INTEGRATION OF NARRATIVE FAMILY THERAPY WITH SYSTEMS THEORY IN PARENT-CHILD CONFLICT

By
Inga Wulff

A Practicum Report
Submitted to the Faculty of Graduate Studies in Partial Fulfillment of the Requirements
for the Degree of

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ABSTRACT

Narrative family therapy is a hot topic these days (Agnus & McLeod, 2004) as an ideology that is dominating the landscape of family therapy (Nichols & Schwartz, 1998). According to constructivist theory, thought is governed by one's social environment where the main component reality is founded in the language systems in which we exist. Foucault (1980) asserts that dominant cultural narratives self-perpetuate positions leaving individuals and families to believe that these positions are their only alternatives. Positions become problematic when the dominant narratives of the culture no longer meet the needs of the family or individual. According to White and Epston (1990) narrative family therapy is designed to free people from the oppression of their problems. The relationship between narrative therapist and client is collaborative allowing both to team-up to confront the problem and reauthor the client's issues into a new story and experience. I completed this practicum to understand the impact narrative family therapy has in families. The effectiveness of this approach is supported by feedback from qualitative and quantitative evaluation instruments used to assess family functioning and outcome with three case examples. In summation, I reflect on the usefulness of the model and my overall learning experience.

CHAPTER ONE

Introduction

Narrative family therapy is an increasingly used and respected therapeutic paradigm (Cowley & Springen, 1995). O'Hanlon (1994) states, "Narrative family therapy is more than a new set of techniques it represents a fundamentally new direction in the therapeutic world." My previous experience working with individuals and families focused primarily on systemic family therapy, an approach that views the therapist as an expert whose objective is to "repair" the intrinsic flaws in family systems where reality exists independent of an attempt to observe it. The narrative approach based on constructivism pulled family therapy from the conviction of what one observes in families is what is in families (Nichols & Schwartz, 2001) towards concern for how families' internal images make meaning of their lives. The premise being individuals can never know the real world but rather how to construct reality from one's experiences (Dell, 1985).

Walsh (1998) views the therapeutic role in systems therapy as disempowering to clients with power imbalances resulting in the client internalizing the therapist's values and worldview. I chose to explore narrative theory as an alternative for assisting individuals and families with their problems. Narrative theorists believe people become oppressed when their efforts to resolve issues deviate from the norm. Postmodernists understand reality as a construction of society, and people's attempts to conform. I appreciate this conception of reality and aspire to challenge my understanding of how theory contributes to therapy. My goal in completing my practicum was to gain

confidence in applying postmodern theory, and acquire knowledge and skills in using narrative family therapy with families experiencing life transitions.

The definition of family used in this practicum is a group of individuals who consider themselves a family and assume the responsibilities and obligations of healthy family life (Barker, 1995). These responsibilities may include income support, child socialization and development, long-term care, and other caregiving behaviours. This definition of family follows the social constructivist perspective, which proposes that a family should be classified as who is influenced by the issue(s), rather than by socially constructed ideas of roles, structure and membership (Anderson, 1995; Laird, 1995).

The practicum is divided into six chapters. Chapter One states the objectives of the practicum and rationale for using narrative therapy in a social work approach for working with parent-child conflict. Research on the effectiveness of narrative family therapy is also addressed. Chapter Two reviews the literature on the family lifecycle, with particular attention to the adolescent phase. Attention is also given to parent-child conflict. The narrative principles for understanding and navigating these transitions illustrate the underlying framework of Chapter Three. The chapter reviews the historical context, philosophy, and supporting strategies and techniques of narrative therapy. Consideration is also given to structural family therapy, cognitive behavioural family therapy, and the strengths perspective to transcend the confines of the narrative approach. Chapter Four describes the organization of the practicum: the setting and client types; duration; supervision; and evaluation procedures. Clinical cases are described in Chapter Five. Chapter Six concludes with my experience with the practicum.

Objectives of the Practicum

The purpose of this practicum was to develop an understanding of family dynamics in family life transitions and the effect on individual family members and their development. The learning objectives of this practicum are as follows:

1. To confirm relational skills within clinical sessions by reading the verbal and nonverbal processes of the client to effectively challenge and support the client's effort.
2. To expand my assessment and clinical skills in working with families with children.
3. To increase my subjective experience of the client, evaluating the significance of the experience, and explore how these might advance therapy.
4. To plan, implement, and explore the usefulness of narrative therapy as an intervention in working with children and their families.
5. To utilize the appropriate evaluation tools to evaluate the effectiveness of the intervention and model employed to work with these families and their children.

CHAPTER TWO

Literature Review

Family Developmental Life Cycle

A family is a social system consisting of people who are related through strong ties, reciprocal affection, and loyalties, which create a lifelong household, or a group of households that pass through the family developmental life cycle (Nichols & Schwartz, 1998).

The family life cycle originated as a sociological construct to describe the influence of the extended family. Duvall and Hill applied developmental theory to family therapy by dividing family development into discrete stages with tasks to be performed at each phase. This life cycle offered concepts for understanding the power extended family has on the overall functioning of the family system (Duvall, 1957; Hill & Rodgers, 1964).

Family therapist Jay Haley (1973) enriched family therapy by introducing the family life cycle framework. He viewed symptoms a consequence of a family's inability to address and cope with environmental or developmental difficulties and adjust according to its configuration to transitional challenges between life cycle stages. According to Minuchin (1974) families unable to adjust their structure to accommodate changed situations become problematic rather than "dysfunctional". The MRI group thought families became troubled in response to members' problematic effort to reach solutions. This view reconsidered family problems as difficulties negotiating the life cycle instead of pathologizing family encounters. The idea that families fixated developmentally as do individuals in development expanded the goal of family therapy to

assist families in recognizing and working through feelings of delayed development by, for instance, balancing freedom with responsibilities, and grieving unresolved loss (Nichols, 2001).

The family life cycle is a therapeutic tool for understanding that families encounter crucial emotional progressions that its members must successfully resolve before transitioning to the next stage, and where no one style for integrating life events is inherently normal or atypical (Nichols & Schwartz, 2001). Of significance is the evolution of symptoms when there is an interruption or disruption in the unfolding life cycle. In large, the therapeutic goal of the family life cycle is to focus on supporting the family through such crisis as its members negotiate new roles and patterns of interaction to foster developmental growth and navigate unpredictable life stressors (e.g. accidents, terminal illness). For this reason, the objective of family is to manage expansion, reduction, and realignment to sustain the entry, exit and development of its members in a functional way (Carter & McGoldrick, 2003).

It is important to realize that there is no fixed or standard family life cycle model, although the Carter and McGoldrick model is the main framework used by family therapists (Nichols & Schwartz, 2001). This model of the family developmental life cycle is a three generational intermingling of members and events that observes the context of previous life transitions and expectations for the future (Carter & McGoldrick, 2003).

Some therapists believe family behavioural patterns and response to crisis and change can best be understood when framed within consideration of the family's growth in its present developmental phase. Family evolution is a dynamic process that

incorporates two kinds of change: first-order change described as an internal rearranging of the family system without changing the system itself, and second-order change needed for the family to advance developmentally. Additionally, individual maturity is dependent on the growth and development of its family members (Carter & McGoldrick, 2003).

This framework consists of six developmental stages, which integrate the following main life events: the unattached young adult; the new couple; families with young children; families with adolescents; launching children and moving on (i.e. the launching of children outside the home, and the family in later life).

Between Families: Young Adulthood

The main concept of this first phase of the family life cycle is the young adult's differentiation of self in relation to their family of origin. Second order change results when differentiation occurs where the young adult implements, refines, or disregards the values and beliefs of the parents as part of their own identity. Of relevance is the extent to which parents have established their own sense of maturity and independence. A parent who is self-indulgent or who has an undeveloped sense of person influences how they relate to their child's development. If the parent or the young adult fails to recognize the need for independence from the family, the following issues can arise: a change in marital equilibrium; unwillingness for parents to relinquish a parenting style suitable for younger children; parental loss (e.g. illness and unemployment); and trauma or stressors in the parental system. Such delays in the transition of parent-child separation can shift family roles and impede functional change to family structure (Carter & McGoldrick, 2003; 1982).

Added developmental tasks involve the young adult learning financial responsibility, personal goal formation, and the establishment of intimate peer relations outside the family unit. Without a sense of separation from the family of origin the young adult will carry their roles into intimate relationships, at which differentiation of self will become secondary to the needs of the individual's parents (Carter & McGoldrick, 2003; 1982).

The Joining of Families in Marriage: The Young Couple

This second phase of the family life cycle focuses on the newly married couple system forming appropriate boundaries around their new family subsystem, while family and friends support the marital union and accept the new spouse into their network. This facilitates a second order change whereby a new marital system is formed and social relationships and family systems are realigned to include both spouses. Though the new couple remains connected to friends and family of origin, the couple learns cohesiveness by spending time acquainting themselves with each other and learning to collaborate and resolve differences (Carter & McGoldrick, 1988).

Marital breakdown results when the new couple fails to establish boundaries around their newly formed subsystem, thus allowing for intrusion from extended family. Failure of the couple to distance themselves from unresolved family issues impedes the success of their intimate union (Carter & McGoldrick, 2003). Additional developmental and social challenges that arise in transition to marriage and the formation of a new family include: pregnancy within the first year of marriage; emotional estrangement from family; unsolved dependency factors; contrasting family backgrounds; a tumultuous

childhood; problematic marital relationships within the family; and significant loss (Carter & McGoldrick, 2003).

Family with Young Children

This third developmental stage is one with various tasks that often dramatically alter the marital dyad, including adjustment of the marital system to accommodate the presence of children with the balancing of career, finances, child rearing, household, and time together as a couple. Often the latter is neglected in effort to accomplish all other tasks, resulting in conflict and stress. Triangulation is apt to occur with the arrival of children to challenge the stability of the family unit and the marital dyad. Failure of spouses to respond and grow in their appropriate roles may lead to one parent becoming closer to their child then their mate consequently, jeopardizing the couples' intimacy (Brandt, 1988). For this reason, "a marriage that has developed intimacy is a marriage better able to respond to the challenge of parenthood, to integrate the lifelong change that parenthood brings, not only to new parents but to the entire family" (Brandt, 1988, p. 243). Commitment to the new family unit, as well as successful navigation through this stage, requires second order change where relationships with extended family are realigned vertically to include parenting and grandparenting roles (Carter & McGoldrick, 2003).

Families with Adolescents

Adolescence expands from the oldest child's entrance into adolescence through the last child's initiation into adulthood. It is considered one of the most emotionally stressful stages of the family life cycle (Carter & McGoldrick, 2003; Preto, 1999). Major psychological and emotional tasks that occur in this phase of the family life cycle affect parents and adolescents as both undergo transformation of independence and philosophy of life.

Parents are the primary socializing force of their children and should focus on assisting adolescents to make their own decisions while discussing social responsibilities and social values as a framework for identity formation. Resulting change influences both the parent-child relationship and the marital union as the entire family must renegotiate their roles in addition to loosening their boundaries to allow children independence and autonomy. For instance, fathers may require assistance to surmount inhibitions in connecting with their sons and daughters emotionally.

Tasks of the family during the adolescent stage include: revising the parent-child relationship to allow the adolescent to move in and out of the family unit; parents responding to the aging process of their own parents; and parents beginning to address mid-life issues of independence, and the satisfaction or dissatisfaction with marriage and career (Carter & McGoldrick, 2003). Of note, parents with adolescents have the lowest incidence of marital satisfaction. Carter and McGoldrick (2003) advise that sole attention by either the family or therapist on parent-child complaints during this phase may conceal underlying marital issues, an extramarital affair or consideration of divorce. Second

order change is required to allow shifts in the parent-child relationship so the adolescent has freedom to transfer in and out of the family system.

Adolescence

The family with adolescent children has been considered a chaotic phase of life. Tasks of the adolescent in the individual life cycle and the family life cycle overlap and sometimes clash as changes arising from the adolescent's progression through the developmental tasks impose new demands and expectations on the family. When the adolescent is undergoing an "identity crisis", their parents are coping with "mid-life crisis" (Preto, 1999; Preto & Travis, 1985). Consequently, adolescence is a stage when both the adolescent and their parents are pressured by expectations, personal goals, autonomy, and individuation (Preto & Travis, 1985).

Erickson (1968) observed the adolescent phase as a period of "normative crisis", "a necessary turning point, a crucial moment when development must move one way or another, marshalling resources for growth, recovery and further differentiation" (p. 15). From this, adolescents develop a sense of self and the knowledge they require to mature and function. This is also a time when development is affected by physical, cognitve, biological, and psychological maturation such as: identity formation, sexuality, and a sense of individuation and autonomy from parents (Blos, 1962). Disengagement from parents and family increases as the adolescent progresses through each phase towards increased identification with peers. Adolescents successfully progresses through their developmental tasks when provided independence to make decisions and consistent guidance as needed from parents and caregivers (Mishne, 1986).

Adolescence begins when the transformation gained in the previous stages begins to strengthen and stabilize. "The developmental task of late adolescence is the consolidation of personality to facilitate stability in handling work, relationships and one's personal value system" (Mishne, 1986, p.19).

In all, adolescents become progressively aware of whom they are through the development of independence, sense of self, and competence. Three developmental tasks commonly describe the adolescent phase of self-discovery: identity formation, sexuality, and autonomy. Attachment, separation, and loss are also characteristic of the adolescent phase of the life cycle.

Identity Formation

"Identity is the stable, consistent and reliable sense of who one stands for as a contributing member of society" (Fullinwider-Bush & Jacobvitz, 1993, p. 87). The adolescent's struggle with identity formation is a source of conflict for parents. Adolescents begin to critique their parents' strengths and limitations. To promote successful individualization the adolescent integrates parental attitudes that will help them develop their adult sense of self, while attempting to reject those they believe unconstructive (Preto, 1999). An "adolescent's advanced reasoning abilities may make it difficult for the parents to exercise previously unquestioned authority, and the young person may feel entitled to have a say in family decision making" (Steinberg, 1987, p.83).

In their search for identity, the adolescent will waver in their relationships with parents and challenge family values and moral principles (Carter & McGoldrick, 1982; Preto, 1999). In all, the family is the most influential social system on the adolescent's

development (Garbarino, 1986). Therefore, it is vital parents understand and provide support in the adolescent's struggle with identity formation, self-worth and dignity — a tumultuous time in which the adolescent needs understanding, nurturance and guidance.

Hormonal fluctuations in teenagers influence moods from "elation and despair, excitement and enervation, restlessness and passivity, rage and calm, sweetness and cynicism" (Siegler, 1998, p. 10). Because of vacillations in physiological, cognitive and emotional changes, adolescent experiences create contention between parents and with the adolescent. From this the adolescent may become susceptible to societal pressures and influences and symptoms of depression, anxiety and fatigue, which allow the child to remain in the family unit and maintain the marital tie (Preto, 1999).

Adolescents unable to complete this stage experience social incongruity and role confusion, which may lead to psychopathology (Erickson, 1968). Haley (1973) postulated adolescent schizophrenia might be a result of stress by the child attempting to separate from parents. As well, Haley (1973) believed that the adolescent develops debilitating problems, which allows them to remain in the family unit and safeguard the marital tie. As well, inattention and the failure of parents to provide intimacy and support are also correlated with adolescent depression and suicidal ideation. Unrelenting attention from parents is a determinant of the same (Sands & Dixon, 1986). Hence, the nature of the failed transition lies more in failure to complete a process rather than failure to initiate it (Breulin et al, 1992).

Sexuality

The second significant task of adolescence involves the formation of sexual identity. The surge in sexual thoughts, feelings, and behaviour is a developmental factor that transforms the self-concept of adolescents and alters how other family members perceive them (Preto & Travis, 1985). Parents may experience discomfort, confusion and apprehension when adolescents begin to manifest their sexuality. Preto (1999) suggests these reactions are in response to incestuous impulses where parents and adolescents of the same sex often become competitive with one another. Also, there is competition over contradictory perceptions of proper gender role formations. For instance, the adolescent may challenge same sex parents if beliefs concerning appropriate behaviours and actions conflict.

Autonomy

The final developmental task of adolescence is autonomy. This is a period of exploration, self-expression, self-assertion, and a time to establish one's own attributes, values, and goals. Individuality and maturity are attempted through decision-making independent of input from parents and authority figures. This need for independence does not mean that adolescents will totally cut themselves off from their parents. Rather, adolescents undertake a physical separation, but remain emotionally attached to family. Adolescents especially need parental support and encouragement during difficult periods. As well these are turbulent times when parents must renegotiate their relationship with the adolescent. By providing encouragement and minimal authority over the adolescent the parent can maintain an influential position in their child's life (Carter & McGoldrick,

2003; Preto, 1999). Preto (1999) charged that adolescents have greater opportunity for independence in families where they are encouraged to participate in decision-making, but where parents make the final decision on what is appropriate. Adolescents reared in systems where involvement in decision-making and self-regulation is restricted are apt to become more dependent and less confident.

Adolescents move towards autonomy when parents support their decision-making while guarding the process. Hence, adolescents that are autonomous are still able to maintain an emotional relationship with their parents even as the adolescent's independence grows. Parents with ineffectual input in their child's decision-making process risk having an adolescent with greater dependency and less self-confidence (Preto, 1999).

Also, Preto relates that adolescent development flourishes in homes where parents maintain structure and direction while permitting opportunities for self-sufficiency and independence. Parents who have not developed these attributes as an adolescent will have difficulty facilitating and encouraging autonomy in their own children, and mutual conflict may result.

Attachment, Separation, and Loss

Attachment in childhood and adolescent relationships offer the person a secure foundation from which to address the stress of daily life. This secure foundation affords the dual system of attachment and exploration, where by attachment protects the child from injury, and the exploratory system allows the adolescent opportunity to learn and

develop competence (Bowlby, 1979). Without secure attachment, the transition through adulthood may be particularity stressful.

In addition to contending with the developmental tasks involved in entering the adolescent phase, the transition from childhood is also marked by an accompanying sense of loss for the adolescent and their parents. Adolescents no longer enjoy the security and self-assuredness of (childhood) latency while the care giving responsibilities of parents requires change (Preto & Travis, 1985).

Strong, cohesive parenting is required to support the adolescent in the process of separation while parents who attempt to manage the adolescent through contempt or child-like behaviour may risk symptomatic behaviour in the adolescent (Preto, 1999). A parent's capacity for managing their adolescent's independence is contingent on whether the parent experienced early loss or an interruption in their upbringing (Carter & McGoldrick, 2003; Preto, 1999). Parents who deter the adolescent from interacting with others outside of the family system jeopardize social development, independence, and separation from the family (Preto, 1999).

Parents who are not capable of providing structure, solidarity, guidance and acceptance for the adolescent are likely to become overwhelmed and respond by either attempting to control their adolescent arbitrarily or by surrendering control all together (Preto & Travis, 1985). Thus, parents may forfeit their parental responsibilities and request premature eviction of the adolescent from the home or even the family.

Garbarino (1986) concludes that the family is the best social system for influencing successful completion of the adolescent developmental tasks and transition to

adulthood by way of parents maintaining stable, supportive, and protective relationships with their children.

Families at Midlife: Launching Children and Moving On

Launching children and moving on, like the previous developmental stage of adolescence, can be emotionally difficult for parents as this is the longest phase of the family life cycle and often the most tumultuous. As Preto (1999) stated the family is transformed from a system that nurtures young children to one that prepares the adolescent to enter the world of adult responsibilities and commitments. What's more is parents must contend with several entrances and exits from the family system. Besides, parents' own unresolved childhood dependence issues might arise at this time as they are faced with their child's growing independence and that of old age approaching. Parents must revise the parent-child relationship in effort to allow the adolescent to move in and out of the family unit as some children return to the nest due to the difficult economic challenges of our times. As well, parents begin to address mid-life issues of independence, marriage and career; and become more involved in the aging process of their own parents (Carter & McGoldrick, 2003). Second order changes involve realignment of relationships between parents and adult children, in-laws, and grandchildren as well as coping with launching children from the home into adulthood while compounded with health concerns, family realignment by way of break-up or separation, along with the death of their own parents.

Often transitioning a child from the home is relatively stress free when children's values and expectations compliment that of their parents. Second order change

transpires when parents renegotiate their marital union in the absence of children in the household.

As children become independent and are ready to move on and form their own families, parents must begin to reevaluate their roles in their marital relationships as well as learn to identify with grandparenting responsibilities. Whether parents perceive this time as a new independence, free of child rearing and financial limitations, or a time of sadness or loneliness may depend on their parents' own marital and personal satisfaction. A couple whose relationship is strained may hold onto their offspring in hopes of avoiding time alone as a couple.

Besides the couple addressing exits and entries of family members they often find themselves existing in different directions psychologically. Men may feel themselves lacking in intimacy with their children and partner as they come to realize the constraints their working life has placed on them. Thus, they may turn to their children for more closeness even as they are transitioning out of the home. Moreover, husbands may turn to their wives for increased intimacy, whereas women who have provided care for so long are more likely to search for opportunities of satisfaction outside the home. Men may consider reconnecting and 'starting over' with their partners will provide a new opportunity to do better. Depending on the couple's ability to redefine their lives and relationship, on top of expanding their options, the marriage may dissolve (Carter & McGoldrick, 2003).

The Family in Later Life

The final stage of the family life cycle is associated with the aging process of older family members. The management of this aging process has a direct impact on family generational roles and responsibilities. The elderly family member must maintain their individual and couple relationships with respect to changes in the elder's economic, social, and physical well-being. At the same time the younger generations need to support the older person without over functioning for them. Other developmental changes include, the older person taking on new family and social roles while addressing the loss of their spouse, siblings and peers. This is also a time when the older person begins to self-evaluate their life and prepares for death (Carter & McGoldrick, 2003). The elderly couple successfully navigates this developmental stage together when they accomplish second order change. Second order change calls for the couple relationship to maintain their interests and functioning as a marital unit while facing physical decline.

The main focus is now on the middle generation to support the older family member without over functioning for them. Emotional transitions are difficult for the middle generation as they are involved in launching their own children and may feel "sandwiched" between the joint caring of children and parents. Some of these developmental tasks may not correspond to the adult offspring's developmental readiness to care for parents, as they may also be aging and experiencing similar losses. For that reason, cross-generational interplay of family life cycle concerns may be entered into with acceptance and a sense of accomplishment, or with acrimony and anguish, the latter often leading to unfavorable outcomes. Overall, the sentiment and acceptance of shifting

family roles is dependent on the capabilities of family members to conclude the developmental tasks of meeting the needs of its aged members.

Emotionality also includes reorganization of the family brought about by loss and the shifting of generational roles. Fostered by illness and dependency, the entire family system is confronted on their ability to cope with loss and reorganization (Walsh, 1999). Second order change challenges the family, especially the older generations to accept the loss of friends, family and the spouse, on top of preparation for one's own eminent death, and the end of a family generation.

Families that address new challenges, shaped by precipitating life events, by applying dated patterned modes of problem solving are apt to become "stuck" in the life cycle process. Therefore, poor negotiation through developmental tasks and premature resolution of a life cycle phase can be problematic for the family's future completion of the developmental stage. Additionally, the way in which the family attends to the developmental phases and corresponding stressors influences individual maturation and overall family development.

The stress and disorganization associated with the crisis initiates reorganization of the family unit. Transitions normally create crisis when life events occur prematurely; out of context of the life cycle perspective (e.g. marital breakdown).

Varying Family Forms and Challenges

The family is a dynamic process of ever evolving social context depicted by increasing divorce and remarriage rates, challenges with single-parent households and the sociopolitical context surrounding lesbian and gay families, whereby family break up or

societal constraints in no way remove a couple or individual from the system (Carter & McGoldrick, 2003).

Divorce

Divorce is an interruption or displacement of the traditional family life cycle that creates considerable disequilibrium related to life cycle transitions with gains, and loss in family membership where cut-off is customary. Significant emotional and structural tasks accompany the divorce phase of the developmental life cycle. Divorce and post divorce reflect a sense of loss families must mourn. Healing involves grieving lost dreams and aspirations while addressing the pain, hurt and resentment, guilt and shame, as well as the loss of roles and identities of the individual, their spouse, children and extended family.

Families who address the challenge of family break-up are not always impaired as popular beliefs maintain (Visher et al, 2003). As long as the couple does not disconnect completely but continue to interact as supportive parents and allow children the maximum possible contact between siblings, parents, and extended family—the family will navigate divorce with success (Carter & McGoldrick, 2003).

Remarriage Families and Step-parenting

Several characteristics of stepfamilies are not shared with first-marriage families. Primarily, a stepfamily often unites at a time when members are at various phases in their individual, marital, and family life cycles. Consequently, there may be competing developmental needs or transitions that may not be discrete. Second, the merger may

have differing traditions, and values and norms in how communication and families ought to function. Third, children have parents and extended family in another place and may make shifts between household memberships among families. Fourth, stepparents have limited legal rights (Mahoney, 2000; Ramsay, 1995), which create feelings of exclusion and potential problems between families, and stepparent and stepchild, especially for those who have developed a strong bond. Fifth, parent-child relationships precede rather than follow the bond between the couple. So, several attachments are formed prior to the couple union. To conclude, stepfamilies are created subsequent to many loses and changes where parent-child relationships and living arrangements have been altered and dreams ruined (Visher et al, 2003).

Remarriage, cohabitation, and step-parenting is a time of personal fears, anxiety, and aspirations of investing in a new relationship, even as one is addressing reactions of hostility, guilt, and acceptance from children, extended family, and one's ex-partner. Emotional pressures, compounded by new roles, accompany each facet and family structure especially if blended and stepfamilies are involved (Carter & McGoldrick, 2003). Accordingly, stepfamilies are much more ambiguous and complex structurally then first-marriage families as boundaries are now less apparent and homeostasis curtailed, where frequent transitions can prompt greater stress and less cohesiveness. As such, step households must manage six ensuing concerns: boundary disputes; power issues; outsiders versus insiders; conflicting loyalties; rigid unproductive triangles; and the unity versus fragmentation of the new couple relationship. Because of varying dynamics and issues, stepfamilies need education and support in addressing their passage

as a newly developing family — a family that lacks the gradual evolution of interpersonal relationships like that of the first-marriage (Visher et al, 2003).

Even though there is greater acknowledgment for stepfamilies, these families continue to live in the shadows of negative stereotyping (Ganong & Coleman, 1997) where grim mythical assumptions of wicked stepparents and their ulterior motives are akin to the unfavourable idiom of "stepchild". Sadly all too familiar in North American society, these families are assumed pathological as they are outside the conventional perception of "family" as an intact two-parent household. Stepfamilies must be understood as a unit undergoing a multitude of transitional difficulties not individuals with intrinsic deficiencies (Visher et al, 2003).

Specific therapeutic guidelines are deemed distinct and helpful when working with stepfamilies. First, the therapist must overcome the emotional concept of the "ideal" family, as no effective effort exists to typecast the stepfamily with the first-marriage family. Second, since cultural and structural characteristics vary greatly and generate added stress in stepfamilies, therapists need to begin with the couple relationships and strengthen the most recent and fragile subsystem prior to seeing the family in its entirety. Third, validate and normalize individuals' feelings, understandings, and experiences with transitions into a stepfamily particularly with stepchildren, in reference to normative stepfamily development. Fourth, have other parents, grandparents, stepparents, important adults, and the couple convene to verify their positions and to solidify the remarried family unit. The basis of the meeting is limited to issues involving the children. Lastly, frustrations with change are revealed through behavioural issues and emotional tension in family members. All require validation and assistance in building confidence and

searching out productive alternatives to circumvent problems. Stepfamilies need to know that their transitional difficulties are likely and not due to personal failure (Visher et al, 2003).

Single Parenting

Theoretically, single parent families transition through the life cycle with most of the same responsibilities as that of a two-parent family. Differences between single and two parent families are seen primarily in the frequency, timing, and duration of the critical transitions experienced (Hill, 1986). Added exceptions being that a second parent is involved as a partner in role modeling, care giving, and providing companionship (Anderson, 2003; Duvall, 1988). Without the second partner the single parent is overloaded as they are the primary in raising their family in a healthy manner, while trying to engage a reasonable adult life style for themselves within the circumstances of unsupportive communities (Anderson, 2003).

Though basic therapeutic skills are used with single families to navigate the family life cycle and other families, Anderson focuses on particular therapeutic skills to be used with single parents. First, becoming a single parent may not exclusively mean a traumatic experience for the parent rather it may be considered good fortune. Listening to the perception of the single parent is central in adequately assisting with issues of greatest concern. Second, continued relationship between the single-family household and the noncustodial parent may be stressful. Still, this can be managed to the benefit of the child and the primary parent as respite and greater financial support can be attained from the custodial parent. Third, social stigma may create distress for single parents

above that of personal inadequacy, as society aggravates the family's opportunity to access a sufficient social, financial and psychological safety net. Really the single parent, above two parent households, requires understanding, and support from society and the therapist in helping to mobilize internal strengths and resources to network and establish a personal and workable life in spite of numerous multifaceted challenges.

Lesbian and Gay Families

Individual and family developmental life cycles are fundamental in working with lesbian and gay families as application is directed towards the family's systematic change in coping with their child's "coming out" process to complement the stages of couple development, the phases of learning they have a gay or lesbian child, and of acceptance (Laird, 2003). DeVine (1984) identified five stages the gay family transitions through in reference to challenges involved in managing their child's homosexual preferences. Stage one to three involves the family's effort to maintain some level of homeostasis, while in the following stages the family moves towards resolution and integration. Here the family modifies its structure to adjust life cycle activities of the identified member. Largely effects are dependent of the degree of family harmony, the nature of its relative structure, and specific family themes.

Slater and Mencher (1991) find the "lesbian family life cycle" paralleling heterosexual experiences of the Carter and McGoldrick model. Yet, Slater and Mencher consider the Carter and McGoldrick model a child-centred, socially contextual family life cycle framework devoid of useful role models. More typical, the lesbian family is neither child-centred nor socially validated by larger society. In affect, the family acquires

greater flexibility freeing the couple from role constraints while establishing greater uncertainty and complication in role negotiation.

Although several stage and life cycles theories exist for lesbian and gay families, criticisms exist based on the sociopolitical position of the researchers. For instance, Faderman (1984/85) charged the Menton and McDonald model of the homosexual life cycle did not adequately reflect the lesbian experience. In fact, the process of coming out via the radical feminist model transpired in reverse order as a result of historical circumstances. Whereas Boxer and Cohler (1985) challenged the validity of such models as these pertain to the authenticity of information gathering based on recollections of participants' past and the changing social contexts affecting people within particular historic periods and age-limited cohorts. Understanding resilience and vulnerability in lesbian and gay youth is foremost to conceptualizing survival during adverse situations and one's overall life philosophy and chosen direction. Too, contemporary views of self and sexual identity neglect that individuals change sexual lifestyle and orientations over time. In like manner, the socially constructed sense of self is a continuously evolving narrative (Gergen, 1991). Hence central issues for heterosexual relationships where one partner may have same-sex attractions may mainly reflect one's understanding of partnerships, of monogamy and nonmonogamy, along with the significance of commitment rather than a revelation of a new core sexual self (Laird, 2003).

A dominant theme surrounding the literature of lesbian and gay family life cycles is the neglect of researchers to consider the success of resilience of these families in spite of the partiality they encounter from individuals and government institutions who refuse to acknowledge their family unit and grant them civil rights. Lack of understanding for

lesbian and gay families by clinicians is evident as therapy evolves from the perspective of mainstream culture by attending to differences as opposed to delving "inside" life meanings and experiences of those we work with (Laird, 2003).

Cultural Dimensions in Family Functioning

Culture is contextual and a transferable metaphor (Laird, 1998) upon which gender, race, and other cultural values and beliefs are in constant motion, shifting meanings and definitions on behalf of the observer and the observed. Culture is neither measurable nor generalized as stories concerning race, gender or physical capability are not identical but rather political. Thus, persons do not have equal voice influencing stories and allowing these to succeed. In all, culture is an individual social construction that can be understood best through a narrated past, a co-interpreted present, and a wished-for future (Laird, 1999).

Working with families means knowledge and awareness that several different cultural narratives exist within the same family. Similarly, variations exist in the extent of acculturation, access to new narratives, generational differences, and many other influences affecting transition through the family life cycle. Therapy means helping families preserve their culture, as if their culture were a collection of basic unending qualities, an entity that is exclusive and protected in unaltered forms. It means receptiveness to client experiences to deconstruct self-narratives based outside the therapist's prior assumptions of the client's culture and components of family development, social class, gender, ethnicity, sexuality, spirituality… (Laird, 1999). Furthermore, it means working with families and exploring how client cultural meanings

and values are acted out, and how these are influenced by self-story and the problem (Akamatsu, 1995).

Intermarried Couples

Intercultural families not only wrestle structural and behavioural changes throughout the life cycle but the impact of how cultural differences shape family norms and values in addressing these challenges. This becomes particularly complicated when one or both parents are confused or conflicted with their own sense of self and differences between religious and cultural identity. Even though these have common characteristics they are not the same. Some couples try to address differences by attempting to forget their past. Even if the individual surrenders attachments to tradition their need to belong remains. Significant agreements become complicated to negotiate when partners in intermarriage remain uncertain of their cultural and religious beliefs (McGoldrick, 1998).

Intermarried couples most likely enter therapy when a life cycle event has exacerbated differences in their relationship. In particular individuals who have curtailed the significance of their different pasts encounter resurfacing of cultural loyalties that may cause ambivalence and misunderstandings leading to family conflict (McGoldrick, 1998).

Immigrant Families

Reasons that bring immigrant families to therapy may not have been problematic in their culture of origin, or to the immigrant experience, rather issues related to parent-

child issues or a partner's estrangement; times at which understanding and support have become hampered. A second issue is change in status and social class upon arriving in a new country, as new immigrants may be less financially stable after migration then before. In addition, several jobs maybe unavailable to immigrants, in particular professional positions that may not be exclusively financially damaging but injurious to one's person. Consequentially, a poor sense of self resounds throughout family relationships. Third, in effort to conform, immigrant families may hide their experiences and cultural rituals resulting in a sense of loss. Fourth, therapy with immigrant families means recognizing their experiences in varying degrees of trauma before and after migration, added to loss and infringement on one's sense of self (Laird, 1999).

Race, Class and Poverty

Race and social class are two of the most multifaceted, and sensitivity laden issues of families within their larger social context. For instance, poor families face daily realities of racism, discrimination, classism, poverty, homelessness, violence, and crime. Lacking economic resources make families vulnerable to ill fortune, and discrimination based on race, gender, and health, to eventually entwine into one's person, family, culture and community.

Ultimately, empowerment is considered the most effective treatment approach for helping families to confront intrusions by obstacles of prejudice, racism, classism, and poverty. Empowerment must begin with the "executive" or parental system, and then extend to include extended family (Minuchin, 1974) to build a supportive community.

Making like experiences can help improve feelings of shame, guilt, anger, and stigmatization (Kliman, 1999).

Narrative Therapy and the Family Developmental Life Cycle

Narrative therapy is guided by postmodern beliefs that there is no one accurate or legitimate way to live one's life (O'Hanlon & Weiner-Davis, 1989) and that people live life according to good intentions and neither want or desire problems. Instead of focusing on defects, narrative therapists attend to how people describe themselves and their goals. Even though the therapist inquires about family and individual history, the objective is not to uncover areas of limitations or stagnated development, but to discover events where individuals transcend obstacles and problems (Nichols & Schwartz, 2001). This strength-based approach holds a concentrated conviction to healthy family functioning (Walsh, 2003) as it avoids generalizing what is normal or abnormal; analogous to Foucault's (1980) reflection on the abusive power of dominant discourses. Thus, families are challenged on cultural based inequities such as sex and gender identity, wealth over poverty, and whites over people of colour (Walsh, 2003). Narrative therapists challenge stigmatizing diversity and uniqueness as pathological and work towards an all-encompassing approach to understanding families.

