Valuing Family Strength and Resilience:

A Narrative Approach to Therapy with Families

By Cheryl Maxsom

A Practicum Report Submitted to the Faculty of Graduate Studies

In Partial Fulfillment of the Requirements for the Degree of

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The successful completion of this practicum was guided by many people. I share this accomplishment with them.

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ABSTRACT

This report focuses on work with families using a narrative approach. Modern families continue to be challenged by a wide range of issues which cut across many dimensions of family life. Effective therapeutic work must focus on family members' abilities to rise above these challenges and regain their sense of competence. A narrative approach provides an opportunity to focus on these resources and strengths within families. A comprehensive literature review is provided in this report, which includes a review of family strengths and challenges as well as a review of narrative therapy approaches. This theoretical framework provides the foundation for the examination of the intervention and analysis of therapy with families seen during the practicum. A qualitative review based on narrative analysis provides the examination of the effectiveness of the therapy with three of these families. I will also discuss how a narrative approach was useful in working with all of the families I had contact with. These findings, as well as client feedback, indicate that narrative therapy was an effective therapeutic approach.

CHAPTER ONE

Introduction

Social work is a profession which has long held a deep appreciation for families and family life. This appreciation is demonstrated by the emphasis on a strengths perspective, which is based on the idea that families are capable, resilient and whole, rather than the sum of their troubles (Dietz, 2000; Early and GlenMaye, 2000). The ability of families to not only support individual members but to maintain their equilibrium, their sense of competence and their healthy coping skills in times of high stress are not easy tasks. However, I believe that in spite of adversity, families can maintain their strengths and build their resilience. This belief in family strength was the basis for this practicum (and subsequent report), which was completed at the Elizabeth Hill Counselling Centre (EHCC) in Winnipeg, Manitoba working with families using a narrative approach. The narrative model provided me with the tools to work with families in a way which supported family strength as well as the values of social work practice. The profession of social work practice holds in high regard the intrinsic worth of people and is committed to providing service which promotes peoples' self-determination, acceptance, social justice and strengths (Canadian Association of Social Workers, 1994).

The counselling process can be a tool which can help reinforce a family's strength and their sense of competence in search of solutions and alternatives to problems. In this regard, the narrative approach is a good fit with families. Social constructionism and the narrative metaphor provide a worldview from which to deconstruct the societal forces which put pressure on families. This worldview also

provides metaphors which encourage families to find strength and meaning in their own personal stories. It is this emphasis on family strengths and the family's point of view which has drawn me to the narrative approach.

Despite the focus on a strengths perspective in the profession of social work, families are often seen as belonging to one of two camps: either having deficits which contribute to their dysfunction as a family, or having enough resources and resiliency that they avoid such dysfunction (Walsh, 1996). This practicum experience gave me the opportunity to work therapeutically with families by focusing on their presenting issues while at the same time focusing on their strengths and deconstructing myths and stereotypes that may have influenced both their view of themselves as a family and their abilities to endure challenges.

Learning Goals

I completed the clinical practice portion of my degree at the Elizabeth Hill Counselling Centre. My aim was to demonstrate not only that the narrative approach is appropriate for work with families, but that there are alternatives to the particular model of narrative therapy described by White and Epston (1990).

My specific educational objectives for this practicum were as follows:

1). To provide ethical, appropriate and effective therapeutic service to families

2). To effectively use White's and Epston's (1990) narrative approach in my clinical practice with families

3). To seek out and practice other narrative models as alternatives to the one described by White and Epston (1990)

4). To improve my clinical skills

5). To practice appropriate and ethical qualitative evaluation in my clinical practice

6). To receive feedback from clients, clinical staff and supervisors about my practice in order to facilitate professional development.

CHAPTER TWO

Literature Review

Work with Families

The purpose of this practicum was to provide family therapy to a wide range of families with a variety of presenting issues. This diversity was determined in part by the definition I used for the client group I worked with. The definition of the family based on the inclusion of father, mother and children as members has been called mythological (Walsh, 1993), and that definition of the family has been called into question since fewer and fewer families fit within it. The definition of family which was used in this practicum is as follows: a group of people who consider themselves a family and assume the obligations and responsibilities of healthy family life (Barker, 1995). These obligations may include child care, child socialization, income support, long-term care and other caregiving activities (Barker, 1995). This definition was used so that groups of people could decide for themselves who the relevant participants were for therapy. This definition is also in keeping with a social constructionist perspective which suggests that a family should be defined by who is affected by the problem, rather than by socially constructed ideas about roles, structure or membership (Anderson, 1995; Laird, 1995).

Family Strength and Resilience

As a social work practitioner, I am aware of the close relationship between the strengths perspective and social work practice. This approach assumes that people have the capacity for growth and change, they have knowledge that is important in defining their situation, and they are resilient (Early and GlenMaye, 2000). Families have a number of areas that they can draw on for strength. Individual family members

bring their own characteristics, roles and experiences which the family as a group can rely on (Early and GlenMaye, 2000). Families also share traditions and rituals, and can tap into the strengths of their extended social network, which may include extended family or community (Early and GlenMaye, 2000). While families often come in for therapy for the purpose of solving a problem, the emphasis is on the abilities and competencies they either already have, or have the capacity to develop (Early and GlenMaye, 2000).

Resiliency is a concept which has been, until recently, largely associated with individuals rather than families. The literature on resiliency has often focused on the abilities and strengths of individuals who have mastered adversity (Walsh, 1996). Resiliency in individuals was also thought to be a biologically determined personality trait (Walsh, 1996). Families tapped into this resiliency by relying on these strong individuals to protect the family from adversity (Hawley, 2000).

There is not one definitive definition of resiliency, but it is commonly described in literature as the ability of people to not only survive, but thrive in spite of negative factors that may be present (Buckley, Thorngren and Kleist, 1997; Early and GlenMaye, 2000; Hawley, 2000; Walsh, 1996). Resiliency is also often described in conjunction with the related concepts of risk and protection (Fraser and Richman, 1999; Hawley, 2000). While risk factors are negative aspects which may decrease effective functioning, protective factors are resources which help people buffer the effects of adversity (Hawley, 2000). Resilience is often found when risk factors have been minimized and protective factors are present (Hawley, 2000).

Several authors have expanded on the knowledge about individual resiliency to

focus on resiliency within families. Family resiliency has been conceptualized in two ways. The first is that resiliency in families can be examined as a set of qualities or characteristics. These qualities include, among others, a strong marital relationship between parents, an emotional balance between work and family, the capacity of family members to accept their own and others' emotions, the ability of all family members to discuss negative emotions that resolve conflict, flexible family roles and an ability to use creative solutions, especially in the face of crisis (Buckley, Thorngren and Kleist, 1997).

According to Walsh (1996) however, family resilience can be conceptualized relationally. In other words, family resilience is a developmental process which fits the family's functioning within a social context and the varied demands they face (Walsh, 1996). Relational resilience involves

> organizational patterns, communication and problem-solving processes, community resources, and affirming belief systems. Of particular importance is a narrative coherence that assists members in making meaning of their crisis experience and builds collaboration, competence, and confidence in surmounting family challenges (Walsh, 1996, p. 262.)

This view of family resilience suggests that a generalized model applicable to all families is not likely to be found. Family resilience is specific to each family, dependent on the social, cultural, historical and developmental contexts in which they live, as well as their particular dynamics and structure (Hawley, 2000).

This process-oriented view of family strength and resilience requires a family therapist not only look forward in time to when the problem or crisis is over, but to look back in time for past successes, and also remember that the current situation is not representative of the family's ability to be resilient (Hawley, 2000). A family therapy approach which views the family from this strengths and resiliency perspective may

focus on family identity, asking the family to articulate what they see as the common beliefs, experiences, traditions and rituals which bind them together and inform their strength (Hawley, 2000). These meaning-making questions, common to the narrative approach, can focus the family on their trust, loyalty and confidence, thereby reinforcing their strengths in times of adversity (Hawley, 2000).

Challenges for Families

While the social work profession focuses on family abilities and resources through a strengths perspective, often agencies are geared towards problem-solving or correcting some personal or family problem, or helping families avoid risk (Fraser and Richman, 1997; Sheafor, Horejsi and Horejsi, 1997). While this practicum is informed by the strengths approach, it is helpful to examine the literature regarding the challenges for families who encounter multiple systemic issues. The Elizabeth Hill Counselling Centre concentrates on providing service to families who may be at risk and who may not be able afford service elsewhere. As such, families who seek service at EHCC often have in common the systemic challenges associated with living in poverty. These challenges may include racism, underemployment, lack of adequate child care, lack of educational opportunities, lack of adequate housing or other societal obstacles. Along with poverty, these factors can increase a family's risk and also decrease their resilience (Fraser and Richman, 1999).

While these systemic challenges are macro level issues, they affect families and family functioning in very personal ways. According to Aponte (1991), poverty is not widespread famine and starvation, but rather, a societal illness which leaves families with few social supports and overwhelming emotional stress. While these issues can be

said to exist at all socio-economic levels in society, these challenges are most acute in families who live with poverty. The challenges associated with living in poverty contribute to families being characterized as either disorganized or multi-problem (Aponte, 1991; Kaplan, 1986). However, Aponte believes that "underorganization", as opposed to disorganization, is a more true description of the functioning of those families who wrestle with multiple problems (1991, p.24). Underorganization results when families lose their sense of power and identity (Aponte, 1991). When a family breaks down because it does not have adequate emotional and social support, the result is a family structure which lacks the definition and flexibility it needs to cope with the demands of modern life (Aponte, 1991). In other words, a family's underorganization is not a product of a family without rules, nor is it a product of a lack of motivation on the part of the family. Despite the chaos that may be present, the multi-problem family is organized, just not in a healthy or functional way (Kaplan, 1986). Families do try to change despite these problems; it is just that social and economic pressures undermine families' basic structures (Aponte, 1991). The concept of underorganization is helpful in understanding how families can lose sight of their own strengths and resilience and can feel overwhelmed by societal pressures to measure up to an image of what a successful, healthy and happy family looks like.

Besides underorganization, there are other issues which impact families' ability to function. Families who deal with multiple systemic issues are sometimes referred to family therapy because of an individual issue in one particular family member (Kaplan, 1986). However, the identified problem often does not indicate the magnitude of the systemic issues underlying it (Kaplan, 1986). The underorganization in these families,

as well as the lack of emotional and social support, help to maintain the status quo. As such, families can neither solve these issues on their own, nor can family members access community services which may be helpful in ending the chronicity of these issues.

This crisis state and the chronicity of problems are also commonly cited issues which affect family functioning (Kaplan, 1986). According to Kaplan (1986), the family which struggles with underorganization is known for its frequent crises, followed by frequent breakdowns. The family needs help when a crisis hits, but once the crisis has passed the family breaks off contact with the agency until there is another crisis. When the family fails to follow through during non-crisis times, they may alienate social service workers and the families often accuse agencies of being unable to help (Kaplan, 1986). However, the social services tend to respond to the family by dealing with the crisis at hand (usually the crisis of a specific family member) without examining the needs of the family as a whole (Kaplan, 1986). The cycle and chronicity of crises becomes exacerbated when agencies fail to address the families' complex needs.

One of the misunderstandings about underorganized families, and one that is commonly cited as a frustration by family therapists, is families' irregular attendance record. However, this seemingly outward sign of a family's lack of commitment to the therapy process needs to be put into perspective. Families who struggle with multiple systemic issues have many global issues to deal with in their daily lives which affect how often they come in to therapy appointments: lack of adequate childcare, lack of transportation, perhaps no phone to change or cancel appointments. A family's lack of financial resources does more than affect its bottom line; a lack of financial resources

translates into not only a decreased network of social and emotional resources, but a lack of professional resources as well (McNeil and Herschell, 1998). The concept of underorganization points to the influence of family therapists and how their perspective of the family may contribute to both the family's daily challenges, as well as continue to perpetuate myths about families who live in poverty.

Narrative Therapy Approaches

"Narrative therapy" is an umbrella term encompassing several different approaches by many different therapists (Andersen, 1987; Anderson and Goolishian, 1988; Freedman and Combs, 1996; White and Epston, 1990; Zimmerman and Dickerson, 1994). While these authors each present a different version of narrative therapy, relating personal narratives through storytelling is one of the fundamental ideas which cuts across all of these approaches. As a social work practitioner, I have worked with many clients who found storytelling to be a useful process that helps them make sense of their experience. Storytelling can connect the teller and listener, and is a way for people to give significance to past events through the choice of what details to include and what to leave out (Cheung, 1998). The telling of personal stories is also a way for people to "become the autobiographical narratives by which they tell about their lives...which mesh with a community of life stories...about the nature of life itself." (Reissman, 1993, p. 2). Storytelling is present in everyday life and crosses cultural and socio-economic boundaries (Reissman, 1993).

Historical Development

There are many influential figures who have contributed to the development of

narrative therapy. However, a full discussion of all of the authors and the various approaches which fall under the umbrella term of "narrative therapy" is beyond the scope of this report. Rather, the focus will be on those authors and the concepts which influenced and guided this practicum.

Michael White and David Epston are arguably the best known in the diverse group who call themselves narrative therapists. White's and Epston's specific approach had several different influences including anthropology, literary criticism, feminism and social philosophy (Nichols and Schwartz, 1998). In the late 1970s White began to be influenced by Gregory Bateson's ideas about information and how people map the world (Nichols and Schwartz, 1998). These "maps" establish guidelines for the selection of information about events and also put sensory limitations on human observation (Monk, 1996). White believed that these selections about what to remember or not remember can be used to understand how families deal with difficulties (Monk, 1996).

Michel Foucault also influenced White's and Epston's narrative approach. White and Epston have written about the connection between knowledge and power and the view that knowledge is political (White and Epston, 1990). Through Foucault, White and Epston look at power as a marginalizing force when people internalize the dominant narratives of mainstream culture, even when these narratives do not speak about individual experiences (Freedman and Combs, 1996; White and Epston, 1990).

Other influential contributors to narrative therapy models include Kenneth Gergen, Tom Andersen, Harlene Anderson and Harry Goolishian. Although not a family therapist, Kenneth Gergen has been influential in the development of narrative therapy through his work in social constructionism. A social psychologist, Gergen has written

extensively on social interactions (Gergen, 1999). Tom Andersen contributed to postmodern family therapy through the introduction of the reflecting team (1987). The process of the reflecting team is based on the idea that people create meaning differently, and it is through conversation that the various meanings can be explored (Biever and Gardner, 1995).

Harlene Anderson and the late Harry Goolishian have also contributed to the literature on narrative therapy. According to Anderson, the early work they did on their collaborative language systems approach is a "conceptual collage," having been influenced by the postmodern theories of biology, physics, anthropology and philosophy, as well as chaos theory, randomness, evolutionary systems, constructivism, structural determinism, autopoiesis, language domains, narrative theory and meaning, postmodern feminist perspectives, hermeneutics and social constructionism (Anderson, 1995, p. 29). Anderson's work has since developed primarily from hermeneutics and social constructionism, and emphasizes the move in her thinking away from language as a representational, accurate picture of reality (Anderson, 1995). Anderson views the process of therapy as one kind of meaning-generating system which examines problems as linguistic events (Anderson, 1995). In Goolishian's and Anderson's writings on the collaborative language systems approach, they emphasize the "not-knowing" stance of the therapist which deconstructs the hierarchy between client and therapist and views the client as the expert on their experience (Anderson, 1995, p. 34).

Theoretical Foundations

If narrative therapy is one of the tools to help families rebuild their strength and find meaning in their own experience, then surely postmodernism and social

construction can be considered the blueprints on which the renovation is based. Postmodernism and social construction are fundamental to the worldview of narrative therapy. While specific techniques and practices are important, some authors have said that it is a firm understanding of this worldview which is crucial to work with families (Freedman and Combs, 1996; Nichols and Schwartz, 1998).

Postmodernism got its start as a criticism of the modernist movement and its ideals. In its beginning, modernism was also a reaction to the movement before it; many of the explanations for how the world worked evolved out of tradition, pagan beliefs and romanticism (Gorman, 1993; Nichols and Schwartz, 1998). Modernism was a reaction to these chaotic explanations and brought a sense of order to the world through an adherence to a positivistic and scientific method. Large scale theories about human nature and behaviour developed out of the modernist idea that an absolute truth could be found for all things through observation and measurement. The field of family therapy developed with an eye to modernism; if human nature could be explained through universal theories, then therapists were the experts who used these theories to distinguish functional families from dysfunctional ones (Nichols and Schwartz, 1998).

First applied to literature, postmodernism has also become a crucial lens for the field of family therapy. As a reaction to the universal yardstick by which peoples' levels of functioning and normalcy were judged, some therapists began to criticize the family therapy field as upholding only the ideas of the mainstream culture. While these critiques were by therapists from a variety of philosophical backgrounds, they culminated in the acceptance of the postmodern metaphor in family therapy. Postmodernists are concerned with specific contextualized details, difference and

meaning rather than grand narratives, similarity, facts or rules (Freedman and Combs, 1996). This emphasis on the relativity of truth is one of the key ideas behind narrative therapy.

There are several streams of postmodernism which have been applied to family therapy. While these streams have in common the belief that human beings actively participate in the construction of reality (Franklin, 1998), social construction is the specific stream of postmodernism with which narrative therapy is closely associated. According to Gergen (1985) the social constructionist movement began when the concept of knowledge as a mental representation was challenged. Social constructionism stresses the intersubjectivity of knowledge (Laird, 1995). That is, reality is experienced through human interaction and the process of creating meaning through stories (Laird, 1995). Social constructionism offers ideas on how to challenge the impact of social discourses, the role of knowledge and power in society, the negotiation of truth, and the role of reflection (Freedman and Combs, 1996; Gergen, 1999; Hoffman, 1990; Laird, 1995; Weingarten, 1998).

Social constructionism challenges the belief that knowledge is gained through scientific discovery and is separate from either the knower or the process of knowing (Laird, 1995). In the hands of people in relationships, knowledge is communal, and language is the interactive process through which we share this knowledge (Freedman and Combs, 1996; Gergen, 1985). Freedman and Combs (1996) discuss language as neither a passive nor a neutral activity. Each time a person speaks he or she gives legitimacy to ideas and concepts, and the "logic of language" authenticates the descriptions we speak about (Freedman and Combs, 1996, p. 29). Knowledge is

conveyed through social discourse and is therefore shareable and not absolute.

The social constructionist view of power is related to knowledge. Foucault's understanding of power stems from the idea that language is a device of power because power in society is gained in proportion to your ability to participate in the various discourses that shape society (Freedman and Combs, 1996). Since societal discourses are more informed by those who have the power to influence them, knowledge is neither value-free nor neutral (Laird, 1995). Many of the common categories of understanding (gender, age, race, intelligence and others) create suffering, conflict and injustice (Gergen, 1999). If, with a social constructionist lens, we begin to examine all possible categories, not just the ones which are mainstream, we begin to understand a much wider view of the world because the acceptance of many categories enriches the perspective (Gergen, 1999). Gergen asserts that "the therapeutic and the political are inevitably linked" (1999, p.169). Social constructionism challenges the view that therapy is a process whereby one person (the therapist) has the knowledge and therefore the power, and the other person (the client) has none of either (Gergen, 1999).

The negotiation of truth is the social constructionist alternative to the one-up, one-down hierarchy of knowledge and power in the scientific/positivistic sense. Through language in social constructionism, people are able to negotiate meaning and truth. Language informs how we see the world, and through the negotiation of new meaning (which is ongoing), new truths based on individual, relative experience are created (Freedman and Combs, 1996). Since there is no objective reality in the scientific/modernist sense and we can only interpret reality there are many ways that an

experience can be interpreted, but no one interpretation is the true reality (Freedman and Combs, 1996). Rather than distilling down several experiences to maintain one universal tradition, social constructionists value the diversity that all the voices bring to the interpretation. Truth is valued and maintained in individual voices and interpretations.

