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Therapists' Perceptions of Family Therapy

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ABSTRACT

Family therapy in New Zealand is practised by people with a wide variety of training and experience. Twelve therapists from diverse academic and professional backgrounds were interviewed about their perceptions of family therapy. Analysis of the interviews using a Grounded Theory approach found that therapists used a variety of ways of distinguishing family therapy from other therapeutic approaches. They stressed the importance of adequate initial and ongoing preparation. Therapists' descriptions of the therapy process included the different ideas about therapy held by therapists and clients (and the resolution of these differences); metaphors of action and danger; and the varied outcomes of family therapy. Discussion of the social and professional ecology of family therapy illustrated some of the constraints under which it was practised.

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CHAPTER ONE

INTRODUCTION

There is no single path to practising as a family therapist in New Zealand, and people working in this field have a wide variety of educational backgrounds and experience.

As they cannot be categorised simply by their training, or by the fact that they work with families, it would be useful to know what family therapists themselves regard as their identifying characteristics, and whether other therapists share these perceptions. However, it is difficult to find information that clearly describes different therapies as they are practised. Without this information, prospective clients cannot make informed choices, and therapists are less likely to find clients whose problems match their own interests and special abilities. Joffe (1986) points out that front-line workers such as counsellors actively create and implement their own strategies to achieve a satisfactory definition of their work. For this reason, it is important to ask practising therapists directly how they describe the work of family therapy.

In this study I set out to ask how therapists themselves perceive what goes by the name of family therapy.

With this in mind the rest of the introduction is organised as follows: First, I will give a brief overview of different approaches to family therapy.

Second, I will discuss some ongoing debates in current family therapy literature. These include the role of the therapist within the family, the role of the family therapist and family therapy within society, relationships between various approaches to family therapy, between family therapy and other therapies, and relationships between family therapy and the wider health care sector.

Third, I will discuss research into clients' expectations about therapy and the effects of those expectations.

Finally a summary is presented, and the aim of the present study is specified.

An overview of approaches to family therapy.

The range of different approaches to family therapy is wide enough, and the disparity of views about what is important in them such, that the authors of one text report six different systems for classifying family therapy approaches before offering their own classification, which organises theory and practice along seven dimensions: time frame (emphasis on past or present); the role of unconscious processes; the extent of emphasis on insight or on present action; the role of the therapist; the unit of analysis (individual, dyad, triad, whole group); theoretical underpinnings; and goals of treatment. (Goldenberg & Goldenberg 1991: p89).

Using this framework, they divide family therapy approaches into six viewpoints: psychodynamic, experiential/humanistic, Bowenian, structural, communication/strategic, and behavioral. The following brief outline of each of these viewpoints is taken from Goldenberg & Goldenberg (1991).

The **Psychodynamic** approach focuses on the past, uncovering early experiences. Unconscious conflicts from the past are seen as affecting current relationships. Insight reduces conflict, and leads to intrapsychic and interpersonal change. The therapist is neutral, interpreting behaviour, and the therapy has an individual focus. Psychoanalysis provides the underlying theory for this approach, and its goals are insight, maturity, and stronger ego functioning in individuals, leading to a reduction in interlocking pathologies and more satisfying relationships between family members.

Most of the originators of this approach were originally trained as psychoanalysts, and include Nathan Ackerman, James Framo, Ivan Boszormenyi-Nagy and Robin Skynner.

The **Experiential/Humanistic** approach emphasises the present, and free choice and self-determination rather than the unconscious. Awareness of the self and the present lead to choice and responsibility, and so to change. The therapist actively facilitates growth and provides new experiences for the family. Problems are seen as arising in dyads, between two family members. The underlying theories are existentialism, humanistic psychology, and phenomenology; and goals are growth, clearer communication and more fulfilling interactions between family members, and greater awareness and authenticity.

An important figure in the beginning of this approach is Carl Whitaker, who had a medical background and some training in psychiatry. Fritz Perls' Gestalt psychology was taken into family therapy by Virginia Satir (whose original training was in social work) and Walter Kempler (a psychiatrist), to become another branch of the experiential/ humanistic approach.

The **Bowenian** approach attends primarily to relationships in the present, although the families of origin of adult family members are important. After at first focussing on the unconscious, the Bowenian approach is now more concerned with interactions between individuals. Rational self-awareness and understanding of present and past family relationships are emphasised. The therapist is direct but non-confrontational, and remains emotionally uninvolved with the family. The entire family, over several generations, is the unit of study, but the whole family need not attend therapy. The underlying theory of this approach is Family Systems Theory, and the goals are to maximise the individual's ability to choose between having his or her actions guided by feelings or by thoughts.

Murray Bowen trained in medicine and worked as a research psychiatrist, originally developing his theories out of his work with families with a member diagnosed with schizophrenia.

Structural family therapy looks at the present and the past, seeing present family structure as coming from earlier transactional patterns. Repeated learned habits and assigned roles by which the family carries out its tasks are considered important, rather than unconscious motivation. The therapist, as an active 'stage director', manipulates behaviour to change transactional patterns. Attention is paid to triads, coalitions, sub-systems, boundaries, and the use of power. Family systems theory is the underlying theoretical basis, and the goals of this approach are to restructure family organisation and change dysfunctional transactional patterns.

The major founder of structural family therapy is Salvador Minuchin, who also trained originally in medicine, and then in child psychiatry.

The **Communication/Strategic** approach has communication and systems theories as its basis, and is influenced by behaviorism. The emphasis is in the present, with problems seen as maintained by ongoing repetitive sequences between family members. Rather than unconscious processes, behaviour is seen in terms of family rules, homeostatic balance and feedback loops. Therapy is action-oriented,

with behaviour change caused by directives rather than interpretations. The therapist is active and manipulative, problem focussed, prescribing behaviour and using paradox. The units of study are dyads and triads, with problem behaviours seen as interpersonal communications between family members. The goal of therapy is to change dysfunctional behaviour sequences or 'games' between family members, and so to eliminate the presenting problem or symptom.

Goldenberg & Goldenberg (1991) list as influential workers in the communication/strategic approach Don Jackson, Milton Erickson MD, Jay Haley, Cloe Madanes, P. Watzlawick, Mara Selvini-Palazzoli MD, and Luigi Boscolo MD.

Behavioural family therapy, based on behaviourism and social learning theory, focuses on how interpersonal environments in the present maintain behaviour patterns. The concept of the unconscious is not considered useful, as behaviour is thought to be maintained by its consequences. Actions are prescribed to modify behaviour, the therapist negotiates contracts and is a directive trainer or model. The unit of study is the dyad, one person's behaviour is seen as affecting another's in a linear causal pattern. The goal of treatment is to change problematic behaviour by changing the behavioural consequences of interactions between family members. (Goldenberg & Goldenberg p. 90-92.)

Influential workers in this field have been Robert Liberman MD, originally trained as a psychiatrist, Richard Stuart (a social worker), Gerald Patterson (a psychologist), Neil Jacobson, and Gayla Margolin.

The framework above represents how Goldenberg & Goldenberg (1991) see the current situation. A more historical outline is given by Auerswald (1987). Auerswald describes family therapy as beginning with a small group of behavioural scientists who challenged orthodox medical and psychodynamic therapies. As family therapy has become a means of livelihood for may, Auerswald believes an epistemological split has developed between those who challenge what he calls Western society's reality system, "rooted in Cartesian/Newtonian, nineteenth century, mechanistic 'common sense' (p. 317", and those who continue to use it.

Auerswald identifies five different paradigms arising in family therapy since 1959:

1. a **psychodynamic paradigm**, which sees the family as consisting

of the "interlocking psychodynamics of its members, who are at different developmental stages";

2. a **family systems paradigm**, for which the family is "a system that operates independently, and from which individual psychodynamics, including those that create symptoms, emerge";

3. a **general systems paradigm**, which defines a family as "a system that shares isomorphic characteristics with all systems, and which arranges systems in a hierarchy according to classes from quarks to universes, with 'higher' systems containing those 'lower' in the hierarchy";

4. a **cybernetic systems paradigm**, "which defines a system, including a family system, in terms of circular information flow and regulatory mechanisms"; and

5. an **ecological systems (or ecosystemic) paradigm**, which regards a family "as a coevolutionary ecosystem located in evolutionary timespace". (p.321).

Auerswald believes that most family therapists are unaware of profound differences between 2—4 (above), and "the ecological systems framework of 5" (p322), which he sees as based in an emerging alternative reality system, part of the "New Science" originating with Planck and Einstein:

> *"...in both the large-scale arena of physics and the small-scale arena of the family, the method of transformative intervention consisted of the introduction of ideas...that changed the basis of reality definition in the target field."* (Auerswald 1987, p 322).

An example of New Science is the significant effects in psychology generally (Gergen 1985), and in family therapy, of what Pare´ (1995) describes as two epistemological views, constructivism and social constructionism. Pare´ points out that these are often referred to as if they were interchangeable, but are in fact distinct:

> *"Constructivism is primarily individualistic, focussing on sense data and information processing, while social constructionism is concerned with the person in the community and focuses on meaning and interpretation."* (p. 4).

Social constructionism in particular argues that our taken-for-granted

understandings of the world have a social and cultural (rather than empirical) basis, and that reality is negotiated. Description and explanation of the world is seen as a form of social action, and human action depends on the world as it is understood, rather than as it is.

> *"From the constructionist position the process of understanding ...is the result of an active, cooperative enterprise of persons in relationship. In this light, inquiry is invited into the historical and cultural basis of various forms of world construction."* (Gergen 1985, p267).

These philosophical approaches have been taken up and developed in family therapy in the teaching and practice of Michael White and David Epston, who are important recent Australasian influences in family therapy.

White and Epston have applied Michel Foucault's social constructionist philosophical analysis of history to their understanding and practice. Foucault described the history of the objectification of persons in Western society, which he saw as resulting in improved social control by the technique of "normalising judgement", by which individuals compare themselves continually to norms or "truths" about how people should be:

> *"These truths are 'normalising' in the sense that they construct norms about which persons are incited to shape or constitute their lives. Therefore, these are 'truths' that are actually specifying of persons' lives."* (White 1989, p. 26.)

White and Epston write that since we cannot know objective reality, all knowing requires interpretation or storying, and that the meaning family members attribute to events determines their behaviour, rather than some underlying structure or dysfunction:

> *"...meaning is derived through the structuring of experience into stories, and...it is the performance of these stories that is constitutive of lives and relationships."* (1989, p.31).

Their approach to therapy largely involves using narratives to allow people seeking help to "re-story" their lives.

White & Epston (1989) critique their own status as family therapists, and the presuppositions of therapy as a discipline. Referring to the work of Michel Foucault, they point out the isolation of these

(therapeutic) knowledges from knowledges at large (that is, those of the general public), as well as their establishment in the hierarchy of scientificity, that gives them their power. According to Foucault, the same 'technology of power' that resulted in the objectification of persons and their bodies made the human sciences possible:

"...the disciplines characterize, classify, specialize; they distribute along a scale, around a norm, hierarchize individuals in relation to one another, and if necessary, disqualify and invalidate." (Foucault 1979, quoted in White 1989, p. 27).

Therapists influenced by White and Epston are often uncomfortable with the ideas of diagnosis and treatment, and work to be as egalitarian as possible.

A general historical change in family therapy has been noted in the United States, from analyzing family problems and prescribing interventions, to seeing such an approach as manipulative or even violent. Sprenkle & Bischof (1994) write that the language of family therapy has changed, with 'empowerment' replacing 'power', 'curiosity' replacing 'certainty', and 'collaboration' replacing 'control', and an increasing awareness of building on family strengths and the self-fulfilling hazards of diagnosis.

Ongoing debates in family therapy

Calls for greater disciplinary awareness by family therapists reflect sensitivity to political issues in relation to the practice of therapy. Perhaps because of the awareness of the wider social system implied by the systems theory approach in family therapy, there has been considerable debate about the part therapy plays within these systems. In the brief discussion of some of these issues that follows, it is useful to keep in mind that the points of view discussed will represent a range of the theoretical and clinical orientations in family therapy, and will be influenced by the fact that most family therapists are educated in one of a variety of disciplines prior to their family therapy training.

The place of the therapist in relation to the family.

Feminist writers were among the first to criticise family therapy, suggesting therapists should be critically examining the values of the society to which they were helping people adjust (Sprenkle & Bischof 1994). They see fathers in families as having more power, reflecting

the status of men in the wider socioeconomic system. In this view, dealing with a whole family together is likely to distort or hide the experience of women and children (James & MacKinnon 1990). Looking at family processes as form, pattern, and organization, rather than in material terms, makes asking whether such power exists irrelevant (MacKinnon & Miller 1987), effectively sanctioning it. Speaking of the autonomy of the family system gives it a false reality, and assumes that families are voluntary organizations functioning for the ultimate good of all members. (MacKinnon & Miller 1987).

The issue of whether therapists should be neutral or directive has an interesting history in family therapy. The traditional view of therapists as neutral and non-directive has been challenged by the Experiential, Bowenian, Structural, Communication/Strategic and Behavioural approaches (Goldenberg & Goldenberg 1991), while only the Psychodynamic and the recent Constructivist and Social Constructionist approaches are non-directive. Recent changes in the concept of neutrality in family therapy can be traced from an interviewing stance used as a source of therapeutic power, (as in its early use as an aid for avoiding unhelpful alliances by the original Milan Group), to a philosophical orientation towards families and their wider networks (Furlong & Lipp 1994). Furlong & Lipp quote Tomm as including in the concept of neutrality,

> *"a sense of respect, acceptance, curiousity, fascination and even admiration of the system. It excludes any prejudice concerning illness or pathological diagnosis. The neutral therapi is not interested in blaming anyone or changing the system..."* (Tomm 1984, quoted in Furlong & Lipp 1994: p114).

Furlong & Lipp (1994) believe that therapy by its nature is concerned with effecting change, and that not wanting to prescribe how families should be is realistic only if therapists accept the public image of the therapist as a neutral, expert technocrat:

> *"Family therapists...are in a contradictory position. On the one hand, they are expected to be disinterested agents; on the other, to be instrumental agents with a proven technology."* (p.118).

From a systemic point of view, problems and conflicts within families reflect larger social issues and viewpoints, so whatever stance a therapist takes, even that of avoiding a stance, is seen to reflect a position within the larger system, regardless of the therapist's

intentions. Relationships cannot remain neutral, nor therapists apolitical, in such a context, although exactly how therapeutic paradigms reflect prevailing ideology may not always immediately be clear, especially when there are claims by therapists that their views are radically different from traditional thinking (MacKinnon & Miller 1987).

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There are also widely different views on the nature of the relationship between therapists and their clients. The constructivist idea that clients and therapists are equal contributors in constructing therapeutic reality has been rejected by some other therapists (see, for example, MacKinnon & Miller 1987). Jackson (1992) also remarks that "conversation" is not what clients expect from people who are paid to see them and who can exercise power over them. He suggests that such metaphors can delude therapists into seeing the therapeutic relationship as equal and sharing. Bograd (1992) describes family therapists as inevitably mediating, challenging, and affirming the way individuals behave with respect to social values, acceptable behaviours, and appropriate expression of feelings. Furlong (1989) writes similarly that social influence is common to all therapies, and criticises portrayals of the family therapist as 'non-interventionist', describing therapists' denial of their use of power and influence as quite disturbing: "It may even be crazy-making to wield unarticulated power and then to deny that this power is being used." (p.213). Another danger suggested for the constructivist view is that it may imply that solutions can be found through changing how one thinks, rather than making structural changes (MacKinnon & Miller 1987). These arguments illustrate fundamental differences in how the role of the therapist is perceived.

Calls have been made for family therapists to be power brokers within the family system. MacKinnon & James (1991) write that this is a therapist's first and most valuable function, that

> *"...after assessing various levels of unfairness, abuse and oppression, the therapist must enable relationships to become fair, just, and safe by aligning with individuals within the family as layers of unfairness and injustice are uncovered and worked through."* (p.177).

Fish (1990) points out that public expectations about therapy are not that the therapist will be neutral, especially if violence is involved. He cites Hoffman's (1986) comments that non-neutral 'linear' attitudes are often necessary, appropriate, and what the therapist is paid for.

The role of the therapist within society

Developing from an understanding that therapy and therapists cannot be neutral in either intent or effect, other writers in the family therapy literature have called for therapists to acknowledge their active role in society, and to use it to further social justice. Libow, Raskin, & Caust (1982) note that as the systems approach considers individual change impossible without change in the wider system, the family therapist should also be working within the system to challenge oppression related to sex, class, or ethnic difference. Family therapists have been accused of doing to families what they accuse others of doing to individuals—that is, seeing them out of context (James & McIntyre 1983). MacKinnon & Miller (1987) also encourage therapists to take a social action perspective, seeing social problems as stemming from differences in control over resources. Luepnitz (1988) refers to Donzelot's writing about governments' interest in maintaining strong families, since people without ties to others are harder to regulate, and suggests therapists reflect on their role in this regard.

Waldegrave & Tamasese (1993) describe becoming aware that as family therapists they were acting politically for the state by adjusting people to poverty. They believe that by not relating their therapeutic work directly to political, economic, gender, social and cultural structures, as therapists they were colluding with those systems in society that oppress, deprive and dehumanize families, while encouraging families in the belief that they themselves, rather than unjust social structures, were the authors of their problems and failures. MacKinnon & James (1991) suggest that one role of the family therapist is to intervene in the relationships between family members and other professionals, at times taking the side of parents to ensure they are perceived fairly and honestly. Bograd (1992) comments that by maintaining a distinction between therapy and social control, therapists do not resolve a moral or definitional dilemma, they just avoid dealing with it.

Waldegrave & Tamasese (1993) also note a lack of cultural sophistication in family therapy, writing that modern psychotherapy's goal of individual self-worth is not an appropriate one for many cultures, and suggesting that social science should be seen as one among many cultural ways.

Relationships between approaches to family therapy

Family therapy includes a range of divergent approaches, and relationships between them are sometimes difficult. Crawley (1993) expresses concern about what he calls

> *"a continuing...problem with exclusivity and even triumphalism within family therapy"* (p.18),

and about new developments in family therapy being spoken of as if they made everything else redundant. According to Crawley, some 'new' approaches closely match the (now neglected) work of earlier theorists.

Speed (1995) writes of the emphasis in United States family therapy on the new and different, that it reflects that society's cultural values and the need for stand-alone professionals to package and market their products. He compares this with a more integrative British approach, which he believes reflects British family therapists' usual employment by the state, filling several professional roles. Carpenter (1994) suggests that it is misleading to describe many British practitioners as family therapists at all, since most are employed in a variety of roles, and are psychiatrists, social workers, nurses, psychologists, and probation officers first, family therapists second. He believes that professionals should be trained to use family therapy thinking and skills, rather than to be family therapists. While family therapy is regarded by some as a distinctive discipline with specialized training, others emphasize that family therapy is not limited to the practice of family therapists, nor is it all that family therapists do (Wynne, McDaniel & Weber, 1987).

There has also been concern about the tone of disputes between the various approaches to family therapy. For example, Snyder (1993) comments that family therapists are vulnerable to "the prevailing argumentative, defensive, aggressive, rivalrous practices of the culture" they belong to, seeming to behave differently in dialogue with their clients and in dialogue with each other. Therapists who co-create new meaning in therapy compete in an adversarial way with their colleagues,

> *"...spar with each other in a way that parallels the less sophisticated forms of sparring that occur in the families who come to us for therapy. In our similar and different ways, we are embedded in the same argumentative discourse."* (p. 83).

Jenkins (1991) makes a similar point about therapists working with domestic violence, describing the competition between therapists about ideology and approach in the context of limited funds and other resources:

> *"These ownership disputes are alarmingly similar to those acted out in situations of abuse."* (p.193).

These comments reflect awareness of, and concern about, difficulties in the relationships between various approaches to family therapy.

Relationships between family therapy and other therapies.

Crawley (1993) describes growing concern in family therapy about its name, identity, and place in the world of therapy as evidence of increasing maturity. But commenting on the energy that family therapists have put into establishing differences between themselves and others who share the name therapy, he sees problems in relationships between family therapy and other approaches to therapy, when the latter are derided and scorned rather than critiqued. Lack of historical awareness and integration by family therapists has in some cases meant that changes in other therapeutic disciplines are ignored. Goldberg & David (1991) suggest that the attraction for family therapists of new scientific models, quite different from those used by other healthcare workers, is as a way of distinguishing themselves from other therapies, gaining status and preserving their specialist position. According to Goldberg & David (1991), this means family therapy models must keep changing as they are absorbed into the mainstream.

In working to become legitimate as a mental health speciality, family therapy has concentrated on developing a unique knowledge base, techniques, and disciplinary boundaries (Doherty & Burge 1987). Shields, Wynne, McDaniel, & Gawinski (1994) see some dangers in these efforts of family therapists to become an autonomous profession, believing internal strength and clear professional identity may bring marginalization. They trace the field of family therapy through what they see as three overlapping, still incomplete phases: from people who shared a particular approach or paradigm but were not organised as a credentialed professional group, to a multi-disciplinary field of persons linked through shared collegial interests in the paradigm but with other primary professional affiliations, finally to an autonomous mental health discipline. (p.123). In the first and second of these phases, family therapists were working in their primary fields to

expand the perspectives of traditional mental health disciplines. Shields et al. (1994) suggest that in the third phase, with credentialing and training solely in family therapy, may come intellectual isolation. This perception that autonomy for family therapy may be at the expense of valuable interdependence with other therapies has led to calls for family therapists to recognize that their discipline is inevitably defined in relationship to other disciplines, and to find ways to be involved in the wider mental health "conversation" (Anderson 1994).

Relationships between family therapy and the wider health care sector.

How family therapists perceive their position in the wider health care sector is also problematic. For example, Shields et al. (1994) believe that family therapy's distinctiveness comes not from any unique theory, but from its primary focus on interpersonal relationships. By being called therapists rather than counsellors, family therapists benefit from the prestige and opportunities associated with health care professionals, but are then expected by the public to diagnose and treat mental disorders, rather than to deal with family relationships in which there is no diagnosed nervous or mental disorder. Shields et al. (1994) remark that many family therapists appear to be in the position of wanting mental health professional status but not accepting the diagnostic, conceptual and clinical approaches that dominate the health care establishment. Sprenkle & Bischof (1994) suggest that family therapists who prefer collaborative, non-expert therapies will have difficulty in health-care delivery systems that demand clear treatment plans and demonstrated efficiency of chosen treatment. Family therapists have joined in what Wynne et al. (1987) call the politics of diagnosis—the use of psychiatric diagnoses to make claims for particular territory for particular mental health professionals. Wynne et al. (1987) note that the illness-related term 'therapy' has not only been retained but demanded, especially as third party payment has become restricted in the mental health field to psychiatric disorders. Even if they regard diagnosis as reductionistic, family therapists will be obliged to include it in their records if they are to be paid by health insurers (Auerswald 1987).

Wynne et al. (1987) note the public understanding that a referral for family therapy implies a family-wide, or family-induced, illness or disability, and suggest that this concept of family pathology is not widely accepted by the public. They note the anger expressed by groups in the United States like the National Alliance for the Mentally Ill, at

the 'family blaming' that occurs when mental illness is diagnosed. Lappin & Van Deusen (1994) describe the successful campaign of the National Alliance for the Mentally Ill against federal financial support of family therapy research, as an example of public perceptions of family therapy directly affecting funding.

Difficulties between family therapists and public welfare professionals have also received comment. Furlong (1989) describes as "almost tribal" the relationship between these two groups, who

> *"...seem to identify themselves as belonging to different reference groups, have apparently distinct discourses, and matters are so polarised that each group will often take the opportunity to tell 'war stories' at the other's expense."* (p.212)

Furlong believes that at issue here is therapists' view of their relationship with clients as voluntary, confidential and benevolent. In contrast statutory agents have low status, and their influence is seen as a result of positional authority, rather than expertise and knowledge. Family therapists and public workers have been described as lacking enough understanding of each other's work to collaborate effectively (Lappin & Van Deusen 1994), yet such collaboration is frequently required in the work of family therapists.

In each of these dimensions, how family therapists perceive and represent their work affects their relationships with the organisations that employ and fund them, with the other disciplines who work with them, and ultimately with the public they hope to serve.

Clients' expectations about therapy.

The public image of therapists affects immediate potential clients, and also people from whom others in distress seek advice and referral, such as general medical practitioners, teachers, the clergy and community agencies. It can indirectly affect government funding of services and training (Hartnett, Simonetta, & Mahoney 1989).

Access to information about therapy is an important part of making an informed choice. Hare-Mustin, Maracek, Kaplan & Liss-Levinson (1979) argue that attending to clients' rights is the therapists' responsibility, as for various reasons (such as distress, unfamiliarity with therapeutic roles and practices, or past experience of the denial of rights) potential clients may not be able to negotiate. Hare-Mustin et al. (1979) suggest that clients should be provided with information

about procedures, goals and possible side effects; the qualifications, policies and practices of therapists; and alternative available sources of help.

Some of this information may serve to reduce the fears of clients about to receive therapy. Kushner and Sher (1989) group such fears into three categories: fears about therapist competence and professionalism ("therapist responsiveness"); about negative judgments by others and self for seeking treatment ("image concerns"); and fears about whether they will be pushed to do, think or say things against their will ("coercion fears"). Kushner & Sher remark that psychotherapy is

> *"...a potentially difficult, embarrassing and overall risky enterprise with respect to the individual's sense of self and environmental homeostasis"* (1989:p256),

and comment on the surprising lack of attention treatment fears have received from clinicians and researchers.

The realism of fears about coercion is borne out by evidence that values and goals of clients come to converge with those of therapists, and that this coincides with client improvement as assessed by therapists (Epperson & Lewis 1987), especially with regard to "ultimate life goals" (Lewis, Epperson & Foley 1989). Perhaps potential clients should be advised of these possible side-effect of therapy, or should at least receive some information about the therapist's values and goals as part of making an informed choice.

Research into information giving sounds some cautionary notes for therapists. Epperson & Lewis (1987) found a significant difference in response to simple labels compared to detailed information. Therapists simply described as 'feminist' were seen quite differently from those to whom an explicit description of feminist values was attached, and preference for therapists varied accordingly, with most subjects, even those who espoused feminist values themselves, rejecting explicitly-described therapists. Epperson & Foley (1989) found explicit pre-therapy information played a similarly important role, although they wondered if in describing the feminist counsellor according to traits they saw as distinguishing her from traditional counsellors, they may have emphasised controversial values, so violating expectations of a value-neutral counsellor.

Lewis & Walsh (1980), cited in Lewis, Davis and Lesmeister (1983), found that when therapists were overt and explicit about goals and values, clients with similar values were more willing to perceive them as helpful. This was not replicated by Lewis et al. (1983), and was contrary to the findings of Epperson & Lewis (1987).

If the explicit description of values and goals conflicts with client expectations of value neutrality to the extent that clients avoid those therapists, there is a problem. Counselling is influential and value-laden. If information provided in the interests of informed choice discourages those who seek help, both the therapeutic interests of clients and therapists' professional (and financial) interests will be affected. Smith (1981) has suggested that in the past counsellors have put their own material gain before informed consent (with regard to the disclosure of information to third parties), but this issue is more complex. Furlong & Lipp (1994) suggest that therapists' public credibility comes from conforming to the expectation that professionals provide neutral, objective and effective services, and that if family therapists publicly rejected the cultural expectation that the therapist is a clinician and a neutral expert, their status, and therefore their effectiveness, would be reduced.

