has

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<sup>1</sup>Satir, op. cit., p. 76.

<sup>2</sup>Watzlawick, op. cit., p. 5.

<sup>3</sup>Ruesch, Non-Verbal Communication, p. 7.

<sup>4</sup>Watzlawick, op. cit., p. 5.



been found that appropriate communication may never have existed or may have been obtained on some areas of intra-familial relationships and not in other significant ones. It has broken down in all aspects or may still be intact in some. People may describe a failure in some crucial area. Patterns of communication may be similar or different for different family members or may be pervasive in the family unit.<sup>1</sup> As a result of therapy it was felt by the researchers and therapists that: (1) communication, both verbal and non-verbal would be more explicit; (2) communicators would perceive that they are understood and had a chance to speak; (3) there would be specific opportunities for communication; and (4) there would be considerations of other's feelings when one member verbally reprimanded another. Family members would be asked if and when they noticed a change in their subjective impressions about communication and if this change was associated "in their mind" with anything that happened in family group therapy.

#### Intra-familial Relationships

In attempting to evaluate the quality of relationship within a family we felt that it was necessary to choose one particular area which would be affected by a change in relationship. The amount of agreement and disagreement within the family and the alliances which formed around decision-making were felt to be highly indicative of the family members relationships with each other. One of the

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<sup>1</sup>Sherz, Frances. "Family Interaction: Some Problems & Implications for Casework," Ego-Oriented Casework, ed. Parad, H & Miller, R. Family Service Association of America, New York; 1963, pp. 129-144.

areas worked on particularly in the actual treatment sessions was identification and elimination of family scapegoats.<sup>1</sup> It was felt that question 3 would evaluate the influence family group therapy had on the position of a scapegoat in the family.

The "parents only" part of the relationship section was designed as the result of a particular interest on the part of the therapists in the sexual relationship within the marriage. They felt that if family group therapy was successful one of the changes should have been an improved sexual relationship as a result of better masculine and feminine identification and a general improvement of relationship.<sup>2</sup> Having parents develop a realistic outlook on their marital relationship is another expected result of successful family group therapy. Question 7 was designed to evaluate any changes in this area. As family group therapy stresses verbal communication as a problem solving process questions 5 and 6 were included to measure not only areas of difficulty but methods and changes in techniques of problem solving.

Upon assignment of each researcher to a specific topic, questions, both objective and subjective were compiled and ordered. These questions were discussed at thesis group meetings with the thesis advisor. Questions were revised

<sup>1</sup> Ackerman, N. W. The Psychodynamics of Family Life, Basic Books, New York; 1958.

Bell and Vogel, op. cit., p. 382.

<sup>2</sup> Satir, op. cit.

and the first draft of the questionnaire was pre-tested<sup>1</sup> on a family, recently in family group therapy at the Burnaby Mental Health Clinic. One of the researchers interviewed the family while the other researchers filled out the questionnaire. This was done to provide consistency in researcher interviewing technique, to provide a standardized scoring of responses, and to give the family being interviewed a chance to criticize the wording of the questions in terms of clarity, comprehensiveness, both for adults and children. Following the pretest the questionnaire was revised with certain sections and questions being deleted or added. Discussions again took place in thesis group meetings to check and revise the questionnaire to its final form. (See Appendix II). The schedule was used in a uniform manner, although interviewers used avenues of exploration which they felt may be pertinent to the study. The only apparent difficulty in this use of the interview schedule was the dissemination of the wide range of information which was gained in this way.

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<sup>1</sup>Goode, W. J. and Hatt, Paul K. Methods in Social Research, McGraw-Hill Book Co., Inc., Toronto; 1952, Chap. 11, especially pp. 157-158.

### CHAPTER III

#### STUDY FINDINGS

##### Reliability Study of Husband- Wife Task Sharing Data.

The husband-wife questionnaire was divided into two sections; the first aimed at ascertaining the normative acceptance of task sharing between husband and wife in daily activities. "A high score indicated an acceptance of task sharing by husbands and wives, and a low score indicated a preference for task segregation and specialization".<sup>1</sup> In scoring this question the responses were weighted from 0 to 4 depending on the category of the response. Each weighted score was added independently for each spouse and the difference was recorded. By weighting the scores the maximum score that could be obtained was 36 as there were 9 questions altogether. Where the amount of agreement was 30 or more we arbitrarily chose those families as having high agreement and where the amount of agreement was 20 or less these families were designated as having low agreement. We first related the low or high agreement scores to number of interviews suggesting two categories: three or less interviews; and four or more interviews. Second, we related low and high agreement with socio-economic class of family using the Hollingshead Index. Third, we related low

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<sup>1</sup>Kerckhoff, op. cit., p. 102.

and high agreement with the therapists' impressions of no change or some change in the family. Fourth, we related high and low agreement with the therapists' impressions of family type as defined in Appendix IV. Table 1 is an overall summary of the findings listed by family, type of agreement, discrepancy score,<sup>1</sup> number of interviews, class of family, therapists' impressions and family type. From this comprehensive table all other tables were originated.

Table 1.<sup>a</sup> Summary of findings for all 18 families interviewed

Fam-ily	Agreee.	Discrep.	Number of Interv.	Class	Therap. Impress.	Family Type
A	L	L	13	L	Change	Constricted
B	L	H	8	L	Change	Chaotic
C	L	L	6	H	Change	Constricted
D	-	-	12	L	Change	Leaderless
E	H	H	13	L	N/C <sup>b</sup>	Leaderless
F	-	-	3	H	Change	Chaotic
G	L	H	12	L	Change	Dictatorial
H	L	L	15	H	Change	Leaderless
I	H	L	5	H	Change	Chaotic
J	L	H	1	L	N/C	Dictatorial
K	H	L	1	H	Change	Leaderless
L	H	H	8	L	Change	Leaderless
M	H	H	6	L	Change	Disconnected
N	H	L	7	H	Change	Disconnected
O	H	L	24	H	N/C	Disconnected
P	H	L	20	H	Change	Disconnected
Q	L	H	1	L	N/C	Constricted
R	H	L	7	H	Change	Dictatorial

<sup>a</sup>Families D and F are one parent (Mother) families.

<sup>b</sup>No change.

As stated in Table 2 we took a score of 30 or more as indicative of high agreement and therefore a score of 29 or

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<sup>1</sup>For a discussion of this term see discussion on "Husband's Participation Index" which follows this section.

less as low agreement. Thus in 9 cases we had high agreement. On most items couples agreed fairly well but there was greatest disagreement in three areas; husband's participation in housework; separation of husband-wife tasks; and dispensation of money. These are areas of general contention. We would suggest that on the one hand high agreement means spouses, although having complete conjugal role separation may, nevertheless, have accurate knowledge of their mate's participation. On the other hand, as agreement score becomes smaller it might indicate less knowledge of what the other is actually doing. In addition, it might indicate some over-estimation or under-estimation of one's own participation or even inaccuracy in communicating one's task accomplishments to his or her spouse.

Table 2. Frequency Distribution of Agreement Scores Between Husband and Wife on Conjugal Role Relationships

N=16 (Maximum Possible Agreement Score: 36).

Agreement Score	Number of Cases
0-6 . . . . .	0
7-12 . . . . .	0
13-18 . . . . .	0
19-24 . . . . .	1
25-30 . . . . .	10
31-36 . . . . .	5
	<u>16</u>

Because agreement, for the most part, is relatively high and because the husband-wife questionnaire was filled out independently it could be said that this is a fairly reliable instrument.

There appears to be a relationship between high

agreement on task sharing and four or more interviews. For an N of 16 it included 50% of the cases. It must be kept in mind that four or more interviews may not necessarily cause high agreement but perhaps the agreement was already established prior to therapy. If this was the case then one might say that with higher agreement there is a greater chance of success in family group therapy.

Table 3. Task-Sharing agreement as Related to number of interviews

N=16

	No. of Interviews		
	3 or less	4 or more	
High Agreement	1	8	9
Low Agreement	2	5	7
	3	13	16

Considering task agreement with family's socio-economic class membership it would appear that there is a higher agreement with higher class and lower agreement for lower class. This is a clear indication that higher class members accept task sharing by both spouses while lower class persons show a preference for segregation of tasks and specialization. (See Table 4).

Considering the therapists' impressions of improvement or non-improvement of families with agreement of task sharing between husband and wife there is an equal split between the four couples who showed no change. Of the 12

Table 4. Task sharing agreement as related to Social Class of Family

	Low Class	High Class	
High Agreement	3	6	9
Low Agreement	5	2	7
	8	8	16

couples who are supposed to have shown some change seven of them or 58% had high agreement. This percent is slightly above chance and not necessarily significant.

Table 5. Task sharing agreement as Related to Therapists' Impressions of Change during Treatment

	No Change	Some Change	
High Agreement	2	7	9
Low Agreement	2	5	7
	4	12	16

When we compare family type with agreement between spouses it appears that disconnected families and leaderless families are first and second, respectively. On the other hand constricted families have the lowest agreement with dictatorial families second in this category. Chaotic families are split.

Table 6. Task Sharing Agreement as Related to Family Type

N=16 Family Type

	Leader.	Constrict.	Chaotic	Disconnect.	Dictat.	
High Agree.	3	0	1	4	1	9
Low Agree.	1	3	1	0	2	7
	4	3	2	4	3	16



Reliability Study: Husband's  
Participation Index.

Part two of the questionnaire filled-out independently by husband and wife was aimed at ascertaining "the actual degree of husband's participation in tasks that are traditionally carried out by wives".<sup>1</sup> We wanted to test the amount of discrepancy between husband and wife on husband's domestic role involvement. Once again in scoring the responses each item was weighted from 1 to 6 depending on the category of the responses. Each weighted score was added independently for each spouse and the difference was recorded. These differences were added and divided by the number of cases (16) and a mean discrepancy score of 4.6 was the dividend. Where the mean was four or less it was designated as low discrepancy while a mean of five or more was designated as high discrepancy. It might be postulated that as discrepancy increases the amount of role or task expectation decreases. Each spouse may view his activity different in terms of his perception or through lack of communication one may not communicate what he has or has not done in domestic chores. Discrepancy differences scored as high or low are recorded in Table 1. As before we related high and low discrepancy scores to number of interviews, socio-economic class, therapists' impressions of change, and family type as defined in Appendix VI.

Using high and low discrepancy in this series of analyses compared with the number of interviews it appeared

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<sup>1</sup>Kerckhoff, op. cit., p. 103.

that in 50% of the cases there was low discrepancy between spouses. These eight couples as well participated in four or more interviews. Of thirteen couples having four or more interviews five scored high discrepancy. This might suggest that a greater number of interviews could lead to lower household task segregation on the part of the husband. Lower discrepancy might indicate more communication and more perception of the actual activity of the spouse.

Table 7. Discrepancy as Related to  
Number of Interviews

N=16

No. of Interviews		16
3 or less	4 or more	
High Discrepancy	2	
Low Discrepancy	1	
	3	13

Comparing class and discrepancy we see a very clear cut and significant relationship. All eight of the high class families scored low on discrepancy score of husband's participation index. For the low class families seven of them showed high discrepancy. From this we might say that higher class persons are encouraged to share domestic tasks and are also encouraged to communicate more about their activities. When communication is clear this often encourages a very clear understanding in delineating one's tasks. See Table 8.

In comparing spouses discrepancy scores with therapists'

Table 8. Discrepancy as Related to Social Class of Family

N=16

	Low Class	High Class	
High Discrep.	7	0	16
Low Discrep.	1	8	
	8	8	

impressions about changes there appears to be some relationship again between high discrepancy and no change and between low discrepancy and some change. In three out of four cases showing no change there was high discrepancy. In eight of twelve cases showing some change there was low discrepancy. These findings might suggest that the higher the discrepancy the less will the couple benefit from participation in family group therapy. Conversely, as discrepancy becomes lower more change might be expected from therapy.

Table 9. Discrepancy as Related to Therapists' Impressions of Change During Treatment

N=16

	No Change	Some Change	
High Discrep.	3	4	16
Low Discrep.	1	8	
	4	12	

By comparing discrepancy with family type we found that constricted and disconnected families showed lower discrepancy; leaderless and chaotic families were split; dictatorial families showed a higher differential score. Lower discrepancy for disconnected families might indicate

they will do better in family group therapy. This was suggested in Table 6. Where family types are split on discrepancy this might indicate at least chance for success in therapy.

Table 10. Discrepancy as Related to Family Type

N=16

	Leader.	Constrict.	Chaotic	Disconnect.	Dictat.	
High Discrep.	2	1	1	1	2	
Low Discrep.	2	2	1	3	1	
	4	3	2	4	3	16

#### Occupation and Education.

This portion of the interview schedule deals with questions pertaining to work and school. These two areas were felt by the authors to be conceptually related in that they both contained several common elements pertinent to family members' social functioning in formal, task-oriented activities external to the family. The first common element is task performance. Both work and school involve the expectation of certain levels of achievement wherein standards of performance are set largely by external rules. Secondly, both of these social institutions involve some kind of satisfaction or dissatisfaction in terms of extrinsic and intrinsic rewards as a result of their performance. Thirdly, each usually involves relationships with others on a peer group basis or on an authority basis. The latter inter-relationships tend to be on an involuntary basis

whereby association is necessitated primarily as a result of practical consideration determined by the environment.

Items in the interview schedule in this section were designed to determine the level of present functioning and any changes in functioning in the following four areas: task performance, task satisfaction, relations with authority, and relations with peers; as were manifested in the responses of the interviewees in answer to questions regarding their work or their schools.

