MOTHERS' EXPERIENCE OF FAMILY THERAPY:

'You're Not Human, You're Mum'

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ABSTRACT

The focus of this thesis is the in-depth analysis of the experiences of eight mothers during the therapeutic process known as family therapy. It examines their experiences in the light of theories of the helping process particularly those pertaining to family therapy, counselling and social work. Several strands are woven through the analysis, including the situation of mothers in contemporary society particularly the prevalence of blaming mothers when problems emerge with children, social policy developments since the 1980s which affect family therapy service delivery, and the feminist critique of family therapy. It takes account of the impact of patriarchy on family therapy delivery and contributes to the reflection on family therapy practice by providing the opportunity for mothers to comment about what it is like for them. The standpoint taken is that mothers have knowledge which tends to be rendered invisible by the preferential of expert knowledge of therapists. This thesis emphasises and presents the knowledge of the mothers with the intention of making it visible to all participants in the therapeutic process, both clients and therapists.

ACKNOWLEDGEMENTS

First and foremost I owe thanks to the eight women who took part in this research and shared their stories so fully with me. I am indebted to each and everyone of you.

Many colleagues have contributed to the thesis either through inviting their clients to take part or by commenting and discussing with me the ideas presented here. I am especially grateful to my supervisors Celia Briar and Mark Tisdall for their encouragement, criticism and advice; although sometimes I did not want to hear it.

The path to the completion of the thesis has been long and I am especially grateful to my patient husband who encouraged me to keep me working at it even when I was convinced that anything I might have to say was pure dross.

Finally but not least a big thank-you to my two sons, Nicholas and Benedict because without them the ideas underpinning this thesis would never have occured to me.

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CHAPTER ONE

INTRODUCTION

INTRODUCTION

The experience of mothers taking part in family therapy consists of a number of strands which combine to make up that experience as a whole. They range from social policy, to family therapy practice, through to interpersonal interactions, and the personal thoughts and feelings of the women who took part in the research. Each one of these strands interacts and contributes to the other. Likewise, analysis and discussion of each of these strands is woven through the text, with various strands receiving particular attention in the different parts of the thesis.

This introductory chapter outlines the development of the thesis topic beginning some ten years ago and culminating in the completion of the thesis. It traces briefly the development of the ideas which led to the thesis, from a personal experience to a political perspective which informed both the topic selection and its analysis. It includes a discussion of the process involved in determining the research topic; an outline of the aims and assumptions underpinning the project; and finally an overview of the structure of the thesis.

It now seems that given my own personal experiences as a mother outlined below; my interest in developing a feminist way of working as a family therapist; and an awareness of the hidden stories of women, the focus of this thesis on women's experience of family therapy was almost inevitable.

THE JOURNEY TOWARDS A RESEARCH TOPIC

The germination of the ideas which led to the development of this thesis and the focus of women's experience of family therapy originate from my own experience of some ten years ago as the mother of a toddler whose behaviour at the time was defined as "problem behaviour" by our family GP. As a result we were referred to a child clinical psychologist, against my will. My efforts to convince the GP concerned that this was something I felt able to handle and which I thought would resolve over time (which it

did) fell on essentially deaf ears. In fact, when I pressed the GP into not making the referral he intimated that he was concerned about the possibility of abuse and I felt, at that point, obliged to comply with the referral.

To date that experience ranks as one of the most painful and disempowering during my parenting. Looking back at it now, I see myself as somewhat passively complying with the pressure that was placed on me to accept the referral despite my conviction, which time proved to be correct, that the matter would resolve itself. The passivity has long since been replaced by an anger that I was treated summarily and a realisation that if this happened to me, a well educated woman, it is likely that it is happening to other women as well. It is no accident, then, that I have become more interested in a feminist perspective both in my personal life and in the development of my social work and family therapy practice.

A further influence on my personal and professional perspectives has been my discovery of some of my grandmother's story and the comparisons and marked differences between her experiences and those of my own. I have only the dimmest memories of her, as she died when I was three. Recently during a family gathering, while browsing through a family photo album, I came across a dreadful picture of her with my grandfather, when she was a young woman, with a toddler of about one year at her feet. She looked one hundred, and in the photograph she was visibly flinching away from my grandfather.
My grandmother's story reflects, I believe, the societal tendency to silence women's stories. Her story is almost invisible in our family history. It is there, but only to be gleaned in snippets and crumbs. It is unlikely that I will be able to determine the full story of her experiences as a woman in the first half of this century, yet that photo, painful though it is, confirms for me that destructive patterns can be changed, and the victims of them are not necessarily trapped into a problem cycle.

The gleaning of her story from photos is, I think, typical of what tends to happen to women in our society, our story is rendered invisible, it is hidden, and most often silenced. Spender (1982:5) eloquently describes the significance of the silencing of women's stories for the maintenance of a patriarchal society:

> Men have proceeded to describe and explain the world from their point of view, and have assumed that their partial experience of the world is all that exists. Women's experience is non-existent, invisible, and unreal from the outset.

During the course of my review of the literature and research I came to a realisation (one which did not surprise me) that family therapy itself was no exception to this. As Braverman (1988:7) points out:

> In the recounting of the history of the family therapy movement, the contributions of the women, most notably social workers of the 1920s and 1930s, are often overlooked.

Given that family therapy leapt into prominence at a time in our history when the overriding emphasis was to discourage women from active participation in the work force in order to ensure that returned servicemen had access to jobs it is unsurprising that women do not feature among the early writers of the 1950s (Cross, 1984; Statistics New Zealand, 1993). Indeed a cursory glance at the literature demonstrates that it is not until the second wave of the feminist movement in the 1960s and 1970s started to take effect that women began publishing in the family therapy field to any great extent. (Satir, 1967; Palazzoli, 1978; and Madanes, 1981 are examples). Furthermore, it has been only since the mid 1980s that the feminist critique of family therapy has gained a noticeable momentum (Braverman, 1988).

If women therapists are likely to be overlooked in terms of their contributions to the development of therapy then the experiences of women clients are even more difficult to determine. The literature is overflowing with research about particular techniques and methods of therapy, it is overflowing with theories and paradigms for explaining and understanding the family, but there is scant attention to the client's experience of family therapy and none that I have discovered which pays attention to women's experience. There is on the other hand, much family therapy writing which seeks to restrict the role of women in families or to blame them for the problems which exist within their families (Caplan and Hall-McCorquodale, 1985; Bograd, 1990).

This situation has its source in the early days of family therapy in the 1950s, when it was a new school of therapy and early efforts to establish it as effective and valid concentrated on theory development and scientific validity. (Such an emphasis is unsurprising given the influence of patriarchy on understandings of knowledge.) This is a preoccupation which continues today with writers such as Shields et al (1994) and Wynne (1988) arguing for more emphasis on quantitative and empirical research. This early emphasis has influenced the selection of knowledge which informed the theories and the access to that knowledge, leading to an emphasis on expert knowledge and an overlooking of the knowledge of the family members the therapists were working with. Gurman (1983)

argued that research into family therapy was needed by five groups of consumers: clinicians; theoreticians; students; clinicians from other disciplines who might be interested in family therapy. Family members taking part in therapy ranked fourth in the list, only ahead of those paying for the therapy and policy makers.

Family therapy, when it initially emerged as a way of working, was heralded as the long awaited solution to the problems which are experienced in dealing with the complexities of life (Goldenberg and Goldenberg, 1985). It has not proven to be this cure all. However, this beginning continues to be reflected in a tendency within family therapy to seize particular techniques and use them out of the belief that a particular technique contains the solution. Towns and Seymour (1990) argue that this tendency necessitates the need for more evaluation of family therapy practice. Despite the case put forward by Towns and Seymour (ibid) it seems that family members' needs for research let alone research into their experience of the process are low in priority.

Moreover, the feminist critique of family therapy, which provides a growing body of literature, has been primarily concerned with the attitudes of therapists and assumptions contained within the theory contributing to family therapy ideas about how families function within society. If there has been limited consideration of the experiences of clients in general, then women's experience in particular has been almost completely neglected, reflecting the subjugation of women's experience throughout society. Women's knowledge and experience tends to be overlooked and when it is noticed, it is not uncommon to find that it is defined as other than normal. This view that women's experience is subjugated and dominated by men's experience which is considered normal is discussed thoroughly in feminist critiques of social work, social policy and family therapy. An example of such critiques is that of The Personal Narratives Group (1989:3) who argue that:

> Traditionally, knowledge, truth, and reality have been constructed as if men's experiences were normative, as if being human meant being male.

This perspective assumes that experience and interpretation of the world is gendered and that the gendered experience and understanding of social reality leads to the subjugation of women. Wearing (1986:44) in her discussion of the work of feminist writers such as Millet suggests that:

> Men, by reason of their culturally constituted gender roles have the power to define women's roles for them and to value these traits less highly than their own.

The patriarchal structure of society and its impact on women, the family, and the development of family therapy is a central theme to this thesis. In my opinion as with many feminist writers, the development of patriarchy derives from a material as well as ideological base (Millet, 1971; Walby, 1990; Briar 1994).

AIMS AND ASSUMPTIONS UNDERPINNING THE THESIS

It is my intention that this research will not only take account of the impact of patriarchy on family therapy but that it will also contribute to the developing reflection on therapeutic practice by providing the opportunity for women to comment on their experiences of therapy.

I think that two knowledges pertaining to family therapy have developed over time. One pertains to the knowledge of the therapist, having as its domain colleaguial debate, family therapy training and supervision, and the academic milieu with its associated publications. The other is the world of the client group, which finds its expression in the so-called 'common knowledge'. This often pertains to the recommendations or otherwise that people seeking help pass on to one another about who to see and who to avoid. It includes the mistrust of the wider community about therapy and therapists. Neither aspects are referred to very often in the domain of the former.

I assume that the people participating in the therapy as clients are people who have knowledge, yet this knowledge tends to be invisible to themselves and to the therapist. The issue of who is defined or perceived as a knower is central to the thesis and is related to the suggestion of Foucault (1980) that knowledge is power and power is knowledge. It is likely that if the client is perceived as a knower in therapy then there is a direct challenge to the usual assumptions about the therapy which Chamberlain (1991:3) argues for. She states:

> I have observed that when a family or individual client enters the therapeutic space certain assumptions are made about the work to be done. The client however powerful in his/her own cultural/social/political context, assumes that the therapist is an expert in resolving certain kinds of problem. The therapist joins this assumption, taking on the mantle of expert, however powerful/powerless s/he may be in his/her own cultural/social/political context.

It is my aim that as the reader progresses through this thesis that she or he will be presented with information and argument which identifies these women as knowers in their own right. As Weedon (1987:7) argues:

> Rather than turning our backs on theory and taking refuge in experience alone, we should think in terms of transforming both the social relations of knowledge production and the type of knowledge produced. To do so requires that we tackle the fundamental questions of how and where knowledge is produced and by whom, and what counts as knowledge. It also requires the transformation of the structures which determine how knowledge is disseminated or otherwise.

I hope that the research will encourage therapists to examine their practice from the perspectives of their women clients and that it will encourage women to talk about their experiences and to demand a service which they find helpful and empowering. This ultimately leads to the making public those experiences and stories women know about but are kept invisible by their subjugation within the dominant patriarchal framework of our society.

Furthermore, I hope that it will provide the means for a greater understanding by therapists of what it is that is taking place for the client in the therapeutic process. It is my hope that it will encourage therapists to consider the experience of the client in addition to considering the techniques which they find to 'work'. The emphasis must shift from the interventions of the therapist to the way those interventions are understood by the people attending therapy. I hope that this heralds a more equitable relationship between therapist and client leading to an enriching dialogue between the two. This project, therefore, has the intention of publicising and validating the knowledges that exist in the latter group about family therapy.

I was primarily interested in the manner in which the participants made sense of the process of involvement in therapy. This derived from reading Goffman (1961) and Bateson (1972 and 1979) who each attempt to explain phenomena from a position of 'symbolic interactionism'. The key principle of this perspective is that: 'human beings act towards things on the basis of the meanings that the things have for them' (Blumer, 1969:2). This perspective is useful when applying a feminist analysis of data as it emphasises the meanings that people attribute to their experience, which was my intention in this project. Thus, in terms of women and patriarchy, the way in which women act towards the world around them is likely to be informed by their experience of oppression. There is much literature available which discusses the constraining effects of patriarchy on women (Millet, 1971; Oakley, 1973, 1974; de Beauvoir, 1974; Rich, 1976;

Chodorow, 1979; Cross, 1984; Joslyn, 1982; Lerner, 1983; Bryson and Edwards, 1988; Walby, 1990).[1]

Goffman (1961), within the framework of symbolic interactionism, in his classic work 'Asylums' examines mental illness and life in an institution for the mentally ill. He argues that mental illness or craziness is socially created and the definitions of such behaviour develop from the separation between patient and in this case doctor. Goffman begins to develop the notion of the significance of belief systems in determining the understanding or perspectives of what might more usually be taken as a given fact. He states (1961:127):

> The student of mental hospitals can discover that the craziness or 'sick behaviours' claimed for the mental patient is by and large a product of the claimants social distance from the situation that the patient is in and not primarily a product of mental illness.

The social distance which Goffman refers to in 'Asylums', also exists in the relationship between therapist and client. Howe (1989:58) established this in his research into the clients view of therapy. He pointed out that:

> What is a familiar routine and taken-for-granted way of operating for the therapist is a unique and peculiar experience for the family.

Bateson (1979:47) in his development of cybernetics (an early theory of family therapy) argues that it is context which provides meaning to a situation and importantly he suggests that: 'it is the recipient of the message who creates the context.'

Despite early theory containing insights such as those provided by the work of Bateson and Goffman, the focus in family therapy research continues to be on what the therapist is doing, rather than on how the action of the therapist is being received. The debate continues to be centred on the need for family therapy to continue to establish itself as a credible profession in the mental health field (Gurman, 1983; Wynne, 1988; Goldberg and David, 1991; Shields et al, 1994).

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[1] Recent debate in feminist theory has been influenced by post-structuralist thought, which critiques the notion of 'woman' as essentialising (Stanley and Wise, 1990; McNay 1992). The emphasis on diversity does have the advantage of preventing middle-class and white women's experience from being used to describe all women's experience. However it prevents any generalisations being made about women. This has the drawback of making unity and action more difficult to achieve. In view of the tendency to overlook the experience of women and clients in general, for that matter, in the therapeutic process I have decided that in order to highlight this gap to use the concepts of patriarchy and women as vehicles for explaining the observations arising from the research with the aim of working towards change.

Absent from the analysis presented in this thesis is a detailed discussion of the interventions of the therapist as part of the helping process. When a discussion of interventions the therapist utilised does appear it is within the context of the women's experience of those interventions, so they are presented as part of the women's observations of the therapist rather than as a direct analysis of the interventions themselves.

Furthermore this thesis does not explore the experiences of Tangata Whenua women in the therapeutic process. However,I think that it can be assumed that if women in general have been overlooked in analyses of family therapy it is even more likely that the experiences of Tangata Whenua women have been rendered invisible. It is outside the scope of this thesis to explore this issue at any length, although Waldegrave and his associates (1990) have begun to develop this issue in their work which was first published as 'Just Therapy'.

AN OVERVIEW OF THE THESIS

The thesis consists of four main parts: the context; methodological issues; data analysis; and the discussion and conclusion.

Part One, the context, provides an overview of the factors which influence family therapy. They include social policy analysis; attitudes to women and mothering; and family therapy theory.

