

WORKING WITH MOTHERS & DAUGHTERS:
INTEGRATING FEMINISM AND FAMILY THERAPY

BY

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

MASTERS OF SOCIAL WORK

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Abstract

The practicum explores the use of structurally based solution focused therapy, from a feminist perspective, with mothers and adolescent daughters. The report reviews the relationship between mothers and adolescent daughters, the models of structural and solution focused therapy, and feminist family therapy.

The model of practice is evaluated through the use of videotaped therapy sessions, live supervision, case consultation and client feedback. Three case examples are provided to illustrate the use of the combination of the above models.

Acknowledgements

It is not often that one gets the chance to thank the people in our lives for their support and encouragement. I am fortunate to have this opportunity. To begin, I would like to thank the women who inspired and fed my thinking around the relationships of mothers and daughters. Thank you to my mother Edith for her constant caring and nurturance. To my partner's mother Sheila for her endless support. To all the mothers and daughters in my life; my sisters, sisters-in law, friends, and my nieces and great niece. These women have shown me the joys and wonders of mothers and daughters. I would also like to acknowledge Lilian and Gabrielle...who share with me their laughter and love and hope for a new generation of mothers and daughters.

To my committee, Joe Kuypers, Sara Axelrod and Shirley Grosser, thank you for your feedback and support. To George and Margo (of MacNeill clinic) thank you for your wisdom and your friendship. And to the mothers and daughters I worked with and learned so much from.

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Chapter 1: Literature Review

" In the story of mothers and daughters the plot is not entirely of our own making. We may be free to unravel the tale, but we have not been free to create the social relations upon which it is based" (Weskott, 1978, p.16).

A. Introduction:

This practicum report will describe my experience as a family therapy intern. It is an experience of learning, not just about family therapy as the title implies, but about myself as a therapist, feminist, woman and mother. One of my professors said that an introduction is the most difficult to write. After much pondering and a great deal of turmoil, I believe this is true, as my perceptions of the experience are constantly changing.

The family therapy internship was at the MacNeill clinic in Saskatoon, Sask. The clinic provides child focused mental health services for the Saskatoon mental health region. Services include individual, group and family therapy in addition to consultation to service providers. Referrals to the clinic can be made directly by the family or by other social services. The staff consists of social workers, psychologists and

psychiatrists. MacNeill clinic is funded by the provincial government and mandated to provide therapy to children and their families.

The clinic is divided into three teams; early childhood, mid childhood and youth and family. I was a family therapy intern with the youth and family team directed by George Enns. Families referred to this team are those with children twelve to eighteen years old. The youth and family team practise family therapy from a combination of perspectives. The primary theory used for assessment is structural family therapy. They use a combination of solution focused models and a gender sensitive philosophy when planning strategies for intervention.

Goals of Practicum:

- 1) To develop greater experience and skills relating to family therapy.
- 2) To develop a greater knowledge of the models of structural and solution focused therapy.
- 3) To develop interviewing and assessment skills in the area of family therapy.
- 4) To develop interviewing and assessment skills when working specifically with mothers and daughters.

- 5) To heighten personal awareness of gender roles when working with families.
- 6) To develop and integrate a method for working with families that acknowledges gender roles.
- 7) Lastly, and perhaps most importantly, to provide a therapeutic environment that is ultimately and completely respectful to women and their families.

I have made some particular choices about my work, in three areas; personal, political and clinical. My political choice is feminism. I will describe what is meant by a feminist perspective with respect to family therapy. Feminist critiques of the family therapy literature will be included. My clinical choice is informed by a systemic viewpoint. A structural family therapy model was utilized for assessment. A solution focused model organized the interviewing process and directed interventions.

An examination of the relationship between mothers and adolescent daughters will also be provided. Although the internship was structured to work with the whole family system, much of my work ended up being with mothers and their adolescent daughters. (Although this occurred by chance, I find it interesting since over the

last few years my personal focus has been on motherwork, as I have a two year old son). A family therapy model was still used for assessment because I believe the issues identified by the mothers and daughters need to be examined in the context of both family constellation and societal position.

Finally, a personal perspective will be included in the case example section of this report. This means that wherever possible I will note my personal impressions of my work and how I believe I have been influenced by my own experiences. This will be included because I believe that our own herstories have a great influence on who we are as therapists and how we choose to work.

The literature review for this report will be comprised of three sections, and will be designed to define and illustrate what is meant by the following:

- 1) an examination of the relationship of mothers and their adolescent daughters.
- 2) the political choice: a feminist perspective.
- 3) the clinical choice: a systemic viewpoint with a structural family therapy model for assessment and solution focused model for intervention.

B. Mothers and Daughters:

"The first knowledge any woman has of warmth, nourishment, tenderness, security, sensuality, mutuality, comes from her mother. That earliest enwrapment of one female body with another can sooner or later be denied or rejected, felt as choking possessiveness, as rejection, trap, or taboo; but it is, at the beginning, the whole world" (Rich, 1976, p.218).

The relationship between mother and daughter is probably the most intense and intimate a woman will ever know. It is often filled with hope and love, while at the same time burdened with expectations and misunderstandings. From the moment of birth or adoption of a child the mother is supposed to immediately feel love. This idea that a mother instinctively loves her child is a myth. Badinter (1980) reports, "Mother love cannot be taken for granted. When it exists it is an additional advantage, an extra, something thrown into the bargain struck by the lucky ones among us" (p.327). Chodorow (1978) notes that, "Chromosomes do not provide a basis either for the wish for a child or for capacities for nurturant parental behaviour" (p.23). It appears then that women have been set up. We have been told that we should want to mother, that we will be good at it and

that our other desires should be ignored at the very least, and are deviant in many cases.

Chodorow (1978), refutes this notion and discusses the importance of ongoing adult relationships and ongoing productive work outside the home as essential for healthy motherwork to take place. She points out that the difficulties many mothers have are because our society historically, and even today have isolated women in the home and blamed them for having interests outside their children.

A world of gender stereotypes and sexist attitudes has put intense pressure on mothers and dictates to us how we should feel and what the characteristics of a good mother are. Badinter (1980), notes that hundreds of years of mother stereotypes have passed. These stereotypes began with the idea that the home should be a place of refuge. Bernard (1974) reports that the privacy of the home originated as a form of protective isolation. In the fifteenth century, the home was protection against the evils of communal festivities. In the eighteenth century it was protection against the many demands being placed upon it by society. The nineteenth century home provided shelter against the evils of industrialization and urbanization. In the twentieth

century the home was a place for refuge and healing from the cruel capitalist world outside. "This isolated home, protected from the outside world for whatever reason, was the mother's responsibility to maintain as a sanctuary" (p. 11).

Women are beginning to break out of the role of the traditionally defined mother. They are making choices about family, career and children. Motherwork is not always the first instinctive choice a woman makes around what she would like to do in her life. In fact many women have chosen not to have children, or to have children and work outside the home. These women are too great in numbers to be dismissed as pathological, as they once were.

However, the previous centuries' prescribed role for mother has left a legacy of myths about motherhood, and has made the transition from isolation and expectations extremely difficult. Some of these myths include that mothers are endless founts of nurturance, that the measure of a good mother is a "perfect" daughter, that mothers naturally know how to raise children, that mothers are bottomless pits of neediness and that mother-daughter closeness is unhealthy (Caplan, 1989). These myths not only grew out of mother's role as prescribed by

a patriarchal society, but also occurred because mother-blaming and isolating women perpetuates the unequal distribution of power between men and women and thus allows a patriarchal society to flourish. Men benefit from women staying in the home and feeling powerless. "No one feels threatened when women work in groups as men's auxiliaries or as advocates or helpers of the poor, the ill, the disabled, or anyone except themselves and other women. Men who consider women's emotional power a threat are led to contemplate the economic, social, and political power that women wield when we get together"(Caplan, 1989, p. 62).

How has the historical view of mothering (and the myths of motherwork) impacted on the mother daughter relationship? The idealized notion of mother and the common practise of mother-blaming, has resulted in conflict between mothers and daughters. Daughters are in a constant struggle between pleasing their mothers and pleasing society. "When we have to choose between pleasing mother and pleasing society, we are caught between the enormous control she has over our daily lives and the message from our culture that mother's opinion isn't very important or worthwhile" (Caplan, 1989, p.68).

Effective mother daughter therapy begins with an understanding that women have little power in society. This fact greatly impacts the mother daughter relationship. "Women's relative lack of power in society creates a bitter complication in mother daughter relationships. One of the most painful ironies of mothering in patriarchal culture is that mothers, because they have to enforce the limits on their daughters to protect them, end up being betrayers in their daughters' eyes" (Debold, E., Wilson, M., Malave, I., p.33, 1993). Many of the mothers and daughters I saw in therapy were in a struggle around the daughters' independence or desire for independence. Mothers were seen as not letting go, or being too rigid. Some mothers were seen as too close to their daughters, needing their daughters for support and affirmation, when they "should" have been meeting this need elsewhere.

I worked with mothers and adolescent daughters, at MacNeill clinic. This stage of the life cycle is very challenging for most families, and often requires family members to make a shift in their established roles. It is usually a time where children develop independence and begin to think of themselves as somewhat separate from their families. They begin to feel the freedom to explore their own interests and desires. During this

phase mothers, like their daughters are experimenting with new roles, exploring new found freedoms as their children grow older. For mothers and daughters this is a particularly vulnerable time of life.

" When her daughter enters adolescence, the mother is usually entering midlife-a time of evaluation and renewal, of regrets and possibilities. Self-assertion for the mother may mean risking loss emotionally, maritally, socially. Yet this is the very time she is required to be more assertive with her daughter. She needs to provide protection and direction at a time when she is questioning her own direction, and feels least protected. She needs to help her daughter, as well as herself, weigh the price of strength against the cost of dependence" (Walters, Carter, Papp, & Silverstein, p.49, 1988).

Inevitably, mothers and adolescent daughters go through conflict in their relationship. By the time they reach the therapist's office the situation has usually reached a crisis.

In order for a therapist to intervene effectively, it may be useful for she/he to have an understanding of the elements that have directly or indirectly led to the development and maintenance of the problem. Nice (1992),

points out that mothers who cling to their daughters and try to prevent them from growing up may in fact be reacting to a society that says they are nothing without their children. Mothers who are too protective, having fear for their daughters safety are simply realists. Mothers who want a better life for their daughters but yet seem hurt when their daughters take a different path, may be feeling like their life path has been rejected... a personal rejection. "What an adolescent girl sees within the family and explores for herself can be threatening to a mother's self image as a mother and as a woman" (Debold, E., Wilson, M., Malave, I., 1993, p.134). These explanations for mother-daughter conflict take into account the mothers experience without blaming her for the conflict between herself and her daughter.

The clinical setting can provide an understanding of both the mothers' and daughters' situation and life experience. Both mothers and daughters must be heard and learn to listen to each other. As one daughter said to me, "I'm not going to be raped just because my mother was". This was difficult for the mother to hear, but made her see how her past experiences were influencing how she treated her daughter. The daughter in turn was then able to listen to her mothers fears and was a little more sensitive to her mothers' rules about curfews and

dating. This example illustrates how therapy can provide a setting for mothers and daughters to communicate effectively about their experiences. It also illustrates that being female shapes our role as mothers, different from that of fathers.

Gender makes a difference in our lives. There are different consequences of violence for men and women, differences in socialization, differences in power and psychological development and finally differences in the way men and women are conceptualized in therapy (Myers Avis, 1989). I am suggesting that these differences must be taken into consideration when working with families, particularly but not exclusively with mothers and daughters.

"The wall of our present culture appears impenetrable and unassailable. As the only reality we know, it seems immutable, just life. Motherhood, as it exists, is a part of that wall; it's a patriarchal institution that subverts women's power to bring life into the world. On closer inspection, though, the wall has cracks in it and places ready to crumble. We see mothering as a gap in the wall that women, through their resistance to cultural demands, can claim as a source of power. The first step is women teaching voice and

resistance in mother daughter relationships. In the next step women move beyond this intimate pair and make allies, creating a revolution of mothers" (Debold, E., Wilson, M., Malave, I., 1993, p. 223).

It is awesome to think about a revolution of mothers and daughters, generations of women who know their rights and abilities, believe in their strength and spirit and honour their mothers who have struggled before them. This can only occur if we can understand how far we have come as women, as mothers and daughters. This can only occur if we have forgiveness, "of our mothers and ourselves-because we have been misguided by the myths of mother-blame" (Caplan, 1989, p.206). This can only occur if we have acceptance of "the only-human nature of both mothers and daughters in a world that simultaneously raises us to heights of an unattainable ideal and consigns us to sometimes appalling depths of devaluation, demoralization, and powerlessness" (Caplan, 1989, p.206).

