Structural and Solution focused therapy augmented by a feminist approach: Is it effective with mother-led families?

By

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ABSTRACT

More and more social work practitioners are using a number of theoretical approaches when working with families to enable them to select from a wide array of tools and techniques with which to help clients. This practicum report outlines the process of working with single mother families using an integrated approach, including structural family therapy and solution focused therapy, augmented by a feminist approach to ensure gender sensitivity.

The practicum took place in a counselling centre in the inner city of Winnipeg. Eight families received services in total, with families receiving a combination of individual and family therapy. Some families attended frequently with the number of sessions ranging from one to eleven. The Goal Attainment Scaling Measure, a client satisfaction questionnaire, and the therapist's observations were used for evaluation purposes. This report discusses themes, highlights and factors to consider when integrating these social work approaches. It also discusses the challenges of evaluating practice with this population. Finally, the learning experience is reflected upon in detail.

CHAPTER ONE

Objectives and Rationale for the Practicum:

This practicum integrates the approaches of structural family therapy and solution focused therapy with single parent families to develop assessment and intervention skills grounded in these approaches and to assess the effectiveness of utilizing an integrated approach with single mother families in a community based family counselling setting, Elizabeth Hill Counselling Centre. An assessment model founded upon structural family therapy, augmented by a feminist perspective to ensure gender sensitivity is used to provide a blueprint for how the family functions and a solution-focused intervention is used to highlight and enhance behaviours that lead to solutions.

My primary purpose for enrolling in the Masters of Social Work Program was to further develop my clinical skills with clients who present with a variety of different issues and problems. As I examined my work experience since entering the profession of social work, it became evident that I am adept at the case management function and at assessing families' functioning and children's well being from a child protection standpoint, but I struggle with the application of therapeutic interventions. Whatever my long-term career goals, whether they be to continue to work in the field of child welfare or move to another setting, knowledge and expertise in the area of family therapy would increase and enhance the skills I bring to any position, regardless of the environment. Given that my experience in family therapy is limited, I chose to focus on the structural

family therapy model to gain a solid base in family therapy and incorporate a solution-focused approach because of its emphasis on strengths and solutions.

It also became apparent to me when I looked at my work experience that many of the clients involved in the child welfare system are single mothers, due to the stress that their life experiences and circumstances produce, therefore I decided to focus on this population group. Single parent "...families comprise a large and growing segment of adults and children whose present and future well-being is frequently at risk" (Lero & Brockman, 1993, p. 91). Within Canada, 19% of families with children are headed by single women and within Manitoba 18% of all families with children are headed by single women (Stats Canada, 2000). Single mother families have the lowest incomes of all family types (Stats Canada, 2000). Further, Aboriginal women are more likely to be mothers and single parents than any other Canadians (Minister of Indian Affairs and Northern Development, 2001). A recent study completed by Winnipeg Child and Family Services titled "Families Returning for Service" (2002), which looked at the types of families being serviced over a 15 month period found that 58% of the families were headed by a single parent, suggesting that this type is at risk for difficulties and requires closer examination. Unfortunately, this study did not breakdown the families by the gender of the head of the household. However, my experience in the system suggests it is safe to assume that the vast majority of the single parents were mothers. This is not to say that single parent families are all unhealthy or experiencing problems, however single parent families are disproportionately represented in the child welfare system and at risk of experiencing a variety of problems. It seems prudent that social work examines the

most effective and helpful methods of assisting single parent families, given the frequency with which they require assistance and service.

Specifically, my learning goals in this practicum were the following:

1. To develop and strengthen assessment skills from a structural family framework.
2. To learn how to incorporate a feminist perspective into my practice, to ensure gender sensitivity.
3. To develop interviewing and intervention skills in solution focused therapy.
4. To become more effective at focusing upon process when working with families.
5. To become more adept at developing rapport and joining with families and to develop effective termination skills.
6. To increase my knowledge and understanding of the issues facing single-mother families.
7. To begin to develop my own personal style as a family therapist.
8. To develop knowledge and skill in effective evaluation procedures and data interpretation.

The goals of the intervention were to reduce or minimize the difficulties presented by each family and to determine whether the integration of solution focused therapy and structural family therapy, augmented by feminist principles was a useful approach to utilize with single-mother families. The individuals and families seen in this practicum experienced a range of problems, such as separation/divorce, parent-teen conflict, domestic violence, parenting difficulties, including children coming into the care of Child

and Family Services, sexual abuse, poverty and substance abuse. A small portion of the families included in this practicum were Aboriginal.

This practicum report begins by reviewing the literature on single mothers, including the specific issues faced by Aboriginal single mothers, structural therapy, feminist theory, and solution focused therapy. Following that, there is a chapter that outlines the intervention used in this practicum, including a description of the practicum site, procedures, supervision, families, and evaluation measures. The fourth chapter discusses the effectiveness of blending together the two primary approaches utilized in the practicum, structural therapy and solution focused therapy, which were augmented by a feminist approach. It also articulates themes that emerged and highlights learning that took place. Finally, the last chapter examines my personal growth and learning during this experience.

CHAPTER TWO

LITERATURE REVIEW

INTRODUCTION

This literature review is divided into 5 sections. The first section provides a profile of single-mother families in Canada and some of the contextual issues and problems they may encounter, including a discussion on Aboriginal single mothers. The second section reviews the assumptions of structural family therapy, followed by a very brief overview of the assumptions of feminist theory. The third section reviews the assumptions of solution-focused therapy. Finally, the last section focuses upon the integration of the approaches and discusses the applicability of the models of therapy to single-mother families.

SINGLE PARENT FAMILIES

Statistics and Demographics

The number of single parent families in Canada is growing rapidly, with more and more families being headed by a single adult. A single parent family is defined as a father or mother with one or more never married children residing in the same household (Lero & Brockman, 1993). Nineteen percent of families with children in Canada are single mother families headed by women and within Manitoba 18% of all families with children are single parent families headed by women (Stats Canada, 2000). Since 1971 the number of single mother families in Canada has almost doubled (Stats Canada, 2000). Lone parents remain overwhelmingly female with families headed by single mothers accounting for 83% of the total number of single parent families (Stats Canada, 2000). Lone parent families headed by women require particular attention because they make up

a large percentage of single parent families; they tend to enter poverty at a higher rate and exit more slowly than two-parent families; and they experience high levels of stress with the well-being of their members being at risk (Lero & Brockman, 1993: McKie, 1993).

Single parent families are at a higher risk of requiring services or assistance and therefore require special consideration. The absence of one parent will risk subjecting children to neglect and to lower levels of parental involvement and supervision (Astone & McLanahan, 1991; Thomson, McLanahan, & Curtin, 1992). A disproportionate number of single parent families (52%) come into contact with Winnipeg Child and Family Services, requiring some type of intervention or service. Evans (1998) also found that single mother families are vastly overrepresented in their involvement with the child welfare system and Gordon (as cited in Swift, 1998) found that they are greatly overrepresented in the population of neglecting mothers. Single parent family structures in and of themselves are not responsible for the problems experienced by members of these family types, but rather the factors associated with single parenthood, such as poverty, multiple stressors, and lack of social supports, contribute significantly to the difficulties experienced by these families. These factors will be discussed in more detail below.

Families are headed by a single parent for a variety of different reasons, ranging from being unmarried, to separation and divorce and to the death of the other parent (Popay & Jones, 1991; Evans, 1998). The majority of lone parent families develop as a result of separation or divorce, with the second most common route to single parenthood being the

birth of a child to a never-married woman (Popay & Jones, 1991; Evans, 1998; Stats Canada, 2000). The incidence of divorce is much higher now than it was in the late '60's, due to changes to divorce legislation in 1968 and 1986, making it easier to dissolve a marriage. This would account for the large number of lone parent families that have developed as a result of divorce and separation. Widowhood is the least common route to single parenthood (McKie, 1993; Stats Canada, 2000). Single, never-married lone parents of today tend to be older than their counterparts were in the past. In 1996, 25% of these lone parents were aged 35-44, up from 15% in 1981 (Stats Canada, 2000). At the same time, 44% of single, never-married lone mothers fell in the 25-34 age bracket in 1996, compared with 40% in 1981. The proportion of single, never-married female lone parents aged 15-24 dropped from 38% to 23% in this period (Stats Canada, 2000).

Single parenthood is a transient state, with many single parent families experiencing the transitions and stresses associated with moving in and out of a single-parent form more than once (Marcil-Gratton, 1993). A person may start off as single parent and then get married; families may start off married and become divorced and than remarried. It is not uncommon for families to experience several different forms over the course of time. Some studies have attempted to distinguish between the functioning of children from single parent families based on how their single parent family developed, with single teenage mothers fairing the worst, separated and divorced mothers doing moderately better, and widowed mothers fairing the best (Biblarz & Gottainer, 2000; Dubow & Luster, 1990).

Challenges Faced by Single Parent Families

Problems experienced by Single Parent Families

The problems experienced by single parent families are varied and are caused and/or exacerbated by life circumstances and living conditions. Within single-mother families problems are often connected to their income, level of social support and stresses associated with the children's well-being and the demands of independently meeting the needs of family members (McKie, 1993). The task for single mother families is to meet their children's needs and accommodate to various transitions with fewer financial and emotional resources and a higher number of life stresses than those living in other types of families (McKie, 1993; Vosler & Proctor, 1991). Children from single parent families are at an elevated risk of experiencing behavioral and emotional problems when compared with children raised in two parent families, particularly if they are exposed to a number of risk factors, such as poverty, poor living conditions, maternal depression and a high number of children in the home. Children from single parent families are at high risk of developing and/or experiencing any number of problems such as delinquency, lower academic achievement, depression, low self-esteem, substance use, acting out, and somatic symptoms (Biblarz & Gottainer, 2000; Gass-Sternas, 1995; Rankin, 1983; Furstenberg, Brooks-Gunn, and Morgan, 1987; Amato, 1994; Luster & Mittelstaedt, 1993; Carlson & Corcoran, 2001; Walters et al, 1988).

Income Level

Single mother families are commonly economically disadvantaged, in fact they are more likely to be poor than any other group, which often further exacerbates stress levels and makes life more difficult (Evans, 1998). Poverty creates feelings of powerlessness,

exclusion, and stigma within the individuals who are experiencing it (Evans, 1998; Volser & Proctor, 1991). The women who are most likely to be poor are single mothers and lone-parent families are almost seven times more likely to live with low-income continuously than the overall population (Evans, 1998; Morissette & Drulet, 2000). Lone- parent families headed by women have, by far, the lowest incomes of all family types (Stats Canada, 2000). In 1997, families headed by female lone-parents under the age of 65 had an average income of only 39% as much as non-elderly two-spouse families with children, and 65% that of lone-parent families headed by men (Stats Canada, 2000). Fifty six percent of all families headed by lone-parent mothers had incomes, which fell below the Low Income Cut-offs, in contrast to 24% of male lone-parent families (Stats Canada, 2000). Further to that, their probability of being ever exposed to low-income is double that of the overall population (McKie, 1993).

The exceptional vulnerability of single mother families living in poverty is produced by three main variables: barriers to earning an adequate income, inadequate levels of child support, and low social assistance benefit rates (Evans, 1998; Hardey & Glover, 1991; Kissman, 1991)). Unemployment, low pay, and occupational segregation are the barriers to earning an adequate income. Further, the availability of affordable child-care is very limited, making it extremely difficult for these women to gain employment and support their families (Ferguson, 1998). Child support payments are often non-existent or woefully inadequate, making it difficult for a single mother to support her children in an adequate manner (Kissman, 1991; Vosler & Proctor, 1991; Hartmann & Splater-Roth,

1996). Lastly, single mothers frequently collect social assistance to support their families and in most provinces social assistance rates leave families well below the poverty line.

The low income levels of single mother families mean that they are more likely to rent than own a home; a large percentage do not have access to childcare; household facilities are often inferior to those of two parent homes; they do not have access to appliances and equipment such as washers and dryers, microwave ovens, and smoke detectors, which places further stress upon the parent and family (McKie, 1993). Because of the low-income levels, single mother families are unable to access services and items that make it easier for them to cope. For example, if the substandard apartment building that a single mother resides in does not possess washers and dryers, she must transport her children and laundry, often on the public transit system to the laundromat, which requires a great deal of time, energy and patience. Additionally, if a single mother wants a break from her children, she routinely does not possess the monetary resources to hire a sitter or participate in a recreational activity.

Social Support

Instrumental and emotional supports are critical to the well being of single parent mothers and their children. Social support is an important mitigating factor in the well-being of single mother families because a supportive network of friends, family members and professionals is correlated with increased levels of physical and emotional well-being and feelings of efficacy and empowerment in single mothers (Furstenburg et al, 1987; Barratt, Roach, Morgan, & Colbert, 1996).

The care of children by single mothers poses potentially significant risks because there is less likely to be an immediate backup should the mother become incapacitated or incapable of caring for the children. If a single mother becomes ill, requires a break or just needs someone with whom to talk and share the burden, there is no partner to provide support and assistance. A study on adolescent parents found that mothers who are well supported by their family of origin and/or male partner perform more competently in the parenting role than mothers with lower levels of support (Helm, Comfort, Bailey, & Simeonsson, 1990). Often divorce or separation causes a change in friendships and relationships because married friends and couple friends routinely cut the ties off once the separation occurs (Kissman, 1991).

Social support and opportunities for socialization are very important components in a single mother's life. Researchers (Stokes, 1985; Thompson, 1995) have found that it is not the number of social supports one has available to them that decreases feelings of loneliness and child maltreatment, but rather the density and embeddedness of the support networks that is most important. This has implications for the interventions utilized with single mother families' to enhance social support, suggesting that it is the quality, not quantity of social supports that is key.

There are a number of factors that affect the accessibility of social supports to single parent families: availability of social supports in the community and in personal networks, developmental history, the mother's age and cultural and racial background (Barrett et al, 1996; Furstenberg et al, 1987; Hetherington, 1989). Social networks that

are unresponsive, unsupportive or simply unavailable are associated with maternal feelings of loneliness and being overwhelmed and are likely to negatively affect the adjustment of mothers and children in single mother families (Barrett, Roach, Morgan, & Colbert, 1996; Gaudin, Polansky, Kilpatrick, & Shilton, 1993). The social isolation of single mothers makes them vulnerable to depression and disempowerment (Kissman, 1991).

Multiple Stresses

A significant factor that affects the functioning of single mothers and, in turn that of their children, is the number of stressors operating simultaneously. Single parent families face more stressors and may be more at risk of stress "pile-up" than are other family types (Vosler & Proctor, 1991; Green & Crooks, 1988). Stressors faced by single parent families are numerous – obtaining adequate economic resources, unemployment, custody disputes and access, child care, child support, the amount of free time for personal care (i.e. sleep), the arrival and departure of household members – and all substantially increase stress levels (Volser & Proctor, 1991; McKie, 1993). The poverty experienced by single mother families further exacerbates stress levels (Gelles, 1992; Halpern, 1990). Single parent mothers also experience stress due to society's expectations that intact families are "better" and "normal" and children's behavior problems are attributable to membership in a single parent home, causing single mothers to feel stigmatized, isolated, guilty and blamed (Walters et al, 1988; Goodrich, Rampage, 1995; Ellman, & Halstead, 1988; Kissman, 1991). Society holds up two-parent families headed by a male as the ideal family type, which causes single parents to feel that they are abnormal and their

children's cognitive, emotional and social well-being are suffering as a result of being a part of this family form.

High levels of stress and ongoing stress are associated with poor mental and physical health and an elevated risk of problem parenting. Therefore, single mother families are at risk for developing these difficulties (Popay & Jones, 1991; Luster & Okakgaki, 1993). The psychological well being of parents is said to be one of the most important predictors of responsive and nurturing parenting (Belsky, as cited in Barrett et al, 1996; Vondra & Belsky, as cited in Barrett et al, 1996). Single mothers, in particular young unwed mothers and separated and divorced mothers tend to have lower self-esteem and experience depression at higher rates, than married mothers (Green & Crooks, 1988; Kissman, 1991). Davies, Avison, & McAlpine (1997) found that single mothers generally had higher levels of depression than married mothers. Mothers of children with behavioural problems have been found to have lower levels of self esteem, less confidence in their parenting abilities and higher levels of anxiety and depression compared to mothers of children without such problems, in particular when limited social supports are available (Sheeber & Johnson, 1992). Researchers (Dubow and Luster, 1990; Furstenberg et al, 1987) have found that children who experienced multiple stressors were at greatest risk for low achievement and behaviour maladjustment, with the risk of developing problems increasing linearly with the number of risk factors to which the children were exposed.

Aboriginal Single Mother Families

It seems prudent that single mother families headed by Aboriginal women receive specific consideration, given that Aboriginal women are more likely to be mothers and much more likely to be single parents than other Canadians (Minister of Indian Affairs and Northern Development, 2001). "The term 'triple jeopardy' may be used to describe Aboriginal single mother households in that they risk experiencing poor social and economic conditions because they are women, because they are Aboriginal and because they are lone parent families" (Minister of Indian Affairs and Northern Development, 2001, p. 2). For the purposes of this practicum, the term Aboriginal will include status, non-status, Metis and individuals who identify themselves as Aboriginal.

In 1996, about one in three Aboriginal mothers was a single mother compared to one in six other Canadian mothers (Minister of Indian Affairs and Northern Development, 2001). Registered Indians have twice as high a proportion of single mother families as other Canadians in both urban and rural locations (Minister of Indian Affairs & Northern Development, 2001). In 1996, more than 25% of Registered Indian children lived in single mother families, compared to 14% of non-Aboriginal children (Minister of Indian Affairs & Northern Development, 2001). Additionally, lone parent families headed by Aboriginal women are more likely to contain higher numbers of children, with 33% of Registered Indian single mother families having 3 or more children in 1996, compared to about 16% of other Canadian single mother families.

Further, a large proportion of Aboriginal families come into contact with Child and Family Services or require some type of support services or resources from social agencies. A recent study completed by Winnipeg Child and Family Services titled "Families Returning for Service" (2002) found that 37% of families receiving services from the agency for a minimum of a second time were Aboriginal and 28% of families having one time contact during the study period were Aboriginal. Unfortunately, the study did not breakdown Aboriginal families in terms of family type. There are large numbers of Aboriginal children in agency care of Winnipeg Child and Family Services. As of April 2002, sixty six percent of children in the care of the Agency were Aboriginal (Winnipeg Child and Family Services CFSIS system).

All Canadian single mothers tend to experience economic disadvantages, but Aboriginal single mothers experience these problems to a greater degree than others. The average incomes of Aboriginal single mother families were about one-half to one-third of those of husband-wife families in 1995 (Minister of Indian Affairs & Northern Development, 2001). Aboriginal female lone parent families had an average annual income of less than $16 000 compared to an average of about $22 000 among other Canadian female lone parent families (Minister of Indian Affairs & Northern Development, 2001). In 1995, 72% of Aboriginal single mothers identified government transfer payments as their major source of income compared to 49% of other Canadian single mothers (Minister of Indian Affairs & Northern Development, 2001).

Violence is a prevalent problem among Aboriginal people. Many Aboriginal women experience physical, emotional and sexual violence perpetrated by their partners. According to the Violence against Women Survey (VAWS) completed by Statistics Canada, 29 percent of Canadian women had experienced physical or sexual violence in a marital relationship, 63 percent of the women reporting violence had experienced more than one episode and 32 percent experienced more than ten episodes (Rodgers as cited in McGillivray & Comaskey, 1999). "It is important to note that VAWS excluded Yukon and the Northwest Territories and homes without telephones, effectively excluding many Aboriginal women. The rate of intimate violence against Aboriginal women is consistently higher than the VAWS figures by a factor of three" (McGillivray & Comaskey, 1999, p. 13). Eight in ten Aboriginal women witnessed or experienced intimate violence in childhood, and the same number have been child or adult victims of sexual assault (Ontario Native Women's Association as cited in McGillivray & Comaskey, 1999). Unfortunately, for many of these women, this type of treatment is considered "normal" and "acceptable" because they received inconsistent affection, neglectful care and abusive treatment as children and/or because it is widespread in their communities.

