EXPLORING BRIEF SOLUTION FOCUSED THERAPY WITH FAMILIES WITH ADOLESCENTS

BY

RSHMI KHER

A Practicum presented to the Faculty of Graduate Studies
in partial fulfillment of the requirements for the degree

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Abstract

The practicum is an exploration of the intervention of Brief Solution Focused Therapy (BSFT) with families with adolescents. The practicum setting is the Child and Adolescent Psychiatry Department at St. Boniface General Hospital. This report examines the integration of BSFT with the important issues of development, culture, and gender (Metaframeworks) in treating various family forms and presenting problems. Four family casestudies are presented to illustrate the practicum process. Evaluation measures used included the FAM-III General Scale, the Family Problem Checklist, the Client Feedback Checklist, and the Client Feedback Questionnaire. The strengths and shortcomings of the intervention in its applicability with families are discussed. Professional learning goals attained during the practicum are highlighted.

CHAPTER ONE

Introduction

The scope of the practicum report is to describe the theoretical framework of Brief Solution Focused Therapy (BSFT) and its application to family therapy in a hospital setting. The use of this intervention was explored in my work with families with adolescents. Other techniques and models of family therapy (i.e., General Systems Theory, Structural) were drawn upon as they appeared to be beneficial to the family's circumstances. Incorporated into the interventive approach was the Metaframeworks model which included the relevant factors of culture, development, and gender.

The clinical practicum explored the efficacy of a Brief Solution Focused framework with families in which an adolescent member was the identified patient within an adolescent psychiatric treatment program. The goal of the intervention was to build on the families' strengths and solution-oriented behaviors rather than focusing on problematic behaviors and why certain patterns of dysfunctional family functioning result in symptoms. It was assumed that concentrating on functional patterns of success would assist the family members in times of crisis and adjustment.

This report is organized into seven chapters. In Chapter One, my rationale for the practicum and the theoretical approaches used are discussed. My learning goals are also outlined. Chapters Two, Three, and Four are a review of the literature. Chapter Two reviews the literature on Adolescence including developmental theories and adolescent tasks. Chapter Three provides a review of the literature on the Metaframeworks model of development, culture, and gender, and how these issues impact on people's lives. Chapter Four provides a review of the literature on the principles and techniques of

BSFT. Chapter Five discusses the practicum setting, evaluation measures used, and the supervision arrangements. Chapter Six highlights four casestudies of families illustrating the integration of Metaframeworks with the BSFT approach and an evaluation of each family. Chapter Seven concludes with an evaluation of my learning during the practicum and an overall critique of the BSFT model.

Rationale of Practicum

In choosing a practicum placement, I wanted a setting that catered to an adolescent population through a variety of treatment modalities. By providing a range of services an integration of individual and familial needs could be actualized. As a student, observing different methods of treatment can be extremely useful in viewing the larger picture of an adolescent's treatment needs. I was interested in working with adolescents in the context of their family relationships, dynamics and processes. I wanted to learn more about the field of family therapy for at the time it seemed to be an open-ended concept of which I knew very little. Therefore, at the very minimum I wanted to develop skills as a family therapist but I also desired to be able to define for myself what family therapy means and what it entails. Defining family therapy generated a host of questions related to the adolescent and his/her needs, and whether or not family therapy was indeed a useful treatment modality and if so, in what instances it would be deemed effective.

My previous work experience with adolescents and their families was more individual-focused and counselling-oriented. It was hoped that a practicum focusing on family therapy would provide me with clinical skills that emphasized a specialized

understanding of familial systems and interventions. Viewing the family as a system of change and place for intervention would demonstrate a broader understanding of how family patterns and roles effect an adolescent.

My attraction to BSFT is its premise of enhancing familial strengths through building a network of solutions for clients' problems or complaints. Its philosophical approach articulates an impetus for change that is a proactive paradigm in family therapy. There is an emphasis on valuing people's inner resources and abilities to express themselves and generate solutions that are feasible and respectful of them.

The move away from an expert-subordinate therapy context is welcomed, refreshing and long-awaited. To truly value the principles of client self-determination, acceptance and individualization (Biestek, 1957) the therapeutic climate must first portray its respect of this through demonstration and not verbal lip-service.

I do not devalue the skills that a professional brings into therapy, however assuming an expert demi-god status propagates power imbalances between therapist and client that may bring long-term implications of blame, control, and resistance expressed in the therapeutic relationship. In BSFT, by viewing the therapist and client as part of the same system, a new reality is co-constructed which allows perceptions and feelings to be reframed and seen differently.

In BSFT, by exploring those times that the "problem" does not happen, viewing the exceptions to problems may be reformulated into goals. At this point, the timing for implementing solutions is optimal as patterns of positive functioning are punctuated and highlighted to the client. By highlighting exceptions to the "problem", the therapeutic system of client and therapist may/can create or reformulate a goal to be achieved, thus

increasing the frequency of exceptions. BSFT is based on systems theory, thereby it is assumed that changes made in one part of the system effect the operation of other parts of the system (de Shazer, 1985). Brief Solution Focused Therapy accentuates the recursiveness of our actions and believes in viewing causality as being circular.

I find the ideas and techniques of BSFT to be congruent with my values which I feel are important to serving clients in an effective and humanitarian manner. Deeply held is the belief that clients genuinely want to change and find betterment for themselves rather than invest themselves in sickness and pathology (de Shazer, 1988; Erikson, 1954; Koman & Stechler, 1985). Unfortunately, many schools of family therapy and traditional thinking believe that clients want to remain in an undesirable state (de Shazer, 1991) because their distress brings them something positive, something which holds them so captive that change is impossible and therefore denied by the helping professional. Acceptance of this by the therapist makes him/her susceptible to finding clients resistant, in which patterns of blame and defensiveness may result.

Brief Solution Focused Therapy postulates the universality of struggles and suffering in which we all participate in one way or another. This humanistic approach promotes rapport and trust in the development of a therapeutic relationship. As we come to understand our clients' issues in terms of our own family dilemmas and context, and as a part of everyday existence, we have greater empathy and tolerance of their struggles. We are then in a better position to view family members as competent in voicing their needs and being successful in fulfilling them.

Within the practicum, I was also interested in integrating the BSFT model with the Metaframeworks model which highlights the impact of development, culture, and

gender for families. The Metaframeworks model enhances the assessment stage by providing a broader understanding of clients' experiences and identities. These frames of reference shape clients' abilities to construct solutions and implement change which is meaningful for them.

At the outset, it seemed that exploring this intervention method would fit nicely in the area of family therapy where families usually come for an average of 4-6 sessions regardless of the theoretical approach (Watzlawick, Weakland, & Fisch, 1974). The solution-oriented focus is appealing to families in crisis who want short-term help and need some positive results quickly. In families where there are intergenerational issues and patterns of ineffectual problem-solving that have contributed to a feeling of "stuckness", a regurgitation of problems and focus on the past can be painful, embarrassing, and frustrating. All this can be a futile exercise that highlights the problem and downplays any sense of real change. Brief Solution Focused Therapy shows clients that changes, even small ones, are generative and conducive to clients re-inventing their sense of reality and re-visioning a future that is attainable.

It is for these reasons that I undertook the practicum in family therapy. In addition to enhancing my practice skills, I hoped to explore the usefulness of the theoretical models of BSFT and Metaframeworks with families with adolescents.

Learning Goals Within the Practicum Experience

I felt that the hospital setting itself would provide many learning opportunities through participation and observation in which professional learning goals could be

achieved. The educational benefits that were anticipated to occur as a result of the practicum placement were an integration of learning resulting from direct interventive practice with clients as well as from introspective evaluation of therapeutic growth as a clinician. For sake of clarity I have demarcated goals I viewed as primary learning objectives with those which I perceived as secondary learning objectives.

Professional Learning Goals:

- To examine the efficacy of BSFT as an intervention with families (Primary goal).

- To develop clinical skills in the area of family therapy using specialized family interventions with adolescents (Primary goal).

- To develop clinical skills in treating adolescents who have experienced trauma and degrees of multi-system breakdowns (Primary goal).

- To assess my therapeutic use of self through direct clinical practice, supervision, and evaluation of the practicum (Primary goal).

- As the client population is linked to a psychiatric setting, to develop a knowledge base in adolescent psychiatry. Albeit a basic understanding, it was hoped that the experience would provide an introduction to an area of interest that may be pursued in the future (Secondary goal).

- To learn how to implement evaluative measures and critique their ability in measuring quantitative and qualitative gains in the treatment of families (Secondary goal).

- To reassess a personal ideology and belief system (Secondary goal).

- To observe and learn from other team members in the hospital through their use of various theoretical frameworks and therapeutic styles of intervention with families (Secondary goal).

The above goals will be discussed more in-depth in the practicum report with an analysis of how extensively learning goals were or were not achieved. By no means are the stated professional goals an exhaustive list, rather, they were ones that I perceived to be salient for my learning at the outset of the practicum.

CHAPTER TWO

Review of the Literature: Adolescence

Client System Served

In the practicum setting the primary clients are families, however, treatment is initiated due to the perceived needs of an adolescent member. Clearly, the identified patient is the adolescent but the system of change and intervention is the adolescent in his/her familial context. The family is the primary target of change as it is the most significant environment for the adolescent's development and expression of needs (Combrinck-Graham, 1989). Working with families of adolescents is an especially challenging endeavor as each member is in a pattern of adjustment and reassignment of roles at this stage of the family life cycle (Carter & McGoldrick, 1989; Haley, 1973).

Families presenting for therapy in the hospital setting are likely to focus on the adolescent as the source of the problem. This is demonstrated by pointing out acting-out or undesirable behaviors of the adolescent that contribute to the overall stress of family problems (Karpel & Strauss, 1983). The historical context of client problems may be as varied as the issues being presented. For instance, there may be a history of family violence, loss and rejection, parental substance abuse, child abuse, and so forth.

A recurrent theme for troubled adolescents seen in this setting is the experience of trauma. Trauma is directly related to incidents of abuse, witnessing abuse, and profound rejection and losses. Trauma can result in Post-traumatic Stress Disorder as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R) which may

manifest itself prior to an adult diagnosis of pathology (American Psychiatric Association, 1987). Trauma creates impairments in cognitive, behavioral, affective, and psychological-somatic realms (Armsworth & Holaday, 1993).

An understanding of adolescence and its relevant issues provides a starting point to assess family difficulties and enables one to place those issues in a developmental context. While adolescents are undergoing developmental transitions, parents are also in transitional phases of their life cycle, thereby making the family dynamics and relationships extremely complex.

Knowledge of how structural changes and role negotiations impact families during the adolescent stage of the family life cycle is required. Theories of adolescent development provide a framework for distinguishing normal and abnormal behaviors in this age group. An overview of adolescence, developmental theories, and developmental tasks will be made. Understanding the family context in response to adolescence is crucial and this will be highlighted in the development metaframework which examines the implications of the family life cycle on families with adolescents.

Adolescent Development

Definition of Adolescence

Adolescence is a transitional period between childhood and adulthood in which considerable adjustment and mastery over life cycle tasks takes place. Historically, the family unit functioned as a contained economic unit prior to industrialization and

urbanization (Sisson, Van Hasselt & Hersen, 1987). Hence, children assumed similar working roles and responsibilities to that of adults. However, an increase in children being educated and no longer a part of the labour market contributed to an increasing segregation between children and adults (Preto & Travis, 1985; Sisson et al., 1987). As urban society made life more complex, attention was paid to the critical needs of childhood. Rituals and rites of passage were created by a culture of youth to address a time period that was extended and confusing (Preto & Travis, 1985). The concept of adolescence was proposed by psychologist G. Stanley Hall (1904) in order to understand the experiences and tasks that individuals face in this middle stage who are no longer children, yet are not fully developed adults either.

The beginning of the twentieth century led to numerous studies of adolescence and legitimized it as a special stage of development. Hall (1904) defined adolescence as:

> A new birth, for the higher and more completely human traits are now born. The qualities of body and soul that now emerge are far newer. The child comes from and harks back to a remoter past; the adolescent is neo-atavistic, and in him the later acquisitions of the race slowly become prepotent. Development is less gradual and more salatory, suggestive of some ancient period of storm and stress when old moorings were broken and a higher level attained...some linger long in the childish state and advance late or slowly, while others push on with a sudden outburst of impulsion to early maturity. (Hall, 1904, p.xiii)

Hall's view of adolescence is seen as a period both of upheaval, suffering, passion, and rebellion against adult authority and of physical, intellectual, and social change (Sisson et al., 1987). Hall's description of adolescence as a time of "storm and stress" is one interpretation in which genetic vulnerability to the transition of adulthood explains the

areas of change for the adolescent. The "storm and stress" view of adolescence has been challenged and disputed as being a result of exposure to and over-emphasis on troubled youth and delinquency with no consideration of environmental factors (Ianni, 1989). Studies on adolescence have shown that most adolescents complete developmental transitions without any major emotional or social difficulties (Offer, 1969, 1981, Peterson, 1982, cited in Ianni, 1989).

The vast literature on adolescent development (developmental, cognitive, social, biological, psychoanalytical) offers multiple views on the onset of adolescence and the stages delineating task accomplishment. A recurrent theme of adolescence is biological changes associated with the onset of puberty in boys and girls (Karpel & Strauss, 1983). Adolescent tasks may also be bifurcated between early teen years and later teen years. Adolescence has also been extended to include a population of "youth" in their early twenties who have not yet committed themselves to vocational and familial obligations due to increased education and poor economic conditions (Nett, 1993).

Our definition of adolescence has evolved with the changing economic and social times of our culture (Mandell & Duffy, 1988; Nett, 1993). Although the legal age of eighteen years old grants adult status in our society, developmental tasks of adolescence may still be pursued. The reverse is also true for adolescents who take on adult responsibilities before they may be emotionally equipped to deal with them, such as teenage parenting.

Theories of Adolescent Development

Erik Erickson's psychosocial-developmental theory postulates the major task of adolescence being identity formation. He viewed adolescence as a time of normative crisis (identity vs. identity confusion stage) in which resolution of certain tasks enabled the individual to achieve a developmental maturity and readiness for the next stage of development. The eight psycho-social stages of development are grounded in the principles of identity and epigenesis in which the process of differentiation of self creates a strong ego-identity integrating parts of the person to form a unified functioning self (Erickson, 1968).

According to Erickson, during adolescence, continuity of preceeding stages provides the opportunity for integration of the ego identity. In each stage there must be a resolution in the form of a balance, for instance, in the previous stage of industry vs. inferiority, the school-age child must acquire mastery in being productive yet able to work cooperatively with peers. Failure to do so may result in feelings of inadequacy and low self-worth on one hand, or an over-emphasis on work and production at all costs. If resolution is only partially obtained in this stage, it will hold implications for how the adolescent begins to perceive him/herself and asserts the need for independence. Stages of childhood affect developmental factors of the adolescent, which in turn have an effect on stages of adulthood.

Although Erickson's stages have been a landmark in adolescent developmental theory they fell short in any empirical testing and research (Kroger, 1989; McKinney & Vogel, 1987). The work of James Marcia (1966) expanded on Erickson's constructs in

the form of Identity Statuses which compared four categories that adolescents could fall into: Identity Achievement, Foreclosure, Moratorium, and Identity Diffusion.

The Identity Achievement status consists of a reflection of childhood thinking and critical decision making around occupation and ideological beliefs. The adolescent demonstrates commitment to a sense of crisis which seeks a resolution. The Foreclosure status individuals are committed but do not perceive a real sense of crisis or threat. They may fall into a vocational path based on conformity to parental expectations and/or societal attitudes. Identity Achievers and Foreclosures have a sense of purpose and direction grounded in the present and future, and are believed to have higher self-esteem and lower anxiety compared to the other two statuses.

The Moratorium status adolescents are experimenting with alternatives in their confusion around decision-making. They are unable to decide and commit to any course of action, thus, they experience a sense of crisis by remaining stuck. Those in the Identity Diffusion status may or may not experience a crisis but appear unmotivated and unconcerned about finding solutions or resolutions. This aspect of identity does not hold much urgency or importance for them.

Cognitive theories of adolescent development have been expanded from the original work of Jean Piaget who examined formal operations of problem-solving and reasoning in the adolescent's identity (Piaget, 1971). Piaget's belief in the universality of his findings has been questioned. It has been challenged by the argument that the adolescent's environmental factors play a significant role in formal operational processing (McKinney & Vogel, 1987; Whitbourne, 1986). Although there are shortcomings in Piaget's unrealistic expectations of adolescent abilities for abstract

reasoning and logical deductions (McKinney & Vogel, 1987) his contributions have paved the way for further knowledge of adolescent cognition and its complementarity to psycho-social theories in understanding adolescence in-depth. Theorists such as Lawrence Kohlberg (1981), Jane Loevinger (1976), and Robert Kegan (1982) have expanded Piaget's original approach with an emphasis on ego-development, object relations, and constructive development regarding the adolescent self.

The theories on adolescent development are individually-oriented with no account for the influences of family and societal systems of interaction. Culture and gender as strong influences of identity and personality are overlooked, thereby the theories form biases and assumptions which do not accurately represent reality. As adolescence is characteristic of regression and ambivalence, failure to master developmental tasks may be an expression of normative development as opposed to being pathological or disruptive (Kroger, 1989). The adolescent stage that stresses autonomy may be frightening to the adolescent who loses a great deal of the security that was held in childhood.

Both Erickson and Marcia convey a gender bias in their conceptualizations of adolescent development (Gilligan, 1982; Whitbourne, 1986). They emphasize the male gender in exclusion to the female gender without distinctions of male and female developmental processes.

Erickson's depiction of processes of autonomy and individuation in the adolescent stage are seen as developmental milestones that must be achieved in order to form healthy commitments in following stages. This viewpoint is male-centered and ignores the identity formation of females as self in relation to others through interdependence,

not solely independence (Chodorow, 1974; Gilligan, 1982). According to Chodorow (1974), female identity involves attachment through relationships and would be misconstrued by Erickson's notion of development as being disruptive to separation and hence, a failure in achieving identity formation. The different experiences of males and females in the adolescent context must be seriously considered so that a gender bias does not mislabel female development as deviant. Gender differences will be expanded on in the tasks of adolescent development and the Metaframeworks model which will be discussed further in the report.

The Identity status of Foreclosure is significant in demonstrating that certain adolescents may seek resolution without turmoil or crisis as indicated by Erickson, thus, there is a positive resolution by an acceptance of how things are (Whitbourne, 1986). The identity statuses also provide insight into personality and attributes, however, caution should be exercised in recognizing that these may likely be altered in later development (McKinney & Vogel, 1987; Whitbourne, 1986). One of the major criticism's of Marcia's findings is that it is unclear in formulating a developmental sequence or possibility of stages around resolution (McKinney & Vogel, 1987). It is useful to recognize the diversity of adolescent identity yet the statuses do not consider the impact of culture and gender.

A critique of Marcia's interview process for identity statuses shows questioning males around occupation, religion, and politics whereas females are asked about males with whom they would want sexual relationships (Sisson et al., 1987). Although sex-role attitudes are currently acknowledged in identity status research, in the past there was a

negative slanting toward stereotypical beliefs as to what should be of importance to boys but not to girls.

Important factors stemming from the adolescent's environment are also not accounted for in Marcia's theoretical model. While there is the assumption that identity is a conscious deliberate choice on the part of the adolescent whereas choice may not play much of a role in certain cultures (Kroger, 1989). The struggle for independence and the quest for autonomy is highly stressed in North American cultures, however, it does not create the same dilemma for adolescents belonging to other cultures of the world (Schlegal & Barry, 1991). Therefore, aspects of identity and self-knowledge may be unrevealed to the adolescent who may not gain insight until the transition to adulthood (Whitbourne, 1986). The lack of positive rewards in one's social environment will also effect self-esteem and decision-making. McKinney (1981) refers to this as the "engagement style" of interacting forces of the adolecent self as a change agent and as an object of change by others. The adolescent's questioning of self must be balanced with a positive perception by others. Peers play a significant role in providing positive feedback which influences self-esteem and motivation in adolescents (Ianni, 1989). Erickson (1968) addresses this point in the developmental stage of the adolescent who is asserting independent choices yet is still self-conscious and doubtful, thereby requiring parents to reinforce self-expression in a cushion of safety and flexibility of structure.

For example, a teenage girl whose family culture is rigid in terms of traditional female roles may find it difficult to assert herself with unyielding parents who expect her to be loyal, passive and accepting of family values. Her gender identity may be foreclosed until a later stage in which she may assert herself as a result of exposure to

diverse female roles, and at a time where the crisis is not only felt but supported by external influences. Adolescents accept superficial resolutions because self-knowledge is not completely accessible. While issues of cultural norms and gender are two environmental attributes which impact on development of identity, others are race, social class, religion, and family structure.

Adolescent needs are conveyed in the developmental tasks or milestones characteristic of this stage. As adolescents separate from their families in their quest for individuation, autonomy, and establishment of identity, certain adolescent themes emerge.

Adolescent Developmental Tasks: Recurrent Themes

The paradoxical nature of adolescence leaves adolescents struggling between dichotomous themes: dependence vs. autonomy, intimacy vs. separation, family vs. peers, play vs. work, and responsibility vs. impulsivity. Straddled between childhood and adulthood, adolescence is a time period of immense changes in the emotional, cognitive, physiological, and behavioral developments of the adolescent (Robin & Foster, 1989; Young, 1991).

Apart from individuating and separating from parents, critical developmental tasks which adolescents require to adequately prepare for the stage of adulthood are the following: (a) adjustment to puberty and sexuality, (b) preparations for a vocation, (c) relationships with peers, and (d) development of a system of values and a sense of identity (Conger, 1984). Different terms are used by theorists to describe developmental

tasks (Carter & McGoldrick, 1989; Preto, 1989; Robin & Foster, 1989, Young, 1991), however, they usually fall into the four mentioned areas or developmental themes. These themes are interrelated and do not necessarily precede each other in a sequential order.

Puberty and Sexuality

Biological and physical changes that accompany the period of puberty bring forth changes in social development, role expectations, and questions around sexuality (Blos,1979; Erickson,1968). The physical and hormonal changes in puberty can be overwhelming and confusing for some adolescents, resulting in problems adjusting to pubescence. Physical formations of sexual and reproductive organs, body/facial hair, and physical growth spurts clearly mark the end of a childhood body and the transition to an adult body. For girls, the onset of menarche signifies a rite of passage to womanhood.

Puberty initiates socio-cultural and familial expectations of adolescents to assume age-appropriate behaviors reflecting maturity and responsibility. For instance, girls are to act and behave more grown-up and ladylike, abandoning the "tomboyish" nature and carefree spirit of childhood (Young, 1991).

Adolescence is highly characterized by sexual feelings, thoughts, and behaviors (Preto & Travis, 1985). Developing a sexual identity is tied closely to one's formation of identity based on role expectations and sexual values. Formulating a sexual identity is a confusing and difficult task, partly because reproductive and physiological maturity does not necessarily indicate psychological maturity. Hence, adolescents engaging in sexual relations too early may experience emotional distress and inappropriate self-images

linking self-esteem solely to sexual functioning. A prevalent consequence of sexual relations between teens are unplanned pregnancies, in which decisions of abortion, adoption, or parenthood are difficult and consequential.

Experimentation around dating allows adolescents to form values and ideas around sexual involvement and behaviors. Sexual expression for some adolescents may be primarily masturbation, for others, it is the decision to have sexual intercourse (Schlegal & Barry, 1991). Self-concepts emerge from one's sense of sexuality and often conflicting values of parents and peers send the adolescent into a state of flux and chaos as to what is the right thing to do.

Sexual identity is typically taught and enforced as a heterosexual experience in the developmental literature although current literature does pay some attention to the emergence and reality of same-sex sexual experiences. Feelings of attraction and intimacy for gay and lesbian adolescents, as with most adolescents, is extremely intense and unlike the experience and experimentation with heterosexuality, it is greatly misunderstood. Socio-cultural views negate and ostracize homosexual relationships. The prejudice and disbelief from their families which gay and lesbian youth may receive results in high numbers of them dropping out of school and/or running away from home (O'Brien & Weir, 1995). Therefore, the lack of support and isolation from parents and peers create a stigmatizing existence for teens questioning their orientation for same-sex relationships (Martin, 1988; O'Brien & Weir, 1995). Many gay and lesbian adolescents will deny or repress their sexual needs and orientation because of financial dependence on their families and the rejection they experience from the culture as a whole (O'Brien & Weir, 1995). The stigma and hostility gay and lesbian adolescents experience may be

expressed through inappropriate sexualized behaviors and coping mechanisms that reflects their inner turmoil, for "the truth is that gay and lesbian youth are not like other adolescents. Their difference stems from their status as members of one of the most hated and despised minority groups in the country" (Martin, 1988, p.59). The lack of information on developmental issues about normative homosexual development relevant to homosexual teens represents a heterosexual bias parallel to the gender bias in the literature on adolescent development.

Vocation and Career

The adolescent begins the process of choosing a vocation or career that best suits his/her abilities and interests. Answering the question of "what will I do with my life?" prepares an adolescent to assume a functioning role in society as a requisite to becoming an adult. Determining an occupation involves reevaluation of competency mastered in preceeding developmental stages (Erickson, 1968). However, if an adolescent is unable to pursue a vocational direction, identity confusion will result (Erickson, 1950, 1968).

The pressure of having a vocation is mostly emphasised in the later teen years, yet with the emergence of a "youth culture", vocational achievement may be postponed into one's twenties. However, the need to have some focus or career path is a developmental task an adolescent must expend energy and thought on. Cultural and familial values may influence gender-specific occupations and roles which may or may not create tensions for young people.

Environmental obstacles which may influence an adolescent's vocational path are the type of value placed on education by families based on ethnic background, the social class to which an adolescent belongs, and the educational system's response to the adolescent (Ianni, 1989). Adolescents who experience poverty are at greater risk for low self-esteem, low motivation, and delinquency in a culture that devalues them, thereby affecting their abilities to succeed in school or the workforce (Ianni, 1989; Parnell & Vanderkloot, 1989).

Peer Relationships

Adolescence is a time of questioning and experimentation in expressing a need to fit in with one's peer culure, whose increased influence yields considerably more power than the family system once did (Eccles, Midgley, Wigfield, Buchanan, Rueman, Flanagan, & MacIvor, 1993; Ianni, 1989; Young, 1991). There is a strong need for acceptance and sense of belonging with peers.

As adolescents assert their independence with parents, the family setting may become a battleground of conflicting values and issues of power and control (Eccles et al., 1993; Robin & Foster, 1989). Adolescents begin to rely heavily on their peer group for support and reinforcement in their quest for separation and independence. Adolescents who feel misunderstood by their parents may find the environment of peer relationships comforting and self-affirming.

Adolescents are a subgroup in mainstream society yet their subculture is diverse and dependent on many factors. Adolescents belonging to an ethnic group are different

than those who define themselves through a street subculture. Identification with the youth subculture sets adolescents apart from other members in society as they adopt a scripted code of behaviors and beliefs (Havighurst, 1987). Peers offer a multitude of positive benefits for teens and the success of these relationships has a profound impact on their self-image (Eccles et al., 1993; Ianni, 1989).

Same-sex relationships are close and intense as adolescents have similarities in social and cognitive needs (Beck, 1976; Eccles et al., 1993). As adolescents spend a significant portion of their day interacting with peers, friendships are built on reciprocity and equality. Peers are experiencing similar biological changes, enabling a shared response to the difficulties and confusion in this area. Opposite-sex relationships allow peers to socialize and appreciate gender differences as well as gender commonalities. Adolescents also begin to differentiate between those relationships based on friendship and are platonic, with others where sexual interest and intimacy are desired.

The need for reliance and support from peer relationships contributes to feeling understood through shared experiences and higher self-esteem (Ianni, 1989; Schlegel & Barry, 1991). However, not all adolescents have positive peer experiences. Beck (1976) points out that there is a positive correlation between withdrawn and peer-rejected children who later have difficulties establishing peer relationships in adolescence.

Identity and Value System

Sexuality, vocational choices, and peer relationships interact in formulating one's identity and belief system. The adolescent stage represents an overt identity crisis in

which ego development is constantly being affected by the environment (Erickson, 1950, 1968). The adolescent is forming his/her identity, however, this is an ongoing process that continues throughout one's lifetime and is not intended for completion at adolescence.

Adolescents define themselves in terms of socio-cultural and familial influences of sex-role behaviors and social norms. Gender role differentiation for both sexes begins primarily in adolescence (Gilligan, 1982; Mackie, 1987). Nett (1993) believes that our culture reinforces male aggression and female passivity which also translates into an encouragement of autonomy at earlier ages for boys and more restrictions placed on girls. Gender roles emerge as strong forces in identity formation and take on stereotypical qualities if they are not balanced and egalitarian.

Physical and emotional changes challenge the adolescent's concept of self as they embark on a journey of discovery which interacts with the process of identity formation (Preto & Travis, 1985). Adolescents rely on others' perceptions to define who they are, especially those of peers. As they overidentify with their peer group it is more likely that adolescents will form beliefs and values that conflict with those of their parents (Eccles et al., 1993).

Bibby and Posterski (1985) conducted a study of values that are important to adolescents across Canada. Ones that rated the highest are the following: friendship (91%), being loved (89%), freedom (84%), success (78%), and a comfortable life (75%). It seems that these values would be acceptable to most parents, yet conflict may center around the process by which teens assert their freedom and the parents' ability in letting go of their control.

Important factors of ethnicity and social class contribute to the adolescent's self-definition as they bring with them issues of accessibility and opportunity. Teens from an oppressed cultural group and/or low socio-economic status will have barriers and disadvantages compared to other teens that do not have to contend with racism or poverty. This in turn affects what certain teens value and emphasize and what other teens take for granted.