Labels alone appear to affect client expectations and preferences. Gelso & Karl (1974) found counsellors with some professional labels were perceived as more knowledgeable and competent than others. Different titles (counselling psychologist, psychiatrist, high school counsellor, college counsellor, clinical psychologist, or advisor) affected the perception of personal characteristics. (For example, a psychiatrist was seen as more inquisitive, analytic, curious, knowledgeable, intellectual, patient, tactful, persistent and stubborn than a college counsellor, who in turn was seen as less knowledgeable, analytic, and purposeful, but more dull and uninteresting, than a counselling psychologist, a clinical psychologist, or a psychiatrist). Titles may also affect the likelihood of seeking help for particular problems. For example, respondents said they were more likely to discuss problems concerning family, friends, feeling and emotions, and sexual adjustment, with psychiatrists than they were to discuss them with counselling psychologists. The same respondents said they were equally likely to discuss personal concerns about self-development, and gaining insights into personal strengths and weaknesses, with either psychiatrists or counselling psychologists (Gelso & Karl 1974). This suggests therapists should be aware that the titles they give themselves may affect the likelihood of people seeking help from them, and suggests there are discrepancies between the roles counsellors

ascribe to themselves and those ascribed to them by the public. Tinsley, Brown, de St Aubin & Lucek (1984) also found that students' tendencies to seek help varied with the title of the helper and the problem for which help was sought, and suggested that the title 'counselling psychologist' made a more favourable impression on potential clients than 'college counsellor' or 'career counsellor'.

Alternative disciplinary identities, such as 'psychologist' or 'family therapist' may be useful for practitioners who can use whichever title best suits the situation (Wynne et al. 1987). In New Zealand the name 'family therapist' also has advantages for those without formal accreditation or qualifications, especially as it is unlikely the public will be aware that no such qualifications are required at present for the use of that title. However, the common public perception that when a family is asked to enter "family therapy" the family or a parent is viewed as to blame for an individual's illness, may make it difficult for the therapist to establish a good relationship with the family (Wynne et al. 1987).

Duckro, Beal & George (1979) suggest that mutuality of role expectations can have an important positive influence, and that shaping clients' expectations to match the actual therapist's style should have beneficial effects. Therapists themselves view 'unrealistic expectations' as almost always having a detrimental effect on counselling (Tinsley, Bowman & Barich 1993). Clarifying the expectations that therapists have about family therapy may increase the chances of good outcomes for clients and therapists.

Summary

The introduction began with an overview of types of family therapy. Many therapists describe their own practice as eclectic, a combination of several of these approaches.

Next I discussed some of the issues currently being debated in family therapy, including the place of the therapist within the family, the role of therapists within society, relationships between different approaches to family therapy, and relationships between family therapy and other therapies.

Finally I looked briefly at some research into client and therapist expectations of therapy, to set the scene for the exploration of some of these issues in family therapy.

CHAPTER TWO

METHOD

Aim of the present study.

The aim of the present study is to explore the way therapists perceive family therapy. The intention is to encourage discussion about family therapy among therapists, and to make information about how therapists view their work available to the public. While any material discussed here will be specific to the participant therapists, it will have some bearing on other therapists' perceptions of family therapy.

Reasons for using a Grounded Theory approach.

This study takes a qualitative, grounded theory approach. I set out to investigate the categories used by therapists to describe the work of family therapy, and to seek relationships between those categories. I believed that the term "family therapy" had very different meanings, both among therapists and to the general public, and that it was important to ask therapists themselves about what it meant to them.

Joffe (1986) in her study of family planning workers writes of the need to understand the occupational culture of workers in a given setting, to look at the shared understandings of those who do this work, and at how the work itself shapes their understandings and values. She also concluded that family planning workers exercised considerable unacknowledged power as regulators of sexual morality, and one intention of the present study was to look at how family therapists saw their role as influencing family interactions.

Joffe's finding that "front-line" counselling workers actively created policies for the work they did, and that these might vary from those that their superiors believed they were using, was also of interest in the present study, as was her discovery that they devised their own strategies for achieving a definition of their work.

These meanings can best be investigated by open-ended questioning, allowing respondents to develop and express their own thoughts about the topic, rather than by quantitative methods.

Justification for using a qualitative approach

Qualitative research is a broad term, covering a wide range of

interpretive techniques. Qualitative methods in social science were developed by researchers who believed that quantitative methods were missing issues of interest both to the researchers themselves and to the people they studied. These researchers saw the natural science emphasis on testing hypotheses as at the expense of attention to how hypotheses were formed, and as glossing over the reality of the research process (Strauss 1987). In particular, the qualitative researcher seeks to discover what is important to the people under observation, assuming that insiders are likely to have a more differentiated and complex understanding of their environment than the researcher (Lofland 1971), and that their accounts should be used to make sense of that world (Huberman & Miles 1988).

By defining concepts and framing hypotheses before beginning research, researchers may come to understand relationships and meanings in a way too different from insiders to be useful to them, or to bring any new understanding to outsiders. Qualitative researchers assume that there is no neutral knowledge of the world, that 'reality' is always interpreted (Strauss & Corbin 1990), and that analysis always involves interpreting data (Strauss 1987). They believe that scientific work that separates knowledge from methods of knowing is too restrictive in social science, as testing propositions by reference to observable facts is complicated when those facts are social actions, subject to many interpretations. Qualitative methods are suited to research questions where researchers are looking for the cultural categories and assumptions people use to construe their world (McCracken 1985).

Grounded theory is intended to explain a phenomenon in the light of a theoretical framework that evolves during the research itself, without the constraint of previously developed theories. At each step the provisional theory must be grounded in the data collected: induction is followed by deduction and verification (Strauss 1987, Strauss & Corbin 1990). Analysis directs the further sampling of data, producing the interweaving of data collection, coding and analysis characteristic of qualitative research (Addison 1989). A grounded theory approach requires that as patterns and relationships appear in the data, these be checked against new data, and gaps or inconsistencies in the developing theory receive close attention.

Data Analysis

In grounded theory, the analysis intended to raise description to a theoretical level begins as soon as data collection does. In the first

step, **open coding**, transcripts or field notes are taken apart, and each separate incident or idea is given a tentative name. This fracturing of data into analytic pieces is intended to give new insights into standard thinking, moving the analysis from the empirical to the conceptual level (Glaser 1978, Corbin & Strauss 1990). By constantly comparing these named phenomena, the analyst groups together similar ideas or events as examples of the same concept. Categories formed by this grouping of like concepts together under a name of higher abstraction remain provisional, subject to checking against new data or the use of new titles, until the end of the study. This ensures the best possible set of connections and explanations.

Open coding is the term used to describe the early process of identifying concepts and developing their properties and dimensions. These concepts are the basic building blocks of theory, and the categories created in this way are the conceptual codes that relate data to theory (Swanson 1986).

Open coding is followed by axial coding, so called because analysis revolves around the 'axis' of one category at a time (Strauss 1987). In this process relationships are sought between the categories resulting from open coding. Some categories come to be seen as subcategories of other, more abstract categories. Rather than seeking the simple properties and dimensions of each category as in open coding, in axial coding the analyst links subcategories to each category, relating them so that subcategories can be seen as either causal conditions (events or incidents leading to the occurrence or development of a phenomenon), as context (the particular set of conditions within which actions are taken to manage, carry out or respond to the specific phenomenon), as intervening conditions (the broader structural context that either facilitates or constrains these strategies), as the action or interaction strategies themselves, or as their consequences. The grounded theorist's interest is in social process rather than structure.

Relationships found during this stage of analysis are provisional until tested and found to recur repeatedly in the data.

In the third step, selective coding, the analyst decides which of the categories discovered is the 'core' category, around which all categories can be unified (Strauss & Corbin 1990). This category should be more abstract than the others, which are related to it as context, conditions, action/interactional strategies, or consequences. This logical linking of the parts of the process—its causes, context, contingencies, consequences, covariance and conditions—is one of the

two essential criteria in choosing a core category. The other is that the core process can be shown to account for a large part of the variation, in type or degree, of the activities studied (Fagerhaugh 1986).

At all stages of grounded theory analysis, sampling is directed by the developing theory, with decisions being made about what groups, events or activities to sample next, and for what theoretical purpose. During open coding the idea is to find as many potentially relevant categories as possible, along with their properties and dimensions. As this proceeds by asking questions and making comparisons of the data, issues emerge leading to and simultaneous with axial coding, during which relational and variational sampling focuses on finding and validating those relationships, establishing whether they occur repeatedly and are important enough to become significant categories in the developing theory.

Ethical considerations

The study was approved by the Massey University human ethics committee as meeting their requirements regarding justification for the project, recruitment of participants, informed consent, research procedures, and the handling and storage of materials.

Recruiting participants

Participants were selected by writing a letter (Appendix 1) to fifteen therapists whose names and addresses were publicly available. These letters were followed by a phone call to each of the therapists. One person contacted by phone did not wish to take part in the study. Two therapists did not respond to messages left on their answering machines; it was assumed after a second call that they did not wish to be interviewed, and no further attempt was made to contact them. The remaining twelve therapists were interviewed. Ten were interviewed as individuals, two (who worked as co-therapists) asked to be interviewed together.

Informed consent

Participants were provided with an information sheet about the project (Appendix 2), and before the interview signed a consent form (Appendix 3).

Handling and storage of materials

In compliance with the Massey University Human Ethics Committee requirements, all tapes and transcripts were kept in a locked cabinet. Tapes were listened to and transcribed by the researcher only. Therapists interviewed were identified on transcripts only by code letters, and a list matching those letters with names was kept in another locked cabinet in a different room. No therapist was identified other than by his or her code letter in any written or spoken communication during this project, except in the letters addressed to participants themselves.

Participants

Participants were twelve therapists in a New Zealand provincial city. They had a wide variety of educational and professional backgrounds, including psychology, social work, counselling, secondary teaching, guidance counselling, theology, marriage guidance, and family therapy. University qualifications ranged from Masters degrees to none. Three had postgraduate diplomas in Clinical Psychology.

Some of the therapists worked entirely privately, others entirely for agencies, although most divided their employment between private and agency work. Several were involved in education, some as students, others as teachers. All had used or were currently using family therapy in their professional practice, although not all agreed that they would describe themselves as family therapists.

Interviews

Interview duration was between forty five and ninety minutes, and all were tape recorded. All but one of the interviews took place in the therapists' consulting rooms; the exception was in a small office at the therapist's place of work.

The first six interviews were based on a set of open-ended questions about the therapists' work (see Appendix 4). These first interviews were transcribed by the researcher, and another set of questions generated after preliminary analysis, for use in the later interviews (Appendix 5).

All interviews were transcribed in full by the researcher, and each participant was sent a transcript of their interview.

Follow up questionnaire

A follow-up questionnaire was sent to get further information about each therapist's original training, theoretical orientation, and influences they considered important in their work (Appendix 6). Seven of the twelve participants returned this questionnaire. With this questionnaire, self-addressed stamped envelopes were sent to participants, offering another opportunity to query transcripts or to withdraw material. While the thesis was in draft form, a copy of the part of the thesis which quoted from transcripts was sent to the participants, offering another opportunity to change or withdraw any material any participant thought might be identifying, or that he or she did not wish included in the printed thesis.

Note about quotations

Quotations in italics in the Results section of the thesis are taken from the interview transcripts. The letter that follows each quotation indicates the code for that therapist, and the number after it represents the page of the transcript. A dash (—) in the quotation indicates a pause longer than that marked by a comma. An ellipsis (...) indicates that some of the transcript has not been quoted, usually because it was a repetition of what had been said, or was not directly related to the matter the researcher is trying to illustrate.

THE RESULTS

Each of the next four chapters examine the content of the interviews, using the framework that was developed by open, axial and selective coding. (A table showing substantive, axial and selective codes is presented in Appendices 7 and 8).

Four selective codes were found, and each of these is presented in one of the next four chapters. Chapter Three looks at the way therapists distinguished family therapy from other therapeutic approaches. Chapter Four describes the initial and ongoing preparation required for family therapy. Chapter Five examines ideas, actions and outcomes arising in the therapy process itself; and in Chapter Six, Ecology, therapists discuss issues relating to interactions between family therapy and its wider environment.

CHAPTER THREE

Selective code 1:

DISTINGUISHING FAMILY THERAPY

Therapists distinguished family therapy from other approaches to problems in various ways. This chapter looks first at what therapists said about their decisions to use family therapy, then at how they described families, and who they believed was the client.

Comparisons between family therapy and other work with families were used by therapists to distinguish family therapy. Distinctions made by some therapists between therapy and counselling also served to illustrate what they saw as characteristic of family therapy. Some therapists preferred to emphasise what family therapy and other approaches had in common.

AXIAL CODES

Key themes emerging included the following:

Deciding to use family therapy
What is a family?
Differences between family therapy and other approaches
Distinctions between therapy and counselling
Continuity between family therapy and other approaches

Deciding to use family therapy

As will become evident in Selective Code Four, Ecology, deciding which approach to use was not always in the hands of therapists themselves. In this section, I will discuss what therapists said about how they decided to use family therapy when they did have that choice.

For particular problems

Deciding to use family therapy almost always involved a problem with a child, both for therapists who used family therapy as one option, and for those who used it exclusively:

> *"In all the contexts that I've worked in family therapy, a child has been the identified patient..."* D:3

Typical issues were problems with controlling a child, aggressive behaviour, sadness, difficult relationships, problems with communication and family rules, and legal disputes over custody or access. Some problems had a physical dimension, such as encopresis, enuresis, or anorexia.

When the problem originates in the family or parents

For therapists who were not exclusively family therapists, the decision to use family therapy was made when the problem was seen as belonging to the whole family, not just the child. A preceding condition for these therapists' deciding to use family therapy was assessment:

> *"I don't know how you tell, you just—you just—I just sort of—know [laugh]—when you do an assessment...I sound like I'm using magic here, I'm not—when you meet with the family...there are certain things that ring bells, like children stealing, I think, is a good example of often what's going on in the family—you know, stealing from other—I don't mean secondary sort of gain by going into houses or shoplifting, I mean stealing from Mum or—that kind of stuff. Or another one would be—I think anorexia or—it's in the research that anorexia with younger anorexics responds well to family therapy..."* I:3

Here certain kinds of behaviour are identified as symptoms that will respond to a particular treatment, and this expectation is backed up by research. Family therapy was described as more effective than other approaches for certain problems:

> *"...where family therapy's indicated it's hugely more effective than trying to do individual work."* I:4

Family therapy was chosen when the source of the problem was either in the family:

> *"...the dysfunction's in the family and the child is just acting out the family's dysfunction..."* 1:2

> *"...the child's behaviour is symptomatic of something going on in the context he's living in."* H:1

or the parental couple, even if they were not living together:

> *"...it becomes very clear sometimes when the child is identified and they come in and you meet with the parents that the marital dysfunction's...what requires work immediately..."* I:3

> *"...conflict is being detoured through other members of the family, acting out somebody else's—some other relationship, generally the marital relationship's problem."* I:8

> *"...it's about the mother being unable to usually set limits, or seeing the father in the child, so it's a relationship issue."* I:8

One therapist suggested that when she believed the problem was with the marital couple, or even with one member of that couple, family therapy could be a face-saving way to encourage them to enter therapy.

When the child cannot change unless the family changes

Apart from the fact that treating an individual would not solve a problem which did not belong to that individual alone, therapists saw children as so embedded in the family that they would be unable to change unless the family changed:

> *"...working with the family if you're going to be able to make any lasting impact on what's happening for the child..."* A:3

"...it's impossible for a child to change when the family context that they're in doesn't change...it's an impossible ask, really." I:3

Family therapy was also seen as something to try when other approaches failed:

"[a social worker] would be working with a family, and she felt that there was really change that wasn't happening, and then would start thinking, well, there's really something that we could look at moving something in this family, and family therapy—and looking from a systems approach would make sense." J:10

One therapist suggested that the history of the approach as something to be tried after other therapeutic approaches had failed was a source of the enthusiasm for original or radical approaches in family therapy.

Three therapists spoke of their beginning to use family therapy after experience working with children or young people, and finding that change could only occur if the family was involved:

"...work with adolescents who were kids who had been basically incarcerated for antisocial behaviour—and in those days there was very much an individual focus, and the kids were seen to be acting out because they were basically bad kids...once you start working with young people in that context then the influence of their family becomes excruciatingly apparent, really, and so I started to work with kids and their families..." D:4

"...I did a lot of youth work, and used to get quite frustrated...often I felt as though I could only go so far, especially with adolescents, and then they go back into their families, and there would be no change. So when people talked about family therapy I thought, ah, that makes sense, because I'm not then working with people in isolation. Change has to take place in the wider family unit for things to happen, really." B:3

Deciding not to use family therapy

There were times when family therapy was described as not a suitable approach, even when a problem was seen as belonging to the family rather than to the individual identified as the patient. This might be

because another approach was thought to be more beneficial for that person:

> *"...it would depend on the age of the teenager and what the problem was. Because the teenager's developmental task is to separate from the family, it's not always a good idea to do family therapy with the teenager if the family is particularly enmeshed and the difficulty is to separate..."* I:2

In some situations family therapy was seen as potentially harmful:

> *"...there are times when to continue encouraging a child to develop an awareness of the nature of that child's difficulties—I'm talking about when a parent might be the problem—I believe you can actually increase risk to the child by doing that. And so there definitely are times when I think you've got to be mindful of the system as a whole, and how changes in one part's going to impact on—not only the change in the system but the change or a reaction from another family member. And working with violent parents or any of those sorts of situations...that becomes really difficult...there's probably going to be more benefit to a child by taking them out and working individually with them in order to help them develop resources to manage a pretty dysfunctional situation."* D:6

> *"There's a sort of a contra-indication for family work...I'm sure there are times when...that is absolutely not appropriate. Sometimes in the areas of sexual abuse or physical abuse I think you've got to be really careful about deciding to approach a problem in the context of the family."* D:7

> *"...the more that you work with [some people] the worse they can become...as they gather sort of an awareness of their own pathology they can become quite—well, amplified dysfunction, and that can make things risky for the child..."* D:7

In these examples, although the problem was described as being with the family system, or the parent, working with the system was seen as potentially dangerous to the child. The choice of treatment was based then not on where the problem was situated, but on what was safest and of most benefit to the child. Another factor in the decision was whether the family was suitable for family therapy:

> *"...can we work together? That's the assessment as much as anything...Are we going to be able to work together? Is this family,*

or this couple, or whatever, are they able to work in this way?" M:10

"...children individually that I would see would be children who are out of their family system, which is too chaotic to engage in therapy anyway..." D:6

"...you made an assessment as to what might be a method that would intervene suitably there, and family therapy might have been one, and you might try it and decide that that wasn't appropriate with that family..." J:3

In summary, when speaking of their decisions to use family therapy, therapists referred to its appropriateness for certain kinds of problems and certain kinds of families.

What is a family?

Joint history
Shared development
Currently living together
A single unit
Self-definition
Relevance to the problem
Who is the client?

Joint history

There were a range of responses to questions about the nature of the family. Sometimes it was described in terms of a joint history:

"...the whole of whoever's living under a roof, or whoever historically has been the family." K:4

"...it's to do with our backgrounds, what's influenced our family before this particular family—intergenerational things—mainly I think what's acceptable and what's not acceptable...it's wider than this family, it goes back, it's quite historical, it goes back many years." B:12

"Sometimes a family might mean bringing two separated parents together, and their children. So it's like going back to working with a former family." K:3

Shared development

A family might be described in terms of shared or intertwined development:

> *"A family is a family because...their individual development has been somehow connected very closely to the development of other... growing individuals in that setting. And that has occurred because their individual growth during a very dependent stage in their lives has occurred alongside other...growing individuals as well at very dependent stages of their lives. So the individual selves are tied up with the individual selves of other people, and that becomes unconscious, so that who I am is very much part of who the other person is."* C:6

Currently living together

Families might be defined by their currently living together, whatever the history:

> *"...a rule of thumb is under the same roof. A family lives under the same roof. It's not a tight definition...so that it might be a reconstituted family, but they're living under the same roof and having a lot of contact with each other..."* K:3

> *"...when people live together for the purpose of their mutual nurturing of each other..."* C:7

A single unit

The family was sometimes spoken of as a single unit, rather than a collection of individuals. This was an important distinction between family therapy and other forms of group therapy:

> *"...there are obviously things that you take cognizance of—the family as a unit, the unit operates separate from how the individuals—sum of the parts and all of that stuff."* D:6

> *"...when they come along and have a session they kind of join forces as a kind of an entity which is separate from the therapists..."* E:4

> *"...you're interfering with this whole thing—I have this idea of some kind of organism..."* E:5

"I think it's very easy to see the family just as a group of individuals, not to see it as something special." C:5

A system

Family systems were sometimes spoken of as 'real', as if they had characteristics beyond those of the relationships that they were made up of. Therapists on occasion described systems as 'closed' or 'chaotic', for example, without suggesting that they were speaking metaphorically:

"...the family's often got a closed family system, and they want to do everything together..." G:8

"...children who are out of their family system, which is too chaotic to engage in therapy anyway..." D:6

"...the pathology...belongs to the system..." I:2

Self-definition

For one therapist, the family defined itself by coming to her together:

"...any group of people that comes here and wants to work together to me is a family..." G:9

In some cases, such self-definition might be affected by a referring agency, especially if there was a statutory component to the referral:

"...they define themselves—who's interested here, who's involved here, who's significant here? So in that sense they kind of define their own involvement...It may be that other people are saying something about that as well, NZ CYPS or the Family Court, so they're having a bar—a piece of the action as well." M:3

Relevance to the problem

Sometimes for the purposes of therapy, the family was whoever was relevant to the specific problem:

"...who's significant, really. Who's significant to this um—the problem genesis or the problem solving..." M:3

That is, the family was whoever the therapists needed if they were going to work with the problem, rather than a preexisting group defined as a family:

> *"...there are times that we consider it important to have the entity —the family—here. For example, when a boy might have sexually harassed his sister, and maybe the parents want to bring in the child for treatment...we do have a sense then of the importance of the entity, the family, and we do encourage and keep the whole family working on the issue."* K:4

> *"...on knowing them better and assessing the situation we can um select a part of the family that we might want to work with. Oftentimes we work with whole families and stay working with whole families, simply because...people who live under the same roof and have a lot to do with each other tend to have ah interlocking processes."* K:4

Anther therapist saw the family's own idea of a family as certain kind of entity as one of the causes of family difficulties:

> *"...to actually say, 'oh this is destroying my family because I have this picture of this happy, altogether, go everywhere all the time with similar interests family.' I mean, some families might operate like that. Some families don't, and I don't have a sense of a proper family, I mean it just doesn't exist, you know, in life."* G:8

For one therapist, individuals could not be separated from their family:

> *"Every individual carries their family around in their head and they bring their family with them."* C:8

Describing a family she had worked with, one therapist suggested that family therapy could be therapy by making the group back into a family:

> *"They...just needed their new unit without Dad recognised as a family—talking about this family and that family without Dad there..."* E:9

Who is the client?

In individual therapy, and group therapy, clients are individuals. In family therapy things are more complicated. My questions on this issue were not very successful—I could not seem to make clear what I was

asking about, and some of the statements quoted above as descriptions of families originated with these questions. However, a few responses gave a glimpse of the issue I was trying to explore:

> *"...in the family therapy sense I see the client as being the family..."* D:2

> *"If I'm working with a couple...my client is the relationship—my focus is on the relationship, and I help them look at what is going to be best for their relationship. And that helps them get away from a sort of win-lose situation...But of course you have to look at what's in each person's best interests, because if each individual isn't functioning well then the relationship will suffer as well."* F:5

> *"...we're not there for any one particular person, but that kind of thing is contracted fairly clearly."* E:2

In summary, therapists described families as people sharing a common history or currently living together, as self-defined, or defined by the problem or a referring agency.

Differences between family therapy and other approaches

The systemic approach
- Cybernetics
- Using two therapists
- Comparisons with 'family work'
- Comparisons with social work

> *"...I'm not sure if it's a qualitative difference...when I think back to the years I spent in social work working with families, and I was mindful that a lot of people work with families but they don't do family therapy—so there's that sort of distinction, too."* D:3

> *"...working with families is a delightful difference from working one to one—I don't think it's counselling at all, I find it refreshing to take that very different stance from time to time."* E:3

The systemic approach

For some therapists, family therapy differed from other kinds of

therapy or counselling because of its systemic way of seeing or thinking about the family in a wider framework:

> *"...individuals inside a family, and the families inside a community, and the communities inside a society—systemically everything is going to affect everything...if you just see one level of that in isolation then you're not thinking systemically...that's one of the things I think is really great about the Family Centre in Lower Hutt is that they think so systemically, they're operating on all of those levels...that's real family therapy, that kind of stuff, because they're not just focussing on one level..."* I:13

> *"...family therapy...is a way of thinking, you're thinking systems, and it's a totally different framework and way of thinking than if you're thinking individual work. It's like if you're a Maori person you think as a Maori, and if you're a Pakeha you think as a Pakeha-it's that different. Systems thinking is just a different way of conceptualising and receiving and responding, to individual...and family therapy involves always thinking systems."* I:3

By removing the common-sense expectation that individuals were causing difficulties, the systemic approach in family therapy was described as reducing the sense of blame felt by families in difficulty:

> *"I think it's the systemic approach...this system within another system, so that...it's less blame and fault focussed and more raising awareness about the whole picture."* H:3

> *"When you get into individual work people tend to slip more into why people do things, or—whereas it's totally irrelevant in family therapy, why you do something..."* I:4

Cybernetics

The workings of family systems were sometimes described in the complex language of cybernetics (the science of systems of control and communication within machines), including references to non-lineal causality, restraints, feedback, and maintenance of problems. Some therapists spoke as if this were a taken-for-granted part of family therapy. For example:

> *"...it's the sort of cybernetic approach...in terms of the sort of feedback response and how that affects family interactions and so on...that to me is really crucial—to try and find out what maintains*

the problem and—which is something to do with the family's functioning...it's sort of taking apart the family process—what happens here, what maintains both positive and negative processes in the family, and finding a place that the family will accept for you to intervene." D:6

"...another part of family therapy is not seeing a lineal sort of explanation for causality...those sort of cybernetic stuff of things happening because they're restrained from happening in other ways." F:2

"...we need to look at it from another perspective, not just what's happening between them but almost like another level with what is it that's restraining them from change. And that's family therapy from my point of view. It's nothing to do with the whole family, it's to do with systemic understanding." F:2

Family therapy was distinguished from individual therapy for one therapist by an emphasis on the present rather than the past:

"...another difference between perhaps specially individual work [and family therapy] would be that...it's not necessarily important to go back into the historical material, but just look at what's happening right now, and how can we make what's happening right now work better than it is...in a way that all the work is right here in the room now..." H:4

Using two therapists

For some therapists, the use of two therapists was a distinguishing characteristic of family therapy:

"...for me family therapy involves a very prescribed process, and again for me that involves working with a co-therapist. And working through a fairly systematic set of problem-solving and problem-identifying steps." D:1

"...in the context of family therapy, that second person is to me really vital..." D:2

"...another thing I have about individual people talking about how they do family therapy—I mean hugely experienced family therapists can do family therapy on their own, but by and large you need two therapists to do family therapy, because the family system is so powerful, it just sucks the therapist in otherwise, and they join the

system unconsciously without even knowing that they're in there." I:5

Comparisons with 'family work'

Several therapists talked about differences between family therapy and 'family work'. Some things said suggested that one way family work was seen to differ from family therapy for these therapists was that while it involved bringing in or contacting the family to assist in diagnosing or treating an individual—which could imply seeing the rest of the family as context or environment for that person—it did not see the problem as belonging to the whole family:

"...if their problems in daily living seem to arise from some sort of interactive process within their family, then I see that indicates the need for some work with the family, that would be family therapy. If it's...an issue that's come up for the person, and involves another family member, but it's not indicative of an underlying dysfunction in some aspect of the family, I see that as working with a family." D:1

'Family work' was more individually based, in terms of the needs of the client:

"...there are times when children too need individual work. They need it within the context of their family, so you might need to do...what I'd call family work at the same time—working with the family system, but you're also working individually with the child..." I:2

"...work with families is perhaps more looking at an individual being able to make some changes, and taking for a short time some cognizance of a situation that—that person functions in without really attending to the whole system there. So perhaps it's more individually focussed..." D:2

And in the way the therapist worked:

"...family work is a bit of a straddle really, where you might think in systems a bit, and see how the system is working, but move into sort of more individual—the responses that you might have as an individual worker." I:3

"Family work tends to be for me...rather than intervening with a family in a systemic way, working with a family as certain needs

arise during a process of a different sort of intervention, which may be couples work initially, and then a child becomes involved, and that, in bringing the child in, maybe the child by itself, and then back with the parents again—working with families but not in a prescribed therapeutic, recognised family therapeutic way." D:1

In family therapy, the therapists engaged with the whole family:

"...looking at a systems approach of the family as being something of its own...it's whether or not the counselling therapist divides the people up..." E:5

"...it's engaging with the family as a—as the entity that I'm working with—it's a difference in my perspective that's quite strong, and it's —yeah, somehow separate—I don't know how to think about that— where to draw the boundaries, but it certainly feels different..." E:4

"...family therapy...specifically works with the family dynamic, its aim is to use what happens in that family system in order to achieve the maturity of individuals within the family. It doesn't see a problem as isolated to an individual, it sees its solutions being part of a whole." C:6

One speaker compared family work—which she did alone—with family therapy, which she did with a co-therapist:

"...working with a family in this context here by myself, I would be responding to what was happening for them right now, rather than trying to bring about any change in the family system..." D:2

Similar points were made about vocational guidance involving the family, and about family counselling, distinguishing them from family therapy:

"[I] often worked with parents and a child, but that was about one person's issues with the others there to support, and that was quite different...not wanting to change the family's relationships...family therapy is, it's about that, it's about very much rocking the boat so that the family relationships get moving again." E:5

"...people who do family counselling, for example, just nudge up against families because there's an individual in the family system who's presenting with a problem...they then make contact with other members of the family, the parents, to get a fuller picture." C:6

For one respondent the distinction between family therapy and family work was in part a matter of the therapist's skill:

> *"I don't think it is that clear [the difference between family therapy and other kinds of work with families], it depends a huge amount on the workers."* I:6

Q: ...once the family's involved, does it then become family therapy?
"No, not necessarily. That would depend on how good the family therapists are, too—that's the other thing that I think comes into this. There's a lot of people that talk about doing family therapy who are doing family work, not doing family therapy." I:3

This last speaker clearly believed that therapists differed in their understanding of what family therapy was, and that one factor in these differences was how good they were at it.

