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The effects of short-term structural-analytic oriented family therapy on families with a presenting child problem.

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THE EFFECTS OF SHORT-TERM STRUCTURAL-ANALYTIC

ORIENTED FAMILY THERAPY ON FAMILIES

WITH A PRESENTING CHILD PROBLEM

A Dissertation Presented

By

LUCILLE L. ANDREOZZI

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

September 1984

School of Education

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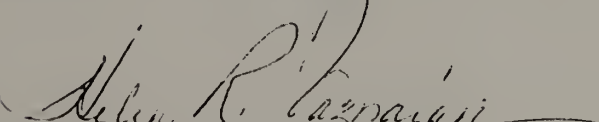
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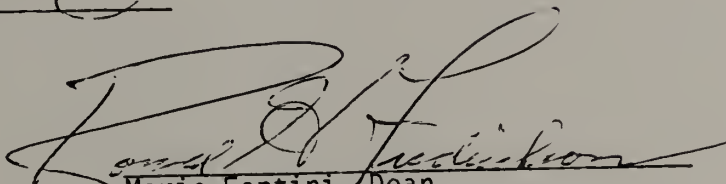Approved as to style and content by:

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iii

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ABSTRACT

The Effects of Short-Term Structural-Analytic
Oriented Family Therapy on Families
with a Presenting Child Problem

(September, 1984)

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This dissertation addressed problems of family therapy outcome and
instrumentation. The purposes of this study were to test the effects
of structural-analytic family therapy and to examine pretreatment in-
tercorrelations on family measures.

The instruments used were Family Assessment Device (FAD), Family
Unit Inventory (FUI REAL, FUI IDEAL), Child Behavior Checklist (CBCL),
Family Counseling Evaluation (FCE), and Family Assessment of the Prob-
lem (FAP).

A stratified random sample (n=40) was drawn from a population of
65 Rhode Island families with a presenting child problem. Treatment
families received seven weeks of therapy. All families were pre-post-
tested.

Change was examined for statistically-significant differences and
clinical findings. Treatment versus non-treatment outcome (T_1, T_2,
gains) was explored along two parameters (means and variances) using
MANOVAS and homogeneity of variance tests. Treatment groups one and
two pre- and posttherapy differences were analyzed using chi-square tests.

A number of statistically-significant findings were obtained,
e.g., gains for treatment group men on FUI REAL Consideration versus
Family Conflict and changes for treatment group men and women following
therapy on problem description, problem resolution, and direction of
change. Results on FCE indicated high percentages of reported improve-
ment in parents' relationship with the presenting child and satisfac-
tion with therapy. Analysis of data on family outcome indicated differ-
ent trends for men and women on self-report measures: men reported more
positive responses on FAD, CBCL and FUI whereas women reported more
positive responses on FAP and FCE. Tests of inter-instrument correla-
tions indicated strongest pretreatment subscale correlations between
FAD and FUI REAL.

One recommendation of this study is the need to develop systemic
models of research more consonant with the meaning and assessment of
systems change. Such a model described briefly herein would consider
change on the individual case and group level, individual member, inter-
personal, and family unit level from a variety of data sources (e.g.,
self-report, direct observation) and concurrent systems vantage points
(e.g., therapist, family, type of therapy).

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I
INTRODUCTION AND BACKGROUND TO THIS STUDY

In recent years a growing number of behavioral scientists (Bronfenbrenner, 1977; Cochran & Brassard, 1979; Hartop, 1979; Keeney, 1979; Learner & Spanier, 1978; Whiting & Whiting, 1975) have proposed methodologies for investigating the influence that various ecological systems (e.g., home, school, neighborhood, peer group, and so forth) exert on the developing child. One such system of influence repeatedly identified in these investigations is the family system. Empirical studies such as those reported by Bott (1971), Henry (1971), Hess and Handel (1974), and McGillicuddy-De Lisi, Sigel and Johnson (1979) have demonstrated that the family's influence on the developing child reflects the interaction of a complex set of variables that comprise the family unit system. It may even be argued that in American society the family system (regardless of how "family" is defined) is the most primary persistent system of influence on the child (Keniston, 1977).

Recognition that the family is a major system of influence on the developing child provides convincing argument for the adoption of a systems approach for viewing child development. Empirical evidence derived from investigations representing a wide range of disciplines suggests the need for and further development of family systems treatment approaches for treating presenting child problems. In this study, the effectiveness of a brief family systems treatment model with families experiencing a presenting child problem will be tested. However, before turning our attention to a description of the treatment model

labeled short-term structural analytic family therapy and to the specific experimental questions proposed in this study, a brief overview of the empirical evidence supporting a family systems treatment orientation is in order.

Overview of Different Types of Family Research

Research findings from a wide range of disciplines collectively support the importance of the family in promoting psychological health and in contributing to psychological problems in children. Empirical data have been collected from a variety of disciplines and across research populations, most notably family interaction, early childhood educational intervention, child-centered family treatment, and family systems therapy. Although it is beyond the scope of this dissertation to review all the pertinent studies supporting the critical role the family system plays in shaping the development of children, a brief survey of the literature is in order.

Family System-Child Interaction

Research with nonclinic (e.g., Belsky, 1981; Clarke-Steward, 1978; Lamb, 1977; Lewis & Rosenblum, 1979) and clinic families (e.g., Anthony & Koupernik, 1976; Burgess & Conger, 1978; Haley, 1973; Kellam, Ensminger & Turner, 1977) cumulatively support the assumption that psychological health and psychological problems in children are influenced primarily by family system interaction. In these studies the child's psychological development is seen as a function of and as a subsystem embedded in wider family system structure and interaction.

Parent-child interaction (mother-child, father-child) within the family system has been investigated experimentally and naturalistically. Parent-child interaction research, as illustrated in reviews of the literature reported by Clarke-Steward (1977) and Martin (1975), provides further evidence to support the premise that parent-child subsystem functioning within the family system exerts a powerful influence on child development. For instance, the work of Sander (1964) and the work in progress of Zeigler and Musliner (1977) provide one of the few examples of longitudinal research that accounted for the relationship between family unit interaction (family system-parent-child subsystem interaction) and individual child development.

Ziegler and Musliner reexamined the pioneering work of Sander. In the early 1960's Sander collected data on 30 nonclinic families (30 firstborn infants and their mothers and fathers). Sander employed a variety of clinical, experimental, and naturalistic methods to collect his data. Ziegler and Musliner are conducting an intensive follow-up investigation 15 years later on three of Sander's original families. One important finding of this follow-up research was that family interaction patterns appeared to display remarkable consistency over time. Unresolved problems identified by Sander as core dilemmas in the families were found by Zielger and Musliner to have repeatedly surfaced as a problem source for the three families over the years. Although such a finding must be viewed with extreme caution because of the small sample size, this research finding nevertheless lends support to the assumption that family interaction patterns often remain stable through-

out the child's developmental stages and that family themes persist
over time.

Early Education Intervention

Another source of empirical evidence supporting the importance of
the family system is found in the research conducted on families with a
preschool child identified as being at educational risk. During the
late 1960's and early 1970's a number of early intervention studies
were conducted. Retrospective examination of follow-up data obtained
from Early Intervention studies (Bronfenbrenner, 1975; Chilman, 1973;
Horowitz & Paden, 1973) concluded that only minor treatment success
could be claimed. A major cause of treatment ineffectiveness was at-
tributed to the focus of the intervention: Intervention efforts were
usually directed at the high risk child and/or the mother rather than
on the family system. Those programs found to be more effective (e.g.,
Bergen & Fowlkes, 1980; Levenstein, 1970; Schaeffer, 1972) were de-
scribed as being family-centered in applying the educational treatment.
This same conclusion drawn by different groups of early intervention re-
searchers across studies provides convincing argument for the important
influence of the family system on the developing child.

Child-Centered Family Treatment

In addition, clinical research has shown that individual child
symptoms often are a function of and reflect wider family system prob-
lems. Research reported by Ackerman (1970), Anthony (1980), Gottschalk,
Brown, Bruney, Shumate and Uliana (1976), Minuchin (1970), and Wellisch,

Vincent and Ro-Trock (1976) are some examples of clinical research that illustrate how presenting child problems can be diagnosed and treated as symptoms that suggest family system dysfunction. Case study evidence presented in the works of Fraiberg, Adelson and Shapiro (1975) illustrate that when the family system rather than just the child is treated, the presenting child symptoms can be treated more effectively.

Family Systems Therapy

Family therapists have documented what happens when family relationships become problematic, conflictual, and pathogenic. In so doing, they also have stressed the crucial role family relationships play in shaping human development and in promoting positive mental health. There are many different schools of family systems therapy currently in use. Different schools reflect different theoretical frameworks. Some of the more widely accepted models reported in the literature and which have been identified by Olson, Russell and Sprenkle (1980) as being in the forefront of family therapy include structural family therapy, experiential family therapy, and social learning theory family therapy.

An overview of the literature compiled by Gurman and Kniskern (1981) describes additional family therapy schools of thought besides those mentioned by Olson et al. These family therapy models include psychoanalytic and object relations family therapy, intergenerational family therapy, problem-centered family systems therapy, and humanistic, growth-oriented family systems therapy. As first pointed out by Ackerman (1972) and later by Lebow (1981) and Pinsof (1981), there is a vast

array of techniques and treatment models that combine concepts and principles from several schools of thought. Thus, it often becomes difficult to categorize models as belonging exclusively to one theoretical orientation.

Constitutional Factors

Finally, some preliminary evidence recently has been reported to suggest the impact that the family environment has on certain childhood cognitive and behavioral conditions principally attributed to constitutional factors. Thomas and Chess (1977) provide longitudinal data to illustrate how different children's temperaments may be affected by different types of family system environments. Sameroff (1975) cites evidence to show how developmental delays in children can be modified by the quality of the child's family environment. Sameroff reports that high risk children reared in family environments labeled as being educationally superior have on average been found to perform better academically than the same type of children reared in family environments labeled as being educationally poor.

Sameroff proposes a diagnostic paradigm that takes into consideration the child's constitutional characteristics and the family environment. According to Sameroff, this child-family interaction paradigm may be used to predict developmental outcome. Sameroff's model is just one example of the growing trend in the behavioral sciences to view psychological development, health, and psychological problems within a systems rather than an individualistic, analytical framework.

The Family as a Social System

It is beyond the scope of this dissertation to present an in-depth treatment of the various schools of family therapy. However, one common thread underlying all of these newly emerging family therapy frameworks, and a fundamental assumption underlying this investigation, is the concept of the family as a special kind of social system. In his article "Family Theory and Therapy," a review of 25 years of family theory and family therapy research, Framo (1979) summerizes the family systems perspective. Clinical and experimental research with families participating in therapy has suggested the following findings.

1. Family system relationships are different from and are more primary than other social relationships. As such, families can bring both the best and the worst out in family members.

2. The family is an intricate and intimate biosocial system that is characterized by personally tailored rules, themes, images, homeostatic feedback mechanisms, communication patterns, myths, and rituals.

3. Families tend to mold individual family member behavior to fit the present needs of the system. Individuals often adapt to either the explicit needs or implicit demands of the family system.

4. A reciprocal relationship exists between the intrapsychic organization and conflicts experienced in individual family members and the interpsychic organization and conflicts expressed in the family system.

5. Normal and abnormal behavior of family members receive meaning from the family system and thus can best be understood and evaluated in

relation to the function such behavior performs for the family system.

6. Whenever two or more family members interact, there is a potential for psychological collaboration occurring, "one person carries part of the motivations and psychology of another" (p. 990). Such collaboration may be benign ("If you are assertive then I can be more submissive") or it may be unconscious and collusive ("If you provide for me then I will internalize and act out your bad self").

7. Individual symptoms characterizing the identified patient may be viewed as symptoms of the wider family system. The system dysfunction is often projected onto, identified with, and localized in one family member.

In reflecting the consensus of most family clinicians, Framo continues to argue in favor of a shift from treating presenting child problems utilizing the traditional child guidance model (mother and child treated separately by different therapists) to treating presenting child problems utilizing a family systems model of orientation. Framo presents a convincing argument for adopting a family systems treatment focus, regardless of theoretical orientation, for treating children.

Other prominent family therapists and theorists provide compelling arguments for the adoption of family systems treatment approaches to treating children. For instance, Anthony (1980) and French (1977) reexamined traditional child psychiatry as a mode of treatment and reframed child presenting problems in a family systems context. French succinctly describes the merits of such an orientation in his book Disturbed Children and their Families:

> Parents of symptomatic children have been the victims
> of a mind-boggling list of accusations. . . . The power
> of the general systems view lies in its ability to view
> all members of the system as involved in the creation,
> maintenance, and modification of all family patterns,
> adaptive and maladaptive, without scapegoating. (p. 28)

Wertheim, another eminent child and family therapist and theorist,

in her series of articles on the science and typology of family systems

(1974, 1975, 1978), provides important commentary on family system dy-

namics and positive mental health. Wertheim bases her observation on

extensive clinical work with children and their families. She proposes

that regardless of the level of health or dysfunction characteristic of

a given family system, the level to which the system may potentially

aspire may be contained within and reflected by the highest level of

perception manifested by current system membership. The important point

Wertheim is addressing is that the strength, sensitivity, and insight

expressed by one family member, once validated and made credible by an

objective source (e.g., therapist), may lead the family forward into

increased states of health and/or through the process of healing.

Wertheim's observations have considerable relevance for a major hypothe-

sis to be tested in this investigation (Hypothesis eleven).

Wertheim's argument underscores a subtle yet powerful merit of the

systems perspective: the developmental course of the family system has

its roots in the qualities of its membership and that the developmental

course of individual family members reciprocally has its roots in the

qualities of the family system interaction. In effect, Wertheim draws

attention to an aspect of family treatment that has not received as

much attention as it rightly deserves, the importance of individual per-

ception as an index of and tool for achieving increased states of individual and family system health. Wertheim directs attention to one important, newly emerging aspect of family treatment receiving increasing recognition: the interface of individual intrapsychic dynamics and family system interpsychic organization and interaction.

Statement of the Problem

There is mounting and convincing evidence to suggest that the psychological functioning of the child often reflects the general level of family system functioning. More specifically, the onset of presenting emotional and behavioral problems in the child may be viewed as an index of wider family system dysfunction. The recognition that presenting child problems may be a symptom of family system dysfunction has led to the development over the past 20 years of numerous family systems treatment modalities. One such treatment modality for dealing with presenting child problems, and focus of this research, is that treatment modality identified in the literature as child-centered family therapy.

However, there currently exists a very limited body of controlled and controlled-comparative studies that clearly document the relative treatment effects of family therapy, in general, and child-centered family therapy, in particular. During the past ten years the family therapy literature has become replete with a wide range of therapeutic innovations that have claimed various degrees of treatment success. As a result, the field of family therapy seems to be emerging as a viable alternative to the more traditional analytical adult and child therapies.

Unfortunately, because the clinical aspects of family therapy have grown in leaps and bounds in a relatively short period of time in comparison to its research efforts, family therapy may be described as a theoretical edifice emerging without an equally solid methodological foundation. The family therapy field is generating so many new treatment models at such a rapid pace that classification schemes identified in the literature are at times so widely divergent that it is almost impossible to cut a clear and reasonable path of consensus through the widespread disagreement among major theorists. The two classification schemes cited earlier illustrate the dilemma that students of family systems theory and family therapy treatment face in making sense out of the field. For example, the behaviorally-oriented family therapy treatment model originally labeled as behavioral family systems therapy (Alexander & Barton, 1976) was recently relabeled by the developers as functional family therapy.

One broad comment may be made with certainty about the field: if family therapy outcome research may be described as being in its infancy, then family therapy process research may be described as being neonatal. While there are very few reported studies currently comprising the body of family therapy outcome research, there are even fewer studies reported in the literature on family process research. This point is consistently documented in the literature.

Recent in-depth reviews of the family therapy literature (Gurman & Kniskern, 1981; Jacobson & Weiss, 1978; Masten, 1979; Olson et al., 1980; Pinsof, 1981; Wells, Dilkes & Trivelli, 1972) graphically point

out the theoretical and methodological problems in most of the family therapy treatment process and treatment outcome research. These reviews of the literature, which will serve as the foundation and point of departure for the method and purpose of this investigation, describe a number of limitations that presently confront family therapy and family therapy research. A statement regarding the limited number of substantive findings of family therapy and family therapy research will be presented in Chapter II. However, a brief description of the state of this research will serve to illustrate the problem at hand.

Summary of Problems Characteristic of Family Therapy Research

Family therapy research has shown, for example, that treating presenting child problems in family therapy can produce some effective clinical results. However, there is a lack of consistent empirically derived data to show that child-centered family therapy, irrespective of theoretical orientation, is on the average any more effective than the more traditional, individualistic child therapies (e.g., play therapy, child psychoanalysis). With the exception of a few illustrative case study accounts of the success of specialized symptom focused therapies reported in the literature (e.g., structural family therapy with anorexics), present research efforts have failed to provide adequate evidence supporting what type of treatment works best with specific types of presenting child problems. Claims of treatment success utilizing family systems therapy have not been scientifically substantiated. Therapeutic techniques reported in the literature often have been la-

beled to be clinically effective without the therapists being able to clearly specify why and how the techniques in effect may actually work. Family therapy techniques are proliferating so rapidly without adequate experimentation being conducted to assess their efficacy.

Finally, there are not enough standardized system-oriented measurement instruments designed to evaluate treatment changes in the child and in the family system. Most family therapy research continues to use case study accounts, individualized-oriented instruments (e.g., personality inventories such as MMPI), borrowed from psychology and un-standardized outcome measures (e.g., child behavior rating scales) specifically developed for the respective study.

Five Myths About Family Therapy Research

There are a number of myths regarding the effectiveness of family therapy. These myths, which will be defined in Chapter II, will provide the basis for adopting a conservative position concerning the limited number of substantive findings (i.e., validly labeled facts) that can be attributed to the field of family therapy. At this point it seems appropriate simply to list these myths. They are as follows:

1. The myth of homogeneity of population.

2. The myth of the uniformity of treatment.

3. The myth of a sufficient body of microtherapy theory.

4. The myth of the objective measurement.

5. The myth of the unbiased set of outcome criteria.

Viewed from a different perspective, these myths highlight three broad questions or problems currently confronting the field of family

therapy and family therapy research.

1. The first problem may be regarded as the specificity question: What treatment works best with what population and with what symptom (problem type) under what set of conditions? This question reflects the problems of methodology and clinical research design.

2. The second problem is contained in the individual-family system interface question: When is the presenting symptom more a function of the individual, the family system, or individual-family system interaction? This question reflects the struggle between the integration of two different but not necessarily irreconcilable paradigms, individualistic and systems models of diagnosis, analysis and treatment.

3. The third and final problem relates to the treatment emphasis question: Where should the emphasis in treatment be placed and what is the link between individual perception and family systems behavior? This question reflects the growing recognition among family clinicians to develop and test treatment techniques that focus on the individual-family system interface, the place of intersection between individual perception and family perception, individual changes and family system change. This question holds considerable significance for the practice of family treatment and therapy.

Clarification of Terms Used in this Study

Before proceeding to a general statement of the purpose of this study, several terms need to be defined. Because the proposed study intends to test the effectiveness of a short-term family systems treat-

ment intervention with families experiencing a child problem, several issues pertinent to this study require clarification. These issues are contained within three broad questions. (1) What are the various levels of intervention and what types of treatments are appropriate for specific levels of intervention? (2) How is the population being defined and what effect does this have upon the study's implications and broader purposes? (3) How is the term family treatment being used in this study?

Levels of Family Intervention

To properly situate the level and type of intervention associated with this investigation, it will be necessary to present a conceptual framework for describing levels of family intervention as a point of comparison. One such framework for describing levels of intervention is presented by L'Abate in the 1981 Handbook of Family Therapy. L'Abate outlines a categorization scheme for differentiating three levels of family system intervention. While L'Abate's framework may not be the definitive framework, it represents an excellent example of a well thought-out and researched classification scheme.

1. Primary Prevention. The first level of intervention is defined as primary prevention. Primary prevention encompasses short-term skill training and enrichment interventions. Skill training and enrichment interventions are associated with "normal," "functional," asymptomatic families who aspire to increased states of mental health and who seek to improve family functioning.

2. Secondary Prevention. The second level of intervention in

L'Abate's scheme is defined as secondary prevention. Secondary prevention is associated with families described as "at emotional risk" where presenting problems are identified as being mild to moderate in their severity. The treatment of choice for secondary prevention families may involve preliminary "pre-crisis" or early intervention family counseling.

3. Tertiary Prevention. The third level of intervention is defined as tertiary prevention. Tertiary prevention is targeted at those families who may be diagnosed as being chaotic, as having a seriously disturbed member (e.g., family member diagnosed as being psychotic) and/or as experiencing severe crises (e.g., suicide). Tertiary prevention families do not appear to respond very positively to skill training and/or brief intervention counseling treatments. Rather, such families seem to require very specific, tailor-made, long term and/or intensive forms of psychotherapeutic interventions.

It is reasonable to assume, human behavior and human bias operating as it does, that there is no one clear-cut classification scheme of intervention levels; levels of intervention most likely overlap. Borderline areas may be assumed to exist, for instance, between level one and level two and between level two and level three in L'Abate's framework. Similarly, types of families receiving one specified treatment may overlap. Just as intervention levels cut across family types, family types cut across types of intervention.

Definition of Research Population

The procedures employed to determine level of family intervention

and selection of treatment technique are related to another set of is-
sues, how the research population is defined. In his article entitled
"Issues in the Assessment of Outcome in Family Therapy," Lebow (1981)
cites two methods that traditionally have been reported in the litera-
ture for describing and defining family research populations. One
method focuses on family unit characteristics as the defining criteria
(e.g., family development life stage). The other method focuses on the
type of presenting problem and/or characteristics of the identified pa-
tient as a means of operationalizing the research population (e.g.,
anorexia). The manner in which families will be obtained in this study
and the type of family selected has relevance to this second procedure.
This study will follow the second method reported by Lebow.

Type of Family in this Research

In this investigation the type of problem, the family's self-
identification of the problem, and the family's definition of the prob-
lem will serve as the operational criteria characterizing the kind of
families under study. Employing such criteria as family's self-defini-
tion of the problem and self-referral will permit a broader definition
of the research population. What all the families will have in common
is that they will be experiencing a presenting child problem which they
primarily and not some outside source (e.g., school, court referrals)
have identified as being a problem for which the family seeks counsel-
ing. The population to be studied in this investigation may be viewed
as representing the intersection of two population sources or two access
routes through which families may initially express the need for family

counseling. This population thus will represent the intersection of what L'Abate defines as early intervention and pre-crisis (secondary prevention) families. These families will be drawn from child guidance, mental health center clientele waiting lists, in the East Bay and Greater Warwick-Kent County area of Rhode Island.

The argument made here is that, in this investigator's opinion, regardless of the initial means chosen for access to counseling, given that the presenting child problem remains within the mild to moderate dysfunctional range (a behavioral/academic problem not principally attributed to the child, e.g., physical condition), primary and secondary prevention families are roughly similar. It does not make that much of a difference whether a family seeks help initially through "educational means" (e.g., school guidance personnel) or mental health counseling (e.g., mental health clinicians). The basis for the argument that there is very little difference between families from different access routes is supported by the acknowledged stigma factor often associated with seeking and receiving psychotherapy (Rabkin, 1977). In this study, the important factors underlying the population will be that treatment is labeled as counseling/therapy and that families seek help for a self-identified presenting child problem.

Definition of Type of Treatment

The third and final issue that needs clarification in order that the limits of the research be clearly specified and its purpose understood involves a brief comment on the use of the term family counseling as an intervention modality. Using L'Abate's classification scheme

once again, family counseling will refer to those techniques character-
istic of the primary and secondary levels of family system interven-
tions. As noted, in differentiating family therapy from other forms of
family treatment interventions, L'Abate labels family therapy as ter-
tiary prevention. This level of intervention he associates with severe-
ly dysfunctional families.

In applying L'Abate's conceptual scheme it is quite reasonable to
argue that many of the techniques comprising numerous family therapy
treatment models currently in use may in fact fall within the category
of techniques generally associated with primary and secondary preven-
tion. In most family therapy circles, as evidenced across a wide range
of clinical studies, the terms family counseling and family therapy are
often used interchangeably to refer to the same general class of treat-
ment interventions.

For purposes of this study, family treatment will be defined as
that class of treatment consisting of that form of psychotherapy or
counseling that is explicitly designed to modify and promote positive
change in the family system. This presents a more liberal definition
of family counseling. Whereas some family theorists define family
treatment in very specific model-oriented terms (e.g., structuralists,
communicationists, behaviorists), the model to be used in this study
reflects the position proposed by a number of brief family systems ther-
apists (e.g., Weakland, Fisch, Walzlawick & Bodin, 1974) and family
therapy researchers (Bowen, 1976; Gurman & Kniskern, 1978).

This position may be summarized as follows: treatment of the family

may be accomplished through treatment of one or several of the family subgroups (e.g., dyads, triads) organized, for example, either according to age (e.g., siblings) or function (e.g., parental) or at times through treatment of one family system member. In this investigator's opinion, family treatment does not necessarily require the presence and/or participation of all family members in all or even most of the treatment sessions. The position taken for this investigation is that family counseling/therapy represents a shift in paradigm, mode of analysis, and approach to problem resolution. In effect, family counseling/ therapy is viewed as representing a shift in the therapist's thinking wherein the family unit, real or conceptual, becomes the basis for treatment. Such a conceptual shift in orientation serves to guide the therapist's behavior and the family's orientation to problem resolution.

This statement of family counseling represents only a broad definition of the operationalization of the treatment proposed. A more detailed description of treatment is contained in Chapter III and Chapter IV.

Purpose of this Research

The purpose of the research proposed in this document will be to advance that body of knowledge within the family therapy field concerned with brief child-centered family systems counseling/therapy and its effect upon parental perception of the target child and the family unit. This investigation proposes to test the effectiveness of a brief family systems counseling model designed to promote in families more

positive reorientation concerning their self-identified perception of a presenting child problem. A presenting child between the ages of three to eleven will be randomly assigned to three sets of conditions: group, therapist, and pre-posttesters. All familes (N=65) will be pretested on the four dependent measures. A stratified random sample of families (n=20) will receive the short-term structural-analytic counseling (7 weeks; 20 hours of treatment). Upon completion of the seven week treatment, all families (N=65) will be posttested on the same four dependent measures.

The overall aim of the treatment model is to facilitate a shift in the family's view of the problem from a unitary, individualistic, blame-oriented perspective, to the family's reformulation of the problem in terms of a family systems perspective and the beginning of the family's development of more positive problem-solving strategies or plans. The desired shift will be from the family's view that one family member (parent or child) or a single cause or factor (child's school, child's constitution) is principally or completely responsible for the problem, to the family's adoption of the view that two, three or more family members and an ecological complex of intervening factors (social, psychological) may have an impact on and may help to contribute to the problem.

For purposes of this study, shifts in family member and family unit perception will be limited to three main variables: (1) perception of general family unit functioning, (2) perception of the degree of congruence or discrepancy between the ideal and real family concepts,

and (3) perception of the target child, presenting symptoms, presenting problem, and problem outcome. The outcome variables will be measured on four family self-report instruments: Family Assessment Device (Epstein, Bishop & Baldwin, 1981), Child Behavior Checklist (Achenbach, 1981), The Family Unit Inventory (van der Veen, 1981), and Family Assessment of the Problem (Andreozzi, 1981), a short questionnaire specifically designed for this research. A randomized pretest-posttest experimental control group design will be used in this study.

Organization of Chapters

In order to provide the reader with the logical background that led to the formulation of this study and the specific hypotheses to be tested, the following organizational plan will be followed in this dissertation. In Chapter II the reader will be presented with a brief literature review regarding prominent conceptual and methodological issues in family therapy research and major substantive findings in family therapy. In Chapter III the reader will be presented with the theoretical background to the experimental treatment to be used in this research and an outline and definition of the treatment steps. In Chapter IV the reader will be presented with a general description of the measurement instruments and the criteria employed for the selection of these instruments. The rationale for selecting the research design and the procedures for collecting and treating the data will be described in Chapter V.

The plan used for organizing and preparing the data for analysis will be outlined in Chapter VI. In Chapter VII, the results of the ex-

perimental study will be described. The results of the correlation analysis on family instruments at T, as well as a discussion of outcome will be presented in Chapter VIII. Summary of the findings and implications and recommendations for future research in family therapy will be discussed in Chapter IX. Two clinical vignettes, illustrating opposite ends on outcome (greatest/least gains), will also be presented in Chapter IX to underscore several major dilemmas encountered in both the conduct of family therapy research and in the meaning/interpretation of outcome.

CHAPTER II

OVERVIEW OF CONCEPTUAL AND METHODOLOGICAL ISSUES
AND MAJOR SUBSTANTIVE FINDINGS IN FAMILY THERAPY

There a number of reviews currently reported in the literature that
provide overviews of family therapy theory and family therapy practice
and research. Four such reviews identified as major works in the field
and that served as primary sources for this investigation were the Hand-
book of Family Therapy (Gurman & Kniskern, 1981), Treating Relationships
(Olson, 1976), the Handbook of Psychotherapy and Behavior Change (Gar-
field & Bergin, 1978), and the Journal of Marriage and the Family, Spe-
cial Issue: Decade Review (Berardo, 1980). For a comprehensive treat-
ment and analysis of the family therapy field the reader is referred to
these four references.

Because it is beyond the scope of this dissertation to review all
existing family therapy literature, only that body of literature pertin-
ent specifically to this investigation will be presented. To accom-
plish this task this investigator identified three areas in the litera-
ture to be most relevant to this study: (1) methodological and concep-
tual issues and substantive outcome findings (knowns and unknowns of
family therapy), (2) major schools of thought and current family treat-
ment models, and (3) family systems assessment instruments. Selection
of the literature review in each of these areas was further limited to
emphasis upon specific works in each area relevant to this study.

However, it should be noted that this investigator recognizes that
this literature review represents one of many possible ways to organize

the current body of family therapy research. This investigator also recognizes that the selection of the specific works that served as the foundation and departure point for this investigation to some extent reflect personal biases and thus represent one limitation of this investigation.

A brief description of the methodological and conceptual issues and a position statement on substantive findings in family therapy process and outcome research will serve as the topic for this chapter. The literature review of methodological and conceptual issues and substantive findings primarily included the works of Gottman and Markman (1978), Gurman and Kniskern (1978, 1981), Gurman and Knudson (1978), Gurman, Knudson and Kniskern (1978), Keeney (1979), Kiesler (1973), Lebow (1981), Mahoney (1978), Masten (1979), O'Leary and Turkewitz (1978), Orlinsky and Howard (1978), Pinsof (1981), Stanton and Todd (1980), Wells (1980), Wells and Dezen (1978), and Wells, Dilkes and Trivelli (1972). The presentation in this chapter will entail a brief description of the methodological and conceptual issues and a position statement on substantive findings in family therapy process and outcome research.

Methodological and Conceptual Issues

A number of methodological and conceptual issues consistently have been identified in the family therapy literature. Discussion of these issues has been expressed in the form of a number of ongoing dialogues in the literature among major critics and reviewers of family therapy research. For instance, there has been a running debate between non-

behaviorally-oriented and behaviorally-oriented reviewers and critics over the methodological adequacies of family therapy research. Two such lively debates presented in the journal Family Process have been the Gurman, Knudson and Kniskern-Jacobson and Weiss debate and the Stanton and Todd-Wells debate. The titles of these articles suggest the spirit and intensity of the disagreements. For example, the Gurman, Knudson and Kniskern-Jacobson and Weiss debate includes such articles as "Behavioral Marriage Therapy: I. A Psychodynamic-Systems Analysis and Critique" (Gurman & Knudson, 1978); "Behavioral Marriage Therapy: II. Empirical Perspectives" (Gurman & Kniskern, 1978); "Behavioral Marriage Therapy: III. The Contents of Gurman et al. May Be Hazardous to Our Health" (Jacobson & Weiss, 1978), and "Behavioral Marriage Therapy: IV. Take Two Aspirins and Call Us In The Morning" (Gurman, Knudson & Kniskern, 1978).

The more current Stanton and Todd-Wells debate includes such articles as "A Critique of the Wells and Dezen Review of Non-Behavioral Therapy Outcome Studies" (Stanton & Todd, 1980) and "Tempests, Teapots, and Research Design: Rejoinder to Stanton and Todd" (Wells, 1980).

The contents of these debates, represented in the article titles, suggest the scope of the complexities currently facing the new field of family therapy and family therapy research. These methodological and conceptual issues may be examined and reviewed in the light of five general myths about the field of family therapy that in this investigator's opinion currently face the consumer of such research and describe the state of the field. These myths listed in Chapter I include

the (1) homogeneity of population myth, (2) uniformity of treatment
myth, (3) sufficient body of microtherapy theory myth, (4) objective
measurement myth, and (5) unbiased set of outcome criteria myth. A
brief description of this investigator's definition of each will be pre-
sented. These myths pose important questions concerning the examina-
tion, evaluation, and interpretation of the body of substantive find-
ings relevant to brief family systems treatment. Use of these myths as
criteria for evaluation accounts for the position that will be taken in
this research; namely, that only a few general statements about family
treatment may be labeled as being valid claims.

The Myth of the Homogeneity of Population

Treatments often are applied to families as if all families were
alike and responded similarly to the treatment intervention. Lebow
(1981) offers an excellent version of the uniformity of population myth
as it currently exists. The gist of Lebow's criticism is that in family
therapy research all families often are regarded as if they were alike,
as if they had similar responses, as if success of treatment outcome
can be summarized across diverse kinds of families, and as if one need
not consider data about the family research population (type of family
in a given study) in interpreting and evaluating the research.

The Myth of Uniformity of Treatment

The application of family therapy treatments in outcome studies
often is approached as if it were a homogeneous activity rather than
as a complex set of steps or events. In addition, family therapy treat-

ment often is approached as if it were uniformly applied to all subjects in a given study. Treatment models usually are reported in the literature as if they were single, specific treatments applied without variation to subject families in a given study. Treatment outcomes reported across studies that claim to use the same labeled treatment type (e.g., six studies on behavior therapy with families reported in Garfield and Bergin, 1978), make the assumption that all the behavior treatments were uniformly and identically applied to all the subjects in the studies involved.

However, upon closer examination, family therapy treatment appears to represent a complex set of events and therefore a class of treatments. Family therapy treatments reported in the literature generally describe the treatment as if there were no within-study variations (from subject to subject) in the treatment applied. Comparative studies assessing treatment effectiveness of the same treatment type seem to suggest that the same treatment type was applied uniformly (conceptually and operationally) without variation across studies.

The Myth of a Sufficient Body of Microtherapy Theory

Claims of the effectiveness of clinical techniques have been assumed to be valid without sufficient scientific documentation. The constructs, concepts, and clinical theory describing the process of family therapy still remain fairly abstract and general. Often family therapists behave as if there were a sufficient body of microtherapy theory about the therapy process. Definitions provided for different clinical approaches as well as the operationalization of the clinical steps that

describe different treatment methods have not been sufficiently or systematically documented. There are very few operationalizations of treatment statements on even the most rudimentary level, what Orlinsky and Howard (1978) refer to as "normative task definitions." What is needed are more treatment and training manuals such as those provided by Cleghorn and Levin (1973), Epstein and Bishop (1980), Kantor (1980), Minuchin and Fishman (1981), and Zuk (1972, 1975) that attempt to relate low level operational treatment constructs that are consistent with theory to behaviorally anchored observations.

The Myth of the Objective Measure

This myth relates to the oversight often made in the researcher's failing to recognize and report the value statements reflected in the choice of assessment instruments in family treatment. This myth also relates to the failure to fully recognize the biases often operating in the developers' construction of the instruments. It has been documented that there is no absolute measure or totally objective measure or totally comprehensive measure of individual and family mental health. Selection of a given study's set of measurement instruments often reflects the investigator's theoretical orientation, one possible definition of mental health, and therefore may represent a small number of variables from a potentially limitless list of variables suitable for study. The instruments from which scores are obtained to assess outcome frequently are assumed to stand on stronger reliability and validity claims than they actually have appeared to demonstrate.

In this investigator's opinion, when selecting a measurement in-

strument, three questions need to be asked that pertain to the objective measurement myth: (1) Does the measure assess what it actually claims to assess?; (2) What type of data source (e.g., self-report, direct observation) does the instrument reliably elicit?: and (3) How does this data source limit the interpretations and generalization of the findings?

The Myth of the Unbiased Set of Outcome Criteria

This myth refers to the impact and influence of unacknowledged values operating in treatment and outcome evaluation. In general the investigator's values often are indirectly expressed in the choice of treatment, the setting of treatment goals, the choice of methodology, the selection of the type of assessment devices, and the level at which outcome is measured (e.g., individual assessment, interpersonal assessment, or family unit assessment).

While the researcher's values may be directly expressed in the assessment of treatment outcome, these values are not always clearly identified and labeled. For instance, there are those investigators who define normality in statistical terms, focusing on statistically significant differences (mean group scores) as evidence of treatment success. There are those researchers who define normality in terms of the presenting symptoms, focusing more on change in the identified patient (clinical description) than focusing on the change process that may be simultaneously occurring in the family unit. Finally, there are those investigators who emphasize the symptom or problem aspect of the family in treatment more than the growth-oriented aspect of the family in

treatment.

Each set of outcome criteria needs to be regarded as expressing a different but equally appropriate focus. Each focus usually is defined by a class of identified behaviors that represents the investigating group's definition of positive treatment change and positive mental health. Gurman and Kniskern (1981), Lebow (1981), and Pinsof (1981) generally agree that the extent to which these values are clearly acknowledged provides the first step in working toward clarification, understanding, and control of these biases.

Substantive Findings

Across studies family therapy appears to be an effective treatment modality. Nevertheless, beyond this broad conclusion, substantive findings may be described as exploratory and speculative. Many crucial questions concerning family therapy still remain open. At best the state of the art and science of family therapy may be described as heuristic. A more conservative view taken of the field may characterize the field as a confused state of contradictions. These confusions and contradictions seem to result in part from the unacknowledged interaction of the previously cited five myths.

The generation and interpretation of findings in the psychotherapy field generally have proven to be problematic. The state of family therapy outcome research reflects the general state of psychotherapy outcome research. What can be said about individual psychotherapy outcome research can be said with even greater conviction about family

therapy outcome research. For instance, in the area of individual psychotherapy, Kiesler (1973) compared outcome studies designed to test the effectiveness of different forms of psychotherapy. In his analysis, Kiesler did not find significant statistical differences regarding treatment effectiveness for any one professed orientation.

In his meta-analysis involving over 200 individual psychotherapy outcome studies, Glass (1981) arrived at a similar conclusion. He found that what the evidence consistently pointed to was that receiving any form of psychotherapy was more effective than not receiving treatment. Glass also demonstrated that there was no consistent evidence to support that one treatment model was more effective than another.

The accumulated body of knowledge generated from conclusion-oriented research is relatively limited in the family therapy field. For example, the list of validly labeled, consistently documented facts about patient population factors, treatment factors, therapist factors, and treatment effectiveness is brief. Because the science and art of family therapy and family therapy research is new, the field may be described as being less substantive than some clinicians would claim.

What family therapists and family theorists may claim about the field may best be presented in the form of several brief descriptive statements that summarize the field. These statements more accurately describe what is unknown, unexplained, and as yet unproven than what is known about the effectiveness of family therapy. Each statement outlines prominent research issues and represents potential research questions warranting further research efforts. A review of research in

family therapy suggests several critical areas of investigation in which the body of family therapy research efforts and substantive findings appear to concentrate. The critical areas reviewed are: treatment effectiveness, treatment procedures, patient factors, and therapist factors. Except when noted, the brief statements concerning the knowns and unknowns of family therapy outcome research are derived primarily from examination and review of works by Auerbach and Johnson (1977); Clarkin, Frances and Moodie (1979); Cromwell, Olson and Fournier (1976a); Gurman and Kniskern (1978a, 1978b, 1978c, 1978d, 1981); Gurman, Knudson and Kniskern (1978); Jacobson (1978); Jacobson and Weiss (1978); Lebow (1981); Masten (1979); O'Leary and Borkovec (1978); O'Leary and Turkewitz (1978); Pinsof (1981); Stanton and Todd (1980); Sigal, Barrs and Doubilet (1976); Wells (1980); Wells and Dezen (1978); and Woodward, Santa-Barbara, Streiner, Goodman, Levin and Epstein (1981).

Treatment Factors

Treatment effectiveness. A baseline establishing the overall effectiveness of family therapy as a treatment modality has been established. However, evidence to support the superiority or universality of any particular family therapy model has not yet been established.

Treatment validity. Outcome studies comparing the effectiveness of different forms of family therapy suggest contradictory conclusions. When the efficacy of a given model was reported to produce statistically significant results, upon further examination conclusions often have been found to be misleading. For example, one form of family treatment, behavioral marital therapy, has been identified to be one of the most

effective treatment modalities. Claims of effective outcome (treatment success) have been in part attributed to the behavioral, testable, and replicable nature of the treatment. However, reexamination of five out of the six most well-designed behavioral marital outcome studies revealed that the treatment applied in these studies contained clinical techniques that included nonbehavioral methods, clinical procedures that can be found in structural family therapy, communication therapy, and client-centered psychotherapy.

This finding suggests the operation of the discrepancy in the research between the treatment defined and proposed for testing and the actual treatment employed in the study. Also, such a finding suggests that perhaps at times there is a "mismatch" between therapist actual in-treatment interventions and his/her claimed or professed orientation. Such a discrepancy may certainly be considered a confounding factor operating in research studies that may contribute to misinterpreted results.

Rate of improvement. Another method used to determine the effectiveness of family therapy treatment is to examine the percentage of families who receive treatment who improve. An analysis across a dozen controlled family therapy outcome studies (Gurman & Kniskern, 1981), identified that imrpovement rates in marital therapy were approximately 61 percent and that improvement rates in family therapy were approximately 73 percent.

Treatment duration. There appears to be no difference in determining treatment outcome between brief family therapy (up to 20 weekly sessions) versus more lengthier family therapy treatment plans (20 weeks

to two to three years). Preliminary evidence suggests that treatment length may not be as decisive a variable in determining successful outcome as has been thought (Fisher, 1980). Treating a family for a brief period of time may be as effective as treating a family for an extensive period of time.

Treatment goals. The only treatment subgoal or treatment component consistently demonstrating positive results across outcome studies of different family therapy models has been the subgoal of increasing couples' communication skills. Increasing communication skills regardless of how it is accomplished is, according to Gurman and Kniskern (1981), "the sine qua non" of effective therapy. To date, no other such single, consistent treatment goal has generated such promising findings across studies and treatment modalities.

Treatment density. To date, there is insufficient evidence to support the position that an increase in treatment density (treatment frequency, e.g., hours in session per week) is positively related to treatment effectiveness. The only tentative finding pointing to the positive effect of intensive, multiple treatment interventions and increased frequency of therapeutic sessions has emerged in the preliminary research conducted of crisis intervention families.

Family treatment unit. Family treatment generally would appear to assume the treatment or involvement of all family members. However, there is insufficient data to support that all family members need to participate in family therapy for the therapy to be effective. Another issue yet unresolved concerns the involvement of key family members in treatment. Considerable conjecture and attention has been directed at

engaging men/fathers in the therapy sessions. There is some preliminary evidence to suggest that the father's participation may increase the probability of positive outcome. While this factor of father's participation in treatment appears promising, the key issue may actually be one of identifying the family member's role/position factor or power/influence factor in the family. The identification of the most influential family member, the most receptive family member and/or the family member most capable of orchestrating family system change may be the more important treatment outcome issue.

Patient/Family Factors

Type of family and presenting problem. Over 50 percent of the family therapy outcome research has focused on the presenting problem of alcoholism. Generalization of the research on alcoholic families to families with other presenting problems (e.g., relationship problems, psychiatric diagnoses, different family developmental crises) poses a serious limitation of the claims of family therapy research.

A similar situation is characteristic of child-centered family therapy (treating presenting child problems in family therapy). To date, most of the research on the effectiveness of child-centered family therapy has been conducted with families of adolescents who for the most part have been diagnosed as being "soft" delinquents. Only a handful of research studies have been conducted on families in which the presenting child was under the age of twelve and in which the presenting problem was a problem other than soft delinquency. The fact that a large proportion of the child-centered family therapy research to date

has emerged from studies of family populations with delinquent adolescents seriously limits the generalization of such findings to families with younger children and different presenting child problems.

Furthermore, as McDermott and Char (1974) have pointed out, the evidence to support child-centered family therapy over more traditional individual child therapies is contradictory. In fact, these authors cite preliminary data to show that when applied indiscriminately child-centered family therapy may not be the best clinical method for treating specific kinds of presenting child problems.

Experimental subject population. One unfortunate occurrence in family therapy research has been that at times the experimental subjects treated have not been representative of actual clinic families. Experiments conducted on nonrepresentative families (e.g., mild-moderate families and mild problem type) have at times been presented as if applicable to a wider range of families and across problem levels or intensity. In fact, a number of studies assessing family therapy outcome (e.g., behavioral and communication models) have employed either volunteers, families with minimal presenting problems, or professional actors in analogue research designs to test and demonstrate how the techniques would work with more dysfunctional families.

Family characteristics related to treatment effectiveness. Although there currently is not enough evidence to support the effectiveness of specific treatments with specific presenting problems, several family patient interaction styles appear to be associated with positive treatment effects. Families who appear to respond better to therapy, more

amenable to family treatment, have been tentatively identified in the research as demonstrating the following characteristics: low authoritarianism, openness to disagreement, low coercion and low competitiveness, and low role traditionality. In other words, it appears that "easy," "cooperative" patients do better in family therapy.

Family/Therapist/Therapy Factors

Cotherapy. Recently, cotherapy has become a prominent, widely used clinical procedure. The assumption underlying cotherapy is that two therapists are better than one and that a male-female therapist team may relate more effectively to respective male-female family members. However, there is very little consistent data or controlled conclusive findings to support the greater efficacy of cotherapy as a treatment technique in relation to more positive treatment outcome.

Therapist experience level. The experience of the therapist has frequently been cited as a critical treatment variable contributing to positive family outcome. Therapist's level of experience (years of experience as a family therapist) has almost become an established fact associated with predictions of positive treatment outcome. However, this factor has not been systematically documented in the research. Examination of the therapist experience level as a treatment factor in the majority of outcome studies indicates that on average therapist trainees or first or second year experienced therapists provide the treatment. The few studies conducted to date suggest that there is little demonstrated correlation between therapist experience level and family therapy outcome.

In comparison to individual psychotherapy, family therapy is a relatively new field. Therefore, it may be argued that in comparison to individually-oriented psychotherapists, family therapists are relatively inexperienced. Because the family field is only 20 years old, except for a few pioneers in the field, the most experienced family therapists have been practicing family therapy for not more than five to ten years.

Therapist interaction style. One therapist variable that appears to be consistently associated with positive treatment effects regardless of the type of therapy (theoretical treatment orientation) identified in a number of studies is the therapist's relationship skills. Preliminary evidence indicates that the quality of the therapist's relationship skills (characteristics such as empathy, openness, warmth, acceptance) appears to be positively associated with favorable family member self reports regarding treatment satisfaction as well as overall positive treatment outcome on objective assessment criteria.

Summary

The field of family therapy at times tends to overestimate its merits. Frequently in the political enthusiasm and competitiveness among theoretical orientations, facts become inflated. Claims or tentative findings often become synonomous with scientific fact. The issues outlined in this chapter admittedly represent one view of or one position on family therapy research and its findings. This position in part undoubtedly reflects this investigator's particular interpretation of the research and personal biases.

However, while at first glance this position may appear to be overly critical or to unduely minimize the progress regarding the body of facts accumulated to date in the field of family therapy, this position may in fact present some advantages. Such an appraisal of the family therapy field may serve to uncover areas for future research, problems which need to be addressed by clinicians, and problems which confound research.

The merits of this position are that it will help to place the family therapy field in context and that it will help to outline a clear path and point of departure for future research. Such a position on methodological and conceptual issues and substantive findings has guided the formulation of the problem, research design, and specific hypotheses to be tested in this investigation. This position has also influenced the approach to treatment procedures, the topic of the next chapter, and the issue of measurement, the topic of Chapter IV.

C H A P T E R   III

TREATMENT

The literature review on the theoretical background to the pro-
posed treatment model involved a two-step process. The first step in-
volved a reexamination of the major schools of family systems treatment
in order to select the most appropriate treatment approach. According-
ly, an examination of family treatment models reported in the works of
Guerin (1976), Gurman and Kniskern (1981), Haley and Hoffman (1967),
and Olson, Russell and Sprenkle (1980) was conducted. The second step
involved focusing on several specific treatment models that were direct-
ly related to the treatment to be tested. The works of Baragin (1976),
Boszormenyi-Nayi and Framo (1965), Minuchin (1974), and Steirlin (1976)
were reviewed, with special emphasis upon Kantor's (1980) structural
analysis. The treatment model to be tested in this research is an adap-
tation of Kantor's structural-analytic model.

Theoretical Background to the Treatment

There are many different clinical models of family treatment.
Several different schema were presented in Chapter I for categorizing
the major schools of thought. Major schools of thought are usually as-
sociated with the principle theorist who has been instrumental in de-
veloping the model in question (e.g., Minuchin as the principle theorist
in structural family therapy, Watzlawick as the principle theorist in
strategic family therapy). At times it is even difficult to differenti-
ate the theoretical model from the style of the particular therapist

(e.g., Murray Bowen, Virginia Satir).

The model chosen for use in this investigation is derived from the family systems treatment model developed by David Kantor (1979, 1980). This model recently has been labeled by Kantor as structural-analytic family therapy. Broadly speaking, the model incorporates concepts, constructs, principles, and techniques that, in this investigator's opinion, appear to be associated with two other major schools of clinical practice and theoretical orientations, psychodynamic systems therapy and structural family therapy.

Psychodynamic Systems Therapy

Broadly speaking, psychodynamic systems therapy may be described as emphasizing the following principles. (1) The importance of past experience (e.g., childhood experience in family of origin, early object relations) on current family dynamics. (2) The critical importance of insight as a stimulus for behavior change. (3) The application of individual intrapsychic concepts to the interpretation of interpersonal relationships (e.g., the bad self/good self splitting into the bad spouse/good spouse). (4) The explanation of emotional illness as a result of the development of dysfunctional interpersonal relationships and developmental transgenerational family life stage insufficiencies (e.g., inadequate, neglectful or abusive fathering of a father who mistreats his son). (5) Focus on the marital or adult intimate relationship in relation to complementarity of roles and the modification of what has been labeled in the literature as marital schism, pseudomutuality, and marital skew. (6) Examination of family member roles and fami-

ly member myths: how shared, unchallenged convictions about family re-
lationships or the images and attributes ascribed to family members or
to the family unit underpin and contribute to problem behaviors.
(7) Owning or disowning inner experience (how family members feel, act,
and fantasize) as being both the product of individuals and the inter-
action experienced between and among family members.

Structural Family Therapy

Structural family therapy generally may be described as emphasizing
the following principles: (1) structural configuration and family organ-
ization (e.g., the arrangement and alignment of subsystems and subsys-
tem membership, affiliation, and level of functioning); (2) balance
(e.g., general level of family accommodation, family member accountabil-
ity, and overall level of family system functioning); (3) boundary and
boundary maintenance, the development and maintenance of boundary type
(e.g., clear, rigid or diffuse subsystem and family system boundaries);
(4) family's developmental life stage (e.g., the task specific to each
developmental life stage and its relationship to the onset of present-
ing problems); and (5) wider social context (e.g., what stresses in the
wider social context are contributing to the problem and what resources
in the wider social context and strengths within the family may help
alleviate the problem).

In summary, both psychodynamic systems and structural family ther-
apy models illustrate how concepts and techniques from two clinical
models may be integrated into an approach that addresses the individual-
family system interface issue. Both models provide examples of ongoing

work in the clinical field that appear to be directing attention to the individual-family system interface question. Structural analysis also represents ongoing clinical work concerning the interface of the individual with the family system. Brief descriptions of both models were presented to provide the background to and to help situate and categorize the structural-analytic family treatment model proposed by Kantor. Examination of structural analysis appears to suggest similarities between psychodynamic systems therapy and structural family therapy. To reiterate, in this investigator's opinion, structural analysis incorporates principles and clinical procedures similar to psychodynamic systems therapy and structural family therapy.

Criteria for Treatment Selection

Three criteria were employed for deciding upon Kantor's structural-analytic treatment model for use in this investigation. Although careful examination of family treatment models suggests that a number of other major schools of thought offer many of the attributes analogous to structural analysis, the Kantor model was chosen over other family treatment models for the following reasons. (1) The treatment model is one of the few existing family treatment models that is built upon a general model of family process. This family process model is the result of a naturalistic study of nonclinic and clinic families (Kantor & Lehr, 1975). (2) The treatment is operationalized and is behaviorally defined. (3) Specific subphases or microsteps in treatment are identified and are therefore testable. (4) Because of its orientation, struc-

tural analysis seems to be a suitable match for the specific subject population (families with young children), problem type (presenting child problem), and treatment focus (individual-family interface) under study.

Treatment and research efforts by Kantor and his associates have been mainly directed at couples therapy (adult dyadic critical identity image problems). However, the major theoretical assumptions and clinical procedures contained in structural-analytic therapy would appear to be a suitable treatment for child problems. Application of structural analysis with a different population and different subsystem emphasis (spouse subsystem and parent-child subsystem) will provide valuable information regarding the reframing of parent-child problems as arising from family members' competing critical identity image claims. In structural analysis, competition among individuals is reexamined not so much as a conflict between the individuals themselves. Instead, the conflict is viewed in terms of a conflict arising from the competing images, personal expectations, and the reality claims of family members.

Background to Kantor's Research

David Kantor's structural-analytic treatment model is the result of some 20 years of clinical and nonclinical investigations into family process. The research and clinical efforts of Kantor and his associates are an outgrowth of work with families at Boston State Hospital, Boston Family Institute, Family Institute of Cambridge, and currently at the Kantor Family Institute in Cambridge, Massachusetts and Family Center in Somerville, Massachusetts. The types of families included in

Kantor's work appear to extend beyond the characteristic college educat-
ed, upper-middle class Boston-Cambridge family to include the working
and middle-class Boston-Cambridge family. Efforts to research and de-
velop the theory involved consideration of both nonclinic and clinic
families from diverse socioeconomic backgrounds.

Development of Kantor's Theory of Family Process

The development of the theory underlying the treatment appears to
have occurred as follows: (1) the integration of seminal ideas and work-
ing hypotheses of the theorist into a loose conceptual framework of
family process; (2) the generation of a five year research study with
nonclinic and clinic families resulting in a more operationally defined
conceptual framework for describing family process (Kantor & Lehr,
1975); (3) the translation of the conceptual framework into a clinical
model with a specific redirected emphasis on clinical research with
couples; (4) the operationalization of clinical steps, refinement of
the clinical theory, and the labeling of the clinical theory Critical
Identity: A Concept Linking Individual, Couple and Family Development
(Kantor, 1979); and (5) the further refinement and operationalization
of the treatment resulting in a relabeling of the model as structural
analysis (Kantor, 1980).

The Structural-Analytic Model of Family Therapy

Structural analysis integrates principles from psychodynamic sys-
tems therapy and structural family therapy. An in-depth discussion of
structural analysis is beyond the scope of this dissertation. However,

a brief description of key theoretical constructs, operational defini-
tions, and treatment procedures will be described. The reader is re-
ferred to Kantor and Lehr (1975) and Kantor (1979, 1980) for a thorough
description of the theoretical background and clinical procedures of
structural analysis.

Psychodynamic Orientation in Structural Analysis

Similar to the psychodynamic orientation, structural analysis
stresses the importance of the individual, intrapsychic organization,
subjective imagery, and prior personal internalized experience. Struc-
tural analysis includes such concepts as image, critical identity image,
and critical identity claims.

1. Image. The individual's intrapsychic organization is viewed
as being strongly expressed in the individual's set of images. An
image is defined as a memory picture of events and experiences. An
image is an individual's "subjective knowledge structure" that serves
to integrate emotion with cognition, "sensibility" and "intellect"
(Kantor, 1979, pp. 29-30). Images contain psychic energy; they are
emotionally charged structures. These images may be positive or they
may be negative. Images are enduring and persist over time. Kantor
proposes that images form the consistent thread in personality develop-
ment, integrating a person's identity and development over time.

2. Critical identity image. A critical identity image is defined
as a special form of image that is distinguishable from other sensory
images. A critical identity image is a highly emotionally charged,
special memory picture that constitutes an individual's operational

identity. "Operational identity is that aspect of personal identity reserved for use in structuring our relationships with intimates" (Kantor, 1979, p. 33).

A critical identity image may be described as the individual's internalized, intensely felt image of the self in relation to others. An individual may have two or three critical identity images. Each critical identity image represents a critical, recurring behavioral scene reported by the individual. Interactions in this scene may be directly or indirectly expressed. However, the element of interaction appears always to be present on some level. Interaction appears to be a vital component of the image scene.

What makes some images positive and others negative and others emerge as critical identity images is that the critical identity image continues to cause problems for the person in intimate relationships. It often represents an operational definition of the self in relation to others that in interaction with another's critical identity image may elicit conflict, disagreement, and misunderstanding.

3. <u>Critical identity claims</u>. Critical identity claims are the observable behaviors of critical identity images. During a crisis intimates do not confront each other with critical identity images but rather with critical identity claims. These identity claims may be expressed verbally (wants, needs, desires, and expectations, e.g., father to his son, "I want respect." Or husband to his wife, "I expect that you, like other women, will treat me badly.") and through strategies (behaviors, e.g., fight or take flight).

Structural Family Therapy Orientation in Structural Analysis

Similar to the structural family therapy model, structural analysis emphasizes family structure, family subsystem configurations, the impact of family structure on individual behavior, the importance of the family's developmental life stage, and crisis as the family's inability to negotiate specific developmental tasks. Structural analysis includes such concepts as formal structures, content structures, family target dimensions, psychopolitical configuration, and developmental tasks.

1. Formal structures. Family system organization centers around both formal and content structures. Formal structures are defined as family interaction patterns as observed through family member behaviors. Formal structures are observed in part in the interactional strategies (psychopolitical parts or configurations) family members use in gaining access to power (effectance, influence), affect (intimacy, nurturance), and meaning (identity, self-worth).

2. Content structures. Content structures are defined as memories and inner meanings that reside in and comprise the intrapsychic organization of individuals. (In this investigator's opinion, this represents the interaction of Kantor's model with psychodynamic systems therapy and structural family therapy.) Content structures are nonobservable, existing in the individual's inner meanings, family themes, and the relationship between individual meanings and themes and family themes. Content structures form the nucleus for formal structures.

The formal structures that a family develops while resolving re-

spective developmental tasks and the content structures that serve as the behavioral and symbolic foundations of the family's communicational life are linked via critical identity images.

3. <u>Psychopolitical configurations</u>. Psychopolitical configurations are defined as an individual's acts and actions in relation to others in the system. Four broad psychopolitical strategies are identified: mover (initiates action), follower (follows the action of the mover), opposer (opposes or challenges the action of the mover), and bystander (neither follows nor opposes the action of the mover). Various psychopolitical configurations are used to gain access to power, affect, and meaning in the family system.

4. <u>Developmental tasks</u>. Kantor identifies seven developmental tasks that summarize the family life cycle: attachment (couple makes a commitment), industry (distribution of labors, responsibilities), affiliation (extending involvements, associations), inclusion (incorporating individuals into the family, e.g., children, close friends), decentralization (launching family members), differentiation (becoming a couple again), and detachment (death of one spouse). Each developmental task carries with it the possibility that the task will not be successfully resolved, creating a crisis for the couple or family. Successful resolution of each developmental task (e.g., moving from attachment and the solidification of the relationship to inclusion of children into the family) is related to changes in the couple's or family's content structures.