Interpretation the family life cycle from a narrative approach means a departure from the assumptions of the dominant value system. A collaborative and nonhierarchal therapeutic stance towards deconstructing cultural self-narratives denotes exploring how cultural interpretations and cultural ideas (pertaining to gender, sexuality, race, ethnicity, religion, social class…) are performed, and how these affect self-narratives and the

problem (Akamatsu, 1995). Of importance are the numerous cultural stories that exist within the same family, open to variations in the extent of acculturation, access to new cultural stories, generational differences, and several other affects. "It (narrative therapy) is a stance uniquely suited to culturally sensitive practice" (Laird, 1999, p. 31) allowing for a transfer between a person's internal experience and the outer world.

Family Therapy within the Family Life Cycle Framework

> Often families continue trying solutions that are ineffective in helping them meet the demands of adolescence. Unable to make the necessary shifts that facilitate growth, they become stuck, repeating dysfunctional patterns that eventually lead to symptomatic behaviour in adolescents. Helping these families find solutions that may break those cycles by precipitating a second order change is a primary goal of therapy (Preto, 1989, p.271).

Prior to the development of the family life cycle model symptoms arising in family functioning was an indication of dysfunctional patterns of family pathology (Minuchin, 1974). Now the family life cycle framework regards symptoms and dysfunction as 'normal' functioning overtime and perceives therapy as a change agent to stimulate the family's developmental momentum (Carter & McGoldrick, 2003).

Value is attributed to patterns of communication and functioning transmitted across and down family generations. Such patterns influence the extent to which family positions, attitudes, values, taboos, roles, and allegiances have upon a members' performance as they move through the life cycle. Family stress and anxiety imposed by intergeneration communication and functioning through the life cycle can be depicted along two separate but related axis; "vertical" and "horizontal". Vertical stress includes patterns of community and operation passed on through the family intergenerationally. These components include family values, moral, taboos, principles, and dependability.

The stress and anxiety created during the family's progression through the family life cycle developmental stages can be viewed along two separate but related axis', the vertical and the horizontal (Carter & McGoldrick, 2003). Vertical anxiety is seen as:

> Patterns of relating and functioning that are transmitted down the generations of a family primarily through the mechanism of emotional triangling (Bowen, 1978). It includes all the family attitudes, taboos, expectations, labels, and loaded issues with which we grow up. One could say that these aspects of our lives are life the hand we are dealt: they are given. What we do with them is the issue for us (Carter & McGoldrick, 1988, p.8)

A family with a high incidence of vertical anxiety is one with a great deal of stress passed down through its generations. In conjunction, a horizontal flow of anxiety represents the family's progression through the nodal transition points that are intrinsically a part of the family life cycle. Unpredictable life stressors such as an expected pregnancy or death, along with predicable life experiences are included on the horizontal axis. A small amount of stress along this axis may make the family appear dysfunctional with intense stress being transmitted intergenerationally along the vertical axis. As a result, families experiencing a great deal of vertical stress will likely experience a significant disruption in horizontal flow of stress. Therefore, a family's ability to manage stress and developmental life cycle issues is established when developmental stress (horizontal axis) interacts with the transitional stress (vertical axis) (Carter & McGoldrick, 2003).

Role of the Therapist

Understanding the three-generational framework of the family developmental life cycles is useful for assessing problems and parent-child conflict. By identifying

unresolved family conflict as well as the generational patterns for addressing and solving conflict the family can build confidence for solving present-day differences.

Within the family life cycle framework the role of the therapist is to assist the family in adapting to transitions within the family life cycle where events at one stage powerfully affect relationships at each of the other phases (Carter & McGoldrick, 2003). Tracking the system in relation to developmental time helps identify the points in the life cycle at which the family appears stuck. Within the family life cycle framework, the family is believed to seek therapy when it has become "stuck" in the process of moving from one developmental stage to another (Carter & McGoldrick, 2003; Minuchin, 1974). The literature review reveals the following key therapeutic interventions in the resolution of parent-child conflict using the family life cycle framework: 1) reframing the family's understanding of time; 2) working with extended family and family subsystems; 3) making the most of family rituals; 4) using successes; and 5) use of self in therapy (Carter & McGoldrick, 1988).

It then becomes the therapist's task to assist family "symptoms" so that the family can become "unstuck" and progress towards the next stage of development. Minuchin (1974) normalizes "symptoms" as normal reactions to stress encountered when families transition between steps. By reframing the family's comprehension of time, the therapist "frees the system from the situation in which time has stopped" into the next stages of life cycle development.

Secondly, working with extended family and family subsystems can be a potent intervention for restructuring and redefining relationships when families with adolescents become developmentally stuck (Carter & McGoldrick, 1988). Meeting the family first in

its entirety then separately within subsystems is helpful in clarifying boundaries, and understanding family reaction, roles, and beliefs. The therapist joins with parents to help them feel more balanced in their parental roles and to explore difficulties they may have in other areas of their lives, such as marriage, career, illness, or problems with their family of origin (Carter & McGoldrick, 1988). By meeting with the children independently, the therapist determines the effects of change and conflict with parents, whereby the overall objectives being to absolve conflict between parents, promote developmental growth, and promote harmony in the sibling subsystem.

Third, using and accentuating family rituals can have a therapeutic effect in reducing and alleviating anxieties associated with change. Growth and maturity accomplished through transitions can be celebrated by commemorating events such as birthdays, graduations, and licenses to drive.

Fourth, the use of self in therapy is essential in engaging the family in therapy. They believe that the therapist must become acquainted with personal issues and experiences in childhood and adolescence, which may interfere with therapy (Carter & McGoldrick, 2003).

Fifth, by observing family communication skills the therapist utilizes family expression of emotions, negotiation, and problem solving to provide a context to influence growth and development by learning more effective ways to work together and enhance favorable interaction. The therapist's task is to assist the family in using existing knowledge to solve their problems.

In summary, families and their members have good intentions and neither desire or want problems. Family therapists are responsible for attuning to the family emotional

system while assisting families to observe choices and abilities as a system that can influence growth and engineer change. The therapist also has the responsibility to help maintain a constructive opinion of parents so that parents are regarded as competent, caring and attentive to the needs of their children. Therapeutic interventions must include parents, as they are usually the first to seek assistance and commit to the helping-process. Likewise, therapy should focus on the effect conflict is having on parental feelings and issues. Attention and energy directed towards parents will strengthen confidence and sense of control in the family (Tomlinson, 1991).

Advantages of the Family Developmental Life Cycle in Family Therapy

The family life cycle perspective aids both family and therapist in formulating the type and extent of support the family may require in passage through the life cycle as well as the obstacles they may face.

Limitations of the Family Developmental Life Cycle in Family Therapy

Although the family life cycle framework offers valuable insight into family and individual stressors, anxieties and dysfunctions, a number of limitations exist. One limitation of the family developmental life cycle approach is the scarcity in empirical research to verify the existence of the distinct transitional stages (Nichols, 2001; Nichols & Schwartz, 2001). Second, no clear conclusions mark the successful completion of each developmental task, in other words, the key points of change. Third, the family life cycle framework pathologizes reactions to family interruptions and neglects to take individual differences in the timing of nodal events (e.g. delayed marriages) into account, in spite of

the fusion of lifestyle today (e.g. blended families, joint custody) which are extensive and practical. Finally, while Carter and McGoldrick attempt to define family normality today this continues to become problematic given the diversity of families in our society over time. Here, the family is viewed through a systems-based philosophy for assessment of what is considered typical and paramount to "normal functioning" within a Western perspective.

Nowhere is practical information about dealing with survival of abuse and trauma, addictions, and behavioural and physical disabilities that challenge the individual and family development mentioned. As well, no where are positions pertaining to the influence of attitudes and values on role transition, marital commitment, childcare and career on the family unit and its members discussed.

Stages in the family life cycle are typically described by the presence and age of children in the household, equally how then is the concept of family life cycle useful to couples without children. As the evolution of families continue to vary, any one particular model of the family life cycle will be hard pressed to embrace the uniqueness of "family".

Conclusion

The family life cycle framework is helpful for understanding families. It identifies significant events in the family such as the marital union, births, deaths, new memberships, child rearing, and leaving the family unit. Such changes require reaffirmation of family structure and challenges to tradition and family tenets.

The concepts of the family life cycle "...not only brought a component of development into family therapy but was also helpful, because it freed family therapy from pathology and deficit based views of families, replacing their views with the idea that problems in families are products of failed transitions" (Breunlin et al, 1992, p. 159). Breunlin et al. (1992) consider that families evolve through five stages: biological; societal; familial; subsystems (relationship); and individual. Together these exist in synergy, where disruptions in one create disruptions in the others.

Parent-Child Conflict

Parent-child conflict is defined as verbal arguments regarding specific concerns between parents and their children that impose frustration and emotional distress. As conflict escalates, verbal confrontations often turn into verbal and physical attacks (Robin & Foster, 1984). Conflict between parents and adolescents is reciprocal with each wanting to change or influence the other (Lorraine, 1991). Differences between both commonly involve power and control, autonomy, and responsibilities (Collins & Laursen, 1997).

"Long term interdependencies of parent-child relationships form the basis for expectations that affect adolescents' and parents' perception and interpretations of each others' behaviours and therefore guide their actions and reactions toward one another.... Conflict is heightened when perturbations to violations of expectations and accumulation of stressors are associated with multiple personal and social transitions" (Collins & Laursen, 1997 p. 183). Parent-child conflict rates and overall conflict fall off across the adolescent years, while conflict affect intensifies with adolescent age and pubertal

maturation. Conflict increases during adolescence as teenagers begin to assert their independence and parents react to interruptions to the life cycle (e.g. loss of relationships due to divorce and death), including their own loss of expectations or dreams (Collins & Laursen, 1991; Carter & McGoldrick, 1988). Other factors linked to parent-child conflict include the family ecosystem and socialization factors such as the "quality of marital dyad, functions of family members within the family system, decision-making contingencies, control and discipline styles, family rules affecting individual physical and psychological autonomy, family history of handling change and stress, and family structure" (Lorraine, 1991). Shagler and Barber (1993) found marital, family and parent-child conflict; along with self-derogation are predictors for adolescent suicide and suicide ideation. Typically, parent-child differences centre on crises such as appropriate dress; disobedience; completion of chores and homework; curfew; and other common irritations.

Adolescence is also a time of cognitive development allowing teenagers to recognize inconsistencies and limitations in others, especially their parents (Carter & McGoldrick, 1988). Consequently, adolescents begin to assert their own ideals and beliefs and so creating discord and tension with parents. Families with intense conflict normally have multiple issues with relationships to others (Collins & Laursen, 1997).

Adolescent-sibling relationships can compound parent-child conflict. Parents may pay a great deal of attention to one child while overlooking the needs of the others, consequently leaving the other siblings more freedom and time then is age-appropriate (Robin & Foster, 1989). Adolescent-sibling relationships may be influenced by the sibling resenting the adolescent. This may cause the sibling to retreat from the family,

side with the adolescent to form coalitions against their parents, or in conjunction with the adolescent act-out to compete for status in the family, and attention from parents.

Rutter et al. (1976) caution "it would be unwise to assume that adolescents will grow out of their problems — the socialized interaction patterns and the cognitive distortions may continue in future relationships. To attribute the "angry" aggression to developmental stages is to make a faulty inference and to possibly stalemate the development of healthy interpersonal relationships between parents and adolescents."

Research on parent-child conflict often focuses on how parents and teenagers discern differences in one another, at present empirical research should focus on therapeutic interventions or educational matters which "ease" intense parent child-conflict (Lorraine, 1991).

CHAPTER THREE

Theoretical Orientations

Post-modernism

Post-modernist thought began in the 1980s in opposition to the basic tenets of structural and systemic theories, and continues to this day (Nichols & Schwartz, 2001; Nichols, 2001). A period marked by uncertainty and a re-evaluation of truth, values, relationships, and language, post-modernism is a re-evaluation of the foundation for what all humans perceive as being reality even reality itself (Nichols & Schwartz, 2001; Mills & Sprenkle, 1995). The significance of postmodernist ideology is that it changed both the therapeutic process and the worldview of therapists. "Transcending models of school and orthodoxies, postmodern family therapy crosses disciplinary boundaries and allows for freedom of thinking and action not possible within the old paradigms. The therapist is forever part of a meaning-generating system with the family, not an outside expert alying medical-style treatment to a sick family" (Doherty, 1991, p.41). Narrative therapy is a product of the postmodernist movement (de Shazer & Berg, 1992) where "[we] no longer saw the therapists as the source of the solution — the solutions rested in the people and in their social networks" (O'Hanlon, 1994, p.23). The therapist is instead viewed as a co-creator of solutions with the client with the emphasis on helping clients achieve solutions that best fit their own lives (de Shazer, 1991). Hence, the therapist brings their specialized knowledge of therapy and the client brings their individual knowledge of reality.

de Shazer and Berg (1992) state that reality in post-modernism is a fluid concept rather then fixed. Multiple realities exist as experiences, thoughts and feelings interpreted

by the individual, whereby realities are exchanged through language regarding the situations in which individuals live. Postmodernists believe that reality is constructed through the use of narrative and language to create meaning and validity for the individuals telling it; there are several stories and as many ways to interpret the meanings and reality of the people telling them (de Shazer, 1985). Consequently, everyone involved in the communication has their own sense of meaning and understanding as to what transpired. Here, the philosophy of reality evolves from the understanding that reality is a single perspective, universal for all, to one where social interactions create a multitude of realities (de Shazer, 1985). Individuals make meaning and define reality through social interaction (Berg & Miller, 1992), where words are representative of "freight engines that are pulling boxcars behind them filled with all their previous meanings," (de Shazer & Berg, 1992, p.73). In this case a problem exists when people agree there is a problem that needs to be addressed.

Families, who enter therapy, are viewed as having their own sense of reality influenced by their particular histories, experiences, and interpretations, as there is only one system of hierarchy or structure that is considered accurate and healthy in a family (Mills & Spenkle, 1995). The post-modernist emphasis resides on assisting people to construct solutions that suit their own lives. Narrative therapy focuses on externalizing problems and discovering their effect on families as opposed to the family's effect on the problem (Nichols, 2001; Nichols & Schwartz, 2001; O'Hanlon, 1994). "If problems are situated by the therapist in individuals or families, the problem can use this pathologizing effect to further its influence and get bigger, while the person or family gets smaller" (Zimmerman & Dickerson, 1996, p.2). Families often enter therapy storing that they are

having difficulty with a child and searching for solutions to contain the child's behaviour. Symptoms for the behaviour can be best understood as a metaphor for the larger issues occurring within the family system for which they have been unable to manage.

Social Constructionism

Postmoderism believes that human beings actively participate in the construction of reality. Social construction, a specific stream of post-modernism challenged the concept of knowledge as mental representation. It believes that people have a need to construct meaning and give cultured importance to one's life experiences through human socialization and the process of creating meaning through narrative (Laird, 1995). Narrative therapy is closely associated with social construction.

Narrative Therapy

Michael White and David Epston are the founders of narrative therapy, a theoretical/clinical model that evolved from social constructionist thought that "people construct their realities as they live them" where knowledge, beliefs, values, mores, and all aspects of reality "arise through social interaction over time" (Freedman & Coombs, 1994, p.23). In narrative therapy the therapist looks for experiences in the client's life that do not fit the dominant problem narrative, and questions are asked that lead to alternative possibilities people can take to re-story their problems and their lives (Nichols, 2001; Nichols & Schwartz, 2001). In other words, people are viewed as separate from their problems, as they hold the expertise, skills, motivation, commitment, and abilities to reduce the influence of problems in their lives (Nichols, 2001; Nichols & Schwartz,

2001). Narrative therapy is a respectful nonblaming approach to therapy, which focuses on individuals as the masters of their own lives (Nichols & Schwartz, 2001).

Historical Context

The narrative approach to therapy emerged in the late 1970s and gained popularity in North America after the publication of Narrative Means to Therapeutic Ends (White & Epston, 1990). Michael White and David Epston arrived at narrative ideology from many disciplines including anthropology, critical theory, feminist theory, sociology, and literacy theory (Nichols, 2001; Nichols & Schwartz, 2001). These ideologies contributed to a clinical approach which focused on how "people organize, account for, and make sense of their experience" (Anderson & Levin, 1997, p.276). They believed by way of experiences, "realities are organized and maintained through stories" (Freedman & Coombs, 1996, p.29).

White and Epston's (1990) view of reality and resolving problems was influenced by Gregory Bateson's (Bubenzer & West, 1994) convictions on cybernetic theory, and Michael Foulcault's (1980) assertions that dominant culture affects the freedom and functionality of the individual. Understanding this historical context of narrative therapy is helpful in developing a balanced view of the main ideas and contributions to this approach and the practical techniques used. Thus, "negative explanations, restraint and news of difference exist within a therapeutic context" (Monk, 1996, p.42). White and Epston (1990) clarify this, as people tend to operate in society according to their own understanding and interpretation of the world around them. The ideas, beliefs and values ascribed from these experiences determine the unique rules by which the individual and

their family process information about events that happen. The core idea of the narrative approach is that individuals are not troubled by things but by their perception of things.

Supplementing Bateson's ideas, Bruner contributed to the narrative approach by saying that people learn about life through learned experience and that they define their life through narratives and stories (Monk, 1996; Zimmerman & Dickerson, 1994). White and Epston (1990) say meaning is constructed either monologically (by oneself) or dialogically (with others) with the later having the greatest influence on one's life. Bruner added people develop dominant stories to make sense of their experiences (Bubenzer & West, 1994). Accordingly, realities are organized and maintained through narratives (Freedman & Coombs, 1996).

Narratives are defined as methods "people organize, account for, and make sense of their experiences" (Anderson & Levin, 1997, p.276). In this model, the word narrative includes "conversations, discourses and stories" (Cheung, 1998, p.5). Discourse is defined as "a system of statements, practices, and institutional structures that share common values" (Freedman & Coombs, 1996, p.42).

Michael Foulcault (1980) asserted that knowledge/power positions are not different truths but "stories" about life. He supplemented that current and commonly accepted stories become or perform as "dominant culture", and are intended for self-maintenance and the minimization of alternative narratives (White & Epston, 1990). While, Griffith and Griffith (1994) explain self-narratives as "those stories of personal experience that define one's sense of selfhood". Freedman and Coombs (1996) believe dominant cultural narratives illustrate ways of behaving and thinking that are absolved by one's family and culture. It is these dominant cultural narratives that must be fully

challenged, as cultural narratives function, to some extent, to diminish or eradicate alternative knowledge positions and alternative narratives (White & Epston, 1990). Because of the influence of dominant cultural narratives, people and their families tend to incorporate these positions into their life as the only ones to accept, even if these positions are of no use or are detrimental (Freedman & Coombs, 1996; White & Epston, 1990; Foucault, 1980). Augmenting Foucault's beliefs, White and Epston (1990) support the feminist perspective in accepting that the dominate culture is designed to perpetuate perspectives, practices, and narratives that serve those who gain from that culture which consequently affect the autonomy and functionality of people and their families. Eventually individuals that hold a smaller amount of power become marginalized in society as their needs are restricted by such dialogues or dominant stories.

Gregory Bateson expanded that individuals have no objective reality, and what people and families know and believe to be 'true' involves interpreting and assigning meaning to their experiences and how they see themselves in these experiences (White & Epston, 1990). Analogously, people have a strong belief in how they would like others to view themselves, how they want to behave, and how they like to be viewed by others. This set of preferences is known as a person's "preferred view". In forming like "maps" to establish rules for selecting information about events while placing sensory limits on human observation. As soon as experience does not fit societal maps these are filtered out and cease to exist (Monk, 1996). White believed when the dominant story loses power to meet the desires and demands of the family, the family has problems. Moreover, it's the selectiveness in what families remember that is used to help families address their difficulties (Monk, 1996).

White and Epston (1990) say individuals attend therapy when their storing of their experiences or storing by others of the individual's life experiences contradict the dominant narratives. The objective of narrative therapy is to assist clients in replacing dominant stories with preferred alternative narratives that allow individuals to construct more satisfying, desirable life experiences. Therapy prepares a return to freedom for the individual and family from the oppression of dominant cultural narratives.

Therapeutic Goal

The goal of narrative therapy is to generate or identify alternative stories that enable individuals to achieve new meanings, through the process of deconstructing and constructing narratives. To accomplish this, narrative therapy exercises the following key concepts: a) collaboration between client and therapist, b) deconstructive listening and questions, and c) mapping the problem and alternatives.

Client-Therapist Relationship

When people enter therapy they are often "stuck" in a dialogue system that holds unique descriptions of their experiences and themselves in relation to "the problem". The view of the therapeutic process in narrative therapy is that these problems are not fixed but changeable (Franklin, 1998). The emphasis is on collaboration between the therapist and client to co-construct the meaning of the problem into new narratives (Gergen, 1999; Franklin, 1998; White & Epson, 1990). This collaborative stance between the client and the narrative therapist is aimed to empower the client and attempt to equate the power dynamic in the client-therapist relationship (Andrews & Clark, 1996).

Collaboration between the therapist and client is seen as an imperative part of narrative therapy, with clients being the experts about themselves. Anderson and Gollishian (1988) say that the therapist taking a "not knowing" stance, rather than that of the "expert" supports a less hierarchical relationship between client and therapist. The therapist questions the client in order to develop life narratives while facilitating the deconstruction and reauthoring of the client's experiences (Kelley, 1996). During this process, the therapist must be conscious of power issues, which can arise in the client-therapist relationship. Therefore, it is important that neutrality, empathy and the therapeutic process prevail over technique.

Since the therapist is responsible for creating an environment where the client feels understood, heard, valued and at ease, the therapist must attend and ask questions in order to help the client understand and construct desired change. Therapists must also be cognizant of and clear concerning their own narratives as separate from the client's experiences, while simultaneously accepting that "therapeutic dialogue is an intersubjective co-creation of meaning between the therapist and the client" (Cheung, 1998, p.7).

In this model, collaboration between the client and therapist emphasizes a therapeutic process that is strengths based. Krumer-Nevo (1998) illustrates that the narrative approach gives the family and the therapist the opportunity to suspend doubt and disbelief. Meaning, that the therapeutic process does not encourage clients to view themselves through problem saturated dialogues and experiences. As clients narrate their stories they decide what to include and what to leave out. The therapist's role is to attend and to accept the client's version of the events rather then to analyze, critique, and stress

the shortcomings. By accepting client experiences, the therapist empowers the client to accept ownership over their problem and their determination to initiate desired change (Krumer-Nevo, 1998).

"Change is found through the opening up of possibilities in therapeutic conversations and in the telling and retelling of stories" (Anderson, 1995, p.31). The therapist assists in creating a context for change while the client authors their experiences and essentially their life (Zimmerman & Dickerson, 1994). Krumer-Nevo (1998) states focus on client directed change in narrative therapy is productive in working with families who live with systemic challenges. Re-storying conversations allows for the evolution of alternative stories for family life that is more engaging of family members. So, as people view themselves as separated from the problem or the problem story and begin to see themselves as being affected by the problem instead of viewing themselves as problematic, alternatives become more readily available.

In summary, "the role of the therapist is that of a master conversational artist — an architect of dialogue — whose expertise is in creating a space for and facilitating a dialogical conversation. The therapist is a participant-observer and a participant-manager of the therapeutic conversation" (Anderson & Goolishian, 1988, p.372).

Therapeutic Techniques

Externalization

Externalizing conversations is the foundation by which many narrative conversations evolve. It is a transformation in the use of language and attitude based on the postulate that the problem is that problem is the problem, as opposed to the individual

as the problem. Externalizing conversations about the problem is constant throughout therapy, and involves talking about the problem as a separate entity; external to the person and their identity or the relationship that is currently ascribed as the problem (Zimmer & Dickerson, 1996).

Internalizing conversations often have a negative outcome on individuals' lives that transpire into thin descriptions. Thin descriptions are narratives lack breath for the intricacies and variations of reality. Using externalization, the therapist cooperates and collaborates in conversation in order to establish that the problem is external — away from the individual. It is not uncommon that through the course of conversation more then one problem requires externalization.

From externalization the therapist and person thoroughly investigate the problem and agree upon a way of naming it. Consequently, this increases the persons' control over the problem by shifting the problem from inside the person to outside the person. Thus, externalization of the problem facilitates clients to take responsibility only to the extent to which they are affected by the problem (White & Epston, 1990). The therapist must take care that the language used in externalizing conversations does not unintentionally reinforce dominant beliefs that maintain the problem. Emphasis is placed on cultural beliefs and customs rather than on the person or their relationship.

Rather than placing blame, externalization of the problem holds the individual responsible for taking the initiative required to re-author a more empowering self-narrative. Externalization promotes that there are particulars of the individual, which are uncontaminated by the problem (O'Hanlon, 1994). White and Epston (1990) maintain that externalizing can be used effectively to:

1. Decrease unproductive conflict between individuals, as well as disagreements over who is responsible for the problem;
2. Challenge feelings of failure that have developed for individuals in reaction to the continuation of the problem in spite of efforts to solve it;
3. Guide individuals in how to cooperate with one another, to unite in an attempt to undertake the problem, and to escape its influences in their lives and relationships;
4. Provide opportunities for new possibilities for individuals to initiate change to regain their lives and relationships from the problem and its effects;
5. Open individuals to accept and initiate a less stressful approach to 'deadly serious' problems; and
6. Offer alternative dialogues, rather than monologues grounded in problem-laden images.

Externalization promotes a sense of personal agency through conversations about problems as opposed to monologues about problems (White & Epston, 1990).

Unique Outcomes

By externalizing the problem, individuals learn to identify when they neglected important parts of their lived experiences. These conversations are followed by questions probing for unique outcomes. As clients often focus on the negativity that exists in their life it's vital that therapy inject a sense of control. Unique outcomes are times in an individual's life when they acted free of their problems. By pointing out unique outcomes the therapist helps the client recognize points of access to the alternative story — times

when the client's behaviours, thoughts and feelings did not conform to the problem story (White & Epston, 1990). In identifying unique outcomes, the therapist can begin to assist individuals in challenging negative views of themselves and their environment, and empower them to engage in acting out new meanings in relation to these unique outcomes. Nichols and Schwartz (2001) encourage therapists to take care in using unique outcomes as focusing on these too early in the therapy process can affect the client into believing that the severity of their problems are not being considered. As a result, the client may feel that they are not part of a collaborative process where they are being heard and understood.

In summary, the therapist uses unique outcomes to explore individuals' stories, tracing their history, to discern what they mean for that individual. Unique outcomes are fundamental in initiating the re-authoring process.

Landscape of Action Questions

Once the therapist begins to discover unique outcomes there is an ambition to probe further, to find out the person's history and perception of what these outcomes may mean to the person involved — the desire being to know the specifics of the person's experiences and link these to a new emerging story. The therapist may ask the following landscape of action questions when exploring unique outcomes: where were you when this happened; were you on your own or with some one else; and how long did it last? Such inquiries probe not only into the details of the particular unique outcome but also historicize the individuals past, present and future to affect an alternative story (White, 1989).

The landscape of action is constituted by experiences of events that are linked together in sequences through time and according to specific plots. This provides us with the rudimentary structure of stories. If we drop one of those dimensions out — experiences of events, sequences, time or plot — then we wouldn't have a story. These events together, make up the landscape of action (White, 1995).

Landscape of Identity Questions

Landscape of action questions gather together and sequence an assortment of unique outcomes. Landscapes of identity questions ask individuals to consider their involvement in the making of such outcomes. The therapist may question what personal values the individual based their course of action upon, or when the individual took the first step what were they intending for their life.

"Landscape of identity questions encourage the articulation of the performance of these alternative preferences, desires, personal and relationship qualities, and intentional states and beliefs, and this culminates in a "re-vision" as a personal commitment in life" (Dulwich Centre Newsletter, 1991, p. 31).

Reauthoring the Whole Story

Revisions of relationships with self, others, and problems derived by persons in responding to the questions.

"In re-authoring work we invite person to traffic in both of these landscapes [action and identity] — by reflecting on what alternative events in the landscape of action most reflect the preferred accounts of characteristics, of motive, of belief and so on — so

that alternative landscapes of action and of identity are brought forth" (White, 1995, p. 31).

Overall, White (1989) has developed a model designed to free individuals from oppression of their problems. The initial target of narrative therapy does not focus on what causes the problems, but rather the growing effects of problems on the family overtime. These questions are organized politically and purposefully to deconstruct oppressive narrative. This change in language deconstructs the original story in which the individual(s) are fused. Consequently, their issues become externalized. The therapeutic process evolves accordingly.

Therapy Sequence Model

Externalize the Problem
(Separate the problem from the dominate problem-saturated story)
▼
Unique outcomes
(Previously neglected vital aspects of lived experiences)
▼
Unique account
(An alternate story)
▼
Extend performances of alternate story
(Invite identification and recruitment of an audience to the performance of new meanings)
▼
Unique possibilities
(New ways of perceiving one's self agency)
▼
Unique re-description
(Reauthoring of one's life and relationships)

Hence, the narrative approach is a "back and forth…unfolding process of externalizing, deconstructing, extending the field of influence of the problem, searching

for unique outcomes, finding a history of the contradictions, and continuing to develop and maintain whatever alternative story evolves" (Zimmerman & Dickerson, 1996, p.88). Understanding the limitations of narrative is imperative in order to select different perspectives to supplement treatment.

Relevance to Social Work

"Parent/child conflict is a professional problem often encountered by social workers" (Besa, 1994, p.309). Empirical research has validated that narrative therapy is an effective intervention in parent-child conflict (Coulehan, Friedlander, & Heatherington, 1998; Weston, Boxer, & Heathington, 1998; St.James-O'Connor, Meakes, Pickering, & Schuman, 1997; Besa, 1994), a common theme in the family life cycle. Narrative therapy is appropriate in emphasizing the social work perspective as therapist and families unite to engage in a therapeutic process of change to address challenges of the developmental life cycle. This process allows individuals to construct their meaning of life through narrative interpretations of what they consider to be "true". Individuals incorporate dominant societal norms of what a family "should be", the extent to which difficulties can be handled, and how problems must be solved within this narrative construction. The objective of narrative therapy is to revive the individual and family from the oppression of external problems within society and the governing stories of larger systems. Moreover, social work pursues betterment of existence through social justice and equality for all individuals. Saleebey (1997) explains "everything you do [the social worker] ...will be predicated, in some way, on helping to discover and embellish, explore, and exploit clients' strengths and resources in the service of assigning them to achieve their goals." Since these beliefs view individuals as true experts of their own

conditions, the therapist's role is customarily that of collaborator. Thus, "the emphasis on mobilizing strengths is in the best tradition of the social work profession" (Kelley, 1996, p.477).

Empowering clients and allowing them to create and reflect on achievements and possibilities is significant to narrative therapy and social work when working with all populations and cultures (White, 1989):

> "When working with children...we need to empower them to become masters of their own lives. We can do this by conveying an optimistic attitude, capitalizing on their competency areas, respecting their defenses, and giving them room to tell their painful stories when, or if, they are ready to do so. As therapists, we need to be sensitive to the fact that our theoretical maps and the way we interact with our clients determine what we see. If we operate from a deficit-model, we inevitably see deficits and become expert repairmen and -women. By capitalizing on our young clients' strengths and resources and what is "going right" in their present lives, we can help these children create their own positive self-fulfilling prophecies" (Selekman, 1997, p.4).

Comparatively, narrative therapy and social work are respectful of clients. Both consider the client's environment and issues when approaching treatment. This ecological approach helps clients to understand their life situations and instill confidence that they are the "expert" at making change.

Although, literature review of the narrative approach with psychological disorders and its impact on family dilemmas is seemingly non-existent when compared to structural therapy, family members involved in the practicum process either experienced a decline or elimination of their presenting issues, from which their lives improved to a preferred state. So far, more investigation is required to understand how narrative therapy can be effectively combined to create long-term effects in families and their members. Such would have significant inference in the field of social work (Besa, 1994).

Influenced by social constructivism, narrative therapy is keenly aware of the social context of the families they treat. Additionally, narrative therapy is cognizant of the oppression of societal norms, attitudes and culture on the individual, as well as the individual's role in their own problems. Offering sympathy alone without acknowledging isolation, alienation, ethnocentrism, and all the other –isms renders a therapist relatively ineffective as the process of therapy works independent of the person-in-the-environment.

Empirical Research

"Narrative approaches to counselling and psychotherapy have risen to prominence over the past decade and a half (White & Epston, 1990). Angus and McLeod (2004) note researchers from various backgrounds of psychology have gained interest in the narratives, scripts, and plots of individuals in relation to society, community, family, and the self, in what is identified as "the storied nature of human conduct" (p. 23).

Lewin's (2001) exhaustive case analysis of three good-outcome and three poor-outcome process experiential therapy dyads focused on the influence of individuals' retelling emotionally significant autobiographical memory narratives or external narrative sequences to bring about individuals to supplement differential emotions experienced throughout the retelling of individual memory. Lewin discovered 30% of all narrative process shifts carried out by therapists entailed good-outcome therapy relationships at which free internal changes were made. On the contrary, poor-outcome therapists noted 16.75% fewer unstructured internal changes. In all, the study revealed that therapeutic attention to emotional meanings with regard to an individual's self-reflection helped the

individual to more fully consider continued exploration of one's own intrinsic emotions. As well, individuals' exploration of emotional pain, distress, vulnerability and distress were notably maintained by feelings of trust and safety imparted by the individual's therapy (Angus & McLeod, 2004). Moreover, Lewin discussed that poor-outcome individuals had emotional experiences where their therapist either (1) did most of the emotional processing, or (2) focused more on the individual's somatic sensations rather than on the internal psychological state. Moreover, poor-outcome individuals showed greater passivity when exploring feelings and centring on emotion in favour of somatic sensations (Levin, 2001).

Lewin's case analysis concluded that the creation of emotional schema along with a person's uninhibited development and involvement towards an explanation of personal meanings in association with emotionally charged events is essential for therapeutic change (Agnus & McLeod, 2004).

Alike, Neimeyer (1998) charges that narrative therapy challenges and loosens individuals to talk with others to construct more fluid identities. In effect inspiring individuals to attempt intrinsic narratives unique to their culture in a nonblaming, nonconstricting manner along with the composition scripts more inclusive and approving of personal power and responsibility. Essentially, the narrative approach offers individuals a fresh non-conforming opportunity to explore a new understanding of "self" (Agnus & McLeaod, 2004; Lewin, 2001; Neimeyer, 1998)

In spite of narrative therapy being a language-based modality, constructivism has not yet considered it a clinical and experimental model (Neimeyer, 1993), as constructivism is based on the "proposition that meaning is a constructed product of

human activity rather than an innate characteristic of the mind, an inherent property of objects or events in the world" (Mascolo, Pollack, & Fischer, 1997, p. 1).

On the contrary, research reveals that individuals are "narrative beings" (Angus & McLeod, 2004). Meaning at the biological level, narrative appears to be the basic process that initiates personal experience with brain structures and processing (Cozolino, 2002). Consideration that brain structure is involved in the process of narrative construction leads to an empirical foundation that the human brain is a "narrative brain". From deduction, psychopathology is a product of an individual's narrative construction (Neiymeyer, 2000; White & Epston, 1990).

It appears that narrative construction of experience akin to language is central to the executive functioning of neural activity in our brain. Research by Gazzaniga (2000) reveals brain regions that act as "interpreters" of ongoing and integrated narratives provide structure and coherence to our daily experience. Another study by Siegel (1999) claims, "vertical, dorsal-ventral, lateral, inter-hemispheric, and spatiotemporal forms of integration (within the brain) are all present within the narrative process" (p. 331).