Despite the fact that Aboriginal women only represented two percent of all women in Canada in 1996, they accounted for 23 percent of admissions to provincial correction institutions and 20 percent of admissions to federal facilities (Stats Canada, 2000). A study by the Winnipeg City Police Incident Reports found that in a random sample of 501 women charged with violent offences between 1991 and 1995, 52 percent were

Aboriginal. Of those women charged with violent offences against their partners or ex-partners, 48 percent were of Aboriginal descent (Comack, Chopyk & Wood, 2000). Grossman (1992) completed a study on Aboriginal women in prison and found that their life experiences consisted of poverty, unemployment, abusive family situations, limited education, criminal victimization and racial prejudice. LaPrairie (1993) argues that Aboriginal women's conflict with the law is linked to macro factors that have shaped Aboriginal relations in society, with micro factors such as family stress, marital discord, unemployment, poverty and physical and sexual abuse leading to alcoholism and violence among Aboriginal women being the result of longstanding oppression and marginalization of Aboriginal people.

Colonization

Aboriginal-white relations have been characterized by racial oppressions whereby whites have historically assumed a position of dominance over Aboriginal people in an attempt to assimilate them into "white society", which was deemed as "better" and more "valuable". On the basis of systemic racism, Aboriginal people were subject to the social process of colonization, which prevented them from effectively participating in the social, economic and political structures of society (Kellough, 1980; McKenzie & Hudson, 1985).

Colonization involves weakening the resistance of and creating a dependency among a group, in order that they may be controlled by the dominant group (Frideres, 1993). Kellough (1980) distinguishes between structural and cultural colonization. Structural

colonization consists of control, power and decision-making by the dominant group for the purposes of obtaining benefits. The government used its authority to remove land rights and resources from Aboriginal people by implementing various treaties, policies and parliamentary actions (Frideres, 1993). Essentially, Aboriginal people were placed on desolate plots of land and were forced to abide by rules and regulations that restricted their movement and controlled their way of life.

Cultural colonialism involves actions that are aimed at achieving normative control over the minority group (Kellough, 1980). These actions were intended to "civilize" Aboriginal people. Missionaries, the health system and the education system, assisted in eliminating the identity and culture of Aboriginal people. The health system moved Aboriginal children to foster homes or medical facilities in urban areas for extended periods of time, with many children never being returned home, even when medical problems failed to justify a separation (McKenzie & Hudson, 1985). The children who did return after a lengthy absence found that they were alienated from their families and communities. Native skill in preventative and curative medicine was completely ignored.

Residential boarding schools were developed with the goal of successfully assimilating Aboriginal people into the dominant "white" society. Aboriginal children were removed from their families and home communities without parental permission for extended periods of time and placed in environments that were foreign to them. They were forced to believe that their language, religion and traditions were sinful. The purpose was to interfere with Aboriginal acculturation and transmit "white" values and

skills to the Aboriginal children. Children were denied contact with their parents; were exposed to Christian values and beliefs; were not permitted to speak their language; had their heads shaved; corporal punishment was used extensively, resulting in injury and student hostility; and sexual abuse was widespread (McGillivray & Comaskey, 1999).

The effect of residential schools on children and their families was devastating. These children were exposed to harsh punishment, severe psychological trauma and a rigid daily routine. "The psychological aftermath or 'residential school syndrome' includes inability to express feeling, a sense of inferiority, apathy, confusion of values, unwillingness to work, culture shock, 'anti-religion' attitudes, and creation of unskilled and unapproachable parents" (Grant, as cited in McGillivray & Comaskey, 1999, p. 43). Aboriginal people in the prairie west were most affected by residential schools because attendance from 1920-1960 was near 100 percent (Armitage, as cited in McGillivray & Comaskey, 1999).

The removal of Aboriginal children from their parents plays a significant role in many of the problems associated with Aboriginal families in Canada (McKenzie & Hudson, 1985; Horejsi, Runner, & Pablo, 1992). The cultural transmission of parent-child attachment behaviors was disrupted because of the experience of residential boarding schools. Aboriginal children were not taught the basics of healthy family functioning or appropriate parenting behaviors/practices and instead learned abusive and neglectful behaviors at residential schools. They missed out on the opportunity to be nurtured and loved by their parents and communities. Therefore, they were not prepared to assume the

parenting role once they had children of their own. New and dysfunctional familial behaviors, such as severe physical punishment and neglect in child-rearing practices replaced traditional behaviors, which rarely involved any form of physical discipline or violence (Horejsi et al, 1992; McKenzie & Hudson, 1985).

Colonization devalued Aboriginal culture leading Aboriginal people to feel worthless and inferior. The colonial relationship is characterized by the belief that the colonizer is the sole carrier of a valid culture and the culture of the colonized is substandard (McKenzie & Hudson, 1985). Aboriginal people subconsciously judge themselves against the standards of white society, which ultimately has contributed to them being ashamed of who they are and what they represent because they do not measure up to the "white ideal" (McGillivray & Comaskey, 1999). This led to a group of people with little self-worth and no pride in who they are and what they have to offer. In order to survive, many Aboriginals participate in behaviors that dull the pain and shame and release the rage.

The suppression of their language, destruction of their culture, harsh punishment, foreign child-rearing practices, isolation, and loneliness left many Aboriginal people unable to resume and maintain healthy lives. Deprivation from their culture and estrangement from their people has contributed to the development of various problems for many Aboriginal people, including poverty, family violence, substance abuse, suicide, and delinquency (LaPrairie, 1993; Canadian Association of Social Workers, 1993). "Colonialism introduced or exacerbated variables associated with high rates of physical

and sexual assault and abuse. These include substance abuse as a coping mechanism, acute poverty and welfarism within a rich society, racism, erosion of parenting skills, learned patterns of intimate violence, and infantilization of adults as wards of the state" (McGillivray & Comaskey, 1999, p. 23). It is important to recognize the links between colonization of Aboriginal people, their marginal position in society, and the devastating emotional and psychological problems many of them struggle with on a daily basis.

Strengths of Single Parent Families

There has been a great deal of discussion regarding the problems and difficulties experienced by single parent families and a picture has been painted which makes them seem unhealthy and dysfunctional. However, there are strengths associated with this family form that are often overshadowed by the negatives. Despite the fact that single mother families income levels are low, their level of control over their income increases, which is viewed as a positive by many of these women (Evans, 1998; Shaw, 1991). Further to that, following divorce/separation emotional gains were identified by mothers – feelings of independence, pride, self-esteem, confidence, achievement and a feeling of doing a hard job well (parenting) (Sharpe, as cited in Shaw, 1991). Single parent families were also found to possess a single line of authority that simplified family decisions and decreased conflict i.e. triangulating parents. Further, while single parents and children often appeared to be like partners, it was clear in these families that the parent had final authority (Walters et al, 1988). Children who are the product of single-parent households are often more autonomous and self-sufficient than are those from two parent families, and this can be viewed as one of the strengths of one-parent units (Amato, as cited in

Kissman, 1991; Walters et al, 1988; Gladding, 2002). Additionally, mothers who have left abusive relationships have enhanced their quality of life and that of their children. Finally, single parent families tend to be more democratic, with the needs of all parties being taken into consideration (Gladding, 2002).

It is also important to be cognizant of the fact that there are single parent families who are functioning effectively and are experiencing fewer difficulties than the typical two-parent family. Single parent families are capable of rising to the challenge and fulfilling the multiple roles and accomplishing the various tasks that two parent families divide between two adults. A single parent has the ability to meet individual and family needs, adapt to changes and address crises by organizing their resources and seeking suitable supports (Dubow & Luster, 1990; Green & Crooks, 1988; Volser & Proctor, 1991; Walters et al, 1988). A single parent family structure does not spell doom and disaster for the family members because there are mediating variables and poor outcomes are never the result of a solitary factor, but are produced by the interaction of several factors. Single parent families, on a whole, function very effectively but are at greater risk when there are a number of stressful factors at play simultaneously and mothers are unable to mediate or buffer the effect that stress has upon their children (Hetherington, 1989; Furstenburg et al, 1987). Children from single parent families experience negative outcomes at a higher rate than children from two parent families, however, the outcomes are not produced by a single factor and instead are caused by the interplay of a number of factors. Income level, cumulative stress, educational attainment, domestic abuse, absent father, changing schools, and neighbourhoods are examples of some of the factors that

are at play (Volser & Proctor, 1991; Walters et al, 1988). Contextual factors play a significant role in the health and well being of single parent families. Further, there is research that links children's well being and development to the adjustment and well being of their mother(s) (Furstenburg et al, 1987; Luster & Okagami, 1993; Carlson & Corcoran, 2001).

The purpose of highlighting this research is not to blame mothers for the negative outcomes of their children, but rather to suggest policies and programs that support and promote the healthy development of single parent mothers and their children. There are several areas that could be focused upon in an attempt to support single mother families. Firstly, more stringent enforcement of child support payments and higher levels of child support could be undertaken by the government and the justice department. Many fathers are required to pay abysmal levels of child support and frequently do not make any child support payments or are sporadic with their payments. Secondly, social assistance levels for single parent families should be increased to make it possible for a single parent to support her family, without having to starve herself to feed her children and without further exacerbating her stress level. Further, social assistance should allow women to stay home with their children until they are school age, instead of forcing them back to the workforce while the children are very young, only adding to their already high level of stress and demands. Thirdly, the number of subsidized day care spots could be increased. Affordable housing in safe and family friendly neighborhoods is necessary to improve the living conditions of single mother families. Finally, accessible programs that target single mother families, offering child-care/respite; opportunities for single mothers

to support and empower one another, normalize their experiences and build networks with other women should be developed. The families involved in this practicum struggled due to inadequate or non-existent child support payments, inadequate housing, demands placed upon them by social assistance to be gainfully employed, lack of child care and limited social support networks.

STRUCTURAL THERAPY

Structural family therapy is a model of family therapy that has gained wide acceptance since its inception and is commonly used with families. It developed as a result of a shift from the psychoanalytical approach, which focuses upon problems and solutions in an individual manner to focusing upon problems in a contextual manner (Colapinto, 1991). Structural family therapy is a compilation of theory and techniques that examines the individual in his/her social context and focuses upon changing the organization of the family which in turn affects the experience of each individual in the family (Minuchin, 1974).

Salvador Minuchin is the recognized founder of the structural model and is well known for his technique/skill as a therapist. The model was developed out of work at the Wiltwyck School for Boys which primarily served Black or Puerto Rican boys whose families were poor and lived in the ghettos and had absent fathers (Minuchin, Montalvo, Guerney, Rosman, & Schumer, 1967; Gladding, 2002). Minuchin's research with the boys and their families from Wiltwyck led to the development of the premise that social context is a most powerful organizer (or disorganizer) of families, and that family context

is also powerful in organizing (or disorganizing) individuals. The cornerstone of structural family therapy is the examination of a problem within its context, rather than in isolation (Colapinto, 1991, p. 419).

Theoretical Formulations

Structural family therapy utilizes the concepts from general systems theory, with the theoretical basis of the model lying in the belief that "the whole and the parts can be properly explained only in terms of the relations that exist between the parts" (Lane, as cited in Aponte & VanDeusen, 1991, p. 311). The approach is based on a belief that the family is not a static entity, instead it is always evolving. The family routinely has demands placed upon it, but it has the capacity to adapt and change while maintaining continuity (Minuchin & Fishman, 1981). Families go through different stages of growth and development and must cope with periods of crisis. "When a family comes to treatment, it is in difficulty because it is stuck in the homeostatic phase. Demands for the status quo constrain the family members' ability to deal creatively with changed circumstances" (Minuchin & Fishman, 1981, p.27).

Structural family therapy is based on three assumptions, forming the foundation of the approach: 1) an individual's psychic life is not entirely an internal process, with an individual influencing his context and the context influencing the individual. 2) changes in family structure contribute to changes in the behavior and inner psychic processes of the members of that system. 3) the therapist's behavior becomes a part of the context (Minuchin, 1974).

There are three main constructs that are essential components of structural family therapy: structure, subsystems and boundaries (Nichols and Schwartz, 1998; Goldenberg & Goldenberg, 2000). Family structure refers to the organized and predictable patterns in which family members interact. Family members require an internal organization that specifies how, when and to whom to relate (Colapinto, 1991). Included in the concept of family structure are roles/rules, hierarchy, reciprocal and complementary functions.

Roles/rules develop within families, such that they determine how family members interact with one another. Family members fulfill certain roles within the family with each family member playing many roles. For example, a man David may be a father, husband and businessman, with each of these roles requiring him to act in a different manner (Nichols and Schwartz, 1998). Rules also play a part in family structure. For example, a family may have developed a rule that conflict is avoided, therefore this governs their interactions with one another and makes it difficult for any members to overtly disagree with other members.

Families also contain some sort of hierarchy within their structure, with different individuals in the family possessing different amounts of power. Typically, the adults, particularly the parents in the family have more power than the children, however families can function with many different kinds of hierarchy. The approach maintains that parents should be in a position of leadership with respect to the rest of the family. Problems develop if family members lack the power to complete their assigned roles and

activities or when family circumstances prevent a member from behaving in an age appropriate manner. A parental child provides an example of an unhealthy distribution of power and an inappropriate hierarchical boundary. However, "in single parent families, a functional hierarchical arrangement may include the role of a parental child, when his/ her clearly defined responsibilities contribute to the overall coping capabilities of the family" (Colapinto, 1991, p.424). Blurred generational boundaries and partnerships between children and their single moms are present in most single parent families and provided there are limits to this, it is not a serious problem (Fulmer, 1983). In single parent families, hierarchical boundaries may be more flexible and permeable than in two parent families, which enables the family to function (Walters, Carter, Papp, and Silverstein, 1988; Kissman, 1991).

Family members also tend to have reciprocal and complementary functions that develop over time. "The behaviors of any two family members mutually accommodate in such a way that one develops selective aspects of himself or herself, while the other develops a complementary trait" (Colapinto, 1991, p. 422). Examples of this are the parenting unit in which one parent functions as the strict parent and the other as the soft parent and the couple in which one of the spouses is domineering and the other is passive. Complementarity allows spouses to divide functions and support one another and only begins to cause problems when it is exaggerated or fails to alter to accommodate changing circumstances (Minuchin and Nichols, 1993). Moderate complementarity allows the family system to function in an effective and efficient manner (Nichols and Schwartz, 1998).

Subsystems are defined as family members who join together to perform certain functions (Nichols & Schwartz, 1998). Subsystems are formed based on generation, gender, interest or function and within these subsystems individuals possess different levels of power and learn different skills (Minuchin, 1974). For example, there could be a parental subsystem consisting of a mother and father, a sibling subsystem, consisting of a brother and a sister and a mother-child subsystem. Within the sibling subsystem, a brother could possess a lot of power because his sister is younger and smaller. However, in a dyad with his mother, the brother possesses very little power and influence. A spousal subsystem forms when two adults join with the purpose of forming a family and it fulfills specific tasks necessary for the family's functioning. In single parent households, the affective and supportive functions of the spousal subsystem are acquired through the formation of other subsystems, which may involve individuals from outside the household (Walters et al, 1988; Kissman, 1991). A parental subsystem is formed with the birth of a first child and its' primary task is meeting the various needs of a child (Minuchin, 1974; Goldberg & Goldberg, 2000). The parental subsystem within single parent households may take on different configurations and alignments, and may cross over both hierarchical and/or household boundaries in an attempt to accommodate to family member's needs (Colapinto, 1991; Walters et al, 1988; Kissman, 1991).

Boundaries refer to the drawing of emotional lines between sub-systems of a family and between the family and the outside world (Minuchin, 1974; Nichols & Schwartz, 1998;Greif, 1996). Boundaries can range from diffuse to rigid, but for proper family

functioning boundaries of family subsystems must be defined well enough to permit subsystem members to carry out their functions without interference. But, they must permit contact among members of the subsystem and family. Disengagement and enmeshment are at opposite ends of the boundary continuum and refer to a specific style of interacting with one another within family systems (Minuchin, 1974). In disengaged families, boundaries are so firm and rigid that there is little interdependence in the family and emotional distance is excessive (Aponte & VanDeusen, 1991). In enmeshed families, boundaries between some or all members are relatively undifferentiated and it is difficult to determine who is included or excluded in specific activities, and family members behave almost as if they are a part of each other (Aponte & VanDeusen, 1991). Families with this type of interaction provide a great deal of mutual support, but at the same time they hinder the development of individual members, by restricting their autonomy and independence (Aponte & Van Deusen, 1991). "It is important to note that the conceptualization of boundaries in any one family varies based not only on the idiosyncratic nature of the family but on their culture or ethnic background" (Grief, 1996, p. 20). What may be viewed as a healthy amount of interaction in an Italian family may not be seen as a healthy amount of interaction in an Aboriginal family, therefore it is important that the practitioner be culturally sensitive in the application of this concept (Greif, 1996). Typical examples of problematic issues related to boundaries in single parent families are: 1) a lack of clarity in a single parent family so that the child is used as an adult substitute and is taking care of the parent(s); and 2) children being triangulated between parents living in different households when it is left unclear which parent is in charge (Greif, 1996).

Within the structural family therapy approach, normal family development is not defined by the absence of stress, conflict and problems and instead is defined by how effectively the family handles them, and this depends entirely upon the structure and adaptability of the family (Colapinto, 1991). The structure of a healthy family alters, as it accommodates to changes generated by its own development. Children are born, grow up, leave home and as adults get older, they lose strengths and abilities and develop different interests. Therefore, boundaries must be reconfigured, subsystems change and hierarchical arrangements alter to accommodate these changes (Colapinto, 1991). The approach views functional families as those: 1) with clear boundaries between individuals and subsystems, 2) that facilitate growth of individuals and prevent intrusion, 3) with generational hierarchies, and 4) with rules and roles that allow flexibility and adaptability to changes (Figley and Nelson, 1990).

Problems develop when family structures are inflexible and do not adjust adequately to maturational and situational challenges (Nichols and Schwartz, 1998). Family dysfunction is caused by a combination of stress and failure to realign to cope with it. Stressors may be environmental such as a family moving or a parent becoming ill or developmental, such as a child reaching adolescence. Families fail to change their structure in response to the stress for two reasons – lack of awareness of alternate ways of interacting or fear of trying different ways of interacting (Colapinto, 1991). Enmeshed or disengaged family structures are problematic because the individuals are smothered

making it difficult to develop autonomy and independence or alternatively they receive no support or guidance from family members (Colapinto, 1991).

The goals of each family in therapy are determined by the problems they are experiencing and the structural dysfunction (Nichols & Schwartz, 1998). Goals are negotiated between the therapist and the client (Colapinto, 1991). Ultimately, the goal of therapy is structural change (second order change) because structural anomalies are believed to cause and maintain problems, with elimination of the presenting problem (first order change) being a by-product of the change in the family structure (Aponte & VanDeusen, 1991; Walsh & McGraw, as cited in Wycoff, 2000). The therapist's task is to undermine the existing homeostasis, creating crises that upset the system toward the development of a better functioning organization. There are some common goals that are focused upon in therapy, with the most important one being the creation of an effective hierarchical structure. Often the goal is to strengthen the executive subsystem, so that parents function as a cohesive unit. In single parent families, one or more of the oldest children is encouraged to take on some extra responsibilities around the home to assist, however ultimately the mother still retains the authority and power within the family (Minuchin et al, 1974). The goal in enmeshed families is to strengthen the boundaries around them and in disengaged families it is to make boundaries more permeable.

Within structural therapy, the therapist plays a critical and fundamental role in therapy. "It is the therapist's behaviour, rather than the intrinsic efficacy of techniques or

prescriptions or the appropriateness of interpretations, that helps families change" (Colapinto, 1991, p. 435). The active stance and the centrality of the therapist in the therapeutic sessions is one of the distinctive features of this approach. The clinical social worker enters into alliances and coalitions, alters boundaries, and opposes or supports transactional patterns (Minuchin, 1974).

Interventions and Techniques

The theoretical concepts of the structural therapy orientation provide a blueprint for understanding family structure. The therapeutic process begins with the therapist observing the family interacting to assess its specific structure (Nichols & Schwartz, 1998). The assessment and intervention processes that facilitate family change are inseparable and interactional, including joining, assessment and restructuring. Structural family therapy is essentially a process of three overlapping phases, in which the therapist joins the family in a position of leadership, maps their underlying structure, and intervenes to transform this structure (Nichols & Schwartz, 1998).