Concepts of Dysfunction and the Onset of Crisis

In structural analysis, a family crisis is defined as an occurrence in a family or couple system in which there is a temporary breakdown of structural laws that govern system functioning. More specifically, a crisis emerges when psychopolitical configurations become "stuck"; roles adopted by members become rigid and inflexible. Family interaction patterns therefore become repetitive, and stereotypical. Because critical identity images link formal with content structures, forming the symbolic foundation for emerging psychopolitical configurations, a family crisis arises when the family system is temporarily immobilized by competing identity claims (the observable behaviors of critical identity images). To use Kantor's terms, a family crisis can be described as a ritualistic impasse: a behavioral standoff or deadlock.

Ritual impasse. Ritual impasse is defined by Kantor (1979) as "the recurrent, episodic nature of the family identity crisis" (p. 28). A family crisis is thus represented through the ritualistic impasse in which family members are involved in escalating competing identity claims that result in an impasse. Kantor proposes that this ritual impasse is maintained and fueled by the development of "rigidly stereotyped psychopolitical behavioral configurations" (1979, p. 38). In structural analysis, resolution of a family crisis occurs through the formation of new content structures (personal meaning) and the development of new behavioral strategies (psychopolitical configurations).

Treatment Goals of Structural Analysis

Briefly, the principle treatment goal of structural analysis is to change family members' behavioral reactions to critical identity images and claims. Although Kantor proposes that critical identity images cannot be changed (e.g., developing new critical identity images), the meanings of these identity forming images and the accompanying behavioral reactions elicited by these images can be modified.

The major assumption of structural analysis is that the understanding and communication among family members of critical identity images results in changes in family structure; changes in family structure lead to family member adoption of new behaviors and actions. Each family member gains insight into and an appreciation of their own identity forming images and the identity forming images of other family members. The therapist works to help each family member identify, verbalize, and interpret the ritualistic impasse (family crisis) as a relationship involving competing identity claims (wants, needs, and expectations). Once the ritualistic impasse is reframed in terms of competing identity images and competing identity claims, the family's efforts are redirected toward developing more effective problem solving plans and communication patterns.

Treatment Steps in Structural Analysis

Kantor outlines an eight step treatment process that reflects his family system developmental framework. These clinical procedures are intended to help the family or couple resolve a developmental struggle that is visibly expressed through competing identity claims that in

turn have escalated into a ritualistic impasse, the conflict.

1. Locating the ritual impasse.

2. Identifying psychopolitical configurations and making pre-liminary changes.

3. Eliciting the competing critical identity images.

4. Pinning down the image elements and their interactions (affects, feelings, themes, moods).

5. Fixing the image and rendering the elements more visible, conscious. This involves three steps: (1) changing those particular psychopolitical configurations each person uses in catalyzing the other's stuck behaviors in the impasse; (2) changing the meaning of each person's image by use of such techniques as psychodrama, video replay, and family sculpture; and (3) making the image more visible (e.g., having an artistic rendering of the image).

6. Accelerating the transformation of the images into positive identity claims. This involves work towards restatement of the negative elements of the critical identity image and associated foundation events as a positive identity claim. This positive identity claim is integrated into the individual's conscious view of self and then expressed as a positive assertion in dealing with intimate partners.

7. Sharing the theory and its vocabulary with the couple or family. The couple or family is coached on how to reframe ritual impasses in the language of the theory. Family members talk about what to do and how to use newly learned behaviors. Family members also discuss what not to do, what behaviors have been ruled out because these behav-

iors escalate into a conflict and produce a stalemate.

8. Generalizing the theory by exploring the application of the theory with past, present, and future developmental stages. This may involve reexamination of past events and on some level rehearsing what the family may expect in the future. This process generally appears to involve the family's or couple's adoption of new perceptions and interpretations of behavior.

Type of Treatment Used in this Study

The treatment model to be tested in this study represents the adaptation of major theoretical principles and clinical procedures of structural analysis to the treatment of presenting child problems. Because the treatment will involve short-term counseling/therapy (treatment has been defined as brief structural-analytic oriented family therapy), the treatment mainly will focus on adaptation of steps one through five of Kantor's treatment model. Slight changes also have been made in the ordering and in the emphasis of two treatment steps. In addition, two other clinical techniques for eliciting images and rendering the images more visible have been substituted in step five. A detailed description of treatment procedures is provided in Chapter V.

Adaptation of structural analysis to presenting child problems is in part aimed at addressing the specificity question: the application of a specified treatment to a specific family type and problem type, under a specific set of circumstances. Moreover, efforts to define treatment steps will help to provide further operationalization of and

process data on treatment steps and substeps. Demonstration of the model will aid in modifying the treatment process. Operationalization of treatment steps provides initial efforts toward identifying the set of behavioral interventions that comprise treatment.

The treatment proposed in this study, brief structural-analytic family therapy is in part the result of this investigator's work with nonclinic and clinic families (N=125 families) who participated in a five year family counseling program that was funded by the Rhode Island State Department of Education (1974-1979). Some of the clinical procedures to be included in the treatment were derived from supervised clinical work with individuals and families (1979-1982).

Treatment Goals

Gurman and Kniskern (1981) describe two types of treatment goals, mediating goals and ultimate goals. Mediating goals describe the process of therapy, its course, intention, and intervention steps. Ultimate goals refer to the end results or specific effects of the treatment. Ultimate goals usually involve the identification of the outcome criteria within a given treatment approach or within the context of a given study that indicate the success of the treatment.

Mediating Goals in this Study

In this study mediating goals will include treatment steps as well as the therapist's role in the treatment. The therapist's role in the treatment will involve consideration of how the therapist views the problem, the assumptions upon which interventions are made, and the

types of behaviors the therapist employs when facilitating interventions. Understanding of the treatment involves three equally important factors: (1) knowing what the treatment steps are, (2) knowing how the therapist approaches and conceptualizes the treatment process, and (3) knowing what the therapist's behaviors include (what the therapist does and does not do). Treatment steps and the behavioral format of the treatment will be described in greater detail in Chapter V.

Assumptions Underlying Therapist's Interventions

One way of examining mediating goals is to describe how the therapist views the problem. In this study five assumptions concerning the treatment of parent-child problems will serve to guide the therapist's behaviors.

Assumption one. Presenting child problems often reflect problems in adult intimate relationships. Treating the adult relationship will result in changes in the parent-child relationship.

Assumption two. Presenting child problems often reflect a conflict between individual expectations wherein personal meanings, positive self-images, and behaviors somehow become misunderstood, distorted, and invalidated. Identifying, clarifying, and helping the family to communicate the positive aspects of each member's individual and interpersonal expectations (hopes, wishes, desires, and intentions) will help the family to decenter from almost exclusive consideration of the negative half or side of the problem.

Assumption three. The symptom or presenting child problem often serves to protect a healthy part of the family, the individuals in-

volved or the identified child. Naming that aspect of health (e.g., misunderstood attempts to cope, to be effective, and to reach out) that is hidden within and is the purpose behind the symptom will help to free up rigid, stuck or deadlocked family member patterns.

Assumption four. The presenting child problem is viewed more as a problem between subsystems (a triangle) rather than as a problem between individuals. Focusing on the individual-family system interface helps to balance and value equally the psychological reality of each family member and the psychological reality of the family unit. Alternating between emphasizing the individual and emphasizing the social context will result in broadening family members' perceptions of the presenting child problem and will help the family to decenter from the problem.

Assumption five. The onset of presenting child problems often reflects the interaction of a variety of factors both inside and outside the family unit that often may be out of the family's awareness. Presenting child problems may be further stressed by other overlooked pressures (e.g., discrimination, job loss, neighborhood, social welfare system, and so forth). These problems may be "softened" or mitigated by the mobilization of talents, strengths, and resources (e.g., family friends, family's own courage, family's sense of humor, and so forth) that have been minimized or even overlooked because of the presence of the problem.

Treatment Steps

The five cited assumptions that serve to guide the therapist's be-

havior provide broad statements regarding how the therapist perceives, conceptualizes, and approaches the problem. Accordingly, these assumptions underlie treatment steps. The following is a brief summation of the treatment steps used in this study.

Step 1. Identifying and listing of the presenting child problems for which the family seeks counseling.

Step 2. Isolating and focusing on the problems to which the family assigns the greatest priority.

Step 3. Exploring the problem in the family's own language and set of perceptions (e.g., having the family describe the problem in their own words, feeling vocabulary, and expectations).

Step 4. Identifying the most influential subsystem or subsystems involved in the creation and maintenance of the problem (identifying triangle) and the key elements that characterize these subsystems and the problem (e.g., membership, function, and so forth).

Step 5. Identifying and reframing of the problem as a conflict in images, subjective experiences, associated behavioral strategies and expectations among family members. Expanding the view of the problem and restating it in transactional terms.

Step 6. Exploring alternative behaviors and problem solving plans for individuals and for the family. This includes identification of individual and family strengths, talents, skills, and resources.

Treatment Unit

For purposes of this investigation, the definition of treatment unit will range from the participation in treatment of two family members (mother and presenting child), three family members (mother, presenting child, and other principal adult caregiver), to all family members. The number of family members who participate in treatment will depend on the particular circumstances and conditions described by each family prior to treatment. However, the underlying treatment assumption (stated in Chapter I in the section on clarification of terms) that will guide treatment interventions will remain consistent across families. The assumption is that family treatment comprises the therapist's conceptual approach and does not necessarily depend on the number of family members who participate in the treatment sessions.

The specific set of family systems treatment interventions associated with the treatment approach in this study treats the family mainly as a conceptual or symbolic unit. The major subsystems that will be engaged in treatment and that will provide the basis for treatment attention will be the parental subsystem, the parent-child subsystem, and the adult intimate or spouse subsystem.

Treatment Outcome

In sum, successful treatment outcome for experimental families will be that these families (1) report more positive family communication, (2) report more flexible family roles and family expectations, (3) report a more positive view of family life and family functioning, (4) report a more positive view of the problem and presenting child on

both an attribute and behavioral level, and (5) report a more positive view of the availability of family network and community supports.

The criteria described in this chapter for determining treatment outcome relate specifically to issues concerning measurement and the choice of family and child assessment devices. The theoretical background and description of the assessment instruments selected for use in this research and the criteria employed for selecting these instruments will be presented in the next chapter.

CHAPTER   IV

MEASUREMENT AND INSTRUMENTATION

The literature review of family assessment instruments required a
two-step process. The first step involved a survey of the current fam-
ily and parent-child assessment instruments reported in Johnson and
Bommarito (1971); Michelson, Foster and Ritchey (1981); Cromwell, Olson
and Fournier (1976b); Riskin and Faunce (1972); and Straus and Brown
(1978). Based upon this review, several specific instruments were se-
lected and the current literature available on each of these instru-
ments was examined. The second step therefore involved an examination
of the following instruments: Family Assessment Device (Epstein, Bishop
& Baldwin, 1981), Child Behavior Checklist (Achenbach, 1980), and Family
Unit Inventory (van der Veen, 1981).

An Overview of Family Assessment Instruments

The fields of marital and family interaction and marital and family
therapy present a wide range of techniques and instruments for assessing
interaction and change in families. A few brief facts about the field
will serve to illustrate this point. In their book Family Measurement
Techniques, Straus and Brown (1978) present abstracts of articles ap-
pearing in over 125 professional journals that identify 813 family-
oriented assessment instruments and techniques. The criteria used for
including instruments and techniques in this source book were that
(1) the instrument/technique appeared in a published report, (2) the
instrument/technique focused on some aspect of family behavior, and

61

(3) the instrument/technique yielded quantifiable data.

In their evaluative review of family interaction research, Riskin and Faunce (1972) identify over 100 family interaction instruments. Their inclusion of instruments for review was not based on any set of adequacy criteria (e.g., predictive validity, concurrent validity, stability over time) except that these instruments were reported in the literature. Cromwell, Olson and Fournier (1978b), focusing specifically on marital and family therapy, identify an additional list of measurement devices. These authors present a codification of existing tools and techniques in marital and family therapy. Instruments and techniques were included in this review if they met one or more of the following three criteria: instruments and techniques were designed as (1) treatment devices, (2) diagnostic tools, and (3) assessment of change during treatment or pre-post assessment of change. In this review over 100 tools and techniques are presented.

In examining these three lists, it is reasonable to assume that there may be considerable overlap among instruments, tools, and techniques reported in these different reference sources. Furthermore, it is important to note that the total number of instruments reported across these sources may represent what may be considered an inflated, somewhat misleading figure regarding the actual number of family-oriented assessment instruments. Such an inflated figure is in part due to the inclusion in these reference sources of instruments and techniques that pertain specifically to marital interaction and marital therapy and/or that may be classified as individually-oriented assessment devices and/or personality inventories.

Selection Criteria

A set of specific criteria needs to be used in order to select the most appropriate assessment technique for a given study. Two such criteria identified in the literature (Pinsof, 1981) as major consideration for instrument choice, and that have been adopted for initial use in this study, are (1) the modality-systems fit, and (2) the orientation-systems fit.

Modality-systems fit. Family therapy represents a shift in treatment paradigm. The features of family therapy are quite different and distinct from those of individual psychotherapy. The modality-systems fit refers to the extent to which the measurement instrument used in the research fits, accommodates to, and describes the unique conceptual and pragmatic features of family therapy. These features include, for instance, the involvement of more than one family member, diagnosis, treatment and evaluation on the family unit level, and direct modification of behavioral, transactional patterns.

Orientation-systems fit. The orientation-systems fit refers to the extent to which the measurement instrument fits and systematically describes specific theoretical and pragmatic features of the school of family therapy associated with the form of family therapy under investigation (e.g., structural, strategic, behavioral, psychoanalytic object relations).

Certainly many other criteria may have been used for instrument selection. However, these are the criteria that in this investigator's opinion were the most crucial in the process of determining instrument

choice and that were initially used by this investigator for screening instruments.

Ultimate goals and instrument choice. Two other criteria identi-fied in the literature (Gurman & Kniskern, 1981) were used to augment instrument selection. These criteria were mediating goals and ultimate goals. As noted earlier in Chapter III, there are two kinds of thera-peutic goals, mediating goals, and ultimate goals. To reiterate, medi-ating goals relate directly to treatment definition. Mediating goals represent the steps or stages specified by a given clinical model through which a family will ideally progress toward increased psychological health and improved system functioning. Ultimate goals relate not only to treatment phases but also pertain significantly to outcome measures. Ultimate goals define the set of treatment outcome criteria used for determining treatment effectiveness within a given study. The outcome criteria describe what the treatment aims to accomplish: where the fam-ilies are expected to be at the end of treatment. Ultimate goals or outcome criteria describe the set of dependent variables under study. Instrument choice relates directly to outcome criteria. Ideally there should be a close match between the theoretical orientation of the in-strument and the described outcome criteria, the ultimate goals of the treatment.

Ultimate goals and instrument selection in this study. In general, the major treatment goal proposed in this study is to modify adult fam-ily member and family unit perceptions of the presenting child and the presenting problem. Three major variables thus have been identified to assess positive shifts in self-reported perceptions: (1) perception of

family unit functioning, (2) perception of the degree of congruence or discrepancy between the ideal and real family concepts, and (3) perception of the target child, presenting symptoms, presenting problem, and problem outcome.

Based upon these three general outcome criteria, three family-oriented assessment self-report measures were selected from the wide range of instruments reported in the literature. The instruments that were selected are The Family Assessment Device, Family Unit Inventory, and Child Behavior Checklist. These three assessment instruments were ultimately chosen over other family self-report instruments (e.g., Family Environment Scale, Faces II) for the following reasons: (1) the instruments are theoretically consistent with the treatment goals and elicit data on the three major variables under study; (2) the instruments are designed to obtain individual, interpersonal, and/or family unit assessment scores; and (3) the instruments elicit respondents' shifts in their perceptions of the family unit or their perceptions of the presenting child within his/her social context.

Three additional factors contributed to the final decision to use these three instruments. Based upon a pilot testing of the instruments conducted with volunteer clinic and nonclinic families (N=30) in which each instrument was administered to the families and families were interviewed about how they felt about the instruments, a number of factors concerning the instruments and instrument administration were found. Briefly, the instruments were found to (1) complement one another when administered as a set of instruments, (2) instrument items were clear and direct, and (3) instruments were relatively easy to understand,

were nonthreatening, and generally elicited positive responses from the families.

In addition to the three instruments cited above, two other assessment measures were developed by this investigator for this research. These measures are the Family Assessment of the Problem and the Family Counseling Evaluation. The Family Assessment of the Problem (FAP) is a short, twelve item questionnaire. FAP was devised to obtain data from family members specifically on their perceptions of aspects of the presenting problem relative to specific hypotheses to be tested in this investigation. The Family Counseling Evaluation (FCE) is a brief, 18 item questionnaire. FCE was designed to obtain data on treatment group families' satisfaction with the counseling experience and evaluation of treatment outcome.

The remainder of this chapter will focus on the assessment instruments chosen for use in this investigation. The origin, theoretical background, purpose, description, scoring procedures, psychological assumptions, relationship of instruments to hypotheses to be tested in this study, and findings generated by other studies using these instruments will be presented.

Family Assessment Device

The Family Assessment Device (FAD), Version III, is a 60 item, self-report questionnaire that is a subset of an original 240 item version. FAD was developed by Epstein, Bishop and Baldwin (1981) to measure family functioning as described in the McMasters Model of Family

Functioning (Epstein, Bishop & Levin, 1978). FAD assesses family member perception of general family functioning on seven fairly independent scales. Six of the scales correspond to the six dimensions of family functioning identified in the McMasters Model. The six scales include: Problem Solving, Communication, Roles, Behavior Control, Affective Responsiveness, and Affective Involvement.

FAD has been used to obtain data on perceived family functioning on both nonclinic and clinic populations. Data analyses on previous versions of FAD (FAD I and FAD II) indicated that all of the scales had item-total reliability at or about .73. In addition, the six McMasters family scales were found to correlate with FAD's seventh, general family functioning scale but also demonstrated scale independence.

In a recent reliability and correlation analysis of FAD on non-clinic individuals (N=209) and clinic individuals (N=296, from 112 families), all scales showed item-total reliabilities at or above .72 for the total sample (N=505). The seven item General Family Functioning Scale, once again, showed a positive correlation with each of the six scales, increasing the reliability of these scales without apparently affecting their independence. Preliminary reliability data on FAD suggests that FAD demonstrates acceptable reliability.

FAD has not been used extensively outside of the research group that developed the instrument and their setting (adult psychiatric hospital). However, based upon personal communications this investigator has had with one of the principle developers of FAD (Dr. Lawrence Baldwin), FAD appears to be ready for use in empirical research with

families, such as the kind of research proposed in this study.

Theoretical Background

The McMasters Model of Family Functioning (Epstein, Bishop & Levin, 1978) serves as the theoretical base for FAD. The McMasters Model is based upon a family systems conceptual framework for describing, assessing, and treating families. In the McMasters Model one of the primary functions of today's family in Western society is identified as the care and guidance of the social, psychological, and biological development of its members, especially its children. The McMasters Model postulates that in the course of performing this function, families need to carry out three kinds of tasks: Basic Tasks, Developmental Tasks, and Hazardous Tasks.

Basic tasks. Basic tasks encompass what may be referred to as instrumental or survival functions such as provision of adequate food and shelter.

Developmental tasks. Developmental tasks refer to individual growth and development tasks (infancy through old age), family developmental stages (e.g., courtship, early marriage, first pregnancy and birth of the first child, and so forth), and the performance of appropriate tasks associated with these family developmental life stages.

Hazardous tasks. Hazardous tasks refer to those nodal or developmental events that may become toxic issues for a family and may arise in the form of crises that the family must face in the course of its developmental life cycle stages (e.g., job loss, prolonged physical or psychiatric illness, death, and so forth).

Treatment component. The McMasters Model also has led to the development of an accompanying treatment model, Problem Centered Family Systems Therapy (PCFST). PCFST is intended to be used in brief problem-focused family therapy. PCFST is based upon a family systems conceptual framework for assessing and treating families. Specific problems that emerge in a family are viewed as occurring as a result of problems in family system structure and interaction. The treatment focuses on involving the family in a systematic problem solving treatment process. The treatment process involves what are termed macro stages and micro interventions of therapy.

Macro treatment stages are defined as the major sequential blocks of the treatment process. There are four macro stages: Assessing, Contracting, Treatment, and Closure. Micro moves are defined as the various interventions made by the therapist while carrying out the macro stages. Each macro stage contains four micro interventions. They are outlined as follows.

Assessment.

1. Orientation

2. Data gathering

3. Problem description

4. Clarification and agreement on a problem list

Contracting.

1. Orientation

2. Outlining options

3. Negotiating expectations

4. Contract signing

Treatment.

    1. Orientation

    2. Clarifying priorities

    3. Setting tasks

    4. Task evaluation

Closure.

    1. Orientation

    2. Summary of treatment

    3. Long-term goals

    4. Follow-up (optional)

A therapist who uses this model is expected to systematically fol-
low the macro stages of treatment and the accompanying micro interven-
tions or micro moves. However, within this prescribed structure each
therapist is free to employ his or her personal therapeutic style.

Description of FAD

As noted, the McMasters Model provides a descriptive framework for
describing and assessing psychological health and for assessing and
treating psychological problems in families. The McMasters Model is
based upon six dimensions of family functioning and a set of accompany-
ing postulates or indices that may be used to describe and assess health
and psychological problems associated with each dimension. FAD scales
are designed to assess these six dimensions.

FAD contains 60 items in the form of brief statements that describe
the family as a unit. Two examples of items are item #18, "People come
right out and say things instead of hinting at them" and item #40, "We

discuss who is to do household jobs." A brief definition of each scale and its accompanying assumptions will be presented.

Problem solving. Problem solving is defined as "the family's ability to resolve problems to a level that maintains effective family functioning" (Epstein, Bishop & Levin, p. 21). Family problems are defined as those crises or situations that appear to threaten the integrety, stability, and functional capacity of the family. These system threatening problems are limited to basic instrumental problems (tasks related to such issues as providing adequate food and shelter) and affective problems (tasks related to issues concerning the feelings among family members). Problem solving stages include:

1. Identification of the problem.

2. Communication of the problem to appropriate resources within or outside the family.

3. Development of alternative action plans.

4. Decision regarding a suitable action.

5. Action.

6. Monitoring the action which is taken.

7. Evaluation of the success of that action.

In reviewing these seven stages, it is easy to see how a family who meets a stumbling block in stage one may be more "incapacitated" or more ineffective as a unit than the family who can achieve stages two, three, four, and five and how a family who can accomplish stages one through six or one through seven may demonstrate an even higher level or greater degree of family functioning.

Problem solving is associated with several assumptions concerning psychological health and dysfunction. The major assumptions made may be summarized as follows. Families who have difficulty resolving both instrumental and affective problems function least effectively. Families who in contrast have difficulty resolving only affective problems are more effective. In this model, instrumental problems are given greater priority as a determinant and/or predictor of dysfunction. In addition, the ideal concept of healthy family problem solving suggests that families engage in all seven stages and that such a level of efficacy may be associated only with exceptional families.

Communication. Communication is broadly defined as information exchange and is restricted to verbal transmission and exchange of information. As in problem solving, communication is similarly divided into both instrumental and affective areas. In addition, communication is further assessed in regard to clear versus masked communication and direct versus indirect communication. This suggests a 2X2X2 matrix for assessing communication or eight communication possibilities: (1) clear, direct instrumental communication; (2) clear, direct affective communication; (3) clear, indirect instrumental communication; (4) clear, indirect affective communication; (5) masked, direct instrumental communication; (6) masked, direct affective communication; (7) masked, indirect instrumental communication; and (8) masked, indirect affective communication.

Communication is associated with several assumptions concerning psychological health and psychological problems. The major assumptions

made may be summarized accordingly. The more masked and indirect the overall family communication patterns, the more ineffective the family is and the more "at risk" the family becomes for problems and the onset of crises. More direct, clear communication is associated with healthier interchange, interpersonal relationships, and more effective family unit functioning.

Roles. Roles is defined as "the repetitive patterns of behavior by which individuals fulfill family functions" (Epstein, Bishop & Levin, p. 23). Once again, family functions are subdivided into instrumental and affective areas and into "necessary family functions" and into "other family functions."

Necessary family functions include (1) provision of resources (food and shelter), (2) nurturance and support, (3) sexual gratification of the couple, (4) life skills development (tasks relevant to the maintenance and development of family members such as parent helping a child start and get through school, adult pursuing a career and being supported by loved ones), and (5) systems maintenance and management (functions such as leadership, division of labor, decision making, maintenance of family unit boundaries and family standards).

Other family functions refer to those unique maladaptive or adaptive strategies each family develops to meet its needs (e.g., channeling the negative social factors of discrimination into effective community or political activity).

The Roles scale also considers two additional factors: role allocation and role accountability. Role allocation refers to how family mem-

bers are assigned responsibilities for family functions. Role account-ability refers to how family members are made accountable for the family responsibility or function he/she has been allocated.

Roles is associated with several assumptions concerning psychologi-cal health and psychological problems. The major assumptions made may be summarized accordingly. Healthier, more effective family function-ing is more likely to occur when responsibilities are assigned to age-appropriate family members, when a clear process of accountability (e.g., checking to see if the task has been performed) is built into the process of task assignment, and when responsibilities are shared almost evenly across family members or are spread almost evenly among family resources. Least effective family role functioning is assumed to be associated with the assigment of unclear and/or inappropriate tasks, the absence of a system of checks and balances for accomplishing tasks, and inconsistent guidelines for planning and assigning responsibilities and expectations.

Affective responsiveness. Affective responsiveness is defined as "the family's ability to respond to a range of stimuli with appropriate quality and quantity of feeling" (Epstein, Bishop & Levin, p. 25). Fam-ily affective responses are divided into welfare emotions (e.g., love, tenderness, happiness, joy) and emergency feelings (e.g., anger, sad-ness, diasppointment).

Affective responsiveness is associated with several assumptions concerning psychological health and psychological problems. The major assumptions made may be summarized accordingly. More affectively

responsive families express a wide range of appropriate emotional responses. Families low on affective responsiveness are characterized as routinely demonstrating several stock affects in which the quantity and quality of the expressed emotions are distorted, inappropriate, and/or superficial. One major postulate about development and dysfunction associated with this dimension is that children reared in families described as consistently low on affective responsiveness would be more likely to develop affective disorders (e.g., inadequate, excessive or constricted expression of feelings).

Affective involvement. Affective involvement is defined as "the degree to which the family shows interest in and values the activities and interests of family members" (Epstein, Bishop & Levin, p. 25). The Affective Involvement scale is comprised of a six-step continuum of affective involvement: (1) lack of involvement, (2) involvement devoid of feeling, (3) narcissistic involvement, (4) empathic involvement, (5) over-involvement, and (6) symbiotic involvement.

Affective involvement is associated with several assumptions concerning psychological health and dysfunction. The major assumptions made may be summarized accordingly. The more effective families fall within the middle range of affective involvement and, on average, appear to demonstrate consistent empathic involvement. Those families who demonstrate low affective involvement are more likely to demonstrate symbiotic affective involvement and/or lack of affective involvement.

Behavior control. Behavior control is defined as "the pattern the family adopts for handling behavior in three specific situations:

(1) physically dangerous situations, (2) situations involving the meet-
ing and expressing of psychological needs and drives, and (3) situa-
tions involving socializing behavior both inside and outside the family"
(Epstein, Bishop & Levin, p. 26). Behavior control refers not only to
child behavior management but pertains to the regulation, monitoring,
and establishment of a range of acceptable and unacceptable behaviors
for adults (e.g., alcoholism, reckless driving, suicide attempts).

Four major styles of behavior control are identified in relation
to the set of acceptable behavior standards established and what degree
of freedom the family establishes for maintaining these standards.
These four styles are: (1) rigid behavior control, (2) flexible behavior
control, (3) laissez faire behavior control, and (4) chaotic behavior
control.

Rigid behavior control refers to a narrow or constricted range of
rules that remain fixed regardless of context. Flexible behavior con-
trol involves reasonable rules and reasonable latitude within the given
context in which the behavior occurs. The laissez faire style of be-
havior control is one in which rules are bent in favor of the individ-
ual. Chaotic behavior control designates the situations in which all
of the three behavior control styles may be employed by family members
as they see fit.

Behavior control is associated with several assumptions concerning
psychological health and psychological problems. The major assumptions
made may be summarized as follows. The most effective families employ
a more flexible style of behavior control. Families who are low on ef-

fective behavior control employ a chaotic behavior control style charac-
terized by lack of clear behavior guidelines, clear checks and balances,
and clear limit setting.

Scoring of FAD

FAD uses a four point response system. Responses range from
Strongly Agree assigned one, Agree assigned two, Disagree assigned
three, and Strongly Disagree assigned four. Responses are scored in
such a way that a score of one on any item indicates a healthy response
and a score of four on any item indicates an unhealthy response. Scores
obtained for unhealthy responses to healthy items are transformed by
substracting them from five. This inverts the response scale on the
unhealthy items and has the effect of equating a strongly agree response
on an unhealthy item with a strongly disagree response to a healthy
item. The scored responses to items assigned to each subscale are aver-
aged to yield seven scale scores: Problem Solving (PS), Communication
(COM), Roles (R), Affective Responsiveness (AR), Affective Involvement
(AI), Behavior Control (BC), and General Functioning (GF). Subscale
scores on FAD have a possible range of 1.00 (perceived healthy family
functioning) to 4.00 (perceived unhealthy family functioning). There-
fore, higher scores obtained by family members on FAD suggest lower
levels of family unit functioning and lower scores obtained by family
members on FAD suggest higher levels of family unit functioning.

Limitations

The postulates stated above comprise a set of assumptions made

about psychological health and dysfunction in the McMasters Model. Examination of these assumptions suggests possible limitations of FAD. As the developers acknowledge, the McMasters Model (basis for FAD) reflects what may be termed a Western, Judeo-Christian perspective on psychological health and dysfunction. It is quite reasonable to assume that based upon such a perspective FAD incorporates cultural values in its construction (e.g., the priorities and indices of health defined in the model). FAD is therefore subject to the unacknowledged operation of cultural biases in its description of mental health criteria.

In addition, the broad concept of health suggested by the model (family functioning dimensions) suggests in this investigator's opinion a bias toward what may be termed a Western, middle-class view of family functioning and toward special, even exclusive consideration of one family form, the nuclear family. Finally, the considerable emphasis placed primarily on instrumental tasks over affective tasks as assessment criteria further delimits the scope of the instrument and suggests another qualification worth noting.

Merits

While FAD does not address all areas of family functioning when evaluated against other comparable family assessment instruments, FAD was chosen because it was one of the few instruments based on a theoretical family systems model of family treatment closely related to the theoretical assumptions of the treatment to be tested and to the specific treatment objectives. The dimensions assessed on FAD most clearly approximate the target areas of change outlined in the proposed treat-

ment. Treatment outcome goals and treatment mediating goals defined in this investigation involve more effective communication, more positive and reasonable role expectations, the identification of the emotions or "real affects" associated with roles and expectations, and the establishment of clear and more effective behavior management and problem-solving plans. For these reasons, FAD was selected as an outcome measure for use in this research.

Child Behavior Checklist

The Child Behavior Checklist (CBCL) was developed by Achenbach (Achenbach & Edelbrock, 1979). Work on CBCL was initiated in 1966. The most recent version of CBCL will be used in this research (Achenbach, 1981). CBCL assesses parental or caregiver's self-reported perception and shifts in general perception of the child's behavior along two parameters (adaptive competencies and behavior problems) according to two sets of scales (a 20 item Social Competence Scale and a 118 item Behavior Problem scale).

CBCL has been standardized on normal (N=250) and clinical (N=450) samples of children. Norms have been obtained for boys and girls age four through five, six through eleven, and twelve through eighteen, respectively. Comparisons of normal children and children referred for mental health services showed significant differences (p<.001) on all Behavior Problem and Social Competence scales, demonstrating the discriminative validity of the instrument. One week test-retest reliability correlations for all children ages six through eleven averaged .89

(range from .72 - .89). Younger girls averaged .88, older boys aver-
aged .82, and older girls averaged .90 respectively, indicating an ac-
ceptable range of reliability.

A recent monograph published by the Society for Research in Child
Development (Achenbach & Edelbrock, 1981) provides additional evidence
to support the use of CBCL as a reliable measurement device in research
on children and their families.

Theoretical Orientation

Unlike FUI and FAD, CBCL is not based upon a particular family
systems theoretical model for describing child and family development.
However, generally speaking, CBCL is based upon an integrated, systems-
oriented theory of child development and dysfunction. The instrument
reflects a systems-oriented concept of behavior. Behavior patterns are
viewed as organized profiles or organized patterns demonstrated over
time and assessed within the child's environmental context. In addi-
tion, CBCL provides a holistic view of the child by eliciting parental
perception of the child's competencies as well as his behavior problems.
While CBCL may not be strictly categorized as a family systems assess-
ment instrument, CBCL is theoretically consistent with FUI and FAD in
that it elicits family members' (parental or caregiver) perceptions of
presenting problems, in this case the child in his/her family.

The development and construction of CBCL occurred primarily in re-
sponse to the lack of standardized and reliable clinical tools for ob-
jectively describing and classifying behavior disorders in children.
As Wilson and Prentice-Dunn (1981) point out, most child behavior as-

sessment techniques are subjective, relying on observational reports of the child's behavior after treatment. Child behavior rating scales are rarely employed as a tool for measuring treatment outcome.

Prior to the 1968 edition of The American Psychiatric Association's Diagnostic and Statistical Manual for Mental Disorders (DSM-I), childhood disorders were differentiated only into two very broad categories: adjustment reactions and childhood schizophrenia. The provisional and somewhat inadequate diagnostic guidelines proposed in DSM-I led Achenbach to the development of a more extensive, descriptive classification device for childhood behavior disorders that would provide a more complete and dynamic picture of childhood behavior disorders. To date, with the exception of The American Psychiatric Association's newest, revised diagnostic manual, The Diagnostic and Statistical Manual (DSM-III), CBCL appears to provide one of the best descriptive, dynamic classification schemes for assessing childhood behavior disorders and behavior problems.

Description of CBCL

CBCL was specifically designed to provide a descriptive classification for grouping children for both research and clinical purposes. The instrument focuses on the identification of patterns of behavior rather than on the enumeration or listing of specific, isolated items of behavior. The instrument emphasizes both the adaptive competence and skills of the child as well as problem areas. Because of its standardized format, CBCL also provides a quantitative assessment of behavior change in children and in parental perception of children over time.

CBCL is a self-report questionnaire administered to parents in written format. CBCL assesses the adult caregiver's perception of the child's behavior along two parameters (adaptive competence and behavior problems) according to two sets of scales (Social Competence scales and Behavior Problem scales).

Social Competence scales. Social Competence consists of three a priori scales: Activities, Social, and School scales. Each scale measures the parent's perception of the child's degree of involvement and attainment in the dimension or context specified by the scale items.

Activities. The Activities scale obtains scores on the amount and quality of the child's participation in sports, hobbies and recreational activities, and jobs and chores at home.

Social. The Social scale consists of scores for the child's membership and participation in clubs and organizations, number of friends and amount and quality of contact with friends, and siblings and the child's behavior or play habits when he/she is alone.

School. The School scale consists of the parent's estimate of the average of the child's performance in academic subjects (the response alternatives include: Failing assigned zero, Below Average assigned one, Average assigned two, and Above Average assigned three, placement in regular or special class, child's grade performance (whether promoted regularly or held back), and the presence or absence of any school problems.

Scoring of Social Competence Scales

The response categories on the Social Competence scales vary de-

pending on the questions. Responses range from a Yes/No response to a
two-point, three-point, or four-point rating scale. Rating scale re-
sponse categories range from below average, average, to above average.
Items are scored in a positive direction, the higher scores indicating
a more positive parental perception of the child's adaptive competence
and social abilities.

Description of Behavior Problem Scales

After a series of factor analyses on scores obtained on a prelim-
inary version of CBCL, nine of the original 13 factors were retained
for the present Behavior Problem scales. The nine factors are derived
from nine behavior problem syndromes in children. The nine scales con-
structed for boys age four through five and six through eleven differ
slightly. With slight variations, the scales for boys four through
five and six through eleven include (1) Schizoid, (2) Depressed,
(3) Uncommunicative, (4) Obsessive-Compulsive, (5) Somatic Complaints,
(6) Social Withdrawal, (7) Hyperactive, (8) Aggressive, and (9) Delin-
quent. The scales for girls four through five and six through eleven
include (1) Somatic Complaints, (2) Schizoid-Obssessive, (3) Depressed,
(4) Social Withdrawal, (5) Sex Problems, (6) Cruel, (7) Delinquent,
(8) Aggressive, and (9) Hyperactive.

A second-order factor analysis of the nine Behavior Problem scales
showed that the nine scales could be further divided into two broad-
band groupings: Internalizing and Externalizing. Based upon this broad-
band grouping, scales one through five for boys four through five and
six through eleven years of age are grouped under Externalizing. Scale

six for these age groups is regarded as a Mixed Internalizing-Externalizing scale. A second-order factor analysis for girls four through five and six through eleven revealed that the nine scales could be divided into two broad-band groupings with scales one through four classified as Internalizing and scales five through nine classified as Externalizing.

The organization of the nine Behavior Problem scales into two different broad-band groupings appears to reflect CBCL's ability to record and respond to developmental differences in children according to age and sex characteristics. This also provides for a more individualized assessment and description of behavior change over time. CBCL's capacity to provide age and sex-appropriate profiles underscores the instrument's sensitivity to the diagnostic differences of presenting symptoms when viewed within the total context of the child.

The nine empirically derived syndromes (the basis for labeling each of the nine behavior scales for the appropriate sex and age perid) do not represent the frequency of the reported behaviors but the covariation among these reported behaviors. Attention to the covariation of such behaviors and not the number/amount helps to create a more complete picture or profile of the child.

Scoring of Behavior Problem Scales

Parents rate items on the Behavior Problem scales according to a three-step response scale ranging from zero ("Not true of your child"), one ("Sometimes true of your child"), to three ("Often true of your child"). Items are scored in a negative direction. A lower score on a

scale indicates the presence of fewer negative behaviors suggesting
that the parent holds a more positive view of the child's behavior.

Child behavior profile. Scores obtained from the two independent
sets of scales (Social Competence scales and Behavior Problem scales)
comprise what is termed the Child Behavior Profile. The Child Behavior
Profile is calculated from normalized T scores obtained on Social Com-
petence and Behavior Problem scales. Profile scores have been standard-
ized separately for different age groups and for sexes. Normative pro-
file scores currently include standardized separate profiles for both
boys and girls ages four through give, six through eleven, and twelve
through sixteen on both the Behavior Problems Scale and Social Compe-
tence Scale.

The hand-scored and computerized printout of the Profile provides
the researcher or clinician with a graphic display and immediate assess-
ment of the child's scores on CBCL. Raw scores for each of the scales
are listed in the nine columns. Percentiles for these scores are listed
to the left and T scores are listed to the right. Reading across the
columns provides the reader with an immediate though admittedly rough
appraisal of the child's scores. This display helps the researcher and
clinician begin to observe what behavior or sets of behaviors consis-
tently occur or covary with other sets of behaviors and how the child
compares with other children of the same age and sex, based upon par-
ental perceptions.

Assumptions

Because CBCL is not based upon a specific set of theoretical as-

sumptions or on one clearly defined school of thought, the assumptions CBCL makes appear not to be as readily identifiable as are the assumptions made by FUI and FAD. However, CBCL is based on a distinct perspective or orientation. This orientation makes certain assumptions.

Two assumptions that CBCL makes have already been stated. The first assumption states that the identification of childhood behavior problems requires a systemic approach to understanding the child's behavior in its context. The second assumption states that the examination of childhood behavior problems should be accompanied by the identification and assessment of coexisting ego strengths. CBCL therefore reflects a holistic, systemic view of health and dysfunction.

A third assumption CBCL makes may be found in the way scores are interpreted. It is assumed that obtaining a higher score on Social Competence reflects a more positive perception of the child's social skills and abilities. A lower score obtained on Social Competence assumes that the parent perceives a less favorable level of social competence for the child and therefore may suggest the presence of problems. And, lastly, higher scores obtained on Behavior Problem are assumed to indicate the presence of more problem behaviors. Lower scores obtained on Behavior Problem are assumed to indicate the absence of problem behaviors, suggesting that the child falls within the normal range of age and sex-appropriate behavior.

Limitations

CBCL presents certain limitations worth noting. The major limitations of the instrument are as follows: (1) to date, data obtained on

CBCL have not been validated by direct, observational assessment of actual child behaviors; (2) the Social Competence and Behavior Problem scales may be characterized as assessing global aspects rather than specific behavioral indices of the child's social adjustment; and (3) the Social Competence and Behavior Problem scales do not take into account the full range of situational parameters that may affect the child.

And, finally, it is important to clearly state at this point what the instrument actually measures. The instrument measures shifts in parental self-reports of the child's behavior. CBCL does not measure nor can it be used to substantiate either (1) accurate assessments of the child's actual behavior, or (2) accurate assessments of changes that may occur in the child's observed behavior over time. Such changes require independent validation from such sources as independent observers, professional diagnostic assessments, or direct observation of the child's behavior.

Merits

Despite its limitations, CBCL presents specific advantages as an assessment instrument. CBCL is one of the few parental child behavior rating scales that has been standardized on both clinic and nonclinic populations. Most adult rating scales of children's behavior have been developed for use by teachers and/or mental health professionals. The parental perspective has been largely overlooked as a critical data source and/or criterion variable in treatment of child-centered family problems.

Michelson et al. (1981) point out some of the merits of CBCL. These merits include (1) the breadth of behavioral items, (2) acceptable test-retest reliability and interparent reliability, and (3) standardization of Profiles on a wide range of ages separately for both boys and girls. These authors conclude that when evaluated against comparable rating scales, CBCL may be one of the best, if not the best, parental child-rating scales that has been developed to date.

In addition, Achenbach and Edlebrock (1981) identify other distinctive advantages of their instrument. Profiles obtained from the Social Competence and Behavior Problem scales provide a comprehensive and economical description of the child's behavior. Child Profile scores also may help to discriminate among children, provide a differential diagnosis, and therefore may aid in the development of appropriate treatment plans. The Profile score responds to and records changes in parental perception of the child's behavior and appears also to record patterns of stability in the child's behavior over time.

CBCL is particularly appropriate as an assessment device for use in this study for several reasons. To begin with, CBCL complements the other assessment instruments. Whereas FUI and FAD assess family system level variables, CBCL focuses specifically on the assessment of the child's behavior at interface with the social environment. Secondly, CBCL coincides with specific treatment objectives: treatment goals include modifying parental perception of the presenting child's behavior and increasing communication and problem solving. And, thirdly, CBCL directly elicits data on changes in parental perception of the present-

ing child and, therefore, provides an independent measure for assessing the effect of the treatment.

Family Unit Inventory

The Family Unit Inventory represents a modified, improved version of its antecedent test form, the Family Concept Q-sort (van der Veen, 1964). While the Q-sort has been widely used in family research for approximately 20 years, the Family Unit Inventory (FUI), the inventory form derived from the Q-sort, developed by van der Veen (1981), will be used in this study.

Recent comparative studies reported by van der Veen and Olson (1981) on both the Q-sort and FUI presents supportive evidence that FUI provides more reliable results. While both forms of the Family Concept Test (FUI and Q-sort) provide moderately acceptable levels of reliability (mean r's range from .54 to .87), studies comparing Q-sort with FUI on stability for similar samples on test-retest reliability suggest that FUI is more reliable (Q-sort REAL, r=.69; FUI REAL, r=.80; Q-sort IDEAL, r=.75; FUI IDEAL, r=.87).

Theoretical Background

The Family Unit Inventory (FUI) is based upon a phenomenological orientation to individual psychotherapy and personality research. van der Veen and Olson (1981) have adapted the person-centered orientation to psychological growth and psychotherapy (e.g., client-centered therapy approach proposed by Carl Rogers) to the field of family treatment. They term their approach the family-centered treatment approach.

The definition and categorization of the theoretical orientation
underlying FUI would appear to extend beyond a family-centered approach.
In a series of articles (1965-1980), van der Veen and associates de-
scribe and outline the family-centered assessment method using what
this investigator would label as clear family systems terminology. FUI
therefore appears to be grounded in a firm family systems perspective.
Examination of the definition of instrument scales to be cited later
supports such an interpretation.

A central assumption of FUI is that the family unit concept is
vitally important to family health and family functioning. Just as the
individual's self-concept is viewed in the person-centered framework as
vitally important to individual psychological functioning, the family
system concept is seen in the family-centered framework as vitally im-
portant to family members' psychological functioning.

Family concept is defined by van der Veen and Olson as follows.

> The family concept is defined as an interrelated and
> potent set of psychological qualities consisting of a
> person's feelings, attitudes, and values regarding his
> or her family unit. The family concept is assumed to
> have certain characteristics: it influences behavior;
> it can be referred to and talked about; and it can change
> as a result of new experience and understanding. It is
> analogous to and complements the concept of self, which
> has proven fruitful in personality research and in the
> study of the individual. (1981, p. 4)

The family concept plays an important role in maintaining the psy-
chosocial organization of the family system. van der Veen and Olson
maintain that the intrapsychic organization and psychosocial function-
ing of the individual reflects, to varying degrees, the psychosocial
organization and functioning of the individual's family system. They

state, "The creation of a shared awareness by the family members of
their experience and their needs lies at the heart of this view of a
family concept" (1981, p. 5). An essential characteristic of the family
concept, and one which bears critical importance for this study, is
that the family concept, besides influencing individual development, is
fluid and changeable and influences family development and perceived
family functioning.

The assumption of the family concept as being fluid and changeable
is consistent with the theoretical orientation and treatment goals pro-
posed in this study: Changes in perceptions of key critical identity
claims (behaviors and expectations) will be related positively to
changes in family members' concept (perceptions, attitudes, and expec-
tations) of the family unit and family life.

Description of FUI

FUI was initially developed to obtain a quantifiable description
of an individual's real family concept and ideal family concept. FUI
assesses family members' concept of their real family as it is presently
and family members' perception of their ideal concept of family life.
The instrument provides for a comparison of the real-ideal family con-
cepts of respondents based upon two separate analyses of the subject's
responses on the same set of 80 items.

FUI consists of 80 items presented to family members (over the age
of 14) in a booklet format. Using a nine point ordinal response scale
(0 to 8), family members are asked to rate each item from 0 (least like
their family) to eight (most like their family).

There are two standardized forms of the instrument, the original Q-sort and the slightly revised FUI, English and Spanish versions. Both the Q-sort and FUI forms consist of 80 items that describe social and/or emotional aspects of family life. Some examples of items are item #26, "We are usually calm and relaxed when we are together," and item #41, "We have warm, close relationships with each other." Each item was designed as a description of the total family unit rather than as a description of particular family relationships and positions (roles) in the family.

Scores on FUI yield measures of three broad family dimensions: Family Congruence, Family Satisfaction, and Family Effectiveness. In addition, factor analysis of response items on FUI has yielded eight first-order factors, with an additional item cluster serving as a ninth set, and two second-order factors.

Family Dimensions on FUI

There are three broad family dimensions on FUI.

Family Congruence. Family Congruence is defined as the degree of agreement among family members' views of family life and family functioning. Family Congruence yields measures of both Real Family Congruence (the degree of agreement among family members' views of the family as it is now) and Ideal Family Congruence (the degree of agreement among family members' view of family life as they would like it to be). Family Congruence is an interfamily member agreement measure of the family concept.

Family Satisfaction. Family Satisfaction is defined as the degree

of discrepancy between the way a family member perceives his family as
it is now and the way he/she would like the family to be. It is assumed
that a person who is relatively satisfied with family life would have a
real family concept score quite similar to his/her ideal family concept
score. Family Satisfaction measures the degree of discrepancy between
the individual family member's view of real and ideal family life. Fam-
ily Satisfaction is an intra-subject agreement measure.

Family Effectiveness. Family Effectiveness is defined as "the ex-
tent to which a person's family concept contains qualities that profes-
sional clinicians consider important for good family life" (van der
Veen & Olson, 1981, p. 22). Family Effectiveness measures how closely
a family member's concept of healthy family life coincides with stan-
dards of healthy family functioning defined by family clinicians. A
subset of 48 of the total 80 item set on FUI were found to demonstrate
considerable consensus (75% agreement) among a sample of 27 professional
clinicians in their descriptions of ideal family life. Family Effective-
ness measures the degree of agreement between a family member's concept
of ideal family life and professional views of the mental health com-
munity.

Content Dimensions on FUI: First-Order Factors

Extensive factor analysis of Q-sort data (approximately 900 clinic
and nonclinic families) have yielded nine first-order factors. First-
order factors were found to account for approximately 30 percent of the
item variance while second-order factors were found to account for 46
percent of the variance of the eight-by-eight correlation matrix. A

brief description of each of the nine first-order factors is as follows.

Factor one: Consideration vs. Conflict (CON). This factor measures the degree of consideration and harmony versus the degree of conflict and anger.

Factor two: Family Actualization vs. Inadequacy (ACT). This factor includes liking to do new things, zestfullness, and adjusting well (the positive pole of ACT) versus dependency, worry, and wanting help with problems (the negative end of the pole).

Factor three: Open Communication (COM). This factor focuses on family communication defined as the open expression of feelings and thoughts including areas pertaining to sexual matters.

Factor four: Community Sociability (SOC). This factor consists of such characteristics as sociability, friendships outside of the family, being liked, and getting along well in the community.

Factor five: Family Ambition (AMB). This factor focuses on the value the family places on success, prestige, and concern with the opinions of others.

Factor six: Internal vs. External Locus of Control (LOC). This factor describes the degree to which family members feel they can depend on each other and also stand up for their rights versus the degree to which family members feel they are overcontrolled by or unduely blocked by externally caused events (e.g., lack of money, others' standards and values, and so forth).

Factor seven: Togetherness vs. Separateness (TOG). This factor focuses on the degree to which the family unit is the center of many

activities versus the degree to which family members pursue their own separate interests without regard for the family unit.

Factor eight: Family Loyalty (LOY). This factor is concerned with such issues as family devotion and pride, and the degree to which family members need and care for one another. The opposite end of this factor describes lack of family member fondness for one another.

Factor nine: Closeness vs. Estrangement (CLO). This item set is concerned with the degree to which family relationships are described as being close, warm, and trusting.

Content Dimensions on FUI: Second-Order Factors

There are two second-order factors: Family Integration (FI) and Adaptive Coping (AC).

Family Integration (Factor A). Family Integration is composed of five first-order factors: Consideration vs. Conflict, Open Communication, Togetherness vs. Separateness, Family Loyalty, and Closeness vs. Estrangement. One assumption FUI makes about healthy family functioning is that a family concept score high on Family Integration appears to indicate a family that is able to communicate with each other, has positive family relationships, and a strong sense of family cohesion.

Adaptive Coping (Factor B). Adaptive Coping consists of three first-order factors: Family Actualization vs. Inadequacy, Community Sociability, and Internal vs. External Locus of Control. Another assumption FUI makes about healthy family functioning is that a family concept score high on Adaptive Coping may indicate a family that adapts well to the extrafamilial environment and feels a sense of control over

its own destiny.

Scoring of FUI

As noted earlier, FUI REAL and FUI IDEAL are identical 80 item questionnaires using a 0 (least like) to 8 (most like) response scale. FUI yields nine first-order factor scores. The nine first-order factor scores correspond to the nine content dimensions (e.g., Consideration, Open Communication) described above. The nine first-order factor scores may be computed for FUI REAL and for FUI IDEAL, comprising a total of 18 first-order factor scores for each family member.

Factor scores are computed by obtaining the means of item scores assigned to the particular content dimension. Scores for negatively loaded items are transformed by subtracting them from 8. Items for each content dimension are summed by using the actual value respondents circle for each item (entering a value of 4, the middlemost value on the response scale, for missing values). The sum of the values for each content dimension is divided by the number of items in that dimension to obtain a mean. The mean is multiplied by 100 to obtain the first-order factor score. Factor scores are computed for FUI REAL and FUI IDEAL. A factor score can range from 0 to 800. Dividing each score by 100 provides the scale point for the item mean. For example, a factor score of 720 on Open Communication indicates an average item placement of 7.2 for that content dimension representing a rather high score, near the "like" end of the scale.

In addition to the nine first-order content factor scores, FUI yields a variety of other family measures. These measures include two

second-order factor scores, Family Adaptation and Family Integration.
FUI also yields a Real Family Congruence score, Ideal Family Congruence
score, Family Satisfaction score, and a Family Effectiveness score.
Real Family Congruence and Ideal Family Congruence represent intersub-
ject agreement scores. For example, the Real Family Congruence score
is computed by obtaining the product-moment correlation between the
real family concept of two family members (e.g., parent-child, husband-
wife). Family Satisfaction, on the other hand, compares the family mem-
ber's real family concept score with his/her ideal family concept score.
Family Satisfaction measures intrasubject agreement. Whereas Family
Congruence (real and ideal) compares scores among family members, Family
Satisfaction expresses the product-moment correlation between an indi-
vidual family member's real and ideal family scores. Family Effective-
ness expresses the product-moment correlation between an individual
family member's ideal scores and the 48 item expert composite. All FUI
dimensions and first- and second-order factors are scored in a positive
direction. Higher individual scores indicate more positive perceptions
of family life, higher levels of family member interagreement scores
suggest greater degree of family satisfaction.

Limitations

One major limitation of FUI is the fact that the family concept
has not been validated by actual observations (family interaction ob-
servations). Instrument items are based upon family members' self-
reported perceptions of the real and ideal family concepts. Another
limitation of FUI may be found in some of its variables or dimensions

and in the assumptions about psychological health accompanying the dimensions selected for assessment. For instance, the definition and measurement method for assessing Family Effectiveness presents such a limitation. In assessing Family Effectiveness, individual family member perceptions of the ideal family concept are correlated with the concept of healthy family functioning defined by 27 professional clinicians. The assumption is that the higher the correlation between the family's concept of ideal family functioning and the professionals' concept of ideal family functioning, the more healthy the family is assumed to be. Such a position appears to minimize cultural and ethnic differences and does not appear to allow for an equal valuing of a wide range of perspectives on psychological health and family functioning.

Merits

When compared with similar family systems assessment instruments, FUI presents some distinct advantages. FUI is one of the few family assessment instruments that has been used in family research over a long period of time (20 years in existence). FUI has also been employed extensively in family interaction research and in family therapy outcome research. An extensive annotated research bibliography on FUI establishes this point. FUI also has demonstrated adequate reliability as an assessment instrument.

In addition, FUI appears to be particularly appropriate to the outcome criteria proposed in this research. One critical assumption being proposed in this research, and an assumption upon which FUI is based, is that a positive treatment outcome in part will be indicated by a

closer match or a higher degree of association between real and ideal family concepts. This assumption is widely supported in the psychotherapy literature. One criterion that has been consistenly identified across studies for assessing positive treatment outcome has been clients' reports of more realistic self-concepts and set of personal expectations. This assumption would appear equally applicable in assessing shifts in family members' perceptions and expectations of their family.

Family Assessment of the Problem

The fourth instrument to be used in this research is the Family Assessment of the Problem questionnaire (FAP). FAP is a 13 item questionnaire administered in written format to family members. FAP was designed by this investigator (Andreozzi, 1982) specifically for this study to assess family member self-reported perceptions of the presenting family problem. This questionnaire was constructed to elicit descriptive information either omitted or not directly addressed in items contained in the other three instruments.

Theoretical Background

FAP is the result of this investigator's work with approximately 125 families of young children who participated in a five-year family counseling and education program (1974-1979) that was funded by the Rhode Island State Department of Education. FAP is based on a general family systems orientation to education and counseling. The questionnaire derives, in part, its theoretical base from the structural-analyt-

ic treatment model and family process conceptual framework developed by David Kantor (1975, 1979, 1980, 1981). The models have been outlined in Chapter III.

Description of FAP

The questionnaire is a 13 item self-report instrument. FAP consists of a pretest version (FAP I) and a posttest version (FAP II). (Copies of FAP I and FAP II are contained in Appendix D.) FAP focuses on three areas that this investigator has identified as critical in the assessment and treatment of family member perceptions of presenting child problems. The three critical variables are Problem Orientation, Behavior Strategies, and Network Support.

Problem Orientation. Problem Orientation focuses on family member description of the presenting problem, presenting child, and presenting child behavior. Problem Orientation items elicit information on family member's perceptions on such issues as (1) problem type, (2) problem level or intensity, (3) degree of family member involvement/responsibility in the creation and maintenance of the problem, (4) key family relationships or principal subsystems at risk, (5) theory of causation in relation to the problem (who or what caused it?), (6) factors contributing to the problem conflict, (7) prognosis for problem resolution, (8) expectations for counseling, and (9) problem outcome.

Behavior Strategies. Behavior Strategies is defined as each family member's self-assessment of his/her psychopolitical roles in the family. Roles is defined as the individual's identification and perception of his/her most typical recurring transactional strategies in the family.

Behavior Strategies provides descriptive data on how the adult family member perceives his/her role in the family. For purposes of this study, Behavior Strategies focuses specifically on the four major transactional roles identified in Kantor's structural-analytic model. These roles are leader, follower, challenger/opposer, and bystander. On FAP, respondents are asked to evaluate the frequency of their performance of these four roles in daily family life. In addition, Behavior Strategies obtain information on family member influence and the couple's child-rearing decision-making style. Items on FAP elicit family member opinions on who in the family has the greatest amount of "objective" power and influence over family members and who in the family is perceived as least influential/least powerful (e.g., helpless, weak or ineffective). Parents are also asked to individually evaluate and categorize their preferred child-rearing decision-making style, how they agree on matters that relate to the care of the children.

Network Support. Network Support is defined as family member perception of the availability of outside resources and network support. Network Support obtains descriptive data on the number of outside influences family members identify as positive resources. These network supports may include extended family, friends, or organizations.

Scoring of FAP

Items one through six on FAP I and II are open-ended questions. These items obtain family members' responses on (1) reasons for participating in the research, (2) main problems or concerns for which the family seeks counseling, (3) description of the presenting child, prob-

lem and symptoms, (4) key factors contributing to the problem, (5) family member(s) most often involved in the problem, (6) who or what can change the problem, (7) who most often makes the final child-rearing decisions, (8) status of the presenting problem following treatment, and (9) the onset of any new problems. A coding system for categorizing the range of possible responses to these items has been developed. The definitions of the categories used and the accompanying scoring method are contained in Chapter VI.

Item seven on FAP I and II obtains family members' opinions on the most influential family member, second most influential family member, and least influential family member. A coding and scoring system based on the family member position or role in the family (e.g., father, mother) has been developed and defined. Items eight through eleven require that family members rate themselves on the frequency that they perform four family roles: leader, follower, challenger/opposer, and bystander/commentator. These items use a five point response system: Almost Always assigned 5, Often assigned 4, Sometimes assigned 3, Seldom assigned 2, and Never assigned 1. Items eight through eleven are scored in a positive direction. Item twelve on FAP I and II requires family members to list in order of importance the people (name, relationship to respondent), and agencies/organizations outside the family who the family can call on for help. The actual number of resources (people and agencies listed) is summed. Respondents who place a checkmark beside the line marked "none" are assigned 0 for this item.

As stated above, FAP I and FAP II assess family member perception

of the presenting problem on three main variables. These three vari-
ables are Problem Orientation, Behavior Strategies, and Network Support.
The data obtained from FAP on all 65 families will be presented in a de-
scriptive fashion. The data will be used to describe the pre-post dif-
ferences between treatment and control group families.

Limitations and Merits

FAP poses many limitations regarding validity and reliability.
FAP is only intended to be used as an additional source of descriptive
data. Although use of FAP with families in private practice and in a
clinic setting has been helpful both for diagnostic and treatment pur-
poses, further validity and reliability studies are needed over time in
order to assess FAP's merits and to identify further limitations.

Family Counseling Evaluation

The fifth instrument to be used in this study is the Family Coun-
seling Evaluation (FCE). FCE is an 18 item questionnaire administered
to family members in written format. FCE was designed by this investi-
gator (Andreozzi, 1983) to obtain treatment group families' assessment
of the counseling experience and evaluation of the treatment outcome.

