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Fathers' Influence on Family Therapy Outcome

by

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Abstract

The purpose of this study was to explore the relationship between fathers' perceptions of their family's functioning at the onset of therapy with the outcome of family therapy. This research used the Family Assessment Measure (Skinner, et al., 1983) to explore fathers' perceptions of their family's functioning at the beginning of family therapy; two raters assessed treatment outcome. Statistical analysis was used to determine whether scores on the FAM between "good outcome" and "poor outcome" groups differed significantly. The study also explored the influence of the following factors on Family Assessment Measure scores (Skinner, et al., 1983): father's age, the identified patient's age and gender, and whether the father was the identified patient's biological father or stepfather. The results of the study suggest there are no particular perceptions of family functioning held by the father at the onset of therapy that are associated with the outcome of family therapy. However, the analysis of the possible mitigating factors revealed significant results.

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Introduction

Identification of the Problem

For years the mother-child relationship has been focal in explaining and understanding the development of the child. Much importance has been placed on this relationship in almost all developmental theories, while the father's influence has been relegated to a peripheral or inconsequential position. For example, in 1962 Margaret Mead referred to fathers as "biological necessities," yet "social accidents." With this focus, mothers were consequently often held responsible for any perceived child or family pathology.

Within the field of social work, this topic has also been attributed little attention. In a review of a major social work journal, "Social Work Abstract," James (1988) found virtually no reference to fathers between 1980 and 1985. Similarly, in a review of eight child and adolescent journals between 1984 to 1991, 48% of the studies exclusively involved mothers while only 1% exclusively involved fathers (Phares & Compas, 1992).

However, more recently, the role of the father has received increased attention. In much of the literature on

child development, fathers have found a position of interest and importance, while "mother-focused" research programs have become increasingly outmoded and criticized (James, 1988; Phares, 1992). New research has shown that fathers have a profound influence on their children's moral development, social adjustment, intellectual growth, and sex role development (Golant & Golant, 1992). Also, research has indicated that paternal deprivation can have significant negative implications on these areas of a child's development (Biller, 1971; Lamb, 1981, 1986). Within the narrative field of therapy (Anderson & Goolishian, 1988; Gilligan & Price, 1993); Schnitzer (1993) recognized that even the stories about fathers who are absent can influence a family and child's development.

Silverstein (1991) further supports this contention with research that demonstrates a positive correlation between father absence and problematic behaviour in sons and daughters. Gabel's (1992) review of the literature on the response of children to parental incarceration and father absence, demonstrated that boys are more likely than girls to act-out aggressively and demonstrate antisocial behaviour in response to the separation. However, Gabel (1992) also suggests that though the separation is likely to be traumatic, behaviour problems that emerge may also be related to other mitigating factors such as developmental stage, existing

family supports for the new single parent, poverty, and coping mechanisms.

Recent research has begun to highlight the importance of the quality of the father-child relationship, which is positively related to better child development (Starrels, 1994). Acknowledging that it is difficult to ascertain direct cause and effect relationships between a father's behaviour and his child's development, much work has been done recognizing and establishing the unique role a father can play in his child's development from birth onward (Popenoe, 1993; Pruett, 1993).

Though research has begun to establish the effects of fathering, or lack of it, on a young child's development, much of the information has been used sparingly in clinical settings when developing treatment plans. Available information is new to the field and requires further research. As clinicians, we should better understand the dynamics and intricacies of a father's relationship with his children, and in particular his perception of his role within the family. Often fathers perceived reluctance to participate actively in parenting can simply be a reflection of his limited awareness of the opportunities and repercussions of his involvement throughout his child's development.

As fathers often seem difficult to engage in therapy, it is imperative that therapists stress the importance of the father's role in resolving their child's struggles. LeCroy (1987) argues that therapists should make concerted efforts to involve fathers in therapy. Simply having the father attend the first session greatly increases the chances that he will remain in therapy until termination (James, 1988).

When the father does remain in therapy, recognizing his role in the family's struggles, and resolutions, positive outcomes in therapy and improved father-child relationships are noted (James, 1988). However, experience demonstrates that simply having the father attend family meetings does not ensure a positive outcome in therapy. Are there particular perceptions held by the father about his family, that are related to improved outcomes in therapy? Though much work has been devoted to examining how fathers influence their child's development, there is a dearth of research exploring how fathers influence family therapy outcome.

In this post modern age of therapy many have come to recognize how perceptions influence the "reality" being observed (Hoffman, 1990). Such paradigm shifts have challenged concepts of one objective and knowable truth. As perceptions develop within a social context, the two are interdependent, influencing, and influenced by each other. This study was

undertaken to explore what perceptions held by fathers at the beginning of therapy, may hinder or enhance their influence on the outcome of family therapy.

Purpose of the Study

The purpose of this study is to explore the influence fathers have on the outcome of family therapy when the identified patient is a child in the family.
The specific goals are:

1. To determine whether there are certain perceptions a father has of his family, at the onset of therapy, that are associated with the outcome of treatment.

2. To provide family therapists with further information to better utilize fathers as a resource in therapy.

Literature Review

The mother-child relationship has been focal in explaining and understanding the development of the child. Bowlby (1966) referred to mother-love as important to a child's mental health as are vitamins and proteins to their physical health.

This narrow focus can often portray fathers as uninvolved in child care, and recognized primarily as the family breadwinner. Today these perceptions have been redefined and challenged by a variety of social changes. "More women today work full time outside of the home than ever before" (Parke, 1981, p.1) and are returning to work sooner after childbirth. The nuclear family has become more isolated from extended family due to increased geographic mobility, demanding that families make better use of resources available to them. Though defining the reasons for these social changes is beyond the scope of this study, such circumstances have created an opportunity, and necessity, for fathers to become more involved with their children.

In response to the above, research has begun to investigate the effects fathers have on family functioning and the development of children. This review will establish the significance of a father's influence on his child's

development, explore the importance of his role in family therapy, and examine how his presence and perceptions can influence other's behaviour.

Childbirth and Early Infancy

Since the 1970s, middle class fathers have become more involved in the preparations for childbirth (Pedersen, 1981). Fathers who participate in the childbirth experience with their mates report the experience strongly reinforces their sense of family commitment. Research also suggests that the father's participation in the childbirth experience further enhances subsequent father-infant interaction (Pedersen, 1981; Pruett, 1993). Fathers who are involved with their child as a newborn are more likely to remain involved and maintain contact with the child throughout their development (Greenberg & Morris, 1974).

Furthermore, research has shown that the father-infant relationship begins simultaneously as the mother-infant relationship begins. However, infants may seem to prefer their mother prior to 2 years of age. Following 2 years of age boys begin to show strong preference for their fathers, though the father also begins to have a greater interest in the male child (Lamb, 1981).

Sex Role Identification

Recently, conceptualization of sex roles within scientific research has changed from the traditional bipolar constructs of instrumentality (masculinity) and expressiveness (femininity). The dichotomy has been reduced with the concept of psychological androgyny; i.e., the integration in the same individual of both dichotomized elements of the previous scale. In this model, personal maturity is associated with greater integration of psychological androgyny (Pedersen, 1981). Studies have shown that fathers with greater androgynous or feminine "measures" are more actively involved with their child (Pedersen, 1981).

All theories of child development purport that fathers have a major impact on sex role development of their sons. This influence is marked at the age of two, when fathers begin to show "preferential" treatment towards their sons, and the boys develop a preference for their father's company. This is referred to by some as the early development of same sex identification and modelling (Lamb, 1981). Still, this does not disclaim that the beginning of this identification began with the child's first contact with the father.

Biller's (1971) research notes significant difference in measures of masculinity between father-absent boys and father-

present boys, the former being less masculine (using traditional constructs of masculinity). His article purports that "father absence before the age of 4 or 5 has a particularly profound effect on masculine development," (Biller, 1971, p.123). Work by Hampson (1965), in his research with individuals with physical-sexual incongruities, found that a child's sex role identification was particularly hard to alter after the age of 2 and 3. These findings seem to support that sex role identification takes place at an early age and the presence of a healthy male figure may facilitate this process.

It is recognized that Biller's (1971) research is dated and based on old premises of masculinity. Within western communities personal maturity has now been associated with greater psychological androgyny. However, some argue that complete androgyny in family life is not ideal. The father's unique role should be acknowledged, supported, and consequently fathers should be held accountable for their unique responsibilities (Popenoe, 1993). Biller's (1971) research may allude to these unique responsibilities.

Given the former, one would expect to find behavioral similarities between involved fathers and their sons. However, there is little evidence to support this. In fact, young boys are found to be no more similar to their fathers as to their

mothers, and furthermore do not see themselves as more similar to their fathers than to their mothers (Lamb, 1981). What research has revealed is that filial identification depends upon the father's nurturance in his relationship with his son. Therefore, fewer similarities are found when the father-son relationship is distant, while a warm accessible "masculine" fathers have "masculine" sons (Lamb, 1981). This indicates that the quality of the father-son relationship is more important in sex role development, than the father's avowed masculinity. Similar results were found between fathers and their daughters. When girls have close affectionate relationships with their fathers, those whose fathers had "masculine" interests had more stereotypical "feminine" interests (Levine, 1993). Withholding any value judgement about these results, the information speaks to the influence fathers have on their child's development.

However, and importantly, research has shown that fathers are more concerned about sex typing than mother are, and have more traditional attitudes towards masculine and feminine roles (Lamb, 1981). This may in turn perpetuate sex role stereotypes, and hinder future development of nurturing father-son relationships.

Moral Development

Though it is difficult to find a consensus in the research on boys' moral development, Biller's (1974) work described a nurturing father-child relationship as salient in the child's internalization of the father's morality. "In fact, Andry (1957, 1960, 1962) found that poor father-child relationships were common antecedents of delinquency, even where there were apparently normal mother-child relationships" (Lamb, 1981, p.21). Studies found that lower-class boys from "female-based homes, in their constant effort to prove their masculinity, are more often involved in antisocial acts (at least by middle class standards) than are father-present boys," (Biller, 1971, p.131). Furthermore, studies have also shown that father-present juvenile delinquents seem to have poor relationships with their fathers (Biller, 1971).

Though dated, Biller's (1971, 1974, 1981) research recognizes the importance of the quality of the father child relationship. More important than just his presence, it is the style of the father's interactions and the nature of his relationship with his children that seems to effect development (Levine, 1993). In families where fathers provide at least 40% of the child care, research reports a greater internalized locus of control in the children (Levine, 1993).

