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Impact of problem solving training on the adjustment of troubled families

PREPARED By

Homa Ansari

Degree: Applied Post Doctorate
Field: Family Counseling
Student number: HRIC-18923-PD

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Abstract:

The present study aimed to investigate the effect of problem solving training on reduction of marital problems of troubled families. The statistical population consisted of 90 families with communication and compatibility problems referring to a counseling center of Tehran City. Among them, 30 maladjusted couples were selected by simple random sampling and formed the sample size. Data collection was done by standardized questionnaire of dyadic adjustment Scale (DAS) that was designed by Spanier (1979) and had 32 questions measuring relationships of (dyadic satisfaction, cohesion, consensus and affectional expression). In the present study, statistical calculations were conducted at the confidence level of 95% (α = 5%) and the test power of 90% (β= 10%) and Δ with moderate impact (0.50). Lawshe`s method (1975) and 6 experts' views (4 advisors and supervisors) were utilized to determine the content validity index (CVI) that was obtained equal to 0.89. To determine the reliability of questionnaire, 32 questions were distributed among the statistical population, and then analyzed using SPSS software; and the Cronbach's alpha coefficient was obtained equal to 0.96 indicating the internal consistency of research. The present study used the pre-test post-test method with a control group; Pearson correlation coefficient was analyzed by the analysis of variance. Statistical analysis at the level of 95% indicated that the problem-solving training was effective in reducing the conflict. There was also a correlation between men and women in terms of the marital adjustment. However, no difference was found between them in the level of being affected by the problem solving training. The marital adjustment was different in men and women.

Keywords: Marital adjustment; problem solving; problem-solving skill training; adjusted couple; maladjusted couple

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Chapter 1
Research Overview

1-1- INTRODUCTION

Marital adjustment and satisfaction with marriage are important in a marriage. Marital adjustment is a situation in which couples often have feelings of happiness and consent. Marriage adjustment can be created through a mutual interest, taking care of each other, acceptance, understanding each other, and satisfaction of needs. In other words, the marital adjustment may include the dyadic satisfaction, dyadic consensus, the amount of company and affectional expression, and satisfactory sex with two features namely the continuity and pleasure (Momenzadeh, 2009).

Adjusted couples have high agreement, are satisfied with types and levels of their relations and types and quality of their leisure, and can well manage their time and financial issues (Sanaei, 2000).

Adjustment refers to the amount of coordination and agreement between s couple in the field of married life issues; and couples without this coordination have maladjusted and ineffective relationships. "Maladjusted couples are not satisfied with their married life and have incompatible relationships with each other". "Problem-solving" means the familial ability to recognize and talk about issues by correct way as well as improving situations and conditions and help members to deal efficiently with problems. Healthy families have problems as much as unhealthy families, but the healthy ones use problem solving skills more efficiently. Obviously, people, who properly learn problem-solving skills in their families, are better able to solve problems (Halford et la, 2006).

The present research sought to investigate the impact of problem solving training on adjustment of troubled families.

1-2- Statement of problem

Among all stressful situations for people in their lives, the divorce and marital problems are ranked second and third respectively. Only the death of a spouse or close kinship is close to these two and ranked first (Holmes & Raheh, 2015). Certainly, good relationships cannot be simply gained and need the constant effort. Levinger (2009): What is important in establishing a good marital relationship or any satisfactory relationship is not your coordination, but it is important how you deal with incompatibilities.

Conflict exists when two people live together as husband and wife. In natural interactions of a couple, there are situations where differences arise or needs are not met. As a result, both partners feel angry, frustrated and discontented with each other. Therefore, if a conflict arises, the husband and wife must prepare for it. This preparation should be based not only on the ability to communicate, but also on the implementation of a systematic problem-solving strategy that provides the structure and order for conflict resolution sessions. Problem solving is an extremely complex cognitive skill that requires higher levels of information processing than other cognitive processes such as language learning and the formation of concepts and represents one of the most intelligent human activities. Problem solving stimulates the attention, perception, memory, and other information processing processes in a coordinated manner to achieve goals; hence, it is considered as one of the most complex solutions to problems of human behavior in the field of clear and well-structured tasks and issues. Problem solving is an applied skill that is now a daily necessity of life.

The main aim of research was as follows: Is the problem solving skill training effective in reducing conflicts between couples and improving the family satisfaction?

1-3- Research purposes

1-3-1- Main purpose

Determining the effectiveness of problem solving skill training in reducing conflicts between maladjusted couples and increasing satisfaction with the family life

1-3-2- Sub-purposes

1- Determining the effectiveness of problem-solving skill training and application in reducing problems of troubled families
2- Determining the effectiveness of problem-solving skill training and application in increasing adjustment in familial life
3- Investigating gender differences in rates of family adjustment
4- Investigating the impact of problem solving skill training on the marital adjustment according to gender

1-3-3- Applied purposes

- Results of the present research can be used by family counselors to reduce marital communication problems and optimize the relationship.
- Research findings can be used in pre and post-marital education to prevent problems. They can be also utilized in educational and therapeutic organizations and institutions of departments of psychology and counseling, welfare, family courts, and family training courses at schools.

1-4- Research variables

1-4-1- Predictive variable (independent):

In the present research, problem-solving skill training was considered as a predictive variable.

1-4-2- Criterion variable (dependent):

Marital maladjustment was studied as the criterion variable.

1-5- Research hypotheses

1-5-1- Main hypothesis

Problem-solving skill training reduces conflicts between maladjusted couples and increases satisfaction with family life.

1-5-2- Sub-hypotheses

1- There is a significant relationship between problem solving skill training and marital adjustment enhancement.
2- There is a significant difference between gender and marital adjustment.
3- There is a significant difference between effects of problem-solving skill training on the marital adjustment in terms of gender.
4- There is a significant difference between levels of marital adjustment on the basis of gender.

1-6- Definition of terms and variables

1-6-1- Conceptual definitions (theoretical)

1- Problem-solving problem training: Problem solving implies a cognitive or obvious behavioral process that provides potential effective responses to a problematic position. Problem solving includes a set of

organized engagements designed to solve conflicts of partners. (Burns et la, 2013).

2- Marital adjustment: The marital adjustment concept has a prominent place in the study of family and marital communication (Spanier, 1976). Marital adjustment can be defined as a process that is along with several consequences such as the difficulty in understanding sexual differences, personal and interpersonal anxiety, and marital satisfaction. Weak marital adjustment has a negative effect on the quality of life, adherence to treatment and sex. (Askins et al, 2009)
3- Marital maladjustment: Maladjusted couples are not satisfied with their marital life and communicate in a maladaptive manner. (Barkley et la, 2001)
4- Troubled Families: Conflict is the disagreement and opposition of two individuals, the incompatibility of views and goals, and the behavior, which is opposed to the other side, as well as the conflicts between individuals as the result of disagreement of interests and differences in goals and perceptions.
5- Marital Satisfaction: It is the proper performance and behavior of couples based on traditional, customary and legal tasks assigned to each of them in the form of family law and subculture. (D'Zurilla, 1986)

1-6-2- Practical definitions (operational)

1- Problem-solving skill training: Problem-solving skill is a set of techniques derived from life skills training courses and it is presented for couples in six 90-minute sessions according to the attached schedule.
2- Marital Adjustment Enhancement: It refers to a score that is obtained from testing the Dyadic Adjustment Scale (DAS).

3- Marital maladjustment: Maladjusted couples are those who referred to counseling centers for solving their marital problems and gained scores of a standard deviation below the average for DAS.

4- Troubled families: Couples who are maladjusted spiritually, intellectually and mentally, etc. In fact, unbridled and shaky families in which people have behavioral and personality disorders.

5- Marital Satisfaction: The marital satisfaction concept can be measured by ENRICH Marital Satisfaction Scale (EMS). This questionnaire is used to assess the marital satisfaction. Each scale of this questionnaire is related to an important aspect of marital life. Evaluation of these aspects within a marital relationship can describe potential problems of a couple, or indicate their strengths.

Chapter 2: Review of literature and theoretical framework

2-1- INTRODUCTION

Results of a major meta-analysis confirm that for child and adult focused mental health problems and relationship difficulties, family therapy is effective. The average treated case fares better than 70% of untreated control cases (Shadish e t al, 1993). This global conclusion is important because it underlines the value of family therapy as a viable intervention modality. Highlighting this overall conclusion is timely since currently increased emphasis is being placed upon evidence based practice by purchasers and providers of mental health services in the UK, the US, Ireland and elsewhere. However, such broad conclusions are of limited value. For in addition to broad statements about the effectiveness of family therapy, there is a clear requirement for specific evidence based statements about the precise types of family-based interventions which are most effective with particular types of problems (Carr, 1999, 2000, In Press).

The present Research addresses this question with particular reference to the following problems which occur during childhood and adolescence:

- Child abuse and neglect
- Conduct problems;
- Emotional problems
- Psychosomatic problems.

This particular list has been chosen because extensive computer based and manual literature searches showed that for each of these areas, controlled trials of family-based intervention have been reported. It is noteworthy that three of the problems listed above are framed in individualistic rather than systemic terms. This reflects a practice among researchers in the field to describe the cases they study in terms of the main presenting problem of one family member rather than the systemic difficulties of which the presenting

problems are but one aspect. One possible reason for this is that the funding of family therapy research is informed largely by an individualistic model of problems of living. It may also be argued that it is useful for practicing family therapists to be able to make claims for the effectiveness of their therapeutic approach in terms of individualistic problems or diagnoses, since this is currently the conceptual framework privileged by health service purchasers. Family therapists working within a social constructionist frame of reference, however, acknowledge that both individualistic and systemic frameworks are no more than social constructions whose validity rests upon their usefulness in helping clients resolve problems of living (Pearce, 1992).

In the following sections, where possible reference is made to important review papers and meta-analyses, when individual treatment outcome studies are cited, unless otherwise stated, these are controlled trials or comparative group outcome studies. Single case reports and single group outcome studies have been largely excluded from this review because this type of evidence is less compelling, than that provided by controlled studies, meta-analyses and review papers.

2-2- PHYSICAL CHILD ABUSE AND NEGLECT

Child abuse and neglect has devastating effects on the psychological development of children (Briere, Berliner et al, 1996). Estimates of the incidence of physical abuse range from less than 1% to more than 60%, depending on the definitions used (Gelles, 1987). One fifth of children on the British Child Protection Register for the year ending March 1993 were registered solely on the basis of neglect (Brown, 1995).

The aim of family therapy for cases in which child abuse has occurred is to restructure relationships and prevailing belief systems within the child's social system so that interaction patterns that contributed to abuse or neglect

will not recur. Significant subsystems for intervention include the child, the parents, the marital subsystem, the extended family, the school system, and the wider professional network. The results of a number of controlled trials show that effective interventions for the family and wider system within which physical child abuse and neglect occurs entail co-ordinated intervention with problematic subsystems based on a clear assessment of interaction patterns and belief systems that may contribute to abuse or neglect (Wesch & Lutzker 1991; Rzepnicki et al, 1994; Gaudin et al, 1990; Nicol et al, 1988; Brunk et al, 1987). For illustrative purposes two of these studies will be described.

Nicol et al. (1988), in a UK study compared the impact of social worker facilitated family-focused casework and individual child play therapy for cases at risk for physical abuse or neglect. Family casework was a home-based intervention which included behavioral family assessment and feedback followed by a programme of family-focused problem-solving therapy. This included parental instruction in behavioral child management principles, family crisis intervention, and reinforcement of parents for engaging in the casework processes. As a result of the intervention the average treated family was displaying less coercive behavior than 76% of the untreated families (Edgeworth & Carr, 2000).

Brunk et al. (1987) compared the effectiveness of multi-systemic family therapy and behavioral parent training on families where physical abuse or neglect had occurred. Multi-systemic family therapy was based on an assessment of family functioning and involved conjoint family sessions, marital sessions, individual sessions and meetings with members of the wider professional network and extended family as appropriate (Henggeler & Borduin, 1990). Interventions included joining with family members and members of the wider system, reframing interaction patterns and prescribing

tasks to alter problematic interaction patterns within specific subsystems. Therapists designed intervention plans on a per-case basis in light of family assessment and received regular supervision to facilitate this process. In the behavioral parent training program, parents received treatment within a group context. The program included instruction in child development and the principles of behavioral management including the use of reward systems and time out routines. Following treatment both groups showed significant improvement in parental and family stress but cases who received multi-systemic therapy showed greater improvements in family problems and parent child interaction.

In developing services for families in which physical abuse has occurred, programme that begin with a comprehensive network assessment and include along with regular family therapy sessions the option of parent-focused and child-focused interventions should be prioritized. To maximize the impact of such programmes, given our current state of knowledge, they would probably need to run over a minimum of a 6 month period. For such programmes to be practically feasible, at least two therapeutically trained staff would be required and they would need to be provided with adequate administrative support and therapeutic supervision.

2-3- CONDUCT PROBLEMS

The effectiveness of family therapy and family based interventions for four distinct but related categories of conduct problems will be considered in this section.

2-3-1- Oppositional behavioral difficulties

Preadolescent children who present with oppositional behavioral problems, temper tantrums, defiance, and non-compliance confined largely to

the family, school and peer group constitute a third to a half of all referrals to child and family mental health clinics and prevalence rates for clinically significant levels of oppositional behavioral problems in the community vary from 2% to 16%(APA, 1994; WHO, 1992; Kazdin, 1995). Oppositional behavioral problems are of particular concern because in the longer term they may lead to adolescent conduct problems and later life difficulties.

Oppositional behavioral difficulties tend to develop gradually within the context of coercive patterns of parent-child interaction and a lack of mutual parental support (Patterson, 1982). When coercive interaction cycles occur the child repeatedly refuses in an increasingly aggressive way to comply with parents' requests despite escalating parental demands. Such cycles conclude with the parent withdrawing. The probability that the cycle will repeat is increased because the parent's withdrawal offers relief to both the parent and the child. The parent is relieved that the child is no longer aggressively refusing to comply with parental requests and the child is relieved that the parent is no longer demanding compliance. As the frequency of such coercive interaction cycles increases, the frequency of positive parent-child interaction decreases. Coercive parent-child interaction patterns are commonly associated with low levels of support between parents or extra-familial support and may be exacerbated by high levels of family stress (Lehmann & Dangel, 1998). Coercive interaction cycles are also associated with belief systems in which parents attribute the child's difficult behavior to internal characteristics of the child rather than external characteristics of the situation (Barton & Alexander, 1981)

Serketich and Dumas (1996) in a meta-analysis of over 100 studies of behavioral parent training concluded that for childhood oppositional behavioral problems it was a highly effective treatment. Behavioral parent training focuses on helping parents develop the skills to monitor specific

positive and negative behaviors and to modify these by altering their antecedents and consequences (e.g., Forehand & Long, 1996; Forehand & McMahon, 1981). For example, parents are coached in prompting their children to engage in positive behaviors and preventing children from entering situations that elicit negative behaviors. They are also trained to use reward systems such as star charts or tokens to increase positive behaviors and time-out to reduce negative behaviors. Behavioral parent training is probably so effective because it offers parents a highly focused way to supportively co-operate with each other in disrupting the coercive parent-child interaction patterns that maintain children's oppositional behavior problems. It also helps parents develop a belief system in which the child's difficult behavior is attributed to external situational characteristics rather than to intrinsic characteristics of the child.