In reviewing the literature on adolescence, it seems imperative to place adolescent issues into a relevant family context in order to assess the impact and relationship of the adolescent in his/her family. The family's response to adolescence relates to how well the family adjusts to this stage in the family life cycle. Intersecting frames of development, culture, and gender convey a Metaframeworks approach of viewing family members and understanding their needs.

CHAPTER THREE

Review of the Literature: Metaframeworks

Metaframeworks

The Metaframeworks approach takes into account the relevant factors of development, culture, and gender. Breunlin, Schwartz, and Kune-Karrer (1992) view these factors as three of six "core domains" of various models in the family therapy literature. These authors believe that the Metaframeworks perspective "takes some of the most useful ideas from seemingly disparate models and links them with common underlying assumptions, so that you can move fluidly from one to another" (Breunlin et al., 1992, p.7). According to a Metaframeworks perspective, focal points of development, culture, and gender are present in all theoretrical frameworks influencing our ideas and interventive endeavors with client systems.

The three Metaframeworks to be looked at are not mutually exclusive, they are "a recursive set of ideas that interact with and complement one another" (Breunlin et al., 1992, p.48). If we fail to examine the critical effects of development, culture, and gender for the clients with whom we work, we are doing them a great disservice by a lack of understanding of their concerns and limiting their prospects of engaging in therapy.

Constraints that families bring to therapy are embedded in the Metaframeworks and thus, the goal of therapy becomes that of removing constraints so that human systems can function in a more effective manner (Breunlin et al., 1992). An integration of these Metaframeworks with the BSFT model will elicit solutions for people that are respective

of meeting the needs of their unique circumstances. In cooperating with clients, BSFT aims at understanding these three Metaframeworks as they profoundly impact on the client's world view which is accepted and utilized in therapy.

Development Metaframework

The importance of family development has been articulated through the family life cycle model (FLCM) of sequential stages that family members pass through over time. The notion of the family life cycle (FLC) introduced into the field of family therapy is the first serious look at the role of development in clinical work (Breunlin et al., 1992; Carter & McGoldrick, 1989; Falicov, 1988; Herz-Brown, 1991). Breunlin et al. point out that the FLCM "...not only brought a component of development into family therapy but was also helpful, because it freed family therapy from pathology and deficit-based views of families, replacing their views with the idea that problems in families are products of failed transitions" (Breunlin et al., 1992, p.159). Haley (1973) states that family stress is symptomatic of the desire for adaptation and change during life cycle transitions.

The FLCM is a valuable piece of analysis as to where families are in their current life circumstances and how its members have developed over time. However, the transitions and stages are sometimes not easily predicted and must take into account the social, political, and economic infrastructures of societal influences. In this sense, defining the development of families relies on other sources which influence them. Breunlin et al. (1992) believe that families develop on five levels: biological, individual,

subsystemic (relational), familial, and societal. These levels are viewed to be acting synergistically, therefore disruption at one level impacts other levels of development. Similarily, if developmental tasks are interrupted or unachieved, this impacts on future stages of development which may be delayed or poorly handled.

The discussion of family development will focus primarily on the FLCM as it closely pertains to family therapy, however, social, political, and economic factors are also examined. The discussion of culture and gender will expand on their interrelatedness to family development as frames of reference for families with whom we work.

Family Life Cycle Model: Stages and Tasks

The FLCM as outlined by Carter and McGoldrick (1980, 1989) identifies the following developmental stages: (a) leaving home, (b) joining of families, (c) families with young children, (d) families with adolescents, (e) launching children and moving on, and (f) families in later life. The FLCM offers a continum of tasks the family has integrated in the past, in the present, and towards the future. Adolescence is considered to be an extremely difficult stage in the family life cycle as immense turmoil brings about the need for changes and restructuring in the family. While parents were the primary socializing force in childhood, they must now compete with the adolescent's peer group and subculture. As adolescents assert their independence and need for increased freedom, parents must relinquish control and power. Negotiations between parents and adolescents around boundaries and family rules are called for (Young, 1991). Granting

teens independence is a difficult task for parents who view adolescent behavior as inconsistent, impulsive, and at times illogical.

Our culture stresses freedom and individuation, however, it is accompanied by responsibility. Parents must strike a delicate balance between giving adolescents their space and freedom yet still offering them stability and structure on which the adolescent can rely on (independence vs. dependence). By "sponsoring independence" parents permit increased responsibility in the area of decision making to their adolescents in an atmosphere of emotional support and gradual letting go (Adams, 1980 cited in Nett, 1993). Carter and McGoldrick (1980, 1989) highlight that family stress is often the greatest when the family changes from one developmental stage to another, for instance, as previously mentioned, the families with adolescents stage requires a great deal of restructuring of family roles and boundaries.

According to Carter & McGoldrick (1980, 1989) the family system and its developmental needs is reflective of at least three generations. Transgenerational stresses which may be unresolved have the ability to resurface as similar developmental themes are addressed from generation to generation (Roberto, 1992).

As the family is composed of individuals, people are in different developmental stages and these may often clash, especially when the family is adjusting to the adolescent stage. Preto (1989) has noted that the adolescent stage is extremely stressful for families. She points out the following:

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

The FLCM is helpful in determining which adolescent behaviors are a "normal" expression of needs being expressed in a dysfunctional and stuck family context, as compared to symptoms which are considered to be rooted in individual pathology. How symptoms are manifested and contextualized in stages of family development is important. Families react to the normal conflicts of adolescence in different ways. How they react can be influenced by their problem-solving skills, communication patterns, belief system, and family structure (Robin & Foster, 1989). Parenting techniques which may have been successful for the child will need to be altered for the adolescent. The inability to find solutions for this family life cycle stage contributes to parent-adolescent conflict and families remaining stuck in a frustrating situation. By failing to address familial issues and interactions, blame is shifted solely to the adolescent whose behavioral acting-out reinforces cognitive distortions held to be true by the parents. A common approach to problems by parents is that the adolescent needs to "be fixed" or "cured" apart from the family environment.

Carter and McGoldrick (1989) caution us that the FLC stages can be slanted towards a traditional two-parent nuclear family and must take into account the diverse family compositions and cultural backgrounds. The consideration of culture needs to

occur so that functional aspects of developmental tasks are not mislabled as dysfunctional (Falicov, 1988). The length and time in each stage is unique for families. The impact of developmental themes depends on cultural values and the importance each culture pays to them (Tseng & Spiegel, 1990).

As families experience anxiety and stressors in developmental stages and in moving from one stage to the next, symptoms which express the family as being stuck emerge (Carter & McGoldrick, 1980, 1989; Haley, 1973; Karpel & Strauss, 1983). Carter and McGoldrick (1980, 1989) suggest that the flow of anxiety in families is viewed as vertical and horizontal. The horizontal flow of anxiety is characteristic of the family moving through time and addressing predictable and unpredictable developmental changes and life events. The vertical flow of anxiety is described as:

> patterns of relating and functioning that are transmitted down the generations of a family primarily through the mechanism of emotional triangling (Bowen, 1978). It includes all the family attitudes, taboos, expectations, labels, and loaded issues with which we grow up. One could say that these aspects of our lives are like the hand we are dealt: they are given. What we do with them is the issue for us. (Carter & McGoldrick, 1989, p.8)

If a family's vertical stresses are great and have been passed down through generations, then the family's likelihood to experience disruption with the horizontal stressors is significant. Carter and McGoldrick (1980, 1989) feel that the family's ability to manage FLC issues and stress is determined when the developmental stress (horizontal axis) intersects with the transgenerational stress (vertical axis).

Generations have changed the patterns of the family life cycle considerably based on societal and cultural influences. The ages of developmental tasks such as marriage and childrearing are significantly different than those once described by Duvall (1977). The family structure has a significant impact on how developmental stages are carried out and, particularily in the adolescent stage what restructuring of the family is required.

Family Structure

Compositions of family structures provide information on how families have transformed or stayed the same over time. Karpel and Strauss (1983) examine the interplay of family dimensions in the factual, individual, systemic, and ethical realms. These areas take into account the other sources of family development which Breunlin et al. (1992) refer to through their multi-dimensional focus.

The factual realm examines facts or events that have occurred in the family's life. Nodal events such as birth, marriage, work, children, death, illness and so on, all serve to punctuate what has gone on for the family but patterns of family life co-exist as time continues to flow rather than slow down (Duvall, 1977). The individual realm is driven by emotions in which feelings, needs, identity and issues of loss and trust are contained. The systemic realm are subsystems, boundaries, roles, and common patterns which affect communication and relationships. The ethical realm views our legacies, loyalties, entitlements and obligations. This categorical representation of a family's structure is useful in portraying what affects the individual, the relationships, and the family in an

integrative fashion. The ethical realm reveals the pull of past issues that influence current functioning.

Parent-adolescent conflict may serve to cover up untreated and unacknowledged familial issues, especially marital difficulties (Herz-Brown, 1991; Roberto, 1992; Robin & Foster, 1989). As parents invest time and energy into problems with their adolescent, the pressure and exposure of the couple's issues are masked and denied.

The role of the adolescent in the family has consequential effects on the siblings. For younger siblings, it models and foreshadows adolescent behavior and family conflict (Robin & Foster, 1989). As enormous attention is paid to the adolescent, parents may neglect other children and overlook their needs, thereby leaving siblings with more free time and freedom than is age-appropriate. The adolescent-sibling relationship may take on varied approaches: siblings may side with their brother or sister and form coalitions against the parents, they may resent the adolescent and retreat from the family, or they may act-out on their own to elicit attention from parents and compete for status in the family structure.

Duvall (1977) stated that knowing three things about a family will enable predictions for what significant areas to address. These are: (a) who is in the family, (b) where they are in terms of the life cycle, and (c) what the social status of the family is. Cultural influences effect family structures in terms of defining its membership. For instance, the role of the extended family on the nuclear family expands the family's boundaries to include different generations in its composition. The extended family may have a role in providing a great deal of emotional and physical support, however it may occur at the expense of decreasing the autonomy of family members (Tseng & Spiegel,

1990). Each family's stressors are different and patterns of coping will rely on their structure and developmental phases.

Impact of Development on Families

In working with families it is crucial to understand their developmental context and tasks being currently worked on. Seeing families in terms of a FLCM reframes their issues as normative extensions of everyday life. Examination of family symptoms in light of development and failed transitions is an entry point to understand the dilemmas for family members.

In working with families of adolescents, it is important to keep in mind that parents have a "generational stake" in the investment of their children (Bengston & Kuypers, 1971 cited in Nett, 1993). As adolescents are in the process of leaving the family, they are quite happy with their new experiences and relationships whereas parents may feel rejected and may want to minimize their loss and emotional separateness. The loss that parents experience as their adolescents separate and individuate is intertwined with other losses they face in the family life cycle, making the adolescent stage especially overwhelming.

The FLCM is a framework for understanding the impact of development on families. It may aid greatly in the assessment phase of treating families and guide our interventions so that systemic issues are addressed. Liddle and Saba (1983) caution against using the FLCM in a reductionist format without adapting it to families. They

also feel that the FLCM is an assessment tool and not a therapeutic intervention (Liddle & Saba, 1983).

The significance of life events is seen in a three-generational format and the legacy of a specific event may make symptoms appear around that same time period for family members (Walsh, 1983). The timing, meaning, and rituals of developmental stages and tasks vary greatly among cultural and ethnic backgrounds (McGoldrick, Pearce, & Giordano, 1982). The culture Metaframework encourages viewing families' developmental needs in a culturally-relevant context.

Culture Metaframework

Culture is a generic umbrella term to include many things about someone. It may be construed to be one's race, ethnicity, language, religious customs, family values and so forth (Falicov, 1983). Culture may also be examined in the belief system of an intracultural setting in which cultural groups within a common society propogate values that are culture-specific and are maintained by historical, political, and economic influences (Breunlin et al., 1992). Intercultural beliefs are those common features that pertain to many different cultural groups, thereby maintaining a cross-cultural perspective of commonalities (Breunlin et al., 1992). Varied viewpoints of culture from sociology, biology, and anthropology offer a diversification of meanings that, when taken separately, offer us only a partial view of what culture actually represents.

In the family therapy context of the practicum, culture was viewed to take on a multicultural dimension in which the following factors emerged in shaping and

sustaining one's culture: generational patterns, immigration, economics, education, ethnicity, religion, gender, age, race, and regional background (Bernal & Alvarez, 1983; Breunlin et al., 1992; McGoldrick et al., 1982). These components directly influence the development and gender Metaframeworks for they are embedded in one's cultural framework (Carter & McGoldrick, 1980; McGoldrick et al., 1982). Culture contributes to how we see the world and legitimizes the way we feel, think, and behave (Davis & Proctor, 1989; McGoldrick et al.,1982; Perelberg, 1992). Cultural scripts provide us with problem-solving abilities and influence our attempted solutions (Montalvo & Gutierrez, 1983).

The therapist must not only seek to understand the client's cultural dimensions but he/she must also be aware of his/her own culture and the interplay between the two parties (Lappin, 1983). Acknowledging cultural influences must be met with flexibility and an acceptance of diversity. Enrichments and constraints of cultures can be used to explore areas of strengths which will facilitate growth (McGill, 1983; Montalvo & Gutierrez, 1983; Tseng & McDermott, 1981). Practicing intercultural therapy may be defined as "effective therapeutic intervention and facilitation by a member of one ethnic group in the decisions, choices and subjectivities of a client of another ethnic group" (Kareem & Littlewood, 1992, p.11). It is the therapist's responsibility to acknowledge issues of the client's race and culture from the onset of therapy. Failure to do so, denies the existence of life experiences intrinsic to a client's identity and fragments any real understanding of clinical issues (Davis & Proctor,1989; Kareem & Littlewood, 1992; Watzlawick, 1984).

Culture is a powerful influence of our values and belief systems that are encorporated into our past, present, and future life experiences. Culture will be examined in terms of cultural transitions, race and ethnicity, and social class that are organizational structures of the familial system.

Cultural Transitions

In asking ourselves "where do we come from?", we turn to the past and look at history for answers to define who we are and how we have turned out this way. Generational patterns as transitions provide explanations as to what we value and place emphasis on depending on the cultural climate we grew up in (Breunlin et al., 1992). This impacts the roles we have played in the past and the ones we take on currently. The expression of a "generation gap" refers to a void in understanding the issues of one generation because they are different and inconceivable to the issues of another generation. Often, children and adolescents are able to adapt and change at a quicker rate than their parents in a new cultural environment (Tseng & Spiegel, 1990). Adolescents may feel that their parents and other adults do not understand the pressures they feel because those same pressures were not felt in past generations.

Historical patterns provide a sense of stability and comfort in the certainty of the past, whereas new generational themes challenge that stability with differences and uncertainty through change. Families have generational differences and how they address these differences will impact on their abilities to seek feasible solutions and maintain respect for each other's cultural themes (Breunlin et al., 1992).

The cultural transition of immigration creates a process of adjustment into a new culture that exists for generations to follow (McGoldrick et al., 1982). This process, known as acculturation, may bring values and beliefs into conflict and negotiation as one adopts the majority culture as one's new home (Breunlin et al., 1992). Immigrating to a new country brings many new experiences and challenges but alongside it are numerous losses that create conflict in how well people acculturate. Losses such as language, support system, relationships, and cultural values and beliefs contribute to this profound transition immigrants face. It is important to know whether immigrating was a choice for the family members and if so, who made this decision. If a family was forced to leave their country of origin, acculturation will be more difficult and unwelcomed (Tseng & Spiegel, 1990). Acculturation exists over several generations of immigrant families, and which generation family members belong to impacts their adjustment and the values encorporated in their daily lives (Lappin, 1983).

Family members acculturate at different rates according to their gender, age, and experiences. For instance, children are able to adjust to their new culture at a quicker rate and are greatly influenced by their peer group (Breunlin et al., 1992). If adults have trouble with the new language, they may find their new life circumstances threatening, isolating, and distressing. Women may welcome new found independence and challenge traditional roles, thereby straining the marital relationship and familial roles implemented in the past.

Cultural transitions signify change and how smoothly this takes place depends on how family members feel about themselves and their new surroundings (Janosik & Green, 1992). In examining this component of culture, the therapist must afford family

members the opportunity to talk freely of their experiences and perceptions of their new cultural environment and the values they wish to retain and those that are in the process of being redefined. A family's values may be on a continuum of traditional, transitional, and contemporary which are influenced by migration patterns, acculturation, and the developmental crises the family has undergone (Bernal & Alvarez, 1983). Allowing families to grieve the insurmountable losses they have incurred enables the therapist to grasp a better understanding of how culture impacts on the family's identity and issues of importance for them.

Race and Ethnicity

Race and ethnicity are predominant features of culture as they are exposed more visibly through the color of one's skin, accent of language, religion, and cultural practices (Davis & Proctor, 1989). Race and ethnicity may be construed synonymously implying that one's race will give a general idea as to one's ethnic background. Ethnicity encorporates culture-specific beliefs, norms, and behaviors of preceding generations to define our ethnic or cultural background. As further generations evolve, different ethnicities may be added offering a diverse ethnic background to individuals. However, it is generally maintained that we define our ethnicity in terms of our parents and how cultural influences were integrated into our lives. Breunlin et al. (1992) define ethnicity in terms of "the national origin of the parents in the family" (p.216).

The term "visible minority" targets people of a different race from those belonging to the majority culture. Ethnicity is then assumed to play a large role in their

cultural development for they are likely immigrants to the larger populace. If one is not a visible minority, ethnicity may be overlooked by assuming that the constraints of cultural influences are not as great. In understanding the culture of a specific ethnic group, some knowledge of their belief system and cultural practices is helpful. However, making ethno-specific assumptions or generalizations may result in stereotyping or narrow-minded attitudes which fail to address each family's cultural dimension uniquely (Lappin, 1983; Tseng & McDermott, 1981).

Race is a factual element to describe someone by placing him/her into a racial category or group. However, defining racial groups may vary from culture to culture. In North America, we categorize races as: Caucasian, Oriental, Asian, Blacks or Afro-Americans, Hispanics, and Aboriginal. However, within racial categories there is a diversity of ethnicities, and some people prefer to have their ethnicity identified as opposed to being part of a general category of race (Janosik & Green, 1992; McGoldrick et al., 1982). For instance, Pakistanis and Hindus fall into the Asian category, yet their beliefs and ethnicities are very different. Religious and political differences of Moslems and Hindus further exacerbate the discontent of being in the same racial category without distinction of their ethnicities.

Ethnicity is a powerful component of one's identity and it prescribes expectations and rules around family relationships, life transitions, gender roles, and cultural-specific behaviors (Breunlin et al., 1992; McGoldrick et al., 1982). For instance, different cultures have a multiplicity of views on the timing and rituals of age-appropriate tasks to be completed in the life cycle such as education, marriage, having children and retirement (Falicov & Karrer, 1980; Tseng & Spiegel, 1990). Failure to complete life

cycle tasks by a certain age is frowned upon and a source of conflict for families in their cultural context. Ethnic affiliations also have strong beliefs around who constitutes a family and the roles individuals take. The role of the extended family (grandparents, in-laws, aunts, uncles, brothers, and sisters) to one's immediate family varies in its definition according to one's ethnic background (McGoldrick et al., 1982).

The stage of adolescence is characteristic of a cultural upheaval as families' cultural values clash with values of the mainstream culture. Although many adolescents assert themselves through questioning family values, for ethnic minority adolescents the question of loyalties to the traditions of one's country of origin is always present (Kareem & Littlewood, 1992). Carter and McGoldrick (1989) point out that stressors for the first few generations will be greater as the acculturation process is still relatively new and families have sacrificed a great deal to immigrate to the host country. Erickson (1968) acknowledges that cultural factors impact on the adolescent's development of personality and may reinforce internal struggles or family conflicts.

The cultural practices of an ethnic group may also be organized by the principles of religion. Religious doctrine conveys beliefs and values that are practiced in one's culture. Religion defines acceptable and non-acceptable behaviors that become an intrinsic part of one's identity (Breunlin et al., 1992; Janosik & Green, 1992). Religion may be an aspect of one's ethnicity, however many different ethnicities may accept the same religious teachings. Religion may or may not play a powerful role in people's lives and the multiplicity of religious interpretations is a very personalized process. Thus, certain religious beliefs may be deeply held whereas ones that are constraining may be disregarded or redefined. The North American culture is rich in its diversity of ethnicities

and the interplay of many religions is greater than in a culture where there are a few or only one predominant religion. Thus, the cultural mileu may reinforce religion as the highest sanction of cultural beliefs or it may view religion as a component of culture yet not necessarily as the prevailing one.

Race and ethnicity play a role in defining the social status of groups in society. Certain races and certain ethnic groups have a higher social status than others which impacts accessibility to education, vocation, and financial security (Tseng & Spiegel, 1990). How one perceives social status is linked to the opportunities and constraints experienced by whether you are part of the majority or whether you are part of a minority group. Breunlin et al. (1992) state that: "Minority status is related not only to the racial sociocultural context but also to economics, education, gender, and age" (Breunlin et al., 1992, p.225). Minority groups often experience racism, prejudice, and/or discrimination which prevents them from receiving the same advantages or rights members of the majority group experience. Even individuals that are part of the majority group based on race or ethnicity may belong to other groups in society that are part of a minority culture, thereby experiencing facets of oppression that affect their social status in the eyes of others. Social status is inextricably linked to the social class one belongs to and this has everlasting effects on the quality of life defined through one's culture.

Social Class

Social class often correlates with the economic or financial lifestyle (poor, middle-class, upper-class, and rich) one maintains. Those of majority status in society

who are of low socioeconomic status will experience facets of oppression regardless of race or ethnicity. The social class families belong to brings with it a cultural context of attitudes and beliefs that pattern behaviors and resources. McGoldrick et al. (1982) found that immigrants who experienced upward mobility often felt an identity crisis through adopting the mainstream culture at the cost of betraying their homeland and ethnic roots.

Economics or money create accessibility and opportunity in most cultures of the world. Therefore, the less you have will make the constraints and negative effects greater. Breunlin et al. (1992) comment on the effects of economics on social class:

> Working-class families report experiencing the greatest burden at times of economic change (whether in a recession, an inflation, or a robust economic period). These families also experience a sense of disenfranchisement, because they frequently do not fit the requirements for supportive social programs. Middle-class families experience themselves as being overtaxed and underserved. At the same time, their high degree of conformity to the consumer ethic of our society ends up constraining the quality of their lives. (Breunlin et al., 1992, p.212)

Social class dictates behaviors in our daily lives by what we can afford to place emphasis and value on. If families are surviving day to day on sparce economic means, material items may be unrealistic even though the desire to possess them exists. For those belonging to upper or rich classes in society, wealth may need to be emphasised through material goods and luxurious lifestyles. Social class dictates our values, how we act, and who we associate with in our daily interactions. On a political level, it also provides or denies us access to education, healthcare, employment, and basic human rights. People

belonging to lower classes of society contend with higher rates of unemployment, delinquency, family instability and illness, and a greater sense of alienation than other social classes (Colon, 1989).

Poor families contend with a culture of social problems and a downward spiral of poverty that can have devastating effects on one's psyche and identity (Parnell & Vanderkloot, 1989). Children of poor families are raised in such deficient circumstances that the influences their cultural environment has on them is readily apparent. They are the least likely group of people to be able to access resources and move upward in social mobility. This in turn, may influence "the manner in which problems and solutions are perceived, explained, and dealt with; the pathways of seeking and obtaining help; what is expected; and how one interacts with a professional are all affected by cultural and social class factors" (Falicov, 1983, p.xiv). There may be a blaming attitude the poor have towards helpers and institutions who have by in large failed and misrepresented them (McGoldrick et al., 1982).

Education has been viewed as a tool of growth and advancement that cuts across all social classes offering the quest for knowlege to anyone. This is a fallacy as everyone does not have the means and similar opportunities to access a high quality of education from childhood onwards. The rising cost of tuitions, stricter entrance requirements, and lack of financial funding for students do not afford all social classes access to education as a right. For single parents, education may appear an impossible goal as they struggle to raise families and provide childcare without adequate financial help.

The social class of women and men are very distinctive based on the gender inequalities perpetuated through a discriminating culture. This is most prevalent in the

comparison of single mothers and single fathers. Households headed by single mothers are far below the poverty line compared to those headed by men (Boyd, 1988; Nett, 1993). Men also experience a higher social status and appreciation by society in being the sole caregiver whereas women are expected to or are perceived as being "unfit mothers" (Gorlick, 1995). Men's social status and higher social class is attainable through having more education and experience in the workforce than women. Women forego education and work to have and raise children, and any career successes achieved occur at later ages for women compared to their male counterparts (Holder & Anderson, 1989).

Aspects of culture influence families as a whole yet they also affect family members individually based on their genders and roles. Gender issues in families impact their relationships, dynamics, and hierarchy of power and control. Gender is a powerful determinant of our identities and a required frame of reference when working with families.

Gender Metaframework

A gender metaframework has evolved partly as a result of the family therapy field challenging current theories and interventions that perpetuate gender imbalances and inequalities women face in every facet of their life, especially in their families (Goldner, 1988; McGoldrick, Anderson & Walsh, 1989; Walters, Carter, Papp & Silverstein, 1988). The examination of current paradigms of therapy have been primarily taken on by female therapists who have redefined clinical assumptions and constructs

that have historically disadvantaged women. Major schools of family therapy have been set up and defined by men who have operated under a patriarchal male-dominated viewpoint ignoring the issue of gender (Breunlin et al., 1992; Hare-Mustin, 1987; McGoldrick et al., 1989; Perelberg, 1990; Urry, 1990; Walters, 1990). At one point in time, this would have been the prevailing attitude as the traditional nuclear family was the norm and roles of men and women were in essence more clearly delineated. Clearly, the monolithic image of a family no longer exists and our assumptions of family life have been challenged (Mackie, 1995; Walsh & Scheinkman, 1989). The multitude of changes to our social, economic, and political infrastructures cannot be denied or ignored, yet they have been. The role of the family unit has changed considerably as varied family structures constitute a family with new legal and functional meanings (Karpel & Strauss, 1983). The roles of women and men have also changed considerably, and the influence of the feminist movement has had great impact on exposing the gender imbalances prevalent in the larger systems of our culture.

Traditional family therapy instigates an institutional oppression of women as our current thinking devalues womens' roles in the family and condones mens' power and control in the family (Hare-Mustin, 1987; Mackie, 1995; Perelberg, 1990; Urry, 1990). This is not always an intentional effort on the therapist's part, yet it is done on a very subtle and ingrained cultural level resulting in faulty assessments and interventions. Integrating a feminist perspective or a gender-sensitive framework to practice, regardless of the theoretical content, will enhance a balanced approach in understanding men and women and their relationships. On a broader level, the family therapy field cannot

operate under a sexist and oppressive domain ignoring the significant role gender plays in our culture.

The Socialization of Women and Men

Historical patterns and themes provide insight as to how our gender prepares us for the roles we assume. What it means to be male or female is defined at an early age through our cultural socialization (Walsh & Scheinkman, 1989). Femininity and masculinity engender specific personality traits and characteristics that are perpetuated and sanctioned throughout our lives. Males are raised to be in control, financially stable and providers for the family (dependents who are women and children), emotionally distant, and autonomous. Females are raised to be nurturing, sacrificing, emotional, and dependent on male authority. These are sexual stereotypes that have been intrinsically embedded in our culture.

Young girls and female adolescents are bombarded with societal images of beauty through the media, fashion magazines, and cultural stereotypes (Faludi, 1991; Liburd & Rothblum, 1995; Waller & Shaw, 1994). Emphasis on body-consciousness and social control on female appearances targets girls for negative self-images and eating disorders as they equate their objectification with self-worth and control (Bruch, 1973; Liburd & Rothblum, 1995). Girls are brought up to be nice, helpful, and caring. While all admirable qualities, this focus creates a context of passivity and silence, as their feelings, thoughts, beliefs, and actions do not quite measure up to what boys feel, think, and do. Sadker and Sadker (cited in Walters, 1990) conducted studies in schools between 1980

and 1986 that consistently showed that more attention, encouragement and praise was given to boys than to girls. Adults, both male and female teachers, will turn to the boys for answers, fail to acknowledge answers given by girls, and encourage boys to compete more than girls. The Toronto Board of Education has used educational studies which confirm similar results, they also add that "in class, teachers call on boys more often, give them more criticism, more praise. While boys are punished more often and more severely than girls, they are also graded on their ideas and complimented on their talents, while girls get marks for having neat papers or attractive presentations" (Cannon, 1995, p.20). The unequal learning opportunities for males and females contributes to the lack of self-esteem girls develop as their voices and opinions are silenced (Cannon, 1995). Girls, and later women, are treated with a sense of fragility in that they need to be taken care of by males.

The long-term effects of this gender training is that females begin to devalue their own experiences, silence their voices, and give in to an authoritative world defined by males. Brown and Gilligan (1992) report on a project in which women and adolescent female students attended retreats in order to explore the girls' psychological development. One woman reports:

> It was first with a sense of shock and then a deep, knowing sadness that we listened to the voices of the girls tell us that it was the adult women in their lives that provided the models for silencing themselves and behaving like "good little girls". We wept...Unless we stopped hiding in expectations of goodness and control, our behavior would silence any words to girls about speaking in their own voice. (Brown & Gilligan, 1992, p.221)

The above testimony painfully shows that gender patterns are repeated and failure to model different behaviors and empower girls and adolescents will result in further silencing of their female voices and hinderance of their psychological development. "When women and girls meet at the crossroads of adolescence, the intergenerational seam of a patriarchal culture opens" (Brown & Gilligan, 1992, p.232).