Treatment Success with Parent-Child Conflict

Even with the apparent success of narrative therapy, an overall analysis of the literature shows a lack of empirical research to support treatment modality. Consequently, the review generated only a few studies that are noteworthy (Coulehan, Friedlander, & Heatherington, 1998; Weston, Boxer, & Heathington, 1998; St.James-O'Connor, Meakes, Pickering, & Schuman, 1997; Besa, 1994) pertaining to parent-child conflict; children's attitudes about family conflict; parental appeals for addressing

children's issues; and families' experience with the narrative approach. Such evidence exists for reasonable success in the treatment of parent-child conflict (Etchison, 2000; Besa, 1994; Hourigan-John & Robinson, 1989; Menses, 1986). Correspondingly, Michael White (1989) developed anecdotal reports of remarkable success in the treatment of parent-child problems using narrative therapy.

St.James-O'Connor, Meakes, Pickering, and Schuman (1997) researched families' understanding of their experience with narrative family therapy and the significance participants ascribed to this experience. The outcome would determine what families found useful and unhelpful in the treatment process. Participants consisted of eight families that were undergoing problems with children ranging from ages six to thirteen. The examiners used an ethnographic research design consisting of a four-question qualitative semi-standardized interview format directed at acquiring an earnest account of the families' experience. Researchers discovered themes consistent with narrative philosophy on a collaborative, reflective and cooperative client-therapist relationship. As well, participants confirmed some improvement in their presenting issues. Reflection of issues was significant for families involved in narrative therapy for a longer duration than those involved for shorter periods. "Results also indicate that an ethnographic method of inquiry is congruent with research on narrative therapy," (Etison & Kleist, 2000, p.64).

Weston, Boxer, and Heathington (1998) studied the ability of children to cognitively comprehend the causes of family disputes. The study proved that compatibility exists between constructivist approaches, such as narrative therapy and family counselling. Also, a majority of children understand and verbalize the causes of

parent-parent and parent-child conflict. This evidence shows that children's reflections regarding the contributors to family conflict can benefit therapeutic interventions with the family. Additionally, Weston et al. proved a combination of quantitative and qualitative research methodology is effective in evaluating narrative therapy (Etchison & Kliest, 2000).

Building on the efforts of Suluzki's (1992) narrative approach to therapy, Coulehan, Friedlander, and Heatherington (1998) examined the change process in family members' transformation of narratives in therapeutic work. Transformation is "an episode in which the therapist successfully facilitates a shift in family members' constructions of their presenting problems from an intrapersonal or linear perspective, to an interpersonal or systemic one" (Coulehan et al, 1998).

Coulehan et al. (1998) used a qualitative approach to assess narrative therapy involving eight therapists of varying disciplines and eight families in an outpatient clinic. Intake interviews were videotaped and questionnaires developed to gain insight into how parents' reflect on family problems. Data uncovered a three-stage model of the transformation of narratives that supplemented and added to Suluzki's (1992) initial work. Stage one describes the process of the various views and descriptions family members have of their problems. Stage two, illustrates the change in family members' affective tone. The third stage depicts the process individuals undergo in the discovery of positive attributes of individual members and the overall family unit. Coulehan et al. (1998) assert that favourable transformations of the issues will progress through each of these three stages, while failed transformations will not. Researchers found a significant

improvement in the presenting issues of families involved in narrative therapy for a longer time period.

Besa (1994) understands that narrative therapy is grounded on the belief that healthy exceptions can be discovered in a problem-illustrated story, and such can promote change. Besa utilized externalization, unique outcomes, relative influencing questioning, accounts and possibilities in addition to unique circulation and between session tasks. Besa trained parents to measure the frequency of parent-child conflict using a single system design by observing specific behaviours during the baseline and intervention phases. Parents were then encouraged to help their child to reauthor a new narrative based on these observed changes. Results showed that five of the six families studied showed improvements in parent-child conflicts, ranging from an 88% to a 98% reduction in conflict. Progress transpired only when narrative therapy was used and was not observed in its absence (Besa, 1994).

In short, Etchison and Kleist (1998) charge "no statement can be made about narrative therapy as an approach to use for any particular family problems…instead be prepared to modify (i.e. tailor) your way of doing narrative-based family counseling to the unique dynamics of your clients (p. 65)." Stith, Rosen, McCollum, Colemand, and Herman (1996) maintain that giving a child a voice in therapy increases the success of treatment. Children participated more frequently and gainfully when therapists display warmth and interest towards them—values validated through therapist/client interaction in narrative therapy.

"Narrative is a hot topic these days…Yet to date, therapists and researchers have not had too much to say to each other on the topic of life stories" (Agnus & Mcleod,

2004). Etison and Kleist (2000) assert limitation in research efficacy is attributed to the social constructionist orientation often inconsistent with traditional quantitative research procedures. Hence, narrative therapy focuses on the interpretation of experience in the world, and why change evolves from exploring language and how it is applied to create and preserve problems (Crowley & Springen, 1995). Accordingly, qualitative research is generally conversational and interactional, in contrast to quantitative measures, which emphasizes definite, objective, and generalized findings (Agnus & McLeod, 2004). Quantitative convictions on researcher objectivity are not compatible with the social constructionist and narrative notion of treatment (Gale, 1993). Etison and Kleist (2000) add that qualitative research methods are more appropriate for examining the effectiveness of narrative therapy.

Moreover, Etison and Kleist (2000) offer that a lack of research reflects the scarcity of researchers skilled in qualitative methodology. Second, more quantitative researchers work in clinical practice where their clinical evaluation skills are more respected and efficient, fundamentally augmenting agency grants. Third, most graduate students emphasize quantitative evaluation, with little exposure to qualitative research, and therefore possible reluctance to accept alternative measurements (Merchant, 1997). Overall, according to Etison and Kleist a concentrated effort must be made to establish qualitative methodology of clinical evaluation for treatment practice.

Criticisms of Narrative Therapy

White and Epston (1999) have been criticized about their approach to violence. Fish (1993) reprove the authors as they theoretically separate the therapist-family system

from several social, historical economic or institutional contexts, and contradict the reality and significance in disparities of power at an interpersonal level. Second, Nicholas & Schwartz (2001) charged that narrative therapy is viewed as cognitively oriented, beneficial to higher functioning clients. Third, Minuchin (1999) accuses narrative therapy of supporting the macro system at the expense of the family. Because the approach only focuses on parts of the family system and it allows for individuals to speak in treatment, the belief of social constructivism is limited in understanding interpersonal relationships as a means to facilitate the development of reasoning. Finally, Minuchin (1998) adds that narrative therapy attempts to address the individual through a collaborative approach to therapy, without admitting the possibility that the therapist may bring personal opinions and biases to treatment. Additional criticisms will be presented, as my research and literature review continues throughout the practicum.

Structural Family Therapy

Structural family therapy views the family as a social entity that confronts a sequence of developmental tasks (Minuchin, 1974). Too, the family is a living organism that is in constant development and ever adapting to its environment. It is part of a complex social system that contains diversity and structure where issues may be particularly challenging as they are embedded in powerful concealed structures (Nichols & Schwartz, 2001).

Salvador Minuchin was an influential developer of family systems theory. Evolving from his work with socioeconomic disadvantaged families in the 1960s, Minuchin recognized the importance of the family's social context. Consequently,

Minuchin (1974) established four foundations of stress which influence family context: (1) a family member in contact with extra familial influences, (2) family members in contact with ex-familial influences, (3) transition stages in a family, and (4) idiosyncratic constraints (e.g. common expectations of particular family members). To adapt positively to these stresses the family must renegotiate and restructure itself. Minuchin advanced his theories and practice into structural family therapy.

Key Concepts

Structural family therapy employs a number of concepts including: family structure, subsystems, boundaries, and alignments.

One of the key concepts of structural family therapy is family structure, a set of distinctive, unseen functional needs and rules that organize how family members associate with each other (Minuchin, 1974). Families have traditional patterns of behaviour, which are changeable (Minuchin & Nichols, 1993). At times, these patterns are altered and the family structure becomes known as "dysfunctional". The goal of structural family therapy is to increase the flexibility of the family structure to help the system recover and function better overall (Minuchin & Nichols, 1993).

Colapinto (1988) says a hierarchy of power governs family structure where functional families have consistent rules concerning who is in charge. This hierarchy defines who governs the behaviours, and makes the rules and decisions of family members. The degree of power within the family changes in relation to the growth and development of family members (Minuchin, 1998). The structural approach stresses the importance of reordering the hierarchy or creating an appropriate one if none has existed.

A second key concept involves the family system comprised of subsystems. Subsystems are units of socialization that join people together to carry out specific tasks that are required for the overall functioning of the family. Subsystems exist around functions, age and gender, and may contain the following groupings: spousal, parental, sibling, and extended family. Subsystems can even extend into the community (e.g. school, service agencies…). Difficulties in the family arise when one system intrudes on another leading to a structural problem (Minuchin, 1974).

Boundaries, emotional barriers used to protect the differentiation of the system, are the third key concept. The differentiation of boundaries within a family is used to assess family functioning. Minuchin (1974) conceptualized two transactional styles to depict structural difficulty in familial boundaries, known as enmeshment and disengagement. Enmeshment implies excessively diffuse boundaries between subsystems, while disengagement entails markedly rigid boundaries. Rigidity facilitates isolation and disconnected relationships. In contrast, diffuse interpersonal boundaries lead to intrusion. A continuum between rigid and diffuse boundaries is desired where individuals have a healthy sense of self while feeling a sense of belongingness within the family system.

The final concept alignment, relates to coalitions, alliances, and triangulations. An alliance is the joining together of two or more family members without consideration of anyone else, while a coalition transpires when two or more members join together against another family member (Minuchin, 1974).

In triangulation, a problem that is not resolved between two individuals directly has a third person brought in to maintain the process. For instance, two parents might

fight each other through the use of their daughter. This places the child in a no-win situation since the child is automatically seen as opposing the other (Minuchin, 1974). Detouring is also a form of triangulation. Here involving a third member can circumvent conflict between two family members. An example of this is when a mother and father appear to be getting along, but do so by using their daughter to support this appearance by either attacking or protecting her. The extent of the conflict between the parents is expressed in the context of the relations between the parents and their daughter, primarily detouring conflict. In consequence, spousal problems remain below the surface, while the daughter experiences blame for their conflict (Minuchin, 1974).

Goals of Structural Therapy

The objective of structural therapy is to alter ambiguous family organizations and to initiate change in the family system by having the family develop more appropriate boundaries, operational rules and patterns (Nichols, 2001; Nicholas & Schwartz, 2001). Colapinto (1991) states that by liberating family members from their stereotypic roles, the family unit can coordinate its resources and improve its ability to cope with stress and discord. Friesen (1995) adds that structural family therapy facilitates:

1. Constructing a viable hierarchical structure in the family.
2. Assisting parents in complementing each other in their roles and function as parents to facilitate an effective parental subsystem.
3. Helping the children become a subsystem of peers.
4. Enhancing the frequency of interactions and nurturance, if the family is disengaged.

5. Aiding the family in differentiation, if the family is enmeshed.

Therapeutic Role

Colapinto (1991) portrays the therapist as taking an active role in therapy while accommodating and adapting to the family. Joining, establishing rapport, is an ongoing process in therapy (Colapinto, 1982) of developing an empathic relationship with the family in order to address their problems (Minuchin, 1974). Part of this process entails the therapist reflecting back an appreciation and understanding of the family's difficulties (Minuchin et al, 1998). Families become resistant to change when individuals feel they are not valued, heard and accepted by the therapist (Minuchin 1993). Therefore the therapist becomes a neutral listener and searches out the positives and makes sure to recognize and reward them (Minuchin & Fishman, 1981). In joining, the therapist is looking for strengths in the family (Nichols, 2001; Nichols & Schwartz, 2001).

Therapeutic Techniques

Structural family therapy utilizes several techniques to organize and understand family functioning: joining and accommodating; restructuring and reframing.

The first technique, joining, is the initial step in therapy. It is the process of building and maintaining a therapeutic alliance with clients. Accommodation is utilized when the focus is on the therapist's modification of himself with the aim of joining (Minuchin, 1974). Three styles of accommodation are used: 1) maintenance in which the therapist supports the existing problematic family structure, 2) tracking, in which the therapist merely attends to the family's communication and behaviour patterns, and 3)

mimesis, in which the therapist joins the family by adopting its pace of communication (Okun & Rapport, 1980).

Minchin (1974) identifies the second technique assessment, as six main tenets to assess family interaction patterns for mapping family structure and organization. These identify any problematic areas and determine the course of proposed goals and treatment:

1) Family structure – observation of the family's preferred and alternative transitional patterns.
2) Evaluation of family flexibility surrounding re-structuring of transactional patterns.
3) Exploration of the degree to which the family exists on the enmeshment-disengagement continuum.
4) Revision of the family's ecological life context to evaluate family functioning.
5) Assessment of family functioning within the developmental stages with consideration to coping and performance.
6) Examination of family practices surrounding the maintenance of the identified patient to preserve family transitional patterns and symptoms (Okun & Rapport, 1980).

Finally, restructuring operations are therapeutic interventions that provoke and challenge a family towards therapeutic change (Minuchin, 1974). He identifies seven categories of restructuring operations: actualizing family transactional patterns; marking boundaries; escalating stress; assigning tasks; utilizing symptoms; manipulating the mood; support; and education and guidance.

Therapeutic Process

Structural family therapy considers three strategies to promote change in the family system. First, the therapist supports that the issue is a feature of the environment and not the child where the challenge may be overt or contained, clear-cut or paradoxical. The objective is to transform the family's perception of their problem and encourage alternative responses within the family system. As follows, the therapist is able to observe the response of its family members to the problem, the significance the problem maintains throughout the family, and the way the problem is utilized by and within the various subsystems of the family (Minuchin & Fishman, 1981).

As the therapist joins with the family the therapist is able to observe and comment on the associations and roles of the various subsystems, the nature of the boundaries within the family, and the transactional patterns that govern and establish the family process. As problems are related to the inner anthology of the family the therapist can speak to the problem as the therapist challenges the family on the beliefs and behaviours they use to support the problem. For instance, Wachtel (1994) states the therapist's role may be to assist parents in understanding their child and to assist them in interacting with the child in ways that impede parents from validating their child to act out matters in self-defeating ways.

Lastly, the structural therapist may also challenge the family's reality since it's their position that has sustained the symptom in a purposeful or inadvertent manner. Hence the therapist

> takes the data that the family offers and reorganizes it. The conflictual and stereotyped reality of the family is given a new framing. As the family members experience themselves and one another differently, new possibilities appear (Minuchin & Fishman, 1981, p.71).

As potential transpires the family can begin to make use of its own resources and initiate required changes. Accordingly, the therapist may decide to accentuate family strengths or employ cognitive constructs and paradoxical interventions.

Co-locating Structural Family Therapy and Narrative Family Therapy

Narrative therapy is present and future orientated (Gladding, 1998) while structural family therapy believes the person is comprised of the past and present. This complementary integration of structural with narrative theory frees the individual from their problem-saturated experience towards anew goal-oriented lifestyle. Also, regarding problem formation, narrative therapy aims at helping the individual to recall unique outcomes and non-problematic events from which the individual can construct a new perception of their being (White, 1990; Minuchin & Fishman, 1981). In effect, the narrative observation of unique outcomes is akin to the structural theorist utilizing family resources to initiate change and strengthen resilience (Minuchin & Fishman, 1981).

Empirical Studies

Although structural family therapy concepts are often used in family therapy, few outcome studies have been conducted regarding the application of the model where the identified patient is a child with behavioural issues.

Minuchin conducted the first treatment studies of structural family therapy with delinquent boys and their families from low socioeconomic status (Minuchin, 1974). Upon evaluation Minuchin discovered that slightly greater then half of the cases

improved after treatment. Although this study had some methodological concerns it was the first to confirm that structural family therapy was somewhat effective (Aponte & Van Deusen, 1981).

Roy and Frankel (1995) report structural family therapy has support for treating families with medical conditions. The model has proven effective in working with children diagnosed with attention deficit hyperactive disorder (ADHD). Barkey, Guevremont, Anastopoulos and Fletcher (1992) also support the use of structural family therapy in treating adolescents with ADHD. Family therapy was used in conjunction with included problem solving, communication training, and behaviour management. All three treatment conditions showed improvement in parent-child communication; amount of conflict; intensity of anger; parent informed school adjustment of the adolescent; parent and self-reported adolescent externalizing and internalizing symptoms; and maternal depression. Change in family functioning was not significant and may be attributed to a change in attitude or the alleviation of stress. Nevertheless, treatment was more effective than no treatment.

Szapocznik, Murray, Scopetta, Hervis, Rio, Cohen, Rivas-Vazquesz, Posada, and Kurtines (1989) compared structural family therapy with psychodynamic child therapy. They found that both treatment conditions were almost equivalent in their effectiveness in reducing behavioural and emotional problems. Noteworthy, while the children receiving treatment showed symptomatic improvement there was no change in family functioning. The research invalidated the basic assumption that structural family therapy enhances family functioning and eliminates sympathology.

Stanton and Todd (1979) studied structural family therapy in the treatment of heroin addicts and their families. The model showed the process of simultaneously exploring the involvement of family system process to problem maintenance and change in the role of treatment. Results showed that the degree of positive change was twofold compared with other conditions. In particular, they established that families at post-treatment exhibited healthier boundaries between subsystems which were sustained at follow-up.

In summary, the structural family therapy approach appears to be an effective model for working with various client issues, although some limitations exist. First, outcome studies conducted by Minuchin and his colleagues have not been replicated (Roy & Frankel, 1995). Secondly, most of the research on the model has focused on children and adolescents. Accordingly, there is a scarcity of empirical literature on the adult population (Colapinto, 1991). Lastly, there seems to be little qualitative studies using this approach in the area of couple, and marriage and family therapy.

Conclusion

The structural family model seems relevant in working with adolescents within the family context as demonstrated in the empirical literature. In the model, the family is seen as the initiator of change and the force to ensure change will be maintained when treatment ends.

Structural family therapy is a model with several strengths. To illustrate, it is a constructive model because of its relative straightforwardness, concreteness and openness (Figely & Nelson, 1990). For this reason, the approach is seen as a popular and useful tool for teaching and performing family therapy in that it takes the family and manages it

into basic concepts to organize and understand family: subsystems; boundaries; hierarchies; power; alignment; and coalitions. The therapist employs these to help the family challenge their existing perception of reality, in effort to recognize alternative transactional relationships to foster new relationships that are self-supporting. As well, it offers therapists a way of focusing on family strengths to conceptualize and understand human issues that had in the past been explained as individual pathology (Okun & Rapport, 1980).

Cognitive Behavioural Family Therapy

Cognitive behavioural family therapy (CBFT) is structured and interactive with the purpose of solving problems in the "here and now" both within and outside the treatment setting. The premise being (Robinson, 1996):

Cognitions represent a synthesis of internal and external stimuli

↓

Individuals structure situations based on their cognitions

↓

Emotional and behavioural changes are caused by cognitions

↓

Cognitive therapy elicits an awareness of "cognitive distortions"

↓

Correction of these distortions leads to improved functioning

The initial target aims at symptom reduction where family members begin to recognize and record their negative automatic thoughts. Thereupon members use objective evaluation and experimentation to discover how pessimistic self-acting thoughts change cognitive thinking patterns (Robin, 1996).

The supplementary target focuses on the naming and changing assumptions (schemes or dysfunctional attitudes) that are understood from the individual's stereotyped thinking and behavioural patterns. Therefore, goal achievement means evoking change in pessimistic thought processes at the perceptive and behavioural levels (Robin, 1996).

Beck (1988) states that in order to interpret the nature of an emotional occurrence or disturbance, it is necessary to centre on the cognitive content of an individual's reaction to the upsetting event or flow of thoughts. The objective being to change the way individuals think by employing their automatic thoughts to reach the core schemata and begin to present the idea of schematic restructuring. This is acquired by encouraging individuals to gather and consider the evidence in support of their beliefs. The cognitive therapist helps the client identify distorted and dysfunctional thoughts thorough a process of evaluation. Through a collaborative effort, individuals learn to distinguish between their own thoughts and events that occur in truth. They learn to monitor their own thoughts, feelings and behaviour. Individuals are trained to gain insight into their automatic thoughts against actuality by processes involving empirically testing their beliefs through carrying out homework assignments, keeping a record of activities, behavioural contracts and gathering information on assumptions they make. Also, CBFT is directed towards addressing the interrelatedness between members' behaviours, cognition, and affect, as they affect the quality of family relations and other intimate relationships. CBFT has important components (e.g. communication and problem-solving training, and behavioural tasks) shown successful with families whose members struggle with conduct, depression, anger and hopelessness.

Clients in the practicum were suspect for a depressive disorder and therefore important to acknowledge Beck's therapeutic approach for this personality type. Beck centres on twenty-one particular problematic issues and symptoms identified in the treatment of depressed individuals. Creating alternatives and reducing problems to manageable entities can expose an individual's ambivalence and attitudes of weakness (Beck, 1988).

The cognitive therapist, like the structural therapist (Minuchin & Fishman, 1981), initially takes the lead in assisting the individual in developing a realistic plan of action and setting priorities. Because clients are often limited by self-deprecating thoughts, therapists must initiate cognitive rehearsal techniques to assist in identifying and changing negative thought processes. A therapeutic intervention may include setting up an activity schedule with graded responsibilities to be completed.

Co-locating Narrative Therapy and Cognitive Behavioural Family Therapy

Griffith and Griffith (1994) identify the following distinctions between narrative therapy and cognitive behavioural therapy. Narrative therapy identifies with shifting stories while cognitive behavioural therapy sites beliefs as changing. In addition, narratives are more all-encompassing, detailed, behaviours, feelings, and all that constitutes experience, supplemented by time. In distinction, beliefs are "timeless abstractions" (p.49) that simplifies rather than indicates experiences. Stories merely are, while beliefs are interpretations that require "rational justification" (p.49) or can be opposed by someone holding a different interpretation. To add, Griffith and Griffith view the storyteller through the narrative approach as the one in authority. In contrast,

cognitive behaviourists state a belief possesses strength or power as accorded by the degree of power or knowledge held by the individual stating that belief.

Resilience and the Strengths Perspective

Resiliency is defined as the ability of individuals not only to survive, but flourish in spite of negative issues that may exist (Hawley, 2000; Walsh, 1996).

Hawley (2000) emphasizes that family resilience is specific to each family as it is contingent on the family's developmental, social, cultural and historical contexts in which they reside, in addition to their specific dynamics and structure. Walsh (1996) adds that resilience can be conceptualized relationally. Meaning resilience is a developmental process that matches the family's functioning within its social context and the various demands it meets. Relational resilience includes

> ...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).

Resiliency in the therapeutic process involves the therapist assisting the client in searching for past successes and to when the issue did not exist. This helps the family consider that their present problems are not indicative of their ability to be resilient (Hawley, 2000). Hawley (2000) sees this approach as focusing on family identity, requesting that the family convey what they see as their universal beliefs, experiences, traditions and rituals that unite to impart their strengths. Likewise, Hawley notes such meaning-making questions, common to the narrative approach, can direct the family on

their conviction, loyalty and self-reliance, so as to support their strengths in times of adversity.

The strengths perspective rests on the belief that the therapeutic process is more productive when it helps clients realize positive and lasting change by focusing on and building on the clients' strengths then by concentrating on and attempting to eradicate existing deficiencies or problems. By focusing on client strengths the therapist is able to avoid pathologizing families, or making a "diagnosis" (Cowger, 1997). Thus, rather than diagnosing client problems or deficits, speaking to strengths allows families to identify issues in terms of their own experiences and perceptions that foster the awareness of inherent strengths which promote expertise, experience and empowerment relevant to solving their obstacles.

Empowerment in the therapeutic process is an internal process driven by the recognition of strengths, supported through encouragement from others, and advanced by developing confidence in coping with daily life (Harper-Dorton & Herbert, 1999). Saleeby (1997) promotes that each individual and their family possesses unique strengths and potentials, and by focusing on these, clients become self-directed and feel empowered to address their difficulties.

Rapp (1998) believes that clinical practice has failed to acknowledge that all individuals and groups have unused reserves of strength, courage, ability, energy, experience, support, truthfulness, and other assets. Rapp extends that when these strengths are accepted and exploited through the helping process, a client's motivation and opportunity for positive change is fostered.

The Integrative Model

The practicum experience has challenged my understanding of the therapy process, and fostered a framework for helping me integrate key concepts and therapeutic goals with techniques from various theories. Alike my philosophy, therapy is not exclusive to individuals who are ill and requiring someone to "cure" them. Rather therapy is a process whereby clients learn to cope with internal and external forces that influence their reality and sense of self. Valuable dimensions of structural therapy, Bowen family systems theory, the narrative approach, along with cognitive behavioural therapy and emotionally focused therapy offer a unique combination to understanding families and relieving the system of conflict. My therapeutic interventions were modified in concurrence with my assessment of the family's needs, and awareness of my own skills. Overall, I choose an approach congruent with my style as a beginning therapist.

The structural approach to therapy concentrates on the individual, family, and societal context in which individuals live with. The structural therapist promotes an accepting and accommodating stance on behalf of family to circumvent resistance, while taking on a decentralized role. The objective of the structural approach is to provide a clear organizational framework for understanding and intervening therapeutically with families. "Structural family therapy isn't a set of techniques it is a way of looking at families" (Nichols, 2001).

The central tenet of structural therapy is every family has a structure, revealed when the system interacts. Structure is defined in relation to boundaries, subsystems, and complimentary patterns. Relative to the family life cycle, structural family therapy addresses the patterning of transactions within the family's structural process in which

symptoms are embedded. Symptoms result as problematic signs of a maladaptive relationship to change, development, and environmental demands (Walsh, 2003). Thus, a structural assessment can identify problems and the family structures supporting it. Failure of the therapist to account for the entire family structure, for instance addressing only one subsystem without acknowledging associations in others, inhibits basic change in the system.

By the structural therapist identifying troubled interactions and reflecting these patterns back to families, an interactional dance ensues. Bowen family systems theory interprets these dances through the concept of problematic relationships that can be modified into more productive interactional patterns to differentiate one from their family of origin.

Bowenian theory was directed at changing individuals within the context of the family system. Problems that manifest throughout the family do not change significantly until one understands and challenges the relationship patterns of one's family of origin. Bowenian family systems theory relieves the family of symptoms and fear, plus increases the level of differentiation within members (Kerr & Bowen, 1988). Lack of differentiation creates emotional reactive polarity in relationships. Eight concepts are central to this multigenerational approach: differentiation of self; triangulation; the nuclear-family system; the family-projections process; emotional cut-off; the mutigenerational transmission process; sibling position; and societal regression. All uncover intergenerational trends that create and perpetuate emotional suffering onto the current family system. In therapy the family's unresolved emotional attachments are addressed, and mature, healthy relations evolve.

Bowen theory considers the extent of unresolved emotional attachment to the degree of undifferentiation. Too, emotional focused therapy regards secure attachment dependent on the ability to maintain close supportive relationships, and differentiation. Bowenian family systems theory and emotional focused therapy like structural therapy alleviates the family of problems in attempt to reorganize family structure.

Addressing emotions is essential to the organization and regulation of social relationships within the family system. Equally, emotion is central to forming attachment behaviours and self-regulatory in the creation of individual schemas. Assessing and restructuring emotional experience is effective in new interactional patterns that redefine an attachment relationship and promote improvement in negative core beliefs that transpire when family conflict result in separation distress. Greenberg and Johnson (1998) declare this process the most powerful method to initiate intrapsychic and intergenerational change.

The objective of emotional focused therapy is to discover and expose key emotional reactions that underlie interactional relations within the family unit. Transitions through life cycle stages often materialize as stress and crisis, at which members become frustrated, annoyed, and distressed in effort to gain assurance or else minimize feelings of anxiety and distress — at a time when greatest support is required. Such emotional states create rigid unsupportive interactional cycles reflecting anger, grief, and fear to limit communication, increase insecurity and form conflictual family relationships (Johnson et al, 1998). The goal being to transform family relationships toward increased openness and responsiveness with the intent of helping families form a protected institution for offspring to learn, grow, and gain a sense of autonomy for

survival outside the family unit. Reflection, validation, evocative responding, heightening and empathetic conjecture, comprise the initial intervention of therapy to access and uncover emotions to prompt change. Next, restructuring interactions, along with tracking and reflecting, reframing, and restricting interactions are invoked to challenge new emotional experiences, consequently challenging the common patterns of family contact (Johnson, 1998). Expression of emotion facilitates attachment, and attachment is associated with the means to control environmental stress.

Cognitive behavioural family therapy is congruent with systems theory as it manages both the major systems and subsystems in which an individual functions with the individual's emotions, thoughts and behaviour. The underlying assumption of cognitive behavioural family therapy is the actions of one family member trigger thoughts, emotions, and dynamics in other members to conversely create reactive dynamics, thoughts, and emotions in the original person (Beck, 1988). Simultaneously, as the pattern continues, the volatility of family functioning increases making the family susceptible to unconstructive conflict (Nichols, 2001). Founded on identifying core beliefs and changing attitudes, therapeutic intervention focuses changing the beliefs by which family members understand and value one another (Beck, 1988).

The narrative approach believes individuals have a sound preference for how they would like to act, how they like to understand themselves, and how they want to be perceived by others; a "preferred view". Preferred views are contingent from narratives people convey about their experiences and the means by which they describe and sense their lives. How individuals contend with interactions in their subsystems is an ongoing effort to achieve a balanced perceptive while maintaining individuality. Similar to

structural therapy and cognitive behavioural therapy, the narrative approach is interested in understanding how relationship dynamics (Bowen family systems theory), thinking, and action affect and sustain individual and relationship problems (cognitive behavioural family therapy). By means of assessing how problems originate and evolve (emotional focused theory), therapy questions how normal interactional patterns and transitions generate distress, and alter how family members think and behave (Nichols & Schwartz, 2001).

The idea of reconstructing life events through coherent narratives helps families to validate experiences (White & Epston, 1990). Behaviour and communication is not exclusive rather understanding reality and the construction of narratives contributes to systemic patterns. Actions are understood and established in narrative form, where the narrative conversely shapes expectations that inspire future behaviours, and so on.

When narratives become problematic and inhibit the freedom and functionality of family members, therapy is sought. Problems orientate with the way members and family construct meaning from encounters and perspectives of dominant cultural positions that are useless to the system. Positions that disrupt homeostasis and perpetuate inequalities minimize or eliminate alternative knowledge perspectives and storied outcomes.

Externalizing questions followed by the development of unique outcome narratives into solution narratives help to deconstruct oppressive stories and separate the problem from the individuals affected by the problem (White & Epston, 1990).

As noted, the focus of integrating the structural therapy, Bowen family systems theory, cognitive behavioural therapy and emotionally focused therapy, along with the

narrative theory enables a new approach in the social construction of new family patterns of interactions, dialogue, and relationship.

Conclusion

In utilizing an integrative approach to therapy I have chosen concepts and methods from a variety of theories. I believe that no one theory is relevant to all individuals and situations, or details the intricacies of human behaviour and experience. Since no one approach has exclusive rights on reality, and no one set of interventions is effective in working with individuals from diverse backgrounds, no one theory encompasses all of the unique characteristics required to bring about a satisfactory outcome. Some therapies regard the therapist in an active and directive role while others empower the individual as the change agent. Still, some models focus on behaviour, and others attend to feelings or thought processes. The challenge as a therapist is to integrate specific components of a variety of therapeutic models to empower change on all levels of experience — the emotional, behavioural and cognitive. Therefore, I acknowledge that several different theories can be used to facilitate an integrative approach to therapy.

With respect to integrating and applying the models the therapist is responsible for maintaining a respectable working relationship with the family, by also drawing on ones own experience. This means using the self in therapy and having supervised experiences in therapy with openness to continuous knowledge of theory and techniques. Without attention to all mentioned dimensions the therapeutic process is incomplete.

CHAPTER FOUR

Practicum Description

Setting

The setting for this practicum was New Directions for Children, Youth, Adults and Families at their Family Therapy Unit in Winnipeg, Manitoba. The agency offers a diverse blend of services to help children, youth and their families with personal and social needs. Services are offered at no fee to clients. Client participation in family therapy is voluntary. Clients may self-refer, or they may be referred by services within the agency, or by social services and community agencies.

Clients

The New Directions for Children, Youth, Adults and Families Family Therapy Unit affords therapy to families experiencing difficulty with their children including: parenting; communication; isolation and depression; separation and divorce, remarriage and blended family life; family violence; and survivors of sexual and physical abuse.

Throughout the practicum I worked with seven families. Typically the three analyzed underwent six to twelve therapy sessions. The identified client was not necessarily the family rather individuals within the family unit with a majority being a parent or the marital couple. Family names and a few other particulars have been altered to protect the confidentiality of the clients involved in the practicum.

Duration

The practicum began in September 2001 and commenced in March 2001. I participated in the Family Therapy Unit three days per week working with families, of which one half day consisted of direct supervision.

Supervision

My advisory committee consisted of Harvy Frankel, Ph.D. (Associate Dean and Social Work Professor at The University of Manitoba), Bernie Klippenstein, M.S.W. (Adjunct Professor of Social work at the University of Manitoba, and Family Therapist with the Family Therapy Unit at New Directions for Children, Youth, Adults and Families) and Kris Balchan M.S.W. (Family Therapist with the Manitoba Adolescent Treatment Centre).

For consultation with my clinical supervisor, family therapy sessions were videotaped upon consent from clients. Pertinent information was recorded in client treatment notes and read by my supervisor as per agency policy. Confidentiality and anonymity was respected throughout the practicum.

I also recorded my daily learning experiences at New Directions for Children, Youth, Adults and Families, in a journal, which proved to be beneficial in understanding the practicum experience.

Evaluation of Outcomes

Three instruments were used to evaluate the practicum. Clinical evaluation of the intervention was assessed using two standardized instruments, the Family Assessment Measure III (FAM III) (Appendix A) (Skinner et al, 1983) and the Problem Checklist

(Appendix B). Both measures, used to assess family functioning, were administered to clients at the beginning and end of treatment. The Client Feedback Form (Cantafio, 1989) provided the therapist with feedback on the treatment process.

New Directions for Children, Youth, Adults and Families uses FAM III as the primary outcome measure (Skinner et al, 1983). FAM III is used in "clinical and research settings as a diagnostic tool, as a measure of therapy process and outcome, and as an instrument for basic research on family process" (Skinner et al, 1983, p. 92). The FAM III provides an "important compliment to a clinical assessment by giving a comprehensive review of family functioning, by providing an objective and independent verification of the clinical assessment, by identifying areas of potential difficulty that would warrant further assessment, by providing quantitative indices of family health-pathology that may be used as a baseline for evaluating the cause of therapy" (Skinner et al, 1983, p. 103-104).

FAM III is a self-report measure based on Canadian norms for both clinical and non-clinical populations (Skinner et al, 1983). It takes thirty minutes to complete, can be administered to family members as young as 10 to 12 years of age, and can discriminate between clinical and non-clinical family systems (Skinner et al, 1983).

FAM III measures family strengths and weakness from three perspectives: the family as a system, dyadic relationships, and individual family measures. The 50-item General Scale of the FAM III measures the family at three levels: (1) the General Scale assesses the level of healthy-pathology in the family from the systemic perspective; (2) the Dyadic Relationship Scale centres on relationships among specific dyads within the

family; and (3) the Self-Rating Scale evaluates individuals' perceptions of their functioning in the family. Family functioning is assessed on the basis of seven concepts: task accomplishment; role performance; communication; affective expression; affective involvement; control; and values and norms; and the response styles of social desirability and defensiveness (Skinner et al, 1983). Skinner et al. (1983) acknowledge the cultural background of the client (i.e. norms and values) influences how the family allocates defines and accomplishes its tasks and the degree of balance between its behaviours and broader cultural context. FAM III "has excellent psychometric properties" (Trute et al, 1988). It has internal consistency, reliability and moderately high correlation with social desirability and defensiveness with a coefficient alpha reported at .93 for adults and .94 for children (Skinner et al, 1983). No test-retest reliability coefficients have been reported for the FAM III.