The impact of a variety of formats on the effectiveness of behavioral parent training has been investigated and the results of these studies allow the following conclusions to be drawn. Behavioral parent training is most effective for families with children who present with oppositional behavioral problems when offered intensively over at least 20 sessions; exclusively to one family rather than in a group format; and as part of a multi-systemic and multimedia intervention package which includes concurrent individual child-focused problem-solving skills training with video-modeling for both parents and children (Kazdin et al, 1992; Webster-Stratton & Hammond, 1997). Such intensive, exclusive, multi-systemic, multimedia programmes are more effective than less intensive, group based, behavioral parent training alone, child-focused problem-solving skills training alone, or video modeling alone with minimal therapist contact. Where a primary caretaker (typically a mother) is receiving little social support from her partner, then including a component to enhance the social support provided by the partner into a

routine behavioral parent training programme may enhance the programme's effectiveness (Dadds et al, 1987)

These conclusions have implications for service development. Services should be organized so that comprehensive child and family assessment is available for cases referred where preadolescent conduct problems are the central concern. Where it is clear that cases have circumscribed oppositional behavioral problems without other difficulties, behavioral parent training with video-modeling may be offered to parents and child-focused problem-solving training may be offered to children. Each programme should involve at least 20 sessions over a period of 3-6 months. Where there is evidence of marital discord both parents should be involved in treatment with the focus being on one parent supporting the other in implementing parenting skills in the home situation. Where service demands greatly outweigh available resources, cases on the waiting list may be offered video-modeling based behavioral parent training with minimal therapist contact as a preliminary intervention. Following this intervention cases should be reassessed and if significant behavioral problems are still occurring they should be admitted to a combined 40 session programme behavioral parent training with video-modeling and child-focused problem-solving training.

2-3-2- Attentional and over-activity problems

Attention deficit hyperactivity disorder is now the most commonly used term for a syndrome characterized by persistent overactivity, impulsivity and difficulties in sustaining attention (Hinshaw, 1994; APA, 1994; WHO, 1992). The syndrome is a particularly serious problem because youngsters with the core difficulties of inattention, over-activity and impulsivity which are usually present from infancy may develop a wide range of secondary academic and relationship problems as they develop through the lifecycle. Available

evidence suggests that vulnerability to attentional and over-activity problems, unlike oppositional behavioral problems discussed in the preceding section is largely constitutional, although the precise role of genetic, prenatal and perinatal factors in the etiology of the condition are still unclear. Using DSM IV criteria for attention deficit hyperactivity disorder, a prevalence rate of about 3% to 5% has been obtained in community studies (APA, 1994).

Hinshaw et al. (1998) and Barkley (1990) following extensive literature reviews have concluded that family based multimodal programmes are currently the most effective for children with attentional and over-activity problems. Multimodal programmes typically include stimulant treatment of children with drugs such as methylphenidate combined with family therapy or parent training; school based behavioral programmes; and coping skills training for children (e.g., Horn et al, 1991; Ialongo et al, 1993). Family based multimodal programmes are probably effective because they provide the family with a forum within which to develop strategies for managing a chronic disability. As in the case of oppositional behavioral problems discussed above, both behavioral parent training and structural family therapy helps parents and children break out of coercive cycles of interaction and to develop mutually supportive positive interaction patterns. Both family therapy and parent training help parents develop benign belief systems where they attribute the child's difficult behavior to either the disability (attention deficit hyperactivity disorder) or external situational factors rather than to the child's negative intentions. School based behavioral programmes have a similar impact on school staffs' belief systems and behavior. Stimulant therapy and coping skills training help the child to control both their attention to academic tasks and their activity levels. Stimulant therapy, when given in low dosages, helps children to both concentrate better and sit still in classroom situations. High dosage levels have a more marked impact on over-

activity but impair concentration and so are not recommended. Coping skills training, helps children to use self-instructions to solve problems in a systematic rather than an impulsive manner.

In cases of attentional and overactivity problems, effective family therapy focuses on helping families to develop patterns of organization conducive to effective child management (Barkley et al, 1992). Such patterns of organization include a high level of parental co-operation in problem-solving and child management; a clear intergenerational hierarchy between parents and children; warm supportive family relationships; clear communication; and clear moderately flexible, rules, roles and routines.

Parent training, as described in the previous section on oppositional behavioral problems, focuses on helping parents develop the skills to monitor specific positive and negative behavior and to modify these by altering those interactions and events that occur before and after them (e.g. Barkley, 1987). School based behavioral programmes in cases of attentional and overactivity problems, involve the extension of home based behavioral programmes into the school setting through home-school, parent-teacher liaison meetings (Braswell & Bloomquist, 1991; DuPaul & Eckert, 1997). Coping skills focuses largely on coaching children in the skills required for sustained attention and systematic problem solving (Baer & Nietzel, 1991; Kendall & Braswell, 1985). These skills include identifying a problem to be solved; breaking it into a number of solvable sub-problems; tackling these one at a time; listing possible solutions; examining the costs and benefits of these; selecting the most viable solution; implementing this; monitoring progress; evaluating the outcome; rewarding oneself for successful problem solving; modifying unsuccessful solutions; and monitoring the outcomes of these revised problem-solving plans.

In terms of service, multi-component treatment packages combined with low dose stimulant therapy are the treatments of choice for youngsters with attentional and over-activity problems. In the short term, effective multi-component treatment should probably include 30 sessions over 12 weeks, with 12 sessions for the family, 12 for the child and 6 liaison meetings with the school. For effective long-term treatment, it is probable that a chronic care model of service delivery is required. Infrequent but sustained contact with a multidisciplinary service over the course of the child's development should be made available to families of children with attentional and overactivity problems. It is likely that at transitional points within each yearly cycle (such as entering new school classes each autumn) and at transitional points within the lifecycle (such as entering adolescence, changing school, or moving house) increased service contact would be required.

2-3-3- Pervasive conduct problems in adolescence

Pervasive and persistent antisocial behavior which extends beyond the family to the community; involves serious violations of rules or law-breaking; and is characterized by defiance of authority, aggression, destructiveness, deceitfulness, cruelty, problematic relationships with parents, teachers and peers and typically leads to multiagency involvement is referred to as conduct disorder (APA, 1994; WHO, 1992). Conservative prevalence rates for conduct disorder range from 2% to 6% (Kazdin, 1995).

From a developmental perspective, persistent adolescent conduct problems begin during the preschool years as oppositional behavioral problems, described in an earlier section. For about a third of children these evolve into pervasive conduct problems in adolescence and antisocial personality disorder in adulthood (Loeber & Stouthamer-Loeber, 1998). Three

classes of risk factors increase the probability that preschool oppositional behavior problems will escalate into later life difficulties, i.e. child characteristics, parenting practices, and family organization problems (Lehmann & Dangel, 1998). Impulsivity, inattention and over-activity (the core features of attention deficit hyperactivity disorder described in the previous section) are the main personal characteristics of children that place them at risk for long-term conduct problems. Coercive family processes (described previously in relation to oppositional behavior problems), which involve ineffective monitoring and supervision of children, providing inconsistent consequences for rule breaking, and failing to provide reinforcement for positive social behavior are the main problematic parenting practices that place children at risk for long- term conduct difficulties. The family organization problems associated with persistence of conduct problems into adolescence and adulthood are parental conflict and violence; a high level of intra-familial and extra-familial stress; a low level of social support; and parental psychological adjustment problems such as depression or substance abuse.

Kazdin (1998) in a review of empirically supported interventions for conduct disorders concluded that functional family therapy and multi-systemic therapy were among the more promising treatments available for adolescents with pervasive conduct problems. Chamberlain and Rosicky (1995) in a review of family-based interventions concluded that treatment foster care may be the most effective intervention for cases of conduct disorder where outpatient family-based approaches have failed.

Functional family therapy aims to reduce the overall level of disorganization within the family and thereby modify chaotic family routines and communication patterns which maintain antisocial behavior (Parsons & Alexander, 1973; Alexander & Parsons, 1973; Gordon &, 1988). Functional

family therapy focuses on facilitating high levels of parental co-operation in problem-solving around the management of teenagers' problem behavior; clear intergenerational hierarchies between parents and adolescents; warm supportive family relationships; clear communication; and clear family rules, roles and routines. Within functional family therapy it is assumed that if family members can collectively be helped to alter their problematic communication patterns and if the lack of supervision and discipline within the family is altered, then the youngsters conduct problems will improve (Alexander & Parsons, 1982). This assumption is based on the finding that the families of delinquents are characterized by a greater level of defensive communication and lower levels of supportive communication compared with families of non-delinquent youngsters (Alexander, 1973), and also have poorer supervision practices. With functional family therapy, all family members attend therapy sessions conjointly. Initially family assessment focuses on identifying patterns of interaction and beliefs about problems and solutions that maintain the youngsters conduct problems. Within the early therapy sessions parents and adolescents are facilitated in the development of communication skills, problem-solving skill and negotiation skills. There is extensive use of relabelling and reframing to reduce blaming and to help parents move from viewing the adolescent as intrinsically deviant to someone whose deviant behavior is maintained by situational factors. In the later stages of therapy there is a focus on the negotiation of contracts in which parents offer adolescents privileges in return for following rules and fulfilling responsibilities.

While, functional family therapy focuses exclusively on altering factors within the family system so as to ameliorate persistent conduct problems, multi-systemic therapy in addition addresses factors within the adolescent and within the wider social system. Effective multi-systemic therapy, offers

individualized packages of interventions which target conduct problem-maintaining factors within the multiple social systems of which the youngster is a member (Henggeler et al, 1986, 1992, 1993; Mann et al, 1980; Scherer et al, 1994; Borduin et al, 1995a, 1995b). These multiple systems include the self, the family, the school, the peer group and the community. Multi-systemic interventions integrate family therapy with self-regulation skills training for adolescents; school based educational and recreational interventions; and interagency liaison meetings to co-ordinate multiagency input. In multi-systemic therapy it is assumed that if conduct problem maintaining factors within the adolescent, the family, the school, the peer group and the wider community are identified, then interventions may be developed to alter these factors and so reduce problematic behavior (Henggeler & Borduin, 1990). Following multi-systemic assessment where members of the adolescent's family and wider network are interviewed, a unique intervention programme is developed which targets those specific subsystems which are largely responsible for the maintenance of the youngster's difficulties. In the early stages of contact the therapist joins with system members and later interventions focus on reframing the system members' ways of understanding the problem or restructuring the way they interact around the problems. Interventions may focus on the adolescent alone; the family; the school; the peer group or the community. Individual interventions typically focus on helping youngsters develop social and academic skills. Improving family communication and parents' supervision and discipline skills are common targets for family intervention. Facilitating communication between parents and teachers and arranging appropriate educational placement are common school-based interventions. Interventions with the peer group may involve reducing contact with deviant peers and increasing contact with non-deviant peers.

In contrast to functional family therapy which focuses exclusively on the family system or multi-systemic therapy which addresses, in addition to family factors, both individual factors and the wider social network, treatment foster care deals with the problem of pervasive conduct problems by linking the adolescent and his or her family to a new and positive system: the treatment foster family. In treatment foster care, carefully selected and extensively trained foster parents in collaboration with a therapist offer adolescents a highly structured foster care placement over a number of months in a foster family setting (Kirgin et al, 1982; Chamberlain et al, 1990, 1991). Treatment foster care aims to modify conduct problem maintaining factors within the child, family, school, peer group and other systems by placing the child temporarily within a foster family in which the foster parents have been trained to use behavioral strategies to modify the youngsters deviant behavior (Chamberlain, 1994). Adolescents in treatment foster care typically receive a concurrent package of multi-systemic interventions to modify problem maintaining factors within the adolescent, the birth family, the school, the peer group and the wider community. These are similar to those described for multi-systemic therapy and invariably the birth parents complete a behavioral parent training programme so that they will be able to continue the work of the treatment foster parents when their adolescent visits or returns home for the long term. A goal of treatment foster care is to prevent the long-term separation of the adolescent from his or her biological family so as progress is made the adolescent spends more and more time with the birth family and less time in treatment foster care.

With respect to service development, it may be most efficient to offer services for adolescent conduct problems on a continuum of care (Chamberlain & Rosicky, 1995). Less severe cases may be offered functional family therapy, up to 40 sessions over a 1 year period. Moderately severe

cases and those that do not respond to circumscribed family interventions may be offered multi-systemic therapy up to 20 hours per month over a period of up to 4 years. Extremely severe cases and those who are unresponsive to intensive multi-systemic therapy may be offered treatment foster care for a period of up to year and this may then be followed with ongoing multi-systemic intervention. It would be essential that such a service involve high levels of supervision and low case loads for front line clinicians because of the high stress load that these cases entail and the consequent risk of therapist burnout.

2-3-4- Adolescent drug abuse

While experimentation with drugs in adolescence is widespread, problematic drug abuse is less common. A conservative estimate is that between 5 and 10% of teenagers fewer than 19 have drug problems serious enough to require clinical intervention (Schinke, Botvin & Orlando, 1991; Liddle & Dakof, 1995; Buckstein, 1995; Pagliaro & Pagliaro, 1996). Drug abuse often occurs concurrently with other conduct problems, learning difficulties and emotional problems and drug abuse is also an important risk factor for suicide in adolescence.

Liddle and Dakof (1995) and Waldron (1996) in literature reviews of a series of controlled clinical trials, concluded that family-based therapy (which includes both family therapy and multi-systemic therapy) is more effective than other treatments in engaging and retaining adolescents in therapy and also in the reduction of drug use. From their meta-analysis of controlled family-based treatment outcome studies Stanton and Shadish (1997) concluded that family-based therapy is more effective in reducing drug abuse than individual therapy; peer group therapy; and family psychoeducation. Furthermore, family-based therapy leads to fewer drop-outs from treatment

compared with other therapeutic approaches. Their final conclusion was that while family-based therapy is effective as a stand-alone treatment modality, it can also be effectively combined with other individually based approaches and lead to positive synergistic outcomes. Thus, family therapy can empower family members to help adolescents engage in treatment; remain committed to the treatment process; and develop family rules, roles, routines, relationships, and belief systems which support a drug free lifestyle. In addition family therapy can provide a context within which youngsters could benefit from individual, peer group or school based interventions.

Family systems theories of drug abuse implicate family disorganization in the etiology and maintenance of seriously problematic adolescent drug taking behavior and there is considerable empirical support for this view (Stanton, & Heath, 1995; Szapocznik & Kurtines, 1989; Hawkins, Catalano & Miller, 1992). Family based interventions aim to reduce drug abuse by engaging families in treatment and helping family members reduce family disorganization and change patterns of family functioning in which the drug abuse is embedded.

Effective systemic engagement, which may span up to 8 sessions, involves contacting all significant members of the adolescent's network directly or indirectly, identifying personal goals and feared outcomes that family members may have with respect to the resolution of the adolescents drug problems and the family therapy associated with this, and then framing invitations for resistant family members to engage in therapy so as to indicate that their goals will be addressed and feared outcomes will be avoided (Szapocznik et al, 1988; Santiseban et al, 1996). Once families engage in therapy, effective treatment programmes for adolescent drug abuse involve the following processes which while overlapping, may be conceptualized as stages of therapy: problem definition and contracting; becoming drug free;

facing denial and creating a context for a drug free lifestyle; family reorganisation; disengagement and planning for relapse prevention (Stanton & Heath, 1995). The style of therapy that has been shown to be effective with adolescent drug abusers and their families has evolved from the structural and strategic family therapy traditions (Minuchin, 1974; Haley, 1980). Effective family therapy in cases of adolescent drug abuse helps family members clarify communication, rules, roles, routines hierarchies and boundaries; resolve conflicts; optimize emotional cohesion; develop parenting and problem-solving skills; and manage lifecycle transitions.