Firstly, while there are no particular policies pertaining to family therapy an examination of social policies demonstrates that mothers' experience of family therapy is influenced by policies about the family, and family therapy service provision. The discussion includes a feminist perspective of social policy informed by the work of Pascall (1986) and Williams (1989). It includes a discussion of the role of women as the providers and receivers of social services; and the influence of libertarian policies on social services and mothers with the focus on two examples which pertain specifically to family therapy service provision: the New Zealand Children, Young Persons's and their Families Act (1989); and the growing practice of contracting counselling and therapy services. An analysis is provided of family therapy as a means of social service delivery. The chapter concludes with a discussion of the impact of libertarian policies on women seeking family

therapy. It is shown that women are disadvantaged as a result of the current emphasis in social policies on individualism, competition, and the market place.

The second major component of part one is a discussion of mothering which comprises chapter three. This chapter describes the changes to family structure; a feminist analysis of mothering and mothers and work. The chapter demonstrates that mothers are disadvantaged as a result of assumptions within society that they are the 'natural' carers. It examines how the role of mother constrains and influences the lives of women who are mothers. The chapter draws on the writings of feminist writers such as, Rich (1986) Chodorow, 1979; David, (1985), (1986), (1990), and Munford (1990). This re-emerges as a central theme in the data analysis section, where it will be seen that many of the participants commented on the ambivalence and struggles that were associated with the role.

The final chapter (Chapter Four) in this section of the thesis outlines the theories which inform family therapy. It includes a definition of family therapy and a brief overview of the three main schools of family therapy. The chapter concludes with an outline of some of the feminist critiques of family therapy, particularly in relation to the context in family therapy, gender, power, and the role of the therapist. As with the issues which are discussed in the preceding two chapters the themes re-emerge in the data analysis section.

Part Two of the thesis consists of Chapter Five which is titled 'Methodological Issues and the Method Utilised'. In this chapter, I consider the methodological issues informing feminist research. I point out that there is not a particular feminist method, but that a feminist perspective influences the way in which the researcher implements the method chosen. This discussion draws from the work of Roberts, (1981); Mies (1983); Jayaratne and Stewart (1991); and Stanley and Wise (1990). I then proceed to outline the method utilised, the ethical issues which arose during the course of the research design, and the steps which I took to address these. The research was designed to explore several key elements in the experience of the mothers including: the path to the point of referral; what it was like asking for help; their expectations of the therapy itself; differences and similarities between their expectations and their recalled experience; what it was like for them during the sessions; and between sessions; how they saw their relationship with the therapist; what it was like once they had finished the therapy; and their views of how the therapy affected the problem for which they initially sought help.

Part Three of the thesis consists of the data analysis. The women's experiences, and opinions about those experiences are presented largely unhindered by a contrived fitting to a theory of therapy. I have utilised a framework which reflects the stages of the therapeutic process. However, the perspective from which it is examined differs significantly, in that is it is the perspective of the mothers who took part in the therapy rather than that of the therapist.

There are four chapters in this part of the thesis and they reflect the key components of the helping process. Namely, the four significant stages in the counselling or therapeutic process (Siporin 1975; Rosenblatt and Waldfogel, 1983; Compton and Galaway, 1984; Chaplin, 1988; Barker, 1992). These are: intake; engagement; the helping relationship; and termination or the end of the counselling relationship. I have used these definitions as an organising framework as I consider they reflect the stages of the process as the mothers progressed through it. They also reflect the way in which therapists tend to conceptualise the process. Other major themes which I have utilised in the analysis include social policies, feminist views of therapy, and the societal expectations of mothers. For a feminist analysis of the therapeutic process I refer to Chaplin (1988) who has written a practice guide to counselling. As a comprehensive guide to feminist family therapy which encompasses the stages of the therapeutic process is not yet available I refer frequently to Chaplin in this part of the thesis. Where possible I include analysis from the work of feminist family therapists.

Chapter Six is titled 'Seeking Help' and it outlines, describes and analyses the experiences of the mothers at the beginning of the process. Chapter Seven is titled 'Meeting the Therapist'. It encompasses the mothers' experiences of the first session. It is shown that this session is of particular significance to the mothers and that most of them reported a high degree of anxiety at this stage of the process. Chapter Eight presents the information pertaining to the events which took place during the sessions. This includes the mothers' perspectives of their relationships with the therapist, their opinions about the effectiveness of the therapist, the interactions they observed between the therapist and their children, and the skills they saw themselves as learning from the therapist.

The final chapter in this section, is titled 'Events Outside the Therapy Room'. This refers to the experiences of the mothers between the sessions and at the termination of the therapy. It includes data pertaining to events which took place between sessions; the other resources used by the mothers; changes to the presenting problem; to whom were those

changes attributed; the decision to end the therapy; and the future plans, if any, for seeing the therapist. This chapter also includes a section discussing the situation of one of the participants whose counselling was still proceeding at the time of the interview.

The final section of the thesis is the discussion and conclusion section contained in Chapter Ten. This chapter provides an overview of the themes which emerge from the data analysis. It identifies the practice issues which emerge from the comments of the participants, the limitations and usefulness of family therapy, and areas for further consideration both by therapy practitioners and for further research.

PART ONE

THE CONTEXT OF FAMILY THERAPY

INTRODUCTION

I have identified three main components of the context in which family therapy takes place. They are: firstly, the social policy developments which inexorably reflect and influence our perception of what it means to be 'family' and 'woman' within that family. Social policy is based on particular assumption about the nature of the family and the prescribed role of women. The second is the role of motherhood within our society and the expectations of women within that role. The third is the family therapy theory which informs the work of family therapists and as with social policy is based on assumptions about 'the family' and women's role within it. The following three chapters present and analyze these themes in order to highlight those assumptions which constrain women into a socially prescribed role and are also likely to constrain the practice of family therapy and therefore women's experience of the process.

CHAPTER TWO

SOCIAL POLICY AND FAMILY THERAPY

INTRODUCTION

This chapter examines social policy as it affects mothers, specifically those mothers attending family therapy. It includes an analysis of how social policy influences the delivery of family therapy services. The analysis I present here is informed by the writings of feminist social policy analysts, most notably James, 1982; David, 1985, 1986, 1987, 1990; Pascall, 1986; Hanmer and Stantham 1988; Waring, 1988; Finch, 1984, 1989; Williams 1989; Gordon, 1990; and Bunkle, 1991 and 1992; Briar, 1992, 1994.

The chapter begins with an outline of a feminist view of social policy as this provides the framework which I use to explore policies affecting family therapy. The argument I present is that women tend to be disadvantaged through many social policies pertaining to the family, which contribute to ideological and material inequalities between men and women (Pascall, 1986; Williams, 1989; Gordon, 1990). I then proceed to a discussion of the role women have as representatives of the state and the effect of that role on both the women they are assisting and themselves.

In order to illustrate the context of the policies which are influencing family therapy service delivery I then provide a brief analysis of the changing role of the state in New Zealand since the 1930s particularly the impact of the libertarian philosophies since the mid 1980s. This discussion is significant, as one assumption informing my analysis is that the state through its policies influences the family and individuals within it (Finch, 1989; Briar, 1994).

This is followed by a discussion of two examples of social service policies which are influenced by those free market policies, and which have a direct bearing on the provision of family therapy, namely the implementation of the Children and Young Persons and Their Families Act (1989) and the trend towards contracting family therapy. The chapter concludes with a discussion of family therapy as a means of service delivery and the effect of monetarist policies on women who are seeking family therapy.

I have given considerable attention to the impact of free market policies in New Zealand because evidence suggests that, despite arguments to the contrary, women in New Zealand rather than having more choice and greater freedom as market policies take effect, in fact, have a narrower range of choices and less access to material resources (Briar et al, 1992).

The provision of family therapy is influenced by the same circumstances. The material presented will demonstrate that women's access to family therapy is affected by the inequalities within our social structure. These inequalities also influence the process of family therapy. However, this is discussed more fully in the following chapter.

The model of Pascall (1986:1) is followed in this chapter. She suggests that there is not a correct "feminist social policy" but rather feminist analysis is "about putting women in where they have been left out". This means a concern with the impact of social policies on women; and specifically, in this instance, with women seeking family therapy. Therefore, the following section outlines a feminist view of social policy, specifically that of socialist feminism, with particular attention to the assumptions which underpin social policies.

A FEMINIST VIEW OF SOCIAL POLICY

Williams (1989) suggests that socialist feminism provides the framework to consider both production and reproduction in social policy analysis. In her discussion of reproduction Williams considers both women's unpaid work generally, and the impact of the assumption that as mothers, women are responsible for the care of children. (Williams also looks at ethnicity). She suggests (1989:68) that socialist feminism analyses both production and reproduction by:

> Demanding the reorganisation of the sexual division of labour and an end to the divisions between paid and unpaid work. In terms of the welfare state this means recasting the concept of welfare in ways in which it no longer underpins female dependency or the sexual division of labour where caring is seen as women's work, and no longer privileges the male-breadwinner nuclear family.

In line with this perspective, the nature of the family and women's role in it has received considerable attention from feminist social policy analysts. Many feminist writers argue that historically women have been consigned to the private world of the family (Oakley,

1972; James, 1982; Millet, 1969; de Beauvoir, 1974; Rich, 1976; Pascall, 1986; Sapiro, 1990). Feminist social policy analysts such as James (1982) and Bryson and Edwards (1988) argue that the consignment of women to the private world of the family has been implemented by social policy which assumes that women will fill particular roles within society and that this consignment serves both the capitalist economy and the patriarchal structure of our society. James (1982:241) argues that as a result of these assumptions social policy is effectively a means of the social control of women. She states that:

> The state controls women through ideology, legislation, and policy. The family is an important site for the operation of all three.

She also discusses the separation of the private and public worlds and the relegation of women through capitalist market economies to the private world of the family. She points out that the family has 'become a retreat from the outside world, a source of love and emotional gratification' (James,1982: 239). It is women, James argues, whose responsibility it is to provide the love and emotional gratification. This is also a central theme for feminist family therapists. Pilalis and Anderton (1986:101), in their discussion of feminism and family therapy, point out that:

> The family is perceived by feminists to be a primary arena in which women suffer systematic social injustice because of their sex.

I will be returning to this subject several times both within this chapter, in relation to the effect of libertarian philosophies on the way in which social policies are currently implemented in New Zealand in my discussion of family therapy theory, and in the results section of the thesis.

Not only are women likely to be relegated to the private world of the family, they are also rendered invisible within it. This is occurring in two ways which again reflects the concerns of socialist feminism with class and gender. Firstly, the measurement of household income disguises the limited disposable income of women in relatively affluent households. Pahl (1985) has shown that there are high levels of poverty amongst women in households where their husbands earn a good wage. Furthermore, the Department of Statistics (1991:61) publication of the report of the Review Committee on Income and Wealth Statistics point out that the measurement of household income enhances the likelihood that women in this situation will be overlooked:

> Where women do not directly receive income it cannot be assumed that they share equally in the income of their households. As analysis of poverty focuses more and more on equivalent household income, the existence of

> poverty for certain individuals within households becomes more invisible. This is not exclusively an issue for women but predominantly so.

As the Review Committee has pointed out the measurement of household incomes rather than individual incomes means that women in married or de facto relationships may be deemed to be 'well off' when, actually, they have very limited disposable income of their own thereby rendering their situation invisible in the recording of statistics.

The second trend which contributes to the invisibility of women within families is paradoxically the growing tendency to use gender neutral language. While this has in part been motivated by the intention to free women from gender prescribed expectations Bryson and Edwards (1988:416) point out that attempts to introduce gender neutral language have masked the differences between men and women, thereby further rendering women's experience invisible:

> Moves towards a gender neutral terminology in the welfare field while apparently adopted in the interests of greater equality may have the effect of masking the differences between men and women as they confront the state. This masking is likely to lead to the perpetuation of the situation we have demonstrated of women's subordinate position, as dependent rather than independent agent.

An excellent example of this is a media release on the commercial radio network news on the 12th of September 1991 by Dr. John Eastwood of the Department of Health on cot death prevention which "urged families to breastfeed their babies." This is a fascinating picture of the Health Department's understanding of the role of women in the breastfeeding relationship. It contains the potential to inspire many entertaining satirical cartoons depicting families breastfeeding. For the purposes of this thesis it is noteworthy that the term 'parents' has come to be used by policy makers even when it is clear that mothers are being referred to.

I have shown that a socialist feminist analysis of social policy is concerned with exposing those aspects of social policy which enhance both patriarchy and capitalism thereby contributing to the ongoing marginalisation of women. Such policy analysis contains the potential to lead to policy developments which acknowledge the importance of nurturing and caring with the result that the responsibility for the provision of what I regard as a human need is shared by both women and men with a consequent widening of choices for both. Therefore, it will mean that the caring which it is currently assumed women do, will be recognised as a significant and vital contribution to our society in

general. It will not continue to be rendered invisible or defined as something which 'the community' provides when in fact women within families are providing the service.

WOMEN AS REPRESENTATIVES OF THE STATE

Women are active within the state both as the providers and recipients of welfare. Gordon (1990:9) begins her paper discussing the feminist analysis of the welfare state with the somewhat bald statement: 'If the state were a family, it would be assumed that welfare is a woman's affair.' This reflects the attitudes and beliefs within our society that women are the ones primarily responsible for caring whether they are providing the caring as representatives of the state or seeking caring assistance, usually for members of their family (Habib and Langral, 1977; Finch, 1989; Gordon, 1990; Hockey 1990).

An examination of the differing roles of women within the state as the providers and receivers of care when examined, highlights an uneasy relationship between professional women carers and the women who receive care from them. Women family therapists for example share the struggles of the women who they see in the course of their practice and are certainly manipulated by the policies of the state in not too dissimilar ways. David (1985:30-31) discusses this in her analysis of the relationship of motherhood and social policy. She argues that the acceptance of the paid caring of some women, that is, social workers, teachers, nurses, as compared to the unpaid caring of mothers leads to a situation where women are judging women and those being judged are usually women who are filling the role of primary caretakers of children. Mary Daly (1978:132) describes this as women becoming "Token Torturers"; where women implement the practices which maintain patriarchy. This is supported by the findings of Bryson and Edwards (1988) referred to earlier who suggested that the welfare state contributed to gender differentiation. The effect of this is to set women against women and deter them from noticing that it is patriarchy which is in fact being maintained through such practices.

Family therapy is, at times, an active participant in this process. The challenge to feminist therapists is to find a way of practising which does not covertly support this process. Judith Cross (1984:63) argues that:

> As family therapists we must question the degree to which we are agents of social control, propping up an institution that in its traditional form is often so damaging to women.

The reader will see that the women in this project were alert to the analysis of the therapists and in some cases it appears that the discussion of this analysis had considerable influence on the women's perception both of the therapist and the outcome of the therapy. For example, Jenny commented that her therapist was 'on to it' about the situation of solo-mothers. This suggests that Cross' call to attend to the degree of social control within therapy requires urgent attention.

To summarise, the role of women as the carers and nurturers in the family setting and as professional carers such as social workers, nurses and family therapists remains firmly established. Because this work is undervalued (or even unvalued) in terms of pay, women remain materially disadvantaged by their gender roles. Pascall (1986:66) suggests change is required both in the means of production and in the nurturing roles within the family:

> Change, then depends not just on finding women a place in the public world but also on changing the relationships of reproduction in the family.

This might mean changing both the value which we give unpaid work, improving the access to childcare services, and challenging the notion that mothering comes 'naturally' to women. The next section examines the influence of the 'new right' on women. I demonstrate that the policies associated with this political perspective in fact exacerbate the already disadvantaged situation of women.