Description of FCE

FCE is an 18 item posttest measure administered only to the experi-
mental group families. FCE focuses on five main areas of clinical in-
terest: These areas of treatment effect include (1) more positive rela-
tionship with children and increased parenting skills, (2) improved re-

lationship with spouse, (3) improved relationship with immediate and extended family, (4) greater insight into self, and (5) satisfaction with the counseling.

Relationship with children and parenting skills. Items on FCE elicit family members' evaluations of changes in their relationship with their children. Changes in parental perception of the parent-child relationship include the identification of shifts in attitudes and behaviors. This set of items on FCE focuses on the parent's assessment of the identified child, overall parenting skills, and relationship with children. Parents are asked to assess whether or not they have gained new insights/awarenesses into the presenting child's behavior, whether or not their interaction with the children has improved, and whether they have developed more effective parenting skills.

Relationship with spouse. Respondents are asked to evaluate the effect of counseling on the quality of their relationship with their spouse. Respondents are asked to assess two broad aspects of their relationship. These aspects include interaction with their spouse (whether the interaction has improved) and communication with their spouse (whether their communication has improved). The term "spouse" is defined to include husbands, wives, adult intimate companions, and ex-partners (ex-husbands).

Relationship with immediate family and extended family. One of the primary goals of treatment is to affect a shift in family members' concept and perception of the problem. The proposed shift is from an individualistic, blame-oriented view of the problem to a family view

of the problem. The treatment is designed to increase family members' awareness of family interaction. The treatment specifically focuses on increasing insight into the attitudes, behaviors, meanings of behaviors, and expectations of family members. Items in this section of FCE elicit family members' perceptions on increased insight in these areas.

Insight into self. The treatment model to be tested emphasized the interaction of individual and family unit. The treatment weighs equally the insight of individual family members and changes or shifts in family structure and interaction. Items in this section of FCE elicit family members' assessment on whether or not they have gained insight into themselves, their own behavior and expectations.

Satisfaction with the counseling. FCE obtains family members' evaluations of the counseling experience. This section of FCE focuses on how satisfied family members are with the counseling, whether or not the problem has been changed (improved) as a result of the counseling, and whether or not they would recommend the counseling to other families of young children. In addition, there is a final open-ended question on FCE. This question is designed to obtain any information that the respondent may wish to include and that has not been addressed in the FCE items. This last item allows for the obtainment of further descriptive, clinically relevant data on the counseling experience.

Scoring of FCE

FCE is an 18 item self-report questionnaire. FCE uses a four point response system of Strongly Agree assigned 1, Agree assigned 2, Disagree assigned 3, and Strongly Disagree assigned 4. Items on FCE

are scored in a negative direction. Higher scores on FCE indicate a
lesser degree of satisfaction with the counseling and problem outcome.
Lower scores on FCE indicate a greater degree of satisfaction with the
counseling experience and problem outcome. (A copy of FCE is contained
in Appendix D.)

Limitations and Merits

FCE raises many questions regarding issues of reliability and va-
lidity. However, FCE is only intended for use in this study as an ad-
ditional outcome measure and source of data. FCE is especially pertin-
ent to an increased understanding of the effect of treatment. FCE will
provide additional descriptive, clinically relevant data.

Concluding Remarks

After a careful examination of family systems and parent-child as-
sessment instruments, FUI, FAD, and CBCL were selected and two addition-
al questionnaires, FAP and FCE, were developed for use in this research.
As is the nature of all assessment instruments, these four instruments
have limitations which restrict the generalization of the findings ob-
tained from these instruments. However, these instruments were chosen
because they appear to best match the treatment goals and outcome goals
proposed in this study. FUI, FAD, and CBCL provide independent assess-
ments of outcome variables identified as key factors in determining
treatment effectiveness.

One qualifying remark needs to be made regarding the limitations
characteristic of the chosen method of assessment. All four assessment
instruments selected for use in this research are self-report question-

naires. Therefore, it should be pointed out that treatment outcome in this study will be assessed solely on subjective, self-report data. This investigator is aware of the limitation imposed by this single assessment perspective on the level of data collection and analysis and on the interpretation of the finding. This investigator also is aware that ideally a more multidimensional assessment method (such as the model proposed by Cromwell, Olson & Fournier, 1976a) would incorporate two different data sources (subjective and objective), using two different assessment methods (self-report and direct behavioral observation). Use of such a multidimensional method would provide a more "well-rounded" assessment of change. However, in this study, the assessment method relates closely to the problem to be researched. As previously stated, the focus of this investigation will be on changing parental perceptions of presenting child problems. A structural-analytic family counseling treatment will be administered to 20 families. Treatment effectiveness will be assessed on three main variables: family member perception of family functioning, real-ideal family concept, and perception of the presenting problem, presenting symptoms, and presenting child. In Chapter V, the reader will be presented with a detailed description of the design, specific hypotheses, and the procedures for collecting and handling the data.

C H A P T E R   V

METHODOLOGY

Purpose

The general purpose of this research will be to advance that body of knowledge within the field of family therapy concerned specifically with that class of treatments referred to as short-term child-centered family counseling. The treatment procedures and the treatment model to be tested have been labeled by this investigator as short-term child-centered structural-analytic family therapy. The treatment has been adapted from the longer structural-analytic treatment model and set of treatment steps developed and defined by the family theorist and family therapist David Kantor (refer to Chapter III for a description of Kantor's work).

Three General Objectives of this Research

There will be three broad purposes of this investigation:

1. To test the effectiveness of the treatment model with a specific family population (families of preschool and primary school children) and problem type (mild to moderate child behavior problems).

2. To test the degree of association or strength of the relationship (a) between family unit characteristics and treatment outcome variables and (b) between different instrument's assessment of operationally-similar family functioning variables.

3. To demonstrate the use of short-term structural-analytic family

counseling with families with a presenting-child problem.

Based upon the three general purposes described above, this investigation will be divided into two separate studies: an experimental study with its related hypotheses and a correlation study with its related hypotheses.

Experimental Study

The term experimental study in this research is defined as the investigation of possible cause-and-effect relationships by exposing one or more experimental groups to one or more treatment conditions and comparing the results to one or more control groups not receiving the treatment with randomization (random assignment) being essential. The experimental study in this research will test for statistically-significant differences on four dependent measures between experimental group families (families who receive treatment) and control group families (families who do not receive treatment).

Hypothesis one. Families who receive the family counseling treatment will obtain higher average posttest scores on the Family Assessment Device than will families who do not receive the family therapy treatment.

Hypothesis two. Families who receive the family therapy treatment will rate the presenting child more positively (obtain higher average posttest scores on Social Competence and lower average posttest scores on Behavior Problems) on the Child Behavior Checklist than will families who do not receive the family therapy treatment.

Hypothesis three. Families who receive the family therapy treat-

ent will report a higher degree of association between how family members perceive how they would like their ideal family to be and how they perceive their real family as it is now as measured by interagreement posttest scores on the Family Unit Inventory REAL and IDEAL than will families who do not receive the family therapy treatment.

Hypothesis four. Families who receive the family therapy treatment will perceive the presenting-child problem more positive as measured by posttest descriptive self-reports of the presenting-child problem on the Family Assessment of the Problem Questionnaire than will families who do not receive the family therapy treatment.

Hypothesis five. Families who receive the family therapy treatment will report a greater number of social and emotional supports available to them outside the family on the Family Assessment of the Problem posttest than will families who do not receive the family therapy treatment.

Correlation Study

The term correlation study in this research is defined as the investigation of the extent to which variations in one factor correspond with variations in one or more other factors based on the use of correlation coefficients. The correlation study in this research will be conducted to test and to describe the degree of association between specific sets of factors. The correlation study will test and determine (a) the relationship between sets of scores obtained on one dependent measure with sets of scores obtained on other dependent measures, (b) the relationship between population factors and posttest composite

scores obtained on the dependent measures, and (c) the relationship between treatment-family factors and level of treatment outcome.

Hypothesis six. There is a positive relationship between scores on Communication on FAD and scores on Family Integration on FUI REAL. Families who report more positive family communication (obtain higher scores on Communication on FAD) will also be those families who report a higher degree of family integration (will obtain higher scores on Family Integration on FUI REAL).

Hypothesis seven. There is a positive relationship between scores on Behavior Control on FAD and scores on Social Competence on CBCL. Families who report more positive behavior management (who obtain higher scores on Behavior Control on FAD) will be those families in which parents report a more positive perception of the presenting child's behavior (will obtain higher scores on Social Competence on CBCL).

Hypothesis eight. There is a positive relationship between the number of network supports identified on FAP and scores on Community Sociability on FUI REAL. Families who report a greater number of social and emotional supports outside the family (indicated by the list of resources on FAP) will be those families who report a greater perception of being connected with and belonging to the outside community (will obtain higher scores on Community Sociability on FUI REAL).

Hypothesis nine. There is a positive relationship between scores on Problem Solving on FAD and scores on Adaptive Coping on FUI REAL. Families who report more positive problem solving (obtain higher scores on Problem Solving on FAD) will be those families who report more posi-

tive adaptive coping (obtain higher scores on Adaptive Coping on FUI REAL).

Hypothesis ten. There is a positive relationship between the real and ideal family concepts and perception of the presenting-child problem. Families who report a higher degree of congruence between their perception of real and ideal family life (as indicated by interagreement scores on FUI REAL and FUI IDEAL) will be those families who report a more positive profile of their presenting child's behavior (obtain lower scores on Behavior Problems on CBCL and higher scores on Social Competence on CBCL).

Hypothesis eleven. There is a positive relationship between (a) level of individual perception of family functioning and family life (high, medium, or low), (b) position in the family (most influential, somewhat influential, or least influential), and (c) level of family-unit treatment outcome (high, medium, or low). Treatment families in which the family member who (a) obtains the highest scores on FAD and FUI REAL and IDEAL, and (b) who also is labeled by family members on FAP as being the most influential family member, will be those families associated with the most positive treatment outcome (will obtain family unit scores on FAD and FUI REAL and IDEAL that will be in the upper third of the family-unit treatment scores).

Defining the Population

The subject population under study will be defined as those families of young children (1) who report a presenting-child problem for

which they seek counseling; (2) who seek counseling on their own initiative (self-referred as opposed to being referred by outside sources, e.g., school, court, pediatrician); (3) who request counseling through school guidance, child development or mental health channels; (4) who consent to participate in research; (5) where the problem the family reports concerning one of their children is defined by the family as being in the mild to moderate range; (6) where the child for whom the family seeks counseling is between the ages of three to eleven; (7) where the problem has been described and/or labeled by the family as a behavior problem (withdrawn or aggressive behavior); and (8) where the problem, to the best of the family's knowledge, is not principally caused by medical and/or organic factors.

In this investigation the population definition of family permits for a wide range of family types (e.g., single parent, blended family, two-parent nuclear family, extended family, and so forth). The only qualification made on family form will be that the presenting child's mother is living in the family unit and that the mother participates in the treatment. Therefore, the subject population can encompass a variety of family forms: mother, presenting child, father or stepfather; . mother, presenting child, adult male or female friend; mother, presenting child, grandparent or extended family member(s); mother, presenting child, other sibling(s); mother, presenting child (in case mother cannot identify another significant caregiver).

Design

The design to be used in this investigation will be randomized experimental-control group, pretest-posttest design. A stratified random sample of 40 families will be drawn from a defined population of approximately 65 families. Sample families will be randomly assigned to three different sets of conditions: group (treatment or control, 20 families per therapist), therapist (one of two therapists, 10 families per therapist), and pretest-posttest administrators (five testers, eight families per tester).

Families will be pretested on four dependent measures: Family Assessment Device, Child Behavior Checklist, Family Unit Inventory REAL and IDEAL, and Family Assessment of the Problem. Experimental group families will receive the short-term structural-analytic family counseling treatment. Control group families will not receive treatment at this time but will be placed on a waitlist (group awaiting treatment).

The treatment will consist of 15 to 20 hours of counseling administered over a seven-week time period. The family counseling will be conducted by a male and female family counselor with approximately the same years of experience. Upon completion of the seven week treatment, the experimental and control group families will be posttested on the same four dependent measures with the experimental, treatment group families given a fifth assessment measure, The Family Counseling Evaluation (FCE).

Procedures

A set of time-ordered procedures will be used in conducting this research. The following set of steps will comprise the experimental plan.

Step One: Pilot Testing the Family Assessment of the Problem Questionnaire (FAP)

The version of FAP to be used in this research represents the fourth revision of the questionnaire. FAP IV will be pilot tested using a sample of families (n=30) whose family characteristics and presenting-child problems are similar to the proposed research population. Data will be collected from two or more family members in each family and analyzed providing for a pilot-test assessment of FAP on both the individual and family unit levels. Such pilot testing will provide for a preliminary, field testing of the adequacy (e.g., reliability) of the measure under controlled conditions. In this pilot-testing phase, feedback will be obtained from respondents as to the structure (e.g., wording, clarity, and item content) of the questionnaire. Based upon respondent's feedback, necessary revisions will be made on questionnaire format and items.

Step Two: Pilot Testing of the Instruments and Test Session Format

Four graduate students in psychology and social work will be used as pilot test administrators. Pilot test administrators will experiment with the format (interview versus written test administration) and the order in which instruments are administered. Pilot testers will obtain data on (1) the average length of time it takes to administer

each instrument under controlled conditions, (2) the length of time it takes to administer the battery of four instruments, (3) the clarity of test directions, and (4) family member responses to specific instruments, specific questionnaire items, and test administration conditions. Data gathered from pilot test families' responses and feedback obtained from pilot testers will be used to make final adjustments in pretest-posttest conditions.

Step Three: Pilot Testing of the Treatment

Five families who seek help for a presenting-child problem from a child guidance center (Emma Pendleton Bradley Hospital) and who consent to the short-term family counseling treatment will comprise the pilot-test treatment group. Selection of pilot treatment families will be based on how close the families meet the proposed research population definition.

Pilot treatment families will be pretested and posttested on the battery of instruments and will receive the proposed family counseling treatment. Based upon recommendations from these families, upon completion of the treatment, final modifications and further operationalization of treatment steps will be made.

Step Four: FAP Test-Retest Reliability Study

Following pilot-test revisions of FAP, a test-retest reliability study will be conducted on FAP. A sample of 20 families similar to the proposed research population characteristics will be administered FAP twice within a one-week, test-retest reliability time period.

Step Five: Obtaining and Training Test Administrators

Ten to twelve female college students in child development and family relations will be recruited as potential trainees as test administrators for the study. These trainees will be referred to the researcher by faculty in the departments of child development at the University of Rhode Island and at the Community College of Rhode Island. These students will be intermediate students with prior field experience with children and families. Students will be trained by the researcher over a four-week time period in the background, theory, and test administration procedures of the instruments. Upon successful completion of the training, five students will be selected as test administrators. Selection will be based upon demonstrated competence in administering the tests and upon students' willingness to participate in the research.

Step Six: Obtaining the Subjects

From a population of child guidance and child development centers in the Kent County area of Rhode Island, 15 sites that have a family counseling or parent education component and that service similar family clientele will be contacted. The staff at these centers will announce to their clientele the availability of an alternative short-term family counseling program.

Interested families will be provided with and will complete applications (a copy of the letter describing the Family Counseling Research and copies of the preliminary and follow-up applications are contained in Appendix A). A master list of families who meet the population definition will be compiled. From this master list, a stratified random research sample of 40 families will be drawn.

Step Seven: Obtaining and Selecting the Sample

After compiling the list of the names of families who will comprise the defined research population (N=65), a stratified random sample of 40 families will be drawn (n=40). The following plan for obtaining and selecting the sample will be used.

1. Each family in the population list will be assigned an identification number (01-65).

2. The population will be divided into subgroups. The subgroups into which the population will be divided are family type (one-parent and two-parent households), sex of the child for whom the family seeks counseling (female and male), educational level of the child for whom the family seeks counseling (preschool and primary school), and type of problem behavior the family reports for the presenting child (aggressive, acting-out behavior, and withdrawn behavior) at the time of referral. The information for assigning families to these subgroups will be obtained from the family's completion of the written application forms (Form 2).

3. The proportion of families in each subgroup in the total population wil be determined. An appropriate (specified number) of subjects (families) corresponding to the proportion of that subgroup in the total population will be drawn. By taking a random start in a random table of numbers a stratified random sample of 40 families will be drawn.

Step Eight: Random Assignment to Experimental Conditions

The sample of families (n=40) will be randomly assigned to three sets of conditions: group (experimental and control), therapist (one of

two therapists), and to pretest-posttest administrators (one of five testers).

Random assignment of families to experimental and control groups. The 40 sample families will be randomly assigned to the experimental and control groups such that the experimental group and the control group will have an equal number of subjects (20 families per group) and an equal number or an appropriate proportion of the subgroups in the population. The experimental and control groups will each have an appropriate proportion of single- and two-parent families, male and female children with presenting problems, preschool and primary school children with presenting problems, and presenting children with reported aggressive behavior, and presenting children with reported withdrawn behavior.

Random assignment of families to therapists. Each therapist will be randomly assigned ten of the 20 experimental group families such that each of the two therapists will have an equal number of families (ten families per therapist) and an appropriate proportion of single- and two-parent families, male and female children with presenting problems, preschool and primary school children with presenting problems, presenting children with reported aggressive behavior, and presenting children with reported withdrawn behavior.

Random assignment of families to pretest-posttest administrators. Families will be randomly assigned to five pretest-posttest administrators such that each test administrator will have a total of eight families for pretesting and posttesting and an equal number of experimental group families (four) and an equal number of control group families (four).

Test administrators (identified by the letters A to E) will be randomly assigned families, control group families being assigned first. Taking a second random start in the table of random numbers, families will be assigned as follows: The first four two-digit numbers that correspond to family identification numbers in the control group list will be assigned to test administrator A. The next four two-digit numbers similarly corresponding to family identification numbers appearing in the control group list will be assigned to test administrator B and so forth until all five test administrators have been each randomly assigned four control group families. The same procedure will be used in assigning experimental group families to the five test administrators.

Step Nine: Pretesting

All 40 families will be pretested within the same three-week time period and under similar conditions. First families will be contacted by telephone by the assigned pre-posttester and an appointment will be set up at the center through which the family applied for the family counseling (a copy of the Pretester Telephone Instructions/Preparation and Pretester Telephone Comment Sheets are contained in Appendix B). At the arranged time, the family will be administered the four instruments in written format. The major function of the test administrator will be to read test directions, monitor the sessions, and make the family feel comfortable. The session will occur on the premises of the child guidance or child development center to which the family applied for counseling.

All family members over the age of 14 who the family defines as "comprising family" and who elect to participate in some capacity in

the counseling, will be presented. All members of the family will be
pretested simultaneously in the same pretest session. The pretest ses-
sion will last approximately 90 minutes. An additional 20 minutes will
be allotted for organization, logistics, and practical aspects of pre-
testing. The proposed order for instrument administration will be as
follows: FAD, CBCL, FUI REAL, FUI IDEAL, and FAP.

The following is a brief description of the pretest session. The
test administrator greets the family, introduces herself, seats the fam-
ily, and then briefly explains her function. The test administrator
then checks names of family members and clarifies relationships of fam-
ily members present for pretesting. Next, the test administrator dis-
tributes and gives directions for completing the first instrument, FAD.
Once FAD is completed by family members, the instrument will be collect-
ed and the second instrument will be given to each family member. The
third and fourth instruments will be administered in the same way.
Standardized directions for administering each instrument will be read.
After each instrument is completed, the test administrator will collect
the instrument, checking to see that test booklets are signed and dated
by respective family members. The primary responsibility of the test
administrator while family members are completing each instrument will
be to keep family members on task by guiding and monitoring time comple-
tion of each instrument.

After all instruments have been completed and collected, the test
administrator will thank all family members for their cooperation and
participation and will tell the family that a family counselor will con-
tact them to arrange for a time to begin the family counseling. (A de-
tailed description of test administrator's pretester-posttester prepara-

tion/checklist, pretester-posttester script, and pretester-posttester comment sheets are contained in Appendix C.)

Step Ten: Treatment

In Chapter III a number of assumptions that the therapists will consciously use in approaching the presenting problem were described. At this point it appears appropriate to reiterate those assumptions. The inclusion of these assumptions in treatment procedures is based upon the position held by this investigator that the theoretical orientation (set of assumptions) guiding the therapist's behavior is an important component of treatment and therefore should be clearly stated.

Assumption one. During periods of family crisis (e.g., divorce, death of a family member, hospitalization of a family member, and so forth), the family unit and individuals in the family appear most susceptible to developoing psychological problems.

Assumption two. When the family unit is confronted with a new developmental stage and its associated developmental task requiring a new system equilibrium (e.g., the skills and behaviors the couple needs to develop to deal with children), this situation may produce a crisis and thus cause distress in an individual (child or adult), the couple, or in the family producing psychological and/or behavioral symptoms.

Assumption three. The onset of presenting-child problems often may be used to draw attention away from problems in adult intimate relationships.

Assumption four. Presenting-child problems may be described less as a conflict between individuals but rather as a conflict between individual reality claims wherein personal meanings and expectations of personal identity images become misunderstood and distorted.

Assumption five. The symptoms of a presenting-child problem often contain an aspect of health that is too frequently overlooked because of the emphasis upon dysfunction or the problem.

Assumption six. The onset of presenting-child problems often may be further complicated by the impact of social and economic factors outside the family of which the family may be unaware.

Treatment Phases

The treatment to be used in this research is labeled short-term child-centered structural-analytic family therapy. The treatment will be divided into five phases: Forming the Therapeutic Alliance, History Taking and Building the Therapeutic System, Listing Priorities and Setting Goals, Treatment Proper, and Closure. Each treatment phase is associated with a specific set of treatment procedures by which the therapist will facilitate specific intervention and will obtain specific types of information. These treatment procedures will include Treatment Objectives, Therapeutic Tasks, and Therapist Role.

1. Treatment Objectives. Treatment Objectives will refer to the major goals of the specific treatment phase.

2. Therapeutic Tasks. Therapeutic tasks will refer to specific procedures used by the therapist in a particular treatment phase to obtain specific treatment objectives.

3. Therapist Role. Therapist role will refer to a general description of the overall behavior style used by the therapist when interacting with the family in specific treatment phases.

In all, the treatment will consist of 15 to 20 hours of counseling conducted over a seven-week time period. Families will meet with the

therapist in a school guidance setting. A description of each treatment phase is presented below.

Phase One: Forming the Therapeutic Alliance

Treatment Objectives

There will be two major objectives for phase one of the treatment.

1. The therapist will create an emotionally safe atmosphere in which family members begin trusting the therapist and therefore feel free to self-disclose.

2. The therapist will support and give personal consideration to each family member's opinions, perceptions, and views concerning the presenting problem.

Therapeutic Tasks

The therapist will obtain an initial description of the presenting problem from each family member present. The therapist will ask family members such questions as "In your questionnaires you described a family problem. Just to start out fresh, can you describe the problem for which you have come for help?" Or, "What has brought you here to counseling?"

The therapist will record this information on the therapist comment sheet (Form 14) following the session.

Therapist Role

In forming the therapeutic alliance with the family, the therapist will employ a specific set of skills that may be described as relationship skills and listening skills. The therapist's behavior may be described as accepting, empathic, patient, and approachable.

Time

Phase one will occur mainly in the beginning of the first few sessions.

Phase Two: History Taking and Building the Therapeutic System

Treatment Objectives

The history-taking phase will be brief. The overriding objective of this phase will be to provide an opportunity for the therapist to invite discussion of all the facts or explanations that may shed light on the presenting problem. It also will help the therapist to rule out any preconceived notions that the therapist may hold concerning "stereotypes" of the problem. History taking also will help the family and the therapist to take an inventory of the wide range of factors that may be influencing the problem and family life.

The ensuing dialogue between family and therapist around the family's description of their history, who they are, where they have been, what they have been through, and what they are experiencing and feeling now, will form the groundwork for building the therapeutic relationship. The history-taking phase is a time when the family can tell its story.

There will be four major objectives for phase two of the treatment.

1. The therapist will obtain a description of the presenting problem (the development, onset, and meaning of the problem) on a family systems level.

2. The therapist will obtain important developmental and diagnostic information that may shed light on the presenting problem.

3. The therapist will begin to organize the facts and identify the emotional process that appears to surround the presenting symptoms.

4. The therapist will provide initial feedback to the family and will introduce alternative ways of viewing the identified presenting problem and will introduce alternative approaches for resolving the identified presenting problem.

Therapeutic Tasks

The primary task will be for the therapist to obtain from the family a brief history in three specific areas: (1) a brief history of the onset of the presenting problem; (2) a brief family history focusing on the couple and the course of the family's development; and (3) a brief developmental history of the presenting problem.

Onset of the presenting problem. The therapist will obtain an overall description of the presenting problem in behavioral terms, a visual picture or scenario of the problem as it is reportedly experienced by each family member and by the family. The therapist will ask questions such as the following: "As clearly as you can, can you describe the problem as you see it happening? When it occurs? How it occurs? Where it occurs (e.g., home school)? Who is primarily involved? What major issues seem to be at stake? What, if any, major events may have preceded or may have happened at the same time you first became aware of the problem (e.g., birth of a child, grandparent moving in with the family, adolescent going away to college)?"

The therapist will record this information on the therapist comment sheet following the sessions.

<u>Family history focusing on the couple</u>. The therapist will intro-
duce this part of the history taking by making a statement to the family
such as the following: "First, I'm going to ask you a few background
questions that are important for an overview of the situation." These
questions will be directed at obtaining information concerning charac-
teristics of family membership, family developmental life stage, nodal
events, relationships with extended family, openness versus closedness
of the family, and the wider social network.

    1. Characteristics of family membership. The therapist will ask
such questions as "Who makes up your family?" The therapist will take
note of the names, ages, sexes, and relationships of people either
living in the household or included in the family's concept of family
membership.

    2. Family developmental life stage. The therapist will make note
of the developmental life stage of the family and the developmental
tasks the family is presently negotiating and may be having difficulty
resolving to the satisfaction of family members.

    3. Nodal events. The therapist will take note of any important
events (positive or negative) that the family describes as having had
a dramatic or important effect on changing the course of the family
(e.g., death of a family member, job loss, divorce, and so forth). The
therapist will also take note of any outstanding events characterizing
the couple's relationship and history as a couple from courtship to pre-
sent (e.g., periods of separation, repeated issues that the couple
fights over, prolonged physical illnesses, and so forth).

4.   Relationship with extended family. The therapist will take note of the couple's relationship with in-laws, parents, and other significant extended-family members. The therapist will take note of (1) the extent to which physical distances and emotional distancing (e.g., provoked or ritualistic fights) are used to solve relationship problems, (2) the repeated reports of any important transgenerational family patterns (e.g., men who are bullies in a family history of women who are victims) and the presence of any important intergenerational triangles (e.g., I was an inadequate, emotionally cold/withholding mother who convinced you that I was perfect and now you feel like an inadequate mother to your daughter who now is your scolding, silent mother "representative" of me), and (3) any reports of cut-offs of significant family relationships (e.g., not talking to a brother or sister).

5.   Openness versus closedness of the family. The therapist will take note of the general level of openness and closedness of specific relationships in the family. The therapist will also take note of the extent to which family members report they can openly express tenderness and provide nurturance. To accomplish this the therapist will ask questions such as the following: "Are there issues the family can and cannot talk about? With whom can you talk about these issues? With whom can't you talk about these issues? Under what circumstances can you talk about these issues? Under what circumstances can you not talk about these issues?"

6.   Social network. The therapist will take note of the reported multiplicity or paucity of supports, resources, and relationship options

available inside the family (e.g., family members parents and children can turn to for emotional support).

The therapist will also take note of the wider social world in which the family lives (e.g., the types of relationships the family reports having with friends, the degree of isolation or connectedness the family reports having with agencies and institutions in the wider community).

The therapist will record this information on the therapist comment sheet following the session.

Developmental history of the presenting child. The therapist will ask a few brief questions to obtain a general impression of the developmental history of the presenting child. Areas of concern will include pregnancy and birth, physical, social, and intellectual (learning) development, medical, and the onset of the presenting problem.

1. Pregnancy. The therapist will ask such questions as the following to obtain an impression of the pregnancy: "Was there anything special, difficult or unusual about the pregnancy (e.g., mother's health before and during pregnancy)?" "How did the mother experience the pregnancy (e.g., physical health, emotional supports)?" "How did the father experience the pregnancy (e.g., how much time did he spend with his wife, was the pregnancy wanted)?"

2. Birth. The therapist will ask such questions as the following to obtain a general impression of the birth: "Was there anything special about the birth of your child (e.g., difficult delivery, use of medication, birth weight, special medical care, and so forth)?"

3. Developmental stages. The therapist will ask a few brief questions such as the following in order to obtain an impression of the child's development: "Was there anything unusual, special, or different about your child's physical development? The way your child learned? The way your child related to others?"

4. Medical. The therapist will ask a few brief questions such as the following in order to obtain an impression of the child's medical history: "Has the child had any long illnesses or hospitalizations? Is the child on any special medication? Has the child ever been on any special medications? Does the child have or ever had any allergies?"

5. Presenting problem. The therapist will ask a few brief questions such as the following in order to obtain an impression on the onset of the presenting problem: "When did you first notice the problem? What was your initial reaction to the problem? With whom did you first discuss the problem? Did you ever seek or think about seeking professional help for the problem?"

The therapist will record this information on the therapist comment sheet following the session.

It should be noted that the areas for gathering information that are presented above are meant to serve as guidelines for the history-taking interview. Based upon judgements of the therapist and based upon individual family needs, life circumstances, and so forth, some areas of history taking may be emphasized or minimized in this phase.

The above cited areas of history taking and the lists of types of information to be obtained will provide a structured outline for the

initial family interview. The method of obtaining information concerning the child-centered problem for which the family seeks counseling has been adapted from two sources: the structured genogram method proposed by Guerin and Guerin (1976) and the family systems interview method for presenting-child problems proposed by French (1977).

Therapist's Role

In taking a family history and a history of the presenting child and presenting problem the therapist mainly will employ interviewing skills. Interviewing skills involve asking clear and direct questions that are tactfully timed to obtain essential information for understanding the family and the presenting problem. In building the therapeutic system the therapist mainly will employ leadership skills. Leadership skills involve providing the family with feedback and suggestions that convey to the family that the therapist is competent and can help the family with its problem.

Time

History taking and building the therapeutic system will mainly occur during the first two sessions.

Phase Three: Listing Priorities and Setting Counseling Goals

Treatment Objectives

There will be three major objectives in phase three of the treatment.

1. The therapist will obtain a more detailed description of the

identified presenting problem by focusing on personal expectations of family members (real and ideal), personal images (positive and negative) maintained by family members in the problem context, and behavior family members tend to rely on when confronted with the problem scenario.

2. The therapist will begin to formulate, clarify, and identify the key issues at stake.

3. The therapist will offer feedback to the family about the presenting problem and will again present alternative ways for viewing the problem and alternative ways (behaviors) for resolving the problem.

Therapeutic Tasks

1. The therapist will ask the family to decide upon the problem or concern of greatest importance to them for the short-term counseling. The therapist will ask the family to take five to ten minutes to decide among themselves the most important problem and to identify small attainable areas for change that they will agree to work on in counseling.

2. The therapist will observe how family members communicate with each other and what the decision-making and problem-solving process appears to be like for the family. The therapist will make interventions in communication at appropriate times to help family members clarify issues and to communicate more directly with each other.

3. The therapist will give feedback to the family by introducing some alternative ways of agreeing on a problem.

4. When family members reach agreement on the presenting problem, the therapist will obtain from family members a more detailed descrip-

tion of the presenting problem. The therapist will focus on each family member's specific role in maintaining the problem. This will involve the therapist asking family members to identify his/her expectations, how he/she perceives him/herself in the problem scenario (a brief visual image), and what type of behavior he/she typically relies on as a way of coping in the problem context or crisis.

5. The therapist will clarify and restate the identified problem and expectations expressed by the family for counseling. The therapist will summarize what has been said and will offer some preliminary feedback to the family. The therapist will emphasize that the counseling will be short-term and will describe his/her role in a way that conveys the therapist as an Ally, Consultant, Challenger, and Commentator.

The therapist will record this information on the therapist comment sheet following the session(s). (The set of family therapist forms used for each phase of therapy are contained in Appendix E.)

Therapist's Role

In this phase of the treatment, the therapist primarily will begin to employ those skills that will be used in treatment proper. In treatment, the therapist's role is described as an Ally, Consultant, Challenger, and Commentator. Each role carries with it a number of behaviors or behavioral characteristics.

Ally. This role involves the following behaviors.

1. Respects each person's view.

2. Supports each person's right to speak.

3. Values each person's opinion.

4. Points out individual and family unit strengths.

5. Encourages risk-taking.

6. Forms alliances with the less powerful or least-supported family members.

7. Structures opportunities for small successes.

Consultant. This role includes the following behaviors.

1. Provides information (e.g., child development information).

2. Offers alternative behavioral strategies.

3. Introduces and models new methods for problem solving and communication.

Challenger. This role encompasses the following behaviors.

1. Offer interpretations of the meanings underlying behaviors.

2. Clarifies misunderstood or unverbalized expectations, perceptions and attitudes.

3. Asks challenging questions.

4. Identifies unspoken beliefs.

5. Reframes negative behavior into positive attempts at coping.

6. Questions beliefs about the absolute nature or unchallengeable nature of family myths and family rules.

Commentator. This role includes the following behaviors.

1. Offers his/her perceptions of the situation to the family.

2. Describes to the family in terms of observable behaviors what he/she sees happening.

3. Describes where the family is repeatedly getting "stuck" in a deadlock or impasse concerning the problem.

4. Interprets to the family what he/she sees and feels each family member may be trying to communicate to each other.

Time

Phase three of the treatment will occur during the first two sessions and will permeate the entire treatment process approach.

Phase Four: Treatment Proper

Treatment Objectives

There will be five objectives for the treatment phase.

1. Families will report more positive family communication.

2. Families will report more flexible family roles and family expectations.

3. Families will report a more positive view of family life and family functioning.

4. Families will report a more positive view of the problem and presenting child on both an attribute and behavioral level.

5. Families will report a more positive view of the availability of family network and community supports.

Therapeutic Tasks

The following eight therapeutic tasks form the treatment procedure that will be used in the treatment proper. The treatment procedure will be repeated in each treatment session.

It is important to note that in all of the eight treatment tasks the therapist will work to improve and enhance family communication.

The overriding goal of each of these treatment tasks is to help family members to talk directly to the person they want to communicate with and to clearly express what their needs are, what they are feeling, and what they expect.

1. The therapist will ask the family to talk about how they have been dealing with the problem. The therapist will ask the family to describe any progress or setbacks they have been experiencing since the last session. The therapist will make a point to support and encourage any reported successes or new approaches the family has been using for dealing with and changing the problem.

2. The therapist will keep the family focused on the problem scene that the family has just described. The therapist will ask the family to recall verbally and/or will have the family demonstrate interaction-ally (when timing seems appropriate) the problem scene (the way the problem interaction seems to happen).

3. The therapist will reframe the problem scene that has just been described or enacted. The therapist will reinterpret the problem scene (offer a different view of the problem) by describing the problem as a sequence of "stuck" interactions, a "mismatch" in different be-havioral styles (plans for problem solving and/or conflict in views of self and the different wants and needs of individuals).

If the family seems willing to discuss their ways of viewing the problem, then the therapist will proceed to step four. However, if the family gets into a discussion about blaming each other, then the thera-pist will redirect the discussion and attention from individual blame

to an interpretation of the problem as a sequence of interactions in which everyone plays some part.

4. The therapist will point out and describe how these interactions have become repetitive for the family and how they usually result in a "deadlock" or "lack" of a satisfactory solution for the family.

5. The therapist will repeat the problem interaction scene just described by the family that ends up in a deadlock and will point out where he/she sees several possible key places where the family usually gets stuck. The therapist will identify critical points in the stuck interaction where alternative behavioral approaches and different interpretations (the meanings underlying the behavioral approaches) could be used but are not being used.

6. The therapist asks each family member present to describe and communicate to those present their view of self in the problem scene: What picture or image do you have of yourself? Positive? Negative? Effective? Ineffective? Adequate? Inadequate? How do you feel about yourself? How do you feel about others? What belief about yourself are you trying to hold onto? What is the real issue at stake for you? How do you want to see yourself? How do you want others to see you?

The therapist will ask each family member present to describe and communicate to those present their expectations: What do you expect of yourself? What are you expecting from others? What do you want to happen that doesn't happen?   Have you ever stated these expectations to others? If so, how? If not, why? You can't? You won't? You don't know how to?

The therapist will ask each family member present to describe and

communicate to those present their description of the behavior they use most often in the problem scene: What do you do? How do you react? What part do you play? What purpose does it serve? What do you expect your behavior to do? What are the reasons for using this behavior? Where did you learn it? What do you think others take this behavior to mean? When you act this way _____, what are you trying to say to others? What do you think others are thinking?

The therapist will point out that behavior is a way of communicating. People sometimes act out of their beliefs, wishes, fears. People sometimes use actions as a way to tell people how they are feeling. Actions unfortunately do the talking where words should.

7. The therapist will describe his/her view of how the problem happens. The therapist will introduce and interpret the problem as a conflict over family members' views about themselves, about other family members, and about the presenting problem (beliefs family members hold and are reluctant to give up, feelings and expectations that have not been openly talked about, and unverbalized wants and needs family members would like met).

The therapist will obtain feedback from the family by asking the family's reaction to the therapist's view.

8. Based upon this dialogue, the therapist will ask the family to decide upon and develop a new plan, a more effective way to deal with the problem. The therapist also will suggest and/or reintroduce new behaviors, new ways of approaching the problem, and new views of family members vis-a-vis each other that the family can use, call upon,

and experiment with in solving the problem. The therapist records this information on The Therapist Comment Sheet follwing the sessions.

The therapist will repeat these eight steps in the next session.

Therapist Role

Throughout the treatment phase, the therapist will continue to use the previously defined roles of Ally, Consultant, Challenger, and Commentator. In applying the treatment procedure, the therapist will repeatedly use a specific set of questions and a specific set of intervention statements. The following is a brief description of what the therapist will ask or state when reframing family members' perceptions, expectations, feelings, attitudes, and behaviors in the counseling sessions.

Describing the problem. What is the problem for you? What bothers you about the kind of interaction you just described? How do you see yourself? What picture do you see of yourself in the interaction? How do you see your child? What picture do you see of your child in the interaction? Your spouse/partner in the interaction?

Misunderstood perceptions, feelings, and expectations. How do you feel when you're misunderstood? How do you feel about yourself in the situation? What do you expect of yourself? What do you expect from other people in the situation? What do you expect from other people but are not getting? In what way are they not giving you the help that you need, what you want from them? Have you come out and told them what you need, what you expect from them? Or, maybe you haven't come out and told them?

Expectations of others. What do you think others might be expecting from you? What do they do? When they do what you've just described, what does that behavior mean or convey to you? If behavior can sometimes be viewed as a message, what message are you giving? How are others interpreting your behavior? How are you interpreting or misinterpreting the behavior of others?

Meaning and roles. You mentioned the bad side of this behavior. Can you come up with any good meanings of the behavior? Can you see a positive side to what his/her behavior is trying to get across? How about your own role in the situation you just described? What were the good intentions that started you off in the beginning for using or relying on this behavior or role?

Present behavior. In other words then, when you are doing this _____, he/she is doing _____. When you rely on this role _____, you do it because you are expecting _____ and because you have these intentions and expectations _____. When he/she is doing _____, then he/she is expecting _____ based upon _____ intentions and expectations. When you do _____, he/she does that _____. In other words, you are doing what you learned to do. Based on past experiences, how you learned to survive. You are simply doing what you know best and what, regardless of the price, has mostly worked for you, or so you thought. You fall back on or rely on this _____ because maybe you don't know what else to do. So, when the problem happens, you do this_____, he does _____, she does _____ and so forth. You get "stuck" or you get into a conflict. The old behaviors and roles (strategies) that each of you have learned just don't work out for you when you have to deal with _____.

Factors outside the family. What else is affecting the problem? Did you ever think that factors outside of your relationship and family were helping to keep the problem a problem or were making the problem worse? When you can name these forces or influences, then you can begin to control them.

New and different behaviors and roles. Can you come up with a new plan, alternative behaviors and roles, that can help you deal more effectively with the problem interaction? (Therapist can make a suggestion.) For instance, if he does this _____ and you do this _____, what do you think will happen? Try these new behaviors this week.

Checking on the progress. When you tried this _____ and he/she did that _____, did you begin to see each other differently? Did your expectations change? How did you feel about one another? Did you come closer this time in getting just a little bit more of what you said you want and what you said you need? Did the interaction around the problem change? If so, how? If not, what happened? (Repeat for each member present.)

Time

The treatment phase will take nine to fifteen hours of therapy.

Phase Five: Closure

Treatment Objectives

There will be four major objectives for the last phase of the treatment.

1. The therapist and family will review the family's progress.

2. The therapist will obtain feedback on the treatment from the family.

3. When appropriate, the therapist will make the necessary referrals for further treatment and/or develop a plan with the family for continuing treatment.

4. The therapist will prepare the family for closure, the disengagement of the working therapist-family system.

Therapeutic Tasks

The major therapeutic tasks for the therapist during closure involve the following.

1. The therapist will discuss with the family what progress they feel they have made in the short period of time the family has been receiving counseling. The therapist and family will review the new plans the family has been using for problem solving.

2. The therapist will support small positive shifts in family members' reported perceptions, feelings, attitudes, and expectations of themselves and of others, and reported behavior changes.

3. The therapist will point out and contribute his/her observations of changes the family made during counseling.

4. When appropriate, the therapist will discuss with the family what the family might expect when and if the presenting problem arises again.

5. The therapist will discuss with the family and help the family plan for future counseling if needed and/or provide the family with information on other available support groups or community resources.

Therapist Role

The therapist will continue to act as an Ally, Consultant, Challenger, and Commentator.

It should be noted that in this phase, the therapist will also work to help the family identify, express and clarify any feelings they may have toward the therapist or any wishes, fears or concerns they may have about leaving the counseling.

Time

Closure will take place during the last two or more sessions with the family.

Step Eleven: Non-Treatment

Control group families will not receive the treatment at this time. Control group families will be placed on a waitlist and will receive the treatment after the experimental group has received the short-term family therapy and after all 40 sample families (experimental and control groups) have been posttested.

Step Twelve: Posttesting

The same procedures described in pretesting will be followed for posttesting. There will be only one difference. This difference in posttesting is the administration of a fifth, additional outcome measure, The Family Counseling Evaluation, to only the experimental families. The instruments will be administered to experimental and control group families in the same order of pretest administration: (1) FAD, (2) CBCL, (3) FUI REAL, (4) FUI IDEAL, and (5) FAP. In order to avoid

the problem of uncomparability of experimental and control group conditions (e.g., the interactive effects of instruments and the uncomparable condition of differential instrument interactive order of administration), The Family Counseling Evaluation will be administered as the last measure in the experimental families' posttest session.

Instrumentation

Four family-oriented instruments will be used in this research: Family Assessment Device (FAD), Child Behavior Checklist (CBCL), Family Unit Inventory, REAL and IDEAL, and Family Assessment of the Problem (FAP). A fifth outcome measure, The Family Counseling Evaluation (FCE), will be administered only to treatment families following therapy. These instruments were described in detail in Chapter IV.

Family Assessment Device (FAD)

FAD is a 60 item, seven scale self-report instrument. FAD assesses individual and family unit perception on Communication, Problem Solving, Roles, Behavior Control, Affective Responsiveness, Affective Involvement, and General Family Functioning. The 1981 version of FAD (Epstein, Bishop & Baldwin, 1981) will be used in this study. FAD takes approximately 17 to 20 minutes to administer. FAD will be administered by a trained tester to experimental and control group families in a school guidance setting.

Child Behavior Checklist (CBCL)

CBCL consists of a 20 item Social Competence scale and 118 item Behavior Problems scale. CBCL assesses parental or caregiver's percep-

tion of the presenting child and interparent agreement on the present-
ing child on Social Competence and Behavior Problems. The 1981 version
of CBCL (Achenbach, 1981) will be used in this study. CBCL takes ap-
proximately 17 minutes to administer. CBCL will be administered by a
trained tester to experimental and control group families in a school
guidance setting.

Family Unit Inventory (FUI)

FUI is an 80 item self-report instrument. FUI obtains measures on
nine first-order family content dimensions and two second-order content
dimensions on both the real and ideal versions. The nine first-order
family content dimensions are Consideration vs. Conflict, Family Ac-
tualization, Open Communication, Family Sociability, Family Ambition,
Internal vs. External Locus of Control, Togetherness vs. Separateness,
Family Loyalty and Closeness vs. Estrangement. The two second-order
family content dimensions are Family Integration and Family Adaption.
FUI assesses individual family member Real-Ideal Family Satisfaction,
family member interagreement on Real Family Congruence and Ideal Family
Congruence and individual family member assessment of Family Effective-
ness. The 1981 inventory version of the Family Concept Q-sort (van der
Veen, 1969) will be used in this study. FUI REAL and FUI IDEAL each
take approximately 20 minutes to administer. FUI REAL and FUI IDEAL
will be administered by a trained tester to experimental and control
group families in a school guidance setting.

Family Assessment of the Problem (FAP)

FAP is a twelve item questionnaire. FAP assesses individual and interparent agreement on Problem Orientation, Behavior Strategies, and Network Support. The 1983 version of FAP (Andreozzi, 1983) will be used in this study. FAP takes approximately ten to 15 minutes to administer. FAP will be administered by a trained tester to experimental and control group families in a child guidance setting.

Family Counseling Evaluation (FCE)

FCE is an 18 item posttest measure. FCE is only administered to treatment group families. FCE obtains treatment group family members' assessment of the counseling experience and evaluation of the effect of treatment on problem outcome. FCE elicits family members' perceptions of shifts in five main variables related specifically to the treatment goals. These five variables are Relationship with children and parenting skills, Relationship with spouse, Relationship with immediate and extended family, Insight into self, and Satisfaction with the counseling. FCE takes approximately five to ten minutes to administer. FCE will be administered by a trained tester to experimental group families in a child guidance setting.

Scoring, Data Analysis, and Statistics

Family member responses on the three self-report questionnaires (FAD, CBCL, and FUI REAL and IDEAL will be scored using the individual scoring instructions provided for each instrument. Scores on these self-report questionnaires will be calculated on the individual level

(individual subjects), interpersonal level (interparent agreement) and, when appropriate, on the family unit level. Instruments will be scored on the subscale level. Individual subscale scores, interparent agreement scores and, when appropriate, family unit scores (one measure, e.g., the mean or median of family member scores) will be used to analyze the data and to test for statistically-significant group differences.

Multivariate analysis of variance will be used to test for statistically-significant differences between the experimental and control groups on each instrument. Responses on the fourth questionnaire, FAP, will be reported as descriptive data, using descriptive statistics (e.g., means, medians, percentages, proportions).

Limitations

This study suggests several limitations. These limitations pertain to issues of design, method of assessment, and treatment variables.

Design

The randomized, experimental pretest-posttest control group design chosen for use in this study poses several limitations. One major limitation of this design involves the issue of external validity. For example, to what subject populations, settings, experimental treatment, and measurement variables can the results be generalized?

In this study, the findings cannot be generalized beyond the specific subject population (family unit characteristics and problem type) from which the research sample will be drawn. Whatever findings are

generated cannot be generalized beyond the specific subject population
(family type and problem type) specific treatment (modified short-term
structural-analytic family therapy), treatment setting (child guidance,
laboratory setting), applied at a specific point in time and in a speci-
fic geographic location (Kent County area of Rhode Island), and under
specific conditions (the specific conditions imposed by the experiment
itself, e.g., pretested population).

Method of Assessment

Another limitation of this research pertains to the chosen method
of assessment. The variables under study are family unit, interpersonal,
and individual family member perceptions of family functioning, family
life, and presenting-child problem. The data source to be used to as-
sess treatment outcome will rely exclusively on self-reports. No at-
tempt will be made to obtain data concerning actual behavior change
(direct observation). Other qualifications worth noting regarding the
method of assessment involve issues concerning choice of instrumenta-
tion and testing conditions. Except for FAP, the instruments are all
standardized self-report questionnaires. It is also important to note
the reactive nature of these instruments. Pretest and posttest condi-
tions create an opportunity in the test-retest administration of the
questionnaires for families to become test sensitive: that families may
learn how to take the questionnaires with families experienceing a
self-reported presenting-child problem. And, finally, this research
will attempt to address the specificity question proposed in Chapter I:
What treatment works best with what population and with what symptom

(problem type) under what set of conditions? Accordingly, this research and its findings will hopefully make a small yet necessary contribution to family therapy process and outcome research.

Treatment Variables

Several limitations are contained in the treatment proposed for use in this research. The treatment could be more operational (e.g., treatment steps more behaviorally defined). Another issue concerns the question of treatment validation and the influence and interaction of the therapist as an important treatment variable. One limitation that needs to be addressed relates to treatment validation: Is the treatment that is intended, the treatment that is applied to all subjects and do both therapists apply the same treatment?

Merits

The merit of this research is to have conducted methodologically-sound family therapy research that takes into account the five research myths (outlined in Chapter II) that currently confront family therapy process and outcome research. Accordingly, the proposed research will attempt to treat a homogeneous population (homogeneity of population myth), will attempt to test and apply a somewhat more operationally-defined family therapy treatment to all the experimental group families (uniformity of treatment myth and the myth of a sufficient body of microtherapy theory), and will attempt to employ standardized treatment outcome measures (the myth of the objective measure and the myth of the unbiased set of outcome criteria).

In an attempt to adhere to an understanding of these five myths, this research, despite its limitations, will hopefully shed some light on the effectiveness of short-term structural-analytic family therapy.

C H A P T E R   VI
ORGANIZATION AND PREPARATION OF THE DATA

In Chapter I, the reader was presented with the problem statement, purpose, and description of the study. In Chapter II, the literature review on prominent methodological and conceptual issues in family therapy and a description of major substantive findings of family therapy outcome research was presented. In Chapter III, the reader was presented with the theoretical background to the experimental treatment as well as an outline and definitions of clinical constructs and treatment steps. In Chapter IV, the criteria used for selecting the measurement instruments and a detailed description of each instrument was presented. In Chapter V, a description of the design, hypotheses to be tested, and procedures for collecting and handling the data were presented.

In this chapter, the reader will be provided with a description of the series of steps used in the organization and preparation of the data for analysis. To accomplish this task, this chapter has been organized into the following seven major sections:

1. Review of the major points of design, method of data analysis and objectives proposed for this study prior to implementation of the experimental phase of the research.

2. Documentation of variations in the proposed design and procedures noted upon completion of the pretest, treatment, and posttest phases of the research.

3. Reassessment and reexamination of predominantly academic research problems and issues of outcome research in the new light of this

investigator's personally acquired knowledge and first-hand experience with the conduct of this study.

4.   Development and formulation of a new design and model of data analysis.

5.   Description of the procedures used for scoring the data on the four standardized, self-report child and family assessment measures (FAD, CBCL, FUI REAL, FUI IDEAL).

6.   Description of the response categories developed and used for sorting, coding, and scoring the data on family demographics.

7.   Description of the procedures used for organizing, coding, and scoring the data on the two family questionnaires (FAP and FCE) specifically designed for this study, including the definitions of response categories used for sorting the data.

Major Points of Design, Method, and Objectives of this Study

Before turning our attention to an analysis of outcome, it would appear quite appropriate to preface such a discussion with a review of the salient points of design, method, and objectives of this study.

A randomized pretest-posttest experimental control group design was chosen for use in this study. The population under study was those families of young children who sought help for a self-identified, mild to moderate presenting child problem where the child was between the ages of three and eleven. A stratified random sample of 40 families was drawn from a population of 65 families. Sample families were randomly assigned to three different sets of experimental conditions: group

(treatment or control, 20 families per group), therapist (one of two therapists, ten families per therapist), and pretest-posttest administrators (five testers, 13 families per tester).

All families (N=65) were pretested on five dependent measures: Family Assessment Device (FAD), Child Behavior Checklist (CBCL), Family Unit Inventory (FUI REAL and FUI IDEAL), and Family Assessment of the Problem (FAP). Experimental group families received the short-term structural-analytic family therapy. Control group families did not receive treatment at that time. Control group families were placed on a waitlist.

The treatment that experimental group families received consisted of 15 to 20 hours of therapy (mean number of treatment hours approximately 18 hours). The treatment was administered by either a male or female therapist with approximately the same years of experience (five years of counseling therapy experience).

Upon completion of the seven week treatment, all families (N=65) were posttested on the same five dependent measures (FAD, CBCL, FUI REAL and FUI IDEAL, and FAP). A sixth outcome measure, Family Counseling Evaluation (FCE), was administered at the end of the posttest session to treatment families to assess their perception of the presenting problem as well as the overall therapy experience.

Reasons for Choosing a Randomized, Pretest-Posttest Design

The basis for scientific inquiry is comparison. A second, important feature of experimental inquiry is control of extraneous or intervening factors. The experimental method consciously plans for and con-

trols (e.g., eliminates, minimizes, equalizes) the effects of specific sets of variables while the independent variables are consciously applied or manipulated. The effects of the independent variables upon a specified set of dependent measures or dependent variables is then observed.

The reasons for using the pretest-posttest control group design rests in its ability to make several important comparisons. The most important set of comparisons were between the T_1 and T_2 mean differences for the experimental and control groups on the four standardized dependent measures (FAD, CBCL, FUI REAL, FUI IDEAL). This comparison assessed the possible systematic effects of treatment.

Use of a Stratified Sample

A stratified random sampling plan was used to insure a proportionately representative sample of families on four clinically relevant variables. These four variables were: family type (one and two parent households), child's sex (male and female), child's problem type (principally withdrawn behavior, principally aggressive behavior, mixed behaviors), and child's grade level (preschool and primary grades). The stratified random sampling procedure equalized the effects of these important variables, and, therfore, had the effect of controlling for them. Controlling for family type, child's sex, problem type, and child's age provided for the analysis of the differential effect and/or the observation of the interaction of any of these variables with other outcome variables.

Pretesting and Posttesting of the Entire Population

The pretest-posttest control group design experiment is usually conducted as follows:

1. Subjects are selected from a defined population using random methods.

2. Subjects are randomly assigned to groups, for example, treatment or nontreatment groups, or treatment A and treatment B.

3. The experimental and control group sample are pretested at T_1 and the mean group scores on the dependent measures are computed for both groups.

4. The treatment group is systematically exposed to the experimental intervention. Or, in the case of the comparison of two methods, each group is exposed to a different type or form of the intervention. With the exception of the systematic manipulation of the intervention, all other experimental conditions and other extraneous factors are kept the same or are controlled.

5. The experimental and control group sample is posttested at T_2 and the mean group scores on the dependent measures are computed for both groups.

6. The differences between the T_1 and T_2 means for each group are calculated separately.

7. The $T_2 - T_1$ mean differences are compared. An appropriate statistical test is applied to determine whether the difference(s) between groups is statistically significant, i.e., whether the difference is large enough to rule out chance occurrence and, therefore, reject the

null hypothesis.

8.   The results of the experiment are generalized to the research population and to other comparable populations, treatments, settings and so forth. The purpose of inferential statistics is to infer or suggest conclusions about wider populations from which the sample is randomly drawn. Therefore, the assumptions underlying parametric statistical tests require that just the randomly selected sample be pre- and posttested. Randomization is reasonable assurance that the sample is representative of the population.

However, for purposes of this study, the decision was made to pretest and posttest the entire population of families (N=65). This decision was made for a number of reasons. The first set of reasons pertained to practical considerations:

1.   The mental health and child development staff at the community centers participating in the research were willing to make space available for testing.

2.   Families offered little resistance to the idea of completing the family assessment questionnaires.

3.   Test administrators were available to complete the pre- and posttesting.

A second set of reasons related directly to the research objectives and plans for data analysis. The added feature of pretesting and posttesting all families made it possible to pose, systematically plan for, and address a number of experimental questions within the structure of the research design. Pretesting and posttesting the entire

population clearly had several advantages. These advantages were as follows:

1. Pre- and posttesting of all families made it possible to obtain the true population means (i.e., for the study's population) rather than estimates of means on all dependent measures at two time points, T_1 and T_2.

2. Pre- and posttesting of all families expanded the scope of the design and, therefore, the possible comparisons for analysis. Testing all families increased the number of groups. Instead of having the original two-group design (N=40, experimental group=20, control group= 20), a second control group was formed. The design thus included an experimental group (N=20), a control group, C_1 (N=20), and another control group, C_2 (N=25).

3. Pre- and posttesting all families on all the four dependent measures at T_1 increased the number of subscale scores and, therfore, provided for a more extensive study and analysis of the concurrent validity of the four family assessment instruments. Instruments could now be compared across subscales on 65 families rather than the original 40 families.

Objectives of this Study

As stated earlier, this study had three broad objectives. These objectives were briefly:

1. To test the effectiveness of short-term child-centered structural-analytic family therapy with families with a presenting child behavior problem.

2. To test the concurrent validity of four family assessment in-
struments with operationally similar subscales.

3. To test the degree of association between family demographics
and treatment outcome.

Based upon these three general purposes, this investigation was
divided into two separate studies: an experimental study with its re-
lated hypotheses, and a correlation study with its related hypotheses.
The scope and design of each study was outlined in Chapter V.

Reexamination of Research Problems in Outcome Studies

The results section in a research article is usually the aspect of
greatest interest to consumers of research. The presentation of results
represents the study's findings and suggests conclusions that may be
drawn from the research. Results signify a study's end-product, and,
therefore, are often given greatest priority.

However, in this investigator's opinion, the results generated
from studies in psychotherapy or any study for that matter should be
regarded as one stage in an important series of investigative steps.
The series of steps that lead up to the presentation of results is
equally important in determining outcome. As a matter of fact, the
steps that lead up to the presentation of results in a published report
are often equally as important in situating and assessing the scope and
meaning of the experimental outcome as are the statistical tables that
are presented.

For example, a study in family therapy outcome research that uses

the group mean as the measure in determining statistically significant outcome should be regarded as a study that employs one model of data analysis (group mean differences) from a potential array of equally valid approaches to analysis. Other equally valid models of analysis could have been used. As a number of researchers (Bergin & Lambert, 1978; Gottman, 1973; and Hersen & Barlow, 1976) propose the same data may be analyzed to equal advantage using a "N of one at a time" or intrasubject model. This brief, hypothetical example suggests the non-absolute nature of any experimental results, and the existence of competitive as well as complementary models of analysis. For this purpose a considerable portion of this chapter will be concerned with describing the reasoning applied to problems of the data analysis.

Steps Involved in the Process of Data Analysis

As suggested earlier, a study's results represent only one event in a wider scheme of conceptual and methodological analysis. Data analysis is not a single act. It represents a series of events (i.e., ways of acting on the data) that culminate in the presentation of findings often in the form of statistical results.

Twelve major steps were followed in the preparation of the data for analysis in this study. These steps were as follows:

1. Organizing the data into a meaningful arrangement/form.

2. Evaluating different models of analysis.

3. Recording variations in aspect(s) of the conduct of the study and determining the effect(s) such variations might have on the original plans for analysis.

4. Integrating these changes into a new design and new model of analysis.

5. Redefinition and reappraisal of outcome on the basis of the actual quantity of data collected upon conclusion of the study.

6. Reexamination of the controversy between clinically relevant findings versus statistically significant findings in relation to the interpretation of outcome in the family therapy literature.

7. Development of a plan of analysis that would incorporate both perspectives on outcome.

8. Organization of the actual model of analysis to be used involving such issues as the definition of a complete case, level of analysis, coding and constructing the data files.

9. Scoring the four standardized instruments (FAD, CBCL, FUI REAL, and FUI IDEAL).

10. Developing a coding and scoring system for the data on family demographics.

11. Developing a coding and scoring system for FAP.

12. Developing a scoring system for FCE.

Organizing the Data: Steps One through Four

To reiterate, steps one through four in arriving at a plan for analysis involved (1) organizing the data into a meaningful form, (2) evaluating different models of analysis, (3) recording variations in any aspect of the conduct of the study and determining the effect such variations might have on the original plans for analysis, and (4) integrating these changes into a new design and new model of analysis.