Since gaining knowledge through conversation is an on-going activity, the recreation of meaning is also on-going. To deconstruct past, present and future narratives and their meanings, we need to continually reauthor our stories, and to do this we must be reflective (Gergen, 1999; Laird, 1995). Critical reflection is necessary in order to understand our traditions and to create our future (Gergen, 1999). The evolution of traditions is maintained through language, and reflection is necessary to acknowledge them as traditions (Gergen, 1999). While the dual tasks of maintaining traditions and creating new meanings is not an easy balance to maintain, in a world with multiple possibilities, critical reflection is necessary to maintain this balance (Gergen, 1999).

Clinical Approaches and Key Concepts

There are several clinical approaches and key concepts which embody the social constructionist perspective in narrative therapy approaches. These concepts have been grouped into three areas: a) collaboration between client and therapist, b) deconstructive listening and questioning, and c) mapping of the problem and alternatives.

Collaboration between client and therapist

Despite the fact that clients often come to therapy with a problem-saturated view

of themselves, the stance of the therapist in narrative therapy is that clients' descriptions of themselves and the problem are not fixed but changeable (Franklin, 1998). The emphasis is on collaboration where both the therapist and client co-construct the problem definition and new narratives (Anderson, 1995; Franklin, 1998; Gergen, 1999; White and Epston, 1990). The collaborative nature of narrative therapy is meant to both empower clients and try to equal out the power dynamic in the client-therapist relationship (Andrews and Clark, 1996).

Collaboration between clients and the therapist takes place with an emphasis on therapy as strengths-based. A strengths-based approach through narrative therapy gives the family and the therapist a chance to suspend suspicion and disbelief (Krumer-Nevo, 1998). Even though a number of facts must be obtained by the therapist about the family, the therapist does not have to adhere to a set of questions which would encourage the family to describe themselves as problem-focused. When the family tells their own story, they decide what facts to include or not include. The therapist's willingness to not only listen to this story but his or her willingness to accept this version of events makes it possible to view the family in a positive light, rather than by analyzing their limitations and shortcomings (Krumer-Nevo 1998).

White's and Epston's (1990) approach emphasizes strengths through specific techniques which move the problem outside of the person. These techniques are the personification of the problem, externalizing of the problem and the discovery of unique outcomes (O'Hanlon, 1994). The personification of the problem focuses on using metaphors or images which separate the client's identity from the problem (O'Hanlon, 1994). By focusing on effects rather than causes, externalizing is meant to ignite

discussion on ways that the problem hinders the client's ability to change. The focus in externalizing is not on blaming, but rather on the accountability of the person (O'Hanlon, 1994). Finding unique outcomes is the process of discovering times when the problem has not dominated the client (Nichols and Schwartz, 1998). This is another way to focus on client strengths and is done by looking for times when the client has been stronger than the problem.

Collaboration between client and therapist is further strengthened by the idea that change comes from the client instead of the therapist (Franklin, 1998). While narrative therapists may take part in creating a context for change, the client is the intervener and reauthors his or her own life (Zimmerman and Dickerson, 1994). The progressive steps of building on competencies, finding unique outcomes and discussing client strengths help clients find a new story about themselves. The goal of narrative therapy is to help the client rewrite his or her life story into something more positive as a whole, not just rethink the part with the problem (Nichols and Schwartz, 1998). The sharing of their narratives is the way that people determine what they notice and remember. Therefore, narrative therapy is concerned with helping clients reauthor their lives so their narratives include positive stories, not just the problem-saturated view of themselves they bring to therapy (Nichols and Schwartz, 1998). Narrative therapy further emphasizes that change comes from the client instead of the therapist by asking the client to look into the future and speculate about what the future will look like for this now strong, competent family (O'Hanlon, 1994). This not only helps the person articulate what their life will be like without the problem, but how their strengths will continue and their new narrative will take shape (O'Hanlon, 1994).

The emphasis on change coming from the client is one of the reasons why Krumer-Nevo (1998) describes narrative therapy as working so well with families who live with systemic challenges. The basic assumption of narrative therapy to view the client as a creative being who is the protagonist in his or her own story is powerful and empowering. On an intrapersonal level, the family actively sees themselves as the creators of their own stories. In composing and telling their story, the family can derive some order and security out of their chaotic perceptions (Krumer-Nevo, 1998). On an interpersonal level, narrative therapy opens up space to allow the therapist to be the listener and the family to be seen as experts about their own lives (Krumer-Nevo, 1998).

Anderson's and Goolishian's collaborative language systems approach is another tool which promotes collaboration between client and therapist. Anderson and Goolishian (1988) state that people are language and meaning making systems, rather than social systems defined by social organizations. In this sense, language and conversation are the main parts of therapy, and the therapist's role is to create space for therapeutic conversation (Anderson, 1995). A person's identity is guided by both their own experience (as told through narratives) as well as the narratives of the socio-political context, and the therapist and the client need to dialogue about which of these narratives are helpful to the client's self-identity (Anderson, 1995). Change is found through the opening up of possibilities in therapeutic conversations and in the "telling and retelling of familiar stories" (Anderson, 1995, p.31).

Deconstructive listening and questioning

One of the contributions of the therapist in narrative therapy is to provide deconstruction through listening and questioning (Freedman and Combs, 1996).

Deconstructive listening places an emphasis on the therapeutic process being conversational, not technical (Franklin, 1998). The initial intention is to listen to the client's narratives and try to understand them, but not change them in any way (Freedman and Combs, 1996). As a mutually trusting relationship develops between the client and therapist, the deconstruction can take a more purposeful role through questioning. This is done by asking questions that deconstruct the negative dominant narrative that the client has of themselves (Andrews and Clark, 1996). In fact, the first step of White's and Epston's narrative therapy has been called "coming up with a mutually acceptable name for the problem" by O'Hanlon (1994, p. 25). This is the start of externalizing the problem through language by asking about the problem's effects rather than its causes (Nichols and Schwartz, 1998).

Deconstructive questioning involves opening up space for clients to begin to understand that there are alternatives to the narrative they have first presented. Externalizing is one way of doing this. While externalizing is often used as a clinical technique in narrative therapy, externalizing is also a way of thinking (Freedman and Combs, 1996). Externalization encourages clients to see the problem as separate from themselves. Roth and Epston clarify externalizing as a form of resistance to the "culture of pathology that often pervades professional conversations" (1996, p.5). Externalizing conversations help to stop clients from blaming themselves, feeling guilty or ashamed for having problems (Roth and Epston, 1996). Externalizing offers a way to both clients and therapists to view the client in a way which promotes the idea that there are parts of themselves which are uncontaminated by the problem (O'Hanlon, 1994). This opens up options for the client to create new narratives for themselves in relation to the problem

(O'Hanlon, 1994).

The reflexive nature of the narrative approach means that the therapist's role is deconstructed and both the power dynamic and the meaning-making process are examined. Fine and Turner (1991) write about this shift to a second-order perspective and discuss the importance of opening up space in the therapeutic process. Fine and Turner suggest that the therapist should be self-observant within the therapeutic system by paying attention to his or her own values and the place that these values have in the process of therapy. Fine and Turner describe tyranny in the therapeutic process as an observer's descriptions which leave "little if any space for the consideration of alternative points of view, either with respect to self or to others" (1991, p. 309).

Anderson and Goolishian (1988) describe the therapist's role in narrative therapy approach as one of participant observation. Not only should the therapist convey openness, respect, and mutuality, but he or she also becomes a member of the problem system (Anderson and Goolishian, 1988). These ideas fit with Anderson's and Goolishian's view that the therapist should also take a "not-knowing" stance in therapy (Anderson, 1995, p. 34). "Not-knowing" refers to the idea that the therapist does not have access to privileged information, nor can he or she fully understand the experience of the client without learning more about what has been said, or not said (Anderson, 1995, p. 34). Collaboration and knowledge in therapy come from the understanding that develops while the therapist is continually being informed by the client and then joins in the unfolding of meaning (Anderson, 1995).

The questioning of dominant narratives which contain myths and metaphors which disempower the client is a task which is accomplished through deconstructive

listening and questioning (Franklin, 1998; Gergen, 1999). The damaging dominant narratives and political realities of society that clients face cannot be ignored by therapists. White and Epston view client problems as the result of oppressive societal narratives, and empowering the client against the problem is the goal of therapy (Andrews and Clark, 1996). White and Epston do this by creating an audience for the client's new identity, which is problem free (O'Hanlon, 1994). The client is able to get reinforcement of his or her new narrative through their social network.

Mapping the problem and alternative narratives

Traditionally, the therapeutic process starts with a family assessment. However, narrative approaches eschew the traditional emphasis on assessment usually found in other family therapy models. Narrative therapy offers a chance to listen and appreciate a family by understanding their choices in how they tell their story. In family assessments, often digressions and segues on the part of the clients are interpreted as "noise" amidst the real facts (Krumer-Nevo, 1998, p. 191). However, narrative therapy allows the listener to interpret these segues as integral to the whole narrative, since choices regarding what to tell the therapist are either consciously or unconsciously testifying to the teller's internal world (Krumer-Nevo, 1998).

The therapeutic process in narrative therapy focuses on the mapping of the problem narrative and alternatives to it. The narratives are explored through conversations about the meaning of the dominant narrative in the past, present and future (Nicholson, 1995). The same process of mapping is then done for the preferred narrative. Letter writing, genograms and the use of reflecting teams are clinical practices which can examine the past, present and future significance of dominant narratives and

alternatives.

While letter writing is not a contribution to family therapy which originated with narrative therapy, White and Epston use this tool to privilege the person's lived experience (White and Epston, 1990). Letter writing "thickens" the plot of new narratives and involves the therapist more heavily in the co-authoring process (Freedman and Combs, 1996, p. 208). White and Epston found through informal research that a letter written to a client is worth 4.5 sessions of good therapy (Freedman and Combs, 1996). Letters give the therapist a chance to reflect on the therapeutic process by choosing questions and words more carefully than is sometimes possible in the sessions (Freedman and Combs, 1996). Letters can also expand on the client's new narratives which were introduced in therapy by creating a lasting record of the positive narratives discussed by the client and therapist. Letter writing is also a tool which can summarize the work that the client and therapist have done so far together (Freedman and Combs, 1996).

Another clinical approach which is helpful in mapping out the influence of the problem and alternatives is the use of the genogram. The very nature of the genogram is the process of telling of stories. However, genograms are traditionally used as an assessment and evaluation tool which is completed in the beginning stages of therapy (Dunn and Levitt, 2000). In narrative therapy, genograms are a process-oriented tool and are used to extend the collaboration between client and therapist, focus on the mutual search for alternatives, and examine the power of social interaction (Dunn and Levitt, 2000). Genograms can also emphasize the respect for the client's point of view and help the client and therapist in externalizing the problem-saturated narrative by

placing it outside of the client (Dunn and Levitt, 2000; Kuehl, 1996). Genograms can explore the intergenerational transmission of problem-saturated narratives as well as client strengths, and explore how the clients have incorporated these into their own meaning-making process (Kuehl, 1996).

Finally, reflecting teams can be a way for families to map their past, present and future narratives. The reflecting team can provide the family with both feedback about their perceptions and increase the alternative explanations to the family's problem-saturated view of themselves (Andersen, 1987). The use of the reflecting team can also reduce the hierarchy between the team and the client (Hoffman, 1988). The team is to give feedback by introducing new ideas, unasked questions, unnoticed exceptions and overall expand the family's new story (Kilpatrick and Holland, 1999), but the family also gets a chance to reflect on the team's ideas and in fact is often given the last word in the process (Hoffman, 1988).

Research on Narrative Therapy

Despite the fact that the narrative approach has been used for some time by family therapy professionals, there is little research indicating its efficacy. A review of the research in this area yielded only four studies which are significant. Etchison and Kleist (2000) present a review of this literature (Besa, 1994; Coulehan, Friedlander and Heatherington, 1998; St. James-O'Connor, Meakes, Pickering and Schuman, 1997; Weston, Boxer and Heatherington, 1998). Two of the studies used strictly qualitative research methods, one study used strictly quantitative research methods and the fourth study used a combination of qualitative and quantitative methods. The focus of the research in these four studies ranged from an examination of parent-child conflicts,

children's beliefs about family arguments, parents' requests for help with a child's problem and families' experience of narrative therapy. Three of the four studies included eight or fewer families. The fourth study included 92 children ranging in age from five to twelve.

All four studies used different versions and clinical practices of narrative therapy. The study by Besa (1994) evaluated an eclectic narrative approach based on the work of White and Epston (1990) and included externalization, relative influence questioning, unique outcomes, accounts and possibilities as well as unique circulation and between-session tasks. The study by Coulehan, Friedlander and Heatherington (1998) examined Carlos Sluzki's narrative approach to therapy, which they describe as looking for transforming narratives. The third study by St. James-O'Connor et. al (1997) looked at an eclectic narrative approach which included the clinical practices of externalizing, examining alternative stories, recognizing family strengths and broadening an audience for the family's success. Lastly, the study by Weston, Boxer and Heatherington (1998) described the therapeutic approach they examined as "constructivist and solution-focused", but nonetheless used clinical practices akin to narrative therapy: examining problem-saturated narratives and alternatives through reframing, circular questioning and exception questions (p. 35).

Etchison's and Kleist's review of these four studies concludes that narrative therapy approaches can be useful when working with families. However, Etchison and Kleist also say that no statements can be made as to the effectiveness of narrative therapy approaches with any specific family problem (2000). Besa (1994) concluded that narrative therapy is effective, since five of the six families showed improvements in

parent-child conflicts, ranging from an 88 percent to 98 percent decrease in conflict. Coulehan, Friedlander and Heatherington (1998) discuss a number of limitations to their study but say in conclusion that in three out of four successful sessions, parents' descriptions of narratives of the problem had shifted. St. James-O'Connor et. al (1997) concluded that the results of their qualitative study show that narrative therapy can be an "empowering personal agency in family members" (Etchison and Kleist, 2000, p. 3). All of the families in their study reported some lessening of the presenting problem (Etchison and Kleist, 2000). Finally, the study by Weston, Boxer and Heatherington (1998) concluded that narrative therapy is compatible with family counselling.

Despite the appeal of narrative therapy and the above studies which indicate the efficacy of narrative approaches, Etchison and Kleist (2000) say that efficacy research is limited for a few reasons. The incompatibility between the objectivity of quantitative research and the belief in individual experience in the constructivist perspective is cited as one of the reasons for the lack of outcome studies on narrative therapy. Etchison and Kleist also say that qualitative research methods are well suited to researching the efficacy of narrative therapy (2000).

Critiques of Narrative Therapy

While narrative therapy provides a valid stance from which to understand and help families, there are criticisms of this therapy approach. A critical stance must be taken with the theory of narrative therapy in order to understand the implications for its use with families in clinical practice.

One of the many strengths of the narrative approach is its ability to challenge the notion of the universal family form: the nuclear family. However, Salvador Minuchin, a

well-known structural therapist, states that the postmodern wave in family therapy has managed to misplace the family as the focus (Minuchin, 1998). The family disappears from the therapeutic process in two ways, according to Minuchin. First, Minuchin says the systemic concept that family members co-construct meanings, and that they can be observed during therapy in this process of co-construction is lost when viewing the family through the postmodern lens because individual voices are privileged over that of the family as a whole (Minuchin, 1998). Second, often postmodern therapists work with families without the whole family being present. To Minuchin's eyes, this focus on the individual seems to go against the social constructionist idea that people construct meaning only in relation to others (Minuchin, 1998).

Minuchin discusses several other questions he has about postmodernism and narrative and their application to family therapy. Minuchin says that he believes that narrativists throw out the idea that a therapist's knowledge can act as a positive healing force for the family (1998). As well, Minuchin says that in the systemic metaphor, the therapist's participation in the family process provides a connectedness with the family where self can be used to witness, collaborate, expand and enrich experience (1998). Finally, Minuchin also criticizes narrative therapy for throwing out the idea that therapists can function without bringing bias to the therapy. Minuchin calls the defeat of these ideas in the new postmodern and narrative metaphors a serious loss (1998).

Several postmodernists responded to the criticisms of Minuchin of the postmodern and narrative metaphors as they are applied to family therapy (Anderson, 1999; Combs and Freedman, 1998; Schwartz, 1999; Sluzki, 1998; Tomm, 1998). While the debate between the two "sides" of the systemic metaphor versus the postmodern

and narrative metaphors will go on, as Sluzki remarked, "a question is as good as the waves it generates" (1998, p. 417). The responses to Minuchin's questions show how postmodernism and narrative therapy are still being changed through on-going dialogue.

There have been other criticisms of the narrative metaphor by other authors as well. Robert Doan (1998) has said that narrative therapy has fallen prey to the mistakes of past therapies by materializing metaphors and making gurus of its leaders. Doan (1998) wonders about the influence of narrative therapy and also claims that narrative therapists have prized "not-knowing" to such a degree that we have made illegitimate those who claim to have knowledge (Anderson, 1995, p. 34).

A second comment by Doan stems from the assumptions of social constructionism. Doan's point is that while social constructionism is "a description of one of the major outcomes of human evolution, [it is] not proof that it should be dismissed" (1998, p. 383). Doan goes on to say that people can be viewed as socially constructed, but "genetically likely stories" have an influence on the process as well (1998, p. 383). Doan's suggestion that family therapy would do well to consider both the socially constructed as well as the biological influences on narratives is not out of turn. This criticism is valid considering the wealth of new integrative models which have cropped up in family therapy, as well as the common practice of family therapists of integrating models to suit client situations in clinical settings (Nichols and Schwartz, 1998).

O'Hanlon (1994) and Nichols and Schwartz (1998) also voice their concerns about the narrative model. Although O'Hanlon writes of his own use of the narrative model, he is skeptical of two things: the claims of narrativists to being non-directive, and

the possibility that those therapists who use narrative therapy will ignore its worldview and use it simply as a set of techniques. Nichols and Schwartz (1998) say that both the strength and weakness of the narrative approach is its cognitive focus. This focus on cognitions ignores family conflict and relationship dynamics. Treating problems as stories which are to be deconstructed may overlook the fact that some families have long-standing conflicts that do not disappear because the family has joined to fight against an externalized problem (Nichols and Schwartz, 1998).

While these criticisms focus on the postmodern influence on narrative therapy, there are criticisms of White's and Epston's specific narrative approach. While the attention that White and Epston pay to the political influences on individual narratives has garnered the authors both criticism and praise, White has been criticized for his judicious application of Foucault's ideas in narrative therapy (Fish, 1993). While Foucault has written on power in society, his interest is in how power relations are constituted throughout culture rather than how power helps people dominate over others (Fish, 1993). As well, while White and Epston, as social constructionists, value individual experience, Foucault does not (Fish, 1993).

Another area where White has been criticized for his interpretation of Foucault is in the area of professional ethics. While White and Epston try to examine their own stance and equal out the power imbalance between therapist and client, Fish (1993) says they are wrong to use Foucault's ideas to support their own in this case. Fish (1993) argues that if Foucault were alive today, he would argue that White and Epston have already set up their practice as containing elements of the dominant discourse (for example, meanings of family, therapist, client). As well, Foucault would consider it

impossible to "establish a position outside the discursive field from which to accurately view their practice" (Fish, 1993, p. 225). Fish states that this injudicious use of Foucault by White and Epston has managed to perpetuate the neglect of social context and power (1993).