Comparisons with social work

As with family work, social work was used to clarify the distinct characteristics of family therapy:

> *"...people sometimes refer to doing family work, and it involves perhaps making some changes in the environment that the family is in, accessing more resources for the families without fundamentally making any changes or attempting to—to have them examine in any way the way in which they're interacting with one another. OK, so that's a level of family work which sometimes is seen to be the role of the social worker, you know, make sure that the family had adequate financial and whatever other sorts of resources that they need."* A:9

This kind of problem-solving was not family therapy:

> *"...a family therapist...has to work a lot more with process. If people can work with process, then that's fine. Some people don't, like I think—thank God this is confidential—I think for example people who are social workers come from a totally different perspective, and they work in a way of solution. They will solve the problem because that's what they do, in social work. A family therapist is there not to solve the problem, but to help the family to number one become aware of what the problem really is, and then to allow them or assist them in making the changes that they need to make them-*

selves. I think that's quite different from a social worker..." B:10

"...practical things of arranging housing and arranging benefits, things like that, I don't see as the family therapist's role, that is more of a social worker role. So a family therapist's boundaries are looking at the interactions between people and helping them to change the ones that aren't productive, those sorts of things." F:5

"...say I've got a social worker for a partner—they tend to collect a lot of superficial information about what's going on... I don't tend to pay much attention to that. I tend to pay more attention to, OK then, how does the person themselves feel, what's happening in them, what do they need to do to sort of bring about a real change that's going to prevent them from getting into this situation again." B:10

"...you can do things like...see to people's needs in the way that they might need time out, so...shift the child, put the child out to care or whatever—that's all superficial. What's necessary I think is being able to do things like genograms, sculptures with people, being able to get them to really communicate at a deeper level." B:8

Making fundamental changes, helping the family become aware of what the problem really is, bringing about a real change—these were phrases used to distinguish family therapy from social work, which by contrast was described by these therapists as dealing with practical and even "superficial" matters.

In summary, family therapy was distinguished from other approaches to problems when therapists referred to it as a systemic way of thinking, to its use of cybernetics, and the need for two therapists. Family therapy was seen as engaging the whole family, unlike 'family work', which some saw as having an essentially individual focus, or as requiring less skill. A problem-solving approach was regarded as characteristic of social work, rather than of family therapy.

Distinctions between therapy and counselling

Problem-solving

Power issues

For some therapists there were clearly-understood distinctions between therapy and counselling, which were spoken of in response to questions about the difference between family therapy and other approaches:

"What comes to me immediately is the difference between counselling and therapy...I would equate counselling with family work, and therapy with family therapy." M:2

Problem-solving

Therapy was described as more wide-ranging, deeper, working on peoples' blocks to getting what they want out of life, how they typically pattern their experience:

"...a counselling approach is essentially much more about solving the immediate problems, straightforward exploration, understanding action, kind of approach. Whereas therapy becomes much more wide-ranging...changing its point of focus a lot, depending on what's emerging." M:2

"For us it's not a distinction between—that this session is family work and this session is family therapy. It's to do with the depth of working at any one time. So in one session you might do family therapy and family work, but we're not used to using this distinction ...some people that we know make a distinction between counselling and therapy, and counselling in that distinction is essentially problem-solving, and therapy is working on people's blocks to getting what they want out of life." K:2

"...if you're counselling someone who's lacking support, you might be talking to them about where they might find that support. But if you're doing therapy with the person who's lacking support, then you're looking at how they interrupt support, how they don't use it when it's available, how they prevent themselves from getting near it...looking at the way they typically pattern their experience, rather than trying to find a corrective experience in this instance." K:2

"...that same differentiation I would make between family work and family therapy, really—family work, we're taking a counselling approach to...what's happening. It may be about getting resources...it might even be about dealing with a particular relationship problem, but it's still a counselling approach to that. Here's a problem, let's see what can be done about it. As opposed to, that's interesting—I wonder how this problem comes about? How do you respond to it? How do you even perceive it? What have you attempted to do about it? What influences what we choose and what we don't choose..." M:2

Counselling, in comparison to therapy, is described here as problem-solving, finding support, finding a corrective experience. Despite these distinctions, therapy and counselling were described by one therapist as existing on a continuum in practice:

> *"...some of our work, we would be much more towards the family work, counselling, problem-solving, mediation...that end of the continuum...even with a family court thing, where there is sometimes some very specific things which need to be discussed, we will be using therapeutic approaches, so we'd be moving along toward the other end of the continuum. Depending on this family's availability to do that, the time pressure, individual availability—there's lots of factors which would influence where along the continuum we were."* M:3

Power issues

For some, an important distinction between therapy and counselling was in a perceived imbalance of power between therapist and client. A therapist was described by some as a powerful figure:

> *"...the term 'therapist'—it connotates quite a lot of power...there are issues of power that do belong in family therapy."* G:1

> *"...I'm not into individual therapy, I'm into counselling, and I separate counselling from therapy, and again that goes back to a power issue..."* G:6

For the same speaker, a counselling relationship was more equal:

> *"I see therapy—a therapist—I mean you've got a colour therapist, you've got a—you know, whatever kind of therapist, and to me it connotates a relationship where the therapist has some kind of answers. For me, and I suppose I take a very Rogerian approach in counselling...I think that...it's a lot more closely working with what the client wants rather than that over the top 'I shall tell you—'"* G:7

In her opinion, family therapy involved too many people for the intimacy of counselling to be possible:

> *"There are too many different parts in a family, and with only two people you can't keep up with that [counselling approach]...I think that that power is there, but it needs to be clear that it's there."* G:7

This speaker saw openess about the power relationship inherent in family therapy as protective of the family. Another therapist, who said something very similar about intimacy when comparing individual counselling with family therapy, saw the family as having protective mechanisms that mitigated the therapists' use of power:

> *"...counselling the way that I work it anyway is very much about the actual relationship between me and my client—set up a very special I suppose environment and safe place and trust...it's very delicate, and I'm aware of every word that I say and response that I have at some level, so that it's careful like that, whereas with working with families, partly because there's two of us, we have a lot of fun, and it's as though the family's going to survive anyhow regardless of what we do...I don't have that same sense of having to step very carefully, although it's treated with the same kind of respect. But I can be a lot more provocative and unconventional and... don't wear the same responsibilities somehow. It's as though the family's a tough...unit that's already got wonderful mechanisms to survive—so is the individual, I know, but I don't get into that same interpersonal equal relationship with [the family]. The family therapist stays in a position of power over the process in a way that the individual [therapist] doesn't. I see them as very different."* E:3

> *"[with family therapy you are] very careful what you do, but not in the same—I don't know—not with the same intensity, the relationship isn't an intense relationship as the one to one relationship is."* E:4

In contrast, the next speaker saw a balance of power as essential to family therapy, something that distinguished family therapy from other forms of therapy or counselling:

> *"...for me family therapy is more respectful of the power and rights of the client than any other way of working...[in] other forms of counselling and therapy that I've been trained in the therapist is the expert to some extent, and even in—I did quite a bit of training in Gestalt therapy, and liked it and still like it...but I have become aware in recent years of how much the Gestalt therapist is a powerful person, an expert in a way, and Gestalt ways of being just don't fit for some people. That leaves the client feeling like they've put down something wrong, or they're resisting the therapy, and those words just don't fit in family therapy. The therapists work really hard to join with the client and understand their way of being in the world or their way of seeing the world."* F:2

Ideas change with time, and different models of family therapy have had different ideas about the place of power. One therapist spoke of her initial discomfort with the use of power in some approaches to family therapy:

> *"...I came across some people using it as a rather controlling method, and I think nowadays clients are being filled in more on what's going on. There was a time when I saw it as a manipulative method...using paradox and those sorts of things...I think that has changed."* J:16

In summary, some therapists believed that counselling and therapy differed significantly, with therapy involving more depth, and important differences in the power relationship between worker and client.

Continuity between family therapy and other approaches

While the therapists I have quoted above were making distinctions between family therapy and other ways of working, others emphasised continuity and integration between the various approaches.

One therapist responded to being asked how family therapy differed for her from working with an individual by saying:

> *"Well it doesn't, because again it's a way of working...with a couple I might look at the interaction between the two of them, the process, with an individual I might look at the interaction between the client and me, or the way the client treats himself or herself too, so I'm still looking at it from an interactional perspective... which is one little part of a family therapy approach. So when I talk about using a family therapy approach, it means adding extra levels to my work..."* F:1

She continued,

> *"...helping people look at what happens between them and others and looking at how they fit in their context...from my point of view that's family therapy."* F:1

Similarly, while they still distinguished between the two, some therapists found that their experience with family therapy influenced how they practised individual therapy:

"...sometimes I will have somebody referred for one-to-one work, I guess I'm always aware and always do check out whether there are any things going on in that person's environment or in their immediate social atom...their home and their family, which might be putting on extra pressure which is what is generating this, or contributing to the generation of these problems that the person is presenting with...I keep an awareness of how that one-to-one might extend further..." A:10

"...I tend to think that when I see individuals I'm also seeing the family, because I think systems-wise when I see the individual, and I imagine the rest of the family to be here..." C:8

And new theoretical and practical developments occurring in family therapy were seen as being observed and adapted by therapists working in individual therapy:

"...there are some quite exciting new developments which are happening in the...family therapy area...a new, I think, coming together of the ways in which problems have been conceptualised by family therapists, which have been seen as coming out of the family therapy literature, that are now moving and being used very effectively in one-to-one work..." A:14

One therapist spoke of therapists dividing themselves unnecessarily into either family or one-to-one therapists, and of her hopes for an increasing awareness of what different approaches had to offer each other:

"...you don't have to be either a family therapist who's seeing families together all the time, or...a one-to-one adult [therapist]—because people do tend to make these sorts of splits, and they see themselves as either people who are interested in child and family work, or adult work, and I think that's unfortunate. And it's a bit of a dilemma for me, as to how to effectively make people aware that they don't have to make those choices...you can...enhance your work in either area by being aware of the other area..." A:15

The origins of family therapy in a variety of disciplines demonstrated the benefits of interdisciplinary contact:

"...some of the key people were who developed a lot of the very interesting schools of thought in family therapy, they did come from a multi-disciplinary background. Some of them had original

background in psychiatry, some of them like Virginia Satir were social workers...there's a whole range of people who developed ideas in the field." A:8

In summary, these therapists took a systemic view of the relationship between approaches to therapy, seeing family therapy as connected to and interacting with other approaches, rather than as something distinct and separate.

Summary

This chapter describes the ways the therapists interviewed distinguished family therapy from other approaches to problems.

One way they did this was by describing the conditions under which they decided to use family therapy. This might be according to the nature of the presenting problem, or their estimation of its cause. Sometimes family therapy was tried because other approaches had failed. Children were described as unable to change unless their families changed, and family therapy was needed to ensure that this happened.

In discussing this topic, therapists produced a range of descriptions of the family, including those based on each family's developmental or residential history, and descriptions shaped by the purposes and needs of therapy. In some cases, the family was defined for the purposes of therapy by an outside agency.

Family therapy was also described in terms of the way it differed from other specified therapies. Therapists referred to differences in theory and technique, as well as in the nature of the changes sought by different approaches.

Finally, some descriptions of family therapy emphasised its continuity with other therapeutic traditions, and the mutual benefits of co-operation and dialogue between approaches.

CHAPTER FOUR

Selective Code 2:

BEING PREPARED TO DO FAMILY THERAPY

All the therapists interviewed spoke of the importance of training and personal preparation before doing family therapy. They believed family therapists needed training in both skills and theory, as well as personal knowledge. Experience and practice in family therapy should be ongoing, as should training and personal work. The relationship between co-therapists also required thorough and continuing preparation.

AXIAL CODES:

Key themes emerging included the following:

Having specific skills
Knowing different family therapy models
Having personal knowledge
Being experienced and practised
Ongoing preparation and supervision
Teamwork preparation

Having specific skills

Being trained in family therapy
Having people skills

Being trained in family therapy

Therapists interviewed commented that before doing family therapy a therapist should have specific family therapy training, knowing that sometimes this was not the case:

> *"...they would have had to have had...specific training in family therapy by an experienced family therapist."* I:5

> *"...a lot of people in my world would say, 'well, there's no such thing as a family therapist, anyone can do it.' I really don't believe anyone can do it. It's a very skilled way of working. It needs training."* B:19

"...there's...very largely a lack of recognition of...how well-trained you need to be...It's like counselling generally...people can do a sort of a basic listening skills course and say that...they do counselling ...that same thing transfers in relation to family therapy...you don't know what you don't know, basically, and it's like if somebody who isn't a counsellor says, 'oh, so-and-so is a great counsellor', it's because they just don't know what a counsellor is... " I:4

These speakers were talking about what other counsellors had to say about family therapy. The second speaker believed that only someone with sufficient training in family therapy was entitled to comment on family therapy skills.

The individual style of trainers could have positive or negative effects on the later work of therapists:

"...the most helpful part of my training was...to have some of the things that I was doing...validated, and working with someone who I had a lot of respect for and being given permission to be the sort of family therapist I am...gave me confidence when I finished my diploma to finally say, 'yes, I do family therapy', because until then I'd never had the confidence to do that—I'd always said, 'I do family work.'" D:4

Another spoke of her training in clinical psychology, which she believed had a bad effect on her practice:

"...the process of the training, which wasn't facilitating the trainees' own style of working or an understanding of how to go about therapy process, but it was imposing on us the model that didn't fit for me...it is an abusive process when you're not facilitating someone's own strengths but squashing them and criticising...to be supervised by someone who's going to be an assessor at the end of the year...and who's sort of part of the whole process of squashing anyway, and has been taught himself through that kind of powerful model—all pretty awful. So that certainly got in the way." F:6

This trainer's style was seen as a result of how he was himself trained, hence the speaker's concern for the effects on her own therapy of this 'squashing and criticising'.

The time and money needed for good family therapy training were also seen as barriers to its delivery:

"...we had four people in our team at one time, so you had two in front of a screen and two behind, four people, one family, that's not very cost- effective...but you've got to train people, and the only way to train people is for them to see what's going on...But...it's expensive to train people, so—that's the problem with it." I:10

There was seen to be a clear relationship between training and cost-effectiveness:

"If you're really well-trained, it's cost-effective. If you're not well-trained, it's not, because people don't change. So you're using two therapists endlessly. You have to be really well-trained, I think, for it to be effective." I:9

Partly because of the expense of training, some of the therapists I spoke to, although previously experienced counsellors, had received their family therapy training very much on the job. Two gave some idea of the amount of family therapy training they received while working:

"...that was quite a thorough course. It went on for at least six months, with I think a whole afternoon a fortnight...So staff from that came back to the agency with quite a lot of interest and knowledge and skills for family therapy." J:2

"I think it was very good training...our work was supervised by one of the trainers, so we worked with families and received supervision...We had four hours a fortnight of theory and practice, and then we saw families...the blend of theory and practice I think was good." H:7

Describing her work with an equally inexperienced co-therapist during this training period, one therapist said of her client families:

"Some of them seemed quite helped, but I wouldn't say very helped... Because we were both so new at it, we were both very much learners. But some people made—took a lot from what we gave them." H:9

There were difficulties in training where experienced and inexperienced family therapists worked together:

"...it's a difficult thing to train [with] a new trainee and a trained person, because you're not modelling [to clients]...anything about what you're saying...it skews the whole thing a bit, which is why

they train people often using screens and things..." I:10

"[students]...had to get up and go out because they couldn't handle the intensity of the stuff in the room, and that immediately distracts you from what you're doing, distracts the family, and you've got to deal with that." D:9

Some agencies provided training for their own workers, based on an understanding of the needs of the people their therapists will be seeing:

"There's no-one here with highly sophisticated skills in family therapy...The clients now we get generally are lower socioeconomic, not highly verbal...it needs to be a form of family therapy that is appropriate to the clientele..." J:10

There was also concern about the contrast between the severity of problems presented to workers at agencies with a high turnover of staff, and the amount of training and experience with family therapy these workers had received:

"What's going on there is...level one training and they're getting level eight problems..." I:10

The last speaker also believed that it was inaccurate, and damaging to the reputation of family therapy, to call the work of people with little training and experience in the field 'family therapy':

"Despite the fact that they call it that [family therapy]—it's not that, and it's a disservice to family therapy." I:11

The therapists interviewed believed—and demonstrated—that perceptions of 'adequate training' in family therapy varied widely. Some saw their own standards as higher than those of others who also called their work 'family therapy'. Where time and continuity of training were limited, the knowledge and skills of less-trained therapists might appear no different from the skills of those without specific family therapy training. In that case, people with no experience of more extensively trained family therapists might understandably say "there's no such thing as family therapy". The earlier-noted suggestion that only someone with sufficient background in family therapy could comment on what it was, or on who could be called a family therapist, arose in the same context.

Having people skills

Although 'people skills' seem a necessity for successful family therapy, therapists believed that they were not always present:

"...you've got to have really good people skills...I know of people working with families where they just don't seem to be able to make that contact with the individual family members, and the family as a whole...there's a balance between being acceptable to the family and also being able to be separate enough to hold up to them or to point out, or to confront them with the issues that you see emerging. And I think that's something that you have to really develop and learn." D:5

"...being able...to make it very safe for people to be able to talk from their hearts in a very safe way, so that one person doesn't say something that's very important, and somebody else over the other side then comes in and squashes them...I think that the therapist has to be quite skilled to be able to prevent that from happening." B:8

In summary, having specific skills included the skills therapists said were required before beginning family therapy, including those acquired in specific family therapy training, and 'people skills'.

Knowing different family therapy models

Coherence in theory and practice

Several of the therapists interviewed expressed the view that knowing a variety of different models of family therapy theory and practice, and the history of their development, were an important part of training and directly relevant to good practice. This knowledge situated the therapist in a growing and changing discipline. Knowing that models change with time, and why particular changes have occurred, gave a sense of perspective:

"...there hasn't been formalised training particularly in this country, in the area, where people will tend to zip along to this, that or the other workshop, and then on to the next, without having any sort of theoretical coherence to why it is or what it is that they're trying to do. And I think that this can be problematic sometimes. People

might not select the best intervention or do the best for whatever the situation is that's arisen, unless they do have that broader overview." A:9

"...having a good overview of the history and the development of different schools of family therapy, and seeing them within a context and historically when and how they developed, I think is quite important." A:9

Eclecticism

One therapist spoke of being exposed to a number of different models in her training without sufficient time to assimilate or choose between them:

"...we had a variety of models offered to us, but the drawback of that was that we just touched on one model, touched on another one, touched on another, and probably the ideal would be to have chosen one model and said, 'I really like this, I'd like to follow this model particularly and do more study and practice in this area', but when you're...taking bits out of all sorts you have a fairly eclectic sort of approach in the end." H:7

For another, eclecticism was the result of experience and skill, after a grounding in one particular model:

"...the most effective workers usually...have a fairly coherent way of working, and they would do that with most of their clients, use that framework...I suppose it becomes eclectic as you get better and better at it. By and large you need to have a fairly good grounding in ***a*** *family systems model and work from that."* I:4

One therapist intended to restrict her future training to a single theoretical model, suggesting that she saw eclecticism as potentially problematic:

"...what I'd be interested in in future in terms of training specifically in family therapy is training within a model...staying more or less within a model, because I'm aware of the stark differences between models, and the way different models approach the situation." K:5

These speakers all thought it was important to be able to distinguish between family therapy models, and to know why they were using one

approach rather than another.

In summary, knowing different family therapy models included the issues of coherence in both theory and practice, and therapists being able to select the best possible intervention. Views of eclecticism as either valuable or problematic were expressed.

Having personal knowledge

The relationship between 'own work' and practice

Knowing your own personal limitations

The relationship between 'own work' and practice

Therapists said that while a certain level of self-knowledge was needed before a therapist could safely and competently practice, reaching this level of understanding was not enough. A therapist's own personal work needed to be ongoing, just as his or her experience did, if it was to be adequate.

Self-knowledge included therapists' understanding that they came to therapy with their own knowledge and beliefs, and knowing what these were:

> *"...counsellors...need to have done their own personal stuff, too, and dealt with their own personal blocks..."* H:8

> *"...because they haven't done their own work properly their skills in relation to effecting change aren't terrific..."* I:12

One reason self-awareness was important was that it would help the therapist avoid imposing his or her own values on the clients. This was a matter of the safety of clients:

> *"...we do develop habits or patterns, and if you've got some level of awareness of where they come from and how we react in certain situations and that I think ultimately makes us safer therapists, because we're not likely to [be] sort of blindly enacting...something in a therapy session because it's triggering off certain...stimuli for us."* A:9

Therapists' imposing their own values on clients was spoken of as 'dangerous', and 'not uncommon':

> *"A person that I'm doing co-therapy with at the moment—who is very much traditional...Dad has his role, Mum has her role, and... that's how [the co-therapist] wants to send them off, all as a family in the traditional way, and I find that really dangerous."* G:9

> *"...trying to make it into a traditional family because that's where the [therapist's] values lie? I think there are really big dangers in that, and...I think it happens, I don't think it's uncommon."* G:9

It was seen as essential that therapists understood the influence of their own family backgrounds, both past and present:

> *"...really important...somewhere during their training the opportunity...to be able to reflect on one's own family and the way in which your own family background has shaped your own view of the world and your own way of responding to different situations..."* A:8

> *"...to have a pretty good acceptance and understanding of your own family dynamics, so that you're not sort of trying something out, working out your own stuff with them..."* H:8

Knowing your own personal limitations

As well as the limits of their professional skills, therapists recognised personal limits to what they were prepared to tackle. For example, one therapist assessed the degree of motivation in the client family to decide whether she was prepared to use family therapy:

> *"...the motivation for wanting change...if that's not evident in the family I won't work with them...some people are unsuitable for family therapy...I'm sure other family therapists would take them on and do a lot more hard stuff, but...I know my limits for that, and I think that needs to be constantly assessed as well."* G:6

In summary, having personal knowledge included understanding the relationship between 'own work' and skills, awareness of the influence of a therapist's own family background, and therapists' knowing their personal limitations. Understanding how personal issues and their own family dynamics might affect their work was spoken of as essential to preparation, preventing mistakes and freeing the therapist to work with the issues that the client family brought.

Being experienced and practised

Apart from training, actual experience in family therapy was mentioned as an important part of a family therapist's preparation:

> *"I've had lots of family therapy training in different contexts, from doing the diploma in social work...and specialist training...but none of that is as helpful to me as actually just getting in there and doing the work."* D:4

> *"...when I'm new to something I'm sort of really anxious, I'm not a very good beginner, I'm much better as I get on with it. So it's just if I'd done it [family therapy] longer I guess I would have been more relaxed about it, not so worried that I was doing it wrong..."* H:8

As well as accumulated experience, being in practice, in the sense of having ongoing exercise specifically in family therapy, was important. In response to a question about anything that prevented her from working as she would have preferred, one therapist said:

> *"Lack of practice...I'm not seeing enough families to feel as though my competence and instinct is improving...I've only been doing work the last three years and not really enough to get a sense of ease...I have to really sit and think what's the best thing to do..."* E:8

Another reflected on the relationship between her skill and current practice:

> *"...if it's a particularly stuck family, because I don't do a lot of it and I haven't continued to upskill myself, I would refer them on..."* I:1

> *"...family therapy involves always thinking systems. I suppose that's why I do less of it now, because I know that it's hard to...keep with that framework when you're not doing it a lot."* I:3

In summary, therapists believed that experience in the simple cumulative sense, while important, was not enough to ensure that a therapist had the skill to work well. Therapists needed to continue to do enough family therapy for their skills to remain current.

Ongoing preparation

Increasing skills
Staying in touch with others in the field
Supervision

Increasing skills

Therapists believed that to remain adequately prepared, they needed to continue their training. One spoke with approval of others, who

> *"...have continued to upskill themselves, they haven't just sort of trained ten years ago and done nothing else about it...[that is] hugely important in any of this work. If you don't keep on working on yourself and your own issues, and continuing to upskill yourself as well, you're going down the gurgler...taking your clients with you."* I:7

Continuing professional education and continuing to work on personal issues were often spoken of in the same sentence, as if they were a single category:

> *"...we have certain obligations as therapists, to keep our personhood well-tuned and well-read..."* K:5

A therapist's professional work was clearly linked to personal well-being:

> *"...a lot of people who work in this field, the way in which they work is very linked in to what's happening for them personally. I think the two have to complement one another, and if there is a lot of dissonance between the two, people do start feeling...they do want to move on and do something differently. Or they have to make some major shifts in their life...I think the two have to be congruent in this sort of work."* A:18

> *"I think that's really important, that I care for me well so I can keep doing this work."* F:6

> *"...because I see myself so much as the tool I use...I never see a time when I won't be continually attending to the tool that's me..."* M:4

Staying in touch with others in the field

Preparation included staying in touch with others in the field:

> *"I do have to keep...educating myself or moving into situations or training circumstances where there are other colleagues or other people who are particularly interested in...the same sort of philosophy of work that I'm involved in..."* A:15

Supervision

The professional contact most frequently mentioned as important was with a supervisor. Supervision was spoken of as essential, for experienced therapists as well as trainees:

> *"...it's so important to have supervision—I'd really like to push for supervision. I think that that is absolutely vital, that all therapists, especially working with families, have very good supervision."* B:18

> *"...supervision of ongoing practice is vital..."* H:8

The supervisor must be experienced and knowledgeable:

> *"...good supervision...by a family therapist, someone who knows about family therapy..."* I:5

> *"Whoever gives you supervision needs to know more than what you do, and to have more experience, so you're learning, you're learning different ways to do things."* B:18

Clinical supervision in therapy can be a forum for discussing the behaviour of clients and what happens in the therapy session, the sharing of responsibilities, and emotional support for the therapist (Goldenberg & Goldenberg 1991). Supervision was spoken of as a source of new information and ideas, an opportunity to benefit from another therapist's greater experience and to learn new skills:

> *"...it keeps the system from being closed, it keeps opening up the system. You're getting more information, you're getting more ideas about what's happening in this family..."* B:18

> *"...supervision keeps broad, and brings in other aspects all the time to consider..."* H:8

> *"...it keeps your creativity up. You have to be quite creative to work with families, you've got to be able to work in different ways, because like I said no family's the same. And I think you get that from supervision...that's why it's so important, it stimulates new ideas."* B:18

It was also a way to keep doing personal work, especially in relation to how the therapists' own personal issues affected their professional work:

> *"...keeps me aware of the process that I'm in with people, and what I'm bringing that may be my own projections or transference issues..."* H:8

> *"...supervision...you need to be able to explore your own interactions with families to your own process, what's happening to you."* B:18

Supervision was also valued as a form of accountability, an outside check on therapists, in a very private profession:

> *"[supervision] keeps me sort of—um—accountable...it sort of feels like I'm on my toes...if I'm going to be talking to somebody next week about what I'm doing, and 'specially if it's live...just keeps me...a bit self-conscious of how I'm working...it's all about accountability really."* H:8

> *"It stops me from going down a track that might—needs to be checked...if you're doing things on your own, or you're private, you can...go down a very narrow sort of track, and supervision keeps broad, and brings in other aspects all the time to consider..."* H:8

In summary, ongoing preparation included increasing skills and staying in touch with changes in the discipline, therapists continuing their own therapy, and the professional checks and balances of supervision.