In only four families of the sample of eighteen were there members who reported positive changes in these areas, which they could attribute to family group therapy. However, when these families were compared, in number of interviews attended, (with the median number of eight interviews by the entire sample) it is interesting to note that their attendance was as follows: eight interviews, fifteen interviews; twenty interviews; and twenty four interviews. The latter three families represent the three highest numbers of interviews attended by all families in the sample. All together there were seven families in which the following criteria applied: one family member reported positive change which he attributed to treatment, in one or more of the four areas of functioning; one family member reported positive change in more than one of the four areas without attributing change to treatment; or, more than one family member reported positive change in one or more of the four areas without attributing change to treatment. In this group, only one family attended fewer

interviews (seven interviews) than the median of eight. The following table illustrates the tendency for families attending a greater number of interviews, to also report positive change in their work or school.

Table 11. Change in Functioning at Work or School as Related to number of Interviews in Treatment

Change	Eight interviews	Fewer than eight
change reported	6	1
no change reported	3	8
Total	9	9

There were differences between the group of seven that changed and the remainder which did not change. Using the Hollingshead Index for a two class system of categorization, based on occupation, the authors compared socio-economic class with change. Four out of seven in the group that changed were classed as "high" as compared to five out of eleven in the group that did not report change; suggesting that there may be a tendency for members of the higher socio-economic classes to change in these areas more readily than those in the lower socio-economic classes. However, differences were too small to be significant in this sample.

It is this authors' impression that if a more sophisticated class index were used taking into consideration education and other factors, more pronounced class differences would have been apparent. Possibly a three

class system would reflect class differentials more consistent with impressions received by the authors interviewing the respondent.

Table 12. Change in functioning at work or school as related to Class

change	Higher Class	Lower Class
change reported	5	3
no change reported	4	6
Total	9	9

In comparing family types with changes in functioning at home and school, it was found that "leaderless" families and "disconnected" families reported greater change than did "dictatorial", "chaotic", or "constricted" families. However, the samples for each family type were so small that it was difficult to generalize from the data. In addition, the family types reporting change also attended more interviews, therefore change could have been a function of interview frequency rather than family type. Another possibility is that interview frequency is a function of family type, with the result that certain family types remain in treatment longer. Hence family type may be more relevant to drop-out rates rather than ability to change. On the other hand the therapist may be typing the family on the basis of their difficulty in treatment, or partly on the basis of their degree of familiarity with the family due to differential periods of involvement with them. Comparison of these factors are as follows:

Table 13. Change in Functioning at Work and School as Related to Family Types and their Respective Interview Frequencies

Family Type	no.	proportion changed positively	percent median eight interviews or more
Dictatorial	3	1:3	33%
Leaderless	6	1:2	100%
Chaotic	3	0:3	33%
Constricted	3	1:3	0
Disconnected	3	2:3	66%
total	18	7:18	50%

Similarly when family structure is analyzed, basing family size on the number of family members attending interviews, the number of families at each interval is too few from which to generalize. Families with four or more members attending treatment (eleven families) report change more frequently than those with fewer than four members attending (seven families).

Table 14. Change in Functioning at Work and School as Related to number of Family Members attending Treatment

change	four members and above	fewer than four members
change reported	6	1
no change reported	5	6
Total	11	7

The apparent tendency for families with fewer members attending, to be less successful in treatment is consistent with the therapist's impressions that families of two and three are more difficult to treat than families with more



members attending treatment. When the number of family members attending treatment is correlated with both number of interviews and change, further inter-relations are suggested insofar as treatability is concerned. Families with four or more members attending the median number of interviews or more, show a much higher frequency of change than families with: four or more members attending fewer than the median numbers of interviews; fewer than four members attending more than the median number of interviews; or, fewer than four members attending less than the median number of interviews. It is interesting to note that among the families represented by Table 14, there was only one family<sup>1</sup> with four or more members attending treatment which reported change after less than eight interviews. However, this family attended seven interviews and was a member of the higher class in the Hollingshead two-class index of socio-economic rating. Similarly, the only family reporting change in the less than four members category, records the second highest attendance of interviews in the whole sample (Family P). The latter family is also rated in the higher socio-economic category. Hence it appears possible that configurations of family characteristics may emerge as being differentially responsive to this type of treatment. On the other hand many of these relationships may prove to be spurious after further investigation. For example it may be found that family size is related to continuation in treatment, only to the extent of the

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<sup>1</sup>Family K.

increasing pressures not to attend, when there are more family members unmotivated to attend. Class variations in the size of family may also enter into the picture, just as they may have difficulty taking time off work to attend treatment. Lower classes have larger families and hold jobs from which it is difficult to take leave.

Table 15. Change in Functioning at Work and School as Related to Number of Family Members Attending Treatment and Number of Interviews Attended

Number of family members attending	Percent showing change after eight or more interviews	Percent showing change after less than eight interviews
Four or more	83%	20%
Less than four	25%	0

Other characteristics of family structure such as one parent families and foster parents, were not studied because of the small representation of each. However, the two one-parent families in the sample reported no change in their functioning in the areas of work or school. No relationships were observed between the age of the identified patient and change through treatment. Diagnosis of the identified patient in its relation to change was also too difficult to analyze in this study because the sample was too small to represent the large number of diagnoses used. Of those diagnoses used more than once, the following observations were made: among five diagnoses described as "adjustment reaction to childhood" two families reported positive change; among four diagnosed as "adjustment reaction to

adolescence" three reported positive change; one family in two diagnosed as "schizoid personality" reported positive change; and one of two diagnosed as "psychoneurotic anxiety reaction" reported positive change. Since only two of the families were rated by the therapists as remaining the "same" as to symptoms, families with change were compared to families with no change on the basis of "greatly improved" versus "moderately improved" and "the same" (as illustrated in Table 16). The tendency for the therapists' impressions to coincide with positive change in these areas is further evidenced by the observation that three of the five identified patients whose symptom relief was rated as "greatly improved" reported positive changes which they attributed as a result of treatment, out of a total of four identified patients who did so (families H, L, P and O).

Table 16. Change in Functioning at Work and School as Related to Therapists' Impressions of Symptom Relief for Identified Patient

change	rated as "greatly improved"	rated as "moderately improved" or "the same"
reported change	4	3
reported no change	1	10
Total	5	13

In analyzing specific sets of responses to the interview schedule the authors found that most of the reports that positive change had taken place occurred in those items

dealing with task performance. Seven families (families, D, E, G, H, L, N, and P) had members who reported these changes in their performance at work or school. Four identified patients (families D, E, L, and P), four mothers, (families G, H, N, and P) three fathers, (families H, N, and P) and one sibling (family L) reported to this effect. Only two family members (families H and K) reported change in the area of task satisfaction. One father and one identified patient recalled positive change in enjoyment of their tasks at work and at school. Three identified patients (families E, G, and O) reported positive changes in their relationships with peers at school. Among the items dealing with relations with authority, only one family member, an identified patient, (family O) reported positive change. One need not conclude that change necessarily is effected more in the area of task performance. Rather, the preceeding observations may merely reflect that change in this area is more readily perceived because there is greater objectivity involved in criteria for performance. Task satisfaction, relations with authority, and relations with peers may be more subjectively perceived and hence more subtle to evaluate over an interval of one year or more.

Technically, this portion of the interview schedule could have been somewhat reduced. Question four could have been incorporated into question five dealing with training or educational programs. The authors felt that the probe, "Do you think the salary is fair?" in question three,

should have been omitted because there appeared to be an interviewee set to respond to the negative, jokingly or otherwise. Upon further probing, the authors frequently found the respondents would reverse their replies.

In conclusion, the data collected in this section of the interview schedule may on superficial examination reveal very slight positive changes which may be attributed to treatment. However, when other factors are taken into consideration there is evidence that treatment can effect positive change through time. First, it has been noted by the authors that family members did not report negative changes in these areas. On one hand, one may conclude that families in general fail to acknowledge negative changes. On the other hand, one can speculate that treatment for the most part, helped to sustain or enhance functioning in these areas. Secondly, analysis of change along in these areas can be deceiving if the present functioning of the family members is not taken into consideration. A trend in change must have a point from which to change. Seven of the families (A, B, C, F, K, I, R) reporting no change reported satisfaction in all four areas at work and school. In other words, these families indicated no problem existing in these areas in the first place. Among the remaining four families classified as reporting no significant changes (those without at least one member reporting positive change in one area which he attributed to treatment, one member reporting positive change in more than one area, or more than one member reporting change in at least one

area), dissatisfaction was reported in present functioning in these areas. The identified patient in family J reported dissatisfaction in both task performance and relations with peers. The father in family Q and the identified patient in family M reported negatively on task satisfaction. In family D the identified patient reported unsatisfactory relations with peers and a sibling reported unsatisfactory task performance. It is interesting to note that three of these four families attended less than the median of eight number of interviews. Families J and Q attended only one interview, and family M attended six interviews. The remaining family attended twelve interviews. Only two of the families reporting significant positive change gave negative responses to present functioning in these areas. (Families H and O).

Hence, it may be indicated that family group therapy is effective in enhancing functioning in external formal task-oriented relations when difficulties are manifested in those areas. There are also suggestions that functioning can also be improved when no difficulties are experienced in these areas. Polansky hypothesizes that work is a "last bastion of defense",<sup>1</sup> that the work life holds out against encroaching pathology, so that when one begins to lose his ability to work, this is taken as a particularly ominous sign. Nevertheless work is interdependent with one's other

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<sup>1</sup>Polansky, Norman A. "The Professional Identity in Social Work," in Alread J. Kahn, Issues in American Social Work, Columbia University Press, New York; 1959, p. 298.

spheres of living. Analysis of the data in this section seems to indicate that many families exhibiting pathology have not as yet been impaired in matters related to task performance. Among those who do evidence impairment analysis of the data suggests that family group therapy does help effect change, particularly when a sufficient number of interviews have been attended. One could speculate that Polansky's assumption may work in reverse; that is, the reversal of pathological processes may be evidenced in work later. In other words, psychological functioning and primary relationships may first evidence improvement through treatment, while functioning in external relations will show improvement later. Some findings in this section seem to bear this out, at least to the point of establishing a hypothesis.

#### Questionnaire Analysis - Roles

The first question asked family members to consider who makes the major decisions in the household. In one case the parents' response was not recorded and in three cases the children's responses were not recorded. Responses were generally mixed with no really clear indication of trends. This might be attributed largely to interviewer questioning technique. For example, in cases M, N, and K responses were the same but this could be merely coincidental. There was a variation in qualifying this question but it seemed that where decisions had to be made of a minor consequence, no consultations were made while major decisions were either handled solely by father or jointly by both parents but never

by mother alone. Roles centering around decision-making tend to be clear cut. Of thirty-four respondents to the question relating decision-making to family group therapy eleven felt there had been some improvement. One couple said they allowed their children more independence; another couple felt there was more "working together as a family team". The qualifying question perhaps did not seek what it set out to ascertain, instead the respondents seemed to given a generalized answer relating to their perceived changes since family therapy and not specifically to decision-making.

Question four asked family members the change, if any, in participation in household duties since family group therapy. Each members activity level was looked at and categorized by less active, no change or more active. The findings coincide fairly closely with the results of the husband-wife questionnaire and so are not discussed in this section.<sup>1</sup> Looking at the identified patient and his siblings activity in the household revealed that not one member reported less activity in household duties, but all reported either no change or increased activity. A no change in amount of activity response must not be construed as indicating improvement. If one was inactive or active in household before and after treatment then this is precisely what was meant by the question. The significant factor here was that not one respondent did less than before therapy. We

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<sup>1</sup>For a discussion of this see the section entitled "Reliability study of Husband-wife Task Sharing" and "Reliability Study: Husband's participation index".



thought it would be relevant to examine the Identified Patient's (I.P.) responses to this question.

There appears to be no really clear relationship between number of interviews and activity in household duties. It might be said that although there is no less participation by the I.P. two thirds of respondents showed no change while one-third or six had an increase in activity. In other words for some individuals more interviews meant more participation.

Table 17. Change in Household Helping Activity related to Number of Interviews

N=18

	3 or less Interv.	4 or more Interv.	
No Change	3	9	
More Active	1	5	
	4	14	18

Once again there is no apparent relationship between change in household participation activity and class membership. There is however, some indication that low class membership might have been a factor in four of those respondents from that class. Perhaps, firmly established patterns are hard to break even with therapy, or it is now more acceptable for children to participate in areas where there is traditionally strong feelings about household task segregation.

Findings from this table (Table 19) at first suggest

Table 18. Change in Household Helping Activity Related to Class

N=18

	Low Class	High Class	
No Change	5	7	18
More Active	4	2	
	9	9	

a slight increase in the amount of household activity by I.P. where the therapists reported a change in the family following therapy. While there may have been no actual change in participation by the I.P. his attitudes and feelings about it may have changed. Of the nine who reported no change in activity but who were supposed to have shown some gain we did not ascertain how many of this group was already active or inactive. Had this been done then this table might be more significant.

Table 19. Change in Household Helping Activity Related to Therapist Impressions

N=18

	No Change	Some Change	
No Change	3	9	18
More Active	1	5	
	4	14	

When we compare activity with family type it becomes apparent that constricted families are perhaps the least susceptible to change. This is a replication of the same figure in Table 21. If we define one who is more active as

having changed positively then leaderless and disconnected families are most likely to change in this sphere.

Table 20. Change in Household Helping Activity as Related to Family Type

N=18

	Leader.	Constrict.	Chaotic	Disconnect.	Dictat.
No Change	3	3	2	2	2
More Active	2	0	1	2	1
	5	3	3	4	3

18

The results of question number five are listed in Table 21. This question was aimed at parents altered expectations of their children and the children's altered expectations of their parents. It would appear that parents have changed their expectations of children far greater than the latter's expectations of the parents. Examining the parent's replies, fathers altered their expectations in eleven out of sixteen cases (69%), while for mothers it was eight out of eighteen (44%). For I.P. only two out of eighteen (11%) altered expectations whereas none of the nineteen siblings responding to this question altered their expectations of their parents.