C. Political Choice: Feminist Perspective:

I believe that our work as therapists, (individual, group or family) is most effective when seen through a feminist or political lens. In my opinion, this is a vast lens that holds an influence over systemic/structural and solution-focused approaches to therapy. The feminist perspective reminds therapists that the role of women, children and men in society must be understood in the context of the traditional stereotypes that society imposes. Historically there has been a power imbalance in the family beginning with the idea that the father is the leader of the household. Mother is the nurturer and caretaker of the children and the home. Children are lowest on the hierarchy, having very little rights at all. Feminists believe that this power imbalance between men, women and children in the home and our culture serves to promote patriarchal ideas that value the male gender at the expense of women and children. "Many feminist writers have demonstrated and documented the patriarchal nature of our society and the variety of ways in which patriarchal values serve masculine needs..." (Kaschak, 1992, p.9). In light of the invisibility of women's experiences or more clearly stated, womens' experiences told by women, the feminist movement arose to give life to womens' lives. As therapists we need to understand the experiences of our

clients with respect to their circumstances and their gender. Kaschuk (1992) states, "Feminist psychotherapy involves awareness and understanding of the way everyday experiences, including so-called psychological disorders, are organized according to gender and other salient variables" (p.214).

In therapy, a feminist perspective enables the therapist to understand a client's experience in the context of her/his gender. Some people may ask, is this the only way? Having wondered this myself many times, I would argue that interventions with clients can and should be of many varieties, (be it art therapy, reading, journalling, solution-oriented questioning, or relaxation exercises, to name a few), but I believe these interventions should be framed in the blankets of feminism. In my opinion, this gives all clients an honest and respectful view of their relationship with their problems. What responsibility is theirs and what influences are out of their control, are then more clearly identifiable. For example, an abused woman can take responsibility to make positive use of her therapy in order to heal from her abuse herstory. However she cannot take responsibility for the abuse itself or the aftermath it has left her with.

"When we speak of feminism, we speak of the philosophy which recognizes that men and women have different experiences of self, of other, of life, and that men's experience has been widely articulated while women's has been ignored or misrepresented.... When we speak of feminism, we speak of a philosophy which recognizes that every aspect of public and private life carries the mark of patriarchal thinking and practice and is therefore a necessary focus for re-vision" (Goodrich, T., J., Rampage, C., Ellman, B., & Halstead, K., 1988, p.1&2).

I would like to specifically focus on how a feminist perspective is important for our work with mothers and daughters. To do so, one must look at the field of family therapy as many issues between mothers and daughters are seen in the context of family work. Feminist family therapy defines the family with respect to the power imbalance between women, children and men. Problems facing families are understood with regard to the stereotypical roles facing all family members. Goodrich et al (1988), confirm that "the feminist family therapist uses a variety of techniques drawn from various schools of family therapy, but will be sensitive not to use any technique that is sexist or oppressive" (p.25).

When concentrating on relationship issues between mothers and daughters, feminists remind us to examine their problems from a female point of view.

" Mothers and daughters' conflicts today have taken new and sometimes heightened forms precisely because many women are trying to construct their personhood in ways different from their 'mothers' ways...many mothers and daughters are developing new ways of relating to each other. Some have worked hard at this and have realized particularly poignant relationships because of the new depths of understanding they have reached about the forces impinging on them both" (Miller,1986, p.140).

Miller is referring to an understanding of the sexist culture we live in and how this shapes our lives as women. She concludes that when women recognize that they have been denied and degraded by the dominant male culture they often change their view of themselves and their desires. Specifically, they work towards re-defining their roles and relationships based on their own ideas and other womens' teachings.

When mothers and daughters begin to recognize their potential as women, their relationship changes, sometimes creating conflict. Walters (1988), notes that,

"As women are entering the world of work and public purpose in ever increasing numbers, they are continuing to search for definitions and images of the individual, autonomous self that include intimacy and familiarity, caretaking and family....More contemporary daughters , conscious of women's issues and the need for more positive female images, are seeking to identify with their mothers in more mutually affirming ways; to explore their mother's lives in the effort to find positive meaning there for their own lives. But we still have no mother-daughter equivalent of being "a chip off the old block" and of "following in his father's footsteps", with the meaning these metaphors convey of value and personal potential in being identified with the same-sex parent" (pp. 37 & 38).

Traditional family therapists who fail to bring in a feminist perspective, may have difficulty understanding the dilemma of mothers and daughters or hope to offer blame - free explanations (as the one above) for the conflicts and possible resolution to the relationship. To identify boundaries that are too close or too rigid, is a simplistic and a too often used explanation for the problems mothers and daughters can experience. Hare-

Mustin (1987), points out, "When we alter the internal functioning of families without concern for social, economic, and political context, we are in complicity with the society to keep the family unchanged" (p.20).

Feminist family therapists have also done a great deal to expand our perspectives and authenticate womens experiences (both young and old), within the family and in society at large. Feminist family therapists note that mother blaming is too often used as a excuse for relationship problems with daughters and all family members in general.

"From Fromm-Reichmann's coining of the term "schizophrenogenic mother" to Bowlby's descriptions of "maternal deprivation," mothers have been held accountable for the mental health of their children. As motherhood was idealized in the 19th century, so motherhood in the 20th century has become inexorably "psychologized". The child's psychological flaws became the exclusive responsibility of the mother" (Braverman, 1989, p.235).

I recently experienced this notion of mother blaming when I was told by a daycare provider that my son was too smart because I spent too much time with him and he was

now too attached to me! The fact that both his father and I co-parented and spent equal time with him was not even a consideration. The fact that it is quite natural for an 18 month old to have difficulty saying goodbye to BOTH his parents when they leave him at daycare for the first time was pathologized and the blame and responsibility was placed squarely on my shoulders.

Feminists have examined the family therapy concept of enmeshment and found it to be of little use when describing the relationship between mothers and daughters. Often enmeshment is described as being too close, having no clear personal or generational boundaries. Kaschuk (1992), points out the obscurity of this notion. She notes that traditional family therapy blames women for being exactly what the culture prescribes them to be... intensely involved with their families. Feminist family therapists respectfully reframe the problems between mothers and their adolescent daughters as a time when, "They are both in the process of restructuring their relationship, not "splitting" from it; and in restructuring their relationship they will need to find ways to acknowledge their sameness in order to feel comfortable with their differences" (Walters, 1988, p.49).

D. Clinical Choice: Systemic Viewpoint; Structural perspective for assessment, solution focused therapy for intervention

The structural model of family therapy is best described by Salvador Minuchin (1974). He states that structural family therapy is

"...a body of theory and techniques that approaches the individual in his social context. Therapy based on this framework is directed toward changing the organization of the family. When the structure of the family group is transformed, the positions of members in that group are altered accordingly. As a result each individual's experiences change " (p.2).

The structural family therapy model is based on general systems theory. Karpel and Strauss (1983), point out that "A major conceptual breakthrough occurred then when a number of theorists and researchers began to apply the concepts and assumptions of General System Theory to the study of family relationships" (P.19). Minuchin (1974), said to be the father of structural family therapy refers to the concepts of subsystems, boundaries, and hierarchies as essential to assess family dynamics.

1. Subsystems:

Karpel and Strauss (1983), indicate that the systems' characteristic of subsystems has great impact on analyzing the family. Subsystems are smaller units or subgroupings of a family system. Subsystems can be formed by generation, sex, function (i.e. marital, parental or sibling subsystem), or by other factors (Karpel and Strauss, 1983). Minuchin (1974), further reports that " The family system differentiates and carries out its functions through subsystems" (p.52). Subsystems occur on many different levels. Each individual in the family can be referred to as a subsystem. There are marital, parental and sibling subsystems within the family. Each of these subsystems interconnect and interplay, making up the family dynamics.

2. Boundaries:

It is impossible to discuss subsystems without discussing boundaries. " The boundaries of a subsystem are the rules defining who participates, and how. For example, the boundary of a parental subsystem is defined when a mother tells her older child, " You aren't your brother's parent. If he is riding his bike in the street, tell me, and I will stop him" (Minuchin, 1974, p. 53). Boundaries differentiate between subsystems and

must be defined well enough for subsystems to carry out their functions without obstacles, while also allowing for contact between subsystems (Karpel & Strauss, 1983, & Walsh, 1982).

Boundaries also occur between the family and the outside environment such as neighbours, social agencies or schools. Often boundaries are described as too firm or not firm enough and this is where problems begin in families according to Minuchin (1974) and other family therapists.

"Firm but flexible boundaries preserve the differentiation of the family. Between individuals, they assure that members can feel and be recognized as part of the whole group but also preserve a measure of individual difference and autonomy. Between larger subgroupings, they assure that the different functions and activities of family life can be carried out by those members for whom they are most appropriate.... Finally, between the family and the outside social environment, boundaries permit privacy and a sense of group togetherness while integrating the family into larger social community" (Karpel & Strauss, 1983, p.23).

3. Hierarchy:

Finally, it should be noted that both systems concepts and the structural model refer to the fact that families are hierarchical organizations (Fish & Piercy, 1987, p.122). According to Minuchin (1974) boundaries establish the hierarchal structure within the family. Minuchin views the family's ability to function as stemming from appropriate delegation of power and authority from the parental system down. I would add that many traditional family therapists see the delegation of power within the family from the father down.

In general, structural family therapy (based on concepts from systems theory) offers the therapist concrete tools with which to analyze the family dynamics. The focus on subsystems, boundaries and hierarchy is useful when working with mothers and adolescent daughters given that often what is necessary is a redefinition of boundaries. Furthermore, "Although Minuchin has never written about gender as a category or about sexual politics in the family, neither does he overtly prescribe sex roles for men and women" (Luepnitz, 1988, p.57). Luepnitz (1988), also describes how structural family therapy, particularly Minuchin, respects all types of families (single-parent, lesbian and gay parents).

Therefor, there are helpful ideas and concepts that structural family therapy offers therapists when working with mothers/daughters, and all family members.

4. Feminist Critique:

From a feminist perspective, structural/ traditional family therapy teachings fall short in a number of areas. Feminist family therapists criticize traditional family therapists for their definition of boundaries. Walters, Carter, Papp and Silverstein (1988) caution us around the definition of appropriate boundaries. They discuss how the definition of appropriate boundaries is based on the male model of closeness and distance in relationships. It is their opinion that this concept typically ignores female styles of interaction and understandings of closeness in relationships. When looking at relationships specifically with mothers and daughters this is a very important criticism. In order to best help solve problems between mothers and daughters one must look at their problems in the context of female styles of interaction, not male defined views of interactions.

Critics also note no reference to power structures within the family and how this might negatively influence female members of the family system. Goodrich et al

(1988), believe that perhaps it is no coincidence that traditional family therapy is based on concepts of systems theory. They describe how systems theory focuses on the "moves" rather than the "players" in families thus leaving out issues of power and gender. It also focuses on individual family members without acknowledging similarities between, for example, female members of all families. This limited view dismisses any acknowledgment of female oppression and the "second class" status of all women in society.

"Traditional family therapy has done nothing to enlighten families about the connection of their own troubles to culture-wide gender stereotypes and power relations, and furthermore has no theory that links the interactions of family members to the larger social system. Feminist theory offers such a linkage" (Goodrich et al, 1988, p.12).

Finally, Luepnitz (1988), notes that although structural (traditional) family therapy offers a lot to therapists, it falls short when it comes to analyzing the family in a historical or political context. More simply stated, it does not address the issue of patriarchy or the impact a male powered culture has on women, children, men and the family as a whole. In my opinion, structural/traditional family therapy needs the help of

a feminist analysis in order to provide complete and respectful intervention to all family members.

5. Solution-Focused Intervention:

The solution focused approach is an orientation that promotes change. It was originally developed by de Shazer and his colleagues at the Brief Family Treatment Centre in Milwaukee. It focuses on the assumption that all clients have the desire and ability to solve their own problems. The therapist acts a guide, asking appropriate questions and developing tasks that enable clients to reach their goal. By focusing on information and resources that the client brings to therapy, the solution focused model promotes client strengths and inner abilities (de Shazer, 1988). Michele Weiner-Davis (Saskatoon Family Therapy Institute Conference, 1991) spoke of the assumptions of the solution-oriented approach;

- a) Social reality is co-created.
- b) Resistance is not a useful concept. Cooperation is inevitable.
- c) Change is inevitable. Rapid resolution of complaints is probable.
- d) Small change is all that is necessary, a change in one part of the system affects change in other parts of the system.

- e) Clients have resources to solve problems. They are the experts.
- f) You don't need to know a great deal about the problem to solve it. You should focus on exceptions and formulate interventions.
- g) Clients define goals.
- h) There are many ways to look at a situation, none more correct than others.
- i) Meanings are negotiable; choose meanings that lead to change.

These concepts implicitly promote and reinforce the therapist belief in clients health and ability to move in positive directions.

In my work with mothers and daughters, I used the following techniques borrowed from a solution-oriented approach to therapy: a) The notion of language as a tool for useful questions. Specifically, when a therapists questions focus on the positive and the future, they implicitly promote the belief that change will occur.