Teamwork preparation

Practical matters

The co-therapy relationship

Practical matters

Many family therapists work in pairs. Co-therapy may have started as a way of training inexperienced therapists in the complexities of family

therapy (Goldenberg & Goldenberg 1991), but it has become for some family therapists a defining characteristic of the approach. Of the twelve therapists interviewed, six said they always had a co-therapist for family therapy. Three more preferred to work with a co-therapist, but had on occasion worked alone with family therapy clients.

Working with a co-therapist required preparation. Some of the issues were practical. Even when therapists in private practice knew someone they would like to work with, they had difficulty arranging to be available at the same time and in the same place:

> *"I like to do family therapy with another therapist, so...I don't do much now, because it requires getting the other therapist that I work with, getting the right time and stuff."* I:1

> *"...my problems in the past and decisions I've made about working or not working with a family have often been to do with the availability of somebody who can—who I can work with and who can work with me."* D:9

> *"...in private practice, working as a...family therapist is really difficult, you have to really set it up..."* I:9

Some of those interviewed felt that they wouldn't do enough family therapy to have sufficient regular practice with a co-therapist, and so they preferred to refer clients to an existing team who specialised in family therapy. The issues of how co-therapists were selected, how much they trained together, supervision as a team, and the opportunity to work through conflicts and differences, were all described as crucial to the success of the team.

Staff turnover, matching levels of experience, and the difficulties of working and training a co-therapist at the same time were mentioned as some of the problems of working with co-therapists. Describing an attempt to train workers to form teams in one agency, one therapist said:

> *"...staff...came back to the agency with quite a lot of interest and knowledge and skills for family therapy. However, some of them left, some stayed, and there was never probably a very comfortable team structure attached to that..."* J:2

The co-therapy relationship

Even therapists who had worked together for a long time acknowledged that their relationship as co-therapists needed constant attention, and supervision as a team:

> *"...we have to keep working at that [relationship]...there shouldn't be any assumptions about that either...this is our tool...we've got to keep working with our tool, maintaining it..."* M:12

> *"...you're not talking here just about working through troubles, as well, because that's important, but also just keeping it—a machine well-oiled. Like keeping in contact with each other."* K:12

It was important to resolve differences in what 'family therapy is about' between co-therapists, before therapy began:

> *"...the co-therapist I find very difficult...I think that what happens before the first session is really important...I'm quite happy to lay down very clear ground rules like I will see everybody or nobody and it will be within working hours...but at other agencies it wasn't easy, and there's one particular [person] who I was working as a co-therapist with...who would do the phoning [who] used to get manipulated always into all sorts of things...even agreed to have an initial session with the family in their home—I think that's just ridiculously stupid—there's no way you can set up a therapeutic session when somebody's refusing to go [out of their own territory] ...that kind of agreement with the co-therapist about how you're going to work, why and within what limitations I think is vitally important..."* E:9

The anxiety caused by a difficult co-therapist relationship is reflected in the next quote. The speaker was concerned about being overheard:

> *"This is really hard. Go away from the door, people!...there are teams that work and there are teams that don't work...I'm not saying that you have to be the same, or even come from the same back-ground, either, because at times differences in the actual co-therapy too is actually quite good...But I think philosophies need to be pretty similar..."* G:1

She continued:

> *"...[working with a co-therapist] is really tricky, and it's potentially*

dangerous...There are issues of power, that do belong in family therapy...it can become difficult when you're working with another person...you're actually into unsticking...and I think that's a power position...that needs to be stated...before you do the work,and I think there are difficulties because...some therapists don't actually see it that way. It's a contentious issue around here." G:1

This speaker was describing a situation where co-therapists could not agree that family therapy involved issues of power, or about how to approach these issues, especially with regard to making them explicit to the family. Another therapist described problems arising during therapy when co-therapists had not resolved their differences:

"...you suddenly become aware that the person you're working with is not with you, or actually doesn't agree with what you're doing, and so you end up with this dreadful situation where the family knows what's going on as well, and it's really hard to manage. I mean, you obviously can stop and go and sort it out, but that for me is the hardest." D:9

Even if such differences were not apparent to the family, they were likely to affect the therapy:

"Another big thing that was always a difficulty for me...was the lack of team cohesion. I don't know how people deal with that in other places...but—the more united, I suppose, not the same, but the more honest and open and trusting the relationship between the workers, I would think, the better modelling and the better work, probably, done with the families..." H:8

She had tried to deal with one difficult co-therapy relationship by redefining it:

"...I tried using him as a consultant in the room, so that he was there, but I didn't have to—keep accommodating to him [laugh]. And that was OK, but it always felt like a real compromise, and I always felt quite irritated by the whole thing. I'm sure he must have found me irritating too, so it wasn't good." H:9

Differences in background training were seen as contributing to these difficulties:

"...sometimes working with other disciplines, because...I come from a counselling perspective, so I don't think my discipline is as clearly

defined as others...I do find that difficult, trying to work across disciplines...that's a real struggle for me at times, a struggle for them, too [laugh]." B:16

The belief that one co-therapist is regarded by the other as less than equal because of different training was mentioned as destructive to the therapy. The next speaker described a competitive and untrusting relationship between co-therapists. Although this was contrasted with the more equal relationship that could also exist between therapists with very different backgrounds, it did raise some questions about how people who felt very uncomfortable working together came to be doing so, and what the implications might be for the families they worked with:

"...people can tend to get into 'I know more than other people', because of their training, which I think is quite sad, because when you actually get in the room with...the family, often that is not so. They don't know more than what I know. They might have an academic training that's vastly more than what I've got, but often doesn't actually fit the situation...I mix with people who are academically...very well qualified and you wouldn't even know it... there's a real feeling of equality between us, and I think it's great, because you need as much skill as you possibly can in that role, that's all it is, is skill, it's not one person being better than another, so there shouldn't be any competition between the two people working...I think that is what it brings up, though, if one's been trained more than the other— you know, 'I know as much', or 'I'll show you I know more'. Which—it is a problem." B:17

For some therapists difficulties with co-therapists seemed to be the norm:

"The biggest restriction I find in my work are...the co-therapists. And that's tough. I mean I'm actually working with somebody who I think is great, and it's the first time all year, it's only just started with one family. I'm actually finding it relatively refreshing—yeah, it's just great." G:10

When I asked one therapist whether there was a contradiction in so many therapists speaking of the co-therapy relationship as their biggest problem, yet insisting that family therapy must be done this way, she replied,

"...that's not so much a contradiction as a reality...I mean families-

maybe it's ideal, maybe it's not, maybe it's ideal to live in families, but families have difficulties. Do you know what I mean? In another context." H:9

Teamwork preparation included the complicated practical arrangements that had to be made before co-therapists could work together. Also important to co-therapists' preparing for family therapy was resolving any differences in philosophy, approach, and background training prior to, and during, a continuing working relationship.

Summary

This chapter began by looking at the special skills and knowledge therapists thought necessary before beginning to do family therapy. Statements were made suggesting the existence of very different levels of training, and that this was a contentious issue for some therapists. Adequate training was described as difficult to get, and difficult to recognise.

The importance of knowing different family therapy models continued the theme of depth of understanding rather than the acquisition of techniques, as did the emphasis on therapists' having personal knowledge and continuing to develop as people. These were seen as issues of professional responsibility.

Family therapy required therapists to be experienced and practised. Preparation should be ongoing, and this included supervision to deal with professional and personal issues. Supervision was also a matter of accountability for the therapists.

Preparing to work as part of a co-therapy team raised similar issues in a slightly different form. Working with a partner required special training. Different models of therapy might now be found in the same team, giving the understanding and reconciliation of such approaches an immediate practical impetus. Self-knowledge and not imposing values were especially important for co-therapists, as were being experienced and practised as a team. The idea of the co-therapy relationship as a tool was seen as something that distinguished family therapy from other therapeutic approaches.

CHAPTER FIVE

Selective Code 3:

IDEAS, ACTION AND OUTCOMES IN THE THERAPY PROCESS

This selective code concerns what therapists said about what happened during or as a result of therapy itself. It is divided into three sections, the first about ideas and knowledge, the second about the metaphors of action used by therapists to describe their work, and the last looking at the intended and actual results of the therapy process.

AXIAL CODES

Key themes emerging included the following:

IDEAS: expectations, awareness, and what people know

ACTION: moving, depth and danger

OUTCOMES

IDEAS: expectations, awareness, and what people know

The family's understanding of what brought them to therapy
Therapists' views of the problems that brought the family
The family's expectations of therapy
Therapists' understanding of their role
Resolving differences between these views
Being a certain kind of expert
Accessing the family's own knowledge and skills
Hope
The family's decision making
Termination

The family's understanding of what brought them to therapy.

The family's views of this were seen as often quite different from

those of the therapist. Families (or parents) were described as usually assuming that the problem was with the child:

> *"...one of the difficult problems is that very often it is true that the family does interpret the problem as that there is a bad child or a child who is behaving in strange ways..."* A:1

> *"...they tend to think at times that it must be some kind of psychiatric problem with the child..."* B:2

Sometimes they were seen as actively seeking help for the whole family:

> *"...saying 'we've tried everything we know—this is not helping, we are in trouble here, can you actually help us out.' And not just for themselves but also for the kids...'are we saying things wrong, or doing things wrong...' so it's not just the parents wanting help, they're actually wanting us to help the kids be able to talk that through as well."* G:3

Therapists' views of the problems that brought the family.

These often involved reinterpreting parents' or families' views in terms of what was 'really' going on, that is, in terms of the therapists' view that the problem was not confined to the child:

> *"...the problem is always with the family as far as I'm concerned, but there are times when the child's problem may be to do with aspects of the child that are not necessarily to do with the family's functioning. And I don't think there are many cases like that, frankly..."* D:3

> *"...if a child is referred for whatever, I will see them in the context of their family so you can get some idea of where the dysfunction really is."* I:3

Expressions such as "...the identified patient..." (I:2), "the symptom-carrier" (H:6), suggested that there were other patients, not yet identified. A child's behaviour was sometimes described as an attempt by the child to communicate about the problems the family was having. Contrary to the parents' belief that they were bringing the child to therapy, some therapists described the child as bringing the family:

> *"...Jimmy is behaving in a way that's unacceptable to them, they*

don't know how to control or manage this behaviour, straightaway we think, oh, rightio, the child is waving flags, saying there's something wrong in the system. So we tend then to try to move the problem away from the child, make things a lot more general and start working in a systems perspective, looking at relationships. What is actually happening in this family that this child has decided that they want control, or that they need some kind of help?" B:1

"...let's have a look at what the system is, what this child, for example, is saying about the system he lives in or she lives in." H:3

Therapists sometimes interpreted the family's problem as arising from a lack of clarity about rules and expectations:

"...the child receives different messages—she can do this with Dad and get away with it, if she does this with Mum she doesn't get away with it. Then Mum might get angry with Dad, and the child feels—the child often feels responsible for the argument that starts between Mum and Dad, and it has lots of repercussions for the child." B:11

"...when you've got a family with two parents you've also got two different families of origin, so there are always going to be mixtures and mixed messages, and I think that their kids often will go one way or another...I think it's not talked about with couples, and I think it's not talked about between parents and children..." G:6

"Often they don't know the ground rules...in families a lot of assumption goes on. They assume that because they're living in a family that each [person] knows what they're thinking and what they're feeling, or should know." B:11

Unfulfilled parental expectations about how the family should be were also seen as contributing to family difficulties:

"...often it's not that their child's actually doing anything wrong, it's that it's just not fitting their sense of family." G:9

In these examples the parents' views of 'how a family should be' are seen as too restrictive compared to the therapists' views.

Inadequate communication skills could cause difficulties:

"...sometimes the communication is so bad that people really don't

know what isn't acceptable, what's good behaviour or what isn't good behaviour, or what's expected of them within their own family." B:11

"...it tends to be a communication problem...most of the family ones that I've dealt with anyway, have been hearing each other and getting alongside and understanding what that's about—understanding the dynamics..." H:5

A family might be seen as coming to therapy because they lacked the skills to negotiate change:

"...[in] families that aren't having family therapy, [change] is a constant thing that's going on all the time, and—but they actually have the skills to...integrate those processes into the family in a way that's acceptable to the family." G:8

"...they haven't really for a variety of reasons had the opportunity to learn proper parenting skills, and in many cases one or both parents...have some really serious problems of their own and find it really difficult to empathise or look beyond their own concerns to those of the child." A:3

The family's expectations of therapy

These were perceived by therapists as likely to be different from their own:

Q: Do you think that they—the families themselves—interpret what brings them to you differently from the way that you interpret it?

"Oh, sure. I don't particularly investigate that, but I'm sure—we talk about the things that—I'm not quite sure what their perceptions are." E:1

"I think children tend to see it...that it's likely that we...are going to side with the parents, and then that tends to be their expectation —perhaps the parents expect the same thing, I don't know." E:1

Although the latter speaker didn't know exactly what parents expected, she was confident that it was different from what she herself expected or knew about the way therapy works. Families might need to be informed:

"...we have to sometimes work hard to explain that approach, when

people are expecting something different. And other times, you know, people sink into it with a great sense of relief." K:10

Needing to 'work hard to explain' again suggests that this speaker perceived a significant difference between the clients' expectations and those of the therapist, as does the 'great sense of relief' described for the client whose expectations (presumably, fears) were not confirmed.

A common expectation of families was that the therapists' job was to 'fix the child':

"...often there is some sort of belief that...it's up to me to do something to change this child so the child will fit into the family..." A:1

"...they would like you to take the child away and do some kind of magical thing with them then bring the child back into the family and everything will be alright." B:2

"...the majority of families that I've worked with...have tended to produce the child for reparation if you like..." D:3

Another common expectation was that the therapist would tell the family what to do:

"...they actually do want us to be expert and to tell, and to instruct, and give advice..." M:6

"...they want the experts to tell them what to do." B:2

The family's expectations of therapy may have been influenced by the way they understood the role of the person who referred them:

"...people may have been referred through a doctor, and they come along and they want the child to be fixed, like you take your child to the doctor and the doctor gives them tablets and they're OK. They come to us and that's what they want, 'Now you take the child and off you go.'" B:6

Sometimes families were seen as trying to fit their expectations of the therapist into another role they understood, such as that of a priest, mediator or referee:

"...it's historical—you used to go to the local church...to the priest

who told you what to do or not to do...there's papers written...that talk about counselling or therapy as sort of the new religion in a sense, that at one time you would have gone to a priest with now you go to counselling." I:12

"...I guess it's in some ways as a kind of mediator, someone who's going to mediate...in the difficulties which might be between the child, the adolescent child and themselves...mediate in order to be able to reach some sort of compromise among the family..." C:1

"...there's some doubt as to whether they see you as the kind of referee..." C:3

Therapists' understanding of their role

Most of the therapists saw their role as less directive. They spoke of 'creating an environment', and of 'enabling' families and individuals:

"...to create an environment...which is conducive to people working on their own issues. What we do here is create an environment." K:5

"...I see my role as just enabling the family members to work towards a solution..." C:2

"...our approach is to...enable them to begin to be more curious about their own process. So that's—that's the environmental thing—create the environment where we become more curious, [rather] than having outcomes in mind...that is hard for some people...a kind of shift for them...They want...some clear outcome—'this is what must happen'." M:6

"...the environment that we create...we bring our skills to that environment, our skills in awareness, so we help people to be more aware of just how...they organise themselves, and so we bring our curiosity and our skilled curiosity to that enterprise..." K:6

"...I influence the way that family relates in that session, adding a factor to it which is not normally there, by my relationship, and they take that with them, that experience, they take it with them in their family life, and it enables them to, hopefully to alter, change..." C:3

They also spoke of increasing awareness:

"...to raise awareness of the bigger picture, of the bigger context, that is, to hope that they would take the blaming focus off the child..." H:6

"...people might want to be different but not know how to go about that, and so we assist with that knowing by our drawing attention to what is happening, now, and bringing it to conscious awareness." K:7

"...we're not aware of our own—of how we organise our experience, we just experience things, and—yeah, when we go to therapy we're helped to appreciate how we do organise our experience." K:7

Therapy was described as definitely not a matter of telling clients what they should do, even if that was what the client wanted and expected:

"We accept that people don't know how to change sometimes, even when they want to, and we do assist with that process. But not by telling how to be different." K:7

"...it's potentially dangerous. I have worked with someone who actually lectures and tells people how to be..." G:1

Resolving differences between these views

Differences between therapists' views and the expectations of the family might be resolved by explanation, by discovery, by confronting or provoking, or by seeking a mutually acceptable viewpoint.

Sometimes therapists explained to the family how therapy worked:

"...you've got to really clearly set it in the beginning...the family comes with a set of expectations that need to be talked about." G:2

"The first session would mainly be talking about what we're there for and what we're going to do and how it's going to work and how we believe in families and the family's there to take charge of itself..." E:2

"...show them how we work...I suppose present them with theory." B:6

"...as therapists we...need to explain what we do do, and how we

will work, and I think that that is important. I mean, that will change over the course of time as well, but I think it—always needs to be spelled out. And that's my philosophy. Lots of people [therapists] aren't like that either—it's sort of like, 'they come, they want help, we'll give it'." G:2

"I would probably spell out very clearly that my role is certainly not to take one side of the family against the others..." C:3

"...sometimes we'll go as far as to explain, quite explicitly sometimes, about how we work, and how we'll work with them, and what we're in a sense expecting of them." M:7

For some therapists one value of such transparency about how they worked was in the resulting therapeutic effectiveness. Not explaining could limit effectiveness:

"...you are actually in that position of power, and...I think that needs to be clearly stated, and I think if it's not then the chances of actually being beneficial to the family are limited." G:2

Some therapists clearly believed that for therapy to be useful to the family, the family needed to know and understand what was going on:

"The clients now we get generally are lower socioeconomic, not highly verbal, some of them not literate, so there are some of the more refined [laugh] and really clever techniques of family therapy that would probably—they wouldn't even know what was going on...it needs to be a form of family therapy that's appropriate to the clientele ." J:10

"[being open with the family]...I think that's the only way to do it, because there's so much secrecy within the family that if we get caught in that, I don't believe that any change can be brought about. So what we're trying to do is bring out anything that's covert, we're to make it open, so we have to role model that, we have to do that ourselves as much as we possibly can." B:5

This last quote suggested a similarity between issues of relationships within the family, and those between the family and therapists, such that any secrets the therapists might have had from (or about) the family could have consequences similar to those secrets that were destructive within the family. However it was not seen as always desirable or even possible to tell the family exactly what the therapist

thought was happening:

> *"I don't know if the differences [between how the therapist and the family see the therapist's role] are ever resolved. I think you can work successfully with the family in some ways and they might still be holding that theory that it's the child that's the problem, and I would still work with the family and have done when I think the child's safety is at risk when the parents have stuck rigidly to the notion that somehow this is nothing to do with us, it's this, you know, the child. And you're never going to get them to consciously acknowledge the role their behaviour has played...so it may mean that dilemma may never be properly resolved..."* D:3

Although this therapist believed that there might be good reason for not making her view clear to the parents, note that she still described this situation as a 'dilemma'.

To resolve such differences, the family might be helped to 'discover' views the same as the therapists':

> *"We try to make it sort of a discovery, that they discover themselves, that 'oh, yes, it is a family problem', which comes out of the way we question, then they start thinking about other issues that are happening within the family..."* B:2

> *"...to help them to—to assist the process of identifying aspects of the problem that might shift it away from the child to a family context."* D:3

> *"...some of them weren't sure why we were wanting to see them as well...When we tried to explain that we wanted to get a bigger picture rather than just focus on the child they accepted that. I think for a while they might think they're here to help the therapists help the child, and then that would move to, 'Oh, we're seeing something different here, maybe there is something that we're doing that is—the child's showing us'. So that was an educative process for the parents."* H:2

> *"...it wasn't appropriate to say 'well, actually we think you're probably the problem' [laugh]...So we had to say it in a way that was still sincere and authentic but 'we'd like a bigger picture here'..."* H:2

This 'discovery' might not be welcome to the family, and getting them

to accept it might not be easy for the therapist:

> *"...We're saying, 'Oh, hold on, we want to get to know the family, we need to know more about what's happening in the family before we can look at the child', so straightaway then there's a lot of resistance, like, 'Well I—there's nothing wrong with me, over there's the problem, don't you dare start looking at the couple system, or don't you dare start telling us that it's perhaps because we need some more [unintelligible] or we're not setting enough boundaries, or we need some more structure in the family' —we don't actually come out and say that but that's the way we work."* B:6

This client has clearly understood, and rejected, what was implied by the therapist's approach. The therapist described dealing with this kind of reaction by explaining her approach to the family:

> *"Usually go with the resistance, really listen to it and agree, 'Yes it is difficult to be here, yes I can see your point the problem appears to be over there, but this is a whole family...'"* B:6

Confronting or provoking might be used to challenge the family's views:

> *"...I work in a fairly sort of up front and confrontational way with people anyway, and with families in particular..."* D:2

> *...I work very provocatively, I do some quite outrageous things sometimes, apparently ..."* D:9

> *"...mock somebody, challenge them, or even empathise with someone to the point that you know it's going to produce an emotional response..."* D:9

> *"...putting a few challenges into some of the boundary issues..."* G:2

> *"...there may be some things that I'm actually hearing I will throw back as quite a good challenge..."* G:4

Provoking, mocking, challenging, confronting—all implied disputing, and working to change, the other's point of view. Note that in the examples given up to this point differences have been resolved by shifting the family's understanding towards the therapists' view.

Finding a mutually acceptable viewpoint could involve seeking a match or compromise between the view of the family and that of the

therapist:

> *"...getting a match between the way that you potentially see it and what they perceive it to be...I don't necessarily go with the aim of imposing my view on it..."* C:1

> *"If I'm working with a couple and what we're doing doesn't fit for them or it doesn't offer them—doesn't allow them to move on, then we need to look at it from another perspective..."* F:2

> *"...one of the biggest challenges for me too working in family therapy, is I don't have any traditional sense of family. I find it really difficult when I get families that are really traditional—I sort of think you know, hey, these things still exist—you know, so it actually pushes me around a little bit as well, which is quite-quite good fun, really."* G:9

Here the therapist described her lack of a 'traditional sense of family', which she contrasts with her perception of the 'traditional' family's understanding that families should be a certain way. By speaking of being 'pushed around', the therapist implied that her views were at least influenced by those of the family. She acknowledged a danger in therapists' imposing their views on the family, although in this case her concern was about the imposition of traditional views, rather than her own:

> *"...not trying to make it into a traditional family because that's where the [therapist's] values lie?...I think there are really big dangers in that—and...I think it happens..."* G:9

Being a certain kind of expert

An expert is a person with special skill or knowledge. While therapists thought training involving skill and knowledge was important, some were uncomfortable about the expectations of clients who saw them as experts. Ambivalence about clients' expectation of expertise was expressed:

> *"...there can be an expectation or hope that we will be expert, and some people are quite clear about that, they actually do want us to be expert, and to tell, and to instruct, and give advice...we've actually had some people who won't come back because they weren't happy about—in a sense being called to take a part in this."* K:6

> *"...it makes some families quite angry, or parents in families quite angry, because they feel that they've done everything they possibly can, and therefore they want the experts to tell them what to do."* B:2

It is unlikely that in rejecting the role of the kind of 'expert' that they perceived clients to be seeking, therapists were claiming that they had no special skill or knowledge. Rather they believed that their understanding of their own expertise was different from their clients':

> *"We're expert in some things and they [client families] are expert in other things...and we pool our effort here..."* K:5

> *"...it's about human beings working with human beings, really. And our expertise is...I suppose, about being an increasingly aware human being myself, to enable other people to be more aware and choiceful about their experiencing. It's not about doctrine, or techniques, even...it's more about philosophy."* M:9

> *"...the environment that we create, that we bring our skills to that environment, our skills in awareness...we bring our curiosity, and our skilled curiosity, to that enterprise."* M:6

These therapists were not denying that they were skilled and knowledgeable, but rejecting the role of the expert as someone who instructs. At least one of the therapists interviewed saw rejecting this role as a defining characteristic of family therapy:

> *"...family therapy is more respectful of the power and rights of the client than any other way of working...[in] other forms of counselling and therapy that I've been trained in the therapist is the expert to some extent...I have become aware in recent years of how much the Gestalt therapist is a powerful person, an expert in a way, and Gestalt ways of being just don't fit for some people. That leaves the client feeling like they've put down something wrong, or they're resisting the therapy, and those words just don't fit in family therapy."* F:2

Accessing the family's different kinds of knowledge

Accessing the family's own knowledge was referred to in some way by all the therapists. Families were seen as bringing their own knowledge to therapy. The ways this knowledge was spoken of suggested that it could be categorised in different ways. Skill on the part of the

therapist was seen as needed to elicit some of these kinds of knowledge, or to help create new knowledge, to allow the family to see its relevance and take action.