The sixth question was directed at the children to find out their acceptance of parental judgment on most decisions. Four out of eighteen I.R.'s reported that they do not accept their parent's judgments. Two of these cases were D and F, one parent families. Of twenty-two

sibling replies only one did not accept his parent's judgments. Perhaps this finding might be explained by the fact that accepting parental decisions is a cultural role expectation.<sup>1</sup> While patients and their siblings accept their parent's judgments in 87% of all responses this must be qualified. Several of the respondents felt that they had greater understanding of their parents since family group therapy and accept their duties in a more responsible manner. Those cases where this applied were families B, E, H, I, L, and P. One I.P. said that the greatest improvements in this area occurred during and immediately after treatment but that since then things had returned to their former state. The trend here was not necessarily greater acceptance of parental decisions but greater understanding of the rationale behind the decisions.

Table 21. Respondents Change in Household Helping Activity as Related to Members Role Performance

	Same Expectation	Altered Expectation	
N=16 Father	15	11	
N=18 Mother	10	8	
N=18 I.P.	16	2	
N=19 Siblings	19	0	
	50	21	71

Question seven served as a qualifier to the previous one by way of asking whether other family members (parents

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<sup>1</sup>Williams, Jr. op. cit.

and siblings) listened to their ideas. We might have worded this question, "Are role expectations reciprocal in your family?". Of the I.P. responses 83% felt 'listened to' by other family members. This compares well with the previous figure of 87% who accepted parental judgment. A similar figure of 80% of sibling respondents felt understood. In discussing this question seven respondents spoke of a very definite change in having their thoughts heard. Only two of the I.P.'s reported a change due in 'their mind' to therapy,<sup>1</sup> while seven siblings reported changes<sup>2</sup> due as a result of this experience.

The eighth question asked parents and children if their place in the family had been altered since attending the clinic. It was hoped this would answer the question "Has your role in the family changes since Family Group Therapy?" but there was no verification that this was the answer received.

For the respondents to this question (Table 22) if we first look at the total number of change versus no change we find almost a perfect chance split. For mothers and I.P.'s this is, in fact, the case. The greatest change is indicated by the fathers where ten of sixteen (62%) reported improvements in feelings of their place in the family. This figure compares very closely with that of father's felt alteration in role performance of 69%. By these two figures it might be indicated that fathers might

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<sup>1</sup>Cases C and E.

<sup>2</sup>Cases B, G, H, and O.

tend to benefit the most often from family group treatment.

Table 22. Respondent's Feelings of Change about their Place in the Family

N=68	No Change	Some Change	
Father	6	10	
Mother	9	9	
I.P.	9	9	
Sibs.	8	8	
	32	36	68

Table 23 would seem to suggest that with the increase in number of interviews the father's place in the family tends to change positively. Conversely, with fewer interviews less change can be expected. The mean number of interviews for fathers feeling a change in their place in the family who had four or more interviews was 12.3 while for those fathers who reported no change in four or more interviews the mean number of sessions was 8.2. If we look at this according to class we see the relationships as outlined in Table 24.

Table 23. Number of Interviews Related to Fathers Change in his Feelings about his Place in the Family

N=16

	3 or Less	4 or More	
No Change	2	4	
Some Change	1	9	
	3	13	16

There is no difference in high class fathers with the

results falling on exactly chance. However, there is a substantial difference in low class fathers with six out of eight (75%) reporting a change in their feelings about their place in the family since attending family group therapy.

Table 24. Father's Change in his Feelings about his Place in the Family Related to Class

N=16

	Low Class	High Class	
No Change	2	4	16
Some Change	6	4	
	8	8	

In the final section of this part of the questionnaire family members were asked to give examples where they felt their place in the family had been specifically altered. Eight of the fathers reported a greatly enhanced self-concept in the role of father. Six mothers reported a gain in self-confidence in their roles. Six of the I.P.'s reported feelings of more belonging to the family and felt more important. Five of the siblings reported they felt better about their place in the family. In case P a sibling is quoted: "I feel there's a place for me in the family", and in case G: "I figure I'm one of them now". There are some indications here that improvement by one member of the family in his feelings about his place in the family will have similar effects on others.

Attitudes to Social Agencies.

In answer to question one concerning the use of social agencies and the changes in attitude following therapy all but one family and part of another felt that family group therapy itself was not the determining factor. However, eight families felt that their feelings had changed following therapy. We would conjecture here then that it was as a result of agency contact and not family group therapy itself that these attitude changes occurred. Five of the eight fathers felt that their attitudes had improved and in four cases the remainder of the family supported his feeling. However, in one case the identified patient felt that he did not like agency contact as his school mates scorned him. Three of the eight fathers felt that their experience at the Mental Health Centre had a detrimental affect on agency attitudes. In all three cases the rest of the family agreed in total. Four fathers and mothers who had originally held negative attitudes did not modify their opinions after contact with the Mental Health Centre. However, in only two cases were they supported totally by their families. In the other two cases despite the father's negative attitudes the I.P.s. both felt that their attitude toward agencies had improved. This might possibly be because the very form of family group therapy removes the onus from the I.P. and places it on the family, thus the father and mothers discomfort. Five fathers and mothers felt that their originally positive attitudes toward agencies had not been altered by their experience at the Mental



Health Centre. In all of these cases the family agreed completely.

In the final analysis it appears that five families were positively influenced and five remained positive leaving a total of ten retaining positive attitudes about agencies after family group therapy at the Mental Health Centre. The remaining eight families were essentially negative, three becoming negative after their experience at the Mental Health Centre.

There were only three cases of change in religious participation or attitudes following family group therapy. One mother (P) as a result of therapy modified her church interests and devoted more attention to her family. One identified patient (H) felt that he was able to accept the teachings of the church more readily. One identified patient (E) as a result of therapy became more outgoing and sure of herself and began participating in more church groups whereas before she was only a nominal attender. One child in an otherwise unchanged family (O) began to attend Sunday School but he felt that this had nothing to do with family group therapy but was only because he had to go to confirmation classes. Only in one case (P) was religious activity actually modified and used in a more productive way since family group therapy.

In answer to question three which is designed to evaluate any change in the family changes in uses of community resources there were very few differences recorded. Only one father felt that family group therapy had

contributed to a change in his level of community participation. He became active in men's instead of boy's sports (E). Three mothers changed. One of them was the wife of the previously mentioned man. She became more sure of the value of her own feelings and interests and joined an art group. The two other women reduced their club activity to spend more time with their families. There were more changes among the I.P. Four identified patients after family group therapy joined groups that they had not been interested in prior to family group therapy. One of these identified patients was in the same family as the above mentioned changed mother and father. This is the only family (E) where the change has occurred in more than one member. Among other children in the families there were no changes they could recall before or after family group therapy. In summation then out of the eighteen families there was one family (E) where three members changed and there were six families where one member changed in use of community resources.

There are only two families whose change in religion and community resources seemed to be connected with each other. One family especially the mother when giving up time for religion also gave up auxiliary groups and spent more time with her family. The other family especially the I.P. became more interested in outside activities and joined church groups. There seemed to be no constancy in these two families as regards agency attitudes. The family who became less active has a positive experience and the more

active ones described their experience as definitely negative.

In this section agency attitudes seems to be the area where most families experienced at least a reaction as a result of family group therapy. Where in the other two areas, Religion and Community resources, aside from two families little change occurred. None of this change was connected in the families mind with family group therapy with two exceptions, the families above mentioned.

As the section on agency attitudes seemed to be the area where most change occurred we used this section for tables in comparison with other variables. The following are tables showing the relation of attitudes to the number of interviews, the family type, the therapists impressions and to all other sections of the questionnaire. The conclusions to be drawn from each table follow the table immediately.

Table 25. Attitudes toward the agency in families with three or less interviews as compared with those with four or more:

No. of interviews	positive	negative
3 or less	2 - (20%)	7 - (87%)
4 or more	8 - (80%)	1 - (13%)
	10	8

There would appear to be some relationship between the attitudes retained by the families and the number of interviews. It could be suggested that those with more positive attitudes stayed for more interviews or that more

interviews tended to make families attitudes more positive.

Table 26. The socio-economic position of families with positive attitudes as compared with those with negative attitudes:

Hollingshead scale (See Key)

Socio-Economic	Positive	Negative	Total
High	7 (70%)	3 (38%)	10
Low	3 (30%)	5 (62%)	8
Total	10	8	18

It would appear that high economic status is related to positive agency attitudes.

Perhaps as these people of high socio-economic status are functioning well in at least some areas it is not as threatening for them to ask for and receive help in other areas. Also as they are more articulate the verbal form of therapy can be utilized well. Their areas of dysfunction are more clearly defined.

Table 27. The therapists ratings of families with positive attitudes as compared with those with negative attitudes:

Therapists	Positive	Negative	Total
High	7 (70%)	7 (87%)	14
Low	3 (30%)	1 (13%)	4
Total	10	8	18

There would not appear to be any connection between the therapist's impression of success of treatment and the family's attitudes toward the agency.

Table 28. Improvement in other areas as related to agency attitudes. Two or more areas of noted change will constitute improvement for these purposes.

improvement level	positive	negative	total
no improvement	3 (30%)	5 (62%)	8
at least some improvement	7 (70%)	3 (38%)	10
Total	10	8	18

The families positive attitudes would appear to be related to their perception of change. The percentage of those remaining positive when they perceived change is much greater than those remaining positive when they perceived no change.

External Family Relationships and use of Community Resources.

Before we describe our findings in this particular section, we wish to explain that in our total sample families of eighteen, two families, designated with the letters D and F, are one parent families, with the mother being the only parent. Therefore in those areas where we are describing data, in reference to the fathers, N will equal sixteen, and where we are describing data concerning the mothers, N will equal eighteen. The only section where there is a deviation of this is in our first part of the questions, where only fifteen families, out of the total of eighteen, have relatives in and around the Vancouver and Lower Mainland area.

In the fifteen families that have relatives in this area, there were five families that had daily contact with each other; five families that had weekly contact; four families that had monthly contact and only one family had contact with their relatives on a yearly basis. The most common way of effecting contact with relatives was by telephone and reciprocal visitations in one another's homes.

It is interesting to note that in the visitation patterns, in these fifteen families, the frequency of visiting the mothers' relatives seemed to predominate, as we found that seven of the fifteen families preferred the mothers' side of the family, and of the four families primarily visited the fathers' side of the family, the remaining four families visited either the mothers' or fathers' side of the family on an equal basis. In reference to the change in the pattern of visiting or contact with relatives subsequent to being treated in family group therapy sessions, twelve families reported that there were no changes in their contact or visiting patterns and three families reported they had experienced some change after having been treated in family group therapy sessions.

In reference to the visitation patterns and contact with family friends, in those families where there was a father present (N equals sixteen), we found that five families predominately visited the fathers' side, six of the families' preferred the mothers' friends and seven families felt that they visited their family friends with

no distinction or preference to either the fathers' or mothers' friends. As for the amount of change in visiting or contact in this area, fourteen families reported no change and four families reported some change subsequent to family group therapy.

In the area of the families' use of community resources, sixteen families, where there were two parents in the family system, seven of the fathers reported that they used community resources and nine reported they did not. The mothers (N equals eighteen), twelve reported they used community resources and six mothers did not. As for the identified patients (N equals eighteen), fifteen I.P.'s used community resources and three I.P.'s did not. The frequency in the use or non-use of the community resources breaks down to this; of the fathers, six used them often, three fathers used them seldom and seven fathers never used community resources. The mothers, on the other hand, (N equals eighteen), eight mothers used them often, four mothers used them seldom, and six mothers never frequent their community resources. As for the I.P.'s, ten used them often, six used them seldom and two I.P.'s never used community resources at all.

In reference to changes in the frequency of use of community resources, fourteen fathers reported that there was no change and two fathers indicated that there was some change since being in family group therapy sessions. Our findings concerning the change in the use of community resources by the mothers (N equals eighteen), sixteen

mothers reported no change and only two reported any change since family group therapy. This figure corresponded exactly with that of the I.P.'s findings, in reference to the amount of change subsequent to family group therapy sessions.

In the area of the desire to associate with people, whether it be with extended family or family friends, sixteen of the fathers reported positive indications that they wanted to join other people in various activities. Moreover, sixteen of the mothers answered in the affirmative, however, two of the mothers reported that they did not wish to have any contact with their relatives or friends, people external to the nuclear family. It is very interesting to note that of the eighteen I.P.'s sixteen answered in the affirmative and only two did not express any desire to have any contact with relatives or friends. This may be significant, in that the only families that did not wish to have any contact with relatives or friends were the two one parent families, designated with the letters D and F, in our study. This may have further significance in that in these two families, there may be a definite trend of a symbiotic relationship between the mother and the I.P., thus showing a pattern of isolation from extended family relationships and very minute contact with people outside the nuclear family. This will be discussed in fuller detail later in our section.

In the amount of contact with relatives and friends, fifteen fathers reported no change in their pattern of visiting and contact and only one of the fathers reported



any change in this area. Of the eighteen mothers questioned, sixteen reported no change in this area and only two had any change since family group therapy. A close relationship to this is the I.P.'s findings, in that they reported fourteen had experienced no change and four experienced some change due to family group therapy.

In our study, we are interested to learn what changes had come about by the use of family group therapy, and it is important to note the following information. When we asked all eighteen families whether any changes in (a) visiting patterns to family relatives and friends; (b) the use of informal community resources; and (c) whether there was a change in the frequency in all three areas, was it more, the same, or less, a preponderant number of families, thirteen out of the eighteen, reported that there were no changes brought about as a result of family group therapy and only five families reported definite change in this area due to their experience in family group therapy sessions.

The general trend of change in the external family relationships and the whole family's utilization of informal community resources seems to be of no great significance, that is directly attributable to family group therapy. Of the five families that experienced change due to family group therapy, three of the families' "type" were described as being a "disconnected family" which is a family where,

". . . there is a lack of family loyalty and pride and one member's hurt is often not felt by another. Each family member goes his own way."<sup>1</sup>

The other two families, were diagnosed as being a leaderless family and these are the families where "there is no power of decision and the children run the family."<sup>2</sup> The family group therapy team states that the diagnostic family types "have been arrived at by the joint decision of the team as being the most useful descriptive terms for the families we have seen,"<sup>3</sup> in family group sessions.