The techniques used in structural family therapy are classified as joining or accommodating and restructuring. Joining and accommodating occurs throughout the therapeutic process, however it must occur before restructuring can be attempted because families will not be able to withstand challenge and confrontation, without feeling accepted and understood by the therapist (Nichols & Schwartz, 1998; Minuchin & Nichols, 1993).

Joining and Accommodating

Joining consists of the therapist making friendly contact with all family members and using deliberate techniques, such as confirmation and maintenance (Colapinto, 1991). Confirmation consists of the therapist responding to family members' feelings and concerns in a sympathetic manner and maintenance consists of the therapist being respectful of the rules that dictate distances and hierarchies in a family system. For example, when the therapist meets with the family for the first time, he/she must ask the parents for their view, before the child is asked for his/her view, as this shows respect for their position and authority within the family.

Accommodation requires that the therapist make adjustments to herself in order to join with the family (Minuchin, 1974; Goldberg & Goldberg, 2000). Maintenance is an accommodation technique in which the therapist provides "planned support of the family structure, as the therapist perceives and analyzes it" (Minuchin, 1974, p. 125). Examples of maintenance are the therapist accepting the spouses' definition of their complementarity, appreciating the family's humour, conveying affection for them, and affirming and supporting an individual's strength and ability. Tracking is also an accommodation technique in which the therapist follows the content of the family's communication (Minuchin, 1974). Examples of tracking are asking clarifying questions or making supportive comments. In the initial phase of therapy, until a therapeutic relationship with the family develops, acceptance of the family's structure and manner of interacting is provided, with no overt challenging on the part of the therapist. Mimesis is

also used by the therapist to accommodate to a family's style and affective range (Minuchin, 1974; Goldberg & Goldberg, 2000). Essentially, the therapist alters her manner of interacting to match the families, so that if they speak slowly and are soft spoken the therapist does likewise and if they are longwinded and sociable the therapist behaves in the same manner.

Reframing

Reframing is a technique that is commonly used in structural therapy and involves changing an individual's or family's perception by explaining a situation from a different context (Goldberg & Goldberg, 2000; Gladding, 2002). In this technique, the facts of the situation are not altered, however the meaning of the situation is examined from a new perspective. This process helps to view a negative situation in a more positive light.

Assessment

Assessment is an ongoing and interactional process, beginning with the initial telephone contact with the family and including the experiences and observations of the family during the therapeutic sessions (Colapinto, 1991). Assessments are based on observed interactions in the first session and are refined and revised over time. Typically, family members arrive at the first session stating that a particular family member is the problem. A structural therapist attempts to broaden the problem beyond the individual family member to the family system, and moves the focus to the present (Nichols and Schwartz, 1998).

Assessment provides a family map that identifies problematic structures and helps conceptualize therapeutic goals for the family (Minuchin & Fishman, 1981). The

therapist redefines the problem for the family, including the family interaction in the formulation. The information gathered from this assessment is used to assist the therapist in formulating a hypothesis, which articulates the dysfunction in the family in structural terms and in turn implies a goal. The working hypothesis is based on the therapist's interactions and experiences with the family and is also founded on the information gathered from the six areas outlined below.

There are six main areas upon which the assessment of the family's interaction focuses (Minuchin 1974; Cleveland, 1999). First, it examines family structure, which is defined as the preferred transactional patterns of family members. The therapist attempts to comprehend the hierarchies, power distribution, alliances, complimentarity of roles and boundaries of the family and its subsystems. Second, it examines the system's flexibility and its capacity for elaboration and restructuring, as revealed by the reshuffling of the system's alliances, coalitions, and subsystems in response to changing circumstances. Can the family mobilize alternative structures to address problems and deal with new situations? Third, the assessment focuses upon where the family falls along the continuum of enmeshed and disengaged, which indicates how sensitive the system is to actions of its members (Colapinto, 1991). Fourth, the family's sources of support and stress are examined. Fifth, the family's developmental stage and its performance of the tasks appropriate to that stage is an important component of the assessment. In this section, the family life cycle stage and the developmental needs related to that stage of development are considered. Transitions within families, such as marriage, the arrival of a child, teenage years, and children leaving home all produce

stress, which can in turn produce dysfunctional behaviors (Minuchin & Fishman, 1981; Colapinto, 1991). Finally, the last section of the assessment explores how the identified patient's symptoms are used for the maintenance of the family's preferred transactional patterns (Colapinto, 1991). Do the family members accommodate to the problematic behavior thereby supporting it? Is the dysfunctional behavior part of a triangle that diffuses conflict?

Restructuring

Families tend to become stuck in their typical ways of interacting and use what is familiar and comfortable, even if it is problematic. Therefore, it is the therapist's responsibility to challenge the family system, so that they modify their organization and interactions. Restructuring interventions are used to confront and challenge a family in an attempt to change the family system (Minuchin, 1974; Cleveland, 1999). Once the therapist joins with the family and begins to devise a working hypothesis, restructuring interventions can be employed by the therapist. There are seven categories of restructuring interventions: actualizing family transactional patterns, marking boundaries, escalating stress, assigning tasks, utilizing symptoms, manipulating mood, and supporting, educating or guiding (Minuchin, 1974; Goldenberg & Goldenberg, 2000).

Actualizing family transactional patterns

Structural therapists focus upon family interactions during sessions, not just on what the family states happens or what the therapist assumes happens. Therefore, they attempt

to develop situations in which they will be provided with the opportunity to observe how the various family members interact with one another, which ultimately sheds light upon the structure of the family system. Creating opportunities to observe a family's transactional patterns is achieved through enacting, recreating communication channels, and manipulating space.

Therapists "stage enactments" by actively creating situations to probe further the strengths and weaknesses of the family (Colapinto, 1991; Cleveland, 1999). An enactment is defined as "bringing problematic sequences into the treatment room by having families act them out so that the therapist could observe and change them" (Nichols and Schwartz, 1998). Enactments provide information about the ways in which the family resolves conflict, support one another, enter into alliances and coalitions or diffuse stress. Enactments are created by the therapist instructing members of the family in a very clear and direct manner, such as "talk with your father about that" or "did you hear his comment about you, what do you have to say about that?" The rationale for using enactments is that families typically try to put their best foot forward when communicating with the therapist. However when the therapist gets the family members to interact with one another they are unable to modify the image they put forth (Minuchin & Fishman, 1981).

The therapist also attempts to actualize family transactional patterns by recreating communication channels (Minuchin, 1974). This is achieved by the therapist directing

family members to talk with one another, instead of talking about the other person and directing the comments to the therapist.

Manipulation of space is also used to create situations in which the therapist will be able to observe how family members interact with one another (Minuchin, 1974; Cleveland, 1999). For example, the therapist may rearrange seating in the therapeutic session, such that the husband and the wife who appear very distant from one another and sit at opposite ends of the room are positioned to be sitting next to one another, with the daughter who has an enmeshed relationship with the mother being seated next to the therapist and two seats over from the mother.

Marking Boundaries

Marking boundaries is a strategy utilized by clinical social workers to strengthen appropriate boundaries and eliminate inappropriate boundaries by altering transactional patterns with the purpose being to promote a balance between interdependence and autonomy within the family (Piercy & Sprenkle, 1986; Minuchin, 1974; Cleveland, 1999). The goal is to ensure that there is the correct amount of permeability between subsystems, depending on the developmental stage of the family. Boundary marking techniques can be aimed at the psychological distance between family members and at the duration of interaction within a family or subsystem (Minuchin and Fishman, 1981). The therapist creates new boundaries by manipulating space within the therapeutic session (seating arrangements) and by altering the duration of the interaction among

members of a subsystem, which intensifies the message of who should be involved in what issues.

The clinician can mark boundaries by imposing rules of communication within sessions that ensure that family members speak to one another regarding problems, instead of about one another and by ensuring that each member is provided the opportunity to speak for himself/herself (Minuchin, 1974). For example, if one family member attempts to answer a question directed at another family member the therapist can silence them with a gesture, or if a family member comments about another family member to the therapist instead of directing her or his comment to the individual, the therapist directs them to speak to that individual.

Escalating Stress

The clinical social worker can produce or increase stress in a family unit to assess the family's flexibility and capability of adapting when circumstances are altered (Minuchin, 1974). Escalating stress can be achieved in several different ways. First, the therapist can block transactional patterns during sessions, such that the usual flow of communication is altered. For example, the parental child in a family functions as the buffer between the mother and the other children and the therapist directs the parental child not to intervene, instead forcing the other child to communicate directly with the mother during the session. Second, the therapist can emphasize differences between family members that the family typically ignores. For example, the therapist may say that "it seems like you and your wife don't agree on this issue, can you discuss it?"

Third, the therapist can force the family members to have conflict when they would other wise avoid it. For example, if a child typically acts up when her parents begin to argue, the therapist blocks the child's interference in the parent's conflict. Finally, the therapist can form an alliance or coalition, by joining with a member or subsystem. For example, in a family where conflict within the spouse subsystem is avoided by scapegoating the son, the therapist joins with the husband in a coalition supporting the wife in requesting that he spend more time at home and be an active participant in running the house, with the technique causing conflict between the spouses, and allowing the therapist the opportunity to help the couple negotiate the conflict without their son's involvement. These techniques force the family to respond to the changed circumstances, and thereby force them to relate in a new manner.

Assigning Tasks

Tasks can be used to further explore a specific area that did not occur naturally in the family transactions or highlight an area on which a family needs to work on (Cleveland, 1999). Tasks highlight new possibilities for restructuring the family and test family flexibility. Tasks can occur within the session or be assigned as homework and occur outside of the session. Tasks assigned within sessions may take several different forms. First, they can take the form of the clinical social worker directing family members on how and to whom they should communicate. Second, tasks can be related to the manipulation of space, which means that the therapist directs a family member about who to sit next to and what type of action to take. Finally, tasks can also be used to dramatize family transactions and suggest changes. For example, he assigns the father the task of

stopping one son from interrupting the other son during the session. Tasks assigned for homework, essentially allow the therapist to be at home with the family. The purpose of tasks is to offer alternative transactional patterns.

Utilizing Symptom

Within this approach, an individual's symptom is viewed as an expression of a contextual problem. However, there are circumstances in which the symptom is worked on directly because of its seriousness or the danger associated with it. For example, in families in which the presenting problem is anorexia nervosa or fire-setting the presenting problem takes priority. Further to that, some families are so fixated on the symptom that they are unable to make a contract that focuses upon anything but the presenting problem. Symptoms can be utilized to restructure in several different ways: focusing on the symptom, exaggerating the symptom, de-emphasizing the symptom, moving to a new symptom, relabeling the symptom, and changing the symptom's effect.

Manipulating the Mood

Each family is characterized by a particular type of affect, which is prevalent despite the content of the issues being discussed. For example, one family's affect may best be described by a depressed mood, while another family's affect is characterized by teasing and joking. The therapist can adopt the family's affect as a restructuring technique. Restructuring the mood in the family can be attempted by exaggerating the family's mood to cause the family to react against it; raise the intensity of a situation to make the

family respond appropriately to a situation that is serious; model a more appropriate affect; or relabel the predominant affect.

Support, Education and Guidance

Support, education and guidance are typically used to join with clients, but they can be used for restructuring as well. The well being of individual family members and the family unit is dependent upon the nurturance, healing and support a family provides. Therefore the clinical social worker must encourage and assist the family's ability to do so. For example, a therapist working with a family in which the executive functioning is weak may have to model appropriate executive functioning, and once parents have had an opportunity to observe this, they can take over these functions. A clinical social worker may also teach families who are in contact with social agencies how to interact with them in an effective manner.

Strengths

A significant strength of the structural model of family therapy is its use as a tool for assessing a family's functioning. It is very easy to get caught up in the *content* of what a family is saying, particularly if one is a beginner. However, structural family therapy provides "a blueprint for analyzing the *process* of family interactions" (Nichols and Schwartz, 1998, p. 244).

A further strength of the approach, is its' focus upon change, rather than looking for pathology and diagnosing the family (Colapinto, 1991). The approach focuses upon the

family as a social system in transformation, instead of pathologizing and labelling the family. Therefore, "with this orientation, many more families who enter therapy would be seen and treated as average families in transitional situations, suffering the pains of accommodation to new circumstances" (Minuchin, 1974, p. 60). Having said that, the approach has very definite ideas about the type of structure (permeable, but yet clear boundaries, well-established hierarchy and a strong parental subsystem) that is healthy and normal and families who do not possess this structure are assessed as "dysfunctional" and requiring change.

The approach also focuses upon a family's strengths and, as such, is very respectful and empowering toward the clients. It "is driven by the assumption that families are competent and should be respected" (Nichols & Schwartz, 1998, p. 253). It does not spend a great deal of time searching for origins of a problem and trying to determine how a problem developed. Instead the focus is on modifying the present (Minuchin, 1974).

The model can be used with various family types and configurations; a variety of presenting problems, including psychosomatic problems, addictions, marital problems, problems in which a child or teenager is the identified patient; and with various socio-cultural groups (Minuchin, 1974; Jung, 1984; Stanton, 1981; Aponte & VanDeusen, 1991; Napoliello & Sweet, 1992; Wycoff, 2000;). The model is very flexible and therefore can be tailored to meet each family's specific needs.

The model is very adaptive, allowing the clinical social worker to utilize his/her own personal style during sessions (Minuchin & Fishman, 1981). Minuchin and Fishman (1981) maintain that the therapist's life experiences play a significant role in the therapeutic process and the techniques articulated by the model simply function as a guide. The model also enables the therapist to borrow theoretical concepts and techniques from other models because of its compatibility with a variety of techniques (Aponte & VanDeusen, 1991). The adaptability and compatibility of structural family therapy enables clinical social workers to utilize an eclectic approach. Therapists commonly utilize an eclectic approach with clients, borrowing techniques from different models (Beckett, 1997; Fefchak, 1997; Cooper & Upton, 1990; Bott, 1994).

Limitations

Structural family therapy is unable to accommodate an individual in therapy, requiring at least two people from the family to participate in therapy, due to its' reliance upon observation of interaction for diagnostic purposes. It requires that those involved in the problem attend to allow the therapist to get a comprehensive understanding of the dynamics contributing to the problem (Colapinto, 1991). Problems are viewed as a function of the entire family structure, therefore it is important to include the whole family in therapy (Nichols and Schwartz, 1998). There are many situations in which one family member is motivated to attend therapy, but the other family members are not prepared to attend, making it impossible to utilize the structural approach.

Feminists criticize structural family therapy, proclaiming that it is ahistorical and asexual and fails to account for the forces of the larger social context which shape family

life, in particular the gender differences in family dynamics (Nichols and Schwartz, 1998). Structural family therapy has been criticized for the assumptions it makes about the nature of men, women and families. The assumptions suggest that structural family therapy accepts the unequal distribution of power between men and women in society. Feminists have criticized Minuchin for his tendency to blame the mother and support the father, in an attempt to unbalance a rigid family system, which is sexist and further blames the mother and reinforces the patriarchy of the larger social order (Luepnitz, 1988). Walters, Carter, Papp and Silverstein (1988) state that the concepts of hierarchy and boundaries are founded on a male model of relating. They state "...the concept of hierarchy disadvantages women and children who will always end up on the bottom of any authoritarian ranking. "As taught and practiced in family therapy, the concept of hierarchy often does not leave room for the female style of decision making in a more consensual or collective way, or for exerting authority (with children, for example) more through relationship than through explicit use of power" (Walters et al, 1988, p.24). According to feminists, gender should be a primary concept for understanding family structure and functioning and when gender is highlighted the clinical social worker is in a position to assist families to change the rules and roles of the family without continuing to maintain the patriarchal structure (Nichols and Schwartz, 1998).

Feminists also criticize structural family therapy for its use of the concept of complementarity, stating that it serves to further enhance the male's position within the family and society at the expense of women (Rampage, 1995). Complementarity is a mechanism that distributes tasks and resources through the process of negotiation.

However, it assumes that the adults in the family possess equal amounts of power and choice within the family, which they argue is not the case. The need to maintain balance in the family is used as a justification to assign roles to women that compliment those of men (Walters et al, 1988; Rampage, 1995). Therefore, women complete those tasks that men prefer not to do, such as housework and child care and do not participate in those areas that men select to participate in, such as finances, work etc. Men and children accrue the benefits associated with families such as nurturing and intimacy, often at the expense of women's social, financial, sexual and psychological freedom (Baines, Evans, Neysmith, 1998). It is argued that complementarity allows men to select the roles that are more respected, powerful and earn more money and leave the other roles for women, thereby reinforcing ideas about the "natural" roles of women and men and "normal" families that do not reflect the real talents, interests or circumstances of family members (Walters et al, 1988; Rampage, 1995).

Feminists are critical of the use of structural family therapy with violence in the family because it seems to view wife beating and incest as being within the normal range of functioning and it values the functioning of the family unit at the expense of individual members (Luepnitz, 1988; Rampage, 1995). They also argue that systemic models blame the victim and diffuse the responsibility of the abuser (Luepnitz, 1988; Bograd, 1992; Rampage, 1995). Systemic models maintain that there are reciprocal relationships between family members and therefore suggest that abuse plays a stabilizing role in families, thereby further victimizing the victim and minimizing the man's responsibility. An abused child or woman does not have equal power, options or equal ability to alter the

cycle of interaction (Walters et al, 1988). As Goodrich (1991) argues, a therapy needs to be evaluated based on how it deals with power and the abuse of power in a family system and structural family therapy does not account for the unequal power that family members possess in transactions/interactions, therefore it cannot effectively deal with family violence. Systems theory fails to account for the variables of power, gender and the connection between the two.

Hoffman (1981) suggests that structural family therapy is difficult to learn because it is difficult for beginning therapists to recognize the behaviors that the experts in structural family therapy could easily recognize, such as invisible behavior patterns. A great deal of experience with families and extensive live supervision is required for individuals learning this approach. A further problem highlighted by Hoffman (1981) is structural family therapy's inability to deal with resistant clients. "It is a genuine limitation that although Minuchin's theory is most eloquent about family systems and family structure, it does not contain a comprehensive enough theory of change to cover the area misnamed "resistance", and the moves which deal most successfully with it, especially in cases of what Minuchin would call enmeshed families" (Hoffman, 1981, p. 270).

Lastly, structural family therapy does not focus on what occurs outside of the therapy sessions, and is only concerned with the transactional patterns that occur in the session. The clinical social worker could be missing some useful information because a therapeutic setting is an artificial setting and may not reveal a comprehensive and

accurate picture of how the family is structured and interacts with one another (Piercy & Sprenkle, 1986).

GENDER SENSITIVE PRACTICE

As noted above, structural therapy is not sensitive to the issue of gender and the power inequalities inherent in gender to the same extent as feminist theory. As such, in this practicum feminist therapy is used to augment structural therapy by broadening the therapeutic lens to encompass the gender dimension that has historically been lacking in the structural approach. The two primary approaches used in this practicum are the structural approach and the solution focused approach with feminist theory being used to address the limitations inherent in utilizing a purely structural approach to assessment, which fails to account for gender, history and larger social factors at play. Feminist principles fill in the gaps of traditional family therapy theories and take into account the issues of power, division of labour and the sociopolitical context.

Feminism is more of a framework than a model of practice. Bricker-Jenkins states that "although there appears to be a common set of principles and assumptions, there is no one single approach to feminist practice. It must be viewed as an evolving and collective endeavour of and by people who share a culture and world view quite different than that of ascendancy today, but who see themselves as able and willing to work through the contradictions imposed by those differences" (1988, p. 254). Feminist theories attempt to understand social and institutional relationships through the lens of gender. Further, gender relations are viewed as problematic and related to inequities in society, rather than as natural. As a result, feminists advocate for social change that

would rebalance power inequities in society that are oppressive and exploit women (Elliot & Mandell, 1998).