CHAPTER THREE

Intervention

Practicum Environment

My practicum took place at the Elizabeth Hill Counselling Centre in Winnipeg, Manitoba from June, 2000 to February, 2001. The Centre is an agency with a mandate to provide general counselling to families and children who may be at risk for abuse (D. Charabin, personal communication, June 9, 2000). The mandate of the Centre has recently changed, and this change further concentrates the Centre's work in the area of prevention and focuses on the issues which may get in the way of parenting (D. Charabin, personal communication, June 9, 2000). Counselling services at EHCC are free, confidential and voluntary. The Elizabeth Hill Counselling Centre is one of the few agencies in Winnipeg which provides this kind of general counselling service to families free of charge (D. Charabin, personal communication, June 9, 2000). Referrals to the Centre for counselling service can be made either by clients themselves or from other agencies, including Winnipeg Child and Family Services. The EHCC offers service to couples, families and children. The Centre also offers group counselling to mothers and children.

The Elizabeth Hill Counselling Centre is also a training facility for University of Manitoba students in the Faculty of Social Work and the Department of Psychology. As such, counselling service to clients may be provided either by paid staff of the Centre, or students at either the Bachelor or Master level who are supervised by Centre staff and faculty members.

Administrative Procedures

All of the counselling sessions for my practicum were held at the offices of the Elizabeth Hill Counselling Centre. All sessions were videotaped and some were also concurrently audiotaped. All video tapes, audio tapes, files and notes were kept in accordance with Centre record keeping procedures. Clients' confidentiality was always respected and consent forms were obtained from families regarding the taping of sessions and the publication of this report. Consent was also obtained from parents regarding the participation of any minor children in the counselling sessions. Families were always informed that I was a graduate student and that I was receiving direct clinical supervision.

My clinical supervision was provided primarily by Dr. Maria Cheung. Consultations on clinical issues were also sought with other staff members and students, when appropriate. Supervision included the reviewing of videotapes and the discussion of clinical issues as well as occasional live supervision. Clients were informed at the first session that live supervision may take place at one of their sessions in the future, and that this would involve the use of one-way mirrors with my supervisor providing feedback to me midway through the session.

The intake procedure at the Centre involved taking basic information regarding the presenting issue from the referral source over the phone. These initial phone calls are received on the Intake line at the Centre and these calls are taken primarily by undergraduate social work students who are supervised by a Centre staff person. Occasionally this initial phone call may be taken by the therapist who will be working with the client. Once the referral information has been gathered, the referral is passed

on to the counsellor, who then contacts the family as soon as possible and makes arrangements to meet with the family. While there was a waiting list for service when I began my practicum, the practice of keeping a waiting list was phased out at the Centre a few months later in order to better serve clients. If the family contact described their family as not quite ready for therapy, the family was urged to call back at a time that was better for them instead of placing their names on the waiting list. For families that wanted service immediately, every effort was made to either schedule an appointment at the Centre or find them a more appropriate referral to another agency or service that could better serve their needs.

Family Cases

During this practicum, I worked with a total of nine families with the length of the counselling varying from one to eleven sessions. While the number of sessions for these families varied, I stayed in contact with many families by phone for longer weeks than is indicated by the number of sessions. A profile of these nine families is provided in Table 1. It is important to note that many of the families who were referred to me did not come in for appointments. However, I often stayed in contact with them for several weeks while they consulted with other family members about the possibility of family therapy. Because I did not see these families in person, profiles of them are not included in this report, but work with them will be discussed in chapter five.

Four of the families I met with in person came for the initial session only. Of these, one family initially indicated that the presenting issue stemmed from the adolescent child's behaviour. Before counselling began, the child said he did not want to attend and therapy was discontinued after the first session for this reason.

Table 1: Profile of the Family Cases

Family	Family Composition	Ages	Gender	Length of Contact	Number of sessions	Involvement with other Professionals	Reason for Refferal
"A"	1 adult 1 child	49 12	Female Male	4 weeks	1 session	Child's school	Child's behavioural problems at school
"B"	1 adult 1 child	48 15	Female Male	4 weeks	1 session	Police	Child shoplifted, conflict between mother and son
"C"	1 adult 1 child	38 12	Female Male	16 weeks	8 plus a transition session	Child's school Business classes Social assistance	Communication, conflict between mother and son
"D"	2 adults	27 26	Male Female	10 weeks	2 sessions	Social assistance	Relationship issues: wife and husband "unhappy in relationship"
"E"	2 adults	24 23	Female Male	8 weeks	1 session	School Social assistance	Relationship issues: "things aren't working"
"F"	1 adult 2 children	26 8 7	Female Male Male	8 weeks	1 session	Individual counsellor	Parenting issues: mother concerned she's not emotionally available for sons
"G"	1 adult 3 children	40 15 13 9	Female Female Female Female	20 weeks	11 sessions	Individual counsellor Trauma counsellor	Alcoholism and effects of parents' separation
"H"	2 adults	51 49	Male Female	17 weeks	7 sessions	Medical professionals Disability pension	Relationship issues: different ways of handling conflict and different verbal styles
"I"	1 adult 1 child	39 13	Female Female	14 weeks	2 sessions	Social assistance Manitoba Housing	Changes in mother-daughter relationship since father's disappearance

In another family, the child moved out of the city. The third family was a woman and her two school-aged children. I cannot speculate as to why they did not return; appointments with me were not kept and phone calls were not returned. The fourth family that attended one session was a couple who subsequently missed two appointments. At the last phone call I had with the female partner, she told me she had not seen her partner for several days and she did not know where he was. This couple case was terminated and I suggested they call back if they wanted counselling to resume.

There were also two families that came to counselling for two appointments. One of these families was a couple who had separated. They missed a few appointments before we mutually agreed that counselling would be better when their schedules were less hectic. Another family was in the midst of bankruptcy proceedings and were trying to buy back their repossessed house. They asked to postpone counselling until that process was over.

Counselling service to the remaining three families ranged in length from seven to eleven sessions. The length of therapy was different for each family depending on their presenting issue, their needs and what they indicated they wanted to accomplish through counselling. The family composition varied. Two families were female headed. Family "C" had no contact with the child's father. In Family "G" the female parent was separated from her husband and he was not invited by the family members to attend the therapy. The children in Family "G" maintained regular contact with their father. The third family was a heterosexual couple. Both partners in this family have an adult child from a previous relationship, but the children were not invited to take part in the therapy.

The minor children in the other families ranged in age from nine to 15, and the adults ranged in age from 36 to 51 years old. The majority of the family members were caucasian.

While the presenting issues for each of the families was different, there were some similarities in the systemic issues that challenged the families. All three families had at some point in the last year dealt with an adult's unemployment or job change. One of the families lived in and owned a home, while another family had, due to financial constraints, sold their house and moved into an apartment. The third family was living in a rented home. The adults ranged in their educational levels from some high school education to education at a post-secondary level. All of the adults, at some point during the therapy, dealt with major health issues. In two cases, the possible diagnosis of a life-threatening disease turned out to be false. One adult had a chronic long-term health problem and another adult had an accident. These health issues impacted the day-to-day functioning of the families. All of the families were currently or had in the past used the services of other professionals such as counsellors, school officials, medical professionals, social assistance or Manitoba Child and Family Services.

A Qualitative Approach to Evaluation

There are currently no specific clinical evaluation measures being implemented at Elizabeth Hill Counselling Centre. For my practicum I chose to use a qualitative approach to practice evaluation. Qualitative methods are consistent with a social constructionist perspective. The hallmark of qualitative research is that it is emic. That is, it seeks to capture the point of view of those involved rather than imposing external

categories or ways of understanding (Padgett, 1998). Although quantitative evaluation through a standardized questionnaire may have given a more cut-and-dry conclusion as to the amount of client change and the effectiveness of my practice, I believe that quantitative evaluation imposes categories and ideas of effectiveness through the use of a standard, universal yardstick which family members must measure up against. In keeping with a social constructionist worldview, qualitative methods are holistic and look to the respondents to create categories and themes which form the measures of their own ideas about how effective the therapy has been. There are three ways that qualitative methods were utilized in the practicum: an examination of client change based on narrative analysis, regularly elicited feedback from family members and the use of a feedback questionnaire at termination.

Narrative Analysis

The primary method I used to examine the change process with families who received full service is based on narrative analysis. Narrative analysis is an interdisciplinary approach which is closely associated with ethnography and cultural anthropology, but also has roots in linguistics and sociology (Reissman, 1993). I chose this research method because it is congruent with social constructionist ideas in that narratives are representations of reality (Reissman, 1993).

Storytelling is an integral part of the therapeutic process as clients relay the meaning of events and the therapist and clients together co-create new narratives as alternatives to the problem-saturated ones. Narrative analysis is a methodological approach which examines not only the underlying meaning embedded in the story, but the structure and sequence of the telling (Reissman, 1993). Although several disciplines

contribute to the core traditions of narrative analysis, it is still largely an interpretive activity and there is not one single method to use when conducting narrative analysis. In fact, many authors disagree about the definition of what a "narrative" consists of. Narratives can include both the therapist's comments or questions which lead into a client's story, as well as non-lexical utterances (ah and umhum for example) and general conversation between the family members and therapist (Reissman, 1993). As opposed to a grounded theory approach which breaks down the narratives into smaller pieces of information for coding, narrative analysis keeps the narratives whole and intact. For the purpose of this report and the qualitative evaluation, I chose to define "narrative" as stories or views the family members told, metaphors family members used and general conversation among family members and myself. I also include my own comments and questions as part of the definition of "narrative". In some cases, narratives were distinguishable by their structure. Labov (1972) a linguist, believes that narratives are identifiable by their structures, although not all narratives fit within his definition. For Labov, narratives have six parts: an abstract (a summary of the narrative), an orientation (to tell when and where the event took place), a complicating action (the sequence of events), an evaluation (the significance and meaning of the event), resolution (telling how the event/action was resolved) and a coda (which returns the perspective to the present) (Labov, 1972; Reissman, 1993). Since not all narratives fit within Labov's structural template, I have not distinguished between "stories" and "narratives" in this report. Rather, this Labov's structure was used strictly to find the entrance and exit talk of narratives and stories within the therapy sessions.

By transcribing the first, middle and last sessions and then analyzing the

narratives in these sessions of each of these families, change is distinguishable through the way that families describe and make sense of the events in their lives. By choosing only these three sessions to examine the narratives, client change will be more readily distinguishable. Analysis of the sessions based on narrative analysis ensured that the themes and subthemes originated from the co-construction of narratives in the sessions by both the family members and myself as therapist. Because of its emphasis on storytelling as well as the belief that narratives are representations of reality, qualitative analysis based on narrative analysis was an ideal choice for the evaluation of clinical practice with the narrative approach.

Feedback from Family Members

A second way that qualitative methods were used was by asking family members periodically throughout the therapeutic process about how the therapy was proceeding. Checking in with family members informally gave the family members and myself a chance to step back from the process and to reflect on how the therapy was meeting their needs. Regular feedback was important in order to continue to co-create solutions and alternatives as well as to deconstruct my role as therapist. This regular feedback from family members was also a way for the family and I to continue to collaborate on the therapy process, as well as ask about any new directions or changes they wanted to make for future sessions.

Thirdly, a feedback questionnaire was given to the families who completed the therapy process (Appendix A). All family members regardless of their age, were requested to fill one out without the therapist present. The questionnaire consisted of four open-ended questions and one question which asked the family members to rate

the effectiveness of the therapy using a four-point rating scale. Family members were also asked about what the counsellor could do differently in order to help other families in counselling. The answers from family members provided insight which was very helpful to understanding how they saw the counselling process. The family members' responses are examined in chapters four and five.

Ethical Considerations in Qualitative Designs

There are several ethical issues to examine when using qualitative methods. Ethical issues for qualitative analysis involve rigor, credibility and trustworthiness (Padgett, 1998). In qualitative analysis, rigor refers to the degree to which the data analysis is authentic and the interpretations are credible (Padgett, 1998). Threats to trustworthiness and credibility include reactivity, researcher biases and respondent biases (Padgett, 1998). Trustworthiness was increased several ways during the practicum when I was gathering the data. The possibility of reactivity due to my own biases was monitored through regular supervision, the use of videotapes and regular record keeping. As a social work practitioner, I am also bound by the Social Work Code of Ethics which discusses integrity, objectivity and competence in the provision of services to clients (Canadian Association of Social Workers, 1994).

Videotaping was also a valuable measurement tool to use for the gathering of data. The use of videotape meant that information for practice evaluation was gathered unobtrusively and the therapeutic process proceeded in a naturalistic way. There was a lowered chance of client reactivity and bias since it is common for people to forget they are being videotaped. Also, clients seemed to be less bothered by the use of videotape over time since it was used every session, not just introduced prior to the three sessions

which provide the data for analysis. In this way, measurement tools were in essence used throughout the intervention with the family, and client change due to the introduction of measurement tools were therefore minimized.

CHAPTER FOUR

Case Reviews and Qualitative Analysis

Overview

This section will illustrate how families and I worked together using a narrative therapy approach. The names and other identifying information have been excluded to preserve the families' privacy and confidentiality. This section will also include the qualitative analysis showing the process of change for each of these families and how narrative therapy facilitated this change. Although I strived to make the transcripts as complete as possible, there were times that I could not hear what was being said on either the audio or videotape. This is marked in the transcript by a (?) for one word which is missing and (??) for two or more words missing.

Over the course of the therapy sessions, the stories each of the families told about themselves and their life varied in subject, content and meaning. According to Pugh, the "transformational power of narrative lies in the capacity it gives to the client to re-relate the events in his/her life in the context of new and different meanings" (1998, p. 259). This qualitative analysis will concentrate on how the meanings of the family members' narratives changed over time so they represent a less problem-saturated view of the themselves and begin to represent a more competent and resilient view of the family.

The process of an initial contact and the first session with all families had several commonalities. First, I tried very hard to contact the family as soon as possible after they called the Centre for counselling service. Occasionally this resulted in playing "phone tag" for a few days. I usually asked the person who was the family's contact to

explain to me over the phone why they were seeking family therapy at this time. This gave me a chance to try to understand what they were looking for from counselling, and how they saw the process taking place. I also took the opportunity to explain how the Centre worked (hours, confidentiality, my supervisors, etcetera). I also tried to use questioning and a non-expert stance in this initial phone call in order to start the joining process with this family member (Anderson and Goolishian, 1992). Part of the process of joining with the family also included trusting the family to make their own decisions about who to include in the therapy process. Composition varied in families that I met with, and this is in keeping with the definition of "family" that was discussed in chapter two.

While narrative approaches do not use a formal, structured assessment process, I found it helpful to concentrate our conversations in a few areas in the initial session. First, I explained again about how the Centre worked so that all of the family members had the same information. I also asked each family member to talk about what was important to him or her in their lives: How they spend their time? Did they work outside of the home? Go to school? What did they do for fun? Who were the people that they relied on in their life? What kinds of things do they do to deal with stress? These questions were not meant to gather assessment information. Rather the intent was to focus on the family's life as a whole, rather than just on the problem area.

Family "C"

The "C" family consists of a 12-year old boy and his mother. Mother "C" contacted the EHCC for family therapy because she felt there were communication problems between her and her son, and she wanted the two of them to be able to

handle their conflicts in a better way. A year and a half before family therapy started, an individual counsellor at the Centre worked with Child "C" because he was being bullied at school. That issue was resolved and Mother "C" said that the individual counselling was helpful to her son. Soon after the individual counselling ended, the mother of Mother "C" (Grandmother "C") died. The family's grief and the loss of Grandmother "C" set the tone for the family therapy. Although we only spent a small amount of time discussing their grief, we often discussed the effects of the loss of this important person in their lives. Mother "C" felt that when her mother died, she spent a lot of time settling her mother's affairs and this took time away from her relationship with her son. She said that she had "no emotional support for him at all" during this time and she was concerned that the conflicts between her and her son would get worse as Child "C" became a teenager. Child "C" spent increasingly more and more time in his room alone in the evenings and on weekends. While Child "C" said that his mom nagged him and was "cranky," he did not agree that there was a problem between them. His explanation for spending time in his room was that he liked to play video games and work on his computer.

The "C" family attended eight sessions of family therapy. There were increasing concerns regarding Child "C" being bullied at school again near the time of the final family therapy session, so there was also a transition session that I attended with Child "C" and an individual counsellor following the last session with Mother and Child "C". At various times, the "C" family had sought out the help of other professionals for various issues they were dealing with. With the bullying that Child "C" coped with, school professionals such as the guidance counsellor, teachers and the school principal

were involved, as well as an EHCC individual counsellor for Child "C". At the time of the family therapy Family "C" was living on social assistance, although part way through the therapy process, Mother "C" began to take business classes which were offered free of charge though another agency. Her dream was to start her own small business. Near the end of the family therapy, Mother "C" got a job with a company she had worked for previously, and she was very happy about this, as it could supplement her overall plan for her business. Mother "C" was also dealing with health problems throughout the family therapy. She had a broken foot and was in a cast for several weeks. She also underwent medical testing which ruled out a life-threatening illness.

Qualitative Analysis

Beginning sessions

Mother "C" described her goal for counselling as wanting to "figure out a way to get through it and maybe end the squabbling and get conversation going". From these initial conversations about goals, several themes developed about the influences on the family's communication. These themes were: a) the "block", b) "video games", c) the influence of Grandmother "C" and, d) "I'm cool with it". These themes were reintroduced throughout the therapy process in various stories the family members told.

Theme A: the "block"

In this beginning session, the first question I asked the family was what brought them to family therapy. I encouraged the family members to tell their stories in whatever way was relevant to them, and I wanted to help Mother "C" keep her positive perspective of the family that she brought in to this session, namely that the family is strong and they can endure. Nicholson (1995) uses the apt metaphor of a dance to

describe White's and Epston's narrative process in therapy. A dance between partners suggests a ritual activity which involves collaboration on the rules, deciding who leads whom, and a blending of the dancers' styles (Nicholson, 1995). Through this first open-ended question I asked, I wanted to honour each person's perspective, and to begin to show my respect for the collaborative process of this "dance" we were engaging in:

> THERAPIST: **Yeah, so, do you guys want to tell me about what, umhum, brought you in?**
> MOTHER "C": Oh, okay, sure, yeah. (laugh). **Start at the beginning or the end?**
> THERAPIST: **Wherever you want to (Mother "C": Alright.) start.**
> MOTHER "C": Umhum. Well, two years ago, my mom passed away suddenly. And after that I handled her estate and **I battled** with the Justice Department and I battled my family and everything else and my whole world changed and I kind of {pause} shut out. You know, **I had no emotional support for him at all and we stopped doing things together** and that? And **it created a block**. And I can, **I can see it and I can feel it** and it's getting worse and worse and worse and like last night, until two in the morning we were up fighting. Right? Screaming, yelling. Yeah. It's like there's no communication at all anymore and it's really {pause} it's getting bad. Like he's twelve now and he's going to be a teenager soon and it's going to get worse and worse and worse. And that's why I thought we better do something now before, {pause} y'know, {pause} there's absolutely no talking.

It is important to note that the answer Mother "C" gave to my question was the first story she told in therapy, and it served two purposes in this first session. First, the story described the background of the problem that brought the family to therapy. The metaphor Mother "C" used for the problem is a "block". I interpreted her meaning of "block" to mean that things changed so much for the family that there was what felt like a physical boundary that she could see and feel, between her and her son. Mother "C" was concerned that she had not been a good parent to her son while taking care of her mother's affairs ("I had no emotional support for him at all and we stopped doing things together") and this contributed to the "block".

Second, the meaning behind this story was to give an example of the family's

ability to endure. Mother "C" told these kinds of stories repeatedly throughout the first part of the therapy process, indicating to me that their meaning is extremely important to her because they indicate the kind of people they believe they are. It is also important to note the other language Mother "C" uses in this story, specifically her word "battle".