Multi-systemic ecological treatment approaches to adolescent drug abuse represent a logical extension of family therapy. They are based on the theory that problematic processes, not only within the family but also within the adolescent as an individual and within the wider social system including the school and the peer group may contribute to the etiology and maintenance of drug abuse (Henggeler & Borduin, 1990). This conceptualization of drug abuse is supported by considerable empirical evidence (Hawkins, Catalano and Miller, 1992; Henggeler et al, 1991). At a personal level, adolescent drug abusers have been shown to have social skills deficits, depression, behavior problems and favorable attitudes and expectations about drug abuse. As has previously been outlined, their families are characterized by disorganization and in some instances by parental drug abuse. Many adolescent drug abusers have experienced rejection by prosocial peers in early childhood and have become members of a deviant peer group in adolescence. Within a school context drug abusers show a higher level of academic failure and a lower commitment to school and academic achievement compared to their drug-free counterparts. Multi-systemic ecological intervention programmes for adolescent drug abusers, like those for adolescents with pervasive conduct problems described earlier, have evolved out of the structural and strategic

family therapy traditions (Henggeler & Borduin, 1990). In each case treated with multi-systemic therapy, around a central family therapy intervention programme, an additional set of individual, school-based and peer-group based interventions are offered which target specific risk factors identified in that case. Such interventions may include self-management skills training for the adolescent, school-based consultations or peer-group based interventions. Self-management skills training may include coaching in social skills, social problem-solving and communication skills, anger control skills, and mood regulation skills. School based interventions aim to support the youngsters continuation in school, to monitor and reinforce academic achievement and prosocial behavior in school, and to facilitate home-school liaison in the management of academic and behavioral problems. Peer group interventions include creating opportunities for prosocial peer group membership and assertiveness training to empower youngsters to resist deviant peer group pressure to abuse drugs.

With respect to service development, the results of controlled treatment trials suggest that, a clear distinction must be made between systemic engagement procedures and the process of family therapy, with resources devoted to each. Following comprehensive assessment, where there is clear evidence that factors within the individual or the wider system are maintaining the youngsters drug abuse, a multi-systemic approach should be taken. If youngsters have problem-solving, social skills, or self-regulation sills deficits, training in these should be provided. Where school-based factors are contributing to the maintenance of drug abuse, school based interventions should be offered. Where deviant peer group membership is maintaining drug abuse, alternative peer group activities should be arranged.

2-4- EMOTIONAL PROBLEMS

The effectiveness of family therapy for anxiety, depression and grief following bereavement will be considered in this section.

2-4-1- Anxiety

While all children have developmentally appropriate fears, some are referred for treatment of anxiety problems when their fears prevent them from completing developmentally appropriate tasks such as going to school or socializing with friends. The overall prevalence for clinically significant fears and anxiety problems in children and adolescents is approximately 2% to 9% (Anderson, 1994; APA, 1994; WHO, 1992). With respect to age trends, simple phobias and separation anxiety are more common among preadolescents and generalized anxiety disorder, panic disorder, social phobia, and obsessive compulsive disorder are more common among adolescents (Klein, 1994).

The effectiveness of family based treatments for anxiety problems has been evaluated in number of studies (Graziano & Mooney, 1980; Kanfer et al, 1975; Blagg et al, 1984; Barrett et al, 1996; March, 1995). For darkness phobia, Graziano and Mooney (1980) found that a brief family based treatment programme was effective in reducing children's fear of the dark. Parents were coached in how to prompt and reinforce their children's courageous behavior while not reinforcing anxious behavior. Concurrently children were given coping skills training which focused on helping them to develop relaxation skills and to use self-instructions to enhance a sense of control and competence in managing the dark. Similar findings were obtained in another similar study (Kanfer et al, 1975).

Blagg and Yule (1984) found that behavioral family therapy was more effective than a hospital-based multimodal inpatient programme and a home

tuition and psychotherapy programme for the treatment of school phobia. Behavioral family therapy included detailed clarification of the child's problem; discussion of the principal concerns of the child, parents and teacher; development of contingency plans to ensure maintenance of gains once the child returned to school; a rapid return to school plan; and follow-up appointments with parents and teachers until the child had been attending school without problems for at least 6 weeks. A year after treatment, 93% of children that received family based behavior therapy were judged to have been successful in returning to school compared with 38% of children in the multimodal inpatient programme and 10% of those from the home tuition and psychotherapy programme.

Barrett et al's (1996) found that a family based programme for children with severe generalized anxiety problems was more effective than an individual coping skills training programme. In the family based programme both parents and children attended separate group sessions and some concurrent family therapy sessions and were coached in anxiety management, problem solving and communications skills and the use of reward systems. In the anxiety management sessions parents and children learned to monitor and challenge unrealistic catastrophic beliefs and to use relaxation exercises and self-instructions to cope with anxiety provoking situations. In the problem solving and communication skills sessions, coaching in speaking and listening skills occurred and families learned to manage conflict and solve family problems systematically. In the reward systems sessions, parents learned to reward their children's courageous behavior and ignore their anxiety-related behaviors and children were involved in setting up reward menus. A year after treatment 90% of those that participated in the family based programme were recovered compared with 70% of those in the individual programme.

March, Mulle and Herbel (1994) found that 80% of children with obsessive compulsive disorder (OCD) in a single group outcome study showed clinically significant improvement after treatment and this was maintained at follow-up following a family-based intervention programme and pharmacological treatment with clomipramine. The family treatment programme, *How I ran OCD of my Land* (March & Mulle, 1998), was based on Michael White's narrative therapy externalization procedure and behavioral family therapy. In the narrative therapy externalization component of the programme the child and parents were helped to view obsessive compulsive disorder as a medical illness separate from the youngster's core identity. Children were encouraged to externalize the disorder by giving it a nasty nickname and to make a commitment to driving this nasty creature out of their lives. They then were helped to map out a graded hierarchy of situations that elicited obsessions and led to compulsions of varying degrees and those situations in which the child successfully controlled these symptoms were noted. These situations were subsequently monitored on a weekly basis, since increases in the number of these reflected therapeutic progress. In the behavioral family therapy component of the programme children were coached in coping with anxiety by using self-instruction and relaxation skills. Parents were coached to support and reward their children through the process of facing anxiety provoking situations while avoiding engaging in compulsive anxiety reducing rituals.

In developing services for children with anxiety disorders, account should be taken of the fact that the majority of anxiety disorders in children can be effectively treated in programmes ranging from 3-24 sessions. Core features of successful family based programmes include creating a context within family therapy that allows the child to eventually enter into anxiety

provoking situations and to manage these through the use of personal coping skills, parental support and encouragement.

2-4-2-Depression and grief

Major depression is a recurrent condition involving low mood; selective attention to negative features of the environment; a pessimistic cognitive style; self-defeating behavior patterns; a disturbance of sleep and appetite; and a disruption of interpersonal relationships (APA, 1994; WHO, 1992; Harrington, 1993; Kovacs, 1997; Reynolds & Johnson, 1994). In community samples prevalence rates of depression in preadolescence range from 0.5% to 2.5% and in adolescents from 2% to 8% while 25% of referrals to child and adolescent clinics have major depression (Harrington, 1993).

There is strong evidence that both genetic and family environment factors contribute to the etiology of depression (Reynolds & Johnson, 1994). Parental criticism, poor parent-child communication and family discord have all been found to be associated with depression in children and adolescents. Integrative theories of depression propose that episodes occur when genetically vulnerable youngsters find themselves involved in stressful social systems in which there is limited access to socially supportive relationships.

Conjoint family therapy and concurrent group based parent and child training sessions have been found to be as effective as various individual therapies in the treatment of major depression in (Brent et al, 1997; Harrington et al, 1998; Lewinsohn et al, 1990, 1996). Effective family therapy and family based interventions aim to decrease the family stress to which the youngster is exposed and enhance the availability of social support to the youngster within the family context. Core features of all effective family interventions include the facilitation of clear parent-child communication; the promotion of systematic family based problem-solving; and the disruption of

negative critical parent-child interactions. With respect to clinical practice the results of these studies suggest that brief family therapy, ranging from 5-14 sessions, is a viable intervention for depressed children and adolescents.

Between 3 and 5% of children fewer than 18 lose a parent by death (Garmezy & Masten, 1994). Worden (1997) in a major US study of parental bereavement found that a year after parental death 19% of children continued to show clinically significant grief related adjustment problems. In a UK study Black et al. (1987) found that for children bereaved through the death of a parent, a 6 session home-based family therapy programme which focused on grief work led to significant improvements in both child and parental adjustment in the short and long-term. Sandler et al. (1992) found that a similar family based programme for bereaved children reduced their depressive symptoms. With respect to practice, therefore, the results of these two studies suggest that following parental death, brief family therapy may be offered to bereaved children who show sustained grief related adjustment problems.

2-5- PSYCHOSOMATIC PROBLEMS

The effectiveness of family therapy for a number of common childhood psychosomatic complaints and anorexia nervosa in adolescence will be addressed in this section.

2-5-1-Common childhood psychosomatic complaints

The effectiveness of family therapy and family based interventions has been evaluated for a limited number of common childhood physical and psychosomatic complaints. These include toileting problems, unexplained stomach aches and poorly controlled asthma. Evidence concerning the impact of family interventions with these conditions will be addressed below.

The development of bladder and bowel control occurs for most children during the first five years of life (Buchanan, 1992; Shaffer, 1994; Fielding & Doleys. 1988). The absence of bladder and bowel control by the age of four or five years has a negative impact on children's social and educational development and so may be a focus for clinical intervention. At five years of age the prevalence of wetting among five year olds is 7% for males and 3% for females, while the prevalence of soiling is about 1% (APA, 1994). A review by Houts et al. (1994) of 78 studies of treatments for bed-wetting found that children benefited more from family-based psychosocial interventions than from pharmacological treatments. 66% of children who were treated with a parent-based urine alarm programme, where the child was awoken immediately wetting began by a bell activated by a urine trigger pad and rewarded by parents for doing so, ceased bed wetting following treatment and at follow-up some months later 51% had not relapsed. In comparison, commonly used medications such as imipramine led to no more than 46% of cases becoming dry following treatment and at follow-up, only 22% had not relapsed.

Thapar et al. (1992) reviewed literature on a wide range of interventions for soiling and concluded that combined family-based behavioral therapy, laxative use and increased dietary fibre was the most effective treatment for children with soiling problems. In these programmes behavioral family therapy involved coaching the family in using reward systems so that children were rewarded by parents for following through on toileting routines negotiated during family therapy sessions. In a recent UK study, Silver et al. (1998) found that a treatment programme based on Michael White's narrative therapy externalizing procedure was more effective than traditional behavioral programmes for soiling (White & Epston, 1989). In this type of family therapy, the soiling problem was externalized and defined as

distinct and separate from the child. The soiling problem was referred to as *Sneaky Poo*. Therapy then focused on the child, the parent and the therapist collaborating in developing a narrative in which the child and family were construed as capable of outwitting and defeating *Sneaky Poo*. In Silver et al's (1998) study, 63% of cases treated with narrative family therapy were not soiling at 6 months follow-up compared with 37% of those treated with behavioral procedures. In terms of service development, from this review it may be concluded that family based urine alarm programmes and family therapy which includes externalization procedures may effectively be used for wetting and soiling problems respectively.

Recurrent abdominal pains - or Monday morning stomach aches as they are colloquially known - are defined as stomach aches which have occurred on three or more occasions over a 3 month period; which were severe enough to affect the child's routine activities such as going to school; and for which no specific organic cause has been found (Apley & Nash, 1958). Recurrent abdominal pain may occur as part of a wider constellation of complaints including nausea, vomiting, headache, limb or joint pains. Recurrent abdominal pain occurs in 10-20% of school aged children and accounts for 2-4% of pediatric consultations (Garralda, 1992). Sanders et al. (1994) found that behavioral family therapy was more effective than standard medical care in the treatment of recurrent abdominal pain. The behavioral family therapy programme included relaxation training and coping skills training for the child. Parents were trained to prompt children to use their pain control skills and to reward and praise them for doing so. The programme was offered over 10 sessions spanning 6 weeks. After treatment 71% of cases treated with behavioral family therapy were recovered compared with 38% of controls. At 1 year follow-up 82% of treated cases were pain free compared with 43% of

controls. With respect to practice, such a programme may be routinely offered on an outpatient basis.

Asthma is a chronic respiratory condition which affects 10-15% of the population (Davies, 1998). In poorly controlled asthma there may be inadequate adherence to medical treatment, inadequate environmental control, and problematic family organization (Davies, 1998; Wood, 1994). Medical treatment typically includes regular inhalation of agents which have a long range preventative effect (e.g. Becotide) and agents which have a short term positive impact on respiration (e.g. Ventolin). Environmental control for asthma includes minimizing the child's exposure to allergens such as dust, smoke, pollen, cold air and domestic pets. Patterns of family organization which exacerbate asthma include rigid enmeshed relationships between the child and a highly anxious parent; triangulation where the child is required, usually covertly, to take sides with one or other parent in a conflict; or a chaotic family environment where parents institute no clear rules and routines for children's daily activities or medication regime (Wood, 1994). Family therapy aims to alter these problematic family organizational patterns; to enhance the child's medication adherence; and to help both the parents and the child develop routines to control environmental allergens. Two controlled trials of family therapy for children with poorly controlled asthma have been conducted (Lask & Matthew, 1979; Gustafsson et al, 1986). The positive results of these studies suggest that in pediatric care, asthmatic control may be fostered by short term family therapy which aims to enhance family communication and problem solving concerning the management of children's asthma and which aims to increase children's autonomy over the management of their condition.

For conditions discussed in this section, it must be highlighted that it is vital that pediatric medical screening be conducted before embarking on

family therapy so that treatable medical conditions may be identified and so that clear advice on appropriate medical management and interdisciplinary collaboration may be arranged.

2-5-2-Anorexia

The prevalence of anorexia nervosa- a syndrome where the central feature is self-starvation - among teenage girls is about 1% (APA, 1994; WHO, 1992). Wilson and Fairburn (1998) in a recent extensive literature review concluded that family therapy and combined individual therapy and parent counseling with and without initial hospital based feeding programmes are effective in treating anorexia nervosa (e.g. Crisp et al, 1991; Hall & Crisp, 1987; Robin et al, 1995; Le Grange et al, 1992; Russell et al, 1987; Eisler et al, 1997). They also concluded that inpatient re-feeding programmes must be supplemented with outpatient follow-up programmes if weight gains made while in hospital are to be maintained following discharge. Key elements of effective treatment programmes include engagement of the adolescent and parents in treatment; psychoeducation about the nature of anorexia and risks associated with starvation; weight restoration and monitoring; shifting the focus from the nutritional intake to normal psychosocial developmental tasks of adolescence; facilitating the adolescent's individuation and increasing autonomy within the family; and relapse prevention. Structural family therapy (Minuchin et al, 1978) and Milan systemic family therapy (Selvini Palazzoli, 1978) are the main treatment models that have influenced the types of therapies evaluated in these treatment trails. With respect to service development, available evidence suggests that for youngsters with eating disorders effective treatment involves up to 18 outpatient sessions over periods a long as 15 months. Initial hospitalization for weigh restoration is

essential where medical complications associated with weight loss or bingeing and purging place the youngster at risk.

2-6- Parents and Families Healthy and Unhealthy

Guardian or family members of those who are troubled and unhealthy, think natural family, have a good and efficient. Good use of words to describe the head and members of their families to do their jobs can not mean the family is intact. Healthy families need beyond housing, food, education and sexual and physical security of its members to meet. Dysfunctional family, the family is clearly ab normal, bad, and is inefficient. On the contrary non-intact families often appear to be natural and good. These families in their appearance, they look good. Unlike many parents, and information, social trauma, and there are clear reasons. Sometimes the damage is very similar in many different and equally well. Many parents worry about their child's future. A group of people that their relationships with each other based on the time of blood And relatives are considered to be the same. Or a group of persons through marriage, together Blood or adoption, with each other as husband, wife, mother, father, brother, sister and son in Interactions are created and shared culture and live

In a particular unit, combination of family that individuals of blood, marriage, and child factors are associated with each other. During an unspecified period of time, living with family is linked with the Marriage, if the sexual relations, which have been approved by the community, are relevant. Family, social group is the adult (male and female) in terms of sex, living together Are. Economically, they are working. With one or more children are. The definitions can be summarized in three axes:

A. - family based on marriage between two the opposite sex takes place.

B - The relative relationship (formal or actual) or causal relationship between members There.