"... Therapists can use presuppositions to introduce change notions and expectations in the therapy session. If a therapist asks, What will be different in your life WHEN therapy is successful?, he or she is not merely seeking information but also implicitly introducing the idea that therapy

will be successful" (Hudson O'Hanlon, W., Weiner-Davis, M., 1989, p.61).

b) The use of exceptions or times when the problem is not occurring (de Shazer, 1985). For example, when a mother and daughter state that they are always in conflict, the therapist might ask them about times (even 1 minute in the day), when they don't fight. This then becomes a point to build on. We can then look at what they are doing differently during that time.

c) The "miracle question". The basic miracle question goes like this, "Suppose that one night, while you were asleep, there was a miracle and this problem was solved. How would you know? What would be different?" (de Shazer, 1988, p.5). This question is a useful tool which helps the client begin to think about solutions to her/his problem.

d) During and at the end of each session it is important to give compliments to the client. These compliments are positive feedback about what they are already doing to solve their problem. (Hudson O'Hanlon, W. & Weiner-Davis, M., 1989).

The solution-oriented approach to intervention is similar to a feminist approach in that it serves to promote client strengths and assumes clients have the ability to make changes and resolve their problems. I have mentioned only a few of the interventions this approach suggests. In my work these have been the most useful.

I believe a point of caution about this approach is in the area of focus on problems or lack of focus on problems. I believe it is important for many clients to tell their stories and be heard, especially when working with women. The important piece of our work is how we frame the problem, and whether we use information the client is giving us. Pathologizing and missing or negating exceptions to the problem can only serve to further clients inability to change.

Chapter 2: Practicum Report

A. Introduction:

As stated previously, my practicum took place at MacNeill clinic in Saskatoon, Sask. I was required to work at the clinic for a four month period. I was at the clinic five days a week, eight hours per day. As a family therapy intern, I was required to carry a small caseload of families (10 - 15) having problems with their adolescent children. The work involved meeting with these families on a weekly or bi-weekly basis. The training format involved weekly supervision (with two different supervisors), and a four hour reflecting team consultation that occurred once a week. Time was allocated for reviewing therapy tapes of staff at the clinic as well as reading appropriate articles and text.

The weekly supervision involved meeting with one supervisor at a time, individually, for a period of ninety minutes. During this time session tapes (we were required to videotape all our work with clients) were reviewed and feedback was given. During supervision we discussed assessment of the family and possible intervention strategies. We also went over assessment reports as we were required to write assessments, progress notes and termination summaries.

As stated earlier the reflecting team met for four hours on a weekly basis. The team was made up of all the therapists on the youth and family team. All therapists were required to bring in a family for a first interview. (As an intern we were required to do this on two different occasions). The primary therapist would conduct a first interview behind a one-way mirror with the team of colleagues watching. After the interview was completed the family and team would switch places allowing the family and primary therapist to hear feedback from the team. The final stage of this process would involve the primary therapist and family going back in front of the mirror to discuss reactions to the feedback. After this was completed a second session (if required or desired) was set up and the family's role in the process was complete. The team and primary therapist would then meet to provide each other with impressions of the work and feedback. Direction for subsequent sessions was also discussed.

1. Personal Herstory; How does our personal herstories impact our work as therapists?

Before beginning the section on case examples I would like to include a few thoughts on what I mean by "the personal". In my opinion, my personal feelings and

experiences informs all my work. So, throughout the section on case examples I will note my opinions, when I have them, or can find words that describe how I'm feeling.

It is my belief that one cannot facilitate the therapeutic process without bringing in her own experiences. "... it is assumed (by feminists) that the therapist as a person, and particularly her values, have an important impact on the process and outcome of therapy" (Sturdivant, p.149, 1980). How does one define personal. It is different for everyone. There is no objective definition. When I refer to the personal, I mean generally who I am and how my own herstory shapes my work. Specifically, how my past experiences shape or influence who I am as a therapist. Through personal work and work as a therapist, I have learned that it is helpful to understand our actions as a therapist in the context of our own healing journey.

This report is not intended to document my own healing journey. However, I feel it is important to overtly state that as therapists we must all be aware of our own life experiences and how they specifically impact on our work. Levine states, "Beginning with my own experience, connecting my struggles with those of other

women, is central to being a feminist and to feminist counselling" (p.75, 1984). I would add that what is central to good therapy is having a strong but permeable personal boundary. One that allows for the development of a caring professional relationship. At the same time there must be a clear understanding by both the client and therapist that therapy is a time for the client to do her/his work and NOT a time for the therapist in her/his own healing work.

Finally, we must not only consider our past experiences as a factor which influences our work as therapists, but also our gender. " Since the therapist is also gendered and gender is never neutral, the therapist's behaviour will always either reinforce or challenge the family's assumptions about gender" (Goodrich et al, 1988, p.22). An example comes from my work at MacNeill. I saw a family where the father asked a colleague if his family could see "one of the girls". I remember immediately feeling on guard with this man, as if I had to prove myself. I felt it was extremely important for him to perceive me as competent and skilled in my work. Of course this is always important but in this case it seemed more crucial. It turned out that this man was not as sexist and patronizing as I had anticipated and some good work happened in therapy.

However this case illustrates how gender could have been a block to the work, (i.e. the father treating me as a girl, younger, not respecting my skills), instead perhaps what occurred was some positive role modelling and perhaps changed opinions about women. "For therapists to deny the impact of gender on their relationships with families means missing not only a powerful dynamic but also the opportunity to use gender role in a therapeutic manner" Goodrich et al ,1988, p.22).

As I stated earlier, most of my clinical work at MacNeill involved working specifically with mothers and daughters. Because I am both a mother and a daughter (and I believe my experiences in these roles influence my work as a therapist) I would like to share some thoughts on how I feel about these two roles. This is intended to give the reader a brief look at my personal experiences in order to better understand why I did what I did in the following case examples.

2. Thoughts on being a new mother:

"I don't even know the date...no need. Jacob is three weeks old and a few days. I am filled with thoughts and feelings. Do I love him enough? Am I a good mother? Do I like this new role...Enough? I suppose these questions are natural but we women

don't often ask them outloud. Sometimes I feel so incompetent, sometimes I feel so angry, not at Jacob, but at all the things I've given up. I look at his peaceful face swinging in his swing and everything I've just written seems irrelevant. I must be doing something right. Just keep telling myself it's O.K. to go up and down. It's O.K. to be sad about the losses. The loss of freedom, my career (temporarily), my ability to come and go, shower and eat when I want to. Tears well up in my eyes... they are tears of wonder... this little miracle child that we made, I carried and gave birth to. They are tears of hope, that his life will be wonderful, free of violence and stereotypes and all the 'isms', perhaps with the exception of feminism (they are always exceptions!). Hope that I will be able to meet his needs. As I write there are pains in my heart... they are also tears of loss... my body is no longer my own, it is Jacob's, it has given him life, it will give him food. I wonder about what I used to think accomplishments were? There is Jacob's cry. It's amazing how such a little child's cry can make a grown woman feel so incompetent" (sometime in March, 1992).

Similarly to the mothers I see in therapy, I too struggle with the notions of what is a good mother and how do I meet the needs of my child while meeting my own needs as well. This journal entry was written about two years ago. I have been able to balance (or should I say struggle with balancing) my career aspirations and personal needs, with being a mother. I still have a long way to go and think that it is important to give myself permission to continue the struggle without sacrificing my desires or those of my child's. Needless to say this is not an easy task but one that I believe will benefit both of us a great deal.

My ability to be empathic to the mothers I see in therapy comes from, in part, an ability to identify with their struggles. I continue to learn from them as well as from my own personal experiences.

3. Thoughts on being a daughter:

Both my mother and father are Jewish (my father died 15 years ago). I come from a large blended family. I have two brothers and three sisters. My mother could be described as a typical Jewish mother. Braverman (1990), characterizes the Jewish mother in the following way;

"The phrase "Jewish mothers" immediately conjures up images of women extraordinarily involved in the

lives of their children. The jewish mother feels an overreaching responsibility to nurture and develop her children's talents, to be devoted to their every need, and do whatever is necessary to help them become successful in life, even if in the process, her own sense of self and development must take a back seat. Achievement is a great theme in a jewish mother's relationship with her children. A child's failure in getting ahead educationally, financially, or in marrying and having children is experienced by the jewish mother as her failure and thus a great source of her own deep personal pain" (p.9).

This characterization could be describing my mother or my maternal grandmother. My connection with my mother is very strong. We speak often and she is constantly thinking of and worrying about me. As a daughter, I have struggled with maintaining a close connection with my mother, understanding and respecting her ways, while also developing and maintaining my own life and ways of being in the world.

Sometimes developing an appropriate distance from my mother, or finding space for myself has been a challenge. This is due to the fact that my mother grew up with

little distance from her mother, so our renegotiation of boundaries did not follow her teachings for mother-daughter relationships. My mother was taught to take little space for herself. To this day her life decisions always involve thinking of and considering how they will affect my grandmother. My mother and I on the otherhand, have managed to find space for each other and from each other in order to stay friends while nurturing our own independent lives, separate from the other. Changing our relationship was a new learning experience for both of us.

Due to my upbringing, I believe I can identify with mothers and daughters who struggle with re-defining themselves separate from the other. I understand the daughter who wants to stay close to her mother, but also wants her independence. I sympathise with the mother who fears her daughters independence and worries about their connection remaining in tact. I have used my own personal herstory (as well as my learning as a therapist) to guide my assessments and interventions for my clients.

To conclude, I hope that these brief glimpses in to my own herstory will give the reader some insight into my personal experiences and how they have influenced my

work. A more complete explanation of my clinical style will be included in the case examples.

B. Case Examples:

1. Introduction:

My work with mothers and daughters is based on the premise that women form a critical, significant part of society. Their roles in the family are equally as important. Assuming this I believe therapy must validate women's experiences and find avenues for change. Balancing the needs of mothers with the ever changing needs of adolescent daughters is not an easy task. At the heart of this task, for me was the assumption that both mothers and daughters are faced with the challenge of feeling good about themselves in the face of a society that devalues them. The conflicts that occur between mother and daughter should be seen as one of many bumps in a road towards a healthy, valuable relationship. "Our mutual clinical purpose is one of eliciting and enhancing the positive power of the relationship as a counterpoint to the prevailing view of daughters caught in an endless struggle to escape from over involved, pathologizing mothers" (Walters, 1988, p.50). My hope is that my work at the very least was respectful and informed by my personal experiences and my feminist beliefs. At best,

I wonder if maybe, one or many of the women I have seen have been able to re-value themselves and their experiences and find energy to continue to fight against the power of a devaluing, sexist culture.

The following three cases were chosen because of their differences. The first case illustrates a mother who has been typically seen by therapists as cold and unfeeling. Using a structural family therapy assessment she could be described as having rigid boundaries. A feminist informed assessment allowed me to look beyond this mother's rigid boundaries and push for an understanding of why she needed to be so defended with her daughter. My task then became helping her to reach for her softness and vulnerability and support her in her efforts to reach out to her "challenging" adolescent daughter. The second case illustrates a mother and two daughters who have a very close, but perhaps somewhat "enmeshed" relationship. The symptoms of their relationship difficulties were illustrated by the youngest daughter's use of a dramatic form of communication to tell her mother that she needed some space. The third case provides an example of a daughter who has difficulty taking responsibility for her own happiness and relied on her mother, (although unwittingly) and myself to solve her problems. This case is included

to illustrate my struggles as a therapist in joining with this young woman. It is hoped that it illustrates how sometimes we are unsuccessful in our work, or at best, how the positive influences of therapy must be seen by reading between the lines. (All names of clients have been changed to protect confidentiality. Some case scenarios have been altered somewhat, in the interests of confidentiality.)

2. Case #1: A Tangled Web of Misunderstandings:

This family was referred by the school guidance counsellor. According to the counsellor, the daughter Susan (17), and her mother Sharon (46) were constantly in disagreement. Susan felt that her mother did not care about her. Susan's parents, Sharon and Joe (47) both worked full time running a family business. Susan was adopted and she had a brother Tim (14) who was a biological son. Both children attended school and were "good" students.

This family had been to the clinic on two prior occasions. When Susan was a toddler the family came in because Susan was hard to handle. The parents described Susan as being too smart, always needing to be the centre of attention and never listening to their wishes. At

that time the conflict was between mother and daughter as mother was the principal caregiver. Therapy terminated when the parents were told that Susan was a normal 3 year old, simply expressing her wishes and that all of her behaviours were common for her age. The mother interpreted this information as she was to blame for her difficulties with her daughter.

The family's second involvement with the clinic occurred one year prior to my contact with them when Susan stated she wanted to kill herself. Susan was assessed (in terms of suicidality) as low risk as she stated she did not have the means or a plan to kill herself, but was overwhelmed with the conflict at home. At this time, mother was not supportive of the idea of coming in for therapy and the situation resolved when Susan left home for summer camp where she excelled as a counsellor-in-training.