While the meaning of "battle" suggests a conflict, Mother "C" also uses the word as a verb, so it also suggests that the family actively fought back. Mother "C" used "battle" throughout the therapy process to describe the struggle she and her son have endured, and won.

I continued to ask open-ended questions which maintained and built on their view that even though the family has been through a lot, and are currently facing a "block", these things are also "no biggie":

> THERAPIST: Do you have other people in your life, Mother "C", like **you mentioned your brothers are important...are they supportive?**
> MOTHER "C": No...it's stressful. I'm trying to help my little brother get a mortgage right now and trying to watch my other brother, plan an intervention with him for him, you know. **But I can still handle all of that and still be there for him**...And then [CHILD "C": (?) minutes.] there's very much the last straw. So we've pretty much been that way since day one. You know, my mom's been a really big help with babysitting and somebody to talk to. And that's about it. I've got a few friends, so...**But that's no biggie. I can deal with that...**
> THERAPIST: Sure**...So how do you deal with all of this stress then? It's it's very [MOTHER "C": Hmm.] difficult sort of. taking over that kind of role [MOTHER "C": Yeah, yeah, yeah.] and helping everybody else out?**
> MOTHER "C": Well I write letters to Justice Departments and **I try to (laugh) change things. [THERAPIST: Social action kind of things?] It's a battle**, you know? [THERAPIST: Yeah.] Umhum, I, **I try help a lot of people** as I do (??) and do resumes for them and help them find jobs and there's a couple of little old ladies who were friends of my mom and I help them sometimes, take them here, take them there. One, Friend's name, we helped her learn how to use the computer. [THERAPIST: Oh wow.] Stuff like that.
> THERAPIST: Oh, yeah.
> MOTHER "C": Yeah. And (??) lonely, it gets really lonely sometimes. I mean, but these acquaintances I have I can phone and, you know and talk to from time to time and complain, do my own complaining [THERAPIST: Sure] and umhum, that's pretty much it. {pause}. **Here I am. Carry on.**

Developing collaboration with the family involved respecting both where the family had come from, and how much strength they have had in getting through these "battles". Deconstructive listening was an important tool in conveying this respect for their strength, the choices they made and the struggles they have made it through. Part of my own process in understanding and using deconstructive listening as a therapeutic tool with this family was paying attention as much attention to the questions that I did ask, as to the questions I had, but did not mention. Taking a stance of "not-knowing" is one of the tools I used in order to refrain from sounding like I was judging the family for the choices they made (Anderson, 1995, p.34). I could have questioned Mother "C" about why she chose to take care of her mother's affairs rather than concentrate on her son. However this is not the point; according to White and Epston (1990) narrative therapy concentrates on the effects of the problem and not the causes. As well, since this is not a case of child neglect, I do not have a right to question these choices by Mother "C". This step in the "dance" of narrative therapy was done to guide conversation away from blame and actively address the power imbalance in the therapeutic relationship.

Theme B: "video games"

Playing video games was one of the activities Child "C" did with his free time. The family had a computer and Child "C" also had a portable game which he carried with him. Playing video games is not an unusual activity for a 12-year old, but the computer and video games of Child "C" were often cited by Mother "C" as things that got in the way of their relationship and in his friendships with other kids:

> MOTHER "C": **And you would actually like to play more Nintendo that you actually do, CHILD "C".**

CHILD "C": All Friends' name (??) plays more Nintendo. **I have a rule.**
MOTHER "C": But you've been playing more than you have in the past. Right? **You guys used to socialize, you used to see your friends more often on week nights? You used to go out and do lots of things.**
CHILD "C": Yeah. [MOTHER "C": And you used to do lots of things on weeknights?] **I used to but not any more. Video games, video games.** [MOTHER "C": Yeah.] **Video games, and then there's probably umhum, the computer.**
THERAPIST: Umhum.
CHILD "C": That's the time (??)
MOTHER "C": And do you remember you and I used to go every night and go to the park or go skating or we'd go somewhere?
CHILD "C": No.
MOTHER "C": Oh, you can remember that CHILD "C". It's before Grandma died. We went tobogganing almost everyday after school and, you know? Stuff like that?
CHILD "C": Well, we can't go tobogganing.
MOTHER "C": I know but {pause} we'd did other things and go out all the time. We were always going to the parks and stuff, and going to other places. Umhum? And we just kind of stopped, right?
CHILD "C": Yeah.
MOTHER "C": Yeah.
THERAPIST: So do the video games and the tv and things you do now, sounds like they've been since your grandma died?
CHILD "C": No. And they've been here long before that.

Child "C" said he "has a rule," meaning that he knew there were limits because he had his own ideas about how much time he should spend on the computer and playing games. It is through his friends, who play games more than he does, that Child "C" formed his ideas on these limits. Mother "C" does not agree, and as she explained previously, she feels it is one of the things that keeps Child "C" in his room, isolated on evenings and weekends. The idea that Child "C" has "a rule" gave me some clues as to his perspective on computers, and how important they are to him. The difference in perspectives between Mother "C" and her son, were explored as the therapy progressed and we discussed the video games in ways which were meant to bridge the gaps between their perspectives on this activity, which were obviously important to Child "C".

Theme C: the influence of Grandmother "C"

While we spent a lot of time talking through the stories Mother "C" had about what the family had endured, we also talked about the influence of Grandmother "C" on the relationship between Mother "C" and Child "C":

> THERAPIST: Well, how, how often do you see, is this something that you want continue, having done this one session, do you guys want to continue with it?
> MOTHER "C": I would like to. Until we get somewhere. I don't know if you see, **is this something, normal?** You know, **I don't even have anything to relate it to any more since I lost my mom.**

In the above discussion, I asked about whether they thought the counselling process would be a useful tool for them, and the answer Mother "C" gave is a clue to her goals for this process. This is a difficult time for the family, and Mother "C" is looking for help in deciphering her son's behaviour, as well as help putting the recent events in the context of their own experience, so that she has something to "relate it to". The stories told by Mother "C" in the beginning stage of therapy about Grandmother "C" look back to the past. Mother "C" lost her benchmark for parenting when her own mother died, and these stories indicate a reason why Mother "C" feels she is not able to parent as well as she would like. Even though Grandmother "C" is no longer present in the family, her beliefs and values are still important for the "C" family and the narrative approach gives us an opportunity to explore this in the therapy process.

Theme D: "I'm cool with it"

Mother "C" often connected her stories of the influence of Grandmother "C" to stories about how Mother "C" is a more flexible parent than her mother. Throughout the therapy process, we discussed how Mother "C" was the same or different than Grandmother "C" in how she parented. The phrase "I'm cool with it" is one example of a phrase that

Mother "C" used which had this positive meaning. Other similar phrases and the meaning will be examined in the middle sessions. In the first session Mother "C" said,

> "And she worked a lot and **she wasn't emotionally there**, she was always clean, food was on the table, the house was always clean you know? Things went on in that house but **she wasn't emotionally there**. That's one of the concerns I have for Child "C" over the past few years because **I don't want that to happen to him, and me, you know? Because I kind of lived through it already once."**

Her use of the phrase "I kind of lived through it already once" is meant to indicate a difference between the way that Mother "C" was parented and the kind of home she lived in and the home she is providing for her own son. Grandmother "C" was not "emotionally there" for Mother "C" when she was growing up, and Mother "C" is trying her best not to repeat this. My goal for these first conversations about parenting was to encourage the family to talk about what they considered "normal", and to help them stay focused on their earlier talked-about view that they are a healthy, strong family. The questions I asked were an important part of guiding this conversation so that we talked both about how Mother "C" is different than her mother, and also on what Mother "C" believed she was doing right in parenting her son.

As we focused more on the positive ways that Mother "C" and her son were able to connect, Mother "C" told stories about how she was a "cool" parent. She used the word "cool" several times throughout the therapy to mean the kind of parent she wanted to be to her son. This "coolness" is a characteristic Mother "C" did not see in her own mother and these comments are a reference to the abilities of Mother "C" to be a flexible parent:

> THERAPIST: So is it partially not just general communication but a way to deal with conflict?
> MOTHER "C": Yeah. I mean, over brushing our teeth we're going to have big fights. And that's, that's terrible. I mean, save the stress for the big fights, not the

> little dinky fights. But at the same time, he can't walk around for a week without clean teeth, right? I'm proof of that, but over the summer I think there was a two-week period without bathing. You know, it's like, get away from me, but it's okay, you know, you're in the lake every day. **I'm cool with it, right?**
> CHILD "C": Except for Child's friend.
> MOTHER "C": Yeah, you and Child's friend. A whole seven days neither one of them bathed or changed their clothes. They were in and out of the water and in the same clothes every day, so I'm trying not to [CHILD "C": (??)] Yeah. I'm sitting next to the two of you. So you know, **I'm not a freak when it comes to stuff like this. It doesn't have to be perfect, you know...**

The above discussion presented us with one of the many unique outcomes in the family. Despite describing a "block" between her and Child "C", Mother "C" gave concrete examples of times when she was trying to be flexible with respect to family rules. This conversation is also an indication that Mother "C" has strong beliefs regarding which behaviours she is okay with from her son, and that she values her ability to be a "cool" parent. This unique outcome sets the stage for further discussions about when this family is able to be stronger than the problem, and alternatives to the way they currently communicate.

Middle sessions

Theme A: the "block"

From the beginning, Mother "C" tended to dominate conversation, often answering questions that I would ask her son, and giving examples of his feelings. While Mother "C" describes the family's situation through several narratives, Child "C" did not speak very much at all. I asked him questions to supplement what his mother said, and I tried not to pressure him into saying things he was not comfortable with. In this regard, I attempted to consider him as an audience for his mother's narratives and respect his comfort level about when to join into the conversation. I was challenged by the reluctance of Child "C" to say much. Mother "C" was increasingly frustrated by his

lack of participation, and she often pressured Child "C" to speak more in sessions. At one point she had grounded Child "C" for not participating in the therapy as much as she would have liked. The way that I responded to this I think, led to another "block", one that showed itself in the sessions between the three of us and was beginning to mirror the block between Mother and Child "C" outside of the therapy sessions. It was in the fourth session that I think we uncleared this block. Mother "C" had to fill out some paperwork for the Centre which took about 30 minutes. In the meantime, we used the time to have a "regular" conversation (as opposed to talk about therapeutic issues). Because Child "C" said he was bored, I suggested he play with his portable video game he had in his pocket. This ended up being a conversation starter for the abilities of Child "C" and his expertise on computers:

> THERAPIST: ...So what kind of games do you like playing on that? [CHILD "C": Umhum.] Do you have a favourite?
> CHILD "C": **The favourite come out in like eighteen or nineteen days, possibly, I'm not sure if it's exactly eighteen or nineteen days**, the Pokemon Gold version is [THERAPIST: Umhum.] coming out in the fall. [THERAPIST: Umhum.] In exactly nineteen days.
> THERAPIST: So it's umhum, what's it, that game, what do you do with the game? What is it, what's special about it, or how do you play it?
> CHILD "C": Umhum.
> THERAPIST: Just a new, new game?
> CHILD "C": Yeah.
> THERAPIST: Oh.
> CHILD "C": **I've been waiting for it for years. I already bought the Japanese version off the internet.**

Past conversations about video games have largely been narrated by Mother "C" and tend to focus on the negative aspects of the games. However, I tried in this session to guide the conversation to bring out and focus on the stories of Child "C". I hoped to engage Child "C" in conversation as therapy continued so that he would feel comfortable to fill out his narratives about family life.

Theme B: "video games"

The session where the three of us cleared the block between us was a turning point for the therapy. I continued to guide conversation using open-ended questions to focus on the strengths of Child "C" and his love of video games. His video games are so important to him that they create a way for him and his mother to remember their stories and map events in their life:

> CHILD "C": I got my Nintendo system when I was like four, or three years old.
> THERAPIST: Umhum.
> CHILD "C": Like four years old.
> MOTHER "C": Six years old. [CHILD "C": What?] You were six.
> CHILD "C": When I got my Nintendo, my normal Nintendo?
> MOTHER "C": Yes...
> CHILD "C": Okay. [MOTHER "C": **This is when we lived in the house on Street name.**] No, no, no, no, no. I know that but it doesn't make any sense whatsoever, because **on my fifth birthday I got my SuperNintendo when I had my normal one long before that and I've always been playing long before that.**
> MOTHER "C": Okay.
> CHILD "C": That made no sense whatsoever. [MOTHER "C": **I don't agree. It was on Street name Street because Friend's name gave it to you.**] Oh yeah.
> MOTHER "C": Have you ever seen (??) with whats-her-name? Child's friend, your friend?
> CHILD "C": Yeah.
> MOTHER "C": That you played with her and you were frightened of it.[CHILD "C": (??)] Yeah.
> THERAPIST: Was it just overwhelming to use it and stuff?
> CHILD "C": I don't know. I don't remember.
> MOTHER "C": You were six [CHILD "C": I was three] you were six [CHILD "C": I wasn't.] **you could be right because we moved in there when you were four.[CHILD "C": Yes.] and moved out when you were six.**
> CHILD "C": **On my sixth birthday you sold my normal Nintendo to get me that SuperNintendo.**
> MOTHER "C": Umhum.
> CHILD "C": **But that doesn't make sense. On my sixth birthday, you got me my normal Nintendo.**

Nicholson's metaphor of the dance of narrative therapy also examined the idea that stories, like a dance, "the therapist and client are involved in an action and meaning shuffle across time" (1995, p. 24). The narrative approach is one where particular

emphasis is placed on examining the stories of the past, present and future, moving back and forth in order to find meaning in experience (Nicholson, 1995). The "C" family and I had examined the past narratives when the problem of communication existed, and we had also examined the present narratives where Mother "C" and Child "C" had differing views about the influence of video games on the problem. In the sessions where we examined what alternatives to the problem would look like, I tried to focus the discussion on times when the video games and the skills of Child "C" helped the family:

> MOTHER "C": So {pause} some day we'll be a household name, eh, you and me, Child's name? You'll run the family business after I'm gone.
> CHILD "C": Nope.
> MOTHER "C": What?! What if it's a million dollar business?
> CHILD "C": Okay. Then I'm willing to do it.
> THERAPIST: **Maybe she'll have this amazing computer system and they'll need this expert to run it. You might be the only guy who knows how to [MOTHER "C": I'll need you to program everything.]** Yeah.
> MOTHER "C": You betcha.
> THERAPIST: **You'll probably do it in like a couple of hours anyway, eh? And then, and do something else in your spare time [CHILD "C": I don't think so. I have no idea what to do in case of crashes.** (??)] I don't think many people know what to do or else so many people's computers wouldn't crash on them (??).
> CHILD "C": **Whenever it crashes just completely reboot it.**
> THERAPIST: Umhum. Would rebooting it make it, the bug disappear?
> CHILD "C": **No, it just makes it like, it takes everything off the computer and makes it as if you just got the computer.**
> THERAPIST: Oh, I see, okay. So the virus that's in it would be [CHILD "C": Would be toasted.] Oh. {pause} **Did you learn all this stuff just by {pause} going on the internet and just sort of learning for yourself [CHILD "C": Nope. I learned it by experiencing it.] Okay.**
> CHILD "C": **I learned it with the virus and broken computers.**

Theme C: the influence of Grandmother "C"

As the therapy continued, we focused less on the negative stories of the influence of Grandmother "C", and more about the kinds of things that help the family have the kind of relationship they want. Our exploration of the dimension of time in their

stories and their meaning was meant to help the family reconnect to the full story of their lives (Nicholson, 1995). We talked more about how Grandmother "C" influenced the relationship between Mother and Child "C", but the stories became more positive in their tone. These stories also included examples of the kind of activities that the "C" family liked to do together:

> THERAPIST: Do you remember all that Child "C" ?
> CHILD "C": **Yeah. Do you remember the story about grandma?**
> MOTHER "C": Grandma what?
> CHILD "C": **In the tent and sleeping?**
> MOTHER "C": Oh, with her head sticking out. Yeah, grandma was claustrophobic and she couldn't sleep in a tent [THERAPIST: Oh. So her body was in the tent and her head out?] And her head was out, yeah. Otherwise she'd be laying out on the picnic table in the morning. And sometimes she'd get up in the night to go to the bathroom and not think anybody else was around to see and people would say, good morning, and she's in the middle of it next to a tree, right? Remember?
> THERAPIST: How old were you Child "C" ?
> MOTHER "C": We started going camping I guess, when you were three. Two or three, yeah...

The above story is one of the first where both Mother and Child "C" are involved in its co-creation; Child "C" introduced the story, and Mother "C" told it. This story is an example of how Grandmother "C" was an important member of the family, and the family has positive, fun stories which include her. As opposed to stories told previously where Grandmother "C" was a reminder that this family was not functioning as well as they would have liked, the above story shows Grandmother "C" is a reminder that Family "C" has been able to connect to each other and they have examples of good communication from past experience.

Theme D: "I'm cool with it"

Mother "C" used a few phrases which I interpreted to be similar in meaning. One of those instances is the shared meaning between the phrases "I'm cool with it" which

was said early in the therapy, and "it's no big deal" which is said in the conversation below. Exploring the meaning behind these phrases, namely that Mother "C" is confident in her parenting skills, and she can handle this situation with her son, opened up possibilities for the three of us to find and discuss further ways that they were able to have the kind of communication they wanted. In the following conversation, I asked the family where they were in the accomplishment of the goals they set in the first session:

> THERAPIST: So, Child "C", do you have any new goals that you want to talk about? Is there, is the system working out okay, that you, you do your chores and the reward is that you get increased [CHILD "C": Yeah.] time. And that's working out okay?
> CHILD "C": Umhum.
> THERAPIST: **Are, are video games still one of the things that the "monster", one of the big things for the "monster"** {pause} [CHILD "C": Nope.] **Get in the way of the monster?**
> CHILD "C": Nope.
> THERAPIST: No, video games are okay?
> CHILD "C": Yeah, video games are okay.
> MOTHER "C": **He actually seems to be opening that door more often and like, wanting to watch a movie with me.** And I caught myself, it was a couple of weeks ago, I can't remember what I was doing, but umhum, he wanted to watch a movie [THERAPIST: (??)] **I couldn't, yeah, so it's like, I knew afterwards that {pause} you know like, he wants to spend, he wants to spend time. And whatever I'm doing, it's no big deal, we can, we can still do this, you know?**
> THERAPIST: Sure.
> MOTHER "C": Because we arranged it. **Because it's been such a long since he wanted to. Really? Okay. Alright. {laugh}. Alright (??). So I make sure we have time. So we just sat and watched a few movies together and, you know, spent more time together, you know?...**

Mother "C" is saying that the way that she handles situations influences whether she and her son spend time together. I interpret her saying "it's no big deal" to mean that she is able to priorize time with her son over other things she is doing. The above conversation took place near the end of the therapy process and the family and I have begun to look back on the changes that have taken place for them. This is a big difference from the beginning of the therapy, where not only did Child "C" not want to

spend time with his mom, but Mother "C" found it difficult to find time for activities together.

Termination with the family

Although this was the last session with the family and they told me they had met their goals set out in the beginning of the family therapy process, we talked about the increased stress in the family because of the bullying of Child "C" at school. I introduced the idea that I could refer Child "C" to an individual counsellor at EHCC. This suggestion was well received, and a few weeks later, Child "C", the individual counsellor and I met together to transition Child "C" to individual counselling.