C - In addition to biological function (reproduction), the educational function, it is expected also for educational and economic. However, a quick look at the course of evolution Family, shows that this ancient institution, in his long life,

Especially during As is well known contemporary changes. That it is difficult to give a comprehensive definition. From this perspective, our stereotypes of the family of a husband, wife and children combine Is, according to family structure throughout human history, so it's not true. Provide a definition of contemporary

sociologists Avoid generalizations about their families, rather than the precise form of words, always talk of family, Work will take terms that appear in this particular aspect of the institution Study is to clarify and define the modal Therefore, the terms Because a single nuclear family, group home and relationships will be used. The most important components and Characteristics of the family during the later period of the challenges faced the axes can be summarized: The official Wedding and socially acceptable, the man and woman. Sexual and biological (reproduction) between husband and wife. Forming relationships and Relative relationships (actual or contractual), and causal relationships. Cross biological functions (such as Operation of educational, economic, psychological and emotional).

2-6-1-Nuclear and extended family:

William J. Goode's Family Nuclear weapons to "the fundamental unit that consists of a husband and wife and children", meaning usually consists of a man, woman, or women's and their unmarried children. Or nuclear family, "a family in which a married couple (or one of Parents) with their children or

adopted children live. "Nuclear family, the most ancient and at the same time, the most common family type is. "In our family, three generations or further, the relative relationship to each other, instead of that." Accordingly, a family May include a grandfather, Jeddah, married couples and their children is likely. Encyclopedia of Social

Sciences, from another angle (low to high), family The military has a broad definition, such as the Chinese family, a husband and wife Families and the sons married and unmarried sons and daughters and grandchildren and the results of Has. This family, which most Western societies and Africa can be seen, in comparison with the nuclear family, many of the privileges would:

* In large families, family members may need in case of persons Many get help, for example, elderly patients, the disabled and protect the family Wide, less than a couple of families over time are because of their cost burden on one or two No. Thus, each individual effort and responsibility under the load is less.

** Family Wide, on the whole, stable family is a husband and wife. Members of this family, Come and go but the main unit, will keep its collective responsibility, while the death Mother or father (the couple) in a nuclear family, the separation or disintegration Family is.

*** Extended family, a couple of small families, the political power there. The family gathered around that many people over the head A small unit, respect and power.

And emotional functions **** Mental extended family, especially in moments of crisis and difficult life, far more than The nuclear family. Extended family members, and also share in the joy and sense of cooperation, Reduces the intensity of their grief.

2-6-2-Family, monogamy and polygamy:

Monogamy Marriage to a woman and a man called. Among the species that can be used to outline the nuclear family, monogamous family, the most common form of marriage in more Countries in the world. Christian communities in the West, marriage and Family's continuity with monogamy. In other words, the only

legitimate form of marriage and Families in the West, are monogamous. Polygamy to marry a man or a woman with more than one sex, in When the unit is applied. There are two forms of polygamy: A woman marries a man who with more than one woman at the same time is called. This type of polygamy, in comparison with Its equivalent (polyandry) is very common. A low of polygamy is polyandry bookmark Married a woman who, at the same time, the husband is said to be numerous. This kind of marriage, Today in Tibet, and masses can be seen in south India. Polygamous situation requires That a woman in there. Usually the baby's blood is not known. Who the child's father is known, the "Todaha" is determined by a ceremony in which one the husband of a pregnant woman's gift makes a toy bow and arrow. If other husbands Later they become parents, this event will be run again later in pregnancy. It seems that a husband, only to communities that are in extreme poverty Are. They are killing the girls in vogue.

2-6-3-Families where the mother, father, place and new place of marriage:

One of the two families, the members Loses and the other to bring it. If her husband's family to live Go, where is the father of the family. If a married woman to go on family life, family where the mother said. But if both the new location to move to a new life, the family called the new location. Before the

Industrial Revolution, the family's place of abundance there was more, but then, the equation in favor of changing the location of new families can.

2-6-4-Family life:

Family consists of Parents; and reproduction is the only biological role. With the evolution of cultures and societies, the role of parents in the multiplicity and diversity. The relationship between father and son, the only other biological No. Parents, were responsible for the socialization of their children. His leadership responsibilities, Socialization, culture, learning, and even the training took over... Although in industrialized societies, many of these species to exist Continued, but the emergence of new competitors, the nature and functions of the family strongly challenged.

*2-6-5-***Chaotic and dysfunctional family***:*

Guardian or family members of those who are troubled and unhealthy, think natural family, have a good and efficient. Indeed, the term natural (or normal, and normal) to be used, for example, is called "natural family," What is the purpose? How safe is it normal? Most of the habit, "normal" to describe situations that are common and universal, to be used. For example, a community of families that control the behavior of its members to use corporal punishment, beating the normal practice is that families in the community, corporal punishment and the general public. It also families in communities that allow their daughters to school do not keep girls uneducated people of the community is a natural act. These are their families, natural families, consider. But these types of families, "healthy families" are?

Good use of words to describe the head and members of their families to do their jobs, can not mean the family is intact. When we have family and good performance. This has often meant that we always somewhere to sleep,

have a roof over head and food to eat, have gone or are going to school and the parents have certain opportunities. Undoubtedly, there are circumstances in the family is essential, but not sufficient condition for a healthy family.

Healthy families need beyond housing, food, education and sexual and physical security of its members to meet. Family members, especially children, to cuddle, hug, too, need to be heard and considered. We feel like we need them to be allowed to be expressed and accepted, and we lost everything that we need for them to mourn Do. We need to honestly reveal our true self so we have a spiritual and creative life.

The applied word "natural good habits" cannot represent the family; hence, it is more appropriate to describe the family of the words "healthy or unhealthy" use.

2-6-6-Dysfunctional Family:

Dysfunctional family, the family is clearly abnormal, bad, and is inefficient. On the contrary non-intact families often appear to be natural and good. These families in their appearance, they look good. They pretend, to lie and deceive those who work with "smart" to learn more honesty are valued. Blackguard, aggression, punishment and blame in this family is normal. They have to obtain a general and unconditional ownership to attract and what the world outside the self. More of the same importance that they actually are. Members of such families with children and adults to physically come to the big guy to play that role, without which the growth and they are great, and thus these "adult children" and the term "dependent" are. I feel the void and emptiness of those who are and are trying hard. Unhealthy way to fill the gap. Usually in dysfunctional families where parents and foster parents, adult children and their families are unhealthy, almost hidden, and saying that the

laws come into force. Not satisfy the needs of the service provided by the parents to their children. Some characteristics of unhealthy families:

- Express their feelings do not:

As emotions such as joy, peace, suffering, joy and pleasure, envy, pride, fear, courage, love and hate are prohibited in the family. The only feeling of sadness and anger or aggression in the family is unhealthy to have occurred.

- According to our (parent or child) may not behave as we behave:

The words with the same message are given to family members: If you say we do not tell lies. Lying is not good!

- It was perfect and flawless:

In non-intact families, "perfection" is attainable and does not forgive mistakes easily. So the children to support, receive the attention and approval, in the perfection of work. They attempt to save the suffering, despair and defeat with no things. As a result, every mistake and failure, worthlessness and guilt over there they will come.

- Do not be selfish:

I do not own, my own and others that we want. We love it and confirmed its condition, we will reward. In other words, non-intact families do not be selfish with the law, which requires family members to teach them directly and honestly with the request not to, but indirectly and with the care of others and to their needs, respond to their needs. It's strange that these people are adults and able to give will be really selfish.

- Be loyal to family law and family about problems with someone who never said no.:

This is a denial that it uses to unhealthy family members do not face the facts about the lack of intimacy and joy in family and non family normal to the so-called "natural" to continue their survival. There are other rules such

as: "Always give yourself a good look, we are right and others are always wrong, Do not ask too much.

2-6-7-Healthy Family:

Healthy family, a family is the fundamental health and mental peace and spiritual support to each family member.

- In a healthy family environment is a powerful but flexible authority as well. This means that before a decision is taken that affects the entire family. The others can be heard. The members feel that their decisions can affect the expression of will.

- In healthy families there is an opportunity for each family member. That can come together with others.

And spend time together. Family members participating in this moment, they felt. Individual and family members are accepted. Of course, just being together, it means a long time it is worth. At that moment, but parents and children to share these thoughts, feelings and their opinions are.

- In such families the joy of recreational activities, games and entertainment, as a responsible activities such as everyday household tasks, family, school and jobs outside the home, given the importance and value.

- Accept each other's families feel safe. Not only allow these feelings to be expressed. But encourage one another. To cause feelings of sadness and anger over a range of feelings, are shown. Develop a sense of the word and talking about them is limited. But the family, we feel like crying, hugging or shouting in protest to the head as well.

- In a healthy family, painful emotions such as fear, embarrassment, anger, sadness, hatred will not last for long. Although family members are encouraged to develop their own feelings, emotions and feelings in order to

work on getting rid of them. This means for example that they also learn the proper form to express your anger, learn to forgive them.

- In healthy families to meet needs such as being approved, attention and affection, intimacy, do not use the material resources, lack of objectivity of material is not considered serious obstacle to the spiritual needs.

- Healthy people in the family as a clear and honest with each other are linked. Disinformation and secrecy has no place in their relationship, children or family members learn to speak the truth, without regard to the truthfulness of what may for them is painful and troublesome.

- In sensitive cases, there are usually families that they are talking about is very important. In intact families, with members to speak on this issue is clear. Even if they considered them to be difficult Such as:

Family finances, unemployment and job loss, criminal records, tender and sweet memories, sex, presence of chronic illness, family death or disability.

- Your healthy family members of such group of people sees the need for effective and useful life and the developmental work together as a unit.

- In a healthy family, each member is given the opportunity to grow and flourish. So to the extent possible, material conditions and comforts of each family member in an atmosphere of encouragement, support, love and affection that are essential for growth and success is interesting that family members' ability to "understand and more cannot expect the family finances.

2-6-8-Parents and families healthy and unhealthy:

Growth and growing up in unhealthy families in our stable for almost three makes sense: fear, embarrassment and insecurity. Even after leaving his first family and the formation of new families, we feel that we have with her. I just feel that we've learned. The types of problems and behavioral disorders in the context of such a situation will provide psychological and spiritual. The

family as society is changing only one of its members found to be fundamentally changed. If you like your family to help them change, it is necessary to know only the change itself can be modified to provide this. Family as the smallest social unit of society and Preservation of human emotions. One of the factors in the behavior of the individual, the family is. The family and how they work.

Family relationship is such that the family environment To provide basic needs of children both physically and mentally, making favorable. Essentially one of the functions of family socialization and education of his children are. Any Adverse effects of failure in family functioning in the normal child do.

The changing role of parents as the child's life is not an amazing story and not the issue. Throughout the life of man, as parents, caregivers, educators, planners and managers of the family as a social institution are considered for their children. The first family is a group normally there and decides that society is founded.

Experience and observation show that the family in shaping children's character is not affected. All healthy children in the family way with great compassion, for that child to be happy and flourish, not necessarily to be strictly supervised by the family of a sensitive life stage passes. Fulfill their duties in the family and how the performance indicators appropriate Performance Evaluation of society. Whatever is good and healthy family functioning. To As the supply is more stable and healthy communities. On the family of Performance is very poor and turbulent, as well as the most threatened Is.

The psychological basis of ethics and education for families of children who have learned undesirable:

A - Without oversight and responsibility of parents in education. B- Putting the value and importance of children and humiliated over the child or

children of the baby too. C- Parents are not coordinated with each other. D- Undesirable social and economic status of parents. E- Children do not support culture. F- Parents have enough experience.

Family dysfunction symptoms of the disorder in the system the family. The family leads to the collapse. Child and adolescent victims the main function of the family are undesirable. Most poor people and Problematic, dependent family members are affected. The children of these families And, due to lack of mental tranquility and lack of concentration and confusion Criminal behavior and are more susceptible to nonconformist. Juvenile crime is one of the most serious problems had become. The majority of the world suffers from juvenile crime. Rising delinquency rates Teenagers held in the country is very disturbing.

Juvenile delinquency as a social phenomenon caused by incompatible interactions between Members of the family. Since the consequences of juvenile delinquency not only the body but also on community Family and all those who have a family relationship, the negative effect From.

Family environment is one of the crucial factors in determining and predicting is a misdemeanor. The annual cost for very heavy Care and treatment of juvenile offenders can be placed on the shoulders of society. That some Corrective and educational programs such as those focused on reforming and changing behavior is delinquent. Unaware of whether the product is damaged teenager tilt function and poor functional Family is. Without understanding the underlying factors and attempt to change the internal relations Families, reforming the criminal behavior has a limited radius of action, efficacy is not well was.

Many parents worry about their child's future. One common concern among parents that children traumatized - social as addiction, crime, be. Although these concerns and needs are crucial, the family is responsible to

pay attention to such cases. It is important to know that fear alone is not enough. Because, sometimes, such concerns have led to extreme reactions and parents with children that are appropriate for the incidence of trauma and social context provides. Because, good communication and friendly parents and children, one of the most important preventive factors of psychological and social damage. Conversely, stress and tension in relations between parents and children, the area provides for a variety of psychological and social damage. If parents fail to properly manage their natural fear of coming in for a variety of problems, unwanted, they are ready.

However, such concerns are normal. Such dangers lurk in our youth is capable.

Unlike many parents, and information, social trauma, and there are clear reasons. Sometimes the damage is very similar in many different and equally well. Psychosocial factors and underlying injury, the parents thought, viruses and bacteria that are not, is dispersed in the environment. Youth and adolescents are affected. But there are certain factors. Common factors underlying psychological and social damage are: communication problems between parents and children, family tension, poor coping skills and problems, an inability to correctly assess the situation and thinking of solutions.

The approach to vaccination and resistance to psychological and social damage are:

A - Facing a natural problem,

B - Blaming others for your problems, not only does not help, but will exacerbate the problems.

C - It is important that the problem, whatever it was before: "Now what do I come?"

D - To help them help themselves to the smaller and more narrowly defined. Instead it is better to say that they have academic problems in certain specific courses in the semester, I have problems.

E - To help them feel it and there are many different solutions to solve problems.

And - to help them when dealing with renal problems and the solutions they think since they do not think it's good or bad, always after the evaluation phase is caused by multiple solutions. Innovative solutions to help them, ineffective and even harmful to the mind (mental precipitation).

G - to help them before they take action to evaluate different solutions. If you think it helps sometimes to young people before specific behavioral, are familiar with the consequences and results.

2-7- Conquest in the Social Relations

Dissected the way in which you can use it when planning for dealing with life problems. The practical coping skills that are useful in terms of cognitive psychology. Methods led to the conquest of confidence in you. When you know these are good skills to feel competent and in control you will be strengthened. With the conquest of good personal skills, adaptability, communication. The successful hatching, are aware of the fact that effort is required to overcome the problems of life. The conquest of the few essential points:

A. It is often those who are powerless and helpless in solving your problem, because that is the only one monolithic solutions are used for different problems. When this solution is not effective, they do not try other solutions.

B. Sometimes using a new and different solution to deal with problems is very useful and effective, especially in dealing with others is true. In the opener of the best are those who are creative. Look into the problem from different angles.