Session 1:

Although I had asked to see the whole family in a telephone conversation with the mother, only Susan and Sharon attended the first session. Sharon explained that the conflict was between her and her daughter and did not involve the other family members. Sharon reported that Susan had always been a difficult child. From an early

age she always disobeyed her mother and never did what she was told. Sharon reported that nothing was good enough for her daughter. She used the example of whenever she went to hug her daughter she always wanted more and would never let go. In public mother stated that Susan portrayed herself wonderfully, people loved her and were astounded at her wit and charm. Sharon stated that she never had any of these problems with her son and that both her son and her husband had a difficult time getting along with Susan. Sharon insisted that she had done all she could with Susan and that as soon as she was 18, she would be gladly rid of her daughter. She felt that her daughter did not love her and didn't want to live with the family anymore.

Susan reported that her mother did not care about her. She felt that her brother was the favourite child and that he got preferential treatment in the family. She stated that her mother did not recognize any of her good qualities and could only see the bad in her. Susan felt that if things did not change, she would in fact move out of the home.

At this point in the session I asked to meet with mother and daughter separately. I did this for two reasons. The primary one being that both mother and

daughter were ready to throw in the towel and not willing to hear the others point of view at all. I felt they needed some space from each other in order to avoid therapy breaking down at this early stage. The second reason being, that I needed to join with this mother and try and understand why she felt so angry and disillusioned with her relationship with her daughter.

Upon meeting with the mother, I found out that she had been home full time up until the last couple of years. She stated that her husband was not actively involved in parenting and that she took control over disciplining both her children. Sharon also stated that she felt the clinic, in the past, did not understand her, took her daughter's side and blamed her for all their problems. (I thought to myself, no wonder mother is so defended, she feels so blamed and needs to protect herself).

Sharon was quite forthright in agreeing with her daughter that she did favour her son but only because he deserved it. When asked for clarification on this point, she stated that he got more praise and trust because his behaviours merited it. Sharon would not take any credit for raising such an independent daughter who excelled in many aspects of her life. She felt it was all biological

and she did nothing to shape who her daughter was. I guessed that by not taking responsibility for the positive aspects of her daughter, she abdicated herself from any responsibility for the problems she and her daughter were having. It was easier to say that her daughter was completely at fault, then to experience the pain of feeling like a failure as a mother. I believe that Sharon felt blamed by previous therapists. I also felt that the societal notion that the mother is solely responsible for a child's success and happiness compounded Sharon's sense of guilt about the failing relationship between herself and her daughter.

Susan stated that she felt her mother did not love her and that she could do nothing to please her. She stated that she and her father got along and that she liked her brother. Susan was quite tearful by this time in the interview and was clearly feeling hurt by the anger between herself and her mother. I assessed whether Susan felt suicidal as that was the last issue that brought her to the clinic. She stated that she was not suicidal and that she would contact myself or the school guidance counsellor, if she felt suicidal again.

After bringing both mother and daughter together before ending the initial interview I asked them if they

were willing to work on changing their relationship. Both agreed and were somewhat relieved to hear that the other was willing to work. I also asked them the miracle question. Sharon wanted Susan to be more helpful around the house and follow rules. Susan wanted her mother to be more affectionate and more positive about the things she liked about her daughter. I was hopeful about their responses in that it gave us something concrete to work with. I gave Sharon and Susan a task to do during the following week. It was the first session task as identified by de Shazer (1988) asking them to focus on times when they did get along or conflict had been reduced. Due to the intensity of their conflict I asked them to remember these times even if it was only a few minutes out of each day. I indicated to them that I felt they needed to be experts not only on their problems, but also on the times when they were free of their problems. I also asked that all family members attend the following interview and explained that it was important to hear from all members. We contracted to meet together for six sessions and to reassess the situation at that time.

From a structural family therapist's lens, my assessment was that this mother had rigid boundaries. She was unwilling to take any responsibilities for the conflict between herself and her daughter. She also

portrayed an ability to see only the "bad" side of her daughter. I wanted to meet the whole family to provide further assessment information as to the parental boundaries and the role of the son in this family system. Meeting with only part of a family system provided a partial assessment.

My assessment from a feminist perspective was that mother was feeling blamed for the problems between herself and her daughter. Referral information indicated that the father did not have the same difficulties with his daughter. Furthermore, mother had been the primary caretaker of both her children which indicated that she must be feeling a great amount of guilt about the relationship failing between herself and her daughter. This frame (picture) helped me to see that mother needed to be validated for all the hard work she had done in the area of parenting, not be criticized for her inability to reach out to her daughter. In my opinion it would also be important to normalize the hardships all women felt around being the principal caregiver of their children and the pressure they experienced to be "perfect mothers".

The solution focused perspective guided my intervention in the initial session. It reminded me of

the importance of establishing a sense of hope for the relationship. The solution focused philosophy assumes that clients can make change. If this is true (and I believe it is) then these two women needed to take the time to remember their positive experiences with each other. Thus, I gave them the first session task. I hoped that this task would also give them the message that I believed they did feel caring toward each other. Since they could not offer any exceptions to the problem during the session, I felt it was extremely important for them to spend some time focusing on the positive feelings they had for each other, not only the anger and hurt.

Personally, I too was somewhat weary of Sharon. She portrayed herself as being a woman who was extremely cold, void of any compassion. I felt somewhat intimidated by her authoritative nature and could understand how her daughter might feel uncared for. I kept myself quite aware of these initial impressions and knew I had to try hard to engage with Sharon and not alienate her. I needed to work on understanding her point of view, especially because my experience of mothers up until this point was with those women who are relatively self sacrificing when it comes to their

children. Most of the mothers I knew and being a mother myself, I could not imagine being so cold to my child.

Session 2 and 3:

During these two sessions I met all family members. It became clear that the parental subsystem had unclear boundaries. Joe and Sharon rarely discussed disciplinary methods and Sharon was left on her own in this area. Clearly, there was a hierarchy in this family that illustrated that the father took care of the outside work and the mother took care of the children. Joe could not understand Sharon's difficulties with their daughter and while he attempted to emotionally support his wife, he spent most of his time focusing on the family business, rather than co-parenting. To conclude the structural assessment, I found this family to be entering a new life cycle stage (family with adolescents), which required a renegotiation of roles and responsibilities. Sharon began working outside the home, was not as available to the children, while the children were working on how to differentiate from the family system. Sharon and Joe were also spending more time together as a couple and as partners in their family business. In my opinion, these changes heightened the difficulties of mother and daughter.

Using a feminist lens I could see evidence of the great burden of guilt and shame mother was feeling for the conflict. Sharon disclosed that she had never thought of herself as cold or unfeeling and that her mother took care of five children with little difficulty. It became clear to me that Sharon felt badly about being perceived by her daughter as harsh. She also felt like a failure as a mother because she could not get along with her daughter. She did not realize that she is not solely responsible for the relationship, (even though she pretended to), and that perhaps she and her daughter could find new ways of interacting that met both their needs.

Session 4:

Sharon and Susan attended this session. I explained to Sharon and Susan that a colleague was behind the mirror (they consented prior to the session) and that I would take a consultation break after 45 minutes into the session. During this session I presented a frame (frame refers to a picture of the presenting problem and why it may exist) of misunderstanding between the mother and daughter and explained that I felt that it had been nourished from the beginning years of their relationship. That when Susan was a toddler Sharon interpreted her acting out behaviour as defiance to her personally. That

Susan in turn interpreted her mother's discipline and subsequent lack of affection as a sign of lack of love. Both women's interpretations were understandable under the circumstances.

Sharon and Susan were open to my explanations and eager to hear more. I then spoke of the difficulty mothers have had historically and today in terms of unrealistic societal and family expectations. We spoke of society's inability to let mothers off the hook, that we expect them to be all knowing and all caring. I suggested that these were also Susan's expectations of her mother and that perhaps she needed to begin to accept her mother for who she was, not for who she thought she should be. Susan agreed and added that she had always assumed that her mother knew what she needed and was unwilling to meet those needs.

Sharon was feeling quite validated and was surprised that someone finally understood how she was feeling. As Sharon seemed more open to hearing what she may be doing to foster the conflict, I asked her if perhaps she was too critical of her daughter and was blinded to the positive things about her. Sharon tentatively agreed, although she felt that she did give Susan a lot of caring and nurturance. We explored what each woman could do to

foster a spirit of cooperation between them and turn down a new road of their relationship. Mother agreed to be more direct about the things she liked about Susan and Susan agreed to try and do what her mother asked of her and state her needs more openly. They both agreed to take a break when arguments occurred rather than saying things in the heat of anger.

After the consultation break Sharon and Susan were given positive feedback around how hard they were working and how impressed we were with their commitment to therapy despite their past difficulties. We told them we had faith in their ability to master new ways of behaving with each other and asked that they keep track of their new behaviours.

Offering Sharon and Susan a frame of misunderstanding for their problems helped to validate both their experiences without discounting anyone. Using a feminist lens in order to bring about discussion around the societal role of mothers in general, normalized Sharon's feelings and allowed her to be a little less defensive about her ability to mother Susan. This in turn made it easier for Sharon to take some responsibility for the problems in her relationship with her daughter. Hearing that her mother was willing to

make some changes, allowed Susan to be more willing to do what she asked of her.

A solution focused perspective guided the intervention of relaying compliments to this mother and daughter. It directed the positive feedback and informed our message to these women that we had faith in their ability to make changes in their relationship.

The teachings of structural family therapy enabled me to see that mother's personal boundaries needed to become more flexible with respect to her daughter. The inclusion of an awareness of the life cycle stage this family was in helped me to keep in mind that the relationship conflict of mother and daughter was probably exacerbated by the changing of roles of all family members. Specifically, that mother was no longer at home all the time and that her daughter was probably feeling somewhat neglected. Susan was also going through her own changes in terms of negotiating independence from the family. This task is never easy and can bring about a blend of feelings including anger and confusion. Her mother's new professional life was interpreted by Susan as a lack of caring and interest in her.

Final Sessions:

I met with Sharon and Susan on three more occasions. During these sessions they reported many successes. They stated that they had avoided arguments and were able to listen to each other more openly. Susan was quite happy to tell me about the time that her brother got into trouble and that she felt that he was not being favoured anymore. During one session Sharon was able to invite Susan to hug her and was supportive of her pain around having to give up playing volleyball because she had too many other extracurricular activities. Susan was surprised at how aware her mother was of her feelings.

During these sessions I was careful to reinforce the changes, no matter how small, these women were making. Using a solution focused perspective to guide me, I continued to ask Sharon and Susan to examine what they were doing differently that allowed them to understand each other and meet each others needs. This was very helpful in enabling them to continue their new behaviours.

We also had the opportunity to examine how each woman expressed their love towards the other. Susan was able to tell her mother how important physical affection was to her. Sharon was able to point out how her love

was sometimes portrayed in other forms. Sharon told Susan that sometimes she pushed her to do her homework because she wanted her to continue to do well in school and have the opportunities for a university education (something she did not do). Both women were more able to understand the other's side. This resulted in mother's ability to become less angry and defensive and offer Susan more affection. Susan, on the other hand began to respect her mother's wishes around homework and household chores. The positive cycle seemed to flourish, just as the cycle of conflict had in the past.

I also spoke to Sharon and Susan about being struck with how similar they both were. That it is difficult for two independent, competent women to live together and that negotiations can be very challenging. Neither realized before that in fact they were similar and both were quite proud to know this. We also explored and normalized the adolescent stage of the life cycle and how both Sharon and Susan were going through many changes, which makes things tough on their relationship. They agreed that in the last few years things had become worse and that they never felt that they were going through struggles that many mothers and daughters went through. This really normalized their behaviours and gave mother the freedom to let go of some of her guilt.

This case was transferred to my colleague who sat behind the mirror on one occasion. The transfer was done because the family felt they needed to continue their work in therapy and my internship was coming to an end. A contract was established where Susan would spend a few sessions on her own in therapy and that her mother and rest of her family would join at a later point. Sharon felt Susan needed some time to talk and hoped this would help her rebelliousness. We felt that by meeting with Susan alone, mother would have a break and be more willing to make changes at a later point. We also felt that the father and brother needed to be included in subsequent sessions in order to solidify the positive changes and address some of the traditional patterns of parenting this family had established that were no longer helpful.

Conclusions:

This family entered therapy with somewhat of a reputation preceding them. Mother was painted as cold and unfeeling. The daughter was described as an "angel" trying to survive in a difficult situation. Noting my personal experiences and feelings during the work with Sharon and Susan was very helpful. I was surprised at how easy it was to blame this mother for all the problems between herself and her daughter. I was struck by how

difficult it was for me to be empathic towards a mother who was "cold". I was not accustomed to seeing this. I made sense of my difficulties by remembering my own models for mothering. My mother and grandmother were exactly the opposite of this woman. If they felt guilt or as if they had failed they would simply work harder to nurture verses pull away as Sharon had done. This case helped me to realize how important it is to recognize our personal biases and make sure they don't jeopardize our ability to make fair assessments.