First, there was knowledge that the family had and the therapist did not, that both could see was relevant to the problem. This included such things as who was related to whom and how, how the family saw and felt about the problem, what they thought was going on, and what they thought would be the solution:

> *"...we were careful I think to say...'we'd really like to hear from you how it affects you, not just your wife, or not just your husband, we're really interested in what you think is going on, and...we'd really like to know what the other children think is going on.'"* H:2

> *"I explain that we're not fix it people, that we're there as a group, and they know their family much better than we ever will know them, so therefore we need everybody to help and give their ideas about why the problem is there and how that can be changed."* B:1

> *"...working with the family to identify for themselves as much as possible and sort of in agreement about what needs to be different in order for the family to function more happily."* D:7

> *"...they're good at generally acknowledging the pain in the family and what they would like to have different."* D:7

Secondly, there was knowledge about their family that the the family were aware of, but hadn't connected with the problem. The therapist didn't have this knowledge, but knew that it was relevant:

> *"...often...we reproduce in our families what's been going on. It doesn't matter how much we don't want to—until we actually know what it is we don't want, then we don't change it."* B:15

> *"...in Pakeha culture...families aren't so aware of their families of origins as perhaps some of my Maori families are...looking at your cultural capital even, is quite a big thing, where you've come from in terms of patterns and stuff. And sometimes that just needs to be actually brought out into the open."* G:5

> *"...what we're trying to do is bring out anything that's covert, we're trying to make it open..."* B:5

Third was knowledge the family didn't know they had. The skill of the therapist was needed to help them access this knowledge so they could make use of it:

> *"...often they come in feeling that they're stupid, that they should be able to work out all their problems, and that they don't know. In actual fact they do know, but they just haven't been able to take a step back to really have a look and see what's going on. Because they're right in here, they're like this [links hands], they're enmeshed in it all...we haven't got that emotional impact that they have, and...to be able to actually attend to the emotional and get them to a stage where they're actually feeling more comfortable, and when they start talking and coming up with their own solutions, it's just wonderful."* B:18

Family members might not be aware of what they themselves, or other members of the family, thought and felt. The work of the therapist was to help them to become aware of it:

> *"...we bring out the...secrets or what's underneath...like when somebody's sitting here talking about something, and you mention, 'Gosh, ...you sound really angry about that'— they may not have realised that they actually felt angry about what they were saying..."* B:7

> *"...in families a lot of assumption goes on. They assume that because they're living in a family that [people know] what they're thinking and what they're feeling, or should know...we concretize that, we bring it out and we say, 'Well, what are you thinking, what is acceptable for Mum and Dad?', and often they're quite different, and hadn't realised all this time that they've been so different in their parenting...so we bring that out in the open, and then it can be seen, and they can attend to it."* B:11

> *"...it's very much a communication thing—probably again facilitative ...I still believe that the families have the answers...they've been together,they know each other, for a longer time..."* G:4

Therapy was seen as making available information that family members could not use until they were aware of it. Family therapy writing often refers to 'family secrets' or 'the covert', and when these terms were used in the interviews it wasn't always clear when or if they referred to information that was hidden deliberately. Making information available was usually referred to as beneficial. For example,

"...to make the covert overt in terms of therapeutic shift..." D:2

suggests that a change from covert to overt was in itself therapeutic. One therapist spoke as if there was a true state of affairs that could be discovered, and as if that discovery would itself be therapeutic:

*"...it's so important I think to bring out what **is**, right? This is the way it really is."* B:12

"That's why communication is so important—'Did you realise that this was affecting so-and-so like that? Gosh, have you ever heard that before?' And usually the person says, 'No, I didn't realise that —oh, this is what I think—blah, blah, blah'—it's like it takes the power out of it. Because people then can see what's happening for what it is rather than your own interpretation of what it is." B:13

For another, a therapeutic interpretation of events, not necessarily the discovery of 'reality', was the aim:

"...I really believe that, that's what life is about, is constantly conning ourselves, if you like, into seeing the best side of things as they occur—things over which we have no control...I think that's probably my philosophy working with anybody, no matter what happens we can revisit it and reshape it, reframe it and make it work for them." E:7

[about remaining with a violent spouse] "...while it is an unchangeable, uncontrollable, part of the past, I'll reframe it. While it's an option for the present, I would be challenging. Whatever anyone has done in the past I believe it was the best they could do at the time. I think it needs to be validated. If it wasn't the best they could do at the time, it would have been a different decision they would have made. That is a safe assumption." E:7

Another therapist was confident that the family would correct the therapists if their interpretations were wrong:

"...you can get it wrong...but usually when you do the family reacts to tell you anyway, so it doesn't matter, yeah, they do." G:12

Bringing out existing family knowledge might not be enough. Therapists spoke of identifying steps for change, where to go next. This might involve discovering or creating knowledge new to the family:

"...to see that they've got more choices and more ways of doing things than perhaps some habits that they have drifted into or fallen into because they don't know that there are any other choices open to them..." A:13

"...sometimes people do quite automatically and blindly behave in ways...not in their or other people's best interests, because they don't feel they've got any other options or any other choices, it's always been like this, they don't perceive that there's any other way of doing things." A:13

"...when we go to therapy we're helped to appreciate how we do organise our experience. And then we have some choice about it, and we have some support as well, to make the changes that we want to make." K:7

Again for some therapists this clearly involved a partnership, with both family and therapists having a part to play:

"[the family] are good at generally acknowledging the pain in the family and what they would like to have different. They're...often not good at identifying the steps in order for that to occur, so I guess it's a sort of a colleage-ial (sic) approach in co-opting family members as part of the problem–solving team." D:7

In contrast to some families' expectation that the therapists would apply their knowledge to the problem, one therapist spoke of the therapists' "not knowing", their curiosity, as a source of understanding:

"...especially initially we are much more in our not knowing..." K:10

Therapists also spoke of the importance of the family working actively to change, of their being active with their decisions. People had to make their own choices, come to their own knowledge about what to do next:

"...what you're going to do is increase their options and their consciousness of how they are limiting those options, or what might be available...and that they can—have to make their own choice about it. [Some clients] will expect much more directive work. But—is that very helpful, in the long run to—what do you do when you hit the next problem? [laughs] 'Oh, here I am again, tell me what to do again'...I think it breeds a culture of dependency." I:11

"People have to make informed and free choices and look at what the options are that are available...I think it is quite liberating...if people do make informed choices, then very often that sense of being out of control or of in some way being oppressed by the situation, it does a lot to remove that, because people do realise that they are doing a balancing act...they realise that they've got some control over where they put their energies and their resources and why they're doing it, and what they're gaining and what they're losing no matter what decision they make. So in that sense I think it is empowering..." A:12

"It's like suddenly there's great insight, and I find that that's really good—it's very good for the parents, because it's like they're starting to know something, they're actually realising it themselves, they're not being fed what we think...they seem to get some power, they don't feel so powerless in the situation." B:2

"...I like people to actually come up with their own answers and stuff...it has longer term effects, you know, I think that if the family thinks that they're actually empowered by the process they are more likely to continue..." G:3

Hope

Creating hope was mentioned as an important part of therapy. I have included it here, as hope is a kind of knowledge, an awareness that things can be different from how they are now. For one therapist, this was so important that she described it as the salient feature of the systems approach in family therapy:

"I think it's the systemic approach...it's like looking at the processes going on here among these people, that to me is the biggest thing, and this...system within another system, so that...it's less blame and fault focussed and more raising awareness about the whole picture." H:3

"...offering I suppose a pretty hopeful sort of encouraging picture which isn't problem-saturated, which is more solution based...even the fact that they've come for therapy is a tremendous sort of affirmation of their interest in—in something better for them. So I suppose that's another piece...looking very positively—not overlooking the problem, but it's putting it in a context of hopefulness rather than hopelessness." H:3

"[the family therapy method I use] creates hope for people who feel they've failed and are inadequate as parents..." H:4

By speaking of therapy offering or creating hope, and putting the problem in a context of hopefulness, this therapist was implying that this hope was something new to the family.

The family's decision-making

Making their own choices and being active in decision-making was spoken of in terms of avoiding dependence, escaping the oppression of the problem, becoming powerful rather than powerless, and long term effectiveness. Several therapists spoke of avoiding the role of helper, of not taking responsibility for solving the family's problem for them:

"...it's very easy to get sucked in to trying to solve the problem of families, and supervision often says, 'Hey, what are you doing there?' It calls you out, because they say, 'No, look, you're getting very much into that family aren't you—you're getting very problem focussed now, it's like you have to solve it.' They talk about the family solving the problem." B:19

"...more and more we're just people here, we're not carrying a big sort of...professional responsibility. We have to be careful here, because we do have professional responsibility, to act ethically and appropriately...but we're not carrying huge responsibility to solve other people's problems." *K:5*

"I...don't have much of a desire to help—I'm not a helper, I've never been a helper." E:3

"...they do it themselves [change], I didn't do it." E:10

Termination.

The end of therapy was also described in terms of what the family knew. When the therapy had been successful, the family's and the therapists' knowledge coincided, rather than the therapists knowing some things and the family knowing other things:

"And so the question is, is it time to finish—I mean we'll just kind of look around and everybody says 'Yep.'—and it's like we all know..." M:11

> *"...I think when people are close to termination there is...an in-body sense that—of comfort and ease, and there's a knowing of that—that they've had enough. And there's a knowing in our bodies too, that there's a kind of completeness about this, that the whole family, or the whole system in here is relaxed, it's communicating contactfully and is relaxed. And when that happens there's no point in us being involved any more, because there's no resistance to contact."* K:11

Q:...how do you know when you've finished?

> *"...it's when the family is able to tell you that they don't need this any more...if people drop out—I don't mean that, I don't mean they don't come any more, there's something wrong then...when I start to realise that...we've entered a termination phase, then I don't dictate that, it gets presented for you. You can see the difference in the family in terms of the way they position themselves, the way the interactions go, and some will actually say 'we don't think we need to come any more'—so yeah, that's something that I think takes care of itself."* D:7

Here the therapy was described as finished when the family were able to tell this therapist what she herself knew from the way they were acting. The knowledge of family and therapist coincide. The therapist spoke of there being 'something wrong' when a family 'dropped out', or unilaterally decided not to come again.

Talking about unsuccessful therapy, one therapist described unilaterally deciding to end therapy when there was no change in the direction of the therapist's understanding of the problem:

> *"...it's not that their child's actually doing anything wrong, it's that it's just not fitting their sense of family. So again that sense of family gets investigated, and quite often once those boundaries start getting pushed around, other people will speak...Sometimes after three or four sessions the family's not prepared to change those boundaries or anything, and then we have to close off."* G:8

In summary, this section looked at a variety of kinds of knowing that were described in family therapy. The different knowledge of therapists and families was described by some therapists as converging during the process of therapy, until they overlapped sufficiently for the therapy to be seen as finished.

ACTION

Moving

Development as movement
Problems as 'being stuck'
Movement as progress
Therapists initiating movement
Therapists moving
Therapy as a journey
Therapy as a place

Development as movement

The therapists often used movement as a metaphor when talking about their work. Metaphors of movement for life itself are common in our everyday language—we talk about life as a journey, about 'getting somewhere', 'going on', 'making our way', and so on. Therapists spoke of development, for both individuals and families, as movement or as a journey:

> *"...when I moved from being um a child to an adult there's a transition, then when you move to having children of your own there's a transition...you're moving you know through that family life cycle..."* A:6

> *"...relationships don't stand still, they keep evolving and changing..."* A:7

The term 'family of origin' implied that a person has come from somewhere else to the family he or she was now a part of:

> *"...with two parents you've also got two different families of origin..."* G:6

Other arrivals were spoken of. Families were described as "at the crossroads of the cultures of each of the parents", or as putting off certain aspirations "until the family's in a different space".

Problems as 'being stuck'

Most of the examples above could have come from ordinary language. But while the metaphor of life as movement is common in everyday

language, that of 'being stuck' for life's problems is more typical of the language of therapy. For example:

> *"...change is endemic, change is happening...the processes of change are here, there may be some areas of their lives where that's stuck..."* M:6

> *"...the family's here because they're stuck, right?"* G:2

Families who posed difficulties for therapists were described as "particularly stuck" and "extremely stuck". One purpose of therapy was resolving this stuckness:

> *"...you're actually into unsticking..."* G:2

> *"...working on people's blocks to getting what they want out of life..."* K:2

While "people's blocks" suggested ownership of the problem, immobility was sometimes spoken of as if it were caused by external constraints:

> *"...given the constraints that they're operating within..."* A:12

> *"...what is it that's restraining them from change."* F:12

> *"...to move on and leave behind any particular problem-type centred behaviours..."* A:13

> *"...to help them find some creative way around this..."* H:7

> *"...The shift can be very tiny sometimes, but be enough...to lift the blockage...It may just be something quite simple and everyday needs to be shifted a bit."* H:4

Movement as progress

As the difficulties that brought families to therapy were spoken of as stuckness or lack of movement, so therapists spoke of improvement or progress as a return to movement. More than one therapist used the phrase "therapeutic shift"; others spoke of improvement as when "the family relationships get moving again", the family "move on from where they're at through their stories about themselves", or of their "choosing ways ahead which are good for them, to enable the movement

that is growth". Other positive descriptions of families' dealings with difficulties were "keeping going" and "going along". These examples were given in the context of progress (or otherwise) in therapy:

> *"...to...have the family believing in themselves and believing that they can make the changes to actually um be able to keep going."* G:9

> *"...it was too difficult for him to actually join that or go right along with it, so he would sort of go along at his head level..."* H:5

> *"...they will pick up that and go with it."* B:9

> *"...they might choose to go further or do things differently at a later date."* A:14

In contrast, a metaphor of impaired movement could be used to describe difficulties with therapy:

> *"...sometimes attendance will limp along a bit..."* K:8

Therapists initiating movement

Some of the therapists saw their role as initiating this movement. Two used very active, vigorous language to describe the way they initiated movement by the family.

The first of these spoke of family therapy as "like pushing and nudging something so that then they can go away and deal with it how they like", and as "very much rocking the boat so that the family relationships get moving again." She and her co-therapist would

> *"...poke holes and get [them] moving, nudge along in one direction, and catch them occasionally and put them back together again..."* E:5

The second spoke of "...breaking through...blocked communication...", and later said,

> *"...there are times that I have to actually jump in there and do some —no, I think definitely the power relationship is there. I mean I am pulling out bits out of this family and thrcwing them back at the family..."* G:6

The same speaker used "run" in an unusual way:

"...I would run probably three families at any one time." G:1

Despite using this vigorous language to describe her own part in the therapy, she later spoke of movement having to come from the family rather than the therapist. Distinguishing between family therapy and 'family work', she said,

"...it's the motivation for wanting change...if that's not evident in the family I won't work with them..." G:6

Before she was prepared to work as a family therapist with a family, she needed to know that some motivation or impetus for change was already present in the family.

Rather than moving the family itself, others spoke of shifting or moving something in the family, or external to the family:

"...the identified problem...is represented by the child's behaviour. To actually shift that and locate it more in the family..." C:1

"...identifying aspects of the problem that might shift it away from the child to a family context..." D:3

"...The shift can be very tiny sometimes, but be enough...to lift the blockage...It may just be something quite simple and everyday needs to be shifted a bit." H:4

"...we could look at moving something in this family..." J:10

Therapists moving

Therapists also used metaphors of movement to describe their own actions in family therapy:

"When I'm working with individuals I just fly...[but while working with families]...I have to really sit and think what's the best thing to do, and I'm very conscious of that—and we take a half time break and go away and thrash out talk about what we're doing, where to go from here..." E:8

"...working with families...I don't have that same sense of having to step very carefully..." E:3

There was an interesting contrast in these two quotes from the same

person, in both cases comparing family therapy with individual work. With individuals she just flies, but at the same time has to step very carefully—this seems a contradiction, but she was talking about two different issues: how fragile the client was, and of her own confidence and skill.

The therapist's movement in therapy might be in and out of the self:

> *"...moving between delving into and then moving out of and helping the person be aware of their environment and their adult self..."* F:5

or it might be like a dance:

> *"[the family is like]...some kind of organism that I dance around the—or two of us do—dance around the outside of..."* E:5

> *"...the co-therapist needs to be able to move in and out with you..."* D:2

And like families, therapists could get stuck—one spoke of "...being able to identify when you're stuck with the family..." B:8

Therapy as a journey

Therapy was often spoken of as a journey, sometimes explicitly. One therapist described her role as "a kind of a guide on a journey". Another, describing a particular case, said,

> *"...he was at the very beginning of a journey, and...it was going to be his journey. And I would come along as an experienced traveller, but I was coming along—not for the ride [laugh], but also not to lead the way...I don't know what the answers will be for him, but I know some things about travelling..."* F:3

Sometimes the journey was referred to more by implication, as when therapists described therapy as "going nowhere", or spoke of working out "where we go from there", or of families being able to "go further or do things differently at a later date." Others spoke of therapy becoming "much more wide-ranging", and of "feeling our way very gently".

Just as improvement in therapy was described by metaphors of movement, it was also described as reaching a destination:

"...if people went on more than six sessions, and I knew about that ...I would say, 'what's happening, is it getting somewhere?'" J:12

"...to reach a place of mutual sort of acceptance or understanding..." D:6

"...there are clients that you have to have that with for a while, to get to the next place..." I:12

Therapists' journeys, like families', could have unfortunate destinations. One therapist spoke of supervision as keeping her on a suitable path:

"[supervision] stops me from going down a track that...needs to be checked...you can just sort of go down a very narrow sort of track..." H:8

while another described the results of inadequate preparation as

"...going down the gurgler...taking your clients with you." I:8

Therapy as a place

Therapy was described as place to be, and to go in and out of, as well as a journey: "a very special I suppose environment and safe place", where families could "find their strength and...head out to face the world". This was a place with boundaries, such that one therapist spoke of "having pushed out" a client, and, of talking with a client about contact after therapy had finished as,

"...marking a boundary...You're talking about over on the other side." J:14

If therapy was a place, it was one that eventually clients should leave:

Q: and what do you find most rewarding?
"...you see people moving on...to see him moving away..." F

In summary, metaphors of movement were widely used to describe the process of family therapy. For most of these therapists, family therapy was an active, even vigorous, enterprise.

Depth and danger

"Depth of working" was mentioned in an earlier chapter, as sometimes used to distinguish family therapy from family work. Metaphors of depth occurred quite frequently in the interviews, sometimes together with metaphors of danger. In each case, these topics were initiated by the therapists. It was suggested that the relationship between these metaphors could be explored by looking individually at statements of several therapists who used both of them when talking about the process of family therapy (Woolley, C. (1996), personal communication).

D, for example, described family therapy as active and intrusive:

> *"...family work is intrusive stuff, therapy is anyway...you've got to be really sure, I believe...that you take the least intrusive option..."* D:10

As well as being intrusive, it was potentially dangerous:

> *"It is dangerous, it's exceedingly dangerous stuff, I think, if...you haven't got the necessary supports and processes in place.."* D:9

D described her own approach as active and confronting:

> *"...I work very provocatively, I do some quite outrageous things sometimes, apparently, and that comes from my history working with teenagers where you've got to be on your toes and you've got to be confronting, and you've got to be prepared to take risks..."* D:9

She believed a co-therapist was essential, partly as a support to clients who might feel threatened by her confrontational approach:

> *"...the person I'm working with...will move in to counter or support the person while I'm perhaps confronting them. And I would never do that on my own in a family work context."* D:2

> *"...I need to know when I'm...going to mock somebody, challenge them, or even sympathise with someone to the point that...it's going to produce an emotional response—the person you're working with is going to be able to move in and balance that or support other people in the family. And if you haven't got that it's really scary..."* D:9

Other things D said suggested that she saw the problem as internal to the family, which is resistant rather than restrained:

> *"...the parents have stuck rigidly to the notion that somehow this is nothing to do with us..."* D:3

> *"...it creates resistance..."* D:6

For D, intrusion was necessary, but potentially dangerous.

E also saw family therapists as acting directly on the family:

> *"...the family's there to take charge of itself, and...[we] push and poke the edges of it until it does that..."* E:2

> *"...it's like pushing and nudging something..."* E:4

> *"...some kind of organism that I dance around the—or two of us do—dance around the outside of, poke holes and get moving, nudge along in one direction, and catch them occasionally and put them back together again"* E:5

> *"...rocking the boat so that the family relationships get moving again..."* E:5

> *"The family therapist stays in a position of power over the process..."* E:3

She spoke of the family as a single unit, and family therapy as by definition not dividing them up. Perhaps for this reason the issue of intrusion did not appear to arise for this therapist:

> *"[what makes family therapy different]...it's whether or not the counselling therapist divides the people up...in a way in family therapy you do interfere, but you're interfering with this whole thing..."* E:5

> *"...it's as though when they come along and have a session they kind of join forces as a kind of an entity which is separate from the therapists..."* E:4

In contrast with counselling individuals, she saw family therapy as less potentially dangerous:

> *"[with family therapy you are] very careful what you do, but not in the same—I don't know—not with the same intensity, the relationship isn't an intense relationship as the one to one relationship is."* E:4

> *"[individual counselling] is very delicate, and I'm aware of every word that I say and response that I have at some level, so that it's careful like that, whereas with working with families, partly because there's two of us, we have a lot of fun, and it's as though the family's going to survive anyhow regardless of what we do..."* E:3

Although E's description of 'poking holes' in the family sounds intrusive, she believed that there was no serious danger to the family:

> *"...I can be a lot more provocative and unconventional and don't... wear the same personal responsibilities somehow. It's as though the family's a tough...unit that's already got wonderful mechanisms to survive..."* E:3

Q...you see a family as more resilient than an individual?
*"Yes, it is in a way—or that **my** interaction with them isn't going to have the same importance, I think..."* E:4

F, on the other hand, explicitly associated 'going deep' with danger, and rejected it as unnecessary to family therapy:

> *"...delved so deeply into the person that we uncovered things that we didn't know how to deal with, really. That led me away from doing exclusively intrapsychic work, because it wasn't productive, it was actually destructive...I don't now see that it's necessary to go certainly as deep as we were going then. And I still see clients making deep and permanent changes from work that isn't anywhere as intrusive into the person."* F:4

There were ways of managing the acknowledged dangers of therapy. F described a family therapy training course, where this work was

> *"...done in a way that was much safer, so all of the time you were moving between delving into and then moving out of and helping the person be aware of their environment and their adult self...it just seems to me to be safer and more understanding of those kind of dangers..."* F:5

F also rejected the idea that the therapist should be a powerful person, or that the client resisted the therapist. If the therapist (or therapy, where therapists were perhaps tacitly denying agency) was not trying to do something to the client, there was no place for the idea of the client as resisting. Speaking of approaches in which the therapists' approach doesn't work for the client, she said,

> *"That leaves the client feeling like they've put down something wrong, or they're resisting the therapy, and those words don't fit in family therapy."* F:2

She replaced the idea of resisting with that of being restrained:

> *"...we need to look at it from another perspective...what is it that's restraining them from change."* F:2

For G, therapy was active and intrusive. She spoke of

> *"...breaking through probably blocked communication..."* G:3,

and describing working with a family, said:

> *"...when we come all together that gets really bossy—I mean, we [the therapists] get to be really bossy..."* G:7

The therapist was in a position of power:

> *"...the term 'therapist'—it connotates quite a lot of power...there are issues of power that do belong in family therapy."* G:1

> *"...you're actually into unsticking...I think that's a power position..."* G:2

> *"...definitely the power relationship is there." G:7*

This power is potentially dangerous to the family:

> *"...it's potentially dangerous...I have worked with someone who actually lectures and tells people how to be..."* G:1

> *"...it's a dangerous area—because you are actually in that position of power..."* G:2

In summary, the use of metaphors of depth and danger continued the themes of activity and challenge. Some therapists thought "going deep"

potentially dangerous, but necessary, and either used safeguards or referred to those built in to the family (E, G, D). One thought it was dangerous and unnecessary, and avoided it for those reasons (F).

OUTCOMES

Key themes emerging included:

Goals
Negative outcomes
Compromise
Rewards

Goals

Outcomes include what follows, or is intended to follow, family therapy. These are the goals of the therapists; negative outcomes (including both undesirable outcomes and the absence of a desirable outcome); compromise by both therapists and families; and the rewards for therapists of their work.

The therapists' goals were the hoped for, worked for, and intended outcomes of therapy. When asked about their goals, most of the therapists spoke first about achieving the goals of the family:

> *"...the short term goals would be to help the family to achieve their goals..."* A:14

> *"...I work on the family goals too, and so each time that will be different..."* G:9

> *"[goals]...would just be determined totally by the...client...what the presenting problem was...If a teenager was acting out, your goal would be to reduce the acting out...to a large extent, and then it would change, because that might stop quite quickly, but then the family might want to keep working on other things that had emerged. It's a bit like peeling an onion, really, it can be..."* I:8

Correcting particular problems was another kind of goal:

> *"...I would like to see the family being able to have the strength to be able to move on and leave behind any particular problem-type*

centred behaviours that they're indulging in because they don't know any better." A:13

The goals therapists mentioned for the family not only suggested desirable results of therapy, but provided insights into how therapists believed families should be. For example,

"...as an ideal goal helping the family to find their way to be able to support each other and provide a really safe and nurturing environment from which they could sort of launch out and achieve the personal goals that they have for themselves in the outside world, and also find fulfilment and nurturing and happiness and... rewarding relationships with each other within the context of the family..." A:13

"...the main goal that I have would be that each one in that family can feel comfortable living there..." B:13

"I would see anyone in any group as going through a developmental process—any hurdle will be a kind of a challenge, a step towards a better future, if you like. So my goals for a family would be that they look ahead and accept the changes that are taking place..." E:8

"...without any specific goals that I want to bring out, but I would be checking them against that sense of the family and each person in it developing towards a richer, freer, fuller life—all those lovely humanistic words." E:8

"...I suppose my overall sort of warm fuzzy goal is—to actually have the family believing in themselves and believing that they can make the changes to actually um be able to keep going." G:9

"...I think it's my goal—yeah—would be that they can actually go away feeling strong in themselves." G:10

Most of the desired goals of the therapists for the family were those that any person might have for their own family, expressed in commonsense language—being able to support each other and provide a safe and nurturing place to be, finding happiness and rewarding relationships, feeling comfortable living together, choosing ways ahead that are good for them, growth, looking ahead and accepting changes, developing towards a richer, freer, fuller life, understanding themselves and moving on, believing in themselves and their ability to change and keep going, being able to feel strong in themselves.