By the time of adolescence, girls are mandated in roles of caring for others and defining their self-worth through relationships. In studies of adolescent girls, Marge Reitsma-Street (1993) concludes that adolescent girls learn: (a) that women are the primary providers of emotional and physical care, (b) a very restricted notion of what self-care means, and (c) that boyfriends are the primary recipients or objects of care.

In families, women are strongly identified with their roles as wives and mothers, hence, the expectation is to provide nurturance and role-modelling to children. Women model to their daughters the instrumental and expressive tasks in caring and attachment to relationships, whereas sons separate from their mothers and identify with their father's autonomy (distance) and role of economic provider (Baines, Evans, & Neysmith, 1993; Chodorow, 1978). If one of the parents is absent in the child's life, socialization from other sources and other role models will impact socialization as our culture condones the bifurcation of genders. Boys learn that feminine aspects of the female caregiver is in direct contrast as to how they should be, therefore, they are socialized and reinforced in assuming the male attributes which define them (Goldner et al., 1990).

Social prescriptions of masculinity are pervasive in cultural beliefs, values and norms. The ideology of "machismo" and being in control is perpetuated in a culture that downplays mens' emotions and vulnerbilities (Goldner, 1988; Neal & Slobodnik, 1991).

Men's sense of adequacy is greatly linked to their workplace and in how they compare to other males in a work setting (Neal & Slobodnik, 1991).

Socialization of gender attributes and roles are powerful pieces of our identities that are well formed by adulthood so that we continue to replay that which is comfortable and prescribed. Gender-specific characteristics are such an engrained part of our culture that any challenge to constraints or deviance from the norm is met with ridicule, punishment, guilt, and low self-worth, thereby strengthening the gender differences and our passive acceptance of them.

Sociopolitical Sphere of Gender Issues

Gender issues are prevalent in the interactions between women and men, yet the unequal priorities and opportunities for women are manifested in the sociocultural, political, and economic systems of our society. The gender of women has been defined by a male-dominated culture that has marginalized and oppressed female rights and strengths.

Culturally and politically, power differences between men and women have given men more economic advantages, a higher status of living, employment stability, and greater accessibility to the workforce. Women are culturally defined in the predominant roles of wives and mothers, and as time is spent on pregnancies and child-rearing, they are likely to be in and out of the workforce, or may take a leave of absence from employment altogether.

Women have maintained employment in low-paying jobs with minimal benefits and are less able to climb the social ladder. The type of jobs that have predominantly employed women are those in the helping and caring professions i.e. teachers, nurses, receptionists, secretaries, social workers, group home and day care workers (Baines et al., 1993; Holder & Anderson, 1989). However, positions of management in these same professions are largely held by men, who are in positions of power and authority over women. This hierarchical arrangement mirrors male-female relationships in the culture at large (Imber-Black, 1989). Not only do women seek out jobs that extend the role of the caring they do on a personal level, their economic value is greatly underestimated as is the quality of their work.

There is no economic value given to all the unpaid labour women do inside and outside the home, and the value our society pays on taking care of others is sadly reflected in the pitiful salaries and low prestige that come with it. Women are expected to take care of others, their children, their husbands, their parents, their in-laws, and complete strangers when they engage in volunteering endeavors (Baines et al., 1991). They do this simply because they are assumed to embody self-sacrificing and caring virtues that make them quintessentially female.

As our society evolves through the women's rights movement and challenges the sociopolitical hierarchies that oppress women, certain measures to address equality have been undertaken. However, as freedoms through equality are achieved, there are increased burdens of stress and responsibility placed on women, not on men (Goldner, 1988). For women, any amount of freedom gained comes with a penalty, for now they must prove themselves to be competent in the public world (workforce) and in the private

world (families) which is still defined by a patriarchal standard. The paradox of women's increased freedoms and roles is that the hierarchy of power and cultural inequities have not been addressed, thereby perceiving men and women to be on equal grounds is an irrelevant and false claim. Women are still the primary caregivers in families, they are responsible for arranging and providing childcare, and they have virtually no power in decision-making in their public and private domains.

Women's lack of accessibility in changing life circumstances holds them captive to maintaining the status quo of an oppressive culture. Domestic violence and sexual assault are vast social problems in our society that continue to sanction men's power and control and women's helplessness and powerlessness (Davis & Proctor, 1989; Goldner, Penn, Sheinberg, & Walker, 1990). Violence perpetuated against women is reflective of a society that devalues and undermines their human rights (Breunlin et al., 1992; Goldner et al., 1990).

The sociopolitical reality of our society does not reflect the changes that need to occur in order for all members to experience the same rights and privileges. The changing roles of men and women challenge the traditional stereotypes, however, these changes must be met with a congruent societal structure that encompasses social, economic, and political systems. The role of the family is a major entry point for the changing roles of women and men, therefore our interventions through therapy must put forth a gender-balanced framework that is respective and healthy for all family members. Imber-Black (1989) recommends that:

> Family therapists must examine and utilize gender as a central organizing principle for their work in order to avoid perpetuating sexism and patriarchy in the family and the larger systems. The work involves sensitivity to the actual power differentials between men and women in families and larger systems, as well as carefully planned interventions to challenge and address these discrepancies.
> (Imber-Black, 1989, p.352)

Gender Issues in Family Therapy

Gender is only starting to be viewed as a focal point of family therapy, yet it is still a "hidden dimension" (Goldner, 1988; Walsh & Scheinkman, 1989). As therapy views the family as a system, it operates under the assumption that all individuals have the same degree of accessibility and control to that system (Breunlin et al., 1992; Urry, 1990; Walters, 1990). This has proven to be untrue if we are aware of the gender inequalities in the roles within families. Focusing on gender with an unawareness of the differences teaches families (microsystems) a view of reality that is supported by the therapist, who is a part of the macrosystem (Hare-Mustin, 1987). Therapy is political and it is in this environment that the therapist challenges her/his own gender beliefs and how they are personified in the labels, interventions, diagnoses and assessments applied to families. If gender inequities are ignored in the guise of the therapist remaining "neutral", then the silence condones an acceptability of the imbalances in the family (Walsh & Scheinkman, 1989; Walters, 1990). Neutrality is a self-serving myth that translates into our own confusion and fear of the powerful effect of gender.

The first step in integrating a gender base in practice is acknowledging its role in

the lives of men and women in families. This also includes challenging outdated family therapy techniques which have unknowingly promoted gender imbalances. Accepting the dilemmas of socialization for both genders will assist in approaching practice with a nonblaming attitude (Wheeler, Avis, Miller, & Chaney, 1989). It is normative to experience constraints with our gender identities, it is not normative to accept them as nonsystemic and incapable of change. Analysis of the macrosystemic patterns which shape gender is minimal in the literature on family therapy (Imber-Black, 1989).

Gender is politicized in therapy when we perpetuate sexual stereotypes and sexist language in our helping endeavors (McGoldrick et al., 1989). Clinicians form theories of family life based on gender perceptions. This influences assessments made on healthy families and families with problems (Davis & Proctor, 1989). Imbalances of power within the family remain unquestioned when society and larger systems sanction them as the prevailing norm (Davis & Proctor, 1989; Imber-Black, 1989). Women have been unfairly treated in our lack of understanding of the heavy responsibilities and feelings of guilt in carrying out their roles. Rather, women are accused of being overly emotional, hysterical, enmeshed, domineering, and somehow responsible for any degree of dysfunction in their families (Hare-Mustin, 1987; Imber-Black,1989). Men have been unfairly treated in our acceptance of their distance and role on the periphery of their families. It is important to validate the experiences of both genders and dialogue as to the effects our gender training has had on family roles. Family therapists have been guilty of expecting females to take ownership of the family's problems and then be responsible in solving them. Telling the woman what she needs to do or making decisions unilaterally places the helper in a one-up position and reinforces the woman's

lack of effectiveness through blame, isolation, and disempowerment (Imber-Black,1989).

The therapist's gender will have profound effects on how family members relate to him/her. It is helpful for the therapist to understand that a client of the opposite gender will have more knowledge of that gender than does the therapist (Neal & Slobodnik, 1991). This will enable men and women to feel less threatened and more willing to share personal aspects of themselves. Haley (1987) comments that families may find a female therapist opposed to traditional values because she is employed outside the home. Clients may have preconceived notions that a female therapist may be more nurturing and supportive but a male therapist will provide credibility and expertise (Epstein & Jayne cited in Davis & Proctor, 1989). Our good intentions may result in forming alliances with both genders that maintain a traditional patriarchal stance without explicit contracting of the power hierarchies that trap us.

According to Breunlin et al. (1992) families are on different levels of a continuum in their gender awareness: traditional, gender aware, polarized, in transition, and balanced. These levels take into account family constraints, individual roles, societal status, and political systems of gender. The goal of a balanced egalitarian family is also influenced by life cycle changes and cultural themes thereby interrelating the Metaframeworks. The therapist's responsibility is to start where the family is in their gender evolution, keeping in mind that family members may likely be at different levels, which all need to be validated and explored. Promoting an awareness of gender imbalances in a non-threatening manner while taking into account developmental and cultural themes can be a profound step towards changes in attitudes and behaviors of family members.

CHAPTER FOUR

Review of the Literature: Brief Solution Focused Therapy

Methods of Intervention

Intervention applied with families in the practicum involved an integration of the preceding frames of reference of the Metaframeworks model and theoretical models that best suited the family's needs and presenting issues. The primary theory of intervention applied was BSFT. The efficacy of this model in treating families of adolescents was explored in therapy. The strengths and shortcomings of this model will be examined through case demonstration and critique.

The multitude of family therapy models and clients' varied yet unique approaches to issues requires an adaptability on the therapist's part to be flexible and knowledgable of interventions that will maximize family functioning in generating solutions to presenting problems. For example, Structural family therapy used in conjunction with BSFT techniques may work well with some families whereas with other families an emphasis on problem-solving skills will complement the BSFT intervention. A common element in the family therapy literature is its emphasis on family strengths that clients arrive with prior to any type of intervention (de Shazer 1982, 1985, 1988; Herz-Brown, 1991; Walter & Peller, 1992). The focus on positive family functioning and resourcefulness is intrinsic to the Brief Solution Focused Therapy model.

Brief Solution Focused Therapy

In viewing BSFT as an intervention, I see its purpose as two-fold. Firstly, it is an ideology with its epistimology rooted in science and philosophy, thereby granting us a belief system for viewing human beings and the nature of their problems, and with the intervention required to address these problems. Secondly, it is a number of techniques used to intervene with individuals in order to predict and bring forth change.

The evolution of BSFT is based on concepts of brief therapy, family systems theory, and the shift in orientation of family therapy as problem-focused to that of being solution-focused. The energy and time expended on discussing problem maintenance is seen as counterproductive to generating solutions and building on people's strengths and resources. This necessary shift in thinking and approach is an important component of BSFT and guides our thoughts, feelings, and the direction of therapy with families.

In understanding families, the field of family therapy relies on systems theory to explain the symptomology of an individual in the context of dysfunctional family patterns. The concept of "homeostasis" has been helpful in explaining the family as a system and the stability it maintains through patterns and sequences of interactions. Family therapists spend a great amount of time tracking homeostatic mechanisms in family relationships which contribute to keeping the identified patient "sick" and the family "stuck". However, focusing on family stability and reasons for no change is contradictory to therapeutic models of change (de Shazer, 1982). Homeostasis offers us insight into why families do not change and the resistant processes that impede change, yet this in itself is not enough.

Through analysis of dysfunctional family patterns and problem maintenance we develop tunnel vision in viewing families as stagnant and invested in futile efforts to change. Therapy communicates the problems more than their solutions to families who in turn elevate their resistance and frustrations toward the therapeutic process (de Shazer, 1986; Weakland, Fisch, Watzlawick, & Bodin,1974). By neglecting families' current strengths and solving behaviors, the focus on promoting change becomes a difficult task.

In order to create a context for change we must develop a therapeutic environment that speaks of change and solutions as a guaranteed outcome for all families. The clinical intervention of BSFT highlights and builds on the family members' strengths, resources, and success-oriented patterns. According to de Shazer (1985), the effectiveness of the intervention is not dependent on a detailed account of the presenting problem, the history of the problem, or the homeostatic patterns which maintain the problem.

The BSFT intervention used in the practicum was largely based on the brief therapy model developed by Steve de Shazer (1982, 1985, 1986, 1987, 1988, 1991) who expands on the works of other brief therapists (Watzlawick, Weakland, & Fisch, 1974; Haley, 1973, 1987) and the therapeutic approaches of Milton Erikson (1954). In explication of the model I will provide a historical review of brief therapy and its underlying principles which are embedded in the relational context of the therapist and family, the use of language and metaphor, the process of reframing, and in the techniques used to promote therapeutic change.

History of Brief Therapy

The concept of brief therapy is often mistaken to be a short-term model based on time constraints as opposed to a conceptualization of understanding and solving problems. Brief therapy has been misconstrued as "temporary treatment" and as an alternative to a longer conventional method of therapy which is often unavailable. In actuality, the "brevity" of sessions in the brief therapy model is a result or outcome of its epistemology in viewing human problems and the nature in which they manifest themselves. The number of sessions of therapy may be construed as brief or short in duration, however this is a superficial explanation of the model. Rather, the brevity facilitates solution construction to problems or complaints families present. The lengthy duration of treatment models of psychotherapy have shown them to be ineffective and frustrating for clients (Weakland, Fisch, Watzlawick, & Bodin, 1974). Setting time limits on the treatment may be more effective and conducive to actualizing goals in an agreed upon timeframe.

The development of brief therapy traces back to the significant works of Milton Erikson (1954), a psychiatrist. His innovative and creative techniques were largely employed in the field of brief hypnotherapy yet were transformed as essential principles of the brief therapy movement in the 1960's and 1970's.

In conjunction with the family therapy movement, the following groups contributed to the field of brief therapy: (a) Mental Research Institute (MRI) led by John Weakland in 1966 established the Brief Therapy Centre in Palo Alto, California, (b) the Milan Group in Milan, Italy consisting of Selvini-Palazzoli, Boscolo, Cecchin, and Prata

(1974), and (c) Steve de Shazer and colleagues, established the Brief Family Therapy Centre (BFTC) in Milwaukee, Wisconsin based on de Shazer's development of the brief therapy model (1975, 1977, 1980, 1982, 1985, 1986 1988). The contributions of each group will be highlighted in order to understand their constructive view of problem resolution that sets apart the brief therapy intervention from other models of therapy.

Mental Research Institute. The Brief Therapy Centre at the MRI conducted a six year analysis of brief therapy with families. Their findings were published by Weakland, Fisch, Watzlawick & Bodin (1974), reporting a 75% success rate in dealing with a family's major complaint. Therapy was limited to ten sessions and a high degree of success was demonstrated at an average of seven sessions.

Weakland and his colleagues found that the problems clients presented with were maintained by their current behaviors and the behaviors of those with whom they interacted. This premise was applicable for all problems and complaints, regardless of their nature or history. Weakland et al. (1974) predicted that solutions or problem resolution would occurr when the problem maintaining behavior was altered and eliminated.

The MRI model draws upon Eriksonian themes and is goal directed in its approach. This group felt that small changes in behavior would initiate changes in other areas of family functioning. The focus on the family to do something different than what they were previously attempting is a key principle of brief therapy. The MRI group departed from traditional family therapy which held the belief that the family's structure and organization needed to change first in order for any tangible change to occur. This

shift in thinking paid less attention to the family's dysfunction and more importance to the family's strengths, thereby change was pragmatic and likely to be successful.

Milan Group. The Milan group derived its theoretical approaches from Watzlawick's earlier work and Haley's model of the schizophrenic family. Selvini-Palazzoli et al. (1974) published "The Treatment of Children Through Brief Therapy of Their Parents" in which they reported resolutions of the behavioral problems of encopresis and anorexia of children. Their interventions stimulated rapid change in the family by altering sequences and patterns of interaction outlined in systems and cybernetic theory of change.

The Milan therapists employed a team approach in which different viewpoints enhanced the therapeutic endeavor and challenged families in constructing a multitude of meanings for their behaviors. This is similar to the "poly-ocular" view of Bateson (1979) which promotes the development of ideas from opposing views, which in turn adds depth and creativity to our understanding of things (de Shazer, 1985). Having a therapeutic team is beneficial to the primary therapist, but is also supportive to family members.

The intervention of the "positive connotation" was a significant contribution of the Milan therapists. The family's symptoms and patterns (homeostasis) were given credit and acknowledgement, however were established as something separate from the individual family members. This reflected Erikson's belief of approving, supporting, and reframing behaviors that were otherwise considered to be rooted in pathology.

Brief Family Therapy Centre. Brief therapy practised by de Shazer and his colleagues (Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986) at BFTC encorporates the traditional approaches of Milton Erikson and Gregory Bateson (MRI). They also work in a team approach similar to the Milan group, however, prefer members of the team to be behind a one-way mirror as opposed to in the room where the therapy takes place. There is a "consulting break" between therapist and team, followed by a "compliment" delivered to the family on behalf of the team. The team approach is central to de Shazer's model of brief therapy.

The explication of the brief therapy model by de Shazer (1975, 1977, 1980, 1982, 1985, 1986 1988, 1991) has evolved into the development of a solution focused approach integrated with brief therapy principles. For instance, there are no limits on the number of sessions (although the average number of sessions is 4 to 5 per case), rather, each session has the potential for change and even a single session may be successful if the client feels the goal has been met. The intervals between sessions are also increased over time as change via solutions is viewed to be occurring outside the therapy sessions. With the emphasis on a solution focused model the phase of problem description becomes less and less and has taken on decreasing importance (de Shazer, 1988). The therapist aims at bringing the clients' conversation back to when the problem or complaint does not occur (exceptions) in order that solution oriented behavior is highlighted.

de Shazer's vast discussion of systemic epistemology is often philosophical in its delivery, however, he does force us to examine our beliefs, assumptions, thoughts and feelings. This in turn, influences our constructions of problems and resolutions, the data we collect, the interventions we utilize, and finally, how we evaluate progress and

change. Specifically, de Shazer examines our constructions of reality and how language and metaphor shape our therapeutic involvement.

The above groups utilize brief therapy in understanding the interconnections of family members that operate in a circular and complex chain of causation (de Shazer, 1982; Watzlawick et al., 1974). Brief therapy conceptualizes the nature of problems and the nature of change through solutions rather than maintenance. The strategies, tactics, and techniques which make up the intervention rely on core ideas that have become guiding principles of BSFT.

Principles of Brief Solution Focused Therapy

The principles underlying BSFT are reflective of its ideology and its techniques are based on them. The principles are guiding axioms for the therapist in conceptualizing human problems and their resolution through intervention. The principles to be discussed are adapted from the brief therapy and solution focused literature (de Shazer, 1982, 1985, 1988, 1991; de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986; Erikson, 1954; Walter & Peller, 1992).

Principle #1: Problems are experienced as oppressive and there is a desire to have relief from them. Human problems are conceived as an outcome of difficulties experienced in everyday living. Difficulties associated with transitional stages of the family life cycle are normal and to be expected, especially in the adolescent stage of the

family. Maladjustments to family circumstances may lead to the development of symptoms in a family member (Carter & McGoldrick, 1989; Haley, 1973; Karpel & Strauss, 1983). Families stuck in interactional patterns are frustrated and overwhelmed as they search for ways of improving the situation.

It is assumed that people want to live a life that is free of problems or complaints, they do not want to personally invest themselves in remaining unhappy. This belief goes against individuals finding merit in homeostatic behaviors and accepts that people want betterment and happiness in their lives.

Principle #2: Accepting and utilizing what the client brings to therapy. Intrinsic to the beliefs of Erikson (1954), the therapist is accepting of what the client offers and utilizes this position to promote positive energy and change. The client may bring resistant behavior yet this should be perceived as important and reframed to assist the process of change rather than hinder it. Acceptance and utilization are identified as key elements of therapy by Weakland et al. (1974) and de Shazer (1985).

This principle also suggests two other important points in viewing clients. Firstly, clients bring with them a wealth of resources that are known and unknown to them. Therefore, clients have inner resources and strengths that are actualized through solutions that are feasible and respectful of them. The belief in wellness and nonpathology (Erikson, 1954) shows that people have within them what it takes to solve their difficulties. Secondly, clients are the experts of their world view and what is of importance to them. Brief therapists take what the client says at face value by looking at observable behaviors, they do not look for hidden meanings or agendas (de Shazer,

1991). The therapy is solution focused with the client in charge of the goals. If the client recognizes other problems but does not wish to delve into them, this is his/her choice (Walter & Peller, 1992).

Principle #3: Problems are situational and interactional in nature, the person is not the problem. The distinction between the person and the person's behavior (problem) is very important in order to avoid judgements and blame. Problems generally arise if people overemphasize or underemphasize ordinary difficulties (Weakland et al., 1974) through both behaviors and perceptions. How we think and act is related to societal norms and expectations of us which in turn influence the meanings and implications of specific behaviors or difficulties. The labels we attach to problems can encourage further difficulties or they can encourage adjustment and solution provoking behaviors (Weakland et al., 1974).

Problems evolve and are maintained through current behaviors and our relational interactions with others. Patterns of interaction become recursive or circular, thereby repeating the problematic behavior in a vicious cycle. Breaking the cycle through externalizing the problem may encourage people to view times when the problem is non-existent and solutions appear more available (White, 1988/89)

Principle #4: Clients' chosen solutions exacerbate the problem as they continue to logically apply "more of the same" solution. As people continually attempt the wrong solution to the problem, a spiral effect develops in which the problem begins to take on a life of its own. The incremental nature of problem development is maintained by a

"positive feedback loop" in which the client repeatedly applies the same solution with the logic that it will bring about change. "When this happens, the situation may remain structurally similar or identical, but the intensity of the difficulty and of the suffering entailed increases" (Watzlawick et al., 1974, p.32).

Long-term or chronic problems suggest that people have been struggling with the wrong solutions or no solutions; it does not imply that people are incapable and unwilling to change.

Principle #5: Altering or removing problem provoking behavior breaks down the positive feedback loop and leads to problem resolution. The interactional nature of problems leads us to believe that a shift or change in one person's behavior will effect others, thereby prompting more of that same positive change in the first person. In breaking down of the original solution the positive feedback loop will be disturbed and therefore, "less of the solution leads to less of the problem" (Weakland et al., 1974). Through redefinition of behaviors, positive shifts may take place in the feelings, attitudes and interactions of relationships.

Principle #6: Small changes are generative while change in itself is constant and inevitable. Any changes made, regardless of how small they are will lead to more changes (larger change). By thinking small we may initiate a necessary shift in the system which will lead to change in other parts of the system. The interactional nature of problems is embedded in the concept of "wholism" which creates a systemic context for change (de Shazer, 1985; Weakland et al., 1974). Wholism examines the individual as a

self in the family and the individual in relation to others (relationships) through interactions in the family. Therefore, change in the individual will effect other members in the system to also change.

How we define the problem with our clients has an enormous impact as to how the problem is experienced and the scope it takes on. By making small changes clients utilize their resources and become increasingly adept and effective in finding solutions to other problems. It is very simple logic that when we tackle problems in parts, we are capable of seeing resolution and progression rather than defeat in taking on something too big and overwhelming. This in turn, increases our confidence and skills at problem-solving.

Change is occurring all the time and therefore nothing is always the same (Walter & Peller, 1992). Therapeutic change involves both perceptual and behavioral change which is achieved through the process of reframing the situation experienced (de Shazer, 1982). Clients experience their problem in relationship to their feelings, thoughts, expectations, and behaviors that create a contextual climate. Through redefining this climate and attaching multiple meanings to experiences, change is likely to occur. In true Eriksonian manner, change is like a puzzle in which you view things from different angles and try different approaches until there is a fit and connection in resolving one's problems.

Principle #7: The intervention of BSFT is symptom-oriented within clearly defined goals. The therapist clarifies the symptoms of the presenting problem through its behavioral output. Observable behaviors enable the family to formulate timely

treatment goals reflective of change. Goals are specific, concrete, realistic, and grounded in the here and now. Even a small or minor amount of change is considered valuable and conducive to greater change (preceding principle) and spontaneous solutions (de Shazer, 1982, 1985).

Symptoms are useful in examining when the complaint does not occur and there are exceptions to the symptomology of the problem. This is easily translated into feasible goals that can be measured by the family when there is behavioral evidence of difference or adaptation of the original symptom (de Shazer, 1991). The family's symptoms are accepted and utilized in therapy as a positive transformation of goals leading to hypothetical solutions.

Principle #8: Exceptions suggests solutions. Finding exceptions to the problem is a major criteria in the path of finding solutions. When clients present a problem or behavior which is distressing to them, the complaint co-exists with a non-complaint. This paradox begins to suggest to the client that there is already something in place that denies the existence of the problem. For instance, the complaint of depression is very open-ended and abstract until further details of description of behaviors, frequency, duration, physiological responses and so forth are extracted. However, times when the client is not depressed suggests that solutions are in place which need to be reinforced, and furthermore, the client is aware that non-depression is as much a reality as depression.

The flipside of the complaint is the exceptions which are instrumental in building on what already works and fostering a positive solution focused approach to therapy grounded in the present and directed to the future.

Principle #9: Use whatever works through direct and indirect means. The use of paradoxical techniques, metaphors, and therapeutic language are symbolic means of indirectly influencing clients to view things differently. The facts of the matter may not necessarily change, however, the context will determine the solutions and inevitably the change brought out as a result. The process of reframing is crucial in BSFT as it constructs the client's sense of reality. Reframing concepts will be discussed in a further section of the report.

Logic and common sense may be direct influences for some people, yet the emphasis on the illogical may stimulate growth and creative change for others. Clients have already employed logic in abortive attempts to make things work, therefore the emphasis on whatever works, even if it appears illogical, is a pragmatic and innovative approach.

Principle #10: Cooperation overrides resistance. Although these principles are not in any sequential order of priority, I purposefully saved this one for last because it had a profound effect on my perceptions of clients and my ability to engage with them. Regardless of how wonderful and accurate one's theoretical framework, if one does not have a sincere rapport with clients based on respect, trust, acceptance, and empathy, the

therapy is doomed from the start and will fail miserably. Therapists will often misinterpret this failure as resistance on the client's part.

Resistance is a popular term in the therapeutic literature and offers explanations for numerous obstacles in therapy. Substituting the term "cooperation" in order to put more responsibility on the therapist's part still renders the belief that clients are resistant. Furthermore, applying other terms to replace resistance which generally have the same meaning can become a game of semantics. de Shazer (1985) comments that the terms "cooperation" and "resistance" are two sides of the same coin, yet it is up to the therapist which side he/she chooses to see since it is impossible to see both sides at once.

Therapists who practice BSFT see cooperation as inevitable and uniquely expressed by each family (de Shazer, 1985, 1988; Walter & Peller, 1992). Therapists must understand the family's methods of cooperating as their best ability to cope with their current circumstances. Any projection of blame or resistance is not helpful and unhealthy for solution construction and rapport. In order to trust client resources and strengths, one must be accepting of where the client chooses to start.

The concept of cooperation encompasses core beliefs of BSFT and sets the stage for other principles to be applied. How it transcends itself in therapy is based on the therapeutic relationship of therapist and family, which will be looked at next.

Relationship Between Therapist and Family

The therapist and family have been viewed as two separate systems in family therapy paradigms. de Shazer (1982) distinguishes between models of family therapy

that view the family as a system and the BSFT model that view the therapy as a system. The latter implies that the therapist is strongly included in the interactional system of the family and that there is a therapist subsystem and a family subsystem that are interrelated.

Within the BSFT model the therapist is the go-between of the agency team of therapists and the family members with whom she/he is involved. The therapist mediates and advocates on behalf of the family with the team, thereby assuming a close stance in that subsystem. The team's message is delivered by the therapist and she/he elaborates the explanation depending on the family's response to it. The therapist has the discretion of delivering a "clue" from the team to the family or witholding this until the family is better equipped to follow through with it.

Building a strong relationship and rapport with clients occurs at the first moment of contact. Walter and Peller (1992) suggest that although there are things the therapist does to maintain and facilitate rapport, assuming that it is present from the very beginning will decrease the time in sessions it takes in building trust. Bandler and Grinder (1975) offer the notion of "pacing" to the therapist as a means of meeting the client's representational view of information. Clients may process information in visual terms, auditory terms, or kinesthetic and feeling terms, depending on what works best for them (Walter & Peller, 1992). The therapist's flexibility in meeting the client on her/his terms enhances the quality of their relationship, helps the client feel valued and understood, and utilizes what the client brings to therapy (Erikson, 1954; Rogers, 1951).

The existence of rapport between the therapist and family paves the way for viewing cooperation as an alternative to resistance. In the BSFT tradition the therapist

knows that each family expresses its cooperation in different ways and it is the therapist's job to acknowledge this belief and apply it in other areas so that cooperation continues to promote change (de Shazer, 1982). If the therapist is prone to viewing resistance then this attitude will promote resistance and impede progress during the course of therapy.

The model of BSFT followed by de Shazer and his colleagues at the Brief Family Therapy Centre strongly emphasizes that the beliefs and attitudes the therapist brings into the therapeutic stage will directly influence clients' reactions to the helping professional. For instance, de Shazer (1991) is critical of the Milan group's description of a family's "dirty games" (Boscolo, Cecchin, Hoffman & Penn, 1987), and feels that it undermines any attempt for the system to cooperate when the family's actions are perceived under a suspicious motive. Therapy does not need to be viewed as a contest in which the expert must reign (de Shazer, 1982). This line of thinking may have been more compatible with earlier traditions of family therapy.