C. The conquest is not the passive approach is needed.

Generally it is dissected 5 steps:

2-7-1-Self-Perception

The first step in solving the problem is that the successful person will develop the understanding that: "Cannot you solve your problem." Orientation for the conquest of their own should be able to say: "Part of life is encountering problems. When I get difficulty, you should be quiet and calm."It provides a better definition of who is smarter. The solution brings more to mind. Makes them more accurate assessment. Select the best solution.

2-7-2-Problem Definition

The first thing you do when you encounter a problem, recognizing the problem. Identify major problems and conflicts, and then make a list of your goals.

2-7-3-List of Solutions

Before choosing a method of working, it is better to check all the possible solutions. Good design should be flexible and creative to build. As far as you can, please bring more solutions.

2-7-4-Decision

Problems ahead of time that you fully understand you. Members of different solutions have also acquired. The decision was very simple and

easier if your first choices are not effective. Must be flexible. Try different designs.

2-7-5-Try

If your solution had better success. Otherwise, you should review the problem again. You must be open to all solutions. Always remember that you are a Conquest.

2-8- Teaching Children about the Skills of Hatching

Life skills, including problem-solving skills in all subjects can be used positively. But naturally the higher the IQ and the ability to use more of these skills can take. Individual intelligence and creativity at all stages of this skill is effective. Who is smarter. Provides a better definition of the problem. The solution brings more to mind. Makes them more accurate assessment. Select the best solution. The only part of problem-solving skills, knowledge and information depends on the person. So the more knowledge we have to study or not proficient. We also need to practice and repeat it. Therefore it is necessary to teach and practice the skills of childhood begins. We are able to experience it gained from adults with major issues of life easier to face.

How to teach this skill level is significantly related to age. These goals can be easily expressed in adult education explicitly and directly taught skills began. But this direct skills training for children is almost impractical. Therefore, in this age of general education based on the "game" is the indirect form. We as parents cannot always create safety for their children. They must be able, with the potential problems, calmly and efficiently, they have. We need our children to start thinking about those issues seriously. They can be encouraged to do these basic skills. Instructions for solving problems usually consists of two main parts.

A. The Q & A Practice

B. Those who make decisions or decide to start exercising.

In fact, these activities are not specific to particular age groups or specific abilities. Ask and answer to their training needs and time is high. The kids at school so no training in this field. Sufficient precision for the thoughtful questions and responses are accurate. True or False questions and questions that kids have only one correct answer, respond. Children can say what they need, schools can provide. Are questions that require thinking. Such as "About What do you think? "Or" How can this problem be solved? "Parents can make it easier for younger children questions to consider. For example, that "to think how this story ends?" Or "Why do you think so?" Of the children are older, can questions about the successes that happens, ask. When you see a television program, you can ask: "What this tells us?" Or "perception of what the program was" almost all the problems are associated with creativity. But some of the questions, they develop more creative. When you ask a child who "hoped it happen? 'Subjective responses you can expect to hear. Ask your child to remedy the problems that have to be. With this method, rather than impose a solution to our kids, they will share in finding solutions. It is our hope that the solutions are found, the problem is resolved. To enhance skills, problem solving can ask your child questions with unlimited response. There is no right answer here. You are not in class. No other children eager to give the correct answer is no. Relaxed atmosphere for learning at home and learn there. Spent time at home, exchanging ideas, feelings, hopes and dreams are. This time, the only family in a "thinker" can be created.

2-9- Family Health Problems

Like any organization, and military family suffers. Several factors threaten the mental health of individuals and families. Mental health of their

spouses and other family members. Under certain conditions of families and family members affect the family system. Not only physical and mental health interrelationships and interactions between family members but also the psychological balance affects families. Thus, the healthy or unhealthy family a healthy or a vicious cycle is created that impact on their members and the mutual regret. This cycle is not just about family. Community and social exchanges, but also plays an important role. The family is not immune to the social damage. Social and political conditions governing the societies, laws and decisions in a sudden, the problem with many challenges and struggles. Environmental, cultural, environmental, air pollution, traffic problems in big

cities like Tehran, architecture, urban style apartment, apartment interior design has followed all the challenges. The family and its members are influenced. Therefore, a number of factors cannot be named Experience irreversible negative effects of war still exists. Natural disasters such as earthquakes, adverse and unexpected events such as death of loved ones, hard diseases, use of sexual abuse, job loss, retirement, not at the University Can help to create a crisis in the family. The impact of these events based on the types of events large and small, and should not be. But they can also look at how to harvest and its harmful effects and the high and low events. Cultures, faiths and beliefs of individuals and communities will play an important role in this field. Due to individual differences, different phenomena may have different definitions for individuals and communities. Accordingly, the extent of their impact is different. Family may not have a problem with divorce. It as a way to prevent injury and pain to consider treatment. But the culture of other families may have to consider divorce as a crisis, a strong reaction to the show. Every family life, sometimes it is a crisis. That may be caused by social conditions, economic conditions, diseases, accidents and natural disasters are unexpected. In this case, the family may be treated effectively and is unable to

deal with the crisis.For the growth, the transition from childhood to adulthood is a stage of maturity, with the rapid changes in physical emotional, psychological, cognitive, and is associated with. The middle stage, the word crisis is used. In other words, about some events we can use the word crisis. In this case there is some consensus. But other events are not considered due to the type and nature of the crisis. But also affects the severity and impact on individuals and families, called the crisis. Psychological and emotional responses to the crisis that followed. Anger, aggression, introspect, depression, guilt, shame, denial, anxiety, physical and verbal violence, mourning, and physical health consequences of the crisis. Crises affect family relationships and may lead to the disintegration of families are also provided. The crisis cannot always prevent or control it. I have tried to reduce the negative effects it gave. Individuals will experience less stress. The relationship between family members, advocacy and dialogue on the crisis, and expressed feelings about it, find solutions and ways of coping with negative events, negative effects can be short and long term to prevent some traumatic event. Today, social networks and informal networks of civil organizations, NGOs and are spontaneous. (Social capital) in the form of physical and mental health groups to promote individual, family and community, is effective in the prevention and treatment of injuries caused .Social capital, including institutions, public or non-governmental organizations, civil society, and relations between people and their work together is not only an efficient public sector in the country creates. Economic development, political and social role playing. But also to promote social, emotional and also helps its members. Organization whose members are hoping gather. For better performance, but their governments to help. People's participation in. The social network of informal and non-governmental organizations have been active, to convene the family, neighborhood,

business partners and others all have their role in promoting mental health. This type of communication takes place in social activities, mutual trust arise. People trust each other, human interactions and exchanges, cooperation and friendship among human beings is a form of social capital. Social participation and cooperation in solving social problems, social responsibility and commitment to the organization that are part of it, is social capital. This type of social capital through member and community activities, trust and belonging, and solidarity between people arise because, in times of crisis, can play an effective role in the psychological stress, social support of individuals. Although the activity of NGOs is widespread in Iran. To the voluntary cooperation of individuals and families in these groups also make use of their services. But the family might be able to look around, group interaction and relationship that they have to find partnerships based on trust. Individuals and groups such as neighbors, partners, extended family, local communities, religious, and so can no formal mechanism, the strong social bonds, and reduce the vulnerability of individuals. Families in the normal course of its development, several steps behind the exhibit. Without the kids, when kids are small, go to school, work and marry and have a family. This change is consistent with its obligation to the family. It does not stop. Social change is the same. Cannot close eyes on the facts. Or tried to live apart from society and social change. Some communities have passed the era of modernity, some communities have entered the modern era. What consequences are being bombarded with information, something that experts in different disciplines of humanities, has been investigated. It is true that modern life may be in some crisis. Transition from one state to another may be stressful. But every phenomenon has its positive and

negative effects. Usually the new phenomena may be resistance from individuals, families and communities will be done. But in some cases it will

not work. At this time we're faced with a bombardment of information. Many of the news and information from different channels and we have to listen. They are all underway. I do not control it sometimes. That's the ordinary people of journalism, photography, journalism, and cinematography are professional, very effective in this role play to listen to news and information around the world deliver the lowest cost. These are things that previous generations have experienced. Therefore, are a new phenomenon. Many changes in thinking, values, beliefs and way of life would occur. Thus, developmental changes, family, environmental, and social, cultural, political, intelligence is something inevitable. Especially for families and communities that are in transition from tradition to modernity. With an awareness of the positive aspects of it, and it reduced losses and damages. Economy and people's livelihood a very important factor in health, family and society. One of the basic principles of family, financial and psychological independence is the couple, who separated from their families of origin and their basic, necessary to gain independence. It's a marriage of physical, mental, emotional and economic, the couple is not followed. Or the hard work done. Due to economic difficulties, the couple are unable to form an independent place to live and have financial independence. How can it be assumed that the family is no problem. Economic independence is the first step to mental independence. Economic problems keep people dependent. In this case, we will be faced with the families to solve their problems have no choice but to get help from parents. This dependence leads to a dependence on the other. Away from each other, provides that a husband and wife. The parents in the lives of many couples, the importance of education and its role in the upbringing of their children is low. Social crises, political and economic weakness of the mental health community provides. Now parts of Western societies are faced with economic crisis. Other communities are experiencing

a political crisis. War, poverty and unemployment have all threats to people and communities. It is a condition that causes discomfort and the disorganization. A person may have enough power and tools to deal with personal crises, family, social and not political. Sometimes people may be brought down, and the family of snuff. It does not have the same impact on all family members. Some family members that they have higher levels of vulnerability, are more at risk. They are sensitive to the age or less, or with women more likely to be damaged. Unfortunately, the crisis in the lives of individuals and families is common. Coping with negative events and crises of life is not easy. Skills may not be enough to solve the crisis. For this reason, their children too do not support the negative event. Let your stress low, and small problems to solve. Thereby to strengthen the immune system to deal with crisis situations. They suffered less damage. Individuals for their performance, to reach the same level before the crisis. Skills and techniques necessary to gain the crisis. Empowerment of individuals and family members of the community functions. Education, the media, like television, newspapers, useful and effective role in teaching problem solving techniques and methods can have a crisis. Various skills, courage and assertiveness skills, listening skills and respect, dialogue and negotiation, expressing emotions, anger control, flexibility, creative thinking, coping strategies, including useful and effective ways to relieve stress and solve has problems. Creating a safe environment for individuals and families affected by mental illness is very important. Without concern for the environment and people can easily talk about their problems and to express their feelings freely. Everyone of course different ways to deal with the traumatic event and event uses. Better family relationships because the crisis is not interrupted. Following the not guilty finding. Withdraw the use of methods and defense mechanisms, such as violence and aggression, or drug use problem-solving methods are not useful.

The non-effective and what the situation is critical, should be avoided. Community with skills training, life skills, including coping with stress, crises and its citizens, it can avoid the escalation of a crisis. In the case of the provision of the resolution, reduce its effects through the actions and resources to the strengthening of social protection.

Chapter 3
Research method

3-1- INTRODUCTION

In this chapter, we refer to the research method, measurement tools and data analysis method.

3-2- Research method:

In this research, statistical calculations were conducted at the confidence level of 95% (α= 5%) and test power of 90% (β= 10%) and Δ with an average impact of 50%. The experimental method of pre-test and post-test was used with the control group.

E: O1 X O2

C: O1 ---- O2

E: Experimental group

C: Control group

O1: Pre-test

X: Problem solving skill training as the independent variable that applies only to the experimental group.

O2: Post-test

3-3- Statistical Population

The statistical population of study consisted of all troubled couples referring to counseling centers in Tehran during 2016-2018. 90 couples, who were adjusted according to our criteria, were selected and then tested. Afterwards, 15 adjusted couples and 15 maladjusted couples were randomly identified.

3-4- Sample and Sampling Method:

Sampling reasons:

1- Description of couples referring to centers

2- Pre-test test for all

3- Selecting troubled couples (sample group)

4- Converting the sample group with a test run to the equilibrium group

5- Teaching the experimental group

6- Comparison of both control and experimental groups

A) Saving time, energy and cost

B) Avoiding increasing the probability of mistakes of questioner and not finding respondents.

C) Results of sampling are equal to referendum results in the case of the observance of its principles and rules.

The sample group consists of two groups:

Experimental group: It consists of 15 maladjusted couples who were selected by random sampling among couples. Participants should be couples; and in many cases, men did not tend to visit of the family counseling, and more importantly participation in the research. The experimental group should meet these conditions:

A) At least a year after their marriage.

B) Their basic complaints about adjustment issues are affected by communication issues and not related to problems of addiction, unemployment, remarriage, etc.

C) Their levels of education should be higher than the secondary school.

D) Their adjustment test scores are a standard deviation below the average.

Control group: It consisted of 15 couples with medium scores in Dyadic Adjustment Scale (DAS), and they expressed their willingness to participate in the research. Given that it was not clear that their performance was medium in the DAS, 30 couples were tested, and 15 out of 30 couples were selected by a draw from those who gained criterion scores.

3-5- Research tools:

The present research used the standard Dyadic Adjustment Scale (DAS) with 32 questions to collect data.

3-5-1-Dyadic Adjustment Scale

This scale was first developed by Spanier (1979) to assess the quality of marital relationship. It was first a 22-item scale, but then turned into 32 by American and Canadian scholars, and thus it consisted of 32 initial cases related to the adjustment and social behavior measuring the quality of marital relationship in terms of husband and wife. The total score of this tool is used to measure the overall satisfaction in a sincere relationship. The scale measures four dimensions of a relationship: dyadic satisfaction; dyadic cohesion; dyadic consensus; and the affectional expression. By applying changes to this tool, it can be also used for interviewing.

The total score of all questions is between 0 and 151, and the high score indicates a better relationship.

3-6- Reliability and Validity:

A) In Iran, the validity of this scale was obtained equal to 0.96 by split half method and 0.92 through Cronbach's alpha by Hassan Shahi (Hassan shahi, M. (1999).

B) Based on results of a research by Amouzegar and Hosseinnejad (1995) in Iran, its validity was 0.86 in total scores through the retest test in two runs; and 0.68, 0.75, 0.71 and 0.61 for the first, second, third, and fourth sub-scales respectively. The total score of scale was 0.96 through Cronbach's alpha indicating a significant internal consistency.

3-7- Validity:

Lawshe's method (1975) and 6 experts' views (4 advisors and supervisors) were used to determine the validity of questionnaire; and the content validity coefficient (CVI) was 0.89.

Table 3-1: Calculating the Content Validity of the Research Measurement Tool

Number of questions	N	E	CVI	Number of questions	N	E	CVI
1	6	6	1	17	6	5	0.67
2	6	5	0.68	18	6	5	0.67
3	6	6	1	19	6	6	1
4	6	6	1	20	6	6	1
5	6	5	0.67	21	6	6	1
6	6	5	0.67	22	6	5	0.67
7	6	6	1	23	6	6	1
8	6	6	1	24	6	6	1
9	6	6	1	25	6	6	1
10	6	5	0.67	26	6	5	0.67
11	6	5	0.67	27	6	6	1
12	6	6	1	28	6	6	1
13	6	6	1	29	6	6	1
14	6	5	0.67	30	6	6	1
15	6	6	1	31	6	5	0.67
16	6	6	1	32	6	6	1
Sum							28.37

$$CVI=\frac{\sum CVI}{N}=\frac{28.37}{32}=0.89$$

3-8- Research implementation

In coordination with managers of counseling centers and obtaining the consent of clients of these centers, the issues of marital and communication

adjustment were investigated in cooperation with investigators of the experimental group. The control group was determined by conventional sampling and parents of students who expressed their willingness to participate in the research. Using a questionnaire, 30 couples were divided into two equal groups (control and experimental groups); and the variance homogeneity of groups was confirmed using the Hartley's Test for Variance Homogeneity.

15 couples of experimental group and 15 couples of control group implemented the DAS test, the phase of problem-solving skill training workshop started for 15 couples of the control group after confirming the status of groups in terms of low score of adjustment. This workshop was conducted in six sessions and a 90-minute session per week. One week after the last session, a post-test was performed on both experimental and control groups. A summary of training sessions for problem solving skills is provided in the appendix.