Organizing the data into meaningful form: step one. Following the conclusion of the experiment, the first task confronting this investigator was to survey the array of data collected and make sense of the quantity of self-report information obtained from the families. A survey of the self-report data revealed information on 65 families (three groups: experimental, n=20; control one, n=20; control two, n=25), all tested at two time points (T_1 and T_2) and some tested at three time points (T_1, T_2, T_3 follow-up). The population included 65 families.

The 65 families consisted of 65 mothers, 54 fathers, 14 ex-husbands and 4 male companions. The self-report data had been obtained on all four instruments and family demographics at T_1 on the 65 families, 137 subjects and 26 male-female married pairs (couples). At T_2 data was collected on all 65 families on the four instruments with a Family Counseling Evaluation added to obtain clinical data. A follow-up T_3 evaluation was included in the study. Data was obtained at T_3 on the original treatment group (n=20) and a reconstituted experimental two group (n=20) comprised of families of the control one and control two groups who received the same experimental treatment following the T_2 testing. This provided for a comparison of two treatment groups based on time as the factor. A comparison of the effect of treatment could be made on the basis of treatment/follow-up versus waitlist/treatment.

This overview of the data suggested a three-group design wherein differences could be compared at T_1 and at T_2 and between T_2 and T_1 differences (T_2 - T_1 gain scores). The analysis could be conducted on the subscale level on the individual subjects (men and women separately)

and on the couple level (the family unit being defined as the couple).

A detailed review of the methodology literature in family therapy and individual psychotherapy outcome research was conducted to appraise research designs. This review included reexamination of the works of such prominent critics as Gurman and Kniskern; Gurman and Knudson, Hersen and Barlow; Gottman; Markman, and Jacobson and Turkowitz. (A more complete list of relevant authors is contained in Chapter II and in the bibliography). The analysis described above comprised the preliminary plan for data analysis.

Recording variations and determining their effects: steps two, three and four. As noted earlier, several variations in the conduct of the experiment occurred. These variations in the experimental plan included: (1) pre- and posttesting of the entire population; (2) expansion of the design from a two-group randomized design to a three-group randomized design; (3) the reconstitution of a second experimental group from the two control groups (control one and control two) following the T_2 posttest; (4) the administration of the same treatment to the second experimental group; and (5) a T_3 follow-up posttesting of the original experimental one group and the reconstituted experimental two group.

These five variations in design directly affected plans for analysis. These variations suggested specific modifications in design and a new conceptual model for analyzing the data. These modifications made it possible now to construct a different paradigm. It was not possible to:

1. Compare pre-posttest experimental outcome between T_2 and T_1 for the experimental treatment group and two control groups rather than one control group.

2. Compare treatment effectiveness between two experimental groups, experimental group one and experimental group two (T_2 outcome scores for experimental group one to T_3 outcome scores for experimental group two).

3. Determine the effect of time as an independent variable on clinical outcome and problem status by comparing the two treatment sequences or types of interventions (i.e., immediate treatment versus a waiting period followed by treatment).

4. Examine the effect of the treatment intervention at follow-up (i.e., comparison of the experimental one group's scores at T_1 pre-treatment with their T_2 post-treatment scores with their T_3 follow-up scores).

Recognition of the possibilities for comparison suggested a new structure for organizing and analyzing the experimental outcome of this study.

Reassessing the Meaning of Outcome: Steps Five, Six and Seven

The next phase in organizing the data included three steps. These steps correspond to steps five, six, and seven listed above. Step five involved the reappraisal and redefinition of outcome on the basis of the actual quantity of data collected upon conclusion of the study. Sept six involved the reexamination of the issue of clinically rele-vant differences versus statistically-significant findings in relation

to the interpretations of outcome reported in the family therapy research literature. Step seven involved the development of a plan for analysis.

This phase of the research was particularly critical. It involved the reconsideration of the meaning of outcome from two perspectives: clinical and statistical. Reexamination of both perspectives highlighted one, overarching conceptual dilemma facing family therapy researchers. This dilemma relates to the development of a satisfactory definition of outcome.

Defining the meaning of outcome is perhaps the single most important issue in determining the analysis paradigm to be imposed on the data of a given study. However, as this investigator experienced, this task was not an easy one. The task and the solution required the conscious consideration of major, multifaceted problems characteristic of family therapy research. Review of major points is as follows.

A growing trend in the field of family therapy research toward methodological adequacy has given rise to the development of improved forms and proposed usages of group design models. With such emphasis on more judicious applications of the group design method, family therapy researchers have focused their attention on the main experimental question: Does the experimental treatment proposed make a statistically significant group difference?

Careful analysis of the assumptions required for fulfillment of group design experiments suggests that the choice of the group design paradigms may be inappropriate for evaluating family therapy outcome.

It may be argued, for example, that the more adequate a sample is (e.g., random sample) with all relevant population characteristics equally represented, the less relevant will the findings be for a specific individual subject, clinical theory, and the refinement of clinical practice.

A number of prominent authors in the field of psychotherapy research (Bergin & Lambert, 1976; Gottman, 1973; Hersen & Barlow, 1976) and family therapy (Keeney, 1979, 1982; Lebow, 1981; Pinsof, 1981) raise and explore this question. For example, Hersen and Barlow convincingly argue that the average response of the group, suggested by use of the group mean, is less likely to provide a valid estimate of the individual respondents in the group.

Most of the skepticism about the effectiveness of psychotherapy is derived from the failure of a large number of controlled and controlled-comparative studies to report statistically significant effects for the treatment group. In addition, closer examination of the lack of statisticallly significant results suggested not only the lack of systematic positive shifts in subjects but also that some portion of the patient populations appeared to worsen. Observation of such a "deterioration effect" reported in the literature (Gurman & Kniskern, (1978b) has subsequently stimulated controversy regarding the benefits, even basic worth of the psychotherapeutic experience.

Such ambiguity surrounding the interpretation of findings in the family therapy research led some theorists to conclude that the group design method was obscuring important clinical information. It has

been strongly suggested that, while positive changes may in fact be oc-
curring in individual subjects during treatment, the posttest mean does
not sufficiently summarize and reflect these changes.

Gottman raises an interesting point in the reanalysis of group psy-
chotherapy outcome studies. He proposed careful analysis that takes in-
to account the study of variance and the operation of the regression ef-
fect. He calls attention to the effect that individuals scoring on
either extreme of the distribution of scores have on the interpretation
of pre- and posttest group mean results.

Gottman makes a convincing case for the study of variances as well
as means in the analysis of psychotherapy group design outcome. In his
"N of 1 and N of 2 Research" article, Gottman states that, "If psycho-
therapy serves to move patients closer to the mean, the major effect of
psychotherapy may be an effect on the variance rather than on the mean
of the distribution. If therapy is effective, we would expect a de-
creased variance in the change scores for the treatment group. Scho-
field (1950) presented data which may support 'the regression hypothe-
sis' . . ." Gottman continues, "Therefore, an analysis of the effec-
tiveness of psychotherapy could be misleading if only means of the
grouped change scores were inspected. Even with randomized analysis of
variance experiments, the assessment of change within individuals over
time (or 'N of 1 at a time research') would shed some light upon the
question of psychotherapy outcome" (p. 95).

Gottman urges researchers to incorporate in their analysis para-
digms the study of intrasubject variability over time. He suggests

that within the context of the group design, comparisons may be made between the individual pattern of response (i.e., the "individual learning curve") and the average learning curve. Gottman unequivocally demonstrates in his article cited above how the study only of intersubject variability or the study of between-group differences (the averaging of data) contributes to potentially misleading conclusions about the effectiveness of the psychotherapy process.

Hersen and Barlow (1976) propose an interesting solution to the integration and study of these two perspectives, namely, intrasubject change/variability and intersubject change/variability. They propose that within the group design model, the outcome results for each subject may be presented either graphically or in numerical form along with the presentation of the means and standard deviations of the control group scores. Using such an approach provides for comparisons of subjects with the group means as well as the comparisons of subjects to themselves. The effect is that each subject is compared to the group average as well as serving as his/her own control. Other authors (Bergin & Lambert, 1976; Gottman, 1973) recommend the inclusion of group medians at pre- and posttest as additional measures of comparison in assessing outcome.

In light of the evidence described above, it is this investigator's opinion that no analysis of outcome is complete without the integration of (1) statistical and clinical perspectives, and (2) consideration of intrasubject change in relation to group averages. In addition, a complete analysis of outcome would ideally extend beyond the group mean.

A complete picture of pre-post differences between groups would include the study and covariation of additional summary measures (e.g., pre- and posttest medians) and measures of dispersion (e.g., variance, standard deviations).

The meaning of outcome in determining the effectiveness of family therapy extends beyond statistical analysis and the reporting of statistically-significant differences. The meaning of outcome should extend to the consideration of trends in the data that suggest clinical patterns on subpopulation and/or subject profiles. In this investigator's opinion, an outcome study would ideally pose two questions. One question would be: Did the experimental treatment make a statistically-significant difference? The other question of equal importance would be: Did the experimental treatment make a clinically-relevant difference for the patient population? Other equally valid questions include: Can subpopulations within the treatment groups be identified? Do certain clusters of patient variables (e.g., family unit characteristics), variables that relate to problem type, or patient-therapist interaction correspond to more positive levels of outcome? Are there trends observed in the data that may be helpful in supporting and refining clinical practice and/or clinical theory? These questions will be addressed, in part, in the final summary and discussion of results in Chapter IX.

Procedures for Preparing and Handling the Data: Step Eight

This phase of the data analysis involved a series of substeps. These substesp reflect a number of decisions regarding the treatment and handling of the data. Substeps in the preparation and treatment of

the data included such issues as consideration and conceptualization of the data as a whole, treatment and preparation of the data, procedures for scoring each of the four standardized instruments (FAD, CBCL, FUI REAL and FUI IDEAL), and the development of coding and scoring systems for the demographic data and data collected on the two questionnaires (FCE and FAP) designed specifically for assessing clinical outcome for this study. Issues addressed in these three substages included: definition of a complete case, determining the level of analysis, and constructing the data files. Each step is arranged in chronological order and is described below.

Definition of a complete case. Originally, the hypotheses to be tested were constructed for analysis on the family unit level. The family unit was defined as the marital couple (mother and father). A complete file consisted of mother's and father's scores obtained at two time points (T_1 and T_2) on the five dependent measures (FAD, CBCL, FUI REAL, FUI IDEAL, and FAP) with a fifth dependent measure (FCE) obtained following treatment.

However, the expansion of the original experimental design altered the definition of a complete case. The decisions to pre- and posttest all of the population and to provide the same type of family therapy to a second experimental group required two new redefinitions of a complete case. These two redefinitions applied to (1) redefinition of the complete case for purposes of the data analysis and the assessment of experimental outcome, and (2) redefinition of a complete case in relation to clinical analysis of the treatment groups.

For purposes of the analysis of the experimental outcome, a complete case for all population families was defined as consisting of the mother's and father's scores obtained at two time points (T_1 pretest and T_2 posttest) on the five dependent measures (FAD, CBCL, FUI REAL and FUI IDEAL, and FAP).

For purposes of analysis of the effect of counseling and the counseling experience, the treatment groups (N=34) were studied separately. A complete case for treatment families was defined as consisting of the mother's and father's scores obtained at three time points (T_1, T_2, T_3) on the same five dependent measures (FAD, CBCL, FUI REAL and FUI IDEAL, and FAP) and a sixth counseling evaluation measure (FCE).

Level of analysis. The decision was made to analyze the data on two levels: the family unit level (male-female dyad) and the individual subject level. In order to insure statistical independence, data on mothers and fathers were analyzed separately. Therefore, analysis of the data involved analysis of couples' congruence scores and the separate analyses of mothers' and fathers' mean group scores on the four dependent measures. In addition, the decision was made to analyze the data on the instrument subscale level for individual subjects and for couples for the entire population.

Coding the data and constructing the data files. Each questionnaire for each subject was assigned a series of identification code numbers (header information). This identification code number consisted of seven digits. Digits one and two corresponded to the identification numbers assigned to the family (01-65). Digit three corresponded to

the family role of the respondent (mother = 1, father = 2). Digit

four corresponded to group membership (experimental group = 1, control

group one = 2, control group two = 3). Digit five corresponded to the

time of testing (pretest T_1 = 1, posttest T_2 = 2, follow-up T_3 = 3).

Digit six corresponded to the sex of the therapist (female therapist =

1, male therapist = 2). Digit seven corresponded to the identification

number assigned each instrument (FAD = 1, CBCL = 2, FUI REAL = 3,

FUI IDEAL = 4, background information/family demographics = 5, FCE = 6,

FAP = 7).

Following the assignment of identification code numbers, the in-

struments were examined for missing values. Missing values were en-

tered as blanks: individual files for each subject for each instrument

for each time point (maximum of three time points) were compiled and

entered on the item level. Files were then constructed for each family

in the manner previously described.

When data was missing for any family member on any instrument at

any time point or if data on all instruments at a given test point were

missing for any subject, a file of blank values was built to represent

the missing instrument, time point, or missing subject. This was done

to insure statistical independence and analysis on the family unit

level.

Procedures for Scoring FAD, CBCL, FUI REAL, FUI IDEAL: Step Nine

Subscale scores were computed for each instrument for each subject.

When appropriate, congruence scores were computed for the couple. Sub-

scale scores were computed for FAD, CBCL, FUI REAL and FUI IDEAL follow-

ing the scoring instructions provided by the developers of each instru-
ment. Some slight variations were made in the scoring procedures. The
guidelines and variations in scoring each instrument were as follows.

FAD. Analysis of FAD on all families (N=65) included all of the
instrument's 60 items with the knowledge that reported reliabilities
(Epstein, Baldwin & Bishop, 1981, 1980) are based on a 53 item subset.
FAD is currently being tested and refined. Reliability and correlation
analyses are being conducted as more data is collected by the developers.
It would be expected that reliabilities on all seven subscales using
the total 60 item set is forthcoming. The decision to use all 60 items
in the analysis was based on this rationale.

As described earlier, FAD yields seven subscale scores: Problem
Solving (PS), Communication (C), Roles (R), Affective Involvement (AI),
Affective Responsiveness (AR), Behavior Control (BC), and General Func-
tioning (GF). The seven subscale scores were computed as follows. All
60 items were scored: Strongly Agree = 1, Agree = 2, Disagree = 3,
Strongly Disagree = 4. Scores for items describing unhealthy family
functioning were transformed mathematically by substracting them from
five. This procedure inverted the response scales on unhealthy items.
The effect was that a strongly-agree response on an unhealthy item was
equated with a strongly-disagree response to a healthy item. Next the
items assigned to each of the seven subscales were summed and averaged
to yield a subscale mean score. The subscale score was based on the
number of answered items. Each subscale score was obtained by summing
the item values and dividing by the number of answered items for that

subscale. Missing values on FAD were entered as blanks.

CBCL. CBCL is composed of Social Competence subscales and Behavior Problem subscales. Subscales scores for each subject on CBCL were described earlier. CBCL yields four Social Competence scores: Activities (A), Social (S), Total Social (TS), and School (SC). Behavior Problem responses yield a Behavior Problem raw score, Behavior Problem T score, an Internalizing score, an Externalizing score, and an interparent agreement score.

The Social Competence subscales listed above were computed using the procedural steps outlined by the developers (Achenbach, 1981; Achenbach & Edelbrock, 1978). The developers suggest that if one score is missing in the six items scored for the A, SC, and TSC subscales, then the mean of the other five remaining scores for that subscale is to be substituted. The scores assigned to the subscale items are then summed, yielding the respective subscale score.

For example, the Activities subscale score (A) was computed by summing the following six scores on Social Competence: Ia, Ib, IIA, IIb, IVa, IVb. The Social Competence subscale score (S) was obtained by summing the following six scores: IIIa, IIIb, V1, V2, VIA, VIB. The School subscale score (SC) was computed by summing the following four scores unless one or more scores was missing. These four scores are VII1, VIII2, VIII3, VIII4. The School scale score was not computed if the child was below the age of six, not in school, or if data was missing for any of the four scores. The Total Social Competence subscale score (TSC) was obtained by summing the total of the three scales

(A, SC, S). On all items, missing values and "I don't know" responses were entered as blanks. The instructions for scoring the Social Competence Section on CBCL were followed exactly. There were no deviations from the developer's instructions.

The Behavior Problem items on CBCL yield a number of measures. For purposes of this study, five subscale scores were computed for the analysis. These subscale scores were Behavior Problem raw score, Behavior Problem T score, Internalizing score, Externalizing score, and an interparent agreement score on Behavior Problems.

The following set of steps was used to obtain these five scores. The Behavior Problem 118 items were scored and totaled following the procedural plan outlined by Achenbach. This sum total provided the Behavior raw score. In computing this score, it should be noted that no adjustments based on clinician's or researcher's judgements were made. Items were scored just as parents answered them. In addition, any comments that parents wrote in beside their circled response were not considered with respect to altering the response. The questionnaire was scored and coded exactly the way the parent responded.

The Behavior Problem raw score was then converted to a normalized T score. Achenbach provides a table of normalized T-score equivalents to the Behavior Problem raw scores based on age and sex of the child. The T score was used for purposes of comparing each child to his/her norm group.

The original guideline established regarding the treatment of CBCL data for analysis was to use CBCL data obtained on one presenting child identified for each family. However, review of the CBCL data collected

upon completion of the study suggested several variations in the actual data.

The variations observed were as follows: (1) in some cases, complete data on the primary presenting child for whom the family initially sought counseling was available at T_1 but was incomplete or missing at T_2, preventing pre-posttest comparisons of parental perceptions of the same identified child; and (2) in other cases, parents completed assessments on several presenting children within the same family at one or both time points (T_1 and/or T_2).

The question thus arose regarding what to do (1) when the family identified more than one child with problems in their family at any given time, and (2) when incomplete data was not available on the primary presenting child. Based upon these observations of the data, the following guideline was established: The child with the most complete pre-posttest data was labeled the primary-identified presenting child. Data on this child was used in the analysis. Data on those presenting children other than the child labeled the primary presenting child (as defined by the rule described above) were excluded from the analysis of group differences.

The results of the breakdown of children were as follows: In all but three family cases, CBCL data on the original child for whom the family sought counseling was used in the analysis. In three family cases (family 05, 07, 47) CBCL pre-posttest data on children other than the "first" or primary child were used. In two families (05 and 07), CBCL data on the second child identified to have problems were used.

In the third family (47), CBCL data on the third child was used for the analysis.

Following computation of Social Competence scores and Behavior Problems scores for the appropriate child, using the guidelines and procedures described above, T-score adjustments were made for each child according to age and sex. In addition to the Behavior Problem raw score and the converted T score, an Internalizing and Externalizing score was calculated.

The Internalizing and Externalizing scores were computed in the same way. Achenbach provides a list of the items assigned to the factors associated with Internalizing and Externalizing behavior profiles for children. The score assigned to the items was summed. This sum represents the raw score on this dimension of the presenting child's perceived behavior. The raw score on both Internalizing and Externalizing was then converted to a T score for each child based on age and gender-appropriate norms. These adjusted T scores were used in the analysis.

Scores on the nine individual childhood syndromes described in detail in Chapter IV were not computed. Computation and analysis of the data on such a specific and diagnostically detailed level is beyond the scope of this research. It was determined that use of the Internalizing and Externalizing scores provided a level of specificity adequate for the purposes of this study. The Internalizing and Externalizing scores provide broad level-classification measures. Use of both scores permits an assessment of shifts in parental perception of the type of

problem behaviors.

A fifth score was computed using the Behavior Problem items. An interparent agreement score was computed for couples. When data was available on CBCL for both parents on the same child at both time points (T_1 and T_2), the interparent agreement score was computed. The pattern of scores for husband and wife (N=26) at T_1 and T_2 was correlated, using the z score. Group differences for couples were analyzed and tested for statistical significance.

FUI REAL and FUI IDEAL. FUI REAL and FUI IDEAL yield the same nine subscale scores. These subscale scores were described in detail in Chapter IV. These subscales are (1) Consideration vs. Conflict, (2) Family Actualization vs. Inadequacy, (3) Open Communication, (4) Community Sociability, (5) Family Ambition, (6) Internal vs. External Locus of Control, (7) Togetherness vs. Separateness, (8) Family Loyalty, and (9) Closeness vs. Estrangement.

Additional scores may be computed from FUI REAL and FUI IDEAL items. The Family Integration and Family Adaptation scores were computed for mothers and fathers and prepared for separate analysis. Family Satisfaction scores were also computed for mothers and fathers and were prepared for separate analyses. Family Real Congruence scores and Family Ideal Congruence scores were computed for the couple (N=26).

All scores used in this study were obtained by following the instructions provided by van der Veen et al. (1981). When items were missing on FUI REAL and/or FUI IDEAL, these items were not entered as blanks. Instead, the missing item was assigned the value of four, the

middle-most value on the 0-8 response scale. The score for each item specified as "R" (to be reversed) was subtracted from eight before summing the subset of items assigned to the subscale and then dividing by the number of items to obtain the mean. van der Veen's instructions for the preparation, scoring and coding of the data were followed exactly.

Response Categories Developed for Coding and Scoring Family Demographic Data: Step Ten

Data was collected at T_1 on an extensive number of family demographic variables. However, prior to analysis of the relationship between demographic variables and outcome variables, a coding system needed to be developed in order to prepare the data for analysis. The first task was to list the total number of demographic variables. The second task was to develop and define mutually exclusive categories into which the data on families could be sorted. The third step involved the development of a system of numerical values corresponding to each category that would be used to code the data.

Survey of the data indicated that data was collected on approximately 30 family demographic variables. These 30 variables were, in turn, divided into five subgroups. The five subcategories were labeled: (1) mothers' background and personal characteristics, (2) fathers' background and personal characteristics, (3) family unit characteristics, (4) characteristics of the presenting child or children and presenting problem(s), and (5) ex-husbands' background and personal characteristics.

Data collected on mothers and fathers consisted of age, occupation,

work status, education, marital status, ethnic background, religion, and rank in family of origin. The following coding system was used for both mothers and fathers.

Age. The actual age of the mother and the father was entered.

Occupation. The first step in the development of a coding system for occupations was to consult the literature for examples for work categorization schemes currently in use. Upon obtaining some basic knowledge of major taxonomies used to classify work, the second step was to return to the data and list all the occupations reported by men and women. Based upon a survey of the population of responses, two different categorization systems were devised for mothers and fathers. Mothers' type of work was divided into seven categories. The following is a brief description of each category and the codes assigned.

1. The category of "housewife," "homemaker" was assigned 0.

2. The category covering blue-collar, unskilled factory work was assigned 1.

3. The category covering blue-collar skilled or trade (e.g., beautician) was assigned 2.

4. The category covering white-collar, clerical and technical work was assigned 3.

5. The category covering white-collar professional and specialized, advanced technical training (e.g., nursing) was assigned 4.

6. The category covering self-employed businesswomen was assigned 5.

7. The category covering advanced academic and advanced professional training (e.g., teachers, lawyers, doctors) was assigned 6.

The categories for fathers' type of work varied slightly. Instead of seven categories, there were only six categories devised for coding the data on fathers' occupations. The following is a brief description of the categories developed and codes assigned.

1. The category of blue-collar, unskilled factory work, including maintenance and janitorial jobs was assigned 1.

2. The category covering blue-collar, skilled or trade including skilled factory and trades (e.g., carpenter, gardener, tool and die maker) was assigned 2.

3. The category of white-collar, skilled work requiring specialized training (e.g., computer programmer) was assigned 3.

4. The category of white-collar, middle management, civil service, and social service (e.g., market managers, social work supervisors, Veteran's Administration directors) was assigned 4.

5. The category covering self-employed businessmen was assigned 5.

6. The category covering advanced academic and/or highly specialized professional training (e.g., certified public accountants, lawyers, doctors) was assigned 6.

Work status. Data was collected on mothers' and fathers' work status. The same categorization scheme and coding system was used for both men and women. The categorization scheme and coding system employed was as follows:

1. Men and women who were unemployed were assigned 1.

2. Men and women reporting part-time employment were assigned 2.

3. Men and women who reported full-time employment were assigned 3.

Education. Data was collected on the years in school and highest
educational degree earned for mothers and fathers. The same categoriza-
tion scheme and coding system was used for men and women. The cate-
gorization scheme and coding system used was as follows:

1. Men and women who reported under twelve years of high school
(did not receive a high school diploma) were assigned 1.

2. Men and women who reported being high school graduates were
assigned 2.

3. Men and women who reported receiving an associates degree or
its equivalent, two years of college or technical training, were as-
signed 3.

4. Men and women who reported earning a four year college degree
were assigned 4.

It should be noted that when a subject reported taking several
years of college courses in varied fields or reported two to three
years of college without receiving the four year degree, this subject
was included in the third cateogry and was assigned 3.

5. Men and women who reported receiving a master's degree in any
field were assigned 5.

It should be noted that when a subject reported taking several
graduate or advanced courses or reported completing several semesters
of graduate school, this subject was included in the fourth category
and was assigned 4.

6. Men and women who reported earning a doctorate in any field
were assigned 6.

Marital status. Data was collected on men and womens' marital status. The same categorization scheme and coding system was used to code the data for men and women. The categorization scheme and coding system used was as follows:

1. Men and women who reported never having been married were assigned 1.

2. Men and women who reported being married for the first time (first marriage) were assigned 2.

3. Men and women who reported being separated from their spouse at the time of the study (and no previous marriages) were assigned 3.

4. Men and women who reported that they were divorced were assigned 4.

5. Men and women who reported that they were divorced and remarried were assigned 5.

6. Men and women who reported being widowed were assigned 6.

7. Men and women who reported being divorced and now living with someone (living together) were assigned 7.

8. Men and women who reported being divorced and just having separated from a current intimate companion (relationship break-up and now living alone) were assigned 8.

Ethnic background. The procedure for devising a categorization scheme and coding system for ethnic background was as follows: The first step was to survey all of the population of responses and to list all of the population of responses and to list all of the ethnic backgrounds that were reported. The next step was to assign a code number to each different ethnic orientation listed and described. The categorization

scheme and coding system that evolved is as follows: Thirteen different ethnic backgrounds were identified. Each was assigned an identification code number. The coding system included:

Irish/American assigned 1.

English/American assigned 2.

French/American assigned 3.

German/American assigned 4.

Italian/American assigned 5.

Hispanic or Spanish/American assigned 6.

Portuguese/American assigned 7.

Armenian/American assigned 8.

Polish/American assigned 9.

Arabic or Persian/American assigned 10.

Cape Verdian/Black assigned 11.

Slavic or Russian/American assigned 12.

Scotch/American assigned 13.

Religion. The first step in devising a categorization scheme for religion was to survey the population of responses and list all the religious affiliations reported. The next step was to assign a code number to each separate category. Three major religious affiliations were identified: Catholic, Protestant, Hebrew or Jewish. The following coding system was used: Catholic was assigned 1; Protestant was assigned 2; Hebrew/Jewish was assigned 3. A fourth category was devised to accommodate "other" (e.g., atheists, Bahai, Budhists). These responses were assigned 4.

Rank in family of origin. Data was collected on mothers' and fathers' rank in family of origin. The same coding system and categorization scheme was used for men and women. The data was coded as follows:

1. Men and women who reported that they were the first-born/ oldest child or only-child in their family of origin were assigned 1.

2. Men and women who reported that they were the second-born or middle-child in their family of origin were assigned 2.

3. Men and women who reported that they were the third or youngest child in their family of origin were assigned 3.

Family unit characteristics. Data collected on the family unit consisted of family income level, family composition, number of people living in the household, number of children in the family, family type, and family ethnic background. The following system was used for categorizing and coding the data on family unit characteristics.

Family income level. The family income cateogries suggested by the developers of FAD (Epstein, Bishop & Baldwin, 1981) was used in this study. Family income level was divided into seven categories. The seven categories and codes assigned to each category are as follows:

$0 - 4,999 was assigned 1.

$5,000 - $9,999 was assigned 2.

$10,000 - $14,999 was assigned 3.

$15,000 - $19,999 was assigned 4.

$20,000 - $24,999 was assigned 5.

$25,000 - $40,000 was assigned 6.

Over $40,000 was assigned 7.

Responses on family unit income were obtained from both husband and wife. Husband and wife's responses were coded and entered separately for the analysis. The results on the data on family income reflect the combined family income of husband and wife.

Family composition. Data was collected on the family composition. Husbands and wives were asked individually to list and describe the persons and relationships that made up their immediate family household. The first step in coding the data on family composition or family structure was to survey the population of responses and develop codes to correspond to the different relationships reported. The following categorization and coding system was used:

Father was assigned 1.

Mother was assigned 2.

Son was assigned 3.

Daughter was assigned 4.

Grandfather was assigned 5.

Grandmother was assigned 6.

Brother or brother-in-law was assigned 7.

Sister or sister-in-law was assigned 8.

Adult intimate companion was assigned 9.

Number of persons living in the household. Data was collected on the family size or number of people living in the household. The names of the people living in the household were counted. The actual number of people listed was entered.

Number of children in the family. The same procedure was used in coding the data obtained on the number of children in the family. The names of the children living in the family were counted. The actual number of children listed was entered.

Family type. Data was collected on the family type. Three family types were identified for use in this study. Each of the three family types was assigned a code number. The categories and codes assigned are as follows: (1) single-parent or one-parent households were assigned 1; (2) two-parent households were assigned 2; and (3) one-parent households living with extended family were assigned 3.

Family ethnic background. Data was collected on the family's ethnic background. Responses were obtained from both mother and father. The same categorization scheme and coding system used for mothers' and fathers' ethnic background was used for data on family ethnic background.

Characteristics of the presenting child and presenting problem. Data was collected on the presenting child and presenting problem. The data collected on the presenting child and presenting problem consisted of the child's age, sex, grade level, and problem type. When the parent(s) identified more than one child with problems at T_1, data was collected on each child.

Age. The actual age in months was entered for each child identified to have problems.

Sex. The sex of the identified child or children was coded as follows: Male was assigned 1; female was assigned 2.

Grade level. Data was collected on the child's grade level or

school status. The following categorization scheme and coding system was used:

1. A child who was not in school was assigned 0.

2. A child who was attending preschool was assigned 1.

3. A child who was in grades kindergarten through third grade was assigned 2.

4. A child who was in grades four through seven was assigned 3.

Problem description. Data was collected on the general description of the child's problem behavior. This data was obtained from the parent's description of the troublesome behavior recorded on the application form parents completed as part of the first step of referral. Based upon a review of the population of responses, five categories were devised for coding the problem description. The categories are as follows:

1. Parental concern over the child's withdrawn behaviors was assigned 1.

2. Parental concern over the child's aggressive behavior was assigned 2.

3. Parental concern over the child's problematic behavior combined with concern over the problem being a parent-child relationship problem was assinged 3.

4. Parental concern for the child's problematic behavior coupled with concern over the contribution of marital problems to the child's symptoms was assigned 4.

5. Parental concern for the identified child's problems coupled with an understanding that the problem extended to and included the

whole family or was complicated by the presence of family problems was assigned 5.

Background data on male companions and ex-husbands. Data was collected on the male companion living in the household and, when applicable, on the ex-husband. Data obtained on the male companion consisted of his age, occupation, work status, education, marital status, religion, rank in family of origin, and ethnic background. Data obtained on the ex-husband consisted of his age, occupation, education, and ethnic background. The same categorization scheme and coding system used to code the data obtained on fathers was used to code the data on ex-husbands and adult male companions.

In summary, data was collected on approximately 30 population variables that related to family demographics, family unit characteristics, and characteristics of the presenting child, presenting symptoms, and presenting problem. Following a survey of the population of responses obtained on each variable, a categorization scheme and accompanying coding system was devised. This coding system and description of the categories for ordering the responses was presented above (copies of forms used to code and record demographic data are contained in Appendix F). The results of the analysis and breakdown of these variables will be described in Chapter VII.

Response Categories Developed for Coding and Scoring the Clinical Data on FAP: Step Eleven

The Family Assessment of the Problem Questionnaire (FAP) was described in detail in Chapter IV. FAP is a 12 item questionnaire con-

sisting of a mixture of open-ended questions and questions with a five-point response system (Almost Always, Often, Sometimes, Seldom, Never). Data was collected on FAP for mothers and fathers at three time points (T_1, T_2, T_3). FAP provided information useful in both the description of the population at T_1 and the assessment of outcome.

FAP obtained data on parents' perception of the problem, presenting child, problem type, factors contributing to the problem, person(s) and/or family relationships principally at risk in the problem situation, who or what can change the problem, status of the problem following treatment, preferred child-rearing decision-making style, self-assessment of the frequency of the performance of four family roles--leader, follower, bystander, challenger--and the number of supports/resources available to family members outside the family.

Following the collection of data for husbands and wives, the next step was to devise a comprehensive categorization system for coding and handling the responses to the open-ended questions. The first step required to accomplish this task was to survey the population of responses and to begin to organize the types of responses into general categories. This involved several rereadings of subjects' responses.

This review of the content of responses led to the development of rough categories and definitions of the categories. The categories were refined and, at times, due to new information gained through several reviews of the written material, additional categories were included in the categorization system. When the number of categories and the definitions of categories were fixed, codes were assigned to each cate-

gory. A brief description of each category and the codes used are as follows.

Description of the problem and problem type. Data was collected on mothers' and fathers' individual descriptions of the problem for which they sought counseling. The population of responses obtained on FAP at all three time points (pretest T_1, posttest T_2, T_3 follow-up) were reviewed carefully. Based upon this review, descriptions of the presenting problem were divided into twelve major categories. A brief description of the criteria used to define, identify, and differentiate categories and the codes assigned to each category is as follows:

1. Perceived solely as a child behavior problem characterized by withdrawn/depressive features. When the parent described the presenting problem as principally or solely the child's problem and described the child's behavior using words or phrases that described depression, shyness, insecurity, timidity and so forth, this type of response was assigned 1.

2. Perceived solely as the child's behavior problem characterized by aggressive/acting out features. When the parent described the presenting problem as principally or completely the child's problem and described the child's problem behaviors using words or phrases that described aggressiveness, violent tantrums, acting our and/or lack of satisfactory impulse control and so forth, this type of response was assigned 2.

3. Perceived principally or completely as a parent-child problem characterized as a mixture of withdrawn and aggressive features. When the parent described the presenting problem as principally or completely

a parent-child conflict and then described the child as demonstrating a mixture of withdrawn and aggressive features, this type of response was assigned 3.

4. Perceived mainly as a sibling or children's problem. When the parent described the presenting problem as a conflict or problem occurring principally among the children (e.g., sibling rivalry), this type of response was assigned 4.

5. Marital conflict or problem behavior of spouse. When the parent described the presenting problem principally as a marital problem that was influencing or causing the child problems, or when the parent identified some behavioral problem (e.g., violence) and/or psychological problem (e.g., alcoholism, diagnosed depression) of the spouse as affecting poor interaction with the presenting child, this type of response was assigned 5.

6. Perceived as a family problem. When the parent described the presenting child's problem in relation to additional family problems or as caused by generally conflictual or problematic family relationships and/or family disorganization, this type of response was assigned 6.

7. Perceived the problem as being outside the family's control. When the parent described a problem affecting the family and/or child's behavior that the parent perceived as external to the family and suggested was beyond the family's control, this type of response was assigned 7. Examples of such responses included "job lay-offs," "the onset of chronic physical illness," and "birth of a handicapped child."

8. Perceived the problem as parent's own personal conflict. When

the parent described and identified the problem as stemming almost ex-
clusively from his/her own personal fears, doubts, worries, and/or
inner conflicts or expressed concern over a personal behavior or trait,
this type of response was assigned 8. The idea conveyed in this type
of response was that the parent was aware of and concerned about some
personal problem or troublesome aspect of self for which the parent
wished help. Examples of responses included in this category are "my
jealous rages," "anger toward other people" and "fears about being un-
loved even when I know it doesn't make any sense."

9. Perceived need for family enrichment and/or need for more
child development or parenting information. When the parent did not
describe any particular child behavior problem, but expressed a lack of
adequate child development information or the opinion that the children/
family would benefit from more family education, this type of response
was assigned 9.

It should be noted that this category was reserved for responses
in which no real or serious child, marital or family problem was de-
scribed. In this type of response the idea was conveyed that the
child's, couple's, and family's general well-being was quite healthy.
The general request for more child development information in this type
of response was confined mainly to questions about how to handle rou-
tine child issues and conflicts characteristic of normal phases of
child development. The idea was conveyed that the request for help was
primarily preventative, and that the counseling would enhance an already
satisfying family life.

Three additional categories for classifying problem type were created to accommodate types of responses observed more frequently on FAP at T_2 and T_3. These categories are: perceived as a mixed, two to three generational problem; perceived and described problem as a set of disparate things unassociated with any family member; perceived and described the disappearance of one set of problems and symptoms in one family member only to have a different but equally serious or troublesome set of symptoms and problems appear in another family member. These categories comprise categories ten, eleven, and twelve. The following is a brief description and illustration of each category.

10. Perceived as a mixed, two to three generational problem. When the parent described the problem in transgenerational terms, naming and identifying extended family factors (e.g., family myths) and/or described the interference or overinvolvement of grandparents, this type of response was assigned 10. This type of response was reserved specifically for those responses in which the parent cited a family or child behavior problem but also clearly associated the complexity of the problem to the involvement of extended family. An example of this type of problem is, "My mother constantly picks on my son. And she pampers my younger daughter. My husband and I fight about it all the time. Why can't she love both my children?"

11. Perceived and described the problem as a number of disparate things without associating or attaching them to any family member(s). When the parent presented the problem in the form of a list of generalities (e.g., "negative behavior," "bad feelings") or things and did not explain the connections, this type of response was assigned 11. A re-

sponse that illustrates this category is "Bad feelings, not enough room, anger and disappointments. Just too much of everything." This category was reserved for those type of responses that were vaguely stated and quite ambiguous. Lists of words or short phrases given to describe the problem are characteristic of this response. However, neither the respondent nor family members nor any person, for that matter, were included, depriving the problem description of specificity and, therefore, preventing further classification.

12. Perceived and described the disappearance of problems and symptoms in one family member only to have a different, equally serious set of problems and symptoms appear in another family member. When the parent described a shift in problem manifestation, this type of response was assigned 12. This category was reserved for those limited number of responses in which the parent described a shift in symptoms, or a shift in the identified "trouble" in the family. An example of such a response is "My younger son's fears about going to school and fears about making new friends has subsided somewhat. However, my older son is now lying and picking fights in school."

Factors contributing to the problem. Data was collected on husbands' and wives' perception of the number and types of factors contributing to the identified problem(s).

Number of factors. The following general procedure was followed in obtaining the number of factors identified by the parent. For each separate and clearly distinct person, psychological trait/behavior, family characteristic, circumstance, event and/or idea of causation

listed and described by the parent in the written narrative, one point was assigned. A tally was made and the actual number was entered.

Type of factors. Following several reviews of the population of responses obtained on FAP for this item, a set of 14 categories was established. The categories used for coding the data to this open-ended question on FAP were as follows:

1. Listed no factors or does not know. When the parent did not identify any factors or could not identify a direct cause of the problem, this type of response was assigned 0.

2. Attributed problem primarily to self. When the parent attributed the problem primarily to him/herself (i.e., personal behaviors, attitudes, attributes, beliefs, expectations), this type of response was assigned 1. An example of this type of response is: "My lack of control and not being able to adjust to motherhood is the main factor."

3. Attributed the problem to the identified child or to the children. When the parent identified characteristics of the child (e.g., constitutional/physical characteristics, personality, behaviors, habits) or children as the only or major factors contributing to the problem, without reference to any other factors, this type of response was assigned 2. Two examples of this category drawn from the population of responses obtained on FAP are: "Bobby has problems with resentments toward his sister and has a bad temper." "The children are all belligerent. My son is especially a brat and just won't do what he's told."

4. Attributed problem to a parent-child relationship problem. When the parent attributed the problem to a parent-child conflict/rela-

tionship problem (limited to the nuclear family) wherein the parent described the problem as one of mutual involvement (regardless of which parent was involved), this type of response was assigned 3. Two examples of responses included in this category are: "My daughter seems to have a love-hate relationship with me." "My son is very close to me and finds it hard to take correction from me. I think we are overinvolved."

5. Attributed the problem to the nuclear family. When the parent perceived family interaction as the primary factor contributing to the problem, referring to almost all, if not all family members of the immediate family (excluding extended family), this type of response was assigned 4. An example of a response in this category is: "One very big factor contributing to my son's fears is the atmosphere in our family. We are constantly arguing--every one of us all the time."

6. Attributed problem to an insufficiency or an excess of a state, thing, trait, or emotion without attaching the state, thing, trait, or emotion to anyone in particular or ascribing it to the family in general. While people and/or family members were mentioned, the parent primarily emphasized and identified the major factor as a lack or excess of something. When the parent stressed the lack of or excess of some condition, state, thing, trait, or emotion, with minimal reference to people/family, this type of response was assigned 5. This category was devised to accommodate those responses in which the parent answered by listing several phrases without elaboration. These phrases suggested a list of things either missing or in excess in the family's life.

Some examples of this type of response are: "poor organization," "too much attention," "not enough discipline," "children too close in age," "too much competition," "trouble carrying out decisions to the end."

7. Attributed problem to a lack of a material thing. When the parent primarily attributed the problem to factors outside of personal relationships and specifically to a lack of material goods or economics, this type of response was assigned 6. Examples of responses included in this category are: "not having own home," "job loss," "poor housing," "not enough money."

8. Attributed problem to specific circumstances/events in the family's life history affecting one member and/or the family. When the parent recounted an event in the family's life circumstances or event affecting the well-being of one member, this type of response was assigned 7. Examples of the responses included in this category are: death of a sibling/child, terminal illness of a family member, automobile accident, physical handicap, divorce, effect of a long child custody suit, frequent family moves, and having an only-child.

9. Attributed problem to a combination/mixture of an insufficiency, and/or excess of psychological/interpersonal traits/characteristics, material goods/objects, and family life history events. This category represents the integration or combination of categories six, seven, and eight. This category was developed specifically to accommodate responses that contained all three elements described in the three categories. When the parent attributed the problem to an excess or lack of material goods, family characteristics/traits, and to specific nodal or

toxic events, this response was assigned 8. An example of a typical response assigned to this category is as follows: "My daughter's bad behavior is complicated by lack of money, my husband's back injury, poor communication, and lack of understanding between us as parents, causing favoritism of one child over another."

10. Attributed problem primarily to something that the parent perceived as physically, psychologically (emotionally), and/or symbolically disassociated with and/or outside of the family and the family's here-and-now immediate experience. When the parent identified the problem as stemming from or attributable to something in the parent's own past personal history or family origin experience, some condition of society, some societal attitude/value or parent's relationship with friends, co-workers, outside world, this type of response was assigned 9.

It should be noted that assignment to this category was reserved for those responses in which there was an unquestionable emphasis on the past and on the outside world/outside influences (rather than what is going on inside the family). This type of response usually included lists of things. Examples of items classified as representing this category are: "School strikes," "uncaring school teachers," "too much violence in the world," "child's friends," "babysitter's or day-care staff's influence on child," "all those should's and would's," "what society expects of a good parent," "my upbringing/poor relationship with my parents," and so forth. This category was used when the parent did not identify or focus on specific people/family events or relationships. This category was reserved for those responses where the parent

used nouns signifying lists of general things/conditions of the outside world.

11. Attributed problem primarily to parent's own concern/worry over his/her competence as a parent. When the parent attributed the problem primarly to questions, doubts, worries, or concerns expressed about his/her role as a parent, competence as a parent, or ability to parent with implications or emphasis on the solution of getting more information, knowledge, or parent training, this type of response was assigned 10. This category included responses primarily expressing a need for more education and/or short-term educationally-oriented parent training. A typical response that fits this category is expressed in the following question response given by a parent: "Do we have enough information about child development? I am not sure how we can really understand and deal with our child if we don't know what to expect of children his own age."

12. Attributed problem primarily to the involvement, interference, or contributing factor of extended family. When the parent described the problem as difficulties with his/her own parents or attributed the problem primarily to live-in grandparent(s), grandparent, or extended family intrusion or interference, this type of response was assigned 11. This category is illustrated by the following type of response: "Our problem is with my mother and father. They spoil the children and constantly undermine or override our decisions on how to raise the children. They say yes when we say no."

13. Attributed problem primarily to a marital problem or to an

emotional/behavior problem of the spouse or self. When the parent de-
scribed the problem as stemming primarily from marital difficulties or
identified marital problems as contributing or causing the presenting
child's symptoms/problems, this type of response was assigned 12. Typi-
cal responses falling into this category are: "husband's violence toward
wife," "husband's alcoholism," "wife's jealousy," "poor communication
between husband and wife," "constant bickering of husband and wife
causing son's recent temper tantrums and daughter's overeating and loss
of interest in school."

14. Attributed problem primarily to parent's perception of a need
for more personal growth, personal development, and/or the identifica-
tion of a specific change in his/her personal life circumstances. This
category was reserved for those type of responses that described the
need for or the anticipated positive change in the presenting problem
status produced primarily by or associated with a change in parent's
own personal life. When the parent attributed the problem primarily
to the need for growth, self-enhancement associated with education,
self-actualization, this type of response was assigned 13. Typical
examples of responses included in this category are: "going back to
college," "resuming a career," "fulfilling my own personal ambitions,"
"getting to know and understand myself better."

Person(s) and/or family relationships principally at risk. Data
was collected on mothers' and fathers' identification and description
of the key family member(s)/family relationships involved and/or princi-
pally at risk in the problem. The population of responses obtained on
this item on FAP at T_1, T_2, T_3 were reviewed carefully. The purpose of

surveying the responses was to determine the range of possible family members/family relationships identified. Based upon the knowledge of the range of relationships identified, an appropriate set of relationship categories with corresponding codes (numerical values) was established. A set of 15 relationship categories was established. These categories were as follows:

1. Attributed the problem to no one. When the parent's response stated "no one," "no one in particular," "I don't know," or when the parent appeared to address the reader(s) of the questionnaire and disassociate the problem from self or anyone else (e.g., "I don't know. Things go wrong. You just get tired."), this type of response was assigned 0.

2. Attributed problem almost exclusively to the presenting child. When the parent named only the identified child and/or ascribed to the child complete ownership of the problem (i.e., the parent perceived the problem as contained within the child's personal system), this type of response was assigned 1.

3. Attributed involvement in the problem exclusively or principally to the parent (self). When the parent names only him/herself or assumed complete ownership of the problem, ascribing the problem exclusively to aspects of the self system, this type of response was assigned 2.

4. Names self and the identified child. When the parent named him/herself in conjunction with the identified child or perceived the problematic relationship to be exclusively between self and the presenting child, this type of response was assigned 3.

5. Identified the marital subsystem/marital relationship as main-
ly or exclusively involved in the problem. When the parent perceived
the key or primary relationship involved in the problem as the marital
relationship, this type of response was assigned 4. This relationship
category was specifically designed for those responses in which the
husband-wife relationship was the only relationship named. This cate-
gory was differentiated from those types of responses in which the par-
ent identified the mother-father subsystem or parental roles/relation-
ship as the key relationship involved in the problem.

6. Identified the children or sibling subsystem as mainly or ex-
clusively involved in the problem. When the parent named the other
children in the family or identified the problem relationships as con-
tained mainly or exclusively among the children (i.e., siblings of the
identified child, or interaction between siblings and the identified
child), this type of response was assigned 5.

7. Identified the whole family. When the parent used the family
"we" and identified the whole family/family interactions as involved in
the problem situation, this type of response was assigned 6. This cate-
gory was reserved for responses that identified the nuclear family or
all members of the immediate family household. This category did not
extend to inclusion or mention of extended family. A separate category
was designed for responses in which extended family member involvement
was mentioned.

8. Identified spouse (other parent) and identified child. When
the parent perceived the problem participants to be his/her spouse and

the identified child, this type of response was assigned 7.

9. Identified extended family as major participants in the problem. When the parent names grandparents, in-laws, and/or other relatives (e.g., nieces, nephews) as principal agents in the problem and as primarily involved in contributing to the problem, this type of response was assigned 8.

10. Perceived both parents with the identified child and/or some but not all the children. When the parent names self and spouse as parents involved with the identified child to be the major or exclusive participants or when the parent identified a parent-parent-identified child-sibling subset (i.e., some of their children) as involved, this type of response was assigned 9. This category was designed to differentiate responses that named/listed the family from those responses in which the involvement was limited to the parents and a specific subgroup of children.

11. Identified other parent/spouse to be exclusively involved. When the parent identified his/her spouse as solely involved in the problem and/or perceived the problem as self-contained within aspects of the personal system of the other parent/spouse (e.g., alcoholism), this type of response was assigned 10.

12. Identified both parents as major or exclusive participants. When the parent named him/herself and spouse in the context of the parental relationship/roles as the sole or exclusive participants involved in the problem, this type of response was assigned 11. This category was devised to differentiate between identification of the

marital relationship at risk (category five) and identification of problems in the parental relationship.

13. Identified people outside the family or groups outside the family as the major or exclusive participants. When the parent only mentioned non-family members and/or groups outside the family or cited "society" or some societal condition (e.g., discrimination), societal institutions (e.g., school, social welfare), this type of response was assigned 12.

14. Identified both the family and social groups/institutions as key participants. When the parent named the whole family or parents (self and spouse) in conjunction with some societal group/institution/ agency (e.g., Church, social welfare, parents of special needs children) as principally involved, this type of response was assigned 13.

15. Identified things, psychological and/or interpersonal traits without any connection/association with people or relationships. When the parent simply listed things or described a set of characteristics without reference or attachment to specific persons and/or relationship systems (i.e., personal, interpersonal, family), this type of response was assigned 14.

Focus of change. Data was collected separately for men and women on FAP on parent's perception of the principal focus of change at three time points, T_1 pretreatment, T_2 posttreatment, and T_3 follow-up. Survey of the range and breadth of responses to this open-ended item on FAP led to the development of a 16 category system. This 16 category system contains categories identical to those described in Factors Con-

tributing to the Problem and Person(s) and/or Family Relationships In-
volved as well as categories defined specifically for Focus of Change.

The 16 categories devised for coding responses to this item, Focus
of Change, were as follows:

1. Did not know. When the parent stated "I don't know" or could
not determine any specific focus for directing efforts to alter the
problem situation, this type of response was assigned 0.

2. No one or nothing can change the problem. When the parent
stated that "no one" or "nothing can change the problem" or "I can't
see how anything or anyone can change what is happening," this type of
response was assigned 1.

3. Self needed to change. When the parent stated that he/she
needed to change self or something about self (e.g., attitudes, beliefs,
behaviors, expectations), this type of response was assigned 2.

4. Identified child needed to change. When the parent stated
that the identified child needed to change or that something about the
identified child needed to be changed (e.g., attitudes, behaviors, per-
sonality, physical appearance), this type of response was assigned 3.

5. Spouse needed to change. When the parent stated that the
spouse needed to change him/herself (e.g., personal characteristics,
traits), how the spouse related to the identified child (e.g., behav-
iors, attitudes, expectations, beliefs, perceptions), and/or how spouse
treated the respondent (marital partner), this type of response was as-
signed 4.

6. Self in relationship with the identified child needed to change.

When the parent who was responding to this item identified that her/ himself needed to change in relation to the child or that their parent-child relationship needed to change, this type of response was assigned 5.

7. Family unit needed to change. When the parent identified that the family unit (nuclear family/immediate family household members) needed to change, this type of response was assigned 6.

8. Changes that occurred naturally or changes that occurred out-side of the parent's perception of his/her personal control. When the parent stated a need for change in things outside the self or family (e.g., bad neighborhood), outside of personal and/or family control (e.g., luck), and/or changes occurring naturally and independently of parent (e.g., the child growing up and growing out of it) and/or changes in the family structure (e.g., having a baby), this type of response was assigned 7.

9. An acquisition of increase in desired personal, interpersonal and/or family attributes or traits without owning these attributes/ traits or attaching them to a specific person, persons or relationship or plan of action. When parents listed traits, attributes, desired personal, interpersonal attributes (e.g., "more love," "more independence," "more patience") without linking these traits to personal ownership or associating their insufficiency or absence with any person or family relationship, this type of response was assigned 8.

10. Gain more knowledge/information about child growth and development, personal/adult development and/or family dynamics. When the parent ascribed the focus of change to a need for more education (informa-

tion, knowledge in the area of child growth and development and/or personal growth/enrichment and/or family enrichment), this type of response was assigned 9. This category was designed to differentiate between responses that identified the clear need for education from those responses that expressed a need for more therapeutically-oriented solutions for promoting change.

11. Both parents needed to change. When the parent stated that the parent-parent relationship needed to change or that the parents needed to change their marital relationship, this type of response was assigned 10.

12. Counseling/therapy or continued counseling/therapy. When the parent specifically identified the need for counseling/therapy as the means for resolving/changing the problem or expressed the wish for more counseling or continued counseling, or when the parent associated the process of change with professional, objective help from an outside person (e.g., "Talking out our problems with a trained, impartial third part"), or associated the process of change with remedial or rehabilitative help for the identified child (e.g., behavior modification school program for disruptive children, art therapy), this type of response was assigned 11.

13. The problem has been resolved, no more help is needed, there is no problem. This special category was designed to accommodate a very small number of respondents who felt that there was no real problem or that the problem was resolved, or who were unable to recognize the problem at that time. Responses falling into this category were assigned 12.

14. Extended family needed to change. When the parent primarily focused on the need for change in the extended family (e.g., grandparents, in-laws) or emphasized change in extended family (attitudes, values, behavior, expectations) in conjunction with the perceived need for changes in themselves (attitudes, values, behaviors, expectations), this type of response was assigned 13.

15. Need for combined help and changes in the parent(s)-identified child-teacher relationship. When the parent identified the need for combined efforts for change between the parents and the child and the teacher/school staff, this type of response was assigned 14.

16. Both parents in relation to the identified child. When the parent focused the need for change primarily and principally on the need for changes in parent-child relationships (mother-child, father-child) and on how the parents and child function as a three-person parent-child system, this type of response was assigned 15.

Family member influence. Data was collected on FAP separately for men and women on how each subject assessed the influence hierarchy in the family. Respondents were asked to identify who they perceived in the family as the most influential family member. Based upon a review of the data collected, the following relationship identification coding system was devised. The set of categories used represents a list and summary of the types and range of responses obtained on FAP for this itme. The relationship categories and codes assigned to each was as follows:

1. No one was assigned 0.

2. Father assigned 1.

3. Mother assigned 2.

4. Identified child assigned 3.

5. Other sibling or siblings assigned 4.

6. Maternal or paternal grandfather, father-in-law assigned 5.

7. Maternal or paternal grandmother, mother-in-law assigned 6.

8. Uncle, parent's brother, brother-in-law assigned 7.

9. Aunt, parent's sister, sister-in-law assigned 8.

10. Male companion assigned 9.

11. The children collectively assigned 10.

12. Both parents together equally assigned 11.

Frequency of performance of initiator, follower, challenger/opposer and bystander roles. Coding of this data was straightforward. The definitions and description of each of the four roles was presented in Chapter III. These descriptions form the basis for defining and differentiating each category. The response system provided for self-assessment of each role was a five-point response system. The response system used was Almost Always assigned 5, Often assigned 4, Sometimes assigned 3, Seldom assigned 2, and Never assigned 1. Details for scoring, the direction of scoring, and the meaning or interpretation associated with a particular type of score was discussed in Chapter V.

Supports/resources outside the family. Data was collected for men and women on FAP on the number of available resources/supports outside the family. Preparation of data and plans for data analysis of this item was limited to the number of outside resources/supports each respondent identified. The actual number of outside resources/supports

listed on FAP was entered on the FAP scoring form. No plans were made at this time to analyze the types/kinds of outside resources/supports men and women and families (couples) identified.

Status of the problem, problem types, and direction of change.
Data was collected separately for men and women at two time points (T_2 and T_3) to assess parental perception of the status of the problem, direction of change, and the appearance/identification of new problems. Status of the problem was divided into two categories. Each respondent was asked a series of questions. The first question was whether the problem for which the respondent initially sought therapy had changed. Two response categories were provided for the coding of parent's perception of problem status. These categories and the codes assigned to each were as follows:

1. When the parent indicated that the problem had not changed substantially or significantly by stating "No, the problem has not changed," this type of response was assigned 1.

2. When the parent indicated that the problem had changed by clearly stating "Yes, the problem had changed," this type of response was assigned 2.

The next phase of preparing the data on problem status/problem outcome focused on the development of a categorization system for coding the direction of change. The three possibilities identified for analyzing this item of outcome data were: the problem improved, the problem remained the same, the problem worsened.

1. When the parent stated that the problem had worsened or had not been resolved satisfactorily either with or without therapy, this

type of response was assigned 1.

2. When the parent stated that the problem had not changed significantly, that the problem still remained the same, and/or had neither worsened nor improved with or without therapy, this type of response was assigned 2.

3. When the parent stated that the problem either had been resolved or had improved considerably as a result of family therapy or stated that the problem had been worked through without therapy, this type of response was assigned 3.

The third and fourth items categorized and coded for analysis in relation to problem outcome were the appearance of new problems and problem type. Data on the appearance/identification of new problems was divided into two broad categories: no new problems and the appearance of new problems.

1. When the parent stated that there were no new problems, regardless of the status of the problem for which the family sought therapy initially, this type of response was assigned 1. The absence or presence of new problems was determined independently of the status assigned to the problem for which the family/parent had initially sought help.

2. When the parent stated and/or described concern for the onset of a new individual, marital and/or family problem/symptom, this type of response was assigned 2.

The fourth item, type of new problem(s) was categorized and coded using the same system designed for scoring the initial problem descrip-

tion. The coding and categorization system for scoring problem type was described above.

It should be noted that two general rules were applied to the treatment and handling of the data obtained on FAP items. Both rules were designed to deal specifically with issues that arose in relation to responses given to open-ended questions. The two rules employed were as follows:

1. In cases where two complete answers were given to the same question and/or when these answers were contradictory, the first answer was categorized and coded using the appropriate system.

2. In cases where the parent responded by stating "I don't know" and then proceeded to list guesses or hunches without clear assertion (e.g., "I really don't know. Maybe this, maybe that. . . ."), this type of response was coded as 0.

Treatment and Handling of the Data on FCE: Step Twelve

Data was collected for men and women separately on the Family Counseling Evaluation (FCE) following family therapy. FCE is a 15 item questionnaire that measures parental response to counseling/therapy based on five main variables. These variables are (1) evaluation of self (perceived degree of insight/change); (2) evaluation in changes of relationship with presenting child and children; (3) evaluation of changes in relationship with spouse, ex-spouse and/or male companion; (4) evaluation of changes in relationship(s) with extended family; (5) evaluation of the counseling experience and problem outcome. With the exception of one open-ended question (item 13), FCE uses a four-

point response system.

Summary and Conclusions

In this chapter, the series of steps that led up to the final model used for the analysis of data and the assessment of outcome in this study was presented. However, at this point in the discussion, one obvious question that the reader might be raising is: Why spend so much time documenting such detailed procedures on the preparation and handling (e.g., scoring) of the data? Why not simply go ahead and present the results of the statistical tests performed on the experimental data and relate these results to the clinical theory proposed in this study?

The answers to these questions lie in a specific point of view on the research process held by a number of critics of family therapy research and in the position taken by this investigator. This position is as follows: Each phase in the series of steps that comprise the conduct of the experiment affects the determined outcome and, therefore, contains important information that relates to the meaning of the results. Viewed within this perspective, no one phase of the research is without its insight or lesson to be learned for the clinician and researcher. All shed light on outcome. Each aspect of the research-- from the conceptualization of the study to the results reflected in, for example, a table of means or a single F statistic--contributes to the total picture of outcome.