The relationship between the therapist and the family is a consensual and cooperative endeavor in which the therapist develops with family members the expectation of change and solutions. The responsibility of communicating clearly is on the therapist, and if the family assumes things differently than what was intended, then the therapist needs to do things differently until the meaning is clearly understood (Walter & Peller, 1992). This reinforces an adaptability on the therapist's part to effectively meet clients' needs through helping them utilize their current patterns in new ways but still accepting what they bring to the therapeutic relationship (Erikson, 1954).

The therapist and family relationship creates the context or climate in which therapy is delivered. Through "circular interviewing" in which the therapist has a family

member comment on the interactions of other members, family members begin to interpret their behaviors and become observers of their own reality (Parry, 1984 cited in Ferrier, 1986). As the family's reality emerges for all members, they are in a better position to start looking at goals and solutions that will lead to desired changes. How one interprets one's reality is a subjective process in which reality is invented and created by the observer rather than discovered as a correct order of things (Watzlawick, 1984), thereby making more of what it actually may be. Constructivist thought is woven into BSFT through reframing and construction/deconstruction of ideas which the therapist explores with the family so that a new state of reality can be realized (de Shazer, 1991; Watzlawick, 1984).

As the therapist helps family members construct new stories and circumstances in which goals appear tenable and solutions attainable, a type of therapeutic language emerges which promotes a future with positive changes. The therapist's use of language and metaphor in her/his relationship with clients is a salient and useful method of communication and intervention.

Use of Language and Metaphor

Language and metaphor are powerful and creative tools in reshaping our constructs of reality through the meanings we attach to our stories and life experiences (de Shazer & Berg, 1991; Dolan, 1986; Durrant & Kowalski, 1993; Wittgenstein, 1958, cited in de Shazer, 1991). Therapy is the system in which linguistic relationships are

formed and enhanced in the creative exhange of dialogue between clients and therapists (de Shazer, 1991).

Wittgenstein (1958, cited in de Shazer, 1991) coined the phrase of "language games" as a system of human communication in which social realities and relationships are constructed through words, gestures, thoughts, facial and body expressions. de Shazer (1991) believes that therapy that is problem-focused creates a problematic language game in which constraints are repeatedly highlighted resulting in a continuance of stuck patterns and no change. Rather, a solution-focused language game must be inserted so that hope and generation of solutions create an active climate for change in which clients' well-being and health is engendered (de Shazer & Berg, 1991; O'Hanlon, 1986; Weiner-Davis, de Shazer & Gingerich, 1987).

The concept of "dialogic orientation" (Mehan & Wills, 1988, cited in de Shazer, 1991) is similar to language games in that it acknowledges the territory, or therapy system, as jointly owned by the speaker and listener in which meaning is reflected by the interaction of the two. The richness of therapy is in the meaning it conveys. Although language is a tool of conveyence, it is a form of communication through which the speaker and listener form a relationship.

Language and metaphor are an interactive exchange of meaning between the therapist and family members. Goals are formulated in therapy yet it is the therapeutic relationship that carries them to fruition. The manifold usage of language constructs "a world of expanding options rather than a world of limitations and constraints" (Friedman, 1993, p.xiiii), thereby offering clients different realities. Meaning which makes a difference to families are differences that significantly matter and alter people's lives to a

hopeful reality (Friedman, 1993). Language becomes reality (de Shazer, 1991; de Shazer & Berg, 1992) and therefore, what we talk about and how we say it becomes extremely important as it changes our internal emotions which give meaning and direction to our external actions and behaviors (de Shazer & Berg, 1992; Friedman, 1993).

The grammatical structure of words and the tenses used shift perceptual thinking in BSFT. For instance, the focus on the present tense describes the client's problem/complaint, whereas the use of the future tense generates hope and solution forming behaviors that are likely to occur in the near present or future. Clients are asked what things will be like once the desired change or behavior is implemented in a solution-focused language game. Overemphasis on past behaviors or previous limited problem-solving encourages a problematic language game and the therapist unintentionally joins in constructing more of the problem instead of more of a solution.

A famous case illustration by Insoo Kim Berg (de Shazer & Berg, 1992) in which a couple comes to see her and the wife reports that she has become a nymphomaniac, demonstrates the construction of a solution-focused language game in which exceptions to the problem and perceptual shifts of words open up possibilities for clients to generate solutions. In this example, criteria of what the word and problem "nymphomania" meant to the couple was explored and then exceptions to when the criteria was nonexistent was inserted. Hence, identifying when the problem was a nonproblem or "non-nymphomania" left room for "more of the same" solutions to be applied. In this case, the actual term "nymphomania" was a troubling world view to the clients and with a perceptual shift in language, the problem was renamed in order to be more accepting to the couple. As sexual activity was a reason for the woman to be able to fall asleep and

sleep disturbance was also an identifying concern to the husband, the complaint was renamed as being "insomnia". The complaint of insomnia was less threatening than the complaint of nymphomania to the clients and therefore it created a contextual meaning that was appropriate as "clients describe their situation from their own particular, unique point of view" (de Shazer & Berg, 1992, p.77). The therapist's ability in valuing the clients' analysis of their problem and using language in a creative and useful manner resulted in interventive tasks and solutions that were helpful for the couple.

Metaphors engage language through techniques of storytelling, enactments, humor and rituals (Dolan, 1986; Haley, 1987; Madanes, 1984, Ritterman, 1986). The value of metaphors as a vehicle for therapeutic communication and change are numerous. Their symbolic representations enable clients to process thoughts and develop solutions in therapy (Dolan, 1986). Used as an indirect technique in helping clients feel supported and challenged, metaphors tap the clients' unconscious resources and strengths (Erikson, 1968, cited in Dolan, 1986). Metaphors make it possible to understand one's experiences that are already acquired. Thoughtful exploration of them in a non-threatening manner derives meaning into current patterns and complaints (O'Hanlon, 1986).

Milton Erikson relied heavily on metaphorical images in hypnotherapy with clients and his valuable insights to the family therapy field relayed that symptoms are not true representations of problems or illnesses, but rather, are metaphorical expressions of problems and attempts at resolving them (Ritterman, 1986). Hypnosis was central to activating repressed memories into a conscious state. Similarily, metaphors are powerful images that creatively address one's belief system and encourage solutions by reframing a desired state of action.

Metaphors in therapy are seen as conversations, stories, and narratives in which the development of new plots signify change (de Shazer, 1991). Gergen and Gergen (1983, 1986, cited in de Shazer, 1991) view narratives in three forms that clients present in therapy. Firstly, "progressive narratives" are ones that are everchanging and producing the desired results. Secondly, "stability narratives" are ones in which life is unchanging and stuck. Thirdly, "regressive narratives" are ones in which life is moving away from desired goals and changes are unmet. In BSFT, the emphasis is on creating progressive narratives through expanding exceptions to the complaint and developing themes of solution.

Clients who engage in stability or regressive narratives are encouraged to construct new stories and transform their life narratives to progressive themes in which changes are more feasible. In Dying Well (Berg & Miller, 1992), a taped therapy session between Insoo Kim Berg and a prostitute dying of A.I.D.S. (Acquired Immunodeficiency Syndrome) is presented in which the therapist transforms the conversation from a regressive narrative highlighted by tragedy to a progressive one in which the dignity and strengths of the client are highlighted. Berg continued to bring the conversation back to what was helpful for the client in order to die well and in a manner that was acceptable and peaceful for her. In her feedback to the therapist, the client stated that the therapist did not judge her lifestyle or tell her what she needed to do, rather she respected her desired changes and made her think of a tenable future that still mattered even though her death was inevitable. Language and interspersed storytelling in this session activated the client's internal belief system that had been buried in a negative thought process based on the client's life circumstances.

Language and metaphors create rituals of therapy that unite the family and therapist in a common path towards betterment and freedom. The portrayal of humor may easily be implemented in any therapeutic endeavor. Humor is a metaphor of humanity, as Margot Taylor Fanger (1993) so aptly states:

> Humor and laughter both promote hope and are a direct antidote for anxiety, fear, rage and sadness. People not only feel better when they smile and laugh but also are more receptive to change. Most humor involves some kind of reframing---seeing things in a new way---so I look for ways to offer new points of view by playing on words and posing new perspectives. (Fanger, 1993, p.105)

Language and metaphor enlist a creativity in therapy that leads to innovation and a multitude of interventive tasks that are as varied and unique as the families that engage in therapy.

The therapist is a partner/catalyst in using imagistic language to challenge old assumptions (Friedman & Fanger, 1993). Through helping families see new possibilities to their lives, new realities are reframed and constructed. The process of reframing, which will be looked at next, is an intrinsic theme in BSFT.

Process of Reframing

Reframing is not an act or technique in BSFT, rather, it is a process that guides therapy towards change by presenting different perceptions of reality for family members (de Shazer, 1988, 1991). Different angles or corresponding isomorphs in a family's

structure reveal more depth as to the context of change that must occur outside the therapeutic environment (Breunlin et al., 1992; de Shazer, 1982). As most change needs to take place in the client's everyday life and beyond the therapy sessions, it is most important that families not only demonstrate insight but alter behaviors that coincide with their construction of reality. The process of reframing includes viewing complaints or problems in new ways through exceptions, goals, and solutions, but also in constructing new frames or rules to define situations (Bateson, 1979; de Shazer, 1982).

Watzlawick, Weakland, and Fisch (1974) define the concept of reframing as the following:

> To change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better, and thereby changes its entire meaning. (Watzlawick et al., 1974, p.95)

Although the facts of a situation may not change, how they are perceived, or the context in which they are maintained is different, thereby offering the family new frames with positive and acceptable terms to live with. Once an old frame is broken the family system reorganizes itself and the change process is underway (de Shazer, 1982). The change process takes a different amount of time for each family with varied tasks or directives given between therapy sessions to activate new behavioral patterns and potential reframes.

White (1988/89) approaches the change in therapy through "externalizing the problem" so that people see that their problems and solutions are defined outside of

themselves. By viewing the problem as being influenced by sources other than the individual, the person is able to feel less blame and approach the complaint is a more objective and favorable attitude.

The shift in paradigm from a problem-solving therapy to a solution-focused therapy enables clients to report behavioral changes around the initial complaint and expectations as to what clients would like to see different. de Shazer and colleagues (Berg, Lipchik, Nunnally, Gingerich & Weiner-Davis, 1986) at the BFTC implement an intervention known as the "formula first session task" in which the following question is asked to promote a perceptual shift in one's thinking: "Between now and next time we meet, (we) I want you to observe, so that you can tell (us) me next time, what happens in your life (or marriage or family or relationship) that you want to continue to happen" (Molnar & de Shazer, 1987, p.349). Reframing the complaint to include things that are happening that are beneficial or worthwhile encourages that these should continue as well as instills the hope and possibility of many other worthwhile things happening (Molnar & de Shazer, 1987).

Techniques of Brief Solution Focused Therapy

The techniques of BSFT may be methods, ideas, questions, rituals or behaviors on the part of the therapist. The techniques are reflective of the ideology of eliciting a positive response in the client so that change in the right direction may be perceived.

Techniques in the form of a specific question are the "formula-one session task" (de Shazer et al., 1986) in which clients are to observe and report things they want to see continue in their lives. The "miracle question" (de Shazer, 1988) aims at asking the client what a solution looks like and places a positive future context in the present setting. The miracle question generally follows as: "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? How will your partner/children know without your saying a word about it to them?" (de Shazer, 1988, p.5).

The "crystal ball technique" and the "confusion technique" are based on Erikson's hypnotic procedures (1954, 1964, cited in de Shazer, 1985, 1988). The crystal ball projects an image that suggests a future that the person would like to attain. The confusion technique is when the therapist admits her/his confusion around the client's vagueness about a situation or in setting a goal. The therapist encourages the client to construct meaning through exploring exceptions to the current situation.

Other techniques centre around the therapy session in which an "intermission consultant break" takes place so that the family/individual can be given a "therapeutic message" consisting of "compliments" or "clues" (de Shazer, 1982). The therapist consults with the team or takes a break if working individually. The team approach offers many perspectives and provides the therapist with valuable input on how to do therapy while engaged in that endeavor (Haley, 1987). Compliments tell clients that what they are presently doing is helpful and useful, and to continue emphasizing these positives. Clues can be given in the forms of directives, tasks, or suggestions. Clues are varied and as creative as possible in addressing the client's needs. Haley (1987) believes

that people who do not carry out or follow through on directives or tasks need to be confronted and held accountable. In BSFT, if clients have difficulties with their tasks then this information should be used to tell us something about what needs to be addressed or changed.

In summary, BSFT communicates how change can occur and the context which it requires. The practice principles of BSFT convey a philosophical framework in viewing people, solution-oriented behaviors, and change. Conceptual maps of the family provide the therapist with the knowledge of what is meaningful to the family. However, if the therapist fails to see important things, the interventions will be lost. A collaborative relationship between the therapist and the client is essential in viewing therapy as a system and in maximizing people's strengths and resources. Integrating the Metaframeworks model and an understanding of adolescence and the family life cycle enables the therapist to know the family's context and be able to provide effective therapy. The way in which the therapist understands the family impacts on the family's expectations of change, cooperation, and effectiveness of the therapist.

Development, culture, and gender for adolescents and their families must be made an explicit part of family therapy as it guides the direction of the treatment. These issues affect families' abilities to perceive, form, and generate solutions. Within the practicum, it was assumed that an integrative approach of Metaframeworks with a BSFT model of intervention would add depth to assisting families with adolescents build on their strengths.

CHAPTER FIVE

Practicum Setting, Evaluation, and Supervision

Description of Practicum Site

The practicum took place at the St. Boniface General Hospital in Winnipeg, Manitoba from October 17, 1994 to April 31, 1995. The practicum setting was the Child and Adolescent Psychiatry Department which has three major areas of focus: an Inpatient Adolescent Unit consisting of seven beds, the Outpatient Adolescent Psychological Trauma Clinic, and the Neurodevelopmental Disorders Clinic. An intake and assessment is conducted for each client upon referral to a program. Treatment options, including individual, family and/or group therapy are discussed by a multidisciplinary team. The team consists of the following professionals: psychiatrists, psychologists, occupational therapists, psychiatric nurses, social workers, psychiatric residents, psychology interns, and a school teacher. A recreational therapist is also available to the inpatient unit.

Families are referred through self-referrals, emergency and other hospital departments, medical doctors, community agencies, schools, and Child and Family Services. All clients participating in family therapy are voluntary.

Family Numbers and Types

Throughout the practicum, I was involved with nine families for a total of forty-nine family sessions. I saw six families as the primary therapist, and three families with another social worker as a co-therapist. Five of the families I worked with were referred from the Outpatient Psychological Trauma Clinic and three families were referred from the Family Therapy Program. One of the families was referred through the Chemical Dependency Program in the Adult Psychiatry Department. The common feature of all the families was that they were families with adolescents in which familial issues involved the adolescent family member (identified patient). In further discussion of the practicum process, four families will be highlighted as casestudies, however, for a general discussion of family themes and intervention, all families will be included.

A breakdown of the different families seen will include the source of referral to family therapy, family composition, family members, number of therapy sessions, and the problems/complaints which brought the family to therapy. The names being used are pseudonyms in order to protect the identity of the families. Families #1,2,3, and 4 were seen by myself and will be discussed in depth in Chapter Four. The other families seen included the following:

Family #5: The Johnsons. The Johnson family was referred to the St. Boniface Family Therapy Program by their family doctor to address parent-adolescent conflicts. The Johnsons are a nucleur two-parent family with two male children. The father came to the first session with the mother and Mark, a thirteen year old adolescent. Subsequent

sessions were with the mother and Mark, as the father was unavailable due to work committments. The parents did not want their other son involved in any part of the therapy.

The initial complaints centered around the parents having difficulties with Mark in following family rules and listening to his parents. The parents felt that Mark had an anger management problem and reported that he would respond with temper tantrums and "hissy fits". In further sessions, it became clear that the mother played the roles of mediator and referee in fights between the father and Mark. There were obvious relational difficulties between Mark and his father, and the different approaches to parenting created marital tensions for the parents. It was considered necessary that the father be a part of the therapy sessions. When this was stressed to the family, their participation decreased and therapy was discontinued after four sessions. In follow-up with the family, some things were reported to be improved, such as Mark listening more and the mother backing out of father-son arguments. The biggest change was largely attributed to decreasing Mark's intake of sugar which the family believed resulted in a decrease in his hyperactive behavior.

Family #6: The Smiths. The Smith family was referred by the emergency department of St. Boniface General Hospital, who saw the seventeen year old adolescent Carol for depression and nightmares following an assault by her former boyfriend. The Smiths are a nucleur two-parent family with a son (age 23) and two daughters (ages 33 and 17). In speaking with Carol, it appeared that her complaints were the consequences of the assault, relationship difficulties with the opposite sex, and the lack of support and

understanding from family members. In particular, she felt competition with her sister for her mother's attention and felt that her father was nonexistent in the family.

This family was difficult to engage as the parents did not feel that their presence was required for therapy. Carol and her mother came for one session and stated that no other family members wished to come in. The mother felt that Carol's complaints were exaggerated and that she needed individual therapy. The mother raised the children largely on her own as the father was out of the home for long periods of time due to his job. While at home, the father did not partake in parenting as this was seen as the mother's role. A great deal of the session consisted of Carol crying and expressing sadness in feeling alone and as an outsider in her family. The mother lectured Carol and believed that Carol overreacted to the family's perceptions of her.

The family would not return for therapy. The option of individual therapy was discussed with Carol, however, she declined.

Family #7: The Kerrs. The Kerr family was referred to the Family Therapy Program by a social worker at the hospital who worked with the family while the mother was hospitalized for cancer. Initial complaints centered on marital difficulties, family stressors around the mother's poor health, and parenting. The mother perceived the father's parenting of their thirteen year old daughter to be controlling and overbearing. This nucleur two-parent family has a daughter (age 13) and a son (age 2). There were cultural issues around spousal roles and parenting as the mother is Caucasian and Mennonite and the father is East Indian and Hindu.

There were difficulties in setting up appointments as the family lived out of the city and the father was away on business trips for two weeks each month. Appointments were often cancelled due to the mother's ongoing hospitalizations and poor health. A hospital social worker and I saw the couple three times and this case was transferred to the social worker when the practicum ended. Issues addressed in meeting with the couple were the wife's depression and previous suicide attempts of which her husband was unaware. The daughter was not invited to therapy as there were marital problems that needed to be examined first.

Family #8: The Glenns. The Glenn family was referred to the Outpatient Psychological Trauma Clinic for family therapy by the assessment team. Two of the children were involved in current programs and family problems were reported. The Glenns are a blended family of a common-law stepfather and a mother with three sons (ages 16, 14, and 12). The couple have been together nine years and although the mother would like to be married, her partner is unsure because of the hostile relationship he had with the middle child. The mother felt that she had to choose between her partner and her child at times when family issues escalated to extreme fighting and stress.

The couple was seen three times by a hospital social worker and I. During these sessions marital issues and parenting were approached in a problem-solving format. The family cancelled a few sessions and then requested that family therapy be terminated. In a follow-up telephone call, the couple reported improvements in their relationship.

Family #9: The Kellys. This family was referred to the Chemical Dependency Program and was seen by my supervisor for family therapy. I participated as a co-therapist for three sessions. The Kellys are a blended family of a common-law stepfather of Jamacian cultural background and a mother with a daughter (age 13) and a son (age 10).

There were numerous issues in the marital relationship, including the male partner's need to take care of the female partner and assume a position of authority as a father to the children. The daughter was openly defiant and acting-out according to the couple and there were concerns that she had anorexia as a symptom of family problems. Sessions with the couple focused on the female partner's depression, history of dysfunction and abuse in her family of origin, and the impact of the former marital relationship on the current common-law relationship. Expectations around marital and parental roles was discussed with an examination of gender and cultural issues. The daughter was seen separately to determine her perceptions of family structures, dynamics, and roles.

As the mother and step-father worked on the marital issues, there was an increase in acting-out behaviors on part of the daughter which led to her moving out of the home to live with her biological father.

Evaluation Measures Used

Evaluation is a necessary component of measuring the effectiveness of one's intervention with families. Ethically, social work must be responsible for providing

effective and cost-efficient treatment that has no known detrimental effects (Trute, 1985). Outcome evaluation measures the family's level of change, which should ultimately be linked to the process of therapy (Trute, 1985). As we evaluate our practice, we test out hypotheses and interventions employed to see if the impact of our therapeutic endeavors has brought about the desired change for families (Rossi & Freeman, 1989).

Families can be very complicated targets for change in that improvement for an individual may have negative consequences on other family members impacting the overall functioning of the family. Trute (1985) points out that it is useful to use a variety of evaluation measures for there are numerous transactional possibilities within families and problems are perceived multivariately.

The evaluation measures which were used with the families for the practicum were the following: the Family Assessment Measure (FAM-III) designed by Skinner, Steinhauer, and Santa-Barbara (1983; see Appendix A), the Problem Checklist developed by the Morrison Centre for Youth and Family Services in Portland, Oregan (see Appendix B), the Client Feedback Checklist developed by Frank Cantafio (1988; see Appendix C), and the Client Feedback Questionnaire developed by myself (1994; see Appendix D).

The Family Assessment Measure (FAM-III). The FAM-III is an evaluative measure based on Canadian norms that compares clinical and non-clinical populations (Trute, 1985) . The General Scale of fifty items (the Dyadic Relationships Scale and Self-Rating Scale were not used) assesses overall family functioning along seven subscales that look at the following areas: task accomplishment, role performance,

communication, affective expression, affective involvement, control, and values and norms. Two response style subscales of social desirability and denial are also included. The FAM-III can be administered to children as young as ten years old and takes 20-30 minutes to complete. The FAM-III complements a clinical family assessment but does not replace it. By providing a comprehensive overview of family functioning, it identifies potential areas to explore that require further assessment (Skinner et al., 1983).

The FAM-III General Scale is comprised of fifty statements in which the respondent circles a response of either strongly agree, agree, disagree, or strongly disagree that coincides with each statement. The various subscales are given a raw score (0 to 15), social desirability is given a raw score (0 to 21), and defensiveness is also given a raw score (0 to 24). These raw scores are then translated into standard scores that are interpreted as t-scores and percentiles on the scoring sheet. Scores falling between 40 to 60 are interpreted as normal and average. If scores are below 40, they indicate strengths in those areas, whereas scores of above 60 indicate weaknesses and problematic areas of concern. For further information, consult the FAM-III Interpretation Guide (Skinner et al., 1983).

The FAM-III is an effective measure to use as its reliability and validity is demonstrated (Skinner et al., 1983). The test and re-test reliability estimates are .93 for adults and .94 for children which indicate that the instrument is reliable in measuring familial strengths and weaknesses (Skinner et al., 1983). It is an unobtrusive and non-threatening evaluation tool that enables the testing of hypotheses formulated in the beginning stage of therapy. Another advantage of using this measure is that it is easy to

administer, complete, score, and interpret. Also, it does not take very much time to complete and it is fairly understandable to family members of all ages.

The Problem Checklist. The Problem Checklist lists 24 family concerns in which family members rate their current satisfaction level. There are 24 statements in which the respondent chooses to answer with: "very dissatisfied", "dissatisfied", "in between", "satisfied", or "very satisfied". There are no norms or psychometric data on the Problem Checklist and therefore the conclusions that can be drawn are limited. It is a descriptive measure that helps family members assess their level of satisfaction with how their family handles things over time. For short-term treatment such checklists may provide relevant results on task accomplishment or treatment goals (Trute, 1985). Problem checklists may be administered frequently on a time-series basis for ongoing information on treatment. They are useful in viewing clients' perceptions of how they distinguish between problem and non-problem states. The Problem Checklist used took under 10 minutes to complete and was easy to understand.

The Client Feedback Checklist. This is a list of twelve items which rates qualities of the therapist and the overall service provided. The Client Feedback Questionnaire consists of ten open-ended questions that request information on the services provided and the family members' perceptions on what has remained the same, what is different, and what the future looks like. These two measures were used to assess my skill development as a therapist.

Measurement Process. The FAM-III and the Problem Checklist were to be administered in the second and last session while the other measures were to be completed in the last session of therapy. Some families only completed the FAM-III and the Problem Checklist in the second session as they withdrew from therapy. For other families a terminating session to complete evaluation measures did not occur as the case was being transferred or the appointment did not take place due to cancellations or failure to come to the appointment. In total, four families completed all the evaluation measures in the pre-test and post-test format.

Single system designs of evaluation assess the family prior to treatment (baseline data) and the family after the treament (result of intervention). Bloom and Fischer (1982) suggest that this research design can provide relevant information in a timely and cost-efficient manner. The FAM-III and the Problem Checklist measure outcome as they report the family's perceptions prior to and at the completion of the intervention.

Statistical significance may be difficult to ascertain and have little impact on families if the problems still exist. Therefore, the concept of "clinical significance" has more utalitarian value as it asks: "Did the therapy really produce meaningful changes in client's lives? Are they demonstrably better off as a result of having been in treatment?" (Letich, 1992, p.70). If there are apparent changes in the family yet it appears that things have gotten worse before they will get better, then this dilemma may translate into positive change if family members have found the treatment helpful. The FAM-III and the Problem Checklist examine family members' perceptions of their functioning level (based on the criterion in the subscales and areas of family concerns) and how it compares with other family members' views on family dynamics.

These two evaluation measures are congruent with the BSFT intervention for they distinguish between problems and non-problems while highlighting the family's strengths. Family weaknesses may be examined on a continuum as families encounter life transitions and crises that are solvable and not necessarily rooted in pathology.

Supervision Arrangements

My advisory committee consisted of Diane Hiebert-Murphy, Ph.D. (Social Work Professor at The University of Manitoba and student's Faculty Advisor/Chairperson of Committee), Steven Moscovitch, M.S.W. (Social Worker in The Child and Adolescent Psychiatry Department at St. Boniface General Hospital), and Shirley Grosser, M.S.W. (Social Work Professor at The University of Manitoba). The advisory committee and I met twice during the practicum regarding the practicum proposal and practicum process.

Ongoing clinical supervision of the practicum was shared by Diane Hiebert-Murphy and Steven Moscovitch. As well, joint supervision meetings between Diane, Steven, and myself occurred at least once a month.

Clinical Supervision

Steven and I met weekly for scheduled supervision sessions of two hours. There were also shorter supervision sessions that were informally planned as the need to consult arose. All areas of my involvement at the hospital was discussed (e.g., family therapy, self-management group, observing other clinicians, and personal development). Steven

provided supervision on seven families. A hospital social worker provided supervision on one family and observed several of my family sessions. Diane provided supervision on one family and I met with her at least twice a month for scheduled clinical supervision. Supervision and guidance was also provided to me regarding the writing of the practicum report and evaluating the therapy sessions.

The supervisors provided some live-supervision by direct observation of me in family therapy sessions. They observed me and the family through the one-way mirror observing room providing feedback during breaks in the session. At times, Steven also met with the family towards the end of the session and gave them personal feedback.

Therapy sessions were also videotaped and later shown in supervision sessions as a method of learning. A few family sessions were audiotaped and reviewed by me. Recording procedures and file documentation were consistent with hospital procedures. The supervisors read and co-signed my file recordings.

CHAPTER SIX

The Practicum Process

Casestudies of Families Served

The core of the practicum was spent conducting family therapy with families with adolescents. The families were as varied as the problems or complaints that brought them to therapy. I have chosen to expand on four families (family numbers 1 to 4) as casestudies by offering a description of the families and their relevant issues. An analysis of the therapeutic treatment is broken down into the following categories: contracting and goal formulation, theme of adolescence, Metaframeworks model, BSFT intervention, and outcome of evaluation. The discussion of the common family themes that emerged in the practicum process will be an integration of the experience of working with all nine families.

Family #1: The Burns

The Burns family consists of the mother Joan (age 47) and her son Nick (age 14). The father Don died two years ago (at age 38) of health problems linked to alcoholism. The Burns are of French-Canadian ethnic background. Nick was initially referred for group therapy which he failed to attend. At this point it was noted that problems between Nick and his mom had escalated and family therapy was offered. The family was seen for a total of fifteen sessions.

In identifying the family problems, Joan perceived that her relationship with Nick had deteriorated since his father's death. According to Joan, they could not get along without a great deal of conflict. She perceived that they needed to improve their communication by talking more and fighting less, they needed to work on trust, and Nick's attitude needed to improve. Joan was also concerned about Nick stealing, skipping school, and using drugs and alcohol. Nick felt dragged to the sessions yet stated that his mother did not trust him because she was afraid that he would start stealing cars. He felt that curfews needed to change and that his mother needed to give him more freedom.

Joan felt that Nick needed to resolve his father's death by grieving and talking with someone. She had tried to initiate talking with him but he did not respond. In the family sessions, any discussion about Don was done by Joan, with Nick listening attentively yet unable to talk much about his father. In the Child and Adolescent Psychiatry assessment, Nick was diagnosed with an adjustment disorder stemming from grief complications.

The beginning phase of therapy was spent exploring the family's problems and solutions that had been applied which kept them in a stuck position. A comparison of the family relationships and patterns prior to Don's death and afterwards were also explored. Two central issues emerged as the focus of therapy: the parent and child conflicts which were more behavior-oriented and the grief and effects of Don's death which remained clearly unresolved for Nick. Although these issues could be interrelated, contracting around specific goals provided the focus and purpose of family therapy for Joan and Nick.