3-9- Data analysis method

Descriptive and inferential statistics were used to analyze data. The mean, median, frequency tables, diagrams and motion dispersion indices as well as standard deviation and variance were used in the descriptive statistics; and the correlation coefficient test, t-test and factor analysis of variance were used in inferential statistics.

Chapter 4
Data Analysis

4-1- Introduction

In this chapter, descriptive analysis of data and testing of hypotheses are discussed.

4-2- Descriptive data analysis

Table 4-1: Demographics of subjects (age and education)

		Experimental Group		Control Group	
		Male	Female	Male	Female
Age in years	20-30	5	8	5	7
	31-40	7	5	7	6
	41 and over	3	2	3	2
Education level	Under high school diploma	4	3	7	6
	high school diploma and associate degree	6	7	4	5
	Bachelor's degree and higher	5	5	4	4

According to Table 4-1, subjects were identified in experimental and control groups in terms of age (20, 30, 40 and above) and education levels (under high school diploma, high school diploma, associate degree, and Bachelor's degree and higher).

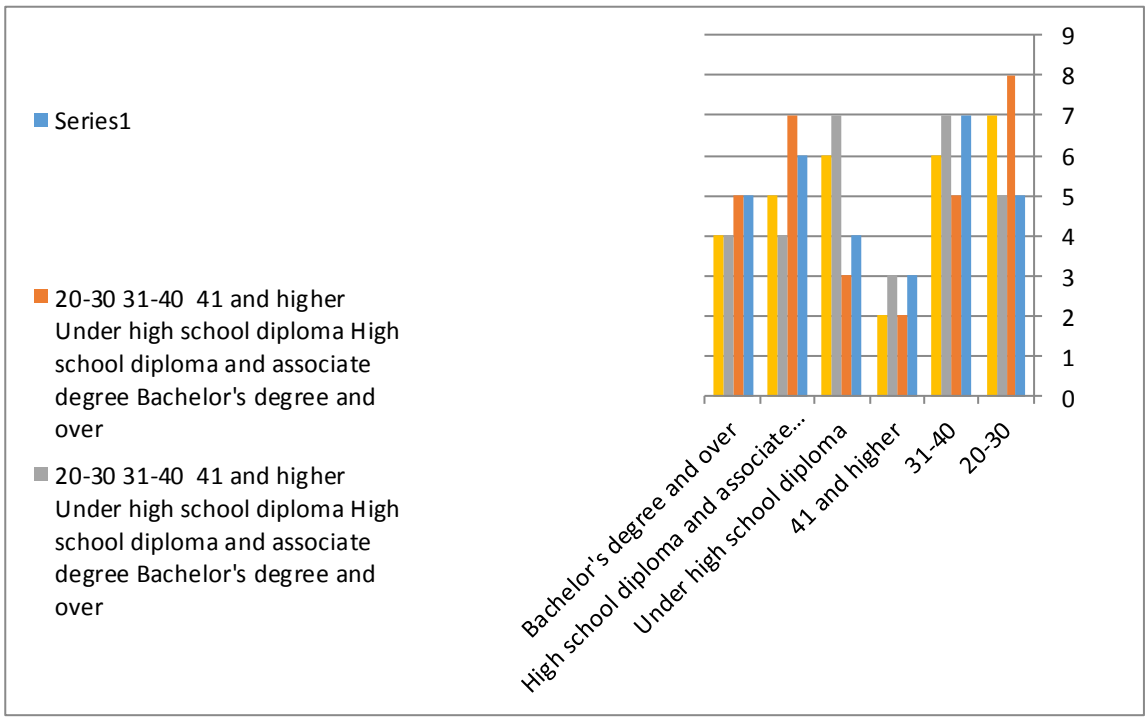

Diagram 4-1- Demographics of subjects in terms of age and education

Table 4-2: Subjects are put into in experimental and control groups in terms of age

		Experimental Group		Control Group	
		Male	Female	Male	Female
Age in years	20-30	5	8	5	7
	31-40	7	5	7	6
	41 and over	3	2	3	2

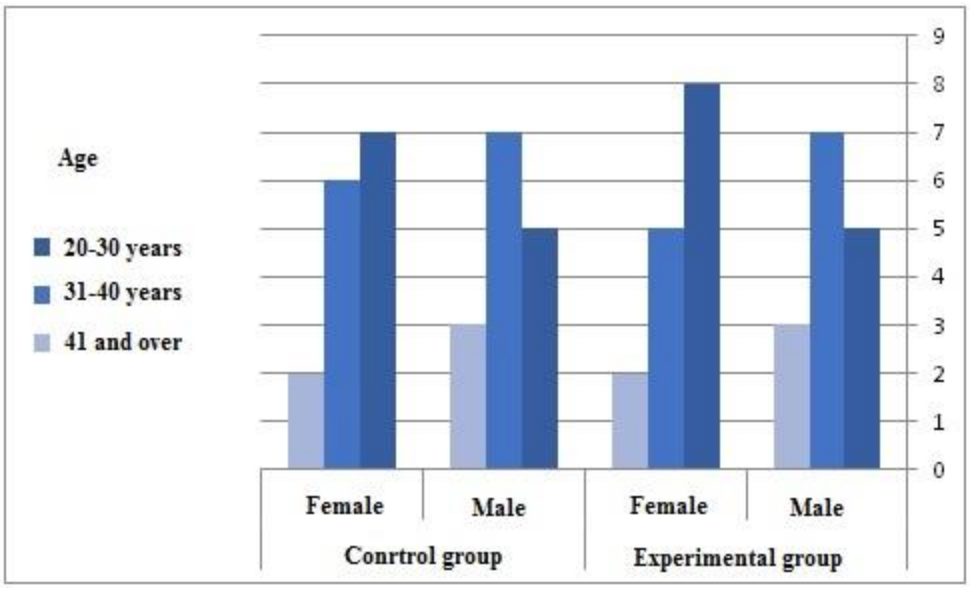

Diagram 4-2- Demographics of subjects in terms of age

Table 4-3: Subjects are put into experimental and control groups in terms of education levels

		Experimental Group		Control Group	
		Male	Female	Male	Female
Education level	Under high school diploma	4	3	7	6
	High school diploma and associate degree	6	7	4	5
	Bachelor's degree and higher	5	5	4	4

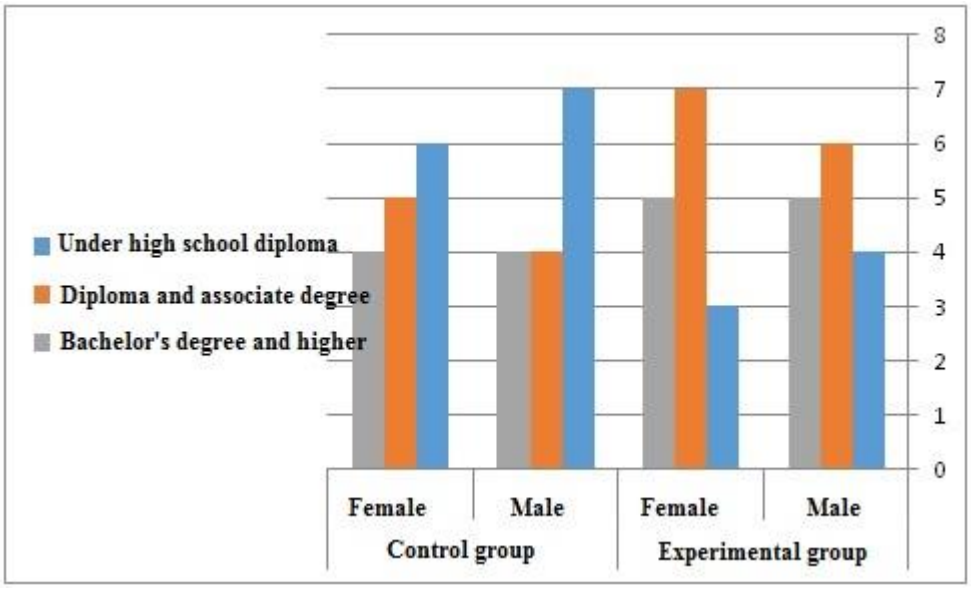

Diagram 4-3- Demographics of students in terms of education levels

Table 4-4: Demographics of subjects (duration of marriage and number of children)

		Experimental Group	Control Group
Duration of marriage	Less than 2 years	5	4
	2-5 years	6	7
	More than 5 years	4	4
Number of children	No child	3	1
	1	5	4
	2	6	8
	4 and more	1	2

According to Table 4-4, subjects are identified according to duration of marriage and the number of children in experimental and control groups.

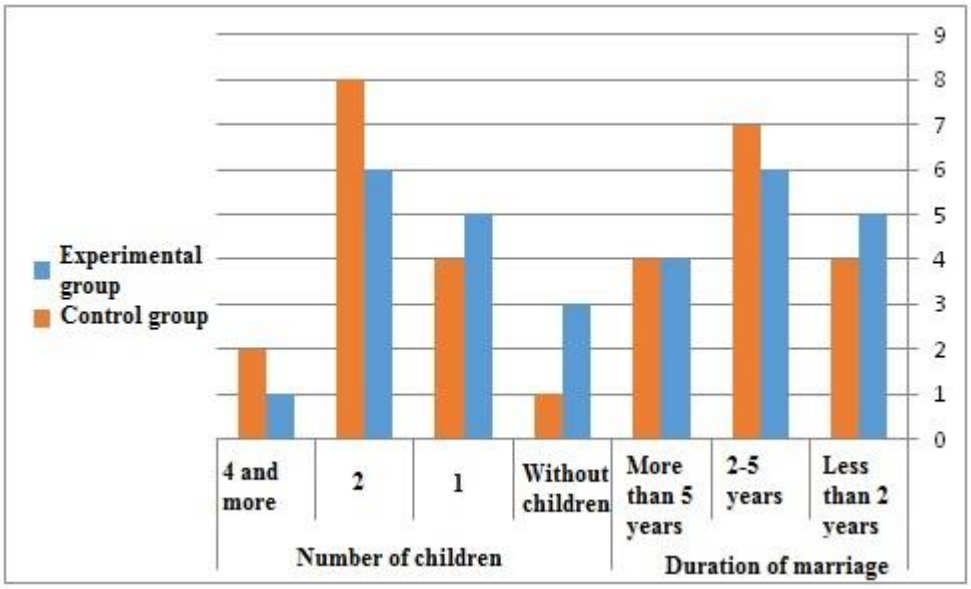

Diagram 4-4- Demographics of subjects in terms of duration of marriage and number of children

Table 4-5- Subjects are put into experimental and control groups in terms of duration of marriage

		Experimental group	Control group
Duration of marriage	Less than 2 years	5	4
	2-5 years	6	7
	More than 5 years	4	4

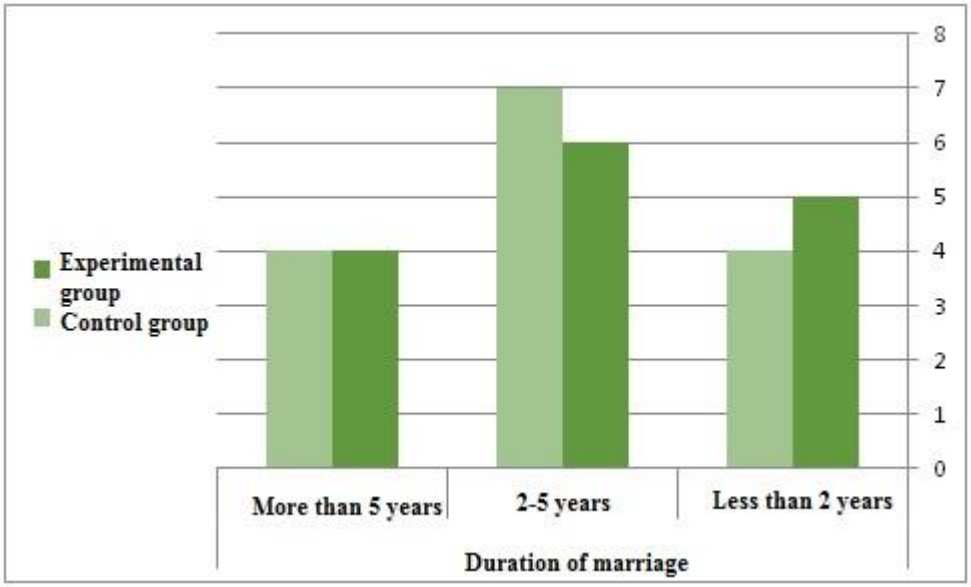

Diagram 4-5: Demographics of subjects in terms of duration of marriage

Table 4-6- Subjects are put into experimental and control groups in terms of number of children

		Experimental group	Control group
Number of children	Without children	3	1
	1	5	4
	2	6	8
	4 and more	1	2

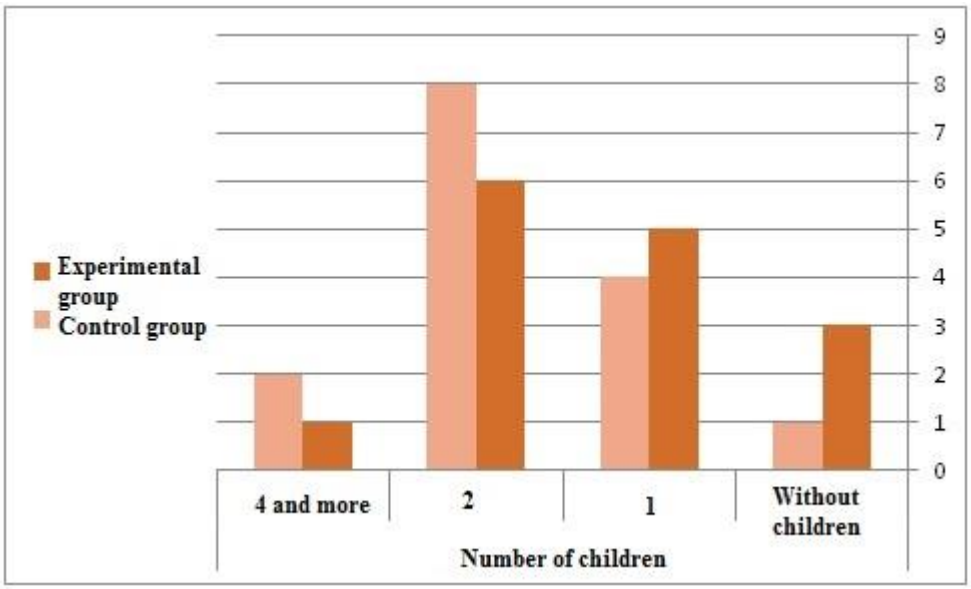

Diagram 4-6: Demographics of subjects in terms of number of children

Table 4-4: The experimental group

Group	Gender	Order of test	Mean	Standard deviation
Experimental	Male	Pre-test	101	2.56
		Post-test	109.93	9.95
	Female	Pre-test	104.87	4.44
		Post-test	121.27	0.81