Intellectual Development

Studies show that nurturing fathers who encourage intellectual performance enhance their sons' scholastic achievements, and that paternal rejection is detrimental to it (Lamb, 1981). Biller (1971) also lists many studies that show paternally deprived boys are more likely to suffer from intellectual deficits. Secondary to paternal presence, again it is the quality of the interaction between father and child that influences cognitive development. It is the creation of a stimulating environment that enhances the child's intellectual growth (Parke, 1981).

Kohlberg (1966) speculated that certain father-absent boys were deprived of particular cognitive experiences with their fathers, which in turn retarded their intellectual and sex role development. However, these detrimental effects seemed skewed towards lower-class father-absent boys. Kohlberg (1966) hypothesised that in their masculine overcompensation, they perceive school as feminine and are further threatened by the prospect of failing in this "feminine world." Biller (1971, p. 133) suggests that "such boys develop an almost phobic reaction concerning intellectual matters."

With young girls, it seems fathers are most influential following infancy (Parke, 1981). They affect their daughter's

cognitive development through verbal stimulation, praise, encouragement, and by being supportive of their social initiatives.

Social Competence and Interpersonal Relationships

Warm and sensitive fathers foster abilities in their sons to relate positively to others. Paternal warmth is also associated with self-esteem, personality adjustment, and a "greater ease in establishing satisfying peer relationships, and later success in heterosexual relationships, particularly in boys" (Lamb, 1981, p. 29). Father-absent children have been found less trusting of other people, in particular of male adults (Biller, 1971). Studies have also shown that they are more anxious than father-present children, have a greater difficulty with delayed gratification of their needs, and lack control of their aggressive and impulsive behaviour. Furthermore, it seems that the psychological effects of fatherlesness may be more harmful to lower-class families as opposed to middle-class families. Basically, middle-class fatherless homes seem to have access to more psychological and economical support (Biller, 1971).

A longitudinal study by Block (1971) showed that better adjusted adults came from warm relationships with their parents, in the context of a happy marriage. Though this

information may seem obvious, it is important in that it highlights the significance of the father's presence and the nature of his relationships, on the development of the child.

It should be noted that most of the research cited to date presents their information with the assumption that fathers they refer to are the biological fathers of the children. However, the prevalence of stepfamilies in our society is significant. Statistics in the United States estimated that 35 million adults are stepparents and that one in every six children is a stepchild (Anderson & White, 1986; Skopin, Newman, & McKenry, 1993). These numbers likely indicate that a large proportion of families in Canada are blended families.

Initially, these families tend to experience stress from forming a new family structure, and difficulties redefining familial roles and developing a new set of family rules and expectations (Anderson & White, 1986; Claxton-Oldfield, 1992; Barber & Lyons, 1994). Stepchildren tend to have less emotional involvement with their stepfathers, and at times feel struggles of loyalty between their biological father and new stepfather (Skopin, Newman, and McKenry, 1993). Consequently, as stepfamilies initially redefine themselves it is not uncommon for them to experience more conflict and less cohesiveness than intact families. In the context of this

review it should be noted that stepfathers may have different influences with their stepchildren as an effect of their unique role.

In conclusion, it appears that father presence is beneficial to a child's development, but more importantly in all areas of development, it is the quality of the father-child relationship that seems most influential (Lamb, 1986; Starrels, 1994). The father's nurturing qualities and warmth are found to be advantageous to the child's psychosocial adjustment, achievement, and sex role development, similar to maternal warmth (Phares, 1992; Pruett, 1993).

Family Therapy with Fathers

The developmental significance of the father's role in childrearing demonstrates the importance of including the father in interventions with troubled children. The treatment of choice with most troubled children is family therapy. As opposed to individual therapy, family therapy can directly address the many interpersonal factors that contribute to the development of the child's symptomatic behaviour (Minuchin, 1971). Recognition of the context within which the maladaptive behaviour developed allows the clinician to optimize the effectiveness of his/her intervention.

Although recent work has established the importance of the father's role in child development, it is still commonly assumed that mothers are the primary care-taker and assume responsibility for the child should something go wrong (Heubeck, Detmering, & Russell, 1986; Lazar, Sagi, & Fraser, 1991). LeCroy (1987) suggest that fathers continue to be a neglected aspect of family work. He recognizes the hidden force of the father when working with families but acknowledges the difficulty in engaging them into therapy. Men are less likely to seek help than women, and use a different schema to recognize emotional problems (O'Brien, 1988). For example, men are less likely to recognize symptoms associated with depression, and consequently do not seek help till a problem reaches a significant level of urgency.

Men may perceive the recognition of a problem, and the act of seeking help, as a sign of personal weakness and consequently are less likely to actively engage in therapy (O'Brien, 1988). Budd and O'Brien (1982) also found that father participation in parent training was significantly correlated to their perception of the severity of the child's behavioral problem. Still, the most frequent reason given by father's for their inability to attend sessions was their work schedule (LeCroy, 1987; James, 1988; Levine, 1993).

Research also demonstrates that therapists can influence

the extent to which fathers participate in therapy. The more contact the therapist has with the family (speaking directly with each family member) the greater his/her success in recruiting them into therapy. In fact, simply inducing the father to attend the first session greatly increases the chances he will remain in therapy (James, 1988). Not directly seeking the father's involvement may only confirm his belief that he is not important in the process of treatment (Berg & Rosenblum, 1977). In fact, Lazar, Sagi & Fraser (1991) found that many family practitioners were more maternally oriented, involving mothers more than fathers in their work.

In a study by Shapiro and Budman (1973) clients stated their termination of therapy was related to the therapist's lack of activity. Reasons for continuing therapy were: "They talked to us a whole lot," "they gave us advice and ideas on how to discuss things and talk with one another," "they told us how we could handle things in different ways."

While much indirect evidence suggest that father involvement in the treatment of their children should improve outcome, there is little empirical research to support this assumption. Based on the limited information available, Gurman and Kniskern concluded that "the father's presence clearly improves the odds of good outcomes" (1981, p. 750). Berg and Rosenblum (1977) in a survey of sixty family therapists,

discovered that most viewed the father as the pivotal figure influencing the families termination of therapy or their continuation. Webster-Straton (1985) found that when fathers are involved in the treatment of their troubled children, long term improvements in outcomes are noted. Father involvement seemed to enhance the maintenance and generalizability of parent training effects. Mothers felt more supported in their care-taking roles and there were fewer reported child symptomatic behaviours.

James (1988) noted positive outcomes in family therapy when the father recognizes his contribution to the family's problems and his role in resolving them. Family therapy with fathers present has also been associated with positive changes in father-child relationships (James, 1988).

Perceptions and Behaviour

Bandura (1977) recognized the interactive relationship between a person's behaviour, cognitions, and their environment. Beyond Skinner (1971), Bandura (1977) believed that a person's behaviour was not simply regulated by environmental stimuli, but that person and environment influence each other."Thus, for example a person's belief about what she is capable of doing and about what the outcome might be if she were to preform a specific action influences

what she does, and her behaviour then affects the environment, which, in turn, may alter her expectation" (Hall & Lindzey, 1985, p.537). A person's perception of their environment will influence their behaviour, and consequently their behaviour will influence their environment. This interaction is ongoing and continuously in flux.

Post modern paradigms in therapy have expanded on this basic premise, suggesting the concept of "true objectivity" may be a moot point in therapy. People behave in particular ways partly due to their perception of "reality" and the meaning they ascribed to it (Hoffman, 1990). The development of perception and its meaning take place within a social interaction. Maturana and Varela (1988) suggest that each individual brings their psychological, social and biological history to their social interactions. These histories function as lenses through which they perceive their environment, and influence it. Meaning ascribed to perceptions is dependent upon the person's history, and the ways in which the environment responds to the person.

White (1993) proposes that peoples' lives and behaviours are shaped by the meaning they attribute to their experiences. Based on their individual history they select out particular aspects of their experiences which partially match their already existing world view. Based on this process of matching

history with current perception, meaning is ascribed. This has led to the recognition of the importance of the "cradle of communication", a multifaceted domain, through which people develop, challenge, and confirm their perceptions of "reality" (Bateson, 1972; Hoffman 1990, White 1986).

DeShazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, and Weiner-Davis (1986) of the Brief Therapy Centre focus their efforts in therapy on changing interactive behaviours (i.e., the cradle of communication) and/or a participant's interpretation of a behaviour and situation. They recognize that behaviour can be observed from a number of different points with the potential for a multitude of interpretations. Any meaning ascribed to behaviour depends upon the observer's interpretation, and construction of reality as influenced by their history.

Anderson and Goolishian (1988) purport the development of meaning and understanding are intersubjective and take place in relationships (e.g., marriage, family, friendship, etc...). Human relationships are language generating and simultaneously meaning making. The experience of the relationship can lead to the development of problematic behaviours, and the problem can maintain the system by confirming perceptions of the relationship; in turn interacting perceptions can rigidify patterns of problem generating behaviours (Hoffman, 1990).

Individuals within human relationships look to their environment to confirm their perceptions. Intersubjective experiences are sifted through in search of actions that confirm expectations (White, 1986, 1993).

The Influence of Perceptions on Therapy Outcome

Friedman, Tomko and Utada (1991) in their work with drug abusing adolescents, explored what perceptions of family functioning at the onset of treatment better predict family therapy outcome. They found that "those descriptions by the clients or the mothers about the family at intake that appeared at face value to be positive predicted more improvement in the outcome criteria" (Friedman, et al., 1991, p. 89). The clients' perceptions of a more positive or less negative relationship with their parents was a good prognostic sign.

Of particular interest to this study, it was found that the adolescents' perception of positive-adolescent-father communication, cohesion in the family, and a greater sense of autonomy for family members, predicted better outcomes (Friedman, et al., 1991). Exploring the influence of perceptions on family functioning, Barnes (1989) found that discrepancies in perceptions amongst family members led to greater tension and reflected poor communication skills within

the family.

Recognizing the importance and influence of individuals' perceptions on family relationships, Kotler and Chetwynd (1980) acknowledge that regard must "be given to each family member's perceptions and conceptions of family reality, since this affects the character of their interpersonal relationships" (p. 102). Exploring the influence of therapy on perceptions, they found the most significant changes took place with the father's perception of the identified patient, his child. At the end of treatment the identified patient was perceived to be more warm, accepting, dependable, and to have a closer relationship with the father.

Stedman, Gaines and Costello (1983), through their research at a child mental health facility, explored how a number of family process variables are related to outcome in therapy. They found that family affiliation and organizational consistency predicted better outcome in family therapy.