Despite the fact that there are different schools of feminist practice and it is ever evolving, there are some basic core assumptions that are common throughout:

1. *Validating the Social Context:* Taking into account the social context within which an individual exists is viewed as being critical to developing a thorough understanding of the individual (Land, 1995; Chernomas & Rainonen, 1994). It is critical that the complete experiences of people are understood and to separate the psychological and/or physical aspects of self from one's social and cultural environment provides an inaccurate sense of people.
2. *Revaluing Positions Enacted by Women:* Society tends to value activities and behaviors that are typically associated with males and in contrast behaviors that are often performed by women, such as caregiving or compromising are devalued (Land, 1995). Feminists argue that behaviors performed by women are essential to the well being of society and are entitled to respect and appreciation.
3. *Recognizing Differences in Male and Female Experience:* Men and women have different life experiences and to understand the psychological structure of women and women's self concepts, the effect of oppressive structures on women must be acknowledged (Land, 1995).
4. *Rebalancing Perceptions of Normality and Deviance:* Feminist practitioners believe that behaviors deemed as dysfunctional by society are often associated with less-privileged groups such as women, poor people, or people of color

(Land, 1995). In order to prevent this error, experiences of women and people from different ethnic and class backgrounds must be taken into account when defining normalcy and deviance.

5. *Attention to Power Dynamics:* Within society, women are disempowered and oppressed, but are expected to exist despite these confines and restrictions, therefore sensitivity and awareness to power dynamics in relationships is an important dimension of feminist practice (Land, 1995). Feminists also acknowledge that inequality occurs in the client/clinician relationship, and rather than ignoring this reality the practitioner encourages the client to share her perspectives and meanings (Land, 1995; Bricker-Jenkins, Hooyman, & Gottlieb, 1991)
6. *The Personal is the Political: Personal* beliefs, biases and prejudices are embedded in political, economic and social structures (Land, 1995; Bricker-Jenkins et al, 1991). "Feminist practitioners often acknowledge in their work with clients the ways that the personal issues clients work with are political in nature and may reflect power inequities in relationships with others" (Land, 1995, p. 8). Therefore, problems such as poverty and substance abuse are viewed not as deficits within an individual or family, but instead are seen as responses to larger political/cultural forces (Kissman, 1991). This does not eliminate personal responsibility, but it does lessen the blame that clients may experience (Bricker-Jenkins et al, 1991).
7. *Empowerment:* "Within this tradition, therapeutic goals for clients are generated cooperatively between clinician and client, and the focus is often on empowering

the client to change the social, interpersonal, and political environments that have an impact on well-being rather than on helping the client adjust to oppressive social context" (Land, 1995, p. 10). The practitioner and client work together to develop goals and these goals generally involve empowerment to work toward change in the environment, which contributes to problems (Land, 1995; Russell, 1989). Feminist practitioners reject the notion of value free therapy and believe that by making their biases explicit, they empower clients to take ownership of their own values and choices (Land, 1995).

Using a feminist perspective in therapy typically encompasses a number of different components. The relationship with the client is extremely important and a social work clinician working from a feminist perspective would attempt to create an egalitarian relationship (Gluckstern & Ivey, as cited in Kerr, 2001; Laidlaw & Malmo, 1991). The clinician never takes the position of expert and instead acts as a facilitator or guide and clients are encouraged to tell their story so the clinician can understand what it is the client knows and feels. Feminist therapy tends to be more conversational, rather than using reflection and interpretation (Kerr, 2001). Reframing is commonly used to assist clients to view their behaviour in an alternative manner. For example, it would be suggested to a client who had been sexually assaulted and didn't fight back that her behaviour was in fact a survival strategy (Laidlaw & Malmo, 1991). Connecting clients to community resources and supports is also a goal of feminist practitioners (Kerr, 2001; Laidlaw & Malmo, 1991; Kissman, 1991). An emphasis is placed upon developing social ties and supports for women with other women who are experiencing what they

are. This assists in helping them recognize that they are not alone and helps to normalize some of their experiences. Further, feminist practitioners recognize that many women have difficulty with self-nurturing and tend to devalue themselves, therefore validation and empowerment are an important part of counselling (Laidlaw & Malmo, 1991; Kissman, 1991). Personal validation is a critical component of the feminist approach because the client is empowered through focusing on her strengths and validating her personal knowledge and experience. Information giving such as normalizing experiences and suggesting possible solutions is also an important aspect of feminist therapy (Kerr, 2001). As Kerr (2001) states "knowledge is crucial to empowerment: expanding options enables meaningful choices."

The most useful aspects of structural therapy can be supplemented by a feminist analysis, ultimately offering an assessment that is more comprehensive and congruent with the realities of the environment that clients exist in. By supplementing structural therapy with the propositions of feminist social work practice outlined above, the limitations of structural therapy discussed previously, primarily the ahistorical and apolitical nature of it are addressed.

It is important to note that many Aboriginal women argue that feminist perspectives are not sensitive to their cultural perspectives (Ouelette, 2002). Much of the feminist literature assumes that all women experience oppression similarly and Aboriginal women reject this notion because not only do they have to contend with sexism, but they also face racism and classism (Ouelette, 2002). Aboriginal women and feminists both feel

oppressed and they are each involved in movements to change this, however their goals are very different. Feminists view male dominance as the basis for women's oppression, while Aboriginal women view colonization, namely the Indian Act, as responsible for the oppression of Aboriginal women.

Ouelette (2002) found that Aboriginal women are concerned with issues that affect Aboriginal people as a whole and in particular their children. Some of the issues they are concerned about are: racism, poverty, housing, health, welfare, education, alcoholism, unemployment, youth prostitution and suicides (Ouelette, 2002). "There is definitely a conflict between the relationship of the Aboriginal women's movement and the broader feminist movement with regard to the concept of 'motherhood' and the role of women" (Ouelette, 2002, p. 42). Aboriginal women typically do not oppose the motherhood and caregiving roles in contrast to many feminists who often perceive the family and household as sources of their oppression. They tend to value their role of life givers and are accepting of the division of labour based on gender. Aboriginal women also include their children and the elderly in their struggle, in contrast to mainstream feminists who struggle primarily for women (Ouelette, 2002).

SOLUTION FOCUSED THERAPY

Solution focused therapy represents a shift away from the traditional models of therapy which focus upon the past and examining the origins and causes of presenting problems, instead focusing upon strengths, resources and solutions to presenting

problems. It is an extremely popular approach, developing initially in 1980 and being formally termed an orientation to therapy in 1982 (de Shazer & Berg, 1997, p.121). It was founded by Steve de Shazer, with other notable clinicians and theorists being Kim Berg, Eve Lipchik, Michele Weiner-Davis, and Scott Miller (Nichols & Schwartz, 1998). The model has been applied to a number of different problems/issues, including alcoholism, wife-battering, marital problems, drug treatment etc. It was influenced by Milton Erickson who believed in utilizing what clients brought with them to help them meet their needs in such a way that they could make satisfactory lives for themselves. He, like other solution-focused therapists did not believe it was necessary to correct the causative, underlying maladjustments (de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich, & Weiner-Davis, 1986).

Solution focused therapy was an outgrowth of strategic therapy, in particular the Mental Research Institute Brief Therapy Model, with each possessing many similarities: each focuses on the complaints of the client; problems are thought to be maintained by interactions in which attempted solutions do not fit the complaint; both approaches attempt to create the smallest possible change believing that any small change in the system will be amplified by the system; and, both models downplay the importance of history and underlying pathology (Cleveland & Lindsey, 1999, p. 139)

Theoretical Formulations

The theory and assumptions that the model is based upon are very simple and straightforward, making it an easy model to learn and understand. The model focuses upon the present and the future, as opposed to the past and there is a strong emphasis on

the language that is utilized by both the client and the therapist. The model insists that nothing exists outside of language, therefore from that comes the belief that altering the talk about a problem will ultimately change the problem (Nichols & Schwartz, 1998, p. 383). As of late, there has been an emphasis placed upon the importance of the relationship between the therapist and client(s), in particular the sense of hope they are given and making them feel good about themselves and competent (Nichols & Schwartz, 1998).

The central philosophy of the model as outlined by De Shazer and Berg (1989), Walter, J. L. & Peller, J. E. (1992), and O'Connell (1998) consists of three beliefs. First, if it is not broken do not fix it. Second, once you know what works do more of it and finally if it does not work, do not do it again, do something different. Walter & Peller (1992), Cleveland & Lindsey (1999), de Shazer, Berg, Lipchik, Nunnally, Molnar, Gingerich & Weiner-Davis (1986) maintain that the following assumptions are at the core of the solution focused model:

1. Families have resources and strengths to resolve complaints, therefore the role of the therapist is to facilitate the change by helping the client access the resources and strengths they already possess.
2. Change is constant and inevitable and it is the practitioner's role is to identify and amplify the change. Clients often complain that problems are unchangeable. It is the therapist's job to help them take note of changes that may have already occurred and to be able to recognize changes as they occur in the future.

3. It is not necessary to know the cause of the complaint or even very much about the complaint itself to resolve it. The solution focused approach maintains that it is not necessary for extensive diagnosis of the problem situation or for a thorough understanding of its' origins. Solution focused therapists believe that it is more important to come up with a solution that "fits" the situation, rather than one that exactly "matches" the situation. Because solutions are not tailor-made for specific situations, it is not necessary to know everything about the problem, only what is necessary to solve it.

4. A small change is all that is necessary because small change often leads to larger change. A change in one part of the system can affect changes in other parts of the system. Problems are maintained by unworkable solutions that continue to be tried.

5. Goals are defined by clients. Solution focused therapists focus attention only on the complaints the clients want to change. They help clients define goals in such a way that they are amenable to change because sometimes problems can be defined in a manner that makes them unsolvable, for example, if a client stated that her husband's personality is such that he cannot accept responsibility. The practitioner would work with the client to reformulate a goal, so that it is achievable. The revised goal could be: I would like my husband to take more responsibility for certain household chores.

6. Rapid change or resolutions of problems is possible. Solution focused interventions are brief and families often notice improvement in their situations very quickly.

7. There is no right way to view things. Solution focused practitioners recognize that any situation has many points of view. The practitioner does not seek a "correct" understanding of the situation, but a point of view that will open up the potential for change. Because families often enter treatment with very restrictive views of their situations, the practitioner attempts to assist them to take a different slant on the problem. As a result, the therapist focuses on exceptions to the problem rather than the problem itself.

8. Cooperation is inevitable. Resistance is not a useful concept and is often used by therapists when they feel stuck.

9. The approach views the client as being the expert. Clients decide what they want to change and they determine what they want to work on. If the client recognizes other problems in their life, but decides not to focus on them at that time, that is their choice. If the practitioner becomes aware of other problems or believes the client could work on another goal, the practitioner might suggest this, but ultimately the focus is on what the client wants.

10. Social reality is co-created. New and beneficial meanings can be constructed for at least some aspect of the client's complaint. It is not that an individual has or does not have a symptom. Behavior can be labelled as a symptom, but in some other setting or with a different meaning attached, the same behavior would be appropriate and normal.

Within the solution-focused approach, the client-therapist relationship is described as falling into one of three different categories: visitor, complainant, and customer (de Shazer, 1988; de Shazer & Berg, 1989). The description is not a characterization of the client's personality; instead it is a description of what goes on between the therapist and the client. The nature of this relationship is not constant and is continually changing throughout the life of this purposeful relationship.

A "visitor" is the type of relationship that occurs when, during the course of the session and/or at the end of the assessment session, it is clear that the client and therapist have been unable to come up with a problem, complaint or goal. The client may have gripes, but there is not an expectation or real desire for change and solution. In this type of situation, therapy cannot begin and the therapist should not attempt to intervene no matter how evident the "problem". With a "visitor" any type of intervention is likely to be rejected, therefore attempts by the therapist to intervene only serve to produce a classic "resistant relationship" between them. The therapist should provide lots of positive feedback about what is going right and lots of recognition and acknowledgement that he/she is going through a difficult time and life is tough.

In the complainant type of relationship, the client is very observant and provides a detailed description of complaints. He is usually good at describing the patterns and sequences of the problem, and sees himself as a victim of someone else's problem. By the end of the assessment phase, it is clear that the therapist and client have the

beginnings of a goal and some expectation of change and possible solutions. The client, however, is either not committed to take steps to solve problems or is not clear that he must take steps to find solutions. In this situation, the therapist should provide lots of positive feedback and can assign an observational task in an attempt to build on pre-existing solutions and strengths.

In a customer type relationship, the client and therapist have constructed a complaint, including the beginnings of a goal and some expectations of a solution. The client is aware that any solution requires action on his part and there is some indication, either directly or indirectly of a willingness to find solutions. As in the other two types of relationships, the therapist should provide a great deal of positive feedback about what the client is doing right and should agree that the client needs to do something to address the problem. Behavioral tasks can be assigned to the client and the therapist can be confident that the client will follow through with the task and find it helpful.

Goals are a very important component of solution focused therapy, should be defined in a very definite manner, and should possess certain characteristics. Generally, goals are modest and focus on the resolution of the presenting complaint (Nichols and Schwartz, 1998). De Shazer and Berg (1989) outline the specific qualities of well-formed goals. Firstly, the goals of therapy should be important to the client and should be small. Goals should be described in specific, concrete, behavioural terms. For example, if a client says that he wants to be happy, that is too elusive. The practitioner would ask "What is it like when you are happy? What do you do when you are happy?" This is done to help make

the goal more concrete. Secondly, goals are described as the start of something, not the end of something. For example, if a client comes with a problem of hitting his or her child, instead of setting a goal of not hitting the child, the goal would be to use time-outs and count to 10 when feeling frustrated. Finally, goals are described as the presence of something rather than the absence of something. For example, instead of the goal being defined as "I will not neglect my children", it is defined as "I will get up in the morning, feed them breakfast, make them a lunch and send them to school on time."

Techniques and Interventions

During the first session the solution-focused therapist makes an effort to join with clients and normalize what the clients are experiencing. Joining is the process of building rapport and O'Hanalon and Weiner-Davis (1989) suggest doing this by chatting at the beginning of the session and asking a few questions about their family life. Utilizing the client's language is very important. Therefore, whatever words the client uses to describe certain experiences or objects, should be used by the therapist. Confrontation and topics that might cause disagreements should be avoided in the beginning, allowing time for the family and therapist to become more comfortable with one another.

Normalizing problems puts family members minds at ease and can make them less focused on the problem (O'Hanalon & Weiner-Davis, 1989). It helps to change individuals' perceptions of the situation. It can be achieved by telling the clients "it's understandable you would feel that way" or "most people in your situation would react as

you have". Further to that, the therapist can tell stories about other families with similar problems or use self-disclosure to help reassure the family.

Michelle Weiner-Davis (1995) stresses the importance of using solution language, which means that "solution language" should be utilized during sessions to convey the belief that the situation will change. Words such as "yet or when" should be used instead of "if, will or has not". Compliments are commonly utilized in sessions and focus upon what the family is already doing that is positive in spite of the situation that is causing distress (Cleveland & Lindsey, 1999).

Searching for and exploring exceptions is a fundamental component of solution focused therapy and the search for exceptions begins during the first session, immediately following the statement of the presenting problem. The focus is on finding out what happens when the complaint does not happen and how the family gets the exception to happen.

Lipchik (1988) identifies four ways a therapist can start an exception sequence after initial introductions. The first way an exception sequence can be started is by responding to whatever is stated as a complaint with "when doesn't that happen or when is that just a little bit better and continuing on with what will have to happen for more of that to happen?" The second method that can be used to start an exception sequence is by inquiring if anything has changed for the better with regard to the problem the client called about since the first appointment was made. If the answer is yes then questions

about how that can continue or be increased are asked to highlight this improvement. Third, whenever there is the slightest indication of a complaint or some positive difference, the therapist can ask, "Is that different?" Finally, an exception sequence can be attempted by asking, "can you tell me how you will know that you don't have to come here anymore?" The answer to this question contains a solution and can be followed up with "when does that happen?' If the answer is negative, the therapist can persist with "not even a little bit, sometimes?" or accept the negative and try for an exception by asking "what do you think will have to be different for that to happen just a little bit?" Once any small exception to the problem is obtained, the therapist must continue to construct a sequence with the clients in which the differences between the complaint and the exception are illuminated.

There are certain questions that can be asked in an attempt to illuminate the differences such as "what has to happen for more of that to happen", "what will you have to do", "what will others have to do", "how will you know the problem is solved" and "how do you think others will know". If it is difficult for exceptions to be remembered or identified, O'Hanlon and Weiner-Davis (1989) suggest using the miracle question, which follows a standard formula: "Imagine when you go to sleep one night, a miracle happens and the problems we've been talking about disappear. As you were asleep, you did not know that a miracle had happened. When you woke up what would be the first sign for you that a miracle had happened?" The intention is to generate a detailed and practical description of life without the problem. It is a way of encouraging the client to temporarily escape from a preoccupation with problems and instead focus on solution

construction. The miracle question aims to reveal how the client can act to improve the situation, with each member in the family offering his or her own version of life without the problem.

Scaling questions are also an integral component of solution-focused therapy. Weiner-Davis (1995); and De Shazer & Berg (1989) outline their use as follows: to measure client's progress before and during therapy; to determine client's commitment/motivation to change; to determine client's confidence in taking steps to solve problems; to assess perceptions of relationships or solutions; and to evaluate progress. Examples of how scales can be used in session with clients are "On a scale of 1 to 10 where 10 is you're willing to do anything to solve these problems and 1 is where you are not willing to do anything, how willing are you to do something?"

"Formula tasks" are a significant component of solution-focused therapy and are utilized with all clients, regardless of the presenting problem. Molnar and de Shazer (1984) and Weiner-Davis (1995) identify seven interventions that are commonly utilized in the solution-focused approach. The Formula first session task consists of the therapist instructing the clients to observe what happens in life, marriage or relationships that they want to continue. This task is always given at the end of the first session and the purpose is to try to focus clients on areas of their life in which they are functioning satisfactorily.

The "do something different" task directs clients to do something different the next time they find themselves about to do the same thing. For example, clients can change

the location that the problem takes place in or they can introduce a step in the complaint sequence. This task is intentionally vague, leaving it up to the family to decide what to do. The task is based on the assumption that families will know what to do differently and it is based on the belief that any small change in the usual cycle of attempted solutions to the problem will be amplified and create more change.

An intervention commonly used by solution focused therapists is to ask clients to pay attention to what they do when they overcome the temptation or urge to perform the symptom or some behavior associated with the complaint. The purpose of this intervention is to increase the amount of time clients think about and are involved in aspects of their life that are not problematic. This serves as the foundation for constructing a solution and implies that families can exert some influence over the symptom or complaint even though they may perceive themselves as helpless in the face of the problem.

Clients can also be asked to identify ways in which they are able to keep doing specific behaviors, which are exceptions to the problem behavior. The purpose of this task is to highlight the difference between functional behavior and problematic behavior.

The rating task, which asks the client to predict or rate something following clearly outlined rules, is commonly used as well. For example, "first thing each morning rate the possibility of an exception behavior occurring before noon." The purpose of this task is to focus the client's attention on the exceptions to the problematic behavior.

'Assess more of the same behavior' is commonly utilized to gather more information about the context in which the problem behavior occurs. In this strategy the client is complimented for focusing upon the problem and asks the client to keep detailed records on what he/she is doing when the problem behavior goes away. This assists in gathering information that may be helpful in identifying or formulating exceptions to the problem.

Finally, the last intervention is used in crisis situations when the focus on the problem is too strong to be redirected in the first session. The client is told that the situation is too volatile and complex and that they should make no changes to the situation until they are able to understand it more fully or the client is asked why the situation is not worse.

Strengths

Solution focused therapy appears to be a simple and straightforward model that follows a certain format and utilizes certain tasks, therefore it is user friendly. A major strength of the model is the fact that it can be used with a family or an individual in a family, due to the fact that it is based on the belief that a change in the therapeutic system can be started anywhere in the system. At the basis of the approach is the belief that every part of a system is so related to other parts in the system that change in one part of the system will cause a change in all of them and in the total system (de Shazer, 1985). Therefore, if only one individual from a family attends therapy, the changes that this individual makes in his/her behaviour will bring about changes in the other family members and the entire family unit. Given that frequently there are family members who

refuse to attend therapy for various reasons, solution focused therapy provides those members of the family who are keen on attending a method of addressing the problems within the family without the entire family being required to attend.