FAM III was not a substitute for a clinical assessment, rather an outcome measure for evaluating changes in family function over the course of therapy.

The second evaluation measure, the Problem Checklist (Appendix B), is a self-report measure of satisfaction consisting of 22 specific areas of concern on an array of family dimensions, which clients may be reluctant to admit in session (Trute et al, 1988, p. 106). Although, weak in generalizability and empirical strength (Trute, 1985), and poorly rated on validity and reliability the Problem Checklist complements the FAM III. The Problem Checklist provided feedback to clients and therapist on individual perceptions of improvements in family functioning.

The final measure, the Client Feedback Form is a qualitative consumer satisfaction questionnaire, administered to clients at the final therapy session. Developed

by Cantafio (1989), the Client Feedback Form consists of ten specific open-ended questions requesting the family's opinion about the value of therapeutic services provided and the helpfulness of the therapist.

Permission was provided by New Directions for Children, Youth, Adults and Families to reprint measures for purposes connected to this practicum.

CHAPTER FIVE

Case Reviews

This chapter summarizes the therapy process of three cases to illustrate the narrative approach along with supplementary family therapy frameworks to resolve parent-child conflict. The three families chosen meet the criteria previously presented for defining families. The names of the families involved and their members have been changed to maintain confidentiality. Common themes that emerged during treatment will be examined in Chapter 6. The cases are described as follows:

1. Reason for Referral
2. Brief Description of the Family
3. Initial Interview Summary
4. Assessment
5. Treatment Goals
6. Strategies to Implement Goals
7. Case Analysis
8. Case Conclusion

Dalton Family

Ms. Dalton was a thirty-seven year old woman who presented with concerns of coping with divorce and custody, as well as the sexual identity of her fifteen-year old daughter. Ms. Dalton tended to focus on limitations that immobilized her strengths from

addressing issues. Ms. Dalton was also recently diagnosed with anxiety for which she was placed on anti-anxiety medication.

Therapy focused on gaining a thick descriptive understanding of anxiety and its effects (Semmler & Williams, 2000; Walsh 1993; White, 1989). Sessions also focused on externalizing circumstances that were beyond her control. As a result, Ms. Dalton began to address ways to influence her anxiety. This involved reiterating Ms. Dalton's strengths and capabilities. Unique outcomes were then used to make significant change in her ability to address and cope with stressors in her life. Sessions provided education on the separation and settlement phase of divorce, in relation to her new role as a single parent. This advanced Ms. Dalton's knowledge of the family life cycle to promote confidence to use her strengths to mobilize her skills.

Ms. Dalton attended three sessions whereupon she stated anxiety was no longer consuming her life, and that she no longer required therapy.

Frank and Gilbert Family

Mr. Frank and Ms. Gilbert, both in their early forties, came to New Directions for Children, Youth, Adults and Families with concerns of emotional and physical abuse, which influenced their decision to cohabitate. Ms. Gilbert suffered from debilitating arthritis, while Mr. Frank was diagnosed with schizophrenia. Winnipeg Police Services had intervened on one occasion when a concerned neighbour phoned to report a heated verbal argument involving Mr. Frank physically acting out on Ms. Gilbert. Ms. Gilbert did not require medical attention, but the couple was startled by the escalation of their disagreement. Ms. Gilbert is slightly mentally challenged and resides with caregivers.

Narrative therapy was useful with this couple. Deconstructive listening was a major part of the therapeutic process as it was used to emphasis the dominant discourse of mainstream society and the influence it had on Mr. Frank and Ms. Gilbert's self-concept. Discussions with the couple centred on stigmas associated with mental health and low intelligence, and the result these had on the couple. Ms. Gilbert was able to articulate her feelings of inadequacy of having low intelligence and being overweight. Deconstruction was prevalent throughout the therapeutic process as frequently as conversations would allow.

Therapy also focused on having Mr. Frank externalize his anger as a separate entity from his person (Semmler & Williams, 2000; Zimmerman & Dickerson, 1996 & 1994; O'Hanlon, 1994; Becvar & Becvar, 1993; Duckworth Centre Newsletter, 1991; White, 1989). Although Mr. Frank was trying to distance himself from his family of origin, he was reactive emotionally to his mother. His mother's cruel and belligerent behaviour left him disempowered. Consequently, he would run off with feelings of frustration and anger. Mr. Frank would then return to her as she promised forgiveness, only to have the pattern repeat itself.

Sessions with Mr. Frank mapped the results of his poor self-concept and anger. Discussions centred on Mr. Frank's relations with his mother, and his use of anger as his defense. Dialogue mapped his interpretation of stress and the effects on his life. Mr. Frank was encouraged to identify unique outcomes to recognize good choices, and challenge problem-saturated stories when these arose (Semmler & Williams, 2000; Zimmerman & Dickerson, 1996; Duckworth Centre Newsletter, 1991). At first, Mr.

Frank ignored unique outcomes nevertheless continuous persistence, accompanied by his lively narratives, changed his position.

Final sessions with Mr. Frank utilized re-storing questions regarding "what does this say about you, as an individual and a partner?" This helped Mr. Frank internalize a healthier narrative. To add to his perception, Mr. Frank visited his parents and Ms. Gilbert's guardian to circulate the news of his alternative story. The emphasis was on gaining support from individuals who valued an improved story.

My clinical belief was that Mr. Frank made some notable changes throughout therapy. Mr. Frank applied anger management strategies, reduced his defensiveness, especially towards his mother. Equally Ms. Gilbert had developed a keen sense of awareness in identifying Mr. Frank's anger. She also gained knowledge and assertion in accessing community supports should Mr. Frank become abusive.

The couple did not complete assessment tests as Mr. Frank refused to participate and Ms. Gilbert could not read.

Millet Family

Mr. Millet was a forty-two year old man who came for family therapy with concerns about his twelve-year old son's poor academics and unlawful conduct in the community. Mr. Millet was a single father on income assistance who was struggling with self-confidence as a parent with mental illness.

Therapy was based on the premise that Mr. Millet had a vested interest in changing his situation and that he held the potential power to do so. Using the narrative approach, therapy placed Mr. Millet's insecurities in a political context in which people

suffering from mental illness are oppressed. This assisted in gaining thorough definitions of schizophrenia and depression, and mapping the effects of illness on Mr. Millet's life (Semmlar & Williams, 2000; Zimmer & Dickenson, 1996; Walsh, 1993; White, 1989). Mr. Millet initiated discussions surrounding the dominant discourse of North American society on low-income single parents, with specific focus on the devaluation of male parents. From restoring, Mr. Millet achieved insight into negative implications associated with accepting these dominant dialogues with respect to his illness and parenting responsibilities. Such conversations were important in the therapeutic process as Mr. Millet's storing allowed for deconstructive listening and realizations on how society influenced his self-worth (Coombs & Freedman, 1998; Neal, 1998; Madigan, 1996; Becvar & Becvar, 1989; White, 1989).

Mr. Millet's initial FAM III established that he was under a great deal of stress in the areas of affection, role performance, communication, and control with regards to parenting his son. Elevated scores for control and communication reiterated Mr. Millet's verbalization of tension with his son. Also, this confirmed Mr. Millet's feelings of inadequacy in his ability to parent an adolescent. The initial problem checklist validated that Mr. Millet was "extremely dissatisfied" in these same areas in his relationship with his son.

The therapeutic process with Mr. Millet was indicative of the narrative approach, which focused on the person narrating their story, and conversing with the therapist. Mr. Millet defined schizophrenia as intruding thoughts and assumptions that influenced his thoughts and feelings of anxiety and sadness. Mr. Millet's undesirable effects of his mental illness allowed him to identify that these were aspects contributing to his poor

self-worth, which he wished changed. Through Mr. Millet's self-recognition of strengths and abilities, he reframed his parenting potential to meet the needs of his adolescent son.

Ms. Nickels

The presenting issue to attend therapy was Ms. Nickels' conflict with her 6-year-old son Taylor. Taylor was argumentative and defiant towards his mother. It was Ms. Nickels' goal to attend therapy and glean strategies for taming Taylor's behaviour. She had already read numerous books on the "explosive child" and was now requesting in person guidance. Ms. Nickels lacked insight into the role her behaviour had in shaping her relationship with her children.

The initial goal was to have both parents involved in therapy with the objective of having Mr. Nickels more involved in his children's life. This would shift some of Ms. Nickels' assumed responsibilities to her husband, and enable the couple to communicate more openly regarding their parenting roles, beliefs, and differences. Having the couple in therapy would also determine whether the children were being triangulated into the couple's conflicted relationship. Therapy would assist the couple to engage with each other in ways that would reduce marital conflict directed towards their children. Ms. Nickels was adamant throughout therapy that she did not wish to work on the couple relationship.

The structure of the family to the external environment was not problematic. The flexibility of the family seemed to meet the social needs of the children. Ms. Nickels and her children were in coalition against Mr. Nickels, which helped Ms. Nickels feel the sole support of her children. The coalition did not appear problematic to family members. In

addition, the parental subsystem was disengaged. Ms. Nickels did not speak with Mr. Nickels. She was adamant that she did not want to change this communication style. As well, Mr. Nickels did not make himself available for sessions as he claimed work hours did not allow for this.

Ms. Nickels presented as a woman secretive with her thoughts and emotions, in particular on certain subjects. The level of Ms. Nickels' differentiation was difficult to establish, as she shied away from sharing information pertaining to her family of origin. She disclosed that she functioned as the primary care provider to her younger sister when their mother was unable to cope with the death of their father. Ms. Nickels left home when she was sixteen as her mother was an "ineffective parent."

The writer attempted to validate Ms. Nickels' experiences to draw out emotions that were over-regulated and remote. Through listening and empathetic conjecture the writer was able to soften Ms. Nickels' demeanor and enable her to show concerns at home. Ms. Nickels storied her dissatisfaction with her husband as a way to avoid feelings. When challenged to speak about her own fears and emotions, Ms. Nickels informed that distancing was used as protection. Ms. Nickels revealed she remains in her marriage as a means to financially support her and her children. She informed that eventually, when enough money had been saved, she would take her children and leave their father.

Externalizing the problem was useful in keeping Taylor from being blamed for his behaviour; instead the problem was described as a separate entity oppressing everyone in the family including Taylor. This helped to liberate Taylor from his mother's blame.

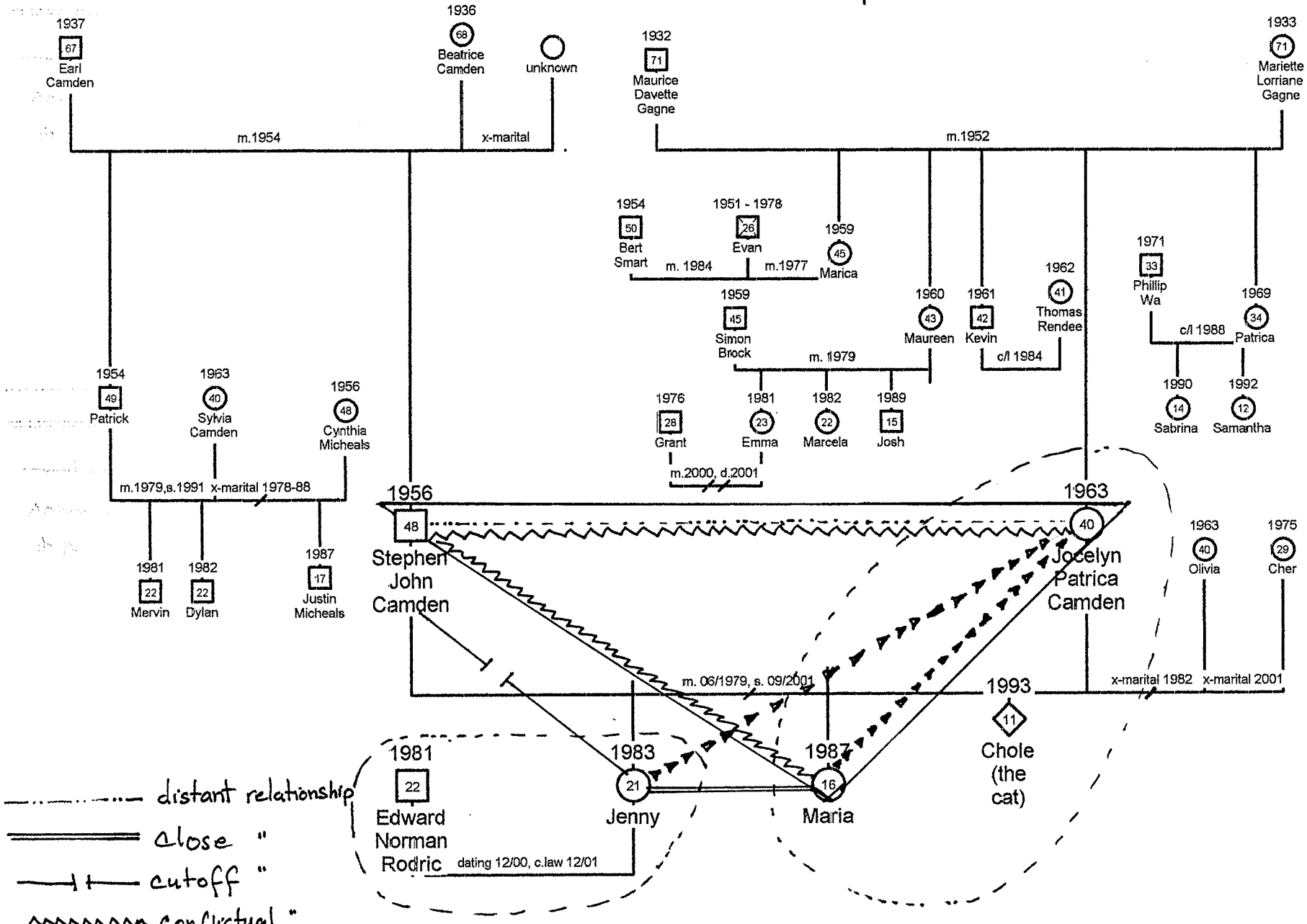
This case was challenging, as Mr. Nickels did not attend therapy, making the process awkward to address parenting and marital issues solely through Ms. Nickels. Therapy focused on restructuring the parenting relationship between Ms. Nickels and Taylor. Ms. Nickels formulated a homework assignment to demonstrate consistent behaviours valued from Taylor at home and school. Ms. Nickels would meet with Taylor's teacher at the end of the school day to discuss Taylor's positive and negative behaviours, and which techniques to reinforce at home. Also, Ms. Nickels recognized that her way of responding to her eldest son created and maintained the problem. By the therapist modeling listening skills to Ms. Nickels, Ms. Nickels reiterated the same with her son. For instance, she was less reactive to Taylor, and listened to his new encounters with friends at school. Ms. Nickels began to understand that Taylor was becoming more independent of her now that he was in school full-time.

Therapy served to strengthen boundaries between the parental (mother) and child subsystem. It was unfortunate that Ms. Nickels did not recognize that systemic intervention with both parents could benefit her children, regardless of her relationship with their father. The therapist drew attention to the reality of this statement by encouraging Ms. Nickels to process feelings of parental abandonment. This created small opportunities to impart knowledge. The therapist informed Ms. Nickels of the short and long-term benefits of having Mr. Nickels involved in his children's life. This psychoeducation supported the therapeutic premise first, to encourage Ms. Nickels to build a communication aspect with her husband for the benefit of her children, and second to increase awareness on the importance of attachment. Ms. Nickels' own family of origin issues were recognized and drawn into her children's present parental

experiences. Yet, she remained cautious of discussing abandonment by her mother and was fearful to acknowledge and attend to this. Ms. Nickels appeared caught in an overall anxious avoidant pattern.

Ms. Nickels' high scores on the affective involvement subscales showed that she was overly involved with her eldest son. Elevated scores on the communication and control subscales supplemented this. Normal scores for role performance indicated that she felt skilled with her role as a mother of a challenging 6-year-old boy. This confirmed her belief that she parented Taylor properly, and that any difficulty in behaviour could be attributed to his stubbornness. High scores for control, and norms and values demonstrated that Ms. Nickels was having difficulty recognizing her inability to adjust to changing life demands. Ms. Nickels' initial problem checklist supplemented the FAM III pre-test, as she considered her parenting role satisfactory.

The Camden Family Relationship



Feb. 2002

The Camden Family

Reason for Referral

Ms. Camden (age 40) contacted the Family Therapy Department at New Directions for Children, Youth, Adults and Families on the advice of her family pediatrician. The reason for referral was that her teenage daughter, Maria (age 16) had been experiencing anxiety, auditory and visual hallucinations, depression and suicidal ideation. Maria's behaviour was compounded by pressure to excel in her final year of high school, and cope with the legal separation of her parents. Ms. Camden wanted Maria to successfully address and meet these pressures. Moreover, Ms. Camden was concerned about the effect marital separation would have on her own ability to cope while assisting Maria and her older daughter, Jenny (age 22), do the same.

Brief Description of the Family

Ms. Camden and Mr. Camden had been married for twenty-one years with two children, Maria and Jenny. Ms. Camden describes her marital relationship as "eighteen years of conflict," and her husband as a verbally abusive man who has had several extra-marital affairs. Ms. Camden separated from Mr. Camden five months ago as a result of tension between Mr. Camden and Jenny. The incident occurred when Mr. Camden slapped Jenny when she and Edward (22), her boyfriend of one year, announced that they were entering a common law relationship. Out of frustration Jenny divulged being sexually exploited by Mr. Camden at the age of six. Mr. Camden made no attempt to defend himself. The family secret was exposed.

When Ms. Camden first became aware of the abuse thirteen years earlier, she left her husband only to return a few weeks later for financial reasons. Ms. Camden wept while explaining the guilt she continues to feel for making the decision to expose her children to an abusive father. As a result of the abuse, Jenny has been diagnosed with Post Traumatic Stress Disorder and has been undergoing psychiatric and pharmacological treatment over the past two years. It is unknown whether Mr. Camden sexually abused Maria.

After Mr. Camden slapped Jenny, she and Maria presented their mother with evidence that their father was having an affair. After feeling pressured by her daughters to leave the marriage Ms. Camden moved out of the family home. Maria followed suit.

Ms. Camden's decision to separate from her husband served to delay Maria's launch into young adulthood. Parental separation together with the final year of high school made it tough for Maria to transition from the home, in addition to explore emotions related to moving out on one's own. Consequently, Maria became stressed and began to isolate herself, in addition to having anxiety, distorted visual and auditory thoughts, and suicidal ideation. Ms. Camden, unable to focus on her own worries, was at a loss in how to address Maria's needs. Because Ms. Camden felt unable to cope with the stress of family break-up and the challenges of a new identity she requested an increase in her anti-depressant medication and contacted New Directions for Children, Youth, Adults and Families for support. Ms. Camden was also searching for assistance to address Maria's stress.

Initial Interview

Ms. Camden attended the initial interview on her own. The therapist informed Ms. Camden that individual sessions would concentrate on her role as a parent. Meeting with Ms. Camden facilitated a clear boundary between the parent-child subsystems, as she needed to take control over family transitions. Therefore, involving the children in the therapeutic process was inappropriate at this time. Additionally, this presented Ms. Camden the occasion to show Maria and Jenny that their mother could foster results independent of their involvement.

Ms. Camden presented as a thoughtful, humourous woman who acted younger then her stated age of forty. She delighted in her ability to converse as a teenager as it placed her on the "same wavelength" as her daughters. Throughout the interview it became clear that Ms. Camden used humour to avoid painful emotions. Until her separation, Ms. Camden had been a stay-at-home mother, who had not been in the workforce for twenty-one years. This too created anxiety, as she now needed full-time employment.

Ms. Camden understood the problem existed within Maria and was at a loss at how to address this. Ms. Camden believed her decision to leave her husband caused her daughter to lapse into isolation. She assumed that Maria's resilience would be sufficient for both her and Maria to persist through marital separation. Ms. Camden had limited awareness that she was enmeshed with Maria.

Ms. Camden drew attention to her and her husband's family of origin issues of incest and abuse. She began to weep as she disclosed that she sacrificed her children's safety in order to remain with their father. She then described anguish surrounding the

discovery of Mr. Camden's exploitation of Jenny, upon which she left the home. She returned as the marriage provided financially for her and her children.

Assessment

Structural Assessment

Ms. Camden appeared to be in a powerless position in addressing family and self issues associated with the separation from her husband. Her parental subsystems were unclear and diffuse, enmeshing Ms. Camden's boundaries with that of her daughters'. Her lack of individualization made it difficult for her to make decisions without consulting with her children first. Too, she bragged to them about recent casual sexual encounters since her separation, and requested advice on returning to the dating scene. Jenny and Maria defined their daughter subsystem by explaining to their mother how challenging and inappropriate it was to learn of their mother's sexual activity. These diffuse boundaries brought chaos to her daughters' lives. Not only did Ms. Camden project her relationship with her husband on Maria but she also substituted Maria for a partner. Such over-involvement with Maria, especially during family separation, stressed Maria into suicide ideation, and impaired thought processes.

The assessment revealed several triangles within the family. Triangles that appeared fixed for several years. Primarily Maria had a lot of power in her family. She aligned herself with Jenny and their mother to support Ms. Camden's decision to leave their father, and contemplate divorce. Ms. Camden spoke with her husband through Maria consequently, exposing Maria to their hostility. In all, Maria became triangulated between her parents, and her father and Jenny. As well, Jenny aligned herself with Ms.

Camden, as she no longer speaks to her father. Ms. Camden had some awareness that the existing triangulations were problematic, still she felt defenseless in addressing her daughters' perception and response to their father's indiscretions. Maria's over-involvement led her to become sick in an effort to keep her family together. Also, a coalition between Mr. Camden and his brother seemingly enabled Mr. Camden's lack of responsibility to support his family through their life transitions.

Family Life Cycle

The Camden family was passing through a number of life cycle stages simultaneously. Ms. Camden and her daughters were making an effort to adjust to the splitting up of their family. As well, Jenny began a common law relationship, while Maria was getting ready to leave home. Even though Maria and Jenny are young adults, both are affected emotionally and socially by their parents' separation and potential divorce, and this can impede their adjustment to life changes.

Ms. Camden left her husband five months ago and now she is adjusting to being a single parent, and contemplating divorce, an adjustment that Carter and McGoldrick say takes up to three years. As well, Ms. Camden's attempts to address the emotional wounds of marriage could stagnant her emotional growth for several years (Carter & McGoldrick, 1999).

As Maria decided to reside with her mother rather then with her father, Ms. Camden is challenged with being the sole caregiver and financial support for Maria. Too, on a personal level, Ms. Camden wanted to enhance her social network.

Role of the Symptom Bearer

Maria's depressive affect and isolation from family and peers have provided her mother the opportunity to divert focus away from her marital break-up. Maria's listlessness and isolation acted to divert the vacant caregiving role her mother once bestowed on her father towards Maria. Regarding, lack of interest in academics, Ms. Camden believes that Maria is anxious about successfully graduating from high school, entering college, and moving from home leaving her mother alone to adjust to a new life. Therefore, Maria's issues serve to have Ms. Camden successfully separate from her husband.

The therapist hypothesized that Maria's emotional issues stemmed from a lack of feeling safe in her family of origin, exasperated by the diffuse boundaries and eventual break-up of the family unit. Similarly, Ms. Camden's diffuse boundaries surrounding her role as a parent robbed her of a sense of identity between being an authority figure in the home and a confidante to her daughters. The family's enmeshed relationship made it hard for Ms. Camden to comprehend age appropriate roles and conduct. Ms. Camden's demand for Maria's support and guidance meant borrowing Maria's sense of self in order to function. Shifting equilibrium within the family blurred Maria's role.

Treatment Goals

As Maria's sadness transpired after her mother's decision to separate, this appeared the most appropriate place to focus therapy. Specifically the primary goal of therapy was to place Ms. Camden in a greater position of control relative to her

functioning as a parent. The purpose of therapy was to encourage Ms. Camden to address developmental life cycle issues pertinent to Maria (for example, launching out of the home into young adulthood, and addressing the separation of her parents) in reference to Ms. Camden's readiness to divorce.

1. Create clearer boundaries between Ms. Camden and her adolescent subsystem.
2. Assist Ms. Camden to process past issues, which interfere with her present functioning and ability to parent her children.
3. Facilitate Ms. Camden's adjustment to marital separation.
4. Provide Ms. Camden suitable resources to offer supportive care for Maria's suicidal ideation.

Strategies to Implement Goals

1. Teach Ms. Camden to discuss issues with her daughters, without overstepping her boundaries as a parent.
2. Help Ms. Camden affirm herself appropriately as a parent and an individual.
3. Explore the processes between Ms. Camden and the adolescent subsystem so, that she realizes how her actions uphold an enmeshed relationship with her daughters.
4. Help Ms. Camden explore suitable treatment for Maria to help alleviate Maria's emotional reaction to her parents' separation.

Case Analysis

The Camden case was tough, as Ms. Camden required a high level of non-judgmental support to cope with decisions and ensuing life experience. Consequently, Ms. Camden had a devalued sense of self. She was a survivor of abuse and incest, yet could not protect her daughters from the same.

The therapist encouraged Ms. Camden to view her life circumstance relative to a worldview that condones domestic violence and the sexual exploitation of children, compounded by a legal system that perpetuates the victimization of victims by neglecting to hold perpetrators responsible. In addition, the failure of the social system to adequately provide a safe, self-sufficient life for single parents, who must flee abusive relationships only to succumb to living below the poverty line,

Narrative therapy was used as the main intervention with Ms. Camden. Externalizing helped Ms. Camden turn her blame outward. Therapy focused on externalizing Ms. Camden's fear of progressing through the family life cycle. Ms. Camden viewed her "fear" as a trader whose role was to steal her right for independence and the will to protect her children. Ms. Camden explained "fear" as her constant companion of fifteen years, which eventually gripped the entire family. Therapy worked with Ms. Camden to centre on how her issues created expectations and how these expectations shaped judgments (Nichols & Schwartz, 2001). She illustrated that "fear" kept her from leaving her husband, rationalizing that leaving her husband would deprive her children of a father. Narrative therapy allowed Ms. Camden the opportunity to grieve the pain of her relationship

Because Ms. Camden used humour to stop the pain of surfacing emotions, therapy focused on slowing down her experiences with fear and pain, as these were uncomfortable. The therapist encouraged her to stay with the emotion to process her experience further. This directed Ms. Camden's attention to her experiences and emotional responses, which the therapist validated, to rid Ms. Camden of self-blame and fear. Validation removed Ms. Camden's irrational beliefs and shame towards greater engagement with experiences. Also, validation facilitated a positive atmosphere in sessions as it defined her personal and societal struggles. By using evocative responding Ms. Camden processed her experience in a more differentiated way. Having Ms. Camden clarify and extend her experience by means of empathetic conjecture led to the creation of new meanings. This intense experience facilitated the therapeutic process of recognizing the emotions that maintained negative interactional patterns between Ms. Camden and her children. The goals of having Ms. Camden recognize that her feelings and experiences are her own — independent of Maria's were achieved.

The attempt to identify with feelings was helpful in having Ms. Camden focus on the effects of the problem and not its causes (White & Epston, 1990). Ms. Camden's effect of having these feelings was usually associated with thoughts and desires to search out Maria as her support. As a result, Ms. Camden was able to discuss her over-regulated emotions and fears with Maria and Jenny. Consequently, Maria shared with her mother the hardships of holding the dual role as an intermediary and confidante for both of her parents. Until this time Ms. Camden was oblivious of the dependability and worry she placed on Maria. Therapy allowed Ms. Camden to free herself of the guilt she concealed

from not protecting her children from their father, leaving her to centre on solving challenges surrounding her separation.

The family life cycle was used to explain Jenny and Maria's progression into late adolescence, and early adulthood. The life cycle approach helped Ms. Camden conceptualize Jenny's need to separate from the family, as well as the need for Maria to do the same in a healthy manner. Marital separation made it difficult for Maria to witness her mother's struggle with an identity that no longer included partnership with Maria's father. Also, enmeshment hindered approval for Maria to develop autonomy from her family unit. Therapy, within the family life cycle approach, focused on Ms. Camden's need to recognize that her feelings of fear and loneliness facilitated interdependence, and delayed all from addressing change in the family system.

The first therapeutic intervention focused on Maria's emotional health. This was a high priority as it was uncertain what risk she posed to herself. The therapist referred Maria to Macdonald Youth Services Mobile Crisis Team for a mental health assessment and possible therapy. Ms. Camden was placed in charge of caring for her daughter. Ms. Camden advised Maria to contact the agency on her own. Effectively Ms. Camden initiated awareness and guidance to direct Maria. Maria made the decision to contact the team where she received immediate care and direction. Maria received an assessment to determine the extent of her suicidal ideation, depression and thought impairment and agreed to attend individual therapy to address personal issues. Ms. Camden's intervention acknowledged Maria's pain, in conjunction with her own altruistic desire to provide help and comfort for her daughter, in turn strengthening Ms. Camden's executive position as a parent. Also Maria's decision to seek assistance on her own increased her

sense of autonomy and differentiation. In all, this allowed the parental system to function by communicating parenting issues, and the life cycle to move forward.

Another intervention involved giving Ms. Camden homework to plan time away from Maria. Ms. Camden was interested in a healthy lifestyle and consequently encouraged to attend the gym. The intent was to have boundary issues and feelings associated with a low self-concept resolved in therapy.

The therapeutic process was based on the premise that Ms. Camden had a desire to change her life. Through therapy, Ms. Camden was able to reclaim control through validation of past and present-day experiences.

Case Conclusion

Again, as Ms. Camden existed in enmeshed relationships, the therapist had to take particular care in the joining process knowing that Ms. Camden's relating style could be quite suffocating. This remained a challenge throughout therapy.

Ms. Camden and the therapist agreed upon termination of the therapeutic relationship. There were eight sessions in total. The initial goals were realized, and the therapeutic process accomplished in helping Ms. Camden focus on her strengths as a means to broaden her abilities. Therapeutic intervention aided Ms. Camden in differentiating from Maria. The therapist believed Ms. Camden evolved an understanding that using Maria as a crutch to overcome life cycle changes stagnated the family's progression through the family life cycle.

Working with Ms. Camden in therapy was difficult on a personal level as the therapist had to work hard to set limits not to get sucked into Ms. Camden's poor

boundaries and her need to have others define her. For instance, Ms. Camden had difficulty saying no and strived to be liked by others.

Above and beyond, the therapist had to separate personal opinion and judgment to objectively confront Ms. Camden's decisions to remain in an abusive relationship and expose her daughters to further sexual abuse. Supervision and guidance from Mr. Klippenstein was instrumental in helping the therapist remain sensitive. Moreover, using the narrative approach, awareness was based on the societal constraints of oppression where women had to remain with husbands no matter what. By Ms. Camden identifying her choices within a societal context, she was able to challenge constraints and move towards independence. Therapy employed Ms. Camden's strengths of being a supportive caregiver and protective mother.

Only months after leaving her husband, Ms. Camden had acquired tremendous power by using her strengths to their potential. She changed her self-concept and status in society by acquiring full-time employment and becoming health conscious. Essentially, as Ms. Camden's position in the family strengthened, her self-concept was confirmed.

The FAM III General Scale was administered to Ms. Camden as both the pre- and post-test (Appendix D). Ms. Camden scored in the normal range for all subscales except for role performance that was considered problematic. This reflected her failure to set limits with her daughters in how much information to share as a parent. Also, results demonstrated lack of awareness that her marital and parental conduct was creating ambivalence between her and her children. This possibly reflects the fact that her parenting roles were not fitting her family's needs. In all, scores did indicate Ms.

Camden possessed several strengths especially in the areas of affective expression, values and norms, and defensiveness.

The post-test indicated results for role performance fell towards the normal range. This indicated that Ms. Camden's family relationships had improved, which was congruent with insight gained in therapy.

Scores on affective involvement, originally high, decreased only slightly to indicate that Ms. Camden had residual ambivalence in her role as a family confidante. This was understandable as she just emerged from a stressful and constraining marital relationship. Even though she possessed greater awareness of enmeshed relations in respect to boundaries, her family of origin had difficulty recognizing her desire to change. In effect, Ms. Camden was feeling caught in her pre-existing role as family members continued to identify with her in this role as a placator and enabler. In particular, her family of origin was "uncomfortable and agitated" about Ms. Camden disobeying family rules where each family member was expected to surrender their sense of self for the family. Instead, Ms. Camden's legal separation stated she did not want to abandon her sense of self at the expense of her "toxic husband", even though her parents were unapologetic for the shame and guilt they placed on her for leaving her husband.

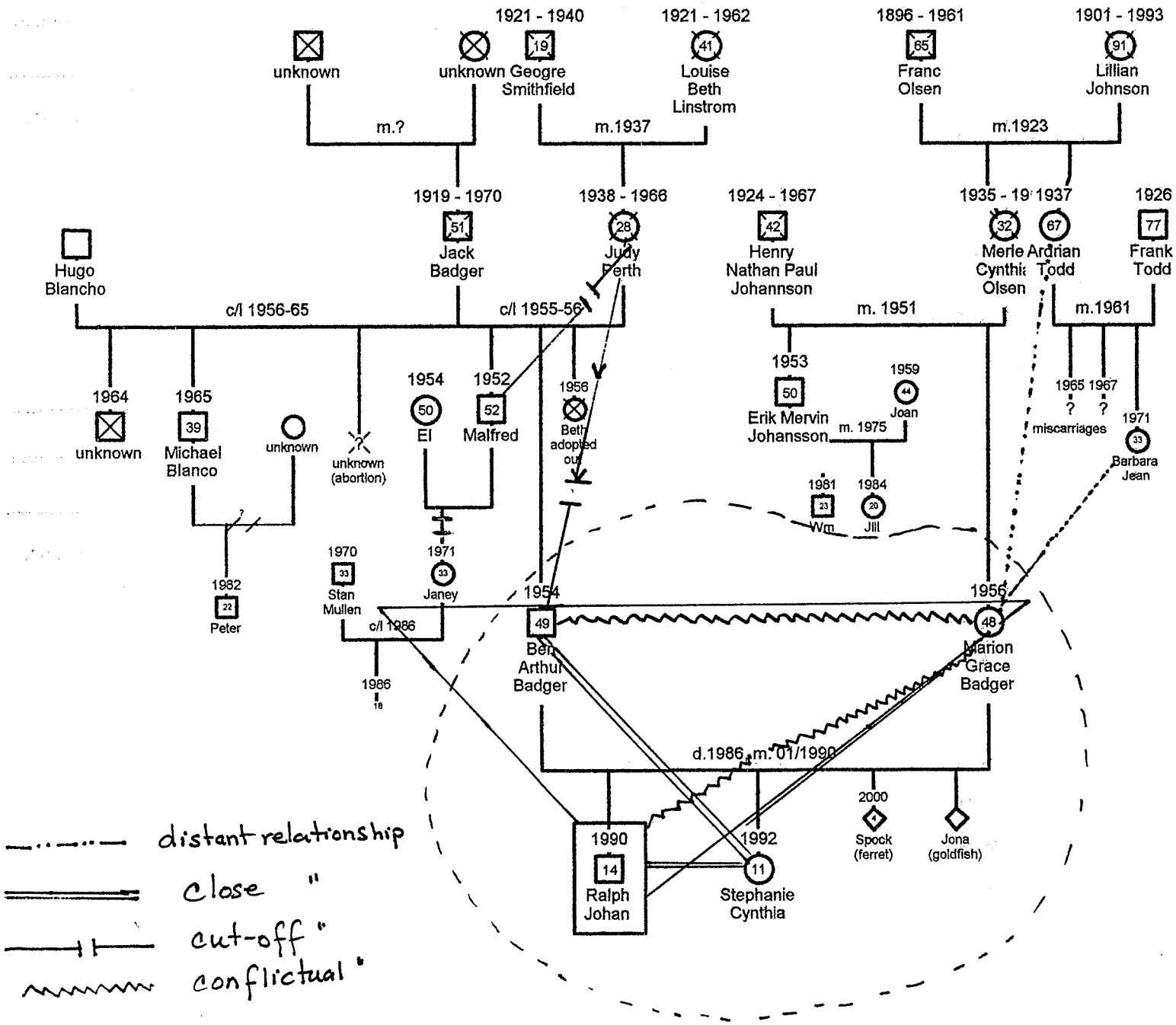
Overall the change in Ms. Camden's FAM III scores from pre- to post-test revealed an appreciation in her movement towards independence for herself and her children. The parent-child relationships were reconfigured as these centred less on Ms. Camden's individuality and safety in her marital and parental relationship, and redirected towards individuality and maneuvering through the family life cycle. Maria was beginning to express optimism about her future and worrying less about her mother's

welfare. Likewise, the alliance between Jenny and her mother against Mr. Camden was becoming less overt. Maria and Jenny were now challenged with forming new relationships with their parents rather then working so hard at trying to keep their parents together in their damaging relationship. On the whole, there were improvements to the Camden family in spite of marital break-up and distant relational patterns with Mr. Camden. The challenge for the Camden family at termination is to continue to seek independence while finding a balance in their crusade to express individuality in a way that they can still maintain family.