The significance we attach to this sectional analysis is that regardless of the diagnostic type of the family, family group therapy, as an agent of change, in the areas of external family relationships and use of informal community resources, has little effectiveness. The small change indicated in this area may be due to the lack of dissatisfaction relative to this area rather than attributable to ineffectiveness of treatment. The amount of dissatisfaction, in the area of kinship relationship is small therefore little change was sought. This suggests, then that external family relationships and use of community resources is not an area of major or frequent change, but apparently it is not an area of frequent serious problems. It will be borne out in the analysis of other areas of the family's functioning, for example communications

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<sup>1</sup> \_\_\_\_\_, Family Types, Unpublished Material on Diagnostic Family Types, BMHC, Burnaby, B.C. See Appendix II.

<sup>2</sup>Loc. cit.

<sup>3</sup>Loc. cit.

and roles, that the amount of change is more significant. This may be due to the fact that external family relationships and the use of community resources are not as important areas for needed change as in the other areas mentioned, such as communication patterns and role performances and expectations.

Another significant finding in this particular sectional analysis is that in the two one parent families (families D and F) there was a definite trend towards social isolation with people external to their own close family system. In these two families the mothers and the I.P.'s did not voice any desire or give any indication of their wanting to join other people in doing things, visiting relatives or friends or using community resources. They seem to prefer the relationships within their own closed nuclear family (with the absence of the father). We can only postulate that if these two families' isolation from the larger community were so outstanding, to preclude all other social relationships, external to their own particular family, then we can further assume that there may be a symbiotic relationship between the mother and the I.P., in these two families. One of the therapists found that the one parent families are the most difficult to treat, in terms of family group therapy. "One parent families take longer (to treat) and not as much can be accomplished and because of the goals have to be limited."<sup>1</sup> In our findings,

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<sup>1</sup> \_\_\_\_\_, Therapist's Impressions, Unpublished questionnaire used for this thesis.

the one parent families experienced little benefit from family group therapy and the changes, if any, were primarily negative, in that their isolation of external family relationships seemed to be re-enforced, rather than modified. It would seem therefore, that one parent families need greater attention on an individual basis, rather than being treated in family group therapy sessions. However, further research is needed in this particular area to justify this stand.

### Communication

Referral to Appendix II will indicate the questions asked our sample size of eighteen families in area of communication. We will first examine this large area of understanding in which we have included both intellectual understanding and the understanding of the feelings of the family members. As Thomas Hora succinctly put it:

To understand himself, man needs to be understood  
by another.  
To be understood by another, he needs to understand  
the other.<sup>1</sup>

This understanding presupposes communication. Under this area, we have grouped questions 1, 2, 6, 8, 9, and 11 of our questionnaire. The second area we will be looking at is this matter of family discussions which will include an examination of the frequency with which the discussions are conducted within the family, the content of these discussions and lastly, their outcome with the families involved. Under this area, we have grouped questions 3, 4, 5, 7, and 10 of our questionnaire.

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<sup>1</sup>Watzlawick, op. cit., p. 4.

Of our sample of eighteen cases, we found nine families who reported some change in their ability to understand what was being said during family meetings. Since we have lettered our cases from A to R, the families who reported change in this area are: B, C, E, G, I, L, N, O, P. In three of the families "O, I, G", mother had difficulty in understanding the rest of the family. However, general improved understanding was reached through the use of clarification, speaking up to make selves understood, or by generally voicing their opinions more often. It was interesting to note that one of the families "B" had reported change in this area, described a dropping off and return to old patterns. We also noticed a tendency for the I.P. to make himself understood by the family and for the parents to show greater understanding of the I.P.

Before we start to make postulations in this broad area of understanding, let us look in more detail at the area of clarity of meanings in what is said by family members. We found that nine families noted some change in their ability to understand what family members mean by what they say, with three of these families N, P, G, feeling that family group therapy was only indirectly helpful to them. We also noted that there were three families in which there was improved understanding between husband and wife. Of these nine families who felt that there had been change in this area, there were seven cases where at least some of the family members felt that they did not always understand what other family members meant by what they

said. This is our first indication of meta-communication, for in these seven families some members felt that the words coming out of another member's mouth did not always match the look on his face. Although it would appear that the meta-communications did not always fit,<sup>1</sup> it would appear that family members still felt that they noted change in a number of different areas. There were many comments in this area with the most common one being an increased effort in the families' attempts to understand family members--this also includes their attempts to understand and be understood by others. Another area of comments pointed out more recognition given to meanings and more seeking out of information for clarification. One could postulate from our findings in this area that it may not be important for the family to always know what its members mean but rather they should be able to check out, clarify, and question meanings where it is appropriate. It would appear that family group therapy gives the family an opportunity to see this process in operation through the observation of and participation with the therapist in a similar process--as described by Dr. Bell in his description of the task for the therapist.<sup>2</sup>

Looking now at the area of understanding feelings, we will look at question six which deals with how family members usually show each other when they are happy and angry with each other. Here we are looking for family

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<sup>1</sup>Satir, op. cit., p. 79

<sup>2</sup>Bell, op. cit., pp. 44-47.

group therapy to effect some change in their ability to express feelings. We found eight families who reported some change in this area. As one might expect, in the answering of this question, family members found this to be a purely individual matter, largely depending on the situation and on whom they were happy and angry with.

To get at this area we asked four questions: Do you tell them directly? We found only three families in which this was the main means of communicating happiness and anger to the rest of the family. (2) Do you do things for them? Here the trend was in the direction of mother and children showing each other by doing something for the other. (3) Do you show them through direct physical contact? We found this to be largely dependent on the ages of the children involved, where they were younger, mother tended to show them through physical contact when she was angry or happy.

(4) Do you usually not say or do anything at all? Here we have found father and the I.P. In two cases the I.P. will walk away and four fathers are less likely to show anger. Looking at the general trends in this area, we found that there was a tendency towards freer expression of feelings to other family members and a tendency towards letting them know more directly when they are happy or angry. In four of the families where father had never let the family know how he felt, we found that after family group therapy he will now tend to tell the family when he is angry and he also finds it easier to express happiness.

Still in the area of understanding, we move on to

question eight which deals with the matter of consideration given to others feelings when one member speaks up against another family member. We found nine families where at least one family member noted some change in the amount of consideration given to feelings. In three of the families, G, C, L, the whole family gave more consideration to others feelings; while in four other of the families that reported change in this area, E, N, P, B, only one member of the family reported increased consideration with N and B showing it was mother who changed. It is interesting to note that there were two families O and I who reported a negative change in this area. In O, mother reported that she had always been "too considerate of their feelings" but now had become less careful of them when expressing herself. In I, father and the I.P. reported that they give less consideration to feelings, with father having stated that he had "made too much of it (feelings) before."

In answer to question nine which is designed in part to get at the area of feedback, that is to find the extent to which family members feel that they are understood by others, we did not note any significant trends with only four families reporting change in this area. In cases P and H, we found both families were better able to understand the feelings expressed by other family members. In O, they noted added understanding between the I.P. and mother since family group therapy, while in G family, it was mother who showed greater understanding of her husband's feelings. The other part of this question was directed



towards the children, trying to get at any significant alignments with the parents.<sup>1</sup> Of the thirty-four children who answered this question, we found nineteen who felt that there was equal understanding coming from both parents.

The last question in the area of understanding is eleven which attempts to look at the family's ability to listen to what family members say to them. Of our sample of eighteen cases, seven families reported some change in this area. With the exception of one family, N, all the other families felt that there was a direct relationship between change in their ability to listen and family group therapy. The seven families generally felt that they listen more completely and discriminately since therapy and that there have been some changes in their "pattern" of listening. Taking one family O, we found that it was mother who noticed a marked change in this area. She stated that "the words are the least meaningful of what goes on, I now look for other things (non-verbal) that I wasn't sensitive to before family group therapy." Mother further stated that the sessions "sensitized" her to the idea of learning what the feelings of her family are, although she felt that she is not fully tuned in to her husband's feelings.

Taking another family, G, where mother and father felt that they listened but both children felt that they did not usually listen to the rest of the family. The

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<sup>1</sup>For this section the sample size is 15, not counting the two one parent families and the one family where only the parents were present for the answering of this section.

parents reported that they try to listen and understand the children by putting themselves in the children's places. At the same time, the children reported that they try to see their parents' side of most matters now. This family felt that change in this area was directly associated with family group therapy. Mother felt that certain things were brought out that she had never thought about before. "I got to know the children."

Perhaps at this point we could note a few general trends in the area of intellectual understanding and the understanding of feelings. First of all, we have noted that in the area of intellectual understanding, family group therapy was effective in getting family members to give more recognition to meanings, to seek clarification and to question meanings in nine cases. Thus referring to Satir, we see where she states that one of her criteria for terminating treatment is when the family members can complete transactions, check, and ask.<sup>1</sup> We also noticed a trend in the area of freeing the I.P.'s within the family to become more active and participate in communication by questioning their parents when the messages are not sent or received clearly. One general trend we noted in this area of understanding of feelings centres around father. It would appear that father is a little more comfortable in the family, feeling more a part of it and with this we see some tendency towards freer expression of his feelings so that the family knows when he is happy or angry.

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<sup>1</sup>Satir, op. cit., p. 176.

Another trend appears to be increased understanding of feelings between husband and wife.

We will now look at the second area of communication which we covered in our questionnaire. This deals with family discussions in which we have included an examination of the frequency with which these discussions occur within the family, the content of the discussions, and lastly, their outcome. The first question in this section is numbered three on the questionnaire and we wanted a picture of the frequency with which family discussions take place. We found five families who noted some change in the frequency of family discussions. Families C and E stated that they have family discussions at least once a week with C stating that there is a greater desire for family discussions and E stating that they just seem to have evolved after family group therapy. It is interesting to note that with cases O and P, there was a marked dropping off of frequency of discussions. Both families used to have frequent discussions right after family therapy when they would practice family discussions at home. However, there was a marked dropping off and now will call a family meeting when necessary. In P family, they used to have the whole family take part in discussions but now they tend to have only those involved at the time--are more spontaneous.

In question four, we are endeavouring to get at the amount of participation of family members in discussions. We found seven families who reported some change in this area and of these we find three families who had reported

no change in the frequency of discussions (from previous question). It is interesting to note that four of the families P, C, O, N agreed that father talks most in family discussion. However, it would appear that, although the families agreed that father talks most, the general trend appears to be quite different. It shows that the family members have become more active in family discussions. There also appears to be a freeing of inhibitions with both the fathers and I.P.'s speaking up more. However, it should be noted that in case P, the family stated that there was more harmony in the home now with the children in different stages of development and being more mature. Therefore, the parents felt that the children participated more intelligently in family discussion.

Still in the area of participation in family discussions in question five we are endeavouring to get at the individual's perception of the opportunity given him to participate in discussions by the other family members. We found seven families who reported change in this area. Looking at the general areas in which change took place, we found that in four families, P, C, O, I, the children reported that they have more opportunity to speak up since family group therapy. Another interesting trend appears to be the increased tendency for the I.P.'s to talk more, voicing his opinion in family discussions.

We now move on to look at the amount of time spent in the discussion of feelings of family members. In question ten, we are trying to get at some idea of the content of

family discussions. We found eight families who reported some change in this area, with two of them feeling that the change was only indirectly related with something that happened in family group therapy. The general trend among the eight families appears to be in the direction of increased time spent in discussion of feelings. It is interesting to note that four families were made aware of a deficiency in this area during therapy. In family O they stated that during a therapy session they would make a statement and the therapist would ask them how they felt about this, and this started them thinking along these lines.

Our last question in this section deals with the outcome of family discussions. More specifically, question seven asks the family if discussions usually end in quarrels and if so, what do they see as setting things off. We found eight families who reported change in the frequency that family discussions end in quarrels. Six families felt that family discussions did not usually end in quarrels. In these families, C, L, G, H, and I, we noted a marked decrease in the number of quarrels. It is interesting to note that family O reported an increase in the amount of quarrelling since family group therapy. They stated that they had more quarrels now because the family members have more to say. In family G, they stated that "before family group therapy there was much yelling and screaming, now we sit and talk, listening more to what is being said and presenting our own side."

It is interesting to draw some generalizations from

our findings in this area of communication. In our sample size of eighteen, ten families showed change in four or more sections, with four families showing change in ten or more of the sections on this subject. Referring back to the two categories under communication--understanding and family discussion--it would appear from our results that family group therapy brings about greater change in the area of understanding, both intellectual and feeling. Taking the percentage of total changes, we found understanding with 57% of the total change and family discussions with 43% of the total change in communication.

We have given no consideration to those eight families who recorded no change in the area of communication. It should be stated that just because these cases record no change, we cannot conclude that they are either functioning poorly or very well in communications within the family. Rather we might state that family group therapy appears to have had little or no lasting affect on these eight families.

We found that of the ten families who reported change, six were diagnosed by the therapists as either leaderless or disconnected families.<sup>1</sup>

Table 29. Family Type and Change in Communication

	Change	No Change
Disconnected and Leaderless	6 (60%)	2 (25%)
Others	4 (40%)	6 (75%)

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<sup>1</sup>Appendix VI on Family Types

It would appear that the leaderless and disconnected families showed the most frequent change in communication. We might speculate that either they needed and sought change more actively in this area, or they were more amenable to the treatment, we are unable to specify which of these is true.

If we take the number of interviews that our sample group had, we see that all ten families had four or more interviews.

From Table 30, we can draw some conclusions about the effects on communication. We might speculate that either better communication channels within the family lead to more interviews, or there is a definite correlation between the number of interviews and the amount of change in family communication.