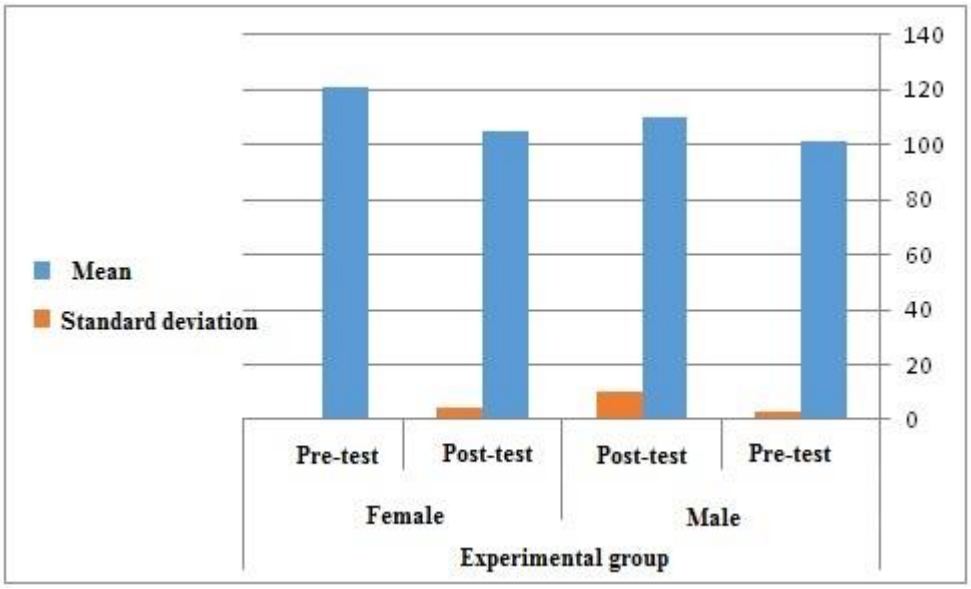

Diagram 4-7- Experimental group

Table 4-8- Control group

Group	Gender	Order of test	Mean	Standard deviation
Control	Male	Pre-test	127.13	5.80
		Post-test	128.06	5.67
	Female	Pre-test	127.40	5.05
		Post-test	128.06	5.67

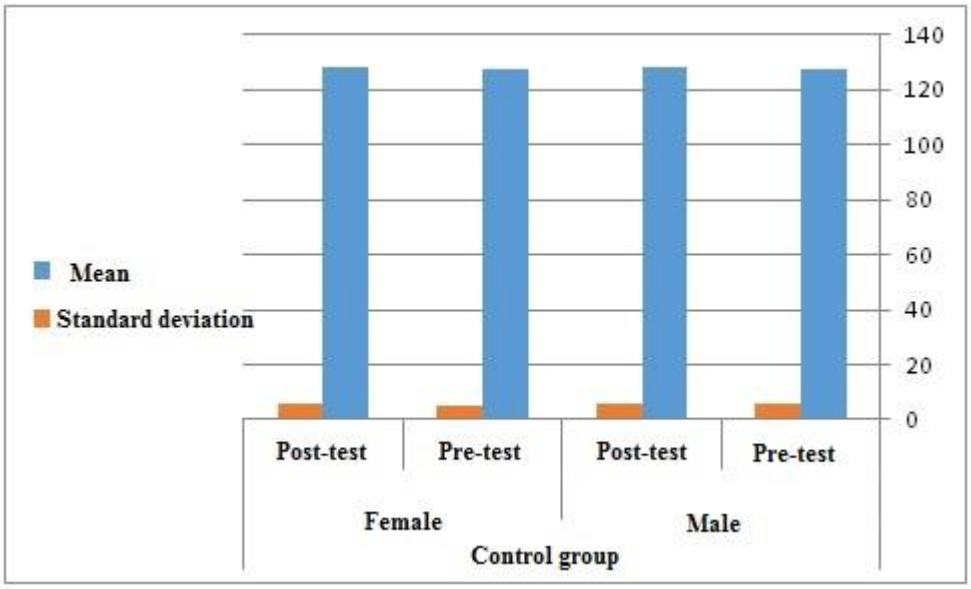

Diagram 4-8- Control group

As presented in Table 4-8, the mean control group, which consists of apparent adjusted couples and families, is much more the mean of experimental group in the pre-test, but the performance of experimental group is much better in the post-test of problem-solving skill training though this gap is still high especially in men. Education seems to be less effective in men.

Table 4-9: DAS Scale and its subscales based on the experimental group and the test order

	Group	Mean		Standard deviation		Minimum		Maximum	
		Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test	Pre-test	Post-test
Dyadic satisfaction	Experimental	36.67	40.80	2.35	2.34	32	35	40	43
	Control	42.2	42.4	2.15	2.35	38	37	46	46
Dyadic cohesion	Experimental	17.47	21.26	1.68	1.75	15	18	20	24
	Control	20.93	21.41	1.33	1.24	19	20	23	24
Dyadic consensus	Experimental	40.67	46	1.99	2.45	38	43	44	50
	Control	51.13	51.13	2.17	2.06	48	46	55	54
Affectional expression	Experimental	8.13	12	1.60	1.9	6	9	11	14
	Control	11.40	11.87	1.35	1.25	10	9	14	14
Total score of DAS	Experimental	102.93	120.07	2.52	351	96	115	106	129
	Control	125.67	126.80	3.27	4.16	117	118	133	133

As shown in Table 4-9, the mean scores of experimental group are increased in subscales and the total DAS in the post-test compared to the pre-test. This increase is obvious both in the lowest and highest scores. In the control group, pre-test and post-test are slightly changed with rise and fall. The significant increase in test scores should be checked by statistical tests.

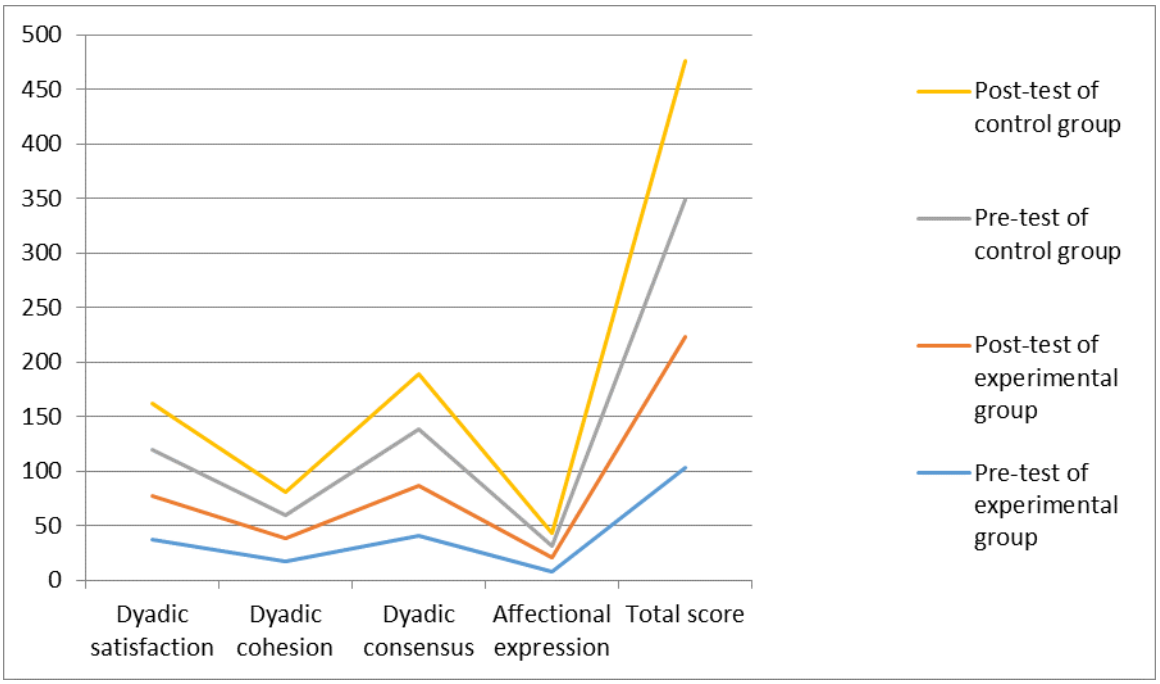

Diagram 4-9: Linear diagram for DAS Scale and its subscales based on the group

4-3- Inferential data analysis

4-3-1-The first hypothesis:

Problem-solving training improves the marital adjustment.

Table 4-10: Differences in pre-test and post-test scores

Group	Number of couples	Mean difference of pre-test with post-test	Sd of difference of pre-test with post-test	Sd of mean difference of pre-test with post-test
Experimental	15	17.13	5.78	1.41
Control	15	1.13	2.77	0.72

As shown in the table above, the mean difference in adjustment score of experimental group of the post-test was increased to 17.13, while this increase was only 1.13 scores for the control group and it can be attributed to factors like time and familiarity with the test and random factors.

Table 4-11: T-test for independent groups for the difference between mean scores of pre-test and post-test

	Levene's test for equality of variances		t-test for equality of variances				
	F	Significance	T	Degree of freedom	Significance	Mean difference	Standard deviation of difference
Homoscedasticity	2.74	0.11	10.09	28	000	16	1.58
Heteroscedasticity			10.09	20.74	000	16	1.58

T-test is performed by measuring differences in subjects' scores in the pre-test and post-test and comparing with independent groups. As presented in the table above, the observed t is $t_{(\alpha=0.05,df=28)}=10.09$ for the mean differences of pre-test and post-test for experimental and control groups and it is higher than t of table $t_{(\alpha=0.05,df=28)}=2.467$.

H0: $\mu_1-\mu_2= 0$

H1: $\mu_1-\mu_2\neq0$

Consequently, the first hypothesis based on the effectiveness of problem-solving skill training in increasing the couples' adjustment is confirmed, but the null hypothesis based on the non-influence of this training on the increase in marital adjustment was rejected. In other words, it can be claimed that problem-solving skill training increases the marital adjustment at the probability level of 95%.

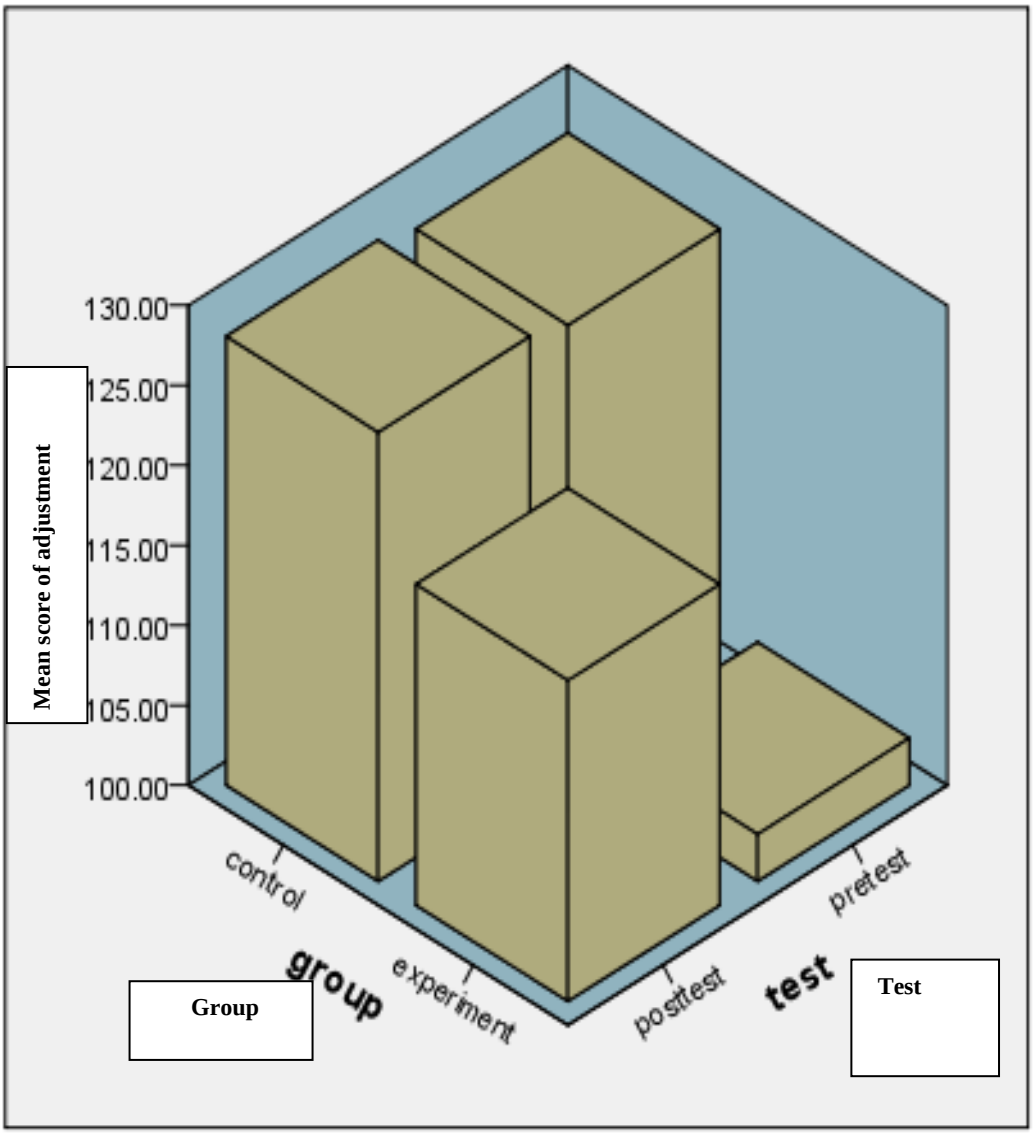

Figure 4-10: Bar chart for the mean adjustment scale based on the subject and test groups

4-3-2-Second hypothesis:

There is a significant correlation between gender and marital adjustment (control and experiment).

Table 4-12- Pearson Correlation Coefficient for gender and marital adjustment variables

	Mean	Standard deviation	Number	Correlation	Control	Experiment
Control	122.90	6.43	30	Pearson correlation coefficient	1	0.563
				Two-range significance		0.001
				Number	30	30
Experiment	123.97	5.01	30	Pearson correlation coefficient	0.563	1
				Two-range significance	0.001	
				Number	30	30

As shown in the table above, Pearson correlation coefficient is equal to r(α=0.01, df=28)=0.563 for gender variables and marital adjustment, and it is higher than r of Table [r(α=0.01,df=28)=0.4487]

H0: $\rho 1 - \rho 2 = 0$

H1: $\rho 1 - \rho 2 \neq 0$

Therefore, the second hypothesis based on the correlation between gender and marital adjustment variables is confirmed, but the null hypothesis based on the lack of correlation between these two variables is rejected. In other words, there is a correlation between these two variables, gender and marital adjustment, at the probability level of 99%.