Summary

This literature review presented the importance of fathering and delineated its influence on particular aspects of a child's development. The father's influence on therapy was also examined, demonstrating the importance of including

fathers in the treatment of their children who present with problematic behaviours. In fact, father intimacy as opposed to mother intimacy seems to have the strongest relationship to measures of self-esteem and problem behaviour with their children (LeCroy, 1987). Still, there is a dearth of research exploring what it is about the father's participation in therapy that actually makes a difference. "The paternal presence is a vital, life giving force in the lives of children and families. Although we have made some progress in understanding the impact of paternal absence on children, we must now begin to understand, define, and appreciate the meaning of paternal presence (Pruett, 1993, p. 50).

"It's hard to imagine how we can raise a better generation of sons until we have a better generation of fathers. The miracle in what seems like a hopeless paradox is what can happen to a man when he becomes a father" (Pittman, 1990, p. 52).

Hypothesises

This study proposes to explore how a father's perception of his family's functioning may influence the outcome of family therapy.

The specific goals of the research are to determine whether:

1. there are certain perceptions a father has of his family, at the onset of therapy, that are associated with the outcome of treatment.

2. gender of the identified patient influences the father's perception of family functioning.

3. stepfathers have different perceptions of family functioning than biological fathers.

4. stepfathers' and biological fathers' perceptions of family functioning differ depending on the gender of the identified patient.

5. the age of the identified patient influences the father's perception of family functioning.

6. the father's age influences his perception of family functioning.

The null hypothesises state:

1. father's scores on perceptions of family functioning will not differ significantly between families with good outcomes in therapy versus poor outcomes in therapy.

2. fathers' scores on perceptions of family functioning will not differ significantly between fathers' of male versus female identified patients.

3. fathers' scores on perceptions of family function will not differ significantly between stepfathers and biological fathers.

4. there will be no significant interactive effect between stepfathers and biological fathers, and the gender of the identified patient on scores of perceptions of family functioning.

5. fathers' scores on perceptions of family functioning will show no relationship to the identified patient's age.

6. fathers' scores on perceptions of family functioning will show no relationship to their age.

Methodology

Subjects

The site of data collection for this study was the Alberta Children's Hospital, in Calgary, Alberta. Subjects for this study were drawn from a population of families who presented to the hospital's Family Therapy Program, where the identified patient was a child. The program has been collecting data acquired from the administration of The Family Assessment Measure (FAM) (Skinner, Steinhauser, & Santa-Barbara, 1983) to families who presented to the program between 1985 to 1993.

The Family Therapy Program provides therapeutic services to families who contact the hospital seeking help for concerns with their child's behaviour. All families are screened by the hospital's intake worker, following a protocol particular to the hospital to determine whether there a mental health concerns that warrant medical attention and/or family therapy. There are no mandated limitations to the number of sessions available to a family. The program also provides training for graduate students interested in learning primarily solution focused family therapy.

The administration of the FAM began in 1985. It was

administered by the therapist seeing the family, to all family members who presented for the first session prior to discussing their concerns. The post-test was also administered by the therapist at the termination session. However, many families did not complete post-tests because they did not attend a formal termination session as the option for a follow up session may have been left open, the family may have terminated prematurely, or the therapist may have forgotten to administer the post-test during the family's final meeting. Only 16% of fathers who completed the pre-test also completed the post-test. Though the information gathered was to be used for research purposes by the hospital, the collected data set has yet to be examined.

Participants for this study consists of families where the father completed the standardized measure at the onset of therapy. Fathers are defined as the identified patient's biological father in an intact family, or stepfather in a blended family, which includes a mother's boyfriend in a common-law relationship (i.e., mother's male partner currently living with the family but not married to her).

Based on an initial review of the data set in 1994 the expected N was to approximate eighty subjects. However, further consultation with hospital staff and a review of information compiled by the family therapy program (following

approval of the research design), revealed access to 50 complete case files. Furthermore, clerical staff were only able to find 39 of the expected 50 files. Consequently the research is comprised of 39 subjects (N=39).

Instrumentation

Family functioning as perceived by the father was assessed with the Family Assessment Measure (FAM) (Skinner, et al., 1983). The FAM is a self-report instrument providing quantitative information on perceived family strengths and weaknesses. The instrument may be used as a measure for therapy outcome, as a diagnostic tool, or as a measure for basic research of family process (Steinhauer, 1984; Touliatos, Perlmutter, & Straus 1990). It is based on a process model of family functioning, creating a framework for varied approaches to family therapy and research (Steinhauer, Santa-Barbara, and Skinner, 1983; Steinhauer, Santa-Barbara, and Skinner, 1984; Steinhauer, 1984). The model is presented as a means to organize various concepts of family functioning into a comprehensive framework.

According to the process model, the primary goal of the family is the achievement of basic developmental and crisis tasks. This allows for the continued development of all family members. Successful accomplishment of the latter is dependent

upon adaptive functioning along several dimensions, e.g. task accomplishment, role performance, communication, affective expression, affective involvement, control, and values and norms (Steinhauer, Santa-Barbara, and Skinner, 1984).

The FAM includes a General Scale, a Dyadic Scale, and a Self Report Scale. For the purposes of this study only the General Scale shall be used. It was administered most consistently of the three scales and meets the needs of this study's design. The General Scale assesses the family system as a whole as perceived by the participant who completes the questionnaire. The instrument consists of 50 statements that are answered on a 4-point scale from "strongly agree" to "strongly disagree". The results are presented along seven subscales: Task Accomplishment, Role Performance, Communication, Affective expression, Affective involvement, Control, and Values and Norms.

Task Accomplishment refers to the process through which the family organizes itself to achieve particular familial tasks. This process requires that the family be able to identify the problem, explore alternative solutions, implement the selected approach, then evaluate its effectiveness.

Role Performance is the family's ability to allocate specific activities to each member, the acceptance of the activity by

family members, and the enactment of the assigned role.

Communication refers to the family's ability to achieve mutual understanding; so that messages are sent in a clear and direct manner. However, recognizing that messages may be distorted by the sender or receiver, it is important that the system be open and available to each other. Communication is essential for ongoing task accomplishment and role performance.

Affective Expression can also impede or enhance task accomplishment and role integration. It includes the content, intensity, and timing of the feelings being expressed.

Affective Involvement refers to the quality and degree of family members' interest in each other. Skinner et al. (1983) suggest five types of affective involvement: "the uninvolved family, a family which expresses interest devoid of feelings, the narcissistic family, an emphatic family and the enmeshed family" (p. 93). The family's ability to meet the emotional needs of its members, and to provide support for autonomous thought and function reflect healthy affective involvement.

Control addresses the family's way of influencing each other. Are the rules and expectations predictable versus inconsistent, constructive versus destructive, or responsible versus irresponsible. Combinations "of these characteristics

gives rise to four prototype styles: rigid, flexible, laissez-faire, and chaotic", (Skinner, et al., 1983, p. 93).

Values and Norms subscale is concerned with "whether family rules are explicit or implicit, the latitude or scope allowed for family members to determine their own attitudes and behaviour, and whether family norms are consistent with the broader cultural context", (Skinner, et al., 1983, p. 93).

The General Scale has two response style subscales, Social Desirability and Denial. The FAM also provides an overall rating of family functioning.

Intercorrelations among the subscales range from .55 to .79. Internal consistency reliability scores on the general scale were .93 for adults, and .94 for children (coefficient alpha). This provides an indication of the consistency with which an individual responds to questions evaluating the same construct. Normative data for the FAM was collected from 312 individuals from non-clinical families, and from more than 2000 individuals of families seeking therapy (Adams, Overholser, & Lehnert, 1994; Skinner et al., 1983). Considering the possible influences of socioeconomic status, the initial sample used to standardize the measure was heterogeneous in presentation. The mean age of the adults was 38.0 years (S.D.= 8.8); 46% were men and 54% were women.

Father's type of employment varied, 30% were professional or senior management, 20% were middle management, 5% were clerical sales, 24% were skilled tradesman, and 20% were semi or unskilled occupations. For the mothers, 46% were homemakers, 15% were professionals, and the remainder were engaged in various occupations. The mean age of the children was 14.9 years (S.D.= 4.3); 45% were male and 55% were female. Half of the children were in Elementary school, 40% were in Secondary school, and 10% had achieved some post-secondary education. The FAM was found to significantly differentiate between clinical and non-clinical families (Skinner, et al., 1983).

FAM Interpretation Guide

The following guide provides the reader with descriptive information used to interpret the results of the FAM questionnaire.

1. Task accomplishment.

Low Score (40 and below) STRENGTH	High Scores (60 and above) WEAKNESS
-basic tasks consistently met	-failure of some basic tasks
-flexibility and adaptability to change in	-inability to respond appropriately to changes

developmental tasks
-functional patterns of task accomplishment are maintained even under stress
-task identification shared by family members, alternative solutions are explored and attempted

in the family life cycle
-problems in task identification, generation of potential solutions, and implementation of change
-minor stresses may precipitate a crisis

2. Role performance.

Low Score (40 and below) STRENGTH
-roles are well integrated:family members understand what is expected, agree to do their share and get things done
-members adapt to new roles required in the development of the family
-no idiosyncratic roles

High Scores (60 and above) WEAKNESS
-insufficient role integration, lack of agreement regarding role definitions
-inability to adapt to new roles required in evolution of the family life cycle
-idiosyncratic roles

3. Communication.

Low Scores (40 and below) STRENGTH	High Scores (60 and above) WEAKNESS
-communications are characterized by sufficiency of information	-communications are insufficient, displaced or masked
-messages are direct and clear	-lack of mutual understanding among family members
-receiver is available and open to messages sent	-inability to seek clarification in case of confusion
-mutual understanding exists among family members	

4. Affective expression.

Low Scores (40 and below) STRENGTH	High Score (60 and above) WEAKNESS
-affective communication characterized by expression of a full range of affect, when appropriate and with correct intensity	-inadequate affective communication involving insufficient expression, inhibition of (or overly intense) emotions appropriate to a

situation

5. Affective involvement.

Low Scores (40 and below)	High Score (60 and above)
STRENGTH	WEAKNESS
-empathic involvement family members' concern for each other leads to fulfilment of emotional needs (security) and promotes autonomous functioning	-absence of involvement among family members, or merely interest devoid of feelings
-quality of involvement is nurturant and supportive	-involvement may be narcissistic, or to an extreme degree, symbiotic
	-family members may exhibit insecurity and lack of autonomy

6. Control.

Low Scores (40 and below)	High Score (60 and above)
STRENGTH	WEAKNESS
-patterns of influence permit family life to proceed in a consistent and generally acceptable	-patterns of influence do not allow family to master the routines of ongoing family life

manner
-able to shift habitual patterns of functioning in order to adapt to changing demands
-control style is predictable yet flexible enough to allow for some spontaneity
-control attempts are constructive, educational and nurturant

-failure to perceive and adjust to changing life demands
-may be extremely predictable (no spontaneity) or chaotic
-control attempts are destructive or shaming
-style of control may be too rigid or laissez-faire
-characterized by overt or covert power struggles

7. Values and Norms.

Low Scores (40 and below) STRENGTH
-consonance between various components of the family's value system
-family's values are consistent with their subgroup and the larger culture to which the family belongs

High Scores (60 and above) WEAKNESS
-components of the family's value system are dissonant resulting in confusion and tension
-conflict between the family's values and those of the culture as a whole
-explicitly stated rules

-explicit and implicit rules are consistent	are subverted by implicit rules
-family members function comfortably within the existing latitude	-degree of latitude is inappropriate

The overall rating score, and the two response style scores follow the same rating scale which falls between 30 and 70. Scores below 40 represent a family strength, 60 and above represent a family weakness. All scores between 40 and 60 represents an average range of scores for non-clinical families.