Table 30. Number of Interviews and Change in Communication

No. of Interviews	Change	No Change
3 or less	0	4 (50%)
4 or more	10 (100%)	4 (50%)

The last table in this section deals with comparison between the socio-economic level of our sample families, using the Hollingshead Scale, and recorded change in the area of communication. We might conclude that families coming from a higher socio-economic level have better results in family group therapy. Frances Scherz and Hollingshead<sup>1</sup>

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<sup>1</sup> Scherz, op. cit., p. 135.

mention that people from the higher socio-economic levels will be better able to verbalize and thus their higher level of verbal sophistication will stand them in good stead in family group therapy.

Table 31. Socio-economic Level and Change in Communication

Socio-economic level	Change	No Change
High	6 (60%)	3 (37%)
Low	4 (40%)	5 (63%)

Intra-Familial Relationships.

The following analysis is based upon section six of the questionnaire. This section consisted of eight questions designed to elicit the families' perceptions of change in their intra-familial relationships, and whether they attributed change to participation in family group therapy. The first four questions were directed to all the family members who had participated in family group therapy. The remaining four questions were directed to the parents only, and were designed primarily to elicit responses concerning the parents perceptions of change in the marital relationships. The form of the questions is such that the respondents are first asked for their opinion concerning a particular area of intra-familial relationships, then asked to describe any change which they feel has taken place in this area as a result of family group therapy. It should be noted perhaps, that where family members report change as a result of family group therapy, it is not



possible to assess the degree of change which has taken place, but only the fact that they perceive change.

Question one asked family members whether they felt they mainly agreed, or disagreed, as a family. Of the eighteen families replying, thirteen reported that they mainly agreed as a family. Nine families reported that they felt they had changed in this area as a result of family group therapy. Of these nine families, eight described change in terms of increased agreement. The ninth family O, stated that prior to family group therapy they had only agreed on the surface, whereas they now were able to voice their disagreements and recognize that as individuals they had a wide diversion of interests. Two families attributed their increased agreement specifically to increased communication between family members C and G. One family reported that they agreed more now because prior to therapy they had trouble deciding what was important (P). In two of the families only the parents felt that there was increased agreements.

Question two dealt with each family members opinion as to which family members disagreed most often when there were disagreements in the family. Responses varied considerably within individual families and from family to family. Seven families, C, H, E, G, I, O, and L reported some change as a result of therapy. In family C all members felt the children disagreed most often, but felt that disagreement took place mainly between parents and children, and all family members reported an improvement in solving

disagreements. In family G, disagreements took place mainly between the I.P. and other members. The parents felt that as a result of therapy the father allowed disagreements to take place. The I.P. stated that he agreed more with his sibling now, and the sibling reported an increased ability to disagree more firmly. In family H, the mother only reported change, and she felt that the children fought less. In family I all members felt that the mother and the I.P. disagreed most often. They reported change in terms of the disagreement still existing, but they "cope with it better". In family L disagreement was mainly between the I.P. and siblings, and the I.P. reported that these disagreements are less frequent since therapy. Family O felt disagreements were "shared around", and they saw change in terms of an ability to disagree now, and felt this was a positive change.

In Question three family members were asked, "when things 'go wrong' in the family, does some one family member usually get blamed?" The rationale for this question was to try to determine the presence of a family "scapegoat". The responses were quite varied, but three families stated quite clearly that one particular member took all the blame. (D, H, K,) of these three, families D and K reported no change attributable to therapy. In family H only the I.P. felt there was any change, and he felt that he now took a bit more blame, rather than it all going to his sibling. Two families, I and P felt that prior to family group therapy one member took all the blame, but

since therapy this no longer occurs. Family O reported that the mother used to get all the blame, but now she is more assertive, and father takes more now.

Question four was designed to try and get a picture of "alliances" within the family groups, and any changes which might have occurred and were attributed to therapy. Six of the eighteen families reported some change which they attributed to therapy. In four of these families, G, O, P, and H, the parents felt that as a result of therapy they were more closely aligned and supportive of one another, and saw this as being beneficial to the family. Family G saw a change in that the father is now more involved with the family. Family C reported alliances between parents and children, and all members stated there was a change since therapy in that the family now gave more support to the I.P.

In this area, change appeared to take place mainly within the marital relationship.

As stated previously, questions five to eight were directed to the parents only. There were two one-parent families within the sample, D and F, and since the questions were not applicable the sample is reduced to sixteen for these questions.

Question five asked parents if they mainly agreed or disagreed upon things that were important to them. Two couples, N and Q, stated they disagreed, three weren't sure, and the rest stated they agreed. Four couples C, G, F, and P reported some change in this area which they

attributed to family group therapy. They expressed the change mainly in terms of increased solidarity and terms of considering and accepting the other's point of view more. One couple, C, stated specifically that they "listened more", and that they had "more confidence in their roles".

In three cases, I, L, and N, the mothers felt there had been a change in this area since therapy but the fathers did not. Two expressed change in terms of increased agreement regarding the raising of children and the handling of money.

Question six dealt with the parents way of handling disagreement. Five of the couples, G, H, L, N, and P reported change as a result of therapy. Three of these stated that they "talk things out more now", and feel they have fewer disagreements as a result. The other two did not handle disagreement through discussion, but both felt that they were beginning to agree more. In two cases one of the partners reported change and the other partner did not, E and O. One of these stated that her husband allows her to disagree more now.

In question seven the partners were asked if their marriage had turned out mainly as they had hoped it would, and if they saw any change in their thinking as a result of therapy. One couple did not reply, so sample is reduced to fifteen. Four couples C, L, N, and P saw a definite change. Couple C felt that their marriage had turned out better than they had hoped, and attributed some of this feeling to their experience of therapy. They said their tolerance had

grown, and the husband stated that he was happier to see his wife feeling happier. Couple L felt their marriage had turned out as they had hoped, and felt that this feeling was a result of therapy. Couple N felt that their marriage had not turned out as they had hoped, but as a result of therapy their standards had changed, and they were now "heading that way". Couple P felt much more satisfied with their marriage since therapy. They stated that they felt more of a team now.

In two cases, one partner reported change and the other did not. One wife felt that she and her husband were closer since therapy. In the other case the husband stated that the marriage had not turned out as he had hoped, but since therapy he found it easier to accept certain things.

In question eight the parents were asked if their sexual relationship had changed since family group therapy. Two did not reply, sample is fourteen. Three couples G, N, and I stated that their sexual relationship was more satisfactory than before therapy. In two cases, H and L the fathers replied "more satisfactory" and the mothers replied that the relationship was the same. The remaining couples replied that their relationship was the same as before. Fourteen couples replied to this question.

At the end of the eight questions the parents were asked again if they felt that any changes in the areas mentioned had been brought about as a result of family group therapy. Nine reported that changes were a result of the therapy.

Summary of Findings.

1. Of the eighteen families interviewed, nine families reported some change in the area of intra-familial relationships which they felt was related to their participation in family group therapy.
2. The changes reported by these nine families were seen by the families to be positive changes.
3. The remaining nine families reported no changes in the area of intra-familial relationships which they felt were attributable to family group therapy.
4. Of the nine families reporting change, there were no instances of isolated change. Families reporting change in one area of intra-familial relationships tended to report changes in other areas as well.
5. The area in which change was reported most frequently was the area of agreement--disagreement. The responses usually indicated either increased agreement, or increased tolerance of disagreement, on the part of family members.
6. Where improvement in intra-familial relationships was reported, it tended to be stated in terms of increased communication and understanding.
7. There was a tendency for parents to report more change than the children. This could in part be a function of the design of the question, or greater verbal ability on the parents part. However, the impression was given that most of the changes took place in the marital relationship.

An analysis of the data on intra-familial relationships using the variables of (1) socio-economic status

(Hollingshead Index); (2) number of interviews; (3) Family Type; (4) diagnostic category of I.P., yielded the following findings.

8. a. Families reporting some change tended to fall into High socio-economic group.
- b. Families reporting no change tended to fall into the Low socio-economic group.

Table 32. Change in Intra-Familial Relationship as Related to Socio-Economic Status

	High	Low
Change	6 (67%)	3 (33%)
No Change	3 (33%)	6 (67%)
	9	9

N=18

9. a. Families reporting some change had four or more interviews.
- b. Families reporting no change tended to have had three or less interviews.
- c. A greater percentage of the families reporting change had eight or more interviews.
- d. A greater percentage of the group reporting no change had less than eight interviews.
- e. The mean number of interviews for the group reporting some change was 12.2
- f. The mean number of interviews for the group reporting no change was 5.7

Table 33. Change in Intra-Familial Relationships as Related to Number of Interviews

	1 - 3 Int.	4 or more Int.
Change	0 (0%)	9 (100%)
No Change	4 (44%)	5 (56%)
	4	14

N=18

Table 34. Change in Intra-Familial Relationships  
as Related to Number of Interviews

	1 - 7 Int.	8 or More Int.	N=18
Change	3 (33%)	6 (67%)	
No Change	6 (67%)	3 (33%)	
	9	9	

10. a. A greater percentage of the families reporting change were families categorized as Leaderless and Disconnected.
- b. A greater percentage of the families reporting no change were categorized as Restricted, Dictatorial, Contricted and Chaotic.

Table 35. Change in Intra-Familial Relationships  
as Related to Family Type

	Leaderless and Disconnected	Others	N=18
Change	6 (67%)	3 (33%)	
No Change	3 (33%)	6 (67%)	
	9	9	

11. A comparison of the change and no change groups by diagnostic category of the I.P. yielded no significant finding.



## CHAPTER IV

### SUMMARY AND CONCLUSIONS

#### Summary of Major Findings

A review of the six sections of data analysis has yielded the following findings.

1. Of the eighteen families interviewed for this study, approximately 50% of the families reported some change in family functioning which they viewed as positive, and which they attributed to their participation in family group therapy.
2. There were no reports of deterioration in family functioning ascribed to family group therapy.
3. The families reporting changes tended to remain constant throughout the six sections of analysis, so that families reporting change in one area of family functioning tended to be the same families who reported changes in other areas. The same applied to families reporting no change.
4. The areas of family functioning where change was reported most frequently were the areas of (1) role functioning; (2) communication; (3) intra-familial relationships, in that order. Little or no change was reported in the areas of (1) use of community resources; (2) external family relationships; and (3) occupation and education.

An analysis of the data from each section, using the variables of (1) Socio-economic status (Hollingshead Index); (2) number of interviews; (3) Family Type; and (4) Therapist's impressions, has yielded findings common to each section. They are the following. (See Tables No. 32 to 35).

5. a) Families who reported change tended to fall into the High Class group.  
b) Families reporting no change tended to fall into the Low Class group.
6. a) Families who reported change tended to have had four or more interviews.  
b) Families reporting no change tended to have had three or less interviews.
7. a) A greater percentage of the families reporting change were families who were categorized as Leaderless and Disconnected.  
b) A greater percentage of the families reporting no change were families who were categorized as Dictatorial, Restricted, Constricted and Chaotic.
8. A comparison of therapist's impressions regarding change at the time of case-closing, with the families perceptions of change at the time of the research interviews, one year or more later, reveals some discrepancy between the therapist's impression of change and the families perception of change. The therapists rated more families as having changed than did the families themselves. It must be remembered in connection with this that the ratings by therapists and families occurred at

different points in time.

The material dealt with thus far represents what we feel were the major findings of our study. There are some other features of the data that we feel are worth mentioning.

9. Parents tended to report change more frequently than children.
10. The two one-parent families in the study consistently reported no change in family functioning.
11. Negative attitudes to follow-up interviews were frequent, leading to difficulty in assembling a random sample.
12. Analysis suggested a fairly high degree of concensus between the parents on most aspects of family life.

This suggests that their reports in other areas may also have been reliable.

Summary Table on General Characteristics  
of all the Changes noted by the  
Eighteen Families Interviewed.

General Characteristics of change in all families in all areas. The areas of greatest change were in the internal areas of family functioning, those being communication, internal family relationships and role performance. More families felt that they had changed in role performance than in any other area. Thirteen of the eighteen families noting a predominately positive change. Communication was the area of second greatest improvement with ten families noting change closely followed by interfamilial relationships with nine positive changes recorded. Ten families retain or gained positive attitudes toward the agency while nine were essentially negative. The external areas showed

Table 36

The General Characteristics of the 18 Families Interviewed, as to Socio Economic Level, Number of Interviews, Therapist's Ratings, and as to the Changes Recorded in each area of our Questionnaire.

x no change

✓ at least some change

neg. - negative agency attitude

pos. - positive agency attitude

F a m i l y	Type	Socio Economic Level	No. of Inter- views	Thera- pist's ratings	Communi- cation	External Family Relation- ships & Use of Informal resources	Internal Family Relation- ships	External Relation- ships & Performance	Role Perform- ance	Agency Attitudes
A	constricted	low	13	✓	x	x	x	x	x	neg.
B	chaotic	low	8	✓	✓	x	x	x	✓	pos.
C	constricted	high	6	✓	✓	x	✓	x	✓	pos.
D	leaderless	low	12	✓	x	x	x	x	x	neg.
E	leaderless	low	13	x	✓	✓	✓	✓	✓	neg.
F	chaotic	high	3	✓	x	x	x	x	x	pos.
G	dictatorial	low	12	✓	✓	x	✓	x	✓	neg.
H	leaderless	high	15	✓	✓	x	✓	✓	✓	neg.
I	chaotic	high	5	✓	✓	x	✓	x	✓	pos.
J	dictatorial	low	1	x	x	x	x	x	✓	pos.
K	leaderless	high	1	✓	x	x	x	x	x	neg.
L	leaderless	low	8	✓	✓	✓	✓	✓	✓	pos.
M	disconnected	low	6	✓	x	x	x	x	✓	pos.
N	disconnected	high	7	✓	✓	✓	✓	✓	✓	pos.
O	disconnected	high	24	x	✓	✓	✓	x	✓	pos.
P	disconnected	high	20	✓	✓	✓	✓	✓	✓	pos.
Q	constricted	low	1	x	x	x	x	x	x	neg.
R	dictatorial	high	7	✓	x	x	x	x	✓	neg.