The feminist in me pushed me to see how mother's position in this family had hurtful consequences. Because she did most of the parenting, she too was most central in the conflict between her and her daughter. Understanding the situation in this way moves a therapist away from mother blaming and allows her/him to see that family roles also accounted for the players in the family conflict. In this case it was understandable that Sharon withdrew from her daughter when one considers how she had been blamed in the past and how she blamed herself for the difficulties between herself and her daughter. Withdrawing from her daughter was a way for Sharon to protect herself. Once her feelings were validated and normalized in terms of other mothers going through similar experiences, Sharon had the freedom to become

less protected and more open to change. Her difficulty taking responsibility for her own behaviours in supporting the conflict were seen as a result of her own pain and her feeling as if she had failed as a mother. She was not blamed or seen as unfeeling and hard.

Seeing the daughter as an adolescent struggling for independence, as opposed to a child victim of a "bad" mother, helped me to invite the daughter to take some responsibility for making some changes. Respecting these two strong women and pointing out their positive attributes opened the door for them to see something other than badness in the other.

A structural model and solution focused interventive approach kept me aware of two important points for assessment and intervention. The first (using a solution focused lens) was the importance of finding a balance between exploring the problem and exploring positive elements of the mother daughter relationship. The structural family therapist in me, helped me to see the family as a system. This understanding made it clear that all members roles must be looked at and addressed in order for therapy to be complete and new patterns of behaviour to continue. For example, the notion of co-parenting and the importance of a clear parental

boundary needed to be addressed with Joe and Sharon in order to prevent Sharon from feeling like she has personally failed as a mother, should further conflict arise with her children.

3. Case #2: "Can mothers love too much?"

This family was referred by the department of social services (D.S.S.), after the 12 year old daughter wrote a letter to her classmate indicating that she was sexually abused by one of her grandfathers, that her mother beat her and that she was going to kill herself by the time she reached a certain grade in school (she did not specify the grade). D.S.S. did an abuse investigation and found no evidence of sexual abuse. That is the young woman recanted, stated that she was dreaming, and a medical examination showed no evidence of sexual abuse. The case was referred to MacNeill clinic for family therapy. All family members were open to therapy and very concerned about the situation. The family members included; mother (Linda, 44), father (Bruce, 46), son (Ken, 21), daughter (Kelly, 19) and daughter (Brenda, 12). Upon referral I received the above information as well as information that mother was sexually abused by someone in her family of origin.

Session #1:

Brenda and her mother, Linda attended the first session. Linda reported how much she loved her daughter and how concerned she was for her. Linda stated she wanted to know if her daughter had been sexually abused. Throughout the first interview Brenda was very quiet. In fact her mother did a lot of talking for her. Linda explained that she had two older children, both out of the home. That she missed her older daughter very much and that they were extremely close. Linda stated that Brenda and Kelly were also close and Brenda concurred. Linda also said that her first child died as a young infant and she still mourned her. At this point Brenda became very tearful and said she missed her sister a great deal. I asked Brenda to talk more about this but she couldn't. She stated that she just thought about her a lot. (I wondered about this as Brenda had never met her sister that died.)

I met with Brenda separately to go over her sexual abuse allegations. Brenda did not disclose anything to me, and could not explain why she had written the letter. She did state she was not suicidal at this time and agreed to talk to her older sister if she felt suicidal again. She cried a lot and I attempted to reassure her

that things would be better again. Not surprisingly, she was not convinced.

I also met with mother separately indicating my concerns about Brenda's safety and asked her what she thought of Brenda's allegations. She stated that she never beat her or watched her being sexually abused. (D.S.S. concurred with Linda's story). She stated that while she knows abuse occurs she can not imagine that Brenda was abused by her grandfathers as they have had no access to her. I attempted to talk with Linda about the referral information and her own abuse history. Linda became very defensive and stated that she was not comfortable discussing it, and that it had no relevance to this case. I did not push Linda on this as I felt as if we needed some time to develop a trusting relationship before I pressed her on this issue (I thought it was quite relevant who abused her). I explained to Linda that if she wanted to talk at a later point to please do so and asked her if it would be alright if I brought the subject up again in another session. I felt it was important to ask this as Linda and Brenda both needed to feel as much in control of this process as they could. I also felt that they needed to be clear about where I was going with the work so there would be no surprises and they could learn to trust me.

I brought Linda and Brenda back together and with Brenda's permission explained that there was no further disclosure. I explained that I did not know what had happened that I needed more information in order to give the family some direction. I explained that when I had more family information, it would become easier to decide what needed to happen in terms of healing. They understood and agreed to meet for another session. (I made no specific contract with this mother and daughter as I felt that everyone was unclear about our process or exactly how much time we needed together).

I received a lot of supervision on this case. My supervisor was extremely supportive and we were both quite challenged working on this case together. The feminist voice inside me and my past work experience in the area of sexual abuse completely blinded me to any other issues in this family besides Brenda's alleged victimization. My supervisor who comes from a more structural/systemic point of view saw more than the possibility of sexual abuse. He saw that the mother had unclear, if not "enmeshed" boundaries when it came to her relationship with her daughter. He assessed that the daughter was asking for "space" from an overinvolved mother. I was sceptical, to say the least and we agreed

to listen to each other and develop assessments taking both points of view into consideration.

From a personal point of view, I felt quite humbled after the first session. Since I had spent many years working with female survivors of sexual abuse, I was quite sure that Brenda would open up to me and disclose her victimization or offer another explanation for the letter. I was somewhat disturbed by the fact that this did not happen in the first session and felt overwhelmed at the tasks ahead. My supervisor gently and humorously suggested, that I leave my "goddess complex" outside the door for the next session.

The solution focused perspective informed my intervention in this first session. The example that comes to mind is in terms of my choice of language. I was very specific about using words like "when" instead of "if" things get better as a way of letting the family know that I believed they would. I also intended that the future tense of my language would indirectly help the family feel some hope for resolution of the problem.

Session #2:

Mother, father and Brenda attended this session. My goal for this session was to further explore the abuse

issue and continue the assessment process. I explained this to the family and proceeded to meet with them individually. I explained that I would meet Bruce first as I had not spoken with him before.

My interview with Bruce confirmed the fact that mother was the one who did most of the parenting. Bruce spent most of his time working on the family farm with his son. Bruce reported that he did not know why Brenda would write the letter she did and said he would support her if her allegations were true. Bruce helped me to see that the boundaries around this nuclear family were quite strong. There was little contact with extended family and they did not spend a lot of time with friends. This meeting also began to confirm the fact that mother spent all of her time caring for her children and received little outside stimulation.

Linda and I met to discuss her own history of sexual abuse. I informed her that I did think it was important information. Linda said she was sexually abused, that her oldest daughter was the only one who knew and that she did not want her husband to know. We explored her fears about this and discussed the fact that secrets never help situations. Linda felt it was better that no one knew, especially her husband. She would not say who

the abuser was but felt she may be able to disclose this next session. I asked her about her own healing journey and offered support and reading material to her.

From a structural family therapy point of view, the fact that Linda disclosed to her older daughter and not her husband indicated that the boundary between herself and her daughter was somewhat blurred. It became clear that Linda used her daughters for a great amount of support. The fact that she felt more comfortable sharing this information with Kelly, rather than her husband indicated that the couple's relationship was perhaps not as strong as it could be.

I met with Brenda who was extremely quiet and did not feel like talking. She stated she had no information for me. I asked her if anything would make it easier to talk and she said she'd like her sister to join us.

The family came together and we put some closer on the session and I invited Kelly to come next time. Bruce said he would not be able to attend for the next while because he was harvesting.

Throughout the last two sessions I felt it was important to go slow and develop a trusting relationship.

I was beginning to wonder what other secrets were in this family and felt that I needed to make mother and daughter feel safe enough to begin talking. Utilizing a feminist lens for assessing the sexual abuse issue reminded me that feeling safe in therapy would be crucial to our work together. Many feminist therapists (Butler, 1985, Courtois, 1988, Dolan, 1991, and Herman, 1992) note the importance of a safe therapeutic environment.

Utilizing a structural family therapy assessment, it became increasingly clear that mother's personal boundary needed to be strengthened when relating to her daughters. In my opinion the daughters found it difficult to take "space" for themselves because they were always thinking of and being concerned for their mother. A clear example of this came from mother's explanation of why she disclosed her abuse history to her eldest daughter. She indicated that she thought this would stop her daughter from moving out on her own. She felt that if her daughter thought she needed her, she would not move. (Kelly, despite her mother's needs, did move out).

Session#4:

Linda, Brenda and Kelly attended. I asked Kelly if she was aware of what occurred in our last sessions, she said she was. I asked Kelly if she could say how she

felt being here. She said she was extremely concerned about Brenda's letter and wanted to know what happened. I suggested to the family that I would like to spend a little time with each of them separately and then come back together.

I met with Linda first. I reiterated my concern about keeping secrets. Linda disclosed that her brother sexually abused her and that it was impossible for him to have done the same to Brenda. I asked her what it would be like to hear from Brenda that she too was a survivor. She said it would be difficult but she would support her. Linda reiterated her need for her husband not to know of her abuse history and I stated I would not tell him but that I felt she should think about doing so. She reported that she was still very concerned for Brenda because she was shut down and was not talking much. I suggested to Linda, that her family had a history of keeping secrets and that Brenda may not feel she has the freedom to speak of her experiences until things opened up, at least a little bit.

My meeting with Kelly shed some light on the situation. She stated she and her mother were really close and she wondered if Brenda was angry about this. I encouraged her to talk to Brenda about this. When

asked she stated that she did know about her mother's history and was relieved to know I was not going to ask her to break any confidences. I checked out if Kelly had an abuse history and she stated she did not. Kelly did state at times it was difficult being so close to her mother and knowing all that she knew. She stated she'd like to continue therapy, and hoped that things would resolve.

I met with Brenda to assess whether coming to therapy was making things better worse or the same at home. She said the same. To all my other questions she answered "I don't know".

I met with all three women briefly to let them know that I did not know whether the abuse happened or not, that I was staying open and hopeful that at some point Brenda would be able to talk more. They all stated that they wanted to continue our work and felt that only good could come of it.

After the session, I met with my supervisor, watched the tape and realized how both these daughters did care for their mother and how much Linda cared for them. The boundaries between the three of them were somewhat weak, and this, we believed, put great stress on the

daughters. In our opinion it would be difficult for them to realize the normal task of differentiating from the family, if they did not have the freedom from mother to do so. The family hierarchy emerged, portraying a traditional family with traditional roles. Father was the caretaker of the family's economic situation, while mother was completely responsible for the home and children.

From a feminist perspective, it became easy to see that mother found it difficult to give her daughters space as they were all she had. Rather than blame mother for this, I believed it would be important for her to realize that she too was going through a new stage in life which required her to develop interests outside her children. I felt that the mother daughter relationships should be seen in a positive light, validating the closeness they shared, while challenging them to make some changes. Focusing on the mother daughter relationship in therapy would be done in an attempt to give the family a break from talking about the abuse allegations. It was also hoped that if mother could give Brenda some assurance that she could take some space from her, without hurting her, then maybe she would feel free to discuss the contents of her letter.

From a personal point of view, I felt myself identifying with the struggles of the daughters in this family. I could understand how difficult it was to take space for themselves without feeling guilty about perhaps hurting their mother. I knew how important it had been for me to become independent, while maintaining a close positive relationship with my own mother. I remember how difficult this was given the fact that I thought that my mother's sole interest in life had been raising and worrying about me. I also remember that I found out that my mother had many of her own interests and as I grew up, she began to have the freedom to pursue them. I hoped to use my experience to help lead these women to a new stage in their relationship with each other.

Session #5:

I presented my assessment to Brenda, Kelly and Linda. I suggested to them that over the years they had developed a wonderful, loving relationship. I suggested that sometimes as a result of how much they loved each other, they worried a great deal as well. I proposed that this amount of worry can sometimes be destructive because it makes it difficult to develop independence from each other, the kind of independence necessary to become healthy adult women.

At first all three women were hesitant and then Kelly stated that she did worry about her mother and Brenda agreed. I wondered, "Was there some relief in Brenda's eyes?" Linda reported that she had no idea that her daughters worried about her. She then said that she liked them thinking of her but she didn't want to worry them. Kelly became very protective of her mother. (I could see that she was feeling guilty and worried about whether she had hurt her mother). I went on to say that sometimes when women have a wonderful closeness with each other that it becomes difficult because they don't know how to do things without always thinking about how the other felt. Kelly said that this was true but that was just the way it was. I suggested that perhaps she was tired sometimes of worrying for everyone. I stayed with this theme in the session in an effort to help the daughters speak honestly to their mother.

Kelly said that sometimes she would like to do what she wanted without considering her mother. This was very difficult for her and she said she felt very guilty. I asked Linda if she could give Kelly some assurances that it was alright to speak to her mother in this way. I then asked Brenda if she was feeling incredible pressure about her letter and I wondered if our work had been creating more worry rather than less. She said it had

created more worry. She said her mother was constantly asking her about things. I thanked her for her honesty.