For this purpose, considerable time and attention was given in this chapter to the following five major points: The first major sec-

tion of this chapter involved the reexamination of the major points of the design, objectives, and procedures originally proposed in this study. For an in-depth treatment, the reader is referred to Chapter V. However, to reiterate, the original design proposed was a pre-post randomized two-group design (n=40). The three major objectives of the proposed study were: (1) to test the effects of short-term child-centered structural-analytic family therapy on families with a presenting-child problem; (2) to test the concurrent validity or degree of association between family assessment and child behavior assessment instruments used in this study; (3) to demonstrate the clinical utility of structural-analytic family therapy as a treatment model with families with a presenting-child problem. Accordingly, this investigation was divided into two separate studies: an experimental study with its related hypotheses and a correlation study with its related hypotheses, and into two perspectives on the data: clinical and statistical.

The second major point covered in this chapter was the documentation of variations in the conduct of the study noted upon completion of the experiment. The three major changes that occurred in the proposed design were: (1) pre- and posttesting of the entire population of families, (2) the formulation of a second treatment group, and (3) the shift to the analysis of group outcome using individual family member scores.

The third major point addressed in this chapter involved the reassessment of several important research questions and methods of analysis proposed in the family therapy outcome literature. This involved

the rethinking of several basic research problems facing family therapy outcome studies combined with the newly acquired knowledge of conducting research gained by this investigator upon completion of the pretest-treatment-posttest phase of the study. The result was that the academic debates on family therapy evaluation characteristic of the current literature took on more immediate, pragmatic meaning as real research problems to solve. The two major questions raised were: (1) the question of the compatibility of group design with the concept of clinical outcome; and (2) the question of the compatibility of two different perspectives--clinical and statistical--and how to incorporate both sets of information into an informed knowledge about outcome. The conclusion drawn in this section was to regard each as a complementary data source and to work into the model of analysis the merits of each perspective on the data.

The fourth major issue addressed in this chapter involved the development of a new design, set of procedures, and model of analysis used for approaching the problem of the analysis. This involved the description of the new design that had emerged following the experimental and data collection phases of this research. In short, the new design now evolved into a pretest-posttest-follow-up randomized three-group design. The level of analysis on group outcome scores now shifted to use of individual family member scores in the majority of cases with the exception of some instances where the husband-wife congruence scores (i.e., mother-father pairs) were used.

The final section of this chapter was devoted to the description of the procedures used for coding and/or scoring the data on the family

instruments. This section focused on the explanation of the methods and rationale used for coding and/or scoring the four standard self-report measures (FAD, CBCL, FUI REAL, FUI IDEAL). Notations on any changes that occurred in scoring of the instruments (i.e., deviations from the instrument developers' instructions) were discussed.

In addition, the procedures used for organizing, sorting, coding, and scoring the data obtained on the two-family questionnaires (FAP and FCE) specifically developed for this study as well as the data obtained on family demographics were described. As the reader will recall, the identification of 30 important family demographic variables and the development of the Family Assessment of the Problem (FAP) and the Family Counseling Evaluation (FCE) questionnaries were originally designed to act as clinical tools and additional sources of clinical data that would be helpful in understanding the families. Both FAP and FCE obtained families' responses (e.g., attitudes and opinions) on aspects of the presenting problem (e.g., theory of causation, factors contributing to the problem), and family life (e.g., flexibility of family member roles, child-rearing decision-making style) that were not covered in the other four standard measures. In addition to obtaining other types of information about the families, FAP and FCE elicited a different kind of data (i.e., a different perspective on the data). In contrast to the fixed set of response categories used on FAD, CBCL, FUI REAL and FUI IDEAL to obtain data on perceived family and child behavior, FAP and, at times, FCE elicited from families more detailed, subjective, individualized answers to open-ended questions.

In summary, all three data sources--FAP, FCE, and data on family demographics--provided invaluable information about the families, the effect of the treatment, and the families' evaluations of the overall family therapy experience. The personal impressions and first-hand answers provided by the participating families lent important information that enhanced both the description of the population and enriched the total picture of outcome derived from this study.

C H A P T E R   V I I
RESULTS OF THE EXPERIMENTAL STUDY

In the preceding chapter, the reader was presented with the rationale and methods used to categorize, code, and score the raw data. The purpose of the preceding chapter was to provide the necessary foundation for an informed discussion of the results. Chapter VI was intended to serve as a preface to an integrated analysis and interpretation of outcome--a view that unites clinical data with statistical findings.

The remaining three chapters of this dissertation will focus on different aspects of the results. In this chapter, the emphasis will be on experimental findings. In Chapter VIII, the emphasis will be on instrument intercorrelations. In Chapter IX, attention will be given to specific recommendations for future research based on a review of findings obtained in this study.

Breakdown of the Experimental Study

In this chapter, the assessment of outcome will be confined to the analysis of data viewed specifically within the context of the proposed experimental study. Therefore, the presentation of results will be limited to a discussion of the experimental study's objectives and its related hypotheses. For clarity of presentation, the results of the experimental study will be divided into seven major sections. The titles and descriptions of these sections are as follows:

Section one, description of the overall population and the three randomly selected sample groups. This section will focus on reporting

the results of the analysis of data collected on all families (N=65) on family demographics, characteristics of the presenting child and presenting problem type. The overall population will be described. Comparisons will also be made among the treatment and two control groups on these variables. Discussion and description of group similarities as well as group differences observed at T_1 will be made on the basis of percentages, medians and, at times, means.

Section two, results of the series of chi-square analyses conducted on these same variables (family demographics, characteristics of the presenting child, problem type) at T_1. A separate, brief section will be devoted to reporting these results. This section will go beyond the above description and report on the breakdown of, for example, family income levels across the overall population as well as within and between groups. The results of the statistical tests of the null hypothesis of no differences on the distribution of these important demographic and clinical variables will be presented. In addition, implications of the results of the chi-square test findings will be explored in relation to the applicability of other statistical tests (e.g., ANOVAS, MANOVAS) used later in the analysis.

Section three, results of the experimental study. This brief section will preface the reports on the separate analyses conducted on men and on women. This section will focus mainly on the reasons for selecting MANOVAS, in some instances, and ANOVAS in other instances. In addition, the decision to analyze group variances will be discussed, including use of univariate homogeneity of variance tests. The general format

used for organizing and reporting the results of the series of analyses conducted separately on women and men will also be described.

Section four, results of the analyses on women. The results of the separate MANOVAS conducted on the data on women collected at all three assessment points (T_1, T_2, gains) on all four standardized instruments (FAD, CBCL, FUI REAL, FUI IDEAL) and second-level factors will be presented. Each of the three assessment points will be discussed separately on all four instruments. Next, the results of the univariate homogeneity of variance tests conducted on all instrument subscales and second-level factors will be presented for women. Once again, each assessment point will be presented and treated separately.

Section five, results of the analyses on men. The results of the separate ANOVAS conducted on the data on men on all four instruments and second-level factors at all three time points will be presented. These results will be followed by the discussion and presentation of the results of the univariate homogeneity of variance tests conducted for men on all instrument subscales and second-level factors at all three time points.

Section six, results of the analyses on the family unit level. This section will briefly address the question of the assessment of outcome on the family unit level. The results of the separate MANOVAS and univariate homogeneity of variance tests conducted on mother-father pairs (mother-father congruence scores) on CBCL, FUI REAL and FUI IDEAL will be discussed.

Section seven, summary and conclusions. This section will focus on summarizing the results of the experimental study. Statistically-

significant differences as well as trends suggested in the data will be explored. The purpose of this section will be to integrate the salient facts about families into a general picture and to relate the description of the population under study to the results obtained on the experimental outcome.

Description of the Population

Subjects

The population under study was families of young children who sought family therapy. The population consisted of 65 families with a presenting child problem. The 65 families were comprised of 65 mothers, 54 fathers, four male live-in companions, and 14 ex-husbands for a total of 137 subjects. The 65 families consisted of 141 children.

Of the 141 children, 82 were male (58%) and 59 were female (42%). Of the total number of primary-identified presenting children (one child per family, N=65), 38 were male (58%) and 27 were female (42%).

When a second tally was made to identify the collection of additional data on children with problems other than the primary/initial presenting child, the overall number of presenting children increased to 74. This was due to seven families reporting two children with presenting problems and one family reporting three children with presenting problems. However, it should be reiterated that unless otherwise specified, analyses of the presenting child problem were limited to data obtained on the first child for whom the parent(s) initially sought help.

Family Demographics/Family Background Information
at T₁: Description of the Overall Population

Data was collected separately at T_1 for mothers (N=65) and for
fathers (i.e., fathers, ex-husbands, adult male live-in companions;
N=72) on approximately 30 family demographic/family background variables.
The data on the 30 demographic/background variables were organized into
five broad subgroups. The first subgroup was labeled "mothers' back-
ground and personal characteristics." This subgroup included eight
variables. These variables were age, occupation, work status, educa-
tion, marital status, rank in family of origin, religion, and ethnic
background. The second subgroup was labeled "fathers' background and
personal characteristics." This subgroup included eight variables.
These variables were age, occupation, work status, education, marital
status, rank in family of origin, religion, and ethnic background. The
third subgroup was labeled "family unit characteristics." This sub-
group included six variables. These variables were family income level,
family composition/membership, (i.e., family member relationships,
ages), family size, number of children, family type, and family ethnic
background. The fourth subgroup was labeled "characteristics of the
presenting child or children and presenting problem type(s)." This
subgroup included four variables. These variables were age, sex, grade
level, and problem type(s). The fifth subgroup was labeled "ex-husband's
background and personal characteristics." This subgroup included four
variables. These variables were age, occupation, education, and ethnic
background. A description of the results obtained from analyses of

data on these 30 variables is presented in the following sections.

Mothers' Backgrounds and Personal Characteristics

The following is a description of the background and personal characteristics of the population of mothers (N=65) who participated in the study.

Age. The mean age of the population of mothers in the study was 33 years with a standard deviation of approximately four years. The age span for mothers was approximately 22 years with a minimum age of 23 years and a maximum age of 45 years. The distribution of the population of ages was trimodal. Three ages appeared equally as frequent: 33 years (8 cases), 34 years (8 cases), and 35 years (8 cases).

Sample medians for the three subgroups (experimental group, control group one, and control group two) reflected a similar pattern. The experimental group median age for mothers was 33 years. The control group one median age for mothers was 34-35 years. The control group two median age for mothers was 33 years.

Occupation. The most frequent occupation reported by mothers was housewife/homemaker (38 mothers, 58.5%). The second and third most frequently reported occupations were clerical/secretarial work (12 mothers, 18.5%), and teachers/college professors (7 mothers, 10.8%). Other occupations reported were nursing (3 mothers, 4.6%), factory or manual work (3 mothers, 4.6%), and beauticians/cosmetologists (2 mothers, 3.1%). The most frequent occupation for the three subgroups was also housewife/homemaker (experimental group, 15 mothers, 75.0%; control group one, 9 mothers, 45.0%; control group two, 14 mothers, 56.0%).

Work status. The percentages on mothers' work status at T_1 for the population of mothers were as follows: 58.5% of the total population (38 mothers) were unemployed at T_1; 24.6% of the population (16 mothers) were employed parttime; 16.9% of the population (11 mothers) worked full-time. The most frequently reported work status for the three subgroups was also unemployment (experimental group, 15 mothers, 75.0%; control group one, 9 mothers, 45.0%; control group two, 14 mothers, 56.0%).

Education. The most frequent education level in the population of mothers was high school graduate. The percentages on levels of education reported for the population of mothers, arranged in decreasing order, were as follows: 40.0% (26 mothers) were high school graduates; 27.7% (18 mothers) earned an associates degree or the equivalent of two years of college; 13.8% (9 mothers) earned a bachelor's degree; 10.8% (7 mothers) earned a master's degree; 4.6% (3 mothers) had not completed high school; 3.1% (2 mothers) earned doctorate degrees. Descriptive statistics on the three subgroups reflected this pattern with the most typical education level being high school graduate (experimental group, 7 mothers, 35.0%; control group one, 9 mothers, 45.0%; control group two, 10 mothers, 40.0%).

Rank in family of origin. Of the population of mothers, 53.8% (35 mothers) were firstborn, oldest, or only-children in their family of origin; 26.2% (17 mothers) were the third or youngest child in their family of origin; and 20.0% (13 mothers were the second-born or middle child in their family of origin. The most frequently reported rank in

family of origin for the population of mothers was firstborn, oldest, or only-child.

Sample statistics on the three subgroups reflect this pattern. The most frequent birth order reported consistently across the three groups was also firstborn, oldest, or only-child (experimental group, 10 mothers, 50.0%; control group one, 14 mothers, 70.0%; control group two, 11 mothers, 44.0%).

Marital status. The most frequent marital status reported for the population of mothers was first marriage (47 mothers, 72.3%). The second and third most frequent marital statuses reported for the population of mothers were divorced (6 mothers, 9.2%) and separated (5 mothers, 7.7%). Other percentages for marital statuses were divorced and remarried (4 mothers, 6.2%), divorced and living together (2 mothers, 3.1%), and never married (1 mother, 1.5%). Statistics on the three subgroups roughly reflected this pattern with first marriages as the most frequent marital status (experimental group, 12 mothers, 60.6%; control group one, 18 mothers, 90.0%; control group two, 17 mothers, 68.0%).

Religion. The following is a breakdown of religious affiliations reported for the population of mothers. 70.8% of the population (46 mothers) were Catholic; 23.1% of the population (15 mothers) were Protestants; 4.6% of the population (3 mothers) were Hebrew/Jews; and 1.5% of the population (1 mother) was Bahai. The percentages reported for religious affiliations for the three subgroups approximated the population pattern. The most frequent religious affiliation for all three subgroups was Catholic (experimental group, 13 mothers, 65.0%;

control group one, 13 mothers, 65.0%; control group two, 20 mothers, 80.0%).

Ethnic background. The following is a description of the percentages of ethnic backgrounds/cultural orientations reported by the population of mothers. The percentages are arranged in descending order, beginning with the largest percentage, the most typical response: 32.3% of the population (21 mothers) were Irish/American; 26.2% of the population (17 mothers) were Italian/American; 15.4% of the population (10 mothers) were English/American; 12.3% of the population (8 mothers) were French/American; 6.2% of the population (4 mothers) were Portuguese/American; 3.1% of the population (2 mothers) were German/American; 3.1% of the population (2 mothers) were Slavic/American; and 1.5% of the population (1 mother) was Cape Verdian. Across all three subgroups the greatest percentages and therefore the most typical cultural orientation was also Irish/American (experimental group, 6 mothers, 30.0%; control group one, 5 mothers, 25.0%; control group two, 10 mothers, 40.0%).

Fathers' Backgrounds and Personal Characteristics

The following is a description of the background and personal characteristics of the population of fathers (N=58) who participated in the study. It should be noted that the N for fathers (N=58) reflects the combined sums of fathers (n=54) and live-in male companions (n=4).

Age. The mean age for the population of fathers at T_1 was 35 years with a standard deviation of approximately five and one-half years. The sample mean for the experimental group fathers was 37 years

(n=17). The sample mean for control group one fathers was 35 1/2 years (n=20). The sample mean for the control group two fathers was 34 1/2 years (n=21).

Occupation. Type of work for the population of fathers at T_1 was distributed as follows: 21.5% of the population of fathers (14 fathers) reported having maintenance, janitorial, or factory jobs; 18.5% of the population (12 fathers) reported skilled trade jobs (e.g., mechanic, tool and die maker); 18.5% of the population (12 fathers) reported white-collar managerial jobs, civil service, social service or supervisory positions; 13.8% (9 fathers) reported jobs requiring technical training (e.g., computer programmer); 10.8% of the population(7 fathers) were unemployed or on temporary disability; 10.8% of the population (7 fathers) were attorneys, medical doctors, certified public accountants, and college professors; 6.2% of the population (4 fathers) were self-employed businessmen.

The percentages on subgroup distributions of occupations did not follow exactly the population pattern. Each subgroup reflected a slightly different pattern. In the experimental group, there were two, equally typical occupations. The two most frequent occupations were maintenance/janitorial/factory (4 fathers, 20.0%) and managerial/social service/civil service supervisors (4 fathers, 20.0%). In the control group one sample of fathers, the largest percentage of fathers' occupations was also maintenance (8 fathers, 40.0%) and the second largest percentage was mechanics (6 fathers, 30.0%). However, in control group two, the largest percentage of fathers was doctors, lawyers, and ac-

countants (6 fathers, 24.0%) and the second largest percentage of

fathers' occupations was managerial/civil service/social service super-

visors (5 fathers, 20.0%).

The precentages of unemployed fathers at T_1 were also worth noting.

15.0% of the experimental group (3 fathers) were unemployed at T_1. None

of the fathers in control group one were unemployed. 16.0% of control

group two (4 fathers) were unemployed.

Work status. This variable overlaps with data obtained on fathers'

occupation. Responses to this item, fathers' work status at T_1, acted

as a check to the percentages of responses on unemployment obtained on

family demographics.

The population percentages of fathers' work status at T_1 did match

with the percentage of unemployment obtained on "occupations"/"type of

work" at T_1. The following were the population percentages for work

statuses at T_1: 86.2% (56 fathers) were employed full-time at T_1; 10.8%

(7 fathers) were unemployed at T_1; 3.1% (2 fathers) were working part-

time. The statistics on work statuses for the three subgroups conformed

with this population pattern.

Marital status. 79.3% of the population (46 fathers) reported

first marriages as their marital status. 8.6% of the population (5

fathers) were divorced and remarried. 5.2% of the population (3 fathers)

were separated. 3.4% of the population (2 fathers) were divorced and

another 3.4% of the fathers were divorced and living with someone.

All three subsamples reported first marriages as the highest per-

centage (experimental group, 70.6%, 12 fathers; control group one, 17

fathers, 85.0%; control group two, 17 fathers, 81.0%). The subsamples varied somewhat in the distributions of other marital statuses. The main differences were briefly as follows.

In the experimental group, as stated earlier, the most frequent response was first marriage (70.6%, 12 fathers). Other percentages were as follows: 0% separated; 5.9% (1 father) divorced; 17.6% (3 fathers) divorced and remarried; 5.9% (1 father) divorced and living with someone. In control group one, the most typical response was also first marriage (85.0%, 17 fathers). Other responses in order of higher to lower percentages were: 0% separated; 5.0% (1 father) divorced; 10.0% (2 fathers) divorced and remarried; 0% divorced and living with someone. In control group two, once again, the most typical response was first marriage (81.0%, 17 fathers). Other percentages in descending order were: 14.3% (3 fathers) separated; 4.8% (1 father) divorced and living with someone; 0% divorced; 0% divorced and remarried.

Education. Data was collected on the population of fathers on education level at T_1. The most typical response on education level for the population of fathers was high school graduate (32.8%, 19 fathers). This held true also for the three subgroups (experimental group, 29.4%, 5 fathers; control group one, 40.0%, 8 fathers; control group two, 28.6%, 6 fathers).

Other population percentages were: 24.1% (14 fathers) bachelor's degree; 17.2% (10 fathers) master's degree; 13.8% (8 fathers) associates degree; 6.9% (4 fathers) doctorates/M.D.'s; 5.2% (3 fathers) no high school diploma.

The three subsamples followed similar trends. There was only one slight difference. Control group two had a slightly higher group median than the other two groups (experimental group median and control group one median for education level fell within the associates degree category as did the population median). However, the control group two median fell within the bachelor's degree level. In addition, control group two contained all of the subjects with doctorates.

Rank in family of origin. Data was collected on the population of fathers (N=40) on rank in family of origin. The population percentages on firstborn, middle child, and youngest child as rank in family of origin were as follows: the most typical response, 52.5% (21 fathers) was firstborn or only-child; 27.5% (11 fathers) were youngest or third-born children; 20.0% (8 fathers) were middle children or second-born in their family of origin.

The three subsamples followed the same general trend with some slight variation. In the experimental group, the pattern was as follows: the most typical birth order, 64.3% (9 fathers) was firstborn or only-children; 21.4% (3 fathers) were middle or second-born children; 14.3% (2 fathers) were the youngest or third-born children in their family of origin. In control group one, there were two equally frequent birth orders: 41.7% (5 fathers) were firstborn or only-children and 41.5% (5 fathers) were the youngest or third-born. Only 16.7% (2 fathers) were middle or second-born children. In control group two, once again, the most typical birth order was firstborn or only-child (50.0%, 7 fathers). An additional 28.6% (4 fathers) were the youngest or third-

born and 20.0% (8 fathers) were the middle or second-born child in their family of origin.

Religion. Data was collected on fathers' religion at T_1. The breakdown of religious affiliations among the population of fathers was as follows: 60.3% (35 fathers) were Catholic; 34.5% (20 fathers) were Protestant; 3.4% (2 fathers) were Jewish; 1.7% (1 father) was Bahai. The subsample followed the same general trends as the population. In the experimental group, 64.7% (11 fathers) were Catholic; 29.4% (5 fathers) were Protestant; 0% were Jewish; 5.9% (1 father) was Bahai. In control group one, 55.0% (11 fathers) were Catholic; 45.0% (9 fathers) were Protestant; 0% were Jewish; 0% Other. In control group two, 61.9% (13 fathers) were Catholic; 28.6% (6 fathers) were Protestant; 9.5% (2 fathers) were Jewish; 0% were Other.

Ethnic background. Data was collected on the population of fathers on reported ethnic backgrounds. The results were as follows: For the population, ethnic backgrounds were distributed in the following way: 32.8% (19 fathers) were English/American; 22.4% (13 fathers) were Italian/American; 13.8% (8 fathers) were French/American; 10.3% (6 fathers) were Irish/American; 5.2% (3 fathers) were German/American; 3.4% (2 fathers) were Portuguese/American; 3.4% (2 fathers) were Slavic/American; 3.4% (2 fathers) were Hispanic; 1.7% (1 father) was Armenian/American; 1.7% (1 father) was Polish/American; 1.7% (1 father) was Cape Verdian. There were only very slight variations in this trend in percentages reported for the three subsamples.

Family Unit Characteristics

The following is a description of the family unit characteristics of the population of families (N=65) at T_1.

Family income level. Data was collected at T_1 separately for mothers and fathers for the population of families on family income level. The results of the analysis of the data obtained were as follows: the most typical income level for the population of families fell within $25,000 - $40,000 (40.0%, 26 families). The representation of other income levels in the population, arranged in decreasing order, were as follows: 18.5% (12 families) reported a family income of $20,000 - $24,999; 16.9% (11 families) reported a family income of $15,000 - $19,999. There was an equal number of families reporting a $0 - $4,999 family income (7.7%, 5 families) and a $10,000 - $14,999 family income (7.7%, 5 families). There was also an equal number of families who reported incomes of $5,000 - $9,999 (4.6%, 3 families) and over $40,000 (4.6%, 3 families). The median income for the population fell within the $20,000 - $24,999 level, slightly lower than the largest percentage income category ($25,000 - $40,000).

The three subsamples had as the most frequently reported income level the same level as the population (i.e., $25,000 - $40,000) and the same median category ($20,000 - $24,999). Observation of the three subsample statistics suggested that the experimental group and control group two resembled closely the population distribution of incomes. However, control group one appeared slightly different. Control group one had a less wider range in the distribution of incomes. In control group one, all of the family incomes (n=20) were concentrated between

$10,000 and $40,000, with no representation of extremely poor (0 -
$9,999) or highly prosperous (over $40,000) families. However, the ex-
perimental group and control group two contained a wider range and more
evenly distributed levels of incomes. All income levels were represent-
ed.

Family composition/family membership. Data was collected at T_1 on
the type(s) and range of relationships that composed family households.
The following is a description of the percentages of the types of rela-
tionships represented in the population of family households (N=65).
The total number of persons identified as members of family households
was 271. Of the 271 persons, 19.2% were fathers (52 fathers); 24.0%
were mothers (65 mothers); 30.3% were sons (82 sons); 21.8% were daugh-
ters (59 daughters); 1.1% were grandfathers (3 grandfathers); 1.8% were
grandmothers (5 grandmothers); .4% were brothers/brothers-in-law (1
brother); .4% were sisters or sisters-in-law (1 sister); 1.1% were male
live-in companions (3 men). It should be noted that the N for fathers
(N=52) was slightly less than the N of 54 cited earlier. This dis-
crepancy was due to the way this variable was coded. This variable re-
ferred only to fathers identifed as "living at home." Two fathers,
while not officially divorced, were regarded by the family (spouse) as
"outside" the family household. Therefore, these fathers were not in-
cluded in this N.

Family size. Data was collected at T_1 on family household size.
The mean household size for the population of families and for the
three subsamples was approximately four persons. The average household
size for the population was four persons. The typical family was a two-

parent, two-child household.

Number of children. A separate analysis of the number of children per family supported the statistics on family size. The mean number of children for the population of families and the three subsamples was approximately two children per family.

Family ethnic background. The following is a breakdown of the ethnic backgrounds/cultural orientations family members ascribed to their families. The percentages are arranged in decreasing order: 32.3% (21 families) were English/American; 23.1% (15 families) were Italian/American; 10.8% (7 families) were Irish/American; 9.2% (6 families) were French/American; 4.6% (3 families) were Slavic/American; 4.6% (3 families) were German/American; 3.1% (2 families) were Portuguese/American; 3.1% (2 families) were Polish/American; 3.1% (2 families) were Scotch/American; 1.5% (1 family) was Hispanic; 1.5% (1 family) was Armenian/American; 1.5% (1 family) was Persian; 1.5% (1 family) was Cape Verdian.

Family type. Data was collected on the population (N=65) at T_1 on family type. The following is a breakdown of the population on family types. The percentages are arranged in decreasing order: 80.0% (52 families) were two-parent households; 15.4% (10 families) were single-parent households; 4.6% (3 families) were extended-family households (single-parent family living with extended family).

The three subsamples substantially reflected this order: two-parent households (experimental group, 75.0%, 15 families; control group one, 95.0%, 19 families; control group two, 72.0%, 18 families), single-

parent households (experimental group, 15.0%, 3 families; control group one, 5.0%, 1 family; control group two, 24.0%, 6 families), and extended-family households (experimental group, 10.0%, 2 families; control group one, 0%; control group two, 4.0%, 1 family).

Characteristics of the Presenting Child or Children and Presenting-Problem Type(s)

The following is a description of the data obtained at T_1 on the population of presenting children and presenting-problem type(s). Descriptive statistics as well as population parameters will be presented for the first or primary-identified child and his/her characteristics, the second-identified child and his/her related characteristics, and the third-identified child and his/her characteristics. Also included in this set of variables were characteristics of the population of children of the families under study.

First or primary-identified child. Data collected from mothers and fathers separately at T_1 on the primary-presenting child's age, sex, grade level, and problem type provided the following descriptive statistics.

Age. The mean age for the population of primary-presenting children (N=65) was 6.3 years. The sample means were: experimental group, $\bar{x} = 6.4$ years (n=20); control group one, $\bar{x} = 5.9$ years (n=20); control group two, $\bar{x} = 6.5$ years (n=25). The age span for the population of primary-presenting children was three to twelve years with a range of nine years. The population median age was approximately five years. The population mode was approximately four years.

The percentages of ages represented in the population of primary children were as follows: 23.1% (15 children) were four years old; 20.0% (13 children) were three years old; 12.3% (8 children) were five years old; 9.2% (6 children) were six years old; 9.2% (6 children) were seven years old; 9.2% (6 children) were ten years old; 6.2% (4 children) were eight years old; 4.6% (3 children) were nine years old; 3.1% (2 children) were eleven years old; 3.1% (2 children) were twelve years old. 70.0% - 75% of the population of primary children as well as the three subsamples of children fell between three and seven years of age.

Sex. Breakdown of the primary-identified children (N=65) at T_1 by sex was as follows: 60.0% of the children were male (39 boys) and 40.0% of the children were female (26 girls). The three subgroups followed roughly the same 60:40 proportion: experimental group, 60.0% male (12 boys) and 40.0% female (8 girls; control group one, 65.0% male (13 boys) and 35.0% female (7 girls); control group two, 56.0% male (14 boys and 44.0% female (11 girls).

Grade level. Breakdown of the population of primary-identified children by grade level was as follows: the largest percentages of children (overall 80.0%) fell within the preschool-kindergarten through grade-three levels. 46.2% (30 children) were in preschool and 33.8% (22 children) were in kindergarten through third grade. An additional 18.5% (12 children) were in grades four through seven and only 1.5% (1 child) was not in school.

The three subgroups reflected approximately the same type of distributions of grade levels. In the experimental group (n=20), 45.0%

(9 children) were in grades, kindergarten through third grade; 40.0% (8 children) were in preschool for an overall 85.0%; 15.0% (3 children) were in the fourth through seventh grades; none were in school. In control group one, 60.0% (12 children) were in preschool; 25.0% (5 children) were in kindergarten through third grade for an overall 85.0%; 15.0% (3 children) were in grades four through seven; none were in school. In control group two, 40.0% (10 children) were in preschool; 32.0% (8 children) were in kindergarten through third grade for an overall 72.0%; 24.0% (6 children) were in grades four through seven; 4.0% (1 child) was not in school. The median grade level for the population, for the experimental group and control group two fell within the kindergarten through third grade category with the median for control group one falling slightly lower in the preschool category.

Problem type. Data was collected at T_1 on mothers' description of problem type for the primary-identified child. The following is a breakdown of the distribution of the different problem types represented within the population of primary-presenting children: 30.8% (20 families) identified the child's presenting problems with some family problem; 23.1% (15 families) reported concern for the primary child's display of aggressive behavior; 21.5% (14 families) reported concern over a parent-child conflict/problem; 15.4% (10 families) reported a presenting child problem complicated by marital problems; 9.2% (6 families) reported concern over the primary-presenting child's principally withdrawn/depressed behavior.

The three subgroups were quite similar and, therefore, representa-

tive of the population of problem types. In the experimental group, 30.0% (6 families) reported a presenting-child problem complicated by family problems; equal proportions of families reported concern over the primary child's aggressive behavior (20.0%, 4 families) and a parent-child conflict (20.0%, 4 families). Equal proportions of families reported concern over the primary-presenting child's withdrawn behavior (15.0%, 3 families) and concern over a presenting-child problem complicated by marital problems (15.0%, 3 families).

Both control group one and control group two followed the same pattern. In control group one (n=20), 30.0% (6 families) reported concern over a presenting-child problem complicated by additional family problems; equal proportions of families reported concern over the primary-presenting child's aggressive behavior (25.0%, 5 families) and a concern over a parent-child conflict/problem (25.0%, 5 families); 15.0% (3 families) reported concern over the primary-presenting child's problem complicated by marital problems and 5.0% (1 family) reported concern over the primary-presenting child's withdrawn behavior. In control group two (n=20), the largest percentage of families was also those who reported a primary-presenting child problem complicated by additional family problems (32.0%, 8 families). Other percentages of problem types were as follows: 24.0% (6 families) reported concern over the primary-presenting child's aggressive behavior; 20.0% (5 families) reported concern over parent-child conflicts/problems; 16.0% (4 families) reported concern over the primary-presenting child's problem complicated by marital problems; 8.0% (2 families) reported concern over the primary-

presenting child's withdrawn behavior.

Second- and third-identified children. As noted earlier, data on only the first-identified child was used in the principal analyses on outcome for this study. However, data was collected on mothers and fathers at T_1 on the second- and third-identified children. Because the population size of second- and third-identified children was extremely small (N=9), data on the second- and third-identified children will be presented in the same section.

Age. The population mean for the second-identified child (N=8) was 6.4 years. Respective means for the subsamples were as follows: experimental group (n=3), $\bar{x} = 5.5$ years; control group one (n=4), $\bar{x} = 6.6$ years; control group two (n=1), $\bar{x} = 8.4$ years. The population mean for the third-identified child (n=1) was obviously 5.0 years. It should be noted that there was only one third-identified child in the study. This child belonged to a family in control group two.

Characteristics of the overall population of children. Analyses were conducted on the overall population of presenting children (N=74) on age, sex, grade level, and problem type. The population of overall presenting children consisted of the original primary-presenting children (N=65) and the group of second- and third-presenting children (N=9). The purpose of extending the original group of presenting children (N=65) to include the additional children cited by parents at T_1 was to provide as complete a picture of children in this study as possible.

It should be noted that the results obtained from the separate

analysis conducted on the overall population of identified children (N=74) were quite similar to the results obtained from analyses conducted on the original group of primary children (N=65). The inclusion of the additional data obtained on the nine second- and third-identified children to the original group of primary-presenting children had very little effect on altering the trends in the data on characteristics of the presenting child. Very little difference was observed in the distributions of age, gender, grade level, and problem type within populations or across subsamples for the overall group of presenting children (N=74) or for the original group of primary-presenting children (N=65). The results on the analyses of data on the overall population of presenting children (N=74) were as follows.

Age. The distribution of the population of ages over all presenting children were as follows: 20.3% (15 children) were three years old; 20.3% (15 children) were four years old; 12.2% (9 children) were five years old; 10.8% (8 children) were six years old; 10.8% (8 children) were seven years old for an overall 74.4% between ages three and seven; 8.1% (6 children) were ten years old; 6.8% (5 children) were eight years old; 5.4% (4 children) were nine years old; 2.7% (2 children) were eleven years old; 2.7% (2 children) were twelve years old.

All three subgroups followed the population trend. The largest percentages of ages for the population as well as the three subgroups fell roughly within the three to seven years age range. In the overall population (N=74), 76.4% (55 children) fell within the three to seven years age range. In the experimental group (n=23), a slightly higher

82.6% (18 children) fell within the three to seven age group. In control group one (n=24), 79.4% (17 children) fell within the three to seven age group. In control group two (n=27), a somewhat lower but comparable 62.9% (17 children) fell within the three to seven age group. Whereas in the original group of primary children (N=65), 70.0% of the children fell within the three to seven age group, the overall population of presenting children (N=74) reported 76.4% of the children within the three to seven age group.

Both the original population of primary-presenting children and the overall group of presenting children followed the same proportionate breakdown within groups (roughly 80:60:80). Both the experimental and control one original and overall groups reported approximately 80.0% of the children within the three to seven age group with the original and overall control two groups reporting a slightly lower 60.0% of the children within the three to seven age group. The original and overall control two groups reported fewer younger children and more older children with presenting problems.

Gender. Analysis of the breakdown of overall presenting children according to sex followed approximately the same 60:40 proportion as the original group: 60.0% of the overall population of presenting children were male, 40.0% of the overall population of presenting children were female. The three subsamples of the overall population of presenting children reflected the same 60:40 male/female breakdown.

Grade level. The overall population breakdown according to grade level followed the original group pattern. The most frequent grade

levels were the kindergarten through third grade group and the pre-

school group. Approximately 82.2% of the children in the overall popu-

lation fell within the preschool and kindergarten through third grade

categories and approximately 77.0% of the original population of pre-

senting children fell within the preschool and kindergarten through

grade three categories.

The original subgroups of presenting children as well as the over-

all subgroups of presenting children followed the same trends in per-

centages. The trend for all three subgroups in both the original and

overall populations was as follows: the greatest percentage of children

fell within the preschool and kindergarten through grade three groups

with the least percentage of children falling within the four through

seventh grade category.

Problem type. The breakdown of problem types across the popula-

tion and within subgroups in the overall group of presenting children

closely followed the trend in the data on problem types for the original

group of primary-presenting children. The arrangement of percentages

of the representation of problem types from most frequent to least fre-

quent reflected the following general order: first, a presenting-child

problem complicated by family problems; second, the presenting child's

aggressive behavior; third, a parent-child problem; fourth, a present-

ing-child problem complicated by a marital problem; fifth, a presenting

child's withdrawn behavior.

The percentages for each of the five categories for the original

and overall group of children were as follows: a presenting-child prob-

lem complicated by family problems, 30.8% (20 families), original group; 28.4% (21 families), overall groups; the presenting child's aggressive behavior, 23.1% (15 families), original group; 24.3% (18 families), overall group; a parent-child problem, 21.5% (14 families), original group; 20.3% (15 families), overall group; a presenting-child problem complicated by a marital problem, 15.4% (10 families), original group; 17.6% (13 families), overall group; a presenting child's withdrawn behavior, 9.2% (5 families), original group; 9.5% (7 families), overall group.

Ex-Husbands' Backgrounds and Personal Characteristics

Data was collected from mothers at T_1 on ex-husbands. Collection of the data on ex-husbands was limited to four main variables. These four variables were age, occupation, education, and ethnic background. The results of the analyses were as follows.

Age. The mean age for the population of ex-husbands (N=13) was 36.1 years. The mean age reported for ex-husbands in the experimental group (n= 8) was 36.3 years. The mean age for control group one ex-husbands (n=1) was 43.0 years. The mean age of ex-husbands in control group two (n=4) was 34.0 years. It should be noted that the experimental group had the largest number of ex-husbands for whom complete data was available for analysis. Control group one reported one ex-husband.

Occupation. The breakdown of occupations for the population of ex-husbands (N=13) was as follows: 30.8% (4 ex-husbands) fell into the category of blue-collar/maintenance/factory work; 23.1% (3 ex-husbands)

fell into the white-collar/technical office work category (e.g., computer key punch operator); 15.4% (2 ex-husbands) fell into the white-collar/middle management/supervisory positions (e.g., social service, government jobs); 7.7% (1 ex-husband) was unemployed; 7.7% (1 ex-husband) was a mechanic; 7.7% (1 ex-husband) was a self-employed businessman; 7.7% (1 ex-husband) was a college professor.

Education. The breakdown of education levels in the population of ex-husbands (N=13) was quite similar to the breakdown of education levels for fathers. The only slight differences observed were that the population of ex-husbands had greater percentages of men with higher education levels and men who did not complete high school.

The breakdown of percentages of education levels represented in the population of ex-husbands was as follows: 46.2% (6 ex-husbands) were high school graduates; 15.4% (2 ex-husbands) did not complete high school; 15.4% (2 ex-husbands) had obtained master's degrees; 7.7% (1 ex-husband) obtained an associates degree; 7.7% (1 ex-husband) obtained a bachelor's degree; 7.7% (1 ex-husband) obtained a doctorate.

Ethnic background. The breakdown of the frequency of types of ethnic backgrounds in the population of ex-husbands was as follows: 21.4% (3 ex-husbands) were English/American; 21.4% (3 ex-husbands) were Italian/American; 14.3% (2 ex-husbands) were Polish/American; 7.1% (1 ex-husband) was Irish/American; 7.1% (1 ex-husband) was French/American; 7.1% (1 ex-husband) was Hispanic; 7.1% (1 ex-husband) was Persian; 7.1% (1 ex-husband) was Cape Verdian; 7.1% (1 ex-husband) was Slavic/American.

Summary

   Data collected separately from mothers (N=65) and fathers (N=54)
at T$_1$ on the population of families (N=65) indicated that the typical
family under study was a two-parent household (80.0%, 52 families)
where mothers (73.3%, 47 mothers) and fathers (79.3%, 46 fathers) re-
ported first marriages. The mean family size (overall 271 reported
family members) was four persons. The mean number of children per fam-
ily was two. Of the overall number of children (141 children), 58.2%
(82 children) were boys and 41.8% (59 children) were girls). The most
frequent family ethnic background reported was English/American (32.3%,
21 families). The typical family income fell within the $25,000 to
$40,000 bracket (40.0%, 26 families) with the population median falling
slightly lower within the $20,000 to $24,999 bracket.

   The typical mother in the study was a homemaker (58.5%, 38 mothers),
unemployed (58.5%, 38 mothers), a high school graduate (40.0%, 26
mothers), a firstborn or only-child in her family of origin (53.8%, 35
mothers), Irish/American (32.3%, 21 mothers), and Catholic (70.8%, 46
mothers). The mean age of mothers was 33 years.

   The typical father in this study ranged in occupation from blue-
collar/factory (21.5%, 14 fathers), blue-collar, skilled trade (18.5%,
12 fathers), and white-collar managerial (18.5%, 12 fathers) for an
overall 58.5%. The typical father was employed full-time (86.2%, 46
fathers), a high school graduate (32.8%, 19 fathers), firstborn or only-
child in his family of origin (52.5%, 21 fathers), English/American
(32.8%, 19 fathers), and Catholic (60.3%, 35 fathers). The mean age
for fathers was 35 years.

The typical primary-presenting child in this study was in pre-school (46.2%, 30 children). The mean age of primary children was 6.3 years. The most frequent age was four years. The most frequent problem type was a presenting-child problem characterized by mixed psychological symptoms complicated by additional family problems (30.8%, 20 children). Approximately 60.0% of the primary-presenting children were male (39 children) and 40.0% were female (26 children).

Results of the Chi-Square Analyses on Family Demographics at T_1

The chi-square test is a means of answering questions about data in the form of frequencies rather than as scores or measurements along some scale (e.g., interval, ratio). The question researchers pose using the chi-square test is whether the frequencies of observations deviate significantly from some theoretical or expected population frequencies. The chi-square test of significance hypothesizes that any relation or difference in the findings is due to chance or random error (e.g., sampling error). This mathematical statement about the experimental data is then put to a probability test.

A series of chi-square tests were used in this study to analyze the data obtained on family demographics at T_1. A separate chi-square test was conducted on each of the 30 family variables, covering the five broad categories cited above (i.e., family unit characteristics, mothers' background, fathers' background, ex-husbands' background, characteristics of the presenting child, and presenting problem).

For purposes of this study, chi-square analyses of the data were

used to test the null hypothesis that in the population distribution, the proportional frequencies of subcategories of the variable under study were equal to a specified value. Chi-square tests were used to determine whether the proportional distribution of class intervals (i.e., categories such as family income) into which data on a specific variable was subdivided and assigned were approximately equal across the three subgroups (experimental group, control group one, control group two).

The results of the chi-square tests indicated that the three subgroups were very similar on the distribution of family demographic variables at T_1. No statistically-significant differences were observed on any of the 30 family demographic variables for the three groups at T_1. Only one variable, fathers' type of work approached near significance ($x^2 = 18.6253$, df = 12, p = .08). This suggested that the frequencies of fathers' work types were not equally distributed across the three groups.

However, the overall results indicated by the series of chi-square tests performed on these important demographic and clinical variables suggested that the three groups were quite similar at pretreatment and, therefore, equitable. In addition, determining that the groups were comparable at T_1 and that the category responses were fairly evenly distributed provided evidence to support the important conditions underlying the use of inferential, multivariate methods (e.g., assumption of normality).

Assessment of Experimental Outcome

Analysis of the experimental data was conducted independently on all four instruments (FAD, CBCL, FUI REAL, FUI IDEAL). Separate, parallel analyses were conducted on men and women. The analysis involved three assessment points (T_1, T_2 and gains). Analyses were divided by parental role (mothers and fathers) and were broken down by instrument (FAD, CBCL, FUI REAL, FUI IDEAL) by group (experimental group, control group one, control group two) by time (T_1, T_2, gains). The analysis of each of the four instruments was conducted on the subscale level. In addition, analyses were conducted on the second-order factor level on CBCL, FUI REAL and FUI IDEAL.

Multivariate analysis of variance tests (MANOVAS) were used to analyze the experimental data on mothers. A separate MANOVA--one for each of the four instruments--was conducted for women at each of the three time points. In essence, each MANOVA test comprised the equivalent of conducting a separate experiment for each instrument. The experimental question posed for each instrument separately at each time point was: "Do the group means for women differ significantly beyond chance?" The null hypothesis of no differences in group means was tested at the .05 level for each instrument.

The experimental data on fathers was analyzed by instrument by group by time. One-way analysis of variance (ANOVA) was used to test the null hypothesis of no differences in group means for fathers. The null hypothesis was tested at the .05 level. A separate ANOVA test was conducted on each instrument subscale at each of the three assessment

points. The reasons for choosing ANOVA tests for men and MANOVA tests for women in the treatment and analysis of the experimental data will be discussed in more detail in a later section of this chapter.

In addition to the MANOVA and ANOVA tests, homogeneity of variance tests were run on the experimental data on men and women. The analysis was once again divided into separate analyses on men and women broken down by instrument by group and by time. Tests of homogeneity of variance (Bartlett's Box F Test) were conducted separately for each instrument at the three time points on both the subscale level and the second-order level. Medians were also calculated for men and women by instrument by group and by time. The sample sizes, medians, means, and variances for men and for women on each instrument subscale at each assessment point are reported in a series of tables presented in Appendix J.

These tables were designed for several purposes: (1) to provide an economical statistical summary of the experimental data; (2) to present an integrated picture of overall outcome; and (3) to provide for the study and observation of trends in the data. Trends in the experimental data may be observed in the study of the data across measures, time points, groups, and parental roles.

In short, the analysis and report on the experimental outcome will be presented separately for men and for women with the presentation of findings on women preceding the presentation of findings on men. However, the presentation of findings for men and women will follow the same general format. The four instruments will be presented in the following order: FAD, CBCL, FUI REAL, FUI IDEAL progressing in time

from T_1 to T_2 and gains.

All four instruments will be discussed completely at T_1 followed by a complete discussion of all four instruments at T_2 followed by a discussion of all four instruments on gain scores. The results of MANOVAS/ANOVAS will be presented first. Next, the results of the univariate homogeneity of variance tests will be presented. In cases where MANOVA or ANOVA tests were found to be significant at .05 or less, the results of follow-up simultaneous confidence interval, pairwise comparison procedures will be presented and discussed.

Results for Women

Multivariate analysis is one statistical tool among a family of inferential, parametric statistics. Multivariate analysis of variance (MANOVAS) was used to analyze the data on women instead of univariate analysis of variance (ANOVAS--one for each dependent variable) for the following reasons: (1) correlations between dependent variables may be expected to occur when the same subject responds to several measures (i.e., people who score higher on one instrument usually score higher on another instrument); (2) under such conditions of correlated dependent variables, use of separate univariate tests cause the probability of a Type 1 error to be higher. Separate univariate tests inflate the alpha level contributing to spurious results. As the number of dependent variables increases, the probability of finding a significant difference by chance also increases; (3) multivariate analysis is recommended when there are more than two levels of the independent variable and

two or more criterion measures are used in the study.

A separate MANOVA was run for women for each instrument at each time point. One-way MANOVAS were used to test for differences for each instrument. Each instrument's subscale mean scores were analyzed simultaneously. The null hypothesis tested for each instrument was that the sample groups' mean vectors (i.e., series of subscale means for each group) were the same. The procedure used for testing the multivariate null hypothesis was the Roy's Largest Root Criterion. Because the initial effect of finding a significant difference pertains to the entire set of subscale means for a given instrument, when a significant overall effect was obtained, simultaneous confidence interval procedures were used to determine the source of the significant difference.

FAD--Women, T_1

A one-way MANOVA was used to analyze the data on mothers on FAD at T_1. Coded FAD subscale scores were used in the statistical analysis following the procedures outlined in Chapter VI. A significance level of .05 was selected. The overall MANOVA on FAD for women at T_1 showed no significant differences. The value of Roy's Criterion was .12814, $S = 2$, $M = 2$, $N = 27$.

FAD--Women, T_2

A one-way MANOVA was used to analyze the posttest scores for women on FAD at T_2. The results of the overall MANOVA were not found to be significant at the .05 level or less. Roy's Criterion value was .17785, $S = 1$, $M = 2$ 1/2, $N = 23$ 1/2.

FAD--Women, Gains

A one-way MANOVA was used to analyze the gain scores for women on FAD. The experimental hypothesis proposed in this research was that mothers who received family therapy would obtain higher average post-test subscale gain scores ($T_2 - T_1$ differences) on FAD than mothers who did not receive the family therapy. The overall MANOVA test was found to be significant. The value of Roy's Criterion was .328, $S = 2$, $M = 2$, $N = 23\ 1/2$, $p = .05$.

Confidence intervals were constructed for the following four comparisons on each variable: group one to group three, group one to group two, group two to group three, group one to the average of groups two and three for mothers on FAD gains. With respect to the confidence interval procedures, none of the pairwise comparisons were found to be significant.

CBCL--Women

The analysis of data collected on women on CBCL was divided into three parts: Part A, Part B, and Part C. Part A included the Internalizing, Externalizing, Activities, and Social subscales. A one-way MANOVA was used to analyze this data. Part B included the Total Behavior and Total Social subscales. A Separate one-way MANOVA was used to analyze this data. Part C involved the School subscale on CBCL. A separate one-way ANOVA was used to analyze this data.

The analysis of data collected on women on CBCL was divided into three separate analyses to avoid the disadvantage of redundance in use of the same items twice in the same MANOVA. The separate three-part

plan for the analysis of CBCL data was followed for all three assessment points. The results are reported below.

CBCL--Women, T_1

The results of the overall MANOVAS conducted separately for Parts A and B and the results of the ANOVA conducted on Part C on the data analysis on CBCL for women at T_1 were not found to be significant at the .05 level. The value of Roy's Criterion for Part A = .14094, S = 2, M = 1/2, N = 27. The value of Roy's Criterion for Part B of the analysis = .07923, S = 2, M = 1/2, N = 26. The value of F for Part C of the analysis = 2.465, df = 2 and 22.

CBCL--Women, T_2

The results of the overall MANOVAS conducted independently on Part A and Part B and the results of the ANOVA conducted on Part C of the data analysis on CBCL for women at T_2 were also not found to be significant at .05. The value of Roy's Criterion for Part A = .09583, S = 2, M = 1/2, N = 24. The value of Roy's Criterion for Part B = .06072, S = 2, M = 1/2, N = 25 1/2. The value of F for Part C of the analysis = .129, df = 2 and 25.

CBCL--Women, Gains

No significant differences were found for women on gains on Parts A, B, or C of the analysis on CBCL. The value of Roy's Criterion for Part A gains = .145, S = 2, M = 1/2, N = 23. The value of Roy's Criterion for Part B of the analysis on CBCL gains = .023, S = 2, M = 1/2, N = 22. The F value for Part C of the analysis on womens' gains = 1.854, df = 2

and 18.

FUI REAL and FUI IDEAL--Women

A one-way MANOVA on the nine subscale mean scores was conducted separately for FUI REAL and FUI IDEAL. This procedure was followed for each of the three assessment time points.

FUI REAL--Women, T_1

The overall MANOVA conducted on women on FUI REAL at T_1 was not found to be significant. The value of Roy's Criterion = .13093, S = 2, M = 3, N = 26.

FUI REAL--Women, T_2

The overall MANOVA conducted on the data on women on FUI REAL at T_2 was also not found to be significant. The value of Roy's Criterion = .25371, S = 2, M = 3, N = 22 1/2.

FUI REAL--Women, Gains

The overall MANOVA conducted on FUI REA1 gain scores for women was not found to be significant. The value of Roy's Criterion = .163, S = 2, M = 3, N = 22 1/2.

FUI IDEAL--Women, T_1

The overall MANOVA conducted on FUI IDEAL mean scores for women at T_1 was not found to be significant. The value of Roy's Criterion = .12985, S = 2, M = 3, N = 26.

FUI IDEAL--Women, T_2

The results of the overall MANOVA conducted on mean subscale scores

for women on FUI IDEAL at T_2 were not found to be significant. The value of Roy's Criterion = .23566, S = 2, M = 3, N = 22 1/2.

FUI IDEAL--Women, Gains

The overall MANOVA conducted on FUI IDEAL mean gain scores for women was not significant. The value of Roy's Criterion = .149, S = 2, M = 3, N = 22 1/2.

Second-Level Factors on FUI REAL and FUI IDEAL--Women

A separate MANOVA was conducted on the five second-order factors identified for study on FUI REAL and FUI IDEAL. The five second-order factors identified for analysis on FUI were as follows: Real Adaptive Coping (RAC), Ideal Adaptive Coping (IAC), Real Family Integration (RFI), Ideal Family Integration (IFI), and Family Satisfaction (SAT). A separate MANOVA on all five second-level factors was conducted for each of the three assessment points.

Second-Level Factors--Women, T_1

The overall MANOVA conducted on the second-order mean scores for women at T_1 was not found to be significant. The value of Roy's Criterion = .99336, S = 1, M = 1 1/2, N = 28.

Second-Level Factors--Women, T_2

Results of the MANOVA conducted on mean scores for women on the second-order factors on FUI were not found to be significant. The value of Roy's Criterion = .05340, S = 2, M = 0, N = 12 1/2.

Second-Level Factors--Women, Gains

The overall MANOVA on mean gain scores for women on the five second-order factors was also not found to be significant. The value of Roy's Criterion = .092, S = 2, M = 1, N = 23.

Univariate Homogeneity of Variance Tests

Because variability has been identified in the literature as an important measure for assessing psychotherapy outcome in addition to group means, group variances were also studied. Univariate tests of homogeneity of variance were conducted on all subscales and second-level factors separately for men and women at the three assessemnt points. The reader is once again referred to the series of tables in-cluded in Appendix J. Results for each instrument on the subscale and second-order level will be presented completely for all three time points (T_1, T_2, gains). The instruments will be presented in the fol-lowing order: FAD, CBCL, FUI REAL, FUI IDEAL.

FAD--Women, T_1

Results of the Bartlett's Box F Test conducted on group variances for women at T_1 suggested that the variances were significantly differ-ent on two subscale variables on FAD. Group variances were significant at a borderline level on Affective Involvement (Bartlett's F Test = 4.91291, p = .05). Group variances were found to be extremely signifi-cantly different on Behavior Control (Bartlett's F Test = 2.39454, p = .008). As a point of interest, a near significant difference in group variances was found on Roles (Bartlett's F Test = 2.39454, p = .09).

Examination of Box Plots suggested that group one, the treatment group, displayed greater variability in scores at T_1 on the three sub-scales than either of the non-treatment groups. No other significant differences on variances were found on the other four remaining FAD sub-scales at T_1.

FAD--Women, T_2

Two significant differences in group variances were found at T_2 for women. The difference in group variances on Communication was found to be extremely significant (Bartlett's F Test = 5.33884, p = .005) and, once again, significant on Behavior Control (Bartlett's F Test = 3.15091, p = .04). Examination of the graphic Box Plots display of the configuration of the distribution of scores for all three groups suggested that group one, the treatment group, had greatest variability at T_2 in comparison to either of the two nontreatment groups. No other significant differences were found on any of the other six variables on FAD at T_2.

FAD--Women, Gains

The univariate tests of homogeneity of variance conducted on FAD subscale gain scores $(T_2 - T_1)$ for women revealed two significant differences in group variances. Subscale gain scores on Problem Solving were found to be quite significant (Bartlett's F Test = 4.61594, p = .01). Subscale gain scores on Communication were also found to be significant (Bartlett's F Test = 3.14571, p = .04).

As a point of interest, subscale gain scores on one other variable, General Functioning, approached significance (Bartlett's F Test =

2.51624, p = .08). Examination of the Box Plots suggested the same pattern observed in the variances at T_1 and T_2: Group one, the treatment group, displayed greater variability in the distribution of gain scores than either of the two nontreatment groups.

CBCL--Women, T_1

Only one significant difference was found on group variances on CBCL at T_1 for women. Subscale scores on School were found to be significant (Bartlett's F Test = 3.213, p = .04). In this instance, group two, the first nontreatment group, displayed the greatest variability with group one, the treatment group, displaying the second largest variability followed by group three, the second control group displaying the least or smallest variance.

CBCL--Women, T_2

Two subscale variances on CBCL were significantly different at T_2. The group variances on Activities subscale scores on CBCL were found to be significant (Bartlett's F Test = 2.94776, p = .05). Group variances on the School subscale were once again found to be significant (Bartlett's F Test = 2.849, p = .05). Examination of the Box Plots on Activities at T_2 suggested that group two, the first nontreatment group, displayed the greatest variance in scores with group one, the treatment group, displaying the second largest variance followed by the third group, the second nontreatment group displaying the smallest variance.

CBCL--Women, Gains

Only one significant difference was found on group variances on

gain scores on CBCL. Once again, group variances on School subscale gains were found to be extremely different (Bartlett's F Test = 5.301, p = .005). Examination of the Box Plots displays of the variance for the two groups studied in the univariate homogeneity of variance tests on the School subscale (the treatment group to the second nontreatment group) suggested that the non-treatment group variance on gains was considerably greater than the treatment group.

FUI REAL--Women, T_1

No significant or near-significant differences in group variances were found on any of the FUI REAL subscales for women at T_1.

FUI REAL--Women, T_2

Once again, no significant or near-significant differences in group variances were found on any of the FUI REAL subscales for women at T_2.

FUI REAL--Women, Gains

However, three significant differences were found on group variances for womens' gains. A significant difference was found on Family Actualization gains (Bartlett's F Test = 3.43557, p = .03). A significant difference was found on Family Communication gains (Bartlett's F Test = 3.37515, p = .03). A significant difference was found on Family Sociability gains (Bartlett's F Test = 3.21017, p = .04). In all three instances, examination of the Bartlett's Box Plots suggested that group one, the treatment group, displayed the greatest variance on gains.

FUI IDEAL--Women, T_1

Only one univariate test of homogeneity of variance on FUI IDEAL at T_1 was found to approach significance. Group variances on Family Locus of Control reached near significance (Bartlett's F Test = 2.59175, p = .07). Examination of the Box Plots suggested that group two, the first nontreatment group, displayed the greatest variance with group three, the second nontreatment group, displaying the second largest variance followed by the treatment group displaying the smallest variance.

FUI IDEAL--Women, T_2

None of the univariate homogeneity of variance (Bartlett's Box F Tests) were found to be significant on any of the FUI IDEAL subscales for women at T_2.

FUI IDEAL--Women, Gains

Two significant differences were found for FUI IDEAL gains. A significant difference in group variances was found on Family Sociability subscale gains (Bartlett's F Test = 4.02174, p = .01). A very significant difference was found on Family Togetherness subscale gains (Bartlett's F Test = 4.79967, p = .008). As a point of interest, a difference in group variances on Family Loyalty was found at the .09 level (Bartlett's F Test = 2.32588).

Examination of the Bartlett's Box Plots suggested that on Family Sociability, group one, the treatment group, displayed the greatest gains variance followed by group two, the first nontreatment group, fol-

lowed by group three, the second nontreatment group. However, review

of the Box Plots on Family Togetherness suggested that group two, the

first treatment group, displayed the greatest gains variance, followed

by group one, the treatment group, followed by group three, the second

nontreatment group, with the smallest variance.

Second-Level Factors--Women, T_1, T_2, Gains

Separate univariate tests of homogeneity of variance were conducted

on five second-level factors for FUI REAL and FUI IDEAL: Real Adaptive

Coping, Ideal Adaptive Coping, Real Family Integration, Ideal Family

Integration, Family Satisfaction. None of the univariate tests of homo-

geneity of variance were found to be significant or near significant on

any of the five second-level factors at T_1, T_2 or on gains.

Results for Men

Because of the small cell sizes and the potential contribution of

this factor to spurious and/or misleading results, one-way ANOVAS were

used to analyze the data on men by groups for all three assessment

points instead of one-way MANOVAS. Separate one-way ANOVAS were con-

ducted on the subscale and second-order level for men paralleling the

analysis paradigm for women. Tables contained in Appendix J summarize

the data (i.e., means, medians, variances) on the experimental study.

The results for men are briefly described below.

FAD--Men, T_1

None of the one-way ANOVAS were found to be significant or to ap-

proach significance for men on any of the subscales on FAD at T_1.

FAD--Men, T_2

Once again, none of the one-way ANOVAS were found to be significant or to approach significance on any of the FAD subscales for men at T_2.

FAD--Men, Gains

One of the one-way ANOVAS on FAD gains was found to be significant. The General Functioning subscale on FAD was found to be significant. The F value = 3.381, df = 2 and 16, p = .05. The group means were as follows: experimental group, $\bar{x}$ = -.284; control group one, $\bar{x}$ = .202; control group two, $\bar{x}$ = .030.

Consideration of the direction of the scoring and coding system for FAD and the direction of the gains determined by the sign preceding the means suggested that the treatment group's scores decreased in the direction of healthier, self-reported general family functioning. However, both nontreatment groups' scores appeared to have increased in the direction of more unhealthy, self-reported general family functioning. It should be noted that scores on FAD may range from 1.00 (healthy) to 4.00 (unhealthy).

CBCL--Men, T_1

None of the one-way ANOVAS conducted on CBCL subscales for men were significant or near-significant at T_1.

CBCL--Men, T_2

None of the ANOVAS were found to be significant at T_2 for men.