The model is based on the belief that to exert change in a family, the therapy must focus upon solutions, exceptions to the problem and strengths of the client(s), which creates hope, encouragement and optimism in families that are often feeling discouraged, exasperated, hopeless, powerless and ineffective. It creates positive energy within dismal situations. Further to that, the approach is very respectful and empowering, viewing the client and family as the expert and as having the resources to solve its problems.

Limitations

Solution focused therapists are routinely criticized for failing to focus on the actual relationship with the client because they are preoccupied with following the solution focused formula, of moving towards the solution (Lipchik, 1994). Solution focused therapists are said to be so focused upon looking for exceptions and strengths that they fail to take the time to join and build rapport with their clients, which is arguably an important component of therapy. Further to that, solution-focused therapists do not encourage the ventilation of feelings during sessions, as therapy is not viewed as a cathartic experience (Lipchik, 1994). However, many clients need to tell their "story" and release intense emotions associated with the problem they are facing and if they are not given this opportunity, it leads them to feel that the therapist is not hearing or understanding them, making it very hard to join with the client.

Solution focused therapy is also criticized for its failure to focus on the past and underlying causes of a problem because of the belief that neither one is relevant in therapy, nor serves a purpose. As Sirles, Lipchik and Kowalski (1993) indicate the approach does not examine the origins of a problem, but rather stresses what must occur in the present to eliminate it. Critics argue that it cannot be an effective form of therapy because it is unable to address the entrenched and deep-rooted nature of most problems due to the limited number of sessions provided to clients (O'Hanlon & Weiner-Davis, 1989). It is argued that only intensive therapy that examines the origins of problems over the course of a long period of time is capable of doing that. Along a similar vein, the model is criticized for its failure to utilize awareness and insight in therapy, which is viewed by many therapy models as being necessary to bring about change (O'Hanlon & Weiner-Davis, 1989).

INTEGRATION OF THE MODELS & APPLICATION TO SINGLE MOTHER FAMILIES

The integration of structural family therapy, a feminist philosophy, and solution focused therapy allows the practitioner to utilize three models of family therapy, each having its own distinct strengths. The strength of structural family therapy lies in its solid conceptual framework, providing a foundation from which to work with families. A further strength of the approach is its ability to assess and describe a family's functioning in a comprehensive manner. However, structural therapy fails to adequately account for historical, cultural and socio-political factors that influence individuals' lives and functioning (Nichols & Schwartz, 1998). Therefore, feminist principles can be utilized to

address these limitations of structural therapy, providing for a more thorough assessment and challenging stereotypical roles and thinking. Feminist principles highlight the fact that women's experiences are fundamentally different than that of men's; people from different cultural and ethnic backgrounds have markedly different life experiences; and this is due to the inequities and oppression within society (Land, 1995). Viewing problems from a broader perspective is less blaming and punitive towards the client, enabling her to see the larger socio-political forces at play in problems she may be experiencing such as poverty, domestic violence or substance abuse. Unlike the structural approach, solution focused therapy lacks a clearly articulated theoretical framework, however the strength of the approach is tied to its ability to articulate techniques and interventions for bringing about change within the family system.

There are some theoreticians who maintain that it would be an error to integrate approaches of family therapy (MacKinnon, as cited in Fish & Piercy, 1987; Rohrbaugh, as cited in Fish & Piercy, 1987; Fraser, as cited in Fish & Piercy, 1987). However, there are a number of practitioners who utilize an eclectic approach to family therapy, combining techniques from several existing models of therapy, regardless of the orientation to which they subscribe (Rosenberg, 1978; Cooper & Upton, 1990; Beckett, 1997; Fefchak, 1997; Bott, 1994). Canvassing therapeutic practitioners reveals that the majority do not subscribe to one particular model of therapy, in fact, they utilize techniques, interventions and concepts from a number of family therapy approaches. As Figley and Nelson (1990) articulate in their article on training family therapists in structural family therapy, "some training programs teach their students to utilize a variety

of theoretical models and approaches, but begin with the Structural approach because of its relative simplicity, concreteness, and directness."(p.226). Theoreticians agree that the integration of different therapeutic approaches must include a solid understanding of the assumptions and the conceptual foundation of each approach (de Shazer, 1984; Sluzki, 1983; Stanton, 1981; Fish & Piercy, 1987).

Structural family therapy provides a solid conceptual framework and powerful tools for having an impact on a variety of different systems. There are significant similarities between structural and feminist approaches. As Mirkin (1990) highlights, both models reject diagnostic labels and assume competence and health, focus on eliminating the symptom, focus upon observable and verifiable change, and utilize modelling as a therapeutic tool. Stone Fish (1989) identifies further similarities between the approaches: joining is perceived as a significant therapeutic technique; they focus on the structure of the nuclear family and the interplay between the individual, family, and society; and lastly both approaches share a fundamental belief that behavior is determined by a defined structure that is inherent in relationships (Stone Fish, 1989). Structural family therapy focuses upon the context of familial interactions, however it fails to account for socio-political context, gender role socialization and how this impacts upon the family system. Feminist theory addresses these issues by taking into account the issues of power, division of labour, and the sociopolitical context of the family.

The solution focused approach fits with feminist thought in several ways. Solution focused literature uses non-sexist language and does not blame women or overtly hold

them up to male standards (Dermer & Hemesath, 1998). Pathologizing language is not used by feminists or solution focused therapists because of the influence it is seen as having upon how clients view their situations (Dermer & Hemesath, 1998). Feminist theory and solution focused therapy also emphasize symptom relief, highlight strengths, assume competency, are respectful, and have a goal oriented vision (Dermer & Hemesath, 1998). Lastly, both attempt to reframe situations into workable and solvable terms within the context of client strengths (Demers & Hemesath, 1998).

Structural therapy and solution focused therapy are both systemic approaches, possessing a belief that problems do not exist in isolation, with one part of the system affecting the functioning of other parts. Further, the concept of reframing from the structural approach, which attempts to alter clients' perceptions of an issue or situation (Goldenberg & Goldenberg, 2000) and the solution focused technique of normalizing problems and sharing stories of families in similar situations (O'Hanlon & Weiner-Davis, 1989) are very similar and share the goal of changing the families perception and reducing anxiety. Fish and Piercy (1987) maintain that structural and solution focused models of family therapy have a number of similarities: 1) both are present-focused, 2) are change, not insight oriented, 3) focus on problems as viewed in their relationship context, 4) involve giving directives, 5) utilize assigning tasks, 6) both are interactional, or contextually oriented, and 7) each are goal directed and concerned with the outcome of therapy. Further to that, the two models are compatible given that they both promote empowerment and focus upon strengths within families.

The three approaches are compatible in several areas: all are strength-based, collaborative, respectful, non-pathologizing, goal directed, empowering and each stresses the importance of joining and developing a solid therapeutic relationship. Structural therapy and solution focused therapy supplemented by a feminist philosophy to ensure gender sensitivity enhance the practitioner's ability to bring about change in families by offering them more options in terms of conceptualizing a problem and devising potential solutions. As many practitioners are aware, the more tools and techniques we have at our disposal the better, given that what proves to be effective with one family is not at all effective with another (Fish & Piercy, 1987).

Structural family therapy was developed using primarily single mother families with low incomes who were experiencing multiple problems (Minuchin et al, 1967; Aponte & VanDeusen, 1991). Given that the majority of single parent families are impoverished and experience numerous stresses and difficulties, the approach seems highly applicable to this population subgroup. Gladding (2002) identifies structural therapy as one of the five most often employed family theories with single parent families.

Structural family therapy is said to be applicable to a wide range of problems and ethnic and racial groups (Colapinto, 1991; Minuchin & Nichols, 1993; Jung, 1984; Napoliello & Sweet. 1992; Minuchin & Fishman, 1981; Wycoff, 2000; Levitt, 2001). Jung (1984) states that structural family therapy "... is an approach with a broad applicability to various socio-economic groups and presenting problems and with an

emphasis on the social context in which families live..." (p. 366), making it highly applicable to single parent families.

Structural family therapy focuses upon the contexts of problems, which is important with single parent families because societal factors contribute to the difficulties that they experience. However, structural therapy fails to account for the larger social context and external socialization forces, therefore requiring additional theory to address these limitations and provide a more comprehensive assessment that is sensitive to gender and culture. This is imperative in working with single mother families because the social context plays a critical role in their life experiences and their current circumstances. Women and people of different cultural groups are marginalized and oppressed within society and therefore have fundamentally different life experiences compared to men (Dermer & Hemesath, 1998).

Integrating structural therapy and solution focused therapy to work with single mother families is logical, given that they each are systemic based approaches that focus upon strengths and empowerment and both are commonly utilized with single parent families (Gladding, 2002). Due to the fact that the focus of this practicum was single parent mothers and structural family therapy is not particularly sensitive to gender and cultural issues, a feminist theory and Aboriginal women's perspectives on oppression were used to augment the structural models' assessment, to ensure gender and cultural sensitivity.

Feminist theory, Aboriginal women's perspectives and the solution-focused approach are all respectful, empowering, and focus upon strengths. Therefore, they are approaches to use with single mother families who are often disadvantaged, disempowered, and stigmatized due to their gender and family configuration. Feminist theory highlights the oppressive structures at play in women's lives, which have contributed to the difficulties and challenges they face and validates their experiences (Land, 1995). Further, feminist practice emphasizes the importance of building support networks and connecting women to appropriate supports, which is an ideal fit for single mother families who are very isolated and lacking in support (Kissman, 1991; Dermer & Hemesath, 1998). Aboriginal women's perspectives, while often not identifying with feminism, also emphasize women's oppression, emphasizing the impact of colonialism in this process (Ouelette, 2002).

Solution focused therapy is identified by Gladding (2002) as one of the five family theories most often employed with single parent families. It is an approach that focuses upon strengths and does not pathologize the individual. This is an approach that is respectful and empowering, without placing further blame upon single parents who are routinely stigmatized and held responsible by society for difficulties encountered by their children. Because it focuses upon what clients are already doing that is effective and helpful, it enhances the self-esteem and confidence of clients, which is necessary given what is known about the level of self-esteem of single parents (Green & Crooks, 1988; Kissman, 1991). Solution focused therapy also relies upon clients to determine the goals of therapy and the therapist views the client as the "expert" on her life, thereby enhancing

the client's feelings of power and control, and increasing her ability to be assertive and self directed. It is important for single mothers to develop leadership skills, which are necessary for the well-being of all family members.

CHAPTER THREE

INTERVENTION

Practicum Site:

The practicum was conducted at the Elizabeth Hill Counselling Centre (EHCC), located at 321 McDermot Avenue in Winnipeg's inner city. It is a counselling centre that is affiliated with the Faculty of Social Work and the Department of Psychology at the University of Manitoba and is dedicated to training Undergraduate, Masters and Doctoral level students from these faculties. It offers free services to adults, children, adolescents, families, couples and groups. It is intended to service low-income families, with a large proportion of clients being Aboriginal and a large segment of the clients having involvement with Child and Family Services. Clients are referred by social services and community agencies or come on their own.

Procedures:

The process of therapy followed a similar format for each family involved in this practicum. Once identified from the general waiting list (clients who contact EHCC on their own requesting services), or the waitlist for Child & Family Services' referrals, the families were called to schedule an initial meeting. Referrals were selected based on their "fit" with my practicum goals and objectives and were discussed with Linda Burnside, my clinical supervisor, prior to establishing contact with the family. At the time of the initial phone call, I updated information on the presenting problem and

scheduled the initial meeting. Sessions with clients ranged from an hour to an hour in a half in duration and occurred at the EHCC. All sessions were videotaped.

The initial meeting with the family served to orient the family to the EHCC and obtain the necessary written consents. I further explained to all family members their participation in the practicum, the videotaping and the supervisory processes, and tried to gain a better understanding of the presenting problem and what they hoped to accomplish in therapy. At this time, the goals, which were to make up the goal attainment scale (an evaluation measure) were to be negotiated and selected by family members and myself. However, it quickly became apparent that the goal attainment scale (GAS) would be cumbersome to utilize with clients and goal selection did not occur that readily. Therefore after consultation with the practicum committee, a decision was made to forgo the use of the GAS, as its purpose was far more about my needs than about the needs of the clients included in the practicum. This issue is discussed more fully on pages 84-90. During the first session clients were more focused on telling "their story" than they were on identifying goals and constructing a GAS. Once counselling had concluded with a family or individual, a Client Satisfaction Questionnaire was mailed to each individual who participated in counselling to determine their perception and satisfaction with the whole experience.

I documented the main issues, following each interview. EHCC has an outline that file recording is expected to follow and it includes who attended the session, the main issues discussed, observations and the plan for the next session. Further, an intake

summary and a termination report was completed for each family included in the practicum, as per the protocol at EHCC.

Throughout the duration of the practicum, I kept a weekly journal, which contained a reflective and objective section. The objective section outlined which families I saw that week, the focus of each session, and the concepts and interventions utilized. The reflective section consisted of thoughts and reflections on my learning process and personal growth. It contained information such as: my comfort level; my ability to act more independently in and out of sessions; my growing ability to speculate about causes of family problems; my ability to come up with interventions independently; and my frustrations and insecurities.

Supervision:

Clinical supervision was provided by Linda Burnside, Assistant Program Manager for Winnipeg Child and Family Services and Instructor at the University of Manitoba. Linda is an experienced clinician who is knowledgeable and skilled in the areas of structural therapy, solution focused therapy, and gender sensitive practice. Linda met with me on a weekly basis to provide direction and consultation, planning interventions, formulating tasks and providing feedback on clinical skills. Supervision took the form of either case discussion (based on my notes & observations) and/or discussion and feedback on videotapes of my sessions that Linda reviewed. Use of videotapes allowed for constructive criticism/feedback on what I had done well and what could have been done differently. Further, it provided Linda with a more accurate picture of the work and skill development I was doing in session with clients. Clinical supervision sessions

incorporated analysis of the content and process of the sessions, preparation for upcoming sessions, and discussions regarding the overall progression of each case. Supervision also included discussion of the theories utilized in this practicum and how they applied to specific cases. For example, supervision routinely consisted of discussing which interventions and techniques I was using from the three theoretical approaches and the underpinnings of these approaches were utilized to gain an understanding of the problems the families were experiencing. Finally, Linda frequently suggested reading materials to augment my learning.

Dr. Lyn Ferguson, my faculty advisor was provided with updates from Linda Burnside and myself on the progress of the practicum. She was responsible for providing supervision and ensuring that a mid-term evaluation of my progress was completed, by convening and chairing a meeting that included Linda and myself. Final feedback on my progress was organized by Dr. Ferguson and occurred in February '03. Dr. Ferguson was responsible for supervising the writing of the final report and the functioning of the practicum committee.

Eveline Milliken, a professor at the Winnipeg Education Centre was my third committee member and provided input at the proposal stage and committee consultation based on student need, during the course of the practicum, including the writing and presentation of the final report.

Duration:

The practicum began in mid August '02 and concluded at the end of January '03, after a period of 5 months. I devoted full-time hours (ranging from 5 to 8 hours per day) to my

practicum for the months of September, October, and November and part-time hours (ranging from 4 hours per week to 8 hours per week) for the months of August, December, and January.

Overview of Families:

The practicum consisted of eight client systems, each of whom were selected from EHCC's regular waiting list or from a list of Child and Family Services referrals. Two of the seven client systems only attended one session. Clients were selected from the waiting lists based on whether they fit the criteria of the practicum. Initially, I had intended on including single parent families, headed by mothers with infants, pre-school children and school age children, regardless of the presenting problem. Families in which the primary issue was parent teen conflict were to be excluded. However, many of the families included in my practicum had teenagers and the presenting issues were frequently related to conflict and problems experienced in the relationship between the teenager and his or her mother. The change in the focus was primarily due to the fact that families with teenagers lend themselves more readily to a structural approach than families with young children, and further, there were many more single mother families with parent-teen issues requesting counselling services than single mother families with small children.

Table 1 (p. 83) outlines some of the background information on the families involved in this practicum. This includes information on the presenting problem, the number of

children, involvement with CFS, ethnicity, number of sessions, and my assessment of the treatment outcome.

The number of counselling sessions ranged from one to eleven sessions. Additionally, counselling with many of the families consisted of some combination of family sessions and individual sessions with the mother and/or a child, depending upon the needs and issues of the family and its' members.

The number of children in these families ranged from one to five, while their ages ranged from 3 to 15 years. All of the families, with the exception of one, had at least one teenager and the family that did not contain a teenager had two school aged children. Three of the families who participated in the practicum were Aboriginal with the remainder being Caucasian, and one of the families identifying itself as Polish. The mothers from the three Aboriginal families that participated in the practicum did not attend many sessions. One mother and 4 children attended one session (family #5), another mother and her daughter attended 2 sessions (family #8) and the final mother attended 4 sessions (family #3), however the teenage daughter continued to attend for individual sessions. The limited number of sessions attended by these families was likely due to a combination of two factors: substance abuse, parental and in one family teenage and mandated involvement with Child and Family Services.

Most of the families had limited financial resources, with four of the families involved in the practicum receiving social assistance benefits. Four of the mothers were employed

outside the home with one earning between $0 and $9999, another earning between $10,000 and $19,999, another earning $30,000 to $39,000, while the fourth earned $45,000.

Four of the families involved in the practicum resided in the suburbs; three lived in the core area of Winnipeg; and one of the families lived in a small town in rural Manitoba. At least half of the families were renting their residence.

Five of the seven families who participated in the practicum had ongoing and concurrent involvement with Child and Family Services. In two of the families, the children were in the care of Child and Family Services due to substance abuse, domestic violence, and neglect. In another family the children had recently been returned to the mother after two years in care. The final two families were involved with CFS due to parent teen conflict and a teenager's difficulty with anger management.

Cancellations and no shows were a consistent problem with the families involved in the practicum. All of the families involved cancelled or did not show up for appointments on at least one occasion during my involvement. Given the stress and demands placed on many of these single parent families in their everyday life, it is not surprising that they found it difficult to attend appointments at EHCC. Half of the families who participated had vehicles accessible to them, however this did not appear to be a factor related to their ability to attend appointments regularly. Families who were involved with CFS tended to miss or cancel more appointments than families who were not connected with CFS.

Table 1. Summary of families handled in the practicum

Cases	Presenting problem(s)	Child-ren	CFS Invol.	Ethnicity	# of sessions attended	Treatment Outcome
Family 1	Parent-child conflict	2	No	Caucasian	11	Significant improvement
Family 2	Conflict b/w sibs	3	No	Caucasian	2	Marginal improvement. Clients terminated b/c the identified problem (adolescent daughter) refused to participate.
Family 3	Parent-adolescent conflict; parental substance abuse	2	Yes	Aboriginal	11	Mom stopped attending after 4 sessions, as she was actively abusing substances. Adolescent daughter continued to attend for support. Problems remained unchanged, but daughter reported individual benefits from counselling.
Family 4	Ineffective parenting; parent-adolescent conflict; parental substance abuse	5	Yes	Caucasian	7	Significant improvement; Client to receive in home supports re: parenting from CFS at conclusion of practicum.
Family 5	Ineffective parenting; children recently returned to mom's care	4	Yes	Aboriginal	1	Client terminated service b/c it was too difficult to attend the centre for appts.
Family 6	Fighting b/w the siblings; behavioural problems	3	Yes	Polish	4	Significant improvement
Family 7	Parent-adolescent conflict	4	No	Caucasian	1	Client terminated service b/c family members unwilling to participate.
Family 8	Substance abuse; family of origin issues; parent-adolescent conflict	1	Yes	Aboriginal	2	Service terminated as family in crisis due to active substance abuse and those issues needed to be addressed before therapy could proceed.

EVALUATION MEASURES

Prior to the practicum commencing, clinical evaluation elements that focused upon the therapy outcome, the process, and client satisfaction were to be built into the practicum to assess the effectiveness of a structural, solution-focused model of family therapy with single-mother families. Different evaluation measures were chosen according to their ability to measure these areas. The strategy to be employed was triangulation of evaluation measures, which would provide information from different sources and thereby increase the reliability and validity of the evaluation.