Table 37

Socio-Economic Level of families as it is related to change in six areas of family functioning. Percentages given indicate percentage of families noting change or in agency attitudes remaining positive.

Socio-Economic Level	Communication (No. and % Reporting Change)	External Family Relationships & Use of Informal resources (No. and % Reporting Change)	Internal Family Relationships (No. and % Reporting Change)	External Perform- ance and Relation- ships (No. and % Reporting Change)	Role Performance (No. and % Reporting Change)	Agency Attitudes (No. and % Reporting Change)
low 9	4 (44.4%)	1 (11.2%)	2 (33.3%)	1 (11.2%)	6 (66.6%)	3 (33.3%)
high 9	6 (66.6%)	2 (33.3%)	6 (66.6%)	2 (33.3%)	6 (66.6%)	6 (66.6%)

Table 38

Therapists Impressions of improvement as it is related to change in six areas of family functioning.

Thera- pists Impres- sions	Communication (No. and % Reporting Change)	External Family Relationships & Use of Informal resources (No. and % Reporting Change)	Internal Family Relationships (No. and % Reporting Change)	External Perform- ance and Relation- ships (No. and % Reporting Change)	Role Performance (No. and % Reporting Change)	Agency Attitudes (No. and % Reporting Change)
No Improve- ment 4	2 (50%)	2 (50%)	2 (50%)	1 (25%)	2 (50%)	2 (50%)
Some Improve- ment 14	8 (57.2%)	2 (14.1%)	7 (50%)	4 (28.4%)	10 (71.3%)	9 (64.2%)

Table 39

The number of interviews as related to change in six areas of family functioning.

No. of Inter-views	Communication (No. and % Reporting Change)	External Family Relationships & Use of Informal resources (No. and % Reporting Change)	Internal Family Relationships (No. and % Reporting Change)	External Performance and Relationships (No. and % Reporting Change)	Role Performance (No. and % Reporting Change)	Agency Attitudes (No. and % Reporting Change)
3 or less 3	0 (0%)	0 (0%)	0 (0%)	0 (0%)	1 (33%)	1 (33%)
4 or more 15	10 (66%)	5 (33%)	9 (60%)	5 (33%)	11 (73%)	10 (66%)

Table 40

No. of families in each type reporting changes in each area of family functioning.

Type of family	Communication. No. Reporting Change	External Family Relationships & Use of Informal resources. No. Reporting Change	Internal Family Relationships. No. Reporting Change	External Performance and Relationships. No. Reporting Change	Role Performance. No. Reporting Change	Agency Attitudes. No. Reporting Change
leaderless	3	2	3	3	2	2
con- stricted	1	0	1	0	1	1
chaotic	2	0	1	0	2	3
discon- nected	3	3	3	2	4	4
dicta- torial	1	0	1	0	3	1

less change with only five families noting change in each of External Family Relationships and Use of Informal Resources and External Performance and Relationships.

There could be several possible reasons for the greater changes in the internal areas. Family group therapy is aimed directly at internal family functioning and external gains are secondary. Internal dysfunction was usually the referring problem and the one the families were most motivated to control. Changes in internal functioning are mainly in the perception by the family and relies on no external forces.

There tended to be changes in all areas of internal functioning if there was a change in one. Changes did not seem to occur in isolation. In only three families, M, J, and R, there was an isolated change in role performance noted. All changes were positive except in one instance D family in role performance noted a negative change.

### Conclusions.

Several tentative conclusions can be drawn from the major findings in this study. These conclusions apply only to the eighteen families studied. First, there are indications that family group therapy is a valid treatment approach, generally, in effecting change in family functioning. There is also evidence that specific goals of this treatment are achieved. It is reasonable to assume that changes in role performance, changes in communications patterns, and changes in intra-familial relations are effected. In addition, there seems to be a tendency for

change to be effected in relations external to the family, although to a somewhat lesser degree. Change in one area of family functioning, (i.e. roles) tends to be correlated to change in other areas. These changes seem to become increasingly apparent through time, with length of treatment. Finally, the therapeutic goal of effecting symptom relief has been observed only indirectly, although impressions gained by the interviewers indicate that this area too, varies directly with the other areas of family functioning.

The greatest change seemed to be observed by the families at time of treatment or immediately after. No real conclusions could be drawn on the long term effects, largely because of the short time span of the study and because of the lack of information obtained at the onset of treatment, from which to base a comparison with follow-up. It was found that the therapists' impressions tend to be higher than the families self ratings a year later. Perhaps this too, may result from the time factor involved, producing divergencies between families and therapists as they rate in retrospect.

There are indications that change is effected by family group therapy, not only in the behaviour of the identified patient, but also in the behaviour of other family members as well. This is consistent with the goals and impressions of the therapists. As was suggested by some of the families interviewed, many of these changes, especially in the children, could be explained by the maturational process. However, evidence suggesting fairly extensive



changes in the behaviour of parents, particularly in the sphere of marital relations, leads us to believe that there are reciprocal effects of treatment among family members.

Some of the questions raised by the researchers with regard to what characteristics of families are most conclusive to change through family group therapy have provided certain clues from which future research can be guided. First of all it appears as if assessment of family interaction patterns may be useful in predicting success in treatment. "Leaderless" and "disconnected" family types show tendencies to change more readily with treatment, while "chaotic", "dictatorial", and "constricted" family types seem to change least. These tendencies appear to vary independently with other family characteristics such as socio-economic class and pathological symptom formation, although a more sophisticated study may show otherwise. Leaderless families may be potentially more democratic in nature and therefore more receptive to higher modes of participation in communications between family members. Dictatorial families may on the other hand be more resistive to treatment and may resent disruption of their communication patterns by the therapist. The latter situations may be a fruitful area for future investigation particularly with regard to the problem of drop-outs in the initial stages of treatment. Improvement in differential diagnosis of families may aid the therapist to develop a more flexible approach in use of techniques in order that he may overcome initial resistances, inhibitions, or inadequacies in the family's ability to make use of

treatment.

Similarly, findings in this study suggest that lower class families do not respond as well to this form of treatment as do higher class families. Some of the implications that can be drawn from these findings may have future consequences in similar refinement of diagnosis and techniques as discussed above. In addition, we may speculate that certain families may not be responsive to family group therapy, or they may require additional preliminary or supplementary forms of treatment in conjunction with family group therapy. Perhaps apparent class differences observed with regard to verbal facility, communication patterns, and role perception may have some bearing on this matter.

Optimal number of family members in treatment was not studied, nor were other aspects of family structure such as age range, foster parents, and so forth. However, the two one-parent families included in the study showed no apparent response to treatment. Therefore it would be reasonable to hypothesize that family structure, socio-economic class, family type, and other characteristics of the family may be predictive in success through treatment. More intensive study in this area may reveal various configurations of family characteristics reacting specifically to particular treatment approaches to therapy.

With regard to the treatment process itself the researchers gained the impression that families found interviews threatening during the initial stages. Possibly this form of treatment conflicts with an interviewee set; or

possibly insufficient preparation and orientation is provided the families by the therapists. Some of the families commented on the personality of the therapist, but no conclusion could be drawn from complaints here. It is conceivable that mechanism's of defense such as projections and rationalizations were used. Nevertheless, the very presence of these comments by families leads the researchers to speculate that the presented personality of the therapist may be a factor, especially in the initial stages of treatment.

Technically, the researchers found that this study relied too heavily on impressional ratings by the therapists and the families themselves. Too little objective confirmation and validation was included in the data. The higher number of families who refused to be interviewed suggests that this sample was not representative of the total population of families who underwent treatment. However, the researchers feel the sample was nonetheless fundamentally similar enough to the total population, that generalization could be made on a hypothetical basis. It was the impression of the therapists that the sample used did not become "loaded" with any one type of family treated. It appeared as if the stigma of "mental clinic", and "mental disease" was the prime motivating factor for families in refusing to be interviewed by the researchers.

#### Recommendations.

It is because of the exploratory nature of this study that very few recommendations could be made on the basis of our findings, with regard to policy, administration, or

treatment practise. However, there are indications that certain positive changes could be made in the intake process. The poor results achieved with families attending less than four interviews suggests to the researchers that cases referred for family group therapy should be done under the stipulation that the families agree to attend at least four interviews. This would establish a contact in the treatment process, and allow the therapists maximum use of their time in practise. Further, it is felt that it would be advisable for the therapists to provide a greater amount of orientation to the family with regard to treatment during the initial interviews.

Several recommendations at this stage can be made with regard to further research. It is felt by the researchers that additional studies are needed on an exploratory basis. Should these studies be initiated, numerous improvements could be made over the present project. Firstly, it may be useful to prepare families at time of treatment for future contact by interviewers gathering follow-up data. This may reduce the number of families rejecting follow-up contact. Secondly, it would be useful to gather information, similar to that gained on the interview schedule, at the onset of treatment. This would allow a basis for comparison of present functioning at time of treatment and follow-up, making the data more reliable in that it would not depend exclusively on subjective impressions of change as does the present study. Thirdly, greater validation could be achieved if information could be gained from external sources. For example, the researchers would have included reports from

school authorities on the functioning of clients at school but the time allowed for the project was too limited to allow for this. Further external information could also be obtained from other social agencies involved.

If a future study were to be conducted along the same lines as the present study, several changes could be made in focus. The researchers feel that more attention should be made to gain information dealing directly with the symptoms of the I.P. In addition, it may also be useful to analyze more thoroughly factors related to family structure. These factors could include absolute size of family, number of family members in treatment, age ranges, missing parents, surrogate parents, and so on.

Future studies of this type could be made more longitudinal, involving follow-up contacts at intervals protracted over a greater time span. Evaluative studies may gain broader validity with the use of control groups (either comparative families undergoing different forms of treatment or families not receiving treatment). If larger samples can be used, useful information may be obtained from the use of inter-correlations between representative characteristics of families, such as class, family types, family structure, and symptom formation. Hence, studies could be made more descriptive and more conducive to statistical analysis.

As stated in the previous section, more knowledge would be useful in refining differential diagnosis and treatment method. Diagnostic tests could be standardized for use in the assessment phase of treatment. Such tests could

be interactional analyses in problem-solving tasks, Thematic Apperception Tests, Rorschach tests, and so forth. The focus for these could be on modes of communication and interaction patterns within the family (in the opinions of the researchers), much in the same manner as are now used by Satir.<sup>1</sup> Here too, criteria for termination of treatment may be evolved. Knowledge gleaned from studies in this area would help the development of appropriate use of differential treatment techniques as applied to specific family constellations. At the same time various combinations of therapy could be studied to find relative effectiveness of supplementary treatments in conjunction with family group therapy. The latter may be able to overcome the suggested difficulty with lower class families, families with disrupted structure, and families with certain unfavourable interaction patterns. Finally, the study of the therapists' personality, or at least the manner in which he interacts with specific family types may be useful in establishing intake criteria for allocation of cases, in selection of candidates' for training, and in practise content of training programs.

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<sup>1</sup> Satir, Virginia. Satir's technique of formal intake diagnostic interview, now in the developmental stage, Mental Research Institute, Palo Alto, California.

ANNOTATED BIBLIOGRAPHY

Bardill, Donald R. "Family Therapy in An Army Mental Hygiene Clinic," Social Casework, October, 1963.

Set in a military hospital dealing mainly with problems of adolescent dependents of military personnel. Outlines first some advantages of family group therapy, e.g. time and personnel saving. Employs Nathan Ackerman's aims. Some discussion of techniques follows emphasizing the importance of not deviating from the family unit.

Scherz, Frances H. "Multiple-Client Interviewing: Treatment Implications," Social Casework, Vol. XLIII, 1963.

Once again outlines advantages of family group therapy. Goes on to discuss types of families able to use family group therapy.

1. "effective in the treatment of persons with acting out character disorders when their central problem is difficulty in a marital or parent child relationship and when the first goal of behaviour is to help them examine their role behaviour".
2. "neurotic parents of phobic children".
3. "chronic illness is main problem".
4. "when first treatment aim is to improve role functioning".
5. "individuals who are too threatened to examine their own personal problems".

Contraindications:

1. when family receives gratification from supporting pathologs.
2. when the neurosis or character disorder of one member is cause of other members disturbance.
3. overwhelmed by anxiety . . . unable to participate.
4. when there is a need to secure historial data.

Discussion of Concurrent Individual and Group Treatment.  
e.g. when strong dependency needs must be met.

Some discussion of techniques:

1. any intervention should be done in terms of family interaction.
2. worker should maintain emphatic neutrality.

3. requires all members to participate by appropriate intervention.
4. attention to non-verbal communication.
5. alert to families growing dependence on each other and not therapist.

More useful article than the average for our purposes.

Coyle, Grace Longwel. "Concepts Relevant to Helping the Family as a Group." Social Casework, Vol. XLIII, 1963.

Discussion of generic concepts from group workers. Emphasis on Family Relationships--significance of family relationships stressed. Incorporation of Social Science concepts discussed--particularly social role. Also a consideration of the family within its culture. Discussion of small group theory and the reaction of a family as a group. Framework for Understanding Group Processes.

1. the establishment of group identity e.g. common goals; overt, implicit, unconscious. Determination of membership. Initial type of structure.
2. Interpersonal Relations or Interaction
  - a) status or ranking process
  - b) sub groups
  - c) role structure
3. Group Control and the Exercise of Authority.
4. Group think as a Basis for Action as a Group, basis steps is decision making.
  - a) becoming aware of problem
  - b) clarifying and evaluating proposed solutions
  - c) reaching a decision
  - d) acting upon the decision
5. Emotional aspects of group behaviour, morale, etc.
6. Value System or Group Culture.
  - (1) beliefs concerning right and wrong.
  - (2) appreciate or aesthetic values--concerning what is considered appropriate or beautiful.
  - (3) cultural values.