Contracting and Goal Formulation

The process of contracting and goal formulation was difficult in the beginning sessions for a number of reasons. First of all, the focus of therapy was unclear. Joan felt that the communication problem needed to be looked at by encouraging Nick to talk with her more, especially about his father's death. I went along with this, to the point of assigning Nick a homework task regarding his feelings around his father's death. It quickly became apparent that Nick was fearful and unable to address his grief at this time and in this setting. He communicated his unwillingness to address these issues by coming late to the sessions and withdrawing his participation. It was clear that Nick's sadness and grief was present, however, addressing Don's death as a primary focus of therapy was not an effective approach in attempting to deal with the parent-child conflicts.

Joan felt that poor communication and lack of trust were interfering in the relationships in the family. Therefore, goals needed to meet specific behavioral criteria so that these issues could improve in the family. It was difficult to have Joan and Nick agree on mutual goals, therefore brainstorming around a list of what things the family would like to see different or changed was attempted. Generating a list of changes led to Joan complaining of Nick's behaviors. Joan's expressions of helplessness, fear, and worry resulted in arguments between mother and son. It appeared that if therapy was to be helpful, it was imperative for Joan to choose one behavior or concern and set goals to address this issue.

It was a slow process to keep the family focused on one issue at a time for Nick's acting-out behaviors would increase between sessions leaving Joan feeling powerless and frustrated. In order to address one of Nick's behaviors at a time, Joan needed to be empowered in her role as a parent and in her ability to set limits and concentrate on one thing at a time. Presenting numerous problems at once created confusion, a sense of being overwhelmed and a belief that attempts at change would appear futile. Continuing to discuss the problems that kept on getting worse and larger in scope set the therapy to be problem-focused, moving further away from the expectation of generating solutions.

It became clear that coming up with a goal was not an easy task for Joan as her decision-making abilities regarding Nick were shared with her husband in the past and the role of being the sole parent was new for her. Part of Joan's gender constraints may be that she was less socialized as a woman to make decisions and therefore the capacity to do so was more difficult for her. In order to empower Joan as a parent, it was crucial that her ability to make decisions was respected and supported in the therapy context. Thus, time was spent focusing on forming a goal that Joan wanted to pursue regarding Nick. Joan decided that her main concern was addressing Nick's drug use as this problem increased as family sessions progressed. Work towards sub-goals around setting limits and boundaries as a parent were ongoing. It was hypothesized that these goals would lead to other changes in the hierarchy of family structure through changes in Nick's perception of his mother's parental role and Joan's perception of herself and her self-esteem.

Theme of Adolescence in Family

The emergence of adolescence for Nick came at a time that his father was ill and shortly afterwards deceased. Nick not only had to contend with the losses of childhood but the profound loss of his father while entering a developmental phase of overwhelming changes and confusion. Joan had to learn how to parent an adolescent as a single-parent after the death of her husband. The transition to the adolescent stage of the family life cycle held many constraints for this family, thereby making this period even more complicated. As she struggled to maintain control and involvement in her son's life, Nick was trying to separate and individuate from his mother. Joan's descriptions of her interactions and expectations of Nick were similar to that of a husband and wife, and it was hypothesized that she had substituted Nick into the role of "the man of the house". She expressed feelings of jealousy, ingratitude, and neglect in her relationship with Nick that echoed her relationship with her husband. Joan's inability to see Nick in an adolescent role created conflict in the dilineation of the appropriate roles in the family (parent/child vs. parent/peer). The impact of this family interaction may have created internal struggles of conflict and guilt for Nick. On one hand, he had replaced his father's position in the household and could therefore seek attachment from that role. On the other hand, his struggle to individuate from the family meant rejecting his attachment to his father's role and leaving that position vacant in the family.

In one of the few sessions that Nick jointly attended with his mother, he clearly informed her of his role as an adolescent by stating: "she expects me to talk to her all the

time, to tell her about my day, I'm a kid, I'm not supposed to do that, maybe when I'm twenty, but not now...". Nick's resistance to his mother's constant need for them to communicate more was seen as his attempt to separate from her as was the increased time spent with his friends and girlfriend. Nick was in an identity diffusion stage (Marcia, 1966) appearing unmotivated and unclear about school and future aspirations which were of utmost importance to his mother. Nick's identity was also reflective of the moratorium stage (Marcia, 1966) in which he remained stuck as to which path he should take. His indifference was highly influenced by his drug use which offered him an escape from problems at home, his grief over his father's death, and the adolescent tasks of separation and autonomy. Nick's drug use was similar to his father's dependence on alcohol. This created a link or identification between Nick and his father. Nick's identification with his peer group set standards for how he thought his mother should have reacted to him and his acting-out behaviors. He would repeatedly wonder why his mother had not given up on him, especially when his friends' parents would leave them alone. There also appeared to be a sense of relief felt by Nick in that his mother continued to stay involved in his life.

Joan needed to view her son in the adolescent stage of development and although she could acknowledge his need to be with peers and have more freedom, she felt strongly that she needed to prevent Nick from straying so much that he would end up completely out of control. As Nick's drug use increased and signs such as weight loss, glassy eyes, and aggression were more visible, Joan's desire to help her son became stronger. She felt that she had some control as a parent over what happened to Nick, more so than she did as a wife dealing with her husband's disease of alcoholism. It

appeared important to Joan that she save or rescue her son from the same patterns she witnessed in her husband. Her desire to help Nick was quite strong for she was fearful of losing him as well.

It seemed that Joan needed to let go of her overinvolvement in Nick's life without letting go of her control. She gave Nick freedoms that brought difficult conditions for herself, such as an enormous amount of stress and worry that created sleep disturbances and fear over being hospitalized. She accepted acting-out behaviors without any limit setting, boundaries, and consequences which resulted in her suffering and feeling powerless. Joan was afraid of her son's rejection and feared that he would completely align with his peer group so she gave in and accommodated him while trying to be consistent in her limit setting.

Nick was the focal point of Joan's life and once he separated from her, she would be forced to look at herself alone without her husband. The missed opportunities due to alcoholism and losses of their life as a couple would come to the forefront. It was not that Joan did not recognize the need for Nick to be independent and separate, yet the adolescent stage for Nick brought a loneliness and sadness for Joan to confront, thus, there was a vested interest in keeping Nick close to her and in the home. Nick's use of drugs could also be viewed as functional in that it prevented Joan from facing her grief and her individual dilemmas.

Metaframeworks Model

The structure of the Burns family had changed drastically in the past two years, from being a two-parent traditional nuclear family to a single-parent family in which widowhood for Joan and adolescence for Nick had greatly altered the family life cycle development. For Joan, becoming a widow had disrupted her development as she expected that she would be parenting and launching her child with her husband. As a single person, she needed to take on parenting responsibilities individually and learn to define herself without a husband, and no longer as someone's wife. Joan has modelled her caregiving in her roles as wife, mother, and daughter and these roles were an intrinsic part of her identity. It was believed that her French-Canadian culture and Roman Catholic religious background had reinforced traditional roles of women that were ingrained in being a wife and mother. Joan had taken care of her husband and remained by his side during his illness. Her devotion to him remained unquestioned and during upheavals in the marriage; Joan stated that separation or divorce were never an option.

Joan and Nick had many life changes in becoming a single-parent household. There had been losses in income and social class which had created economic hardships and financial stressors for both. Nick's loss of his father altered his development considerably for without a male figure for support and role-modelling his gender identity was affected. However, the role-modelling his father provided him may have been compromised due to the alcoholism, therefore, issues of attachment may be more complicated and conflicted for Nick. Joan had become the predominant parent yet she

could not teach Nick what it means to be a man or do things he previously relied on his father for, such as father and son outings of hunting and fishing.

Joan's gender identity was influenced by her ethnic and religious background, cultural norms, and her life cycle development. She initially presented as a fragile, powerless, and passive woman who needed to empower herself to make decisions and value her inherent strengths that had enabled her to cope with her life transitions. As therapy progressed there was a transformation in Joan's parenting abilities and improvement in self-esteem demonstrated by her body language, presentation of self, and initiative in seeking out resources. Although Joan did not have many close personal friends she had support through her parents and nieces and in her committment to Al-Anon weekly group meetings. Joan's ability to build up her support system or go out with friends had been undermined by focusing all her attention onto Nick and depriving herself of personal interactions. Once she began to acknowledge her needs as important, she was more open to enjoying time with friends without constantly worrying about Nick.

Brief Solution Focused Therapy Intervention

Joan was a highly cooperative client in therapy and acknowledged that it was a part of her support system in dealing with stressors regarding Nick. After the first few sessions Nick began to arrive late and shortly afterwards would stop coming entirely. It was beneficial to see Joan individually in order to assist her in the parental role. Initially, Joan was reluctant to meet with me individually as she felt the therapy sessions would be a helpful place for her and Nick to communicate better. She was fearful of

addressing her limitations and would appear nervous discussing anything that did not involve Nick. Joan would call home and the school when Nick did not show for sessions, she would be visibly upset, and would plead with Nick to attend. As Joan became more empowered as a parent she appeared relaxed in individual sessions and was not bothered by Nick's lack of attendance. She started to recognize that she could not force Nick to do things but rather could regain control in her responses to his actions. These changes in Joan were necessary before she could feel as if she was an equal partner in the therapeutic process in which goal setting was in her control. Joan would have gladly taken directions and seen me in an expert role as this may have been her experience with other relationships in her life in which her opinions were devalued and her self-confidence was lacking.

Joan's involvement and preoccupation with her son was accepted and utilized as what she brought to therapy. It was obvious that she loved Nick a great deal and took her job as a parent very seriously. This was reiterated in the form of compliments to her. It was her parental role that gave her the drive and motivation to be resourceful in accessing services and working hard on setting limits even when she was not treated favorably by Nick. In order to address the negative consequences of Joan's parenting style in her response to Nick's behaviors, exploring the family's repeated patterns through reframing how the impact of doing more of the same prevents the ability to form solutions was done.

Joan's constant state of worry was addressed with scaling questions in which her response of a ten indicated that she was often in a state of distress. At this point her narrative would be regressive and the conversation would become problem-focused. In

order to de-emphasize a problem-oriented approach, exceptions to her worry were probed in which she could see differences so that a solution could seem promising and her worry could decrease. During the times that she was not very worried, Joan was encouraged to do the same things that were of help to her. It was useful to compare and contrast the differences a state of worry and a state of non-worry held for Joan and the impact on her abilities as a parent. The positive benefits Joan felt when she was not in a state of worry were conducive to her implementing changes and being confident about her decisions. However, if Joan did not worry about Nick, or if Nick's problems were to disappear, Joan would have to begin to examine her own life. This possibility was discussed with Joan who admitted feeling nervous and fearful of looking at herself once she would not be in such an extreme worry state.

Joan would describe Nick's acting-out behaviors as a detached observer. Rather than confront him, she would investigate on her own and intervene in silent and indirect ways when she caught him with stolen goods or using drugs. The confusion technique was used in questioning Joan's motives so that she could conclude if her approach to the problem was the most appropriate. She appeared to enjoy the power game of not letting Nick know she was on to him and seek revenge by throwing Nick's belongings out without dealing directly with him. This also put the onus of responsibility on Nick to bring up an issue with Joan for she felt he knew what she was doing and if he was upset he would talk to her. Feedback in the form of a clue was given to Joan by labelling her approach as one of "sneakiness" and asking her to think about how helpful this approach was compared to an approach of "confrontation" or direct talk with Nick.

Promoting a positive future for this family was done by having Joan name the future phase of the family's life in terms of a chapter of a book. She named it "Serenity" similar to the Serenity Prayer referred to in her Al-Anon meetings. She was unsure as to how the present phase of her life would turn out, or the name of the current chapter, yet she was in the process of moving from enabling to finding interventions for her and Nick.

Outcome Evaluation

The FAM-III measure for Joan (see Figures I & II) showed minimal overall change from pre-test to post-test. Her scores in the post-test increased in the areas of role performance and affective expression while they decreased in the areas of communication, affective involvement, and values and and norms. The identification of conflict around roles in the family may be linked to the adjustments Joan and Nick have had to make in becoming a single-parent family. For Joan, the onset of adolescence in the family life cycle created confusion as to the expectations Nick had of her. Joan's improved scores in the above areas seemed reflective of the changes she demonstrated during therapy. She felt better about herself with increased self-confidence and self-esteem. She appeared more empowered as a parent in her ability to make rules and follow-through in implementing them. Although Joan may not have felt that Nick was talking much more with her than before, she perceived improvement in the clarity with which she delivered messages. Similarily, her involvement with Nick appeared to be more supportive with boundaries rather than an overinvolvement in which her needs were overlooked.

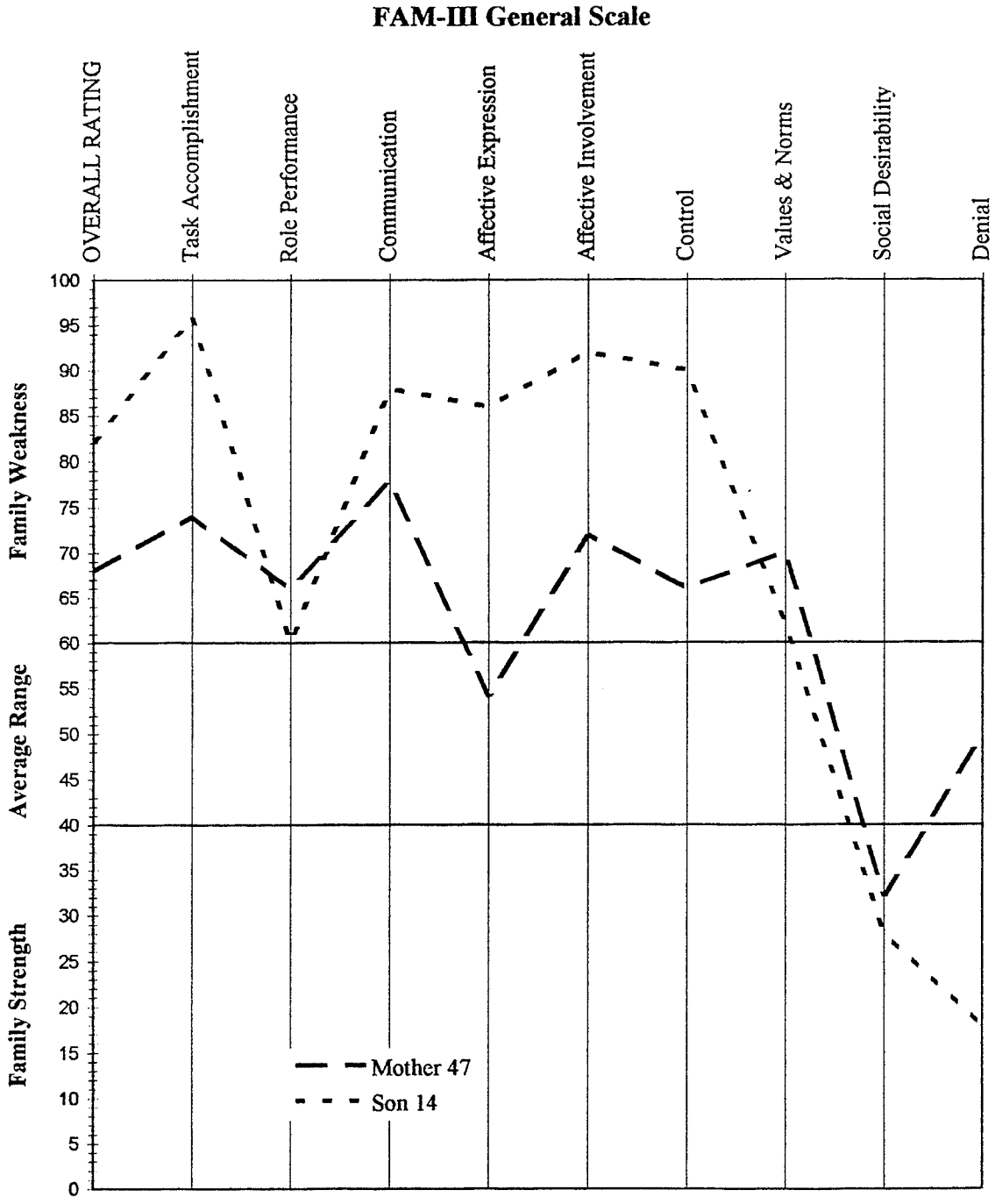

Figure I
Pre-test FAM-III profile for Family One.

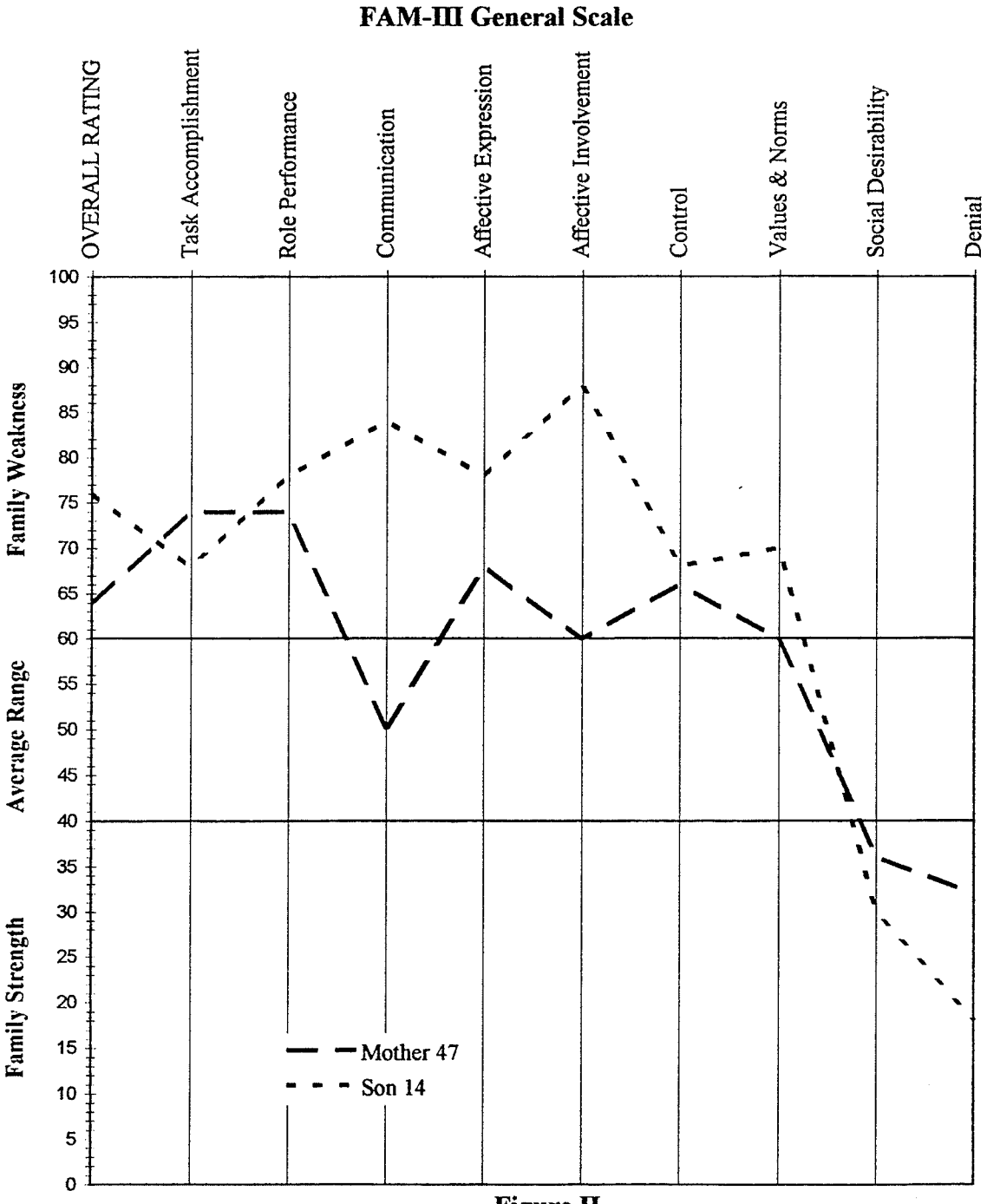

Figure II
Post-test FAM-III profile for Family One.

Nick's scores (see Figures I & II) were extremely elevated in the pre-test with an overall rating of 82. His extreme views were indicative of his frustration with the family rules and his lack of freedom. It appeared that Nick was responding in an impulsive and egocentric manner holding his mother responsible for the conflict at home. His scores did decrease in most areas in the post-test except for two: role performance and values and norms. As Joan became firmer in her parental tasks of discipline and rules she established more structure as to what family values and norms were acceptable. By standing firm in her decisions and expectations, Joan's degree of latitude with Nick was more appropriate which forced him to consider his actions more seriously based on the consequences.

It is interesting to note that the developers of the FAM-III state that: "family members may be less consistent or reliable if FAM is administered while the family is undergoing a crisis" (Skinner et al., 1983, p.97). I found that most of the families were in a crisis situation that prompted them to attend family therapy. This may explain pre-test scores that are highly elevated which may remain the same or decrease considerably in the post-test. The crisis state that families felt they were in may also account for the consistently higher than average scores. Even when improvements were shown in certain areas the scores still fell into the high score category.

The Problem Checklist remained fairly consistent for Nick except the post-test showed that he was a little more satisfied with his individual abilities to handle things whereas in the pre-test he was "very dissatisfied" with every item except how he felt about himself which was "very satisfied". The differences between Joan's pre-test and post-test of the Problem Checklist revealed similar information to that of the FAM-III.

She felt less satisfied about the family's general functioning in areas of doing things together, agreeing on discipline, talking, and sharing of feelings. She felt more satisfied with her individual abilities of making rules, making decisions, taking more responsibility, and use of self-control. She continued to remain "very dissatisfied" about proper use of alcohol or drugs in the family. Although the problem of Nick's drug use worsened from being suspected to being confirmed, it appeared that Joan's ability to intervene in a timely and effective manner was greater for she was a stronger individual and parent.

Family #2: The Evans

The Evans family consists of the mother Janet (age 39), her son Brian (age 12) and her daughter Nicole (age 14). The parents had been divorced for three years and the father David resided in the same city. Brian resided with Janet and Nicole had moved into her father's home two months before family therapy commenced. Nicole had been seeing a psychologist in Child and Adolescent Psychiatry for individual therapy on and off for the past year. Janet had approached the team coordinator in November for family therapy as she and Nicole had been fighting frequently making the home situation unbearable. However, therapy did not begin until three months later for there were difficulties in the family meeting appointments due to Janet's school committments. Later, when Nicole moved out, Janet felt that the major crisis was over and she did not want to start therapy around the Christmas holidays fearing that it would jeopardize her visits with Nicole. The family was seen for a total of eight sessions.

The Evans family had gone through family therapy with Child and Adolescent Psychiatry a year and a half earlier. At that time Janet and Nicole's conflicts were highlighted and it was concluded that Janet had trouble setting limits and following through with them, that her parenting skills were poor, that she was emotionally unavailable to the children, and that she intervened only when the situation would explode to a crisis level. Nicole was described as very needy of her mother's attention, manipulative, and dramatic in getting her point across. Brian was seen as candid and honest in describing the family situation yet sadly caught in the middle of his mother and sister's interactions. A significant incident was reported in which Janet's former boyfriend Jack, had taken Nicole to the United States without Janet's permission. During this trip, some type of sexual incident occurred in which Nicole called her mother for help stating that she felt unsafe. Upon returning home, Nicole would not disclose anything and Janet was unclear about what had in fact occurred.

During my involvement with the family Janet's purpose for pursuing family therapy was so that there would be a safe environment for her and the children to communicate more effectively. Brian and Nicole felt dragged to therapy by their mother, yet were able to acknowledge that they wanted less fighting at home. Brian saw the major family issue as decreasing the fighting between his mother and sister whereas Nicole described a distant relationship with her mother in which she felt neglected and devalued. Both children felt that Janet was caught up in her life of school and friends without noticing what was going on for the two of them. In sessions, Janet felt "ganged up on" by Brian and Nicole yet would maintain an air of indifference while the children complained about her. Janet appeared more concerned with Brian's comments and

feelings and would interact with him in the sessions whereas she found Nicole to be exaggerating and tended to withdraw from her in the sessions. As therapy progressed Janet's relationship with Nicole improved. There was a healthier balance in how Janet and Nicole interacted which resulted from effort on both sides outside of the sessions.

Once Nicole moved in with David there was less tension at home yet Nicole's visits with Brian and Janet were still plagued with arguments and hostility. Janet felt a huge sense of relief with Nicole out of the home for it was much quieter and more peaceful and Brian appeared much happier to her. Janet felt drained in mediating the fights between Nicole and Brian which had escalated to physical matches in which property had been damaged in the home and Brian had punched holes in a door.

Each child stayed with the other parent every second weekend and Nicole had visits with her mother and brother twice a week. Janet stated that Nicole could move home at anytime but would have to follow rules and discipline in the home for she would not tolerate their relationship deteriorating to the level it did prior to Nicole moving out.

The beginning phase of therapy identified the family's presenting problems as improving the relationship between Janet and Nicole, and assisting Janet in her parenting abilities through clear communication and following through on setting limits. Secondary issues that I felt were important were reviewing with all family members Nicole's placement with her father in case this broke down and assessing with Janet and Nicole the family's resolution of the sexual incident that impacted Nicole.

Contracting and Goal Formulation

The first few sessions of therapy were spent identifying the defined roles for members in the family and how their interactions and communication styles impacted their relationships. The family was asked how previous family therapy had assisted them in doing things differently and what they found helpful. The repeated family patterns prevented the family issues from being resolved which kept the family stuck in the past, therefore an emphasis on providing new coping techniques and addressing solution-oriented behaviors was considered necessary in order for any real change to take place. A former therapist had recommended that a confrontive approach with Janet was necessary in order for her to take more responsibility in the change process. This appeared to be a worthwhile suggestion so that the therapy extended beyond the sole task of supporting family members and encouraged changes in behavior. It was believed that confronting Janet directly would be perceived as blaming and unsupportive to her, rather, confronting the family issues involved motivating Janet and providing her with the means to make behavioral changes.

It was apparent that although Janet desired a better relationship with her children, her motivation to work towards achieving this goal was low. Much of her energy and time was invested in her school aspirations and the stressors of schoolwork meant less of a focus on the children. In order to help her develop familial goals, I felt it would be useful for her to listen to what her children were telling her. Nicole repeatedly gave examples of how her relationship with her mother was non-existent and all Janet would talk about was her schoolwork. Nicole craved attention from her mother and wanted

Janet to take an interest in her life as she felt a parent should rather than her constantly supporting her mother's endeavors. Nicole's sadness and pain is reflected in the following statement: "I come home for a visit and she doesn't even ask me how my day has been or what I've been doing, she just starts in with clean the bathroom or do your chores... what am I, a cleaning lady?".

While forming a goal of Janet and Nicole fighting less, it was hard to get Janet to verbalize how her behaviors needed to change. She felt that Nicole had to be more responsible by helping out at home and improving her attitude by becoming mature. It seemed that Janet desired Nicole to grow up so that she would not have to parent her. Discussing their ideal images of what a mother and a daughter should be compared with the reality provided a basis of what expectations each had of the other. I directed Janet to think of what Nicole's behaviors were telling her, especially when they fought. Initially, it was difficult to generate exceptions to how things were when they did not fight for Janet could not remember times that were conflict-free between her and Nicole. In changing the behavior of fighting, brainstorming was done around what could be done differently that Janet and Nicole could try out in their visits.

In the middle phase of therapy Janet decided that a family goal would be for the three of them to have more fun, which would also include spending individual time with Nicole. Thus, this could be seen as two separate goals. In this session, Janet asked Nicole if she would like to go for a walk in the evening to which she agreed.

A goal which I felt was important to discuss with Janet individually was her following through with consequences. Janet's pattern was to set limits and then engage in power struggles and fighting matches when they were not followed. She would become

frustrated with her children's inability to listen to her and then she would give up and immerse herself with school as an avoidance technique.

It was decided that discussing the sexual incident that occurred in the past would be brought up with Janet individually at first. She surprised me by disclosing that she still had contact with Jack secretly without the children's knowledge. This opened up the discussion for how important it was that she communicate to Nicole whether or not she believed that something had occurred. Addressing this issue was on my agenda as it greatly impacted feelings of trust and safety for Nicole. There was a court date coming up in which Jack was being charged for kidnapping and sexual interference so this issue was currently affecting the family. The incident occurred when the family was in therapy in the past and although it was brought up they did not delve into it a great deal. Janet stated that it was important for her and Nicole to talk about this issue, yet her fears in acknowledging her feelings prevented her from taking any action. Therefore, reaching some type of resolution on this issue for Janet and Nicole was a goal I pursued with Janet in the later part of therapy.

Part of forming goals and obtaining them also involved empowering Janet in her parental role. Although she could make decisions and had certainly demonstrated that through her life experiences, she required assistance in making wise choices that were of benefit for all family members. This was hoped to be done in a collaborative effort with Janet, rather than assuming an expert role and disempowering her.

Theme of Adolescence in Family

Janet had a good recognition of her children's developmental stages and the age appropriate behaviors that came with being an adolescent. What she did not appear to recognize was that Nicole required an atmosphere of structure and support in order to individuate in a healthy manner. It was hypothesized that Nicole's pseudomaturity was a result of taking on too much responsibility too soon and providing her own mothering to herself, Brian, and now, her father as well. On one hand, Nicole was self-sufficient, yet on the other hand she would act-out impulsively in order to get attention and reinforce that she was still an adolescent. Janet did not find the adolescent stage unwelcoming, it was as if she was in a hurry for her children to grow up so that she could spend time on her individual pursuits such as travelling and working abroad. However, the adolescent stage for Nicole did bring disruptions to Janet's life that were forcing her to do things differently. Janet resentfully stated that it was so much easier parenting Brian and that she hoped he did not turn out like Nicole.