I had planned on using the Goal Attainment Scaling (GAS) approach to evaluate the effectiveness of the solution focused-structural family therapy approach incorporating feminist principles with single parent families, as it seemed to be the most appropriate approach for evaluation. GAS is a goal-oriented model of evaluation where systematic procedures identify, document, measure and evaluate unique programme goals for individuals or groups. It involves setting goals in collaboration with clients, implementing the programme, and taking measures to determine whether or not and to what extent goals have been attained (Mitchell & Cusick, 1998; Woodward, Santa-Barbara, Levin, & Epstein, 1978). GAS measures are flexible enough to be employed in a wide range of clinical, research, and administrative settings (Kiresuk & Lund, 1979). The application of GAS measures has been used in the field of counselling and family therapy (Mitchell & Cusick, 1998; Woodward, Santa-Barbara, Levin & Epstein, 1978). GAS consists of developing a plan in the form of a goal attainment guide for each

client/family based on expected or desired performance (refer to Appendix A). The use of a GAS guide involves five steps: 1) selecting the general areas in which the impact of treatment will fall; 2) weighting these areas according to their comparative importance; 3) filling in a scale of potential outcomes for each area, with the expected or most probable outcome being in the middle level, and the less likely favourable and unfavourable outcomes on either side; 4) determining at a predetermined time which outcome of each scale actually occurred; 5) and finally aggregating the scores on the individual scales through the calculation of a summary goal attainment score (Kiresuk & Lund, 1979). The summary score integrates goal outcomes and produces a measure of overall programme success in the form of a "T-score".

The family and therapist should both be active in selecting goals, suitable measures for the goals, and the weighting given to each scale or goal. It is important to have the client and/or family involved in this process to ensure that goals are individualized, realistic and meet client needs. The weight assignment is flexible, accommodating any number of goals and any preference for relative numerical weighting (Kiresuk & Sherman, 1968). Weights of 1, 2, 3 can be used or 2, 4, 6 or 10, 20, 30.

There are a number of strengths associated with this approach. It assists in the assessment of client change over time, moving towards established individualized goals. GAS is the one method that allows one to assess client status or progress in a way that is specific and unique to individual clients and families. Therefore, it permits the uniqueness of each family's situation to be acknowledged. No other methods allow for

this and given that this practicum focuses upon a specific population group, but not on a certain type of problem or issue, it was deemed important to utilize an evaluation method that could assess the status of many different types of problems. Further, there is evidence that being involved in goal setting increases client receptivity to treatment and therefore has therapeutic benefits (Kiresuk & Lund, 1979). As Jones and Garwick (as cited in Kiresuk & Lund, 1979) point out the therapeutic benefits of GAS may be due to factors related to reality testing, being oriented toward the future, and having specific targets for which to aim. The GAS method of evaluation appeared to be an appropriate method to use when evaluating the effectiveness of solution focused and structural models of therapy because they are compatible with one another in terms of their foci, with each focusing upon change, the future, and strengths.

However, GAS has certain limitations. When compared to other devices for measuring outcome, GAS has low construct and concurrent validity (Seaberg & Gillespie, as cited in Mitchell & Cusick, 1998). Further, reliability studies that have been conducted show the reliability of the instrument ranges from adequate to good (Rock, 1987). Goal attainment scores are not meant to have high correlation with other measures. It was not developed as a traditional research method. It does not attempt to establish causal relationships between variables, nor discriminate between clients based on a set of norms of behaviour or development (Ottenbacher & Cusick, as cited in Sladeczek, 2001). Therefore, although "...a family may have attained or surpassed the goals set by the therapist, this family may not be functioning well by universal standards of mental health and pathology. Some families who exceeded their therapist's goals may

not, in an absolute sense, be healthier than some who did not meet the goals set" (Woodward, Santa-Barabara, Levin, & Epstein, 1978, p. 474). The literature also highlights some potential difficulties and pitfalls with constructing this evaluation measure and I encountered many of the difficulties outlined below. Practitioners may find that they are spending a significant amount of time learning how to develop and construct a GAS (Sladeczek, 2001). Sladeczek (2001) suggests that training in the use of this technology is necessary. Further, as Rock (1987) points out when constructing a GAS it is often difficult to specify outcome standards and the implementation process can be tedious (Woodward et al, 1978). Goal setting can require a lengthy period of time (Woodward et al, 1978).

During the practicum it became apparent that the GAS would not be suitable with this client population. In the first week of September following the initial sessions with a few families, I became concerned about how I would go about constructing or devising a GAS guide with the families with whom I was working. Families were able to identify problem(s) that they wanted to address, however constructing a GAS guide that included scales of desired and undesired outcomes proved to be a difficult task. Clients had difficulty articulating what would be indicative of a desired or undesired outcome. I would have had to spend a great deal of time and energy with families to construct this guide and families initially appeared to want to focus on telling "their story" and were very reluctant to spend time on constructing a GAS guide. Further, for many clients this task would have proved to be overwhelming and beyond their abilities while they were in crisis. Construction of the GAS guide proved to be cumbersome, tedious and time

consuming which ultimately contributed to the decision not to utilize it in this practicum. Families attended counselling with their own agendas, which were to resolve their problems, feel heard and reduce their stress level. Constructing a GAS guide for the purposes of assisting me in evaluating my practicum was not high on their list of priorities, understandably so. In consultation with my committee members, I concluded that the needs of my clients should take priority over my own needs of evaluating my practicum and therefore decided that I would not use the GAS measure. Ethically, I could not continue to attempt to utilize this evaluation tool with the primary purpose being to meet my own needs and agenda, rather than being guided by what was in my clients' best interest.

To supplement the GAS snapshot information and provide a more thorough and comprehensive picture of the processes and outcomes of the intervention I mailed a qualitative consumer satisfaction questionnaire to each individual who participated in therapy (refer to Appendix B). The intent of the satisfaction questionnaire was to obtain the clients' perceptions of their progress in therapy, and to give me feedback as to what they found most helpful about the therapeutic process and their overall satisfaction with the services they received at EHCC. Unfortunately, none of the clients returned the qualitative consumer satisfaction questionnaire, and therefore I do not have any feedback on their perception of the experience. I contacted each of the families a couple of times to encourage them to fill out the questionnaires, but ultimately none of the questionnaires were returned to me. When I spoke to the mothers, they tended to apologize for not having completed them, and often shared that they had forgotten or were too busy. Given

this population group, this result is not surprising due to the limited amount of time, energy and resources available to single mothers (McKie, 1993; Volser & Proctor, 1991). Filling out the satisfaction questionnaires was unlikely to be high on their list of priorities and would only have served to deplete their already stretched resources.

However, my clinical assessment on the progress and change of the families during the course of therapy and client feedback was used to supplement the snapshot information obtained by Goal Attainment Scaling. This data was to provide qualitative data, which would have supplemented the information provided by the GAS.

The third evaluation measure, a clinical assessment by myself and my clinical supervisor was used to assess outcome as noted on table 1. We assessed treatment outcome based on client feedback that was provided verbally during sessions, particularly during the concluding session with families or individuals and based on our own perception of the families functioning. Throughout the sessions with individuals and families, they were regularly asked if the problems they had attended counselling for had improved or deteriorated. With some families in which the termination occurred on a planned basis, I asked them during the last session what they found helpful and typically they had a difficult time articulating what specifically had been helpful. Further, I assessed their progress by observing their mood, presentation and interaction with one another during sessions. When many of the families began counselling, they presented as angry, sullen, and confrontational with one another. In family #1, the mother presented as very negative when she spoke of her daughter and the daughter refused to speak to her

or sit near her, however towards the end of our work together the mother spoke much more positively of her daughter, they interacted in a civil and pleasant manner with one another and smiled and laughed much more frequently. Family #6 reported a decrease in the fighting between siblings by about the third session, the mother reported an improvement in the quality of the interactions between herself and the children, and noted that she felt better about herself. Further, it was evident to me during the individual sessions I had with this mother that she was feeling better about herself, as she spoke more positively about her children and herself, smiled more often, and her demeanor was much more relaxed.

As a result of this experience, I learned that one must consider the client group that the evaluation measure will be used with, not just the applicability of the measure to the presenting problems. I chose the GAS measure primarily because it could be used with a variety of presenting issues, given that I did not focus on families with a specific type of problem. However, I quickly learned that the GAS measure entailed a construction process that was far too cumbersome and labour intensive for this population group. Due to the number of demands and stressors facing these single mothers, the limited education of many of the women, the number of problems facing them, and the amount of distress they were experiencing when they began counselling, constructing the measure was not a priority.

I recognize that there is a great deal of pressure from many systems and funders to evaluate the effectiveness of programs and therapeutic interventions, however I do not

believe that this should be done at the client's expense. Evaluation should be completed in a manner that is not too onerous for the client(s) or ultimately we may cause clients to be reluctant to seek out and participate in services. Clients who most need assistance are often in the worst position to complete and/or construct evaluation measures due to the level of stress they are under. Unfortunately, social work practitioners and social service agencies are sometimes put in positions in which they have to evaluate their work, regardless of what is in the client's best interest, however every effort must be made to make the evaluation task as user friendly as possible for the clients. Additionally, the reality is that we cannot force clients to provide feedback or complete questionnaires, despite our need for this information.

I would recommend that anyone who is attempting to select a method of evaluation for a program or practicum consider whether the measure is appropriate for the specific issue they are focusing upon, whether it is suitable for the population who will be completing it, the length of time it requires to complete it, and the degree of training required to administer it. I would strongly suggest looking closely at the critiques of the particular measure being considered. Looking back upon my client population and the various problems they presented with, I would have been wise to use the Family Assessment Measure III (FAM III) or the Family Environment Scale (FES), as they are much easier and faster to complete, requiring no effort on the part of the social worker or client to construct. The FAM III only requires a 5th grade reading level and examines the areas of: task accomplishment, communication, involvement, values, norms, role performance, affective expression, control, social desirability, and defensiveness

(Maddox, 1997). The FES is a self-report instrument consisting of 90 Likert-type items that look at three major dimensions of family functioning: family relationships, personal growth, and system maintenance (Moos & Moos, 1994). With respect to client satisfaction questionnaires, I learned through this process that they must be simple, short and as user friendly as possible. I believe that I asked too many questions in the client satisfaction questionnaire and further that it would have been helpful to use multiple choice questions, as opposed to open ended questions. I would suggest incorporating scales into the questionnaire, such as on a scale of 1 to 10 how helpful were the services you received at EHCC. This would have enabled clients to complete the questionnaire with greater ease and in a more timely fashion and therefore would have increased the likelihood of them filling it out. Further, it would also have been beneficial to have the clients fill out the questionnaire during the last session for those clients where termination was planned or to complete it with them over the telephone. Requiring clients to mail back a questionnaire decreases the likelihood that it will be completed. Lastly, it is important to pay attention to the wording used in questions, so as not to make the clients feel stigmatized. For example, some people have a negative perception of the word therapy and it may make them feel poorly about themselves, instead the words services or counselling could be used.

CHAPTER FOUR

DISCUSSION

The Process of Integrating Structural Therapy, Solution Focused Therapy and Feminist Theory

The manner in which solution focused therapy and structural therapy were utilized in this practicum was contingent upon the nature of the problem, the families' level of functioning, and the number of individuals participating in therapy. Therefore it was determined on a case by case basis and was altered during the therapeutic process once the issues were more apparent. In most cases a blending of the two approaches occurred, with one approach being more dominant than the other. Kilpatrick and Holland (1999) highlight that the nature of the problem experienced by the family suggests the type of approach to be utilized. They indicate that structural therapy is better suited to "families in which the basic needs of minimal safety, stability, and nurturance have been met, and maintaining authority and setting limits are the prominent issues" (Kilpatrick & Holland, 1999, p. 6).

Structural therapy is frequently used to address problems with family structure, boundaries and power, which are commonly associated with single parent families (Minuchin & Fishman, as cited in Gladding, 2002). The approach is designed to put the parent in charge of the functioning of the family and therefore the family transitions from being a system in which there is a parentified child or an equalized relationship between a parent and child to one in which the power is possessed by the custodial parent (Gladding, 2002). However Bott (1994) states that a structural approach may be used

"even in the absence of other family members and without having the opportunity of having the family demonstrate its process in the therapy room, the individual counsellor or therapist can address the following questions (p. 108)": 1) What was the function of the client's role in their family of origin at critical transitions in the family life-cycle? 2) How differentiated is the client from her family of origin? 3) How functional is the structure of the present family system?

Questions number 2 and 3 were used during this practicum, but question number 1 was not, primarily because I tried not to focus on the mother's family of origin in order to keep the focus on the present and not become preoccupied with history. Solution focused techniques such as searching for exceptions, focusing on the strengths and giving directives at the end of sessions were incorporated into structural therapy. One of the criticisms of structural therapy is that it does not focus on what occurs outside of therapy (Piercy & Sprenkle, 1986). Solution focused therapy's techniques such as, "first session task" or "the assess more of the same" assisted in addressing this limitation because each require that the client engage in them outside of therapy (Weiner-Davis, 1995).

Solution focused therapy lends itself more to use with families who have their basic survival needs met and have achieved some degree of success in dealing with family structure, limits, and safety (Kilpatrick & Holland, 1999). Most of the families in this practicum had difficulty with family structure and limit setting and therefore structural therapy was used with each family to some degree. Alternatively, it is suggested that the solution focused approaches' emphasis on making minor changes is well suited to the

beginning developmental phase of single parent family life, which is characterized by much unrest and the ability to engage in therapeutic work is limited because of demands and fatigue (Gladding, 2002). Only one of the families involved in the practicum was in the early phase of single parent family life and I used more of the solution focused approach with this family, however the structural approach was also incorporated as this family had significant problems in terms of their structure and the mother's ability to set limits.

Throughout the therapeutic process the feminist philosophy was used to assist the mothers to become cognizant of the factors at play, thereby lessening the blame and guilt they felt about the problems they were experiencing. The feminist philosophy assisted in making connections between their experiences and the experiences of other women, helping them to realize they were not alone. Assessment from a feminist philosophy included the extent to which the single mother saw her experiences as similar to other women and common to many women in society. In addition such an assessment explored what society says about women and families and what is available to assist them to become aware of the sociopolitical factors involved. Many of the women who were provided service in this practicum were disempowered and in stereotypical female roles. The goal was to empower them, validate their experiences, instill confidence and assist them in identifying their options and recognizing that they could have choices (Kissman, 1991).

Structural therapy theory and concepts are based primarily on a two parent family system and the structure, boundaries and hierarchy outlined as being ideal are those of this family type. For the purposes of this practicum, which focused upon single mother families, the expectations around boundaries and hierarchies were less rigid, given that this family type is less prone to clear boundaries and well-established hierarchical structures (Colapinto, 1991; Walters et al, 1988). Further, expectations about what is a structurally healthy family structure, in particular the strong executive subsystem was altered somewhat to fit with Aboriginal people and their cultural view on parenting. My experience with Aboriginal families in the child welfare system suggests that they have a more permissive attitude toward parenting and less differentiation of power between parent and child. As highlighted by Greif (1996), the conceptualization of boundaries in any one family varies based not only on the idiosyncratic nature of the family, but on their culture or ethnic background.

Whether a presenting problem or structural family problems was the focus of therapy, was dependent upon the nature of the problem presented by the family. Therefore, when the problem was structural in nature, structural issues such as boundaries and hierarchy were addressed. However if the problem lent itself more readily to solution focused therapy then the presenting problem was addressed. Often there was a dual focus, including a focus on both problems to varying degrees. Clients were encouraged to participate in identifying goals of therapy as much as possible, as solution focused therapy and feminist theory would suggest.

There are some aspects of the structural approach, the solution focused approach and feminist philosophy that contradict or conflict with one another. Therefore decisions about conflict had to be addressed. Structural therapy maintains that the entire family must be seen in therapy or therapy cannot be conducted. In contrast, solution focused therapy suggests that one individual can be seen in therapy because change in one part of the system will produce change in other parts. During this practicum, an individual was seen if other members of the family system were unable or unwilling to participate. For example, an adolescent female was seen in counselling without her mother and brother, as they stopped attending appointments after a few sessions. I felt it was important to tailor the intervention to the client and not to attempt to search for clients who fit with the intervention model that was selected.

Each of the approaches takes a different position with respect to the role of the therapist, with the solution focused model articulating a neutral and supportive stance (Dermer & Hemesath, 1998). Structural therapy articulates a directive role in which clients are challenged once a relationship is established (Cleveland, 1999) and feminism encourages therapists to identify and share their beliefs in a respectful manner because the "illusion of neutrality inclines one to reinforce the status quo" (Dermer & Hemesath, 1998, p. 245). I took a respectful and supportive stance, however clients' beliefs and values were challenged through questioning during the process. For example, if a mother implied that a woman's place is at home in the kitchen and caring for the children, I asked questions such as "what expectations are placed on mom's and dad's; where did these messages come from; and what would happen if you didn't do that."

Themes & Highlights

Theories and approaches do not apply perfectly to families and therefore a therapist must be able and willing to modify them as necessary. Flexibility and adaptability allow one to utilize what is likely to be most effective with the problems and issues presented by a specific family (Beckett, 1997; Fefchak, 1997; Bott, 1994). The incorporation of three approaches in this practicum provided me with the tools and ability to do this. It proved to be extremely useful to utilize Structural therapy, Solution Focused therapy and feminist theory with families, as it provided me a broader range of techniques to select from and it didn't limit and confine me to one model, which may have had limited applicability or usefulness with a specific family.

The Structural approach served as a framework to assess where families were at in terms of their functioning and structure, and I found that the assessment framework was applicable to single parent families despite the fact that it was constructed with two parent families in mind. The structural approach is criticized for being paternalistic, however it is possible to modify the language used when applying it and the incorporation of the feminist approach helps to make it more gender sensitive.

I utilized aspects of solution focused therapy and feminist principles with each family. With some families I used primarily a structural approach because the issues the family presented with lent themselves readily to this approach. For example, with family #1 I primarily used a structural approach because boundaries and power dynamics proved to

be central issues in this family. Enactments were routinely utilized during therapy with this family, which gave me an accurate picture of what went on at home and gave me the opportunity to alter the interactions during sessions. However, I also used solution focused therapy with family #1 at various points in time by focusing on strengths and searching for exceptions to the problem. Further, feminist principles of empowering, validating, reframing and connecting the mother's experience to that of other women were incorporated into my work with the mother in family #1 because she was feeling very isolated, alone, discouraged, ineffective and generally seemed to possess very low self-esteem and a negative outlook about her circumstances.

With family #6, I started out with the intent of using primarily a structural approach, given that the issues they presented with were related to boundaries and power dynamics, with the mother's position and role in the family needing to be strengthened. However, after two family sessions, the mother started attending sessions on her own because she had started school downtown and was no longer able to bring the entire family to sessions. It was much more convenient for her to see me on her own. Therefore, I shifted to using primarily a feminist approach, focusing on validating her experiences, empowering her, reframing experiences, focusing upon her strengths as her self-esteem was extremely low, and connecting her experiences to that of other women so she would not feel so alone and isolated. I also incorporated some solution focused interventions, such as searching for exceptions and focusing upon strengths as I worked with this mother.

With family #4, I utilized a combination of all three approaches because some sessions were family sessions including all 4 girls and the mother and some sessions including just the mother while still others included the mother and the teenage daughter and the mother. In the sessions that included the whole family, I tended to utilize more of a structural approach, including enactments, restructuring boundaries, and strengthening the executive subsystem. In other sessions that included just the mother I tended to utilize more of a feminist approach, including focusing on hearing her story, validating, empowering, connecting her experiences to that of other women and reframing. In one session with the mother she was spending a great deal of time and energy talking about her teenage daughter's behavior, focusing exclusively upon the negatives and stating that she had failed as a parent. However she mentioned that her daughter had been calling her frequently and had given her a thoughtful card despite the fact that she was no longer residing in the home. During this session, I focused upon the positives in her daughter's behavior and pointed out that clearly she had done some good parenting and there was a relationship given some of her daughter's positive behavior. This was an absolute revelation to her and she actually started to cry. Further, I incorporated solution focused therapy during various sessions by focusing on strengths, searching for exceptions and reframing.