Procedure

The study incorporated a case file review of therapists' termination notes and closing summaries to assess the outcome of therapy. A preliminary review of the files indicated that therapists clearly noted whether there had been any change in family functioning and child symptomatology following termination of therapy.

Review of the case files was undertaken by two trained raters. They identified two groups of families, "positive outcome" versus "poor outcome." Within each group raters were

asked to judge whether the outcome was slightly, moderately, or very changed. Results of the fathers' responses to the Family Assessment Measure (Skinner et al., 1983) were then compared between the groups. The FAM was administered by the family therapist, at the time of referral, to all family members who attended the first session.

Descriptive data was also collected : father's age, the identified patient's gender and age, and whether the father who completed the FAM was the child's biological father or stepfather.

Rater Training

The raters for this research were a third year undergraduate student from the faculty of Social Work at the University of Calgary who had completed a course in family therapy, and a counsellor from a community counselling agency with a bachelors degree in social work. Each rater was instructed to review closing summary and termination notes to determine the outcome of treatment as presented by the therapist. Based on the review, raters classified each case as "poor outcome" or "positive outcome". Therapists' termination notes describe whether there have been any observable behavioural changes by the identified patient, related to the concerns that brought the family to the hospital. Therapists'

notes also describe any observable structural and/or interactive changes in the family's dynamics related to their child's behaviour. Within these descriptions therapists' notes also intimate the degree of change noted.

The "poor outcome" group consists of families where no change in family functioning and/or reduction in child symptomatology is noted by the therapist at termination of treatment; or of families who prematurely terminate therapy without improvement. The "positive outcome" group consists of families where improvements in family functioning and/or a reduction in child symptomatology is noted by the therapist at the termination of treatment, whether initiated by the therapist or the family.

To further determine the extent of the change noted at the end of therapy (based on therapists' notes), raters were asked to consider whether the outcome was slightly improved, moderately improved, or very improved; or was there a slightly poor outcome, moderately poor outcome, or very poor outcome.

Prior to reviewing the files the raters were provided information describing the research and the protocol used to determine outcome, as mentioned above. They reviewed 8 practice files, rated them, and discussed them as a group with the researcher to reach a consensus on outcome, to further

develop consistency in the information used to determine outcome. When disagreement between raters occurred with an actual case, the file was reviewed together without input from the researcher, and discussed until a consensus was reached. Results of interrater reliability are presented in chapter 4.

Statistical Analysis

Statistical analysis compared average mean scores between the "poor outcome" groups of fathers versus the "positive outcome" groups of fathers, on the "General Scale" of the FAM (Skinner et al., 1983), and its nine subscales. Analysis of covariance was used to control for possible mitigating factors. Correlation analysis was used to determine the influence of the father's age, and the identified patient's age, on FAM scores. A two factor analysis of covariance was used to determine the interactive effect of the identified patient's gender and of the variable biological father/stepfather on FAM scores.

Limitations of the Study

Discretion shall be used when interpreting the results of this study. The proposed methodology to evaluate outcome has inherent weaknesses to reliability and validity. Too much time has elapsed since the end of therapy to reliably administer a

standardized measure of outcome to all subjects. Also, families were seen by different therapists, and though much of the work at the Family Therapy department was based on Solution Focused theory, the researcher cannot not control for therapist's effect on treatment outcome, or for therapist's reporting bias.

Furthermore, participants in the study are limited to those families were the father completed the FAM questionnaire. During the eight years when the data was collected, a number of families were seen by the program who did not complete the questionnaire, and for obvious reasons cannot be included in the sample size. There are also limits to whether the results can be generalized to the population at large as there was no random sampling or assignment.

Although the study attempts to understand how some mitigating factors may influence the fathers perception of family functioning, (e.g., sex and age of the child, and age of the father) the design did not control for other factors such as, quality of the marital or common law relationship, presenting problem, number of children in the family, birth order of the identified patient, and number of therapy sessions.

Subjects' Safeguards and Procedures

To ensure confidentiality of all participants, each family was assigned a number used in the compilation and analysis of the data. The raters signed consent forms regarding their participation in the research to further assure the anonymity of any client information reviewed. If a rater recognized any identifying information they were asked to immediately cease reading the file and notify the researcher. Consequently material contained in the case file would not be used in the research.

This study involved case file reviews. There was no direct consequences to families who's FAM scores (Skinner et al., 1983) were used in the research. As there was no experimental design and assured anonymity, there was no risk to participants. Upon the approval of this proposal by the University of Calgary, it was also submitted to the Alberta Children's Hospital Research Committee to ensure hospital research guidelines were met, and to the Faculty of Medicine for their final ethics approval.

Results

Overview

The data for this study was collected in two stages. From 1985 to 1993 the Family Therapy Program of the Alberta Children's Hospital attempted to administer the Family Assessment Measure (Skinner et al., 1983) to all family members who presented for therapy with the program. The FAM was administered by therapists at the onset of therapy. The second stage of data collection entailed a case file review undertaken by two raters who assessed the outcome of therapy for each father who completed the FAM. The identified patient's age and gender, and the father's age were collected. It was also noted whether the person who completed the FAM was the identified patient's biological father, or stepfather, which includes a stepfather in a blended family, or a mother's boyfriend in a common-law relationship (i.e., mother's male partner currently living with the family but not married to her).

The collected information was analyzed to determine whether particular scores on the FAM, completed by fathers, were related to outcome of therapy as assessed by the raters. Statistics were also used to explore if factors such as the father's age , the identified patient's age and gender, and if

the respondent is the child's biological father or stepfather, influence the FAM scores.

Inter-rater reliability scores are presented first, followed by descriptive information of the data set, then the analysis of the data addressing the null hypothesises.

Results of Inter-rater Reliability

With the 8 practice files, there was a 75% agreement rate on whether the outcome was positive or poor, and 25% agreement of the extent of change noted. Following the review of case files used in the study there was an 87% agreement rate on whether the outcome was positive or poor, and a 51% agreement on the extent of change noted. Again, when there was disagreement, raters reviewed the file together until a consensus was reached regarding outcome.

Descriptive Data

The age of fathers ranged from 19 to 55 years old, with a mean age of 37.6 years old. Of the 39 subjects (N=39), 9 (23%) were stepfathers, and 30 (77%) were the identified patients' biological father. The age of identified patients ranged from 2 to 17 years old with a mean age of 10 years old. 18 (46%) of the identified patients were males, 21 (54%) were

females. Presenting problems were related to the child's behaviour, but did not warrant a mental health diagnosis. Table 1 presents an overview of scores on the FAM for all subjects. Of interest is the mean score for affective expression which falls in the clinical range as a family weakness; though it should be also be noted this score has the highest standard deviation.

Table 1.

Mean Scores of the Data Set on the Family Assessment Measure

Variable	Mean	SD	N
Overall Score	57.64	9.52	39
SUBSCALES			
Task Accomplishment	59.79	10.73	39
Role Performance	53.79	12.06	39
Communication	59.10	13.37	39
Affective Expression	61.69	14.23	39
Affective Involvement	55.51	9.36	39
Control	56.62	12.00	39
Values and Norms	43.44	11.14	39

Results of Statistical Analysis

Pearson correlations with fathers' age and scores on the FAM showed a significant negative relationship to the subscale Task Accomplishment, where $r = -.335$. This suggest that as fathers get older they perceive their families as better at managing the daily familial concerns and needs. This finding rejects the null hypothesis that fathers' scores on perceptions of family functioning will show no relationship to their age.

Pearson correlations with the identified patients' age and fathers' scores on the FAM revealed many significant relationships. The identified patients' age was positively related to the Overall scale ($r = .326$) and the following subscales: Affective Expression ($r = .293$), Communication ($r = .356$), Role Performance ($r = .332$) (Table 2). Thus, as the identified patient's age increases fathers perceive more difficulties in their families; particularly with their ability to communicate supportive emotional expressions, to communicate clearly with each other, and to allocate and enact particular family roles with flexibility. These findings reject the null hypothesis that fathers' scores on perceptions of family functioning will show no relationship to the identified patients' age.

Table 2.

Results of the Correlation Analysis between the Identified Patients' Age and Fathers' Scores on the FAM

Variable	Correlation	P
Overall Score	.3260	<.05
SUBSCALES		
Role Performance	.3320	<.05
Communication	.3560	<.05
Affective Expression	.2930	<.05

Results of the Correlation Analysis between the Fathers' Age and their Scores on the FAM

Variable	Correlation	P
Task Accomplishment	-.3353	<.05

Note, fathers' age is positively correlated to the identified patients' age; .5423 P <.05 .

With the use of analysis of covariance there was no significant main effect found between gender of the identified patients and fathers' scores on the FAM. The identified patients' age was entered as the covariate in all the analysis of covariance to control for its influence, as found in the correlation analysis. In this case the null hypothesis is confirmed as fathers' scores on perception of family functioning did not differ significantly between fathers of male and female identified patients.

The analysis of covariance did reveal significant differences on the main effect between biological fathers and stepfathers on their FAM scores, in particular on the subscales of Affective Involvement and Role Performance (Tables 3 & 6). On Affective Involvement, biological fathers' mean score was 61, and the stepfathers' mean score 64. On Role Performance the biological fathers' mean score was 52, and the stepfathers' mean score 59.8. Stepfathers observed more difficulties with their families' ability to develop an emotionally supportive environment, and to allocate specific activities and roles to each family member. These results reject the null hypothesis that father's scores on perceptions of family function will not differ significantly between stepfathers and biological fathers.

Table 3.