MOTHERS AND THE ROLE OF THE STATE IN NEW ZEALAND

The state influences both families and the individuals despite an apparent absence of a clear family policy (Briar, 1994). The role of the state in social policy has tended to vary according to the prevailing political philosophies of the time. Armstrong (1990) points out that between 1930 and the present day the role of the state has moved from 'social democratic consensus' which was characterised by interventionist policies; to a transitional period between 1960 and the mid 1980s, characterised by a mix of interventionist and non-interventionist policies; to the economic liberalism characteristic of current social policies. The latter has led to the dismantling of the welfare state as a result of libertarian philosophies which emphasise the importance of the market place,

freedom of choice, and the provision of social services through the voluntary sector and the family (Williams, 1989; Shirley, 1990; Armstrong, 1990; Kelsey 1993).[2]

This section of the chapter examines the impact of the economic liberalism and the associated free market policies on mothers attending family therapy. It is argued that the situation of women is deteriorating as a result of policies which emphasise individual responsibility and competition and assume that applying the principles of the market place to social services will lead to a more efficient and effective social service delivery through targeting, and user pays. A further premise is that the consumer will have a greater range of choice (Shirley, 1992:7).

The shift from state responsibility for the well-being of the community to an individualistic approach is based on the argument that the welfare state is, as Williams (1989:26) describes:

> Morally disruptive by sapping people's initiative and self-reliance and inducing them into states of dependency upon provision. Social security, it is argued, removes people's incentive and responsibility to find work.

Consequently, there has been a reduction in social service provision by the state and a corresponding emphasis on voluntary work as a means of providing social services. Shirley (1990) points out that the competition of the market place has also been introduced into the community so that community groups which once cooperated together now compete for resources with the effect that community groups which might have worked together to resist such policies are now each preoccupied with their survival.

A review of the Treasury Briefing Papers from 1984 until 1990 illustrates the implementation of this philosophy in New Zealand. They emphasise the importance of voluntary work as a means of reducing the financial costs to the government of social service provision based on the argument that we cannot afford alternatives. This is an argument repeatedly put forward by Finance Ministers in recent years and the Business

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[2] The implementation of these policies after the election of the third labour government in 1984 have lead to sweeping changes to the infra-structure of New Zealand society. I realised their far reaching impact when my twelve year old son asked: "What are free market policies". In my explanation I described the interventionist policies of the Muldoon era. He could not conceive of such a way of organising things. My younger son wondered if in those days hospitals were closed down! Just as I grew up assuming that the Welfare State was the way society worked they are growing up with the assumption that the current way of organising our society is the way it has always been. Their questions and comments suggested to me that ten years on, free market policies are merging into the fabric of New Zealand society in the way that the Welfare State did beforehand.

Round Table although it has yet to provide evidence to support it (Post Budget interview of Ruth Richardson interview on 31st July 1991, screened on One Network News; Post Budget interview of Bill Birch 30 June 1994 screened on One Network News; New Zealand Business Round Table, 1992).

The emphasis on the role of the individual and the family in the Treasury briefing papers increased between 1984 and 1990. Not only do the 1990 briefing papers emphasise the importance of these social groups in providing social services and the concomitant reduction in the role of the state in the direct provision of services, they go so far as to argue for a social control role for friends and family. The Treasury Briefing Papers (1990:102) state:

> Neighbours, family and friends are able to use information on personal effort and motivation to assess the extent to which the needy are suffering from events beyond their control, or whether they are neglecting opportunities to meet their own needs.

This makes explicit that when people require assistance as a result of their own actions then somehow they are less deserving. I think that this attitude percolates through the implementation of social policies and is detrimental to mothers given that they are already likely to be blamed and perceive themselves as at fault when they encounter problems, reflecting the change in stance. What was once social security which all could rely on, from the state, is now social assistance to those who, through some personal shortcoming, are unable to provide for themselves (Jenny Shipley, 1990). Furthermore, such an approach increases the tension between the women employed by the state as carers and those receiving the assistance.

There has been little evaluation of the potential drawbacks by those spearheading the new direction. The emphasis is on the market economy with the assumption that the good of the community is served by meeting the needs of the market place. The community has witnessed the gradual undermining of resources, such as the reduction in income support benefits; the withdrawal of health and education services across the board, with the widespread closing of hospitals, and the limiting of services to children with special needs (Briar, 1992; Shirley 1990, 1992).

To a large extent this has been disguised under the rationale that the welfare state did not work, that in fact it served to support the well off. While there is some truth in the notion of 'middle class' capture, the use by better off people of state services for which they have paid through taxation is not in itself an indictment of the system of state provision

of social services. The provision of counselling and family therapy services on a universal basis is necessary for women because of the material constraints which impinge on the ability of women to finance such assistance themselves.[3] This is not only because the income of women is likely to be lower than that of men, but as I have shown previously the tendency to measure household incomes overlooks the poverty of women within households even those where the income is considered to be high.

Currently, the steadily reducing investment in social services in real terms in New Zealand means that those services which are free to consumers are under growing pressure[4] and women who are eligible for them are experiencing considerable difficulty in gaining access, as was the experience of the women in this project. The difficulties they encountered ranged from incorrect advice, to being placed on a long waiting list, to being passed from agency to agency and/or worker to worker over a period of years. The barriers to assistance conveyed to this group of mothers that they must sort their situation out for themselves and contributed to their already developed sense of blame for their situation. It made it more difficult for them to see that their situation was a function of the structure of society.

State provision of social services conveys a message and meaning about our responsibility to each other and cooperation which contributes to the well-being of members of community. This is supported by Finch (1989:90) who found that:

> When the pressure is taken off a little by the provision of some state support, people are actually more willing, not less willing, to give their relatives some assistance.

Based on recent research it is questionable whether we can afford not to invest in social services. Gartner (1991) compared family structure, welfare spending, and homicides of children in developed democracies. She found that New Zealand shared the highest homicide rates of children in the 1 - 4 years age bracket with the United States. Gartner suggested that certain types of family structure such as teenage or single parenthood; non-intact families (separated parents); and families with many young children are likely to increase the risks of child homicide. She argues that people in these types of family

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[3] A tension exists here between the necessity for universal provision of therapy and the possible harmful effects of motherblaming in therapy. So, in arguing for universalisation I believe that at the same time it is necessary for family therapists to be addressing the way in which they practice.

[4] The media is constantly reporting examples of long waiting lists, for example: a six month waiting list for methadone treatment in Dunedin (National Radio News 21/9/94); and waiting lists for children for sexual abuse counselling (Morning report 16/8/94).

structure have reduced access to resources and when that is combined with lower levels of social service spending the child homicide rate is likely to be higher.

It would seem that where there are teenage or single parents, non-intact families, and families with many young children as in New Zealand (Statistics New Zealand, 1993) the ability of women to provide the social services which are no longer provided by the state is substantially reduced with dire consequences. The results of this study are alarming and highlight the importance of a critical review of the impact of social policies which emphasise individual self responsibility and competition. While this research highlights an extreme situation it is apparent that mothers are paying a high price as a result of the reduction of the welfare state.

This research takes on particular significance when considered in the light of analyses of the expectations of women in an economic and political environment characterised by social service retrenchment. Finch (1989) has pointed out that at times of economic retrenchment the pressure increases for family members, usually women, to assume responsibility for each other. This is a view supported by Bunkle (1992:10) who points out:

> The libertarian right needs the invisible labour of traditionally defined women. It needs them to do all the things the Welfare State isn't going to do. It needs us to be 'the community'.

Thus, it can be seen that the pressures on women at such times increase.

TWO EXAMPLES OF LIBERTARIAN POLICIES INFLUENCING FAMILY THERAPY

The Children and Young Persons and Their Families Act (1989) and the practice of contracting out therapy both affect the provision of family therapy, therefore, the following discussion analyses the impact of libertarian philosophy on these policies. Firstly, the legislation itself contains the potential for innovative social work practice but is severely constrained by lack of resourcing and assumptions concerning the role of women in families. Secondly, the practice of contracting out is a reflection of market policies with the social work task broken down into brokerage and counselling or therapy. The discussion here is concerned with examining the rationale behind the

practice of time-limited contracts as they were the subject of much discussion by the women in this project.

The Implementation of the Children, Young Person's and Their Families Act (1989)

This legislation, despite its innovations in family decision making and the concomitant potential for bicultural practice, is limited by two factors: the first is inadequate resourcing, about which there is growing debate; and the second, assumptions about the role of mothers in families. The latter has received negligible attention in the growing body of literature pertaining to the act.

I think that these two factors combine to reduce the act to a vehicle for monetarist policies. This has occurred because at the same time as the act has emphasised and encouraged family decision-making the resources to support those decisions have gradually diminished. This is a matter raised by Laurenson (1993:21) in his discussion of the implementation of the legislation. He argues that economic forces are undermining its effectiveness:

> There has not been an increase in funding to match this increased referral rate. Agencies are having to get by on resources which are not in keeping with the service expected of them.

Both the Department of Social Welfare's internal review of Care and Protection Family Group Conferences (FGCs) (Paterson and Harvey, 1991) and the Ministerial Review Committee have raised concerns about the lack of resourcing available to implement the intent of the legislation. The report of the Ministerial Review Committee (1992:30) states:

> Undoubtedly the severest criticism has come from paediatricians, nurses, hospital social workers, and others involved in areas of child abuse. Again and again they emphasise the need for a time-framed follow up of FGCs and *access to adequate financial and personal resources* [my italics].

Without adequate resourcing the legislation, through the innovation of the FGC reflects the trend towards the privatisation of welfare, with the family or whanau, hapu and iwi being given the responsibility for finding solutions to problems with children and young people.

The second factor I raised above is that assumptions about the role of women in the family influence the outcomes of FGC. The legislation itself and much of the debate

around it repeatedly refers to the family. However, there is no analysis of power differentials within family groups. The FGC process in fact assumes that all family members have equal power (Barbour 1990). However, as discussed at length in the first part of this chapter much feminist analysis of the role of women in families suggests that women are disadvantaged both by gender and class and that the locus of this disadvantage is the family (Rich, 1976; David, 1985, 1986, 1990; Finch, 1989; Williams, 1989; Gordon, 1990; Briar et al 1992). Therefore, as FGCs are aimed at family decision-making, women in my view, are unlikely to have an equal voice in the process.

To date, there has been little comment on the impact of this important development in social work practice on women in the literature despite two issues of the Social Work Review, February 1991 and December 1993, being devoted entirely to reviewing the implementation of the Children, Young Persons and Their Families' Act. There was not one mention of the role of women in the family or in the FGC process. Barbour (1991:20), however did mention that: 'there is no guarantee that everyone in the family group gets a fair hearing at the FGC'. I think that it is likely that due to their disadvantaged position (discussed earlier) women will be expected to carry out the 'family' decisions and also be blamed for the problems for which they are seeking assistance. (Anecdotal evidence from social workers suggests that this is precisely what is happening.)

Social workers with whom I have contact have raised this issue many times in discussion with me. For example at one FGC recently, a mother (in receipt of the Domestic Purposes Benefit) struggling to get her difficult teenage daughter to attend school was repeatedly criticised by her family, for a perceived inability to manage her budget effectively, so that she could ensure her daughter had adequate clothing. This was despite a report from the budgeter supporting the mother concerned. This example reflects the observation of the 1990 government briefing papers referred to earlier, of the role of neighbours and family in monitoring the efforts of individuals, in this case the mother, to address her problems. In this example she was blamed for ineffective budgeting despite evidence to the contrary. Furthermore, it was overlooked that the Domestic Purposes Benefit is set at minimum levels (Waldegrave and Conventry, 1987, Briar, 1994). If the example provided above is more than an isolated incident, the blaming of mothers in the FGC has implications for women and their families referred to family therapists following an FGC. It is likely that the women who have found themselves to be blamed and subsequently referred to family therapy will expect that they

will be further blamed in the therapy. This is supported by the comments of the women in this project for whom the fear of being blamed was a major concern. Moreover, it perpetuates the idea that the problems are situated in the individual rather than a result of the inadequate distribution of resourcing.

The Department's internal review of the outcome of FGCs also noted that counselling and/or assessment was the most likely service to be decided upon at the FGC (Paterson and Harvey, 1991:37). It should be noted here that a distinction was not made between counselling and family therapy. A decision only to refer to counselling or family therapy where problems arise from lack of resources implies that the problems are psychological in origin rather arising from the stress associated with a lack of resources and the responsibility for dependents. Both Ungerson (1985) and Rich (1976) have discussed the strain experienced by women when they themselves are dependent (whether on the state or a husband) and have the responsibility for dependents. While counselling or therapy may be able to assist women to manage the strain it does not provide change to the structural features which contribute to it. It is likely that a redistribution of resources and valuing of the unpaid work which it is assumed that it is 'natural' for women to do is required before the situation of mothers will improve (David, 1986; Pascall, 1986; Waring, 1988; Williams, 1989; MacKinlay, 1992).

Arguably, the Children and Young Persons and Their Families legislation represents the shift of welfare to the private base of the family. It is an excellent example of social policy which at first glance appears to provide the opportunity for greater self-determination by family members but when examined more closely it sustains the trend within our society to attribute the caring to individuals, especially women and Maori with a concomitant reduction in resourcing.

It is important to point out, however, that there are advantages to women in the non-interventionist policies which underpin this act. For example, women are now less likely to have their children removed from their care by the State. According to Koopman-Boyden and Scott (1984:72) in 1982 there were 6588 children in the care of the state. According to a One Network News item about foster care screened on the 26/9/94 the number of children in the care of the state had reduced to three thousand.

While this change may be potentially beneficial to women and their children, its success depends on the availability of alternative resources to assist them in dealing with the problems they are facing.

Family Therapy Contracts

A further example of the influence of libertarian policies in the social services significant to the women in this project has been the development of time - limited therapy contracts. Those agencies which contracted out the therapy for the women in this project, the Family Court and the New Zealand Children and Young Person's Service (NZCYPS) have a policy of time -limited contracts which limit the total number of therapy hours available to families. The practice of contracting out in the NZCYPS developed as part of the implementation of the Children, Young Person's and Their Families Act (1989). The practice in the Family Court commenced with the establishment of the Family Court itself (Heugten, 1994). In attempting to determine the rationale behind this I spoke to both a practice consultant with the NZCYPS, Jim Murphy, and a Family Court counselling coordinator.

Jim Murphy commented that the primary consideration for limiting the counselling hours was budgetary, to ensure that the department was able to operate within its annual budget. He identified a secondary consideration, which he referred to as very much secondary, as the intention of the department to fit with the overall government philosophy that any intervention ought to be time-limited and focused in order to encourage self-sufficiency and self-responsibility of the client group. The possible issue of the most effective number of counselling hours in order to effect change was not raised. The Family Court Counselling Coordinator also commented that the six hour limit arose from budgetary restraints and that because of a growing demand on the service a proposal had been put forward to restrict the number of sessions from the current six to five. Their comments suggest that the overall philosophy of the market policies which encourage individual responsibility and discourage reliance on the state is experienced at the local level as budgetary constraints. These budget restraints are the means by which the government is implementing its policy. This is reflected in the comments of Buster Curson (1994), President of the New Zealand Association of Social Workers, (NZASW), who commented that he regarded the contracting out of services to private practitioners as part of the government's philosophy to divest itself of any role in the direct provision of social services.

It is interesting to note that the optimum number of sessions necessary to effect change has not been a feature in determining the length of the time limited contracts, at least not

at the local level where the policy is implemented. While this seems a logical research area Barker (1992:252) in his discussion of contract setting and termination said that:

> While some therapists use time based contracts and others do not, no scientific study of the respective results seems to have been carried out.