Although the therapists believed they differed from families in their interpretations of what brought people to therapy, or of what the roles of therapists and therapy were, they described most of their goals in language that would be understood by their clients. Some of the language was more technical:

> *"...if you can determine what the purpose is of that behaviour, and ...determine other ways of getting those needs met, that are not going to be damaging to other people or to themselves..."* A:14

> *"...I suppose the general goal would be to try and...increase the healthy functioning of the family ..."* I:8

There was usually an awareness that the family's and the therapists' goals might not coincide:

> *"...often insight is important, that's something I value, so I tend to ...I don't want to say impose that goal, but, yeah, if people can relate to that then I think understanding more about yourself and how you're acting in your situation is useful...for coping with it if you're not able to change it. So awareness and certainly change, I guess."* F:6

Negative outcomes

As well as accepting limited change within families, therapists acknowledged that there were times when there would be no change. For example, families might drop out of therapy, or their problems seem unaffected:

> *"...it really distresses me when families sort of after two sessions just don't turn up and you don't hear from them and stuff like that. Um—and that's actually common."* G:10

> *"The most difficult probably is the families that you can't reach... that don't come back for one reason or another...I struggle with that..."* G:11

> *"...step-families—my experience, which is limited, was...some of them were unresolvable, really, because of the particular dynamics, about lack of bonding between the parents and the children, there was no bond there, and there probably—might never be any great bond. There was...generally speaking much more energy to...recreate the lost bond if it was a natural family...But I imagine with some families that would be an impossibility too, if*

the damage was great and the lack of—bonding was very low." H:6

"...you're not going to have a hundred per cent success rate, but by and large you're going to effect—there is going to be effective change, without it taking, you know, five years, by which time you change anyway." I:6

As well as the lack of a positive outcome, it was also possible for therapy to cause harm. For example, one therapist spoke of not involving children unnecessarily in therapy, saying,

"...you don't want to pathologize those children..." A:11

Or therapy of the wrong sort may create dependency:

"...if you're not aware of what you're doing you build up this um—the culture can so easily be dependency and needs based..." I:12

Another possible negative outcome was harm for the therapist:

"The accumulation of negative—you know, sometimes it's hard to...not forget, kind of put in perspective, that I am only seeing, I don't know, x per cent of the population, and there are lots of people around who are actually quite happy [laughs], who aren't really depressed or ...haven't been abused, and those sorts of things. So I find that hard. The other thing is getting the balance between my ability to empathise and join with my client and allow myself to feel, in the counselling room. It's so important and I don't ever want to not do that, but then letting go of those feelings and still having some energy at the end of the day for my family and for myself—I find that hard. Sometimes I do it really well, and sometimes there's just an accumulation, or what someone's telling me is just too horrific...that has costs, I think..." F:7

Compromise

Therapists spoke of accepting limited improvement by family members as a successful outcome of therapy, rather than seeking what they saw as an unrealistic perfection. Therapists had to compromise:

"...you can't rebuild a whole family, it's impossible, because it goes back intergenerationally. So often it's just looking at what's not healthy in a family and then allowing them to be able to make that little bit healthier for them." B:13

"It's impossible to say this is the ideal family, and this is my goal, this is what I'm going to make happen. For me it's like looking at the family and saying, OK, this family has been together for how many years, and they've been able to get on, and get through life—but now this little chunk has gone wrong here, so what needs to happen to that chunk for them to be able to keep on functioning how they need to function." B:13

And therapists had to accept the family's compromise:

"...if people feel that they're at a stage in their life or the family life-cycle where they can't achieve those ideal goals, is to be able to help them to be able to achieve as much as they can given the constraints that they're operating within, with an understanding that they have made this choice, and that they might choose to go further or do things differently at a later date...you always leave the door open rather than making people feel rejected if they don't ...come up to some standard or ideal that you've...set as the ideal level of change for them." A:14

Compromise could also be an explicit goal for the family. Therapists spoke of encouraging individuals within the family to accept that while it might not be possible for any of them to achieve their ideal solution, they could arrive at a compromise in which the difficulties and benefits of change were shared equally:

"...there could be some way of reframing things so that all the parties could realise that there was some cost involved here, but also their needs would be better met somehow, even though there might be—there would be a cost. So no-one was going to come out better off than anybody else, but everybody sort of had to deal with it—that sort of accommodating—and if everybody else could see everybody else was doing their bit, putting up with their bit, sort of, so it was all sort of fair, that sometimes helped." H:6

"...encouraging them all to say, 'Well, I'd like that but I'll take that much if—I'll accept that if I see everybody else having to do the same.' So it's like—a fair compromise." H:6

"...sometimes...you get to a point where one of the things you have to have a look at is ah what is a fair compromise in terms of how far can she go to achieve her individual agendas, or to achieve what's best in terms of what she wants for herself while still keeping a

balance and being aware of the needs of her children and her partner..." A:12

Rewards

Only one of the therapists spoke of change as a specific goal (perhaps because it was usually taken for granted). Instead what they described when asked for goals were the particular changes they hoped and worked for. However, when therapists were asked what they found most rewarding in their work, the most frequent response was seeing people change:

"...to see the amazing changes that people are able to make, and within quite a short space of time, is quite mind-blowing sometimes...seeing people whether they be children or adults...who... have been...feeling really vulnerable, and really sort of beaten by whatever the problem is, and to see them actually find their strength and you know head out to face the world...feeling really positive and stronger than they've ever been before, that's really rewarding..." A:17

"When they change [laughs]. And you see people moving on...Like that young guy that I was telling you about...he certainly started out being very closed off, and his excitement as he began to sort of explore what that was about and understand it—was really nice. And then hopefully in...x weeks time to see him moving away, saying...'I now feel like I can handle it—things—for myself'—that's really rewarding." F:7

"It's obviously when you can see some change in the family. But sometimes it's not that obvious or that clear cut, and I think you don't always get that sort of 'aha'—that...dramatic change there...for me personally the really rewarding experiences have been when you see a family—even just becoming aware of the contribution that they all make to a child's...dysfunctional behaviour. And that for me is a real breakthrough, because children—I just think children are incredibly vulnerable in families, and to see a shift from this 'fix this horrible child, this child is breaking up our marriage, this child—'—you know, whatever—to some sort of discussion even... between the parents about the ways in which they might be doing different. And getting a sort of detached parent involved again, and seeing the child derive some sort of sense of their own value and worth from that is really rewarding. So it doesn't have to be...a dramatic change, but just in understanding too that...the family has

the problem not the child—that's heartening." D:10

"Oh, change, always. Sometimes it's quite dramatic, things happen really quickly...just thinking of the last family that we—there were two boys aged about 11 and 13 were bedwetting, and stopped—that was just lovely." E:9

Change was given priority in these remarks about rewards. In each case the pleasure of the therapist was linked to the reduction of the suffering of those seeking help. Another therapist describing the rewards of her work spoke first of change, then went on to describe the trust and courage of her clients:

"[most rewarding]I think probably the changes that people made, and the willingness to come and tell their stories in front of us. That—trust that they had, or hope that they had, that we could help them...I think I would have enormous difficulty taking my family along to a family therapist saying 'We're actually not coping very well'...And the fact that they did that, I think...that would be the greatest thing." H:9

Other responses about rewards described therapists' pleasure at seeing people reconstruct their lives, a relationship healing and growing, kids being allowed to be people, families finding their own strength and getting their confidence in each other back, and finding their own solutions.

"...it's very rewarding to see people who've reconstructed their lives..." A:18

"...the relationship between her and her mother which had always been bad...and these two women got to know each other for the first time. Watching that relationship heal and grow and get renegotiated..." E:9

"...seeing kids come out of the covers and actually be allowed to be people—that kind of stuff is really interesting. Just families finding their own strength would have to be—well, it's just lovely." G:11

"It's watching people's reaction when they actually say something about what's been happening in the family and the family accepts that. It's like almost their confidence comes back in that person. And in the whole family, because often they come in feeling that

they're stupid, that they should be able to work out all their problems..." B:18

"...when they start talking and coming up with their own solutions, it's just wonderful. I get so excited, it's neat." B:18

Of course, change was also evidence of the therapist's effectiveness and success. Only one person described rewards primarily in terms of the therapists own performance, rather than the consequences for the family:

"The most rewarding part would be the times when there's been some good work backed up by some good supervision." C:10

In summary, therapists described the outcomes of family therapy as varied—not always positive, and occasionally negative for either family members or the therapists. Therapists' goals sometimes changed during therapy, according to what was possible. When families changed in accordance with their own and the therapists' goals, it was a source of real pleasure to the therapists.

Summary

This chapter looked at some of what therapists said about the family therapy process itself. First it explored the different ideas and expectations that therapists and families brought to the therapy and how these might be reconciled during therapy, then the metaphors by which therapists described family therapy as an active and, for some, even potentially dangerous activity. Finally the intended and actual outcomes of therapy, including therapists' goals, negative outcomes, compromise, and rewards were examined.

CHAPTER SIX
Selective code 4:
ECOLOGY

The family was commonly described in family therapy terms as a system within a network of wider systems, each one influencing the others. In this section I will look first at how the therapists described the effects of the wider system on the problems that brought families to therapy, and then at the ways they saw these systems affecting their use of family therapy, and the relationships between therapists themselves.

AXIAL CODES

Key themes emerging included the following:

The relationship between family and society
Institutional issues and family therapy
Coercion
Status and factions among therapists

The relationship between family and society

Community fragmentation
Economic issues
Gender issues
Cultural issues

"...systems within systems...the context within which the family is living, affect the family as it affects the child—so those things always are kept in mind, as to whether they are socioeconomic factors or inter-racial factors, or employment factors—those were all sort of part of the whole jigsaw puzzle..." H:2

Societal issues that were seen by therapists as contributing to the problems that brought families to family therapy included community fragmentation, economic, gender, and cultural issues.

Community fragmentation

Society was described as becoming less closely connected than in the past, and this was seen as contributing to the seriousness of the difficulties that families found themselves in:

"...in the past with more close-knit communities, closer access to extended family, there probably would be within the family or at least within the extended family...enough resources to make sure that the child didn't end up living in these really very harsh sorts of conditions which are not conducive to healthy development... what's happened over time is that communities have tended to become less close-knit and there don't seem to be the interconnections between various parts of the community...to generate a fail-safe...safety-net situation..." A:3

"...families don't have that strength quite often now...isolation and all that sort of stuff...we're a very transient population now, or grand-parents are working now, so you don't have that sense of bonding..." G:10

"...more people are needing to work, too...I think there's a really big sense of isolation in that...often there's no time for friends or outside the actual family in the house, for any contact...because it's so busy doing the things that have to be done..." G:10

Economic issues

Poverty contributed to the difficulties which brought families to therapy:

"...this agency does service...the unemployed population, the people that can't afford counselling...and their issues are very much basic needs—you know—it's like there's so much stress going into putting food on the table, and often crime to do that..." G:5

Economic changes which have made jobs harder to get were seen as contributing directly to family relationship problems, and to the difficulties family therapists have in dealing with them:

"...there may be genuine personal differences between the parents and [teenagers] which could be resolved with family therapy. But hanging over that is this powerful awareness that the young person feels as if their future will be one in which they will not have the opportunity to reach economic independence." C:5

"...the children...they're too scared to hope for too much and I see that very much as something that's happening in the world at the moment... the opportunities are so closed now that kids get defeated—that we're never ever going to be able to make it—at a

very young age now, and—this is my reading anyway, of what's going on with acting out, of 9, 10, 11, 12 year olds...against what's going on because it's not going to benefit them...there's a general [feeling] of what's the point of life. And I think that's a kind of a fear...the whole thing is just too frightening..." E:2

Gender issues

I found it surprising that little was said about gender issues, given the amount of discussion that this topic has received in family therapy literature recently. Where gender was mentioned, therapists described contending with a complex combination of power, economic and cultural issues:

"...the person who will present for help will be very often the mother...the woman of the family...One of the criticisms which has been levelled at people who do have a more I guess family therapy type of orientation [is] that one may be perhaps contributing to the oppression of women, because...if you were to work towards your female client achieving...a self-actualised lifestyle for herself, then perhaps one thing which would have to go would be some of these burdening relationships." A:12

"We're talking about male—female relationships here [laugh]. It's one of those recurring themes in the third term—people who have partners who burn their books, chase them with guns and knives, and keep them awake for three nights in a row before their first exam—amazing power plays going on, because should this person, and it's almost certainly a woman...if this woman does finish her training and enter the middle classes or enter the power group or pakeha society... because it does often tend to be culturally connected, then that's going to really upset the power relations in that family. The violence that's expended is quite incredible." E:7

Cultural issues

There was some mention of the effects of cultural differences on the kinds of problems that arose, and on the way therapists worked:

"...there are differences working with Maori families and Pakeha families as well—and it's just a difference in world view, and what constitutes knowledge...a whole lot of those kind of things...I'm the person in the agency that tends to get Maori families..." G:5

"...if you're a Maori person you think as a Maori, and if you're Pakeha you think as a Pakeha..." I:3

"...it's a cultural thing too—Maori kids—you know, they will expect much more directive work..." I:11

A given of the systemic understanding of family therapy is that as the wider society affects families, so therapy at the family level will affect the wider society to some degree:

"...the individuals inside a family, and the families inside a community, and the communities inside a society—systemically, everything is going to affect everything..." I:13

As much as the therapist needed to be aware of the effects of the wider society on the family, he or she should be aware of the reciprocal impact of therapy on society:

"...I think therapists have a real responsibility to be thinking in terms of the effect of what they're doing on society and the culture..." I:12

The concern of this therapist was for the possible effect of the way therapists responded to client families' reactions to social fragmentation:

"...there are a lot of things breaking down in society, institutions and things that have been there for ages—there's a huge breakdown, and when that happens, people become more dependent and clingy—that's what happens with children if the family breaks down—hugely clingy as they start picking up that things aren't going ok... if you just respond to the clinginess by sort of clinging back—it's not particularly helpful." I:12

This comment illustrated a sense of responsibility toward the wider society, and the belief that her work could have some impact on that society.

In summary, families were perceived as affected by the wider society, and their difficulties were seen in part as a consequence of unresolved conflicts that existed on a wider scale. The systems understandings that have been a part of family therapy suggest that these effects must be taken into account in family therapy, and that family therapy itself will affect the wider society.

Institutional issues and family therapy

Tailoring therapy to attract funding
Direct influence of funding bodies
The effects of competition for funding
Access to therapy
Schools
Interagency relationships

Tailoring therapy to attract funding

Several therapists expressed serious concern about the way funding issues affected their work. Some felt that funding problems threatened the very survival of the agencies that employed them.Self-monitoring and self-restriction occurred prior to the allocation of funding. Workers described tailoring what they said and how they worked to what they believed was required by the funders:

> *"...people are really quite anxious about funding, they could say the wrong thing and therefore not get what they're expecting in the next funding round."* J:1

> *"...we are very insecure here...the only security we have is that we look out and everyone else is finding [it] almost equally...insecure."* J:8

Q: Is that insecurity about discontinued funding, or reputation, or what?

> *"Um, I think it's both those things, and more as well. It's—um—in fashions and directions, which I think some of them come from grass roots level, and from the community, and others come from the top or the political area..."* J:8

In speaking of fashions and directions, this therapist was describing the agency's uncertainty about how they should work, and the need to take into consideration factors other than the therapists' own views about what was best for the clients. This led to a feeling that they lacked control over how they practised, especially with regard to trying new approaches:

> *"If we were going to go on getting funding, I think probably there would be no other insecurity, if it was sufficient you were getting, because then you could afford to take risks, and to learn from your risks...I think it's sad that...I see around me a lot of people playing safe...and not doing as exciting work as was possible two years ago...*

Because you want to be sure for your funding." J:8

Direct influence of funding bodies

Detailed accounting to funding bodies for the money they did receive was time consuming:

> *"...we make ourselves accountable to everyone all the time! [laugh]."* J:5

And the way agencies were required to account for funding made taking a long view difficult:

> *"...one of the outcomes of the funding—the whole change...in the last few years is we are all working very hard, and we don't have time to step back...creative experimental work...needs a bit of time, and a bit of space...that's not being provided...I don't think I've ever tried to put in a funding application for a week's time, please [laugh] to stand back and look at what we're doing, a week's salary for the whole agency, to just contemplate...If you put in an application you're expected to account for Monday morning 8:30 to Friday at 5:00, and the number of people, and they're being treated like little packages that come in the door, and we change them a bit, and put them out again."* J:15

Despite believing that they needed to do work appropriate to their clients, these therapists felt that they were unable to develop such practices. And when funding did come, it might be with strings attached:

> *"...that is a risk, yes, that we get money specifically for one therapy."* J:5

The possibility that an agency that badly needed money might receive it for a specific purpose was described as "a risk", because that purpose might not coincide with their own perception of where the need was greatest, or of what they were best equipped to provide. Concerns about continuity of funding affected the delivery of services, with agencies themselves making cuts to save money in anticipation of possible reductions that might cause problems if they were not foreseen:

> *"...we've cut back our counselling hours just recently because of anxiety. My own view is that we didn't need to do it, and there was*

panic, but that was difficult because the government spent two months before it came to a final decision whether it could pay us or not..." J:6

The effects of competition for funding

Competition for limited funding had affected previously co-operative relationships between agencies, limiting the sharing of information and expertise:

"...I do think there's been a real shift, and much greater anxiety than there was seven or eight years ago...I think that we're in competition, and competition produces anxiety, which can be really stimulating and exciting, and it also can be destructive and depressive." J:8

"...I'm someone who enjoys working collaboratively with other agencies...and I'm fairly determined to do it. I know myself I'm a bit more guarded in doing it, at some point along the sharing, than I would have been...there are other agencies here in town that I respect and very much appreciate how much they share, and that we share together, yet I'm fairly sure on their part, too, there's a limit to what they share. They go so far, and then you go into a sort of no-man's-land you know you're to stay away from there." J:9

This caution was partly because the agencies were not sure of the grounds on which the competition for funds took place. Because they did not know what they should be keeping from their competitors, sharing was further limited:

"The grounds probably are within the closed knowledge of the funding bodies...And I say closed knowledge, because it is quite hard to get hold of what they are judging agencies on." J:8

In its role as gatherer of the information that the agencies were now keeping from one another, the Community Funding Agency itself was seen as in a position to benefit the community by making that information available:

"...as long as...there are clear standards of accountability, you don't need competition, and you need very open sharing of information, so that it bothers me that the Community Funding Agency, where probably most of us are getting [funding] from, must have information there, that they are not drawing us together and

throwing information at us...The organization is for funding and monitoring standards, and not for sharing information..." J:9

The need for sharing of information expressed here has as its end the benefit of the clients of agencies, and thus, in the view of this therapist, the whole community.

Even where therapy was publicly funded, some therapists saw funders as believing that family therapy was not cost-effective:

"...one ideal goal would be to help the CHEs [laugh] realise that...you can't always take a strictly financial view of what is going to benefit the community. I've seen what I consider to be some fairly disturbing trends which are working against the possibility of being able to work effectively with families in terms of the way the funding structures are set up...In terms of looking at units of efficiency...if I were to see six members of a family individually, for five sessions then I would have been seen to have had thirty sessions with people and therefore I would be working harder than if I saw a whole family of six people...I think that's a bit short-sighted, actually..." A:15

"...the way that things seem to be going in terms of resources for working in families—that's frightening...the system is willing to react with resources for individuals, especially children, but the resources are not as forthcoming—family work as far as I'm concerned is a cost-effective way to work, but it's not seen to be that by resource providers..." D:10

In both these cases, therapists believed that the funders paying for therapy did not understand sufficiently what family therapy was or how it worked. They saw it as more expensive because each session cost more, without understanding why:

"...family therapy sessions tend to be longer, too, than one-to-one therapy sessions, because you've got more people there, and it takes longer to...get around and hear everybody, and...to integrate at the end. So yeah, the argument between...the strictly economic dollars and cents argument and what looks on paper like a more extensive throughput of people—I think it is impacting on the way in which people are being able to work with families." A:16

As well as not understanding the costs, funders did not understand that family therapy could be more effective than individual therapy. By

making conditions about what they were prepared to pay for, they limited the way therapists could work, and, in the therapists' view, their effectiveness:

> *"...with ACC funding we work with...children who have been sexually abused, and very often the key to these children being able to overcome the effects of that abuse really involves being able to help the non-offending parent, who normally is the mother, to actually come to terms with all the issues and to be able to parent effectively and to be able to be supportive of her child...it would be important as well as doing one-to-one work with the child to be doing something with the two of them,or indeed have some sessions with Mum—but the way the funding operates it's not very easy to do too much of that."* A:16

Another found funders more understanding of family therapy, but believed they were reducing the number of referrals to cut costs:

> *"...definitely NZ CYPS are tightening their belt, their financial belt, and I'm not sure about the court. My feeling so far has been that if we're engaged with a family, and we need to continue, then I feel we're supported...But the belt-tightening seems to result from NZ CYPS in fewer families being referred, rather than a course of treatment being interrupted because the money's run out."* K:12

The same therapist felt that some funding bodies had a good understanding of the value of family therapy:

> *"...I think there's a real...belief in people getting deeper than the sort of surface problems, and kind of working on their relationships with each other...there's definitely a valuing of that in Family Court, and there probably is in NZ CYPS as well."* K:7

Where this therapist worked, families were referred for family therapy rather than individual children being referred for problems. In the latter situation, therapists sometimes felt that their professional judgement—that family therapy was the best treatment for the problem—was disregarded because of a lack of understanding, and cost considerations.

Access to therapy

Another concern about limited funding was that decisions about who received help were made on the basis of who caused most problems for

whoever was paying, rather than who was most in need or most likely to benefit:

> *"...if a child is really quite depressed and hurting and it's interfering with their academic performance but they're quiet, not causing anybody any trouble, very often nobody really tunes in to the fact that there's something wrong for this child...it does tend to be the kids who are acting out and bullying other kids in the school ground and engaging in fights and socially unacceptable behaviour who get referred, because they are causing hassles for the teachers and the other kids in the school..."* A:4

> *"...I don't think children get help—unless there's something dramatically wrong...But yeah, in the end they'll act out, and in the end they'll get attention and in the end they'll be the only ones that will be able to get into Child and Family, and they'll be blocking up the access for people again who could have been caught at an earlier stage."* E:10

Sensitivity to funding issues combined with inadequate resources led to one therapist feeling that by accepting doctors referrals her agency was providing services to a sector that was not paying for them:

> *"We're not getting any health funds, and I think we should be...Each year we make a plug for it, then we're told, 'Well, this year that sort of funding hasn't yet passed from the CHE to the Regional Health Authorities, and probably next year we'll be looking at community counselling for that'— and so another year goes on. But I think we should be, we get a lot of referrals from GPs, from Northcote...A lot of them have a health aspect to them."* J:9

The limited resources available for those who could not afford to pay privately meant that there was in effect competition between publicly- funded clients. This could affect how therapists felt about them. For example, one expressed concern that if clients who were paid for by public funds were slow to change, they prevented others from receiving treatment:

> *"...you might see people through ACC or the Court, or Child and Young Persons Service, and again what's spread there is a bit of culture of dependency...how much are they taking on board the responsibility that they've got to change, when someone else is paying for it? It isn't so much the paying for issue, it's...the length of time it takes to do some work, and the lack of facilities for people who can't pay*

with adolescents." I:14

When this issue of the time one client took limiting access for others was raised with another therapist, she replied:

> *"...we don't worry ourselves with that. We more take the philosophy it takes as long as it takes."* K:12

Money issues were also a serious restraint with private clients, again affecting the availability of family therapy:

> *"I find it very difficult to work as a family therapist, because it costs so much for a family to pay for two therapists...it's very difficult...for a family to be able to afford to pay for the time of two therapists at an hour and a half a session...you might only need four or five sessions, but a family's looking at a thousand bucks to do that work..."* I:9

There were other difficulties with referrals. For example, some referrals came with the expectation of a particular treatment approach:

> *"...that decision should be made after engaging the family, and it should be made within this agency, although the suggestion can come from outside. For instance, a doctor may meet a family and say [to the agency] '...you're offering family therapy...it would seem that this would be a suitable family.' And so I think there you've got problems, because it comes, you're expecting, you're looking at it in terms of family therapy...I think we as an agency have to be very careful that we're making our own assessment...we've got a right in a way to make our own assessment of what the method of intervention is, otherwise I don't think we're treating clients correctly."* J:3

This issue of where the therapists' responsibility lay arose in other situations, where institutions were seen as contradictory in their aims, or as asking (and paying) a therapist to do work that the therapist saw as not in the best interests of the client family. Unlike the cases discussed in the chapter on casework, where therapists felt able to use family therapy despite the parents' perception that the problem belonged to the child, when a referring agency has this perception, therapists might be obliged to do it their way:

> *"The health system...at least in terms of child pathology is still*

family focussed and I think that's really good. In my experience the legal and welfare systems are not as family focussed, they're more problem focussed, and they see the child because the child is presenting to the system as the problem, and so I get asked to individual this and individual that when to my mind it needs to be family. So you get six sessions to do an assessment of a child, and you say, 'Well I can't assess the child in the context of the family with four or five family members in six sessions, including the things that might be going on for the child on an individual basis'—and there's this real resistance—'But that's not what we've asked—we want an individual assessment of the child'—and I get that a lot, and it's very very frustrating." D:10

(Another therapist commented that the different approaches of the health system and the legal and welfare systems resulted from the historically adversarial nature of justice and welfare in New Zealand.)

"...I do assessments with young people for Children and Young Persons Service—it becomes immediately apparent to me that this is a family problem, this family needs therapy, and there's the social worker that has very clearly proscribed this problem as child focussed, the child is there, there is the problem, and it gets sent for an individual assessment, and I immediately go home to the kid's family and say 'what's going on here'—which isn't what I'm asked to do, but one of the constraints I think—and I'm talking about CYPS...is the change in the roles that social workers now have, and it's very much administering legislation, and I think that's sad, because they're still the frontline workers, and...they act as the gate-keepers. So you've got a young social worker who might have just finished a BSW, making a very influential decision about how this case is going to proceed, and it's very often in an individual direction." D:8

"...the competing objectives...of a system like DSW...care and protection on the one hand and control on another...those dilemmas, while they're not insurmountable, can really get in the way of being able to do good work with families...the way that the Children and Young Persons Service for example has evolved is a classic example of that—it's just not in a place...to work with families, and while that's been intentional to some extent, contracting out services or whatever, there's still young people that are being worked with on an individual basis when the problem is clearly with the family...that in a way becomes an impediment to that organisation's doing good work with families." D:8

Schools

Therapists working in schools, or with referrals from schools, had particular problems, again compounded by a lack of resources:

> *"...educational institutions have been asked to do absurd amounts in relation to mental health, that they have no resources for, or training—just none...and so they get a bit intransigent about it...fit the kid into the system, or it can just—piss off...that's being a bit harsh, but the bottom line tends to get down to that. Because other kids are getting beaten up, and you know [laugh] teachers, and no-one's learning anything, you've got to have the exam passes or no-one comes to your school any more, so, this again—the system sort of goes like that, and I just found that—it's been hugely freeing to go into private practice."* I:13

> *"...I always had to put so much energy into trying to work in that institution. Systemically I could always see what was going on, and how awful my role was. A school counsellor's role—just—stank ...That role is just structurally impossible, especially in today's climate, where there's no other health care for adolescents, and everyone else is into education and you're there into mental health, just swimming against the tide, really."* I:13

> *"...if you get a referral because some child is acting out in the class and you institute a behavioural management programme in the class without referring back to what's going on in the child's home environment, hopefully that's going to work and it will be a quick and efficient way of dealing with the problem." A:10*

Interagency relationships

Sometimes one agency referred a family for therapy to another agency, or to therapists in private practice. Sometimes the parties to this arrangement worked together well:

> *"...It's a shared care situation, usually, and most of the time in fact we're glad of it, because um usually—oftentimes the social worker has worked pretty hard to get a family here—like they're not coming off their own bat, entirely, the social worker has suggested it, seen the need for it and suggested it and worked with them on getting themselves here."* K:8

This therapist was describing a co-operative relationship, with the

parties taking complementary roles, and the therapists feeling that their expertise was valued. Sometimes the relationship was not so positive. In the next example, the therapist speaking felt that the referring agency did not value the therapists' expertise enough to pay what was asked:

> *"...we had some [referrals] from the Youth Justice side...and—we were then discussing how much we'd charge, and we wrote to them saying that we would charge what the Family Court charged, and the first reply from them was that that was rather high. I don't think that is high, actually, I think it's very moderate."* J:7

Interactions with a referring agency could go badly for other reasons:

> *"...the report we did was rather judgemental in this one case of the social worker concerned, who had referred them, and I wonder if that has contributed to us not getting any more [laugh]. The view of the therapist here was that [the social worker] referred the case and didn't monitor it at all, and then at the last minute turned up to get a quick summary to report back to cover her part, and they felt that that didn't help the family, that they were handed over and left a bit bereft while they received the therapy...some of the tension in that was that therapists here didn't feel the referral system contributed well to the outcome, and they tried to change it by making [laugh] judgemental comments. So...it wasn't a satisfactory inter-agency setting for it."* J:7

The institutional issues mentioned involved relationships between therapists or their employing agencies and other organisations. These relationships were seen as influencing family therapy directly or indirectly, often by limiting the way therapists worked.

Coercion

Another influence on the work of family therapists is that families may be referred for therapy by agencies that have considerable power over the consequences for those families if they do not attend:

> *"...sometimes there might be a situation where one person is saying 'I've got what I want, basically, I don't want to be here.'...sometimes we'll use our own um influence, I suppose, sometimes we might even need to use the influence of other people, to like get them here, so that they will face up to issues."* M:4

Q: ...can CYPS require them to attend, I mean can they make them come if they don't want to?