Analysis of Covariance for Affective Involvement With the Variables Biological Father/Stepfather and The Identified Patients' Gender

Source	DF	SS	MSS	F	P
Covariate	1	276.25	276.25	4.24	.05
Father	1	636.13	636.13	9.76	.00
Gender	1	137.23	137.23	2.11	.16
Interaction	1	374.18	374.18	5.74	.02
Error	34	2216.35	65.19		
Total	38	3327.74	87.57		

The analysis of covariance revealed significant results for the interactive effect of biological father/stepfather with the identified patient's gender on the Overall scale (Table 4) and the following subscales: Affective Expression (Table 5), Affective Involvement (Table 3), Role Performance (Table 6), and Values and Norms (Table 7).

Table 4.

Analysis of Covariance for the Overall Scale With the Variables Biological Father/Stepfather and The Identified Patients' Gender

Source	DF	SS	MSS	F	P
Covariate	1	481.14	481.14	6.82	.013
Father	1	233.61	233.61	3.31	.08
Gender	1	169.01	169.01	2.40	.13
Interaction	1	511.37	511.37	7.24	.01
Error	34	2400.51	70.60		
Total	38	3446.97	90.71		

Table 5.

Analysis of Covariance for Affective Expression With the Variables Biological Father/Stepfather and The Identified Patients' Gender

Source	DF	SS	MSS	F	P
Covariate	1	679.83	679.83	4.10	.05
Father	1	123.76	123.76	.75	.39
Gender	1	68.54	68.54	.41	.52
Interaction	1	1165.94	1165.94	7.04	.01
Error	34	5631.78	165.64		
Total	38	7692.31	202.43		

Table 6.

Analysis of Covariance for Role Performance With the Variables Biological Father/Stepfather and The Identified Patients' Gender

Source	DF	SS	MSS	F	P
Covariate	1	860.05	860.05	7.49	.01
Father	1	524.13	524.13	4.56	.04
Gender	1	366.81	366.81	3.19	.08
Interaction	1	537.07	537.07	4.68	.04
Error	34	3905.00	114.85		
Total	38	5524.36	145.38		

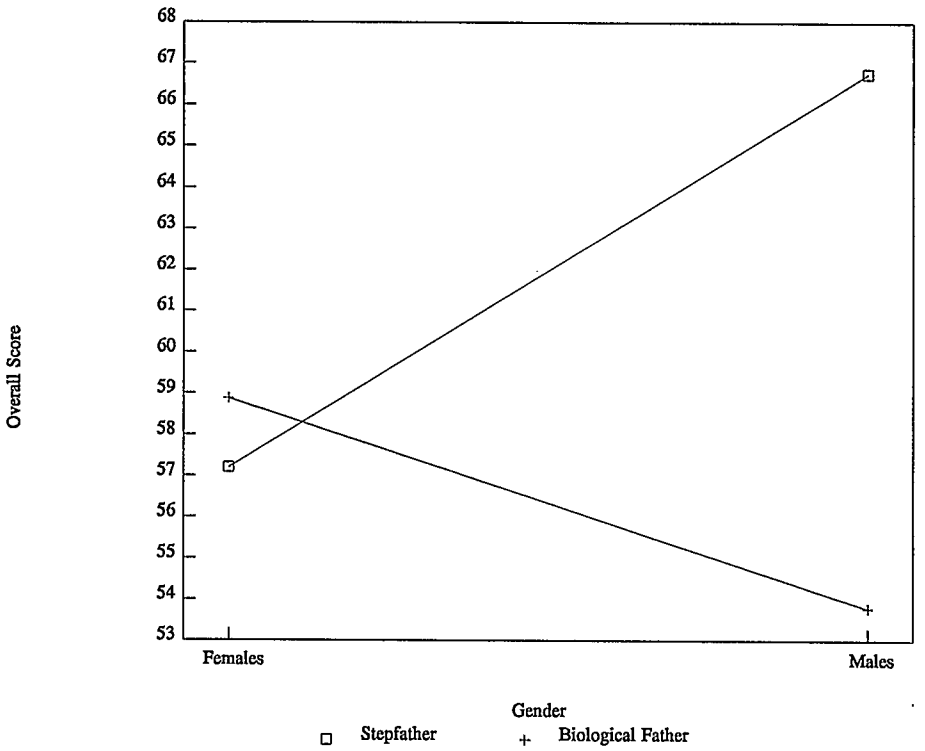
Table 7.

Analysis of Covariance for Values and Norms With the Variables Biological Father/Stepfather and The Identified Patients' Gender

Source	DF	SS	MSS	F	P
Covariate	1	18.69	18.69	.16	.70
Father	1	30.87	30.87	.26	.62
Gender	1	22.56	22.56	.19	.67
Interaction	1	555.55	555.55	4.62	.05
Error	36	3910.04	115.00		
Total	38	4719.23	124.19		

On the Overall scale stepfathers of male children had a mean score of 66.75 while biological fathers of male children had a mean score of 53.79. However, stepfathers of female children had a slightly lower mean score of 57.2 compared to biological fathers of female children with a mean score was 58.88 (Figure 1). Thus, stepfathers of male children perceived significantly more difficulties in general with their families than stepfathers of female children, and biological fathers of male of female children

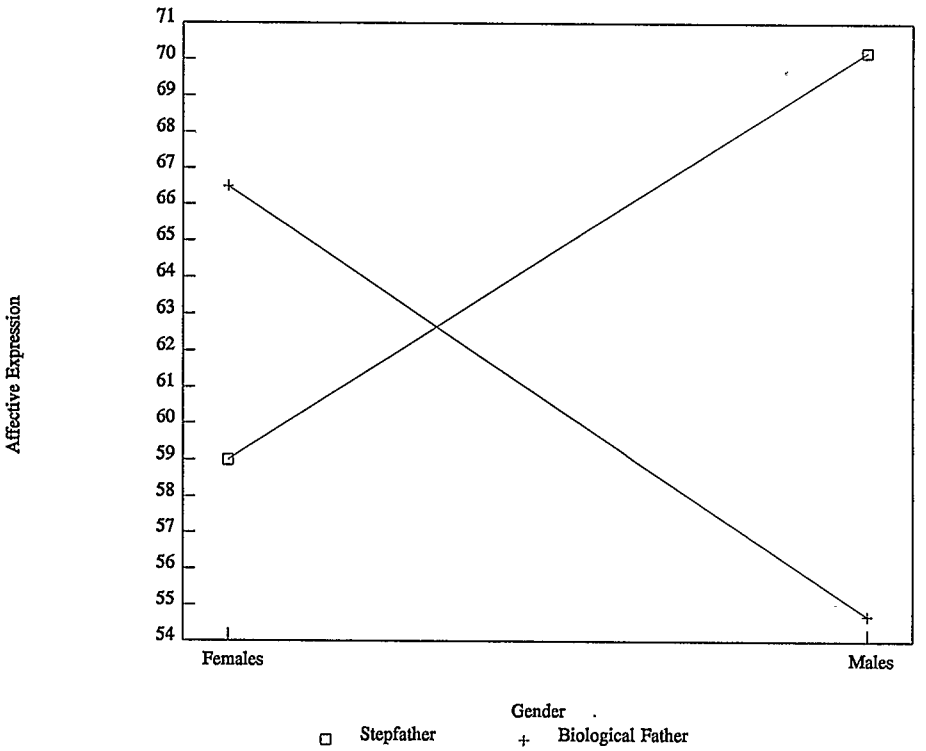
Figure 1.
Differences of Mean Scores for the Overall Scale As a Function of Stepfather/Biological Father And the Identified Patient's Gender



On the subscale of Affective Expression the mean score for stepfathers of female children was 59, while biological fathers of female children had a mean score of 66.5. Stepfathers of male children had a mean score of 70.2 and biological fathers of male children had a mean score of 54.7 (Figure 2). Biological fathers of female children perceived more difficulties with their families ability to communicate supportive emotional expressions than stepfathers of female children. However, stepfathers of male children observed significantly more difficulties with their families ability to communicate supportive emotional expressions than biological fathers of male children.

Figure 2.

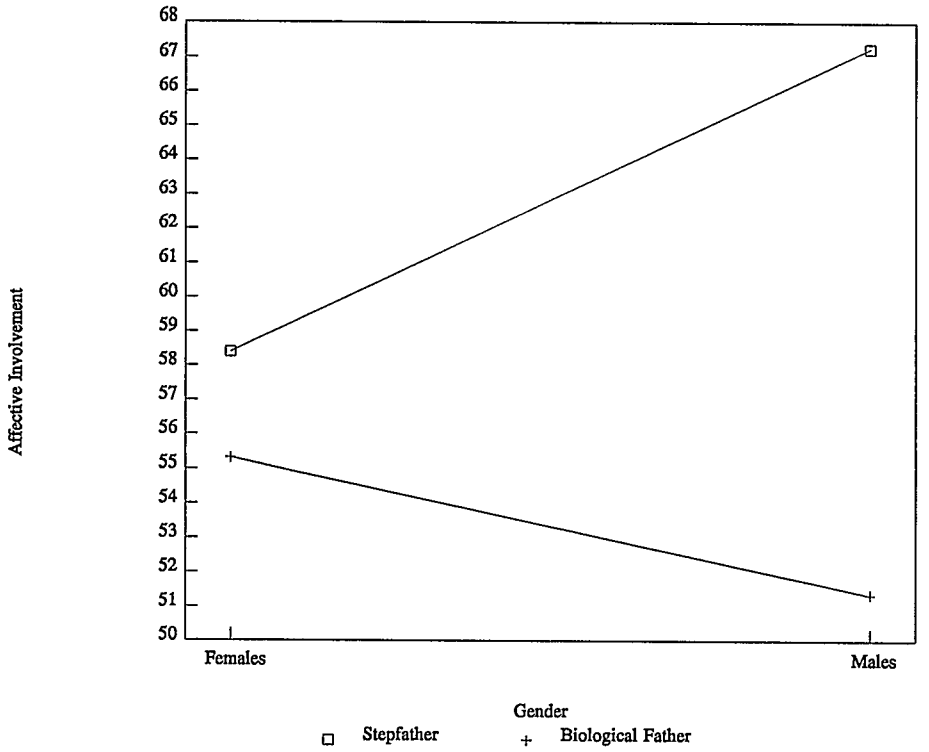
Differences of Mean Scores for Affective Expression As a Function of Stepfather/Biological Father And the Identified Patient's Gender



On the subscale of Affective Involvement, stepfathers of male children had a mean score of 67.25, while biological fathers of male children had a mean score of 51.36. Stepfathers of female children had a mean score of 58.4, and biological fathers of female children had a mean score of 55.31 (Figure 3). Stepfathers of female and male children perceived more problems with their families ability to provide an emotionally supportive environment for each other, than biological fathers.

Figure 3.