FAMILY THERAPY AS A MEANS OF SERVICE DELIVERY

It is interesting to speculate whether the rapid changes in family structure combined with firmly held ideas of what it means to be family have lead to the upsurge in family therapy in New Zealand over the last ten to fifteen years. As mentioned earlier the women who took part in this project saw family therapists who were based in one of three different agencies: health; a church based agency; and a private practitioner. These differing settings for family therapy influenced the participants experience of the process and reflect Foucault's (1980:119) notion of the dispersal of power discussed in the following chapter.

In the health sector it appears that the decision to use family therapy rested with the individual practitioner rather than as the result of a policy decision which identified family therapy as a preferred means of service delivery. A review of the draft service goals for the agency in the health sector covering the period during which this research was undertaken shows that family therapy per se did not receive particular mention although members of that organisation were utilising family therapy as a way of working with the clients (Trotter, 1991).

While some of the participants in this survey were referred to a therapist by NZCYPS, the review of Care and Protection FGCs conducted by Paterson and Harvey (1991) records only the number of conference decisions recommending counselling. These findings did not separate out the percentage who were referred to family therapy. Thus, it is unclear whether the referrals were a policy decision based on the idea that family therapy is more effective.

This was not the case for the agency in the voluntary sector. In this agency family therapy appears to have been adopted as the preferred means of operating as the result of the policy implemented by the agency director. His experience has been that family therapy is the most effective method of intervention for breaking that which he refers to as the dependency cycle. He argues that this effectiveness is due to the ability of family

therapy to take account of the context within which clients live out their daily lives. He argues that this is dependent on a high skill level and good quality supervision, both of which his agency have given a high priority (McDonald 1991). This approach reflects the influence of Waldegrave and his associates (1990) who have a well developed contextual approach to family therapy and who were utilised extensively by the agency concerned for training when the agency was in the process of being established.

In addition to the changes in social service delivery characterised by contracting out, coping with shrinking budgets in all of the agencies concerned takes much needed energy and time away from issues concerning the client group for which the agency purportedly exists. This is discussed by Kayrooz (1993) in the Network News section of the Australian and New Zealand Journal of Family Therapy. Her conclusion was that therapists and families are under considerable pressure. For example at one Child and Adolescent Health Centre in Australia, referrals had more than trebled over a ten year period. This meant that families were often on a waiting list for up to two months. The practitioners had responded by introducing a 'blitz day' which involved screening assessments of families to facilitate the quick turnover of cases. Kayrooz (1993:98) interviewed one of the team members:

> With this procedure, Terry [the child psychiatrist at the centre] suggests the family must quickly understand its responsibility for change and the clinician must struggle with the feelings that can accompany a premature closure... Terry suggests that the client may often feel dissatisfied under such a system of quick turnover, which in turn has effects on the job satisfaction of the personnel.

While this is an Australian example the situation in New Zealand as mentioned earlier is similar with waiting lists as part of the mental health service and for private practitioners now a common feature of the social services.

The voluntary sector has also been significantly affected by changes in policy concerning funding. The voluntary agency referred to earlier has had their level of government funding drastically cut with the agency forced to consider other alternatives in order to survive (McDonald, 1991). This is a widespread phenomenon rather than particular to just this agency with the result that voluntary agencies are shifting from their focus as social change agents to a concern with their survival (Koopman-Boyden, 1992).

Koopman-Boyden (1992:14) also suggests that at the same time as having to cope with budget restraints the expectations of the voluntary sector are rising:

> Indeed, the role of volunteer agencies is changing very rapidly in today's society. With the demise of the welfare state and the 'quiet revolution' in responsibility for society's caring work, volunteer agencies are being asked to take over much of the work previously undertaken by the state.

The Impact Of Social Policies On Women Seeking Family Therapy

If, as Hockey (1990) suggests, women are the family members who usually seek assistance from social service agencies then the market philosophy in social policy has particular implications for women. The market is presumed to provide the necessary controls but, as Kendrick (1989) points out, it is assumed that the consumer will be articulate and well informed and able to shift her trade elsewhere. It is questionable whether women who seek help because of stressful family situations fall into this category. The reader will see in the results section that one of the participants questioned her ability to advise the referring agency if she found the therapist did not provide the service she was seeking.

The market philosophies have led to less money available in the provision of social services as the government places emphasis on other sectors of the economy and implements its policy of individual and community responsibility. As the rate of unemployment has increased there has been a greater demand on the social services as families experience higher levels of stress. The growth in demand combined with reduced spending in the social services has made access to family therapy in the public sector more difficult. In the region where this research was undertaken one family therapy team operated by the NZCYPS has been closed down and the other was about to close.

A few, whose income can support it, seek family therapy privately, and the remainder must gain access through the public or voluntary sector. The latter was the case for all the women in this project. As discussed in the following chapter, the earning power of women (especially mothers) is significantly less than that of men. This, combined with the difficulty women experience in obtaining access to employment, the low wages they receive and the high costs of childcare, renders the option of private therapy unaffordable to most mothers with dependent children. It is significant that none of the women in this study paid for the therapy they attended themselves.

While it could be argued that the women were able to obtain access to the therapy through the benevolence of the state I think that this is an indication of their dependence

due to the limitations in their income. Ungerson (1985) points out that it is both dangerous and stressful to the mothers and their children that at the time when women have dependents for whom they are responsible they are also likely to be dependent either on their husband or, as in the case of most of the women in this study, on the state in order to meet those responsibilities. There are no guarantees for the women that either their partners or, when they are on the Domestic Purposes Benefit, the state, will perceive the needs which they themselves have identified for the children. For example, the reader will see that Brenda, who was a sole parent and dependent on a benefit income, had extraordinary difficulties in gaining access to the assistance which she required for her son. She was reduced to threatening to abandon him on the door step of social welfare to get anybody to listen to what she was saying. Even Rose, who worked four days a week, and had a measure of independence, relative to the other women in the study, was constrained by her husband's interpretations of the needs of her son. She commented that she was under pressure from her husband to adjust her working hours so that his responsibility for childcare was reduced.

The financial constraints leave women with the options of attending therapy through the health sector, with the associated waiting lists or obtaining funding through agencies such as the NZCYPS or Family Court. This immediately increases the element of social control into the therapeutic relationship. In order to obtain the funding the woman must meet the criteria of the referring agency. This usually involves participating to some degree in a procedure which potentially increases her marginalisation through a process which involves the assessment of her situation by helping professionals. It will be seen that this was of significant concern to most of the women in this project at the time of referral. They all referred to anxiety that they would be blamed either by the therapist or 'people' for the problems they were experiencing.

The difficulties in attending therapy once access is obtained are exacerbated for women who are also dependent on benefit income to support themselves and their children. As Waldegrave and Conventry (1987) and Briar (1992) point out the benefits are set at a level which allows the women to barely provide for the care of themselves and their children and a minimum level of participation in the community. Therefore extra costs such as travel to the therapist become hurdles to their attendance. The growing waiting lists and pressure on therapists to maximise the number of people may contribute to the therapist expecting the client to come to them as was the case for the women in this sample.

Once access has been established with an agency the type of service provided is inexorably influenced by the social milieu within which it operates. This means that assumptions about the role of women in providing care either for children or other family members which influence social policies also influence the family therapy service delivery. Family therapy practice which is not informed by an analysis of the position of women in families is likely to reinforce the traditional roles of women. The feminist critique of family therapy which I briefly outline in chapter four provides an analysis of the impact of patriarchal assumptions on family therapy practice.

SUMMARY AND CONCLUSION

The reduction in social service spending in real terms in New Zealand is part of a trend towards a society where the emphasis is on competition rather than on responsibility for one another. The argument as outlined by Birch (1994) is that the country cannot afford alternative strategies. Such an argument does, however, beg the question: can we afford the potential costs, which are suggested in the study by Gartner (1990) of the solutions we are experimenting with at the moment? Moreover, current policy directions are leading to more inequalities for mothers as the emphasis on individual responsibility and competition for scarce resources takes effect.

Women working in the social services, whether as family therapists or in the provision of other social services are forced to question the effectiveness of the services they offer in addressing women's oppression. Finch (1984:16-17) argues that:

> The only intellectually honest position is to admit that non-sexist caring policies are NOT possible without such a transformation [structural change] and - until it happens - we must abandon the quest for them.

If we are to do as Finch suggests for many women continuing to provide services would, I think, become untenable as they come face to face with the stark realities of implementing policies which perpetuate womens inequality. However, it is apparent that the efforts to date have not effected the structural change which is required. It is arguable that the view of Finch is one that needs to be applied to family therapy, but as she herself asked what do we do in the meantime to address the misery that so many women face in their daily lives?

If social policy is being developed which still continues to assume that women are the primary caregivers in society, that undervalues or ignores our work and that assumes that as mothers we have the responsibility for the nurturing of children, then it is likely that the provision of family therapy within that context will tend to reinforce these attitudes and as Finch says, reconcile women to their lot.

I think that family therapy will inevitably fall into such a performance unless the practitioners have a well developed feminist analysis which they are able to operationalise in their day to day practice. Effective therapy requires both an analysis of the situation of women, as it is influenced by social policy and attention to women's experience of the process of therapy. The provision of family therapy only, to assist women to address their situation is insufficient. Mothers also require material assistance which is aimed at reducing poverty and enhancing their ability to meet the needs of their children. Williams (1989:17) argues that:

> State assistance [is] important for the amelioration of women's lives but also reinforces female dependency and the sexual division of labour.

So, it seems that while the reduction of state intervention has disadvantaged women the solution is unlikely to lie in a return to interventionist policies.

CHAPTER THREE

MOTHERHOOD

INTRODUCTION

The aim of this chapter is to provide the context for understanding the experience of mothers during therapy, by analysing the factors which influence the experience of women as mothers. Women, at the time they are seeking help for their families, are marginalised due to three fundamental factors; they are women, mothers, and finally mothers needing assistance. It is my opinion that this marginalisation derives firstly from, as Millet (1971) suggests, the power which men have to define what it is to be women; and, secondly the societal prescriptions concerning mothering (Chodorow and Contratto 1982; Caplan and Hall-McCorquodale, 1985; Wilkinson, 1986;). These issues underpin the discussion of the following: changes to family structure in New Zealand, mothering, mothers and work, and motherblaming. While the role of mother is a central component to most women it will be shown that the role also constrains their lives due to assumptions about the way in which that role ought to be performed.

CHANGES TO FAMILY STRUCTURE

Social policy affecting women and the family is based on assumptions about how the family ought to be. The family is one of the basic institutions of society which, to a large extent, has remained a sacred concept to most people even though their lived experience of family is different from the widely purported view of what it is to be 'family'. The idea of the family as constituted by the traditional nuclear family characteristic of European culture, despite being a relatively recent phenomenon, (that is, a development alongside industrialization) remains a strongly held creed in New Zealand (Hyam and Webster, 1990). Perhaps it is this adherence to the importance of the family which has allowed the libertarian policies with the emphasis on the family as the primary unit responsible for the care of the members of our society to be implemented with relatively little questioning.

The last twenty years have seen a dramatic change in the actual structure of the New Zealand family. These changes have been reflected in the legislation pertaining to the

family, particularly in the establishment of the New Zealand Family Court in 1981. Coinciding with the establishment of the Family Court were several pieces of legislation which made it easier for women to leave unsatisfactory relationships. These included the Domestic Protection Act 1982, and the Family Proceedings Act 1981. The former made it possible for women to obtain protection from violent partners, the latter introduced the availability of counselling through the Family Court system. The extent to which this has been utilised was unexpected, and Marriage Guidance (whom it was originally intended would receive the bulk of referrals) quickly becoming overloaded which resulted in an associated rise in referrals to private practitioners (Maxwell, 1989).

The Royal Commission on Social Policy publication, "Towards a Fair and Just Society", (1988:13) states:

> Today more young people are remaining unmarried, more marriages are ending in separation and divorce and there are more remarriages. Overall there are more households, particularly one and two person households and solo parent households. There are fewer nuclear family households.

More recently, Maskill (1991:35) cites the work of Fergusson who analysed a birth cohort of 1,067 children. He found that by the time these children had reached the age of 16 years up to 40% would have spent time in a single - parent family.
Maskill (1991:37) also states:

> The majority (79%) of 10 - 14 year old adolescents lived in two parent families, with 125 being in 1 -parent families and the remainder (7%) being part of extended families.

She does not separate two parent families from reconstituted families when citing these statistics. The number of defacto relationships has also grown considerably. However, the comparisons of the numbers of people entering into and leaving defacto relationships is problematic as there is currently no reliable means of counting people in this category (Maxwell, 1989; Rochfort, 1993).

Arguments about the deleterious effects of the breakdown of the family unit are part of the romanticization of the family structure of the past (Craven, 1985; Finch, 1989). Craven (1985:24) states that, 'Ideas about the past are used as a means of social control in the present.' This is discussed in the light of the so-called breakdown of the family unit:

> People talk about the breakdown of the family unit as though that were a recent phenomenon; behind this idea is the premise that once there was a time when families didn't breakdown.

Furthermore, the argument does not take account of the different ways families have lived together in the past. For example, the features of the post war baby-boom period and the correspondingly high rate of marriage tend to be used as the yard stick in commentaries about so-called 'family breakdown' when in fact the patterns of that time were the unusual. This suggestion is made in the Department of Statistics publication 'All About Women' (1993:41) which points out:

> In 1991 ten per cent of women in the 35-39 age group had never married, the highest proportion since 1951 and twice that of 1971 (5%). Before 1951 the percentage of women aged 35-39 who had never married ranged from 14% in 1945 to 20% in 1911. This highlights the pattern of the post World War II baby boom period of high marriage rates as a deviation from the norm, rather than the norm as it has been seen since that time.

Nevertheless, the assumption that the traditional nuclear family is the natural form of family life underpins much social policy and was the motivation behind the cuts to the Domestic Purposes Benefit in 1992. It was the intention that women would remain with their partners if the government reduced the benefit (Briar, 1994). However, Rochfort (1993) suggests that the cuts may not have reduced the numbers going on to the benefit, but that it may have had the effect of limiting the total period of time that they are reliant on it as a source of income.

While it appears that sole parenting is for many women a stage in their family life cycle which they move through it is at this time in their lives when women potentially experience the greatest degree of poverty. For example, in 1991 the median income of mother only families was $14,599, eighty-five per cent of the income of father only families (Statistics New Zealand, 1993:111). This figure takes on particular significance when it is considered that it is women who head the vast majority of sole-parent families (Statistics New Zealand, 1993). Six of the women in this research project were solo mothers reliant on benefit income.

At current benefit levels it is very difficult to sustain adequate care of children let alone provide any quality of life. This was a concern raised by Waldegrave and Conventry (1987) *prior* to the cuts to the Domestic Purposes Benefit. So, where alternatives are available, women are seeking them out. Some may be obtaining employment, but as I will suggest later, this is not the easy solution it appears. I suspect that many women may

be entering into new relationships because of the possible greater economic security which they hope will come along with the relationship. The changes to family structure which have occurred in the last twenty years appear to indicate that women rather than being able to share the responsibility of their children more are, in fact, shouldering those responsibilities on their own, as a result of the growth in the number of households headed by women and in reconstituted families. In the latter case, while the women may have a partner, they remain the sole parent to their children who live with them.

MOTHERING

There are three factors in the performance of mothering as undertaken by women which are outlined in this discussion. They are: the gender prescription attached to the role, the socially engineered division of labour, and the judgements about the way women meet the role.