"Depending on what the status the family of the child or young person is under. There may be ah as the result of a supervision order or something, or family group conference decision, and then they have the right to enforce..." M:8

This therapist described the family group conference as deciding that the family should go to therapy;

"So that the family together have decided that this should [happen]." M:8

and continued,

"...there are management issues in the work we do with NZ CYPS, which aren't in the private work that we do. Private people come or they don't come, according to what they want to do, but there's probably an element of coercion or feeling that they have to come, through NZ CYPS, to begin with, anyway." M:8

As well as obliging people to attend family therapy, statutory agencies have the power to remove a child from the family:

"In some cases the referral will come through an agency such as Children and Young Persons, and that is sometimes generated because of complaints arising from the school or in some cases there are concerns being expressed by either people from the school or within the neighbourhood that there is something wrong going on in this particular household. So those sorts of referrals the family often doesn't really particularly want to come along, they are referred by an agency, and in some cases the agency if they feel that the child is in danger or at risk, the child may actually have been removed from the home..." A:2

Therapists may be involved in that decision:

"...a decision may be made that indeed it's not suitable for the child to go back into the family environment, but efforts are made to help the family come to terms with that and to make sure that the child does continue to have access and continue to maintain a relationship with the parents, with the family." A:2

One of the few positive comments about the relationship between a

funding and referring agency and therapists was made about working with a statutory agency with power to make clients attend:

> *"...it's a shared care situation, usually, and most of the time in fact we're glad of it, because um usually—often-times the social worker has worked pretty hard to get a family here—like they're not coming off their own bat, entirely, the social worker has suggested it, seen the need for it and suggested it and worked with them on getting themselves here."* K:8

These examples illustrated very real power over the family by the statutory agencies making referrals to therapists, which must have coloured the families' feelings about therapy. Clients' reactions to this were described by some therapists as "part of the deal":

> *"It actually means that some of the process that we're dealing with is negativity around coming...we're reasonably comfortable with that, expect that, that's part of the deal."* K:9

> *"People are always going to have mixed motives and mixed energies, no matter where it comes from."* M:9

Although that power rested with the statutory agency and not the individual therapists, sometimes the therapists' views influenced agency decision-making. Such an imbalance of power was contrary to the ideal of equality between therapist and client expressed by some therapists.

In the next quotation a therapist who had worked under similar circumstances described her pleasure at now working somewhere that clients were happy to come:

> *"I've never worked anywhere before where there's an almost one hundred per cent show up rate. It's just incredible. If someone doesn't turn up I get incredibly concerned. If they're sick or something they always phone up. It's a whole different little society —a most beautiful place to work from that point of view. Everybody's totally voluntary—it may be suggested to them that they come, but no-one's allowed to enforce it...and the place understands that. After [a public agency] where I worked before it's really quite a revolutionary [situation] ..."* E:8

In summary, several therapists described working in situations where client families were subject to sanctions if they did not attend

therapy. These cases were spoken of only briefly, as an everyday part of the work. The pleasure expressed by one therapist, about the entirely voluntary clientele of her current workplace, suggested she had found working with non-voluntary clients difficult.

Status and factions among therapists

There were definite issues of hierarchy for the therapists interviewed. Several expressed the belief that family therapy was not always well-regarded by people trained in other therapeutic disciplines. For example, one therapist who was also a clinical psychologist said,

> *"...being a family therapist or having that sort of orientation to looking at problems has not tended to even up until the present time get as much recognition as some of the more traditional behaviourally-based therapies which have had a fairly strong tradition both in the training and in the development of the sorts of research methodologies that clinical psychologists tend to use. So because of that...sometimes the people who would have more of an affinity or an interest in the ideas that I might be discussing, or the way in which I might be dealing with some of my clinical work, might not come directly from within my profession, although there are some clinical psychologists interested in this area..."* A:7

The implication was that family therapy was seen by some psychologists as somehow lesser than psychology. Another therapist, also a psychologist, believed that some family therapists saw psychology as an impediment to good family therapy:

> *"...psychologists are not generally considered to be good family therapists because they have this individual focus...but I actually believe that to be an effective family therapist you do need to have some knowledge of individual pathology, normal and abnormal development, and a basic sort of understanding of—not necessarily psychological disorder—the range of human dysfunction...you can miss something that might be quite integral to the family problem if you're not able to spot problems like depression, post-traumatic stress, or attachment problems..."* D:5

Her perception that some people saw psychology training as detrimental to family therapy was confirmed by another therapist's comments:

> *"...psychologists, they can start doing an assessment—someone says*

they feel suicidal, so what happens is they will start...asking all these questions about these suicidal thoughts, where I might say, 'oh, gosh, I wonder where that comes from?'—involve the whole family, because it's just a thought that they have had— here the psychologist's training is, you must now attend to this and assess whether this person is in any kind of danger. I would do it in a different way by using the whole family system. So that gets in the way a little bit, becomes quite clinical." B:16

One therapist spoke of the positive influence of her social work training:

"...ethical issues that stem from my sort of personal theories, but also from my social work training...When you're going in to work with a family you've got to be really sure, I believe, that...you take the least intrusive option in your work or approach." D:10

While another believed that social work training made family therapy more difficult:

"...social workers...go into the individual...or they want to fix things up, solutions, crisis stuff...people who haven't actually been trained in that way—it's much easier for us to come to family therapy, to look at a system." B:16

One therapist was critical of what she saw as psychologists' and psychiatrists' sense of their own superiority:

"...I think the health profession's got a huge amount to answer for, psychiatrists and psychologists in particular, in relation to that, because there's that whole bloody patriarchy that you know—we're up here and we know what we're doing, and we're the top dogs..." I:12

She believed that in fact their therapeutic skills were limited:

"...they do a lot of assessment and diagnosis, and they're very good at that...but because they haven't done their own work properly their skills in relation to effecting change aren't terrific, and what they do...develop is dependency. I mean, we just have to look at the psychiatric—you know, a place like Manawaroa—any of them,though... they're into management, they're not into therapeutic change. They're into managing people, so that they can function for a while in society and then come back in when they hit the skids again." I:12

A lack of confidence in the skills and training of other therapists was also reflected in remarks about difficulties in referring families who needed skills therapists themselves did not have:

> *"...I don't work with children well...that's not my area of interest, and there's a huge lack, I think...of people who can. I'm working with a family where there is a child that needs individual attention, there's nowhere that I know that I can refer them to with confidence. I'm sure there are people around who do it, but not that I can recommend...that kind of help's not available except through [a public agency] where the turnover of staff is just frightening..."* E:10

> *"...what's going on there is...level one training, and they're getting level eight problems...So it's just fingers in dykes stuff really."* I:10

Other statements suggested a status hierarchy in therapy and counselling. For example, one therapist's right to call his or her work 'family therapy' could be disputed by another therapist:

> *"I think it's important to—yeah, that would be great, to draw a big distinction between people who do family work and people who do family therapy...Despite the fact that they call it that—it's not that, and it's a disservice to family therapy."* I:11

> *"They're all new, they're all psych nurses, and there's some—they're different, but they have a very minimal experience, most of them. Except for the people that've been there for quite a long time, who don't—who I would consider often would do more family work than family therapy, but don't tell them."* I:7

Such comments implied belief that family therapy was a superior approach, an implication that the next speaker had evidently noticed:

> *"...it seemed to me that it was regarded as an elite or rather precious element of work, and somehow gave superiority to those who were involved with it. And one of the ways I'd express that is that the word 'therapy' is always attached to it. And when I...had written something like 'family counselling' there was quite a strong reaction—'this is therapy, it's not counselling'—and although I appreciate that it's got a very specialised methodology and practice, then I still felt that within an agency like this, which is a general agency, it was better not to put it into too precious a*

compartment..." J:2

There was certainly an awareness of tensions between therapists, not only on the grounds of training and orientation:

> *"...there are various factions, that I'm sure you've found."* M:13

> *"...[I] try to stay away from the kind of who's in who's out, who's qualified, who's not—and that doesn't mean to say I don't have some opinions about some people who I would, um, regard as more skilled than others, more aware than others, or—all those opinions ...I don't feel particularly part of any tensions myself..."* M:13

> *"I think that this—it's not just in Palmerston North—I think that, you know, from what I hear from people all round the country, this kind of syndrome of who's in, who's out, who's qualified and who's not, who's a good therapist and who's not—this—all that kind of talk goes on. I—I get quite fed up with it, and distance myself from it..."* M:14

One therapist's comment suggested that she believed that the issues of secure income and autonomy of practice contributed to these tensions:

> *"...it's possible some people might resent our position, because in a sense...it feels like we're comfortably working away here at what we want to be working away at, and um I mean it's a reasonable income, and...whereas we don't feel that is an issue...it's possible other people might."* K:13

Another distinction and source of differences was between public and private work:

> *"I think the only place where I've been aware of some possible resentment is at—we used to work at [a public agency], and we haven't had referrals from them, and really we—we were respected people in that agency. I think some of that is a kind of a public-private distinction—'we're the public here—'"* K:13

Also illustrating the public-private issue, another therapist said :

> *"...I don't know I'm going to stay in private practice for ever, because I do have a social conscience. It's not that private practitioners aren't involved in society in general at all, and can't be, but—"* I:14

In summary, there were acknowledged conflicts over status in the therapeutic world, with family therapy taking different places in a perceived hierarchy according to who was speaking. Some therapists believed that a certain background training reduced a worker's ability to practice family therapy, while others defended the usefulness of their own training.

Summary

Family therapy was part of a complex environment, which directly and indirectly influenced the way it was practised.

The wider social environment contributed to the problems brought to family therapy, and influenced what could be done about them. It also affected the amount and kind of help that could be offered, who had access to it, and who could be obliged to attend.

Most of the therapists described or referred to factions, or disputes about the quality of work in the therapeutic community. It was suggested that some of the tensions expressed in terms of hierarchies of perceived effectiveness could be related to insecurity of income and lack of control over ways of working.

CHAPTER SEVEN

DISCUSSION

This chapter discusses the present findings in relation to existing literature on family therapy. The format follows that of the axial codes found in the analysis of the interviews.

Distinguishing family therapy

All the therapists distinguished between family therapy and other approaches to therapy or counselling, although these distinctions were made on a variety of grounds.

Deciding to use family therapy

Most of the therapists interviewed did not see deciding to use family therapy in terms of symptoms and diagnosis as problematic. These therapists described using the approach because the child would not change otherwise, or because it was not the child's problem, so other members of the family had to be involved. The effectiveness of the family therapy approach, or the suggested ineffectiveness of other approaches given the perceived cause of the problem, were their reasons for using family therapy. On the other hand, one therapist was quite clear that the salient characteristics of family therapy were respect for clients and gentleness, and for her these characteristics were more important than effectiveness or power.

The seven therapists who returned the questionnaire all mentioned the influence of the Australasians David Epston and Michael White (discussed in the introduction), so at least these seven had been exposed to their concerns about the objectification of persons involved in diagnosis. One therapist in particular spoke of giving priority to these concerns when describing her approach to clients.

There was considerable awareness of dangers in using family therapy when abuse was occurring in a family, suggesting that when they saw a clear problem with a power imbalance in the family, therapists took into consideration the concerns mentioned by James & McKinnon (1990), that family therapy might distort or hide the experience of children and women.

The decision to use family therapy appeared most often to be based on

therapists' anticipation of its effectiveness in dealing with specific problems. Concerns about social control by Foucault's "normalising judgement", or the wider social and political issues such as those cited by Waldegrave and Tamasese (1993), were given by only one therapist as a reason for using family therapy, although others referred to them in describing how they practised. For each of these groups, "family therapy" appeared to mean quite different things, to the point that each therapist's version of "family therapy" was unique, with some common elements.

What is a family?

Some of the therapists described families in operational terms, that is, for the purpose of this therapy, whom did they need to see. This response may in part have been a result of the way the question was put. Some therapists described families in more general terms. None described families primarily in political terms, at either the individual, group, or the wider societal level. One therapist described his understanding of the family in psychodynamic language; the descriptions of others were similar to the general systems or cybernetic systems paradigms referred to in the introduction. Three offered descriptions of families defining themselves, either by being interested or involved in the issues, or by turning up together for therapy. Several therapists described families in more than one way, and these alternative descriptions suggested that a definition of a family was not an important or even usual part of family therapy.

The idea of a family as something that can get sick, or induce sickness in its members, which Wynne et al. (1987) suggested was not accepted by the general public, appeared taken for granted by some of the therapists. It was acknowledged as an occasional hurdle in treatment when rejected by the family. Descriptions of the systemic approach as "less blame and fault focussed", and as rejecting linear causality, addressed the issue of cause or blame at the level of the individual family member. The unwillingness mentioned by two therapists of the Accident Compensation Corporation to pay for family therapy may result in part from their not accepting that a family is something that can suffer an accident.

My attempts to introduce questions about how family therapy could serve the interests of all family members equally, or how therapists dealt with situations where the interests of the family as a group conflicted with those of individuals, received little response, and I felt I had not made myself understood. On this issue, Rachel Hare-

Mustin writes that different members of the family benefit unequally from family therapy, "a fact that some family therapists seem unable or unwilling to recognize or acknowledge." (1980, p.936).

Differences between family therapy and other approaches

Auerswald (1987) suggested that family therapists were unaware of profound differences between the older systemic approaches and emerging 'new science' or constructionist approaches. There was some mention of constructivist and social constructionist ideas by the therapists interviewed, but again despite frequent references to Michael White and David Epston as influences, only one of them appeared to be really immersed in that perspective.

The suggestion (by, for example, James & McIntyre 1983) that family therapists take families out of context in the same way as they accuse other therapies of taking the individual, was to some extent confirmed by these interviews. Six of the therapists spoke of factors external to the family itself as contributing to the difficulties that brought them to therapy, but the other six did not mention the wider social context of the family. However, four of the latter did refer to other agencies with which the family might also be engaged.

Some of the therapists clearly did see their role as including taking the side of the family with other professionals, as advocated by McKinnon & James (1991). For others, however, anything beyond the immediate family was explicitly not the concern of family therapy, indicated by their use of this restriction to distinguish between family therapy and social work.

In distinguishing between family therapy and other approaches, the therapists often made comparisons with other disciplines. Furlong (1989) described relationships between family therapy and other disciplines as antagonistic. All of the therapists interviewed in the present research had mixed backgrounds. None had trained and worked exclusively in family therapy. Four had backgrounds in social work (two of those also in psychology), three in a mixture of education and psychology. Some of the therapists had worked as social workers for welfare or statutory agencies, and these people described the problems and limitations of social work in structural terms, rather than in blanket criticisms of training and approach. The same was true of comments about schools made by workers with a background in education. Therapists with combined backgrounds may be more likely to have the understanding needed for effective collaboration with other

disciplines, and less likely to describe family therapy in terms of its superiority to another discipline.

Distinctions between therapy and counselling

Distinctions made between therapy and counselling included describing therapy (including family therapy) as more complex and less straightforward than counselling, and as dealing with the causes of problems rather than with the immediate problems themselves. For the people making these distinctions, someone who could do therapy was able to do more than "just" counselling.

Several therapists used issues of power and of responsibility to distinguish family therapy from individual counselling, or from other therapeutic approaches in general. In most cases, a therapist was described as having and using power more than a counsellor; however one therapist saw family therapy as different from all other therapy and counselling approaches because it required equality between therapist and clients. While there were differences in the way they interpreted these distinctions, it was around these issues that important distinctions were made. Some of the therapists thought that the therapist was necessarily in a position of power, and should make this clear to clients.

Continuity between family therapy and other approaches

The therapists who emphasised continuity between family therapy and other approaches more often described the positive contribution their background in family therapy had made to their work with individuals, rather than the influence their individual work had on their family therapy. It is noteworthy that the three therapists quoted on this topic had extensive training and experience in other fields. The comment by one that it was *"a bit of a dilemma...how to effectively make people aware that they don't have to make those choices..."* between adult work or child and family work, suggested that she saw this as a division clearly marked in the world of counselling and therapy.

Being prepared to do family therapy

Having specific skills

When describing the special training and skills needed for family therapy, therapists were again describing what set it apart from other

approaches, and sometimes disputing claims made by other professionals that family therapists were no different from other therapists or counsellors. They were also distinguishing between who was, and who was not, entitled to speak about the competence of particular family therapists. These therapists evidently regarded family therapy as a distinct discipline with specialized training, while at least one other therapist saw it more as part of the repertoire of any competent social worker or therapist.

These different views reflected the distinction made by Wynne et al. (1987), between those who see family therapy as a distinct discipline with specialized training, and those who regard it as not limited to the practice of family therapists. The question of whether family therapy is a profession, an orientation to human problems, or just another approach to psychotherapy (Goldenberg & Goldenberg 1991) is likely to be answered differently according to the training and current practice of the therapist asked.

The therapists described difficulties associated with specialist training in family therapy. Some of these arose from the numbers of people involved both as therapists and clients. 'On the job' training was described as having both advantages and disadvantages. It was cheaper than observing an experienced team, and gave the trainee experience with real cases, but the disadvantages for client families included seeing inexperienced therapists, or a team in which the experienced partner may be attending to, or distracted by, a trainee.

Knowing different family therapy models

Statements that therapists should be familiar with different models of family therapy suggested a belief that such knowledge was lacking or inadequate in some practitioners. One therapist referred to a lack of formalised family therapy training in New Zealand, and her perception of a consequent lack of theoretical coherence, was echoed by another's describing her own family therapy training as having "touched on one model, touched on another one...". Reference to "stark differences" between models and their different approaches to therapy, and the linking of coherence and effectiveness, showed that the distinctions between family therapy approaches (and the possibility that they may not be compatible) were seen as important. The noting of these distinctions in the context of training did not amount to the aggressive disputes between practitioners of different approaches described by Snyder (1993), but critical remarks made in different contexts by some therapists about others were less measured.

Having personal knowledge

Two issues that arose in the context of discussing the importance of self-knowledge by therapists practising family therapy were professional responsibility, and power versus neutrality.

Therapists were described as needing to be aware of their own "personal stuff", so as not to impose it unwittingly on the family. Implicit in this, and its description as a safety issue, is the effect of therapy on the family, and therapists' responsibility for that effect. Different approaches to family therapy have different views about the role of the therapist (as noted briefly in the introduction), ranging from the neutral interpretation of the psychodynamic approach to the active manipulation of the structural and communication or strategic approaches. The history of directive versus neutral therapy in family therapy is complex, in part reflecting family therapy's mixed origins in psychiatry and social work. The concern of all the therapists interviewed with doing their own personal work suggests that they accepted that they would influence their clients, and wished to be aware of how they did.

Being experienced and practised

All the therapists interviewed were experienced professionals currently in practice, so those who spoke of the importance of being experienced and practised specifically in family therapy were again distinguishing it from other therapeutic approaches.

The therapists interviewed perceived the need for family therapy training, and especially practice and experience, and related this to the unique characteristics of family therapy. This is similar to Margolin (1982), who writes that the strong emphasis on the experiential dimension of training is a result of recognising that there are therapist factors unique to marital and family therapy. It also constitutes a claim for the unique character of the approach, and to expertise for those who (properly) practise it.

Ongoing preparation

Ongoing training was seen as necessary for all therapists. The therapists interviewed believed that, like experience and practice, continuing training and supervision specifically in the area of family therapy was vital. In this they concurred with the American Association for Marriage and Family Therapy, who list remaining

abreast of new developments in family therapy through educational and clinical activities as an ethical requirement of membership of their organisation (Goldenberg & Goldenberg 1991).

Supervision

Supervision was described in uniformly positive terms by the therapists. It was seen both as a source of new information and ideas, and as maintaining the quality of therapy. The word "keeps" was used frequently when describing the work of a supervisor. According to the therapists quoted, a supervisor keeps the therapist broad, keeps his or her creativity up, keeps him or her aware of the process he or she is in, keeps the system from being closed, keeps the therapist accountable. All these suggest that the role was perceived as protective of both the therapist and the clients, and valued highly for that reason.

Teamwork preparation

Unlike individual therapy, it has been common for family therapy to involve co-therapists. The importance of the relationship between co-therapists was apparent in comments made about teamwork preparation, as were the difficulties that arose when there were unresolved differences between workers. It was not always clear, when discussing these difficulties, whether the therapists involved were working together by choice, or were assigned partners by their employing agency; certainly the latter was sometimes the case. The relationships between different approaches to family therapy that emerged in the interviews as existing between co-therapists were similar to those discussed by Crawley (1993), Snyder (1993), and Jenkins (1991) as destructive to the discipline. Perceived—and defended—distinctions between different disciplines were seen as contributing to the difficulties between co-therapists. Crawley's "triumphalism" and Snyder's "argumentative, defensive, aggressive, rivalrous practices" sound extreme, but are not so far from "ridiculously stupid", "a contentious issue", "this dreadful situation", and "I always felt quite irritated", all used by interviewees in describing interactions with co-therapists.

Ideas, action and outcomes in the therapy process

Ideas: expectations and awareness

The view of some of the therapists, that the family's understanding of

what brought them to therapy was often quite different from that of the therapists themselves, suggested that those therapists could be grouped with those who analyze family problems then prescribe interventions (Sprenkle & Bischof 1994). They worked to shift the family's understanding in the direction of their own, or to use their own understanding of the problem to change the family. Such views correspond to Parry's description of a privileged position:

> *"...the therapist has retained a privileged vantage point arising out of access to a body of knowledge that explained the client on a different and superior level to her experience of herself."* (1991, quoted in Pare´ 1995, p 10).

Some of the therapists rejected the diagnosis and treatment approach as something that therapists do alone, opting for involving the family in both. Some of those who avoided prescribing appeared to do so not because they did not know what was causing the problem or what would be best, but because they believed that if the family itself decided what to do it would be more effective and long lasting. This idea is similar to that of neutrality as source of therapeutic power (Furlong & Lipp 1994). Can 'therapeutic' neutrality be distinguished from 'real' neutrality, or 'therapeutic' self- determination from 'real' self-determination? Bograd (1992), and Furlong (1989) write that therapy always involves influence and power. As with getting the family to 'discover' the cause of the problem (which the therapist had already identified), getting the family to come up with a solution may have meant their finding a solution the therapist thought suitable.

None of the therapists spoke of what Kushner & Sher (1989) describe as "coercion fears", the category of concerns clients have about being pushed to do, think, or say things against their will in therapy. This was consistent with Kushner & Sher's suggestion that such fears receive little attention from clinicians and researchers.

The therapists who described confronting, provoking, mocking or challenging the family seemed quite comfortable with actively working to change the family's point of view. Only two of the therapists spoke explicitly of mutually seeking an acceptable interpretation of the problem, although when other therapists described the way they worked, they did consider the family's own interpretation in making their diagnosis, and tried to involve them in deciding what to do next.

Some of the therapists expressed discomfort with the role of expert, or at least the kind of expert they believed clients were expecting or

hoping for. Their rejection of that role is arguably another area in which, when therapists and families differed in their understanding, the therapists' view of therapy prevailed. (The 'non-expert' stance in therapy has been described as a useful corrective "that has gone way too far" by Kerrie James (Hollonds 1996, p. 102), who believes that it can at times be disrespectful not to share ideas and knowledge with clients.)

However, even therapists who described their clients as "co-therapists" found it necessary to direct the process of therapy, as indicated by reference to people who would not return to therapy "because they weren't happy about...being called to take a part in this." Unlike the therapists described by Furlong (1989), they did not deny that they used their influence in therapy, but they saw their role as much less directive of clients than did other therapists who saw their role as unavoidably directive and powerful.

The different kinds of knowledge

The knowledge described as arising in the therapy process can be categorised in the following way. At the beginning of therapy, there were three kinds of knowledge that the family, or individuals in the family, had, and the therapists did not. The first of these was knowledge about the family and the problem that both therapists and the family could see was relevant to the problem. Knowledge the family was aware of but had not connected to the problem, and knowledge the family were not aware they had, came to their notice during therapy. New knowledge was also created during the therapy process, about possible steps for change; and hope, the knowledge that things could be different (Yalom (1985) lists hope as an important curative factor in therapy).

The description by several therapists in the present study of therapy being over when the knowledge of the family and therapists coincides, was consistent with findings that the values and goals of clients come to converge with those of therapists, and that this occurs concurrently with client improvement as assessed by therapists (Epperson & Lewis 1987; Lewis, Epperson & Foley 1989).

Action

Moving

The metaphors of movement found so often in these interviews about family therapy may have their origins in the discussions of linear and circular causality found in family therapy theory. These ideas are often expressed or illustrated in terms of the moving parts of mechanical or engineering systems (see, for example, Goldenberg & Goldenberg 1991, pages 41-43). Describing a mechanical system as 'stuck' makes sense, describing a biological or planetary system this way does not. Therapists who use this imagery would appear to be referring to one of the "Cartesian/Newtonian, nineteenth century mechanistic" paradigms of family therapy identified by Auerswald (1987), rather than to the "New Science" paradigm (although Constantine points out that therapists use systems terms to refer to the idea of the family as a complex network, rather than with the specific meanings with which they originated (1986, cited in Goldenberg & Goldenberg 1991)).

Pare´ (1995) argues that the metaphor of a system is founded on ontological rather than epistemological premises; that is, it is used to describe how the world *is,* rather than how we come to know it. For this reason the introduction of the constructivist and social constructionist approaches, and attempts to integrate them into a largely systemic family therapy, have caused confusion.

Depth and Danger

The possibility that therapy could have dangers was a significant one for some of the therapists, although sometimes mentioned only when stating that their particular approach avoided the dangers inherent in other forms of therapy. Of the therapists who spoke of the possibility of danger in family therapy, all but one described taking a comparatively directive approach to family therapy. The exception was the therapist who appeared most committed to Michael White and David Epston's work, and designed her whole approach around not intruding or imposing on the clients.

The idea that families are protected from potential danger in therapy in ways that individual were not, which emerged from several of the interviews, was contrary to the view of Goldner (1993), who writes that:

"...family treatment, unlike individual work, involves consultation to a social group whose ideas and feelings about one another have material social consequences." (p. 159).

Outcomes

Goals

The first response of almost all the therapists, when asked about their goals, was that their goals depended on the goals of the family. This suggested that they would see their own positions as congruent with the general movement in family therapy towards empowerment of, and collaboration with, families (Sprenkle & Bischof 1994). Even slightly technical expressions, such as "increasing healthy functioning" and "developmental processes", were rare when talking about goals. Although the expression "family goals" suggests the unproblematic acceptance by some family therapists of the family as a voluntary organization that works equally for the good of all members, criticised by MacKinnon & Miller (1987), three of the therapists specifically included in their goals the welfare of individual family members.

Negative outcomes

The possibility that there might be no positive result from family therapy, or that it might be harmful to clients, was mentioned, most often in response to a question about what therapists found most difficult in their work. The examples given were the lack of a positive outcome, such as the family's not returning to therapy or the family not bonding successfully; or a bad outcome, such as the pathologizing of children by involving them unnecessarily in therapy or the creation of dependency.

Rewards

Seeing people change was described as the most rewarding part of family therapy. These changes were invariably talked about in terms of positive consequences for the family. The therapists differed in this regard from the trainee psychiatrists followed by Light (1980), whose views of success in their work changed from "getting patients better", to "mastery of the therapeutic hour." (p.116).

Ecology

Current family therapy literature includes calls for therapists to acknowledge their active role in society, and to use it to further social justice (see, for example, MacKinnon & Miller 1987, Waldegrave & Tamasese 1993, MacKinnon & James 1991). If individual change is impossible without change in the wider social system, as systems theories imply, family therapists should also be working within the system to challenge the oppression related to sex, class, and ethnic difference that they describe as contributing to the problems that come to family therapy (Libow, Raskin & Caust 1982). One of the interviewed therapists described the work of the Family Centre in Lower Hutt as"real family therapy...because they're not just focussing on one level, which isn't about thinking systemically at all." For this therapist, it seemed, true systemic family therapy included not only awareness of the wider societal environment, but active engagement with it.

The relationship between society and the family

The effects of poverty on clients arose when therapists referred to how family problems were affected by difficulties in earning enough to buy food, lack of time to socialise, transience, and family separation because of work commitments. The effects on young people (and on their families) of their not becoming economically independent were described as directly affecting family therapy, by complicating "genuine personal differences", suggesting a distinct- ion between causes internal to the family and those of the outside world. The implication was that economic issues complicated existing relationship difficulties, rather than causing them.

Some of the therapists interviewed described challenging oppressive gender roles. One described "join[ing] the family by supporting" a (female) partner who was "unable to find space to talk freely", another spoke of challenging a woman's decision to remain in a violent relationship. None suggested that they saw gender relationships as always or usually oppressive.

Culture or ethnicity were mentioned mostly in passing. A description of Maori children as expecting a more directive approach may reflect the kind of cultural differences noted by Waldegrave & Tamasese (1993), with the therapist placing a higher value on individual self-worth than is thought appropriate in some cultures. Another therapist spoke of Maori families having a greater awareness of their

family background, which brought them closer to her idea of what families needed to know about themselves.