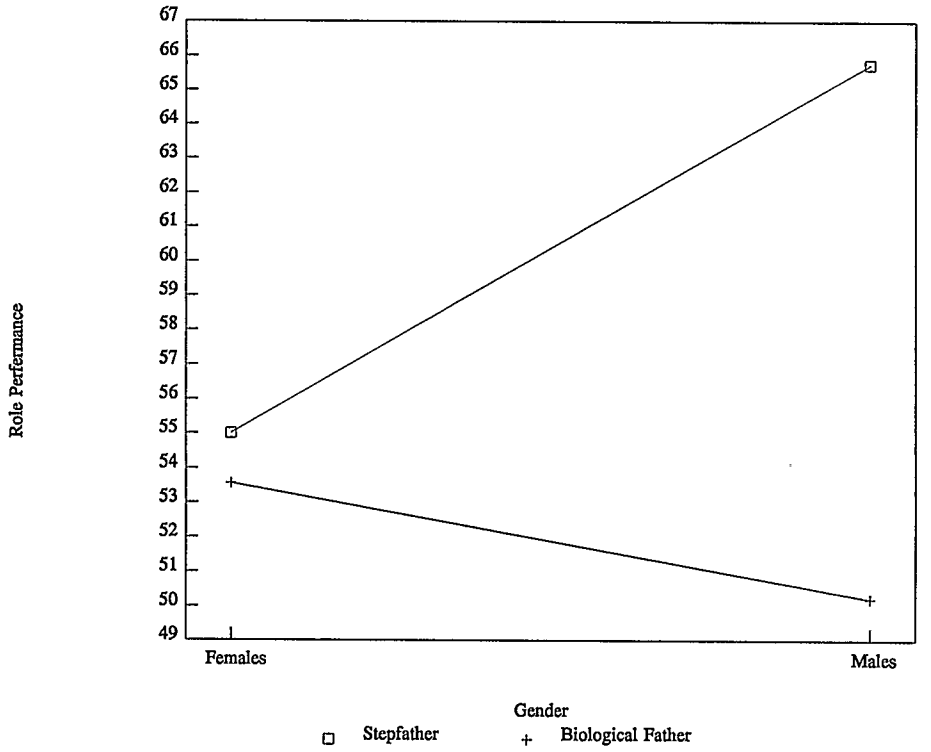
Differences of Mean Scores for the Affective Involvement As a Function of Stepfather/Biological Father And the Identified Patient's Gender



On the subscale of Role Performance, stepfathers of male children had a mean score of 65.75, while biological fathers of male children had a mean score of 50.22. Stepfathers of female children had a mean score of 55, and biological fathers of female children had a mean score of 53.56 (Figure 4). Stepfathers of female and male children perceived more difficulties with their families ability to allocate and integrate family roles, and to adapt to new roles required over time, than biological fathers.

Figure 4.

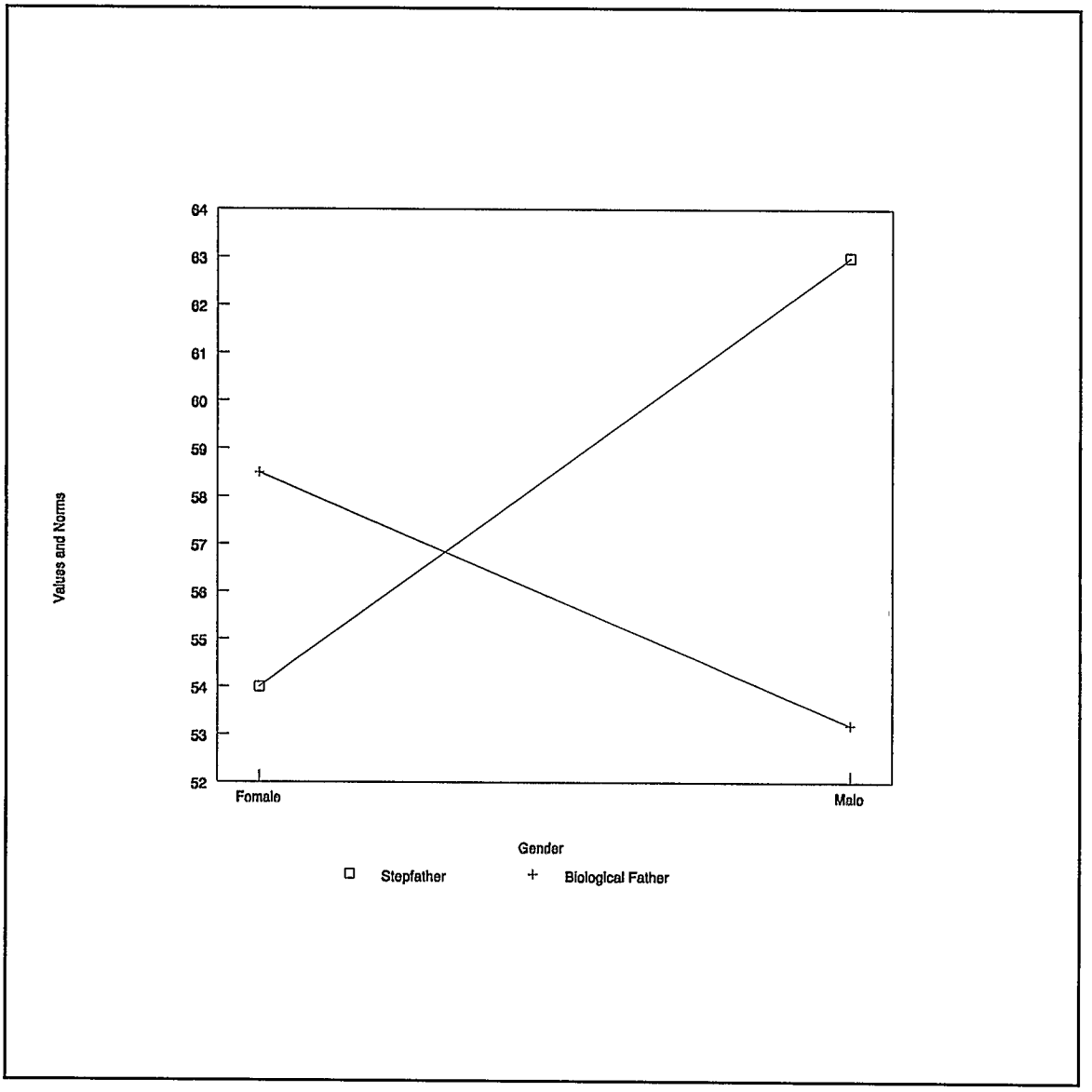
Differences of Mean Scores for Role Performance As a Function of Stepfather/Biological Father And the Identified Patient's Gender



On the subscale of Values and Norms, stepfathers of male children had a mean score of 63.25, while biological fathers of male children had a mean score of 53.43. Stepfathers of female children had a mean score of 54, and biological fathers of female children had a mean score of 58.56 (Figure 5). Biological fathers of female children perceived more problems with their families ability to create and maintain clear and consistent family rules, than stepfathers of female children. The family's explicit rules are more likely to be subverted by implicit rules, leading to confusion and tension. However, stepfathers of male children perceived significantly more difficulties in this area, than biological fathers of male children.

Figure 5.

Differences of Mean Scores for Values and Norms As a Function of Stepfather/Biological Father And the Identified Patient's Gender



These findings reject the null hypothesis that states there will be no significant interactive effect between stepfathers and biological fathers, and the gender of the identified patient, on scores of perceptions of family functioning.

With the use of analysis of covariance, to control for the influence of the identified patients' age, there were no significant differences found on the FAM overall scale, or any of the subscales, as a function of family therapy outcome. The null hypothesis was confirmed as father's scores on perceptions of family functioning did not differ significantly between families with good outcomes in therapy versus poor outcomes in therapy.

Summary of Findings

1. Father's age is negatively correlated to scores on the subscale Task Accomplishment.

2. The age of the identified patient is correlated to the father's scores on the following subscales: the Overall scale, Affective Expression, Communication, Role Performance.

3. Stepfathers have different perceptions of family

functioning than biological fathers along the following subscales: Affective Involvement, and Role Performance.

4. There are no significant differences on FAM scores between fathers of male or female identified patients.

5. The combination of the variables Stepfather/Biological father and the identified patient's gender lead to significant differences on FAM scores along the following subscales: the Overall scale, Affective Expression, Affective Involvement, Role Performance, and Values and Norms.

6. There were no significant differences found on FAM scores between families with good outcomes in therapy and families with poor outcomes in therapy.

Discussion

The purpose of this study was to explore the influence fathers' have on the outcome of family therapy; in particular whether fathers' had certain perceptions of their family's functioning at the onset of therapy that were associated with the outcome of family therapy. The literature review established that fathers play an important role in their child's development and in the resolution of problems they may encounter (Golant & Golant, 1992; Lamb, 1981, 1986; Phares, 1992). However, it was found that little work has been done exploring particulars about the influence fathers have during family therapy. This research used the Family Assessment Measure (Skinner, et al., 1983) to explore fathers' perceptions of their family's functioning at the beginning of family therapy, assessed therapy outcome, and analyzed the results to determine whether scores on the FAM differed significantly between "good outcome" and "poor outcome" groups. The study also explored the influence of the following factors on FAM results: father's age, the identified patient's age and gender, and whether the father was the identified patient's biological father or stepfather.

Results of the study suggest there are no particular perceptions of family functioning held by the father at the onset of therapy that are associated with the outcome of

family therapy. Friedman et. al's (1991) study which found mothers and clients with more positive perceptions of their family at intake predicted better outcomes in treatment did not generalize to fathers in this research. Likewise, Stedman, Gaines & Costello's (1983) findings that family affiliation and organizational consistency predicted better outcomes in family therapy were not born out. Though research suggest the father's participation in family therapy improves outcomes (Gurman & Kniskern, 1981; Webster-Straton, 1985; James, 1988) this study did not reveal any particular information about the father's participation in family therapy which is related to outcome. Much has been written on how perceptions influence behaviours and relationships (Hoffman, 1990; White, 1993) yet this research found no significant result identifying perceptions held by the father about relationships in his family that are associated with outcome.

The lack of significant results may be explained by the study's limitations and the weaknesses in design of the research. There was no standardized measure used for outcome. There was a small sample size and an inability to control for certain mitigating factors. These conditions may have limited the sensitivity of the design to find significant results, increasing the possibility of a type II error.

However, the analysis of possible mitigating factors

revealed significant results. The correlations found between the identified patients' age and fathers' scores on the FAM suggest that fathers who present for therapy with older children may perceive greater difficulties in family functioning in the area of Communication, Role Performance, and Affective Expression.