It is assumed that as childbearers women naturally provide the care of children (Rich, 1976; Chodorow, 1979; Chodorow and Contratto 1982; David, 1985, 1986; Pascall, 1986; Oakley 1986; Williams, 1989; Sapiro 1990). Walby (1990) points out that there is a conflation of childbearing with childrearing, as if both were equally natural. This assumption overlooks the experience of most women that motherhood is associated with feelings of ambivalence towards the demands placed on them by the responsibilities of caring for the child or children (Rich, 1976). This ambivalence is also discussed by Rowbotham (1989:88) who argues that for most women having children carries with it a, 'psychological image of motherhood as power and submission bound together'. Women are able to exert power over their children. However, when caring for children they are also required to place the physical and emotional needs of children before their own desire for a life separate from the child.

Secondly, the way in which women meet the demands of mothering is also influenced by division of labour associated with the role. The performance of mothering takes place essentially, in social isolation, in the privacy of the home. This is socially engineered through the division of labour (Pascall, 1986; Hanmer and Stantham, 1988).

According to David (1986, 1990) bringing about change to the division of labour would mean addressing the question of how children are cared for. The care of children strikes at the root of women's role in society as they are considered responsible for caring for

the young, the sick and the elderly (Finch, 1989; Munford, 1990). It also, unsurprisingly, strikes at the heart of the central concerns for each of the women who took part in this project. I will return to these points in the results section.

In addition to the assumption that women are the 'natural' caregivers, decisions between couples about who will provide the care of young children are usually based on the level of income of each partner (Easting, 1992). As discussed below women are unlikely to receive an income equivalent to that of their male partner, if they have one. In her outline of the development of childcare in New Zealand Easting points out the development of childcare services has been influenced more by attention to the advantages to children than the advantages to women. She concludes that the provision of childcare services for pre-schoolers is improving, although the level of government funding still does not match that provided to pre-school education.

Furthermore, according to David (1985) social policies about education, health services and family services which rely on the mother as the consumer of social services on behalf of the family and the provider of services voluntarily, reinforce the responsibility of women as the primary care-givers of children. Hanmer and Statham (1988:54) suggest that:

> Even when a man is part of the family women are seen, and see themselves, as being the person primarily responsible for childcare.

The authors go on to point out that employment is seen as a problem for mothers, whereas it is unemployment which is regarded as a problem for fathers. They point out that as a result of the attribution of responsibility for children to mothers, social workers concentrate on the mother and usually only include the father when he is unemployed.

Thirdly, and finally, feminist discussions of mothering point out the mothers are usually categorised as good or bad. The good being those in the middle class who are able to 'naturally' meet the needs of their children and the bad being those who require state assistance (Chodorow and Contratto, 1982; David 1985; Wilkinson, 1985).

Related to the notion of good and bad mothers is the argument of Rich (1976) that mothers are controlled through the guilt feelings which are engendered when they are unable to fully meet the needs of their children. She argues that the guilt which women experience when faced with this inability serves the institution of patriarchy through the location of the problem with the individual rather than with the way in which society is

ordered. The women I interviewed in this research also struggled with feelings of guilt associated with their children and were concerned with reaction of others to their perceived inability to meet the needs of their children.

It is through this process that women become particularly vulnerable to the impact of motherblaming. That motherblaming occurs within clinical work is well-documented (Caplan and Hall-McCorquodale, 1985; Gavey et al, 1987; Hourigan-Johnston 1989; and Jacobs 1990).

Caplan and Hall-McCorquodale (1985:349) found that in major clinical journals the overwhelming trend was to attribute problems to mothers:

> In every category the mothers emerged in a far less favourable and more blameworthy light... the overwhelming picture in all journals for more than two thirds of the items was one of motherblaming.

As most of these articles are written by clinicians it would be reasonable to conclude that the same or similar perspectives are present in their clinical practice. These findings are consistent with the observation of Hanmer and Statham (1988), referred to earlier, that social workers focus
on mothers rather than fathers. The incidence in New Zealand is likely to be similar.

Motherblaming derives from two characteristics of power which Foucault refers to in the interview "The Eye of Power" (1980). The first is the way in which participants in society have internalised the norms and expectations of that society and as a result are subject themselves to constant evaluation. Foucault (1980:155) describes this is the following way:

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, a gaze which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over, and against, himself.

The second feature of power which Foucault (1980:119) describes is the manner in which power is 'at once continuous, uninterrupted, adapted', and 'individualised throughout the entire social body'.

Through this process of both the internalisation of the gaze and the dispersal of power' mothers are compared with other mothers, found wanting, subjected to blame and then blame themselves when they do not perceive themselves as performing to the

requirements of them as mothers. This mechanism becomes an efficient and effective means of control which everyone, including those perceived as holding power' are subjected to.

These observations are supported by the research of Bryson and Edwards (1988:413) who, in their analysis of the relationship between gender, social control and community services' found that women were less likely than men to be in situations where the social control was overt but that they were subject to pervasive covert social control which defined who they were:

> They are systematically reinforced in their roles and self concepts as dependent and inadequate. They are basically defined in terms of their relationships with others, specifically their children and husbands.

Through the gender prescriptions about mothering, the social isolation which is associated with the role, and the judgement to which mothers are subjected in their performance of the role, alternatives such as the purchasing of childcare, the selection of a boarding school, choosing to be childfree, or even the sharing of the role with a partner are available to only a few. Wearing (1985) in her research about the ideology of motherhood found that it was only those women who were well educated, had an independent source of income, and the strong social supports who were able to combat the societal prescriptions about their role. Thus it is only likely to be middle-class women who can effect alternatives. This is supported by the following section which demonstrates that women have yet to achieve equity with men in employment.

Furthermore, the libertarian philosophy of individual responsibility and social assistance to those who are not able to provide for themselves accentuates the dichotomy between good and bad mothers and is likely to lead to even more blaming of mothers when they are unable to provide for their children.

MOTHERS AND WORK

The situation of women in New Zealand was a major area of concern for the Royal Commission on Social Policy, citing it as one of two areas of marked inequality, the other being that of the Maori. The Commissioners (1988:18) found that:

> While women have made a massive contribution to New Zealand life there is no real equality between men and women in politics, business, paid and unpaid work, family life or community activities.

The issue of women's invisibility in the means of production has been discussed previously by Waring (1988) and Briar et al (1992). Waring argues that womens work occurs within the home on an unpaid basis and therefore the contribution of women to the Gross Domestic Product is unmeasured. This matter is echoed by the Department of Statistics (1991) who as mentioned earlier suggested that the measuring of household incomes has the potential to render the economic situation of women invisible. This is further discussed by Briar (1992:47) who points out:

> Women's economic dependence within the family disguises both a great deal of inequality in the distribution of resources within the households, and the poverty and insecurity experienced by many married [or defacto] women and their children. Often government statistics look only at aggregate household incomes without considering how those resources are shared. The man may not be able or willing to provide properly for the woman and children.

While the assumption still tends to prevail that men should provide for women and children given the changes in family structure outlined above, Burden and Gottleib (1987:3) suggest that: "the societal assumption that women should be provided for by men may no longer be a viable one". During the latter part of this century it has become more usual for women to move out of the workforce because of motherhood rather than marriage (Statistics New Zealand,1993; Briar,1994) and as a result of the assumption that childbearing means childrearing, mothers often experience downward occupational mobility and are at least partially economically dependent. Furthermore at the time of the birth of the first child fathers are more likely to increase their hours of work (Birks,1994; Briar 1994). While it is possible that this derives from the need to increase the income as the family expands, it results in men becoming less available to help with the demands of childcare, and increases the power imbalance between mothers and fathers.

Women have yet to achieve full economic independence via employment. Women are less likely to participate in paid employment and when they do it is more likely to be part time and at lower rates of remuneration than men (Pascall, 1986; Statistics New Zealand, 1993). Furthermore, if the measure of jobless rather than unemployed is used, women are much more likely than men to be jobless. (The measure of jobless includes those officially registered as unemployed as well as those would accept a job if it was available although they may not be actively seeking employment, Statistics New Zealand, 1993).

There is a mutually reinforcing relationship between women's low pay and status in the work force and women's responsibility for caring in our society. Despite their poverty women carry huge responsibilities. As Hanmer and Statham (1988:2) point out:

> Caring for others, whether husbands, children aged parents, or someone else, makes women financially dependent on individual men or the state. Yet at the same time it is children, men and other dependent adults who are psychologically, and often socially and financially, dependent on women.

Indeed women bear the brunt of the caring tasks in our society. This is discussed thoroughly by feminist writers such as David (1985, 1986, 1990); Finch (1984, 1989); Munford, (1990); Sapiro (1990); Bunkle (1991); Bunkle and Lynch (1992); Briar (1992); Craig (1992). Where they work in paid employment they are expected to combine both tasks. This is a feature of the comments of the mothers interviewed by Jenny Phillips (1988) who were working full time and caring for children.

The tendency for women to be employed in lower paying jobs, on a part time basis when combined with the difficulties encountered in accessing childcare, and the expectation that mothers are the 'natural' caregivers effectively constrains the ability of mothers to obtain financial independence either from the state or their husbands (defacto or married). Pascall (1986:64) points out that:

> It is economic dependence and domestic/people work that makes them [women] such a useful pool of low-paid, insecure, part-time employees.

It can be seen that mothers in this situation may have very little disposable income with which to purchase the assistance of family therapy.

CONCLUSION

The role of mother continues to constrain women's lives, rendering them either dependent on the state or husbands. Adequate access to childcare would provide the material means to address this issue but as Easting (1992) points out that despite recent progress in this area there is still a long way to go before childcare is readily available to all mothers who want it.

Attitudes to mothering in fact do not appear to be changing. Mothers are still regarded as the ones with the responsibility for their children, regardless of whether they pursue the option of employment. Social policies pertaining to the family and to mothers and social work practice reinforce the notion that it is mothers who are primarily responsible for the care of children. This response by women is discussed at length by Rich (1976:52) who suggests that:

> This 'powerless responsibility' as one group of women has termed it, is a heavier burden even than providing a living.... because the mother's very character, her status as a woman, are in question if she has 'failed' her children.

Rich argues that it is through this identification of women with the role of mother that engenders guilt and contributes to patriarchy. It is through this process that women become particularly vulnerable to the impact of motherblaming.

CHAPTER FOUR

A BRIEF OVERVIEW OF FAMILY THERAPY THEORY

INTRODUCTION

In order to understand the mothers experiences of family therapy an understanding of that which makes up family therapy is also required. Therefore this section briefly describes family therapy, and the key concepts which underpin it. It begins with a discussion of definitions of family therapy and a brief outline of the three main schools of family therapy. I then explain the focus on the experience of mothers in family therapy in this research, given the systems theory which underpins family therapy theory. The chapter concludes with a discussion of the feminist critique of family therapy.

WHAT IS FAMILY THERAPY?[5]

Family therapy, along with other forms of clinical social work, due to its attention to small groups of people is closer to the discipline of social psychology than sociology. Myers (1993:5) suggests that:

> The primary aim [of social psychologists] is to discern the basics of how people think about, influence and relate to each other.

This differs from the discipline of sociology where the focus is on trends in larger groups of people. The similarity between the focus of social psychology and family therapy is illustrated in the ensuing discussion about definitions of family therapy.

Barker (1992:2) in his introductory text suggests that family therapists are primarily concerned with:

> Human problems in the context of their clients' environments, especially their families. They concentrate on interpersonal processes, rather than those occurring within the minds of the individuals they treat.

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[5]Family therapy and counselling share some similar processes although the focus of each is different. It is the concern with both the family, and wider context, and interpersonal interactions which distinguishes family therapy from counselling (Hayes, 1991; Barker, 1992).

This definition identifies two areas which have been the subject of much critique within family therapy. Firstly, the focus on the family as the location of therapy has led to a tendency to overlook the context in which the family is situated (Taggart, 1985; Hare-Mustin, 1986; Mirkin, 1990a). Secondly, Barker also refers to the notion of treatment, which carries with it implications about the expert role of the therapist and the objectification of the people attending therapy. This is a remnant of the medical model which was influential in the early development of family therapy (Goldenberg and Goldenberg, 1985; Barker, 1992).

Barker also discusses the notion of a healthy family and provides a range of family types but does not include the extended family at all, which in New Zealand society is untenable because of the influence of Maori culture in our understanding of family. I do not intend to explore this in detail here, although I think that the Maori view of family is undoubtedly having an impact on European New Zealander's views of the family. As a result we may be more aware of extended families compared to English writers such as Barker. When considering an adequate definition of the family I prefer that suggested by Briar (1994:255) which includes:

> Extended networks of kin, children and their caregivers, as well as cohabitating sexual partners whether heterosexual or not.

I think that this definition provides a breadth to the concept which takes account of the many forms of the family which are found in today's society.

Despite the limitations in Barkers definition, he does highlight the concept which makes family therapy different from other forms of therapy, that is the focus on interactions between people. This focus is shared by other key writers in the field such as Gurman and Kniskern (1981), Goldenberg and Goldenberg (1985), and Wynne (1988). There is extensive literature within family therapy which both attempts to describe and explain those interactions (Bateson, 1973, 1980; Epston and White, 1989; MacNamee and Gergen, 1992); the features which occur in the interactions when problems occur, (Satir, 1967; Minuchin, 1974; Haley, 1976; Palazzoli et al, 1978; Madanes, 1981); and finally, I think as a result of the feminist critique, a growing awareness of the impact of the context in which the 'family' is located on the problem, the family members, and the therapy. (Fish, 1990; Walters, 1990; Mirkin, 1990a; Epston and White, 1992).

As family therapy developed early theorists looked for ways to explain the interactions between family members, and they drew heavily from theories of cybernetics, systems

theory and circular causality. Very briefly, cybernetics derives from mechanical theory and describes systems that operate by feedback loops. (Bateson, 1972; Barker, 1992). Such systems are viewed as self regulating, and this theory was used to explain family situations where the problems appeared to be ongoing in nature and difficulty was experienced in effecting change. Barker suggests that systems theory has more to offer family therapy than cybernetics. It has certainly received considerable attention in the literature. The principles as applied to family therapy include: the sum is greater than the parts, the system (ie the family) has a boundary which in the case of the family is semi-permeable, and the system interacts with other systems, and subsystems (Barker, 1992). Circular causality is based on these theories and may be regarded as the cornerstone of most family therapy. Circular causality focuses on the ongoing process and relationships rather than on linear causation (Goldenberg and Goldenberg, 1985; Barker, 1992).

These theories have been the subject of much debate within family therapy theory. However, and as Barker points, out it is questionable whether these concepts succeeded in achieving any more than providing one description of what takes place within families.

As family therapy gained momentum from the 1950s onwards three main schools of family therapy have developed including systemic family therapy developed, by the Milan group, strategic therapy, and structural therapy. Each of these schools has concentrated on the interactions between people but they have gone about it in different ways. Hayes (1991) provides a brief and comprehensible discussion of the three main schools which for the sake of clarity and information to the reader I will very briefly summarise here.

Firstly, structural family therapy which was developed by Minuchin, and is based on systems theory assumes that people's behaviour is organised and regulated by an invisible set of rules which are based on the family's culture as well as societal demands (Hayes 1991:29). The therapist who uses this method is likely to be directive in her interventions with the family and concerned with re-establishing boundaries both within the family and between the family and its social system.