We continued with the theme of how closeness can sometimes create a lot of worry which is hard on everyone. I suggested that perhaps what was needed was for each woman to have a little more space, not less closeness but permission to worry a little less about each other. Both daughters looked at mother who said so eloquently, " I love my daughters so much that I wonder if I forgot to let them grow-up and I am living my life through them?" There were a lot of tears at this point and I explained that I felt that nothing was done wrong here. That Linda mothered so well but perhaps she did such a good job that now it was time to trust her work and watch her children fly on their own. A metaphor was suggested to me by George Enns, that maybe it was time for mother bird to watch and allow her children to fly and develop their own flight patterns.

At this point I asked mother and daughters if they'd like to continue, as we were over our time, they said they would. I felt it was important to keep going as well, as everyone was beginning to open up.

Another metaphor used by Mr. Enns is about coffee. I explained to these women that I felt honoured that they were open about their relationship with me and that I could see that they had something very special. I explained that their relationship was very rich. I suggested that like with coffee sometimes we need to use milk instead of cream because the cream is too rich. They all laughed and said maybe sometimes they only need skim milk.

We continued exploring this theme of a rich and intense relationship. I asked Linda if she thought it would be alright for her daughters to take a little space for themselves without worrying or feeling guilty for her or each other. Linda was extremely supportive of her daughters doing this and said that she did not realize how her love for them had caused them to feel trapped. I assured her that it was normal for this to be a difficult time for all mothers and daughters and that many have difficulty re-negotiating their relationship to make room for their own independence. I also pointed out that it must also be difficult for a mother to begin to find her own interests separate from her family (now that she had the time to do so).

Both daughters said they worried that their mother was alone. When asked mother was able to say that she was starting to develop some of her own interests, working part-time and that she enjoyed it. Both children said they felt much better when their mother was busy. I asked what assurances the kids could give their mother that they would take space when they needed, at this point they could not answer this.

I met with mother and Kelly separately to discuss why I moved away from the abuse. I told them that while what happened to Brenda was still a question, I felt that they also might need some support in restructuring their relationships because their family was again entering a new life cycle stage of children entering adolescence and moving out. They agreed and felt somewhat relieved by our previous work this session. I also asked if Brenda's letter may be a way of her asking for space and showing her anger. Linda and Kelly also wondered if Brenda was angry at mother for her closeness with Kelly, and also angry about not having enough room for her own growing up. I said we needed to explore this.

I then met with Brenda who was feeling somewhat relieved that we had not been talking about the letter all session. I presented her with two possible

explanations for her letter. I told Brenda that one explanation was that she was abused, but understandably was too scared at this point to discuss it. The other explanation was that she was angry with her mother, that she wanted more space from her and in a moment of anger wrote the letter. Also that she was angry about the closeness between Linda and Kelly and felt confused about whether she wanted that closeness or wanted some distance from the family. I explained to Brenda that she might want distance and closeness at different times. Brenda began to cry and stated that the second explanation was correct. She stated that sometimes she feels like she wants her mother far away and sometimes she'd like to remain close to her. She also stated that sometimes she would like have a similar relationship that Kelly and her mother have. When asked about where the idea of sexual abuse came from, Brenda said it had come from a television movie. I told Brenda that I believed her but that if she ever wanted to change her story that all she had to do was call me or D.S.S. or tell someone else. She said she would not need to but that she could also talk to her sister.

At this point we all met together and Brenda was able to talk openly to her mother and sister about the letter and her explanation for it. I also reiterated my

invitation to Brenda to add things to her explanation at any time and that it was natural for children to take a long time to speak up about abuse, or offer a different explanation for initial disclosures. Brenda stated she was safe and was not being sexually abused. By this time we were all exhausted and I complimented these women on their hard work and asked that they all practise honouring their closeness but also taking some space this week.

Throughout this session I was very careful to validate the close relationship these women had. My personal experiences helped me to understand how difficult it was for Brenda and Kelly to take the space they needed from their mother in order to establish independence. I also could understand how difficult it was for Linda to "let go" of her daughters in order for them to continue the process of differentiation. My mother also had difficulty "letting go" but found it easier when she realised that we would become friends and stay close to each other.

A feminist viewpoint made me be attentive to the fact that mothers and daughters are close and that it is a unique relationship. Working with the conflicts of the mother daughter relationship requires a sensitivity to

the needs of all women involved. Not only do adolescent daughters need the freedom to explore their own aspirations, but mothers require assistance in developing a world outside their family life and separate from the lives of their children. Miller (1986), suggests that a renegotiation of the relationship is possible especially when new depths of understanding are developed which take into consideration the forces impinging on both mothers and daughters. The important thing is that no blame should be taken or prescribed, just some new learning encouraged.

From a structural family therapist's perspective, my supervisor reassures me or points out that when relationships are so close and children feel that they need some space sometimes they will do drastic things... even make allegations of sexual abuse. I find this somewhat comforting, as I still worry about whether Brenda has been sexually abused. He also reminds me that the door was left wide open for Brenda to add to her story. I believe in my heart that when she is ready if she needs to she will.

Final Sessions:

I met with Linda and her daughters on one more occasion. During the this session all three women

discussed how relieved they felt about discussing and clarifying their difficulties in their relationships. Kelly reported how she was able to take some space for herself during the last week. Linda was very encouraging of this new behaviour and said she felt proud of both her daughters. Linda reported that she told her husband about the last session. She stated that she and her husband went out and did not even discuss the kids, which felt good. The fact that Linda and her husband were able to spend time together that did not involve thinking about or being with their children was an indication (from a structural family therapy perspective), that the parental subsystem was becoming re-engaged.

I met with Linda alone to discuss the difficult changes ahead and how hard it will be to trust the good job she did parenting her daughters but now it was time to let her daughters "fly" on their own. We also discussed how exciting it was for her to have some time for herself. Linda stated she would like to do some work on her own abuse and I gave her some reading material and referrals for therapists in the future. (At this point she did not know if she wanted or needed to see a therapist around this issue). She also said she was thinking about talking to her husband and I suggested if she wanted some support with that to call.

I met with Brenda and reiterated my invitation for adding or changing her story. Brenda said she had nothing to add but felt a weight lifted after talking with her mother and sister.

Kelly stated that she felt great. She said she spoke to Brenda alone and she believes her explanation as to why she wrote the letter but told her she would be there if any thing changed. Kelly stated she felt that she wanted to make a lot of changes in her life and that she felt freer to do so. She was glad she was able to talk with her mother about needing space and her worries.

When we all met together this family decided they'd like a break from therapy to practice their new behaviours. I gave them referrals as I was leaving the clinic soon, if they wanted to come back. I complimented these women again on their integrity, closeness and ability to share very difficult things with each other. I told Linda that I thought she showed a great amount of openness and courage in hearing her daughters concerns and was excited to hear about what her interests would become in the next months. Kelly, I congratulated for speaking some difficult things and supporting her sister. I suggested that she continue caring for herself and meeting her own needs. Brenda too was a very special

young woman. I pointed out how she helped her family share some difficult things and that it was courageous to bring things out in the open by writing a letter. I again left the door open for any further disclosure and thanked them all for their hard work. As they were leaving Kelly said to me that I had changed all of their lives and they'd never forget it. I suggested that they had done it for themselves and that I was there to guide them.

Conclusions:

It is not often that cases turn out like this. That such a dark beginning can turn into light at the end. I will never know if Brenda was sexually abused and that is difficult since my training suggests that children never lie. I believe that Brenda's relationship with her mother and sister was causing her a great deal of pain. Certainly, some of that pain was alleviated by providing a setting where these women felt safe enough to be open and honest with each other. The feminist in me suggested how important it would be to normalize their struggles in order to help them understand that they were not alone in their need to restructure their relationships. I believed this normalization also assisted them in feeling less guilt and responsibility for each other.

At this time the family was not willing to do any more work, or should I say work with a therapist. I need to trust that they will continue to reorganize their relationships in a way that meets all of their needs, in a way that allows them to have the space they need but to remain connected as mother and daughters. A piece that was not addressed in our work was where the father and son fit into the family system and how their roles either help or hinder the situation. During the therapy process it did not seem appropriate to address this work because the family came in specifically to address and work through why Brenda had written her letter. As family therapists, my supervisor and I felt that should this family re-enter therapy, this would be a piece of work that should be addressed.

The solution focused perspective played a less active role in the intervention process with this family. However this perspective informed my work in the sense that I trusted the clients, and believed in their abilities to work through their difficulties. The solution focused perspective did come into play when terminating this case. Although I felt that the whole family would benefit from further therapy, my clients felt that their goals were met and that they were finished therapy. Weiner-Davis (1989) reminds us that

"Therapy is not meant to be a panacea for all of life's challenges" (p. 178).

4. Case #3: "Hindsight is always twenty twenty"

This family was referred by the school. The guidance counsellor indicated that the 16 year old daughter, Kerri, was sad all the time. Kerri requested counselling. Kerri lived with her mother Pat, while her other siblings were older than she and lived outside the home. Kerri's mother and father were divorced and her father lived in another city. Kerri and her mother had been to the clinic a number of years ago, when Kerri was 5 or 6 years old and was encopretic. The previous therapist felt that Kerri and her mother had a strong relationship, but perhaps Pat needed to work on allowing or helping the children to do a bit more for themselves, rather than always meeting all of their needs and desires. Pat, at this time agreed that she would like to find a balance between mothering and meeting her own needs. Therapy terminated when Kerri was no longer encopretic and Pat felt ready to practice a new style of mothering that left time for herself.

Session #1:

Kerri and Pat attended the first session. Kerri reported that she was sad all the time and she would like to change this. Pat agreed that over the last year she had noticed that Kerri had been sad. We spent time investigating Kerri's sadness, what it looked like and felt like. Were there specific times when she was more sad than others? We also spent time exploring any exceptions to her sadness. Kerri was able to report that at times when she was with her friends or cycling she felt happy, but there was no pattern to it. When asked the miracle question Kerri stated she wanted to be happy but did not know what that would entail. Her mother reported that if a miracle happened for her she would also like Kerri to be happy. Pat said she would like Kerri to do more around the house, and perhaps spend more time with her.

We explored this family's history. Kerri has three brothers, one who she was closest to, and one adopted sister whom she did not get along with. Kerri stated that her parents divorced 10 years ago but this had not affected her and that she had a good relationship with both her mother and father.

Due to Kerri's intense sadness, I assessed suicidality, and Kerri's eating and sleeping habits. Kerri reported that she was not suicidal and she ate and slept well. At this point I asked Kerri if she had any other information she'd like to share, and she did not. Her mother also had nothing further to share. I asked Kerri to pay close attention to the times when she was not sad and what she was doing at those times. I told her that I hoped this might help us figure out what makes her happy and then she could continue those behaviours. Kerri agreed to pay attention to the times when she felt good but she did not think this would help her feel any less sad.

From a structural family therapy perspective, my assessment was that the boundaries between Kerri and her mother needed to be clarified. Pat spent a lot of her time looking after Kerri's basic needs, like waking her up a number of times in the morning so that she would not be late for school. Pat reported that if she did not do this Kerri would sleep in and get in trouble in school. I suggested to Pat that it might be helpful for Kerri to begin to take responsibility for her own behaviours, like sleeping in. I also assessed Kerri as needing to take some space from her mother in order to develop confidence in her own abilities.

Using a feminist lens in conjunction with a structural perspective, I believed that Kerri's sadness needed to be explored more thoroughly. I believed that taking space from her mother without understanding her feelings would only solve part of her problem. A feminist and solution focused perspective reminded me that a client is the expert on her problem and since Kerri was presenting with a problem with sadness, this, as well as her relationship with her mother needed to be addressed.

Solution focused therapy informed my interventions in the first session. By exploring exceptions and asking the miracle question, I hoped to get a better picture of the problem. The responses to the miracle question helped to identify specific avenues for change. Pat's suggestion of having Kerri do chores around the house was one example of a change that they could begin to work on. Kerri's ability to have fun when she was cycling was an indication that her sadness did not affect her all the time and therefor she was already on her way to making changes.

Session #2:

This session began with an exploration of the results of the homework task. Kerri stated there were

few times when she was happy but that it really did not help her to look at those times because they were so erratic. I disagreed but respected Kerri's judgement. Kerri also reported that the week prior had been fine, and that there were no changes to her sad feelings. I asked to meet with Kerri separately and we further explored her sadness. She had nothing new to report, and when asked also disclosed that to her knowledge she had not experienced any kind of abuse (I asked Kerri about any history of abuse because sometimes this is what sadness is a result of, and my experience has been that if one does not ask about abuse, it usually is not disclosed). I also asked Kerri about her first counselling experience at MacNeill and she stated she remembered coming but not what it was about. When I told her about the encopresis she clearly expressed that she did not want to talk about it.