By the final session of the therapy with Family "C," their narratives about their family had changed. Instead of fighting each other, they were now fighting together against the bullying that Child "C" was again dealing with. They also spoke about hope for the future and how Mother "C" had plans to open her business soon. They had also found a way to change the meaning and value of computers and video games so that they did not interfere with their relationship:

> THERAPIST: Yeah, yeah. Because it sounds like some of the things that you and your mom have been talking about, the stuff that we've been meeting about {pause} a lot of that has been {pause} gone away?
> CHILD "C": Umhum.
> MOTHER "C": Yeah. **We're spending more time and less stressed, much less.** How often, do we have a fight now? As far as you're concerned, I'm nagging and crabby all the time but [CHILD "C": Umhum.] no I'm not. What, just clean up your room or whatever?
> CHILD "C": Because you're trying to quit smoking.
> MOTHER "C": Yeah, that too.
> THERAPIST: Ooh, that's a tough thing.
> MOTHER "C": Well, I don't last that long (laugh). Like today I've gone three hours and that's it. Picked him up from school, told me what's happened. That's it.
> THERAPIST: (Laugh)
> MOTHER "C": Here we go again. Fire inside. **No, I mean, we don't have a big battle, maybe once a month now at the most.**

THERAPIST: Umhum.
MOTHER "C": **And it ends pretty quick.** You know, we stop and we have you're whatever you know, so, big difference. [THERAPIST: Oh, wow.] **A really big difference.**
THERAPIST: And so what about, I know that you were talking about, one of the other things was meal times and spending more meals together?
MOTHER "C": Yeah, trying. Doesn't always work out that great, but {pause} I'm not so worried about it because we're spending other time together?
THERAPIST: Umhum.
MOTHER "C": **And he likes to go and sit and watch his shows when he's eating, and {pause} as long as at least a couple of times a week we're sitting down for a meal together, good enough. You know?**
THERAPIST: Yeah, yeah. And I remember at one point, it was about once or week or less, so {pause}.
MOTHER "C": Yeah. Yeah.
THERAPIST: So that's an improvement.
MOTHER "C": Yeah, well, **the door doesn't stay closed as much now.** [THERAPIST: Umhum.] So it's not, quite the same.
THERAPIST: Umhum.
MOTHER "C": You know, **he's a little bit more interaction** and that and, and umhum {pause} to tell you the truth, we don't always eat at the same time. Like, he comes home from school and he's starving to death and stuff, or I'm dieting or whatever. **So, but we're spending other time you know?**

When Mother "C" says that "the door doesn't stay closed as much now" she's referring to the bedroom door of Child "C" but her meaning also makes a reference to her use of the metaphor "block" that she used in the first session; there's no longer a physical boundary that she can see and feel between her and her son. Her use of the words "good enough, you know?" also indicate to me that her strength as a flexible parent is showing through, because she's not expecting perfection from her son, as she mentioned earlier. She knows that conflict will still occur between her and her son. Her use of the word "battle" has changed; whereas before it was used as a verb to indicate how hard they were working, here it is used as a noun and is something outside of their relationship. Her goal of keeping little battles from turning into big ones is the key, and is one of the goals which is realized with the help of the narrative therapeutic process.

Letter writing

At the beginning of the last session, I gave Mother "C" a letter that I wrote which commented on the changes she and Child "C" had made throughout the past few months. A copy of the letter is shown in Figure 1. I used this therapeutic tool in order to create a written testimony to the strengths they talked about in the early sessions. All of the letters I wrote to family members were written by hand, not typed, in order to avoid having the letters appear too clinical. I also gave Child "C" a certificate which praised him for working so hard against the "evil monsters" that had bothered them earlier (Figure 2).

Feedback from Family "C"

I made a point of checking with Mother "C" in the middle of the therapeutic process as to how she felt the therapy was going, and if she saw any changes for them. At the time, one of the things she brought up was that she did not think there had been any changes so far and this, I think, can be attributed to the block that occurred in the previous session. Part of our conversation about the therapy process involved Mother "C" offering feedback to me on how to engage Child "C" in the sessions. She said that she thought it might be helpful for me to meet with Child "C" alone without her present for a session. We did not end up doing this, as Child "C" began to feel more comfortable and began to engage both Mother "C" and I in conversation in the next session.

Besides giving informal feedback, Mother "C" filled out a questionnaire after the family therapy ended. She indicated that the therapy was "extremely helpful" because "my son and I have been able to improve our communication with each other".

Figure 1: Letter to Mother "C"

Dear Mother "C",

I decided to write you this letter since this is one of the last times we'll meet together, and I wanted a chance to tell you how much I think you and Child "C" have accomplished over the past few months.

When I saw you and Child "C" two weeks ago, it seemed like so much had changed for both of you! There were a lot of hurdles to jump over the last few months and you and Child "C" have done so much to get where you are -- including enduring your car breaking down and having a cast on your foot. Now you've got some additional skills by small business management classes.

I remember the first time I met you and Child "C". Child "C" was about to start a brand-new school year and you were concerned that the time that you'd spend taking care of your family would have an impact on Child "C" and your relationship with him. You also talked about the grief that you feel about your mom. I hope some day Child "C" will look back on that time and know that his mom is a great daughter and sister. You put a lot of energy into making sure your mom's matters were taken care of properly. I also remember you saying that you helped your brother out when he was having problems with his broken arm. It takes a lot of understanding to help others out like that.

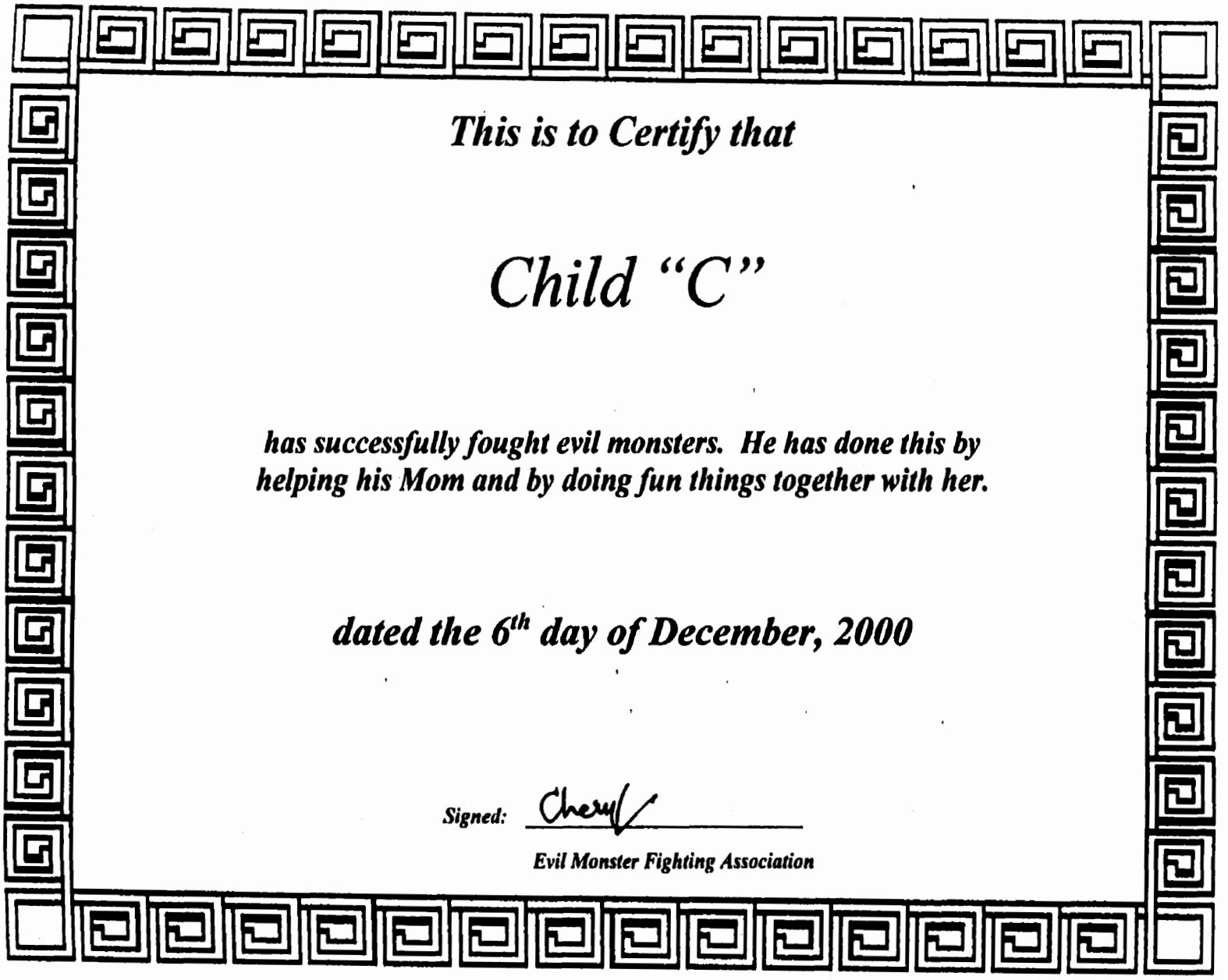
At our last meeting you talked about the things you've done to protect and take care of Child "C" while all this stuff with Child's friend is going on. Even though you're unhappy about this, your compassion and empathy for others showed through when you talked about Child's friend's upbringing and why he may behave the way he does. Are there other things that we haven't talked about that you're continuing to teach Child "C" about how to be a good person? Child "C" is a wonderful kid and you've talked about how he's helped you out, especially when you had your cast. I think he gets his great sense of humour from you -- what do you think? I can tell that he's trying to out-think Child's friend instead of retaliating against him. Have the two of you talked a lot about how to handle yourself when facing adversity like that?

I think this is just a small sample of the things we've talked about the past few months. Do you and Child "C" have other goals you hope to accomplish in the future?

I wish you and Child "C" all the best. Keep fighting those "evil monsters"!

sincerely,

Cheryl



This is to Certify that

Child "C"

has successfully fought evil monsters. He has done this by helping his Mom and by doing fun things together with her.

dated the 6th day of December, 2000

Signed: Cheryl

Evil Monster Fighting Association

Figure 2: Certificate given to Child "C"

My reflections on the therapy process

Reflecting back on the work that the "C" Family and I did together, I am struck by how much of the conversation was in fact guided by Mother "C". Looking back, I see that perhaps I should have met with Child "C" alone for a session in order to not only provide him with an opportunity to express himself more fully, but as a way to honour the fact that Mother "C" knows her son better than I do, and we may have been able to avoid the block between the three of us in the first place if I had heeded her suggestion. I also could have acted more as a mediator in the sessions as well, in order to challenge Mother "C" on how much conversational "space" she was leaving open for Child "C" to give his own views.

Because I met with this family early in the practicum and I struggled early on with the narrative model, I did not have to reach far into my "bag" of clinical tools to exemplify the concept of "not-knowing"; I relied on the family quite heavily to guide both the therapeutic process, and to help me understand how my skills and the narrative model could be helpful to them (Anderson, 1995, p. 34). Although this co-construction of the therapy process helped to convey my respect for the family and their concerns, I think it also made the therapy process less streamlined, and our conversations tended to meander much more than is evident with families I worked with later in the practicum. This also made the process of qualitative practice evaluation difficult since I had a hard time pinpointing narratives which directly exemplified how the narrative approach was working with this family. One area where I could have been more direct with my questioning was in the discussions where the meaning behind "I'm cool with it" was introduced. The interpretation of the similarity in the meaning behind this and phrases

such as "it's no big deal" helped us to co-construct alternatives to the problem-saturated narratives. However, the family and I did not co-construct the idea that these phrases were similar in meaning, and so this is an interpretation on my part. While I do not think I interpreted this incorrectly, looking back I think it would have been helpful to ask directly about this connection, even to just point out that I knew Mother "C" was using these phrases to indicate strength in herself.

The work with "C" was one of the families in which I felt the technique of externalizing the problem did not work very well. Although I would find this to be a difficult tool to use with almost all of the families I worked with, it felt most awkward with the "C" family. Looking back, I think this tool would have been used more effectively if I had used the transcripts of the sessions as a process-oriented tool early in the therapy in order to understand their language and their meanings in detail instead of trusting myself to hear these metaphors of the problem in the early part of the therapy.

Although the family presented with issues stemming from loss and grief, I tackled these issues from the perspective of examining the effects of these losses, as the narrative model suggests. However, there are ways that I think the loss issues for the family could have been handled better. First, although the family and I discussed how Grandmother "C" impacted the family and the values she brought to it, we focused very little on how Mother and Child "C" were dealing with their grief. By discussing only the effects of this loss rather than the loss itself, the model inadvertently neglected the family's feelings regarding the death of Grandmother "C". I could have paid more attention to how the narrative model was impacting the family and I could have deviated from the narrative model to focus more fully on their grief and how they were dealing

with it.

Second, the family and I could have discussed the impact of social discourses and how this resulted in losses for the family. We did not discuss if poverty had an impact on the family, nor if they struggled as a single-parent family. It appeared to me that Mother "C" could have been trying to overcompensate for some of the systemic issues impacting Child "C". This would have been a good area to explore with the family and how Child "C" was able to make friends at school. This may have connected what was happening for the family to the bullying Child "C" was subjected to at school.

Overall, the therapy process with Family "C" was one which had ups and downs, partially because I struggled to gain my footings with the narrative approach. Despite these ups and downs in the therapy process, the conversations with Family "C" about their strengths were very powerful, and this family case was one which exemplified the concept of "not-knowing" (Anderson, 1995, p.34). The therapy process with this family is a bona fide example of the power of the family's strengths in guiding it.

Family "G"

Mother "G" contacted the Centre for family therapy because she was concerned about the effects of her husband's alcoholism and the couple's separation on their three daughters. Mother "G" and her husband had been separated for nearly two years when the therapy began. She and the three daughters, ages 9, 13 and 15 had been living in a different household from Father "G" since that time. Although after the move the alcoholism was no longer a fact of everyday life for the four of them, Mother "G" felt that there were some long term effects of her husband's alcoholism which they were dealing

with, specifically in the way the family handled conflicts and how they related to each other. Mother "G" also said she was concerned about how the alcoholism would affect the three children as they developed and matured. As the therapy progressed we also discussed how Father "G" had a mental illness and how this impacted his use of alcohol. We also discussed his suicidal thoughts and behaviours, which the children were aware of. Approximately ten days before Christmas, the "G" family's husband and father committed suicide.

There were several systemic issues that the family was dealing with concurrently, such as Mother "G's" underemployment. Mother "G" mentioned that she had not been able to support her family and this bothered her. She found suitable full-time employment about halfway through the therapy, but had debts which needed to be paid off. There were other financial strains which were mentioned periodically; at one point the father was thinking of selling a truck that the family owned. Mother "G" also had medical tests which eventually ruled out the possibility of a life-threatening illness.

Over a twenty week period, the "G" family attended eleven therapy sessions. The children were involved in various after-school activities, and therapy sessions were attended by whichever family members could attend that week. The sessions varied from two family members in attendance to all four attending. Working with whichever family members attend is one of the underlying principles of narrative therapy approaches (Nichols and Schwartz, 1998).

Qualitative Analysis

Beginning sessions

The focus of the first few sessions was on establishing rapport, joining with the

family and beginning discussions about the effects of the alcoholism and the separation. There were several key concepts of the narrative approach which were helpful for work with this family, including promoting co-construction with the family, viewing the family as the expert, using deconstructive listening and questioning, and using open-ended questions. These were helpful in conveying to the family my belief that they were experts on their own experience, they were competent and were capable of finding answers for themselves.

Mother "G" described one of her goals for the counselling as: "And what's important to me is that [it] sort of works [for] everybody [and] that it becomes **peaceful and harmonious**" ([ ] mine) . She also emphasized that it was important to work through issues so they could "leave it behind." Another concern for Mother "G" was that the family had not really talked together about how they all felt about moving away from their dad. She wondered if the children had internalized their feelings about those stressful events. We also talked about how Mother "G" felt that she and her daughters did not know very much about alcoholism and its effects on them. She wanted education on alcoholism to also be a goal for counselling.

These goals were reintroduced throughout the therapy in various stories and became the themes of the therapy. Using the family's words, these themes are: a) a "peaceful and harmonious" family life, b) "education" and "codependency" and, c) "we never functioned as a regular family". I will examine these themes as they changed throughout the therapeutic process.

Theme A: "peaceful and harmonious"

The theme of wanting a peaceful and harmonious family life is first introduced by Mother "G" in the first session. In the following excerpt, I have just asked each of the family members to describe **what is important to them in their lives.** I used this first open-ended question to focus on the family's life as a whole, not just the problem-saturated narratives. The response by Mother "G" to this question reflected her goal for counselling:

> MOTHER "G": And what's important to me is that sort of works or everybody that it becomes **peaceful and harmonious** and that my daughters umhum {pause} understand {pause} all the effects that the alcoholism and sort of, kind of the the background has had on them, so that they, they, they have that awareness of, of addiction that may {pause} umhum {pause} the**, the awareness of the addictive aspects and the awareness of the effects (?) on their personalities. And then also there's going through a separation** and {pause} that we can uncover some of the issues that {pause} you know, come up with that. Like all the, the emotions that they've been going through and which each of them and from experience (?). So to me that is important to just really understand what's going on in their lives so far so that {pause} we can kind of work through that and they can, you know, **leave it behind.**

The family members began in these first few sessions to construct their meanings through the retelling of their experience. In the above example, Mother "G" raised the theme of what she would like family life to look like in the future. The answer Mother "G" gave shows hope for the future and looks forward to a time when the problem will not be present. This is also a narrative which begins the process of examining the problem so that we can find alternatives to it. In the above example, Mother "G" explained how her goal of peace and harmony was connected to the issues of alcoholism and the separation, and how having a peaceful and harmonious life is achieved by leaving behind those issues.

Theme B: "education" and "codependency"

I have grouped the two themes of "education and "codependency" together because the family members told stories which connected the two concepts. "Codependency" was introduced in the third therapy session by Mother "G". "Codependency" was a word Mother "G" used several times throughout the therapy to mean both her own level of responsibility in maintaining her former husband's alcoholism, as well as a character trait of her own. As we talked together about how alcoholism affected the family, I continued to use the word "codependent" because it was the family's language. According to Anderson (1995), language and conversation are the main components of narrative therapy, and a client's language can give the therapist clues to developing problem definitions and interventions. A person's language can also give clues as to how mainstream narratives in a sociopolitical context influence people and their personal narratives (Anderson, 1995). In the following example, Mother "G" was describing how she had seen an individual counsellor on her own in order to help her deal with current stresses:

> MOTHER "G": Sometimes I just use him as a bit of a crutch too, because **I still feel like there's a sort of a codependency on my part** where, umhum, I guess {pause} the, there's a, maybe a guilt factor. There's a factor of getting something to the **grey area** [cm: Umhum.] when I, **sometimes I'm able to see it the black and white way**, and the reality is their dad is very manipulative.

Here, Mother "G" is describing the codependency as belonging to herself and is something that she feels she must change. She is "codependent" when she is not able to see her husband's "grey area" manipulative behaviour. Although what she means exactly by "grey area" is not talked about explicitly, I understand her to mean that "grey area" manipulation happens when her ex-husband talks her into something that she

does not feel comfortable with. When things are "the black and white way" Mother "G" feels strong and is able to listen to her own instincts in decision making, rather than her ex-husband, especially when decisions are being made regarding the children's visits to their father.

The choice of language in the above narrative by Mother "G" may indicate that the "problem" of codependency originates in a social narrative about who is to blame for alcoholism in a family, and ultimately, with whom the responsibility lies for the break up of the marriage and family. Because the word "codependent" is vague and can have different meanings for people, I needed to listen to their narratives in a deconstructive way in order to later challenge the family members on their definition and how much responsibility they had in maintaining the alcoholism of Father "G". Externalization as a way of thinking was one way of doing this deconstructive listening.