Nicole's expression of identity was closely tied to her physical appearance and tough demeanor. She dressed to shock people in her "grunge" attire, dyed black hair, heavy make-up and painted black nails. Her appearance offered a uniqueness that set her apart from others, including isolation from peers at school. Her "tough as nails" attitude kept people at a distance and gave the impression that she was strong enough to handle anything.

Nicole seemed stuck in her decison-making as she tried out different ways of defining her identity (moratorium status). A vocational committment was not an

important task at her age, however, Nicole demonstrated a commitment to school which she also saw in her mother. Nicole did not find much support from peers at school for she had not formed many friendships and found her peers to be "nerds". Her peer group was outside of school and included adolescents older than herself. Nicole's relationships with males were with ones that were considerably older. Her need for attention and a sense of belonging may initiate Nicole into a sexual relationship for which she may not be emotionally ready or feel she has any control over. Janet's unwillingness to discuss the sexual incident which occurred between Nicole and Jack reinforced to Nicole her mother's disbelief and blame towards her. The manner in which Janet chose to deal with this situation had the possibility of affecting Nicole's sexual identity a great deal.

It could be speculated that Janet's discomfort with her own sexuality had been heightened in the adolescent stage of the family as issues of sexuality for Nicole and Brian were emerging.

Metaframeworks Model

The structure of the Evans family was altered by the parent's divorce and Nicole's recent move to live with her father. The family's income declined by becoming a single-parent household and with Janet's return to school financial burdens became greater. Janet's inability to afford extracurricular activities for the children was a source of disappointment for them and a conflict between the parents as Janet attempted to have David contribute more financially in raising the children. Since Janet initiated the divorce, she felt that the children resented her for the lifestyle changes they have had to

make. The children were caught in the middle for David had communicated that they would still be a family if Janet had not left him. It was clear that David had not resolved the family separation and divorce.

Janet married and had children at a very young age and did not have the chance to enjoy any freedoms as a single person. In her marriage Janet assumed traditional roles of wife and mother in which she was responsible for the decision-making and emotional well-being of all family members. Janet felt she stayed in her marriage for the children's sake regardless of how unhappy she was. Janet's caretaking may have been modelled to Nicole who now feels she must be responsible in taking care of her father since the divorce.

Janet's decision to divorce David was the first step in her assertion of independence. She felt much happier, confident, and emotionally healthier, however, she was the only one to have welcomed the divorce. Now as a single person, she was doing what she could not do before, which was to pursue her educational and vocational aspirations. However, being a parent and raising children complicated these efforts and conflicted with Janet's desire to be independent.

At this stage in her life, Janet stated that she did not wish to be defined by a man, nor had any interest in having an intimate relationship. She stated that once the children were close to being adults she would consider a relationship at that time so that it did not complicate their lives. Her rationalization suggested that the children were preventing her from forming intimate relationships. She was not being completely honest with herself for she continued to see Jack secretely without anyone's knowledge. In order to understand the contradiction in Janet's comments and her actions, it was

suggested to Janet that she may have felt jealous or competitive with Nicole for the attention of men. This may have been the case in Janet's relationship with Jack and possibly with Nicole's father.

As Janet struggled to break the mold her culture and gender had defined she was met with a social stigma and lack of supports. Her family members felt sorry for David and found Janet to be vindictive and insensitive to the children's needs in breaking the family apart. Janet felt an incredible amount of guilt and responsibility in having to alter the children's lifestyle so drastically. As a single-parent household, they functioned poorly economically and Janet constantly felt the strain of financial stressors by being unable to adequately provide financially for her family. Janet also experienced the structural and emotional constraints of being a single parent and a single woman. Janet felt guilty in pursuing her education at the cost of being available to her children and this is reinforced in societal expectations of her to be a dutiful mother first and foremost, whereas less expectations are placed on men in fulfilling their paternal role. This made family and school responsibilities difficult for her to combine. Understanding how the Metaframeworks have impacted Janet provides some explanation for constraints she felt as a parent and how they complicated this role for her. However, the dilemmas faced and the choices made by Janet presented consequences for the children that she had to reconcile in her role as a parent.

Brief Solution Focused Therapy Intervention

Janet was resourceful in accessing services for her family. However, this frequently occurred when the situation had reached a crisis state. She initiated family therapy after the divorce in order to help the children adjust and express their feelings. More recently, she sought out family therapy when stressors in the home reached crisis proportions. The crisis dissipated in the home when Nicole moved out, making the family therapy sessions less of a priority. Appointments were often cancelled and postponed due to Janet's school committments. I made special considerations in meeting the family for evening appointments yet these were also cancelled with little notice. Janet modelled cooperation in therapy by being receptive to my suggestions and encouraged the children to openly express their feelings. The children were at ease in providing examples of scenarios which portrayed the family's problems. Their candidness suggested that they felt safe in discussing things in front of Janet without the fear of repercussions.

Part of the process of empowering Janet as a parent was to have her take more control in the sessions in disciplining her children. In sessions where the children would act-up and be disruptive, Janet would turn to me to intervene as she felt it was my responsibility as "the boss" and the children would listen to me. Directing Janet to intervene clarified her role as the parent and modelled the desired change or solution that could be implemented outside the sessions. This also guided the therapy system towards becoming equalized, bridging the gap between me and the family or the roles of expert and subordinate.

Janet experienced tension between her student role and her role as a mother. The message sent to Brian and Nicole was "leave me alone". Although I desired that Janet would be more overtly concerned about the impact of her actions on her children, it was relevant to examine the effects culture and gender have had in shaping her development and identity. Her caring may not be expressed in conventional ways with the expectation of a mothering role, yet she did demonstrate her caring in other ways. It was her level of committment to her children that created confusion for me as to what she was capable of expressing. Therefore, both Janet's abilities as a mother and her need to excell as a student were accepted and utilized in therapy. Her positive self-esteem linked to her accomplishments as a student was instrumental in demonstrating a strong work ethic and responsibility to her children. Nicole admired Janet for going back to school in order to become a teacher and improve herself and her family's economic circumstances. The reframing process aimed at providing the family with a different reality in which Janet could effectively balance her role as a parent with her role as a student in a more healthier manner through which the children did not feel their needs were being neglected.

Nicole's need to have her mother's attention constrained her in appreciating and respecting Janet's loving qualities because she felt she was in competition with Janet's school obligations. It became an either/or situation that was reframed as a yes/and possibility. The family's solution to improving relationships was to decrease conflict (fighting) and increase the time spent together. This was measured in terms of scaling questions which coincided with the number of fights that decreased during visits.

Any small measure of improvement in family communication and less parent/child conflict were used as an entry point to maximize differences or exceptions that were occurring in former problematic situations. For instance, Janet found that she would behave differently around the time that she and Nicole would be approaching a fight, which would in turn alter how Nicole responded. Janet stated the she would not allow herself to be "baited or hooked" when Nicole would start to lose control. Instead, Janet would take a half hour and spend time by herself relaxing so that she could talk to Nicole later after having reflected on things. Janet found that there were less fights and less tears shed when the interactional sequences around how they fought changed. This resulted in Janet feeling better about her abilities and role as a parent which improved her self-esteem and motivation to do "more of the same". At this point family members could identify when they would know things had changed and the problem would be a nonproblem. There would be a "crystal ball" effect in perceiving solutions that were future-oriented based on the current solutions being applied, leading to goal attainment.

Outcome Evaluation

The scores of the FAM-III for the Evans family are shown in Figures III & IV. Janet's pre-test scores were the lowest and mostly fell into the average range. Nicole had the highest scores in which she saw role performance, communication, and affective involvement as problematic areas in the family. Brian's scores generally fell in-between his mother's and sister's scores with the areas of affective expression and control indicative of some weakness in the family. The FAM-III's overall rating at the beginning

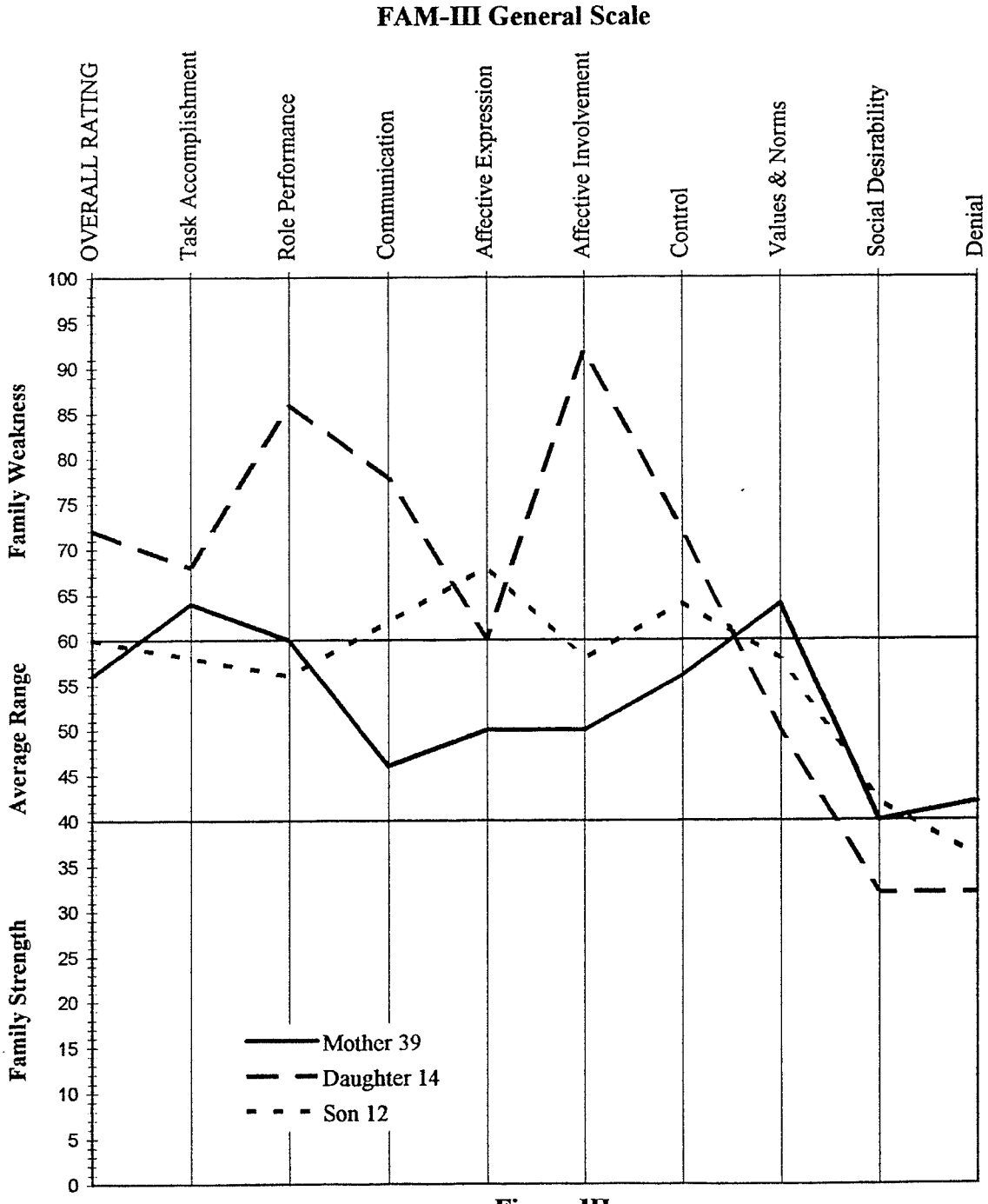

Figure III
Pre-test FAM-III profile for Family Two.

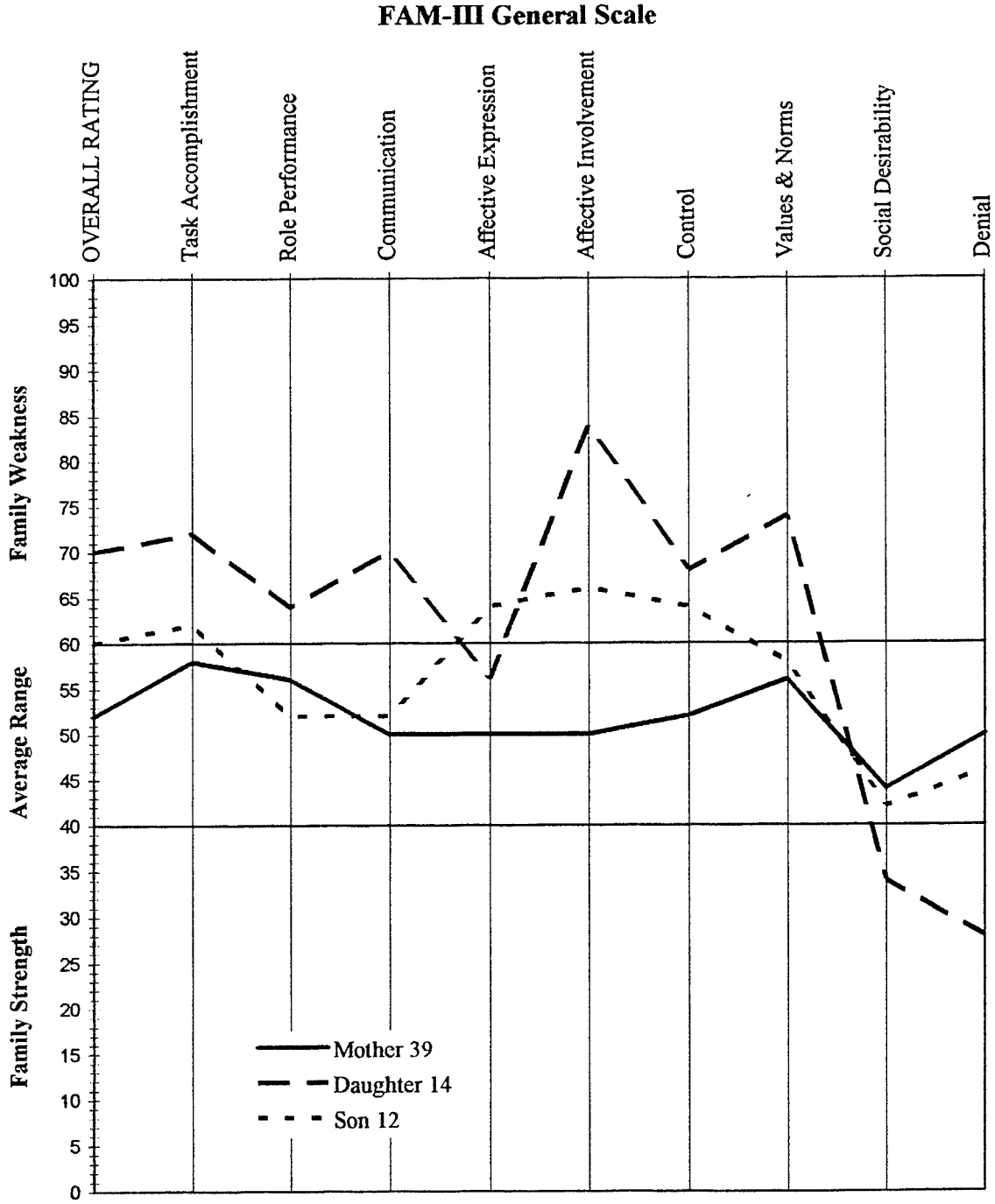

Figure IV
Post-test FAM-III profile for Family Two.

of therapy showed Janet and Brian viewing their family within the normal range whereas Nicole was outspoken as to the dysfunction of their interactions. Janet's low scores appeared consistent with how she presented in therapy. She tended to minimize the degree of family problems, especially in terms of how Nicole felt. Therefore, a comparison of Nicole's high scores with Janet's low scores reflected the disparate views of family members in defining problematic areas.

Janet's overall rating on the FAM-III changed very little over the course of therapy. Her scores remained the same or decreased in all areas except in the area of communication which she perceived as the one that needed improvement. This was reflected in a slight increase in the subscale score and in Janet's statements in the family session in which she acknowledged that Nicole and her needed to spend more time talking. Janet realized that this goal would be met by her making the time available for her and Nicole to talk. Nicole's decreased scores in the areas of communication, affective expression, and affective involvement may reflect her increased satisfaction in her relationship with her mother. There was a noted improvement in Janet and Nicole's relationship in terms of meaningful interactions, less fighting and arguments, and their ability to laugh together and have fun.

Interestingly, Brian's overall rating stayed the same at pre-test and post-test. He stated that things were generally the same in the family except he did notice that his mother and sister were getting along better. When asked if he and his sister were getting along better, Brian replied that he was not sure, but sometimes they did. Janet stated that there was a noticeable change in Nicole in that she did not "bully" Brian as much as she used to, which made the visits much more peaceful and quiet according to Janet. It was

speculated that Brian may start to act-out for attention once Janet and Nicole started to spend increased time together, however, at that time, this was not the case. Rather, Brian continued to spend time out of the home with peers as this had been his way of coping with the family fighting in the past. Brian did not seem to be jealous of Nicole and he stated that he understood why his mother and sister needed to do "girl things". However, if Nicole moved back with Janet and Brian, the dynamics of the children's interactions may very well worsen again. All of Brian's scores in the subscales were considerably less than Nicole's scores, except in the area of affective expression. This may suggest that although there is a wide range of affect expressed, Brian was uncomfortable with the display of emotions compared to his sister's and mother's perceptions.

The Problem Checklist showed improvements from pre-test to post-test for all family members. Janet's ratings indicated that she was "satisfied" with most areas of family concerns. She felt more satisfied about her individual abilities in making decisions, setting rules and discipline, and dealing with stress. Concerns that improved to the "in between" rating yet still required further change according to Janet were having the children take on more responsibility with chores and behaviors in the home.

Nicole's ratings went from "very dissatisfied" to "in between" which suggested that she would still like changes to be made in a positive direction yet she recognized that some improvements had been made. It appeared that Nicole's anger and distress was replaced with a more hopeful attitude about her family situation and relationships. Brian's ratings show a pattern similar to Nicole. However, he jumped from the "in between" level to the "satisfied" level in most areas, which suggests a perception of change.

Both Nicole and Brian felt dissatisfied with how the family dealt with matters concerning sex and the level of participation in family fun and recreation. Janet on the other hand, felt satisfied with both these items. The children's views seemed consistent with their need to have Janet more available and take more initiative in planning family activities. The topic of sexuality was never brought up in sessions with all family members. However, the sexual incident regarding Nicole did have ramifications on her sexuality that Janet would only address if it was brought up by Nicole. The Problem Checklist was helpful in identifying the above two areas to which the family could pay further attention.

The results of the measures were useful in showing how the attitudes and perceptions of the family members had changed in a positive direction towards their initial problems and towards each other. The family had moved out of a crisis situation and had taken some positive steps to generating solutions.

Family #3: The Prices

The Price family consists of the mother Cheryl (age 49), the father Rick (age 54), and their daughter Tara (age 17). There is also a son named Steve (age 20) who resides on his own in the same city. Both children were adopted at birth however were not biologically related. Tara was sexually abused by Steve from the ages of eight to eleven and disclosed this to her parents a year and a half ago. At the time of the disclosure, the family was attending family therapy (outside the hospital) focusing on family problems involving their son's acting-out behaviors. They continued with therapy (without Steve)

and briefly discussed the effects of the intrafamilial sexual abuse, at which time the therapist referred Tara to the Psychological Trauma Clinic. After the initial assessment, she was referred for the Sexual Abuse Survivors' Group at the hospital. During the group sessions, it was assessed that the fact of the abuse continued to have negative effects on family interactions and a damaging impact on Tara. Family problems were brought to the team's attention and family therapy was suggested to the parents by team members. Although the parents were surprised by the recommendation, they agreed to attend if it would help their daughter. The family was seen for a total of nine sessions.

The parents' prime concern was that they did not fully know what actually occurred between Tara and Steve and reported that this obstructed their ability to help her. The parents' wish was that Tara would get the help she needed from the group so that she could feel comfortable in discussing the abuse and "get better and move on with her life".

Tara also desired to get her life "back on track". She planned to start school again after quitting the previous semester. Tara felt guilty and blamed herself for the family's dissolution. Her stressors also included feeling pressured by her parents to disclose details of the abuse which she found impossible to do because the perpetrator was her brother. It appeared that Tara was protecting her parents from finding out what her brother did to her while also remaining loyal to her brother and his relationship with the family. She stated that if the abuser was an outsider she would be able to talk about it with her parents yet presently she felt too embarrassed and shameful to discuss it.

The complications of intrafamilial sexual abuse left the parents unsure and confused as to the role Steve should play in their lives and how they should relate to him.

Tara understood her parents' need to have contact with Steve yet she was jealous of the close attention being paid to him. She perceived that she was being punished for what happened to her while Steve was absolved of any responsibility.

The family dealt with the sexual abuse by avoiding discussion of the abuse and their overwhelming feelings as to how they had been affected, with the hope that with time things would smooth themselves out. The denial stage the family members was in left them isolated without any supports as the secret of the abuse continued to be perpetuated. It seemed imperative that the therapy sessions provide the family with a safe environment to voice their feelings and find ways to reconstruct their roles and relationships in the family.

The beginning phase of therapy was spent exploring each family member's feelings and losses associated with the intrafamilial sexual abuse. The parents' intense feelings of rage, guilt, and sadness was further compounded by their conflicting and ambigous feelings towards their son. They felt that hearing the details of the abuse would impact their decision to either have contact with their son or to disown him as a member of the family. Cheryl and Rick commented that they had heard numerous stories and rumors about the abuse from the guidance counsellor at Tara's school and from her peers, and that as parents they were very upset that they were in the dark over what had happened. This further reinforced their guilt and confusion as to what they needed to do to help their daughter. Tara felt pressured to talk about the abuse which she was clearly unwilling to do. It was assessed that any move to force her to talk about the details of the abuse would be further traumatizing and not in her best interests at this time.

Issues that emerged at this stage in the therapy were educating the parents around the effects of sexual abuse so they could differentiate between normative behaviors and behaviors linked to the abuse that Tara was demonstrating, and formulating alternatives around the role Steve would play in their family. The parents' primary focus was to address ways to help Tara and not necessarily to examine ways of helping themselves in the process.

Contracting and Goal Formulation

Establishing concrete goals was a difficult task in working with the Price family. A major obstacle was the parents' unrealistic expectations of the purpose of therapy and what my role was. As indicated, the parents felt that Tara should disclose details of the abuse and that I should gear the therapy towards this direction. Rick and Cheryl relied on me to be instructive and provide them with answers as to what they should do in a prescriptive manner. They expected me to demonstrate credibility through interventions that would have successful outcomes. Any regression in the family's circumstances were taken as evidence that the therapy was not working. The responsibility for change was placed on me. It was important to clarify the therapist-family system roles with the purpose of the family identifying goals and methods of achieving them through their own efforts and solutions. My taking control and telling them what to do would not be helpful. Explanations of the above would suffice temporarily if things were going smoothly, yet as soon as a family crisis would occur or Tara would start to act-out

behaviorally, the parents' fears and constraints would resurface and they would redirect the focus of therapy to the therapist providing them with clear-cut answers.

Having the parents educate themselves on sexual abuse through their readings was one way of increasing their understanding of the impacts and effects it had on Tara and themselves as parents. This was seen as a first step towards the family addressing the effects rather than the details of the abuse. Cheryl was open to understanding that Tara would disclose in her own time, whereas Rick had difficulty with this idea. I suggested that redefining the roles and the relationships in the family would strengthen ties that would be conducive to family members receiving support from each other. Creating a different family environment may prompt different behaviors and perceptions that would enable the family members to tackle the difficulties with fresh approaches. Setting down goals would move the family away from repeating behaviors that were keeping them stagnant and in conflict. It was clear that the sooner the goals were defined, committed to, and acted upon, the sooner the change process would have an effect on the parents expanding their approach.

Theme of Adolescence in Family

Tara was in the late stage of adolescence preparing herself for turning eighteen years old. The ramifications of legally becoming an adult were frightening and worrisome to her. Societal and familial expectations of Tara to be self-sufficient with a vocational direction were incongruent with Tara's circumstances and capabilities. She felt ambivalence over leaving school, was unable and unwilling to find full-time work,

and did not express any desires to make steps towards independence. Although chronologically Tara was approaching adulthood, developmentally she had a long way to go. Her level of immaturity, impulsive behaviors. and poor decision-making placed her at mid-adolescence in her developmental identity. Tara's lack of emotional readiness to become an adult suggested that there were tasks of childhood and adolescence that had not been mastered succesfully, leaving her stuck and unsure of how to behave.

Tara's approach to adulthood had been a time of confusion and ambivalence for Cheryl and Rick. They wanted their daughter to be self-functioning yet at the same time they had a strong instinct to protect her and shield her from further pain. Cheryl became very emotional and possessive over keeping Tara at home with them for as long as she could. Their fears of allowing Tara to "grow up " were manifold. Cheryl and Rick felt a great deal of blame and guilt for not protecting Tara from the abuse. It seemed that their protective stance was heightened in an attempt to redeem themselves from their perceived sense of failure as parents. Cheryl and Rick perceived their daughter as sweet and innocent whose naivety could get her into danger, therefore, they feared Tara's associations with peers and boyfriends who were far more worldly and street-smart than she was. Cheryl and Rick's resistance to Tara's adulthood also meant her separation from them. With the loss of Steve from their family unit, the parents' dreams and aspirations for their children were refocused solely onto Tara. If Tara individuated from her family, her parents might feel that they had less control and influence over her to ensure that some of their goals for their children were met. Tara's separation from her parents also meant that Cheryl and Rick would confront post-attachment issues and be left on their own together.

Tara's fragility and passivity may be solely an effect of the sexual abuse, however Cheryl and Rick continued to treat her in a way that reinforced her helplessness. Addressing themes of adolescence alerted the parents to behaviors that were normative which may or may not have been exacerbated by the sexual abuse. Taking into account the sexual abuse, it was imperative that Cheryl and Rick learn ways of parenting an adolescent. Systemically, it was important for the parents to take control in the family and reestablish the power and boundaries of their roles. As Tara began to act-out behaviorally and disobey her parents she was shedding the image her parents held of her. This was instrumental in Cheryl and Rick believing that it was up to them to provide structure through rules and consequences.

In terms of Tara spending time with peers and having freedom outside the home, Cheryl and Rick had a good understanding of her age-appropriate needs. They did however, desire that she spend at least one evening a week at home with them. As Tara increased the amount of time she was out of the home, her parents felt that she was avoiding them in order to purposefully avoid talking about the abuse. Her actions were hurtful to her parents and Cheryl especially felt rejected, unappreciated, and blamed. I speculated that Cheryl and Rick were forced to address their marital stressors which were easily covered up while they focused all their time and energies onto Tara.

Individual issues that were central for Tara were her low self-esteem, negative self-image, destructive feelings and behaviors (compulsive lying, substance abuse), her sexuality, and her negative relationships with males. These issues needed to be understood in the context of the sexual abuse rather than the traditional theories of

adolescence. It was recommended that Tara engage in individual psychotherapy to address her individual needs that would not be adequately met in family therapy.

At an age when Tara should have a clear direction of her future, she was clouded by feelings of helplessness and hopelessness. Her identity diffusion, which prevented her from setting goals, was greatly affected by the long-term effects of the sexual abuse.

Marital issues during the stage of adolescence in the family life cycle were explored with the couple, however, any discussion or probe was met with avoidance and denial. Cheryl and Rick were very protective of their relationship and insistent on presenting a favorable impression. Redirecting family issues to Tara enabled the parents to avoid examining their relationship. Cheryl was offered an individual session to focus on her feelings of guilt and sadness and the "mother blaming" she experienced over the sexual abuse. She considered my offer and chose to decline.

Metaframeworks Model

The traditional nuclear structure of the Price family had remained the same but the family composition had drastically changed with the exit of Steve. Although Steve had been told to move out prior to the parents' knowledge of the sexual abuse, after the disclosure, he was definitely an outcast of the family. The intrafamilial sexual abuse left the parents on Tara's side with her brother as the outsider. The extent and type of relationship family members will have with Steve was yet to be defined and accepted by all involved. Another profound impact on this family was adoption and this had become a more important issue, especially for Tara.

The parents were at the launching of children stage in their family life cycle. As the children individuated from the family, Cheryl and Rick were left to confront mid-life issues and reflect on their career, health, and mortality. This stage was disrupted as the secret of the abuse was exposed and halted the family's development significantly. Cheryl and Rick's development appeared contingent on helping their daughter overcome the devastating effects of sexual abuse. Cheryl adamantly said "we're never going to get better until Tara does".

Cheryl and Rick held their role as parents in high regard. They stated that Tara and Steve being adopted had no impact on their ability to parent and love them. Their committment to Tara was strong and loving. However, Tara's desire to know more about her birthmother's whereabouts created feelings of insecurity and possessiveness for Cheryl and Rick. This reinforced their feelings of guilt and failure as parents to Tara. Although they understood Tara's curiousity of her birthmother, Cheryl stated that they would support her but not help Tara find her. It was apparent that Cheryl felt highly threatened by Tara's birthmother. It also appeared that she felt that Tara was rejecting her for not loving her enough to prevent the abuse. Cheryl felt that her love should have helped Tara, rather than connecting the need for protection and communication to occur in the family in order for healing to take place. For Tara, knowledge of her birthfamily was significant as it impacted on her sense of self and identity. The timing of Tara's need to know about her birthmother was crucial as she fantasized that the abuse would never have occurred if she had not been adopted. I wondered if there were losses around Cheryl and Rick's inability to biologically have children that impacted on their role as

parents, however, they were reluctant to discuss this topic and the impact of adoption on their relationship was dismissed as being unimportant.