My observations confirmed Ms. Camden's testimony to healthful transformation in her nuclear family as well as her relations with her family of origin. She seemed more restful and spoke with self-respect and dignity about the changes made outwardly and intrinsically. Her greatest pride stemmed from Maria's affirmation that her mother is a strong and driven woman who tolerates challenge with a sense of worth and strength. Accordingly, Ms. Camden's personal appearance reflected this as she wore brighter colours, changed her hair to a sophisticated style, chose funkier eyeglass frames, and continued to physically tone her body. I thought Ms. Camden had become more confident and tenaciousness. Then again her FAM III scores established a slightly increased total for control. What did this contradiction mean? I was confused as Skinner et al. (1983) explained scores above 60 to reflect an individual who was too rigid or laissez-faire. It was not until I reviewed my own journals kept after each session that I was able to deduce from Ms. Camden that control and structure were the greatest challenges of her marriage. Nevertheless, her style was flexible enough to allow for spontaneity with her children and her aspirations to come alive.

The primary goal throughout therapy was to put Ms. Camden in charge of her children and her life. Results on the client feedback form (Appendix D) indicated that Ms. Camden had utilized her strengths to initiate positive change in her family and in her life. She improved in parenting her children, as well as learning to continue to take risks towards independence. Ms. Camden stated she found boundary making the most insightful aspect of therapy, as she was learning to recognize when she was enmeshing and scarifying her boundaries in search of validation from others. This also validated the two-fold increase in outcomes from her pre-problem checklist (Appendix D) for items such as relationships between parents and children; dealing with matters concerning sex; overall satisfaction with family; and feeling respectable, and good to one's self. Ms. Camden concluded she was off her anti-depressants and that Maria was no longer experiencing suicidal ideation as Maria continues to meet with a psychiatrist to manage thought processes.

The Badger family Genogram



Dec. 2001

The Badger Family

Reason for referral

The Badger family is composed of Ben (49) and Marion (48) and their two children Ralph (14) and Stephanie (11). Marion contacted New Directions for Children, Youth, Adults and Families to refer her family for family therapy. The parents were searching for assistance in addressing Ralph's disrespectfulness and defiant behaviour. The presenting problem was that Ben and Marion were having a hard time with Ralph's anger and transition into adolescence. In addition Ralph was experiencing attending difficulties at school. At the same time, there was concern that Stephanie was becoming like her brother as she was becoming more assertive. Marion added that Ben was too lenient in dealing with Ralph's lack of respect. Marion said she preferred scheduling family sessions for late afternoon so the children would not miss school, and on account she had several appointments during the day, plus Ben worked days. Marion shared she was on short-term disability.

Brief Description of the Family

Ben and Marion were both separated from their parents at a young age. Ben was placed in the care of an aging grandmother at the age of five when his mother abandoned him. At the age of eleven, when his grandmother passed away, Ben was bounced between group homes. At age thirteen, Marion was hospitalized for several months due to injuries to her upper extremities resulting from an automobile accident that claimed the lives of her parents. For that reason, Marion was placed in the care of a maternal aunt —

a hard-spoken tyrant who emotionally neglected her. Marion rarely spoke with her Aunt Adrian.

Initial Interview

The writer met with Ben and Marion. Marion reported she felt stuck in her depression, which impacted her parenting. Marion charged Ben needed to take on more responsibilities at home, especially with disciplining the children.

Marion presented as a competent, resourceful woman with dramatized emotions that lacked energy due to medical conditions. Her depression was exasperated by a wrist injury that left her temporarily disabled. As a result, she was unable to complete her nursing degree, and work part-time. This left her feeling exhausted, incompetent, and short-tempered especially when family failed to comply with her expectations.

Marion stated that she was comfortable setting limits and disciplining the children when needed. She maintained Ben was having difficulty enforcing rules, and would undermine her authority, upon which Marion burst out in profanities insulting his inadequate companionship and fathering.

Marion was correct that she held too much power and authority in the parental subsystem, affecting an imbalance in the family. The therapist had to remain cautious in not allowing Marion to overpower conversations, as she could become volatile and heightened Ben's guardedness. The therapist used a calm voice to validate Marion's experiences, which helped soften Marion's approach towards Ben. By remaining neutral the therapist blocked the potential of being emotionally entangled with one partner over the other.

Ben was primarily unresponsive throughout sessions, even when Marion was belligerent and blaming towards him. He sat motionless confirming his wife's assertions he was detached. Ben attributed feelings of hopelessness to an internalization of Marion's guilt, rendering himself powerless and ineffective. He charged that Marion threatened to end the relationship if he didn't attend therapy. Although Ben didn't believe this, he believed her hostility would increase. He concluded he wanted Marion to recover from depression, stop throwing things when frustrated, and refrain from using the "f-word".

In all, Ben and Marion agreed depression was impacting their family's welfare, with their greatest concern being the children. Stephanie, their twelve year old daughter, had spoken of wanting to die. She had made one attempt to jump out of the family car while it was in motion. Ralph, age thirteen, was developing poor hygiene and refusing to complete household chores. He was also having difficulty attending while in school. Stephanie and Ralph seemed respectful of their parents, intelligent, and engaged in age appropriate behaviour. The Badger Family seemed tenacious with several strengths to build on and initiate change. For instance, the parents were educated and had assumed advocacy roles on behalf of their children's education.

Marion felt her children needed to be present so the therapist could speak to them about their behaviour. Marion believed her children were rebelling against her on account depression was restricting her caregiving responsibilities. The therapist informed the couple that therapy would work on strengthening the parental relationship, which in turn would impact the children.

It was unclear who the identified patient was in the family. Initially, the parents presented that Ralph was defiant and disrespectful of authority. As the session evolved it became obvious that each family member could be considered the patient.

Family Life Cycle

The Badger family had successfully transitioned through the family life cycle until their children started to enter the adolescent phase of development, at which time Ralph and Stephanie were beginning to individuate and demand more autonomy. Ralph and Stephanie's progression into adolescence enhanced stress within the family, as their parents were already addressing depression and their own family of origin issues.

Carter and McGoldrick (1982) state that anxiety and distress in the family is exacerbated when the adolescent phase of developmental stress intersects transgenerational stress. As parents try to slow down or punish their children's transition into adolescence problems arise out of change. This change is compounded by two entities. First, the adolescent's demands shift interaction and relationship patterns within the family. For instance, the adolescent becomes triangulated into the parental relationship. Second, the adolescent's demands evoke emotions and unresolved issues within the parents pertaining to family of origin issues. Therefore, the emotions Ben and Marion experienced in adolescence were played out in their family of creation.

Because both parents experienced abandonment at this age they were fearful of not providing enough guidance, safety, and care for their children. Instead, the Badgers tried solutions that were detrimental in helping their children's development. In actuality,

the children were smothered allowing little opportunity to develop their own identity (e.g. permitting them little time to socialize with peers outside school hours).

Multigenerational and Structural Assessment

The mutigenerational family framework was useful in transforming family members within the context of their family system, as well as helping them understand their relational patterns. The premise being issues manifesting in one's family of creation will not particularly change until relationship patterns in one's family of origin are identified and challenged. Hence the source of one's problems is best understood by considering the role of family as an emotional unit (Bowen, 1978).

Focusing on separating emotion from intellect was useful in allowing Ben and Marion independence of the self. Thus, differentiation could be strengthened so the parents could do the same with their children. For example, Marion had difficulty controlling her temper as it escalated to where she would destroy property in the home. Also, Marion's emotions were regulated when discussing her family of origin. She worked hard not to cry when discussing her parents' death, while overreaction occurred when addressing Ralph's defiance. From this I saw how emotional over reactivity transpires when emotions override cognition and reason. Consequently, Marion was unable to react differently and became dominated by such feelings (Bowen, 1978). In all, it was difficult to assess whether Marion was manipulating family into catering to her need to maintain control, gain sympathy, or address developmental life cycle issues. Regardless, the therapist assumed Marion's illness and pre-menopausal symptoms played a role.

Like Marion, Ralph had difficulty regulating anger. On the opposite spectrum, Ben appeared void of affect. Marion interpreted Ben's demeanor as an attempt to hide from family issues, including depression. Ben agreed. He revealed aggression and hopelessness "sends me into my shell" — a behaviour he used to block painful memories of growing up with mean-spirited foster parents. Thus, Ben learned to numb emotion. Now Ben recognizes such effects and is fearful his children will react the same. So far Stephanie seemed to have little difficulty regulating emotions however she would distance herself when family argued.

Marion's feelings of loss were owing to premature cut-off by the death of her parents during early adolescence. Marion was conscious her children were now the age when she and Ben lost their own parents. As well, she was experiencing anxiety about her children becoming independent, while reflecting on her own mortality and lifelessness.

Marion and Ben were triangulating Ralph into their conflict to reduce the emotional strain between the couple. Stephanie was also triangulated into her parents' relationship through her expression of suicidal ideation. This was Stephanie's attempt to force her parents to seek help for their irrational relational styles and the effects of depression on the family. Unfortunately, family triangles were discouraging the children from maximizing their coping potentials. Triangulated relationships contributed to confusion and tension in the family unit. It appears once tension and anxiety increased in the Badger family, one relationship became intertwined with the others. Likely, interlocking triangles would manifest within the family had the family not decided to create change.

Sessions utilizing the multigenerational approach gave the couple opportunity to confront the reality of their own adolescence, and the fact depression was ruling the family and couple relationship. Therapy focused on Ben and Marion's self-identifying strengths such as commitment to family, support and guidance for their children, and their desire to show affection and express emotion.

The Badger's failure to share positive feelings made encouragement literally impossible. Each partner developed different coping mechanisms to keep depression at bay. Again Marion resorted to erupting in frustration followed by sobbing. At one point in session, Ben placed his hand on Marion's in an effort to console her. I used Ben's gesture to broaden emotional experience. Ben felt compelled to remain in control of his feelings as a commitment to keeping family worries in check. He stated he loved Marion dearly and wanted her depression free. Marion was astonished to hear Ben express love for her. Here empathetic conjecture was a useful technique to uncover existing emotions hidden beneath Ben's own feelings of oppression.

Couple sessions provided partners the opportunity to express their feelings. Marion was unaware that her husband worried about her. The unreceptive tone of Marion towards her husband transformed to a more encouraging and hopeful one. The couple began to communicate more openly as Ben began challenging and sharing his concerns and beliefs of parenting with Marion. The parenting subsystem was becoming more flexible and understanding. In effect, the couple also worked on improving their communication. Sessions involved interrupting the argumentative cycle, by modeling listening and attending skills in effort to maintain emotional neutrality.

From a structural perspective, the parental subsystem had become fragmented creating conflict among the parents, prohibiting the system from functioning in a cohesive manner. Essentially, each found it difficult to support the other. As Marion became increasingly demanding and confrontational, Ben withdrew. A lack of communication and inability to set childrearing limits posed a lapse in the parenting subsystem creating disequilibria in the couple relationship. The couple had assumed a pursuit/withdraw dance where Marion would approach her husband in order to gain closeness, and then withdraw and verbally attack him when he failed to demonstrate the same. Even though Marion demonstrated that she wanted emotional closeness from Ben, she prevented any opportunity for intimacy. This pursuit/withdraw dance continued and eventually consumed intimate couple moments such as, their weekly coffee dates away from children. Ben and Marion's communication reflected conflict avoidance.

In all, stress between the couple mirrored failure in communication relative to the intrusion of depression. Marion believed her husband was emotionally distancing himself from her, as he didn't understand depression. Capacity for change was a struggle for the family as they were dealing with the intrusion of depression.

Inequality in the parental subsystem revealed an imbalance of power and control in the executive system, as Ben was alienated from decision-making. Issues stemming from Marion's marital and physical issues made her feel inadequate. From Ben's perspective he was an ineffective parent and consequently escaped by playing with Stephanie. By leaving Marion and Ralph to argue, Ben was allowing Ralph to disrespect his mother, creating greater discord.

Incidentally, Ralph's deviance required parental interaction. As Ralph challenges his mother she must involve his father. Thus, the parents must interact, with any luck engaging Ben and freeing Marion from hopelessness. Essentially, Ralph was surrendering to his parents, as his behaviours were intended to move his parents together.

Increased frustration and avoidance amplified family stress permitting enmeshment to overtake the family system. Marion articulated her dissatisfaction with Ben in front of the children, essentially using Ralph as a spectator consequently leaving both parents guilt-ridden. The parental and sibling subsystems were fused and over-involved, especially pertaining to Marion's rigid leadership role.

The boundary around the parental subsystem was once clear and flexible, where Marion was firm with her expectations yet sensitive. When Marion was confronted by depression she assumed a protective role over her family by insuring that the despondency would not consume them. Insightfully, Marion began to realize her effort and expectations were lofty, and insensitive. As well, Ben recognized family leadership problematic and he wanted more responsibility. Boundaries surrounding the marital subsystem became disengaged as these turned rigid, and the partners emotionally distanced themselves from each other.

As Marion's depression was creating frustration and terror among members of the family, a coalition between Ben, Ralph, and Stephanie began to form. Members colluded to share emotions and debrief personal experience with Marion's depression.

Prior to depression, natural alliances existed within the family in relation to favorite hobbies. Ben and Stephanie enjoyed artwork and reading, while Marion would help Ralph with his homework. These alliances were interrupted by depression.

The sibling subsystem appeared typical. Both children played together without much intervention from parents. Their mother's depression only reinforced connectedness within the sibling subsystem.

Ralph and Stephanie had accepted change to the parental and marital subsystem. Both supported one another when their mother confronted them through tyrannical tangents and emasculation of their father. Encouragement for the other fortified a clear boundary around the sibling subsystem. Such care and support was displayed in session. Each sibling answered truthfully and respectively for the other, offering protection when questioned by the therapist.

The structure of the Badger family and their association with their external environment could be considered rigid based on strong parenting and religious beliefs however, this did not appear problematic in their interactions with community.

The pre-test FAM III (Appendix E) showed that Marion identified role performance, affective involvement, and communication as problematic, supporting worries with personal wellness, and adapting to her children's transition into adolescence. These results were concurrent with Marion's belief that she was over-involved with her children, and anxious about transitioning them into adolescence.

Ben's results on the FAM III pre-test reflected those of Marion however, his scores offered a slight worry towards inappropriate expression of emotions by family members. These clinical results supported Ben's revelation that Marion was using control and force to parent. Ben considered social desirability and family norms and values family strengths.

On the initial problem checklist (Appendix E) Ben indicated he felt satisfied or very satisfied with his family while in between for the use of physical force in the family. Ben was troubled Marion's hostility and property destruction would increase. Marion's results pointed to frustration with family roles, emotional expression and the use of physical force. She fared in between for family functioning.

Treatment Goals

1) Teach Ben how to assert himself with Marion and how to take a firm position in parenting.
2) Help Marion engage with Ben in a less intrusive manner.
3) Help Ben and Marion articulate expectations of their adolescent children within therapy and then assist them through role-plays to manage change at home.
4) Reframe and challenge the family's understanding of depression.

Strategies to Implement Goals

1) Teach Marion to speak with Ben in a less intrusive manner.
2) Instruct Marion and Ben in how to form a clear boundary around the parental subsystem while preparing for changes to the family life cycle.
3) Assist Ralph in how to communicate with his mother in a less aggressive manner.

Case Analysis

The therapist assigned tasks to the family to learn to address anxiety and challenge their thoughts on depression. The first intervention involved an assignment

whereby the couple was challenged to plan a date independent of the children. Although, the couple perceived this as an exciting venture and had committed to this on a weekly basis prior to depression entering their life, they failed to complete the task. Marion and Ben were each awaiting the other to plan the task. I learned I had mistakenly assumed that the task would repair the couple union since this had been routine. However, having Ben and Marion return to date night did not fit the couple's reason for referral. Therefore, it was doubtful that they would understand the task would indirectly influence their children's communication patterns, consequently contradicting their own assumption of how children need to progress through the family life cycle.

Second, assigned tasks were aimed at resolving structural problems involving Ben and Marion in meeting with their children to establish household rules. Even though Marion had pressured the therapist to do the same with her children in session, she recognized how empowering the task was. The therapist instructed both parents to alternate being in charge of the task. The assignment would force family members to discover new, constructive transactional patterns, and foster role flexibility between parents.

Using circular questioning to determine the degree of fusion between the couple accomplished resourceful techniques to address confrontation during assigned tasks. What's more, the couple learned to become skilled observers at regulating emotions and moving towards objectivity. Questions that helped the couple think how their family interacts were (a) what are some other responses you (Marion and Ben) may consider should Ralph's present approach not be respectful towards you and not transform him, and (b) Ben do you want to continue to react to Marion in ways that keep problems going

or do you want to feel more in charge of your life? As these questions are asked of individuals as part of a family unit, processing the experience was helpful in assisting family members differentiate from their family of origin and their family unit. This was of particular importance for assisting Ben and Marion to facilitate a healthy transition for Ralph and Stephanie into adolescence.

Too, couple sessions discussed the family life cycle in accordance with expectations relating to the developmental stage of both the children and parents and how these intertwine. Individual roles and expectations were discussed based on the age and sex of the children.

Homework was congruent with the family's goal for therapy. The assignments focused on requiring change (Minuchin & Fishman, 1974). To ensure this was a collaborative task and not a directive from the therapist, role-play was used to facilitate parent confidence to initiate tasks. This prepared Ben for possible disagreements with the children.

Enactments and role-plays appeared to be effective for addressing problems, rather then merely talking about these problems (Colapinto, 1991). What's more, enactments helped block existing patterns, determine the family's adjustment to different roles, and challenge members to try more practical rules. Accordingly, structural family therapy perceives family membership in a social context.

Structural therapy was useful in helping the family to achieving their shared goal of freeing "the family symptom bearer (Ralph) of symptoms, to reduce conflict and stress for the whole family, and to learn new ways of coping," (Minuchin and Fishman, 1981). Equally Minuchin (1974) articulated that the framework is directed toward changing the

organization of the family. When the structure and the position of members in that group are altered, individual's experience change.

The family reacted in various ways to their assignment. First, Ralph testified he was grateful for the chance to speak and discuss concerns without his mother shouting. Hearing this, Stephanie agreed. Second, she said it made her feel older and more responsible. Third, Ben said he felt some uneasiness with his new authority nevertheless, empowered as a father. Fourth, Marion described how hard it was to share the power yet was committed to giving her husband room to be in charge. .

The structural perspective was beneficial in working with the sibling subsystem. As the therapist offered that their mother's problem was not depression but a desire to help her children into adolescence, the therapist requested that the children speak to how they would address their mother's temper tantrums, and anxieties with their teenage years. Watching the interaction the therapist would raise her hand to stop the children from being disrespectful towards their mother. Similarly, the therapist observed a session between parents and children again, stopping the children from interfering in their parents' discussion. The reverse was accomplished to set boundaries around the sibling subsystem. In addition, reframing helped Ralph and Stephanie understand tension within the family structure, contributing to individual and interpersonal conflict. Then, one sibling does not assume the absolute guilt or blame for their mother's depression or sole responsibility for resolving it.

The sibling session also allowed Ralph and Stephanie opportunity to testify to positive change in their family, as their parents sat behind the one-way mirror. This presented an opportunity for the children to voice worries and anxieties about the family

and how these changed. This helped the therapist substantiate whether the parental subsystem was becoming a flexible executive system. Meeting independent of the parents gave Ralph the chance to express how his mother's depression impacted his emotions and struggle for independence. Likewise, Ralph felt guilty burdening his mother. For instance, he dropped out of sports, as she was increasingly concerned for his welfare. Therefore, with more restraints he became increasingly frustrated and began to emulate her mannerisms to gain attention to his dilemmas. Stephanie believed their mother's depression improved the sibling relationship. Too, separating children from parents and discussing the impact of the boundary around the sibling subsystem, autonomy from the parental subsystem was being formed. Sitting behind the mirror gave Ben and Marion insight into their children's concerns about growing older, compounded by the interference of depression.

The narrative perspective of family therapy was useful as relative influence questioning deconstructed the oppressive narratives of Ralph's fusion with his problem (anger). Mapping the influence of anger on Ralph's life was a remarkable experience for the client and therapist as it began an exploration into Ralph's relationship with anger. Externalizing deconstructed Ralph's entanglement with the problem and objectified it as external — outside of him and his family. This was valuable in helping Ralph monitor his own power in the life of anger. Ralph became expressive:

> "I just explode too much when I can't control my anger. My mother makes me angry and I explode. It (anger) feels like this swarming black cloud lands on my head, and then it (anger) just rips my head off (laughs). It's like my head blasts off and all the anger oozes out…Afterwards my head aches and I wanna take it (the anger) all back… I wanna tell her (Marion) that I'm sorry and that I didn't mean to be mean to you (Marion). I know my anger causes a lot of problems for my mom and dad."

For that reason, externalizing questions were significant in helping Ralph recognize he had control over anger.

Therapist: What is the purpose of the anger?

Ralph: To get my parents to stop arguing. I figure if I say something I can get them to stop.

Therapist: And do they manage to stop?

Ralph: (Shakes his head) No.

Therapist: So you think anger does not fit here.

Ralph: No it doesn't work. And it doesn't fit either.

Therapist: So anger doesn't fit for getting your parents to stop arguing? But it keeps exploding and getting you involved?

Ralph: (Nodding yes) And getting me in trouble.

Therapist: So, does it seem to you like you are in charge of your life, or does it seem more like what happened to you is a fluke or interference?

Ralph: I don't know what happens when anger happens. I don't know if I can stop it 'cause it takes over my concentration.

Therapist: How does it steal your concentration and take you under its control?

Ralph: It gets really loud and mean [the arguing] and I get frustrated with the arguing and it just happens. I guess I let it take over.

Therapist: So does the anger make you feel active or passive? Are you like a boat on the river that fights the waves, or do you allow the waves, the anger, to carry you.

Ralph: Passive I guess — I'd let the waves carry me. It's fun.

Therapist: Have you ever been on a river? If you have you'll remember that rivers have currents?

Ralph: Yeah, at camp we learned to paddle. I've seen currents. You can get caught in them. It's like having to paddle against the wind. It's hard. Currents and winds are very powerful. You have to paddle lots.

Therapist: So, you managed to paddle against the waves and the wind?

Ralph: Yeah. I guess I just learned. It took a lot of work and a lot of muscles.

Therapist: So, if you can take control of the currents what are you doing to allow anger to be so powerful?

Ralph: I don't know.

Therapist: What does the anger need you to do?

Ralph: I don't know. Get in trouble. Lose control.

Therapist: What would it look like for you to stand up to anger?

Ralph: I guess I'd just have to say stop in my head. Take more control and stop before I start — when I hear them yelling. Just don't start the anger.

The therapist then probed for other examples and occasions when "anger exploded" to help Ralph chronicle his influence over the anger. Using the narrative process with Ralph was effective in evoking thought about what kind of future he would have without anger, being the strong skillful person that he is.

In session Ben described depression as like an insatiable monster that kept growing when watered with constant worry and overexertion. Marion added it seemed liked a grey cloud held over the family that continued to grow and "hold them (the family) down." Ben's and Marion's illustrations of "depression" made the therapeutic process easier as they already viewed their problem as external to themselves. So, therapy focused on depression as an independent functioning member of the household, with its own separate identity. Depression was considered a selfish entity, demanding its own schedule, assuming its own roles, consuming family finances, and intruding on healthy relations. Depression was bringing forth anger, creating fear and stress, and causing isolation among family members. Thus, as therapy progressed Ben and Marion were able to identify unique outcomes to their situation. They spoke of ways they were able to overcome previous sadness, isolation, and physical impairments, in favor of independence. Marion recognized that by internalizing her depression she continued to have people rely on her. On the whole, praise was given to the family for reauthoring their stories as that of survivors rather than victims of depression.

To empower Ben and Marion individually and as a couple, the therapist helped identify circumstances in which they made favorable choices for themselves, their relationship, and their family — a time in which they took a stand against depression. A result of observing unique outcomes, and facilitating alternative narrative, enabled the couple to focus on success and perceive themselves as competent people. Unique outcome stories were then developed into solution stories by means of circulation questions (e.g. now that you have successfully reach a point in your life and with your partner, who else should know about this?), which the couple was able to share with their children.

Deconstructive listening helped to liberate the couple from Marion's externalized depression and allow her to develop coping strategies as well as relinquish her constrained role over the family. Consequently, Ben became more involved in parenting, as Marion recognized his ability to parent. Together the Badgers noticed their efforts made Ralph more respectful and accountable around the house. As well, Stephanie no longer spoke of wanting to harm herself. Toward the end of therapy, Marion returned to part-time work with a sense of well-being.

Time was also spent discussing dominant cultural narrative regarding gender role socialization and the message parents pass to their children. Marion cherished the memories of her mother as nurturing and strong. Even though Ben lacked a primary male caregiver he felt societal pressure to be the "man of the house". Ben acknowledged he didn't feel worthy of the role as he was not an assertive individual. Yet, he would appreciate Marion giving him more opportunities to prove himself. Discussion on role socialization proved enlightening for Ben and Marion. Marion realized she accepted that

her husband should be the head of the household when in fact she was initially doing well in her previous position, albeit overly autocratic. Also, societal expectations challenged Ben's caregiving beliefs. By using the narrative Ben gained freedom from the dominant stories of effective parenting without the father having to dominate his family.

Narrative therapy was helpful in working with Ben who was initially reluctant to speak, as the couple began to understand that each other's behaviours had been exacerbated by the depression and sense of loss. In summary, directing family members' frustration at depression rather than on Marion, the family was able to lessen their guilt, thus bringing the family closer. Therefore, the therapeutic goals were met as each learned to support the other and discuss family issues separate from their children. Mostly therapy provided the therapist and couple with awareness on how reasoning and multigenerational practices and patterns direct the family's organization of meanings about health (i.e. depression), family roles and control, respect between subsystems, and what can affect progress. In addition, the couple increased their understanding of the significance and influence in development surrounding values and stories around illness, positions on gender and appropriate care giving.

The last session provided an opportunity for the therapist to summarize the family's victory over depression using Robert Munsch's 1997 The Dark as a summarizing metaphor to reframe the family's experience with the intrusion of depression and anger in their lives. Storytelling also celebrated the end of therapy as well as validated the family's strengths and tenacity.

Previously "problematic" pre-FAM III scores in role performance decreased to within the normal range. This reflected Marion's and Ben's increased acceptance that

their parenting and couple roles were no longer meeting the needs of the family. They recognized throughout sessions the need to relinquish trying so hard to keep their family together, and direct their responses to the natural developmental challenges of the life cycle with acceptance rather than adversity. The latter would agitate their children into defiance.

Marion's pre-FAM III scores on affective involvement were problematic from which I understood she was dissatisfied with her involvement in family rendering feelings of inadequacy, insecurity and resentment. I believed if this reflected initial feelings that family communication was insufficient and that her relationship with Ben lacked mutual understanding. In spite of that, both Marion's post-FAM III and problem checklist indicated a two-fold improvement in family relationships, communication patterns, and role performance. As well, Marion's client feedback form (Appendix E) declared her family had made great strides towards "more respectful communication with less angry outbursts and more willingness to resolve issues". What's more, the couple relationship was regenerated as both parties spent more time together.

As a therapist and evaluator I was perplexed with Ben's scores on the pre- and post-FAM III, and my observations in sessions. What does it mean when evaluation scores were moderately unchanged, still the family and therapist witnessed notable improvement? In hindsight another empirical measure may have provided greater insight into existing strengths and problematic areas of the family and conflict relationship.

Even though the post-test FAM III scores indicated an overall improvement in family functioning I questioned whether the presenting issues were constant or reflective entirely of the distress the family faced in reaction to Marion's illness, and once her

medical symptoms subsided all became better. Too, Marion's explanation of the presenting issues were not reflective of her answers on the initial problem checklist as she noted relative satisfaction in family relationships with frustration linked to expression and interpretation of emotions. Alike, my disbelief with the Badger's FAM III scores, Skinner et al. (1984) stated results can be influenced by the client's emotional state and degree of motivation since these ultimately mirror family functioning at the time of assessment.

Contradictory viewpoints between Marion and Ben post-FAM III results on values and norms give notice that Marion remained concerned about family social desirability though this contradicted her presentation in sessions and on the post-problem checklist. Post scores indicated the couple was satisfied that family rules were subverted by unspoken rules, greater than that of the culture and environment in which the family lived.

Again I was puzzled. What does it mean when Marion's post-test score on social disability swelled to the problematic stage while the family identified change for the positive? I speculate that I may have not obtained enough information on the family's religious beliefs and its incorporation into the culture in which they live. The same for identifying family strengths, I may have provided parts of the family unit with positive strokes based entirely on my understandings in turn possibly leaving the family to feel dejected.

A third bewildering incident occurred with the Badger's client feedback form which revealed that Marion had loosened up affording her husband more control, responsibility, and authority as a member of the household and as a parent. In contrast,

the problem checklist and FAM III scores revealed otherwise. I disagreed with the evaluation results. What does it mean when evaluation results remain relatively unchanged yet the family and researcher have observed a shift in therapy? Although Marion improved her hostile tone and desire to control, these remain problematic. The FAM was not presented to Stephanie and Ralph.

The post problem checklist depicted that Marion had progressed from in-between to satisfied on several areas concerning family including the use of physical force and the amount of autonomy each parent had in the family. Ben's scores reflected that of Marion's. I sensed a shared responsibility within the parental subsystem to cooperate in finding alternative strategies to consequence and discipline the children. Marion encapsulated her self-descriptive transformation in the therapeutic process from a "depressive and confined individual" to a "real butterfly." Stephanie and I valued Marion's analogy.

Foremost, the client feedback form established that Marion and Ben felt positive about the outcome of therapy as their "family structure improved". Too, family members seemed more comfortable and respectful expressing feelings as they continue to develop techniques for solving frustration. Altogether, it appears that the parental subsystem became conscious of the effect communication patterns had on the child and couple relationship.

Case Conclusion

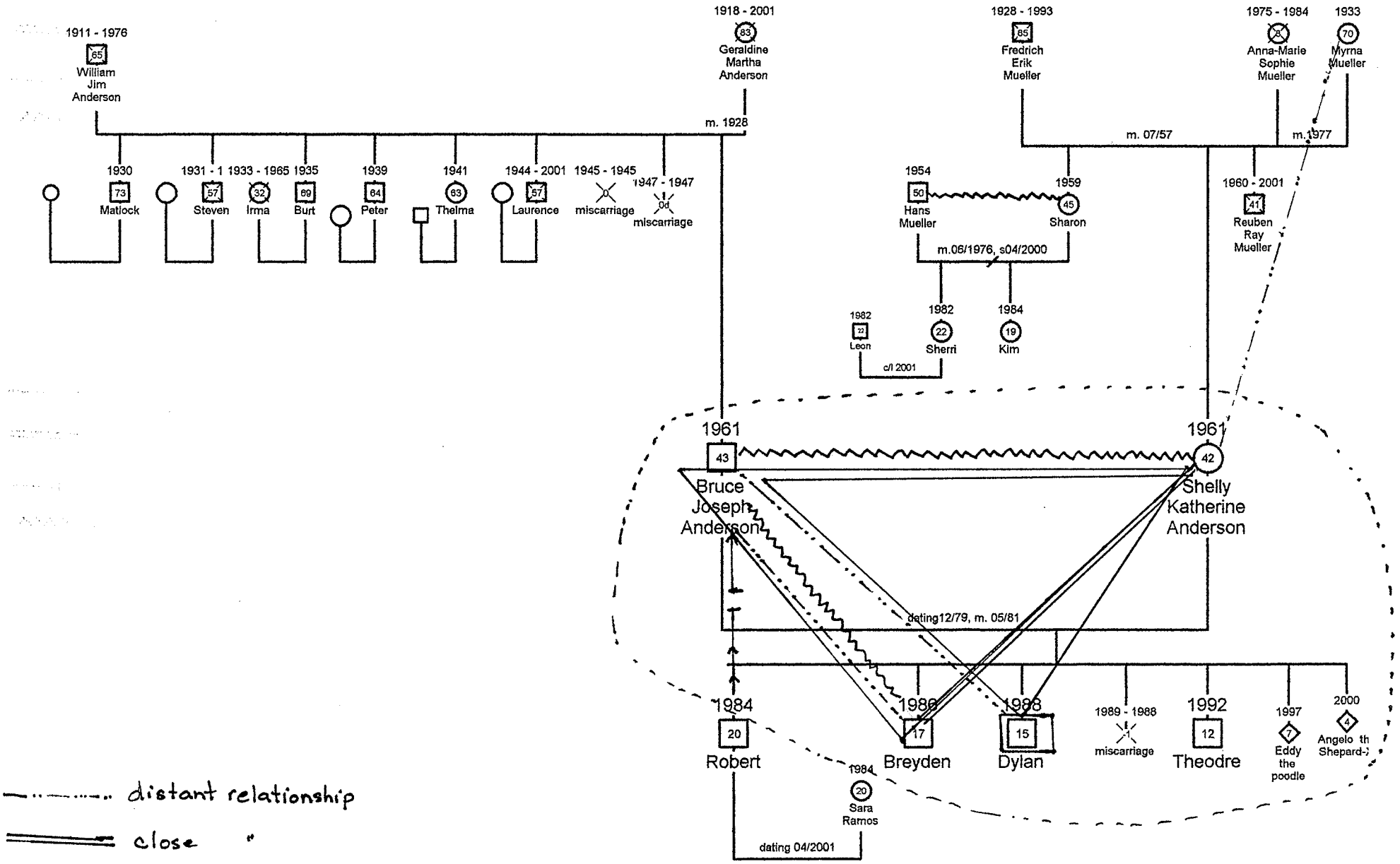
I gained knowledge of how mental illness can exert a centripetal pull on the family unit. The onset of depression in the Badger family activated centripetal

progression of interconnectedness with the disease (Beavers & Voeller, 1983). Association with the illness altered family symptoms and roles, consequently changing family equilibrium. Thus, since the onset of depression corresponded with a centrifugal phase in the family life cycle, the family became stuck and disorganized as they attempted to adapt. In consequence of working with the Badger family I become aware of Bowen's view of illness as a threat to family equilibrium. Bowen (1978) viewed anxiety as a threat to normal family equilibrium in which heightened anxiety emerged as depression. As equilibrium in the family shifted, once effective coping mechanisms were no longer useful in reducing anxiety and tension. As a result, interpersonal and systemic stress developed into symptoms and emotional sickness. Ben's reaction to Marion's stress determined the degree of influence the couple could endure.