One of the goals for counselling was to educate the children so that the codependency does not get passed on to them. In the following narrative, Mother "G" connects and defines the two concepts of education and codependency:

> THERAPIST: It sounds like you have a sense of what those are. Do you have specific things you're trying to educate them on, or {pause}
> MOTHER "G": **I think just trying to maybe trying to correct some damage done**, or, it sounds crass, it sounds (??) undo wrong. I think I would like the girls to become more wholesome, (??) can be better because they can be in relationships where there's going to be, you know, umhum, like (laugh) healthy relationships and umhum, {pause} something that I can't at the present offer them is examples, except for myself, **but I can't offer them an example of a healthy relationship**, maybe someday I will. Umhum {pause}

According to the family, the meaning behind "education" and "codependency" was that neither Mother "G" nor her three daughters had the knowledge or skills to understand either the effects of the alcoholism or the "codependency trap"; they needed "education" in order to understand it. I wanted to deconstruct the problem-saturated

narrative so that there would be opened up space for alternative narratives. Deconstructing the word "codependent" meant asking Mother "G" if she in fact had made healthy choices which she is proud of, and therefore does set a healthy example for her daughters. My questions were meant to not only externalize the problem, but to ask about the connection between healthy examples and having a "peaceful and harmonious" life together. She said that the children would always know that both of their parents loved and cared for them. My questions were meant to focus on the ways that they did have knowledge and strength, and to question the myth of the "normal" family that they were comparing themselves to.

Theme C: "we never functioned as a regular family"

The third theme of "we never functioned as a regular family" is a phrase that was used in a later session, but is one that captured the meaning of stories that occurred throughout the therapeutic process. Despite saying in the first session that they have gone on vacations together, gone to movies and eaten dinner together, the following narrative of Mother "G" indicated that for this family, they did not seem themselves as a "regular family":

> MOTHER "G": And so I think that whole thing affected us to that, **we never functioned as a regular family with him.**
> THERAPIST: **What do you mean, "a regular family"?**
> MOTHER "G": A **"regular family"** means that maybe we all go to a movie together or you go on holidays, or you go on a, maybe the most we would have done is going on a walk or (??) on our property. [THERAPIST: Umhum.] But going out together, unless it was a family gathering, never happened. So it was always me and the girls. Sometimes it was their dad and the girls.

The way the four women talked about their family led me to question if these stories and their choice of words indicated there were gaps in their narratives about the kind of family they were and whether they fit their own definition. In order to explore

these gaps in the narratives, my questions involved not only asking the family about this definition, but also discussing whether all family members felt this way, and opening up space for alternatives to these definitions.

Middle sessions

The middle sessions with the "G" family focused on discussing the three above mentioned themes further. There were several specific tools I used to further the discussion and to co-construct alternative narratives with the family. Externalization was one of those tools used in order to place the problem outside of the family. The family also introduced a unique outcome, which became a pathway for alternative narratives. Finally, a reflecting team process was also used. Although Andersen originally conceptualized the reflecting process as a team process with a group of therapists behind the mirror, other uses of the reflecting process have been employed, including having the therapist talk to one member of the family while the other members listen and then having the two groups of family members switch places (Biever and Franklin, 1998). These tools will be discussed further as they apply to the specific themes introduced by the family.

Theme A: "peaceful and harmonious"

Externalizing the problem

Externalization of the problem through personification was a useful tool in the therapy process with the family. By personifying the problem and moving it outside of the family we were able to change the meaning of the problem and remove the focus on the blame and responsibility. By the fifth therapy session we had discussed whether the family had a name for the issues that were affecting them. The importance of honouring all family

members' narratives of the events and their understanding of the "truth" is evident through this process of personifying the problem. The daughters were all at different developmental stages, and so both their understanding of the issues as well as their recollection of the alcoholism were vastly different from each other. Instead of forcing the family to choose between the definitions, we opted to use both names suggested by the middle and youngest daughters respectively. The externalized language used to describe the problems became "changing" and "growing up".

The meaning of "changing" and "growing up" differed in that the youngest daughter described "changing" as the hopeful change process that was taking place through the counselling. For the middle daughter, "growing up" was a dynamic term which described the continuing process of the learning that she has done so far, and would continue to do as she matured. Despite the differences in the externalized language, a commonality found between the terms was that they both described the things that the family was challenged by, such as the alcoholism, the separation, the day to day issues, and the current fighting that occurred between all the family members.

Once we discussed what the names would be, we talked about how the "changing" and "growing up" affected them, and we began to connect the fighting among the three daughters to the alcoholism, and how these things impeded the family's ability to have a "harmonious and peaceful" life together. My questions to the two daughters in the session were:

"What did the 'changing' and 'growing up' teach you about fighting?"

"Did 'changing' and 'growing up' teach you to deal with conflict in the family?"

Mother "G" and I had talked in a previous session about the connection between the fighting between the daughters and the alcoholism, so the externalization of the problem was a way to bridge the gap between these two concepts for the three daughters. Although the "G" daughters answered "I don't know" and did not think they knew how the fighting and the alcoholism were connected, I asked the above-mentioned questions in a way that deconstructed their beliefs about fighting between them. This questioning was meant to open up space for alternative narratives about the effects of the conflict, and to ask if they had some sense of how they would like conflict to be resolved in the future. Although the daughters did not verbalize their understanding of the connection between the fighting and their knowledge of alcoholism, as the therapy progressed, Mother "G" and her daughters made several statements about how the fighting among them decreased. An example of these statements is found in the narratives described in the next section.

Reflecting team process

The reflecting team was a particularly useful process with the "G" family and I believe it provided us with a turning point for the therapy. I further emphasized the family as expert by having them be the reflecting team for each other and have their own ideas open up the space for alternative narratives. It was also helpful in that it was a way for the family members to hear each other's narratives in a more constructive, therapeutic way, since blaming and interruptions were often a way for the family members to challenge each other's version of the "truth". The reflecting team process provided an opportunity to hear each other out without the above mentioned dynamic present, and focused the discussions on validating individual narratives rather than

debating the legitimacy of specific details. By dividing the family along generational lines (parent and children) for the purpose of the reflecting team, we were then able to see more clearly the gaps in the narratives more easily and focus on finding ways to lessen the impact of these gaps.

The reflecting team process gave us a chance to map out the past and present effects of the "changing" and "growing up", as well as understand from Mother "G" what she wanted the family to look like without the problem present. The daughters, in turn, were then able to comment on this hopeful view of their family.

Using the reflecting team process gave us the opportunity to examine further the meaning behind wanting a "peaceful and harmonious" life. In the following discussion, Mother "G" and I talked while the three daughters watched behind the mirror. We mapped out a more preferred narrative for the family by discussing how conflicts could be handled different in the future. We also discussed how this process had already began because the fighting had decreased since the beginning of the family therapy. The underlying meaning that we were exploring was that the family had begun the process of becoming the kind of family they wanted to be:

> THERAPIST: So how does the, **what place does the yelling and fighting have in the family?** Where do you see it going or how do you see it, see it being resolved? I guess I'm wondering umhum {long pause} how, how, umhum, often do you see it happening now and how often would you like it to see, **in a regular family day**, if there's any if at all, or do you see that as a part of a normal family or how do you see it?
> MOTHER "G": Umhum, **I've seen families where umhum, people I used to work for, there's never, they all speak calmly, quietly all the time.** [THERAPIST: Umhum.] I mean there's just, if there's yelling it's because something really funny happened or something... I think I'd like to see people making serious effort every single time to keep their voice down and to speak normally. **I have noticed a huge difference though. It's greatly improved already.**
> THERAPIST: Oh.

> MOTHER "G": Yeah. Youngest Daughter as well. And, and **she responds better to me** when, I think this morning she's looking for her vest and umhum, she was under the impression maybe it was in her sister's room and she started escalating and I told her that I would not be able to speak to her unless she spoke to me in a normal, quiet voice. [THERAPIST: Umhum.] But otherwise I would not umhum, continue the discussion. **And she was able to actually listen to me.** [THERAPIST: Oh.] **So that's very good.** [THERAPIST: Yeah.] **And we were able to resolve that.** I mean, we never found the vest, **but we were able to resolve that umhum, searching for the vest in a way that was acceptable to all parties.**

By asking what place the fighting had in the family, I focused the discussion on alternative ways to handle conflicts. I used the phrase "regular family day" to emphasize the family's language and bring forth ideas about positive alternatives to fighting. Mother "G" then gives two examples of families that have handled conflicts in the way that a "regular family" would: a family she knows from work, and then an example from the "G" family itself, which gave us a unique outcome for the family. Up until this point, there had not been any narratives describing conflict being resolved without fighting present.

When Mother "G" and her daughter switched places, I discussed with the daughters about how they thought conflict had changed in the family. The youngest daughter agreed that conflict had changed in the family, and how she handled the situation with the missing vest was much different than the way that similar situations had been handled in the past.

Theme B: "education" and "codependency"

The reflecting team process was also a useful tool to deconstruct the use of the word "codependency" and to further explore what the family members meant by "education". In the following discussion the daughters talk about their definition of "codependency":

THERAPIST: Umhum. Okay.{pause} What did you guys think about what your mom was saying about umhum, she was talking about codependency and {pause} and the way her background sort of influences the way that she is a parent and {pause} the kind of things that she learned?...Do you...have an idea about what umhum, what your mom was talking about or [YOUNGEST DAUGHTER: Well, umhum, umhum, umhum, **we always tip-toe around the house** because {pause} [OLDEST DAUGHTER: I heard that.] **we didn't know if he was going to be happy or mad.]**
THERAPIST: Umhum.
YOUNGEST DAUGHTER: (??)
MIDDLE DAUGHTER: **It's kind of like they kind of having their own way of doing things. We never really know {pause} like what's going to happen or,** like {pause} [OLDEST DAUGHTER: Stop it.] **have their own little world**, kind of thing.
THERAPIST: Umhum.
MIDDLE DAUGHTER: **You can't, just depend on them.**

This part of the discussion shows that the daughters had a different meaning for the word "codependency" than Mother "G" did, and that their understanding of the effects of the alcoholism were also much different than their mother's. While Mother "G" saw codependency as something her daughters needed to learn to avoid, the daughters saw it not as a character trait, but as something outside of themselves and having more to do with the behaviour of their father who was the alcoholic in the family. The examination of the meaning of codependency for the family was an important discussion in the search for alternatives, since it has a meaning in a larger societal sense and is also accepted by many other counseling professionals. These discussions also provided an alternative way for the family members to view their relationship with Father "G" as well as an alternative way for the family members to see themselves in relation to him. I focused on deconstructing the concept of codependency with the family as a whole, since Mother "G" found the concept of codependency to be helpful in her quest to regain power back from Father "G".

The following narrative shows the connection between education and

codependency for the three daughters. I asked the daughters what stood out for them in what their mother said in the first half of the reflecting team:

> YOUNGEST DAUGHTER: Umhum, (pause) about alcoholism [THERAPIST: Umhum.] and **about us, like, not being together as a family and going places.** [THERAPIST: Umhum.] Like together.
> MIDDLE DAUGHTER: And then us like, trying to like, make a decision for ourselves and pick the right person and not like, go half and half and have to do it all over again, kind of thing.
> THERAPIST: Umhum.
> MIDDLE DAUGHTER: Like, start good from the beginning.
> YOUNGEST DAUGHTER: Yeah.
> THERAPIST: Why do you think that's important to her?
> YOUNGEST DAUGHTER: **Because she cares about us and she wants us to** [MIDDLE DAUGHTER: Yeah.] **make the right choice.** And not have somebody that is an addict (??).
> MIDDLE DAUGHTER: Because she knows about how it can like, ruin your life and stuff I guess.

While their mother used the word "education" to describe the knowledge they needed, the two daughters described it as "make the right choice". Mother "G" said that she was not a good role model for her children and could not "provide them with examples of healthy relationships". I understood this to be the reason why she was seeking "education" from outside resources. However, the difference in the language choice between "education" and "make the right choice" indicated that the daughters do see their mother as a good role model for themselves. I talked with the two daughters about choice, and how they would know how to make the "right choice" for themselves when it comes to choosing a spouse, or dealing with alcohol at parties. Both daughters thought they would make the right choices for themselves because they have gotten advice from their mom, and they also admired the self-control that their older sister has when she dealt with issues around alcohol. For the youngest daughters, "making the right choice" involves turning to their mother and their older sister for "education" as much as it means gaining knowledge from outside resources.

Theme C: "we never functioned as a regular family":

This final theme was also explored using the reflecting team process. We began this discussion by my asking Mother "G" how she found the experience of viewing the conversation behind the mirror, especially listening to her daughters' conversation about family life. Mother "G" said that we had not come up with many examples of how the alcoholism affected family life. She provided some examples of the effects from the past, and in doing so, her narrative shows the change in the meaning of "regular family" from earlier in the therapy process to now:

> MOTHER "G": Yeah [MIDDLE DAUGHTER: Yeah.] but you know, I mean, he, not everything [YOUNGEST DAUGHTER: (??)] we did had to do with big crowds. It's the, **he didn't operate as a family**. And then of course, he was home all winter. And he was always a very critical person, very negative person. So he was always you know, kind of looking over my shoulder and, complaining. Whining. It's true. And I mean really, **like if I wasn't, hadn't been {pause} so codependent** at that point before I was going to be sucked in too deep, I would have just packed you guys off and I would have left. But because, that's part of {pause} you know, **the illness of codependency** is that you sort of lose your self-confidence and you don't sort of think you can manage. And so then you sort of stay in an unhealthy situation that's **part of being a codependent person**.{pause} I mean I had tried to get away but I guess I had not {pause} I hadn't been able to change enough so I got sucked back into it...

While this narrative indicates that Mother "G" believes she has the "illness of codependency", the family began the process of re-narrating their stories through the narrative process, since the meaning of "regular family" has now changed from the previous sessions. The subtle change in her choice of words from "we never functioned as a regular family with him" which was said in an earlier session, to "he didn't operate as a family" indicates the gradual reconstruction of a new narrative with regards to the meaning of their family. This narrative indicates that the gaps in their narratives are changing and lessening as they begin to hear each other's perceptions of the word "regular" and its meaning in relation to their family. The family's separation from Father

"G" means they can operate as a "regular" family together, according to their definition.

In the beginning stages of therapy the phrase "healthy family" did not apply to the "G" family, as indicated by their narratives. However, the reflecting team process made it possible to hear and understand all of the points of view on the meaning of this phrase, particularly with respect to the differences in perspectives of Mother "G" as compared to her daughters. The reflecting team process also made it possible for the family and I to co-construct alternative narratives where it is possible for the family to fit their description of a healthy family.

Termination with the family

The loss of the "G" family's father and husband was a shock and was very difficult for the four women. They were in touch with other professional resources who specialized in trauma and grief counselling and who met with the family shortly after Father "G's" death. The family elected to not continue with family therapy after his death. I met with the family for a final family therapy session after this decision was made in order for us to have some closure on the family therapy. However, we did get a chance to reflect on the therapy process as a whole and talk about the family's successes. The family began the process in the previous session of re-narrating the stories of their family and changing the meanings associated with the kind of family they were. In this last session, I asked the family members if they thought they had reached the goals they set out for themselves in the first session. In the following narrative we talked about where they were in the process to gain "peace and harmony":

> THERAPIST: So I know we were talking about this being, your mom and I talked about this being the last session for counselling and umhum, in the very beginning when we first all met umhum, **you guys were talking about wanting things to be more harmonious and peaceful** and having more times together.

Where do you think you are on that?
MIDDLE DAUGHTER: Umhum {pause} I don't know. **I think we've gotten better.**
THERAPIST: Umhum. {pause} What, why do you think it's better?
MIDDLE DAUGHTER: I don't know. **I guess we don't fight as much and stuff. We're all like, understanding and stuff.** {pause}
THERAPIST: Yeah, it sounds like the **fighting and the conflicts aren't sort of, for a while there they kind of had the upper hand in things, but they, it's not so much any more?**
MOTHER "G": No. No. No, and really, I think when we first moved there was a lot of, there was just so much going on and so much work and so much things to do and now {pause} the longer, the more, like things were kind of in, in place. [THERAPIST: Umhum.] ...if it had been when we first moved into the city, it would have like, been yet a lot more difficult for us to function, because we would have, you know, really been still very in a chaotic umhum, [THERAPIST: Umhum.] situation so now (??) **we are really truly settled in the house** and so with our (??) and, also the fact that we have been on our own in the city for a year before...we can kind of, **we are used to function day-to-day** umhum, comfortably umhum. So I think that kind of might have made it easier. Umhum, but needed to learn everything at the same time. (??) very good at being just so much harder on everybody. **At least we've been able to learn how to live on our own already.** So I think that all, we've sort of gotten, figured out the ropes of how to live in the city now. What all we need to do, so we can coexist comfortably, right? To stay on top of the housework and everything else [THERAPIST: Umhum.] So, that's really I think that's {pause}.

Although it is a difficult time for the family and they are in the midst of their grieving process, the narratives have changed. In this section Mother "G" is looking back to the chaotic time when the family moved to the city and comparing that time to the present where things are much more "settled", they are "functioning day-to-day," and they have "learned to live on their own". Not only are they more "settled", but as the middle daughter says, the fighting has stopped and there is more understanding from one another.

Although in this part of the discussion Mother "G" does not indicate that the family therapy has been one of the agents of change for the family, I believe that the change in the above narrative about their recent past indicates that the narrative process we have undertaken in therapy is one of the contributors to the positive

changes they have made. The phrases in the above narrative impart a meaning that in previous sessions had been narrated as something the four women were hoping for. Now these phrases are being used to indicate where the family is now. Mother "G" talks about the events of the past few years in one continuous narrative, and is now making sense of them for herself and her children. The meaning of the above narrative is that Mother "G" is looking back at the challenges they have faced and is able to say that they have survived them and that there is hope for the future.

Feedback from Family "G"

In my opinion, verbal and written feedback from the family were consistent with the observations made from the qualitative evaluation. Three of the family members filled out feedback questionnaire following the conclusion of therapy. On the four-point scale regarding how helpful the therapy had been, two family members, including Mother "G", indicated the family counselling had been "quite helpful". One family member indicated the counselling was "a little bit helpful". The written feedback indicated that the therapy had been helpful because "communication with one another on a neutral ground and with [an] outside person, involved to keep things on even keel," "communication with one another," and "I/we have learned to control and stay calm during fights". Mother "G" also indicated that she "appreciated this kind of service being offered to the public at no cost, which gives everybody the opportunity for family counselling". Another family member wrote "I appreciate Cheryl's help".

About half way through the therapy, Mother "G" and I spoke briefly before the session about the therapy process. She mentioned that she wanted the sessions to focus more on educational information regarding alcoholism. We talked about what kind

of educational information she was looking for, although she could not say specifically what she wanted. My interpretation of this feedback and the direction I took in the therapy was to focus on the knowledge the family already had instead of providing the family with outside resources. The comments Mother "G" gave on the feedback questionnaire following the termination of therapy indicated that she still would have liked more educational information.

My reflections on the therapy process

In looking back on the therapy process with this family, I think both reading material and other professional resources regarding alcoholism should have been offered to the family. Even though I think that concentrating on helping the family reconnect with their strengths and their own knowledge were important aspects of the therapy, the comments from the family indicate that this did not fill their need for information. Perhaps an additional theme for discussion in the therapy could have been the lack of control they felt due to the chaotic nature of alcoholism, and how additional educational information may have helped them find their way out of the chaos.

Work with this family provided me with the opportunity to understand how changes in the family narrative can make a difference in the family's day-to-day functioning. I think a large part of this understanding came from using the reflecting team in a new and creative way. The reflecting team process opened up space for the family to hear each other's internalized narratives and then work together to reauthor the narratives in ways which supported a more competent view of themselves. However, while the theme of "education" and "codependency" was one which the family and I discussed a great deal during the reflecting team, I think that it would have been

helpful to discuss the connections between "education", "codependency" and "making the right choice" more fully However, Father "G" died the week after this session, and the next session was a month later when we ended the therapy.