I met with Pat briefly and she stated that she was quite unclear as to what was going on with Kerri. She did well in school, had a lot of friends and overtly seemed to have everything going for her. After meeting with mother and Kerri together, we agreed that next week I would meet alone with mother to try and get more information. My goal was to work with mother alone

because I felt that I was getting no where with Kerri and perhaps her mother could help shed some light on the situation.

Session #3:

My session with mother was very informative. Without Kerri there she felt the freedom to talk about her divorce, how painful it was and how puzzled she was that Kerri never would speak about it. Kerri's only symptom of pain at that time was the encopresis. Pat also reported that she felt that she was too protective of Kerri, that she was the youngest child and never really had to do anything for herself. Pat stated that she learned from her mother that mothering meant a woman should be all giving and self-sacrificing. Pat stated that just in the last year or so she was beginning to change, take more time for herself and expect more from Kerri. I asked if she had or could discuss some of these changes with Kerri and how she may be interpreting or seeing them. She said she'd like to. Pat also reported that she felt that perhaps Kerri could not take care of herself, or look at what might help her feel happy, because she has never had to do a lot for herself. She stated, "Perhaps my strength and love have made my daughter feel weak...". We explored this further. I complimented Pat on her insight and wisdom and reinforced

that I believed that she was not to blame for Kerri's sadness.

A feminist lens informed our discussion on the legacy of motherwork. We talked about the fact that many mothers believe they must take complete responsibility for their children and that society reinforces this fact by historically promoted women's roles to be in the home. Pat described how her mother did everything for her and rarely allowed her to take risks or make decisions for herself. I was quite careful to validate Pat's motherwork and her courage to look at how things might need to change. Pat felt that she might need to urge Kerri to do more on her own, like wake up for school by herself and accept the consequences of sleeping in.

The structural family therapist in me described to Pat how many families go through a renegotiation of roles during their children's adolescence and that this is often extremely difficult for mothers and daughters because of how close they are, but also because mothers have learned that they need to protect their daughters from "the world outside". I gave Pat information around what might be helpful during their renegotiation process and emphasized that I believed she had done good work with Kerri. Pat reported that she had experienced the

session as being very informative and that she felt supported and validated.

Session #3:

Kerri and Pat had talked about our previous session. To my surprise Kerri was quite angry at what we had come up with. She felt that I was blaming her mother for her sadness. Both Pat and I explained this was not the case. I asked Kerri what she had been thinking her sadness was caused by and she said she did not know but was sure it had nothing to do with her mother, her family, her parents divorce or her friends. She stated that I was the therapist and I should be able to solve her problems, if she could do it on her own then she wouldn't need me. I validated Kerri's frustration but also said that I needed her help. Kerri said she had nothing further to say.

At this point I took a break in the session to gather my thoughts. I explained to Kerri and Pat that I would like to consult about a new direction in the work as Kerri clearly did not agree with the one we had taken. I believed that taking a break was an important thing to do, rather than going on in the session without clear direction. In this case I was quite overwhelmed by Kerri's anger and needed to consult with my supervisor.

After some consultation, I went back into the session asked that I have a colleague watch behind the mirror next time to see if he might help us find some solutions. In the meantime I suggested mother and daughter continue to dialogue about how things may be changing at home.

Session 4 & 5:

During the following few sessions we worked (my supervisor and I) with Kerri and her mother developing the frame that Kerri and her mother needed to work on restructuring their relationship. We explained that perhaps Kerri's sadness partially resulted from the desire to be more in control of her life, a natural thing for teenagers to want. We suggested that maybe Kerri and her mother needed to work on having Kerri take more responsibility for her own affairs and that would result in her feeling more confident in herself. We explained that Pat had learned about taking care of children from her mother and that perhaps what she did not learn was about helping kids take responsibility for themselves. We explained that this was no one's fault but that most women care for others much better than for themselves and we must be careful that we also learn how to care for ourselves. Kerri did not agree.

We also put forth the following picture of the problem to Kerri. We explained that we thought that Kerri had experienced a lot of pain in her life, had put it away , blocked it, and now with the turmoil of adolescence she had no more room to store her pain and sadness. So her jar or container of pain and sadness was spilling over and when the normal pains of growing occur, Kerri feels much worse because she still has old pain hanging or spilling about. Kerri thought this may be true. Her mother shared a story of how Kerri once saw her father beat her brother (the only time there was physical violence in her home) and when asked about it later, Kerri said nothing happened. I pointed out to Kerri that as a child she was very creative to tuck her pain away, that it helped her get through some difficult times but it was no longer working for her. Kerri agreed to think about this. She asked what else she could do with her pain and sadness and since she liked to draw, I suggested she spend some time each day drawing a little bit of her sadness so she could slowly empty the jar.

This session utilized a structural model for assessment in that Kerri and her mother needed to try to spend more time developing independence from each other and turn down a road of friendship. This was suggested as an alternative to the role of mother taking care of

daughter, because we felt that Kerri needed to begin to take care of herself. I also incorporated a feminist perspective, normalizing the fact that all women are better caregivers than caretakers of self. Suggesting to Kerri that she needed to re-learn how to cope with her pain, but honour her past methods as a creative tool for survival is an example of the normalization process.

Solution focused ideology encouraged me to search for solutions and exceptions to Kerri's sadness. It also reminded me to keep reinforcing the work that Pat and Kerri were doing to make positive changes in their life. Solution focused ideology was also most difficult to keep in mind at this point in the work because Kerri was simply not willing to look at anything in a positive frame. (A good lesson for me, that nothing ever works all the time and we must follow the clients lead).

From my own personal experiences , I found it helpful to remember my own need to protect my mother and the closeness we shared. If anyone suggested that our relationship needed to be restructured when I was sixteen, I would have found that difficult to believe and probably would have been very angry. I used this knowledge to help me understand Kerri's feelings and work

on alternative assessments, such as blocking or holding in her sadness.

I had two more sessions with Kerri. She knew that I was leaving MacNeill about one month prior to my departure date. Both these sessions focused on termination. Kerri came in alone for these sessions. She was quite angry that I was leaving. She reported that I should not have taken the case if I knew I had to leave in four months. She also said that I knew that people leaving her was a big issue for her and knowing this, it was irresponsible of me to take this case. Kerri explained that she gave me all this information at the beginning of our work. She also reported that I knew that when her physiotherapist left it was very painful for her and I was as uncaring as her physiotherapist.

These last few sessions were very difficult for me. Kerri was extremely angry and confrontative. I did my best not to become defensive, which was very difficult especially since I saw things very different than she. I also recall nothing of her telling about her physio or the fact that her difficulties were around people leaving her. Kerri added that she felt MacNeill did not care about children and that when she became a doctor she would never treat people the way I did. This particular

statement brought up quite a stir of emotions in me. On the one hand I was thrilled that Kerri's sadness was not so debilitating that she did not have dreams and aspirations for the future. I thought she'd make a great doctor and told her so. I also was somewhat hurt because no one has ever accused or suggested that I have been thoughtless or disrespectful of the people I work with.

Kerri and I worked through her concerns by discussing them. I told her that I had no idea where our work would take us and that many clients complete therapy in four months. I said that for those who do not, I felt I gave her enough time to make some decisions about alternative referrals. I explained that I was not leaving to hurt her and in fact my leaving had little to do with her. I told her that I was sorry that it would disrupt her therapy process. I also explained that it sounded like she was not feeling safe with me or at MacNeill and that concerned me and we needed to find a way to change that or find her another therapist, if she wanted to continue work. Ironically enough she said she wanted to continue at MacNeill and said she'd like to talk to me more about "this sadness and cup thing". I felt uncomfortable going a lot further with our work because I believed Kerri felt unsafe and that needed to be worked through before continuing. We agreed to meet

on one more occasion to continue to discuss Kerri's anger and transfer the case.

Transfer Session:

A female colleague, myself and Kerri attended this session. My colleague and I decided prior to the session that we'd talk with Kerri about her concerns and review our work and then my colleague would take over. Kerri explained her concerns and asked if my colleague planned to leave the clinic. My colleague explained that while she had no plans to, there were no guarantees. We spent some time discussing our work and then Kerri and Margo began discussing Kerri's sadness. After a few minutes we decided that it made sense for me to leave. Kerri and I said our goodbyes and Margo continued the session.

After the session Margo told me that Kerri was extremely open about her sadness, and felt she'd like to also concentrate on what makes her happy. Margo felt that some important work had been completed with Kerri, in that she was able to state her anger, that she was heard and now she was ready to continue. Margo and I also believed that Kerri had begun to realize that she needed to take some responsibility for her problems. Perhaps Kerri had learned more from our work together than she was able or willing to let on.

I learned a great deal from this case. Perhaps the most important being that client's have a right to disagree with our assessments and that when this occurs we should find another avenue for change. " Like Milton Erickson, solution oriented therapists attempt to utilize clients' attitudes about life, relationships, therapy and so on, rather than persuade clients to replace these views with those that are deemed healthier (Hudson O'Hanlon & Weiner-Davis, 1989, p.171). de Shazer (1985) reminds us that if assessments and interventions work to solve the problem, don't fix them, if they don't then do something different.

In this case Kerri reminded me that she was not ready to restructure her relationship with her mother. She was angry at my suggestion that this may be part of the problem. She was however, able to understand that she needed to find some new ways of coping with her pain and sadness. Upon reflection, I wonder if Kerri became distrustful of me because she felt I was not listening to her. I wonder if I pushed her too hard around taking some space from her mother. Perhaps my feminist and solution focused lens should have been opened a little bit wider with this family.

I know that we can't be "on" with every client that we work with. I am happy that Kerri is continuing her work with another therapist. I am also glad that she had the courage to speak up in disagreement and that the therapeutic setting allowed for that. Kerri is a client I will always remember because she reminded me that the therapist is not always right and that our assessments are only useful if they can be heard and utilized by the client. She also suggested to me that hindsight is indeed twenty-twenty and we must reflect and evaluate our work in order to improve our skills as a therapist.

Chapter 3: Evaluation and Conclusions

A. Evaluation

How does a therapist effectively evaluate therapy? This question remains without an answer. According to Trute (1985) comprehensive measurement instruments and packages relevant to social work are not readily available, and utilization within a clinical setting often requires a time commitment greater than the benefits provided to both the practitioner and the client. However, ethically social workers are responsible for providing effective treatment that has no known detrimental effects on clients. In order to evaluate the effectiveness of my work, I utilized three tools. They were videotaping each session, live supervision as well as case consultation, and feedback from clients.

1. The use of videotaped sessions as a tool for evaluation.

At MacNeill clinic we were required to videotape each therapy session. After each session I would review the tape. This review provided me with a picture of my therapy style and allowed me to see any dynamics in the clients relationships that I may have missed. In Case #2 this was particularly helpful for assessment purposes.

As stated previously, it was initially difficult for me to see the "enmeshed" relationship between mother and daughter. Reviewing the tape allowed me to gain some distance from the intensity of the therapeutic relationship and see the dynamics between mother and daughter.

Another reason why videotaped sessions are an important tool for evaluation is because it allows one's supervisor to see exactly what went on in the therapy session. Describing a session to a supervisor allows her\him only to hear about the therapists own impressions of the case and does not allow for another objective opinion. Furthermore, the therapists description is based on memory, which can change and be lost over time. With the benefit of a videotape, a supervisor can see exactly what occurred in each session and nothing is lost due to memory lapse.

2. Live Supervision and Case Consultation

Supervision occurred on a weekly basis with George Enns MSW, the director of the internship program, and Margo Couldwell MSW, a staff member. Interns also participated in the weekly reflecting team seminar (explained earlier). These supervision sessions allowed me the time I needed to reflect on my work and make sure

I was providing the most effective treatment to all my clients. My supervisors helped me to pick up on pieces that I had missed in my initial assessments. For example, in case #1, Margo was helpful in pointing out that it is difficult to be empathic to mothers who portray themselves so harshly. She also pointed out how we expect mothers to be warm and supportive of their children. Margo's comments helped me a great deal in working through my perceptions of this mother and find a way to be empathic towards her.

During live supervision, George was able to help me get "unstuck" with Kerri in case #3. His suggested frame of "the overflowing cup" was extremely useful. The live supervision process allowed for immediate feedback and as de Shazer (1988) notes, there is a bonus present when two or more perspectives are considered on any given situation.

3. Client feedback

All families I worked with at MacNeill provided this writer with feedback about the therapy. In case examples 1 and 2 the clients felt that the therapy process helped them to resolve their problems and learn new (and more helpful) ways of relating to each other. In case #3 the clients, specifically the daughter, Kerri, was less

pleased with the therapy process. However, Kerri felt safe enough to provide this writer with valuable feedback that taught me some important lessons and allowed Kerri to continue her work at MacNeill.