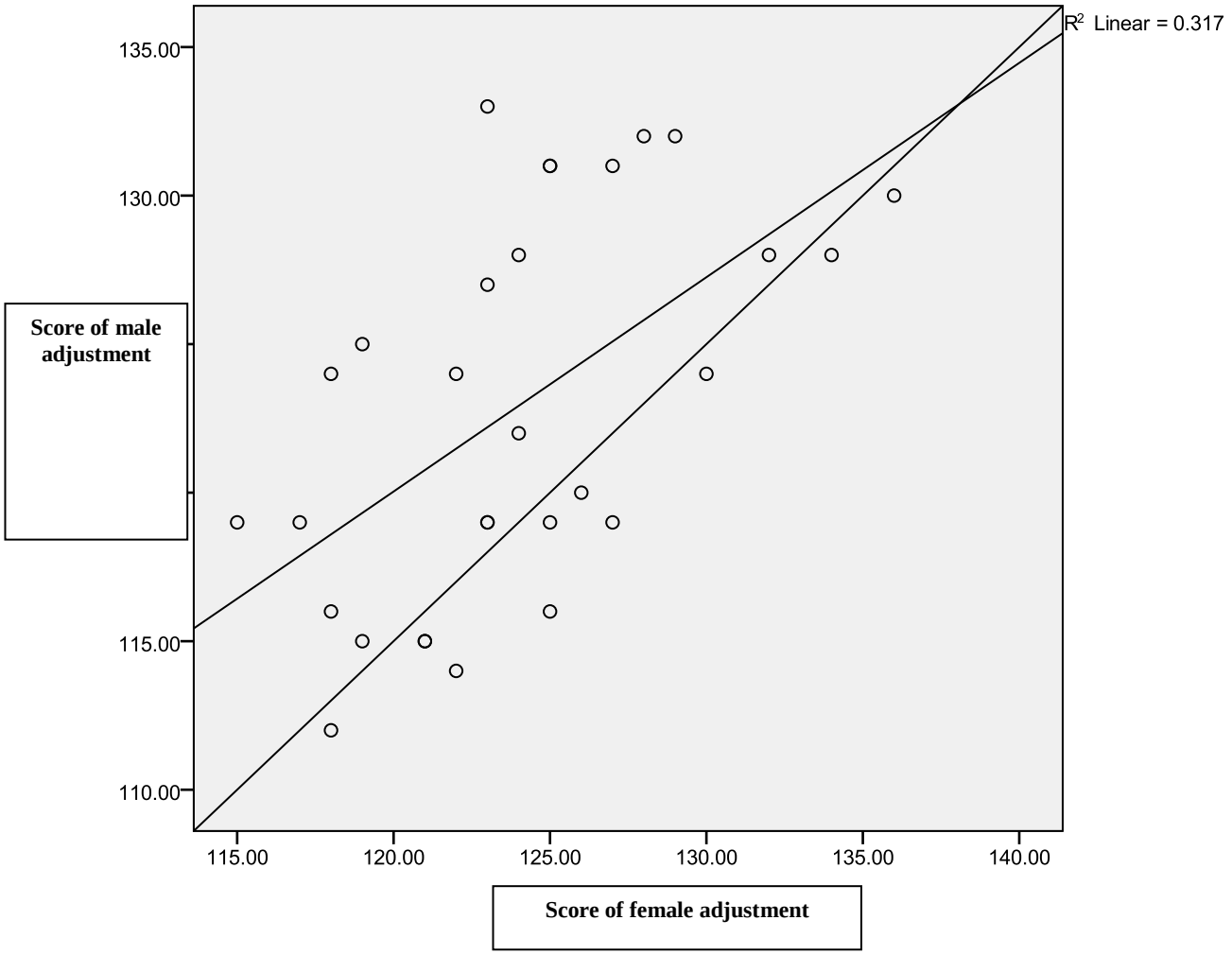

Diagram 4-12: Correlation and dispersion of DAS scores in males and females

4-3-3-Third hypothesis:

There is a significant difference between effects of problem-solving skill training on the gender-based marital adjustment

Table 4-13: Analysis of variance of mean difference of the impact of problem-solving training on the gender-based marital adjustment

Source	Sum of squares	Degree of freedom (df)	Mean square	F	Significance level (Sig)
Adjusted model	12409.57	7	1772.80	73.71	0.000
Intercept	1716020	1	1716020.83	71352.22	0.000
Group	7840.83	1	7840.83	326.02	0.000
Gender	80.03	1	80.03	3.33	0.71
Test	2412.03	1	2412.03	100.29	0.000
Group*gender	67.50	1	67.50	2.81	0.097
Group* Test	2000.83	1	2000.83	83.19	0.000
Gender*Test	5.63	1	5.63	0.234	0.629
Group*Gender*Test	2.70	1	2.70	0.112	0.738
Error	2693.60	112			
Total	1731124	120			
Total adjusted value	15103.17	119			

As shown in the table above, the effects of group (experimental and control), test (pre-test and post-test), and the interactive effect of group and are significant in the analysis of variance, but effects of gender, and interactive effects; gender and group; gender and test; and gender, group, and test are not significant. Since the observed F-value $F(\alpha/2=0.05, df112,1)= 2.70$ is lower than the F of table ($F(\alpha/2=0.05, df112,1)= 3.92$, the research hypothesis is rejected, and the null hypothesis based on the lack of difference in the impact of problem solving skill training on the basis of gender is not rejected. In other words, there is no difference between males and females in the impact of problem-solving skill training on the marital adjustment.

4-3-4-Fourth hypothesis:

The degree of marital adjustment varies according to gender.

Table 4-14: t-test for independent groups for gender differences in the marital adjustment

	Levene's test for equality of variances		t-test for equality of variances				
	F	Significance	T	Degree of freedom	Significance	Mean difference	Standard deviation of difference
Homoscedasticity	0.68	0.41	-2.56	58	0.013	-7.97	3.12
Heteroscedasticity			-2.56	58	0.013	-7.97	3.12

To test this hypothesis, the pre-test scores of subjects were used in both experimental and control groups. As shown in the table above, the observed t for the mean difference of DAS subscale for men and women is $t(\alpha=0.05,df=28)= -2.56$ that id higher than the t of table [$t(\alpha=0.05,df=28)=2$].

$H0:\mu1-\mu2=0$

$H1:\mu1-\mu2\neq0$

Consequently, in the fourth hypothesis, the hypothesis about the different marital adjustment scores of men and women is confirmed, but the null hypothesis about the difference of marital adjustment in terms of gender is rejected. In other words, it can be claimed that the gender factor is likely effective in the marital adjustment at the probability level of 95%.

Chapter 5
Conclusion and Suggestions

5-1- INTRODUCTION

Family is the smallest social unit of society and preservation of human emotions as one of factors in the individual behavior. Family Nuclear basic unit consists of a husband and wife and children. In large families, family members may need in case of person many could help; family Wide, on the whole, stable family is a husband and wife. Members of this family, Come and go but the main unit, will keep its collective responsibility, and emotional functions mental extended family, especially in moments of crisis and difficult life, far more than the nuclear family. In poor families and the child's parents, adult children and their families are unhealthy, almost hidden rules and saying to come into force. Not satisfy the needs of the service provided by the parents to their children. Healthy family, a family is the fundamental health and mental peace and spiritual support to each family member.

Life skill training without any control or controlling the marriage duration can increase the marital adjustment in families. The quality of couples' relationships is enhanced by teaching problem solving skills and life skills using effective methods of listening, speaking and providing effective non-verbal answers. Furthermore, learning problem-solving skills can provide effective strategies in dealing with problems, and thus increase their satisfaction with the marital life. A great number of studies found that marital adjustment rates of couples with strong communication skills in different aspects of marital relationships were significantly more than couples with poor communication skills. These results point out the need to pay attention to roles of communication skills in achieving the marital adjustment and prevention of maladjustment.

This chapter provides the discussion of research findings with theoretical principles of studied variables namely the marital adjustment and problem solving, and compared and analyzed results with other research findings.

5-2- Discussion and conclusion

The first hypothesis was based on the effectiveness of problem solving skill training in increasing the couples' adjustment, and rejected the question about the lack of effect of this training on increasing the marital adjustment. In other words, the problem-solving skill training is effective in increasing the marital adjustment at the probability level of 95%. In previous studies, for example, Vincent et al. (1975) found that unsuccessful couples significantly showed less positive problem solving behavior and more negative problem solving behavior than successful couples. Different researchers have successfully used problem solving training in the treatment of marital adjustment (Sternberg et al., 1981). Jakobson (1977) treated a group of ten unsuccessful couples using a set of problem-solving training and attachment commitment practices.

Therefore, training problem-solving skills is effective in increasing the marital adjustment with respect to internal and external research.

The second hypothesis based on the correlation between couples' marital adjustment was confirmed. The question about the correlation between these two variables was not confirmed. In other words, it is likely that there is a correlation between two variables namely the gender and marital adjustment. The relationship between men and women is a two-way relationship in the marriage. The question seems to be so obvious that even the research subject has not been addressed; hence, this question is raised in this research: To what extent the male adjustment model (as a group) is changed in the case of increasing the female adjustment (as a group)? This correlation exists

according to research findings. According to previous studies such as the research by Esmat Danesh (2004) on the effect of Islamic self-knowledge in increasing the level of marital adjustment in Iran, results indicated that the self-knowledge increase significantly improved the marital adjustment of experimental group than before consulting with the control group. Yalissen and Carahan (2007) conducted a research entitled "Couple communication program" and found that the communication skill training program had a positive effect on the marital adjustment.

Therefore, there is a correlation between male and female in terms of marital adjustment according to internal and external research.

As presented in the fourth chapter, effects of groups (experimental and control) and tests (pre-test and post-test) and the interactive impact of group and test were approved in the analysis of variance. However, the effect of gender and interactive effects of 1. Gender and group, 2. Gender and test, and 3. Gender, group and test were not approved, but the question about the lack of difference in the impact of problem-solving skill training on the basis of gender was confirmed. In other words, there is probably no difference between male and female in the impact of problem-solving skill training on the marital adjustment. According to other studies including problem solving and marital adjustment practices such as Mazaheri's reserach (2001), there was no significant difference between scores of marital adjustment and problem-solving methods in terms of gender variable through variance of analysis. Bahloli-Asl (2010) did not report any significant relationship between gender and marital satisfaction in the research on the predictive role of personality traits and marital satisfaction on the job satisfaction.

Therefore, the question about the impact of problem solving skill training on the gender-based adjustment is accepted; hence, the problem-solving skill training affected the gender.

In the fourth hypothesis, the question about the difference in marital adjustment scores of men and women is confirmed, but the about the lack of gender-based maturity adjustment is rejected. It can be claimed that the gender factor is most likely to be effective in the marital adjustment. Previous studies on this finding have provided opposite results. Taleshi (1990) reported the lack of a significant difference between marital adjustment of men and women. On the contrary to the present study, Ellson (2004) declared the higher marital adjustment of men than women. When we encounter such different results in the research, it is difficult to provide a basic theory. The difference in the result of Ellson's work with this research can be attributed to the cultural factor. In other words, despite the higher marital adjustment of men or women in some countries, it is not probably similar to Iran, and there is no significant difference between men and women in terms of the marital adjustment. Many theories on the marital adjustment and gender are consistent with findings of the present research. According to Lewinsohn (1993), women are more likely to love interpersonal relationships than their husbands, and thus they are more likely to resolve maladjustment or seek to utilize out-of-home resources and professionals before men.

According to the previous research, the gender can affect the marital adjustment.

5-3- Research limitations

1- The statistical population of research consisted of troubled families in Tehran; hence, the generalization of results to other cities should be carefully performed.

2- There is the probability of some households' bias in answering questions of questionnaire, and this affect results. Therefore, the caution should be observed in the generalization of results.

3- Limited access to new and valid international and national scientific resources
4- Lack of similar work in this field especially in terms of physical domain of research.

5-4- Suggestions

According to the first hypothesis and research results, the following cases are suggested:

1- It is suggested teaching problem solving skills to families and couples by different counseling centers in order to increase the couples' adjustment.

According to the second hypothesis and research results, the following cases are suggested:

1- Since the marital adjustment is higher in women than men, problem-solving training should be provided within families
2- It is also better to select different problem-solving methods to check the possibility of comparing them.

According to the third hypothesis and research results, the following cases are suggested:

1- The effect of problem solving skill training on the marital adjustment varies according to gender; hence, planners are suggested considering this point in the implementation of skills and planning based on the differences.

According to the fourth hypothesis and research results, the following cases are suggested:

1- Given the difference in male and female marital adjustment scores, this skill should be taught within the family or with men and women.
2- Given that these skills can be effective from the early years of life, these skills should be taught to students at schools.

5-5- Suggestions for future research:

1- It is suggested that similar research should be used to generalize results to statistical societies and similar samples.
2- It is also suggested using methods of problem solving in more diverse and comprehensive ways in the future research.
3- It is also suggested implementing ten skills to determine results of this skill in families.
4- Problem solving skills, which are implemented at schools and cultural education centers, should be investigated according to the statistical population in order to determine its results for future cultural plans of families
5- It is also suggested using films and mass media in future programs.

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Appendix

Measuring Marital Quality

There are few more enduring and researched topics in family science than the idea of marital satisfaction , marital quality , and/or marital happiness . In 1979, Spanier and Lewis published a chapter about marital quality in the family science handbook entitled contemporary Theories about the Family (Burr , Hill , Nye , & Reiss,1979).They found that(by 1979)there were several hundred studies that dealt with marital quality . Given the scope of this research topic , we cannot hope to present a cogent history of this complicated research topic here . However , we can distill from several reviews what seem to be the more compelling ideas that have emerged.

First , the construct of marital quality(satisfaction , happiness , adjustment , integration)is clearly separate from the idea of marital success . Most authors would agree that marital success or marital status describes the degree to which a relationship is intact . That is, marital stability or status is not truly a dichotomous variable(married or divorced),but instead describes ,a continuum of 'intactness' .Indeed, when we assess this concept, researchers often ask about disintegration of a relationship and want to know if a couple has seriously talked about splitting up ,or how many times a partner has moved out.

Measures of relationship quality, on the other hand ,have less straight-forward conceptual clarity. Some researchers see marital quality as a subjective evaluation of one individual's assessment of the relationship, while others see this construct describing relational attributes, and yet others focus on a broad spectrum of behaviors that can be observed .For example, Lewis and Spanier (1979)declared that many researchers chose to assess marital quality as the "subjective evaluation of a married couple's relationship(p.269).In that vein, Spanier (1976)published that most widely used measure of marital adjustment called the Dyadic Adjustment Scale(See Table 1).This scale is a multi-dimensional scale that favors the relational elements of the marriage dyad .The first 15 items asks the married person to rate their marriage on an agreement scale .For example:"How much do you and your partner agree about handling family finances(scored on a six point scale)".The remaining items ask the person to rate such things as how often they discuss divorcing or separating ,do they leave the house following a fight ,and if they regret getting married. Spanier's scale moved researchers away from asking the couple (or usually one member of the dyad) if he/she thought she was in a strong , viable relationship .Instead, Spanier's scale asks about behaviors and sources of agreement.

Table 1.
Dyadic Adjustment Scale

	Alwayas agree	Most always agree	Ocassionally disagree	Frequently disagree	Almost always disagree	Always disagree
1.Handling family finances	5	4	3	3	1	0
2.Matters of recreation	5	4	3	2	1	0
3.Religious matters	5	4	3	2	1	0
4.Demonstration of affection	5	4	3	2	1	0
5.Friends	5	4	3	2	1	0
6.sex relations	5	4	3	2	1	0
7.conventionality (correct or proper behavior)	5	4	3	2	1	0
8.Philosphy of life	5	4	3	2	1	0
9.Ways of dealing with parents or in-laws	5	4	3	2	1	0
10.Amis,goals,and things believed important	5	4	3	2	1	0
11.Amount of time spent together	5	4	3	2	1	0
12.Making major decisions	5	4	3	2	1	0
13.Household tasks	5	4	3	2	1	0
14.Leisure time interests and activities	5	4	3	2	1	0
15.Career decisions	5	4	3	2	1	0
16.How often do youdiscuss or have you considerd divorce,separation or terminating your rehationship?	5	4	3	2	1	0
17.How often do you or your mate	0	1	2	3	4	5

leave the house after a fight?						
18.In general,how often do you think that things between you and your partner are going well?	0	1	2	3	4	5
19.Do you confide in your mate?	5	4	3	2	1	0
20. Do you ever regret that you married?(or lived together)	0	1	2	3	4	5
21. How often do you and your partner quarrel?	0	1	2	3	4	5
22.How often do you and your mate"get on each other's nerves?"	0	1	2	3	4	5
From:Spanier,G.B.(1976).Measuring dyadic adjustment:New scales for assessing the quality of marriage and other dyads.Journal of Marriage and the Family,38,15-28						

Another research approach emerged in the 1990's with regard to assessing marital quality.Norton and colleagues returned to the work of the 1940's and re-established a more global and steered away from behavior assessments of partner activity(See Table 2.The Norton Quality Marital Index).While there are a few items in the Quality Marital Index(QMI)that assess behavioral indicators or hint at interactional style,most of the items are global assessment and rate an individual's overall attitude toward the marriage and/or ling term partnership.