The impact of the abuse affected Cheryl and Rick in ways that were congruent with their gender and upbringing. For instance, Rick internalized his failure to be a protector to his daughter and felt responsible for letting her down. In turn, he treated Tara with caution and gave in to her wishes whenever she cried or became overly upset. Cheryl also felt responsible and blamed for the abuse having taken place. She felt as the mother, she should have sensed that something was wrong with her children and done something about it. Even though she felt anger towards Steve, she met with him out of pity and still felt that as his mother she had to love and protect him.

Brief Solution Focused Therapy Intervention

The Price family had an extremely difficult time visualizing a time when the problem was not present. Cheryl and Rick knew what should happen in order for them to feel positive yet their expectations and timeframes were at times inappropriate. For instance, Rick stated that things would be better when his daughter would be the same as she was before the abuse and nothing had changed. I expressed to the parents that Tara would never be the same but there were possibilities around her feeling better. Education around the effects of the sexual abuse and the impact it has had on the family needed to occur prior to a strict BSFT approach. These family members did have their story to tell; about the impact of the abuse, about their feelings and losses, and about their perceptions of how the helping systems contributed to the parents' feelings of failure in protecting

their daughter. The assessment or probing phase which is generally quite short in BSFT was extended for this family.

The family structures of power, control, and hierarchies were addressed so that the parents could regain control in the family in order to deal effectively with Tara's behaviors. One of the tasks given to the family was to find some way to sit down and talk about a family issue, not necessarily directly related to the abuse. However, this task did not occur primarily because sitting down and talking on an emotional level was still difficult and threatening, especially for Tara. As Cheryl started to retreat from taking charge and planning the activities for "family togetherness", it became the responsibility of each family member as to how they wanted to participate in the family unit.

Compliments and positive feedback were given to this family as an intervention. Their ability to function and care for each other was highly commendable in light of the trauma they had all experienced. Systemic issues around gender and violence were reframed so that the family could begin to look at its roles and structures. Cheryl felt a great deal of guilt and responsibility for the sexual abuse as the mother and examining other burdens she felt in the family exposed the family's gender imbalances.

BSFT techniques were most useful in working with Cheryl and Rick around parenting issues of discipline and rules. Reframing and promoting a positive future were done by repeating the positive changes the family had made. Generating hope from these changes to the future was linked to the efforts being made in the present.

Outcome Evaluation

There was an increase in all family members' subscale scores of the FAM-III from pre-test to post-test (see Figures V & VI). This indicated that the seven areas of family functioning had worsened and the family's distress was greater at the end of therapy than at the beginning. To a large extent, this was true as the family members' perceptions were that family problems had increased over the course of therapy rather than decreased in their magnitude. There were many factors that led to this conclusion. Firstly, the family denial and secrecy around the sexual abuse had been broken, thereby causing the family members to confront many painful and distressing emotions individually and as a family. Secondly, Tara begun to act-out behaviorally and her rebellion increased over the course of therapy. This left her parents feeling confused and helpless in their ability to support her and parent her effectively. An examination of parenting issues and techniques required that Rick and Cheryl reassess areas of their family functioning. Thirdly, the vast amount of adjustment the family needed to make around roles and tasks in the transition to a family with adolescents was complicated by the disclosure of the sexual abuse. This presented numerous losses that still had to be acknowledged and grieved adequately. Fourthly, as therapy was close to finishing, the family was in a crisis state which would account for the elevation in their scores. I recommended that family therapy continue (transferred to another therapist) yet the parents chose not to. I believed that Rick and Cheryl felt helpless and powerless in their abilities to help Tara and themselves even though there were many signs of progress.

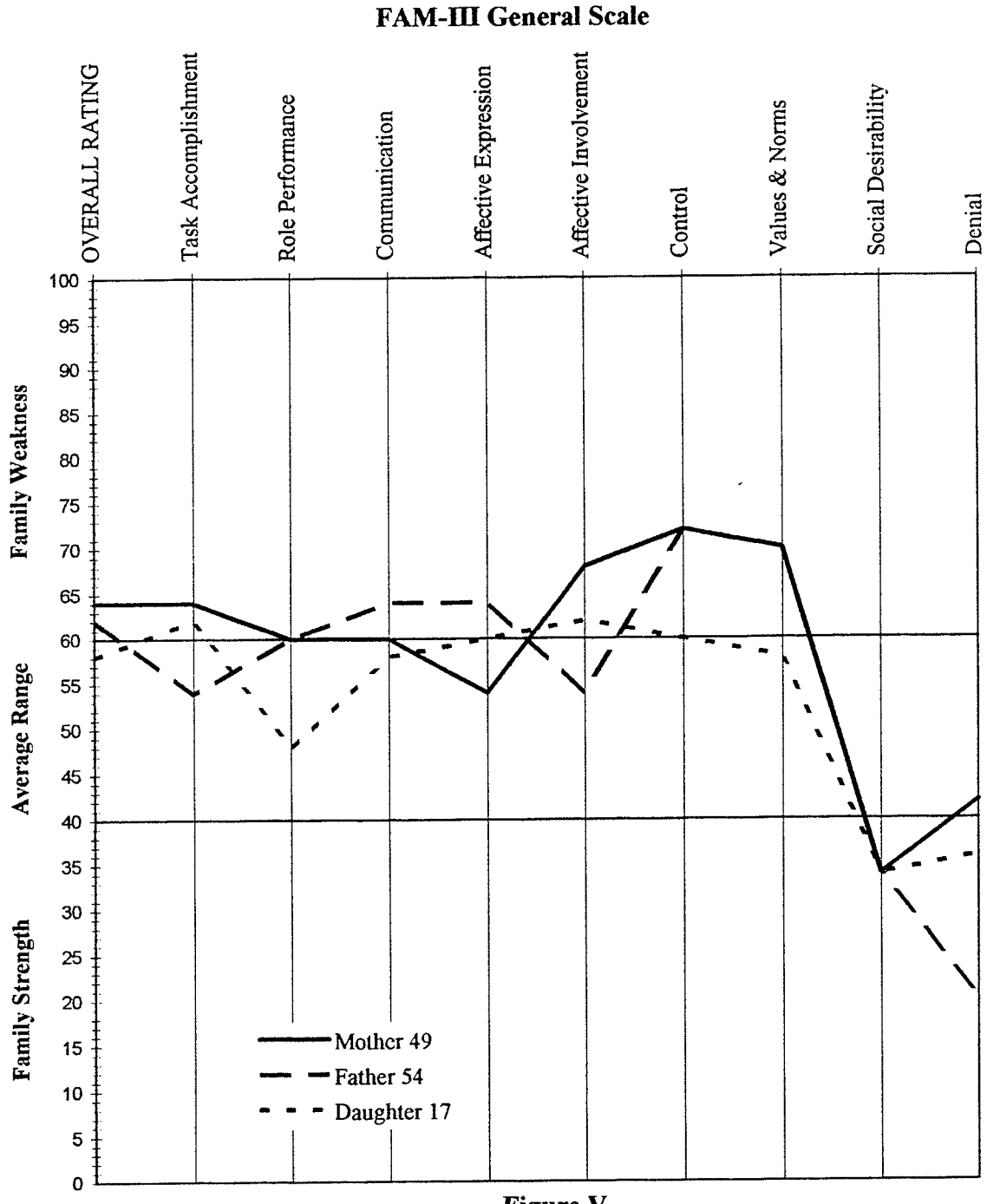

Figure V
Pre-test FAM-III profile for Family Three.

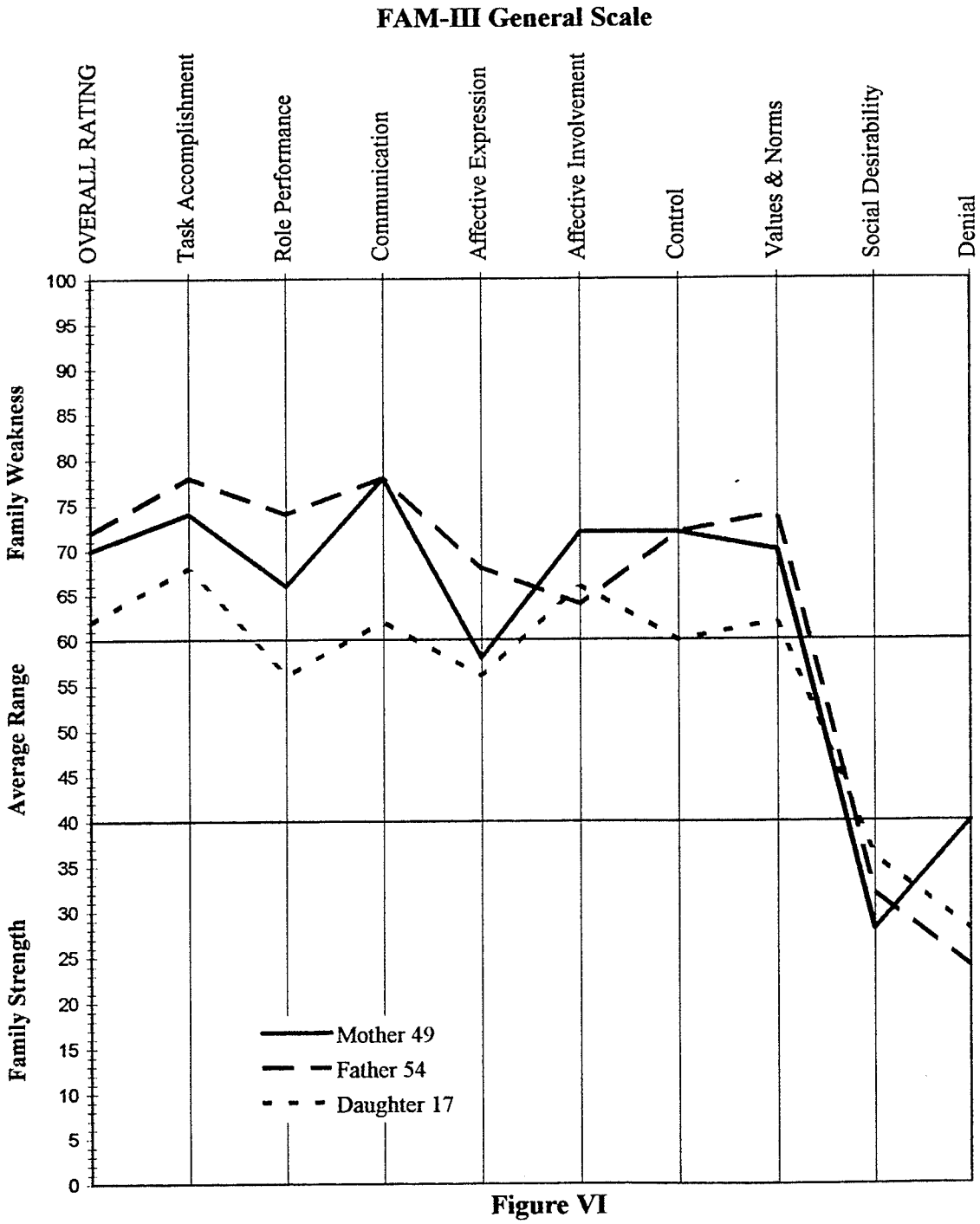

Figure VI

Post-test FAM-III profile for Family Three.

They stated that they felt disappointed that the family problems had worsened and perceived that Tara would do better in individual therapy without the family component.

Tara's perceptions of the family's weaknesses were less severe than those of her parents. Half of her pre and post-test scores fell in the average range. It made sense that the areas of concern to the parents were not as great of a concern for Tara since her actions and statements indicated that she wanted to be left alone. However, her scores could have been much higher in areas of affective involvement, control, and values and norms if she truly desired her parents to back off. It seemed that Tara's need to individuate coincided with a strong need to have her parents' support, family structure, and guidelines. Some of her behaviors were consistent with the effects of the sexual abuse, namely, that she required that her parents remained available and protective of her.

Cheryl's overall rating on the FAM-III went from 64 at the beginning of therapy to 70 at the end of therapy. Rick's overall rating jumped from 62 to 72. One interpretation of the increase in the parents' scores was that their perceptions of the family's levels of functioning had become more realistic. For instance, in the area of task accomplishment Rick had pre-test score of 54 and a post-test score of 78 while Cheryl had a pre-test score of 64 and a post-test score of 74. This significant leap suggested that family stressors were high and their abilities to respond appropriately were met with difficulty and little change. Scores in the area of role performance went from 60 to 74 for Rick and from 60 to 66 for Cheryl. These high scores were indicative of a lack of role integration and confusion around expectations of roles in the family. The change in the parents' perceptions of their roles was demonstrated in the family shift that occurred

when Cheryl acknowledged that she was taking on too much responsibility for attending to everyone's needs in the family. The disagreement between Rick and Cheryl around role responsibilities related to Tara also reflected a possible area of stress in their marital roles. Communication in the family was viewed as more of a problem at post-test. Rick and Cheryl agreed that communication had been masked and ineffectual in the family due to their avoidance and optimistic attitude that "things would take care of themselves". Once the family began to verbalize the effects of the sexual abuse the problem of communication became more apparent. It was believed that the difference of opinions created tension in the marital subsystem whereas prior to therapy Rick and Cheryl's perceptions were presented as more alike. Tara also expressed that the areas of task accomplishment, role performance, and communication had deteriorated due to "everyone going their own separate way and not listening to what anyone else has to say...we're more confused now". Tara's scores were generally consistent with her parents, although they were not as elevated.

The affective involvement subscale scores increased considerably for Rick. In the family, Rick may be the one most negatively affected by the lack of support and security. Tara appeared to go to her peers to have her emotional needs met and Cheryl had begun to withdraw her involvement and control in order to reinvest her energies towards herself. A surprising finding was that the control subscale remained the same for all family members from the pre-test to post-test. The issue of control was discussed in therapy and one of Cheryl's goals was to be less controlling which she had made positive steps toward achieving. Therefore, it would make sense that the area of control should have improved for the family. A possible reason for this discrepancy was the family's

unwillingness or inability to acknowledge the issue of control at pre-test. On the other hand, lack of change may reflect the ongoing power struggles in the family.

The Problem Checklist yielded similar results to that of the FAM-III. Areas of family concern were predominantly in the "very dissatisfied" category for both parents in the post-test. Cheryl's pre-test indicated that she was "satisfied" with most areas of the family. Tara's results fluctuated from the pre-test to the post-test. She listed mostly "in-betweens" in the pre-test which changed to "dissatisfied" in her post-test. Tara felt "very dissatisfied" with those concerns which involved her individual capabilities.

Family #4: The Walters

The Walters family consists of the grandmother Marie (age 58) and her granddaughter Anita (age 17). Marie's daughter Simone (Anita's mother) resides with her husband in another province. Anita's biological father resides in the same province as her mother. Anita moved to Winnipeg to reside with Marie when problems with her mom and step-father escalated to the point where Simone could not control Anita and thought it would be better for her to live with Marie. Anita had spent long periods of time with her grandmother before and therefore welcomed the idea of staying with her. However, Anita was under the impression that she would visit Marie for a few weeks while her family situation cooled down, yet Simone had informed Marie that this stay may be for good as Anita's step-father would not have her back in the family home.

Anita's placement with Marie had been difficult for their relationship was full of tension and conflict as they adjusted to their new roles. Anita's acting-out behaviors left

Marie feeling helpless and ineffective in her guardian role. Family therapy was recommended to assist Marie and Anita in their interactions and to strengthen the family unit in order for this placement to be a success. The referral for family therapy coincided with Anita commencing individual therapy with a clinical team member to address her personal issues. Anita was prescribed medication to address her anxiety that was seen to underlie compulsive behaviors (i.e., hair pulling).

According to Marie, the issue that precipitated the need for family therapy was her anger at how she and Anita interacted and dealt with things. She acknowledged that she would internalize her frustrations and anger and then she would flare up and release her temper in a fit of rage, usually directed towards Anita. Marie stated that Anita's temper was also easily triggered and their volatile interactions were a source of worry to her. Anita's medications were assisting her somewhat in that her behaviors were more manageable yet this area required further monitoring by Anita's therapist and psychiatrist. Marie's coping techniques during this time were poor as she acknowledged feeling depressed and suicidal, and had started to drink again (Marie stated that she was a reformed alcoholic). Although Marie was highly in favor of family therapy and wished to improve her communication with Anita, Anita was reluctant to attend. I saw Marie for a total of three sessions and, in addition, numerous phone contacts were made.

I met with Marie individually while Anita was encouraged and made to feel safe and supported by her therapist so that she could attend family therapy. It was hard to know how Marie's indirect comments about family therapy influenced Anita's non-attendance, however she was afraid of upsetting her grandmother and getting kicked out of the home. Anita had previously experienced family therapy as negative and not

helpful. There was an incident of Anita assaulting her step-father during a session. As Anita's individual therapy at the hospital progressed, she formed a strong connection with her therapist and feared her therapists's rejection of her based on information shared in the family sessions. Therefore, the feared consequences that family therapy held for Anita were far too threatening for her to engage in joint sessions with her grandmother in spite of reassurances made by me and Anita's therapist. It became clear that protecting Anita's therapeutic relationship with her therapist was in Anita's best interests and perhaps one of the few times she felt safe and connected with an adult figure in her life.

Once Anita's lack of readiness to engage in family therapy was accepted, Marie was given the option to continue sessions on her own to address personal and familial issues. She declined and informed me that Anita would be moving out as that was what they both had decided. I felt that it was important for Marie to formulate a plan around her relationship with Anita and anticipate any possible difficulties that would arise with Anita once she was living on her own. While there was the possibility that the placement could be salvaged, Marie was not interested in this. She felt that Anita moving out was the solution to their problems, and thus, family therapy sessions were discontinued.

The focus of therapy became two-fold. Firstly, it involved working with Marie and strengthening her as an individual while assisting her address her patterns and coping mechanisms. Secondly, it involved addressing familial issues, specifically, Marie and Anita's relationship and the living adjustments that were required.

Contracting and Goal Formulation

Since there were only three sessions with Marie, the contracting stage was in its beginning form when therapy was discontinued. Gathering a cultural and social history provided relevant information on family background that influenced patterns of behavior for Marie and Anita. Marie's expressed coping difficulties met criteria that indicated a suicide risk assessment be made. Although her risk was assessed as minimal, her depression and vulnerability to harm herself needed to be monitored. Marie stated that she was drinking to cope with her stress yet it appeared that she minimized her use and frequency. As a former alcoholic this increased her likelihood to start using alcohol again. Marie and I discussed her feelings of depression and the resources available to her in getting help. Marie had a scarce support system yet she was aware of helplines and agencies to contact if needed. I made a referral for Marie to be assessed by the Urgent Treatment Clinic (St. Boniface Hospital, Adult Psychiatry) regarding her anxiety, depression, suicidal ideations, and life stressors, however, Marie decided to have antidepressants prescribed by her family doctor as an alternative.

It was difficult to contract familial goals with Marie for she was unwilling or unable to take control in the guardian role. She relied on Anita to take the initiative and define their relationship yet became frustrated with how Anita's behaviors communicated the difficulties in their relationship. Marie gave Anita a fair degree of latitude and control for she feared the consequences of limit setting (i.e., Anita losing control). Marie's fear of upsetting Anita prevented an open and honest forum for communication. As Marie internalized what she felt, her frustrations built until she could no longer

contain them and exploded. Thus, a goal to work on individually with Marie which would impact on her relationship with Anita was to decrease her explosive outbursts of anger by examining the cognitive and behavioral factors that precipitated her explosiveness.

Theme of Adolescence in Family

Anita was in late adolescence preparing herself for the tasks of adulthood. Leaving her immediate family of origin provided a distinct opportunity for her to assume independence outside the home. Although she moved in with her grandmother, Anita rejected placing Marie in a guardian role and then decided to move out on her own rather than moving in with her father. In many ways, living independently was forced on Anita prior to her emotional readiness. Her living options and placements had been exhausted, leaving her little choice but to move out.

Anita's vocational goal was to complete highschool, however this task was poorly accomplished. Unknown to Maria, Anita had been missing school frequently. She demonstrated a stuckness in movement toward her life goals which placed her in the moratorium stage of identity (Marcia, 1966). I was unable to comment on Anita's motivation to complete school, yet it was clear that her ability to concentrate was diminished by the weight of her personal and familial stressors.

Anita's transition to adulthood was halted by her emotional delay and immaturity. She asserted her independence yet craved structure and the safeness of dependency. Practically, her life skills were poor and her decision-making impulsive which placed her

at risk for setting herself up in problematic situations. Anita's involvement with her peer group caused a great deal of concern and worry for Marie. Anita had assaulted female peers and her relationship with males was ambivalent and hurtful to her. Marie worried about Anita's anger with her peers and feared that once she moved out, her reliance on her peer group would increase.

The adolescent stage disrupted Marie's life cycle progression as she had not planned to be providing guardianship to an adolescent. The stage of adolescence had a distressing impact on Marie as she was reminded of her troubled adolescence. Marie commented on the stressors involved in parenting her children as teenagers, suggesting that this stage in particular held many intergenerational themes for Marie.

Metaframeworks Model

The Walters are a biological extended family in which the grandmother was acting in a guardian role. The family's composition was formed recently (past year and a half) which brought forth many changes for its two family members. Previously, Marie had been living as a single person while Anita previously resided with her mother and step-father. Operating as a single-parent household with Marie on social assistance made the financial situation constrained and stressful.

Marie's family life cycle tasks of being married and having children had been achieved. Marie's children are adults with families of their own. She did not expect to be in the position of raising any more children yet felt responsible to Anita since Simone had rejected her. Marie wanted to help Anita out yet she did not anticipate the stressful

impact it would have on her ability to function. Anita required a structured and stable environment which was unavailable to her. Marie's guilt in being unable to assist Anita in a healthy manner stemmed from her own life experiences in which gender and culture played a large part.

Marie's cultural background was Aboriginal, therefore she had grown up in an oppressed and marginalized cultural group in society. Her life experiences included being raised in fostercare as a child, physical abuse by her grandmother, alcoholism and suicide in her family, the death of her mother as a teenager, and numerous unhealthy relationships with men. Marie has had many profound losses in her life which she had repressed and failed to grieve adequately. She adamantly stated that she was tired and fed-up with all the misery in her life and wanted her present life experiences to be healthy and positive. Her desire to "rewrite" and change her family history was commendable in light of the difficult life circumstances she had survived. However, identification with Anita being moved around brought back many painful memories she would rather forget. Marie exhibited aspects of Post-Traumatic Stress Disorder which were intensified as she observed her grandaughter's troublesome experiences. Marie had shared aspects of her life with Anita however the negative effects served as reminders of her childhood which she worked hard to repress.

Anita's numerous moves and tenous relationships with family had contributed to her difficulty forming significant attachments. She had also encountered numerous losses that had formed a pattern of abandonment and expectation of rejection resulting in feelings of worthlessness and low self-esteem. A significant loss had been her close relationship with her brother whose wherabouts was unknown at the time. Anita's

family background has been one of chaotic functioning, instability, and upheaval. Marie suspected that Anita had been sexually abused although there was no disclosure regarding this. Disappointment for this adolescent has also been caused by the helping system's failure to address her needs in an effective manner in the past.

The impact of gender for Marie and Anita was extensive. Marie's relationships with former boyfriends and husbands had been exploitive and abusive resulting in depression and self-loathing behaviors. Anita's relationships with boyfriends were plagued by hostility, anger, and low self-esteem. Marie stated that Anita hated men which mirrored Marie's sentiment of her relationships with men. Marie had internalized feelings of inadequacy, guilt, and shame as a woman as she recalled her experiences of being trapped in unhappy relationships. Socialization and gender expectations had contributed to Marie being passive and accepting of her life circumstances. In the later stage of Marie's development she had been alone struggling as an older single woman marginalized by her culture, gender, and social class. Her dependency on others, especially men, had left her isolated with virtually no support system.

As an adolescent, Anita had encorporated her role as a female through pleasing and accommodating males in order to define her self-worth and be accepted. Her relationships with female peers was aggressive and assaultive as she attempted to have some control through victimizing someone of the same gender weaker than herself. Certainly, there were some indicators to suggest that Anita has been sexually exploited or abused.

The interplay of development, culture, and gender issues provided explanations for family patterns and behaviors that influenced Marie and Anita's current functioning and problem-solving abilities.

Brief Solution Focused Therapy Intervention

The technique of highlighting exceptions to problems was used in order for Marie to view the problems in a manner which suggested the possibility of solutions and change. It was believed that altering her focus would be instrumental in implementing feasible goals. It was difficult for Marie to envision changes in her situation with her granddaughter, for she felt she had no influence in effecting Anita's behaviors. All her previous attempts to instill control with rules and curfews had failed, leaving her feeling helpless and frustrated. Her failures recalled for her past failures and guilt in her roles of wife and mother in which she experienced herself as helpless. She expressed continous worry and fear regarding Anita which exacerbated her stress level and depression. Marie relied on Anita's attendance in family therapy for direction as to what her role should be with her. Therefore, the difficulty for Marie to imagine a more positive future related to her belief that she could not be part of the change process if she was not a valuable player. It was imperative to strengthen Marie as an individual before she could be empowered in her capacity as a guardian.

Questions promoting a focus on exceptions were directed towards the circumstances in Marie's life over which she had more control. For instance, questions such as: How will you know you are not feeling depressed?, How are you different when

you are not thinking about suicide?, What are you like when you do not worry about Anita?, What will tell you that you are feeling better about your problems?, and How will you know a problem has been solved? were all examples of forming non-problem states that were geared towards a life of functioning and adaptation (future state of solutions).

Marie had shown problem-solving skills in relation to her personal issues over the years; her experience and success in forming solutions was complimented. Her determination in times of adversity was demonstrated by making a family tree which placed parts of her cultural puzzle together in order to understand herself and where she came from. She had also created/reinvented a different reality for herself by refusing to be another statistic in her family lost to alcoholism or suicide. These changes contributed to Marie's reframing process and were instrumental in giving her the momentum and pride to continue in her solution-focused behaviors.

Assisting Marie cope in a healthier manner was a priority, therefore addressing her methods of expressing anger became a behavioral goal which I began to explore with Marie. Although she was encouraged to try something different to break up the pattern of response that kept her stuck, Marie's fears of intervening with Anita prevented her from doing so. She also hoped that medication would subdue Anita's behaviors and positively effect their interactions. After the sessions were discontinued I made a follow-up telephone call in which Marie informed me that she was helping Anita find a place to live with the confidence that this was the best course of action. Marie was prescribed antidepressants by her family doctor and reported she was coping much better now knowing that Anita moving out would improve their relationship.

Outcome Evaluation

None of the evaluation measures were given to this family. I was waiting for Anita to attend the session so both her and Marie could complete them together, however, this did not occur. Due to the few sessions and uncertainty of whether family therapy would continue with Marie the evaluation measures were not administered. I would speculate that scores in the subscales of the FAM-III pre-test would be considerably high in relation to the problems presented. As this family was in a crisis situation regarding their interactions and expressive abilities, the scores would likely be elevated and suggestive of problematic areas that were weaknesses for the family members. It would have been useful to compare Marie's and Anita's scores on the FAM-III to view how similar or different their perceptions were of the family's overall functioning.

Some of the family concerns on the Problem Checklist were verbally discussed in the session. It was clear that Marie was generally dissatisfied with all areas of the family and experienced feelings of low self-esteem at her inabilities to control the family situation.

Common Themes of Working with Families

Several common themes were present in my involvement with the nine families during the practicum placement. The themes generated ideas about what elements were helpful in understanding families in therapy and in which areas interventions could be

used effectively. Common themes which emerged were the following: (a) the impact of family composition on familial relationships, (b) the interrelatedness of development, culture, and gender as organizing principles of families, (c) the effects of adolescence on the family life cycle, and (d) changes in parenting skills required as families confronted different stages of adolescence.

The above four themes were all addressed in one way or another with the families regardless of the different problems/complaints each family brought to therapy. Examination of these themes may suggest commonalities amongst the client systems served that might assist in forming effective interventions. My particular interest was in how Brief Solution Focused Therapy was or was not an effective intervention in addressing these four themes.

Familial Compositions

The different types of family structures and compositions among the nine families were reflective of the changing social fabric of our culture. They included three traditional nuclear families, one family with adopted children, two blended common-law families, and three single-parent families. The female single-parents included a grandmother who was parenting an extended family, a single-parent as a result of widowhood, and a single-parent as a result of divorce. The diversity of family compositions reflects the changing roles of men and women in society. Full acceptance and understanding of the varied types of families has to be reflected in the field of family therapy and how we choose to intervene.

Issues raised by the Metaframeworks model may be different depending on the family's composition which the therapist needs to be aware of in assessment and treatment of the family member's needs. For instance, my work with single-parent families highlighted their economic and social class differences from other types of families. The stigma of being from "a broken home" is decreasing as single-parent households are increasing in numbers making it a normative and prevalent family environment (Faludi, 1991; Gorlick, 1995). This is not meant to glorify single-parents in any way, rather, it makes single-parent families a reality with a set of common issues and needs. For example, children of divorced parents experience long-term effects throughout their lives that children of non-divorced parents do not experience (Wijnberg & Holmes, 1992). The stressors faced by single-parents, usually women, are much more complex than those faced by two-parent families. Similarily, blended families of two parents have unique issues around parenting compared to families with two biological parents. Thus, parenting issues for all families may have commonalities, yet the familial composition will create its own problems and opportunities.