These findings could be regarded as consistent with the claim by Hoffman (1990), that race, class and gender are often overlooked by systemic family therapists.

Some actions that the therapists described taking to change the immediate environment in which they worked included refusing to allow a competitive funding system to prevent all cooperation between agencies; making representations to funding bodies about the effectiveness of family therapy; and arguing for the provision of funding for clients currently excluded from family therapy by its cost.

One therapist, who moved from working as a school counsellor into private practice, described the move in terms of the impossibility of working effectively (that is, to the benefit of clients) in the current school environment: "Systemically I could always see what was going on, and how awful my role was." In this case, a perceived inability to effect change because of a constraining environment contributed to a therapist leaving one workplace for another.

Institutional issues and family therapy

The relationships between funding bodies and agencies or individuals providing family therapy were perceived as important influences on family therapy. They were seen as affecting co-operation between agencies, access to therapy, and the way therapists practised.

The negative effects of these relationships included therapists feeling they could not freely choose how to treat problems, and a lack of security about employment and funding, both of which were seen as reducing positive outcomes for clients. Funders and referring bodies were described as not understanding either the way family therapy worked, or its cost-effectiveness. Two therapists who were also clinical psychologists spoke of their frustration at having children referred for psychological assessment, and then having their recommendation that family therapy be used rejected because the referring body had employed the psychologist *after* a decision to treat the individual child. As was noted in one interview, therapists might set up as family therapists, and have families referred for family therapy; or a child might be referred to a private practice or agency for a decision about treatment to be made. In the former situation, the referring agency have already made a decision about the need for

family therapy. In the latter, they may dispute what they perceive as a more expensive option.

Positive relationships with referring agencies were described by therapists who spoke of having their wish to continue working with particular families supported, of being assisted with the attendance of clients, and of believing that family therapy was understood and valued by the referring bodies they worked with. In each of these cases, referrals had been made specifically for family therapy.

Making representations to a referring agency for a family to receive the treatment the therapist thought best was an example of the intervention on behalf of the family with other professionals that MacKinnon & James (1991) regard as an important role of the family therapist.

Several therapists expressed concern that access to family therapy was difficult for those who could not pay privately, as public treatment was unlikely unless a child was causing real trouble outside the family. What began as a criticism by one therapist of the "culture of dependency" spread by the public funding of therapy, ended as an expression of concern at this lack of available help for people with few resources.

Coercion

Bograd (1992) suggested that family therapy has not resolved the dilemma of the relationship between therapy and social control. The therapists interviewed in the present study spoke of clients being legally obliged to attend therapy largely in terms of the implications for therapy of having to deal with reluctant clients. Two described possible client discomfort, which might interfere with therapy. Reference to family group conferences making the decision that the family should attend therapy implied that the family had itself chosen to come. They did seem to be describing the intervention of statutory agencies as just another source of reluctance for the client, rather than seeing it as an issue of power and control in which they were involved. Although the historical change in the language of family therapy noted by Sprenkle & Bischof (1994), away from analysis and diagnosis, was reflected in these therapists' use of the words "empowerment", "collaboration" and "curiosity" to describe activity within the therapy itself, there was less evidence of an awareness of the contexts of power and control in which therapy might occur.

Status and factions among therapists

Several of the therapists perceived a clear hierarchy of professional status in the world of therapy and counselling, based on training and orientation. Some of them described this hierarchy by claiming a place in it, although some of them were critical of its existence. Where a particular discipline or approach was placed in this hierarchy might differ, usually reflecting the speaker's own background. Some comments were simple assertions of the superiority of family therapy; several suggested that the speaker felt he or she needed to defend his or her own training and approach against being placed lower in the hierarchy by other therapists.

"Factions" between therapists in a local area were also mentioned, with criticisms described in terms of perceptions of competence and experience, rather than the discipline in which an individual was trained. Another element in these distinctions appeared to be the organisations for which therapists worked, including whether they were in public or private practice.

Some of comments made about hierarchies and factions confirmed the point made by Snyder (1993), that family therapists were vulnerable to "argumentative, defensive, aggressive, rivalrous practices" (p. 83) found in our culture. Light (1980) suggests that in fields of low paradigm development, with little consensus and no powerful theories, criticism is likely to become personal. He cites research findings in both psychiatry and medicine, that these problems were dealt with by mixing only with compatible colleagues, leading to professional isolation.

There is increasing discussion in family therapy about these issues. Under the heading "Things we hate about family therapy", The Australian & New Zealand Journal of Family Therapy (1995) includes in its Network News section a number of independent submissions from different geographic areas expressing concern about hidden conflicts, competition about ideas and their ownership, pressure to identify with one school of thought or another, constraints on open debate, and "the personalising of theoretical differences and hiding of personal disputes behind theoretical rhetoric", summed up as "a regrettable lack of tolerance of differences".

Parallel process

One of the therapists drew a clear parallel between family therapy and

families themselves, responding to a suggestion of something contradictory about insisting on co-therapy while finding it the biggest difficulty:

> *"...that's not so much a contradiction as a reality...I mean families —maybe it's ideal, maybe it's not, maybe it's ideal to live in families, but families have difficulties. Do you know what I mean? In another context."* H:9

Examples of such parallel process (Yalom 1985), or isomorphism (Goldenberg & Goldenberg 1991) were found throughout the interviews. Sometimes the similarities were clearly intentional, as with comments about the negative effects of secrecy in therapy and in families, or about co-therapists modelling desirable behaviour. Other similarities were not spelled out. Other examples were: a lack of clarification of expectations causing difficulties in families and between co-therapists; the "two cultures" of parental families of origin and the different cultures of disciplinary origin of co-therapists; rigid boundaries between families and the social world, or between a therapeutic approach and the rest of the therapeutic world, as a source of problems; and the therapist who described how "former families" might need to work together later expressing hurt at being cut off from a former workplace. One therapist, describing the process of assessment of a family prior to therapy, asked the perfect question for assessing the relationships between practitioners of family therapy:

> *"...can they actually talk to each other, or can they listen to each other, do they—does that raise lots of anxieties for them, or do they in a sense kind of disappear out of the room for ten minutes and talk to themselves, or—all those sorts of things."* M:10

CHAPTER EIGHT

SUMMARY AND SUGGESTIONS FOR FURTHER RESEARCH

Summary of findings

The four selective codes nominated illustrate the major areas of concern for therapists that emerged from interviews about their perceptions of family therapy. These were, distinguishing family therapy; being prepared to do family therapy; ideas, action and outcomes in the therapy process; and the ecology of family therapy.

The therapists distinguished family therapy from other therapeutic approaches by reference to its unique interpretation of interactional problems as family problems (a systemic approach); its being therapy rather than counselling; and its unique effectiveness in producing change. Less important as distinctions, but still significant, were matters of technique (although several therapists expressed discomfort with that word), such as using two therapists. Others distinguished family therapy on the basis of its respect for clients.

The therapists emphasised the need for adequate preparation to do family therapy, which they believed needed a high level of skill. Most expressed concern about the limitations of either their own training, or that of others, and the consequences of this for clients and for the reputation of family therapy. Also important as preparation was increasing and maintaining the therapists' own self-knowledge, (which, with the need for supervision, was an issue of professional responsibility), and resolving difficulties between co-therapists

A variety of kinds of knowing were described in family therapy, with therapists and families bringing different ideas and expectations. In some cases, knowledge of therapists and families was seen as converging during the process of therapy, until they overlapped sufficiently for the therapy to be seen as finished. Metaphors of movement were widely used to describe the process of family therapy, which was described as an active, even vigorous, enterprise. Therapists acknowledged that outcomes of family therapy were not always positive, often involved compromise, and could include harm to clients or therapists.

Family therapy exists in relation to other therapeutic approaches, and the wider society, and its history of systems thinking suggests

considerable awareness of this by therapists. Social change, poverty, gender, ethnicity and culture were all seen as affecting families, and family therapy. Relationships between therapists and their employers and funders were perceived to have either negative or positive effects, influenced by the extent to which they limited or supported therapists' control over how they practised. Therapists also described factions and hierarchies of status existing in the therapeutic world generally, in which family therapy was involved.

Limitations of the study

One limitation of this study was that the background training and experience of individual therapists was not related in detail to the content their interviews, although this information was sought in the follow-up questionnaire. The decision not to use this information in conjunction with interview material was made at the outset of the research for reasons of confidentiality, as in a small community each therapist could have been readily identified by these details.

Another limitation was that the single interview provided a limited opportunity to hear from each therapist. Questions that arose from transcribing and analysing one interview could not be clarified with that therapist, although they could be asked of another therapist. It also meant that the changing nature of therapists' perceptions was not apparent. Two of the therapists told me some months after the interviews that their views on some issues were changing.

Contrary to ideal grounded theory method, therapists were not observed at work.

In this study, analysis intended to raise description to a theoretical level was not completed, and the findings remain at a descriptive level.

Some implications of this study

One implication of this study is that the wide range of different views and approaches to family therapy found in even this small sample, and the almost unanimous anxiety about standards and competence, indicate that family therapy is not a unified or even readily described body of practice in this community.

It is evident from the literature that this situation is not unique to New Zealand. Some other countries have begun a process of licensing or certification of family therapists, ensuring certain standards of

education and experience are met. It is likely that under these conditions a more unified understanding of family therapy will arise, or a division into several different identified therapeutic approaches may occur.

Therapists trained in other professional disciplines prior to family therapy training in most cases retained a commitment to that earlier training, even when they perceived conflicts with their understanding of 'what family therapy is about'. This was reflected in the reluctance of several of them to accept the title "family therapist", while agreeing to "I do family therapy". The expression of rather stereotypical views about other professionals and their limitations in practising family therapy suggest that the isolation of family therapy that concerns Shields et al. (1994) is a possibility, although the small size of the New Zealand client population makes this less likely than in the USA.

Suggestions for further research

Research into the effects of prior professional training and later understanding and practice of family therapy may reveal useful information about relationships between them (and between practitioners). It would also be useful to investigate how therapists' places and conditions of work interact with their views on family therapy.

Most of the therapists interviewed referred to the work of Australasian family therapists David Epston and Michael White, although only one appeared to be totally immersed in their approach. Therapists are sometimes accused of using ideas imported from overseas that do not fit local conditions. Is a uniquely New Zealand form of family therapy developing, influenced by Epston and White, and if so, how can it be distinguished from 'imported' family therapy? And if as Pare´ (1995) suggests, the metaphor of the family as a system is being replaced by that of an interpretive community or storying culture, will that affect the commitment to social change that some therapists see as implied in the systems approach?

REFERENCES

Addison, R.B. (1989). Grounded interpretive research: An investigation of physician socialisation. In M.J. Packer & R.B. Addison (Eds.). Entering the circle: Hermeneutic investigation in psychology. New York: State University of New York Press.

Anderson, H. (1994). Rethinking Family Therapy: a delicate balance. Journal of Marital and Family Therapy 20, 145-149.

Auerswald, E.H. (1987). Epistemological confusion in family therapy research. Family Process 26, 317—330.

Bogdan, J. (1987). "Epistemology" as a semantic pollutant. Journal of Marital and Family Therapy 13, 27-35.

Bograd, M. (1992). Values in conflict: Challenges to family therapists' thinking. Journal of Marital and Family Therapy 18, 245-256.

Carpenter, J. (1994). Family therapy and the public sector in the UK: Comment on Lappin & Van Deusen. Journal of Family Therapy 16, 97—101.

Crawley, J. (1993). Family therapy...what's in a name? Australian and New Zealand Journal of Family Therapy 14, 17-20.

Doherty, W.J. & Burge, S.K. (1987). Attending to the context of family treatment: pitfalls and prospects. Journal of Marital and Family Therapy 13, 37-47.

Duckcro, P., Beal, D. & George, C. (1979). Research on the effects of disconfirmed client role expectations in psychotherapy: A critical review. Psychological Bulletin 86, 260-275.

Epperson, D.L. & Lewis, K.N. (1987). The issue of informed entry into counselling: Clients' perceptions and preferences resulting from different types and amounts of pretherapy information. Journal of Counselling Psychology 34, 279-285.

Fagerhaugh, S.Y. (1986). Analysing data for basic social science processes. In W.C. Chenitz & J.M. Swanson (Eds.). From practice to grounded theory: Qualitative research in nursing. Menlo Park, Calif.:Addison-Wesley. pp 133-145.

Fish, V. (1990). Introducing causality and power into family therapy: a correction to the systemic paradigm. Journal of Marital and Family Therapy 16, 21-37.

Furlong, M. (1989). Can a family therapist do statutory work? Australian and New Zealand Journal of Family Therapy 10, 211-218.

Furlong, M. & Lipp, J. (1994). The multiple relationships between neutrality and therapeutic influence. Australian & New Zealand Journal of Family Therapy 16, 113—122.

Gelso, C.J. & Karl, N.J. (1974). Perceptions of "counsellors" and other help-givers: What's in a label? Journal of Counselling Psychology 21, 243-247.

Gergen, K.J. (1985). The social constructionist movement in modern psychology. American Psychologist 40, 266-275.

Glaser, B. (1978). Theoretical sensitivity: Advances in the methodology of grounded theory. Mill Valley, Calif: The Sociology Press.

Goldberg, D. & David, D. (1991). Family therapy and the glamour of science. Journal of Family Therapy 13, 17-30.

Goldenberg, I. & Goldenberg, H. (1991). Family therapy: An overview. (3rd ed.). California: Brooks/Cole.

Goldner, V. (1993). Power and hierarchy: Let's talk about it! Family Process 32, 157-162.

Hare-Mustin, R.T., Maracek, J., Kaplan, A.G. & Liss-Levinson, N. (1979). Rights of clients, responsibilities of therapists. American Psychologist 34, 3-16.

Hare-Mustin, R.T., (1980). Family therapy may be dangerous to your health. Professional Psychology 11, 935-938.

Hartnett, J., Simonetta, L. & Mahoney, J. (1989). Perceptions of non-clinical psychologists towards clinical psychology and clinical psychologists. Professional Psychology: Research and Practice 20, 187-189.

Hoffman, L. (1990). Constructing realities:An art of lenses. Family Process 29, 1-12.

Hollonds, A., (1996). Criticism from within: An interview with Kerrie James. Australian & New Zealand Journal of Family Therapy 17, 97—103

Huberman, A. M. & Miles, M. B. (1988). Assessing local causality in qualitative research. In D. N. Berg & K. K. Smith (Eds.). The self in social inquiry: Researching methods. Newbury Park: Sage. pp.351—381.

Jackson, S. (1992). Naivety and family therapy: An interview with John Carpenter. Australian and New Zealand Journal of Family Therapy 13, 93-98.

James, K. & McIntyre, D. (1983). The reproduction of families: the social role of family therapy? Journal of Marital and Family Therapy 9, 119-129.

James, K. & MacKinnon, L. (1990). The "incestuous family" revisited: A critical analysis of family therapy myths. Journal of Marital and Family Therapy 16, 71-88.

Jenkins, A. (1991). Intervention with violence and abuse in families: the inadvertent perpetuation of irresponsible behaviour. Australian and New Zealand Journal of Family Therapy 12, 186-195.

Joffe, C. (1986). The regulation of sexuality: Experiences of family planning workers. Philadelphia: Temple University Press.

Kushner, M.G. & Sher, K.J. (1989). Fear of psychological treatment and its relation to mental health service avoidance. Professional Psychology:Research and Practice 20, 251-257.

Lappin, J. & Van Deusen, J. (1994). Family therapy and the public sector. Journal of Family Therapy 16, 79—96.

Lewis, K.N., Davis, C.S., & Lesmeister, R. (1983). Pretherapy information:An investigation of client responses. Journal of Counselling Psychology 30, 108-112.

Lewis, K.N., Epperson, D.L. & Foley, J. (1989). Informed entry into counselling: Clients' perceptions and preferences resulting from different types and amounts of pretherapy information. Journal of Counselling Psychology 36, 279-285.

Libow, J.A. , Raskin, P.A. & Caust, B.L. (1982). Feminist and family systems therapy: Are they irreconcilable? American Journal of Family Therapy 10, 3-12.

Light, D. (1980). Becoming psychiatrists: The professional transformation of self. New York: Norton.

Lofland, J. (1971). Analyzing social settings: A guide to qualitative observation and analysis. Belmont, Calif.: Wadsworth.

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

McCracken, G. (1988). The long interview. Newbury Park: Sage.

MacKinnon, L. & James, K. (1991). Initial meetings in child-at-risk meetings: developing a therapist-family alliance. Australian and New Zealand Journal of Family Therapy 12, 175-185.

MacKinnon, L.K. & Miller, D. (1987). The new epistemology and the Milan approach: feminist and sociopolitical considerations. Journal of Marital and Family Therapy 13, 139-155.

Margolin, G. (1982). Ethical and legal considerations in marital and family therapy. American Psychologist 37, 788-801.

Miles, M.B. & Huberman, A.M. (1994). Qualitative data analysis: An expanded sourcebook. (2nd ed.). Thousand Oaks: Sage.

Murstein, B.I. & Fontaine, P.A. (1993). The public's knowledge about psychologists and other mental health professionals. American Psychologist 48, 839—845.

Network News (1995). Australian & New Zealand Journal of Family Therapy. 16, 39-46.

Pare´, D.A. (1995). Of families and other cultures: The shifting paradigm of family therapy. Family Process 34, 1-19.

Shields, C.G., Wynne, L.C., McDaniel, S.H. & Gawinski, B.A. (1994). The marginalization of Family Therapy: A historical and continuing problem. Journal of Marital and Family Therapy 20, 117—138.

Smith, D. (1981). Unfinished business with informed consent procedures. American Psychologist 36, 22-26.

Snyder, M. (1993). Argument versus dialogue: a response to Luepnitz, Madigan, and other argumentative authors. Journal of Family Therapy 15, 81-86.

Speed, B. (1995). A comment on "Contemporary family therapy in the US". Journal of Family Therapy 16, 25-29.

Sprenkle, D.H. & Bischof, G.P. (1994). Contemporary family therapy in the United States. Journal of Family Therapy 16, 5—23.

Strauss. A.L. (1987). Qualitative analysis for social scientists. Cambridge: Cambridge University Press.

Strauss, A. & Corbin, J. (1990). Basics of qualitative research: Grounded theory procedures and techniques. Newbury Park: Sage.

Swanson, J.M. (1986). Analysing data for categories and description. In W.C. Chenitz & J.M. Swanson (Eds.) From practice to grounded theory: Qualitative research in nursing. Menlo Park, Calif.: Addison-Wesley.

Tinsley, H.E.A., Bowman, S.L. & Barich, A.W. (1993). Counselling psychologists' perceptions of the occurrence and effects of unrealistic expectations about counselling and psychotherapy among their clients. Journal of Counselling Psychology 40, 46-52.

Tinsley, H.E.A., Brown, M.T., de St. Aubin, T.M. & Lucek, J. (1984). Relation between expectancies for a helping relationship and tendency to seek help from a campus provider. Journal of Counselling Psychology 31, 149-160.

Waldegrave, C. & Tamasese, K. (1993). Some central ideas in the 'Just Therapy' approach. Journal of Australian and New Zealand Family Therapy 14, 1-8.

White, M. (1989). Selected papers. Adelaide: Dulwich Centre Publications.

White, M. & Epston, D. (1989). Literate means to therapeutic ends. Adelaide: Dulwich Centre Publications.

Wynne, L.C., McDaniel, S.H., & Weber, T.T. (1987). Professional politics and the concepts of family therapy, family consultation, and systems consultation. Family Process 26, 153—166.

Yalom, I.D. (1985). The theory and practice of group psychotherapy. (3rd ed.). New York: Basic Books.

APPENDIX ONE

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FACULTY OF
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DEPARTMENT OF
PSYCHOLOGY

20 July 1994

Dear

I am writing to you in the hope that you will agree to be interviewed for my MA thesis research.

I am a graduate student in the Department of Psychology, Massey University. As part of my thesis research I wish to interview therapists who work with families. My aim is to gain an understanding of what therapists themselves mean by the term 'family therapy'.

In these interviews areas of interest will include whether therapists see any issues that arise in their work with families as particularly common; whether family therapy can be clearly distinguished from other work with families; and how therapists see their own background and training as contributing to their own therapeutic orientation.

This project has been approved by the Massey University Human Ethics Committee. An information sheet is attached, with more details about intended procedures for interviews, and for confidentiality.

I hope that participants in these interviews will find them an interesting opportunity to reflect on their work.

I will contact you by telephone within the next ten days to ask if you are willing to take part. I will be happy to answer any questions you may have regarding this project.

Yours sincerely

Lesley Phillips

Lesley Phillips

APPENDIX TWO

THERAPISTS' PERCEPTIONS OF FAMILY THERAPY CHARACTERISTICS

Information Sheet

The researcher is Lesley Phillips, a graduate student in the Department of Psychology, Massey University, working to complete a Masters thesis under the supervision of Cheryl Woolley, Senior Lecturer in the Department of Psychology.

Both Lesley Phillips and Cheryl Woolley can be contacted through the Department of Psychology, Massey University.

The study aims to investigate what Family Therapists and other Therapists who work with families perceive to be the distinguishing characteristics of Family Therapy.

Participants will take part in a tape-recorded interview lasting approximately one hour, at a time and place mutually agreed upon. They may be asked to take part in a follow-up interview at a later date. Participants will be given an opportunity to read any material that quotes from or discusses their interview before the thesis is bound, and at this point will be able to have anything they disagree with or believe may identify them removed.

Participants' time involvement will be approximately one hour for the initial interview, with the possibility of a further hour if they agree to a follow-up interview. The time taken to read material from the thesis containing quotation or discussion of interview material will vary.

Confidentiality of information given in the interviews will be protected throughout in the following ways:
(a) The interview tape(s) will be listened to only by Lesley Phillip
(b) Tapes will be transcribed by Lesley Phillips, and the transcript seen only by her.
(c) During transcription all names will be changed, and a list identifying participants will be kept in a locked cabinet separate from the transcripts.
(d) Tapes, transcripts, and any identifying material will be destroyed on completion of the project.

If you take part in the study you have the right to:

* refuse to answer any particular question, and to withdraw from th study at any time
* ask any further questions about the study that occur to you durin your participation
* provide information on the understanding that it is completely confidential to the researcher. It will not be possible to identify you in any reports that are prepared from the study
* be given access to a summary of the findings of the study when it is completed.

APPENDIX THREE

Consent Form For Interviews.

I, ... agree to be interviewed for a research project concerning perceptions of Family Therapists about their work, to be conducted by Lesley Phillips as part of an MA in Psychology at Massey University. This means that:

1. I agree to take part in a one hour interview, with a brief follow-up interview with the researhcer, at an agreed time.

2. I am free to withdraw from the research at any time. If I decide to withdraw, the tape and transcript will be returned to me.

3. Confidentiality of information given in the interview will be protected throughout in the following ways:

   a) The interview tape(s) will be listened to only by Lesley Phillips.

   b) Tapes will be transcribed by Lesley Phillips, and the transcripts seen only by her.

   c) During transcription all names will be changed.

   d) Quotations from the transcripts may be used in the thesis, but only in such a way that the person interviewed cannot be identified. Chapters of the thesis which contain quotations will be made available to me before it is bound, so I can ensure that I cannot be identified. Any material I regard as identifying will be removed from the thesis.

   e) Tapes and transcripts of confidential interviews will be destroyed within three months of completion of the thesis.

4. I am aware that the interview will cover my views about the nature of my work as a Family Therapist.

Signed ..... (Interviewee)

..... (Researcher)

Date .....

APPENDIX FOUR

1. Can you describe your work in terms of any most common or typical issues that families come to you with?

2. Can you describe the most common or any typical ways the families themselves interpret the issues that bring them to you?

3. How do you think families see your role?

4. How do you see your role?

5. How do you resolve any differences between these?

6. Do you see any common issues external to the family that contribute to their difficulties?

7. Can you describe anything in your background that you believe contributed to your becoming a family therapist?

8. Is there anything in your experience or training you believe has been particularly helpful?

9. Anything that has made your work more difficult?

10. Is there anything you think should be part of a family therapist's training or experience, or that you think is really important?

11. There are a variety of therapists and other professionals who work with families. When you use the term family therapy, how would you distinguish that work from that of other people who work with families?

12. Do you sometimes find a situation when what seems best for one family member isn't going to be good for others?

13. How would you describe your goals? For the family? For yourself?

14. Is there anything that prevents you from working in ways you would prefer?

15. What do you find most difficult?

16. What do you find most rewarding?

17. Would you like to comment on anything that hasn't come up that you believe is important?

APPENDIX FIVE

1. Does family therapy have unique characteristics? Would you distinguish between family therapy and family work?
2. Do you see whole families? If not, who usually comes?
3. Who or what is the client?
4. What do you think about the issue of continuing training and working on your own issues?
5. The issue of expertise has come up—who is the expert, and what sort of an expert?
6. With regard to referrals, why do you think CYPS and the Family Court call on family therapists?
7. Do they have powers to make decisions, and enforce them, with the people who are coming to you?
8. Does that affect the way you work with people?
9. How is the decision made to terminate therapy?

The following questions were included for therapists working in agencies:

1. Why does this agency offer family therapy?
2. Who makes the decision that family therapy is to be used?
3. How does a family come to be referred, rather than an individual?
4. Where does funding for family therapy come from?
5. Is there a set amount of time available for each family? How is this rationed?
6. How much freedom do therapists have when doing, or to choose to do, family therapy?
7. How are therapists assigned to do family therapy—is it part of everyone's job?
8. How are co-therapists assigned?

APPENDIX SIX

THERAPIST'S PERCEPTIONS OF FAMILY THERAPY

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FACULTY OF
SOCIAL SCIENCES

DEPARTMENT OF
PSYCHOLOGY

1. What was your original training (for example, Social Work, Psychology, Education, Counselling)?

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2. How would you describe your own theoretical orientation with regard to Family Therapy?

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3. Do you see yourself as following any particular school or model of Family Therapy?

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4. Which authors in the field of Family Therapy have you found especially helpful?

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5. Have there been any workshops or further training that you have found particularly useful?

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.....

APPENDIX SEVEN

Substantive codes	Axial codes	Selective codes
for particular problems when problem is with family/parents child cannot change unless family changes deciding not to use family therapy	deciding to use family therapy	**DISTINGUISHING FAMILY THERAPY**
joint history shared development currently living together a single unit self-definition relevance to problem	what is a family?	
the systemic approach cybernetics using two therapists comparisons with 'family work' comparisons with social work	differences between family therapy and other approaches	
problem solving power issues	distinctions between therapy and counselling	
	continuity between family therapy and other approaches	
being trained in family therapy having people skills	having specific skills	**BEING PREPARED TO DO FAMILY THERAPY**
coherence in theory and practice eclecticism	knowing different family therapy models	
the relationship between own work and practice knowing your personal limitations	having personal knowledge	
	being experienced and practised	
increasing skills staying in touch with others continuing own work supervision	ongoing preparation	
practical issues the co-therapy relationship	teamwork preparation	

APPENDIX EIGHT

Substantive codes	Axial codes	Selective codes
family's understanding therapist's own views family's expectations therapists' understanding of role resolving differences being a certain kind of expert	expectations and awareness	
accessing family's knowledge and skills		**IDEAS, ACTION,& OUTCOMES IN THE THERAPY PROCESS**
development as movement problems as 'being stuck' movement as progress therapists initiating movement therapists moving therapy moving therapy as a journey therapy as a place to be	moving	
	depth and danger	
goals negative outcomes compromise rewards	outcomes	
community fragmentation economic issues gender issues cultural issues	the relationship between society and the family	
tailoring therapy to attract funding direct influence of funders effects of competition for funds	institutional issues and family therapy	**ECOLOGY**
access to therapy schools interagency relationships		
	coercion	
	status and factions among therapists	