Building rapport and engaging with families proved to be a very important aspect of the therapeutic process. Each of the approaches utilized in this practicum stresses the benefits of building a relationship first and foremost, prior to utilizing techniques or interventions to bring about change in the family. This proved to be key in my work with clients. Proponents of structural therapy speak of the necessity of joining with clients as

the first task in counselling, prior to restructuring and challenging the system (Nichols & Schwartz, 1998). The approach outlines specific techniques that can be utilized to engage with clients: confirmation, accommodation, maintenance, and mimesis (Minuchin, 1974; Colapinto, 1991). The Solution Focused therapy model also stresses the importance of developing rapport (O'Hanlon & Weiner-Davis, 1989) while Feminist theory maintains that the relationship between therapist and client is paramount in the therapeutic process and highlights the importance of respect, support and affirmation of the client (Gluckstern & Ivey as cited in Kerr, 2001; Laidlow & Malmo, 1991). If a relationship is not established with the clients/families in the first few sessions, they are unlikely to want to return for future sessions. Nor will they be inclined to share personal information with the social work practitioner. Further, it is difficult to challenge and confront clients on different issues without the foundation of a therapeutic relationship.

My work with different families proved the importance of developing a relationship with clients. For example, with family #1 the 11 year old daughter was very resistant to participating in counselling and it was extremely difficult to engage with her. Four sessions were devoted to working with her individually in an attempt to develop a relationship so that she would trust me and realize that I did not believe that she was the identified problem as her mother was attempting to portray. The individual sessions with her proved to be very beneficial because during the family sessions following the 4 individual sessions, the daughter opened up and challenged her mother on a variety of issues, which she had previously refused to do. She presented as much more vocal and interactive during family sessions than she had prior to working with her individually.

I also worked extensively with a teenage girl (pseudo name Lucy) from Family #3 who was in the care of Child and Family Services due to her mother's drinking and parent-teen conflict. Lucy was reluctant to work on any specific issues during counselling, but reported that the relationship that she had developed with me was key in her returning to see me on a weekly basis. She indicated that she had never opened up with anyone like she was able to do with me and that was due primarily to her feeling comfortable and accepted by me.

Finally, with family #6 the teenage male who I will refer to as Grant was totally and completely opposed to participating in counselling and stated during the first session that he would not speak nor would he come back to see me again. However following the first 15 minutes of the first session he readily contributed to discussions and in fact participated more than any other member of his family. The importance of devoting time and energy to engaging with clients and developing relationships was demonstrated throughout my work with the families in my practicum.

It became apparent during this practicum that there are a number of factors that affect a family or client's participation in counselling services. I found it very frustrating how frequently clients did not attend appointments, but this is not an uncommon experience at EHCC and there appear to be a number of factors that contribute to this problem.

This practicum included both clients referred by a mandated agency and self referrals. More than half of the families initiated counselling because they felt they required some assistance and the other families in the practicum were strongly urged to attend by Child and Family Services. In fact their Child and Family Services social worker made the referral to EHCC. Attendance and participation was definitely more difficult and there appeared to be less of a commitment for clients who had been directed to attend by their CFS worker than for clients who had made the decision on their own. Cancellations and no shows were more frequent for those referred by CFS, making it more difficult to develop a relationship, identify problems and bring about change in the family. There appeared to be more time spent on complaining and telling their story than on a desire to alter the family situation.

However, at the same time missed appointments or appointments cancelled at the last minute occurred with all families involved in the practicum, whether they felt pressured or not. The fact that services at EHCC required no payment may have played a role in this, as it could be perceived that there was no material consequence for missing appointments.

In-home counselling would have been an easier alternative for many, if not all of these families given the demands in their lives. For many of these families, attending counselling appointments was simply not a high priority on their list, given all of the other day to day stressors and tasks with which they were faced. I suspect that there would have been far fewer cancellations and no shows had I been attending their home as

opposed to having them come to me. Over half of the families involved did not have a vehicle, therefore attendance at counselling appointments meant they had to take public transportation which is costly and time consuming.

In my literature review I spoke of determining where families were at in terms of having their basic needs met for minimal safety and stability as important in facilitating their participation in the counselling process (Kilpatrick & Holland, 1999). The importance of this was readily apparent during my practicum, as the families whose basic needs were not being met were not able to participate in counselling in any meaningful manner. For example, families #1, 2, 4, and 5 had their basic needs for food, shelter, and safety met and therefore they were in a much better position to engage in the therapeutic process. Families #3 and 8 are perfect examples of families whose basic needs were not being met.

In addition members of these families struggled with substance abuse issues, making participation in therapy in a meaningful manner impossible or very difficult. In family #8, the decision to terminate therapy was made after 2 sessions by the mother in discussions with her CFS worker because it became apparent that the drug abuse had to be addressed first before counselling would be of any benefit. The mother had decided to attend an inpatient drug rehabilitation program for her addiction to crack cocaine. Most of the mother's money was spent on drugs, leaving little if any funds for food, shelter and clothing. Further, due to the individuals the mother associated with and the nature of her boyfriend's temperament, her safety was compromised. In family #8, the adolescent

daughter was in the care of Child and Family Services and she did not want to continue to participate in counselling. In family #3, family counselling was terminated because the mother was actively abusing alcohol and drugs, but counselling continued with the adolescent daughter in the family to assist her to deal with the feelings she had about her mother and being in care.

The two primary approaches utilized in this practicum do not place sufficient emphasis on the need for clients to "tell their stories" to ensure that they felt heard and understood. Structural therapy and solution focused therapy stress goal identification and the utilization of techniques that will bring about change such as restructuring or focusing upon exceptions to problems, focusing upon strengths, reframing etc. Nor did the feminist orientation I used sufficiently acknowledge this, as would a "narrative" perspective for instance. During my work with clients it became apparent that clients need to "tell their story" and it is difficult to push them forward towards finding solutions and solving problems until this occurs. Clients need to spend the beginning stage of counselling talking about their lives and the problems they have encountered, and when I tried to shift the focus to solutions and goal identification they continued to shift the focus back to their stories and problems. Some clients told their story in a session and others took two to three sessions to complete this. Once I realized this, I began to give clients the opportunity to tell me about their lives and the various problems they encountered and I viewed this as part of joining, engaging and building a relationship with them.

For example, when working with the mother in family #4, I continually attempted to shift her focus to solutions to problems and to the present and future, rather than the various problems she had faced during her life. However the harder I tried to stop her from telling her life story the more she kept shifting the focus back to her life story. I eventually gave up and let her tell her story and once she was done she readily shifted her focus to goal identification and problem solving. It took her approximately 3 sessions to complete this process and it encompassed her talking about her childhood, family of origin, teenage years, when she had children, and her marriages, but as I look back on it, it was not wasted time because it assisted me in developing a relationship with her. I empathized, validated, attended to what she shared with me and clarified information by asking questions and this assisted in her feeling heard and accepted by me, which assisted in the therapeutic process.

My experience with family #8 was very similar, as the first two sessions were spent entirely on the daughter telling her story and then the mother telling her story which consisted of sexual and physical abuse, domestic violence, separation, substance abuse, mental health problems, suicide, prostitution, and intensive involvement with Child and Family Services. Ultimately, they did not return after the first two sessions, but that was the result of active and pervasive substance abuse plaguing the family, making it difficult to engage in counselling.

Finally, some clients are unable to focus upon goals and change, but instead prefer to "vent" about past and current life experiences. I learned that clients follow their own

path and pace in counselling and they determine whether the experience has been valuable to them or not. My work with the teenage girl in family #3 proved to be a situation in which she was not ready or willing to do anything aside from sharing her story past and present, but this still proved to be helpful. Her goal was simply to have someone she could confide in about her life experiences, nothing more and nothing less. She reported that she had never confided in anyone previously because she doesn't trust people, but she consistently and willingly did so with me. She reported that I helped her feel supported, less alone, and I helped her get through some difficult times just by listening, encouraging and validating her. If she chooses to engage in therapy in the future, this experience will assist her in trusting and engaging more readily and perhaps at that time her goals in therapy will be more explicit, specific and concrete. As articulated previously, relationship building is a critical component of the counselling process. Clients telling their stories is not time wasted and there is a great deal of merit in providing clients with the opportunity to share significant aspects of their lives.

Each of the approaches incorporated into this practicum takes a strength based approach that supports the use of validation and compliments. I must admit that I never recognized the tremendous value in affirming, validating and complimenting clients, but it was hugely successful in building a relationship with them. Further, it did wonders for their levels of self confidence which were routinely very low, despite the fact that they had a lot to offer and had accomplished many difficult things in their lives, especially given the various obstacles they had endured.

The research literature (Green & Crooks, 1988; Kissman, 1991; Sheeber & Johnson, 1992) and my experience with the single mothers in this practicum highlight the fact that they experience low levels of self-esteem and often felt ineffective in their role as parents. Most of these women lacked nurturance in their own childhoods and lives and had many unmet emotional needs. Therefore part of my role was to zero in on the positives in these women in an attempt to nurture them and meet some of their emotional needs, so that they could in turn do the same for their children. One could look at it as a form of modelling. These women were delighted and grateful when I spoke positively about their character or something they had done; however initially their reaction was one of surprise and tears because they were so unaccustomed to positive feedback. It was not uncommon for the mothers to start crying when I gave them a compliment and to thank me.

For, example, when working with the mother in family #6 I routinely complimented her on a variety of different accomplishments, such as: returning to school; surviving an abusive marriage and being able to remove herself and the children from that situation; the love and connection in this family which was readily apparent to me; and on some of the parenting she had done with her boys who had many good qualities despite some of the challenges she was experiencing with them. This mother appeared to thrive on the affirmation and validation she received in counselling and routinely teared up when I complimented her.

Further, the use of compliments also provided the foundation to be able to challenge and confront clients because clients were less likely to respond to challenges and confrontation in a defensive and combative manner when they felt that you viewed them in a positive light. This is what I refer to as the "stroke/kick" method – the stroke refers to giving them a compliment and this is done first before you challenge or confront them on a specific issue (kick). The literature on structural therapy, solution focused therapy and feminist theory refers to this as joining and building a relationship with a family (Nichols & Schwartz, 1998; O'Hanlon & Weiner-Davis, 1989; Kissman, 1991). For example, with the mother in family #1 I did not get to the point where I directly challenged her on her lack of nurturing behavior, her punitive approach and her tendency to label her daughter as the problem, until I had had several sessions in which she felt supported and validated by me. She had poor self-esteem and tended initially to react in a very defensive manner when called on these things. However when I challenged her on some of her parenting after we had established a relationship and she seemed to perceive me as seeing many positive characteristics and qualities in her, she did not become as angry and defensive and instead looked at how she could change her behavior. I learned during my practicum that one cannot undervalue the benefits of focusing upon strengths and that 'honey' will get one much farther than 'vinegar'.

The structural approach and solution focused therapy each stress the importance of having a clear understanding of the families' problems and articulating clear goals. In my work with the families this proved to be crucial in terms of providing a focus to the sessions and giving some direction on the issues that were highlighted. It would have

been easy to become lost and get caught up in the multitude of issues they presented, in the absence of identified goals and the salient problems in the family.

The Structural approach was very useful in this regard, as its assessment framework assisted me in developing a comprehensive overview of the functioning of the families with whom I was working. The structural approach identifies six main areas upon which an assessment should focus: family structure, the system's flexibility, boundaries (enmeshed or disengaged), families' sources of support and stress, families' developmental stage, and how the identified patient's symptoms are used for maintenance of the family's typical patterns of interacting (Colapinto, 1991). This framework was of great assistance in guiding my work with families and helping me to obtain the information necessary to develop a thorough understanding of a family's functioning.

During my practicum, I also became much more aware of the importance of taking into consideration the life cycle stage that a family is at, the developmental needs related to that stage of development and the transitions associated with that stage (Minuchin & Fishman, 1981; Colapinto, 1991). Transitional challenges during the teenage years and separation/divorce, which all of the families in my practicum had experienced, can produce a great deal of stress/turmoil and can in turn cause dysfunctional behaviors. Prior to this experience, I had not given this area the attention or consideration that it so clearly requires.

It also became apparent to me that it is critical to start with the families' view of the presenting problem and focus upon the their goals, a factor emphasized by solution focused and feminist theory. Two of the families I worked with, families #2 and #4, had very clear ideas about the presenting issues and their goals in coming for counselling. In family #2, the mother readily indicated in the first session that she wanted "a stronger family" and with some assistance from myself the family was able to articulate what a stronger family would look like. A stronger family would communicate more (talk about their day at dinner, tell one another what is bothering them), go on outings with one another such as taking a trip to the beach for the day or going shopping, and each member of the family would pitch in with chores around the house. In family #4, the mother was able, after a few sessions of "telling her story" to identify that she is emotionally unavailable to her children and she wanted to be more attentive to their emotional needs. The mother had some thoughts on what she could do to be more emotionally available, however her four girls also had some very clear thoughts on what their mother could do: walk them to school, read to them, hug and kiss them, tuck them in at night, help them with their homework, and be at home more frequently.

It also became apparent during my practicum that some families or individuals have a range of fairly serious problems that are creating huge chaos and insecurity in their lives, none of which seem any less significant than the others. Consequently, they do not have any clear goals in therapy. Instead they simply come to vent and feel heard and supported. This tends to be frowned upon by counsellors and agencies, however the merits of simply providing an ear to listen and a shoulder to cry on must not be

underestimated. My work with family #3 is the perfect example of this. I initially started working with the entire family, which consisted of a mother, 13 year old daughter and 15 year old son. However the mother's use of alcohol and prescription medication intensified and she stopped attending. Her daughter was already in agency care and her son came into care again as the mother's behavior deteriorated. This family was struggling with a multitude of problems: substance abuse, the children being in agency care, the daughter's dislike of her foster family, the daughter's school problems, the daughter's past sexual abuse, the children's witnessing of domestic violence, the children's experience of severe neglect during childhood, and intense conflict between the daughter and the mother. My work switched from a focus on the family to individual work with the 13 year old daughter once her mother's behavior spiralled out of control. She was very clear that she had no one to talk to and just wanted a place to vent, feel heard, supported and validated. She did not want to focus on any specific issues, nor was she at a point where she was ready to address specific problems such as her relationship with the foster family.

During my work with the families in this practicum, I became very aware of the benefits of learning about clients' childhood experiences and history, despite the fact that the two primary approaches used in this practicum, structural therapy and solution focused therapy, do not encourage or support soliciting this information. I am not suggesting that it is useful to spend large amounts of time reviewing someone's history, but someone's childhood experiences and history can offer insight into behaviors, themes and patterns in families and can assist in coming up with solutions. For example, in

family #1 the mother shared that when she was growing up she was identified as the problem in her family and her mother tried to have her labelled with a mental health problem and actually had her hospitalized. The mother in family #1 advised that she did not believe that she had a mental health problem, but instead was responding to her mother's parenting and the home environment. This mother was repeating her mother's behavior with her own daughter and was attempting to label her daughter as the problem. By examining her own experiences with her mother, she was able to see how her behavior was affecting her daughter and was also able to identify what her daughter needed from her by looking at what she had needed from her own mother when she was a child. Clearly, looking at her childhood experience and history with her family of origin was a useful tool in assisting her to recognize the mistakes she was repeating and to alter her parenting with her own daughter to ensure that her daughter received the nurturing and unconditional acceptance she required.

In family #4, the mother indicated that her behavior when she was a teenager was identical to that of her eldest daughter. She shared many examples of this and was able to use her own experiences as a teenager to understand what her daughter was experiencing and to help her determine what her daughter needed from her. Her own childhood experiences assisted her in empathizing with her daughter and in determining what would be the most effective manner to deal with the conflict and difficulties that she was experiencing with her. Neither of the key approaches I used in the practicum value the importance of "insight" in counselling, however I learned during my practicum that it can be a significant factor in creating change in a family system.

In conclusion, I would recommend integrating these three approaches when working with single mother families, as it proved to be useful. It provided me with the tools to complete a comprehensive assessment and a wide array of techniques and intervention strategies to assist in bringing about change. When using these approaches together, it is imperative that you decide how you will approach contradictory issues including the role of the therapist, who is included in therapy, and whether the presenting problem or family structure will be the focus. However, it is also very important that you be flexible when blending together approaches to ensure that you are able to adapt your approach and use what is most effective with the client(s).

The structural approach provided a thorough outline for completing an assessment, which was extremely useful and feminist theory assisted in making it gender sensitive. In particular, the structural assessment's emphasis upon the life cycle stage of a family proved to elicit information that was very useful. Further, the structural approach provided interventions such as enactments, reframing, and restructuring to bring about change, each of which were instrumental in bringing about change. The solution focused approach offered questions and techniques that assisted in identifying goals, focusing on strengths, and illuminating change. Each of the approaches stresses the importance of building a relationship with clients and this proved to be critical in the counselling process. Further, each of the approaches emphasizes the need to focus upon strengths, providing validation and compliments and this proved to be an important tool in therapy. Acknowledging a client's history, family of origin issues and the need for clients to tell

their story is not encouraged or recommended by the two primary approaches used in this practicum, structural and solution focused therapy. However, it became apparent during this process that it is helpful and necessary to do so. Finally, this experience highlighted the importance of taking into consideration the impact that other factors play in a client's ability and willingness to participate in therapy, such as substance abuse and voluntary participation versus pressure from a social welfare agency.

CHAPTER FIVE

PERSONAL GROWTH & LEARNING

The personal growth and learning I experienced during my practicum was tremendous. I began my practicum feeling incredibly insecure and incompetent about my knowledge and skills, and over time I began to realize that I already possessed many of the skills needed in my practicum. My work in the field of child welfare had equipped me with many of the basic skills and knowledge I needed to complete this practicum, but I had simply not recognized or labelled the skills that I already possessed until I began my practicum. I was skilled at developing relationships with clients and I had a solid understanding and comfort level with the information necessary to complete a preliminary assessment on a family. Thomas Gordon (1970) wrote a book on *Parent Effectiveness Training: The tested new way to raise responsible children* in which he outlines how new communication skills are acquired. He explains that this process consists of moving from being unconsciously unskilled (not skilful and unaware of not being skilful), to being consciously unskilled (not skilful but aware of the need to develop skills), to being consciously skilled (developing the skills but needing much conscious effort), and finally to being unconsciously skilled (being skilled and having the responses flow with little thought). Following my experiences in this practicum, I believe I was at the third stage of the model outlined by Gordon (1970).

The evaluation of my skill development and learning was completed from two different perspectives. The first perspective was through supervision with committee member and primary clinical supervisor, Linda Burnside. The second source of

evaluation was my own self-assessment of the level of progress achieved. I based my self-assessment upon what was contained in my personal journal, which provided me with a comprehensive outline and review of my learning process and level of skill development.

Learning Objectives Revisited

1. To develop and strengthen assessment skills from a structural framework

The assessment framework as outlined in the Structural approach was utilized with every family included in this practicum to assist in formulating a hypothesis regarding the nature of the problem in the family. As Colapinto (1991) points out, the heart of the structural approach is its way of conceptualizing family problems. Therefore having the structural goal in mind to guide the intervention is more important than using the classical structural techniques.

I began seeing my first family in mid to late August and by the end of September I felt much more confident in my ability to complete intake sessions with families. I completed an intake session with family #2 on October 10, 2002 and I felt that there was a notable difference in my confidence, comfort level and competence with utilizing the structural approach. I was able to develop rapport with them quite quickly and was able to laugh and joke with them when appropriate during the session, instead of being preoccupied with my focus and my next question or comment.