Kerri taught me how important it is for clients to have the freedom to speak up when they are not happy with the work. She reminded me of how important it is for a therapist to remain open to hear criticism from our clients. We are not the experts on a client's life history or what is necessary to resolve the presenting problems. Therefore even if we believe our assessments to be accurate they are without benefit if a client is unable to hear them or make use of them. In my opinion, it was important for Kerri to be able to become angry with me and state what she liked and did not like about our work. In so doing, she became more ready to take control and responsibility for her own difficulties. Working through our relationship modelled a way of doing this that she could use in her other relationships. Due to the fact that her concerns were heard, she felt she could continue therapy at the clinic.

In conclusion, I attempted to include both client and supervisor feedback in my evaluation of my work as a therapist. Sturdivant (1980) reports the importance of

a cooperative evaluation process between therapist and client. I would add the importance of case consultation and supervision as integral parts of "good" therapy. As a therapist, I know that I can not always see things clearly or objectively. I also do not always know the most beneficial way to work with my clients. Listening to clients as well as supervisors and colleagues prevents me from being isolated in my work and allows for accurate and honest assessments as well as clinical integrity.

B. Conclusions

As a result of this practicum it has become clear that the structural and solution focused models of therapy, can be integrated with a feminist perspective. The combination of these three approaches manifests into a respectful and complete model of therapy for mothers and daughters. This conclusion will describe how one can use all three of these approaches and how each affects the other.

The structural model is often a clinician's initial exposure to family therapy. It is based on the teachings of Salvador Minuchin. Minuchin (1974) suggests that family problems are a result of an inappropriate family structure. This can be a result of the family's

inability to adapt to change in a particular stage of family development.

With respect to the relationship difficulties of mothers and daughters, structural family therapists would often attribute the problem to an "enmeshed" boundary. "The mother-children subsystem may tend toward enmeshment..." (Minuchin, 1974, p.55). When the boundary between mother and children is clarified, structuralists would suggest that the problem would be resolved. "For proper family functioning, the boundaries of subsystems must be clear. They must be defined well enough to allow subsystem members to carry out their functions without undue interference, but they must allow contact between the members of the subsystem and others" (Minuchin, 1974, p. 54).

The structural model of family therapy is based on the identification of problems, specifically (but not solely) in the area of family structure. The solution focused model challenges this assumption by suggesting that the family structure may have developed as the solution to a perceived problem. It suggests that there are many ways of viewing a situation. It proposes that one view is no more correct than another. Weiner-Davis (1991), suggests if indeed one must make a choice, it

should be the perspective that offers hope and leads to change.

While the structural model is problem focused, the solution focused model is based on resolutions. de Shazer (1988) suggests that calling a situation a problem is only one way of labelling and interpreting an event. The structural model provides the therapist with a way of organizing information that allows for an understanding of family interaction and descriptions of the problem. The solution focused model analyzes the interactional pattern that maintains the problem.

A combination of these two models balances the exploration of the problem with the search for solutions. In a sense a solution focused model depathologizes the structural approach to family therapy. This idea, in fact fits with the thinking of Minuchin. "The orientation of family therapists toward "constructing a reality" that highlights deficits is therefore being challenged. Family therapists are finding that an exploration of strengths is essential to challenge family dysfunctions" (Minuchin and Fishman, 1981, p. 268). The solution focus model discusses the importance of the highlighting of family strengths and the search for exceptions to the problem (Weiner-Davis, 1991). The

structural model reminds the therapist that one can not only focus on solutions, but an exploration of the problem is also important in therapy.

While a combination of the structural and solution focused models provide valuable tools for assessment and intervention, they fall short in the area of addressing women's experiences in a patriarchal society. This gap in the models reinforces traditional ideology that the inferior role of women in society need not be questioned. Kaschuk (1992) notes that, "... the basic power inequity of gender difference and the influence of larger social systems such as gender arrangements have been deemed irrelevant and thus steadfastly ignored by mainstream family systems theorists" (p.17). The feminist perspective provides a political analysis to both the solution focused and structural models of therapy. "Feminists call for reconstruction of terms and development of models that can better illuminate the contradictions and consequences at the point of interaction between gender, power, family and society" (Goodrich, T.J., Rampage, C., Ellman, B., & Halstead, K., 1988, p.9).

The structural and solution focused models of therapy are also heavily influenced by the teachings of

men and therefore do not fully consider a woman's point of view. " Of the founders of family systems therapy, all but Virginia Satir were men, and they have typically approached families as regulated, rule-governed systems, like computers, or as hierarchical, executive-run systems, like businesses" (Kaschuk, 1992, p.17). This notion is especially detrimental when thinking about therapy with mothers and daughters.

Mothers and daughters learn early that they will experience conflict with each other. Because they have an intense relationship, the closeness that brings them joy will also bring them pain when an adolescent daughter begins the natural need to "separate" from her mother or find her own voice. While a structural family therapy assessment of this experience would be that a renegotiation of boundaries is necessary and a solution focused model would invite the therapist to search for exceptions to the conflict, these assessments and interventions are still largely male defined. " The perspective of a feminist therapist might suggest a framework that would enable mothers to view their daughters as they mature as not so much struggling to free themselves from the maternal bonds that constrict them, but rather moving towards a self-determined, powerful, autonomous position of their own. In this way

the conflict viewed as two people seeking alternative ways to bond at different life stages" (Walters, 1988, p.49). The feminist influence over assessment and intervention depathologizes the unique closeness of the mother daughter relationship.

In summary the clinical approach suggested in this report combines the teachings of the structural and solution focused schools of therapy with an overall feminist philosophy to treatment. When I began my practicum, I must say I was weary of the teachings of family therapy and "systems" thinking. I was concerned about how respectful this approach was to women. I was surprised to find that family therapy has many benefits. An understanding of the tools of both the structural and solution focused schools of thought can enhance therapy with women in families. I would suggest, however, that in order to have a complete and respectful understanding of the conflicts in mother daughter relationships, and the necessary solutions, a feminist perspective should also be incorporated. "There are many feminists who use elements of structural family therapy in their work...The task that remains is to address the issue of patriarchy as well " (Luepnitz, 1988, p.68).

On a personal note, I complete this report with much relief. As I stated previously, I can identify with the struggles of mothers and daughters because I carry both these roles. From the mother's voice inside me I would like to suggest that as therapists I hope we continue to reinforce the health of a mother's desire for experiences outside the realm of motherwork. I wish for a therapeutic community that no longer practises or reinforces the notion of mother-blaming. I believe that for many therapists, this community exists. I feel proud to be part of that community and fortunate that I have had the support and resources to balance my need to work and grow outside motherwork, with the challenges and wonders of caring for my son.

Bibliography

- Andersen, T. (1987). The reflecting team: Dialogue and meta- dialogue in clinical work. Family Process. 26, 415-428.
- Badinter, Elisabeth. (1981). The myth of motherhood, an historical view of the maternal instinct. London: Souvenir Press.
- Baker Miller, Jean. (1986). Toward a new psychology of women. Boston: Beacon Press.
- Bernard, Jessie. (1974). The future of motherhood. New York: Penguin Books.
- Braverman, Lois., & Myers Avis, Judith (Eds.). (1991). Woman and power: perspectives for family therapy. Journal of feminist family therapy. 3, (1&2).
- Braverman, Lois. (1991). Jewish mothers. Journal of feminist family therapy. 2, (2).
- Butler, Sandra. (1985). Conspiracy of silence, the trauma of incest. California: Volcano Press, Inc.

- Cameron, Anne. (1981). Daughters of copperwoman.
Vancouver: Press Gang Publishers.
- Caplan, Paula. (1989). Don't blame mother. New York:
Harper & Row.
- Chodorow, Nancy. (1978). The reproduction of
mothering, psychoanalysis and the sociology of
gender. Los Angeles: University of California
Press.
- Courtois, C. A. (1988). Healing the incest wound,
adult survivors in therapy. New York: Norton.
- Debold, E., Wilson, M., & Malave, I. (1993). Mother
daughter revolution, from betrayal to power. New
York: Addison - Wesley.
- de Shazer, S. (1988). Clues: Investigating solutions
in brief therapy. New York: Norton.
- de Shazer, S. (1985). Keys to solutions in brief
therapy. New York: Norton.

de Shazer, S. & Berg, I.K. (1988). Constructing Solutions. Family Therapy Networker. 12, (5), 42-43.

Dolan, Yvonne, M. (1991). Resolving sexual abuse, solution-focused therapy and ericksonian hypnosis for adult survivors. New York: Norton.

Eisler, Riane. (1987). The chalice and the blade our history, our future. San Francisco: Harper Collins.

Fish, L. S., & Piercy, F.P. (1987). The theory and practice of structural and strategic family therapies : A delphi study. The Journal of Marriage and Family Therapy. 13, (2), 113-125.

Fishman, H.C., (1988). Treating troubled adolescents: A family therapy approach. New York: Basic Books.

Fitch, S. (1993). In this house are many women. New Brunswick: Goose Lane Editions.

Gilligan, C. (1982). In a different voice. Cambridge: Harvard University Press.

- Goodrich, T.J., Rampage, C., Ellman, B., & Halstead, K.
(1988). Feminist family therapy, a casebook. New
York: Norton.
- Hare-Mustin, R. (1978). A feminist approach to family
therapy. Family Process. 17, (17), 181-194.
- Hare-Mustin, R. (1987). The problem of gender in
family therapy theory. Family Process, 26, (1),
15-28.
- Herman, Judith, L. (1992). Trauma and recovery, the
aftermath of violence-from domestic abuse to
political terror. New York: Basic Books.
- Herman, Nini. (1989). Too long a child: the mother-
daughter dyad. London: Free Association Books.
- Hudson O'Hanlon, W. & Weiner-Davis, M. (1989). In
search of solutions; a new direction in
psychotherapy. New York: Norton.
- Jackson, Marni. (1992). The mother zone, love, sex,
and laundry in the modern family. Toronto:
Macfarlane, Walter & Ross.

Karpel, M.A., & Strauss, E.S. (1983). Family evaluation. New York: Gardner Press Inc.

Kaschuk, Ellyn. (1992). Engendered lives a new psychology of women's experience. New York: Basic Books.

Levine, H. (1983). The power politics of motherhood. J. Turner, & L. Emery (Eds). Perspectives on women in the 1980's (pp28-40). Manitoba: The University of Manitoba Press.

Levine, H. (1983). Feminist counselling: approach or technique? J. Turner & L. Emery (Eds.). Perspectives on women in the 1980's (pp.74-87). Manitoba: The University of Manitoba Press.

Luepnitz, D., A. (1988). The family interpreted: Feminist theory in clinical practice. New York: Basic Books.

Mattessich, P., & Hill, R. (1987). Life cycle and family development. In M.B. Sussman & S.K. Steinmetz (Eds.) Handbook of marriage and the family. (pp. 437-470). New York: Plenum

Myers-Avis, J. (1989). Integrating gender into the family therapy curriculum. Journal of Feminist Family Therapy. 1, (2).

Minuchin, S., & Fishman, H. C. (1981). Family therapy techniques. Cambridge: Harvard University Press.

Minuchin, S. (1974). Families and family therapy. Cambridge: Harvard University Press.

Molnar, A., & de Shazer, S. (1987). Solution-focused therapy: Towards the identification of therapeutic tasks. Journal of Marriage and Family Therapy. 13, (4), 349-358.

Nice, V., E. (1992). Mothers and daughters. New York: St. Marten's Press.

Park, Christine, & Heaton, Caroline (Eds.). (1987). Close company stories of mothers and daughters. London: Virago Press.

Phoenix, A., Woollett, A., & Lloyd, E. (Eds.). (1991). Motherhood meanings, practices and ideologies. London: Sage Publications.

Rich, Adrienne. (1976). Of woman born, motherhood as experience and institution. New York: Norton.

Smith, M., & Smith-Blackmer, D. (1981). The mother-daughter relationship, a dialogue continued. Clinical Social Work Journal. 9, 57-68.

Turner, J., & Emery, L (Eds.). (1983). Perspectives on women in the 1980's. Manitoba: University of Manitoba Press.

Trute, B. (1985). Evaluating clinical service in family practice settings. Canadian Social Work Review 1985. 100-122.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). The invisible web; Gender patterns in family relationships. New York: The Guilford Press.

Walters, M. (1988). Mothers and Daughters. In M. Walters, B. Carter, P. Papp, & O. Silverstein (Eds.). The invisible web; gender patterns in family relationships (pp.33-89). New York: Guilford Press.

Walsh, F. (Ed.). (1982). Normal family processes.
New York: Guilford Press.

Weiner-Davis, M. (1991, May). In search of solutions:
A new direction in psychotherapy. A workshop in
solution-oriented brief therapy. Workshop
conducted by the Saskatoon Family T h e r a p y
Institute, Saskatoon, Sask.

Webb, M. (1992). Our daughters, ourselves: how
feminists can raise feminists. Robyn Morgan
(Eds.). Ms Magazine. (pp.30-35). New York.

Weskott, Marcia. (1978). Mothers and daughters in the
world of the father. Frontiers. 3, 16-21.