CBCL--Men, Gains

Two experimental hypotheses were proposed for this instrument in this study. It was hypothesized that fathers who received family therapy would obtain higher average posttest gain scores on the Social Competence subscales on CBCL than fathers who did not receive therapy. It was also hypothesized that fathers who received family therapy would obtain lower average posttest gain scores on the Behavior Problem subscales on CBCL than fathers who did not receive therapy.

Both of the experimental hypotheses were tested statistically using the null hypothesis. The null hypotheses tested were that there were no differences in (1) posttest mean gain scores on the Social Competence subscales on CBCL, and in (2) posttest mean gains scores on the Behavior Problems subscales on CBCL. One-way ANOVAS were conducted on all CBCL subscales. None of the ANOVAS were found to be significant on fathers' gains.

FUI REAL--Men, T_1

None of the ANOVAS conducted on subscales for fathers at T_1 were found to be significant. However, it should be noted as a point of interest that some difference between group means was found on Family Sociability at a .10 significance level for men at T_1 (F = 2.582, df = 2 and 16).

FUI REAL--Men, T_2

Once again, results on only one ANOVA, Family Sociability, were found to approach significance for men at T_2 (F = 3.289, df = 2 and 16,

p = .0502). As a point of interest, the group means were as follows:
experimental group, $\bar{x}$ = 5.600; control group one, $\bar{x}$ = 6.420; control
group two, $\bar{x}$ = 6.277. Ordering of the means suggested that group two,
the first nontreatment group, obtained the highest average posttest
scores followed by group three, the second nontreatment group, followed
by the treatment group.

FUI REAL--Men, Gains

The experimental hypothesis proposed in this study on FUI REAL was
that fathers who received family therapy would obtain higher average
posttest scores on FUI REAL subscales than would fathers who did not
receive therapy. Null hypotheses were tested--one for each subscale--
that there were no differences between average posttest group means.
The ANOVA on fathers' gain scores on Consideration vs. Conflict on FUI
REAL was found to be very significant (F = 7.055, df = 2 and 16, p = .006).
Average posttest gain scores for rathers on Loyalty on FUI REAL ap-
proached significance (F = 3.617, df = 2 and 16, p = .0506). As a point
of interest, the group means on Consideration and Loyalty on FUI REAL
were as follows: On consideration on FUI REAL gains, the experimental
group, $\bar{x}$ = .676; control group one, $\bar{x}$ = .230; control group two, $\bar{x}$ = .008.
On Loyalty on FUI REAL gains, the experimental group, $\bar{x}$ = 1.000; control
group one, $\bar{x}$ = .040; control group two, $\bar{x}$ = -.222.

Simultaneous confidence intervals were constructed as a follow-up
procedure for Consideration and Loyalty. Confidence intervals were
constructed to investigate the following four comparisons: group one
and group three, group one and group two, group two and group three,

group one, and the average of group two and three. Group one was found to be significantly different from group three. Group one was also found to be significantly different from the average of groups two and three. Simultaneous confidence intervals were also constructed to investigate the same four comparisons on Loyalty gain scores. However, no significant differences were found.

Examination of the mean gains on Consideration on FUI REAL suggested that the treatment group made significant gains on perceived Family Consideration vs. Family Conflict. Examination of the group means on Family Loyalty suggested that the treatment group made gains (1.00); the first nontreatment group also gained (a somewhat smaller increment--.04). However, the second nontreatment group, group three, decreased (-.22).

FUI IDEAL--Men, T_1

None of the ANOVAS conducted on FUI IDEAL subscale scores for men were found to be significant at the .05 level or less at T_1. However, as a point of interest, two subscale variables were found to be near significant (less than .10). These variables are: Family Sociability (F = 2.916, df = 2 and 16, p = .08) and Family Closeness (F = 3.230, df = 2 and 16, p = .06). The group means were as follows: On Family Sociability at T_1, the experimental group mean was 6.200; control group one mean was 7.367; control group two was 6.960. On closeness at T_1, the experimental group mean was 6.232; control group one was 7.313; control group two was 7.265.

Inspection of the group means on IDEAL Family Sociability suggested that at T_1 group one, the treatment group, obtained the lowest mean

scores. Inspection of mean scores at T_1 on Family Closeness suggested a similar trend. The treatment group obtained the lowest mean score on IDEAL Family Closeness. However, both nontreatment groups displayed higher group mean scores on Family Closensss at T_1.

FUI IDEAL--Men, T_2

None of the ANOVAS conducted on FUI IDEAL were found to be significant or to approach significance at T_2.

FUI IDEAL--Men, Gains

The experimental hypothesis proposed in this study on FUI IDEAL was that men who received family therapy would obtain higher average posttest scores on FUI IDEAL subscales than would men who did not participate in therapy. The null hypothesis of no difference in average posttest group mean gains was tested for each subscale variable on FUI IDEAL. Only two ANOVAS were found to be significant or to border significance on FUI IDEAL for mens' gains. Family Togetherness was found to be significant for mens' gains ($F = 3.711$, df = 2 and 16, $p = .047$). Once again, Family Sociability was found to be borderline significant ($F = 3.628$, df = 2 and 16, $p = .0502$).

Simultaneous confidence intervals were constructed as follow-up procedures on Togetherness and Sociability to investigate the same four group comparisons. None were found to be significant. As a point of interest, the group means on Togetherness and Sociability were as follows: On Togetherness on gains, experimental group, $\bar{x} = .280$; control group one, $\bar{x} = -1.400$; control group two, $\bar{x} = -.022$. On Sociability on

gains, experimental group, $\bar{x}$ = .560; control group one, $\bar{x}$ = -1.000; control group two, $\bar{x}$ = .311.

An inspection of the group mean gains for all three groups on both variables suggested a trend. Group one, the treatment group, appeared to have the highest positive group mean gains. Group one, the treatment group, increased in self-reported perception of Family Togetherness and Family Sociability whereas group two, the first nontreatment group, decreased in positive perception of Family Togetherness and Family Sociability (-1.0 on Sociability and -1.40 on Togetherness). Group three, the second nontreatment group, indicated some increment of positive change. However, group three gains were not the highest.

FUI REAL and FUI IDEAL--Second-Level Factors, Men, T_1

ANOVAS were conducted on five second-level factors on REAL and IDEAL, paralleling the analysis on women. The five second-level factors were: Real Adaptive Coping, Ideal Adaptive Coping, Real Family Integration, Ideal Family Integration, and Satisfaction. None of the ANOVAS were found to be significant or borderline significant at the .05 level or less on any second-level factors at T_1.

FUI REAL and FUI IDEAL--Second-Level Factors, Men, T_2

Only one ANOVA was found to be of interest at T_2. Group means on Ideal Adaptive Coping were found to be different at a .087 level for fathers at T_2 (F = 2.445, df = 2 and 16). The means on Ideal Adaptive Coping were as follows: experimental group, $\bar{x}$ = 6.203; control group one, $\bar{x}$ = 6.519; control group two, $\bar{x}$ = 6.652.

Inspection of the means suggested that, while the means were very close, the two non-treatment groups appeared to have obtained higher average group scores at T_2 than the treatment group.

FUI REAL and FUI IDEAL--Second-Level Factors, Men, Gains

The ANOVA on Satisfaction was found to be significant at the .05 level or less for mens' gain scores. The value of F was equal to 4.724, df = 2 and 16, p = .027. Simultaneous confidence intervals were constructed as a follow-up procedure to investigate the four group comparisons. None were found to be significant. However, as a point of interest, the group mean gain scores on Satisfaction were as follows: experimental group, $\bar{x}$ = .190; control group one, $\bar{x}$ = .588; control group two, $\bar{x}$ = .107.

An inspection of the group mean gain scores on Satisfaction for fathers suggested that group two, the first random nontreatment group, obtained the highest average gain scores. The treatment group, group one, and the second nontreatment group, group three, made about the same gains.

Results of the Univariate Homogeneity of Variance Tests for Men

Because the study of variance has been identified as an equally important index for investigating change in psychotherapy, tests of homogeneity of variance were conducted on all instrument subscales and second-level factors for men. The same design for analysis used for women was followed for men. The results of the univariate homogeneity of variance tests were as follows.

FAD--Men, T_1

Only one univariate test of homogeneity of variance was found to be significant for men on FAD at T_1. Communication was found to be quite significant (Bartlett's Box F Test = 4.847, p = .008). Visual inspection of the Bartlett's Box Plots displayed the differences in variances between the three groups as follows: group one, the treatment group, and group two, the first nontreatment group, appeared to have quite similar variances. Group three, the second nontreatment group, appeared to have the largest variance and to be quite different from groups one and two.

FAD--Men, T_2

None of the univariate homogeneity of variances tests conducted on FAD subscales were found to be significant or near-significant at T_2.

FAD--Men, Gains

However, variances on Communication gain scores were found, once again, to be quite different. The univariate homogeneity of variance test was found to be quite significant (Bartlett's Box F Test = 4.905, p = .008). Inspection of the Bartlett's Box F Test suggested that all three variances were quite different from each other. The treatment group, group one, displayed the smallest variance. Group two, the first nontreatment group, displayed a slightly larger variance. Group three, the second nontreatment group, displayed the largest variance.

CBCL--Men, T_1

One subscale variance was found to be significant for men on CBCL at T_1. The group variances on the Social subscale were found to be

quite different (Bartlett's Box F Test = 3.049, p = .048). Examination of the Bartlett's Box Plots displays suggested group two, the first non-treatment group, was quite different from groups one and three. Group two displayed the largest variance at T_1. Groups one and three appeared more alike. Group one, the treatment group, displayed the smallest variance at T_1.

One other variable, the School subscale, is worth noting. The group variances on School at T_1 for men were somewhat different (Bartlett's Box F Test = 2.805, p = .099). In the comparison of the two variances (i.e., group one, the treatment group, and group three, the only other nontreatment group), group one, the treatment group, displayed a considerably smaller variance at T_1. Group three displayed a remarkably large variance at T_1.

CBCL--Men, T_2

Three univariate homogeneity of variance tests were of note at T_2. The results of the univariate homogeneity of variance test on the Social scale at T_2 was quite significant (Bartlett's Box F Test = 5.275, p = .005). Variances on the Internalizing subscale were also found to be significant at T_2 (Bartlett's Box F Test = 3.049, p = .048). The total Social scale was found to be borderline significant (Bartlett's Box F Test = .2895, p = .056).

Observation of the Bartlett's Box Plots display on the Social scale variances suggested quite a difference in group variances. None of the variances appeared to be alike. Group two displayed the largest variance. Group three, the second nontreatment group, displayed a considerably small variance. Group one, the treatment group, displayed

the middle variance.

Observation of the Bartlett's Box Plots displays on Internalizing indicated that group two, the first nontreatment group, had the greatest variance, followed by group one, the treatment group. However, group three, the second nontreatment group, displayed the least variance.

Observation of the variances on Total Social at T_2 indicated a similar trend in the data for men on CBCL. Once again, group two, the first nontreatment group, displayed the greatest variance at T_2 followed by group one, the treatment group. Group three, the second nontreatment group, displayed the smallest variance--a group variance quite different from groups one and two.

CBCL--Men, Gains

Two group variances were significantly different on gains on CBCL for men. The Externalizing scale was significant at .03 (Bartlett's Box F = 3.447). The Activities scale was significant at .037 (Bartlett's Box F = 3.331).

In both cases, observation of the Bartlett's Box Plots suggested a similar pattern. One group variance was extremely large and quite different from the other two group variances which were quite alike. On Externalizing, group two, the first nontreatment group, displayed the largest, quite different and extreme group variance. Groups three and one variances were quite similar and small with group one, the treatment group, demonstrating the least variance. On Activities, group two, once again was set apart by an extremely large group variance. Groups three and one displayed similar variances that were

quite small. In this instance, however, group one had the smaller group variance on gains.

FUI REAL--Men, T_1

None of the univariate homogeneity of variance tests were significant at .05 or less for men at T_1. Only one group variance test is worth noting. Group variances on Consideration on FUI REAL were found to be significant at .10 confidence level (Bartlett's Box F Test = 2.304). Examination of the Bartlett's Box Plots indicated that group one and group two were quite similar and had considerably smaller group variances. Group three was quite different and displayed an extremely large group variance at T_1.

FUI REAL--Men, T_2

Once again, nothing was significant at the .05 level on the univariate homogeneity of variance tests for men on FUI REAL at T_2. However, it should be noted that Family Ambition was found to be significant at a .08 confidence level (Bartlett's Box F Test = 2.508). Examination of the Bartlett's Box Plots indicated that groups two and three, the two non-treatment groups, were quite similar in group variances. However, the treatment group variance in comparison was quite different and smaller.

FUI REAL--Men, Gains

Three univariate homogeneity of variance tests were found to be significant at .05 or less on gain scores for men. Ambition on FUI REAL was found to be significant (Bartlett's Box F Test = 3.820, p = .02).

Loyalty on FUI REAL was found to be significant (Bartlett's Box F Test = 3.450, p = .03). Closeness on FUI REAL was found to be very significant (Bartlett's Box F Test = 4.839, p = .008).

One other subscale group variance was borderline significant. Locus of Control on FUI REAL was found to be significant at the .05 level (Bartlett's Box F Test = 2.945). The results of the univariate homogeneity of variance test on Family Sociability were also worth noting. Family Sociability was found to be significantly different on group variances at .06 level of confidence (Bartlett's Box F Test = 2.773).

Visual inspection and comparison of the three sets of Bartlett's Box Plots on Ambition, Loyalty, and Closeness suggested a trend in the data--at least, across these three variables. Group one, the treatment group, appeared to consistently display the greatest group variance in group scores. Group two, the first nontreatment group, followed consistently with the smaller variance. Group three, the second nontreatment group, consistently displayed the least group variance.

As a point of interest, examination of the Bartlett's Box Plots on Sociability and Locus of Control reflected some similarity with slight variations. In both instances, group one, the treatment group, once again, displayed the greatest variance in gain scores. However, on Sociability, and on Locus of Control, group three displayed the least variance.

FUI IDEAL--Men, T_1

Only one univariate homogeneity of variance test on FUI IDEAL was

found to be somewhat near significant for men at T_1. Family Closeness
was found to be significant at a .06 level (Bartlett's Box F Test =
2.752).

FUI IDEAL--Men, T_2

Three univariate homogeneity of variance tests were found to be
significant or borderline significant at T_2 for men. Family Loyalty on
FUI IDEAL was found to be significant at .02 (Bartlett's Box F Test =
3.733). Family Togetherness on FUI IDEAL was found to be borderline
significant at T_2 (Bartlett's Box F Test = 2.850, p = .058). Some group
differences were found on Family Sociability at the .06 level (Bart-
lett's Box F Test = 2.706).

In all three instances, examination of the Bartlett's Box Plots
indicated that group two, the first nontreatment group, displayed the
greatest group variance. However, on Sociability and Togetherness,
groups two and three, the two nontreatment groups, were more alike,
whereas the treatment group was quite different. In both cases, the
treatment group displayed the smallest variance. However, on Family
Loyalty, while group two demonstrated the largest variance, groups
three and one appeared more alike with two smaller variances.

FUI IDEAL--Men, Gains

Five of the nine univariate homogeneity of variance tests were
significant or borderline significant for mens' gains. Consideration
on FUI IDEAL was found to be very significant at .004 (Bartlett's Box
F Test = 5.562). Loyalty on FUI IDEAL was also found to be very sig-

nificant at .001 (Bartlett's Box F Test = 7.100). Communication (Bart-
lett's Box F Test = 3.056) and Ambition (Bartlett's Box F Test = 3.052)
were both found to be significant at .04. Sociability was found to be
borderline significant (Bartlett's Box F Test = 2.954) at .053.

Inspection of the group variances listed in the table on FUI IDEAL
scores for men (contained in Appendix J) as well as review of the Bart-
lett's Box Plots displays suggested certain trends in the data. On
Consideration, the treatment group displayed the greatest variance in
gain scores, followed by group two and group three, the nontreatment
groups. On Loyalty, a subscale found to be very significant in group
differences on variances, the treatment group demonstrated the greatest
variability in group gains. However, the treatment group and group two
appeared quite similar. In contrast, group three appeared quite differ-
ent from groups one and two. Group three also demonstrated the least
variability in group gains. On Communication, Sociability, and Ambi-
tion, the treatment group consistently displayed the greatest variabil-
ity in group gains on FUI IDEAL for men. In all three instances, groups
two and three displayed quite smaller group variances on gains. While,
in some instances, groups two and three interchanged places for the
middle versus the least variance position, group one, the treatment
group, clearly stood out in all five instances as the group demonstrat-
ing the greatest variance in gain scores.

FUI REAL and FUI IDEAL--Second-Order Factors, Men, T_1

Univariate homogeneity of variance tests were conducted on five
second-order factors: Real Adaptive Coping, Ideal Adaptive Coping, Real

Family Integration, Ideal Family Integration, Satisfaction. None of the univariate homogeneity of variance tests were found to be significant for men at T_1.

FUI REAL and FUI IDEAL--Second-Order Factors, Men, T_2

None of the univariate homogeneity of variance tests conducted on the five second-order factors on FUI REAL and FUI IDEAL were found to be significant for men at .05 or less at T_2.

FUI REAL and FUI IDEAL--Second-Order Factors, Men, Gains

Four out of the five univariate homogeneity of variance tests on the second-level factors were found to be very significant for men on gains. These were as follows: Ideal Adaptive Coping (Bartlett's Box F Test = 6.177) was found to be significant at .002. Real Family Integration (Bartlett's Box F Test = 6.349) was found to be significant also at .002. Ideal Family Integration (Bartlett's Box F Test = 6.780) was found to be significant at .001. Satisfaction (Bartlett's Box F Test = 6.685) was found to be significant also at .001. As a point of interest it should be noted that Real Adaptive Coping, the fifth second-order factor, was found to approach significance (Bartlett's Box F Test = 2.621) at .07.

Group variances on the four significant variables--Ideal Adaptive Coping, Real Family Integration, Ideal Family Integration, and Satisfaction--appeared to be quite different for men on gains. Examination of group variances for mens' gains in the tables contained in Appendix J and visual inspection of the Bartlett's Box Plots displaying the distribution of mens' gains scores on each of the five second-order factors

suggested certain trends in the data. These trends were as follows: In four out of the five univariate homogeneity of variance tests, the treatment group demonstrated the greatest variance--or the most variability in gain scores. The treatment group displayed a substantially larger spread of scores. In four out of the five instances (with the exception of group variances on Satisfaction), the same pattern appeared. On Ideal Adaptive Coping, Real Family Integration, Ideal Family Integration and the near-significant, Real Adaptive Coping, the following order of group variances, from largest to smallest group variance, were observed: The treatment group demonstrated the greatest variability. Group two, the first nontreatment group, demonstrated the next largest variance. Group three, the other nontreatment group, consistently demonstrated across all four second-order variables, the smallest group variance on gains.

It is interesting to note that on the above four variables, the situation did not exist in which two of the group variances were close while the third group variance was quite different and apart. Except for the ordering of the groups in terms of decreased magnitude (i.e., treatment group one, nontreatment group two, nontreatment group three), all three groups appeared to be quite different from one another. It should also be noted that on Satisfaction, the same pattern was observed in which all three variances were quite different. In addition, while the general pattern of "distances" among group variances remained the same, the ordering of the group variances differed. In this case, nontreatment group two displayed greatest variability followed by group

one, the treatment group, followed by nontreatment group three. It is also of interest to note that of all the five second-order factors, Satisfaction displayed the smallest variances on gains across groups.

Results of the Experimental Study: Mother-Father Pairs

In the original phrasing of the hypotheses proposed for testing in this study, the family unit was identified as the basic unit under study. The term "families" appeared consistently throughout the experimental hypotheses. In the preceding and present chapter, plans for data analysis and methods for investigating and reporting the results of the experimental study have focused exclusively on the testing of hypotheses on the individual family member level. Individual family member scores were used as the primary level of analysis for the study of change. The reasons for shifting the level of data analysis to the individual family member level were discussed in Chapter VI.

However, in order to address the question of the assessment of outcome on the family unit level, mother-father congruence scores were computed on CBCL, FUI REAL and FUI IDEAL. Because the type of family under study was, for the most part, comprised of mother, father, and young children, the mother-father dyad was designated as the equivalent of the adult family unit. Therefore, the assessment of change using mother-father congruence scores seemed quite appropriate as an index of change in the family unit. In addition, in consideration of the primary method used for collecting data and assessing change (i.e., shifts in self-reports of family functioning and the presenting child's behavior) as well as consideration of the nature of written questionnaires, the adult,

parental/marital dyad appeared to offer an adequate measure of change on the family unit level.

A series of MANOVAS were conducted at all three time points on family congruence scores. Each MANOVA simultaneously analyzed group mean differences on CBCL Congruence scores, FUI REAL Congruence scores and FUI IDEAL Congruence scores. The three experimental hypotheses tested were that families who received the family therapy would obtain higher average group mean scores on (1) CBCL Family Congruence, (2) FUI REAL Family Congruence, and (3) FUI IDEAL Family Congruence. The null form of no group differences was tested statistically at the .05 level. Paralleling the general plan for analysis, univariate homogeneity of variance tests were conducted on the Family Congruence scores on all three assessment points. The results of the tests on variance were as follows.

Family Congruence--T_1, T_2, Gains

None of the MANOVAS conducted on Family Congruence scores on CBCL, FUI REAL and FUI IDEAL were found to be significant at the .05 level or less. The value of Roy's Criterion and the degrees of freedom for each MANOVA were as follows: At T_1, Roy's Criterion value = .24525, S = 2, M = 0, N = 6 1/2; at T_2, Roy's Criterion value = .05340, S = 2, M = 0, N = 12 1/2; gains, Roy's Criterion value = .224, S = 2, M = 0, N = 4 1/2.

Tests of Homogeneity of Variance on Family Congruence--T_1, T_2, Gains

None of the univariate homogeneity of variance tests conducted on CBCL Congruence, FUI REAL Congruence or FUI IDEAL Congruence were found

to be significant or borderline significant at T_1, T_2, or gains.

Summary and Conclusions

The data collected on demographic and clinical outcome variables on the population under study was quite extensive. These included approximately 30 demographic and clinical variables, covering such areas of interest as individual family member characteristics, characteristics of the family unit, and characteristics of the presenting child, problem type, and symptoms. The list of family therapy variables used to assess the effects of treatment were even more extensive. Approximately 40 subscale variables obtained across four self-report child and family assessment instruments, yielding a number of different measures of change (i.e., group means, medians, and variances) were used to study outcome.

Several things become quite clear in this brief overview of the data. There was an extensive amount of data and breadth of information on families and on outcome available for analysis (70 variables overall: A complete list of outcome and subscale scores is contained in Appendix G). In addition, the possibilities for analyzing the data on a number of different levels (individual, couple, and family) and from two equally important perspectives--clinical and statistical--were also quite apparent. Overall, what the review of the data suggested was the difficulties involved in the task of organizing and condensing the results of the analysis into a coherent picture of outcome.

Therefore, after some consideration, this investigator determined

that the best way to approach the task of consolidating the data was first to organize the facts about the data into three separate summaries. The idea was that each summary would highlight special aspects of the study. All three summaries would then be integrated into a more complete discussion of outcome.

The three summaries were, respectively: overview of the population, overview of the nature of the data from a research perspective, and overview of the results. The first summary, overview of the population, addressed the basic question: What do we know about the families who participated in the study? What types of problems concerned them? The basic questions associated with the second summary, overview of the data from a research perspective, were: What general statements can we make about the nature of this data? How does the type of data used affect the inferences we can make about the assessment of change? In the third summary, overview of results, the basic questions addressed were: What can we conclude about the overall picture of outcome? What is the effect of the therapy experience? What were the results of the statistical tests? What other observations can be made about the data? Trends? Patterns?

Therefore, in order to (1) consolidate the mass of data into a more manageable, clearer picture, (2) bring some life to the disparate facts about families and findings on outcome, (3) integrate the data beyond the level of statistical description, and (4) provide a bridge for future clinical discussion of the effect and experience of family therapy, the following three general summaries were constructed.

Overview of the Population

The following descriptions of the typical family, typical mother, typical father, and typical presenting child and presenting problem(s) were developed to give the reader a sense of the type of family in this study.

The typical family under study was a two-parent family with two children. These were all families with young children within the infancy-preschool-grade school developmental stages. The typical combined family income fell within the $25,000 to $40,000 bracket. The families were predominantly Catholic and of English/American heritage.

The typical mother who participated in this study was 33 years of age, unemployed, married for the first time, Catholic, and of Irish/American heritage. She was also a high school graduate and the firstborn or only-child in her family of origin.

The typical father who participated in this study was 35 years of age, full-time employed, married for the first time, Catholic, and of English/American heritage. He was also a high school graduate and the firstborn or only-child in his family of origin. He was mostly employed in factory or trade jobs as, for instance, a janitor, mechanic, or tool and die maker or he held a position such as a skilled technician as a computer programmer/operation or as manager, supervisor or counselor in, for example, social service, sales or veteran's administration.

The typical presenting child in this study was male, approximately six years of age, in the first grade, and presented predominantly aggressive/acting-out behavior for which the family sought help. As a

point of interest, the female presenting children were slightly younger, between four and five years of age, and in preschool or kindergarten and were exhibiting symptoms associated mainly with withdrawn behaviors.

Overview of the Type of Data from a Research Perspective

It should be emphasized that all the dependent measures used were self-report questionnaires. Some of the questionnaires were standardized and therefore, more reliable and valid in terms of the accuracy of perceptions obtained on family functioning and child behavior. Other questionnaires may be regarded as less objective in the types of responses they obtained. For example, FAP and FCE elicited subjective, individual responses. However, regardless of the level of reliability/ unrealiability, or objectivity/subjectivity, all of the instruments used obtained written self-reports on family items. The basis for assessing change rested exclusively on the assessment of pre-post shifts in written responses on these self-report questionnaires. Both positive change and the effect of the therapy experience was assessed solely on the basis of written answers. All results should be viewed within the context of the limitations of the nature of this type of data.

In addition, one other important feature of the data and the method of assessing outcome worth noting was the respondents becoming test sensitive (i.e., learning how to respond to the questionnaires). The outcome data and the study's findings are subject to consideration of the effect of test sensitivity. However, one advantage of the design used is that this factor may be assumed to operate equally among all three groups and was, therefore, assessable.

All in all, these cautions about the nature of the data should be kept in mind when the results are discussed in the next section.

Overview of Results and Overview of Outcome

In this chapter, the question of outcome and the effect of the therapy was explored from the perspective of statistically-significant group differences. The assessment of outcome was based on a three-group comparison. The treatment group mean and group variance scores were compared to two control groups using various statistical tests. Comparisons were made at three time points or three "moments" in the study where change or the observation of group differences were thought to carry the most significance for the study of outcome. The three "moments" of group comparison were: T_1, pretreatment; T_2, posttest; and T_2 minus T_1, posttest differences (gains).

Results for women: pretreatment group mean and group variance differences. The results of the tests of group mean and group variance differences, based on the three-group comparisons, indicated the following: For women, out of the 32 subscale comparisons over the four instruments or approximately 90 percent of the time, there were no significant pretreatment differences on group variances at T_1. This suggested that the data on women at pretreatment sufficiently satisfied the assumption of equal variances.

It should be noted that the testing of group variances was done for two reasons: to study variances across time as a measure of change and the effect of therapy, and to determine whether the data on group variances actually satisfied the assumption of equal variances. What

we may conclude about the homogeneity of variance tests on womens' pre-test-pretreatment data was that all three groups were substantially alike--quite similar at T_1.

Examination of the overall results on MANOVAS for women at T_1 reflected a similar finding. The separate MANOVAS conducted on FAD, CBCL, FUI REAL, and FUI IDEAL on women also did not show any statistically-significant pretreatment group mean differences. Therefore, it may be concluded that all three groups of women were substantially alike or statistically the same on group variances as well as group mean scores on all instruments at T_1.

One intriguing clinical trend observed in the data was that group two appeared rather consistently to be the most healthy group of mothers (e.g., out of 32 subscale mean comparisons, group two occupied the position of "greatest health"/highest mean score 27 times or 84.4% of the time). In contrast, the treatment group appeared to consistently demonstrate the lowest or most unhealthy pretreatment scores (e.g., 21 out of 32 comparisons or 65.6% of the time), with group three falling consistently in the middle (26 out of 32 mean comparisons or 81.1% of the time).

Based upon the expectation that each group would fall into each position (most healthy, least healthy, middle) one-third of the time by chance, we can conjecture that some factors or patterns of factors, perhaps not great enough to be detected statistically, were operating to contribute to some pretreatment between-group differences at T_1. Because the percentages were actually higher than chance, suggesting

a fairly consistent trend in the data on women, we may speculate that some factors or characteristics of the groups were operating to account for pretreatment differences on, at least, some level.

Results for men: pretreatment group mean and group variances. Approximately 90 percent of the time (29 out of 32 univariate homogeneity of variance tests), the three groups were found to have substantially the same pretreatment variances. In addition, none of the ANOVAS were found to be significant at T_1. This suggested that all three group means were statistically the same (i.e., statistically similar) before treatment.

However, once again, examination of individual comparisons of the three groups across the 32 variables subscale means suggested an interesting trend parallel to the pretreatment data on women: Treatment group men obtained the most unhealthy group means (24 of the 32 comparisons of group means, or 75% of the time), whereas group two consistently demonstrated the highest or most healthy mean scores (26 out of 32 comparisons or 81.2% of the time), with group three consistently falling in the middle (23 out of 32 comparisons or 71% of the time).

Results of outcome for men and women. In the first analysis on the data for women, a borderline statistically-significant difference was found on FAD gains. However, follow-up procedures conducted on the pairwise comparisons did not support this finding. For men, five ANOVAS on mean group gains were found to be significant. These were: General Functioning on FAD, Consideration and Loyalty on FUI REAL, and Sociability and Togetherness on FUI IDEAL. Follow-up procedures on pairwise

comparisons on these five variables supported only one of the statistically-significant differences. The mean gain scores for treatment group men on Real Consideration were found to be significantly higher in comparison to group two, group three, and the average of groups two and three.

Concluding Remarks

A study of the overall results suggested the following findings:

1. The family therapy experience appeared to have a greater effect on men in this study than on women. This was evidenced in two ways: only one MANOVA was found to be significant on gains for women whereas five ANOVAS were found to be significant on gains for men. In addition, when a tally was made of the total number of times treatment group men obtained the position of highest gain scores across the 32 subscale variables on all four instruments, the treatment group men obtained the highest mean group gains 62.5% of the time (20:32), whereas control group one men demonstrated greatest gains only once or 3.2% of the time (1:32) with control group two men obtaining the greatest gains only 34% of the time (11:32).

2. The list of variables on which treatment men scored higher on gains than either control group were as follows: On FAD, treatment group men scored highest on gains on five out of seven of the subscales. These subscales are: Problem Solving, Roles, Affective Involvement, Behavior Control, and General Functioning, the most reliable of all the seven subscales. On CBCL, treatment men scored highest on Social Competence. On FUI REAL, treatment men scored highest on gains on seven

out of nine of the subscales. These subscales are: Real Consideration, Real Sociability, Real Ambition, Real Locus of Control, Real Togetherness, Real Loyalty, and Real Closeness. On FUI IDEAL, treatment men once again scored the highest gains on seven out of the nine subscales. These subscales are: Ideal Actualization, Ideal Sociability, Ideal Locus of Control, Ideal Togetherness, Ideal Loyalty, Ideal Closeness, and Ideal Consideration.

3. Finally, group variances for the treatment group for both men and women appeared to be the largest in comparison to either of the two control groups a greater percentage of the time at T_1 as well as on gains. This finding appears contradictory to what would be expected. According to some theorists in the psychotherapy literature, if therapy is effective, the results should indicate a reported decrease in post-test variance (i.e., fewer extreme individual scores after therapy). Therapy is supposed to move families toward the middle (i.e., closer to the group mean). This issue will be explored in greater detail in Chapter IX.

C H A P T E R   VIII

RESULTS OF THE CORRELATION ANALYSIS
AND TREATMENT OUTCOME

This chapter has a twofold purpose: to describe the results of the correlation analysis and to explore both the effect and the experience of family therapy. The discussion of treatment effects will be based on the analysis of the results obtained on the four, standardized instruments (FAD, CBCL, FUI REAL and FUI IDEAL) with special emphasis on the clinical data obtained on the Family Assessment of the Problem (FAP) and the Family Counseling Evaluation (FCE), two questionnaires devised for this study by this author.

This chapter will address (1) the interrelationships between instruments as well as (2) the effect of family therapy on treatment families. In order to accomplish these tasks, this chapter will be divided into two main sections: (1) the correlation study with discussion of its related hypotheses, and (2) presentation of the data collected on FAP and FCE as well as comparisons of the treatment groups in relation to the overall effects of the family therapy experience.

The Correlation Study

As the reader will note, this investigation was originally divided into two separate studies: the experimental study with its related hypotheses and the correlation study with its related hypotheses. In the preceding chapter, the results of the experimental study and the testing of a series of hypotheses on outcome were discussed. The experi-

mental study focused exclusively on group mean and group variance differences based on comparisons of random groups. The emphasis was upon the examination of statistically-significant group differences in the direction of positive gains on the subscale level on the four, standardized instruments. In this chapter, the results of the correlation analysis will be described.

Purpose of the Correlation Study

The primary purpose of the correlation analysis was to examine instrument concurrent validity. The correlation analysis was designed to assess the degree to which comparable subscale variables on different, independent child and family assessment measures shared substantial proportions of systematic variance.

Design Used in the Correlation Analysis

Because the major objective of the correlation study was to assess the degree and strength of association between instruments' subscales without the confounding factors of treatment intervention or test-retest effect, only data on family members at T_1 were used in the analysis.

The design was as follows: All 65 families, comprising an overall N of 87 individuals, were tested at T_1. The instruments were administered by a trained tester to each family within a two-hour test session. The instrument order was as follows: FAD, CBCL, FUI REAL, FUI IDEAL. The data on men and women were combined in the analysis. A correlation matrix was constructed across all four instruments on a total of 32 sub-

scale variables. Subscales were compared within instruments as well
as between instruments. In addition, Cronbach's alphas were computed
on reliabilities for each instrument on the subscale level. With re-
gard to the inter-instrument subscale correlations, the following tests
of instrument concurrent validity were examined: (1) FAD with CBCL,
(2) FAD with FUI REAL, (3) FAD with FUI IDEAL, (4) CBCL with FUI REAL,
(5) CBCL with FUI IDEAL, and (6) FUI REAL with FUI IDEAL.

Hypotheses Tested in the Correlation Analysis

A separate set of hypotheses was proposed for the correlation
analysis. Overall, these hypotheses predicted that higher average
posttest scores on one instrument or instrument subscale, indicating
positive shifts in family member self-reported perception, would be
systematically associated with higher average posttest scores on another
instrument. The relationship proposed was that scores on one instru-
ment subscale would be highly associated and somewhat predictive of
scores on comparable scales or subscales on another instrument.

However, because such a detailed correlation analysis was deter-
mined to be beyond the scope of this dissertation, the data on instru-
ment subscales were investigated only at T_1. The decision was made
upon completion of the data collection stage to study mainly how the
instruments behaved at T_1 (i.e., how the subscales correlated at pre-
treatment). The question of prediction will be left to future study
and analysis of the data. Therefore, the question proposed was a simple
test of inter-instrument relationship or correlation.

Results of the Correlation Analysis on Instrument Subscale Scores at T_1

Data on men and women (the overall population of families, N = 65, 87 individuals) were analyzed. Pearson's product-moment correlation coefficients were used to compute the inter-instrument subscale correlations. A cutoff point of .70 was used to define and identify substantial correlations from other less significant correlations. The cutoff point of .70 or above was used because .70, for example, indicated that approximately 49 percent of the variances were accounted for and therefore shared by the two correlated variables, suggesting a substantial correlation.

Results of the correlation analysis at T_1 indicated that, out of all the possible combinations of variables identified and tested, eleven relationships between nine subscale variables on two of the four child and family measures were found to be substantially significant. Significantly high correlations were found between four main variables on FAD and five main variables on FUI REAL. The results of the instrument subscale intercorrelations (i.e., the strength and direction of subscale relationships) on FAD and FUI REAL are described in Table 1. The correlations reported in Table 1 were computed on an N of 87. For an obtained correlation value to be significant, based on a two-tailed test, at the .05 level, the obtained value must exceed .211; for the obtained correlation value to be significant, based on a two-tailed test, at the .01 level, the obtained value must exceed .275. The subscale intercorrelations reported in Table 1 were tested at .01.

TABLE 1

Significant Subscale Correlations on
FAD and FUI REAL at T_1

FUI REAL Subscales	FAD Subscales			
	General Functioning	Problem Solving	Communication	Affective Response
Actualization	-.7590	-.7063		
Communication	-.7118	-.7584	-.7524	
Togetherness	-.7371	-.7290		
Loyalty	-.7044			
Closeness	-.8351	-.7917		-.7224

The type of relationships found for correlated subscales reported in Table 1 were consistently inverse (i.e., as scores on one instrument increased, scores on the other instrument decreased). The direction of the relationship on all FAD and FUI REAL subscale correlations indicated that high scores on one instrument were consistently paired with low scores on the other instrument.

However, what was important to note in interpreting these correlations was that each instrument was scored in a different direction. FAD was scored in a negative direction and FUI REAL was scored in a positive direction. Lower scores on FAD represented more positive, healthier perceptions of family functioning whereas higher scores on FUI REAL represented more positive, healthier family concepts. Therefore, the negative correlations between FAD and FUI REAL subscales described in

Table 1 may be interpreted as representing consistent patterns of per-
ceived healthy family functioning or unhealthy family functioning as
measured on both instruments.

Generally, we may infer that healthier scores on, for example,
Problem Solving on FAD will correspond with healthier scores on Communi-
cation on FUI REAL. The results of the correlation analysis suggested
that all nine variables, represented in the eleven inter-instrument cor-
relations found to be significant, share a certain, substantial degree
of concurrent validity.

One other interesting observation derived from Table 1 was that
General Functioning, reported by the developers of FAD to be the most
stable and reliable of all FAD's subscales, was the variable that ap-
peared most often in significantly high correlations. In addition, the
strongest of all the significant correlations reported was between Gen-
eral Functioning on FAD and Family Closeness on FUI REAL.

It should be noted that no statistically-significant correlations
were found on subscales on either CBCL and FAD, CBCL and FUI REAL, CBCL
and FUI IDEAL, or on subscales on FUI REAL and FUI IDEAL. Reasons ac-
counting for the failure to find statistically-significant correlations
between subscales on CBCL and the family instruments will be discussed
in a later section.

In summary, study of the instruments' intercorrelations indicated
that strong relationships (i.e., patterns of systematic responses) were
present between specific subscales on FAD and FUI REAL. The major sub-
scales demonstrating substantially high correlations were Problem Solv-

ing, Communication, Affective Responsiveness, and General Functioning
on FAD and Actualization, Communication, Togetherness, Loyalty, and
Closeness on FUI REAL.

Intra-instrument Subscale Correlations and Subscale Reliabilities

A few brief comments should be made about the correlations between
subscales computed for each instrument and on the instrument subscale
reliabilities. As part of the overall correlation analysis conducted
at T_1, Pearson product-moment correlation coefficients were also comput-
ed for intra-instrument subscale comparisons using individual family mem-
ber subscale mean scores. All possible combinations of subscale vari-
ables on a given instrument were correlated and tested for significance.
For example, a total of 22 intra-subscale comparisons were correlated on
FAD. A correlation matrix was constructed to report and present the
results separately for each of the four instruments. For complete ta-
bles on intra-instrument correlations and reliabilities, the reader is
referred to Appendices H and I.

However, two general observations regarding trends in the results
of intra-instrument correlations may be made: First, trends observed in
the results of this study's correlation analysis generally supported
findings on correlations reported by the respective instrument develop-
ers. A second interesting observation was the general trend in the re-
sults of this study's correlation analysis in which the obtained sub-
scale correlations (r's) and subscale means were, in the majority of
cases, somewhat, if not substantially higher than r's and subscale means
presented in the instrument developer's published reports. For a more

detailed study of the results of the correlation analyses and reliabilities reported by the respective instrument developers, the reader is referred to The Family Assessment Device: Version III (Epstein, Baldwin & Bishop, 1981); Behavioral Problems and Competencies Reported by Parents of Normal and Disturbed Children Aged Four through Sixteen (Achenbach & Edelbrock, 1981); Manual and Handbook for the Family Concept Assessment Method (van der Veen & Olson, 1981).

However, one caution regarding the comparison of this study's findings to those of published reports should be noted. The main factor accounting for the lack of comparability rests in the discrepancy between procedures used in published reports and procedures followed in this study's handling of the data. In this study, the decision was made to conduct the correlation analysis on the subscale level, using subscale means, rather than on the individual item level. The decision was also made to include all items in the computation of the subscale means. However, this set of procedures deviated slightly from the methods used by the instrument developers with respect to their analyses.

For example, all 60 items on FAD were used to compute FAD subscale means for the inter- and intra-instrument correlation analysis. In contrast, FAD's developers used a 53 item subset of the complete 60 item set to compute correlations and reliabilities. This difference in computation method has resulted in two discrepant sets of measures (i.e., two different populations of scores). Such variations account for the inability to compare results obtained in both studies. Similar varia-

tions occurred on FUI REAL, FUI IDEAL, and CBCL. Factor scores were not used in this study for computing means in the correlation analysis. Lack of the use of the same basic score (e.g., factor scores) contributed to some degree of incomparability of the results obtained in this study to those obtained by van der Veen et al.

Finally, dissimilarities in the computation and use of CBCL scores produced a situation in which comparisons between this study's results and those obtained by Achenbach et al. were not completely valid. While normalized T scores were used to compute subscale correlations, what should be noted with caution was the fact that within the population of subscale scores, there was quite a diversified age range of children. Correlation analyses conducted on CBCL by Achenbach et al. were based on age-specific and gender-specific groups. However, in this study, correlations on any given subscale on CBCL included such a diversified range of age subpopulations producing a confounding effect and, therefore, eliminating any basis for valid comparison.

Comparisons of Treatment Groups

In previous sections, considerable attention was given to trends in the overall population of scores at T_1 and to the differences observed between random groups. This section will focus primarily on (1) differences (statistical and clinical) observed between treatment groups, (2) the results obtained on the Family Counseling Evaluation (FCE), and (3) the identification of statistically-significant treatment group differences found at T_2 posttest and T_3 follow-up on the

Family Assessment of the Problem Questionnaire (FAP).

Results of the Family Counseling Evaluation

Data was collected on families' experience and satisfaction with therapy on the Family Counseling Evaluation Questionnaire (FCE) on an overall treatment population of 34 families for a total of 60 individuals. The overall population was composed of two treatment groups. The first treatment group was comprised of the original randomly selected treatment group. The second treatment group represented a reconstituted group composed of control, waitlist families who, after T_2 testing, still wished to participate in the study and receive professional help with their family problem(s).

A series of chi-square tests were used to analyze FCE data. FCE outcome for treatment families (N=34) was analyzed in four different ways: by group, by gender, by couples (a slightly smaller n of 26), and for the overall population. The results on FCE were examined for statistically-significant findings as well as for trends such as patterns of responses based on group differences (i.e., the first treatment group versus the second treatment group) and gender differences (i.e., male versus female responses). In addition, item by item correlations of the responses of the subsample of couples (n=26) were studied. The item by item correlations were tested to determine whether there were any consistent patterns of husband-wife responses. However, none of the correlations between husband-wife responses on any of the 17 FCE items indicated a strong enough degree of association to warrant further discussion and analysis at this time.

Organization of FCE Tables

Two tables were constructed to report FCE results. Each table was designed to describe the overall results on FCE from a slightly different vantage point. The purpose of each table was as follows: In Table 2, the percentages of responses falling within each of the four response categories (Strongly Agree = SA, Agree = A, Disagree = D, Strongly Disagree = SD) for each of the 17 FCE items were reported for women and for men by group. In Table 3, the percentages based on the four category response system (Strongly Agree to Strongly Disagree) as well as percentages based on a simply dichotomous system (Agree-Disagree) were reported for the overall population on all 17 FCE items.

Group Differences and Gender Differences Based on FCE Results

When percentages for responses for men over all 17 FCE items were compared to the percentages of responses for women on the same 17 items as shown in Table 2 regarding the usefulness of therapy, an interesting trend appeared.

The trend was as follows: Women, regardless of group, responded more positively in comparison to men. In addition, when groups were compared on the overall percentages of reported agreement/disagreement on responses on the usefulness of family therapy, group one (regardless of gender) reported more positive responses. In contrast, group two reported more disagreement in their FCE evaluations. However, the level of disagreement needs to be situated within the context of the overall results obtained on FCE. The level of disagreement was relatively small for the overall treatment population as well as for both treat-

TABLE 2

Percentages of Responses on FCE Items for Men and Women by Groups

FCE Items	Group #	Women (n=34)				Men (n=26)			
		Strongly Agree	Agree	Disagree	Strongly Disagree	Strongly Agree	Agree	Disagree	Strongly Disagree
1. Change the Problem	1	42.1%	52.6%	0%	5.3%	38.5%	61.5%	0%	0%
	2	60.0	40.0	0	0	46.2	38.5	15.4	0
2. Insight into Child's Behavior	1	55.6	44.4	-	0	38.5	61.5	0	0
	2	40.0	60.0	0	0	53.8	38.5	7.7	0
3. Insight-Interaction with Children	1	61.1	38.9	0	0	16.7	83.5	0	0
	2	40.0	60.0	0	0	38.5	61.5	0	0
4. Insight - How Family Interacts	1	42.1	57.9	0	0	23.1	76.9	0	0
	2	26.7	66.7	6.7	0	30.8	69.2	0	0
5. Understand Meaning of Family Members' Behavior	1	55.6	44.4	0	0	23.1	61.5	15.4	0
	2	26.7	73.3	0	0	23.1	61.5	15.4	0
6. Expectations of Family Members	1	38.9	61.1	0	0	15.4	84.6	0	0
	2	20.0	73.3	6.7	0	30.8	61.5	7.7	0
7. More Effective Parenting	1	44.4	55.6	0	0	23.1	76.9	0	0
	2	40.0	53.3	6.7	0	23.1	46.2	30.8	0
8. Insight into Childhood Family	1	47.4	47.4	5.3	0	7.7	61.5	30.8	0
	2	26.7	20.0	53.3	0	7.7	38.5	53.8	0

Continued

TABLE 2 - continued

FCE Items	Group #	Women (n=34)				Men (n=26)			
		Strongly Agree	Agree	Disagree	Strongly Disagree	Strongly Agree	Agree	Disagree	Strongly Disagree
9. Better Communication with Spouse	1	29.4%	58.8%	11.8%	0	53.8%	20.8%	15.4%	0
	2	21.4	50.0	28.6	0	15.4	69.2	15.4	0
10. Better Relationship with Spouse	1	42.1	52.6	5.3	0	53.8	30.8	15.4	0
	2	20.0	60.0	20.0	0	15.4	53.8	23.1	7.7
11. Insight Into Self	1	57.9	42.1	0	0	15.4	76.9	7.7	0
	2	20.0	60.0	20.0	0	0	76.9	23.1	0
12. Expectations about Self	1	44.4	50.0	5.6	0	0	92.3	7.7	0
	2	33.3	40.0	26.7	0	15.4	61.5	23.1	0
13. Getting Along Better with Children	1	36.8	63.2	0	0	23.1	76.9	0	0
	2	46.7	53.3	0	0	15.4	69.2	15.4	0
14. Getting Along Better with Spouse	1	36.8	57.9	5.3	0	53.8	38.5	7.7	0
	2	21.4	35.7	42.9	0	0	83.3	16.7	0
15. Getting Along Better with Parents	1	31.6	42.1	26.3	0	7.7	38.5	53.8	0
	2	7.1	35.7	57.1	0	7.7	15.4	76.9	0
16. Was a Worthwhile Experience	1	89.9	10.5	0	0	91.7	8.3	0	0
	2	80.0	20.0	0	0	69.2	23.1	7.7	0
17. Would Recommend Counseling	1	89.5	10.5	0	0	84.6	15.4	0	0
	2	80.0	20.0	0	0	69.2	30.8	0	0

ment groups.

In sum, the following general statement may be made on FCE results on the basis of gender (male and female) and group (first and second treatment groups): Women overall responded more positively than men. Men and women in the first treatment group reported more positive FCE evaluations than men and women in the second treatment group. Men in the first treatment group responded more positively to family therapy than men in the second treatment group. Conversely, men in the second treatment group accounted almost exclusively for the percentages of disagreement.

Outcome on FCE for the Overall Treatment Population

Table 3 was designed to present an overview of the percentages obtained for responses on FCE items for the overall treatment population (N=34 families). The breakdown in percentages of responses was described in two ways: by percentages across four response categories (Strongly Agree, Agree, Disagree, Strongly Disagree) and by percentages across a dichotomous response system (Agree - Disagree) reported in Table 3.

FCE items were originally organized into six main categories. These categories were: (1) insight(s) into the child, (2) insight(s) into the family, (3) insight(s) into self, (4) insight(s) into spouse, (5) insight(s) into family of origin, and (6) overall satisfaction with therapy. The two main variables that obtained the greatest positive response to family therapy (almost 100% Strongly Agree - Agree) as shown in Table 3 were item 3, increased insight(s) into how the parent

TABLE 3

Percentages of Responses on FCE for the Overall Population Based on Strongly Agree, Agree, Disagree, Strongly Disagree and on Agree-Disagree

	Overall Treatment Population (N=60)					
FCE Items	Strongly Agree	Agree	Disagree	Strongly Disagree	Agree	Disagree
1. Change the Problem	46.7%	48.3%	3.3%	1.7%	95.0%	5.0%
2. Insight-into Child's Behavior	47.5	50.8	1.7	0	48.3	1.7
3. Insight-Interaction with Children	41.4	58.6	0	0	100.0	0
4. Insight - How Family Interacts	31.7	66.7	1.7	0	98.4	1.7
5. Understand Meanings of Family Members' Behaviors	33.9	59.3	6.8	0	93.2	6.8
6. Expectations of Family Members	27.1	69.5	3.4	0	46.6	3.4
7. More Effective Parenting	33.9	57.6	8.5	0	91.5	8.5
8. Insight - Into Childhood Family	25.0	41.7	33.3	0	66.7	33.3
9. Better Communication with Spouse	29.8	52.6	17.5	0	82.4	17.5

Continued

TABLE 3 - Continued

FCE Items	Overall Treatment Population (N=60)					
	Strongly Agree	Agree	Disagree	Strongly Disagree	Agree	Disagree
10. Better Relationship with Spouse	33.3%	50.0%	15.0%	1.7%	83.3%	16.7%
11. Insight - into Self	26.7	61.7	11.7	0	88.4	11.7
12. Expectations about Self	25.4	59.3	15.3	0	84.7	15.3
13. Getting Along Better with Children	31.7	65.0	3.3	0	96.7	3.3
14. Getting Along Better with Spouse	29.3	53.4	17.2	0	82.7	17.2
15. Getting Along Better with Parents	15.3	33.9	50.8	0	49.2	50.8
16. Was a Worthwhile Experience	83.1	15.3	1.7	0	98.4	1.7
17. Would Recommend Counseling	81.7	18.3	0	0	100.0	0

interacts with the presenting child and item 16, that the parent felt the therapy was a worthwhile experience.

When the remaining 15 FCE items (i.e., excluding items 3 and 16) were organized into an array of descending percentages, the following trend was indicated for the overall treatment population. Variables on FCE that obtained the highest percentages of the most positive evaluations (90-99% agreement) involved (1) insight(s) into the child's and children's behavior; (2) insight(s) into family members' behaviors, expectations, the meanings behind family members' behaviors and how the family interacts; (3) satisfaction with treatment, perception that the problem had changed in a positive direction following therapy and that families would recommend the therapy.

The second group of variables that obtained positive reports on FCE (82-88% agreement) involved (1) insight(s) into self and (2) insight(s) into spouse and marriage. The areas of least improvement, in comparison to responses on other FCE items, related to increased insight(s) into family of origin and (2) improved relationships with parents and extended family.

In sum, the results obtained on FCE reflected the general goals of treatment. The areas occupying the greatest clinical attention in the family therapy model used were affecting positive shifts in parental perception of the presenting child and presenting problem. While attention was given to the development and encouragement of insight(s) into self, spouse and marital relationship, these areas were addressed less emphatically during therapy. The areas of least attention within the context of the relatively short-term family therapy were parental

past, unresolved childhood issues and relationships with extended family.

Finally, it should be noted that the results obtained on FCE were derived from self-report data. Undoubtedly, the subjectivity character- istic of this type of data suggests several limitations of the data as well as of the conclusions drawn from such results. For instance, it may be argued that the overwhelmingly positive response to family ther- apy obtained on FCE was influenced by such intervening factors as social desirability and appreciation for receiving help. However, it may also be argued in defense of the validity of self-report data that such sub- jectivity is the "stuff" of psychotherapy.

It may be argued further that the primary goal of psychotherapy is often to facilitate such shifts in subjectivity: The therapist works to facilitate change in the way the individual and/or family sees things, whether these things be of self, family, the presenting child, or the therapy experience.

Therefore, in light of this argument, the self-reports obtained on FCE in relation to the effects of family therapy provided valid informa- tion on outcome. It should also be noted that FCEs were administered following therapy. FECs were obtained at a time when dissatisfaction with therapy could be expressed with minimal fear of the risk to the quality of treatment or therapist's reaction.

Results of the Analysis of Items on The Family Assessment of the Problem Questionnaire

Clinical data was also collected on a sixth dependent measure, The Family Assessment of the Problem Questionnaire (FAP). Similar to FCE,

FAP was developed by this investigator specifically for this study. FAP obtained data on additional, important clinical variables on outcome, status of the presenting problem, and family life. FAP was pilot tested prior to use in this study. For a more detailed description of FAP, the reader is referred to Chapter IV and to a copy of FAP, both pretest and posttest versions, contained in Appendix D.

FAP was administered at three time points (T_1, T_2, T_3) to the overall population of families. A series of chi-square tests were used to investigate and report the results obtained on FAP. FAP data was analyzed by group by time by item using two different breakdowns of the family research population: in the first analysis the data was analyzed using the original randomized experimental control group classification (i.e., experimental group, n = 20; control group one, n = 20; control group two, n = 25). In the second analysis, the data on FAP was viewed from a somewhat different perspective: the original randomly-selected treatment, n = 19; the second self-selected treatment group, n = 15; the remaining random control group, n = 21.

For purposes of economy of discussion, only statistically-significant findings will be discussed. The results of the series of chi-square tests will be described in chronological order: significant findings at T_1, T_2, and T_3. Significant findings on the same variable will also be examined in relation to treatment versus nontreatment differences as well as comparisons between the first and second treatment groups.

Organization of FAP Tables

A series of tables were constructed to organize and describe the

data on FAP. Each table was designed to express in reported frequencies and percentages the interrelationships of reported responses within groups and between groups as well as between groups and the overall population.

Table format. In order to summarize and express these interrelationships, the following information has been presented in each table:

1. Each cell lists four numbers arranged in vertical order. The first number expresses the actual number or frequency of responses obtained for the group for the particular response subcategory under study. The second number expresses the percentage of frequencies reported for that response subcategory within the group. The third number represents the percentage of responses for each group expressed in relation to the overall representation for the given response subcategory. The fourth number signifies the breakdown of these group percentages in relation to the overall population percentage for the respective response category.

2. In right-hand table marginals, the group n's were reported as well as the percentage that the group n expressed in relation to the overall population of responses. Because the total number of responses sometimes varied from item to item, the n's were reported individually for each table.

3. Marginals reported at the bottom of the table express the representation of responses for each category for the overall population. In addition, the actual number (frequencies) of reported responses upon which the population percentages were based were also included.

For example, in Table 4 which follows, the FAP item under study was Problem Level and Intensity. Problem Level and Intensity was divided into four subcategories: mild, moderate, serious, very serious. For treatment group one before therapy, ten women reported a serious problem based on a group n of 20; 50.0% represents the percentage of serious problem responses reported within this group; 22.2% indicated the percentage the ten responses represent in relation to the category of serious problems; 15.4% depicts the proportion these ten responses in group one represent in relation to the total number of serious problems reported for the population overall (69.2% overall).

Use of the terms "before therapy" and "after therapy" in tables. The phases "before therapy" and "after therapy" that appear in parenthesis in specific instances under either treatment group one or treatment group two in the following tables were included to indicate the following: At T_2, while treatment group two had been formed, treatment group two had not participated in family therapy. Only the first treatment group had completed family therapy at the T_2 testing. The results should be viewed in this light.

Use of the terms "reconstituted" and "experimental" groups. Two analyses were conducted on the data on FAP. The rationale for the two analyses was based on the recognition of specific changes in the original experimental-control group design as well as in differences in control group memberships at T_2. Originally, one experimental group and two control groups were randomly selected, pre- and posttested to study the effects of family therapy. Only the experimental group received

family therapy between T_1 pretest and T_2 posttest. The term "experimental groups" refers to analyses obtained on the original random three group comparisons. However, at T_2, a second group of families self-selected from the two control groups who wished to continue on and participate in family therapy was formed. These families became the second treatment group. However, at T_2, while their character as a group was essentially the same as the other control group, they did become a group motivated by other factors. They were thus regarded as a reconstituted group who were about to participate in family therapy. The term "reconstituted" was used to identify analyses based on comparisons involving this nonrandom group.

Rationale for presentation of tables based on comparisons of reconstituted as well as experimental groups. Tables describing both sets of results were included to explore and/or reveal any factors or characteristics that would differentiate one group from another group either at T_1 before any of the groups received therapy or at T_2, after the experimental group completed therapy, and the second treatment group was about to participate in therapy in comparison to control group one families.

Inclusion and discussion of tables in the text. Only those tables indicating clear-cut, nonambiguous group differences will be discussed in the text. Only those findings that, in this author's opinion, most directly address the questions and hypotheses raised in this study will be considered. Other tables appearing in the text without discussion were included to provide the reader with the complete data on FAP items

that obtained significance. Three reasons that accounted for the lack of discussion of specific tables (Tables 9-14, 17) were as follows: (1) the relationships as well as differences in groups was not dramatic or pronounced, (2) the relationships and/or differences in groups was not of major clinical significance, (3) differences were noted mainly between groups who did not receive family therapy at that time involving a situation in which the treatment group was similar to at least one control group.

Results of Comparisons of Treatment Group One, Treatment Group Two, and the Control Group on FAP at T_1

As a statistical procedure, the chi-square test poses the question: Are the population proportions of a given variable under study equal or distributed differently between two or more populations? In this analysis, the two treatment groups and one control group were compared on all 21 clinical variables on FAP (pretest version) at T_1. Only one significant difference was found at T_1 for all comparisons on the analyses of items conducted separately for men and for women. Item 6 on FAP, Problem Level/Intensity was found to be significant at .07 level. With respect to Problem Level and Intensity, women responded as shown in Table 4.

The frequencies of problem levels (i.e., mild, moderate, serious, very serious) reported in Table 4 indicated that, prior to therapy, mothers in the first treatment group perceived the presenting problem more seriously than did mothers in either the control group or second treatment group. Of the overall 15.4% of presenting problems assessed

TABLE 4

Responses on Problem Level and Intensity for Women
on FAP Before Therapy (Reconstituted Groups)

	Mild	Moderate	Serious	Very Serious	n's
Treatment Group 1					
*Number of responses	0	4	10	6	20
Percentage within groups	0	20.0	50.0	30.0	30.8
Percentage by subcategory	0	44.4	22.2	60.0	
Percentage of population	0	6.2	15.4	9.2	
Treatment Group 2					
Number of responses	0	0	14	3	17
Percentage within groups	0	0	82.4	17.6	26.2
Percentage by subcategory	0	0	31.1	30.0	
Percentage of population	0	0	21.5	4.6	
Control Group					
Number of responses	1	5	21	1	28
Percentage within groups	3.6	17.9	75.0	3.6	43.1
Percentage by subcategory	100.0	55.6	46.7	10.0	
Percentage of population	1.5	7.7	32.3	1.5	
	1	9	45	10	65
	1.5%	13.8%	69.2%	15.4%	100.0%

x^2 = 11.54676; df = 6; p = .0729

*The headings that appear in the left-hand are provided as guidelines
to explicate the information provided in the table. However, in future
tables, these headings will be indicated by an * and will not be re-
peated.

by parents in the population to be very serious psychological problems, 9.2% or almost two-thirds was accounted for by the first treatment group with 4.6% accounted for in the second treatment group and only 1.5% accounted for in the control group.