The strongest correlation was found between the identified patients' age and the fathers' scores on the subscale of Communication. This suggest fathers who present for family therapy with older children may have greater difficulties than fathers of younger children, with direct communication. Messages sent between family members may be misunderstood with limited ability to clarify confused communications. Such fathers may present for therapy frustrated that their children don't listen, while their children may complain that their fathers just don't understand them.

Fathers' of older children also saw their families having greater difficulties in Role Performance, adapting to new roles and the demands to redefine them as their children grow older. Such fathers may present to therapy concerned that their child seems to want too much freedom as they age, while the child complains they feel as if they are being treated as a baby. The results also suggest that difficulties in the

area of Affective Expression become more problematic with older children. This suggest that most fathers of older children who presented for therapy saw their family having trouble appropriately expressing emotional support, or problems with overwhelming expressions of affect at inappropriate times. These fathers may present to therapy very concerned and angry about events that may seem to warrant less intense of a response, while accomplishments of the child may elicit little recognition.

However, older fathers in the study were found to have lower scores on Task Accomplishment suggesting the development of a strength in this area over time. Older fathers perceived their families as being better able to consistently accomplish familial tasks. Do these results suggest that fathers become more task focused over time to the detriment of other responsibilities? Or do fathers actively develop these skills in the family because they do not feel proficient in the other areas of family functioning identified in this research? These questions remain unanswered.

Perhaps with little surprise the mean score for Affective Expression of all fathers fell in the clinical range indicating a problem area. Though there is no comparison group in this research design, it can be questioned whether these results support O'Brien's (1988) report that men are

more likely to be involved in professional help when problems have reached a significant level of urgency.

The families who participated in the study presented to the Family Therapy program with child centred problems. Based on previous research it may be anticipated that fathers might perceive difficulties in familial relationships with appropriate emotional warmth and support. The findings related to Affective Expression may speak to the importance of the nurturing quality and warmth of the father-child relationship, or the lack of it, found to be associated with the child's psychosocial adjustment (Phares, 1992; Pruett, 1993). Levine (1993) reports that beyond the father's presence in the family, it is the quality of his relationship with his children that leads to their improved behaviour. Parke (1981) also recognizes the need for healthy affective expression between father and daughter which seems to influence her cognitive development and abilities to achieve. Most all the research cited in this study speak to the primacy of the quality of the father child relationship as it influences the child's development and behaviour.

The results revealed differences between biological fathers and stepfathers in their perceptions of family functioning. In the area of Affective Involvement and Role Performance stepfathers scored significantly higher indicating

a problem area. They perceive greater difficulties meeting the emotional needs of their stepchildren. Stepfathers also believed their families had difficulties establishing clear roles within the family, and adjusting to new ones over time. Such stepfathers may present to therapy concerned about their role with the family and how to involve themselves emotionally in their stepchild's life. The stepfather may be confused about his new parental responsibilities, possibly exacerbated by the stepchild's confusion about the new family constellation. These findings are congruent with the literature that suggests stepfamilies may experience less cohesiveness, have difficulties establishing emotional bonds, and struggle with redefining their family structure (Anderson & White, 1986; Claxton-Oldfield, 1992; Barber & Lyons, 1994).

Stepfathers of male children saw more problems with their families than did stepfathers of female children or biological fathers with children of either gender. They scored higher on the Overall scale, on Affective Expression, Affective Involvement, Role Performance, and Values and Norms, all indications of problem areas.

Stepfathers of male children perceived difficulties with their families' ability to express appropriate emotional support, suggesting an inhibition of expression or an overly intense exhibition of emotion. They saw problems with their

families' ability to create an emotionally supportive environment, consequently influencing family members' sense of security and autonomy. These findings may represent the struggles of loyalty experienced by a male child between his stepfather and biological father (Skopin, Newman & McKenry, 1993). Such tension may manifest itself in a number of ways as the stepfamily attempts to define itself as a nuclear family excluding the child's biological father. These issues may be more pertinent to the male child by extension of the obvious gender identification and their need for role validation. Also, perhaps the male child views his stepfather competitively and as a disruptive figure. Before their mother's involvement with their stepfather, the child likely had more access to her time and energy, which was limited following her involvement in another adult relationship.

Stepfathers of male children saw their families having greater difficulties adjusting to demands for change in family roles over time. Finally, they also perceived their families having problems establishing family norms consonant with their community's, and difficulties maintaining clear and consistent family rules and values that are not subverted by other implicit rules. These results seem to speak to the expected difficulties a blended family may experience as they attempt to integrate a new member.

Biological fathers of female children scored significantly higher on the subscales of Affective Expression, and Values and Norms. These findings suggest that biological fathers of female children who present for family therapy may perceive their families as having difficulties providing adequate emotional support through the expression of appropriate affect. There were also perceived difficulties maintaining clear and consistent family values and norms, which can create dissonance between explicit and implicit rules, leading to confusion and tension within the family. These results do not support previous research which suggest stepfathers, not biological fathers, of female children experience difficulties establishing their roles and responsibilities with their stepdaughters, and with the demonstration of affection toward them (Barber & Lyons, 1994; Claxton-Oldfield, 1992; Skopin, Newman & McKenry, 1993). Respecting the limitations of this study, it is difficult to speculate as to the possible reasons for these results; yet they warrant further exploration.

Implications for Future Research

The design of this study was exploratory, with limitations to its ability to generalize findings to the population of families who present for therapy. However, the results may be indicative of the need for a more stringent

research design. Barnes (1989) identified that discrepancies in perceptions of family functioning create tension and may reflect poor communication skills within the family. Further studies may address the differences between family members' perceptions of family functioning and whether they are associated with outcome of family therapy. With pre and post-testing with the FAM, and the use of a validated and standardized tool to measure outcome, research might reveal whether certain perceptions held by fathers change following therapy and whether such changes are related to outcome. Kotler & Chetwynd (1980) found that following therapy fathers perceived improvements in the quality of father-child relationships.

Though not the focus of this research, results indicated differences in perception of family functioning between biological fathers and stepfathers, which was further influenced based upon the gender of the identified patient. These findings deserve further exploration. Do these perceptions change following therapy? Are they related to the outcome? Research has identified that time spent together as a family may significantly influence the extent to which stepfamilies experience distress (Anderson & White, 1986; Barber & Lyons, 1994); this factor was not controlled for, or explored in this study. It warrants further investigation of its influence on family therapy outcome with stepfamilies.

Furthermore, it may be misleading to expect stepfamilies to experience the same kind of emotional closeness as intact families can.

Implications for Social Work Practice

The results of this study provide social work clinicians with information about how fathers may present at the onset of family therapy. Their presentation may differ depending on the following factors: the identified patient's age and gender, the father's age, and whether the identified father is the child's biological father or stepfather. First, the results indicated that most fathers who present for family therapy may perceive their family as having difficulties with affective expression. As an identified problem area and a recognized asset to a child's development (Phares, 1992; Pruett, 1993), perhaps therapist should pay particular attention to fostering change in this area.

Therapists referred pre-adolescent girls for family therapy could be sensitive to the possibility that the child's father perceives their family as having difficulties sharing with each other supportive emotional expressions, and establishing clear rules and values congruent with their community. Therapists working with blended families could be sensitive to the possibility that they may be experiencing

problems adjusting to new roles and creating an emotionally inclusive and supportive environment for all its members. These difficulties may be further exacerbated if the identified patient is male, compounded by problems with the expression of appropriate emotions and the development of clear family norms and values. Perhaps simply normalizing the families experience with difficulties in these area may lead to change. The findings highlighting difficulties stepfathers may perceive, could be used in the development or enhancement of short programs addressing the needs of blended families, recognizing the prevalence of this family structure in our society.

Bibliography

Adams, D.; Overholser, J.; & Lehnert, K. (1994). Perceived family functioning and adolescent suicidal behavior. Journal of the American Academy of Child and Adolescent Psychiatry, 33, 498-507.

Anderson, H. & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. Family Process, 27, 371-393.

Anderson, J. & White, G. (1986). An empirical investigation of interaction and relationship patterns in functional Family Process, 25, 407-422.

Bandura, A. (1977). Social Learning Theory. Prentice-Hall, New Jersey.

Barber, D. & Lyons, J. (1994). Family processes and adolescent adjustment in intact and remarried families. Journal of Youth and Adolescence, 23, 421-436.

Barnes, H. (1989). Cross-generational coalitions, discrepant perceptions and family functioning. Journal of Psychotherapy and the Family, 4, 175-198.

Bateson, G. (1972). Steps to an Ecology of Mind. Ballantine Books, New York.

Berg, B. & Rosenblum, N. (1977). Fathers in family therapy: A survey of family therapists. Journal of Marriage and Family Counseling, 3, 85-91.

Biller, H. (1971). Father absence and the personality development of the male child. Annual Progress in Child Psychiatry and Child Development, ed. by Chess & A. Thomas; Brunner/Mazel Publisher, New York, 120-152.

Biller, H. (1974). Paternal Deprivation; Family, School, Sexuality, and Society. Lexington Books, Massachusetts.

Biller, H. (1981). The father and sex-role development. The Role of the Father in Child Development, ed. by M. E. Lamb; John Wiley, New York, 319-358.

Block, P. (1971). Lives Through Time. Berkley, Bancroft.

Bowlby, J. (1966). Maternal Care and Mental Health. World Health Organization; Geneva.

Budd, K. & O'Brien, T. (1982). Father involvement in behavioral parent training: An area in need of research. The Behavior Therapist, 5, 85-89.

Claxton-Oldfield, S. (1992). Perceptions of stepfathers. Journal of Family Issues, 13, 378-389.

De Shazer, S.; Kim Berg, I.; Lipchik, E.; Nunnally, E.; Molnar, A.; Gingerich, W. & Weiner-Davis, M. (1986). Brief therapy: Focused solution development. Family Process, 25, 207-222.

Friedman, A., Tomko, L., Utada, A. (1991). Client and family characteristics that predict better family therapy outcome for adolescent drug abusers. Family Dynamics of Addiction Quarterly, 1 (1), 77-93.

Gabel, S. (1992). Behavioral problems in sons of incarcerated or otherwise absent fathers: the issue of separation. Family Process, 31 (3), 303-314.

Golant, M., and Golant, S. (1992). Finding Time for Fathering. Fawcett Columbine, New York.

Greenberg, M., and Morris, N. (1974). Engrossment: The newborn's impact upon the father. American Journal of Orthopsychiatry, 44, 520-531.

Gurman, A., & Kniskern, D. (1981). Family therapy outcome research: Knowns and unknowns. Handbook of Family Therapy, ed. by A. S. Gurman & D.P. Kniskern; Brunner/Mazel, New York.