The relationships in families were affected by their composition. A teenage girl who was adopted at birth in her family, experienced being adopted to impact very strongly on her feelings of identity and sense of belonging. Her parents, secure in their roles when she was younger, were now feeling threatened and ovewhelmed with their daughter's interest in her birth parents. Clearly, the fact of the adoption was influencing the structure of relationships during this family's life cycle. In the blended families, the biological mothers were often caught in the middle between their children and their male partners. Coordinating parenting and discipline were ongoing tasks for these couples.

These issues were further complicated when the children resented and lacked respect for their relationship with the step-parent. One of the single-parents had initiated the divorce from her ex-husband therefore the children resented her for the family break-up. Their compassion and sympathy was extended towards the father for he desired the same as the children, for them to be an intact nuclear family.

BSFT is compatible with different family compositions and does not differentiate among them. However, the unique set of circumstances that exist in different familial compositions is not accounted for in the BSFT model. As it does not pay much attention to the emotional and developmental characteristics of relationships it does not predict the possible issues that different types of family compositions may experience.
For example, reconstructed families through divorce, remarriage, widowhood, and common-law relationships have issues of reestablishing boundaries, roles, and responsibilities which affect the family's ability to perceive and apply solutions. The lack of direction around the specific needs of different family types does weaken the BSFT model as it does not take into account the multivariate family roles which influence decision-making capacities and goal implementation.

The Interrelatedness of Development, Culture, and Gender

In all nine families, the Metaframeworks of development, culture, and gender intersected, highlighting the important effects they have on family members. These factors helped increase my understanding of family problems and why people may be behaving, thinking, and feeling the way they do. Family members' development, culture,

and gender provide valuable information on family patterns and family limitations which may be utilized in the assessment stage in order to plan appropriate interventions. These principles are also useful in viewing the family system as part of the larger social and cultural environment (Carniol, 1992; Imber-Black, 1989). This provided me with insight as to the larger dilemmas families feel constrained by.

Culture and gender affect perspectives that clients bring with them when they present in therapy. The culture and gender issues of clients interact with the therapist's culture and gender which pave the context of the therapeutic relationship. Culture was explicitly addressed with families four and seven as it strongly impacted clients' relationships with their environment and with their world view. Gender issues were strongly addressed with families two, three, four, and seven, however all the families were influenced by gender values in roles and responsibilities taken on in the family. In most families it was apparent that the women strongly identified with their roles as wife/partner and/or mother. Family stress resulted from the responsibility placed on the women by themselves and other family members. In families three, five, and seven, the men strongly identified with their careers and did not express feeling burdened or conflicted with their roles as parents. They were able to separate their individual roles from their parental roles much clearer than the women were able to do. The three men in these families all expressed that the therapy sessions interfered with their job committments and the family sessions were arranged around the men's work schedules. In family five, the therapy discontinued because the father was unwilling to make time for the sessions and it seemed unfair to address family issues with the mother and son without the father's involvement. Culture and gender are highly interrelated because

facets of one's culture define relationships and expectations in terms of one's gender. This in turn, influences the developmental tasks that are expected to occur in the different stages of the family life cycle.

As our traditional theories of culture, gender, and development are challenged and revisioned in the social work profession, practical dilemmas are created for individuals. For example, in family two the mother had fulfilled her development tasks of marriage and having children in her twenties but now faces dilemmas as a single-parent with two adolescent children while she returns to school for post-secondary education. Nowadays, the family life cycle is affected by the both the priority and emphasis placed on education by women and increase in the ages for meeting the tasks of marriage and childrearing. Family seven experienced conflicts in parenting styles between the two parents. The approaches in parenting reflected two very different cultural backgrounds of Mennonite and East Indian in which values and cultural practices were opposed. Themes of culture also carried over into the marital relationship resulting patterns of stuck behaviors and hostility between the couple.

The family life cycle affected each family differently according to where each family member was in terms of development. Disruptions to the family life cycle affected the family members' developmental needs and ability to meet them. Aldous (1978, cited in Wijnberg & Holmes, 1992) identifies a prominent stage of development for single-parent women as instituting or reinstituting their careers once the family unit is in a process of being reconstructed. The reorganization which occurs for families has salient implications for family roles, especially for the parenting role. The BSFT intervention unfairly assumes that everyone is at the same level to make goals without

any reference to generational patterns of development, culture, and gender which affect decision-making, problem formulation, and the range of solutions they have access to. BSFT does not eradicate problems which may need to be addressed through a long-term process of recovery and change.

Each family was in the family life cycle stage of adolescence which brought forth a great deal of stress and confusion. The theme of adolescence was common for all families and presented some common issues.

Effects of Adolescence

Understanding adolescent development and age-appropriate tasks enhanced my understanding of the stressors these families were facing. It was helpful to have a clear idea of how parents were responding to their adolescent's struggles with autonomy and identity and to what extent this was encouraged or hindered in families. The meaning of adolescence depended on the family's perception of what this family life cycle stage held for them. It was important to assess how adolescent themes appeared in various cultures rather than make universal assumptions about them.

As adolescence can be a crucial stage in terms of difficulty and family conflict, previous unresolved family issues are highlighted, especially between the couple relationship in the family. This was shown to be the case in families three, five, seven, eight, and nine. In families five, seven, and eight it appeared that the adolescent had clearly been triangulated into the couple's marital problems.

Knowledge of adolescent development assisted me in identifying normative behaviors that are appropriate to this stage in the family life cycle as well as recognizing those issues that are reflective of the family's inability to adjust to the adolescent stage. Contextualizing the family's transitional dilemmas enables understanding and recognition of the family's patterns which are no longer effective.

Meeting with the adolescent subsystem and the sibling subsystem can be significant in widening the therapist's understanding of familial issues. It also gives the message to children in the family that their viewpoints are relevant and respected regardless of their ages, thereby acknowledging that their participation is valid and necessary.

Talking to the adolescent and seeking his/her understanding of family problems is crucial as blame is often projected on this person as the identified patient. Adolescents may appear resistant to family therapy, however their non-compliance may be due to the inability to express themselves without conflict with their parent(s) or the belief that the therapist, another adult, will side with the adults and could not possibly understand the problems of a teenager (Young, 1991). Unless the therapist takes the time to give importance to the adolescent as an individual in the family context, the teen may retreat and withdraw in therapy.

Ackerman (1980) believes that families of adolescents initiate treatment for four major reasons. Firstly, there are marital difficulties and stressors which may reactivate unresolved issues between the couple and there may be a triangulation of the adolescent and the marital relationship. Secondly, the symptomatic behavior of a younger sibling may take on a focal role as the adolescent separates from the family or draws the sibling

into the family conflict. Thirdly, the symptomatic behavior of one of the parents is exacerbated and comes to the forefront as the adolescent separates and the parent(s) reflect on life goals and interpersonal relationships, especially those in the family of origin. Fourthly, the symptomatic behavior of the adolescent may range from minor behavioral problems to serious psychiatric issues. Symptoms may exist in one or more areas yet it appears that the adolescent life cycle stage brings other issues to the forefront and the symptomology of teens is the most common factor in families seeking treatment (Preto, 1989).

BSFT does not specifically address stages of the family life cycle or give direction around adolescent themes. Some authors who have used BSFT with adolescents and their families see the benefit in exploring past family issues which may reappear during the adolescent stage. BSFT does acknowledge that family behaviors may be serving a functional aspect in preventing other drastic family secrets from emerging yet feel it is up to the family if they wish to explore these issues. I found this rationale unhelpful, especially where issues of safety for children and adolescents are of prime importance. Placing issues of family/parental responsibility on to the adolescent creates a great deal of conflict and turmoil in the family relationships and for the individual. In the practicum setting, an understanding of adolescent trauma is extremely important as many of these adolescents and their families have experienced traumatic events and multi-system breakdowns. Working with adolescents involves addressing the generational issues of trauma and empowering families to feel safe enough to share their feelings and life stories.

The developmental processes for adolescents are affected and/or distorted by layers of trauma which may impact the interpersonal realm and impair coping skills and sense of self-worth. The limitations of BSFT and the Metaframeworks model is that they do not address the experience of traumatic events on adolescents and the intrapsychic effects which result.

Learning Parenting Skills

Concentrating on the parent(s) acquiring new skills and techniques in parenting an adolescent became a focus for almost all of the families. As the presenting problems were defined and my understanding of them broadened, the need to work separately with the parent(s) became more of a priority. It also became clear that whatever worked for the family in the past was no longer helpful, therefore applying "more of the same" solution yielded the same negative results. For some families, the problems existed for a long time prior to adolescence, thereby making the defeating patterns more entrenched in familial interactions. It was important to improve parenting skills while at the same time empowering the parent. BSFT is helpful to parents in addressing behavioral problems, it is not helpful in teaching one how to parent. There were differences in parenting issues dependent on the family composition, especially with a non-biological parent attempting to implement rules and discipline. In my experience, women were often caught in the middle between their partner and their children as they took on most of the responsibilities in parenting.

In order to intervene effectively, seeing the parent(s) as a subsystem was helpful in implementing change in the family. Working with families often means meeting with subsystems in order to bring about change. This provides family members with the opportunity to speak freely and without fear of the reactions of other members. I found that working with the parent(s) separately from the adolescent(s) enabled the parent to feel empowered without losing credibility in front of their child(ren). There are important marital and parenting issues that should not be addressed in front of the children. Subsystem work with parents will effect change in other parts of the system, including interactions with the symptomatic adolescent who may not actively be involved in the therapy. As the parents responded differently to their adolescents' behaviors, the family structure would automatically be altered and bring about different outcomes. Teaching parenting skills became part of the intervention that stimulated change towards the desired outcome.

Addressing parenting issues often meant educating parents on the needs of adolescents and the implication on parenting style. For instance, are the family's boundaries a result of an authoritarian style of parenting or is the parenting so permissive that there are no realistic expectations? The parents in families two and three were unable to provide structure and clear expectations because they felt that their adolescents needed their freedom. They did not understand the need to provide a healthy balance of active and involved parenting with semi-permeable boundaries for young people to express their independence. Conversly, the parents in families five, seven, eight, and nine operated in an authoritarian manner in which their control and rigidity was met with rebellion and power struggles from the adolescents in these families.

In working with the families, it became clear that new skills were required in parenting an adolescent, however, for many parents this involved a sense of feeling capable and confident in their abilities, which was often lacking. The connection between empowering and strengthening the individual so that roles may be actualized was a prevalent theme. BSFT does not help prepare parents to feel confident in their roles because it does not explore the constraints people are experiencing. Rather, BSFT provides suggestions and ideas as to how parents can respond to their children's behaviors. BSFT techniques such as scaling questions and viewing exceptions may be useful in assessing the different levels people are at in terms of their feelings about a problem and how they measure the rate of success of their goals being achieved. I found that subsystem work and exploring parental roles needed to occur so that parents could feel understood, supported, and confident in viewing exceptions and then formulating a plan to generate solutions.

CHAPTER SEVEN

Critique of Practicum

Evaluation of Professional Learning

I feel that my learning goals were met by the following sources: clinical supervision, observation of other therapists in clinical practice, personal reflection on learning, and clients' feedback.

Clinical supervision provided me with on-going learning in which I could assess my skill development as a therapist and implement changes in my work with families. I found the supervision sessions extremely helpful for they provided me with an opportunity to ask numerous questions, to brainstorm different hypotheses and seek consultation to gain perspective in viewing families. I also learned a great deal about myself through the supervision sessions as I was encouraged to think of my subjective self in relationship to families. This was a new process for me as I tended to want to view things in objective and neutral terms in the past, which meant minimizing or ignoring uncomfortable feelings. I became more aware of how things and people affected me and the decisions I made as a result of this reaction. I realized the importance of my subjective experiences and how they impacted my abilities as a therapist in approaching isssues or having "blind spots" for protective purposes. According to Kerr (1984) the emotional changes occurring within the learner are increasing one's ability to distinguish behavior that is based on thinking with that which

is based on feelings and the emotional process. Reviewing my family of origin issues was a starting point to think in systems terms regarding human behavior.

Clinical supervision was also provided through live-supervision by observing my family therapy sessions behind a one-way mirror. Although this style of supervision was new for me and initially left me feeling nervous, I found it an excellent method of learning. The families observed were fairly relaxed and adapted to the knocks on the mirror to call me out of the session for feedback from the supervisor(s). It was supportive and useful to have ongoing feedback while I was in a session, especially, when I felt stuck or unsure of how to proceed. The team approach behind a mirror with scheduled consultation breaks and feedback to the family is regularly used in the BSFT model. I was able to explore the usefulness of this application for my learning and for the family's benefit. Most families appreciated the attention of a few professionals and the different perspectives on their problems.

The "compliment" delivered at the end of the session after the consulting break carried more credibility and weight coming from the "team". It also heightened the family's expectancy for negative feedback so that when positive feedback in the form of compliments was given, it promoted a "yes set" of thinking which validated and accepted the clients. People's responses to compliments as evident in their verbal and body language suggested that they felt understood and resulted in a shift in thinking and behaving. Highlighting and punctuating the family's healthy patterns and positive change is believed to promote a "ripple effect" of change which emphasizes future successes and an expectation of change for the family (de Shazer, 1985).

Observing other therapists behind a one-way mirror or as a co-therapist in the session was another valuable method of learning. It was valuable in that I watched different styles of therapists and theoretical approaches with families which expanded my knowledge and gave me some new ideas on how to do things. It also made me aware that others make mistakes just as I do and that it is a lot more difficult being in the session than behind the mirror as a detached observer. Working with a co-therapist was challenging in coordinating the session but helpful in being able to rely on someone else while in the session. It was also helpful to receive feedback from the co-therapist and consult on different perspectives in viewing the family.

Reflecting on my personal learning I saw many changes in myself and in my skills as a therapist. Important changes were my ability to look at families more systemically with a better understanding of families and their problems. I feel that I increased my knowledge of family therapy concepts and implemented them in my work with families. My interviewing skills and questions changed from individually focused to systemic and interactional in the family sessions. These changes were given as feedback by supervisors.

Learning more about my therapeutic use of self enhanced my self-confidence and ability to provide leadership in sessions. For example, I feel that I did not back down from confrontations yet was still able to be supportive and understanding. I feel that being able to define resistance differently resulted in more patience and success when encountering obstacles with families. The therapeutic role or relationship the therapist takes on in the context of family therapy is a critical one that must be well-thought out in advance. Often, theoretical models will provide direction on the therapist's role in

relationship to the family. A diversity of labels such as: coach, consultant, teacher, expert, colleague, helper, advocate, and so forth may be employed. It is important to communicate to families what you perceive your role to be and see if it matches their expectations. If clients want something of you that is not feasible, discussion and negotiation around this issue is crucial. If therapeutic roles are not addressed there will be obstacles, lack of cooperation, and frustration in meeting therapeutic goals.

My mind-set and attitudes about families was revised in that I learned to view all family members individually and as a family unit. This was important because my previous experience in child welfare had me advocating for the child and forming a strong alliance with him/her. I needed to place the parental responsibility with the parents and not take on the parental role in therapy. This in turn, made me conscious of staying away from triangulating with the adolescents or the parents. It took some practice, but my judgement in forseeing this possibility did improve.

My skill acquisition of BSFT techniques was inconsistent. I required more practice in uniformly applying BSFT methods for all families. I spent time exploring the exceptions to problems and complaints yet identifying these were sometimes difficult for people. I found that I relied on other concepts (structural family therapy) as they fit more appropriately in understanding the family interactions and hierarchies. Where I did feel I learned the most from BSFT was in its practice principles and philosophy which helped considerably in understanding how to help families solve their problems. In examining the efficacy of BSFT as an intervention, I also desired clinical skills to use this approach in working with adolescents who have experienced trauma. Often, addressing that trauma for families meant exploration of the family's past and the telling of their story.

Taking into account the effects of trauma for family members meant approaching the BSFT intervention in another way. Similar questions could be asked but the sequence and time spent on issues may be longer in duration. Selekman (1993) comments that in his practice of solution-oriented brief therapy with difficult adolescents, the families should be able to have the opportunity to talk about negative treatment experiences and past traumatic events as this provides the therapist with information of what he/she needs to do differently. If there is denial or repression of past issues, this may be detrimental for clients who may require a safe environment to become angry or ventilate so that they have the opportunity to resolve things. For adolescents and families who have experienced trauma, the inability to express emotions has resulted in avoidance of their interpersonal realm. Once again, the interventions explored do not address the effects of trauma on the individual family members.

The therapist must connect on some level with all family members in the first session. Failure to do so will result in the likelihood that the family will not return for a second session (Herz-Brown, 1991). As therapy is considered to be a female arena of emotions and talking, males are often hesitant in coming. Usually, therapy is initiated by a female family member and the therapist is often female, therefore, it has been suggested that steps be taken to make males feel welcome (Herz-Brown, 1991). It is important to invest energy into understanding men's role in therapy by making the environment conducive to them feeling safe enough to attend (Neal & Slobodnik, 1991). However, overaccommodating to men has the danger of absolving them of their responsibility in participating in therapy (Imber-Black, 1989). Therapists must balance

gender roles so that we do not over affiliate with one gender and perpetuate a gender imbalance in the therapeutic context.

Verbal feedback that was given by a few clients was generally positive. The Client Feedback Checklist and Questionnaire gave some feedback on my qualities as a therapist and how each family member perceived the therapeutic services rendered. A similar comment made by clients is that they felt supported and understood in therapy. I felt that I was able to connect fairly well with most of the family members, and in particular, with the adolescents. Some of the comments around the intervention suggested that some family members felt as if they still needed to learn new ways of solving their problems and were unable to see their future in a positive light.

I felt that the above sources of learning helped me meet my primary learning goals of developing skills with families and with an adolescent population in the area of family therapy. I was also able to assess my therapeutic use of self in direct practice and through supervision. A secondary goal of observing and learning from other team members was met and quite valuable in learning varied approaches to family therapy.

Strengths and Shortcomings of Brief Solution Focused Therapy

I found the philosophy and practice principles of BSFT to be its biggest strength. Its emphasis on promoting positive change in clients through accepting and utilizing what they brought to therapy is validating and empowering. The cooperative shift in therapy is significant in establishing an egalitarian context of relating between the therapist and client.

The cooperative context of therapy is helpful in providing a positive approach for families who have experienced system failures or were labeled as resistant and difficult clients. Often, families are viewed as resistant because of their involuntary participation. This affects the therapist's resistance and defensiveness leading to further isolation of the family. BSFT urges the therapist to take responsibility for how the roles in therapy define the outcome or potential for change.

Promoting exceptions and defining non-problem states makes BSFT a therapy about growth and change. It attempts to decrease the focus on problems and non-change by accepting change as inevitable and required in perceiving and creating a positive future. Creating a hopeful attitude in families is done through the usage of solution focused language, compliments, and reinforcement of people's strengths and survival instincts in times of crisis.

BSFT is very much a client-based model which attempts to address those issues that are most relevant to the clients' current functioning level. No detailed assessment or probe into the past is required. This may be extremely appealing to clients who do not wish to be reminded of painful issues. By starting in the present, clients may feel relieved that they will not be judged for past mistakes or overwhelmed by negative experiences. The focus on the present aims at problem-solving and future solutions rather than an emphasis on problems and the family's inability to have solved them.

I felt that a strong assessment of familial issues was required and therefore exploration into the family's former patterns, structures, and interactions was done. For treating these families it was important to have a grasp and understanding of the effects of trauma and transgenerational issues. The psychological injury inflicted by trauma

results in feelings of powerlessness, distrust, shame, and low self-esteem (Armsworth & Holaday, 1993). These negative feelings are not conducive to clients feeling confident and capable in making decisions. Therefore, the expectation of goal formulation in the BSFT approach appears unrealistic. The disempowerment clients feel as a result of trauma must be addressed in order for clients to feel understood and supported in their abilities. Often, the family's functioning was a result of interrelated factors which made issues complicated and long-term. de Shazer (1985) talks in great length of there being no need for an assessment or past information in order to help people find relief from their problems. However, he also states that there must be a good fit between the client's complaint and the intervention if new behavior is to be initiated (de Shazer, 1985). Therefore, time needs to be taken to clearly understand and define the problem/complaint.

I felt that the Metaframeworks model and other family therapy concepts provided the framework to understanding the family's problems in a context. Issues of development, culture, and gender are not explicitly stated in the BSFT model, even though they may be implicit in the client's world view. Berg and Miller (1992) state that the Brief Family Therapy Centre has been successfull in treating different ethnicities with the BSFT approach. They offer some different ways of asking questions that are culturally sensitive and may represent a shift in thinking systemically (Berg & Miller, 1992). However, overall the emphasis on culture, gender, and development has been overlooked in the BSFT literature. The lack of understanding around why people may have difficulties in finding solutions is not addressed in BSFT. BSFT operates under the purpose of solving problems and establishing behavioral criteria for change, but it does

not account for changing why these problems exist. Decision-making and contracting goals in the BSFT approach assumes that all clients have the ability to do these tasks without any thought of the macrosystemic influences on people's lives. The need for empowering clients is related to a multitude of complex factors and life experiences in which the Metaframeworks play a predominant role. Carniol (1992) in his discussion of progressive social work practice based on Maurice Moreau's structural approach, rejects the status quo model and states the following:

> Empowerment is examined with reference to the social worker's actions in: maximizing client resources; reducing power inequalities in client-worker relationships; unmasking the primary structures of oppression; facilitating a collective consciousness; fostering activism with social movements; and encouraging responsibility for feelings and behaviors leading to personal and political change. (Carniol, 1992, p.1)

Exploring the above facets of empowerment is very much required yet not completely provided for in the BSFT model. There is an emphasis on an egalitarian and collaborative relationship between therapist and client where responsibility for change and solutions are placed with clients. However, there is little emphasis on empowering clients with their larger systems or attempting to change the larger systems.

There have been recent shifts in the orientation of the BSFT model. One of these has been the "integration of emotion in solution-focused therapy" (Kiser, Piercy, & Lipchik, 1993) which addresses why clients may have difficulties expressing exceptions

to problems or in viewing a positive future. These authors feel that emotions and the role of affect play a large role in instilling change, especially where themes of loss, trust, and abandonment prevail. In the context of family therapy, emotional responses have "the effect of increasing empathy and interpersonal sensitivity among family members (Kiser et al., 1993, p. 239). I feel that this shift is important, necessary, and a positive step in helping people feel understood and heard. Clients may be better able to identify with the exceptions to problems if they experience a validation of their emotions. Through my practicum experience, I have learned that families are complicated with complicated issues which require a sensitivity and committment on the therapist's part to explore past hurts and grievances that tap into the emotional aspects of people's lives.

I feel that the strengths of BSFT have to be complemented by an integration of other frameworks in order to completely understand and treat families. The BSFT approach may work well on its own if problems are short-term and strictly behavioral in nature. However, complex familial issues may require long-term work which addresses why problems exist alongside with work to finding the solutions for them. Exceptions to problems may provide some assessment information but perhaps not enough or not the right kind of information needed. de Shazer (1988) acknowledges that BSFT may not be effective if exceptions are unable to be stated or the therapist and family have large differences around what should occur. It appears that implementing a Metaframeworks approach provides an in-depth analysis on how to improve family functioning so that solutions can be generated and long-term success in changing family patterns may be achieved.

There are many benefits in the techniques and practice principles of BSFT which I would like to integrate in future practice with families. I have found that this model challenges old beliefs and offers new ideas about how to view people and the process of change. It promotes creativity in the therapist and family by trying unique methods of solving problems that are of value if they work for the family. BSFT is an approach which can be used easily with other theoretical models, thereby making it flexible.

Overall Critique of Practicum Process

I found the hospital practicum setting an excellent environment for professional learning through direct practice and observation of other professionals. Being part of a multidisplinary team enhanced my knowledge of clinical issues affecting adolescents. The psychiatric treatment setting offered an introduction to conceptualizing adolescent trauma and to the use of psychiatric medical diagnostic criteria (DSM-III-R). I also had the opportunity to participate as a co-facilitator in an anger management group for adolescents, and to observe the adolescent sexual abuse survivors' group. The group work experience afforded me the chance to work with adolescents in a different treatment modality to have a better understanding of their individual needs.

The families I worked with offered a variety of presenting problems and a range of family compositions which made the work interesting, challenging, and full of potential for learning about family therapy and oneself as a therapist.

The use of evaluation measures with families was new for me. I found them interesting and informative tools in broadening the assessment of families. I would like

to continue encorporating evaluation measures in my future work with families as they are helpful in assessing the effectiveness of the efforts of the therapist and the clients.

The practicum process has instilled a great deal of valuable learning for me personally and professionally in the field of family therapy.

Conclusion

In providing a conclusion on the BSFT intervention used with families with adolescents, I will attempt to integrate the learning themes which were the most helpful for me.

Applying BSFT in the context of understanding how issues of development, culture, and gender impact family members provides an integrated approach in treating families effectively. By understanding the needs of different families through the Metaframeworks model I have been able to approach therapy with more clarity, direction, and focus. Through the BSFT approach I have increased my knowledge of how change can be achieved with the solution focused philosophy and techniques. Conceptualizations of adolescent development and the family life cycle have provided a framework for assessing problems and solutions that families encounter at the adolescent stage of development. The above considerations create a context for each family in which what they bring to therapy is "accepted and utilized" to promote change in the right direction. It was important to view that change was not adequate if it was change in the wrong direction or was continuing to create harmful effects for clients. Once people know what they need to do in order to alleviate a problem, there is a great deal of risk in

following through. Therefore, change can take on a different direction or the problem can be seen as serving a functional aspect which is safer than change.

I found the intervention of BSFT to be most helpful in working with families with adolescents for the following reasons: it builds on families' strengths and provides momentum in generating solutions, it respects and maintains that clients know what is in their best interests and they have the capabilities to promote positive change, it is a cooperative and encouraging intervention that validates and supports family members, and it creates a therapeutic climate that is egalitarian and collaborative.

Integrating an understanding and focus of family development, culture, and gender is a necessary component of family therapy which I will continue to pay attention to and implement in my work with families. Relying on other family therapy frameworks and concepts as they best served each family has broadened my understanding of systemic interactions and relationships.

In assessing my skill development as a therapist, I have shown improvement in areas which I have been able to witness and evaluate. I have also been given suggestions and guidance as to what I need to pay attention to in order to continue being effective in my work. Most significantly, being able to differentiate between content and process of therapy has been valuable in viewing families and change.

Integrating all the pieces of learning through the practicum and in the writing of this report will be an ongoing endeavor for me. I feel that I have a valuable understanding of families and my abilities in helping people. I look foreward to applying this new found knowledge in clinical practice with adolescents and their families.

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APPENDIX A: The Family Assessment Measure (FAM-III) (pgs. 188-190)

Appendix B: The Family Problem Checklist

FAMILY PROBLEM CHECKLIST

Below is a list of family concerns. Indicate how satisfied you are with how your family is doing now in each area. Put a mark (X) in the box that shows your feelings about each area.

	Very Dissatisfied	Dissatisfied	In Between	Satisfied	Very Satisfied
1. Showing good feelings (joy, happiness, pleasure, etc.)					
2. Sharing feelings like anger, sadness, hurt, etc.					
3. Sharing problems with the family					
4. Listening and understanding					
5. Being patient or calm with others					
6. Showing care and concern					
7. Being positive, saying nice things about others					
8.Knowing what behavior to expect at different ages					
9. Dealing with matters concerning sex					
10. Making sensible rules					
11. Being able to discuss what is right or wrong					
12. Taking on responsibilities					
13. Encouraging others to take on responsibilities					
14. Use of self-control					
15. Proper use of alcohol, drugs					
16. Deciding, agreeing upon discipline					
17. Being consistent with discipline					
18. Participation in family fun and recreation					
19. Making individual decisons					
20. Making family decisions					
21. Making contact with friends, relatives, church, etc.					
22. Dealing with stress					
23. Feeling good about our family					
24. Feeling good about myself					

Appendix C: The Client Feedback Checklist

CLIENT FEEDBACK CHECKLIST

Below is a list of questions concerning the counselling services you have received. These questions provide information about what was helpful, what was not helpful, and how the services you received could be more helpful.

Put an (X) in the box that best describes your opinion about the services your counsellor has provided.

	Very Dissatisfied	Dissatisfied	In Between	Satisfied	Very Satisfied
*Keeps to appointments and time commitments					
*Communicates clearly					
*Demonstrates an understanding of our family					
*Provides suggestions that are helpful					
*Demonstrates a sense of humor					
*Provides a relaxed atmosphere					
*Helps family to find own solutions					
*Provides information in a way that is not imposing					
*Demonstrates warmth					
*Helps family to see things differently or in a new way					
*Overall quality of service					

*Note: Permission to use this checklist given by Frank Cantafio

Appendix D: The Client Feedback Questionnaire

The following questions are for you to provide feedback to the therapist on the services you have received. Your input is very valuable in providing information on what has been helpful for you and what could be improved in providing quality service. Thank you for your assistance and time in completing this form.

#1a: Based on the reasons that brought you to family therapy, what has changed in your family?

#1b: What has remained the same?

#2: What did you personally find the most helpful in the services you received?

#3a: What did you personally find the least helpful in the services you received?

#3b: What could be improved upon?

#4a: How have the relationships in your family changed?

#4b: How have they remained the same?

#5: What solutions have you formed in viewing your family problems or issues differently?

#6: How do you feel about bringing the therapy to a close and/or terminating services?

#7: What do you think the future looks like for you and your family?

ANY ADDITIONAL COMMENTS???