The overall lack of significant differences found for men or women on the overwhelming number of clinical variables tested at T_1 suggested that the three groups were quite similar prior to treatment. This is, of course, a quite favorable finding. With the exception of the somewhat significant difference on Problem Level/Intensity, the data indicated that the groups were approximately equal on these important clinical pretreatment variables.

Results of Comparisons of the Original Randomized Experimental-Control Groups on FAP at T_1

Analysis of the same data on FAP at T_1, using the original randomized groups, provided slightly different results as well as a slightly different view of the data. Viewed from the perspective of the three original random groups, item #6, Problem Level/Intensity, was, once again, found to be statistically significant for groups of mothers. However, in this instance, the statistical significance increased somewhat, approaching a borderline significance at .05 level. With respect to Problem Level and Intensity, women responded as shown in Table 5.

As indicated in Table 5, the greatest percentage of the most serious presenting-child problems were reported once, again, by the original experimental group mothers. In addition, one other pretreatment difference was uncovered in this analysis. A borderline pretreatment group

TABLE 5

Responses on Problem Level/Intensity for Women on
FAP Before Therapy (Experimental Groups)

	Mild	Moderate	Serious	Very Serious	n's
Experimental Treatment Group	* 0	4	10	6	20
	0	20.0	50.0	30.0	30.8
	0	44.4	22.2	60.0	
	0	6.2	15.4	9.2	
Control Group 1	1	4	15	0	20
	5.0	20.0	75.0	0	30.8
	100.0	44.4	33.3	0	
	1.5	6.2	23.1	0	
Control Group 2	0	1	20	4	25
	0	4.0	30.0	16.0	38.5
	0	11.1	44.4	40.0	
	0	1.5	30.8	6.2	
	1	9	45	10	65
	1.5%	13.8%	69.2%	15.4%	100.0%

$$\chi^2 = 12.53778; \; df = 6; \; p = .0510$$

*See Table 4 for explanatory heading levels under each group.

difference was found for men on item #21, Number of Resources/Supports available outside the family. With respect to number of outside resources and supports, men responded as shown in Table 6.

When the categories on item #21 were collapsed into a broad dichotomy of 0 to three responses or four or more, the differences between groups were clearer. The original treatment group and control group two were quite similar (i.e., all reported responses for men in both groups falling totally within the 0 to three category). In contrast, control group one clearly stood out as quite different. Control group one solely accounted for the representation of responses falling within the four or more resources category. However, because of the specific source of the difference (i.e., control group one) and the fact that the treatment group was equatable with at least one control group (i.e., control group two), this borderline finding did not raise very serious considerations regarding rival hypotheses operating in relation to important pre-therapy differences.

Results of Comparisons of Treatment Groups One and Two to Control Group on FAP at T_2

It is important to note that at T_2, the second administration of FAP, the original treatment group had just completed family therapy. However, the second treatment group had not received family therapy. Five significant differences were found between groups at T_2 on FAP for women and three significant differences were found for men. Statistically-significant treatment versus non-treatment group differences were found for both men and women on item #5, Did the problem change? and

TABLE 6

Responses on Resources and Supports for Men on
FAP Before Therapy (Experimental Groups)

	None	1	2	3	4	5	6	n's
Experimental Treatment Group	* 1	2	1	2	0	0	0	6
	16.7	33.3	16.7	33.3	0	0	0	27.3
	25.0	50.0	16.7	66.7	0	0	0	
	4.5	4.1	4.5	9.1	0	0	0	
Control Group 1	0	0	1	0	1	1	3	6
	0	0	16.7	0	16.7	16.7	50.0	27.3
	0	0	16.7	0	100.0	100.0	100.0	
	0	0	4.5	0	4.5	4.5	13.6	
Control Group 2	3	2	4	1	0	0	0	10
	30.0	20.0	40.0	10.0	0	0	0	45.5
	75.0	50.0	66.7	33.3	0	0	0	
	13.6	9.1	18.2	4.5	0	0	0	
	4	4	6	3	1	1	3	22
	18.2%	18.2%	27.3%	13.6%	4.5%	4.5%	13.6%	100.0%

$x^2 = 20.77778$; df $= 12$; p $= .0537$

*See Table 4 for explanatory heading levels under each group.

item #6, Direction of change. With respect to status of the problem (i.e., Did the problem change?), men and women responded as shown in Table 7.

Results on FAP indicated that the first treatment group (the only group to have received therapy) reported a substantial change in the problem status. A total of 94.7% of treatment group women and 100% of treatment group men reported a change in contrast to their control group counterparts (treatment group two awaiting family therapy and the random control group). Both non-treatment groups reported the problem had remained substantially the same (group awaiting therapy, men, 69.2%; women, 76.5%; control group, men, 77.8%; women, 63.69%).

With respect to direction of change, mens' and womens' responses in the reconstituted groups were as shown in Table 8.

Following therapy, 89.5% of the women and 100% of the men reported that the problem had improved. However, 58.8% of women and 53.8% of men awaiting treatment reported no change in the presenting problem whereas 77.8% of control men and 59.1% of control women reporting no change with an additional 18.2% of control group women describing the presenting problem as "worse."

Additional statistically-significant differences were found between treatment group women and family therapy waitlist and control group women on item three, problem level and intensity at the .01 level; item 25, clarity of reasons for participating, at the .03 level; a borderline significance on item four, clarity of original problem description at the .05 level. The frequencies reported by groups on these

TABLE 7

Responses on Problem Status on FAP for Men and
Women at T_2 (Reconstituted Groups)

| | WOMEN | | | | MEN | | | |
	Do Not Know	No	Yes	n's	Do Not Know	No	Yes	n's
Treatment Group 1 * (after therapy)	0	1	18	19	0	0	12	12
	0	5.3	94.7	32.8	0	0	100.0	35.3
	0	3.6	62.1		0	0	75.0	
	0	1.7	31.0		0	0	35.3	
Treatment Group 2 (before therapy)	0	13	4	17	1	9	3	13
	0	76.5	23.5	29.3	7.7	69.2	23.1	38.2
	0	45.4	13.8		50.0	56.3	18.8	
	0	22.4	6.9		2.9	26.5	8.8	
Control Group	1	14	7	22	1	7	1	9
	4.5	63.6	31.8	37.9	11.1	77.8	11.1	26.5
	100.0	50.0	24.1		50.0	43.8	6.3	
	1.7	24.1	12.1		2.9	20.6	2.9	
	1	28	29	58	2	16	16	34
	1.7	48.3	50.0	100.0	5.9	47.1	47.1	100.0

WOMEN: X^2 = 24.23453; df = 4; p = .0001

MEN: X^2 = 21.21368; df = 4; p = .0003

*See Table 4 for explanatory heading levels under each group.

TABLE 8

Responses on Direction of Change on FAP for Men
and Women at T_2 (Reconstituted Groups)

	Unable To Judge Women	Unable To Judge Men	Problem Worsened Women	Problem Worsened Men	Remained The Same Women	Remained The Same Men	Problem Resolved Improved Women	Problem Resolved Improved Men	Same Type Of Problem Different Symptom Women	Same Type Of Problem Different Symptom Men	n's Women	n's Men
Treatment Group 1 (after therapy) *	0	0	1	0	1	0	17	12	0	0	19	12
	0	0	5.3	0	5.3	0	89.5	100.0	0	0	32.8	35.3
	0	0	20.0	0	4.2	0	77.3	75.0	0	0		
	0	0	1.7	0	1.7	0	29.3	35.3	0	0		
Treatment Group 2 (before therapy)	1	1	0	1	10	7	3	3	4	1	17	13
	0	7.7	0	7.7	58.8	53.8	17.6	23.1	23.5	7.7	29.3	38.2
	0	50.0	0	100.0	41.7	50.0	13.6	18.8	66.7	100.0		
	0	2.4	0	2.9	17.2	20.6	5.2	8.8	6.9	2.9		
Control Group	1	1	4	0	13	7	2	1	2	0	22	9
	4.5	11.1	18.2	0	59.1	77.8	9.1	11.1	9.1	0	37.9	26.5
	100.0	50.0	80.0	0	54.2	50.0	9.1	6.3	33.3	0		
	1.7	2.1	6.9	0	22.4	20.6	3.4	2.9	3.4	0		
	1	2	5	1	24	14	22	16	6	1	58	34
	1.7	5.9	8.6	2.9	41.1	41.2	37.9	47.1	10.3	2.9	100.0	100.0

WOMEN: X^2 = 34.43128; df = 8; p = .0000   MEN: X^2 = 24.01068; df = 8; p = .0023

* See Table 4 for explanatory heading levels under each group.

three variables are described in Tables 9, 10, and 11.

Two additional findings were indicated for men on FAP at T_2. A significant difference in reported frequencies was found between the original treatment group men, the treatment group two waitlist men, and the randomly selected control group men on item #1, number of problems retained at T_2 at the .06 level and item #12, number of people involved in the presenting problem at the .006 level. Tables 12 and 13 describe these results.

However, while significant differences were found on these additional five variables for groups of men and women, examination of the frequencies of responses reported by groups did not reveal any clearcut trends. The most notable findings indicated at this time point were on problem status for the first treatment group following therapy and direction of change.

Results of Comparisons of the Original Random Experimental-Control Groups' Responses on FAP at T_2

The same data obtained on all FAP items for men and women were re-analyzed on the basis of the original three-group classification. These statistically-significant findings were indicated on differences between the original treatment group's responses on FAP following therapy to the two non-treatment groups. These findings included item #3, assessment of the problem level and intensity following therapy; item #5, status of the problem following therapy; item #6, direction of change; and item #23, number of resources and supports outside the family.

With respect to problem level and intensity, men and women respond-

TABLE 9

Responses on Problem Level and Intensity on FAP
for Women at T_2 (Reconstituted Groups)

		Mild	Moderate	Serious	Very Serious	n's
Treatment Group 1 (after therapy)	*	0	1	11	7	19
		0	5.3	57.9	36.8	32.8
		0	16.7	27.5	70.0	
		0	1.7	19.0	12.1	
Treatment Group 2 (before therapy)		0	0	15	2	17
		0	0	88.2	11.8	29.3
		0	0	37.5	20.0	
		0	0	25.9	3.4	
Control Group		2	5	14	1	22
		9.1	22.7	63.6	4.5	37.9
		100.0	83.3	35.0	10.0	
		3.4	8.6	24.1	1.7	
		2	6	40	10	58
		3.4	10.3	69.0	17.2	100.0

$$x^2 = 16.69615; \ df = 6; \ p = .0105$$

*See Table 4 for explanatory heading levels under each group.

TABLE 10

Clarity of Reasons for Participating in Therapy
on FAP for Women at T_2 (Reconstituted Groups)

		Blank	Unclear-Vague	Moderately Clear	Very Clear, Specific	n's
Treatment Group 2 (before therapy)	*	0	8	6	2	16
		0	50.0	37.5	12.5	42.1
		0	66.7	26.1	100.0	
		0	21.1	15.8	5.3	
Control Group		1	4	17	0	22
		4.5	18.2	77.3	0	57.9
		100.0	33.3	73.9	0	
		2.6	10.5	44.7	0	
		1	12	23	2	38
		2.6	31.6	60.5	5.3	100.0

$$\chi^2 = 8.85792; \; df = 3; \; p = .0311$$

*See Table 4 for explanatory heading levels under each group.

TABLE 11

Clarity of Original Problem Description on FAP
for Women at T_2 (Reconstituted Groups)

	Blank	Unclear, Vague	Moderately Clear	Very Clear, Specific	n's
Treatment Group 1 * (after therapy)	0	2	14	3	19
	0	10.5	73.7	15.8	32.8
	0	18.2	35.9	50.0	
	0	3.4	24.1	5.2	
Treatment Group 2 (before therapy)	0	6	8	3	17
	0	35.3	47.1	17.6	29.3
	0	54.5	20.5	50.0	
	0	10.3	13.8	5.2	
Control Group	2	3	17	0	22
	9.1	13.6	27.3	0	37.4
	100.0	27.3	43.6	0	
	3.4	5.2	29.3	0	
	2	11	39	6	58
	3.4	19.0	67.2	10.3	100.0

$$x^2 = 11.87852; \ df = 6; \ p = .0547$$

*See Table 4 for explanatory heading levels under each group.

TABLE 12

Number of Problems on FAP for Men at T_2
(Reconstituted Groups)

		No Problem	1	2	3	4	6	n's
Treatment Group 1 (after therapy)	*	0	2	4	4	0	2	12
		0	16.7	33.3	33.3	0	16.7	35.3
		0	50.0	30.8	57.1	0	66.7	
		0	5.9	11.8	11.8	0	5.9	
Treatment Group 2 (before therapy)		1	0	4	3	4	1	13
		7.7	0	30.8	23.1	30.8	7.7	38.2
		33.3	0	30.8	42.9	100.0	33.3	
		2.9	0	11.8	8.8	11.8	2.9	
Control Group		2	2	5	0	0	0	9
		22.2	22.2	55.6	0	0	0	26.5
		66.7	50.0	38.5	0	0	0	
		5.9	5.9	14.7	0	0	0	
		3	4	13	7	4	3	34
		8.8	11.8	38.2	20.6	11.8	8.8	100.0

X_2 = 17.44095;   df = 10;   p = .0652

*See Table 4 for explanatory heading levels under each group.

TABLE 13

Number of People Involved on FAP for Men at T_2
(Reconstituted Groups)

	Do Not Know- No One	1	2	3	4	5	Whole Family Plus Outsiders	n's
Treatment * Group 1 (after therapy)	0	2	5	1	4	0	0	12
	0	16.7	41.7	8.3	33.3	0	0	35.2
	0	25.0	55.6	50.0	80.0	0	0	
	0	5.9	15.7	2.9	11.8	0	0	
Treatment Group 2 (before therapy)	2	6	3	1	0	1	0	13
	15.4	46.2	23.1	7.7	0	7.7	0	38.2
	25.0	75.0	33.3	50.0	0	100.0	0	
	5.9	17.6	8.8	2.9	0	2.9	0	
Control Group	6	0	1	0	1	0	1	9
	66.7	0	11.1	0	11.1	0	11.1	26.6
	75.0	0	11.1	0	20.0	0	100.0	
	17.6	0	2.9	0	2.9	0	2.9	
	8	8	9	2	5	1	1	34
	23.5	23.5	26.5	5.9	14.7	2.9	2.9	100.0

x^2 = 27.33884; df = 12; p = .0069

*See Table 4 for explanatory heading levels under each group.

ed as shown in Table 14.

With respect to responses on status of the problem at the T_2 posttest, men and women responded as shown in Table 15.

With respect to perceived direction of change for the presenting problem, men and women responded as shown in Table 16.

Number of resources and supports available outside the family was found to be significant for women (X^2 = 26.51121, df = 16, p = .04) and borderline significant for men (X^2 = 16.86002, df = 10, p = .07). Responses reported for men and women organized by group are presented in Table 17.

In summary, statistically-significant findings were obtained for women based on the original random three groups on the following items on FAP at T_2: item #3, problem level and intensity (X^2 = 16.23871, df =6, p = .0125); item #5, Did the problem change? (X^2 = 24.66270, df = 4, p = .0001); item #6, direction of change (X^2 = 42.49743, df = 8, p = .0000); item 23, number of supports and resources available outside the family (X^2 = 26.51121, df = 16, p = .0472) and a borderline significant difference on item #28, type of factors contributing to the problem (X^2 = 19.78743, df = 12, p = .0712):

Statistically-significant findings were also obtained for men on four main variables, paralleling the results obtained on women. These included item #3, problem level and intensity (X^2 = 14.79085, df = 6, p = .0219); item #5, Did the problem change? (X^2 = 26.33547, df = 4, p = .0000); item #6, direction of change (X^2 = 30.04579, df = 8, p = .0002) and item #23, number of resources and supports available outside the

TABLE 14

Responses on Problem Level and Intensity on FAP for Treatment and Non-Treatment Group Men and Women Following Therapy (Experimental Groups)

	WOMEN					MEN				
	Mild	Moderate	Serious	Very Serious	n's	Mild	Moderate	Serious	Very Serious	n's
Experimental Treatment Group (after therapy) *	0	1	11	7	19	0	2	7	3	12
	0	5.3	57.9	36.8	32.8	0	16.7	58.3	25.0	35.3
	0	16.7	27.5	70.0		0	100.0	29.2	60.0	
	0	1.7	19.0	12.1		0	5.9	20.6	8.8	
Control Group 1	2	4	12	0	18	3	0	5	1	9
	11.1	22.2	66.7	0	31.0	33.3	0	55.6	11.1	26.5
	100.0	66.7	30.0	0		100.0	0	20.8	20.0	
	3.4	6.9	20.7	0		8.8	0	14.7	2.9	
Control Group 2	0	1	17	3	21	0	0	12	1	13
	0	4.8	81.0	14.3	36.2	0	0	92.3	7.7	38.2
	0	16.7	42.5	30.0		0	0	50.0	20.0	
	0	1.7	29.3	5.2		0	0	35.3	2.9	
	2	6	40	10	58	3	2	24	5	34
	3.4	10.3	69.0	17.2	100.0	8.8	5.9	70.6	14.7	100.0

$x^2 = 16.23871$; df = 6; p = .0125 $x^2 = 14.79085$; df = 6; p = .0219

* See Table 4 for explanatory heading levels under each group.

TABLE 15

Responses on Problem Status on FAP for Treatment and
Non-Treatment Group Men and Women Following
Therapy (Experimental Groups)

		WOMEN				MEN			
		Did Not Know	No	Yes	n's	Did Not Know	No	Yes	n's
Experimental Treatment Group (after therapy) *		0	1	18	19	0	0	12	12
		0	5.3	94.7	32.8	0	0	100.0	35.3
		0	3.6	62.1		0	0	75.0	
		0	1.7	31.0		0	0	35.3	
Control Group 1		1	13	4	18	2	5	2	9
		5.6	72.2	22.2	31.0	22.2	55.6	22.2	26.5
		100.0	46.4	13.8		100.0	31.3	12.5	
		1.7	22.4	6.9		5.9	14.7	5.9	
Control Group 2		0	14	7	21	0	11	2	13
		0	66.7	33.3	36.2	0	84.6	15.4	38.2
		0	50.0	24.1		0	68.8	12.5	
		0	24.1	12.1		0	32.4	5.9	
		1	28	29	58	2	16	16	34
		1.7	48.3	50.0	100.0	5.9	47.1	47.1	100.0

$X^2 = 24.66270$; df = 4; p = .0001 $X^2 = 26.33547$; df = 4; p = .0000

* See Table 4 for explanatory heading levels under each group.

TABLE 16

Responses on Direction of Change on FAP for Treatment and Non-Treatment Group
Men and Women Following Therapy (Experimental Groups)

	Unable To Judge		Problem Worsened		Remained The Same		Problem Resolved Improved		Same Type Of Problem Different Symptom		n's	
	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women	Men
Experimental Treatment Group (after therapy) *	0	0	1	0	1	0	17	12	0	0	19	12
	0	0	5.3	0	5.3	0	89.5	100.0	0	0	32.8	35.3
	0	0	20.0	0	4.2	0	77.3	75.0	0	0		
	0	0	1.7	0	1.7	0	29.3	35.3	0	0		
Control Group 1	1	2	2	1	12	4	3	2	0	0	18	9
	5.6	22.2	11.1	11.1	66.7	44.4	16.7	22.2	0	0	31.0	26.5
	100.0	100.0	40.0	100.0	50.0	28.6	13.6	12.5	0	0		
	1.7	5.9	3.4	2.9	20.7	11.8	5.2	5.9	0	0		
Control Group 2	0	0	2	0	11	10	2	2	6	1	21	13
	0	0	9.5	0	52.4	76.9	9.5	15.4	28.6	7.7	36.2	38.2
	0	0	40.0	0	45.8	71.4	9.1	12.5	100.0	100.0		
	0	0	3.4	0	19.0	29.4	3.4	5.9	10.3	2.9		
	1	2	5	1	24	14	22	16	6	1	58	34
	1.7	5.9	8.6	2.9	41.4	41.2	37.9	47.1	10.3	2.9	100.0	100.0

WOMEN: x^2 = 42.49743; df = 8; p = .0000   MEN: x^2 = 30.04579; df = 8; p = .0002

*See Table 4 for explanatory heading levels under each group.

TABLE 17

Number of Resources Reported on FAP for Treatment and Non-Treatment
Men and Women Following Therapy (Experimental Groups)

WOMEN:	None	1	2	3	4	5	6	7	8	n's
Experimental Treatment Group * (after therapy)	2 10.5 25.0 3.4	5 26.3 62.5 8.6	3 15.8 30.0 5.2	2 10.5 18.2 3.4	4 21.1 57.1 6.9	2 10.5 33.3 3.4	0 0 0	0 0 0	1 5.3 100.0 1.7	19 32.8
Control Group 1	4 22.2 50.0 6.9	2 11.1 25.0 3.4	1 5.6 10.0 1.7	4 22.2 36.4 6.9	1 5.6 14.3 1.7	0 0 0	5 27.8 83.3 8.6	1 5.6 100.0 1.7	0 0 0	18 31.0
Control Group 2	2 9.5 25.0 3.4	1 4.8 12.5 1.7	6 28.6 60.0 10.3	5 23.8 45.5 8.6	2 9.5 28.6 3.4	4 19.0 66.7 6.9	1 4.8 16.7 1.7	0 0 0	0 0 0	21 36.2
	8 13.8	8 13.8	10 17.2	11 19.0	7 12.1	6 10.3	6 10.3	1 1.7	1 1.7	58 100.0

MEN:	None	1	2	3	4	5	n's			
Experimental Treatment Group * (after therapy)	4 33.3 30.8 11.8	2 16.7 66.7 5.9	1 8.3 14.3 2.9	3 25.0 50.0 8.8	1 8.3 50.0 2.9	1 8.3 33.3 2.9	12 35.3			
Control Group 1	3 33.3 23.1 8.8	1 11.1 33.3 2.9	0 0 0	3 33.3 50.0 8.8	0 0 0	2 22.2 66.7 5.9	9 26.5			
Control Group 2	6 46.2 46.2 17.6	0 0 0	6 46.2 85.7 17.6	0 0 0	1 7.7 50.8 2.9	0 0 0	13 38.2			
	13 38.2	3 8.8	7 20.6	6 17.6	2 5.9	3 8.8	34 100.0			

WOMEN: X^2 = 26.51121; df = 16; p = .0472   MEN: X^2 = 16.86002; df = 10; p = .0775

* See Table 4 for explanatory heading levels under each group.

family (X^2 = 16.86002, df = 10, p = .0775). In addition, three other statistically-significant differences and three borderline differences were found for men. The three significant differences observed for groups of men were item 1, number of original presenting problems (X^2 = 22.71696, df = 10, p = .0118); item 4, clarity of original problem description (X^2 = 14.56294, df = 6, p = .0239), and item 7, number of original problems retained (X^2 = 22.63803, df = 10, p = .0122). The three borderline findings were item 16, most influential family member (X^2 = 12.72336, df = 6, p = .0476); item 25, clarity of reasons for participating (X^2 = 7.16931, df = 3, p = .0667); item 12, number of people involved in the presenting problem (X^2 = 19.65413, df = 12, p = .0739). However, because of the length of this chapter, only those findings significant for both men and women were supplemented by tables. (Tables 14-17 reported frequencies of responses on FAP items 3, 5, 6, and 23 for men and women.)

Family Therapy Outcome for the Second Treatment Group

Following the T_2 posttest, the remaining waitlist control group families participated in the same seven week family therapy. These families comprised the second treatment group. Upon completion of the seven weeks of family therapy, the second treatment group was posttested on the same set of dependent measures.

This T_3 assessment served two equally important purposes: (1) for the original treatment group, this third retesting served as a means of gathering data on family change seven weeks after completion of family therapy, providing important information on follow-up; (2) for the sec-

ond treatment group, the T_3 assessment served as a means of assessing the impact of family therapy immediately following therapy. In addition, the information gathered on FAP as well as all the family instruments provided a second profile of a treatment group (i.e., self-reports from families) on the overall family therapy experience.

The results obtained on FAP for the second treatment group reflected the same positive response to the experience and satisfaction with therapy. Approximately 93.3% of the women and 84.6% of the men reported that the problem had been resolved or was improving.

Results of Follow-up Data on FAP for the Original Treatment Group

Follow-up data was collected on FAP at T_3 (seven weeks after treatment) for the original, randomly-selected treatment group. The results were as follows: when retested at T_3, 93.3% of the original treatment group reported that the problem for which they sought help remained resolved or was improving, in comparison to 6.7% who reported either that the original presenting problem had resurfaced or had gotten worse. Similarly, 90.9% of the original treatment group men reported that the problem continued to remain resolved or was improving whereas only 9.1% of the men reported that there had not been any improvement or that the problem had intensified. The data obtained on FAP as well as on FCE strongly support the positive effects of the short-term, child-centered family therapy adapted in this study.

Concluding Remarks

The following overall set of statements regarding instrumentation

and general outcome may be made.

1. Results of inter-instrument correlations indicated that FAD
and FUI REAL were strongly correlated. Of the four child and family
functioning instruments tested at T_1, FAD and FUI REAL appeared to
share the most systematic variance. This suggested that a significant
level of concurrent validity was present between both instruments. It
may be inferred that assessments drawn particularly from the more highly
correlated inter-instrument subscales on FAD and FUI REAL provided a
more reliable, cross-check of family functioning.

2. Results on the data on intra-instrument subscale reliabilities
corroborate findings of published reliability studies on the respective
instruments. It is interesting to note that reliabilities (Crombach's
alphas) obtained in this study were somewhat higher in comparison to
those reported in the literature on these instruments.

3. Results obtained on FCE and FAP indicated quite positive clini-
cal effects of treatment. A review of results on both questionnaires
indicated two rather strong and consistent findings. First of all, the
self-report data collected at posttest (immediately following treatment)
indicated that the family therapy had a positive effect on problem
resolution. The data supported the overall conclusion regarding both
positive outcome and overall effectiveness of the structural-analytic
model of family therapy used. Families reported a considerably high
level of satisfaction with the outcome as well as with the overall ex-
perience of therapy.

In addition, one interesting trend consistently appeared across

FCE and FAP. Men as a group appeared to report more conservatively in their responses. In contrast, women as a group appeared to be somewhat more inclined toward more positive responses (i.e., more "effusive" in their evaluations of therapy and treatment gains). As a point of interest, this trend observed in the data on FCE and FAP appeared to be the inverse of the general trend observed on the four standardized measures used in this study. In the overall results on FAD, CBCL, FUI REAL, and FUI IDEAL men, in contrast to women, tended toward the more positive end of the response scale.

C H A P T E R   IX

SUMMARY OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

This final chapter will present an overview of the research. This overview will include a restatement of the problem, purpose, design, procedures, summary of findings, and discussion of results. In addition, recommendations for future research will be proposed.

The Problem

The family therapy literature is replete with a wide range of therapeutic innovations claiming various degrees of treatment success. Consequently, family therapy has emerged as a viable and popular treatment modality. Unfortunately, because the clinical aspects of family therapy overarch the field's research efforts, the field of family therapy may be best described as a theoretical edifice without an equally solid methodological foundation. Such a characterization of the state of family therapy research has been well-documented throughout the literature. Examples of such critiques of the field's knowledge base were described in detail in Chapters II and VI.

Within the field of family therapy, there is mounting and convincing evidence that the psychological health of the child is strongly influenced by the wider family system's functioning and interactions. One treatment modality frequently identified in the literature as a method for treating presenting-child problems has been labeled child-centered family therapy. However, while a baseline of effectiveness has been generally established for family therapy (Gurman, 1983), there

currently exists a very limited body of controlled and controlled-comparative studies that systematically document the relative treatment effects of child-centered family therapy (Masten, 1979). With the exception of a few specific, symptom-focused forms of therapy (e.g., structural family therapy with anorexics), there is a lack of consistent, empirically-derived evidence to support the claim that child-centered family therapy is on average, anymore effective than other, more traditional methods (e.g., play therapy, child psychoanalysis) in the treatment of presenting-child problems. In addition, research efforts have failed to provide adequate evidence supporting claims regarding what type(s) of child-centered family therapy is more effective in treating specific childhood problems.

This lack of an adequate knowledge base (i.e., accrued validly labeled facts) has been attributed to the interaction of a number of conceptual and methodological problems characteristic of family therapy research. These problems (described in Chapter II) may be summarized in the form of five basic myths about research: (1) the myth of homogeneity of population; (2) the myth of uniformity of treatment; (3) the myth of a sufficient body of microtherapy theory; (4) the myth of the objective measure; and (5) the myth of the unbiased set of outcome criteria. This research was designed to address the issues of outcome and instrumentation in relation to these five basic problems of family therapy research.

Purpose of this Study

The general purpose of this research was to advance that body of

knowledge within the field of family therapy concerned with that class
of treatments referred to as short-term child-centered family therapy.
The treatment procedures and the treatment model tested were labeled
by this investigator as short-term child-centered structural-analytic
family therapy. The treatment was adapted from the longer structural-
analytic treatment model and set of treatment steps developed and de-
fined by the family theorist and family therapist David Kantor (1979,
1980).

The overall aim of therapy employed in this study was to effect
positive shifts in parents' perception of the problem, presenting child,
and family interactions. The proposed change was in the direction of
more positive self-reports on the status of the problem, family unit
functioning, family communication, and the presenting child following
therapy. The main focus of therapy was to stimulate shifts in the di-
rection of a family systems view of the problem as well as the develop-
ment of more positive, productive family unit problem-solving action
plans. Four standardized, pre-post family assessment measures were
used: FAD, CBCL, FUI REAL, and FUI IDEAL. Two other questionnaires,
FAP and FCE, designed by this author, obtained additional data on family
change as well as overall satisfaction with the therapy experience.

Two General Objectives of the Research

This study was designed for two main purposes: (1) to test the ef-
fectiveness of short-term child-centered structural-analytic family
therapy with a specific family population (families of young children)

and specific problem type (mild to moderate child behavior problems);
and (2) to test the degree of association and concurrent validity of
three standardized family assessment instruments (FAD, FUI REAL and FUI
IDEAL) with operationally-similar subscales. Based upon these two main
purposes, this investigation was divided into two separate studies: an
experimental study with its design and related hypotheses and a correla-
tion study with its design and its related hypotheses. The rationale
and general methods of each study as well as a description of the hy-
potheses were presented in Chapter V.

Design

A randomized experimental-control group, pretest-postest design
was used in this study. The population under study was those families
of young children who sought help for a self-identified, mild to moder-
ate presenting-child problem where the child was between the ages of
three and eleven. A stratified random sample of 40 families was drawn
from a population of 65 families residing in the Kent County and River-
side areas of Rhode Island.

Sample families were randomly assigned to three different sets of
experimental conditions: group (treatment or control, 20 families per
group), therapists (one of two therapists, ten families per therapist),
and pretest-posttest administrators (five testers, 13 families per
tester). All families (N=65) were pretested on five dependent measures:
Family Assessment Device (FAD), Child Behavior Checklist (CBCL), Family
Unit Inventory (FUI REAL and FUI IDEAL), and the Family Assessment of

the Problem Questionnaire (FAP). Experimental group families received 15 to 20 hours of short-term child-centered structural-analytic family therapy administered over seven weeks. Control group families did not receive therapy at this time.

Upon completion of the seven-week treatment all families (N=65) were posttested on the same five dependent measures (FAD, CBCL, FUI REAL, FUI IDEAL, and FAP). A sixth outcome measure, Family Counseling Evaluation (FCE), was administered at the end of the posttest session to treatment families to assess their perceptions of the presenting problem as well as their overall satisfaction with therapy.

Immediately following the T_2 posttest assessment, control group families received the same seven-week family therapy. The second treatment group (n=15) was comprised of families drawn from both randomly selected control groups. Upon completion of the seven-week family therapy, the second reconstituted treatment group (comprised of self-selected control group families) were posttested on the same five dependent measures with the addition of FCE. The original experimental group was also posttested at this time, constituting a T_3 follow-up assessment. The design thus provided for three assessments of the effects of family therapy (T_1, T_2, T_3) for an overall population at T_1 and T_2 of approximately 65 families (97 individuals) and at T_3 for a two-group treatment population of 34 families (19 families in the original randomized experimental treatment group and 15 families in the self-selected second-treatment group) for an overall 60 individuals.

Procedures

A series of time-ordered procedures was used in the conduct of this study. These procedures were divided into three main phases: (1) preparation, (2) the experimental steps, and (3) treatment and handling of the data. Each phase with its corresponding steps was as follows.

Preparation

This phase involved the following steps: (1) pilot testing of The Family Assessment of the Problem Questionnaire (FAP); (2) pilot testing of the instruments and test session format; (3) pilot testing of the treatment; (4) obtaining and training test administrators, and (5) obtaining the research population.

Experimental Steps

The following set of steps comprised the experimental plan: (1) obtaining a stratified random sample based on family type (one- or two-parent households), problem type (principally withdrawn or aggressive child behaviors), grade level (preschool or grade school) and sex (male or female) of the presenting child; (2) random assignment of families to experimental conditions; (3) pretesting of all 65 families; (4) the provision of family therapy to the original randomly-selected treatment group; (5) posttesting of all 65 families; (6) the provision of the same family therapy to the second self-selected treatment group reconstituted from the two original randomly-selected control groups; and (7) T_3 follow-up posttesting of the original randomly-selected treatment group and the T_3, posttesting of the second treatment group immediately fol-

lowing therapy.

Treatment and Handling the Data

Twelve major steps were followed in the organization, treatment, and handling of the data. These steps were as follows: (1) organizing the data into meaningful form; (2) evaluating different models of analysis; (3) recording variations in the conduct of the study and determining their effects; (4) integrating these changes into a new design and model of analysis; (5) reappraisal and redefinition of outcome in relation to the actual quantity of data collected; (6) reexamination of clinically-relevant differences versus statistically-significant findings in relation to the interpretation of outcome reported in the family therapy literature; (7) development of a plan of analysis that incorporated both perspectives on outcome; (8) organization of the actual model of analysis to be used involving such issues as the definition of a complete case, level of analysis, coding, and constructing the data files; (9) scoring the four standardized instruments (FAD, CBCL, FUI REAL, and FUI IDEAL); (10) developing response categories for coding and scoring family demographic data; (11) developing a coding and scoring system for FAP; and (12) developing a coding and scoring system for FCE.

Scope and Nature of the Data

Data was collected on an extensive list of outcome variables comprising a total number of 70 variables. Of the overall 70 variables, data was collected on approximately 30 family demographic variables in-

cluding such areas as mothers' background and personal characteristics, fathers' background and personal characteristics, family unit characteristics, characteristics of the presenting child and presenting problem. In addition data was collected at T_1, T_2 and T_3 on 40 subscale variables derived from four standardized instruments (FAD, CBCL, FUI REAL, and FUI IDEAL) yielding a number of different measures for assessing change (i.e., group means, medians, variances, and interparent agreement scores).

The analysis and assessment of outcome was based exclusively on self-report data. Pre- and posttherapy shifts in parental perceptions of the presenting child, presenting problem, and general family unit functioning were derived completely from the standardized self-report family instruments (FAD, CBCL, FUI REAL, FUI IDEAL) chosen for use in this study. The other sources of data providing additional clinical as well as demographic data included FAP and FCE, two self-report questionnaires developed specifically for this study. FAP obtained self-report data on family members' descriptions of the problem, presenting child, and family life. FCE elicited family members' assessment of the status of the problem following therapy, the direction of change as well as level of satisfaction with the family therapy experience.

Description of the Population

The research population consisted of 65 families with a presenting child problem. The 65 families were comprised of 65 mothers, 54 fathers, four male live-in companions, and 14 ex-husbands for a total of 137 individuals. The 65 families consisted of 141 children. Of the

141 children, 82 (58%) were male and 59 (42%) were female. Of the total number of primary-identified presenting children (one child per family; N=65), 38 (58%) were male and 27 (42%) were female.

When a second tally was made to identify the collection of additional data on children with problems other than the primary/initial presenting children, the overall number of the presenting children increased to 74. However, the inclusion of the additional second- and third-presenting children did not substantially alter the 60:40 proportion of male and female presenting children reported in the original group of primary presenting children.

The typical family under study (N=65) was a two-parent household (80.0%, 52 families) where mothers (73.3%, 47 mothers) and fathers (79.3%, 46 fathers) reported first marriages. The mean family size (overall 271 reported family members) was four persons. The mean number of children per family was two. Of the overall number of children (141 children), 58.2% (82 children) were boys and 41.8% (59 children) were girls.

The most frequently reported family ethnic background was English/American (32.3%, 21 families). The typical combined family income fell within the $25,000 to $40,000 bracket (40.0%, 26 families) with the population median falling slightly lower within the $20,000 to $24,999 bracket.

The typical mother in this study was a homemaker (58.5%, 38 mothers), unemployed (58.5%, 38 mothers), a high school graduate (40.0%, 26 mothers), firstborn or only-child in her family of origin (53.8%,

35 mothers), Irish/American (32.3%, 21 mothers), and Catholic (70.8%, 46 mothers). The mean age of mothers was 33 years.

The typical father in this study ranged in occupation from blue-collar/factory work (21.5%, 14 fathers) and blue-collar/skilled trade (18.5%, 12 fathers) to white-collar social service/managerial positions (18.5%, 12 fathers) for an overall 58.5% population representation of major work types. The typical father was employed full-time (86.2%, 46 fathers), a high school graduate (32.8%, 19 fathers), firstborn or only-child in his family of origin (52.5%, 21 fathers), English/American (32.8%, 19 fathers), and Catholic (60.3%, 35 fathers). The mean age for fathers was 35 years.

The typical primary presenting child in this study was in preschool (46.2%, 30 children). The mean age of the primary presenting children was 6.3 years. The most frequent age was four years. The most frequent problem type was a presenting-child problem characterized by mixed psychological problems (i.e., a combination of withdrawn, aggressive behaviors) complicated by additional family problems (30.8%, 20 children).

Summary of Findings

The results of the series of MANOVAS, ANOVAS, homogeneity of variance tests, interinstrument subscale correlations, intrainstrument subscale correlations, as well as subscale reliabilities were described in detail in Chapter VII and Chapter VIII. However, the following is a brief recapitulation of findings obtained in this study:

1. A statistically-significant posttherapy difference was found for treatment group mens' gains on FUI REAL Consideration versus Family Conflict. Follow-up simultaneous confidence interval procedures used to determine the source of the significant difference indicated that treatment group men obtained higher (more positive) average posttest gains on FUI REAL Consideration versus Conflict than control group one, control group two, and the average of control groups one and two.

2. When a tally was made (i.e., by ordering the three group means according to highest, middle, and least gains on each of the 32 subscales), the treatment group men were found to have obtained the highest posttest gains 62.5% (20:32) of the time whereas control group one men demonstrated greatest gains only 3.2% (1:32) of the time with control group two men obtaining the greatest gains 34.0% (11:32) of the time.

The variables that indicated highest gains for treatment group men in comparison to either control group were as follows. On FAD, treatment group fathers scored highest on Problem Solving, Roles, AFfective Involvement, Behavior Control, and General Functioning. On CBCL, treatment group men scored highest on gains on Social Competence. On FUI REAL, treatment group men scored highest on Real Consideration, Real Sociability, Real Ambition, Real Locus of Control, Real Togetherness, Real Loyalty, and Real Closeness. On FUI IDEAL, treatment group men scored the highest gains on Ideal Actualization, Ideal Sociability, Ideal Locus of Control, Ideal Togetherness, Ideal Loyalty, Ideal Closeness, and Ideal Consideration.

Based upon the expectation that each group would probably occupy

one of the three positions (highest, medium, and least gains) one-third of the time by chance, the appearance of such a trend in the gains would indicate that family therapy had a positive effect on mens' perceptions of the presenting child and family functioning following treatment.

3. Statistically-significant differences were found on group variances between treatment and control group gains for both men and women. Treatment group men and treatment group women most often demonstrated the greatest variability in the distribution of gain scores than did either of the control groups.

4. While none of the ANOVAS and MANOVAS conducted on mens' and womens' treatment versus nontreatment group differences were found to approach statistical significance on the four standardized instruments (FAD, CBCL, FUI REAL, FUI IDEAL) at T_1, the following general trends in the differences between pretreatment group means were observed: treatment group men and treatment group women demonstrated most of the lowest/most unhealthy pretreatment means of the three groups (i.e., treatment, control group one, control group two). Treatment group men obtained the lowest pretreatment scores 75.0% of the time (24:32) across instruments' subscales in comparison to control groups. Treatment group women obtained the most unhealthy pretreatment group mean scores 65.6% of the time (21:32) across the 32 instrument subscales in comparison to control groups one and two. Both control groups one and two demonstrated more healthier pretreatment means.

5. Substantially high correlations (.70 and above; $p < .01$) were

found at T_1 between four main subscales on FAD and five main subscales on FUI REAL. Significant interinstrument pretreatment correlations were found between Problem Solving, Communication, Affective Responsiveness, and General Functioning on FAD with Actualization, Communication, Togetherness, Loyalty, and Closeness on FUI REAL.

6. A number of statistically-significant treatment versus non-treatment group differences were found at T_2 on FAP. The two most clinically-relevant findings among all the statistically-significant differences involved status of the problem following therapy and direction of change. On status of the problem, 94.7% of treatment group women (18:19) and 100.0% of treatment group men (12:12) reported that the problem had changed. In contrast, however, 72.2% of control group one women (13:18) and 55.6% of control group one men (5:9) and 66.7% of control group two women (14:21) and 84.6% of control group two men (11:13) reported that the problem had not changed.

On direction of change, 89.5% of treatment group women (17:19) and 100.0% of treatment group men (12:12) reported improvement and/or resolution of the problem. However, only 16.7% of control group one women (3:18) and 22.2% of control group one men (2:19) and 9.5% of control group two women (2:21) and 15.4% of control group two men (2:13) reported improvement of the problem without therapy.

7. On FCE, regardless of group (first-treatment group or second-treatment group) or gender (male or female), the two main variables that indicated the greatest positive response to family therapy (approximately 99% overall population Strongly Agree - Agree) were item #3, greater insight(s) into how the parent interacted with the presenting

child and item #16, that the parent felt the therapy was a worthwhile experience.

8.   When the percentages of agreement and disagreement reported on FCE items were studied by gender, between groups and between genders, the following trends were observed: women overall were more positive than men in their evaluations. Men and women in the first treatment group responded more positively than men and women in the second treatment group. Men in the first treatment group were slightly more positive than men in the second treatment group. Men in the second treatment group responded least positively of all and accounted almost entirely for the percentages of disagreement reported on FCE.

Discussion

A number of statistically-significant findings were obtained in this study. These findings were summarized in the previous section. However, three major findings suggesting specific trends in the data merit further discussion. These findings related to the following family therapy issues: (1) use of self-report family instruments as the exclusive method of assessing family health; (2) the reconciliation of discrepant results obtained on different sets of measures on the same families; (3) the biased view of outcome obtained when family change is studied solely on the basis of the group (i.e., group design level).

1.   In this study families were assessed on the four standardized instruments, FAD, CBCL, FUI REAL, and FUI IDEAL as well as on two ques-

questionnaires, FCE and FAP, specifically developed for this study. Convincing evidence has been presented by the developers of FAD, FUI REAL and FUI IDEAL regarding their use as reliable and valid measures of family health and family functioning. When the means and standard deviations of the families under study were compared to norms for appropriate clinical samples identified in the literature, families in this study appeared healthier. If FAD, FUI REAL, FUI IDEAL had been the only set of measures used in this study, then families would have been erroneously reclassified as healthier families. The population thus would have been redefined as a non-clinic population.

However, additional data on the problem, problem level and intensity as well as on general dissatisfaction with family life obtained on FAP (over 100 family members' written self-reports) indicated that the families were experiencing serious family problems (e.g., alcoholism, depression). The family population was therefore appropriately described as a clinic population.

2. Discrepancies were also noted among instrument results obtained in this study. When results were compared across instruments at pretreatment and posttest, the following was observed: Families who reported serious communication problems on FAP at pretest were not obtaining markedly lower (more unhealthy) pretest scores on the corresponding Communication subscales on FAD and FUI REAL as one would expect. Considerable contradictions were noted between the level/direction of scores obtained on the appropriate standardized instruments and the results obtained on the open-ended questions on FAP. The ex-

pected relationships between family members' scores on the standardized instruments and problem descriptions provided on FAP were not found. When a closer study was made of those families and family members who presented a clear-cut example of a specific subproblem type (e.g., family estrangement, emotional isolation) to appropriate subscale scores (e.g., Affective Responsiveness, Affective Involvement on FAD and Family Closensss, Family Togetherness on FUI REAL), very little association was found.

In this investigator's judgement, both FAD and FUI REAL did not identify either subtle changes in families or those class of families associated with moderate family problems raising the issue of the instruments' discriminant validity. While FAD and FUI REAL did identify those families falling on either end of the outcome continuum (i.e., extreme cases), these instruments did not readily identify those who reported moderate difficulties in a specific subcategory such as family communication or affective involvement. The decision was thus made to treat the discrepant evidence obtained on FAP, FAD, and FUI REAL as complementary rather than competitive views on outcome. The two sets of results were regarded as evidence of the complexities inherent in both the conduct and interpretation of family therapy outcome and outcome research.

3. While group results (i.e., the average response as well as group variability) did obtain statistical significance in some instances, these findings did not always convey the type(s) of changes occurring within families. However, when individual family profiles

were constructed for family change over the three time points (T_1, T_2, T_3) based on outcome scores and individual family cases were studied, the following was observed: some families increased steadily. Some families remained relatively the same. Other families decreased in scores at T_2 only to improve at T_3. The patterns on "cycles" or change were as individualistic or idiosyncratic across measures as were the 65 families who participated in the study.

In addition, the concept of family progress was complicated further (i.e., on the level of outcome scores) when, for instance, one member of the marital dyad demonstrated gains whereas the other partner decreased in scores or demonstrated minimal change. If the criteria for the study of change had resided solely in the study of group statistics and the evidence obtained by mathematical models of differences, then significant family change would have been overlooked.

The conclusion drawn by this investigator regarding such findings was as follows: The study of outcome must extend beyond the first level of tests of significant differences. The study of changes in family therapy must extend beyond the analysis of group measures (e.g., group variances, group means) to the study of the individual family member(s), individual family case, the identification of specific subpopulations contained within research populations as well as the identification of family case study extremes.

Recommendations for Future Research

The conduct and assessment of family therapy involves a complex set of events that combine to create an ecological field wherein change

often occurs. The family therapy enterprise, embodied in the working family system-therapist relationship, provides an almost limitless list of variables available for inquiry. Therefore, in approaching the problem of family therapy outcome, the following important factors should be considered: (1) the complexities presented by the family system as the unit under study; (2) the complexities of therapist as a developing self; (3) the complexities inherent in the developing methodology and rapidly evolving systems' concepts labeled "family therapy"; (4) the equally rapidly growing technology (i.e., the wide range of techniques used to translate family therapy concepts into effective clinical practices); (5) the politics of social service delivery as well as the oppositional stances often taken by clinicians and researchers in the process of research; (6) the heterogeneous nature underlying ostensibly homogeneous populations of families and family problem types.

Based upon the acknowledgement of these factors as well as findings generated in this study, the following recommendations for future research are proposed.

1. On the conceptual level, modify and adapt the logic underlying the group design model to incorporate systems concepts of change. For example, amplify the randomized experimental-control group pre-post design methods to accommodate the concept of "family systems feedback loops" by using in such a design the added outcome methods of, for instance, a time-series design.

2. On the level of practice, expand the group design model to include study of the individual family member as well as the individual

family case. The following is a proposed example of such a model:
First, obtain group data on families at several time points. Second,
compute group measures as well as individual statistics on each family.
Finally, compare groups within the defined family population over as-
sessment points (T_1, T_2, T_n); compare subpopulations of families within
groups, organized, for example, by a specific subproblem type to the
group measures on assessment points; compare individual families to
group measures and compare families to themselves as they progress over
time.

3. Develop and refine assessment methods that study change on the
family unit level. Construct and utilize assessment techniques that ac-
quire data consonant with such systems concepts as "type of family
structure" or "interactional sequences in family communication" (pat-
terned after the communicationist's school of thought). Implement more
observational methods of assessment (e.g., the assignment of family
tasks). Utilize a multi-method paradigm for collecting and assessing
data, drawing upon such methods as self-report and direct observation
as well as varied perspectives on the data such as subjective/objective/
insider/outsider assessments of outcome.

4. Assess family outcome on multiple system levels. Assess change
from the following concurrent systems perspectives: change on the family
unit level; change in specific dyads/triads (e.g., marital subsystems,
parental subsystem, sibling subsystem); change in the identified patient
(presenting family member); change in the presenting problem or symp-
toms; change in the family's surrounding system environment or family's

perception of the wider social field.

5. Study the impact of the therapist on an interactive or re-
ciprocal influence level. Extend the study of the therapist beyond the
usual considerations of, for example, the therapist's effect upon the
family and/or his/her professional style/characteristics to include in-
formation on the effects of the family (e.g., specific family types) on
the therapist and how these subtle influences affect the therapist's
role as well as overall outcome.

6. In summary, develop research models in which the family, the
therapist, the mental health setting, the technology of family therapy,
and the family therapy research (itself a systems intervention) are
studied in concert as active system participants. Such a model would
consider the interaction of all these system participants as greater
than the sum of its parts, producing the overall phenomenology of out-
come.

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APPENDIX A

FORM ONE: Announcement Letter/First Application

ATTENTION PARENTS

Our Child development/mental health staff is pleased to announce
a Family Counseling Program that will be available at no charge to the
families of our children. This program is intended for any parent/
family who may have a question, concern or problem regarding their
child or their family.

The Family Counseling Program. The Family Counseling Program will
provide you and your family with a special opportunity to meet with a
family counselor on an individual basis for a six to eight week time
period. There is no fee for this service. The individually arranged
meetings will be held in private at our agency at a time (day or
evening) that is convenient for your family. This program provides
you with an opportunity to explore your child's and/or family's
problems with a trained counselor. All information will be kept
confidential.

How to Apply. If you are interested, please complete the
application below and return it to one of our staff.

We look forward to your participation.

Sincerely,

(Director's name)

Tear Along Dotted Line
. . . .
Application for Family Counseling Program

NAME _____ PHONE _____

STREET_____

CITY/TOWN _____ ZIP _____

FORM TWO: Second Application/Initial Description of
the Problem

Thank you for expressing an interest in our Family Counseling
Program. The response has been most positive. In order to assist us
in best meeting your needs, please fill out this brief information form.
Please return this form to our agency. After we receive this form we
will contact you.

NAME _____   PHONE _____

ADDRESS _____
                No. and Street

_____   _____
                City   Zip Code

Reasons why you want to participate in this program. Please be
as specific as you can so that we can best meet your needs. In your
own words, as best as you can, please describe the problem.

Name and ages of persons living in your home.
_____
NAME   AGE   RELATIONSHIP TO YOU

_____

_____

_____

_____

_____

                              _____
                              SIGNATURE AND DATE

APPENDIX B

FORM THREE: Comments/Instructions to Pretesters:
First Telephone Contact

Give your full name.

We are calling for the Family Counseling Program. Thank you for returning your application. We have had a large and positive response to the program.

Purpose of the phone contact. We are calling you for the Family Counseling Program to let you know that we have received your application and that we are setting up the program in a way to best meet everyone's needs.

Pause to see if the person has any questions. If the person does, listen to them, record questions, and then tell them that you will be meeting with the researcher and family counselor and that the family counselor will be contacting them next week. If there are no questions, tell the person that the counselor will be calling the family next week to arrange for a time to get together.

Please note.

If the person who signed the information form is not home, take down the name of the person who answers the phone and then ask them when would be a good time to reach the person.

Record any comments you may have, initial impressions about the person who you talked to and response to the program.

FORM FOUR: Comment/Instructions to Pretester: Second
Telephone Contact

PHONE CONTACT TWO

Instructions to Pretesters.

The purpose of this telephone call is to gather scheduling
information from families and to identify and clarify any questions/
concerns families might have about the upcoming counseling. In
addition, talking with you will help the families feel more relaxed
when they come for the pretest.

Please say something like this to each family: "We would like
to begin to work out a preliminary schedule of days/times to meet with
families, do you have a preferred day or time? When is the best time
for all or most of your family to come in to see us?

Comment Sheet

Name of family _____

Record regular time family can meet weekly

    1st time   day _____   time _____

    2nd time   day _____   time _____

    3rd time   day _____   time _____

Record times family cannot meet (e.g., days/evenings, times)

Are there any unusual circumstances (e.g., husband works nights,
problem getting babysitters, etc.).

FORM FOUR (continued)

General Comments/Impressions.

Signature of Pretester_____

Date_____

FORM FIVE: Comments/Instructions to Pretester:
             Third Telephone Contact

1. Review the first two telephone contact sheets to familiarize
    yourself with family information and with whom the contact
    person is going to bring to counseling. (Name and relationship
    of the person(s) to the contact person.)

2. Call the contact person. "We are ready to being the program. We
    are pleased at the response we have received from the families.
    Some 70 families are participating in the program."

3. Ask the contact person: "Who in your family will be coming to the
    first meeting?"

    Make sure you are clear on the identity - name and relationship of
    this person to the contact person.   If no one else is identified,
    don't push the person to name someone. Instead encourage the
    contact person by making a comment such as the following:
    "In the past it has been our experience that for the program to be
    most helpful for the family more than one person in the family has
    participated in the program."

    Listen to what they say. Based on this, if the situation is such
    that the person says that someone can come to the first meeting but
    not all the time, encourage them to bring anyone they think they
    can to the first meeting. This would be appropriate adult family
    members; husband, aunt, adolescent, grandparent, male/female live-
    in friend.

4. Description of the first meeting.

    The first step is for us to get together. When can we get together?
    Record: DAY _____   TIME _____

    What we are going to be doing in this first meeting is to fill out
    some brief questionnaires.

    These questionnaires are about family life and your particular
    interests, concerns and needs.

    These questionnaires will help the family counselor to become
    familiar with your concerns and will help them to design the program
    to best meet your concerns. This will also give you a chance to
    express your views on family life.

FORM FIVE (continued)

Review of Purposes of Telephone Contact:

1. Set up a definite time for pretesting.

2. Determine who (which family members) will be at the pretest.

3. Obtain additional information on families, especially the identification of any worries or concerns about filling out the questionnaires.

Major Interventions You Are Making:

1. You are providing the families with an explanation of the purpose of the questionnaires. The purpose is to provide families with an opportunity to give their own views on their family and family life.

2. By identifying and talking about the possible concerns and worries that families bring up, you are affecting how they view the upcoming pretest.

3. You are providing support and some reassurance to families by responding to their questions and in making personal contact with them initially by phone.

FORM FIVE   (continued)

Family's Worry/Concern	Pretester Response
1. Everyone will know who I am, how bad my family/problem is. Someone will tell on me. Family secrets will be exposed. I'll be blamed, get in trouble.	1. All information will be confidential. Only the family's counselors will see this information. Your privacy will be valued and respected.
2. I am being singled out as an example of having the worse problem. My problems are like no one else's problems.	2. All families (70) are filling out these questionnaires. Families in the past have filled out these questionnaires.
3. I am not smart enough to fill out a questionnaire. I am afraid of failing on these questionnaires.	3. These questionnaires are easy to fill out. Families in the past have found these questionnaires to be simple and brief. These questionnaires simply ask your own views. You cannot fail because your opinion is a point of view. Opinions are sub-jective. There is no right or wrong opinion.

Comments: Please describe contact person's reactions to anticipating or planning this first meeting. No observation is too small or minor. Please record any feelings, observations you may have.

FORM FIVE (continued)

Name of the Contact Person: _____

Name(s) of Other Family Members Coming to First Meeting: _____

    <u>Name</u>   <u>Relationship To Contact Person</u>

_____

_____

_____

Time for Pretesting:

Day _____   Time _____

Comments. (e.g., worries and concerns contact person may be having.
            Observations you have on this phone contact and the
            family.)

APPENDIX C

FORM SIX: Pretest-Posttest Preparation Checklist

Preparation for test session.

1. Review application and contact sheets (Forms One, Two and Three) on family scheduled for pretesting or posttesting. Note the number of family members scheduled for test sessions (i.e., names and relationships).

Preparation of instrumentation (questionnaires).

1. Questionnaires. Prepare a folder containing all four questionnaires, the letter of introduction, and information sheet for each family member scheduled. Prepare two extra folders in case additional unscheduled family members arrive at the session.

2. Check that all the questionnaires contain all the pages and that pages are in the right order.

Preparation of the folders.

1. Check that each test folder contains all four questionnaires and that questionnaires are arranged in the order of administration (FAD, CBCL, FUI-REAL, FUI-IDEAL, FAP).

2. Check to make sure that the information sheet is the last item in the folder.

Preparation of the envelopes.

1. Prepare envelopes to be given to each family member in test session.

2. Label each envelope: Write the name of the family member in the upper left hand corner.

3. Have two extra unlabeled envelopes in case extra family members come for testing.

Preparation of materials necessary for test session.

Check that you have the following:

1. Pencils (extra)

2. Envelopes (appropriate number labeled and two extras, blank)

3. Cover letters (appropriate number plus extras)

FORM SIX (continued)

Preparation of materials necessary for test session (continued).

     4. Folders (appropriate number plus two extra)

     5. Wristwatch

     6. Reading material (for tester)

Information: Make mental notes of the following:

     1. Names and relationships of family members who completed the questionnaires.

     2. If there were any additions, substitutions or absences of the original list of family members scheduled.

     3. Important comments made by family members, any unusual occurrences, any variations in testing format.

Remember at the end of the session to ask family members to see if all the questionnaires are signed and dated before they are sealed in the envelope.

Wrap Up.

After the family has left, beside the family member's name on the envelope, record the following: Family ID number, date of testing, whether it was pretest or posttest, and name of tester (your name).

Complete the tester comment sheet.

FORM SEVEN: Pretest-Posttester Script

1.   The tester greets the family, introduces herself, welcomes the family, and defines her role.

Hello _____. I am _____. We welcome you to the program. (Seats family members, makes them feel comfortable, obtains names and relationships of family members present. This information will be recorded by tester after test session on Comment Sheet.)

2.   The tester describes her role.
The reason for me being here is to give you this material and to distribute the questionnaires. (The matter of the questionnaires was discussed with families when tester made phone contact to set up test session.)

3.   The tester distributes cover letter.
Before we begin, let me give you a letter from the family counselor who will be meeting with you after this initial meeting. This letter explains the general purpose of these questionnaires.
(Give each family member present about five minutes to read the letter.)
If there are any questions tester will reiterate the salient points outlined in the letter. She will restate the content of the letter in a pleasant fashion. She will tell family members that she knows no more about the project than what is contained in the letter that they have just read. She will gently guide them to the next step, the completion of the questionnaires.

4.   The tester distributes labeled envelopes.
Give the appropriate envelope (family member's name on it) to each family member present. She will then explain that they will place their

completed questionnaires inside this envelope and that if they wish they can seal the envelope.

If they ask about confidentiality, she may state that placing the questionnaires in this envelope will safeguard their privacy. All other questions she will direct to the family counselor. The tester will explain to the family that if they wish, they may discuss these questionnaires with the family counselor. (However, please make a mental note of their questions.)

5. Description of questionnaires.

In describing the questionnaires, the tester may state the question-naires are about family life, about children, and about the concerns that families may be having. The questionnaires are a way to describe and present your own views on these subjects.

6. The tester distributes FAD.

Tester distributes copies of FAD, the first questionnaire. She asks family members to read the directions.