Secondly, strategic therapy which was developed by the Mental Research Institute and Jay Haley and Cloe Madanes suggests that the family's attempt to solve a problem contributes to its severity. They describe the situation which develops as a 'vicious cycle'. David Epston and Michael White (1989) are well known proponents of this school in New Zealand and Australia. A strategic therapist will suggest interventions to the family which are designed to cut across the vicious cycle.

Thirdly, the systemic school as developed by the Milan group (Palazzoli; Cecchin; Boscolo; and Prata, 1978) and draws heavily from systems theory, cybernetics and the work of Bateson. As Hayes (1991:35) suggests:

> Systemic therapists examine the meaning a family gives to the symptom and relate the symptom to all parts of the system.

The therapist utilising this approach is likely to be interested in the ideas that family members have about the problem they are dealing with and may begin hypothesizing about those ideas before meeting with the family.

There are other family therapy schools which I have not mentioned. However, these three represent the broad categories to which family therapists align themselves. The various schools of family therapy have, in the past, been competitive in their attempts to delineate theoretical perspectives (Barker, 1992). However, since the early 1980s there has been a move from family therapists not to align themselves with a particular school of therapy but rather a search for a more integrated approach (Walsh, 1983; Flaskas, 1990; Hayes, 1991; Barker, 1992; Larner, 1994). In terms of practice this means that therapists are less likely to be model-bound in their methods of working with families and more able to draw from each of the schools of therapy according to their assessment of what will be the most effective in assisting families.

THE FOCUS ON WOMEN IN THE RESEARCH

Each of the schools of family therapy outlined above shares the focus on the interaction between people and are influenced by ideas from systems theory. The idea that the sum of the system is greater than its parts which informs systems theory has resulted in a tendency within family therapy to focus on patterns which connect all family members. This has been critiqued by James and MacKinnon (1990:71) in the light of the feminist analysis of incest and they suggest that a systems view: "obscures the gender politics in incest". I have taken a similar position in the decision to focus on only mothers experience of family therapy in that a focus on families' experiences of family therapy, for example would be likely to obscure the experiences of mothers. While systems theory has been helpful in developing ideas about the interactions between people it overlooks the impact of power and gender issues (Pilalis, 1983; Pilalis and Anderton, 1986; Taggart, 1985; Goldner, 1985; 1988; Hare-Mustin, 1986; Beecher, 1986; Braverman,

1988; Esler, 1988; Epston and White, 1989; Fish, 1990; James and MacKinnon, 1990; Jenkins, 1990; Walters, 1990).

Systems theory has tended to overlook the effect of power and gender within families at the same time as assuming that the way families are structured is natural rather than the result of patriarchal structures in our society (Leupnitz, 1988).

Walters (1990:54) argues that:

> Systems theory and systemic modalities unfortunately have functioned to discount gender socialization and to blur gender differences. Systemic equations treat the parts as interchangeable, depending only on their configuration within the system for definition and explanation of their motivation and behaviour. The fact that such configurations must have origins in larger contexts is acknowledged but goes largely unattended and unexplored. Systemic equations and formulations conjure up the illusion of an objectivity that obscures the value-laden reality that they are meant to represent.

The most striking example of this is the development of the notion of the schizophrenogenic mother. According to Goldenberg and Goldenberg (1985) this term was introduced by Fromm-Reichman in 1948 to describe a cold and domineering mother who alongside an ineffectual father caused her sons to feel confused and inadequate and to eventually develop schizophrenia. A review of Bateson's (1972:206 - 209) ground-breaking 'double-bind' theory shows that he refers to all family members potentially having a role in the development of the double-bind. However, his ensuing illustrations of how the double-bind works to reinforce the schizophrenic patterns all focus on interactions between mother and child, thereby reinforcing the concept of the schizophrenogenic mother.

The schizophrenogenic mother is probably the most debated example of motherblaming in the literature[6]. Although now widely discredited this concept and others like it was influential for more than twenty years. Ideas such as this have contributed to the suspicion with which women approach therapy (Caplan and Hall- McCorquodale, 1985; Neill, 1990; Goldner 1991). The reader will see that many of the women who took part in this project were fearful that they would be blamed for their problems when they first sought therapy.

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[6] A more detailed account of motherblaming and the relationship between it and the situation of women in society is contained in the previous chapter.

It is likely that if the labelling and blaming which developed out of these ideas had not been attacked as roundly as it was by the feminist critique of family therapy, which pointed out the context in which these ideas developed and their function in maintaining a patriarchal society then such notions would have survived for much longer (Hare-Mustin, 1980, 1986; Goldner, 1985, 1988; Beecher, 1986; Bograd, 1990)

Nevertheless, it is important not to overlook the contributions made by Bateson concerning 'double-bind' theory, circular causality, and communications theory. These theoretical developments held the potential which enabled family therapy theory to continue to develop and engage itself with new ideas and understandings. Bateson's discussion of the importance of context in communication contains some of the early seeds for the ideas which now inform theories of deconstruction and post-structuralism (Bateson, 1972 and 1979).

To conclude, it is necessary to consider the experience of women in family therapy because of the neglect of context in family therapy theory and also possibly practice.

In the following section I outline the feminist critique of family therapy.

A FEMINIST CRITIQUE OF FAMILY THERAPY

As I have already commented the feminist critique of family therapy has made a significant contribution to the development of theories within family therapy. The following provides an overview of that critique as a means of providing a framework for analysing the experience of the women who took part in this study. Although the participants in this study all recognised that therapy might help them to deal with the problems more effectively, most of them worried that they would be blamed for their situation. Consequently they struggled with the prescriptions they perceived about mothering, and that they felt powerless to effect change. Furthermore there were external factors for which they were not responsible, which contributed to their difficulties, such as their isolation as mothers, their limited incomes and the associated difficulties in raising their income level, and the lack of support they received from the fathers of their children.

Each of these issues can be readily connected to the key features of both feminist theory and a feminist critique of family therapy and feminist practice issues. The following is a

brief outline of those features of the feminist critique including: significance of context, gender in family relations, power, and the role of the therapist. I think that when any of these factors remain unaddressed in the therapy then the therapy is likely to become a means of social control as overlooking them allows the therapy to function to reinforce the prevailing social norms and assumptions about women. Examples will be given in the following discussion (Pilalis, 1983; Pilalis and Anderton 1986; Cross, 1984; Beecher 1986; Bograd 1988; Hare-Mustin 1994).

The Significance of Context

The feminist critique has accurately pointed out that therapists through adherence to concepts such as cybernetics and homeostasis in family therapy theory have tended to ignore the connections between the family and societal structures and the way in which social structures may enhance the problems which people are dealing with. Concepts such as systems theory have tended to encourage therapists to focus on the family, as the system, and to overlook the influences of wider systems on the family. As Mirkin (1990a) suggests, a focus only on the family merely leads to a change from blaming the individual to blaming the family. The now widespread use of the term 'dysfunctional family' in the popular press suggests that, in fact, this has happened.

As most family therapy invites people to examine their ideas, beliefs, thoughts, feelings and actions about their situation it seems to me that the therapy is a political process whether the therapist acknowledges this or not. MacKinnon and Miller (1987) and James and MacIntyre (1983) suggest that the failure of family therapists to situate the family in its political context limits the effectiveness of family therapy. Pilalis and Anderton (1986) suggest that feminist practice must take account of both the family and the societal level, recognising that therapy is a political process. Through a case presentation they illustrate how a political analysis of women's experience can be introduced into and inform the therapeutic process, thereby contributing to the possibility of change for all family members. It seems to me that inattention to the wider context in which the family is situated reduces the therapy to social control, thereby blaming the family, and usually the mother for the problems. The wider context, includes access of the family to material resources, how those resources are utilised within the family, as well as power relations, and the politics of gender (Bograd, 1990).

Power

Power is of central concern to feminist therapists concerned with women in the family. Many writers have commented on the power structures both within the therapeutic process and within the family itself (Goldner, 1985; Taggart, 1985; Flaskas, 1990; Walters, 1990; Chapman, 1993; MacKinnon, 1993; Hare-Mustin, 1994). The over riding issue of dispute has been the limitations of systems theory for understanding power in the family. Each writers points out that systems theory and family therapy assumes that each member of the system is able to exert equal power in order to effect change. Such an analysis, of cours,e does not take account of the historical and social prescriptions affecting womens role within the family consequently serving to protect the patriarchal structure of our society. As Goldner (1985:33) illustrates:

> The idea, for example, that work or suffering or pleasure might be distributed unequally between men and women would clearly complicate, and perhaps compromise, the circular presumption that family members are eternally involved in a balancing operation in which all positions are interchangeable - that anyone can play any part in the service of system maintenance.....No matter how subtle the argument feminists detect at its core the notion that 'battered women are asking for it' or that women's anger is misplaced because their manifest powerlessness is 'just another move in the game'.

It seems to me that therapy without a corresponding analysis of power can potentially define the mother as in some way co-responsible for the abuse of her child, or as a wife co-responsible for her victimisation.

Gender[7]

As with all feminist theory the issue of gender has received considerable attention from feminist therapists. The central argument is focused on the familial and societal role prescription for women according to gender and the overlooking of that issue in family therapy practice (Joslyn, 1982; Hare-Mustin, 1987; Goldner, 1988; Bograd, 1990; Walters, 1990). The central argument is that gender differentiation of roles within the family structure has a high cost for women whether as individuals they conform to the expectations that they assume the responsibility of primary care-giver or if they attempt to create a different role for themselves. Furthermore, not only do therapists tend to overlook the gender differentiation, often within their practice they reinforce it by

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[7] The issue of gender in relationship to mothering has been discussed more fully in the previous chapter.

assuming that the mother has the responsibility for the emotional needs of the family members (Bograd, 1990).

Hare-Mustin (1987:15) argues that:

> the uncritical use of gender role concepts supports power differences between men and women and ignores the complexities and commonalities of human experience.

Hare-Mustin details the impact of assumptions about gender roles on women in the family and the practice of therapy. She concludes that without attention to the issue of gender in family therapy practice family therapy will continue to have little impact on the way that families and society is structured.

The Role of the Therapist

A second component of the issue of power in family therapy process which has been criticised by therapists is the issue of the therapists objectivity. It has been argued that systems theory necessitated a 'neutral' position by the therapist which feminist therapists concluded led the therapist to situations which endorsed the dominant view of the family (Avis, 1988).

McKinnon and Miller (1987:148) discuss this in their article about systemic family therapy:

> Attempts to remain neutral by refusing to actively take a position on gender issues in marital therapy, whether or not these issues have been raised by the couple implicitly aligns with the status quo, which benefits men more than women.

Moreover the position of therapist neutrality allowed therapists to consider themselves as outside the family system and to assume an expert role.

Since the mid eighties many theorists and feminist writers have argued for the therapist to join with the family in the therapeutic process in a manner which does not emphasise the leadership role of the therapist, but emphasises instead the therapist 'teaming-up' with the family in a colleaguial manner (Taggart 1985; Pilalis and Anderton, 1986; MacKinnon and Miller, 1987; Epston and White, 1989; White 1990; Walters 1990; Goldner, 1991; Chapman, 1993; Hare- Mustin, 1994). This argument has taken on more ferocity with the influence of theories of deconstruction on family therapy theory which emphasise the

creating of spaces within the discourse of therapy for the family members to effect change.

However, as Goldner (1991:102) suggests, the danger can also lie in the therapist not assuming leadership and thereby failing to be of assistance to the people who seek it from her:

> The reluctance to claim our authority is a legitimate reaction against the abuse of power in the name of 'normative hierarchy,' whether in the organisation of a family or in the organisation of family therapy. However such a stance leaves us at risk of an arch falsification, since our qualifications confer expertise upon us, induce an appropriate expectation from families for some form of guidance, for which we expect to be paid and from which we expect some measure of social power and status.

Thus the challenge for feminist family therapists is to analyze their own work with the family, to attend to issues of power in determining how the work will be completed without becoming paralysed out of a reaction to the damage that has occurred in the past through the abuse of power.

CONCLUSION

While I believe that family therapy has much to offer people seeking assistance for a variety of problems there are a number of limitations to the theory of family therapy which impinge on practice. I have shown that these limitations centre around the focus on systems theory and the tendency which has developed in therapeutic practice to overlook issues of the wider context, power, gender, and the role of the therapist. Avis (1988:29) suggests that an alternative would be based on:

> A positive view of women as competent and as the best experts on themselves, on an understanding of women's problems as socially and culturally induced, and on a commitment to the full development of women.

Feminist family therapists have begun to work towards developing a feminist theory of practice as applied to particular problems (Avis 1988; Walters, 1990; Mirkin, 1990b; Goldner, 1991). Such a practice must include the means to make links between the family problem and the wider social issues. Otherwise as Bernal and Ysern (1986) suggest, family therapy can become a means to exonerate society of its problems. They suggest that referral to family therapy is only part of the solution and argue for an approach

consisting of three components. The first is mentioned above and is the necessity to link the individual and family problems with social issues. The second is to help the family to identify those wider issues which contribute to the family problem. Finally, they argue that the therapist is required to support initiatives for social change.

Further progress towards the integration of feminist thought and systemic family therapy is contained in the work of Goldner (1992). She suggests the powerful metaphor of "Making Room for Both/And". This has derived from her work in the field of family violence. She argues (1992:57) that it is:

> An attempt to recognise the value of competing and contradictory perspectives and to tolerate the psychological experience of extreme ambivalence without splitting ideas and people into good and bad.

There are parallels between the work of Goldner as a feminist family therapist and that of Chaplin, a feminist counsellor. Chaplin (1988:3) suggests that a feminist perspective:

> Rejects the prevailing hierarchical model of thinking in which one side must always win. It recognises the interconnection between different, even opposite, sides of life and of ourselves.

However, neither approach exonerates family members from responsibility for their actions. Goldner provides an excellent illustration of the influence of a power analysis in work with sexual abuse offenders and victims, pointing out the therapeutic usefulness to both of the offender accepting responsibility for his or her actions. This issue is further discussed in the work of Jenkins (1990). Thus the role of a feminist family therapist is to make the links between the wider social attitudes towards women and their contribution to the position the individual woman, in the family, finds herself in. Furthermore, the therapist provides the opportunity for the woman and other members of the family to develop those links, apply them to their position, and find solutions to the problem which brought them to therapy (Esler, 1988; Hourigan-Johnston, 1989; Walters 1990; Goldner, 1992).

PART TWO

METHODOLOGY

INTRODUCTION

This part of the thesis sets the scene for the implementation of the research itself. As discussed earlier the research focus of mothers' experience of family therapy developed from my feminist perspective; and my experiences as a therapist and previously as a mother seeking therapy on behalf of her children. Therefore, it was necessary to consider the methodological issues which arose from a feminist perspective in order to determine which method or methods of research best suited my approach to the research focus. Discussion of this issue is guided by the distinctions between method and methodology identified by Jayaratne and Stewart (1991:96):

> Quantitative and qualitative 'methods' are simply specific research procedures; secondly 'feminist methodology' or a 'feminist perspective on methodology' must be taken to refer to a much broader theory of how to do feminist research. There may be, then, a 'feminist methodology' without any particular feminist 'methods'.

So, while there is not a particular feminist method, it is the way in which methods are utilised which determine whether the research is feminist or not. In this project I chose a qualitative method as I intended to explore in detail the experiences of a small group of women. The following chapter demonstrates how that method has been implemented in accordance with feminist principles.

CHAPTER FIVE

METHODOLOGICAL ISSUES AND THE METHOD USED

The chapter encompasses a discussion of the issues pertaining to feminist methodology; a justification of the method utilised; a discussion of the ethical issues pertaining to the research, the steps taken to ensure the rights of the participants are protected; and the method of analysis utilised in the presentation of the data. Eight women were interviewed who had participated in family therapy within the previous three - six months and who had one or more children. The interviews all took place in the participants' own homes.