One area that, upon reflection, I wish I would have handled differently has to do with the way that I tackled the impact of dominant discourses on this family, particularly those discussions about the meaning of codependency. I think I was overly cautious about challenging Mother "G" on her definition of codependency and how it related to her own responsibility. As a strong proponent of the feminist perspective in social work, I find codependency to be a concept which is blaming, and I do not introduce it in therapeutic work. However, in this case, Mother "G" introduced it, and I struggled to find a balance in the therapy process which honoured the family's language while challenging their meaning, without introducing my own politics into the process. I think work with Family "G" would have been helped if I would have challenged Mother "G" further and questioned why she found this concept helpful to her, especially since the family was trying to find their own identity as a "regular family" separate from Father "G". There are other related topics that I wished the family and I could have discussed further. For instance, I could have asked if a lack of systemic help contributed to the four women having to leave their husband and father in the first place? I also could have tackled the topic of peer pressure, since it was introduced by the daughters and the two oldest daughters had reached an age where alcohol at parties is fairly commonplace.

Family "H"

Family "H" is a married couple that consists of a 51-year old man and a 49-year old woman. The husband and wife each have an adult child from a previous relationship

but they were not included in the therapy. The couple presented a life that was problem-saturated, and the stress that built up had an impact on their relationship. Although the couple began their relationship living in a house that they owned, financial difficulties made this impossible and the couple moved to an apartment block where they became the caretakers. Also, Husband "H" had a life-threatening illness which he had been living with for a number of years. He often talked about how the illness changed his view on life and because of this, he did not want to spend his remaining time fighting about "little" things. He was also in the care of medical professionals and was taking medications for pain management and depression. Husband "H" felt his ability to have an active life was curtailed because of this illness. He no longer worked outside of the home and could no longer do things which took a lot of physical energy. The couple also talked about how the illness of Husband "H" had impacted their relationship and their ability to have physical closeness and intimacy.

Wife "H" also had health problems which impacted the relationship. She had been dealing with menopause since her early 40s and had recently seen a specialist who helped her alleviate some of the symptoms. Wife "H" worked outside of the home, but had recently switched jobs because of the extreme stress she went through at the previous job. Husband "H" currently had no income, but was involved in the lengthy process of receiving his disability pension.

The couple came to therapy for seven sessions. Although the three of us had not planned termination after the seventh session, the health of Husband "H" deteriorated and he was bedridden. I spoke to Wife "H" a number of times by phone after the seventh session and the couple came to the conclusion that they would end therapy

and work on issues on their own while also concentrating on the health issues of Husband "H".

Qualitative Analysis

Beginning sessions

In the first session, Husband and Wife "H" said that they sought therapy because they wanted to improve their relationship. The spouses each had different ways of handling stress and different verbal styles which made conflict resolution difficult for them. The couple had been married for about five years and described the beginning of their relationship as "comfortable" and "peaceful". However, Husband "H" had moved out of the couple's home briefly a few months before the therapy began because he felt the conflicts were out of hand. The couple got back together again a few weeks later, but the conflicts remained.

There were several themes which emerged from the narratives the couple presented in the therapy. These themes were: a) the use of metaphors, b) how they each learned about caring and, c) the impact of social discourses.

Theme A: the use of metaphors

Although the spouses described many events and challenges that had an impact on their relationship, the conversations in the first session also introduced some of the couple's metaphors which the three of us used later on to externalize the problem narratives and their impact on the relationship:

> WIFE "H":...**I always call myself a cross between Martha Stewart and Tina Turner. I'm a very outgoing, lively, fun-loving person. But when it comes to the Martha Stewart side, I'm organized, and I'm precise and, and I want things done a certain way**, and so, [THERAPIST: Okay.] **there again you see the clash that those two personality traits in me can bring.**[THERAPIST:

> Sure.] **And I've always said we need less Martha. (laugh). I need less Martha, and yet, you sort of can't do without her in this situation either. So it's trying to find a way to mesh these things.** [THERAPIST: Sure.] **And communicate.**

While this is a metaphor which that Wife "H" uses to describe herself, her meaning of these metaphors goes beyond her "dual personas". These metaphors are an example of the language Wife "H" uses in order to create meaning. By incorporating this same language into the meaning-making process in the therapy was one of the ways that I tried to promote collaboration between the three of us. We were able later on to use it to indicate what both partners need from each other and how "Martha" and "Tina" can help the couple reconnect to their "comfort and peace".

<u>Theme B: how they each learned about caring</u>

Conversations with Family "H" regularly focused on how and from whom they learned about caring, and the meaning of marriage. This was the start of the process of deconstructing the history of each spouse's beliefs and values in order to understand which values would help the relationship. In the first few sessions, this theme was discussed in terms of what they learned from others and how this knowledge influenced their marriage:

> WIFE "H": Umhum, **we're also from very different parental homes. I'm from a 55-year marriage of two people that still hold hands, and that's not his situation at home at all. So our examples of relationships have been different, and so I think together we need to learn {pause} for both of us, what a, what a real relationship should be. Me having not had a good long term one ever and so, you know, you're not really sure then, what's sort of expected, or what you should be doing.**

Husband "H" also talked about what influenced him, specifically what he learned through experience about his contributions to the marriage with Wife "H":

HUSBAND "H": This is my second marriage, okay. And I always figured that umhum, if I ever got married again, well, **there are three things that wouldn't ruin the marriage would be: another woman, alcohol, or drugs, okay**. [THERAPIST: Umhum.] And those three have no play in this at all.[WIFE "H": No.] Okay? (laugh).[WIFE "H": No.] **They did in my first marriage, but not in this one.** [WIFE "H": No.]

Theme C: the impact of social discourses

The first session also gave us a chance to start examining some of the social discourses which influenced the marriage. Challenging the impact of social influences was an important narrative tool in exploring the roles of husband and wife, and the personal power that goes along with having income:

HUSBAND "H": You know, no regrets.
WIFE "H": **But you haven't mentioned the loss of {pause} your own income and the loss of feeling important** [HUSBAND "H": Yeah, well that too.] or needed like a job makes you feel [HUSBAND "H": **There's an old Chinese proverb (laugh) a man who gets his money from his wife is not a happy man.**]
THERAPIST: That can be, that sounds like that's a significant sort of, [HUSBAND "H": that too.] shift?
HUSBAND "H": That too...As it stands now, the job we do as caretakers is just in lieu of duties. [THERAPIST: Umhum.] So we get the suite for free. **So there's no money to be, there's no money there.**
THERAPIST: Sure.
WIFE "H": **And I want him very much to consider it our money. Our money.** [THERAPIST: Umhum.]...**So he's felt a loss of being, feeling important. He's always had good jobs, social, social kind of jobs, a lot of people interaction. And earned, earned a decent wage** [THERAPIST: Sure.] and so those two losses as well as his health have been a significant to him as well. And I've watched those, that kind of thing happen. **I've watched him feel those losses and I'm not even sure until I mentioned it, and until he used that Chinese proverb that he was really, really conscious of {pause} that the losses have affected him that much.**
THERAPIST: What do you think about that, Husband "H"?
HUSBAND "H": **She's right.**

The influence of social construction is particularly important in this part of the narrative therapy with Family "H". The worldview of social construction was a helpful starting point from which to discuss how the categories of "husband" and "wife" and

their connection to roles and power differences. These differences in the spouses' power and this connection to their roles is one that was narrated by the couple throughout the therapy process.

Middle sessions

Theme A: the use of metaphors

By the middle sessions, the three of us had talked together about how the metaphors of "Martha" and "Tina" influenced their relationship. The metaphors of "Martha" and "Tina" became a way for us to externalize the problems and explore what the couple wanted their relationship to look like, and what baby steps they could take towards achieving these goals. In the next discussion we were talking about the influence of "Martha" and "Tina". Wife "H" has just said that currently she feels like she is 80 percent "Martha" and 20 percent "Tina", but would like the two of them to work towards having "Martha" at 60 percent and "Tina" at 40 percent:

> THERAPIST: So, does the **sixty-forty sound about right to you?**
> HUSBAND "H": Umhum, yeah, that's about where I would put it.
> THERAPIST: So that sounds like a good place to get to then. **So then how do we help Wife "H" get to sixty-forty?**
> HUSBAND "H": **Well not by being like Turner for sure. [WIFE "H": (laugh).] But umhum, there's got to be a happy medium in there somewhere. {pause} You know. {pause}**
> WIFE "H": **Could you nurture Tina a little bit?**
> HUSBAND "H": **{pause} Yeah if I could get past Martha.**
> WIFE "H": I'm trying. I am trying to let, to let part of her go, I'm trying to let Tina come out more, I really am.
> THERAPIST: **So how do you get this teamwork?** We're talking about teamwork and (?) these really good things that go on. So in a relationship it's not, you know, we use the phrase "it takes two to tango". So, so it's not, is it just your job to sort of make sure that Martha's {pause} , do other people around you help, help you [WIFE "H": **I think that that would really help is if someone was, was nurturing Tina then Martha would have to withdraw to a certain point.** Because she would have to be making room for more of that to come out. And, and it wasn't always**, it wasn't always eighty percent Martha and twenty**

percent Tina, in the beginning. No, not, how would you have rated it in the beginning?
HUSBAND "H": Hmm. {pause} **I would say fifty-fifty. But I didn't know, I didn't know Martha**. [WIFE "H": No, well that's because she wasn't] There was Tina.
WIFE "H": She wasn't necessary. Obviously at that point in time.
HUSBAND "H": **But then it took over, once we were together, she took almost over everything and umhum, well I give her credit for doing it but {pause} that's when Martha came out.**
WIFE "H": **Yeah, I agree with that. That having to, to be responsible for a great deal of things, that (laugh) nurtures Martha, you know? I mean that just** [THERAPIST: Umhum.] **gives her more strength because I would, I needed her more so then that side was, grew in strength and there wasn't enough opportunity for Tina to come out.**

Externalization of the problem

Although the above conversation used the language introduced by Wife "H", it was a discussion where the three of us externalized the problem outside of the two spouses by talking about the "teamwork" that is needed from both of them. We discussed the responsibilities of both people in changing their narratives so that they focus on the positive strengths of the relationship. By "nurturing Tina", the couple could focus on the relationship strengths. "Nurturing Tina" is also a phrase Wife "H" uses to refer to the loss of physical intimacy between them. Although the illness has impacted this part of their relationship in a way which may be irreversible, she uses the word "nurture" to indicate to her husband that her definition of intimacy has expanded, and for her, holding hands while watching television is a step towards the closeness that she feels is missing.

Later in the same discussion, Husband "H" expands on the kind of things he used to like doing with "Tina", further emphasizing the couple's competencies:

THERAPIST: Okay, well what kind of stuff do you want to do with Tina?
HUSBAND "H": Hmm. {pause}. With Tina?
THERAPIST: Umhum.
HUSBAND "H": **Well we use to enjoy going out, well we still enjoy going out**

umhum, we use to go to a few concerts, go to the lake, dinners, that type of thing.
WIFE "H": **Umhum. Yeah, and we used to just put the music on and no television**, and that's not, especially since we got the apartment block, and that's not something that happens hardly at all anymore. [THERAPIST: Umhum.] And you know, just little things like that. **Umhum, that would take that, I think that would draw her out more and umhum, and I, and I like that. It's like, it's not that I don't like it. I really would like that more. I know that.**

In drawing out "Tina", we talked about how the couple could return to the activities that focused on their relationship and emphasized their strengths. Externalization was a helpful tool that reconnected the couple to these competencies and focus the attention less on responsibility for their conflicts.

Theme B: how they each learned about caring

Genograms

In subsequent sessions, we used genograms to examine each spouse's values and beliefs that they brought to the relationship. We first made a genogram of Husband "H". We discussed who taught him the meaning of being a husband, and which of these meanings he continued to use in his marriage. We also made a genogram for Wife "H", also as a way to talk about her values and their meaning in the marriage. The following discussion took place while working on the genogram of Husband "H" and focused on from whom he learned what affection was:

THERAPIST: **So, did anybody, did any of these relationships sort of form how you sort of, how you and Wife "H" relate?** Did anybody sort of, contribute to your understanding of how that would work? You, you were even saying that you were married before, or even in that relationship, how you thought about relationships?
HUSBAND "H": **that's tough. That's tough. I really can't put, put it into words, umhum, what I was taught or shown how I should feel, or how I shouldn't feel.**
THERAPIST : Umhum.
HUSBAND "H": But yeah, I've had problems in relationships in the past. But umhum, hmm. {pause} I've never been the affectionate type, let's put it that way.

So I guess, guess that's been lacking, and I'm sure you'd like to see more affection, but {pause} I didn't, **I didn't get taught that real well.**
THERAPIST: Well, what's, what's affectionate to you then? What do you feel, you know, when you see somebody, what would you call that?
HUSBAND "H": When I see somebody?
THERAPIST: **I guess I'm I'm asking what you would call affection? Where's your, where's your comfort level?**
HUSBAND "H": Hmm. That's another good question. Where's my comfort level. What, with people?
THERAPIST: Umhum. Like [WIFE "H": **Well, like for example, my dad didn't hug, do a lot of hugging. He wasn't comfortable with that at all.**] Umhum.
WIFE "H": So that where, that would be the limit of my dad's (laugh) comfort level was [THERAPIST: Yeah.] He [HUSBAND "H": Oh.] wouldn't do that to much.
HUSBAND "H": **No, I'm not that comfortable with it either. It's just {pause} the way I was raised I guess.**
THERAPIST: **How do you show people you care about them?**
HUSBAND "H": Another good question. (??) [WIFE "H": Tina, Tina would like to hear the answer (laugh) to that one.] Maybe I haven't been. So, it's hard to say. {pause} You tell them, like, my son, **I talk to my son and I tell him. He tells me he loves me, so {pause}.**
WIFE "H": **Yeah, you say it fairly freely with Husband's son.**
THERAPIST: {pause} Okay. **So that's somebody that you feel more comfortable saying that and being more open** [HUSBAND "H": (??) **Yeah.**] Umhum.

The genogram is a tool which made it possible for the three of us to deconstruct the historical influences on both Husband and Wife "H" of how they learned to show caring. Although early in the therapy process the spouses named some of the differences in the ways that they relate to each other, the genogram was helpful because we explored not only where these beliefs originate, but how they have influenced the meaning of caring in the relationship. By examining each spouse's past narratives, we were able to then focus on creating alternative narratives which would focus on the positive beliefs of both spouses. As well, this conversation about showing affection gives us a unique outcome from which to change the meaning of how Husband "H" demonstrates affection towards his wife.

Termination with the family

Letter writing

Since the Centre closed for a few weeks in December, at the end of the last session before the break I asked the couple if I could keep in touch with them by writing them a letter which we could then discuss in the next session. The couple agreed, and I sent the letter a few days before Christmas (Figure 3). I based the narrative language in this letter on one which appeared in Freedman's and Combs' book (1996). Wife "H" also mentioned that they received the letter and had each read it several times. She said it had been a catalyst for discussion about the relationship. She also said the letter had also helped them try to understand each other's point of view better. The response of the couple to the letter seems to echo the informal research done by White and Epston that a letter written to clients is worth 4.5 sessions of good therapy (Freedman and Combs, 1996). This first letter sent to the couple appears to have been a turning point in the therapy for them.

The couple cancelled their first January appointment, but I spoke to Wife "H" who told me how sick Husband "H" was. I kept in touch with Wife "H" throughout January. While the health of Husband "H" had improved throughout the month, he was not well enough to come in for a final appointment, and by the final phone call with Wife "H", she said that the couple was looking at the future more positively and that their relationship, while not perfect, had improved significantly. She also said that they were communicating more openly with each other and this was helping them to understand each other. In turn, this understanding was helping them to achieve some of the closeness that she had mentioned in earlier sessions.

Figure 3: Letter sent to Family "H" after the seventh session

Dear Wife "H" and Husband "H",

How are your Christmas celebrations going so far? As I said in the last session, I wanted to write you both a letter to keep in touch over the holidays. I've also been thinking about some things that I wanted to share with you.

The last time we all met together, it seemed like some of the challenges that you've both been struggling with for so long had gotten the upper hand. You've both talked about how these struggles are difficult, and how the feelings associated with them are powerful. It seems like these challenges can sometimes be so powerful and strong that they overshadow all of the positive things in your relationship. These struggles that you're both experiencing are not unimportant, nor are they easy to tackle. However, both of you have said how committed you are to your marriage. It seems to me that part of that commitment would include a focus on the new things you're doing to change your relationship, as well as a focus on the positive things you both bring to it.

Husband "H", a few weeks ago when we mapped out your family tree, you spoke about how important your grandfather's influence was on you. I was wondering if you've thought any further about other family characteristics that influence you in your relationship with Wife "H"? You've talked about the values that are important to have present in this relationship. Your list of the three things that you're not letting enter your marriage are significant to the strength you bring to it. You spoke last session about your feelings on the influence of income. How does this impact your marriage? Besides income, are there other stereotypes or dominant ideas in society which you feel are pressuring you to behave in a certain way?

And Wife "H", Your goal of having your marriage be one of calm and comfort has taken some steps forward since the three of us started meeting in October. You've talked about going on dates with Husband "H", and having good days where the two of you can be comfortable and just watch tv together. I definitely see some of the things that you do -- that both your "Martha" side and your "Tina" side are working to have more days like these. You mentioned last time about how there have been times where you notice things take "two steps forward and three steps back." Do you have some ideas about how long your goals will take to accomplish, and how much time you want to be in counselling? You've also said that you've been learning about your anger in a way that better fits for you and your relationship with Husband "H". Can you see how, at least in my mind, these statements fit with your goals of having a calm and comfortable relationship?

Does reflecting on some of this progress help you both to more effectively fight against the negative effects of the struggles that you've both encountered? I'd like to explore these thoughts with you when I see you in the new year. I hope you have a nice holiday together.

Merry Christmas,

Cheryl Maxsom

Wife "H" said that her husband had started to hold her hand while they fell asleep and that this was very meaningful to her.

Wife "H" indicated in the last phone call that she and her husband had met their goals of improving their relationship and would not need a referral to another therapist. I sent one final letter to the couple in order to bring closure to the process for all three of us (since I had not spoken to Husband "H" since our final session) and to ask them to fill out a feedback questionnaire. This final letter sent to the couple is presented in Figure 4.

Feedback from Family "H"

The "H" family regularly gave feedback about the therapy throughout the process. They told me that it was helpful to have someone who they were able to bounce ideas off of, and that it was also good to have someone to hear both sides of the story. Wife "H" said that she thought they were listening to each other differently and were then able to give credence to the other's ideas. Wife "H" also mentioned that she had seen a student counsellor in the past, and she felt that by being a part of a student counsellor's learning process she was able to give back to this person that was helping her. I found her insight into our relationship to be quite enlightening, and I think it contributed to the lessening of the hierarchy usually found between therapist and client.

At what was to be our last session, the couple brought a Christmas gift for me, which I had not expected and was completely surprised by. They told me that by doing this work with them I had, in a way, become a part of their family. I was very touched by this statement, and their regular feedback throughout the therapy was an important part of the therapeutic process.

Figure 4: Letter sent to Family "H" at termination

Dear Husband "H" and Wife "H",

How are you both doing? I'm happy to hear that you're both feeling positive and it's a good time to finish counselling. I think that says a lot about how hard you've worked to bring back those things into your lives that are important. I was sorry to hear that you haven't been feeling well, Husband "H". Wife "H" told me that you are recovering at your own pace, though, and I'm glad you didn't risk your recovery to have a final counselling session.