7. Tester explains Directions.

The tester states the following: This booklet contains a number of statements about families. Please read each statement carefully and decide how well it describes your own family. You should answer accordingly. Each statement has four possible responses.

Strongly Agree (SA): Check SA, if you feel that the statement describes your family very accurately.

Agree (A): Check A, if you feel that the statement describes your family for the most part.

Disagree (D): Check D, if you feel that the statement does not describe your family for the most part.

Strongly Disagree (SD): Check SD, if you feel that the statement does not describe your family at all.

SA - very accurate
 A - accurate for the most
     part

D - does not describe my family
    for the most part
SD - does not describe my family
     at all

For each statement in the booklet there is an answer space below.
Don't pay attention to blanks at the far right hand side of the answer
space.

8. Spending time on questions.

In answer to this question, the tester may state: Try not to spend
too much time on any one statement. Respond as quickly and honestly as
you can. Answer with your first reaction.

The tester will refrain from answering any additional questions
prior to or during questionnaire administration. If questions do arise,
she will restate what is contained in the general description and
instructions to the questionnaire.

9. Tester will keep time. FAD takes about 15 minutes to complete.
(Tester may want to busy herself while family takes questionnaire.)

10. When family members have completed the questionnaires tester will
remind family members to be sure the questionnaire booklet is signed
and dated.

11. She will ask the family member to place the questionnaire in the
envelope.

12. The tester distributes CBCL.

The tester distributes CBCL, the second questionnaire. The tester
will describe CBCL as follows: CBCL is a child behavior checklist
designed for parents. It obtains information about the skills of the
child and about the child's behavior. The checklist has been used with
children who do not have problems and with children who demonstrate
behaviors parents may be concerned about.

13. Tester explains that CBCL is divided into two parts:
Part I-VII and Part VIII. She reads the directions that explain the
response system exactly as these instructions appear on the question-
naire. CBCL takes approximately 15-20 minutes to complete.

14. Refer to and repeat steps eight, nine, ten and eleven.

15. The tester distributes FUI REAL and IDEAL.
The tester distributes FUI-REAL and FUI-IDEAL, the third
questionnaire. She distributes both the yellow (REAL) and blue (IDEAL)
versions of FUI. She states that these are both part of the same
questionnaire.

16. Tester explains FUI.
In presenting FUI-REAL and FUI-IDEAL, the tester may state
the following: These two questionnaires are exactly alike. They have
the exact same 80 statements. The statements describe family life.
The difference between the two versions is on how you rate the state-
ments.

Yellow Version (REAL). The tester explains: In this version you
will answer how true the statements are for your family as it is now
according to a scale of 0 (means the statement is completely false) to
8 (means that the statement is completely true).

Blue Version (IDEAL). The tester states: In this version, you
will rate these same statements in a different way. How you would
ideally want your family to be. You will use the same 0 to 8 rating
response.

In other words, when you answer the Yellow version (REAL) you will
be answering according to how you see your family now. When you answer
the Blue version (IDEAL), you will be answering as you would ideally
like your family to be. Answer the REAL version first, then answer the
IDEAL version. Both versions take approximately 15 minutes to complete.

17. Refer to steps eight, nine, ten and eleven. Follow these procedures.

18. <u>The tester distributes FAP</u>.
     The tester distributes the fourth questionnaire, FAP.

19. Tester explains the directions to the questionnaire. She states: This is a very brief questionnaire designed specifically to obtain your description of your special concerns about your children and/or family. Please be as specific as possible. FAP takes about ten minutes to complete.

20. Refer to steps eight, nine, ten and eleven. Follow these procedures.

21. Tester asks family members to place the questionnaires in the envelope.

22. <u>The tester distributes Information Sheet</u>.

23. <u>The tester explains the purpose of the information sheet</u>.
     She states the following: This information will provide a group profile or description of the large group of families as a whole. This information sheet takes about three to five minutes to complete.

24. Have each family member read the directions and then have them complete the information sheet. This will take about three to five minutes.

25. Tester asks family members to put the information sheet in the envelope and then to seal the envelope (if they wish).

26. Tester collects the envelopes and expresses appreciation for their participation.

27. Tester tells the family that the next step is that they will be contacted by the family counselor.

FORM EIGHT: Pretester-Posttester Comment Sheet

Check: ____ Pretest   ____ Posttest

Enter the following information:

Names and relationships of people who attended.

Name _____ Relationship _____

_____

_____

_____

If there were any additions, substitutions or absences other than the
original list of scheduled family members.

Any important or unusual comments made by family members.

Any unusual occurrences or variations in test format. Reasons why?

Other comments: Tester's impressions of test session and overall
evaluations.

Signature of tester: _____   Date: _____

APPENDIX D

FORM NINE: The Family Assessment of the Problem
             Questionnaire -- Pretest Version

<u>Family Questionnaire</u>

Name _____   Today's Date _____
                                                        Mo.   Day   Year

Please place a checkmark beside your role in the family:

___ Mother   ___ Father   ___ Daughter   ___ Son

___ Grandmother   ___ Grandfather   ___ Aunt   ___ Uncle

___ Other (Please Specify)_____

_____

_____

Please give brief four to five sentence answers to the following
questions. Please be as specific as you can. If you refer to another
person(s) in your answer, give their name and their relationship to you.

1. What are your reasons for wanting to participate in this program?

2. What are the main problems or concerns for which you would like
    counseling? Please list these problems/concerns in order of
    importance.

3. What factors do you feel are contributing to the problem or
    concerns?

c. 1981 L. Andreozzi

4. Who do you feel is mainly or most often involved in this problem or concern?

5. In your opinion, who or what can change the problem or concern?

6. Who most often makes the final decisions on how to raise the children?

7. Who in your family seems to have the most influence over family members, the second most influence over family members, the least influence over family members?

	Name	Relationship
Most influential family member		
Second most influential family member		
Least influential family member		

8. I lead other family members. I take charge of situations. Others listen to my views.

   ___almost always   ___often   ___sometimes   ___seldom   ___never

9. I follow the decisions of others. I mainly support decisions and views of others.

   ___almost always   ___often   ___sometimes   ___seldom   ___never

10. I challenge the views and decisions of others. I offer different opinions. I disagree with the views and decisions of others.

    ___almost always   ___often   ___sometimes   ___seldom   ___never

11. I make comments on how family members get along with each other.
     I comment on where I see problems. I comment freely on family
     relationships.

     ___almost always   ___often   ___sometimes   ___seldom   ___never

12. Please list in order of importance the agencies or people outside
     your family who you feel you could turn to if you needed help.
     When naming a person, give his/her relationship to you. If there
     are no agencies or people whom you feel you could call on for
     help, place a checkmark beside number 7 (none).

     1. _____   4. _____

     2. _____   5. _____

     3. _____   6. _____

                                         7. None _____

Please add here anything about you or your family that is important
to you but has not been asked in the questions above.

FORM TEN: The Family Assessment of the Problem Questionnaire
-- Posttest Version

Family Questionnaire

Name_____   Today's Date_____
                                                                Mo.   Day   Year

Please place a checkmark beside your role in the family:

___ Mother   ___ Father   ___ Daughter   ___ Son

___ Grandmother   ___ Grandfather   ___ Aunt   ___ Uncle

___ Other (Please Specify) _____

_____

_____

Please give brief four to five sentence answers to the following
questions. Please be as specific as you can. If you refer to another
person(s) in your answer give their name and their relationship to you.

1. Describe the problem or concern for which you first sought
    counseling.

2. How has this problem or concern changed?

3. List your original concerns for which you sought counseling. Then
    list any new problems or concerns in order of importance or
    priority to you that have developed.

c. 1982 L. Andreozzi

4. Who do you feel is mainly or most often involved in this problem or concern?

5. In your opinion, who or what can change the problem or concern?

6. Who most often makes the final decisions on how to raise the children?

7. Who in your family seems to have the most influence over family members, the second most influence over family members, the least most influence over family members?

	Name	Relationship
Most influential family member		
Second most influential family member		
Least influential family member		

Please place a checkmark beside the answer that best describes how frequently you feel that you perform the following roles in your family.

8. I lead other family members. I take charge of situations. Others listen to my views.

___almost always   ___often   ___sometimes   ___seldom   ___never

9. I follow the decisions of others. I mainly support decisions and views of others.

___almost always   ___often   ___sometimes   ___seldom   ___never

10. I challenge the views and decisions of others. I offer different opinions. I disagree with the views and decisions of others.

___almost always   ___often   ___sometimes   ___seldom   ___never

11. I make comments on how family members get along with each other. I comment on where I see problems. I comment freely on family relationships.

___almost always   ___often   ___sometimes   ___seldom   ___never

12. Please list in order of importance the agencies or people outside your family who you feel you could turn to if you needed help. When naming a person, give his/her relationship to you. If there are no agencies or people whom you feel you could call on for help, place a checkmark beside number 7 (none).

1. _____   4. _____

2. _____   5. _____

3. _____   6. _____

                               7. None _____

Please add here anything about you or your family that is important to you but has not been asked in the questions above.

Please place a checkmark beside the answers to the following questions that best describe how the problem for which you first sought counseling was resolved.

13. Did the problem for which you first sought counseling change?

    ___ Yes   ___ No

14. How did the problem change?

    ___ Improved (got better)   ___ Remained the same   ___ Became Worse

15. Are there any new problems?

    ___ Yes   ___ No

    Please place a checkmark beside the answer that best describes the type of new problem(s).

    a. ___ Mainly a child problem involving withdrawn behavior
       (e.g., anxious, timid, fearful, depressed, etc.).

    b. ___ Mainly a child problem involving aggressive behavior
       (e.g., tantrums, disruptive, emotionally explosive,
       rebellious, stubborn, etc.).

    c. ___ Mainly a parent(s)-child problem involving a mixture of
       withdrawn and aggressive behavior.

    d. ___ Mainly a problem involving only the children (e.g., sibling
       rivalry, jealousy, fighting among siblings).

    e. ___ Mainly a marital problem.

    f. ___ Mainly a family problem involving all immediate family
       members but not extended family members.

    g. ___ Mainly a problem outside the control of you and your
       family as you see it (e.g., job loss, inadequate finances,
       chronic illness, etc.).

    h. ___ Mainly your own personal problem (e.g., your own doubts,
       fears, anxieties, attitudes, and inner conflicts).

    i. ___ Mainly a problem involving your parents, in-laws, and/or
       extended family and their effect on the way you deal with
       your children, spouse, and/or family life.

j. ___ Mainly a problem of lack of child rearing and/or family
         life information.

k. ___ Other: Please specify _____

         _____

FORM ELEVEN: The Family Counseling Evaluation

Family Counseling Evaluation

The following statements pertain to the short-term family counseling experience that you have just participated in. Please respond to the following statements according to whether you Strongly Agree (SA), Agree (A), Disagree (D), or Strongly Disagree (SD). Please answer these statements as honestly as you can.

1. The counseling helped to change the problem for which counseling was sought.

    ____ SA   ____ A   ____ D   ____ SD

2. The counseling has helped me to gain new insights and awareness into my child's behavior.

    ____ SA   ____ A   ____ D   ____ SD

3. The counseling has helped me to gain new insights and awareness into how I interact with my children.

    ____ SA   ____ A   ____ D   ____ SD

4. The counseling has helped me gain new insights and awarenesses into how my family interacts.

    ____ SA   ____ A   ____ D   ____ SD

5. The counseling has helped me to better understand the meanings of family members' behaviors.

    ____ SA   ____ A   ____ D   ____ SD

6. The counseling has helped me to better understand the expectations that family members have of each other.

    ____ SA   ____ A   ____ D   ____ SD

7. The counseling has helped me to develop more effective parenting skills.

    ____ SA   ____ A   ____ D   ____ SD

8. The counseling has helped me to develop new insights and awarenesses about my childhood family.

    ____ SA   ____ A   ____ D   ____ SD

9. The counseling has helped me to communicate better with my spouse.

    ____ SA   ____ A   ____ D   ____ SD

10. The counseling has helped me develop new insights and aware-
    nesses about my relationship with my spouse, ex-spouse, or intimate
    companion.

    ____ SA   ____ A   ____ D   ____ SD

11. The counseling has helped me to gain new insights and awarenesses
    about myself.

    ____ SA   ____ A   ____ D   ____ SD

12. The counseling has helped me to gain new insights and awarenesses
    about my expectations about myself.

    ____ SA   ____ A   ____ D   ____ SD

13. The counseling has helped me to get along better with my child or
    children.

    ____ SA   ____ A   ____ D   ____ SD

14. The counseling has helped me to get along better with my spouse
    or intimate companion.

    ____ SA   ____ A   ____ D   ____ SD

15. The counseling has helped me to get along better with my parents
    and/or members of my extended family.
    ____ SA   ____ A   ____ D   ____ SD

16. The counseling was a worthwhile experience.

    ____ SA   ____ A   ____ D   ____ SD

17. I would recommend the counseling to other families.

    ____ SA   ____ A   ____ D   ____ SD

18. What new insights or new awarenesses did you gain about yourself?
    The meaning behind your behavior? Your expectations?

    _____   _____
            Name   Today's Date

FORM TWELVE: Family Information/Family Demographics Sheet

In order for us to best describe the characteristics of the large group of families who are participating in this Family Counseling Research Program, we ask that you provide the following information on the form below; Please be assured that all information about your family will be kept strictly confidential. We appreciate your cooperation.

1. List the names of people in your immediate family.

Name	Relationship	Age

2. Please check your marital status.

___ Single ___ Married ___ Separated ___ Divorced

___ Divorced and Remarried ___ Living Together ___ Widowed

___ Other (Please specify)_____

3. Please check your yearly income level.

___ 0-$4,999 ___ $5,000-$9,999 ___ $10,000-$14,999

___ $15,000-$19,999 ___ $20,000-$24,999 ___ $25,000-$40,000

___ over $40,000

4. Please check your religious affiliation.

   _____ Catholic   _____ Jewish   _____ Protestant

   Other (Please specify) _____

APPENDIX E

FORM THIRTEEN: Therapist Telephone Contact Sheet

Name of Family _____

Date _____   Time _____

Person Talked With _____

Comments:

Signature _____

Date _____

FORM FOURTEEN: Therapist Comment Sheet: Phase I

Name of Family _____ ID#_____

Date _____   Session No. _____

Length of Time _____

Therapist _____

Site _____

Family members present _____

_____

_____

_____

_____

_____

_____

Completing Phase I: Forming the Therapeutic Alliance

What was the family's initial description of the presenting problem?
Briefly describe the problem as it was stated by the family (as much
as possible, use family's own words). Record each family member's
description of the problem.

1. Comment briefly on the following:

    Facts or theories family members seem to be using to explain the
    problem.

Anything special or striking about the family's presence or style or quality of interaction.

Anything special, unusual or striking about the family's or family members' demeanor or appearance (e.g., voice, tone, attire, seating arrangements, etc.).

2. General comments on completion of Phase I:

How does the therapist feel he/she completed the tasks and objectives?

Were there any changes in the procedures or method? If so, what were the changes? What were the reasons for deciding to adopt a different plan?

How close does the therapist feel his/her behavior approached the description of therapist's role?

3. Please check:

Was the problem described by the family in the first session the same problem that the family described on the application or was it different?

The same problem._____

A different problem._____

List and briefly describe the interventions made by the therapist.

FORM FIFTEEN: Therapist Comment Sheet: Phase II

1. History Taking and Building the Therapeutic System.

    Record the following information.

        Description of the onset of the problem:
            Who, what, when, where, how it happens as family
            describes the problem interaction.

        Developmental life stage of the family.

        _____

        Developmental task and major issue(s) at stake. _____

        _____

        _____

        Role/behavior strategies of family members. Who mainly is
        the mover? Who mainly is the follower? Who mainly is the
        challenger/opposer? Who mainly is the bystander? List
        these roles and record the words or labels family members may
        be using and that, in the therapist's opinion, correspond to
        these four general role descriptions.

        Did any family members identify personal images or use striking
        personal imagery?

        How does the family define itself: membership issues, family
        concept, sense of family in relation to outside world, etc.

Any sense the therapist has about the meaning of the problem:
What does it mean to this particular family? Symbols used?
Critical issues at stake?

Who is primarily involved? What subsystems?

2. History of the family and the couple:

Record the following information.

Any events preceding or corresponding to the onset of the
problem?

Nodal events that affected family's course of development?

General way couple describes their relationship?

Issues couple repeatedly fight over?

Course of the couple's relationship:
    Striking events?

First or second marriages?
    Comments about former spouses? children? reasons for
    the divorce(s)?

Any important medical history, illnesses, medication or
hospitalizations of spouses?

Spouse's present relationships with parents?

Spouse's relationship with in-laws?

Any striking or important comments about spouse's experiences in family of origin (e.g., image of being a parent, parenting, being a child)?

Any important or unusual events that marked either of the spouse's family's of origin development?

Any transgenerational patterns?

Any intergenerational triangles?

Any emotional cut-offs with members of either family?

Issues family members can talk about? with whom?

Issues family members cannot talk about? with whom?

General impression of overall openness--closedness of family? why?

How freely is tenderness and affection shown?

Family strengths?

Kind of social network family lives in?

Social and emotional supports available to family? family members?

3. Developmental history of the child:

Record the following information:

Description of the pregnancy.

Description of the labor and delivery.

Any problems at time of the birth? For child? For mother? In the family?

Any prolonged illnesses or hospitalization of child?

Any problems with child's learning?

Any problems with developmental milestones?

Strengths or talents of the child?

Did the family ever seek professional help at any other time? Where? With whom?

4. General comments.

   Hunches about the emotional process that surrounds the problem.

   Working hypotheses: therapist's description of the problem.

5. General comments on the completion of Phase II.

   How does the therapist feel he/she completed the tasks and
   objectives? Some of them? All of them?

   Were there any changes in the procedures or method? If so, what
   were the changes? What were the reasons for deciding to adopt a
   different plan?

   How close does the therapist feel his/her behavior approached
   the description of therapist's role?

   Did the family begin to focus in on issues for the counseling?
   If so, list these issues.

FORM SIXTEEN: Therapist Comment Sheet: The Main Phase

Name of family _____

Date _____   Time _____   Place_____ Session_____

Family members in attendance_____

_____

Treatment phase _____

Objectives completed _____

_____

_____

Therapeutic tasks completed _____

_____

_____

_____

Major issues of the session _____

_____

_____

_____

_____

Interventions _____

_____

_____

_____

Alternative behavioral strategies for family to experiment with _____

_____

_____

_____

Comments:

Date and Title of Next Session _____

Signature of Therapist _____ Date _____

APPENDIX F

FORM SEVENTEEN: Original Form Used to Describe Clinical
and Demographic Data

Item #	Code	Variable	Data Description
1	___ ___ ___	Child's age	
2	___	Child's sex	
3	___	Child's race	
4	___	Child's grade level	
5	___ ___	Child's school	
6	___	Child's problem type	
7	___	Mother's type work	
8	___	Mother's work status T_1	
9	___	Mother's work status T_2	
10	___	Mother's work status T_3	
11	___	Father's type work	
12	___	Father's work status T_1	
13	___	Father's work status T_2	
14	___	Father's work status T_3	
15	___	Mother's Ed. level	
16	___	Father's Ed. level	
17	___	S's rank in fam. of origin	
18	___	# of Ch. in pres. family	
19	___ ___	# of person's living in household	
20	___	Relationship	
21	___ ___	Age	
22	___	Relationship	

Item #	Code	Variable	Data Description
23	__ __	Age	
24	__	Relationship	
25	__ __	Age	
26	__	Relationship	
27	__ __	Age	
28	__	Relationship	
29	__ __	Age	
30	__	Relationship	
31	__ __	Age	
32	__	Marital status T_1	
33	__	Marital status T_2	
34	__	Marital status T_3	
35	__	Income level	
36	__	Religion of S	
37	__	Family type	
38	__ __	Mother's ethnic background	
39	__ __	Father's ethnic background	
40	__ __	Family's ethnic background	

FORM EIGHTEEN: Coding Form for Data Obtained From Women

Name:_____   I.D._____

Item #	Variable	Code
1	Mother's type of work	___
2	Mother's work status T_1	___
3	Mother's work status T_2	___
4	Mother's work status T_3	___
5	Mother's education level	___
6	S's rank in family of origin	___
7	# of children in family	___
8	# of persons living in household	___
9	Relationship	___
10	Age	___ ___
11	Relationship	___
12	Age	___ ___
13	Relationship	___
14	Age	___ ___
15	Relationship	___
16	Age	___ ___
17	Relationship	___
18	Age	___ ___
19	Relationship	___
20	Age	___ ___
21	S's marital status T_1	___

Name:_____ I.D._____

Item #	Variable	Code
22	S's marital status T_2	__
23	S's marital status T_3	__
24	Income level	__
25	Religion of S	__
26	Family type	__
27	Mother's ethnic background	__ __
28	Family's ethnic background	__ __
29	Referring agency	__ __
30	Child's age	__ __
31	Child's sex	__
32	Child's race	__
33	Child's grade level	__
34	Child's prob. type-init. ref. form	__
35	Child's age	__ __
36	Child's sex	__
37	Child's race	__
38	Child's grade level	__
39	Child's prob. type-init. ref. form	__
40	Child's age	__ __
41	Child's sex	__
42	Child's race	__
43	Child's grade level	__
44	Child's prob. type-init. ref. form	__

Name:_____ I.D._____

Item #	Variable	Code
45	Ex. husband type of work	___
46	Ex. husband education level	___
47	Ex. husband ethnic background	___ ___
48	Ex. husband age	___ ___

FORM NINETEEN: Coding Form for Data Obtained From Men

Name:_____   I.D._____

Item #	Variable	Code
1	Father/M. comp. type of work	___
2	Father/M. comp. work status T_1	___
3	Father/M. comp. work status T_2	___
4	Father/M. comp. work status T_3	___
5	Father/M. comp. education level	___
6	S's rank in family of origin	___
7	S's marital status T_1	___
8	S's marital status T_2	___
9	S's marital status T_3	___
10	Religion of S	___
11	Father/M. comp. ethnic background	___ ___
12	S's age	___ ___

FORM TWENTY: Coding Form for FAP Data at T_1

Name:_____   I.D._____

Item	Variable	Code
1	No. of reasons.	___
2	Level of clarity in reasons for wanting to participate.	___
3	Type of reason(s).	___
4	No. of problems T_1.	___
5	Type of problem(s) T_1.	___
6	Problem level/intensity.	___
7	Clarity of request for help.	___
8	No. of factors contributing to the problem.	___
9	Type of factors - theory of causation.	___
10	No. of people involved.	___
11	Relationship(s)/subsystem(s) prin. id. as problematic.	___
12	Prin. focus for change.	___
13	Who makes final child rearing decisions?	___
14	Most influential family member.	___
15	Second most influential family member.	___
16	Least influential family member.	___
17	Frequency of role - initiates.	___
18	Frequency of role - follows.	___
19	Frequency of role - challenges.	___
20	Frequency of role - comments.	___
21	No. of helpful supports/resourses outside immediate family.	___

FORM TWENTY-ONE: Coding Form for Posttest Data on FAP
on Treatment Families T_2 and T_3

Name:_____   I.D. _____

Item	Variable	Code
1	No. of problem(s).	____
2	Type of problem(s).	____
3	Problem level/intensity.	____
4	Clarity of problem description.	____
5	Did the problem change?	____
6	Direction of change.	____
7	No. of original problems listed at $T_{2/3}$.	____
8	No. of new problems.	____
9	Type of new problem(s).	____
10	Problem level/intensity.	____
11	Clarity of new problem description.	____
12	No. of people involved.	____
13	Relationship(s)/subsystem(s) prin. id. as problematic.	____
14	Prin. focus for change.	____
15	Who makes final child rearing decisions?	____
16	Most influential family member.	____
17	Second most influential family member.	____
18	Least influential family member.	____
19	Frequency of role - initiates.	____
20	Frequency of role - follows.	____
21	Frequency of role - challenges.	____
22	Frequency of role - comments.	____
23	No. of helpful supports/resources outside immediate family.	____

FORM TWENTY-TWO: Coding Form for Posttest Data on FAP
on Control Families, T_2 and T_3

Name:_____   I.D._____

Item	Variable	Code
1	No. of problems(s).	____
2	Type of problem(s).	____
3	Problem level/intensity.	____
4	Clarity of problem description.	____
5	Did the problem change?	____
6	Direction of change.	____
7	No. of original probelms listed at $T_{2/3}$.	____
8	No. of new problems.	____
9	Type of new problem(s).	____
10	Problem level/intensity.	____
11	Clarity of new problem description.	____
12	No. of people involved.	____
13	Relationship(s)/subsystem(s) prin. id. as problematic.	____
14	Prin. focus for change.	____
15	Who makes final child-rearing decisions?	____
16	Most influential family member.	____
17	Second most influential family member.	____
18	Least influential family member.	____
19	Frequency of role - initiates.	____
20	Frequency of role - follows.	____

Name:_____ I.D._____

Item	Variable	Code
21	Frequency of role - challenges.	____
22	Frequency of role - comments.	____
23	No. of helpful supports/resources outside immed. family.	____
24	No. of reasons.	____
25	Level of clarity in reasons for wanting to participate.	____
26	Type of reason(s).	____
27	No. of factors contributing to the problem.	____
28	Type of factors - theory of causation.	____

APPENDIX G

FORM TWENTY-THREE: Complete List of Subscale Variables Used to Assess Outcome on the Four Dependent Measures

FAD Subscales

1. Problem Solving
2. Communication
3. Roles
4. Affective Responsiveness
5. Affective Involvement
6. Behavior Control
7. General Functioning

CBCL Subscales

8. Activities
9. Social
10. Total Social
11. School
12. Behavior Problems
13. Internalizing
14. Externalizing
15. CBCL Congruence

FUI REAL Subscales

16. Real Consideration vs. Conflict
17. Real Actualization
18. Real Communication
19. Real Sociability
20. Real Ambition
21. Real Locus of Control
22. Real Togetherness
23. Real Loyalty
24. Real Closeness

FUI IDEAL Subscales

25. Ideal Consideration vs. Conflict
26. Ideal Actualization
27. Ideal Communication
28. Ideal Sociability
29. Ideal Ambition
30. Ideal Locus of Control
31. Ideal Togetherness
32. Ideal Loyalty
33. Ideal Closeness

FUI REAL and FUI IDEAL Second-Order Scores

34. Real Adaptive Coping
35. Ideal Adaptive Coping
36. Real Family Integration
37. Ideal Family Integration
38. Real Family Congruence
39. Ideal Family Congruence
40. Family Satisfaction

APPENDIX H

TABLE 18

Subscale Correlations on FAD
(N=87)

	Problem Solving	Commun- ication	Roles	Affective Respons.	Affective Involve.	Behavior Control	General Function.
Problem Solving	1.00	.7989	.6265	.7834	.7114	.6154	.8612
Communication		1.00	.4077	.7697	.6189	.4875	.7761
Roles			1.00	.4275	.5751	.5751	.6281
Affective Responsiveness				1.00	.6499	.5441	.8055
Affective Involvement					1.00	.6983	.7201
Behavior Control						1.00	.6466
General Functioning							1.00

TABLE 19

Subscale Correlations on CBCL
(N=87)

	Internal	External	Total Behavior	Activities	Social	Total Social	School
Internal	1.00	.6531	.8941	-.0365	-.3611	-.2585	-.1065
External		1.00	.8924	-.0806	-.3458	-.3210	-.4774
Total Behavior			1.00	-.0362	-.4029	-.3191	-.3518
Activities				1.00	.0785	.7713	.3880
Social					1.00	.6509	.4625
Total Social						1.00	.5916
School							1.00

TABLE 20

Subscale Correlations on FUI REAL
(N=87)

	Real Consider-ation	Real Actual-ization	Real Commun-ication	Real Sociability	Real Ambition	Real Locus of Control	Real Together.	Real Loyalty	Real Closeness
Real Consideration	1.00	.7332	.5125	.6210	-.1167	.6021	.6378	.6748	.7963
Real Actualization		1.00	.6478	.6888	-.1286	.6199	.7302	.6962	.7751
Real Communication			1.00	.5258	-.3432	.4610	.6377	.5775	.7580
Real Sociability				1.00	-.1775	.5587	.6906	.7076	.6851
Real Ambition					1.00	-.3200	-.1006	-.0327	-.1408
Real Locus of Control						1.00	.4971	.5585	.6297
Real Togetherness							1.00	.7032	.7757
Real Loyalty								1.00	.8373
Real Closeness									1.00

TABLE 21

Subscale Correlations on FUI IDEAL
(N=87)

	Ideal Consider- ation	Ideal Actual- ization	Ideal Commun- ication	Ideal Sociability	Ideal Ambition	Ideal Locus of Control	Ideal Together.	Ideal Loyalty	Ideal Closeness
Ideal Consideration	1.00	.6721	.4913	.5804	-.1091	.5404	.6582	.6249	.6775
Ideal Actualization		1.00	.5699	.6092	-.0096	.4773	.5659	.5674	.6278
Ideal Communication			1.00	.4461	-.2445	.3995	.5208	.3973	.5458
Ideal Sociability				1.00	.0079	.3038	.6405	.6347	.6844
Ideal Ambition					1.00	-.2500	-.0317	-.0531	-.0502
Ideal Locus of Control						1.00	.4232	.4248	.4108
Ideal Togetherness							1.00	.5839	.7001
Ideal Loyalty								1.00	.6406
Ideal Closeness									1.00

APPENDIX I

TABLE 22

Subscale Reliabilities on FAD
(N=87)

	# of Items	Mean	Standard Deviation	Cronbach's Alpha
Problem Solving	6	2.019	.514	.852
Communication	9	2.082	.519	.845
Roles	11	2.282	.430	.786
Affective Responsiveness	6	1.816	.595	.825
Affective Involvement	7	2.026	.553	.832
Behavior Control	9	1.782	.391	.752
General Functioning	12	1.903	.551	.904

TABLE 23

Subscale Reliabilities on FUI REAL
(N=87)

	# of Items	Mean	Standard Deviation	Cronbach's Alpha
Consideration	13	4.692	1.526	.915
Actualization	10	4.722	1.326	.836
Communication	5	5.046	1.821	.812
Sociability	5	5.855	1.276	.732
Ambition	3	3.525	1.846	.701
Locus of Control	7	5.512	1.226	.624
Togetherness	5	5.147	1.539	.736
Loyalty	5	6.777	1.290	.851
Closeness	8	5.648	1.768	.906

TABLE 24

Subscale Reliabilities on FUI IDEAL
(N=87)

	# of Items	Mean	Standard Deviation	Cronbach's Alpha
Consideration	13	6.551	.849	.721
Actualization	10	6.426	.836	.692
Communication	5	6.660	1.167	.635
Sociability	5	7.005	.958	.788
Ambition	3	2.881	1.629	.457
Locus of Control	7	6.376	.916	.467
Togetherness	5	6.561	.971	.516
Loyalty	5	7.414	.823	.760
Closeness	8	7.063	.921	.754

APPENDIX J

TABLE 25

FAD Median, Means, and Variances for Men and Women at T_1

		Women				Men		
	Group	n	Median	Mean	Variance	n	Median	Mean	Variance

	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Problem Solving	1	20	2.080	2.118	.404	6	2.028	2.140	.138
	2	20	1.910	1.841	.174	6	1.830	1.777	.063
	3	25	2.060	2.100	.294	10	2.027	2.049	.253
Communication	1	20	2.000	2.122	.483	6	2.165	2.183	.023
	2	20	1.945	1.905	.202	6	2.000	2.055	.052
	3	25	2.192	2.141	.254	10	2.275	2.154	.314
Roles	1	20	2.315	2.355	.303	6	2.225	2.348	.131
	2	20	2.120	2.181	.111	6	2.090	2.090	.216
	3	25	2.359	2.391	.168	10	2.135	2.137	.134
Affective Responsiveness	1	20	1.670	1.934	.577	6	1.910	2.083	.163
	2	20	1.580	1.692	.337	6	1.775	1.777	.195
	3	25	1.723	1.747	.240	10	1.750	1.867	.481
Affective Involvement	1	20	2.070	2.129	.541	6	2.070	2.120	.206
	2	20	1.964	1.822	.166	6	2.070	2.118	.258
	3	25	2.132	2.039	.317	10	2.070	2.085	.196
Behavior Control	1	20	1.703	1.811	.311	6	1.945	1.945	.054
	2	20	1.615	1.634	.098	6	1.780	1.797	.295
	3	25	1.876	1.823	.095	10	1.780	1.812	.074
General Functioning	1	20	1.920	2.012	.426	6	1.965	2.002	.144
	2	20	1.620	1.791	.268	6	1.410	1.540	.112
	3	25	1.947	1.980	.271	10	1.845	1.874	.406

TABLE 26

FAD Median, Means, and Variances for Men and Women at T_2

		Women				Men		
	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Problem Solving	1	19	2.064	2.185	.277	12	2.000	2.069	.154
	2	18	2.027	1.981	.202	10	2.016	2.050	.056
	3	21	2.000	2.016	.214	13	2.014	2.065	.215
Communication	1	19	2.014	2.235	.412	12	2.055	2.157	.082
	2	18	2.018	1.994	.097	10	2.055	2.122	.083
	3	21	2.014	2.010	.133	13	2.192	2.145	.120
Roles	1	19	2.338	2.397	.202	12	2.225	2.243	.070
	2	18	2.180	2.263	.097	10	2.225	2.308	.045
	3	21	2.292	2.320	.160	13	2.090	2.105	.112
Affective Responsiveness	1	19	1.947	1.939	.417	12	1.910	1.973	.223
	2	18	1.857	1.814	.340	10	2.080	2.016	.176
	3	21	1.723	1.722	.270	13	1.830	1.988	.442
Affective Involvement	1	19	2.045	2.122	.341	12	1.937	1.939	.124
	2	18	1.953	1.873	.158	10	2.070	2.084	.202
	3	21	2.044	2.102	.186	13	2.047	1.966	.096
Behavior Control	1	19	1.743	1.813	.287	12	1.652	1.759	.220
	2	18	1.890	1.833	.133	10	1.890	1.845	.131
	3	21	1.711	1.753	.093	13	1.711	1.752	.069
General Functioning	1	19	2.000	2.057	.383	12	1.790	1.847	.117
	2	18	1.920	1.889	.243	10	1.770	1.900	.129
	3	21	1.750	1.830	.216	13	1.750	1.885	.198

TABLE 27

FAD Median, Means, and Variances for Men and Women: Gains

	Group	Women				Men			
		n	Median	Mean	Variance	n	Median	Mean	Variance
Problem Solving	1	19	.004	.035	.161	5	.000	-.002	.056
	2	18	.157	.083	.036	5	.057	.168	.084
	3	21	.002	-.063	.137	9	.110	.058	.098
Communication	1	19	.110	.106	.219	5	.003	.024	.009
	2	18	.005	.031	.069	5	.000	.044	.028
	3	21	-.113	-.137	.098	9	-.110	-.012	.197
Roles	1	19	.003	.015	.116	5	-.045	-.128	.090
	2	18	.000	.051	.057	5	.090	.146	.120
	3	21	-.004	-.034	.050	9	.000	-.011	.073
Affective Responsiveness	1	19	-.001	-.027	.122	5	.300	.270	.036
	2	18	.160	.054	.091	5	.330	.266	.064
	3	21	.160	.031	.118	9	.057	.129	.124
Affective Involvement	1	19	-.001	-.051	.149	5	-.038	-.088	.097
	2	18	-.001	.016	.093	5	.210	.198	.179
	3	21	.002	.109	.143	9	.000	-.064	.077
Behavior Control	1	19	-.001	-.018	.097	5	-.327	-.244	.015
	2	18	.217	.153	.112	5	.000	-.066	.064
	3	21	-.110	-.041	.080	9	-.110	-.062	.040
General Functioning	1	19	.080	.040	.113	5	-.090	-.284	.172
	2	18	.005	.066	.039	5	.170	.202	.030
	3	21	-.083	-.138	.097	9	.020	.030	.081

TABLE 28

CBCL Median, Means, and Variances for Men and Women at T_1

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Internalizing								
1	20	63.500	65.150	178.239	5	54.000	55.000	66.500
2	19	58.750	58.211	137.175	6	53.000	55.833	69.767
3	23	60.250	62.391	152.431	9	60.000	59.119	48.111
Externalizing								
1	20	63.500	63.700	151.589	5	57.000	60.000	32.500
2	19	55.000	54.842	62.696	6	55.500	55.500	41.900
3	23	62.750	63.000	128.545	9	60.250	61.667	60.750
Activities								
1	20	45.833	46.550	133.313	4	46.000	46.500	49.000
2	19	52.000	50.474	260.152	6	37.500	37.167	268.567
3	23	46.000	45.913	126.083	9	40.500	38.222	105.694
Social								
1	20	35.500	36.450	215.418	5	39.000	39.200	59.700
2	19	39.000	28.632	197.023	6	20.500	35.333	483.467
3	23	39.750	37.174	189.241	9	42.000	40.556	92.528
Total Behavior								
1	19	62.750	64.526	145.374	5	59.000	59.000	30.000
2	18	56.500	57.278	81.624	6	51.500	55.500	62.300
3	21	62.250	63.048	139.748	9	60.000	60.222	49.400
Total Social								
1	19	39.750	40.789	125.064	4	37.500	38.000	19.333
2	18	41.500	44.833	121.324	6	34.000	38.167	76.167
3	21	40.125	40.190	105.362	7	36.000	37.286	31.571
School								
1	10	44.500	43.600	105.600	4	44.000	44.500	33.667
2	6	48.000	56.500	344.700	-	-	-	-
3	9	44.000	45.333	44.750	3	48.000	57.667	376.333

TABLE 29

CBCL Median, Means, and Variances for Men and Women at T_2

Group	Women				Men			
	n	Median	Mean	Variance	n	Median	Mean	Variance
Internalizing								
1	19	61.250	60.632	168.690	10	52.500	56.700	118.233
2	18	55.000	55.333	188.471	10	53.500	56.200	266.844
3	20	56.500	58.300	210.853	13	50.250	52.615	53.590
Externalizing								
1	19	63.667	61.526	186.263	10	55.000	56.400	176.489
2	18	55.000	53.889	93.399	10	50.500	54.900	199.211
3	20	56.500	58.050	119.313	13	54.750	55.231	86.526
Activities								
1	19	46.333	45.105	137.655	10	39.500	44.100	146.989
2	18	53.000	49.556	244.732	9	51.000	45.333	210.500
3	20	48.500	49.900	75.884	13	41.750	43.000	54.167
Social								
1	19	39.250	40.368	243.468	10	46.500	42.100	196.767
2	18	42.000	42.667	227.765	10	34.500	41.300	496.011
3	20	39.500	40.350	130.239	12	40.000	41.667	54.788
Total Behavior								
1	19	63.000	60.632	146.357	10	53.500	57.300	155.344
2	18	54.500	54.611	137.310	10	49.500	53.400	193.378
3	20	57.500	58.600	123.726	13	53.000	53.692	65.397
Total Social								
1	19	40.000	41.421	167.591	10	36.500	42.800	120.844
2	18	46.500	46.500	147.794	9	40.750	44.111	283.611
3	20	41.250	43.500	66.368	12	37.500	40.667	56.606
School								
1	10	44.500	47.400	230.711	7	52.000	58.857	411.476
2	7	45.000	49.286	208.905	4	41.500	59.250	575.583
3	11	51.875	50.091	47.491	7	58.000	64.857	205.143

TABLE 30

CBCL Median, Means, and Variances for Men and Women: Gains

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Internalizing								
1	19	-2.750	-5.105	78.766	4	-3.000	-3.000	6.667
2	17	-3.625	-2.765	52.566	5	-2.000	1.200	92.200
3	18	-.500	-3.500	85.559	8	-4.000	-6.125	42.696
Externalizing								
1	19	-2.000	-2.632	46.135	4	-1.500	-.1000	10.000
2	17	-.750	-.235	40.191	5	1.000	2.000	130.000
3	18	-1.500	-2.722	39.624	8	-7.500	-5.500	18.571
Activities								
1	19	-2.000	-1.895	43.211	4	.500	.500	68.333
2	17	.250	-1.353	81.493	4	-18.500	1.750	746.250
3	18	1.833	3.333	78.118	8	.500	2.625	83.982
Social								
1	19	3.000	4.842	187.696	4	.000	1.000	102.000
2	17	.417	2.118	82.110	5	-4.000	1.000	256.000
3	18	-1.500	1.167	128.971	8	-4.500	1.250	129.929
Total Behavior								
1	18	-1.500	-3.778	40.418	4	-1.000	-1.500	11.667
2	16	-1.500	-2.000	38.000	5	-2.000	-1.000	40.000
3	16	-3.000	-2.500	34.933	8	-5.500	-5.875	32.125
Total Social								
1	18	.167	.944	65.232	4	3.000	3.000	60.000
2	16	1.500	1.625	63.383	4	.500	1.500	221.667
3	16	1.167	2.188	57.629	6	3.000	2.833	94.967
School								
1	9	.125	.222	11.694	4	3.500	8.750	175.583
2	5	-3.500	-5.600	156.800	-	-	-	-
3	7	.333	1.857	20.143	3	7.000	13.000	283.000

TABLE 31

FUI REAL Median, Means, and Variances for Men and Women at T_1

		Women				Men		
	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Consideration	1	20	4.500	4.455	2.778	6	4.040	4.373	.565
	2	20	4.725	5.058	1.778	6	4.925	5.207	.895
	3	25	4.230	4.364	2.828	10	5.040	5.146	3.101
Real Actualization	1	20	4.550	4.465	2.438	6	4.500	4.633	1.399
	2	20	4.850	4.900	1.425	6	5.350	5.400	1.144
	3	25	4.700	4.704	2.170	10	4.550	4.570	.880
Real Communication	1	20	5.100	4.680	4.827	6	4.100	4.700	2.316
	2	20	5.600	5.640	3.459	6	5.900	5.465	1.979
	3	25	5.400	5.000	3.190	10	4.900	4.660	1.850
Real Sociability	1	20	5.500	5.710	2.158	6	4.100	4.967	1.303
	2	20	6.500	5.990	1.754	6	5.500	6.067	1.195
	3	25	6.267	5.888	1.500	10	6.500	6.200	1.138
Real Ambition	1	20	3.495	3.599	4.312	6	3.495	3.277	3.535
	2	20	2.945	2.950	2.915	6	4.495	4.778	1.274
	3	25	3.560	3.601	3.745	10	3.670	3.734	2.754
Real Locus of Control	1	20	5.500	5.442	1.403	6	5.570	5.190	4.197
	2	20	5.780	5.721	1.173	6	6.360	5.572	1.808
	3	25	5.465	5.400	1.607	10	5.500	5.671	1.069
Real Togetherness	1	20	5.300	4.990	3.678	6	4.600	5.033	1.575
	2	20	4.900	5.190	2.015	6	6.500	6.200	.896
	3	25	5.560	4.992	2.638	10	5.100	5.200	1.333

Continued

TABLE 31 - continued

		Women					Men		
Group	n	Median	Mean	Variance		n	Median	Mean	Variance
Real Loyalty									
1	20	7.300	6.910	1.947		6	6.500	6.200	2.272
2	20	7.100	6.770	1.955		6	7.700	7.200	1.456
3	25	7.125	6.664	1.589		10	6.900	6.900	.927
Real Closeness									
1	20	6.190	5.515	3.693		6	5.125	5.105	.981
2	20	6.060	5.791	3.664		6	7.250	6.522	2.205
3	25	5.880	5.507	3.037		10	6.195	5.803	3.605

TABLE 32

FUI REAL Median, Means, and Variances for Men and Women at T_2

Group	Women				Men			
	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Consideration								
1	19	4.460	4.583	1.705	12	5.035	5.076	.905
2	18	5.310	4.983	1.445	10	5.012	4.892	1.505
3	21	4.770	4.659	2.480	13	5.460	5.124	2.246
Real Actualization								
1	19	4.700	4.653	1.117	12	4.900	4.892	.806
2	18	4.950	5.094	1.141	10	5.483	5.250	1.149
3	21	5.088	4.829	1.605	13	4.900	5.154	1.448
Real Communication								
1	19	5.325	4.947	3.377	12	5.300	5.183	2.171
2	18	5.700	5.767	3.036	10	4.700	5.320	2.162
3	21	5.400	5.314	2.306	13	5.150	4.862	3.603
Real Sociability								
1	19	5.575	5.589	1.651	12	5.900	5.600	.735
2	18	5.800	5.933	1.228	10	6.500	6.420	.271
3	21	6.350	6.257	1.133	13	6.250	6.277	.917
Real Ambition								
1	19	3.412	3.684	3.389	12	4.000	3.888	.735
2	18	2.752	3.167	1.900	10	4.000	3.999	2.565
3	21	4.220	4.063	1.974	13	4.248	4.563	2.861
Real Locus of Control								
1	19	5.140	5.264	1.269	12	5.360	5.715	1.190
2	18	5.780	5.824	1.057	10	5.780	5.827	.980
3	21	5.617	5.422	1.280	13	6.000	5.714	1.115
Real Togetherness								
1	19	4.800	4.611	2.313	12	5.300	5.233	.690
2	18	5.500	5.133	2.047	10	5.300	5.280	.615
3	21	5.000	5.181	1.920	13	5.200	5.169	1.626

Continued

TABLE 32 - continued

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Loyalty								
1	19	6.850	6.716	1.535	12	7.100	6.933	.802
2	18	7.033	6.600	1.567	10	7.200	6.900	1.282
3	21	7.175	7.010	.702	13	7.200	6.631	1.626
Real Closeness								
1	19	5.500	5.272	3.109	12	5.940	5.938	1.222
2	18	6.440	5.746	3.741	10	6.375	6.078	2.519
3	21	6.030	5.824	2.036	13	6.718	5.877	3.647

TABLE 33

FUI REAL Median, Means, and Variances for Men and Women: Gains

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Consideration								
1	19	.230	.209	1.010	5	.620	.676	.071
2	18	.092	-.034	.689	5	.080	.230	.109
3	21	.150	.138	.387	9	.000	.008	.114
Real Actualization								
1	19	.100	.221	1.144	5	-.100	.380	1.017
2	18	.050	.222	.318	5	.300	-.020	.527
3	21	.100	-.062	.577	9	.425	.311	.566
Real Communication								
1	19	.200	.242	2.749	5	-.100	.400	1.640
2	18	.100	.089	.745	5	.000	-.280	2.552
3	21	.225	.305	1.830	9	.150	.111	.751
Real Sociability								
1	19	.067	-.032	1.019	5	.600	.200	1.780
2	18	-.033	-.044	.548	5	.000	.080	.832
3	21	.133	.248	.312	9	.000	.044	.228
Real Ambition								
1	19	-.002	-.035	1.937	5	-.330	1.000	4.627
2	18	.165	.519	1.652	5	-.670	-.402	.859
3	21	.657	.300	1.845	9	.670	.702	.458
Real Locus of Control								
1	19	-.290	-.142	1.160	5	.430	.914	2.164
2	18	.145	.078	.513	5	-.290	-.174	.280
3	21	.287	.095	.667	9	.118	.128	.363
Real Togetherness								
1	19	.000	-.242	.967	5	.600	.120	2.972
2	18	.100	.044	.638	5	-.750	-.960	1.088
3	21	-.200	.124	1.142	9	-.400	-.178	.664

Continued

TABLE 33 - continued

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Loyalty								
1	19	-.133	-.137	.582	5	.850	1.000	1.860
2	18	-.100	-.133	.489	5	-.150	.040	.468
3	21	.050	.162	.782	9	-.175	-.222	.194
Real Closeness								
1	19	-.130	-.139	1.354	5	.280	.850	2.472
2	18	-.070	.034	.552	5	-.250	-.348	.622
3	21	.253	.167	.728	9	.120	.194	.160

TABLE 34

FUI IDEAL Median, Means, and Variances for Men and Women at T_1

	Group		Women				Men		
		n	Median	Mean	Variance	n	Median	Mean	Variance
Ideal Consideration	1	20	6.770	6.669	.446	6	6.040	6.103	2.156
	2	20	6.655	6.700	.506	6	6.580	6.295	.656
	3	25	6.540	6.400	.805	10	6.885	6.817	.758
Ideal Actualization	1	20	6.650	6.545	.418	6	6.050	5.817	1.710
	2	20	6.783	6.645	.523	6	6.150	6.350	.899
	3	25	6.225	6.224	.789	10	6.500	6.670	.569
Ideal Communication	1	20	7.033	6.820	1.107	6	6.400	6.100	1.644
	2	20	6.800	6.730	1.416	6	6.100	6.567	1.639
	3	25	6.867	6.720	1.553	10	6.400	6.440	1.376
Ideal Sociability	1	20	7.400	7.110	1.118	6	6.500	6.200	1.344
	2	20	7.367	7.230	.822	6	7.400	7.367	.263
	3	25	7.150	6.864	.909	10	6.833	6.960	.647
Ideal Ambition	1	20	2.000	2.450	2.639	6	4.000	3.222	2.870
	2	20	2.835	2.749	2.548	6	3.495	4.165	1.144
	3	25	2.670	2.667	2.315	10	3.330	3.567	3.732
Ideal Locus of Control	1	20	6.780	6.763	.353	6	5.575	5.857	2.431
	2	20	6.210	6.185	1.014	6	6.140	6.095	.499
	3	25	6.308	6.372	.818	10	6.647	6.470	.662
Ideal Togetherness	1	20	6.900	6.760	1.009	6	6.100	6.000	1.520
	2	20	6.700	6.680	.675	6	6.300	6.567	.311
	3	25	6.550	6.464	1.249	10	6.300	6.500	.749

TABLE 34 - continued

		Women					Men		
Group	n	Median	Mean	Variance		n	Median	Mean	Variance
Ideal Loyalty									
1	20	7.800	7.537	.335		6	7.500	7.000	2.240
2	20	7.933	7.460	.514		6	7.900	7.567	.759
3	25	7.775	7.336	.869		10	7.700	7.440	.469
Ideal Closeness									
1	20	7.130	7.133	.635		6	5.945	6.232	1.834
2	20	7.560	7.239	.988		6	7.375	7.313	.434
3	25	7.100	6.933	.905		10	7.440	7.265	.320

TABLE 35

FUI IDEAL Median, Means, and Variances for Men and Women at T_2

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Ideal Consideration								
1	19	6.3380	6.462	.544	12	6.035	6.210	.526
2	18	6.345	6.448	.384	10	6.955	6.598	1.465
3	21	6.513	6.513	.583	13	6.540	6.675	.632
Ideal Actualization								
1	19	6.267	6.158	.501	12	5.900	5.975	1.022
2	18	6.450	6.461	.754	10	6.750	6.350	1.556
3	21	6.225	6.200	.595	13	6.675	6.677	.414
Ideal Communication								
1	19	6.400	6.200	1.409	12	5.900	6.050	1.957
2	18	7.100	6.811	1.518	10	6.300	6.160	2.176
3	21	7.000	6.524	1.766	13	6.217	6.277	1.104
Ideal Sociability								
1	19	7.000	6.937	.654	12	6.700	6.683	.280
2	18	7.050	7.044	.732	10	6.833	6.820	1.222
3	21	7.050	6.971	.521	13	6.867	6.908	.991
Ideal Ambition								
1	19	2.670	2.824	2.018	12	3.835	3.692	2.353
2	18	2.615	2.482	2.381	10	3.165	3.667	4.093
3	21	3.000	2.968	2.029	13	4.000	3.898	4.952
Ideal Locus of Control								
1	19	6.187	6.399	.847	12	5.780	5.952	1.416
2	18	6.070	6.120	.581	10	6.710	6.386	1.626
3	21	6.290	6.272	.890	13	6.140	6.372	.754
Ideal Togetherness								
1	19	6.600	6.505	1.015	12	6.100	6.133	.279
2	18	6.433	6.244	1.546	10	6.300	6.080	1.344
3	21	6.425	6.486	.894	13	6.267	6.385	.876

Table 35 - continued

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Ideal Loyalty								
1	19	7.267	7.179	.684	12	7.100	7.250	.445
2	18	7.700	7.544	.272	10	7.567	7.100	1.549
3	21	7.550	7.352	.444	13	7.350	7.400	.313
Ideal Closeness								
1	19	7.220		.987	12	6.940	6.826	1.049
2	18	7.310		.465	10	7.060	6.926	1.527
3	21	7.250		.790	13	7.600	7.194	.648

TABLE 36

FUI IDEAL Median, Means, and Variance for Men and Women: Gains

	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Ideal Consideration	1	19	-.150	-.186	.464	5	-.563	.028	3.030
	2	18	-.145	-.278	.492	5	.130	-.586	1.420
	3	21	-.003	.150	.363	9	.000	-.079	.154
Ideal Actualization	1	19	-.325	-.353	.389	5	-.100	.660	4.483
	2	18	-.150	-.217	.793	5	.100	-.460	2.033
	3	21	.033	.048	.504	9	.000	-.022	.322
Ideal Communication	1	19	-.450	-.558	1.136	5	.000	-.280	6.232
	2	18	-.100	-.078	1.177	5	-1.000	-1.560	.928
	3	21	-.150	-.200	1.764	9	.000	.200	.920
Ideal Sociability	1	19	-.175	-.126	1.494	5	.000	.560	2.588
	2	18	-.100	-.256	1.157	5	-.700	-1.000	.880
	3	21	.017	.114	.398	9	.200	.311	.311
Ideal Ambition	1	19	.107	.245	2.969	5	-1.000	-.068	8.974
	2	18	.330	-.073	1.903	5	-.330	-.198	.917
	3	21	.327	.348	1.859	9	.333	.556	1.666
Ideal Locus of Control	1	19	-.428	-.299	.875	5	.150	.486	3.037
	2	18	-.415	-.189	.438	5	-.290	-.428	.870
	3	21	.000	-.130	.847	9	-.150	-.174	.218
Ideal Togetherness	1	19	-.200	-.189	.940	5	-.200	.280	2.372
	2	18	.000	-.433	1.931	5	-.950	-1.400	1.760
	3	21	.075	.105	.438	9	-.050	-.022	.204

TABLE 36 - continued

		Women				Men		
Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Ideal Loyalty								
1	19	-.267	-.326	.472	5	.000	.440	3.888
2	18	.011	.044	.261	5	-.300	-.760	3.128
3	21	-.050	-.029	.745	9	.000	-.022	.144
Ideal Closeness								
1	19	-.127	-.178	.649	5	.500	.776	3.694
2	18	-.245	-.125	.575	5	-.120	-.650	2.853
3	21	.045	.106	.729	9	-.120	-.029	.327

TABLE 37

FUI REAL and FUI IDEAL Second-Order Factors for Men and Women at T_1

		Women				Men		
	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Family Integration	1	20	5.746	5.310	2.390	6	4.845	5.082	1.222
	2	20	5.325	5.690	1.975	6	6.547	6.119	1.173
	3	25	5.606	5.303	2.025	10	5.895	5.542	1.629
Ideal Family Integration	1	20	6.895	6.983	.394	6	6.509	6.287	1.594
	2	20	7.105	6.962	.573	6	6.645	6.862	.231
	3	25	6.886	6.771	.677	10	6.927	6.892	.502
Real Adaptive Coping	1	20	5.565	5.206	1.529	6	4.667	4.930	1.823
	2	20	5.735	5.537	.998	6	5.967	5.679	1.151
	3	25	5.547	5.331	1.392	10	5.702	5.480	.613
Ideal Adaptive Coping	1	20	6.723	6.806	.252	6	6.387	5.958	1.570
	2	20	6.782	6.687	.475	6	6.430	6.604	.352
	3	25	6.503	6.487	.563	10	6.660	6.700	.449
Family Satisfaction	1	20	.652	.627	.385	5	.689	.735	.405
	2	20	.831	.863	.374	6	.793	.810	.301
	3	25	.702	.595	.405	10	1.049	.839	.304

TABLE 38

FUI REAL and FUI IDEAL Second-Order Factors for Men and Women at T_2

		Women				Men		
	Group	n	Median	Mean	Variance	n	Median	Mean	Variance
Real Family Integration	1	17	5.332	5.241	2.017	12	5.562	5.673	.736
	2	18	6.032	5.646	1.769	10	6.027	5.694	1.082
	3	20	5.305	5.511	1.183	13	5.954	5.532	2.119
Ideal Family Integration	1	17	6.704	6.664	.674	12	6.389	6.494	.474
	2	18	6.938	6.860	.480	10	6.911	6.573	1.295
	3	20	6.767	6.770	.516	13	6.766	6.786	.529
Real Adaptive Coping	1	17	5.287	5.182	1.129	12	5.357	5.402	.397
	2	18	5.565	5.617	.838	10	6.013	5.832	.531
	3	20	5.865	5.412	.931	13	5.730	5.715	.884
Ideal Adaptive Coping	1	17	6.453	6.515	.506	12	6.028	6.203	.632
	2	18	6.547	6.542	.415	10	6.792	6.519	1.294
	3	20	6.605	6.468	.489	13	6.537	6.652	.318
Family Satisfaction	1	17	.841	.704	.385	12	.955	.950	.212
	2	18	1.035	.961	.402	9	.973	1.025	.663
	3	20	.864	.790	.302	13	1.137	.885	.389

TABLE 39

FUI REAL and FUI IDEAL Second-Order Factors for Men and Women: Gains

	Group	Women				Men			
		n	Median	Mean	Variance	n	Median	Mean	Variance
Real Family Integration	1	17	-.032	-.054	.511	5	.436	.609	1.261
	2	18	-.109	-.000	.348	5	-.262	-.264	.394
	3	20	.013	.150	.403	9	-.012	-.017	.050
Ideal Family Integration	1	17	-.366	-.289	.278	5	-.298	.249	3.255
	2	18	-.091	-.174	.476	5	-.648	-.991	1.196
	3	20	.021	.055	.192	9	-.012	-.017	.050
Real Adaptive Coping	1	17	-.087	-.081	.445	5	.110	.498	1.076
	2	18	-.075	.085	.197	5	.057	-.038	.336
	3	20	.062	.066	.323	9	.250	.161	.149
Ideal Adaptive Coping	1	17	-.133	-.184	.408	5	.017	.569	3.177
	2	18	-.152	-.221	.540	5	-.530	-.629	1.158
	3	20	.028	.067	.221	9	.083	.038	.128
Family Satisfaction	1	17	.049	.044	.110	4	.234	.190	.031
	2	18	.055	.114	.130	4	.415	.588	.267
	3	20	.176	.149	.051	9	.106	.107	.009

TABLE 40

FUI REAL, FUI IDEAL, and CBCL Congruence Scores
for Mother-Father Pairs at T_1

	Group	n	Median	Mean	Variance
Real Congruence	1	5	.330	.448	.241
	2	6	.396	.726	.180
	3	9	.736	.648	.141
Ideal Congruence	1	5	1.124	1.052	.209
	2	6	.995	1.025	.144
	3	9	1.016	1.116	.145
CBCL Congruence	1	5	.409	.398	.019
	2	6	.518	.632	.082
	3	9	.672	.676	.044

TABLE 41

FUI REAL, FUI IDEAL, and CBCL Congruence Scores
for Mother-Father Pairs at T_2

	Group	n	Median	Mean	Variance
Real Congruence	1	10	.666	.710	.179
	2	9	.810	.798	.186
	3	13	.781	.716	.216
Ideal Congruence	1	10	1.184	1.101	.090
	2	9	1.060	1.088	.059
	3	13	1.250	1.178	.057
CBCL Congruence	1	10	.540	.530	.034
	2	9	.541	.531	.038
	3	13	.541	.561	.069

TABLE 42

FUI REAL, FUI IDEAL, and CBCL Congruence Scores
for Mother-Father Pairs: Gains

	Group	n	Median	Mean	Variance
Real Congruence	1	4	.123	.200	.024
	2	4	.109	.036	.078
	3	8	.068	.064	.041
Ideal Congruence	1	4	.013	.014	.063
	2	4	-.105	-.057	.057
	3	8	.037	.112	.045
CBCL Congruence	1	4	.065	.022	.042
	2	4	-.082	-.092	.058
	3	8	-.113	-.148	.023