Through supervision I also recognized the difference between Bowen and Minuchin's definition of triangulation. Bowen focused on the historical origins of anxiety while Minuchin addressed issues in the family's present interactions, with all members involved in the triangulating. Minuchin's three components of triangles are always individuals while Bowen includes objects, material items, or individuals as potential third parties.

Structural therapy was useful in assessing family dynamics, while narrative therapy was used to intervene in the family. I learned to integrate the structural approach by way of the parental subsystem with the narrative approach with Ralph and Stephanie. Narrative techniques were useful in having the couple experience depression as a manageable third entity, and a meaning of self, while Ralph and Stephanie gained a sense of autonomy and strength.

The Anderson Family Genogram



Oct. 2001

The Anderson Family

Reason for Referral

The Anderson family consisted of Shelly (42) and Bruce (43) and their sons Theodore (12), Dylan (16), Breyden (18), and Robert (20). The initial referral came to New Directions for Children, Youth, Adults and Families as an ongoing case from the school psychiatrist who was treating Dylan's ADHD (Attention Deficit Hyperactivity Disorder). The main issue affecting Dylan and his parents was Dylan's diagnosis of ADHD and anxiety, as well as academic difficulties and parent-child conflict. Dylan had been seen by his psychiatrist for both individual and group therapy to address his diagnoses and anger management issues. The psychiatrist had recently begun psychopharmaceutical treatment to help Dylan with concentration and impulsiveness, while encouraging Shelly and Bruce to seek family therapy to address associated parent-child conflict.

Brief Description of the Family

The couple had few supports in the city, as the couple married young and moved to Winnipeg leaving family in Eastern Canada. Bruce's parents both passed away, while Shelly's stepmother, diagnosed with Alzheimer's, resides in a nursing home in St. John. Shelly's biological mother died when she was fifteen years old. Shelly's father married a few years later. He passed away from cancer in 1993. She has no real contact with her stepmother. Bruce and Shelly speak with family from time to time. Shelly stated that she had a few friends from work however family responsibilities consumed most of her time. Bruce said being employed nights left little time for socializing and family. Years in a

hectic supervisory role and a chaotic work environment, contributed to Bruce being diagnosed with depression in 2001. Six months ago he moved to daytime employment as a dockworker effectively reducing his depression. Shelly and Bruce agreed the small decrease in pay was worth the financial stress of relieving Bruce of depression. Immediately prior to Bruce's decision, Shelly transferred in her place of employment from a line worker to an accounts payable position. The position motivated Shelly to take courses at Red River College with the intent of obtaining her diploma. Even though her employment was reduced to half time, Shelly chose to remain in the position. Bruce supports Shelly's choice though he is concerned they won't have enough time together.

Shelly and Bruce have been married for twenty-three years with four sons: Robert; Breyden; Dylan; and Theodore. The couple describes their marital relationship as mostly satisfactory, with the occasional crises. Both agreed the past few years have been the most tumultuous due to Bruce's employment-related stress. Bruce said that he had attempted to shelter his family from the pressure however this became impossible when Breyden was employed at the same plant, much to the disapproval of Shelly and Bruce who had wanted Breyden to pursue mechanics at technical college. In fact it had always been Breyden's goal to complete vocational high school and enter automotive studies at Red River College. Consequently, tension between Bruce and Breyden often erupted into verbal and physical confrontations. Shelly's voice tensed explaining her disgust with her husband's challenging conduct. Shelly believes Bruce should take medication to control his anger and frustration, symptomatic behaviours of ADHD.

Son Robert moved into university residence one year earlier as part of an athletic scholarship. Breyden's time was spent working in a manufacturing plant with his father,

spending time with peers, and rebuilding an old car. Four months after the referral, Dylan had stabilized on his medication and was no longer struggling academically. He had also been employed part-time for two months, with no remarkable behaviour issues. Theodore is a respectful twelve-year-old who excels socially and academically.

Initial Interview

Shelly and Bruce attended the initial interview. Shelly presented as a capable, resourceful mother who was angry and determined to confront her husband's explosive manner towards their children, particularly Breyden. Shelly charged Bruce must interact differently with the children, as he is pushing Breyden and Robert away from the family. Shelly overheard Breyden telling Robert that he wanted to leave home and enter the military to escape their father's tyranny.

Bruce admitted he needed to gain control of his temper, as he found it difficult to talk with Breyden, and had noticeably seen little of Robert in the past several months. Bruce confessed he was at a loss in dealing with Breyden's poor employment choice. Bruce also admitted occasional jealousy of Shelly's relationship with their children, particularly the two eldest. Bruce confessed he wanted to be equally comfortable and open to communicating with them. He had considered taking Ritalin to resolve the issue and make Shelly happy however the side effects were too bothersome. Bruce appeared to genuinely care for Breyden even though their relationship was conflictual. What's more, Bruce showed an interest in wanting to be more responsible in the home (e.g. cooking, cleaning, and child care) yet he was at a loss in how to please Shelly.

Shelly remained quiet when Bruce spoke. Still, she looked visibly injured and frustrated by Bruce's explanation. She acknowledged that she wanted Breyden to attend college and remain at home as he earns money for school. She noted that, Robert was beginning to stay away from home as conflict between Breyden and his father was escalating. Bruce appeared pained and physically uncomfortable by Shelly's comments. He leaned towards Shelly and, taking her hand, he apologized saying that he was now with her in therapy to resolve such issues. Shelly pulled her hand away, and firmly commented that she was afraid of her husband's temper. Although he had never hit her, he had damaged the family room months earlier. The incident occurred after Breyden and Bruce returned home from work. Father and son became involved in a physical brawl throwing things, damaging family possessions, and cracking walls. Although no one was hurt Shelly was fearful of a reoccurrence. Bruce expressed his distress over Shelly's fear, assuring her no reoccurrence would occur. Shelly continued to state that she was uncertain whether she wanted to remain in the marriage, as she could never forgive herself if Bruce's anger injured the development of their children. Bruce was stunned by her comment. She believed her decision to leave Bruce would indeed impact their sons but overall it was for the best. She revealed she had contemplated this for some time and needed a safe environment to express herself. Shelly clarified she was not afraid that Bruce would intentionally harm anyone but she was afraid her thoughts and feelings would not be effectively addressed.

The therapist informed the Andersons that sessions would focus on meeting with the couple independent of the children an effort to concentrate on their roles as parents in

a couple relationship. Sessions with parents would create a clear boundary around the parent-parent and parent-child subsystem.

Assessment

Family Life Cycle

The Andersons were scaling four developmental stages. First, they were a family with a pre-adolescent child. Theodore is at the stage were he still requires parental guidance and structure, while his peers are becoming central in his life. For instance, his curfew has been extended to allow him more time with peers and involvement in social activities like sports. Second, Shelly and Bruce have an adolescent, Dylan, who wants more autonomy and independence. Third, the Andersons were launching adolescents into adulthood. Thus, they needed to create boundaries that were more flexible to allow Breyden, and to some extent Dylan, the opportunity for individuation to differentiate from their family of origin. Breyden's parents were in essence chocking him and interfering in this process. Likewise, Robert was having some difficulty with the latter as his mother was holding him back as a confidant against his father. This leads to the fourth stage, the empty nest, which the Andersons were beginning to navigate. This included exploring the marital relationship and the midlife stage of the life cycle without the presence of their children.

In terms of the parents fulfilling their responsibilities in response to the previous four developmental stages, Shelly and Bruce had to negotiate midlife. In midlife parenting children in adolescence or entering adolescence brings unique challenges. At a time when parents are becoming increasing aware of their own mortality and limited

options their children cause forgotten ambitions and past compromises to surface. Primarily, adolescence is a time of budding sexuality and physical maturing, leaving parents to consider existential issues of sexuality and physical attraction with the likelihood of these fading over the years (Preto, 1999). As well, raising adolescents is demanding as youth challenge the value and significance of nearly everything for which their parents stand.

Parents in midlife anticipating the launch of their children are forced to make tremendous shifts in their marital relationship. Couples who used their role as parents to "glue" their interaction together are no longer "bonded" together as a couple and each partner is forced to focus on the other's interpersonal needs. Couples with long-term conflicts may have difficulty adjusting to the tension, which remains unresolved ultimately transpiring into feelings of indifference about the future of their marital relationship.

Structural Assessment

The Anderson family has characteristics of both an enmeshed and disengaged family. As Shelly's relationship with Breyden became an enmeshed subsystem this disengaged the parental subsystem. Shelly has always been close with her sons; Bruce has been predominately disengaged.

The Anderson children are relatively independent of each other. Each is able to appreciate the other's uniqueness in opinion and choices. Arguments are particularly rare as each of the children attend their own schools and social commitments. Although Bruce has changed his work schedule to spend more time home, he still functions as a peripheral parent and, he is having difficulties establishing himself in his household.

Shelly does not agree with Bruce's discipline techniques, as she finds these too emotionally and physically abusive. Bruce believes he can become a better communicator and father to his children.

The hierarchical structure of the family is seemingly that of a single parent family with Shelly being the head of the household, and Bruce entering into the family unit. Difficulties in parenting and couple relations arise from Bruce's age inappropriate behaviour with his young adult sons. Bruce often resorts to bullying techniques to fight for his position in the family hierarchy as well as his relationship with his wife. Bruce's attachment with Theodore and Dylan appeared age appropriate.

The distribution of power and the development of a hierarchy within the Anderson family system resulted in rigid family patterns that hindered autonomy and individualization. For instance, a cross-generational coalition occurred when the couple system became stressed. The couple transferred their conflict to Breyden and Robert in an unconscious effort to acquire their sons' support against the other parent. Shelly understood pressure on the couple system to be a result of her husband's ADHD. In a similar manner, cross-generational coalitions have been found in families with psychosomatic sickness (Colapinto, 1982).

Family pressure and ill health evolved from the developmental change of family members and the influence of societal institutions (e.g. the school and the workplace) on the overall family unit. Minuchin (1974) asserts all families have some intrinsic drawback, which overrides the unit's ability to cope. Hence, the family's ability to challenge and adapt to patterns of transaction no longer meets the needs of its members.

In effect Bruce' was treating Breyden as an adolescent rather then a young adult who deserves independence.

A number of triangles existed in the Anderson family, the first triangle being between Shelly, Breyden and Bruce. This triangle served to protect Breyden physically and emotionally from his father's disapproval and anger. Shelly acted as an intermediary to keep husband and son safe. Similarly, the second triangle between Shelly, Dylan, and Bruce survived to protect Dylan from negative messages Bruce directed at his son's behaviour. In the third triangle Robert acted as a confidant to his mother against his father.

Shelly's test results showed she was satisfied with most family issues. She progressed from being dissatisfied to satisfied about feeling good about herself. Also, she indicated she felt more satisfied with her family's display of feelings; using appropriate discipline; taking more responsibility; and the use of physical force. Bruce felt very satisfied with using suitable discipline and consequently a reduction in the use of physical force. He also indicated that he was very satisfied with handling anger and matters concerning sex.

Results of the initial problem checklist (Appendix F) revealed that Shelly and Bruce equally rated their couple relationship, as well as their parent-child systems as dissatisfied. Likewise, they felt dissatisfied about themselves, and scored alike on the initial FAM III (Appendix F) profile indicating unhappiness with task accomplishment, communication, and involvement. The couple did believe their family strong on social desirability and defensiveness.

Multigenerational Assessment: The Genogram

The multigenerational perspective utilizes the family genogram to illustrate presenting problems in the context of the family with the purpose of focusing on facts surrounding the family system (Bowen 1978):

1) During the surfacing of the presenting problem;

2) At the time of Breyden's birth; and

3) Breyden's birth order.

Shelly and Bruce's problems with Breyden began in September 2001 and came to a head in June 2001. At that point, Bruce had transferred from a supervisory role to that of a dockworker due to job dissatisfaction and a resulting diagnosis of depression in May 2001. In February 2001, Bruce's mother was diagnosed with terminal brain cancer. She had lived with Bruce's sister Thelma since 1986 when their mother suffered a paralyzing stroke that left her unable to speak and care for herself. Breyden's paternal grandmother had since developed dementia. She died in June 2001. Around this time Shelly was on a leave of absence nursing her brother who was comatose resulting from a heroin overdose, from which he never recovered. Reuben was removed from life support in March 2001. He was a classmate and dear friend to Bruce up until Reuben was diagnosed bipolar. In fact, Bruce met Shelly through Reuben. Reuben had struggled with substance abuse since adolescence. Because Shelly and Bruce were consumed with their own grieving for both Reuben and Bruce's mother neither felt the other particularly supportive. In addition Sharon, Shelly's sister, filed for divorce from her husband of twenty-one years, as he was unfaithful. Shelly and Bruce described Sharon's second daughter as a spoiled,

self-centred, burden on her parents as she chummed with "unsavory street characters". Sharon's eldest daughter was engaged and living common law.

Throughout this time the Anderson sons were also reacting to stressful transitions in their own lives. Robert was awaiting news of an athletic scholarship to enter university. Dylan was placed by his parents into a behaviourally inclusive classroom located in a junior high separate from that of his peers. Similarly, Breyden transferred into a vocational high school to study automotive mechanics. Breyden had to sacrifice several hours on the bus as well as after-school activities with parents to attend this particular school, while all the brothers had to take turns caring for Theodore.

Presenting problems came to a head in June 2001 when Breyden refused entrance into college, deciding to work with his father instead. By coincidence, Breyden was at the age that his father was when he had to leave home to support himself and forgo his college education. Shelly also noted that Breyden was at the same age at which Reuben dropped out of school and became heavily involved in drugs and crime.

Consider the emotional climate into which Breyden was born, as there were several significant family events. First, Reuben was diagnosed as bipolar. Shortly after, street drugs left him cognitively impaired. Second, Bruce accepted a management role at work during a violent strike at his worksite. Third, Bruce's mother was beginning to exhibit signs of dementia for which her children were embroiled in a heated battle in how to care for her.

The Anderson genogram depicts rigid and stereotypic male role models. There are the tyrannical men who appear emotionally distant such as the maternal grandfather and Bruce. Then there are men who self-sacrificed for their family such as Breyden's

paternal grandfather who died in a farm accident and paternal uncle who died in the Korean War. Breyden's father had also sacrificed his education for the benefit of his mother. He married and left home so as not to be a financial burden on her. Now Bruce is reminded of his loss of educational opportunities through Breyden's dismissal of post-secondary education. The impact of these male role models on Breyden may lead him to become a problem child like Reuben, a tyrannical individual like his paternal grandfather, self-sacrificing like his father — or defiant from these roles altogether. This remains unknown until one or more family members learn to reposition in a different way, the likelihood is that the patterns of the past will be repeated.

Hypothesis

The therapeutic hypothesis was that the Andersons lacked clear boundaries around their role as parents, while their couple system was disorganized. I believed their lack of co-parenting challenged the parental unit when Bruce became more visible in the home and tried to pick-up as a parent without understanding the dynamics of the household or appreciating Shelly's role as parent. As I observed the couple's interaction and listened to their narrative, I realized while Dylan's diagnoses may have been the primary source of his difficult behaviour, still a fraction of his conduct was attributed to his parents' poor adaptation to change. In addition, Bruce has not appeared to encourage Breyden to develop autonomy from him and seemed content to have Breyden remain in adolescence. Bruce believed Breyden was defying his parents by not pursuing secondary education, and Breyden's defiance was prohibiting him from seeking suitable independence and responsibility. Consequently, intervention would focus on restructuring

the couple relationship, and solidifying their parenting roles. Shelly seemed to parent independent of her partner and she needed to learn how to involve Bruce. In particular, he needed empowerment in his role as a parent so he could assume a more appropriate role other then an individual feared by his family and himself.

Dylan was initially believed to be the identified patient but it appears that his symptoms, ADHD, and a learning disability were exacerbated by his parents' adaptation to change in the family, and his mother's animosity to his father. From Shelly and Bruce's presentation it became obvious that the couple subsystem was the patient, and their children the wounded.

Shelly and Bruce were having a great deal of anxiety in their parenting and intimate relationship which seemed more noticeable to Shelly. Attempting to decrease the anxiety and stress and gain stability in the parental subsystem, Shelly recruited Breyden into the parental subsystem. Since Bruce was becoming more involved in the home he was unknowingly crossing over into Shelly's roles as a homemaker and a caregiver. As a result, conflicts arose. So, instead of resolving this as a couple they focused their attention on Dylan who was entering high school with a lack of confidence owing to his impulsiveness and reading disability. As Dylan became stabilized through medication, psychotherapy, and appropriate special needs education, his parents were no longer able to recruit him to balance out the system. Since Shelly and Bruce had not resolved their conflict, they triangulated in Breyden who was hesitant to enter college. If Breyden were to leave the home the couple might shift distress to their remaining sons, begin to fight openly, or file for divorce. Because the family is a system, change in one part of the system affects all other parts (Bowen, 1978).

Role of the Symptom Bearer

Dylan and Breyden's behavioural issues served to detour Shelly and Bruce from their own developmental issues of midlife and marital discord.

Treatment Goals

1) Clarify the boundaries between father and sons in order that Bruce can support the developmental needs of his children.
2) Strengthen the couple bond and protect it from the other subsystems, e.g. the influence of Breyden.
3) Challenge the couple's complementary relationship, and assist them in negotiating functional roles within the family system.
4) Redefine the couple's past, present and future to help Bruce and Shelly gain strength from their earlier years together to generate new visions for their second stage of life together.

Strategies to Implement Goals

1) Help Bruce engage his children, especially Breyden in a different, less aggressive manner, and to assert himself appropriately as a parent.
2) Explore the processes between Shelly and Bruce so that each can learn how their individual conduct and overall transactional patterns serve to maintain their present couple relationship.

3) Assist the couple in successfully launching their adolescents into early adulthood while beginning to address their "empty nest."

4) Help Bruce and Shelly liberate lost dreams and patterns of blame and bitterness to achieve increased satisfaction for their couple and individual lives.

Case Analysis

Bowen (1978) described the family genogram as a clinical tool from which behaviour can be understood as a result of natural family patterns which have evolved over several generations. These patterns label one individual or small subgroup of members as the cause of the family problem. The genogram portrayed the Anderson family unit as a non-static, and ever-changing family relationship. Completing the genogram with the couple was instrumental in decreasing the emotional intensity attributed to symptoms and symptomatic people. In fact, the genogram did lessen the focus on fault and pathology of the problem individual, to make room to discover new opportunities for behaviour that can effectively address pressure and change.

Therapy with the Anderson family appeared to benefit from the integration of narrative therapy with associated systemic theories (emotionally focused couple therapy and structural theory) in addition in cognitive behavioural family therapy (CBCT).

Emotionally focused couple therapy (EFCT) was used with the couple as it employs a social constructivist perspective nonpathological orientation that transforms "stuck" negative interaction patterns into safe emotional engagement (Johnson, 1997; Johnson & Tiltman, 1997; Johnson, 1988). The therapist assists each partner in redefining his or her relationship through new interactions where "emotion is part of the solution not part of the problem" (Morgan, 2000). Johnson (1998) illustrates the process

of expanding and reorganizing the affective responses to suggest new emotional experience. The following interaction between therapist and couple demonstrates part of this transformation:

Shelly: Initially, we were seeking therapy to address Dylan's ADHD behaviours however he is doing much better. His medication and time with his psychiatrist have helped to make Dylan more productive at school, and stick to house rules. He also has a part-time job which he has been taking on extra hours which I believe will eventually affect his schoolwork. By the way the reason he spends so much time at work is the real reason we are here today.

Bruce: We're here because Shelly wants me to take medication to control my ADHD as it's getting in the way of me caring for our children.

Shelly: He thinks I'm making this all up.

Bruce: She thinks I'm a crazy, destructive man who can't think straight and control my behaviour.

Shelly: I don't think you're crazy, and I do believe that you can control your behaviour.

Bruce: Really? That's not what you've said.

Therapist: Is this what happens at home? And are these the main argument topics that happen?

Shelly: Usually, I think this is why the boys stay away from home so much.

Therapist: If this is what happens how then does it play out? What would usually take place next? (looking at Bruce to respond).

Bruce: Usually, I keep trying to defend myself. Usually I give up and go into the garage. I like being by myself. On occasion I push the chairs out of my way, which she says is abusive.

Therapist: Shelly, how do you view what happens at home. I'm asking you because usually everyone in the home experiences things differently.

Shelly: When it comes to discipline I tend to be firmer but I don't use putdowns and get in the boys face like Bruce does.

Bruce: Well you've had more experience at parenting these boys than me.

Shelly: That may be so but you can't go around threatening them — acting like a bully — getting into a pushing match with Breyden. These are growing boys. Especially, Breyden, he's an adult. He has his own job. He has goals of going to college. Bruce you're just driving these boys away.

Bruce: (raising his voice) I am not driving the boys away. You think you're always right. You keep saying this. How am I doing this? You always take up part for the boys. I have a right to be angry. This is frustrating.

Therapist: (in a calm voice) Bruce it's happening here too as you're becoming angry. I think it's hard for you to hear Shelly speak to me about this — like she's right. That's how you described it isn't it? "She

thinks she's right." You're disagreeing...saying that she's not always right and that you don't want to be thought of as crazy. Am I correct?

Bruce: Yeah that's right.

Therapist: Maybe you can help me comprehend how this problem seems to you. Help me to understand from your opinion what happens at home when arguments with Breyden take place.

Bruce: First of all Breyden is a very strong-minded person who's very good at not listening to me. Every since he was a child he did things opposite of what he was supposed to. It's like he wants to spite me. Anyhow he listens to Shelly. They have always had a good relationship. Anyhow when I ask him to do things, he pretends he hasn't heard or he grumbles under his breath. When his mother asks him he's much more polite — that I give him credit for but I get so fed-up with him. I have to talk louder and get closer to him because I think he's hard of hearing. He makes me so angry. He has so much potential. (pause) Yeah. I admit we get into shouting matches.

Therapist: So, then what happens?

Bruce: I don't think Shelly recognizes how difficult it is for me with the boys. She doesn't seem to think I'm trying to be a good father.

Therapist: Shelly is this correct? Is Bruce correct in saying that you never seem to think that he is trying to be a good father?

Shelly: Yeah, I believe he means well. But when he losses his cool I become mistrustful that he won't hurt someone.

Therapist: So a part of you believes that Bruce is trying to be a "good father", but you also used the word "wary" to describe your uncertainty with his intentions. It seems there's a part of you that believes Bruce is committed to being a "good father". Can you please tell me of a time when he was being a good father?

Shelly: Well Bruce is a good provider and he genuinely wants what's best for his boys. I mean he's made the decision to give up a possible promotion to a managerial position because it was literally wrecking his health. Also, he admitted he was missing his boys grow up. He is concerned. He would sooner work to the bone to see that we're happy. Also, he's been faithful and supportive. No matter what, he tries to attend the boys' soccer or baseball games. He goes to parent teacher meetings and has never missed one. Now all of this is very difficult for someone who works nights. What's really special is he organizes and cooks a hot breakfast Sunday morning before church.

This dialogue helped the therapist understand to what extent the couple was unfeeling and detached in their perception of each other, how patterns of difference developed, and whether there was any break in the cycle. Once a break in the cycle was discovered therapy moved to pursuing preferred stories of the present (White, 1990).

Therapist: Do you like who you are with Bruce?

Shelly: You mean who I am now?

Therapist: Yes, how you are now in your relationship with your husband.

Shelly: I like who I am. I find that I'm more assertive and confident then when we first got married. I think that I've grown this way. But I think Bruce hasn't changed that much. Sixteen years as a supervisor in the plant has really hurt his self-esteem. I think he was so stressed he always second-guessed himself. And some of that pain still exists. I just want him to be happy to feel good with his capabilities — like when we were first married and Robert and Breyden were born. Bruce was so responsible, sociable, and loving. He was so happy then and he wanted the boys and me to be happy too. Don't get me wrong he still wants these things. It's just that he's not involved with being happy as much as he use to.

Therapist: Wow, it seems like both of you have given up a lot. You both are so unselfish but somehow this has created an imbalance in your happiness.

Shelly: That's an interesting way of putting it. (silence). But of course it wasn't all that easy. I had to work at parenting the boys — a lot of which I did on my own. Bruce did make an effort to be around the boys and he and I would spend time walking the dogs. This is how we managed to connect.

Therapist: So, in spite of all the commotion and turmoil in your life you still managed to have a relationship with your husband, where both of you were unselfish and you didn't have to make any great effort.

Shelly: Yeah, I guess that's right.

Therapist: So, you're not like most couples that become so consumed when they get married they become separated by career and childrearing that they forget to work on their marriage.

Shelly: No you're right. We're not like that. We never really became consumed and had to go out of our way to work on our relationship.

Therapist: That's wonderful, there's not many couples whose relationship happens naturally and that they don't feel like it's a struggle to work on. You admitted there were conflicts that both of you repeat and here you guys are in one.

This perspective seemed to help Shelly and Bruce experience the secure versus insecure bonds of their relationship that contributes to rigid interactional patterns and a hindrance in emotional connection.

Tomm (1989) described how the "internalized other" interview with couples creates interpersonal patterns of healing and wellness. This narrative technique was used with the Andersons an effort for Bruce and Shelly to take in and reflect on each other differently, with the goal to help each achieve a better understanding of their partner, and their union as a couple. This approach concentrates on transforming interpersonal patterns of communication into an externalizing process where alternative meanings are

formed and integrated with emotions (Tomm, 1991). Externalizing conversations consider that the problem is spoken of as if it is outside of the person to create space for negotiation concerning the person's relationship with the problem (White & Epston, 1996; Zimmerman & Dickerson, 1996: White, 1993).

Therapist: I'm hearing that both of you have very similar issues with your partner but at the same time seem to have difficulty understanding your partner's experience. I'm interested in hearing how much each of you is aware of the experience of your partner. I would like to interview "the Bruce within the Shelly" and "the Shelly within the Bruce" meaning you are going to answer as if you were your partner. After completing the interview you will be given the chance to explain and say whether you agree or disagree with your partner's representation of you. (pause) So, which of you would like to go first?

Bruce: I'll go.

Therapist: Okay Bruce, remember you are actually Shelly and you are going to share your thoughts, feelings and experiences as if you are Shelly, any questions?

Bruce: No, I don't think so.

Therapist: (to Shelly) Shelly, in order to help you interpret and remember the process I am giving you a pad of paper to write down what you agree with, and also for what you would have answered difficulty.

This way we can review your thoughts and understandings of Bruce's interpretation of you.

Therapist: Okay Bruce let's begin (to Bruce) "Shelly," how did you feel coming to therapy about your family problems?

Bruce: (as Shelly) Well, I felt a little bit anxious and nervous because I thought that I had had control in my house but it doesn't seem as though I do. (silence) Everything is slipping through my fingers. Bruce is beating up the boys, especially Breyden. I think someone's going to get hurt. (pause) I don't know who Bruce is anymore. He's around all of the time now. He wants to be helpful but he's always in the way. I want to learn how to get control back and not have Bruce interfere in raising the boys. Everything was perfect before he took the day shift at work. I just want all of us to be happy.

Therapist: So, what are you wanting from Bruce?

Bruce: (as Shelly) I want him not to argue and be so aggressive with the boys. I want him to help around the house with more housekeeping especially since I'm now at school in the evenings.

Therapist: So, you want him to tone down his anger and aggression.

Bruce: (as Shelly) Yeah, because someone's gonna get hurt and the boys are leaving home because of it.

Therapist: Okay and you want him to help with housekeeping but let you parent the boys.

Bruce: (as Shelly) Yes, that's right.

Therapist: Shelly one of the key statements I heard it that you want to be happy? What does happy look like?

Bruce: (as Shelly) Yeah, for us to get along and me not to be afraid of Bruce's anger.

Therapist: So, Shelly you want to get along and be happy. I'm interested in what you find likeable and attractive in Bruce. What are his strengths?

Bruce: (as Shelly) I don't know. I need some time to think (pause). I think Bruce is a good provider to the family. I think he's a hard worker and that he's reliable.

Therapist: Shelly, is there anything else I forgot to ask so that I can understand your relationship better?

Bruce: (as Shelly) Yes, I would like the sex in our relationship to return. I sleep in the bed while Bruce sleeps on the basement couch. (Bruce starts laughing out of his character) Maybe this is more a Bruce problem then a Shelly issue.

Shelly: (smiling) Well I may not have put it that way but I would agree our sex life is a concern.

The therapist then asked Bruce how difficult it felt to do the interview as Shelly. Bruce believed at lest 80% of his responses reflected Shelly's character and values. Shelly disagreed saying Bruce was only 70% correct in his interpretation. Shelly noted he was accurate about her anxiety and concern with his anger. She remarked she was still

attracted to him and he had much more valuable strengths than being a good provider. Shelly opposed that she was that controlling and possessive of her parenting role, and was shaken that she had given Bruce that idea.

In therapy, Bruce and Shelly gained insight into the possibility that their mutual conduct was impinging on their relationship with their children and their qualities as a parent. Subsequently, Shelly questioned how her sons interpreted her behaviour, as well as her assumptions of their father, his roles as a father and parent, and how she was contributing to this.

Using the internalized-other interview was powerful in understanding couple experiences through their partner's perception (Tomm, 1989). Shelly related that since Bruce's depression left, she had never really considered his feelings. Bruce acknowledged the interview awakened his awareness of his jealousy towards Shelly's relationships with their older sons, as well as how ineffective threatening and anger was in parenting and maintaining couple relations. Essentially, Bruce began to transform his internalized conversation that he was the problem to an externalized position where he saw anger as the problem, and not his self was the problem. Thus, I was able to witness Bruce locate his anger (the problem) in a context that was external or outside of himself and his role as a parent. The internalized other interview also provided me with a new perspective to investigate how interpersonal patterns can lead to opportunities for generating and discussing meanings (Morgan, 2000). Drawing on the internalized other interview invited Shelly to separate her own meaning and explanations of family events from Bruce's interpretation of her actions. Thus, Shelly recognized she held the expertise to change some of her own interpretations in life and relationships.

Cognitive behavioural couple therapy (CBCT) was used as a collaborative approach to working with the Andersons to help each partner identify and modify their thoughts, behaviours, feelings and emotions that contribute to pressure, stress, and conflict in their marital relationship. CBCT focused on the Andersons present functioning, with some attention to the family's history; beliefs; issues of power and control; assumptions; and structural components (e.g. boundaries, transactional patterns….). The goal of CBCT as a therapeutic intervention was to integrate this theory with family systems approaches to create movement towards the Andersons effectively resolving their issues.

Therapist: Bruce, recall in your mind what you were thinking when you approached Shelly to touch her and she pulled away.

Bruce: I thought that she wasn't interested because she was still mad with me.

Therapist: Bruce you believe she isn't interested in you. So, what is your sense of how your wife sees you?

Bruce: I don't know but I'm beginning to feel like she is not interested in me as a parent for the children, and that I'm not really needed at home. I can't help thinking that if I didn't work and bring home some money then she won't need me. Maybe this will happen when she becomes employed full-time; then she's able to afford the house payments and the groceries on her own.

By the therapist allowing opportunity for the couple to escalate in conflict, the therapist was able to witness the couple's cycle of interaction, argumentation, and resistance.

Therapist: Please explain to me what you implied when you stated that your wife doesn't really need you at home and that she's not interested in you anymore?

Bruce: I guess I believe that she doesn't love me anymore and that she doesn't want any intimacy from me anymore. I believe she sees me only for financial reasons.

Therapist: Bruce, earlier you said that Shelly complains that the two of you are no longer intimate and that she would eventually want to become intimate. What do you suppose she means by this?

Bruce: I think she would like to have sex, and touch and kiss like she said earlier.

Therapist: Shelly is Bruce correct in what he's saying?

Shelly: I think he gets the part that I didn't want to be touched but I do remember the particular incident that he's talking about when I pulled away.

Therapist: Can you tell me how you interpreted that incident and what it meant to you?

Shelly: Yeah, I was lying on the couch watching the late show and he came up and sat beside me — blocking the TV he reached over to kiss me and he started pushing his hand up my shirt. It bothered me. Here we were, we hadn't been together intimately for a while

and he was pawing me — especially after I had explained to him what type of affection I needed to feel close. It turned me off and it pissed me off because he hasn't heard a word of what I have been saying — especially since we talked about this in our last session.

Therapist: Shelly what was it about Bruce's touching that made you consider it pawing as opposed to affection, and what was it that pissed you off? I'm asking you to clarify the distinction you're making as both you and Bruce appear to not have clarified the differences in your understanding of what each of you need.

Shelly: I meant I was feeling as though he was pawing me in that he just started touching me. You know like groping me. He does this every now and then and I even tell him it's kind of sleazy and not to do that. It's like he just wants sex, and he doesn't want the intimacy — the hugging or kissing. The stuff that makes me feels special and connected emotionally not just physically.

The Andersons issues surrounding sex seem to represent some of the differences between men and women when discussing the differences between sex and intimacy. Supervision offered a cognitive behavioural approach to addressing each partner's assumptions about intimacy. Since Bruce lacked relationships with emotional closeness and was having similar problems with his sons, it is understandable that he may confuse sex with love, affection and intimacy. CBCT seemed useful in helping the Andersons appreciate their partner's notion about sex and the feelings that this brings forth.

Shelly: Well I think by coming for therapy we are both talking more and gaining an understanding that we both need to spend more time together. But I would like to hug and kiss sometimes rather then just having sex. I really enjoy being with him, sitting with him. When Bruce became stressed he slept a lot. Now we're moving closer together again — talking and going for walks more — like old times.

Therapist: So, Shelly you're saying that you need more intimacy — the hugging and kissing and holding each other helps you feel connected rather then just having sex.

Shelly: That's right.

Therapist: But Shelly you also said that you feel isolated sometimes. What do you mean by that?

Shelly: Bruce spends so much time in the garage. Maybe he could spend more time with me. Maybe he can just come inside and share coffee with me sometimes. It's lonely in the house since the boys are out more.

Bruce: You know I love you and I want to show you. It's been so long since we've been together. I want to touch you. I don't know why I can't touch you and kiss you at the same time. (Laughs) Maybe you're right. Maybe I have to work on my technique. I don't know exactly what I'm supposed to do. After a while I just want to give up.

Shelly: (raises her voice) So, you get mad and distance yourself in the garage?

Bruce: (calmly) You know that isn't true. I've always spent a lot of time working in the garage. I'm not avoiding you. Maybe you're right, I should spend some of my time with you.

Shelly: Bruce, you're still not listening.

Therapist: I'm hearing many important things from both of you that seem more similar than you two may realize. First of all, each of you describes incidents where you assume what your partner is feeling and what their actions represent. Each of you doesn't seem to believe that your partner values you. Am I correct about this?

CBCT appeared effective in addressing the interactions between Shelly and Bruce's behaviours, thoughts and feelings, and how these impacted the quality of their marriage and other personal relationships.

My observations and experience with the Andersons concurred with the family's FAM III post-results on communication and affective expression scales in that their hostility gave way to a more optimistic and promising tone. Bruce's improvement in task accomplishment was representative of his attempt at different ways to resolve disputes. Conversely, Shelly mirrored Bruce's improvement in test scores, making gains in role performance and communication. The challenge upon termination for the couple is to venture slowly and carefully into the empty nest stage of the family life cycle, as each family member continues to struggle with their ambition to express difference in a way each can enjoy one another.