Summary - discussion of thoughtful use of theoretical frameworks and concepts in general. A descriptive but useful article for our study.

Pollak, Otto and Brieland, Donald. "The Midwest Seminar on Family Diagnosis and Treatment." Social Casework, Vol. XLII, 1961.

Attempting to focus on data that will help identify the family's most burdensome problem



constellation and the way it affects the family.

1. what is the most burdensome problem?
2. deficit or excess in family membership.
3. is the interaction problem mutually harmful.
4. external pressures?
5. internal pressures of one partner?
6. in view of the causative factors, how can the caseworker help the member's of the family group to change.

Must take into account in diagnosis--family sub-systems, sub-cultural setting. Focus on the family as a treatment unit from worker outside the family. Some discussion of special problems:

1. transference and counter transference.
2. interaction analysis (establishment of long and short term goals).

Fairly good descriptive article but covering much the same points as did the Grace Coyle article and therefore not of too much value for our study.

Mitchell, Celia B. "Integrative Therapy of the Family Unit." Social Casework, February, 1965, Vol. XLVI, No. 2.

Describes the focus and very brief theoretical concept behind family unit therapy at the Family Mental Health Clinic of the Jewish Family Service of New York. Suggests that the initial response of the family is one of the most important criteria for predicting success of family group therapy. Suggests some flexibility even after family group therapy has been decided upon. Some problems involved in family therapy were mentioned: establishment of an affective bond; therapists feeling of being an outsider. Mentions some contraindications to family group therapy such as fixed pathology of any member; basic dishonesty of parents, etc.

Not a particularly useful article, completely descriptive in nature, adds nothing to knowledge on family group therapy.

Brandzel, Esther. "Working through the Oedipal Struggle in Family Unit Sessions." Social Casework, July, 1965, Vol. XLVI, No. 7.

Takes place at the Family Mental Health Clinic of Jewish Family Service. Entirely descriptive article concentrating almost entirely on one family case.

Then goes on to discuss one case in detail. Of little value.

Lindberg, R. Dwaire and Wosmek, Anne W. "The Use of Family Sessions in Foster Home Case." Social Casework, March, 1963.

Takes place in a Child Care Agency in Minneapolis. Outlines briefly some values of Family Sessions for foster families "each family member is helped to recognize the importance of his particular contribution to the success of the child's placement". Outlines one case history following very brief conceptual introduction. Not very applicable.

Bardill, Donald R. and Bevilacqua, Joseph J. "Family Interviewing by Two Caseworkers." Social Casework, May, 1964, Vol. XLV, No. 5.

This article is totally descriptive. It outlines very briefly some of the theoretical concepts behind the choice of two caseworker interviews and then goes on to discuss the method used. This is not a particularly useful article as it is very broad and general and adds nothing new.

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APPENDIX I

Introductory Letter to Prospective Interviewees

Mental Health Centre,

Dear

The Mental Health Centre is interested in assessing its program in order to improve and develop services to families. This means research into the problems and usefulness of services to different families and we are requesting your assistance in assessing this from your point of view. It requires a meeting with families which will be entirely confidential and the data obtained would in no way identify any person or family group.

This research is being done in conjunction with the University and involves a social worker who has been associated with the staff of this clinic.

If this is acceptable to you this social worker will be calling within the next few days to arrange a meeting at your convenience. Since the aspect which we are assessing is Family Group Therapy we would wish such a meeting to be with the family group. In order to take up less of your time the meeting could be in your home.

Sincerely,

K. J. Davies, M. D.  
Director.

## APPENDIX II

### The Interview Schedule

#### Occupation and Education.

1. Are you now working? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. If so, have you acquired work since attending F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
2. Is the job you are now doing, the same job at which you were employed while attending F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. What changes have been in employment since attending F.G.T. (a) in place of work? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (b) in type of job? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (c) promotions or demotions? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (d) merit raises (as opposed to general raises)? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (e) are you planning or anticipating any changes in one of these areas in the near future? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
3. How do you like the job you are now doing? (a) do you like this type of work? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (b) do you think the salary is fair? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (c) do you feel you are performing your work better than average? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (d) average? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; (e) or are you having difficulties? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. How do you feel you are getting along with your boss or bosses? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. How do you feel you are getting along with your fellow employees? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Have there been any changes in these areas since attending F.G.T.? (repeat categories if necessary). F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
4. Have you entered any job training or education programs since attending F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. If yes, are these completed? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; incompleted? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; progress? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
5. In any training or educational program in which you are now involved: how well do you feel you are now performing the required work? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; how do you enjoy the work? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; how do you get along with teachers or instructors? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_; how do you get along with other students? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Have there been any changes in these areas since attending F.G.T.? (repeat categories if necessary). F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
6. Are there any additional comments on any changes in work or school since attending F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.

Do you feel that any changes in these areas have been brought about as a result of family group therapy.

Role Performance.

1. Who would you say makes the major decisions in your household? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.
2. Are there certain situations where either mother or father makes the decision without consulting each other? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Could you provide an example? (money, sex, work, religion, play, discipline, household chores). F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.
3. Would you describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.
4. Are you more active or less active in household duties since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.
5. Do you expect different things from your children since F.G.T.? (Give an example). F \_\_\_\_ M \_\_\_\_\_. Do you expect different things from your parents since F.G.T.? (Give an example). IP \_\_\_\_.
6. Do you accept your parents' judgment on most decisions? (Give an example). IP \_\_\_\_\_. Describe any changes since F.G.T. IP \_\_\_\_.
7. Do others in the family usually listen to your ideas or suggestions? (Give an example). IP \_\_\_\_\_. Describe any changes since F.G.T. IP \_\_\_\_.
8. Mother: Have you feelings about your place in the family since F.G.T.? Yes \_\_\_\_ No \_\_\_\_\_. If yes, could you give an example? \_\_\_\_\_.  
Father: Have you feelings about your place in the family since F.G.T.? Yes \_\_\_\_ No \_\_\_\_\_. If yes, could you give an example? \_\_\_\_\_.  
I.P. Have you feelings about your place in the family since F.G.T.? Yes \_\_\_\_ No \_\_\_\_\_. If yes, could you give an example? \_\_\_\_.

Do you feel that any changes in these areas have been brought about as a result of family group therapy?

Formal Community Resources.

1. How do you feel about using social agencies in your community? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. If the above question does not bring out attitudes about the M.H.C., say - How do you feel about the M.H.C. now that you have had some contact with that agency? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes that occurred in your attitudes about social agencies since F.G.T. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.
2. Does religion play an important part in your family life? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes that may have occurred since F.G.T. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_.



3. Do you belong to any organized groups or clubs in your community? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ . Describe any changes in your participation since F.G.T. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .

Do you feel that any changes in these areas have been brought about as a result of family group therapy?

External Family Relationships and use of Informal Community Resources.

To Family.

1. Do you have any relatives in the Vancouver or Lower Mainland area? Yes \_\_\_\_ No \_\_\_\_ .
2. If yes in what way does the family keep in touch with each other? By telephone \_\_\_\_ Visiting each other's houses \_\_\_\_ Combination of both \_\_\_\_ Other \_\_\_\_ . How often: Daily \_\_\_\_ Weekly \_\_\_\_ Monthly \_\_\_\_ . If no how often do you keep in contact with friends and neighbours? Explain how contact is made and the frequency. \_\_\_\_ .
3. Which side of the family do the members of this family visit or have contact with most often, the husband's side or the wife's side? \_\_\_\_ . Can you explain the reason for this? \_\_\_\_ . Describe any change in the amount of visiting or contact since F.G.T. \_\_\_\_ . Which side of the friends do the members of this family visit or have contact with most often, the husband's side or the wife's side? \_\_\_\_ . Can you explain the reason for this? \_\_\_\_ . Describe any change in the amount of visiting or contact since F.G.T. \_\_\_\_ .
4. Do the members of this family use community resources such as neighbourhood playgrounds, community centres, night school courses, living room learning courses, library, etc. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .
5. How often do you use these community resources, often, seldom, not at all. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .
6. Describe any change in the amount of the uses of these community resources since F.G.T. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .
7. Do members of this family want to join other people (relatives and/or friends) in various activities. For example father and mother wanting to go out and do things with their relatives/or friends, and the children wanting to do things with their friends. F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .
8. Describe any changes that have occurred since F.G.T. (Increase, about the same, or decrease, etc.) F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_ .

Do you feel that any changes in these areas have been brought about as a result of family group therapy.

Communication.

Observe and make a brief note at the end of this section on:

1. who usually speaks first
2. what alignments take place
3. is there much laughter in the interview and is it appropriate.

1. Can you usually understand what is being said by family members during the family meetings? F Yes \_\_\_ No \_\_\_, M Yes \_\_\_ No \_\_\_, IP Yes \_\_\_ No \_\_\_. Have there been any changes since F.G.T.? Yes \_\_\_ No \_\_\_. If yes, can you give an example where the family shows added understanding? \_\_\_.

2. Do you usually feel certain that you know what another family member means? F Yes \_\_\_ No \_\_\_, M Yes \_\_\_ No \_\_\_, IP Yes \_\_\_ No \_\_\_. If no, could you describe what it was about his behaviour that made you uncertain? (Probes)

a) Did the words coming out of his mouth match the look on his face? F Yes \_\_\_ No \_\_\_, M Yes \_\_\_ No \_\_\_, IP Yes \_\_\_ No \_\_\_.

b) Do you usually try to check out the meaning of what the other person says to you, to see if that is really what was meant by the message? F Yes \_\_\_ No \_\_\_, M Yes \_\_\_ No \_\_\_, IP Yes \_\_\_ No \_\_\_.

Describe any changes since therapy? \_\_\_. Is this change associated with anything that happened in F.G.T.? \_\_\_ (If yes, probe for further details). \_\_\_

3. How often do you get together to have family discussions? Once a week \_\_\_ Twice a month \_\_\_ Once a month \_\_\_ Less Frequently \_\_\_. Describe any change since F.G.T.? \_\_\_

4. Who would you say talks the most in family discussions? F \_\_\_ M \_\_\_ IP \_\_\_. Describe any changes since F.G.T.? \_\_\_.

5. Do you think that your family usually gives you a chance to take part in discussions? F Yes \_\_\_ No \_\_\_, M Yes \_\_\_ No \_\_\_, IP Yes \_\_\_ No \_\_\_. Describe any changes since F.G.T.? \_\_\_.

6. How do you usually show other members of the family that you are happy or angry with them? (Please read all possible replies to question before obtaining a reply).

- a) Do you tell them directly. F Happy \_\_\_ Angry \_\_\_  
 M Happy \_\_\_ Angry \_\_\_ IP Happy \_\_\_ Angry \_\_\_
- b) Do you do things for them. F Happy \_\_\_ Angry \_\_\_  
 M Happy \_\_\_ Angry \_\_\_ IP Happy \_\_\_ Angry \_\_\_
- c) Do you show them through direct physical contact.  
 F Hugging and kissing \_\_\_ Spanking and hitting \_\_\_  
 M Hugging and Kissing \_\_\_ Spanking and hitting \_\_\_  
 IP Hugging and kissing \_\_\_ Spanking and hitting \_\_\_
- d) Do you usually not say or do anything at all.  
 F Happy \_\_\_ Angry \_\_\_ M Happy \_\_\_ Angry \_\_\_  
 IP Happy \_\_\_ Angry \_\_\_.
- Describe any change since F.G.T. \_\_\_.

7. Do family discussions usually end in quarrels? Yes \_\_\_  
 No \_\_\_. If yes, could you describe what usually sets  
 things off? \_\_\_. Describe any changes since F.G.T. \_\_\_.

8. When you speak your mind or complain about a family  
 member, how much consideration do you give to their  
 feelings?

	Father	Mother	I.P.
A lot	___	___	___
Some	___	___	___
A little	___	___	___
None	___	___	___

Describe any changes since F.G.T.? \_\_\_.

9. When you express your feelings to family members, do  
 you usually feel that they understand you? F Yes \_\_\_  
 No \_\_\_ M Yes \_\_\_ No \_\_\_ IP Yes \_\_\_ No \_\_\_.
- To Children: Do you feel that mother understands you  
 more than father; or less than father; or about the  
 same?

Much More \_\_\_  
 More \_\_\_  
 Same \_\_\_  
 Less \_\_\_  
 Much Less \_\_\_

Describe any change since F.G.T. \_\_\_.

10. Have you noticed any change in the time spent in  
 discussion of feelings of family members since F.G.T.  
 Yes \_\_\_ No \_\_\_. If yes, when did you first notice a  
 change? \_\_\_. How did you first recognize it? \_\_\_.  
 Is this change associated in your mind with anything  
 that happened in F.G.T.? \_\_\_. If yes, probe for further  
 details). \_\_\_

11. Do you listen to what other family members say to you?  
 F Yes \_\_\_ No \_\_\_ M Yes \_\_\_ No \_\_\_ IP Yes \_\_\_ No \_\_\_.
- Describe any change since F.G.T.? Is this change  
 associated in your mind with anything that happened in  
 F.G.T.? \_\_\_ (If yes, probe for further details). \_\_\_

Intra-Familial Relationships.

Parents and Children.

1. Do you think that as a family you mainly agree, or disagree, about most things: F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
2. When there are disagreements, which family members are the ones who disagree most often? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
3. When things "go wrong" in the family, does some one family member usually get blamed? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.
4. When things "go wrong" in the family, which family member(s) usually "stick up" for each other, or "back the other person up"? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_. Describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_ IP \_\_\_\_\_.