METHODOLOGICAL ISSUES

It was important to me that the research design reflect a feminist approach to the issues focused on in the research. It was necessary therefore to determine exactly what it is that constitutes feminist research. Primarily, feminist research assumes that women's experience has a validity which derives from its existence rather than from its comparison to the masculine. Sutherland (1986:148) outlines this issue in her discussion of feminist research. She states that:

> Feminist research as distinct from research on women (even that by women) takes the experience of women's lives as central, as the norm, not as a deviation from or in relation to the masculine, (falsely presented as 'universal').

Many feminist researchers including: Oakley, (1981); Roberts, (1981); and Sutherland, (1986) argue that the positivist research tradition is based on patriarchal assumptions, that quantitative research can therefore not be feminist in perspective. More recently the position on this issue amongst feminist researchers has shifted from a rejection of the positivist tradition, including quantitative techniques to a recognition of the merits of both quantitative and qualitative research methods.

Writers such as Harding, (1987); Bhavnani, (1990); and, Jayaratne and Stewart, (1991) have argued that the quantitative method provides information which is important and useful to a feminist perspective. They suggest it is the way in which a method is used, whether qualitative or quantitative, which determines whether it is feminist. Feminist

research, therefore, is not necessarily linked to a particular method, rather it is the stance of the researcher towards her participants which is central to feminist research and how this stance is then translated to her preferred method.

It was important to me that the research process itself provided for, firstly, the opportunity for the women to tell their story from their point of view and secondly, that their experience of taking part would be one of empowerment. This reflects the suggestion of Mies (1983:123) that feminist research reflect "the view from below rather than the vertical view from above" characteristic of other methodological perspectives. Thus it was necessary that the voices of women participants in family therapy be heard. I was also cognisant of the points raised by Bhavnani (1990) that it is insufficient to merely provide the space for the stories to be heard, but that there must be an accompanying analysis of why those voices have been previously silenced. Bhavnani (1990:152) concludes that:

> It is true that, often, 'giving a voice' may be a necessary step towards empowerment.... But such an emphasis can also hide, or mask, the reasons *why* the voices are not being heard, or listened to. In other words, the idea of 'giving a voice' must provide a simultaneous analysis of those who are potential hearers, and why they do not hear (emphasis in original).

My analysis of why the voice's of women have been silenced is woven through the preceding chapters, pertaining to social policy and family therapy theory. The discussion of what must happen in order for the voice's of women clients to be heard is contained in the final chapter of the thesis.

Mies (1983:124) takes this argument a step further and suggests that feminist methodology is characterised by a move from spectator knowledge to: "active participation in actions, movements, and struggles for women's emancipation". It is therefore incumbent upon me as the researcher to make suggestions concerning possible future research, possible ways of changing the practice of therapists in order to address the issues raised by the women in this project, and to ensure the widespread circulation of both the findings and recommendations. This is in line with two assumptions common to all feminist thought and research. These are firstly, despite having a variety of strands and differing ways of explaining the situation of women, women are disadvantaged and secondly, feminist writing and research is committed to changing that.

A further aspect of feminist methodology identified by Mies is that which she describes as "conscious partiality". She defines this as: "the partial identification with the research objects" (Mies, 1983:186). This is an important feature of feminist research. It involves the researcher situating themselves in the research and in relation to the research group. Moreover, it requires the researcher to make explicit her assumptions and world view and the way they have influenced her approach to the research.

Finally, the epistemological assumption underpinning this research is that the mothers have knowledge about the problem, about the therapy, which derives from their experiences and observations of the problem and the therapy itself (Harding, 1987; Stanley and Wise, 1990). This is informed by the position of symbolic interactionism which argues that we interact with the world around us according to the meaning which we invest in that world. As Blumer (1969:5) points out: "symbolic interactionism sees meanings as social products". There is a connection between the perspective of symbolic interactionism and the feminist analysis that the 'natural order' is in fact socially created. Symbolic Interactionism is one of the theories which underpin emancipatory research, in general, and feminist research, in particular. Therefore, in this research, I am concerned with determining the understandings which the women participants in family therapy have applied to the therapy process.

As previously shown, the knowledge of women clients has been largely overlooked in most family therapy research and concomitantly in the development of family therapy practice and theory. This realisation led me to evaluate the research methods which would be the most effective in highlighting the experiences and knowledge of the mothers who took part in the family therapy process. The following section outlines the methods I considered and describes in detail the qualitative method which I subsequently implemented.

THE METHOD USED

The research method chosen, in order to be consistent with the overall aims of the thesis, needed to allow for an emphasis on the experience and knowledge of the mothers. I initially considered a combination of quantitative and qualitative methods, involving a wider postal survey, followed by an in-depth interview with participants selected from those who took part in the postal survey. This was abandoned due to the small number of women available in the research pool. Furthermore, I considered that a qualitative method

which focused on a small group of eight to nine women would allow a thorough exploration of their thoughts and ideas about their experiences. Moreover, as there is little previous work on the subject the qualitative method would highlight areas for further research. This is one of the advantages which Babbie (1992) identifies in qualitative research.

Babbie goes on to suggest that in qualitative research reliability is problematic as the perspective of the researcher is likely to influence the outcome of the research. Thus it is questionable whether another researcher would be likely to obtain similar results. However, another researcher would be able to establish their position in relation to mine as a result of making explicit the perspective utilised in designing the research and analysing the data, that is, that of a socialist feminist family therapist who is also a mother. This is consistent with the requirement of a feminist researcher for 'conscious partiality' as suggested by Mies (1983:186) and the suggestion of Tait (1990:183) that it is important for the reader to be able to determine whether the research is valid for them.

The In-Depth Interview

The following discussion outlines the characteristics of in-depth interviewing which are a feature of this project including: the length of the interview; the relationship between researcher and participant; the focus on the participants point of view; and, the language used in the research (Minichiello et al, 1990:93).

Firstly, the in depth interview necessitates a longer period of time to be spent with the client. This can typically range from one to two hours and in some situations may involve several interviews. The increased amount of time with the participant in an in-depth interview provided the opportunity to become familiar with the world view of the participant, with the researcher consequently more able to understand that view (Finch, 1986; Minichiello et al, 1990). In this project the interviews typically ranged in length from one to one and a half hours in length. The interviews were preceded and followed by telephone contact with the participants which I have also considered to be part of the research process.

Secondly, the power to decide what happens in the research project rests primarily with the researcher. However, it is possible to design research projects to take account of this and provide the participant with as much power as possible. An egalitarian approach to research is discussed repeatedly in the literature about feminist research (Oakley, 1981;

Roberts 1981, 1985; Mies, 1983; Graham, 1984; Finch, 1984, 1986; Sutherland, 1986; Harding, 1987; Stanley and Wise, 1990; Tait, 1990; Jayaratne and Stewart, 1991).

An egalitarian approach to the people who were to take part in this project was central to the theoretical stance and the aims of the research. Furthermore, I considered that it demonstrated the respect I felt towards the women who had agreed to take part. Thus throughout the research design there was an emphasis on making the relationship between researcher and participants as equal as possible, recognising that there was some inequality inherent in the situation as I was both a therapist and a researcher (Tait 1990).

I did this by providing several opportunities for the participants to comment on the research process, and to have control over how their information was utilised. Each participant has a copy of the transcript and has been consulted about the interpretation I have placed on her information in the writing up of the results. This provided the opportunity for her to confirm, alter, or withdraw the information from the research. A fuller discussion of the steps I have taken to ensure the empowerment of the participant can be found in the discussion of ethical issues pertaining to this research later in this chapter, especially in the area of informed consent.

I found that through my attempts to create a more equal relationship with the women who took part that, in the phone contact which has occurred since the interview, some of them have been eager to talk with me about events which have occurred since the interview, in a manner which indicates that the relationship has extended beyond the interview.

This interest in maintaining the relationship was something which Oakley (1981:47) also commented on. She said that she found that the women came to regard her as a friend:

> I certainly set out to convey to the people whose cooperation I was seeking the fact that I did not intend to exploit either them or the information they gave me....The attitude I conveyed could have had some influence in encouraging the women to regard me as a friend rather than purely as a data-gatherer.

Thirdly, in-depth interviewing provided the means for presenting and discussing women's experience from their perspectives. This is supported by Graham (1984:119), who states that a qualitative or story gathering methodology: "counteracts the tendency to fracture women's experience". Furthermore Minichiello et al (1990) argue that the participants point of view should be actively sought; which is consistent with the aims of

this project. My task was to find out what the participant thought rather than to seek confirmation of my own ideas and opinions.

Finally, language can either be a means of inclusion or exclusion. Minichiello et al (1990) suggest that it is important for qualitative researchers to use language which reflects that of the people taking part in the research. This necessitates the understanding of the participants milieu, an issue raised by Finch (1986) in her discussion of qualitative research techniques. Minichiello et al (1990:93) argue that the in-depth approach involves a move away from: "the interrogative process used in the structured interview toward that of a more conversational process". A conversational approach to the interview necessitates a more casual use of language. Although I had an interview schedule which was used as a guide in the interviews, I found that each of the questions stimulated further discussion which reflected the conversational approach suggested by Minichiello.

I think that it is important for language to provide for ease of communication. Therefore, both in the interviews and in the writing of this thesis, I have attempted to use language which adequately explains that which I am discussing in a manner which is accessible to a wide range of readers. This has presented a tension between ease of access and the necessity to ensure that the work presented is sufficiently academic to be eligible for the award of a Masters degree. Reconciling the two has not always been easy.

After consideration of the debates about qualitative and feminist research an interview schedule was developed which consisted of questions which were designed to enable the participants to talk about their experience, their thoughts, actions and feelings about the therapeutic process in which they were involved (See Appendix i).

IMPLEMENTING THE RESEARCH

There are two key features to the implementation of the research which are outlined below. These are a discussion about the issues involved in selecting the research group; and the ethical issues which arose in the designing of the research.

Identification of the Research Group

The first step in the research process was to identify the research pool. This took place over a lengthy period of time from the initial decision that I was interested in women's experience of family therapy to actually attaining a research pool.

I selected mothers who had attended family therapy as the research group as a result of my own experiences (referred to in the introductory chapter), the reading of the feminist critique of family therapy, and the experience in my own practice that it is usually women who ask for therapy on behalf of their families. The latter is a view shared by Goldner, (1983); Hockey, (1990); and Gordon, (1990).

The potential research group was further narrowed down to include those women who had attended family therapy during the months of June and July 1992 in a provincial part of New Zealand. This time frame was imposed as I wanted to interview the women while their experience of attending the therapy was relatively recent, yet sufficient time had elapsed in order to allow them to have evaluated the process after its completion. The women were interviewed during October of 1992. All the participants had completed the therapy at the time of the interview except Barbara, who, I found during the course of the interview, was still attending the therapy. As she wanted to proceed with the interview I made the decision to include her information in the research. This situation arose due to the varying interpretations of my requests about selection of the research pool by the therapists who invited their clients to take part. This is discussed more fully in the section regarding access to the research pool.

The geographic limitation was imposed due to the issue of access which is also discussed later. It had disadvantages as I was likely to have ongoing contact with the therapists and this may have intruded into what the women felt they were able to tell me. (As a consequence of this I emphasised both to the women and to the therapists the confidential nature of the research interview, this is discussed more fully in the next section). However, the advantage was that contact with the women after the interview has been reasonably easy to maintain, except in the instance where one has moved away without leaving a forwarding address.

Ethical Issues

The research was designed in accordance with the requirements of the Massey University Human Ethics Committee and the local Area Health Board Ethics committee. The former required me to attend one of their meetings. They questioned me about the confidentiality of the research and the safety of the participants. I was required to present the research proposal to the latter as at the time I was an employee of the Area Health Board concerned. They required a written proposal and bibliography which I provided. They also requested a brief summary of the research once it was completed.

The following discussion describes the steps taken to address the ethical issues which were of significance to this research including those raised by the Massey University Ethics committee. They included: access to participants; informed consent; voluntary participation; confidentiality; and the minimising of harm to participants.

Access

The particular nature of this research contributed to difficulties in gaining access to the research pool. Minichiello et al (1990:272) state that: "getting people to agree to be interviewed is a difficult task". Due to the confidentiality of family therapy and the sensitive personal information involved in the therapeutic process I found the process of gaining access more difficult than would have been the case if I had chosen a different subject.

The following dilemmas were raised in the process of determining how to gain access to the research pool. Firstly, how to gain access to a group who have taken part in a confidential process. Secondly how to ensure voluntary participation both for the therapists (who may be considered indirect participants) and the clients.

Due to the confidential nature of family therapy finding out who was a potential participant proved difficult. One possibility was to apply for access to agency records. However, this did not provide for the voluntary participation of therapists. Furthermore, most clients were advised that their therapy was confidential. Therefore, unexpected contact by a researcher about the therapy could have been deemed a breach of confidentiality.

A second possibility considered was advertising through the media for potential participants. I decided not to pursue this as it was costly and I thought unlikely to generate a significant response. Consequently I decided to ask family therapy practitioners to invite their clients to take part in the research. This had the advantage of ensuring the voluntary participation of the therapists. However, this also meant that the therapists had an element of control over who took part in the therapy. I also did not know how they decided to choose whom to invite and therefore am unsure of the degree of bias present in the research sample.

I approached colleagues working in the family therapy field in the public and private sector who were members of a Family Therapy Practice Group. As I was also a member of the group I was concerned that they may have felt compelled to take part in the research in order to preserve that relationship or to enhance it in some way. Hence the emphasis was on the voluntary participation of not only the clients but also my colleagues.

Obtaining the research pool through family therapy practitioners may have introduced some bias into the results as the practitioners may possibly have only invited those clients who they thought would give a favourable account of their work. I believe, however, that this possible bias is outweighed by the need to consider the client's right to confidentiality. While this bias may affect the reliability of the findings by creating a research pool which consisted only of women who were likely to be satisfied with the therapy, it does not affect the validity of the results for this particular group of women. It did mean that I was unable to interview women who had not been successfully engaged in the therapeutic process.

The practitioners were informed about the research in three ways: a letter to each group member outlining the research; an initial presentation of the research proposal at a meeting of the family therapy practice group; and individual discussions about the research.

The intention was to provide the practitioners with as much information as possible about the research. It included an outline of the objectives of the research, pointing out that the focus was on women's experience rather than critiquing practitioners approaches or methods. This distinction was important as I thought that it was unlikely that the practitioners would discuss the research with their clients or invite them to take part in the research if they themselves felt that there was any likelihood that they would be open to critique, particularly in view of my working relationship with many of them. Even with

this distinction having been made clear, many of the practitioners expressed some anxiety about the research and only four out of a possible pool of twenty invited their clients to take part[8].

Also included in the information to the practitioners was an outline of: the aim of the research, the method I intended to utilise, what would be involved for the practitioners and their clients, and the type of feedback I would be able to give to the therapists.

The letter sent to the therapists outlined a method which combined a postal questionnaire, with an in-depth interview for some participants. This method was later changed to include only the interview. The practitioners who had invited their participants to take part were advised of this change verbally. A copy of this letter is contained in Appendix ii.

The therapists were advised that the content of the interview between their client and myself would be confidential and that as a result of this I would be unable to give them feedback which pertained to their particular client. I did, however, undertake to provide general feedback about the overall findings of the research.