Hall, C. & Lindzey, G. (1985). Introduction to Theories of Personality. John Wiley & Sons, New York.

Hampson, J.L. (1965). Determinants of Psychosexual Orientation: Sex and Behavior, New York.

Heubeck, B., Detmering, J., & Russell, G. (1986). Father involvement and responsibility in family therapy. The Father's Role: Applied Perspectives, ed. by M.E. Lamb; John Wiley and Sons, New York, 191-226.

Hoffman, L. (1981). Foundations of Family Therapy: A Conceptual Framework for Systems Change. Basic Books, United States of America.

Hoffman, L. (1990). Constructing realities: An art of lenses. Family Process, 29, 1-12.

James, D. (1988). Fathers: An emerging frontier for social workers? Australian Social Work, 41, 5-8.

Kohlberg, L.A. (1966). A cognitive-developmental analysis of children's sex role concepts and attitudes. The Development of Sex Differences, ed. by E. Maccoby; Stanford University Press.

Kotler, T., & Chetwynd, J. (1980) Changes in family members during psychotherapy. Human Relations, 33 (2), 101-110.

Lamb, M. (1981). Fathers and child development: An integrative overview. The Role of the Father in Child Development, ed. by M. E. Lamb; John Wiley and Sons, New York, 1-33.

Lamb, M. (1986). The changing roles of fathers. The Father's Role: Applied Perspectives, ed. by M.E. Lamb; John Wiley and Sons, New York, 3-27.

Lazar, A., Sagi, A., & Fraser, M. (1991). Involving fathers in social services. Children and Youth Services Review, 13 (4), 287-300.

LeCroy, C.W. (1987). A model for involving fathers in family treatment. Family Therapy, 14, 237-245.

Levine, J. (1993). Involving fathers in Head Start: A framework for public policy and program development. Families in Society: The Journal of Contemporary Human Services, 74, 4-19.

Maturana, H. & Varela, F. (1987). The Tree of Knowledge: The Biological Roots of Human Understanding. Shambhala Publications, Boston and London.

Mead, M. (1962). A cultural anthropologist's approach to maternal deprivation. Deprivation of Maternal Care: A reassessment of Its Effects, Geneva: World Health Organization.

Minuchin, S. (1971). Reconceptualization of adolescent dynamics from the family point of view. Teaching and Learning Adolescent Psychiatry, ed. by D. Offer & J.F. Masterson; Thomas Books, Springfield, Illinois.

O'Brien, M. (1988). Men and fathers in therapy. Journal of Family Therapy, 10, 109-123.

Parke, R. (1981). Fathers. Harvard University Press, Massachusetts.

Pedersen, F. (1981). Father influence viewed in a family context. The Role of the Father in Child Development, ed. by M. E. Lamb; John Wiley and Sons, New York, p. 295-317.

Phares, V. (1992). Where's poppa: The relative lack of attention to the role of fathers in child and adolescent psychopathology. American Psychologist, 47, 656-664.

Phares, V., Compas B. (1992). The role of fathers in child and adolescent psychopathology: Make room for daddy. Psychological Bulletin, 11, 387-412.

Pittman, F. (1990). The masculine mystique. Family Therapy Networker, 14, 40-52.

Popenoe, D. (1993). Paternal Androgyny. Society, 30, 5-11.

Pruett, K. (1993). The paternal presence. Families in Society: The Journal of Contemporary Human Services, 46-50.

Schnitzer, P. K. (1993). Tales of the absent father: Applying the "story" metaphor in family therapy. Family Process, 32, 441-458.

Shapiro, R.J. & Budman, S.H. (1973). Defection, termination and continuation in family and individual therapy. Family Process, 12, 55-67.

Silverstein, L. (1991). Transforming the debate about child care and maternal employment. American Psychologist, 46, 1025-1032.

Skinner, B. (1971). Beyond Freedom and Dignity. Bantam Book Inc., New York.

Skinner, H. A., Steinhauser, P. D., & Santa-Barbara, J. (1983). The family assessment measure. Canadian Journal of Community Mental Health, 2, 91-105.

Skopin, A.; Newman, B.; & McKenry, P. (1993). Influences on the quality of stepfather-adolescent relationships: views of both family members. Journal of Divorce and Remarriage, 19, 181-196.

Starrels, M. E. (1994). Gender differences in parent-child relations. Journal of Family Issues, 15, 148-165.

Stedman, J., Gaines, T., & Costello, R. (1983). Prediction of outcome in family oriented therapy from family characteristics. Family Therapy, 10 (3), 211-218.

Steinhauer, P. (1984). Clinical applications of the process model of family functioning. Canadian Journal of Psychiatry, 29, 98-111.

Steinhauer, P.; Santa-Barbara, J., & Skinner, H. (1984). The process model of family functioning. Canadian Journal of Psychiatry, 29, 77-87.

Touliatos, J., Perlmutter, F., & Straus, M. (1990). Handbook of Family Measurement Techniques. Sage Publications Inc., California.

Webster-Stratton, C. (1985). The effects of father involvement in parent training for conduct problem children. Journal of Child Psychology and Psychiatry and Allied Disciplines, 25, (5), 801-810.

White, M. (1986). Negative explanation, restraint, and double description: a template for family therapy. Family Process, 25, 169-184.

White, M. (1993). Deconstruction and therapy. Therapeutic Conversations, ed. by S. Gilligan & R. Price; W. W. Norton & Company, New York & London.

Appendices

Family Assessment Measure

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DIRECTIONS

On the following pages you will find some statements about families. In the first section the statements refer to your family as a whole. The second section considers relationships between yourself and another member of the family. In the third section the statements refer to how you function individually in the family. Please make sure that you complete all three sections. Indicate your answer by circling the appropriate number beside each statement.

PLEASE FILL IN THE FOLLOWING INFORMATION ABOUT YOURSELF

Your Name _____

Today's Date _____

Your Birth Date _____ (day) _____ (month) _____ (year)

Sex 1. _____ (male) 2. _____ (female)

Your Family Position

1. Father/Husband _____
2. Mother/Wife _____
3. Child _____
4. Grandparent _____
5. Other, specify _____

Highest Education Level (reached or current)

1. Elementary School (grade 8 or lower) _____
2. Some Secondary School _____
3. Secondary School _____
4. Some Non-University Post-Secondary _____
5. Non-University Program Completed _____
6. Some University _____
7. University Degree _____
8. Post Graduate/Professional Degree _____

==========

OFFICE USE ONLY:

Belongs with:_____ Ref. Rte: _____

Therapist: I.P. Non-I.P.

Pre Rost Other Cr. Non-Cr.

SECTION I. GENERAL SCALE

This section contains 50 statements about your family as a whole. Read each statement carefully and decide how well the statement describes your family.

If you STRONGLY AGREE with the statement then circle the number "1" beside the item; if you AGREE with the statement then circle the number "2".

If you DISAGREE with the statement circle the number "3"; if you STRONGLY DISAGREE with the statement then circle the number "4".

Please answer only one number from 1 to 4 for each statement even if you are not completely sure of your answer.

GENERAL SCALE

		STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
1.	We spend too much time arguing about what our problems are.	1	2	3	4
2.	Family duties are fairly shared.	1	2	3	4
3.	When I ask someone to explain what they mean, I get a straight answer.	1	2	3	4
4.	When someone in our family is upset, we don't know if they are angry, sad, scared or what.	1	2	3	4
5.	We are as well adjusted as any family could possibly be.	1	2	3	4
6.	You don't get a chance to be an individual in our family.	1	2	3	4
7.	When I ask why we have certain rules, the answers I get don't make sense.	1	2	3	4
8.	We have the same views on what is right and wrong.	1	2	3	4
9.	I don't see how any family could get along better than ours.	1	2	3	4
10.	Some days we are more easily annoyed than on others.	1	2	3	4
11.	When problems come up, we try different ways of solving them.	1	2	3	4
12.	My family expects me to do more than my share.	1	2	3	4
13.	We argue about who said what in our family.	1	2	3	4

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
14. We tell each other about things that bother us.	1	2	3	4
15. My family could be happier than it is.	1	2	3	4
16. We feel loved in our family	1	2	3	4
17. When you do something wrong in our family you don't know what to expect	1	2	3	4
18. It's hard to tell what the rules are in our family	1	2	3	4
19. I don't think any family could possibly be happier than mine.	1	2	3	4
20. Sometimes we are unfair to each other.	1	2	3	4
21. We never let things pile up until they are more than we can handle.	1	2	3	4
22. We agree about who should do what in our family	1	2	3	4
23. I never know what's going on in our family	1	2	3	4
24. I can let my family know what is bothering me.	1	2	3	4
25. We never get angry in our family	1	2	3	4
26. My family tries to run my life.	1	2	3	4
27. If we do something wrong we don't get a change to explain.	1	2	3	4
28. We argue about how much freedom we should have to make our own decisions	1	2	3	4

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
29. My family and I understand each other completely.	1	2	3	4
30. We sometimes hurt each others feelings.	1	2	3	4
31. When things aren't going well it takes too long to work them out.	1	2	3	4
32. We can't rely on family members to do their part.	1	2	3	4
33. We take the time to listen to each other.	1	2	3	4
34. When someone is upset, we don't find out until much later.	1	2	3	4
35. Sometimes we avoid each other.	1	2	3	4
36. We feel close to each other.	1	2	3	4
37. Punishments are fair in our family.	1	2	3	4
38. The rules in our family don't make sense.	1	2	3	4
39. Somethings about my family don't entirely please me.	1	2	3	4
40. We never get upset with each other.	1	2	3	4
41. We deal with problems even when they're serious.	1	2	3	4
42. One family member always tries to be the centre of attention.	1	2	3	4
43. My family lets me have my say, even if they disagree.	1	2	3	4
44. When our family gets upset, we take too long to get over it.	1	2	3	4

	STRONGLY AGREE	AGREE	DISAGREE	STRONGLY DISAGREE
45. We always admit out mistakes without trying to hide anything.	1	2	3	4
46. We don't really trust each other.	1	2	3	4
47. We hardly ever do what is expected of us without being told.	1	2	3	4
48. We are free to say what we think in our family.	1	2	3	4
49. My family is not a perfect success.	1	2	3	4
50. We have never let down another family member in any way.	1	2	3	4

Reasearch Assistant Agreement Form

Fathers' Influence on Family Therapy Outcome

As a reasearch assistant reviewing sensitive casefile material I, _____ agree to ensure confidentiality of all information pertinent to this study. Should I recognize any identifying information, I will immediately cease reading the file and notify the researcher.

Signature: _____

Witness: _____

Date: _____