Parents only

5. Do you think you mainly agree, or disagree, upon things that are important to you? For example: feelings related to sex, management of money, raising the children, religion, or any other issues which you feel are important. F \_\_\_\_ M \_\_\_\_\_. Describe any changes since F.G.T.? F \_\_\_\_ M \_\_\_\_\_.
6. When there are disagreements, can you describe what happens? For example: Does somebody lose his or her temper, does somebody stop talking, or somebody "give in", are things "talked out", or does something else happen? Can you describe what happens in your case? F \_\_\_\_ M \_\_\_\_\_. Describe any changes which have occurred since F.G.T.? F \_\_\_\_ M \_\_\_\_\_.
7. Do you think your marriage has turned out mainly as you had hoped it would? F \_\_\_\_ M \_\_\_\_\_. Describe any changes in your thinking about this which have occurred since F.G.T.? F \_\_\_\_ M \_\_\_\_\_.
8. Since attending the M.H.C. for family group therapy, do you feel your sexual relationship is: F more satisfactory than before \_\_\_\_, the same as before \_\_\_\_, less satisfactory than before \_\_\_\_. M more satisfactory than before \_\_\_\_, the same as before \_\_\_\_, less satisfactory than before \_\_\_\_.

Do you feel that any changes in these areas have been brought about as a result of family group therapy.

APPENDIX III

Lickert Scale of Task Sharing

Conjugal Role Relationships - (Ideal Task Allocations).

To be completed separately by each husband and wife.

1. Yard work is the man's job, and his wife should not be expected to help with it. Strongly agree \_\_\_\_ Agree \_\_\_\_  
Uncertain \_\_\_\_ Disagree \_\_\_\_ Strongly disagree \_\_\_\_.
2. Unless is absolutely necessary for the family support, a wife should not work. Strongly agree \_\_\_\_ Agree \_\_\_\_  
Uncertain \_\_\_\_ Disagree \_\_\_\_ Strongly disagree \_\_\_\_.
3. Housework is for women. A man should not do housework. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_ Disagree \_\_\_\_  
Strongly disagree \_\_\_\_.
4. A man should simply "stay out of the way" as far as housework is concerned. Strongly agree \_\_\_\_ Agree \_\_\_\_  
Uncertain \_\_\_\_ Disagree \_\_\_\_ Strongly disagree \_\_\_\_.
5. Certain family tasks are "women's work" and other tasks are "men's work", and it is best to keep them separate. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_ Disagree \_\_\_\_  
Strongly disagree \_\_\_\_.
6. Although fathers are concerned with their children's welfare, the raising of children is really the mother's job. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_ Disagree \_\_\_\_  
\_\_\_\_ Strongly disagree \_\_\_\_.
7. When the children need to be punished or scolded, the father should do it. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_  
\_\_\_\_, Disagree \_\_\_\_ Strongly disagree \_\_\_\_.
8. When it comes to money matters, what the man says should be the rule. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_  
Disagree \_\_\_\_ Strongly disagree \_\_\_\_.
9. A woman's place is in the home, not on a job. Strongly agree \_\_\_\_ Agree \_\_\_\_ Uncertain \_\_\_\_ Disagree \_\_\_\_ Strongly disagree \_\_\_\_.

Husband's Participation Index.

To be completed separately by both husband and wife.

Who does the following tasks in the family:

1. Washes and dries the dishes. Wife always \_\_\_\_ Wife

usually \_\_\_\_ Usually done together \_\_\_\_ Sometimes one,  
sometimes the other \_\_\_\_ Husband usually \_\_\_\_ Husband  
always \_\_\_\_.

2. Pays the monthly bills. Wife always \_\_\_\_ Wife usually \_\_\_\_  
Usually done together \_\_\_\_ Sometimes one, sometimes the  
other \_\_\_\_ Husband usually \_\_\_\_ Husband always \_\_\_\_.
3. Sweeps and scrubs the floors. Wife always \_\_\_\_ Wife  
usually \_\_\_\_ Usually done together \_\_\_\_ Sometimes one,  
sometimes the other \_\_\_\_ Husband usually \_\_\_\_ Husband  
always \_\_\_\_.
4. Does the grocery shopping. Wife always \_\_\_\_ Wife usually \_\_\_\_  
Usually done together \_\_\_\_ Sometimes one, sometimes the  
other \_\_\_\_ Husband usually \_\_\_\_ Husband always \_\_\_\_.
5. Makes the beds on weekends. Wife always \_\_\_\_ Wife usually  
\_\_\_\_ Usually done together \_\_\_\_ Sometimes one, sometimes  
the other \_\_\_\_ Husband usually \_\_\_\_ Husband always \_\_\_\_.
6. Dusts the furniture. Wife always \_\_\_\_ Wife usually \_\_\_\_  
Usually done together \_\_\_\_ Sometimes one, sometimes the  
other \_\_\_\_ Husband usually \_\_\_\_ Husband always \_\_\_\_.
7. Does minor household repairs. Wife always \_\_\_\_ Wife  
usually \_\_\_\_ Usually done together \_\_\_\_ Sometimes one,  
sometimes the other \_\_\_\_ Husband usually \_\_\_\_ Husband  
always \_\_\_\_.
8. Hangs out the clothes to dry. Wife always \_\_\_\_ Wife  
usually \_\_\_\_ Usually done together \_\_\_\_ Sometimes one,  
sometimes the other \_\_\_\_ Husband usually \_\_\_\_ Husband  
always \_\_\_\_.
9. Sets the table. Wife always \_\_\_\_ Wife usually \_\_\_\_ Usually  
done together \_\_\_\_ Sometimes one, sometimes the other \_\_\_\_  
Husband usually \_\_\_\_ Husband always \_\_\_\_.

## APPENDIX IV

### Therapists' Impressions

#### Family A.

1. Family Type: Constricted.
2. Diagnosis of I.P. Adjustment reaction of childhood with habit disturbance.
3. Number of interviews: 13
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

#### Family B.

1. Family Type: Chaotic.
2. Diagnosis of I.P. Passive aggressive personality.
3. Number of interviews: 8
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

#### Family C.

1. Family Type: Constricted.
2. Diagnosis of I.P. Psychoneurotic anxiety reaction.
3. Number of interviews: 6
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

#### Family D.

1. Family Type: Leaderless.
2. Diagnosis of I.P. Psychoneurotic behaviour disorder.
3. Number of interviews: 12
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

Family E.

1. Family Type: Leaderless.
2. Diagnosis of I.P. Psychoneurotic anxiety reaction.
3. Number of interviews: 13
4. Assessment of Family functioning.
  - a) Communications: Same.
  - b) Roles: Same.
  - c) Intra-familial relationships: Same.
  - d) Symptom Relief: Same.

Family F.

1. Family Type: Chaotic.
2. Diagnosis of I.P. Psychoneurotic depressive reaction.
3. Number of interviews: 1
4. Assessment of Family functioning.
  - a) Communications: Improved.
  - b) Roles: Improved.
  - c) Intra-familial relationships: Improved.
  - d) Symptom Relief: Moderately Improved

Family G.

1. Family Type: Dictatorial.
2. Diagnosis of I.P. Adjustment reaction of childhood.
3. Number of interviews: 12
4. Assessment of Family functioning.
  - a) Communications: Greatly Improved.
  - b) Roles: Greatly improved.
  - c) Intra-familial relationships: Greatly Improved.
  - d) Symptom Relief: Greatly improved.

Family H.

1. Family Type: Leaderless.
2. Diagnosis of I.P. Adjustment reaction of childhood.
3. Number of interviews: 15
4. Assessment of Family functioning.
  - a) Communications: Greatly Improved.
  - b) Roles: Moderately Improved.
  - c) Intra-familial relationships: Moderately Improved.
  - d) Symptom Relief: Greatly Improved.

Family I.

1. Family Type: Chaotic.
2. Diagnosis of I.P. Adjustment reaction of childhood.
3. Number of interviews: 5
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately Improved.



Family J.

1. Family Type: Dictatorial.
2. Diagnosis of I.P. Adjustment reaction of childhood.
3. Number of interviews: 1
4. Assessment of Family functioning.
  - a) Communications: Same
  - b) Roles: Same
  - c) Intra-familial relationships: Same
  - d) Symptom Relief: Moderately improved.

Family K.

1. Family Type: Leaderless.
2. Diagnosis of I.P. Adjustment reaction of childhood, habit disturbance.
3. Number of interviews: 1
4. Assessment of Family functioning.
  - a) Communications: No improvement.
  - b) Roles: No improvement.
  - c) Intra-familial relationships: No improvement.
  - d) Symptom Relief: No improvement.

Family L.

1. Family Type: Leaderless.
2. Diagnosis of I.P. Adjustment reaction of adolescence.
3. Number of interviews: 8
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Greatly improved.

Family M.

1. Family Type: Disconnected.
2. Diagnosis of I.P. Adjustment reaction of adolescence, conduct disturbance.
3. Number of interviews: 6
4. Assessment of Family functioning.
  - a) Communications: Moderately Improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

Family N.

1. Family Type: Disconnected.
2. Diagnosis of I.P. Schizoid Personality.
3. Number of interviews: 7
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom Relief: Moderately improved.

Family O.

1. Family Type: Disconnected.
2. Diagnosis of I.P. Adjustment reaction of adolescence under achievement at school.
3. Number of interviews: 24
4. Assessment of Family functioning.
  - a) Communications: Moderately improved.
  - b) Roles: Same
  - c) Intra-familial relationships: Same
  - d) Symptom Relief: Moderately improved.

Family P.

1. Family Type: Disconnected.
2. Diagnosis of I.P. Adjustment reaction of adolescence. Habit disturbance.
3. Number of interviews: 20
4. Assessment of Family functioning.
  - a) Communications: Greatly improved.
  - b) Roles: Greatly improved.
  - c) Intra-familial relationships: Greatly improved.
  - d) Symptom Relief: Greatly improved.

Family Q.

1. Family Type: Constricted.
2. Diagnosis of I.P. Schizoid personality.
3. Number of interviews: 1
4. Assessment of Family functioning.
  - a) Communications: Same
  - b) Roles: Same
  - c) Intra-familial relationships: Same
  - d) Symptom Relief: Greatly improved.

Family R.

1. Family Type: Dictatorial.
2. Diagnosis of I.P. Specific learning defect.
3. Number of interviews: 7
4. Assessment of Family functioning.
  - a) Communications: Moderately Improved.
  - b) Roles: Moderately improved.
  - c) Intra-familial relationships: Moderately improved.
  - d) Symptom relief: Moderately improved.

## APPENDIX V

### Refusals

We were able to gather data on eleven families, who refused to allow us to interview them, from file material and therapists' impressions.

#### General Characteristics of the Refusals.

The general characteristics were: seven families were considered improved and four unimproved; of these latter four, three of them had three or less interviews. The family types were; constricted, four families; affectionless, four families; leaderless, dictatorial and disconnected one family each.

#### Attitudes Expressed.

Most of the refusals in refusing to be interviewed expressed very negative attitudes toward the agency. Some of the reasons given were: the therapists were not on time; therapists interested only in sex; disinterested; general hostility; children refused; impossible to get the family together.

Please see table number 1, 2, and 3 for a comparison of refusal with interviewed families.

Table 1. The number of interviews participated in by families interviewed in our follow-up interviews compared with families who refused to be interviewed.

No. of Interviews	Refusals	Acceptances
3 or less	4 (36.2%)	3 (17.6%)
4 or more	7 (63.8%)	14 (82.4%)
Total	11	17

Table 2. The Therapists' ratings of the outcome of therapy in cases which subsequently refused compared with those who accepted for a follow-up interview.

Therapists Ratings	Refusals	Acceptances
no improvement	4 (36.2%)	2 (11.7%)
improvement	7 (63.8%)	15 (88.3%)
total	11	17

Table 3. Types of families interviewed in follow-up as compared with those who refused to be interviewed.

Types of families	Refusals	Acceptances
constricted	4 (36%)	3 (16.6%)
affectionless	4 (36%)	0
leaderless	1 (9%)	5 (27.7%)
dictatorial	1 (9%)	3 (16.6%)
disconnected	1 (9%)	4 (22.2%)
chaotic	0	3 (16.6%)
Total	11	18

### Conclusions drawn from Tables.

On the basis of the preceeding tables the refusals would seem to differ from the acceptances in the following ways; there were more refusals with three or less interviews than acceptances, and fewer refusals with four or more interviews than acceptances; the therapists ratings seemed to have some relationship to the numbers in each group, the therapists rated fewer no improvements in the acceptances; in the data on family types it would appear that there were fewer leaderless, dictatorial and disconnected in the refusals than in the acceptances. The families that were interviewed were probably highly unrepresentative of the total families who were seen at the Mental Health Centre for family group therapy. The eleven families studied here are just a sample of the thirty-six total that we were unable to interview. However, even among these eleven there are considerable differences between those who were interviewed and those who refused to be interviewed.

## APPENDIX VI

### Family Types

The following definitions of family types have been developed and utilized by the treatment team at the Burnaby Mental Health Centre as conceptual guides for practise.

#### Constricted Family.

The children cannot speak freely in this type of family and the family finds difficulty in talking about or identifying family problems.

#### Chaotic Family.

The chaotic family is characterized by noise and confusion. Members talk freely, and often simultaneously, but do not listen to one another. The major communication problem is an inability to listen.

#### Dictatorial Family.

In this family type one member, usually the father, is excessively authoritarian or bossy.

#### Affectionless Family.

The affectionless family is characterized by a lack of overt expression of affection between the family members. There are often overt expressions of dislike.

#### Disconnected Family.

There is a lack of family loyalty and pride in this type of family. One member's hurt is often not felt by another, and family members tend to go their own separate ways.

#### Leaderless Family.

There is no power of decision in this family type. The children seem to run the family.

#### Delinquent Family.

In this family type there is an apparent lack of conventional values, frequently leading to difficulties with the community. A number of the family members are delinquent or unsocialized. The multiproblem family is in this group.