The last couple of times we've spoke, Wife "H", you sounded very positive about the future. In the seven times that the three of us met together, you both spoke about how you both bring positive qualities to the relationship. Even though there have been some difficult times did your individual strengths contribute to getting through it? Does the strength of your relationship increase because of all of those characteristics you both bring to it?

As Wife "H" and I discussed the last time we spoke by phone, I've sent along two copies of the final questionnaire from the research project for both of you to fill out. I've also included a stamped envelope for you to return them to Elizabeth Hill. I am hoping you do not mind filling out one final questionnaire for me as well. It's the typed five-question one, and I've also included a stamped envelope for it. Please return those ones in the envelope addressed to me.

It was nice to meet both of you and I wish you all the best in the future.

sincerely,

Cheryl Maxsom

My reflections on the therapy process

This case was one which exemplified for me the importance of language, and how useful metaphors can be in helping families realize change. Working with the spouses' own language was an extremely powerful tool in promoting a collaborative relationship between us as well as the examination of meaning. The letters I wrote to the family are an example of my contributions to this emphasis on language in the process, and seemed to further open up space for the couple to concentrate on reauthoring their story.

While the importance of language, conversation and meaning can clearly be seen in the therapeutic process with this family, there were times when I felt we concentrated on the stories of Wife "H" more than those of her husband. Wife and Husband "H" presented differently in their conversational styles in that Wife "H" talked with more emphasis, using varying voice tone and using more descriptive words. Husband "H" on the other hand was a man of fewer words, often talking with a more even tone than his wife. I often struggled with how to ask Husband "H" questions which would allow him the space to give fuller answers and describe his narratives in more detail. At the same time, Wife "H" would tell stories in which there was almost too much detail for us to absorb in the session. Another aspect of this emphasis on language with this family was the fact that we used the metaphors of Wife "H" as the starting point from which to talk about change in the relationship. While I asked if Husband "H" had metaphors or stories which described the relationship from his point of view, he said he did not think of things in this way. It seemed to me that the emphasis on language with the narrative approach may have created an imbalance in the therapy process with this

couple. I found it tiring to keep on top of this conversational dynamic in sessions while at the same time trying to maintain an emphasis on their goals and be respectful of how they told their own stories. I would have liked the opportunity to ask Husband "H" if he felt he was given enough space in the sessions to tell his own narratives at a pace that was comfortable for him. Unfortunately, all the final conversations with the family were with Wife "H" since Husband "H" was too ill.

CHAPTER FIVE

Summary of the Practicum Experience

Discussion

In reflecting back on the practicum experience as a whole, I cannot help but consider some of the issues which contributed to the success of this practicum. Using a narrative approach with this particular client group came with some unique challenges, which I would like to discuss. I will also provide a critique of the narrative approach, and finally, review the goals of my practicum.

My Work with Families

Since it can be difficult to get families to even keep an initial appointment, it takes an extraordinary amount of involvement on the part of the therapist to help the family to change. According to Aponte (1991) the therapist must include himself or herself as part of what must change; he or she cannot stand outside of the therapeutic process and expect only the family to put energy into the it. To this end, the therapeutic process must change, including the involvement of the therapist. I found that an increased involvement with families began with an eye to increasing structure for the family. The impact of multiple systemic issues could be lessened by helping the family increase the structure around therapy appointments (McNeil and Herschell, 1998). Using attendance contracts and providing families with a phone call to remind them of appointments are ways to increase families' attendance (D. Charabin, personal communication, June 9, 2000; McNeil and Herschell, 1998). These are strategies that I regularly used to help families continue with therapy.

However, I also found that helping families remember the appointments was but

one small part of the overall picture. I encountered families whose phone numbers had changed, or had lost the use of their phone but did not remember to let me know, so it fell back to the family to resume contact with me. There were also families for whom childcare, transportation and bus fare were issues which increased how hard they had to work in order to get to the EHCC office. I realize now how much my previous community-based experience with families could have come in handy -- I could have met families at their homes, or somewhere else convenient for the session. I also could have provided the transportation myself.

While it seems self-evident in this reflecting stage of the practicum that these issues could have been solved this easily by increasing my involvement, the family members I spoke to over the phone often did not say these were problems they were enduring. I learned that gently asking some pertinent questions during that first phone call could point to some of the on-going issues that were getting in the way of being able to meet with the family not only once, but regularly; all of the six families I began therapy with were able to carve out energy and time to get to an appointment once or twice. It was the long term planning of the therapy process over a number of months that became a difficult task.

One of the ways that I learned to combat these challenges in working with families was by using the phone to keep in contact more often. I found that even for families that were calling about intake, I generally had several phone calls with them, regardless of whether they came in for the appointment or not. The narrative approach was very useful in these phone calls, and I believe this approach helped to validate the family's concerns. I used a "not-knowing" approach on these calls as well as

deconstructive questioning to convey my respect for the family (Anderson, 1995, p.34). I also tried to normalize and validate the family's struggles by using the family member's own language. These phone calls indicated to me the importance of paying attention to the systemic issues facing families; the family members were very willing to engage in the therapeutic process but sometimes things got in the way of therapy appointments that were out of their hands, and mine.

Another issue that I would like to add to this discussion is how I dealt with families who were "shopping" around for services. Many of the families I spoke with over the phone were, to their credit, trying to find the best service for their family which could be provided in a timely fashion. I encountered three families (Families "A", "B" and "C") where the parents were looking for individual service for their children, but were coming to family therapy because it was offered free and immediately. I welcomed all families with any kind of presenting issue, regardless of where (or with whom) the family indicated the problem originated from. However, I struggled with parents who indicated to me that they would be physically present in the session but did not really think they needed to participate. In reflecting back on these difficult conversations with parents, I think this is another area that my skills in that initial phone call became crucial, and I learned to ask more direct questions and talk candidly about our differing expectations about how much they would participate and be engaged in the family therapy process.

For families that I met with in-person, phone calls became a way that we kept in touch when smaller crises or unforeseen issues prevented them from coming to the appointment. As the profile of the family cases indicates, I kept in contact with families for a longer period of time than is suggested by the number of therapy sessions. It

became common for there to be as many, if not more phone calls with the families than we had in-person sessions, and I feel that these phone calls lent support to the family and helped them through the small crises of day-to-day living. For both the "G" and "H" Families, phone calls were a way that we did some significant therapeutic work. For the "G" Family, I spoke to Mother "G" twice after the death of Father "G" and I made sure they had resources for crisis services to help them through the holidays. In the case of the "H" Family, Wife "H" and I spoke several times during the final month of the therapy. We even had the termination "session" over the phone.

Critique of the Narrative Approach

There were six families that I met with at least once, but who did not complete the therapeutic process that we started. I would like to review those cases and discuss how the narrative approach was used with these families. An overview of these families, their presenting issues and family demographic information is found in chapter three.

Families "A", "B", "E" and "F" all came to family therapy for one session only. The narrative approach was used minimally with these families due to the amount of time spent with them. However, I think the narrative approach was helpful in the first session in starting to build rapport with family members and validating their strengths and experiences. In the case of Families "A" and "B", the therapy was terminated after speaking to a parent by phone (Son "A" did not want to attend the counselling, and Son "B" moved to his father's house outside of Winnipeg). Families "E" and "F" said that they were interested in continuing with the therapy, but subsequently missed appointments. I spoke to Wife "E" a few times by phone and we talked about the current issues she was facing, and how often she was hearing from her partner. I tried to normalize her feelings

and validate her experience in these calls by using several narrative concepts, including deconstructive questioning and the "not-knowing" approach (Anderson, 1995, p. 34). In the case of Family "F", Mother "F" did not return my calls so I wrote to her to terminate the counseling process.

Family "D" came to family therapy for two sessions. The narrative approach with Husband and Wife "D" began by discussing the problem-saturated narratives that brought them to therapy. We also had initial discussions about what their relationship looked like when things were going well, as well as what they wanted their relationship to look like after the counselling was completed. It seemed that these initial questions about mapping the positive aspects of their relationship were difficult for the family to answer. They both seemed to have differing goals for the future and had difficulty articulating how counselling could be helpful to them. If I had been more experienced in family-based work at that point in the practicum, I may have been able to help them articulate this better. After missing a few appointments, both Husband and Wife "D" said they were busy with many other activities and the therapy was discontinued.

Family "I" also attended two sessions. These two sessions focused on discussing the effects of the problem narrative (the disappearance of Father "I"), and how living in different households affected the relationship between Mother and Daughter "I". We also discussed how societal messages affected them, such as gossip about Father "I", the family being on social assistance, and if the friends of Daughter "I" treat her differently. The narrative concept of discussing dominant discourses provided the family with a unique outcome. Despite all of the changes in their relationship and feeling distant from each other, Mother and Daughter "I" talked about how they shared the

same feeling of being displaced, and not having their own space in someone else's home. Shortly after the second session, I spoke to Mother "I" by phone and she said she was going to try to buy back their house, which had been repossessed earlier in the year. This was causing the family a lot of stress, and she wanted this to be over before resuming therapy. I called Family "I" a few weeks later but my calls were not returned.

While multiple systemic issues provided challenges for families, the practice evaluation showed that the narrative model is an effective clinical approach with families who have systemic issues to deal with. The narrative approach was effective in helping these families find ways to redefine not only their problems, but also their identities as families, as was discussed with Family "G". One of the tools that I found to be most helpful in working with families was the deconstructive questioning. I found that questions conveyed my "not-knowing" stance so that the family members could better concentrate on telling their own stories rather than trying to measure up to some ideal (Anderson, 1995, p.34; Anderson and Goolishian, 1992). The questioning also gave us a chance to collaborate and co-construct new narratives together, especially in situations where the person I directed the question towards had not thought of the particular idea that we were talking about in the way that I introduced it. I found those moments in sessions to be particularly gratifying because questioning gave me a chance to nudge a person into examining the problem in a different way.

Another tool which I found to be particularly useful was the letter writing. I do not think that I would have believed how much impact the letters had if I had not written them myself, and then heard about their impact from the people who received them. Not only did they give me a chance to put down on paper some of the positive things I was

seeing in sessions, they also gave me a chance to think through and put into my own language the narrative ideas that I sometimes tripped over in sessions. My only regret is that I did not use letters more often and earlier in the therapy process. I had tried on one occasion to use letter writing as a tool with Family "H" for the spouses to communicate to each other. However, Husband "H" did not like this idea, and we abandoned it soon after. I also think that perhaps having family members write about their own strengths and competencies to others outside the therapy process is something I would have liked to explore further.

The reflecting team process where the "G" Family provided their own reflections was a very useful tool. I found it to be useful in not only decreasing the conflict among family members within the session, but it opened up space for alternative narratives in ways which were new to the therapy process with the "G" Family.

I found that the narrative therapy approach I used was flexible and helped families to find ways to change their narratives about the problems they presented. However, there are ways that this clinical approach could have been used more effectively. For instance, the technique of externalization was applied with mixed results. While I used externalization as both a way of thinking and a technique, as a technique I found it awkward and mechanical, and family members seemed to find it confusing. I think there are several ways I could have used externalization in a more useful way. Because the narrative approach was new to me, I think using transcription as a process-oriented tool would have been helpful in finding clients' own externalized language and metaphors. The sessions themselves, as well as viewing videotape afterwards did not always help me to hear the metaphors and externalized language of

the families. However, the transcripts were very clear and small instances where family members used phrases more than once immediately stood out on the written page. One of the criticisms I had of the narrative model early in the practicum was that externalization did not seem to work with children or with people who did not narrate their life stories using metaphors. However, after analyzing the transcripts of the sessions so thoroughly, I found that families used phrases which could have easily been externalized. For example, Mother "G" in one session used the phrase "melt down" to tell the story of a particularly difficult week for the family. They talked about how the severity of the "melt down" could be gauged by how much she used inappropriate language (swearing). This would have been a great way to externalize the problem outside the family if I had picked up on these words at the time. I think the reason that I did not find this language either during the session or while viewing the video was that I was thinking about language from my own point of view, and I had more rigid views about what could be externalized, or what would constitute a metaphor in this clinical sense.

Part of this shift in my thinking about families' own use of language came as I shifted my thinking from relying on the narrative approach as a series of steps, to one which embodied a social constructionist point of view. Although I strongly believed in the ideas of social construction before the practicum began, I found that initially it was a daunting task to rely strictly on a way of thinking to guide the sessions. As I became more comfortable with the approach, I let go of the techniques and I think this evolution can be seen in my analysis of the family cases.

I also had some difficulty finding the transition point with a family from discussing

their problem-saturated views to discussing alternatives without the problem present. This transition happened differently for each family. Mother "G" suggested that I could have provided more direction to the counselling process, and this may fit with my discomfort over this transition. I struggled at times to find my own language to describe narrative ideas, and I think this contributed to the awkward transition between problem-saturated views to discussions about alternatives.

A final comment I have about the narrative approach is in regards to its applicability to families who have multiple systemic issues. Although I did not follow any one particular author's description of the narrative approach, I found it nonetheless to be a therapeutic model which examined the "big picture" of families' issues. While the examination of dominant discourse can bring into focus the issues which plague families who live in poverty, I do not feel that the narrative model accommodated those families for whom these struggles include more basic needs or who were facing a crisis such as lack of a stable income, drug abuse by children or needing resources to better manage a disability. The narrative model is one which focuses on the cognitive shifting of perceptions, and while I believe that this is an important part of the therapeutic process, thinking differently about one's income does nothing for the person who has none. Even though I approached the narrative model from the perspective of using it eclectically to suit the needs of the families, it worked best when I incorporated it with case management, and was able to help families find resources for their most pressing needs.

Assessment of the Practice Evaluation Methods

I would like to address the specific ethical concerns which are unique to the

practice evaluation method I used, due to its basis on narrative analysis. First, because it is highly interpretive, this kind of analysis bears my mark as researcher. The fact that I am a feminist, middle class, born in Canada, caucasian and educated are the lenses through which I made my interpretations. As much as I tried to be respectful and ethical, I am aware that these are nonetheless the lenses through which my ideas are filtered.

Second, it is important to keep in mind that while I used transcribing extensively as a way to understand the meanings of narratives in therapy sessions, transcripts are not *the* reality, but representations of it (Mishler, 1986). In my narrative analysis I kept this in mind throughout the analysis that I did of the sessions. I also used the audiotapes extensively, often listening to the tapes as I read through the text on the pages. This helped me to refrain from seeing the sessions as text-based, instead of language-based. I also used the audiotapes as a way to find the entrance and exit talk of stories.

One final dilemma in using transcripts as representations involves equipment failure. There were times that the audiotapes and/or videotapes were unclear and I could not hear what was being said. Having transcripts which are as complete as possible is crucial, and I tried to avoid having these unclear gaps in the written account of the sessions as much as possible.

Looking back on the evaluation method I chose, I am still content with my choice of qualitative methods and I believe this was an appropriate choice to measure the effectiveness of my practice by examining client change. The congruence of qualitative methods to the narrative approach is one that is significant, and warrants further exploration, especially in practice evaluation. However, initially I viewed the transcription of sessions also as a process-oriented tool that would help me find narratives,

metaphors and understand the families experience better. This did not end up being possible since transcription is a time-consuming process and one that is not possible to complete for every first session that I did with a family. I also used narrative analysis loosely as a tool for my practice evaluation, since this is not a pure research project. Narrative analysis helped me to understand how meaning could be embedded in narratives and stories, and helped me to find where narratives and stories would begin and end. Also, I initially thought that I would transcribe only the first, middle and last sessions and then analyze the narratives in these sessions of each of these families. However, I found that the family members told their stories at various times throughout the therapeutic process, and did not necessarily fit neatly into these three sessions that were transcribed. I therefore also listened extensively to both the audio and video tapes, and then also transcribed narratives told in other sessions that were pertinent to the themes as told by the family members. In this way, change was distinguishable through the way that families described and made sense of the events in their lives.

Conclusion

The main goals of this practicum were to provide ethical, appropriate and effective therapeutic service to families, and to seek out alternatives to the narrative model as described by White and Epston (1990). I believe I have met these goals as well as the other goals I set out to guide me through this practicum.

This practicum experience helped me to gain a solid understanding of the narrative model as described by White and Epston (1990). The technique of externalizing the problem, while initially awkward to use, was instrumental in changing how I conveyed to clients my belief that they were not synonymous with the problem. I

also feel that discussions regarding dominant discourse were fruitful, and helped to examine how family members organize details of their own narratives. These conversations with families widened my understanding of the intertwining of the public and private spheres of experience, as well as indicated to me how powerful the sharing and retelling of stories can be. I also found the concept of deconstructive questioning to be a strong tool to convey my respect for people. Far from being just a way to ask about a person's experience, deconstructive questioning gave me another way to step back from the role as therapist, and try to even out the hierarchy in the therapist-client relationship.

Besides the key concepts which are specific to White and Epston (1990), I also had a chance to incorporate a number of alternatives into the work I did with families. These alternatives gave me a chance to be creative with the narrative approach. For instance, a reflecting team where the family members provide their own ideas as alternative narratives was a tool that I found to be particularly useful. Having family members provide their own reflection further promotes co-construction between the family and therapist, and provides further validation of the family's own experience. I also believe this approach to a reflecting team is one which warrants further analysis in the clinical literature. I also have a firm understanding to the meaning-making process (Anderson, 1995). Another narrative alternative that I incorporated into my practice is the "not-knowing" approach as described by Anderson and Goolishian (Anderson, 1995, p. 34). Along with the related concept of opening up space, as described by Fine and Turner (1991), these key concepts helped me to examine my influence in the therapeutic process, and to pay attention to the place my own values had in the therapy.

Overall, I believe in the strength of the narrative approach with families. As a social work practitioner I also find the narrative approach is a good fit with the values of social work practice. An emphasis on social justice, empowerment and belief in the intrinsic worth of people are at the core of both the narrative approach and social work practice. I also found the as a feminist practitioner, the narrative approach fit well with my own belief system because of its examination of dominant discourses and questioning of the power imbalance between therapist and family.

Along with an examination of the literature regarding families and narrative models, as well as feedback from the families, my knowledge about family strength and resilience and narrative therapy has increased significantly. Although my expectation going in was that this would be training in which I would experience new ways of approaching clinical work with families, I did not expect to come away with a whole new way of thinking and responding to family issues. Although I had significant theoretical knowledge about families and their abilities to deal with multiple systemic issues, my learning curve was steep in the transition from being a clinician whose work was primarily individually-based to a practice which was family-based. The beginning of the practicum was geared towards not only learning new family-based clinical skills, but becoming comfortable with them. Also, although I had done case work before, some families dealing with multiple systemic issues need a therapist to perform wider case management duties than I was initially prepared for. Before this practicum, I was very much a clinician who focused on problem solving, and the narrative approach broadened not only my understanding of family strength, but my repertoire of clinical skills which can help families get reacquainted with their own competencies. I feel that I

am a much more flexible clinician now, able to tailor my practice in significant ways to suit the needs of families.

Overall, I believe I have completed a practicum which has been helpful to families and contributed significantly to my professional development.

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APPENDIX A

Feedback Questionnaire

Any feedback you could give about the family counselling that you received would be appreciated. It would be very helpful to find out what you liked or disliked about the counselling, as well as what you think could have been done differently.

To preserve your anonymity, please do not write your name on this page. This questionnaire will only be seen by the counsellor you worked with. It will not be included in your file, nor will it affect any future service you may want from the Elizabeth Hill Counselling Centre. All questionnaires will be opened together after all of them have been collected.

1. What has been the most helpful about the family counselling?

2. What has been the least helpful about the family counselling?

3. Are there any suggestions you would like to make as to how you would have liked the counselling to be different? Are there changes the counsellor can make in order to better help other families?

4. To sum up, would you say that the family counselling has been:

__ not at all helpful
__ a little bit helpful
__ quite helpful
__ extremely helpful

5. Are there any other comments you would like to make?