I went beyond my stated goal of learning to conduct assessments from a structural framework and became familiar with the various techniques and interventions used in this approach. My supervision sessions with Linda Burnside helped me to label and articulate the various techniques I was using. She would regularly ask me what aspects I used with each family and early on she would tell me when and how I was using the structural approach, pointing out I often didn't realize it or couldn't identify it. I utilized enactments during sessions with families, clarified roles among family members, helped the mothers establish rules & boundaries, aligned with family members as needed, joined and accommodated to form relationships with family members, and finally examined the hierarchy and power dynamics in families. With family #1 I frequently attempted to facilitate interaction between family members during sessions in an attempt to create enactments. I also tried to align with the identified problem child by having individual sessions with her initially, and then by sitting beside her in session so that she would recognize that I was there to be her "helper" during sessions with her mother. With family #4 I regularly attempted to create enactments by having the mother and the children tell one another how they felt on different issues and by asking the mother what she thought the children needed to hear from her and how she could give them that message. A great deal of effort was put into strengthening the parental subsystem by clarifying roles, boundaries and rules in this particular family.

The homeostatic concept is a fundamental concept in the structural approach and stipulates that a family will relate in a manner that is most familiar and comfortable to

them, even if it is creating problems for the family system. I routinely employed this concept with families as a form of explanation for the tendency for a family's functioning or an individual's behavior to deteriorate or revert back to old ways. I found that this concept was very useful for helping families not to become anxious and discouraged because of a deterioration in functioning or reverting back to old ways of interacting. People truly do behave and interact in a manner that is most familiar to them, whether it is functional and healthy or not. When families can recognize this, it takes away some of the pressure, shame, and discouragement when things deteriorate after progress is made.

I found that my learning with respect to the structural approach was very much an unconscious, gradual process in which I didn't even realize that I was understanding and utilizing the assessment framework and the techniques and interventions. I was most intimidated by learning to use the structural approach, given its complexities and the level of skill and knowledge required by the clinical social worker when using this model. I eventually had what I refer to as an epiphany moment some time in November in which a light bulb went off in my head and I realized that I grasped the concepts, the theory behind it and was readily able to apply the theory and techniques in session.

2. To learn how to augment an assessment from a structural approach with a feminist perspective to make it gender sensitive

I learned how to augment structural therapy, which tends to be paternalistic with the feminist perspective when working with single mother families in order to create a more gender sensitive approach. I became adept at using feminist principles such as empowering, affirmation, reframing, focusing on strengths, identifying supports, normalizing experiences and connecting women's experiences to that of other women. I used the feminist principles with every family I worked with, however I incorporated them most frequently with families #1, #4, and #6. These families were headed by women with very poor self worth who received minimal nurturance in childhood and lapped up the affirmation. Each of these mothers was very strong deep down, but they just needed encouragement and support to recognize their own strengths to empower them. The feminist principles were very effective and a significant addition to the other two approaches, given that the focus of the practicum was women and all of the women included in the practicum had low self-esteem. I found that by November '02 I became much more conscious and aware of the feminist principles I was utilizing in session with clients.

3. To develop interviewing and intervention skills in solution focused therapy

I used solution focused techniques with each of the families included in this practicum and found that the tools from solution focused therapy served me in difficult situations when I felt stuck. For example, when families were fixated on the negatives it helped to shift the focus to positives/strengths and to devise goals. It provided me with an attitude to the family that allowed me to enter their world in a respectful and empowering manner. It also gave me simple language to communicate

and enhance the strengths in the situation. I regularly used the techniques of "searching for exceptions to the problem", "what's different when the problem isn't present", "how were you able to do that", "doing something different", the miracle question, and homework assignments. I found it is easy to utilize the techniques in this approach to augment other approaches, such as structural therapy and feminist theory.

4. To learn to integrate process with content

Learning to focus upon process and content was a gradual shift that required me to continually remind myself to pay attention to the process, as I found that at least initially I frequently became hooked on the content in the session. I found that as I became more comfortable and confident during sessions, I was much more able to examine process instead of just focusing on the content. Once my anxiety was reduced I had more energy and attention to focus on who sat by whom, body language, tone, who talked the most in a family, who talked the least, facial expressions etc. In Family #1, the 12 year old daughter in the family refused to speak for many of the sessions, glared at her mother, and sat as far away from her as possible. However by the last couple of sessions she requested that her mother sit beside her, she smiled, laughed and was very talkative and interactive. I also came away from this practicum being cognizant of the fact that there must be a balance between process and content in therapy and one cannot pay attention solely to process to the exclusion of content or vice versa. Typically, I tend to focus upon content

more readily than process, however this practicum experience has caused me to focus on process more readily.

As a social work clinician, I learned the importance of paying attention to the manner in which things are carried out with clients (process) and the pace at which they are carried out. I became more aware of the need to slow down the pace and spend the time and energy on preparing clients for what was ahead. This is in stark contrast to my typical manner of approaching situations, particularly in the child welfare field when one does not have the luxury of slowing things down. With the adolescent daughter in family #3, a face to face meeting was planned with her and her mother to discuss both her feelings about the prospect of returning to her mother's care and the manner in which her mother treated her throughout her childhood. I spent a couple of sessions with the adolescent preparing her for this meeting and discussing with her what she wanted to say to her mother and how she wished to say it. Ultimately the meeting between mother and daughter did not occur, but the experience reminded me of the need to slow down and prepare clients for the tasks ahead.

5. To become more adept at developing rapport and joining with families and to develop effective termination skills

This practicum taught me a great deal about developing rapport and how critical it is to develop relationships when working with families. Developing rapport is key when working with a family or individual and failure to do so can derail the whole therapeutic process. The reality is that the techniques and interventions used with

families will not be effective if a relationship with the family is not developed. It doesn't matter what approach one uses, relationship building skills are necessary for the therapeutic process. Prior to beginning this practicum, I did not pay close attention to rapport building and developing a relationship, but I quickly learned that it must be the first priority and I think it is the most important skill to possess. I believe that I began the practicum with some skills in this area that I acquired from my experience in the child welfare field, but I just never realized I possessed them. Over time as I became more comfortable with the process I became more adept at engaging families by chit chatting initially, laughing, joking and mirroring some of their behaviors and was less focused upon getting information needed to complete an assessment.

During my practicum I struggled with developing effective termination skills. In mid October '02, Linda made some suggestions on how to begin to wrap up sessions with clients. She had noted that I tended to end sessions somewhat abruptly with little warning for clients that the session would be concluding. She suggested that 15 minutes before the end of a session I should tell the client(s) that we were nearing the end of the session and at that time summarize what we had discussed and inquire if there was anything in particular that they would want to carry forward and focus on during the next session. I began to be much more conscious of the need to allow an opportunity to summarize what was covered during the session and give clients a warning that the session would conclude in 10-15 minutes. This ensured that we did not begin talking about any weighty issues that would not get properly discussed.

However, I struggled with implementing this practice in every session with clients. I tended to feel like I was cutting them off and disturbing the flow of the session by beginning to terminate 45 minutes into the session. The reality is that this awkwardness with terminating was more about me than the clients, as there was nothing that they said or did that would have directly supported my feelings. In fact, sessions concluded in a smoother and less abrupt manner when I gave the clients a heads up that we had 15 minutes left and began to summarize the session and talk about where we were headed. Over time I became more certain this was more comfortable for the clients.

I also struggled with terminating with clients when it had been decided that our work together was finished and they would no longer be coming to see me. There were only a couple of families in which our work did not terminate abruptly, without discussion and planning. Family #1 and Family #2 were the only two families in which some planning occurred about when termination would take place. I spent the last session with these families summarizing our work together, discussing the progress they made, and highlighting their strengths. I tend to have difficulties saying good-bye in my personal life and often avoid formal good-byes needed for closure. Not surprisingly, this was a difficult process for me to do with clients.

6. To increase my knowledge and understanding of the issues facing single mother families

My experience during this practicum greatly enhanced my understanding of the various issues facing single mother families. Regardless of the background of each of the women in this practicum, they faced many of the same issues and difficulties. Financial resources were tight in all families, with some having a more constrained financial situation than others. Access to social activities and amenities that could make their lives more enjoyable or just plain easier were not available to many of these families – going out for dinner, to movies, in home laundry facilities, access to a vehicle etc. Lack of time and energy were dilemmas faced by all of the women in the practicum. Like all single mothers, the women were exhausted due to caring for children, managing household tasks, working, and attending school. In addition their lives were unusually stressful due to conflict with ex-partners, difficulties with their children at school and often involvement with Child and Family Services. Lack of formal or informal childcare or lack of financial resources to pay for child care was also a theme in many of the families, making it extremely difficult for these women to get a much needed break from their children. Most of the women in the practicum had low educational levels, making access to decent paying jobs very difficult. Many were on social assistance which presented its own set of issues in terms of self esteem, having enough money to cover the basics and having a social agency dictate various aspects of one's life, such as with whom one can live and training programs one must attend. Some of the mothers also had boyfriends, which posed difficulties for their children learning to adjust to this other individual while also accepting that their mothers would not be reuniting with their fathers. The children's reactions to their mother's boyfriends tended to cause the mothers to feel guilt and frustration.

Further, many of the mothers in this practicum had unresolved feelings and conflict with respect to the children's fathers. Over half of the women involved in this practicum had substance abuse problems, with some being in recovery and others continuing to abuse substances. This finding is not surprising given that the level of stress experienced by many of these women and the frequency with which substance abuse is used as a coping strategy. Finally, every single woman involved in this practicum possessed very low self-esteem and no self confidence, which made each very amenable to the use of the feminist approach including validation, affirmation, focusing upon strengths, and connecting their experiences to that of other women so they did not feel so alone.

7. To begin to develop my own personal style as a family therapist

My own personal style as a clinical social worker developed gradually over the course of the practicum and became more pronounced in the later stages as my comfort level increased and I could be more myself, rather than focusing so intently on what aspects of each approach I was using. During the first few weeks of my practicum, I thought I had made a huge mistake by doing a practicum involving family therapy. I began to question whether I was cut out to be a clinical social worker and whether it was a good fit for me a person who is direct and honest, but not overly "touchy, feely". I had a preconceived notion of clinical social workers and in my mind they were all soft spoken, compassionate, indirect, introspective, and non-confrontational. When I first began I was attempting to focus upon being validating, complimentary, empathic, and non-confrontational. This felt very foreign to me at

first, but gradually I realized that I could find a way to integrate my tendency to be forthright with a sensitive, compassionate and affirming side. I began to realize that there are many different kinds and types of social work clinicians, with not all of them possessing the same attributes, personalities and styles, which helped me to find a style with which I was most comfortable. For me it was a matter of becoming accustomed to operating in a slightly different manner, somewhat akin to a family or an individual's tendency to revert back to functioning in a manner with which they are most comfortable (homeostatic state).

When I first began the practicum I found that I was very uptight and anxious prior to each session and I would routinely outline in my head or on paper the information I needed to gather or the issues upon which I would focus. I very much needed to have some sort of agenda going into the session, which was likely the result of my experience as a child protection worker in which we entered meetings with a very clear agenda of what needed to be covered. By October, I began to be able to begin a session without an agenda and was able to "go with the flow" so to speak and see what the family brought to session. I had more confidence in myself and began to trust that I could utilize whatever the family brought to the session. I also noted that by November I was relying much less on Linda for direction on how to proceed with a family and in fact I was comfortable seeing a family without having had supervision prior to that session.

8. To develop knowledge and skill in effective evaluation procedures and data interpretation

I had every intention of becoming more familiar with using evaluation procedures and data collection, such as Goal Attainment Scaling (GAS) and client satisfaction questionnaires. However I quickly realized that GAS was not going to be easy to use with the clients and in fact it would be more of a hindrance to the therapeutic process. Therefore, the decision was made to forgo its use in the practicum and instead rely upon the client satisfaction questionnaires for feedback. Unfortunately, none of the clients involved in the practicum returned their questionnaires, which in hindsight is not particularly surprising given the demands and stressors that are already placed upon single mothers. The questionnaire was likely just another pressure and task to be added to all of their other demands. I believe I learned a very valuable lesson as a result of this practicum, which is that clients' needs direct your action as a social work practitioner, rather than your needs directing their behavior. The bottom line is that client's needs are paramount over the goals of the social work practitioner or the agency and ethically we must to what is in the best interest of the client.

As I examine my practicum experience I am led to think about how this experience has assisted me as a social worker in the field of child protection. Firstly, I have learned that my therapeutic skills have a lot of applicability to my current work as a child protection social worker. I had initially wondered how the skills I had learned in my practicum would transfer over into my job as a front line protection worker, as the perception is often that this job primarily requires case management

skills as opposed to clinical skills. There seems to be a real distinction between social workers who do what is perceived as clinical social work (primarily counselling) and those who do not, with there being more respect and prestige associated with clinical social work. I believe that any social work position requires clinical skills, whether it is in corrections, the hospital, a women's shelter, a counselling setting or child protection. In fact, in the child protection field one is often working with very difficult clients who face a number of problems, therefore it is extremely important to possess the clinical skills that assist with engaging, assessing and facilitating change. Case management skills are necessary to determine a case plan and put it into action, however clinical skills are necessary to assist in developing a relationship and bringing about change within the family system. The clinical skills of engaging, assessing, reframing, normalizing, providing support & education, knowing when & how to challenge clients, affirmation, validation, and empowerment are all useful in any social work setting. Much of what I learned during my practicum has been and is useful in my job with Child and Family Services.

Secondly, I learned that I do not have to approach my work with Child and Family Services clients with a specific agenda and I don't have to approach meetings with clients thinking that I need to deliver a specific message to them, as I had tended to do previously. There is a great deal of leeway in how I approach clients and it is not always necessary for me to be directive and intrusive. For example, shortly after I returned to work following my practicum I was assigned a case in which the family had two young children, with the concerns being that the father had a mental health

problem, the children were being disciplined in an inappropriate manner, and their basic needs were not being met. I approached the situation with the knowledge that the family was extremely resistant and afraid of agency involvement. Therefore instead of addressing the concerns in a direct manner, which would have undoubtedly caused this family to become anxious and resistant to accepting services, I focused on connecting, engaging, highlighting strengths and being supportive. This approach was extremely useful as they readily agreed to receiving services from the agency, which would not have occurred if I had taken a more confrontive approach.

During my practicum I also discovered that I enjoy working with adolescents and I am able to connect well with this population. I entered my practicum thinking that I did not enjoy working with teenagers and that I was not particularly adept at working with this population group. I found that I learned a tremendous amount about dealing with parent-teen conflict and these skills are very useful for my job as an intake worker, given that about a third of my cases involve parent-teen conflict. For example, upon my return to work I was assigned a case in which the primary issue was conflict between a 14 year old girl and her father and the conflict had escalated to the point of becoming physical. I met with the parents and took a very supportive, non-confrontational approach during the meeting. We discussed the alleged altercation, the problems they were experiencing with their daughter and I normalized their experiences, reframed them, used the life cycle stages to explain the struggles they were experiencing, providing suggestions on how to deal with the conflict. For instance, I suggested picking and choosing battles, and assigning appropriate

consequences. The parents were most appreciative of the agency's involvement and the help they received from me and my ability to assist them was very much enhanced by the knowledge and skills I had learned during my practicum.

Finally, the feelings of apprehension, uncertainty, anxiety and inadequacy I experienced during the initial stages of my practicum provided me with a solid understanding of what my CFS clients experience when they become involved with the agency and when they are challenged to alter their approach to parenting. Initially during the practicum, I found it very difficult to shift from child protection work to counselling, as I was most comfortable relating and approaching situations as I would have in the child protection field. I had to be very conscious of trying to approach situations in a more supportive, less direct and confrontational manner than I would have when I was a child welfare worker. I was also very anxious and uncertain about my clinical skills and knowledge. This experience just highlighted for me how difficult it is for clients to shift their thinking and manner of relating because it is easiest to behave in the manner with which you are most familiar and comfortable. During one of my sessions with family #6, the adolescent male in the family spoke of the police watching his every move and I responded by stating that if you misbehave and get in trouble with the law there are certain consequences. I very clearly aligned myself with the authority figures, which is the approach I would have taken as a child welfare worker. However, I should have asked him how he felt about the police following him. As soon as the comment came out of my mouth I knew that I shouldn't have said it, but it was too late. Overall, my practicum has equipped me

with skills and knowledge that I am using in my job as a child protection worker and should I decide to leave this field my practicum experience will assist me in any social work field.

In conclusion, completing this practicum provided me with a great deal of knowledge and many skills related to the theoretical approaches used and this population group. It also assisted me to sharpen my assessment skills and expand my abilities to intervene with families in a clinical setting. My learning went beyond what I had initially intended in that I had hoped to strengthen my assessment skills from a structural framework and I did indeed accomplish that. However I also became adept at utlizing structural intervention strategies. Most importantly, it has elevated my self-confidence, stimulated significant personal growth and equipped me with skills that I have been able to implement in the field of child welfare. Finally, it has given me the kind of skills and confidence that I will maintain wherever my social work career takes me in the future.

APPENDIX A

Goal Attainment Follow-up Guide

Predicted Attainment	Score	
		1. Discipline
Most unfavourable outcome	-2	Use of physical discipline only during a 2-week period.
Less than expected outcome	-1	Use of physical discipline more than 50% of the time, during a 2-week period.
Expected outcome	0	Use of physical discipline less than 50% of the time, during a 2-week period.
Greater than expected outcome	+1	Use of physical discipline less than 25% of the time.
Most favourable outcome likely	+2	Use of time outs only during a 2-week period.
		2. **Suicide**
Most unfavourable outcome	-2	Patty commits suicide.
Less than expected outcome	-1	Patty has acted on at least one suicidal impulse since she began counselling, but has not succeeded.
Expected outcome	0	Patty has reported having at least 6 suicidal impulses since beginning counselling, but has not acted upon any of them.
Greater than expected outcome	+1	Patty has reported having no more than 3 suicidal impulses since beginning counselling, but has not acted upon any of them.
Most favourable outcome likely	+2	No suicidal impulses since beginning counselling.
		3. **Isolation**
Most unfavourable outcome	-2	Patty does not leave her home for any social activities.
Less than expected outcome	-1	Patty does not leave her home other than to grocery shop or pick up the children.
Expected outcome	0	Patty attends a social activity on 2 occasions, during a 7-day period.
Greater than expected outcome	+1	Patty attends a social activity on 4 occasions, during a 7-day period.
Most favourable outcome likely	+2	Patty attends a social activity on a daily basis for a week (i.e. coffee @ friends, go to shopping mall, go to the gym, attend a parent support group)
		4. **Conflict**
Most unfavourable outcome	-2	Physical altercations a minimum of once per day between Patty and her 17 year old son for a 7 day period.
Less than expected outcome	-1	Physical altercations less than 5 times during a 7 day period.
Expected outcome	0	No physical altercations between Patty and her 17 year old son, but yelling and screaming for a 7 day period.
Greater than expected outcome	+1	No physical arguments or screaming between Patty and her 17 year old son for a 7 day period.
Most favourable outcome	+2	Patty and her 17 year old son spending time with one another doing an activity i.e. watching a movie together

Adapted from Mitchell & Cusick, Evaluation of a client-centred paediatric rehabilitation programme using goal attainment scaling, 1998, p. 11

APPENDIX B

CLIENT SATISFACTION QUESTIONNAIRE

Your opinions about the services you received at the Elizabeth Hill Counselling Centre are important in helping the agency and therapist provide the best possible service to families. We are interested in your opinion, including both positive and negative. We are also interested in any thoughts you have about what might improve the program. We appreciate your participation in this evaluation.

Please comment in the space provided or circle the answer that best describes your opinion.

1.What was the main reason for coming to therapy? How many people in your family attended therapy?

2. What were your goals?

3. How often did you feel you got the kind of help you needed in therapy sessions?
a) always b) usually c) sometimes d) rarely

4. Was the therapy helpful in providing ways for you to understand your family better?
a) always b) usually c) sometimes d) rarely

5. What has changed since you came for help?

6. What in therapy was the most helpful to you?

7. What in therapy was the least helpful to you?

8. How would you rate the therapy on a scale of 1 to 10, with 1 being completely dissatisfied with the therapy and 10 being very satisfied with the therapy? Please explain.

9. Before you began therapy, how would you rate the problems/issues you came to therapy for, with 1 being very distressing and troublesome and 10 not causing any distress or affecting your daily life? Please explain.

10. Following therapy, how would you rate the problems/issues you came to therapy for, with 1 being a significant deterioration and 10 being greatly improved? Please explain.

11. If you needed help in the future would you come back to Elizabeth Hill Counselling Centre? Please explain.

12. Any additional comments?

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