The symmetry of positive change in Shelly and Bruce's post-test FAM III scores was particularly interesting for affective expression and affective involvement. The couple's conscious effort to spend more time together revealed interest in making their relationship work. Having time together allowed for discussions about children, empty nest issues, and increased comfort with one another. A feeling of contentment filled the therapy room as Shelly and Bruce reminisced on the solitude they experienced together. It evoked the tenderness experienced prior to Bruce's depression and employment stress. This was helpful as I became more aware of their mutual concerns for each other. As well, I was given the opportunity to observe Bruce's potential to be nurturing and supportive, a strength often overlooked in therapy as the couple became confrontational and. I wondered why his esteem was overlooked in pre-test scores.

I sensed a major shift in sessions transpired when the couple began empathizing and using emotions present in the room to understand stressors their partner was facing. I assumed their difficulty in doing so accounted for discrepancies in initial problem checklist results particularly in identifying with their partner on communication, affective involvement parenting, and the couple relationship. I had thought the Anderson's problems stemmed largely from the use of aggression however, the Andersons and I began to feel overwhelmed with differences in how the couple understood and processed information.

I also felt participating in Shelly and Bruce's time together exposed me to the congruence of their emotions, as well as provided a basis for working with core emotions rather then the simulated affect individuals bring to sessions to address daily crises rather then systemic issues.

I came to believe the couple was enjoying each other and was fairly contented with steps taken towards working together. I was surprised to find the couple's client feedback form indicated otherwise. Shelly's responses expressed speculation. She disclosed that, although therapy had improved family functioning and the marital relationship, she was in a quandary deciding whether the change was good enough. Shelly added therapy did not facilitate the overall changes that she had hoped. Thus, evaluation measures and client presentation in therapy did not emulate overall client experience or objective not clear. A possible explanation may be Shelly's lingering anxiety in deciding whether present relations with Bruce are sufficient to last a lifetime. Sensing Shelly's continuing uncertainty with remaining in her marriage I separated her and Bruce twice throughout the therapy process. This garnered individual objectives for therapy and individual needs. Given the opportunity to explore this in the absence of her husband, Shelly gave the impression that she was solely in therapy for the benefit of her children even while she realized this was at the expense of herself. After that, as the couple became more oriented towards parenting and family, Shelly became more comfortable with her need to explore her individuality.

I speculated as the Andersons transcend the most difficult stage of the family life cycle, adolescence (Carter & McGoldrick, 2003), parental individuality and role formation would become more ambiguous as challenges mount (e.g. career, additions to the family). Shelly may return to wondering whether individualism exists outside the marital dyad. Already a decline in social desirability echoed her belief family is oblivious to her physical and personal transformations. Anxiety was represented in her initial and post problem checklist. Typical expectations of navigating this life cycle

phase were provided to the Andersons so as to prepare and normalize their experiences. Bruce held he would appreciate more time and involvement with his sons yet pragmatically recognized time was needed before his sons would feel at ease As predicted, the Anderson (Appendix F) showed appreciation for positive therapeutic outcomes made with continuing frustration that change was not happening as promptly as wished.

I found working with the Anderson family challenging as everyday issues brought to sessions took time away from greater issues that they were struggling with, such as disillusion with their partner and ambivalence in staying together. On occasion, I felt a spectator to a dance where presentation mattered more then the meaning of the moves.

Case Conclusion

As Shelly and Bruce had a long-term marriage and were at midlife with children in young adulthood, I realized in joining with the couple that my younger age and life experiences might impact the process of therapy. In spite of my professional and personal experiences, I needed to develop a sense of awareness to appreciate that working with couples in midlife does not follow any highly ordered design. Specifically, the midlife stage of life is not an obvious treatment stage with expected categories of interventions like that of parenting the pre-adolescent. Hence, greater opportunity existed for me as the therapist to bring forth the couples problems and strategies.

Part of the joining process with the couple was listening attentively to concerns and acquiring creditability by normalizing similar encounters. In addition, accomplishing

an understanding of each partner's awareness was helpful in establishing credibility to develop a constructive therapeutic relationship. Through supervision, I worked to serve as an escort who assisted in keeping tension and anxiety in check as painful and distressing topics arose. Additionally, my role as a therapist was to provide the couple with a safe environment to reduce risk.

I discovered the cadence of therapy to be particularly important when working with couples in midlife. Moving too quickly to support or resolve issues may heighten pain and distress in both couple and therapist. Still, when speaking about loss, abandonment, and missed possibilities the therapist must value the uncertainty of life.

I discovered that the assessment phase of therapy not only provided an opening to assess the Andersons interaction patterns and concerns influencing the presenting issues, it provided information on areas of distress related to the developmental and family life cycle which required immediate change. I realized the process of assessment is not only information gathering but also an opportunity to intervene quickly to lessen family pressure. Besides gaining a new theoretical lens to understand their presenting problems, the couple became aware of how developmental and family life cycle factors were manipulating existing challenges.

In attempting to address intimacy issues, I nearly passed over the possibility of integrating CBCT with narrative therapy in an attempt to have the couple independently rethink their beliefs of themselves and others. Prior to working with the Andersons, I thought CBCT was a directive, concrete therapeutic approach. Instead I gained knowledge that it could also be explorative and non-directive, while empathizing with the need for individual responsibility. Therefore, responsibility as identified by CBCT is

akin to the narrative approach where the goal of therapy is to motivate the individual to reconsider their views of themselves and others. In all, CBCT and narrative therapy embrace an empowering process where the individual restructures their perceptions through an elaborative approach. Working through CBCT with the Andersons has made me more aware that I need to recognize the difference between the various models of CBCT. As well, these do not vary entirely on philosophy, and on the therapeutic process but on the style and personality of the therapist.

I learned that CBCT can be incorporated into family systems theory to challenge and assist clients to abandon and move beyond irrational thoughts and feelings, I concur with Ellis (1988) that self-defeating thoughts may be so engraved that individuals generally do not change these on their own. CBCT techniques helped the Andersons understand the harshness of their self-perpetuating cycle.

Regarding CBCT, I agree with Beck (1995) that therapy needs to consider approaches that alleviate emotional distress through the medium of correcting faulty conceptions and self-doubt. I found helping Bruce learn to identify distorted and dysfunctional thought processes of evaluation effective in helping Bruce to discriminate between the event(s) and his thoughts. Essentially, Bruce began to understand how cognition affected his feelings and responses. Overall, he began to recognize, observe, and check his thoughts and assumptions without the use of medication.

A limitation I realized with CBCT was the possibility that the couple became dependent on the therapist to help them decide what constitutes reasonableness and how to appropriately resolve issues. I needed assistance from Mr. Klippenstein to keep Bruce from assuming a dependency on the therapeutic process. The challenge became teaching

the Andersons to question each other and to partake as active participants in therapy. In effect, CBCT was useful in assisting the Andersons to recognize and change maladaptive beliefs and corresponding internal dialogue. Some of the criticisms for CBCT are its failure to explore underlying causes of couple difficulties, while neglecting the role of feelings. However, by using CBCT in conjunction with narrative therapy and emotional focused therapy, individuals gained understanding of responses pertaining to family symptoms.

Another unique experience I had in working with this family was witnessing the similarities between EFCT, CBCT, structural family therapy, and narrative therapy. First, narrative therapy has some common techniques as EFCT, specifically during the change process. EFCT addressed change by identifying the destructive interactional cycle that preserves attachment insecurity and couple distress, similar to the narrative approach of externalizing the problem.

In all, narrative therapy incorporates beliefs from various disciplines of family therapy to help individuals to develop and express their stories in order to understand how their problems fit into the entirety of their lives. In therapy individuals are involved in a collaborative effort to recognize how presenting issues are created to produce conflict and tension for all involved. Therefore, when individuals leave therapy they often have their issues resolved with the know-how to address future problems.

CHAPTER SIX
Conclusion

Practice Themes

Throughout the practicum process, the following general themes emerged which have implications for clinical intervention with parent-child conflict: family strengths; the family life cycle; and the structural perspective of therapy.

Family Strengths

Recognizing and supporting client strengths were important strategies throughout the practicum process and were quite helpful in the assessment phase in discovering points for intervention. Minuchin et al. (1998) state therapists must attend to client strengths and beliefs. As

> belief systems are at the core of all family functioning and are powerful forces of resilience. We cope with crisis and adversity by making meaning of our experience: linking it to a social world, to our cultural and religious beliefs, to our multigenerational past, and to our hope and dreams for the future. How families view their problems and their options can make all the difference between coping and mastery or dysfunction and despair (Walsh, 1998, p.45).

By focusing on client strengths I was able to circumvent pathologizing families and allowing "diagnosis" (Cowger, 1997) to impede client abilities. This framework was imperative when working with all of the families. Focusing on client strengths rather than working with clients under their diagnosis of depression or ADHD proved valuable in allowing families to define their issues in terms of their own perceptions and to promote the belief that they possess inherent strengths useful for solving their problems. Additionally, by acknowledging their strengths clients could be acquainted with the many

talents and resources they were already utilizing to effect change and support in their families. For example, overtime the Badger family seemed more empowered and less pathological.

Ms. Badger had experienced several years of counselling surrounding her depression and ensuing periods of crisis. Yet, in spite of years of treatment focused on understanding and managing her feelings of sadness as well as developing coping mechanisms, her relationship with Mr. Badger became increasingly problematic. Ms. Badger felt that Mr. Badger was unsympathetic to her needs and a failed support. Therefore, instead of trying to free the couple from the stress caused by Ms. Badger's sadness, therapy focused on working together to form a detailed plan on cooperative parenting, and finding time for their relationship. Sessions focused on identifying the couple's individual talents and finding ways of expressing these in their home life and relationship. Mr. Badger learned to reframe his apprehension towards Ms. Badger's sadness and shift his attention to his family. The paradox seemed to be that Ms. Badger's sadness did not abate until her daily life provided enough satisfaction to make it worth the effort to overcome her issues with depression. Ms. Badger's sadness was minimized when she felt supported by her family and she began to focus her attention on other matters.

I also discovered that family strengths could be uncovered by inquiring about family supports (Saleeby, 1997). By exploring with Ms. Badger what community supports she found particularly valuable, she discovered that her work with geriatric patients was especially significant and gave her a sense of self-worth and satisfaction. Ms. Badger realized that she possessed a wealth of characteristics, which allow her to

work and remain committed in her field as a nurse as she is a caring, kind, and an empathic individual. Ms. Badger could become acquainted with these attributes as a foundation for working on her relationship with Mr. Badger.

In all, the Badger family displayed strengths of kinship for wanting each other to find belongingness in the family along with a commitment to resolve their issues. This was particularly true for Ms. Badger. Those resiliencies supported her resolve to return to and liberate some troubling issues from her own adolescence.

Another important method of recognizing strengths was by confirming Mr. Anderson's attempts to parent his two middle sons, adolescents who many would find tough to manage. Thus, at the end of each session I affirmed some of the strengths Mr. Anderson displayed in session as well as positive changes that he effected in parenting his sons. In identifying Mr. Anderson's strengths, he was able to feel confident to model the same with his children.

It is helpful when the therapeutic process addresses unique outcomes, which allow families to attend to exceptions in their problems as a means of discerning strengths (Saleeby, 1997). Families begin to identify similar occurrences in their past which they endured and successfully conquered. This proved helpful, as clients were able to reflect on situations where they worked together to overcome obstacles. For instance, this technique of questioning proved particularly useful for Ms. Camden, as she was able to utilize intrinsic strengths to work with her daughter in understanding her daughter's behaviour in reaction to the present family situation. This process proved uplifting for Ms. Camden as she was able to recognize what a valuable support and role model she was for her daughter. This appreciation helped to reframe her daughter's behaviour in

terms of depression and frustration over the pending divorce of her parents. In addition Ms. Camden began to identify the support and validation she received from her daughter in making her decision to leave her husband.

It was also important to focus on Ms. Camden's strengths as a single parent. With Ms. Camden's recent separation, the initial step was to assist her in mobilizing her resources and recognizing and accepting what she has control over. Accordingly, Ms. Camden felt supported and competent in fulfilling her role as the primary caregiver.

In summary, it is important to consider that a "family always has a broader potential repertoire than appears in its repetitive patterns" (Minuchin et al, 1988, pp. 39). Once a family begins to recognize and build on its existing strengths, it desires to become more engaged in life and look towards the future. People must be considered continuously connected in their situations and dedicated to improving on them even if they decide to surrender themselves or their opportunities. Situations can overpower; however, terrible circumstances can also augment tenacity to resolve and stimulate competence and attitude (Saleeby, 1997).

Moreover, identifying strengths is an essential part of therapy with parent-child conflict in terms of goal formation; points of intervention; understanding the parents' and child's defenses and coping mechanisms; and in facilitating empowerment and support for caregivers.

The Family Life Cycle

In the family life framework divorce and separation do not remove a couple from a system but rather interrupt the life cycle to trigger affective issues to facilitate change in

the status of family relationships (Carter and McGoldrick, 1988). Carter and McGoldrick (1999) identify three stages experienced by families affected by divorce. During the first stage, family members must address accompanying emotional phases prior to progressing into the next developmental stage. This includes owning one's part in the break-up and accepting the demise of the relationship. In the second stage, the system begins to divide by attending to matters of finances, custody, visitation and relations with extended family. Third, the couple officially separates. They attempt to accommodate a joint parental relationship while resolving attachment to their partner. The affective dilemmas created by divorce are not experienced in succession and may reemerge in various sequences.

Ms. Camden was in between the family life cycle phase of being a parent with an adolescent and the second phase of separation where she has already accepted the termination of her marital relationship. At the time of therapy Ms. Camden was confident about her decision to end the marital relationship however she was not convinced that she could survive without it. With help from the framework I was able to assist Ms. Camden in putting her transition through divorce into perspective while praising the confidence she demonstrated in her abilities to become independent of her husband.

Divorce also disrupts family relationship and structure. During divorce, demands are often placed upon children to meet the needs of their parents. Ms. Camden viewed her relationship with her youngest daughter as a friendship and less as a parent. Ms. Camden had difficultly discerning that her daughter's journey through identity exploration was not to be confused with her own. Moreover, Ms. Camden was unknowingly trying to

maintain her daughter's friendship and support by affording unrestricted autonomy. Therapy focused on differentiating Ms. Camden from her daughter through role redefinition and boundary assertion, as well as preparing Ms. Camden for her own transition into "launching" her daughter out of the home. Utilization of the family life cycle assisted the therapist in normalizing the emotions and behaviours Ms. Camden would typically expect as she progressed throughout these stages of life.

The Andersons were experiencing different stages of the family life cycle. First, they had three children they were "launching", while another was entering adolescence. Second, the parents themselves were at different stages. Mr. Anderson was inflexible in his parenting and worried about his children leaving home. As, Ms. Anderson accepted that her children were being "launched" and prepared to re-assess her career prospects, and explore new interests and social contacts. Third, the couple faced issues pertaining to their children's increasing autonomy, and associated change in roles.

Hence, introducing the Andersons to the Carter and McGoldrick family life cycle framework offered insight into what boundaries, roles, emotional dilemmas, and stress would be discussed in therapy. Intervention centred on defining and strengthening Anderson family roles, boundaries and affective dilemmas. Therapy focused on structuring the couple system to address these issues. Boundaries were outlined around parents and children. With this the couple was better able to address their relational issues and consequently, paths in life. The framework also helped the couple define the common challenges their relationship and family would face as the family transitioned through multiple stages simultaneously. As a result, the couple became united in developing ways for sharing their concerns and needs by setting aside specific time for

each other. Therapy reinforced the couple's need to share time together, allocate roles and responsibilities while guiding family members successfully through developmental tasks and life cycle progression.

In summary, careful consideration to the family life cycle of participants, and their transitional points, proved helpful in understanding and assessing family functioning in therapy sessions, treatment plan formation, and how to direct therapeutic interventions.

The Structural Perspective

Structural family therapy was developed as a child-oriented therapy method. This approach concentrates on the ability to describe the organizational pattern of families from which families relate. The basis of the approach is that families are stuck in patterns of relating and the purpose of therapy is to free them from their rigid boundaries, leaving opportunity for new family organizations to emerge (Nichols & Schwartz, 2001). Therapeutic work can be accomplished using various approaches. However, I believe that that its success is assured only when the structure of a family is understood, while the how, when, and to whom family members relate must also be appreciated before the helping process can begin to thrive.

Structural therapy like behavioural, is often denounced for not addressing insight. It is true that insight is not a principal goal of structural therapy, but insight does transpire as a result of changing the family structure. Nichols and Schwartz (2001) note that although this may not be as profound as that of the psychoanalytic perspective, insight is acquired through the knowledge gained in the change process initiated through the structural approach. Supplementary therapy using cognitive behavioural family therapy

offered additional insight into the issue of Ms. Badger's experience with depression after she injured her wrist, as it may not be the injury itself that caused the depressive reaction but her beliefs about being a failure in her new line of work, or being rejected for employment due to a competitive job market. Helping Ms. Badger to see how she can change unfounded beliefs that directly "cause" her troubled emotions is the basis of cognitive behaviour therapy.

Assigning tasks is an important technique used to restructure existing family patterns, and assess family flexibility, while at the same time instill responsibility and effect change. To illustrate, I instructed Mr. and Mrs. Anderson to explore issues and the areas around them, for a short time period. This was intended to initiate shifts based primarily on momentary maintained changes. In session, I instructed the couple to "talk to each other for the next few minutes about what the problem is and I will sit back and listen." After some experience, I left therapeutic homework with the couple until the next session. I assigned the couple to walk or talk alone for thirty minutes a day (Kaufman, 1979). These observations contributed to the overall assessment of the relationship patterns in the family, as well as exercising new transactional patterns in the family's natural environment.

Noticing and addressing diffuse boundaries can be seen as a potential means for re-establishing subsystems and enhancing the integrity of family members. Structural techniques are active in inspiring the family system towards changing inappropriate structure. For instance, I asked the children in the Badger family to solve a sibling problem by discussing it without involving their parents. This technique was appropriate in allowing the parents to relinquish their need to solve their children's issues. This over

involvement and excessive need to accommodate on behalf of the parents to fostered dependency, disempowered their children's abilities to problem-solve, and made it difficult for the children to form relationships outside the family. The outcome is a deficit of autonomy for parents and children.

In addition, Minuchin and Fishman (1981) propose that enmeshment leads to disengagement, and in turn disengagement leads to enmeshment. This is a perception that is reflected in Ms. Camden's relationship with her youngest daughter whereby Ms. Camden formed a coalition against her husband. This enmeshed behaviour corresponded with her husband's disengagement and gambling. To this day, Ms. Camden is not sure whether her husband's gambling led her to form a coalition with her daughter, or that her coalition with her daughter caused Mr. Camden husband to disengage and turn to gaming.

I believe structural theorists' consideration for the behavioural component is sufficient in that it focuses on changing disengaged and enmeshed behaviours into healthier behaviours. In contrast, the approach is weak in addressing the cognitive elements of symptoms. Structuralists claim further insight results from change however, not intrapsychic change.

To understand family structure it was important to relate to concepts of the therapeutic approach employed. Minuchin and Nichols (1993) deem that both complementary and symmetry are essential components in a marital relationship. The notions of complementary and symmetry were reflected in the Badger family. The couple was symmetrical their views of spirituality, and in their ambition to raise their children within a comparable environment. They were complementary regarding their views on

parenting and household responsibilities. For example, Ms. Badger was responsible for the household, while Mr. Badger was responsible for maintaining the yard and vehicles. Such combinations of complementary and symmetry are required for a relationship to function effectively.

To conclude, the structural perspective to therapy appears to be an effective treatment approach for ensuring that families sustain functional transactional patterns, so that family subsystems remain problem free. In addition, the structural perspective is effective in showing the co-morbidity of disengagement, enmeshment, alliances, and problems — effective techniques to determine and eradicate problematic conditions within the family system.

Practicum Experience

In this section I provide a general overview of my learning experience, and appreciation for learning assessment and intervention tools, along with a critique of the measures used.

The goal of distinguishing between process and content in therapy was one of my most important learning tools, from which I have come to a satisfactory conclusion that analysis of process/content interactions between family members is a useful mechanism of change. Supervision and reviewing videotapes between sessions helped me attend to how families speak to one another rather then the content of their speech. For instance, a mother may tell her daughter that she shouldn't wear so much make-up because she looks like a clown. The content of the mother's message albeit insensitive is "respect and

admire yourself for who you are and the qualities you possess rather then making yourself into someone you are not" (Nichols, 2001).

I continue to find reading process challenging. Through the practicum experience I learned to remain relatively decentralized to allow family members in the room opportunity to relate to one another. At times the content of discussions was so fascinating it was difficult not to become diverted from attending to process. This was particularly true when working with the Anderson family. Whenever I would invite Ms. Anderson to speak with her husband about her needs as a partner, she would respond with a lecture about her need for him to be less aggressive as his actions were violent and creating a rift amongst family members. As a helper I found it difficult not to get drawn into supporting Ms. Anderson as I recognized her content correct in that family violence leads to family disintegration. Conversely, I assessed that the violence had subsided and recognized that by focusing on the process of Ms. Anderson's message it was more important to help Mr. Anderson learn how to speak up for himself and to have his wife listen to his fears and frustrations, plus his needs as a father and partner.

When families entered therapy they focused on content issues. I discovered exclusive attention to content tied me into instructing parents how to solve problems with their child as opposed to helping parents feel confident in their relationship with their child — in essence improving the overall functioning of the family system. Nevertheless, there were times when content was important as when Ms. Camden was engaging in hasty sexual encounters, and Mr. Anderson was physically aggressive towards his sons.

By focusing on process within a narrative-oriented practicum I became aware that this approach is less interested in process and interaction patterns than in how individuals

interpret their problems. Plus, little attention is directed on the evolution and maintenance of problems and how family processes contain and strengthen the problem. In effect, narrative therapy seems less interested in changing behaviour and experience than in broadening stories. Narrative theorists observe "exceptions" when the problem wasn't the problem, with little attention given to the interactions that surround these events.

As I increased my awareness of process underlying the content of family dynamics, I recognized Bowenian as therapy useful in re-establishing family relations by blocking triangulation, fusion, and differentiation. Equally, structural family therapy attends to family interaction by recognizing boundaries, and strengthening hierarchical boundaries. Correspondingly, as my comprehension and insight into the process of family interaction increased, I became cognizant of how cognitive theorists attempt to reduce and isolate behaviour at the expense of interaction patterns. These attempts negatively affect individual expression. Using emotion focused therapy with cognitive behavioral family therapy softened an otherwise rigid, directive approach.

Throughout the practicum I found that I became more skillful at conceptualizing families through a structural framework. As well, Minuchin's (1974) attention to social, economic, and developmental life cycle pressures that affect the family was a valuable frame for acknowledging life pressures on family relationships. Identifying structural concepts within the family helped me organize families and prepare them for interventions with the ambition to help them become "unstuck" in their present developmental cycle by making necessary change. I became aware structural therapy is an effective intervention to promote change in family structure and development of

family members. Likewise, I came to appreciate the flexibility of the structural model in that Minuchin leaves the ideological stance of therapy open to fit the uniqueness of the family.

The cliché that a picture is worth a thousand words holds true for the use of the genogram in family therapy. I found the genogram an essential tool for assessing and hypothesizing family problems by examining a concrete representation of relationships, quality of interaction, and possible development of problems across generations. What's more, the genogram functioned as an instrumental clinical tool for involving families in therapy. When constructing the genogram with each family I began to realize how each individual's affect contributed to an understanding of the presenting issue. Clients also gained insight into how events were shaped and fit together. Employing the genogram with the Badger family was effective during a period of resistance when Marion was unable to distinguish that ill treatment of her husband was related to abandonment issues from early adolescence. In addition, reviewing Ms. Camden's genogram during the assessment phase helped to explain lackadaisical cross-generational boundary making patterns, and how ACOC (Adult Children of Alcoholic) traits were passed to offspring. The pictorial descriptions of the complex triangulating within the Anderson family created a basis for the couple to problem solve. In all, the genogram provided opportunity for families to visualize new solutions and opportunities for addressing problems that affect family.

Use of the genogram in supervision assisted in organizing vast amounts of family data into patterns while thinking systemically of the family unit in terms of assessment, intervention, and sensitivity. Furthermore, the genogram influenced my process of

therapy. It slowed my need to develop techniques to effect change in the family and reinforced my need to understand the family as a system.

All of the families involved in the practicum reported some improvement over the course of therapy. Change was reflected in my experiences with the family, through supervision, and results garnered from evaluation measures.

With respect to the pre- and posttest measures employed in my practicum, some dilemmas were apparent. First, some of the families stated that they felt impartial to some of the answers, and could not determine whether they agreed or disagreed with the statement. Incidentally, the FAM III did not accommodate for these response types. Second, I found that the FAM III did not adequately measure the complexities apparent in some of the families I met. These included depression, violence, and suicidal ideation. Of note, the FAM III is not a replacement for a clinical assessment (Skinner et al., 1983). Third, reports from the FAM III posttest did not always agree with my observation or the families' self-reports. Fourth, client perceptions would fall between agree and disagree either demonstrating ambiguity or situation specific events rather then broad experiences. Some clients expressed the questions and answers did not reflect what they wanted to communicate. On top of the FAM 's limitations, I was perplexed when family members agreed with observations made throughout the therapeutic process that personal growth had transpired, while evaluation scores indicated little improvement. Similarly, what did it mean when evaluation measures, observations, and client behaviour showed change for the better while clients denied any progress?

Another drawback in using FAM III became evident when I moved from couple to family therapy with the Badger family. I found the information from the FAM III of no

value as it supplemented the marital relationship and not the couple dyad. In hindsight, it may have been more beneficial to use another measure that focuses specifically on couple relationships and related dyadic relationships, such as the Dyadic Adjustment Scale (DAS) (Spanier, 1976). First, this may have been effective in identifying issues in the marital relationship that were not observed by the FAM III such as which were the areas of strength in the relationship and which were problematic. Second, the DAS may have helped the family in shifting from concentrating on parenting and family issues to couple issues. Third, the DAS may have provided baseline data about marital adjustment prior to therapy and at termination. Fourth, the FAM III did not measure client strengths. I had to rely instead on my own observations acquired in sessions and in families' self-reports. I question if the FAM III took client strengths into account and if its findings would reflect the families' self-reports and my observations.

On the whole, I did find the FAM III helpful in supporting what the family was reporting from what I was observing. Second, the FAM III is easy to use as its questions were rather specific and straightforward to use, and its readability is at a fifth grade level. Third, the FAM III was also useful in comparing family members' scores to each other while acquiring information on how members' perceptions were similar or dissimilar. Fourth, the two subscales were effective in measuring response bias as they allowed for an examination of the results in a more systematic manner. Fifth, the FAM III was beneficial in acting as an intervention as it prompted families to consider specific situations and how they would resolve these. Sixth, the FAM III was based on the Canadian population, and integrated features unique to our Canadian culture.

The client feedback form was helpful in providing feedback on family members' subjective experience with therapy and what they found most helpful. The questionnaire also supplemented items identified as unchanged in the FAM III as well as my own clinical observations. As well, client feedback reports clarified that families felt they learned new ways for resolving issues as a couple and as a family. All believed that their futures looked positive, and all demonstrated more functional relational patterns since their initial assessment. Generally, the questionnaires indicated that the families were largely satisfied with the therapist, and the level of treatment received.

Supervision was helpful as it allowed for more options for expanding possibilities and command of client situations. Growth was witnessed through my supervisor offering me a greater sense of freedom with clients in a creative manner by modeling the application of metaphors, stories, or narratives to fit the particular needs of the client. This was effective as I often left supervision feeling "unstuck" as I then possessed a multitude of new insights of each individual within the family system.

The clinical supervision I received helped me to understand that metaphors are valuable in helping families and individual members modify perceptions of their circumstances. I have learned that metaphors are not always clearly understood depending on the individual's experience, and cognitive level. Thus, I gained knowledge that techniques must be both purposeful and modified to address the particular needs and experience of the client.

Moreover, I was able to improve my abilities to engender new information and form new competencies, as an emerging therapist. For instance, I increased my familiarity with taking a "not knowing" stance rather then that of "an expert" with clients.

This collaborative approach provided greater opportunity for identifying client strengths and competencies, in turn offering clients more self-understanding of their approach for changing problem-saturated stories. Largely, Mr. Klippenstein's ability to address supervision through a postmodern approach was a good fit in helping me achieve greater understanding of the narrative approach in combination with other systems theories in working with parent-child conflict. White (1989/90) recommended that all supervisees be presented with ample exchange of information whereby various insights are formed about family narrative and dilemmas. Overall, supervision strengthened my ability to manage conversations in a therapeutic manner; an objective goal of postmodern supervision.

The Narrative Approach with Clients

The narrative therapy technique of deconstruction was difficult to use with some families as their problems were real and could not be rationalized away by externalizing the problem. For instance, Mr. Millet's schizophrenia left him financially impoverished as well as incapable of providing constant care to his teenage son. Naming these problems and externalizing them as situational does not speak to the real dilemma Mr. Millet and his son must continue to face.

One challenge I discovered while using the narrative approach was helping clients understand why problem behaviour exists, as it is not entirely a linear and causal process. According to narrative therapy, people function according to how stories influence their understanding of reality in society, themselves, and other people, with each individual's action embedded in a continuous, common ebb and flow of interaction. Essentially,

functioning is an interface between an individual and another's actions, responses, and interpretations to given events. So, by renaming family problems as an affliction, narrative theorists have limited themselves to focusing on outcome rather then on cause. At times, I also found externalizing the problem to be quite abstract and unnatural, in effect challenging the objective of sustaining a collaborative relationship with clients.

An additional limitation in using narrative therapy is the failure of the model to consider problems as interactional, for example the relation between psychological issues to family functioning, and the treatment of the family as a system.

Narrative Therapy as an Exclusive Approach to Therapy

When beginning the practicum I had numerous reservations about narrative therapy. First, I questioned whether the narrative style might be too cognitively centred, as it required individuals to deconstruct societal expectations and accept multiple truths. Devalued persons attending therapy or those with low sense of self may have limited understanding of societal contexts outside their own and therefore unable to form constructs. Equally, how does one deconstruct problems with children, and individuals with learning difficulties? Second, most individuals may have difficulty grasping societal expectations and circumstances as no one can truly appreciate another individual's experience and world view. Third, I queried how to integrate the micro system of the family experience, and address intrapersonal relationships within the narrative approach.

I discovered my uncertainties with narrative therapy challenged my understanding of treatment with families. What's more, I was at a loss in how to provide client focused care through one perspective since a gap existed in how to effectively meet the needs of

the client system. A final dilemma using narrative therapy was the application of narrative techniques. For example, during the identification and naming of the problem a number of clients chuckled, remarking on the childish presentation of the problem. Likely, I need more skill in the presentation of narrative concepts. In my opinion, externalizing and other narrative techniques do not allow full understanding and resolution of the problem. Overall, I recognized I could not use the narrative approach in it's entirely to empower clients towards inter- and intrapersonal change.

In my experience when people feel burdened in their lives they need to reeducate understanding of their emotions and cognitions, in an attempt to liberate themselves of intense, unrealistic fears. Fears and other strong emotions (e.g. anger and despondency) influence an individual's behaviour. Emotions that override the person's ability to cope eventually enable a conscious effort to seek help. Therefore, an individual seeking therapy has awareness that something is "wrong".

I believe the therapeutic relationship is central to facilitating interpersonal learning. In this relationship the client shows fears, and interconnected emotions of wanting to maintain harmony while anticipating change. Under these circumstances the client in therapy becomes the vehicle through which they rehearse ways to address problems.

Moreover, when working with clients there is the need to uncover emotional reactions to bring about interaction patterns. I believe that in understanding emotion, the conscious and unconscious can be tapped, adding to another dimension of person. Through surfacing of the unconscious the intrapsychic is known, unearthing individual

and systemic attributes outside the person-in-the-environment position of narrative therapy.

Through the practicum experience I became enlightened that various forms of therapy are needed to help clients understand their thoughts and behaviours, as each approach facilitates a different process towards self-assurance, growth and development of the person. Furthermore, clients are unique in their understanding of reality, willingness to learn, processing of information, and learning style. My challenge as a therapist is to continually assess the therapeutic process with the purpose of empowering the client(s) to overcome conscious and unconscious tension. For that reason, therapy is more then having clients rid themselves of unwanted behaviours, it is helping the client exploit their strengths and potentials to achieve personal responsibility and free choice.

Implications for Social Work

The implications of social work practice using the narrative approach are beneficial as the narrative practice supports social justice for all people, focuses on individual strengths rather than their weaknesses, and places problems within a sociopolitical context. The tenets and principles of narrative therapy are particularly important in preventing the inadvertent disempowerment, ill treatment, and diagnosing of individuals that often transpire when using traditional therapy.

In general, I believe the main goal of my practicum to work with families to improve parent-child conflict using narrative therapy within a family-based approach was achieved. The experience provided me with unique learning opportunities. My confidence in assessing families, identifying treatment goals and formulating a treatment

plan has grown. I was able to gain knowledge in family therapy, advance my understanding of narrative therapy, advance my clinical skills, and gain supervised experience in family therapy. As well, the existing literature contributed to my academic and professional development, while it supported my clinical application of knowledge and skills.

Implications for Further Study

One of my goals generated by the completion of this practicum process is to seek out added information and understanding of how the brain and growth of our mind unites neuroscience with psychotherapy.

I have always been interested in the neuropsychological development of the human brain in relation to psychotherapy. Unfortunately, many therapists have a bias against neuroscience (Cozolino, 2002). Yet, psychotherapy like neuroscience is a result of several interacting processes such as etiological theories, and the development and impairment of cognition, sensation, and affect, where language is instrumental in stimulating connections between experiences with thought (Agnus & McLeod, 2004).

Kandel (1998) professes that at the heart of psychotherapy is an understanding of the interwoven forces of nature and nurture, what goes right and wrong in the unfolding of development, and how to reinstate healthy neural functioning. When psychotherapy results in symptom reduction or experiential change, the brain has, in some way, been altered. Hence, problems may possibly be lodged at a somatic level even when it is barely within conscious awareness. Freedman & Lobovits (1993) refer to this as "somatic conversation."

Thus, language and the co-construction of narratives is important both in the psychological and neurological development of the person. Essentially, discussion and experience bring forth stories of the self capable of supporting affect regulation in the present and the maintenance of homeostatic functions into the future. Memory in this form may maximize neural network integration as it organizes vast amounts of information across multiple processing tracks (Cozolino, 2002). Stories operate to bridge and integrate neural pathways both in the present moment and through time (Scott, 1995).

In effect, therapists may have to give way to multi-modal interventions based on the principles of neurobiological growth regulation and integration, where neuroscience presents an added perspective in the treatment of families and individuals.

Conclusion

My main goal of the practicum was to work with families engaged in parent-child conflict using narrative therapy in association with other family systems theories to enhance the limitations of social constructivism.

Examination of the literature, results on the empirical measures, and clinical supervision have contributed to my knowledge of the therapeutic process, family resourcefulness and resiliency, systems theory and the narrative approach to therapy. Not only did this increase my learning base concerning family adjustment to the developmental life cycle, the experience provided me with a fresh approach to thinking and responding to family problems. Prior to the practicum I was a practitioner whose understanding of therapy was grounded in the field of marriage and family therapy, a framework focused on theory and intervention. Clinical practice from a social work

perspective furthered my appreciation for the impact social welfare, empowerment, family strengths, and social justice has on the family system.

On the whole my learning goals were achieved and appeared beneficial to the families involved as their experiences provided them a new understanding of themselves, while adding appreciably to my professional development.

With my practicum experience I continue my professional growth with new confidence and renewed competencies, to meet families where they are at and empower them towards achieving their goals in a way that meets their needs in a respectful manner.

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APPENDIX A:

GENERAL SCALE SAMPLE STATEMENTS AND FAM GENERAL SCALE

Scale Sample Statements From

the

Family Assessment Measure[1] General Scale

The General Scale of the Family Assessment Measure is comprised of fifty statements consisting of nine subscales. Participants are asked to respond to a particular degree of agreement or disagreement with each statement; whereupon the reply is then allocated a numerical value. The values of the responses within each subscale are totaled to achieve a raw numerical score. These scores are converted into standard scores and the outcomes are graphed to obtain a FAM profile for each participant. The overall score of family functioning is then obtained for each family participant. In total, an absolute score of each participant's subscale scores (excluding the response style subscales of defensiveness and social disability) is attained by dividing this sum by seven.

Statements from each of the nine FAM III subscales are illustrated:

Task Accomplishment:

When problems come up we try different ways of solving them.

Role Performance:

My family expects me to do more than my share.

Communication:

We argue about who said what in our family.

Affective Expression:

We tell each other about things that bother us.

---

[1] Copyright Skinner et al. 1983

Involvement:

We feel loved in our family.

Control:

Punishments are fair in our family.

Values and Norms:

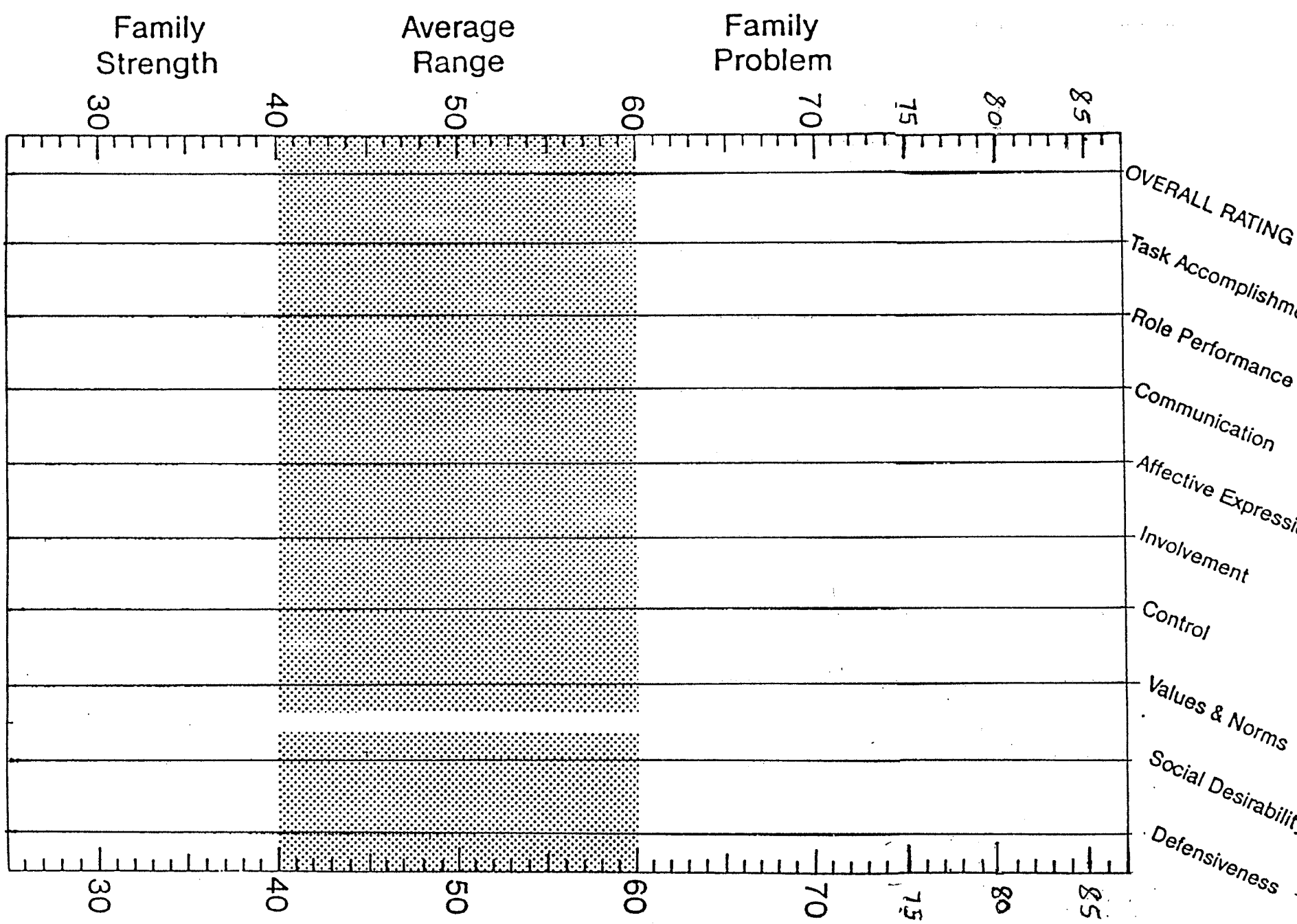
The rules in our family don't make sense.

Social Desirability:

My family and I understand each other completely.

Defensiveness:

Sometimes we are unfair to each other.


Family Strength
Average Range
Family Problem
30
40
50
60
70
75
80
85
OVERALL RATING
Task Accomplishm
Role Performance
Communication
Affective Expressi
Involvement
Control
Values & Norms
Social Desirabilit
Defensiveness

APPENDIX B:

PROBLEM CHECKLIST

PROBLEM CHECKLIST

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.					
2. Showing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Making sensible rules					
5. Being able to discuss what is right and wrong					
6. Sharing of responsibilities					
7. Handling anger and frustration					
8. Dealing with matters concerning sex					
9. Proper use of alcohol, drugs					
10. Use of discipline					
11. Use of physical force					
12. The amount of independence you have in the family					
13. Making contact with friends, relatives, church etc.					
14. Relationship between parents					
15. Relationship between children					
16. Relationship between parents and children					
17. Time family members spend together					
18. Situation at work or school					
19. Family finances					
20. Housing situation					
21. Overall satisfaction with my family					

Make the list rating for yourself:

22. Feeling good about myself					

NAME:_____ DATE:_____

APPENDIX C:

LETTER OF AUTHORIZATION

NEW DIRECTIONS
FOR CHILDREN, YOUTH, ADULTS AND FAMILIES

Since 1885. Formerly Children's Home of Winnipeg

June 2003

This is to verify that Inga Wulff has the permission of New Directions for Children, Youth, Adults and Families to reprint, use for illustrative purposes or any other purpose connected to her practicum, the Client Feedback form, standardized instruments, and any other forms used by New Directions.

Elizabeth Adkins, PhD., C. Psych

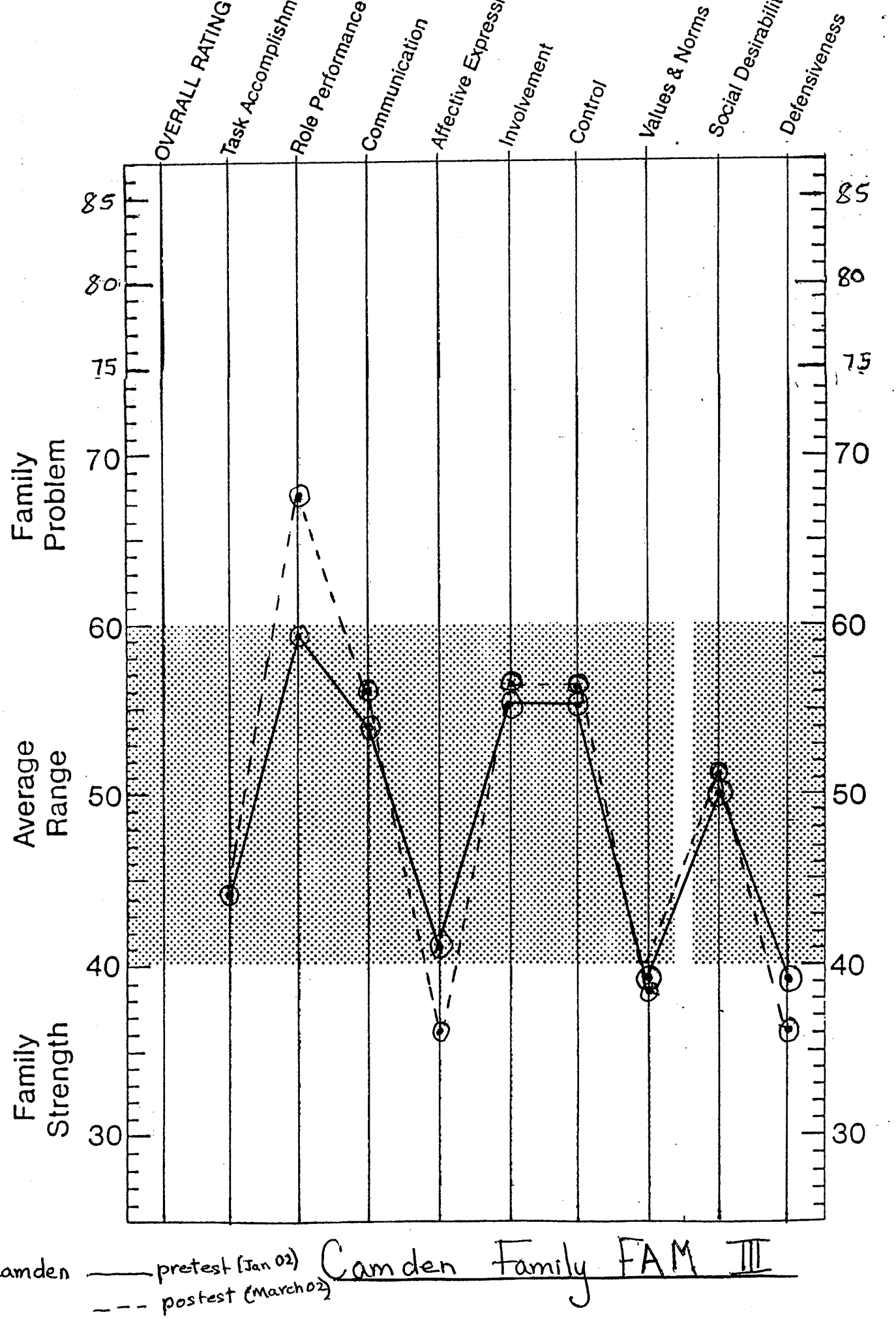
Executive Director

New Directions for Children, Youth, Adults and Families

400 - 491 Portage Avenue, Winnipeg, Manitoba, Canada R3B 2E4
Telephone: (204) 786-7051 Fax: (204) 774-6468 TTY: (204) 774-8541

APPENDIX D:

CAMDEN FAMILY FAM-III GENERAL SCALE AND PROBLEM CHECKLIST


OVERALL RATING
Task Accomplishm
Role Performance
Communication
Affective Expressi
Involvement
Control
Values & Norms
Social Desirabili
Defensiveness
85
80
75
70
60
50
40
30
Family Problem
Average Range
Family Strength
s. Camden
pretest (Jan 02)
postest (March 02)
Camden Family FAM III

PROBLEM CHECKLIST: Pre-Problem Checklist for Camden Family (January 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.		X			
2. Showing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family		X			
4. Making sensible rules			X		
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities		X			
7. Handling anger and frustration	X				
8. Dealing with matters concerning sex		X			
9. Proper use of alcohol, drugs			X		
10. Use of discipline			X		
11. Use of physical force		X			
12. The amount of independence you have in the family			X		
13. Making contact with friends, relatives, church etc.		X			
14. Relationship between parents				X	
15. Relationship between children		X			
16. Relationship between parents and children		X			
17. Time family members spend together			X		
18. Situation at work or school				X	
19. Family finances		X	X(in-between)		
20. Housing situation				X	
21. Overall satisfaction with my family		X			

Make the list rating for yourself:

22. Feeling good about myself		X			

NAME: Jocelyn Camden DATE: January 2002

PROBLEM CHECKLIST: Post-Problem Checklist for Camden Family (March 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family				X	
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong					X
6. Sharing of responsibilities			X		
7. Handling anger and frustration			X		
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs				X	
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church etc.			X		
14. Relationship between parents				X	
15. Relationship bet-veen children				X	
16. Relationship between parents and children				X	
17. Time family members spend together				X	
18. Situation at work or school				X	
19. Family finances			X		
20. Housing situation				X	
21. Overall satisfaction with my family				X	

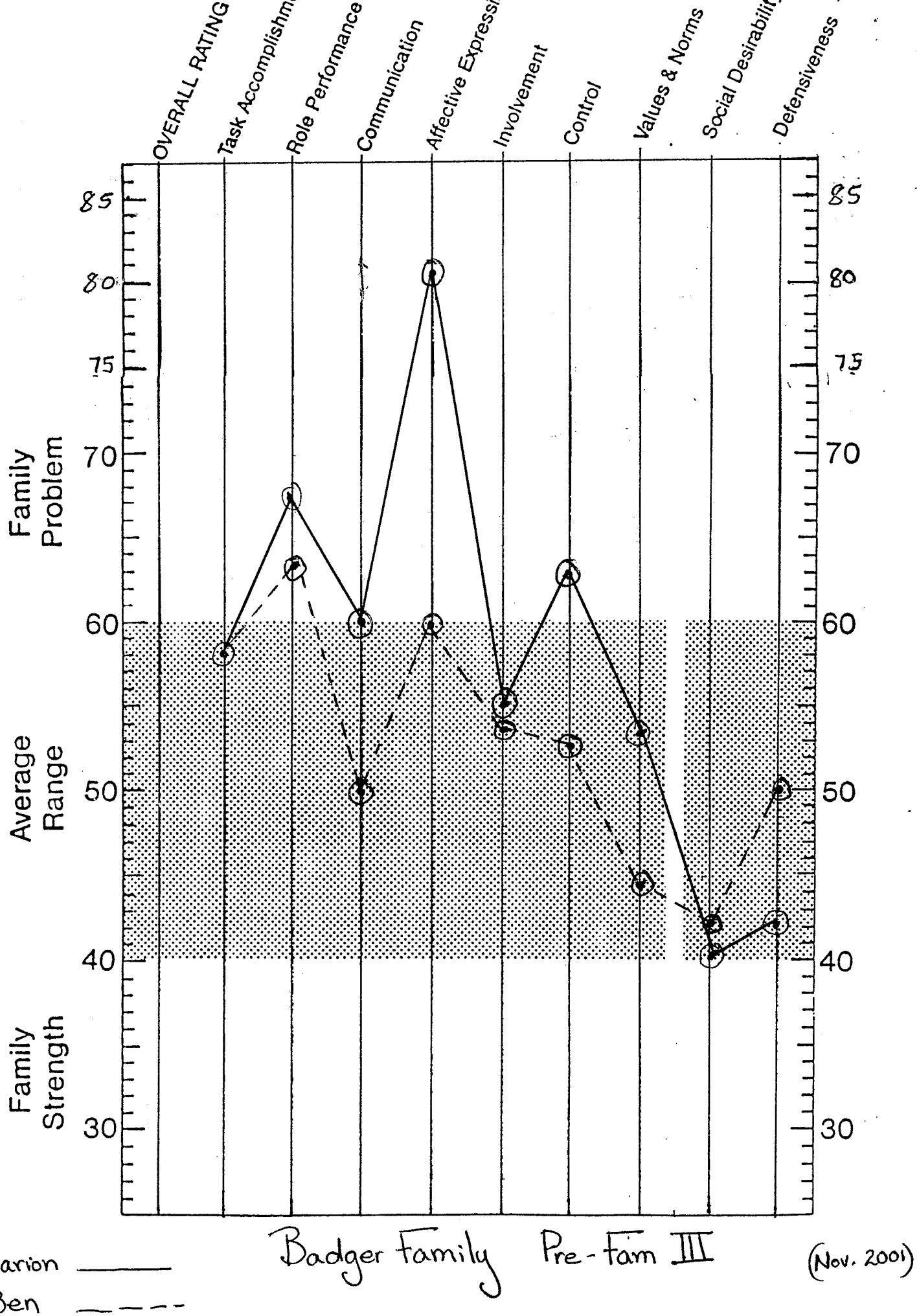
Make the list rating for yourself:

22. Feeling good about myself				X	

NAME: Jocelyn Camden DATE: March 2002

APPENDIX E:

BADGER FAMILY FAM-III GENERAL SCALE AND PROBLEM CHECKLIST


OVERALL RATING
Task Accomplishm
Role Performance
Communication
Affective Expressi
Involvement
Control
Values & Norms
Social Desirabilit
Defensiveness
85
80
75
70
60
50
40
30
Family Problem
Average Range
Family Strength
Badger Family Pre-Fam III
(Nov. 2001)
Marion
Ben

PROBLEM CHECKLIST: Pre-Problem Checklist for Marion Badger Family (November 2001)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.		X			
2. Showing feelings like anger, sadness, hurt, etc.	X				
3. Sharing problems with the family		X			
4. Making sensible rules			X		
5. Being able to discuss what is right and wrong			X		
6. Sharing of responsibilities		X			
7. Handling anger and frustration		X			
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs					X
10. Use of discipline			X		
11. Use of physical force					X
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church etc.			X		
14. Relationship between parents			X		
15. Relationship between children			X		
16. Relationship between parents and children				X	
17. Time family members spend together				X	
18. Situation at work or school		X			
19. Family finances			X		
20. Housing situation					X
21. Overall satisfaction with my family			X		

Make the list rating for yourself:

22. Feeling good about myself	X				

NAME: Marion Badger DATE: November 2001

PROBLEM CHECKLIST: Pre-Problem Checklist for Ben Badger Family (November 2001)

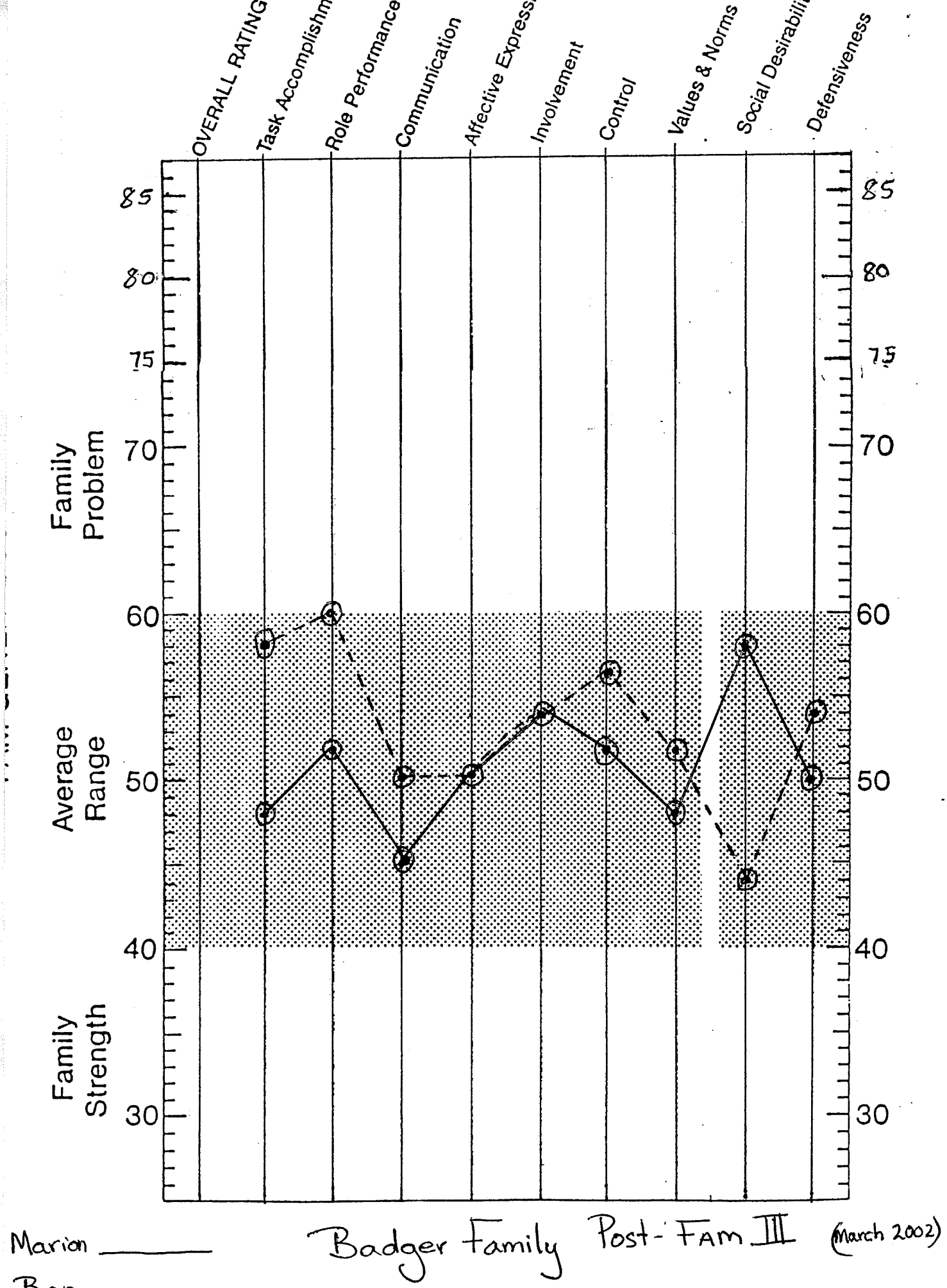
BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family				X	
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities			X		
7. Handling anger and frustration		X			
8. Dealing with matters concerning sex			X		
9. Proper use of alcohol, drugs			X		
10. Use of discipline			X		
11. Use of physical force		X			
12. The amount of independence you have in the family					X
13. Making contact with friends, relatives, church etc.					X
14. Relationship between parents			X		
15. Relationship between children				X	
16. Relationship between parents and children					X
17. Time family members spend together				X	
18. Situation at work or school				X	
19. Family finances			X		
20. Housing situation					X
21. Overall satisfaction with my family				X	

Make the list rating for yourself:

22. Feeling good about myself				X	

NAME: Ben Badger DATE: November 2001


OVERALL RATING
Task Accomplishm
Role Performance
Communication
Affective Expressi
Involvement
Control
Values & Norms
Social Desirabilit
Defensiveness
85
80
75
70
60
50
40
30
Family Problem
Average Range
Family Strength
Marion
Ben
Badger Family Post-Fam III (March 2002)

PROBLEM CHECKLIST: Post-Problem Checklist for Marion Badger Family (March 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family			X		
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities				X	
7. Handling anger and frustration			X		
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs					X
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family					X
13. Making contact with friends, relatives, church etc.			X		
14. Relationship between parents				X	
15. Relationship between children				X	
16. Relationship between parents and children				X	
17. Time family members spend together				X	
18. Situation at work or school			X		
19. Family finances			X		
20. Housing situation					X
21. Overall satisfaction with my family				X	

Make the list rating for yourself:

22. Feeling good about myself				X	

Name: Marion Badger DATE: March 2002

PROBLEM CHECKLIST: Post-Problem Checklist for Ben Badger (March 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family				X	
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities			X		
7. Handling anger and frustration				X	
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs					X
10. Use of discipline				X	
11. Use of physical force			X		
12. The amount of independence you have in the family					X
13. Making contact with friends, relatives, church etc.					X
14. Relationship between parents				X	
15. Relationship between children					X
16. Relationship between parents and children					X
17. Time family members spend together					X
18. Situation at work or school				X	
19. Family finances				X	
20. Housing situation				X	
21. Overall satisfaction with my family				X	

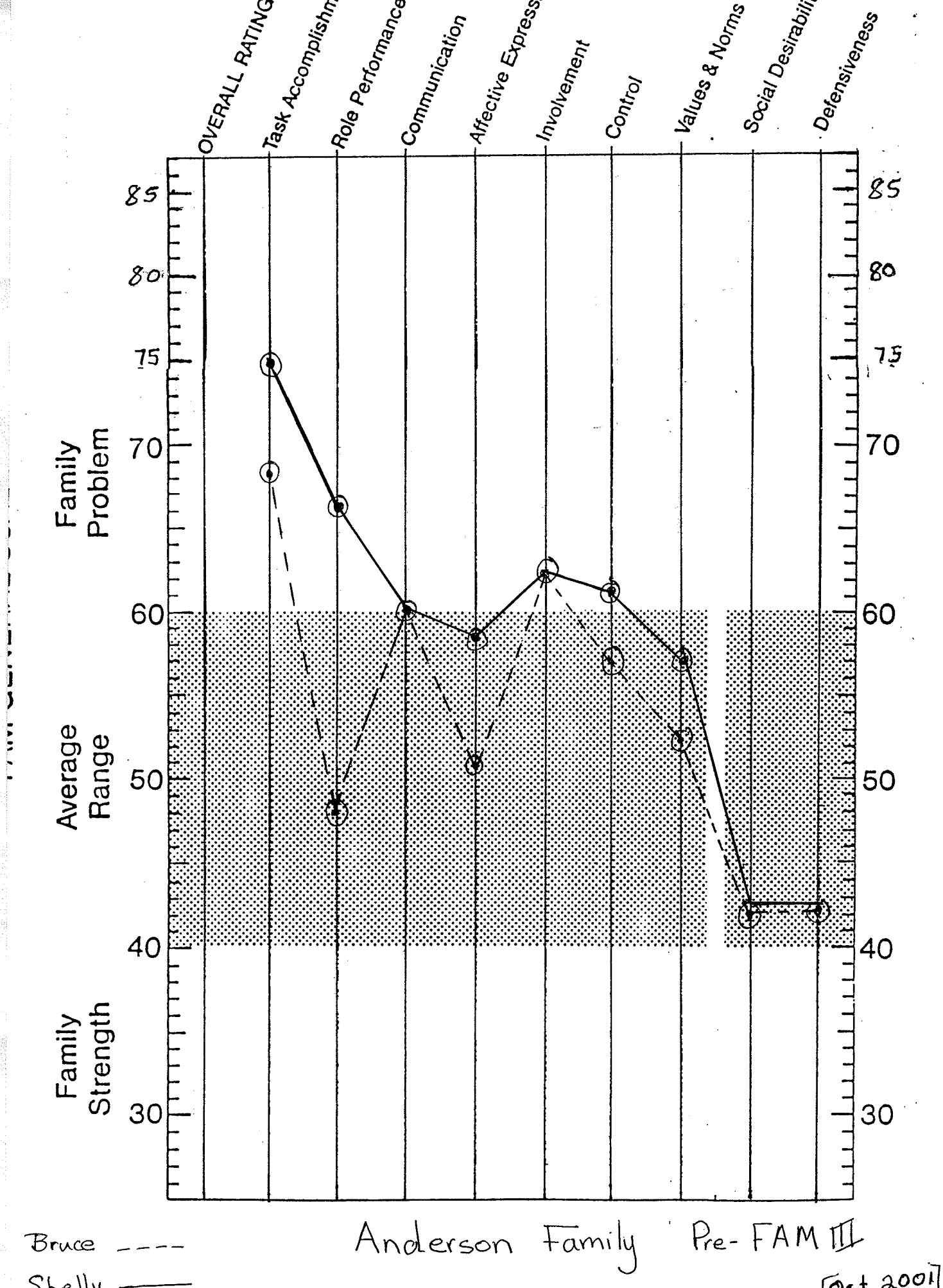
Make the list rating for yourself:

22. Feeling good about myself				X	

NAME: Ben Badger DATE: March 2002

APPENDIX F:

ANDERSON FAMILY FAM-III GENERAL SCALE AND PROBLEM CHECKLIST


OVERALL RATING
Task Accomplishm
Role Performance
Communication
Affective Expres
Involvement
Control
Values & Norms
Social Desirabili
Defensiveness
85
80
75
70
60
50
40
30
Family Problem
Average Range
Family Strength
Bruce ----
Shelly ——
Anderson Family Pre-FAM III
[Oct. 2001]

PROBLEM CHECKLIST: Pre-Problem Checklist for Shelly Anderson Family (October 2001)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.	X				
3. Sharing problems with the family	X				
4. Making sensible rules		X			
5. Being able to discuss what is right and wrong		X			
6. Sharing of responsibilities		X			
7. Handling anger and frustration	X				
8. Dealing with matters concerning sex	X				
9. Proper use of alcohol, drugs					X
10. Use of discipline		X			
11. Use of physical force			X		
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church etc.		X			
14. Relationship between parents		X			
15. Relationship between children				X	
16. Relationship between parents and children			X		
17. Time family members spend together		X			
18. Situation at work or school					X
19. Family finances				X	
20. Housing situation					X
21. Overall satisfaction with my family			X		

Make the list rating for yourself:

22. Feeling good about myself				X	

Name: Shelly Anderson DATE: October 2001

PROBLEM CHECKLIST: Pre-Problem Checklist for Bruce Anderson Family (October 2001)

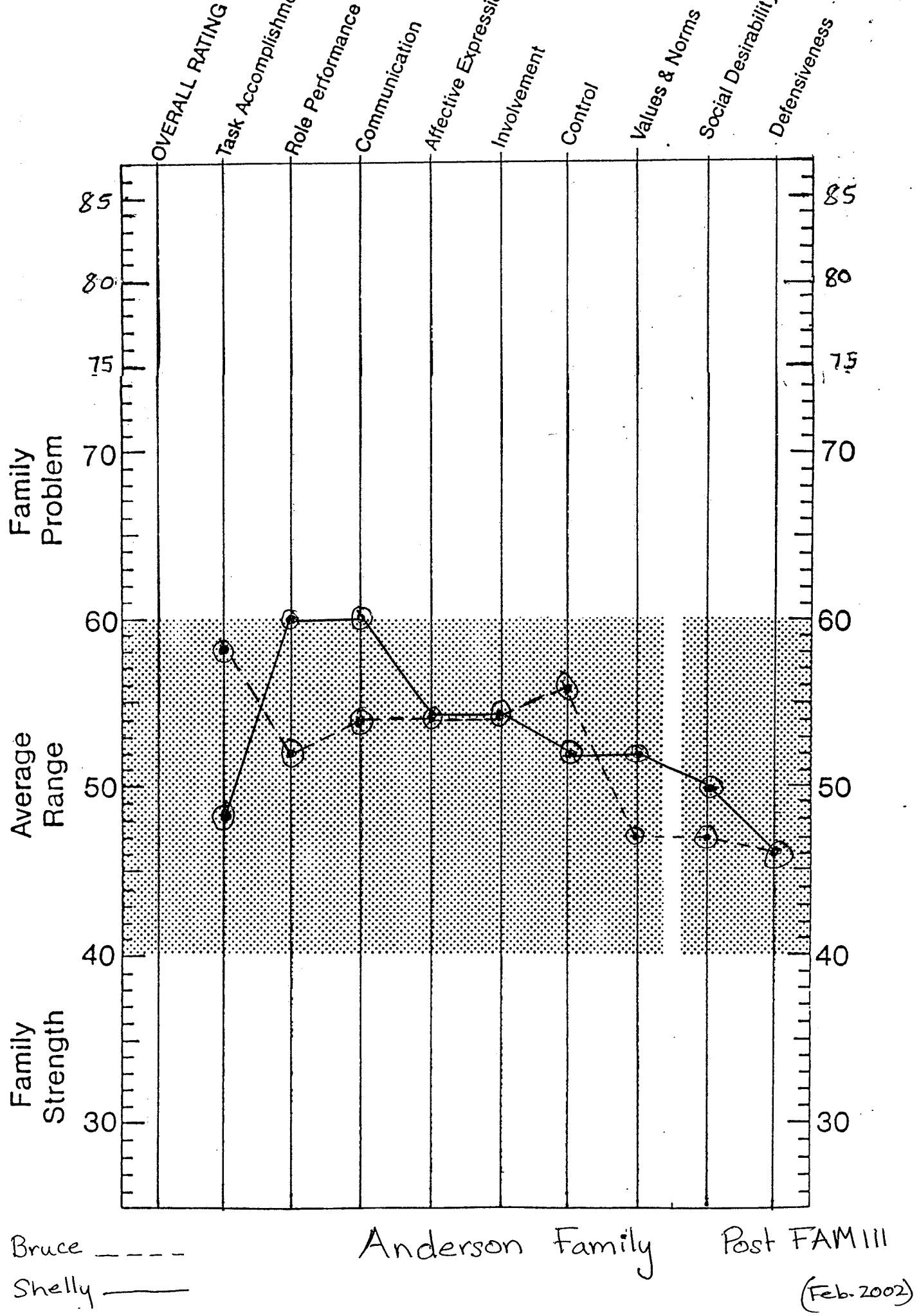
BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.			X		
2. Showing feelings like anger, sadness, hurt, etc.		X			
3. Sharing problems with the family		X			
4. Making sensible rules			X		
5. Being able to discuss what is right and wrong		X			
6. Sharing of responsibilities			X		
7. Handling anger and frustration		X			
8. Dealing with matters concerning sex			X		
9. Proper use of alcohol, drugs				X	
10. Use of discipline	X	X (in-betwee n)			
11. Use of physical force		X			
12. The amount of independence you have in the family			X		
13. Making contact with friends, relatives, church etc.		X			
14. Relationship between parents		X			
15. Relationship between children			X		
16. Relationship between parents and children		X			
17. Time family members spend together		X			
18. Situation at work or school				X	
19. Family finances				X	
20. Housing situation				X	
21. Overall satisfaction with my family		X			

Make the list rating for yourself:

22. Feeling good about myself		X	X (in-between)		

NAME: Bruce Anderson DATE: October 2001


OVERALL RATING
Task Accomplishme
Role Performance
Communication
Affective Expressi
Involvement
Control
Values & Norms
Social Desirabilit
Defensiveness
85
80
75
70
60
50
40
30
Family Problem
Average Range
Family Strength
Bruce ----
Shelly ——
Anderson Family
Post FAM III
(Feb. 2002)

PROBLEM CHECKLIST: Post-Problem Checklist for Shelly Anderson Family (February 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.			X		
3. Sharing problems with the family				X	
4. Making sensible rules				X	
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities				X	
7. Handling anger and frustration				X	
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs					X
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church etc.			X		
14. Relationship between parents				X	
15. Relationship between children				X	
16. Relationship between parents and children			X		
17. Time family members spend together			X		
18. Situation at work or school				X	
19. Family finances				X	
20. Housing situation				X	
21. Overall satisfaction with my family			X		

Make the list rating for yourself:

22. Feeling good about myself				X	

Name: Shelly Anderson DATE: February 2002

PROBLEM CHECKLIST: Post-Problem Checklist for Bruce Anderson (February 2002)

BELOW IS A LIST OF FAMILY CONCERNS: INDICATE HOW SATISFIED YOU ARE WITH HOW YOUR FAMILY IS DOING **NOW** IN EACH AREA. PUT A CHECK (X) IN THE BOX THAT SHOWS YOUR FEELINGS ABOUT EACH AREA.

	VERY DIS-SATISFIED	DIS - SATIS FIED	IN BETWEEN	SATIS FIED	VERY SATIS FIED
1. Showing good feelings (joy, happiness, pleasure, etc.				X	
2. Showing feelings like anger, sadness, hurt, etc.				X	
3. Sharing problems with the family				X	
4. Making sensible rules			X		
5. Being able to discuss what is right and wrong				X	
6. Sharing of responsibilities				X	
7. Handling anger and frustration				X	
8. Dealing with matters concerning sex				X	
9. Proper use of alcohol, drugs					X
10. Use of discipline				X	
11. Use of physical force				X	
12. The amount of independence you have in the family				X	
13. Making contact with friends, relatives, church etc.			X		
14. Relationship between parents				X	
15. Relationship between children				X	
16. Relationship between parents and children			X		
17. Time family members spend together			X		
18. Situation at work or school				X	
19. Family finances				X	
20. Housing situation				X	

21. Overall satisfaction with my family				X	

Make the list rating for yourself:

22. Feeling good about myself				X	

NAME: Bruce Anderson DATE: February 2002