The therapists were asked to invite the women clients who they saw during the months of June and July 1992 to take part in the project. This request was interpreted differently by the therapists. Two therapists invited their women clients whenever they remembered about the research project. One of these therapists invited three women to take part, the other invited fifteen. One therapist invited those clients who were considered to be 'suited' to the research. This was defined as meaning the client having an interest in women's issues, being able to discuss those issues readily, and also having some 'insight'.

When inviting their clients to take part the therapists were asked to give the client a letter of introduction which outlined the research project and the procedures that they were being asked to take part in. (See Appendix iii)

Selection of the participants from the pool provided by the therapists aimed at including participants from a range of therapists working in different settings. Therefore, as one therapist had invited fifteen of his clients to take part only a proportion of these were actually selected to take part in the project. They were selected randomly. In order to

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[8] Two of these therapists worked conjointly with one of the participants.

achieve some spread of participants all those women who had indicated to the other two therapists that they were interested in taking part were invited to do so. One of these subsequently withdrew.

Through this process the maximum range of therapists and employing organisations was achieved from the initial pool of potential participants. Two of the women were seen by a therapist within the health sector, one from the voluntary sector, and the remaining five were seen by a private practitioner who received contracts from the NZCYPS and the Family Court. Two participants saw a woman therapist, one saw two therapists working together conjointly, and the remainder saw a male therapist.

Potential participants were provided with a letter of introduction given to them by the therapist which outlined the research project and the procedures which they were asked to take part in. It also contained a guarantee from myself of confidentiality. (See Appendix iii).

The letter proposed a postal survey as the initial contact. As previously mentioned this method was subsequently changed. The therapist were advised of the change by phone. It was discussed with each therapist how they would like their client informed. They each suggested that the matter be discussed with the potential participants at the time of my first contact with them.

There was a potential for the women to feel compelled to participate as they were initially invited to take part by someone whom they may have perceived as relatively powerful. Informed consent was then of paramount importance so that this could be overcome if necessary. From the time of my initial contact with the participants they were advised that they could withdraw from the research at any time. One participant did withdraw, after not keeping her appointment with me. She cited family pressures as the reason for this.

Informed Consent

If the participants were to have control and power over their involvement in the process then the ethical principle of informed consent required particular attention. Homan (1991:69) defines informed consent in the following way:

> The principle of informed consent is that the human subjects of research should be allowed to agree or refuse to participate in the light of comprehensive information concerning the nature and the purpose of the research.

I attended to this issue by providing participants with information about the process at several different stages of the research as well as providing them with the opportunity to withdraw at those stages. In addition to the information the participants received from their therapist I also discussed with them what their participation would involve when I made my first contact by telephone. The aim of the phone call was to ascertain whether or not the potential participant wanted to proceed and if so to arrange a suitable time to conduct the interview.

Prior to commencing the interview each participant was provided with an information sheet which outlined the research, the time and commitment involved, their right to withdraw at any stage and my obligation to ensure their confidentiality. Each participant was asked to sign a consent form before the interview proceeded. The information sheet and a blank copy of the consent form are contained in Appendix iv. A flow diagram demonstrating the steps taken at each stage of the research to ensure voluntary participation was developed and can be found in Appendix v. This was also provided to the Massey University Human Ethics Committee and to the Area Health Board Ethics Committee.

Confidentiality

In this research confidentiality was important due to both the life situations which had caused the women to take part in a therapeutic process and the research focus itself, that is their experience of the therapeutic process. The former meant that the women discussed with me some very personal and sensitive information which was on tape and in the transcripts. This information has not been used in detail in the presentation of the data. The latter meant that the women were commenting on their view of the process and indirectly the therapist.

The other significant factor was that the research took place in a small community where the potential for participants or therapists to be identified is greater than in a metropolitan area.

Due to these issues the excerpts of transcripts included in the text of the thesis have been kept brief; participants are referred to by fictitious names; and any identifying information has been deleted from the text. Furthermore, the interview was considered confidential to the research process and has not been discussed with the therapist. These steps to ensure

confidentiality were based on the guidelines of the Human Ethics Committees to which the proposal was presented and the discussion of Oakley (1981) and Roberts (1985) pertaining to interviewing women participants.

All data was handled in a manner to ensure confidentiality. The interviews were taped, with the consent of the participant, however the tapes were kept in a locked cabinet. The only people who had access to them were myself and an assistant who was engaged to transcribe the tapes. She was asked to treat the material as confidential and to sign a statement to that effect. The tapes will be destroyed six months after the submission of the thesis to the university.

Potential Harm to the Participants

The steps taken to ensure informed consent, voluntary participation and confidentiality minimised any harm to the participants. However, I was also aware that discussing their personal issues with me may elicit counselling issues for some of the participants. In that event it was my intention to suggest that the woman take those up with her therapist or where that was inappropriate provide her with a choice of therapists to contact. Furthermore, I also intended that if a participant became distressed during the course of the interview I would terminate the interview and arrange support.

If a participant revealed information which indicated that the practice of their therapist demonstrated extreme incompetence or a severe breach of accepted ethical standards, it was my intention to advise them on how to make a complaint, for example informing them on how to contact that therapist's supervisor or manager. If the participant felt unable to make the complaint without support I intended to advise them of possible sources of the support.

It was not necessary to either recommend further counselling or advise a participant about how to make a complaint. However, one of the participants did comment that when she had decided to take part she had thought to herself that if she felt upset after the interview that she would contact her therapist.

Participants were also provided with a copy of their own transcripts, with an invitation to make any changes they deemed appropriate. Each participant was asked if she would like a summary of the overall findings of the research, they all indicated that they were interested in this and have subsequently received a brief outline of the findings. My

observations here reflect those of Oakley (1981:45-46) who noticed that her participants were also very interested in the outcome of her research.

Conflicts of Interest

Conflicts of interest existed due to my roles as family therapist and researcher. I foresaw that this could arise in my contact with both the participants and the therapists.
In the case of the participants this was attended to by declaring at the beginning of each interview that I am present in my role as researcher. Furthermore I planned to make re-referrals as discussed above if therapy issues arose during the course of the interview and if necessary stop the interview.

It is possible that this conflict of interest may have influenced the information that the women provided to me, thereby potentially affecting the validity of the findings as it will be seen that overall their comments about the therapy tended to be positive. Nevertheless, personal experience is valid, no matter how small the sample, as long as the person being interviewed does not feel constrained. In this project the participants may have felt constrained as they knew I was a therapist and that I also had contact with their therapist, although I had assured them of the confidentiality of our contact. However, they did tell me about aspects of the therapy process which are usually less visible to the therapist including the other resources they used to overcome the problem, their thoughts and actions between sessions, and in one instance a detailed description of their criteria for selecting a therapist. Furthermore, partly as a result of the conflict between my two roles I focused more on how the women made use of the therapy and what they did thereby maintaining the focus on what the women did rather than on what the therapist did.

In the case of the therapists I advised them at each point of contact about the research proposal that I was unable to give them any direct feedback about the interviews although they were each offered a brief summary of the findings. I found that the therapists tended to be very interested in the results of the research and at times requested information to which they were not entitled because of the restrictions of the contract of confidentiality between myself and the participants. This arose both out of their interest in the research and the vulnerability they felt about my having access to their clients. I was able to discuss these conflicts with the university supervisors which assisted me to maintain clarity about the contract. I found that the therapists accepted these limitations once they were reminded about the confidentiality contract.

ANALYSIS OF THE DATA

The issue of what to include and exclude in the data analysis quickly became more problematic than I had expected. Decisions about what to include derive firstly from a common problem in qualitative research, which is the amount of material gathered as a result of the face to face interview (Minichiello et al, 1990; Babbie, 1992). Furthermore, the decisions which are made about management of the material are informed by the subjective view of the researcher. Minichiello et al (1990:290) point out the identification of the themes and the ensuing analysis is a subjective process. They argue that:

> Whenever we read between the lines, we must ask ourselves whether our reading is consistent with the informant's perspective.

They suggest that "all social interpretation is dependent on this latent content analysis and it is inherent in the analytic enterprise itself". I initially attempted to avoid contributing my own analysis of the material as I felt that the stories of the mothers I had interviewed needed to stand on their own. Furthermore, I was reluctant to contribute in any way to the power differential between the participants and myself. Eventually, however, I concluded that a rigorous analysis of the material provided to me by the participants would not necessarily contribute to the power imbalance, particularly if I was explicit about my presence in that analysis. Tait (1990:183) outlines her efforts to overcome similar issues in her research about women's experience of mastectomy. She concludes that: "the researchers understanding, which is my own, must be made explicit". She suggests that when the researcher does this then the relationship between researcher and participant is more likely to remain equal. (A view also held by Mies, 1983). Tait (1990:183) argues that this shifts the focus from data which is "out there" to a focus on what the researcher has done with the material. I found that my attempt to use such an approach left me feeling somewhat exposed as a researcher, as the inconsistencies and ambiguities in the project become both readily identifiable and reflected the inconsistencies in my own life[9]. Nevertheless, as Tait points out, adoption of such an approach to the data analysis avoided the objectification of the participants.

Most of the participants stated that one of the reasons that they decided to take part in the research derived from an interest in the notion that others may benefit from their

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[9] An example being the ongoing ambivalence and tensions in my own life between my roles as a family therapist and as a mother. This ambivalence in my life while contributing to my decision to explore the research topic also contributes to some of the inconsistencies which are present in the analysis.

experience of the family therapy process. Although the extent to which the mothers are able to realise their aims in this respect rests with the choices I have made, and will continue to make after the completion of the thesis. Those choices centre around what to include in the material presented in the thesis and secondly, what to do with the material in terms of ensuring that it is more widely accessible than it will be in thesis form. Consequently, as the researcher I see myself as having a responsibility to ensure that the material that they provided me with is readily accessible and understandable to a wide range of readers.

As previously described, the data was collected through the means of in-depth interviews. Each interview was taped, with the permission of the participant, and subsequently typed into transcript format. In order to provide some structure to the abundance of data obtained each transcript was broken into three sections: the experiences of the participant before, during and after the therapy. This was the basis for the further identification and analysis of common themes and noticeable differences in the material as discussed by Babbie (1992:301-302).

The transcripts of each section were further broken into sections which dealt with the issues presented by the participants. For example, issues which emerged in the experience of the participants before the therapy commenced were: how the referral was made, how the participants felt about asking for help, their expectations of the referral process, and the time between the referral and the first session.

The material in the sections was then further compared and analysed to determine the impact of each of these factors on the overall experience and opinions of the participants about the therapy. Williams (1990:255) makes an important distinction between demonstrating that something is the case rather than merely asserting that it is. I found this to be an easy trap to fall into and have attempted to avoid it by substantiating my claims with other research and theory. This was not straight forward as there is limited research available in this area. However, through comparing my results with those of other researchers such as Howe, (1989) and Bennun (1989), and by analysing the results according to family therapy theory and feminist theory, issues and possible trends have been identified.

The results of this research while highlighting a number of areas which warrant further research are not able to be readily generalized to other groups of mothers attending family

therapy because of difficulties in research design derived from problems in establishing access to the research pool.

SUMMARY AND CONCLUSION

This chapter has considered the methodological issues for feminist research making a distinction between research methods and the theory of research, which is methodology. I have discussed the approaches to both methods of research and methodology itself according to current feminist practice and writing in the area. I have outlined the process which led to the selection of a qualitative research method and identified the advantages and drawbacks of that method. The second half of the chapter focuses on how the research was implemented and the ethical issues which arose from the research design.

It seems to me that while a number of complex ethical issues arose in the course of planning the research, which were potentially problematic, they were effectively resolved. However, the design of the research and the presentation of the results has been inexorably influenced by the importance of confidentiality for the client and the potential conflict of interest between my role as researcher and therapist. This has influenced both access to the research group and the analysis of the data. While these could be considered limitations in terms of the results gained, nevertheless, the bias which may have been introduced as a result of the steps I took to ensure the confidentiality of the participants does not affect the validity of the results due to the focus of the analysis on what the women did during the therapy and the use they were able to make of the therapy. The outcome of this focus is that it affirms the usefulness of therapy for these women; points out avenues for improvement in family therapy practice, and furthermore avoids inadvertently blaming the mothers for the problems they have encountered and highlights their agency in relation to both the problems and the therapy.

Furthermore, I think that the research I have conducted is important in that it covers an area which has previously received only limited attention. The matters which emerged from my conversations with the participants highlight issues which I think will be of interest to both family therapists and their clients, as well as those involved in family therapy research.

The data obtained from the interviews with the participants is presented in the four chapters contained in the next section. The presentation of the data reflects the therapeutic

process in that it follows the key components of therapeutic intervention including engagement, itervention, the helping relationship, and the termination of the therapeutic relationship. While this framework is that which is commonly used by a wide range of therapists to explain the therapeutic process in this research I am considering the process and the framework from the point of view of the participant.

PART THREE

THE RESEARCH

INTRODUCTION

This chapter and the three following present and discuss the data obtained from the interviews with the women who took part in this project. The information is presented in four sections. Firstly, it looks at their experiences of the events prior to the therapy. Secondly, the first interview and thirdly, events which occurred during the therapy, and finally what happened outside the therapy room, including occurrences between interviews and immediately after termination of the therapy. These sections reflect the key elements of the therapeutic process, that is intake, engagement, intervention, and termination. I have chosen to present the information in this way because it reflects the stages of the process the women experienced and also, the way in which therapists and other helping professionals tend to think about the process of therapy. The analysis presented here draws primarily from the works of: Siporin, (1975); Compton and Galaway, (1984); Chaplin, (1988); Barker, (1992).

A number of other themes are woven through the data as presented here which are significant to the women in the project and also reflect the situation of women in society. They include: motherblaming; the caring role of women; and the lack of material resources available to women. It seems to me that each of these issues is related to women's position within a patriarchal society as discussed in part one of this thesis. It can be seen from this research that patriarchy influences both how the women approach therapy, and how they experience it. Furthermore, it undoubtedly influences the delivery of the therapeutic service. It also fundamentally influences how women see themselves and this too is apparent in the comments of the women in this project.

Demographic Information

The eight women who took part in the research had all recently been involved in therapy, with members of their family. For reasons of confidentiality, and to avoid the danger that they could be identified, I do not intend to discuss their personal situations in detail. However, in order to facilitate the reading of the thesis the following is a very brief outline of demographic details pertaining to this group of women.

They were aged between thirty and forty years of age, they were all mothers of dependent children, ranging in age from six months to fourteen years. The size of their families varied between one child to four children and other step-children who moved in and out of the household.

They either sought or were referred to family therapy for the following reasons: marital problems (1); conflict about maintenance (1); behavioral problems of children (6). The behavioral problems of the children included aggression and fighting between the children, difficulties adjusting to the separation of their parents, behavioral problems which derived from sexual abuse, and a grief reaction to the suicide of a father.

Six of the women were sole-parents. Of these one worked part-time to supplement her income, the other had just left a job, the remainder worked primarily in the home. These six women relied on benefit income and the resultant lack of financial resources constrained the solutions they were able to use to resolve the problems they were dealing with.

One woman was married. She worked almost full-time in a professional position. One woman had remarried and worked full-time in the home. Neither of these women had access to material resources which enhanced their independence. The income Rose received was committed to supporting the business venture of her husband. Joanne, who worked full-time in the home, was dependent on the income of her husband and this contributed to her decision to apply for maintenance for her son from her former husband.[10]

It can be seen that for most of the women in addition to facing complex problems, either in their relationships or in the behaviour of their children, they had limited material resources with which to deal with these problems. They faced severe problems which were ongoing and which they had attempted to deal with, either on their own, or with the help of other helping professionals for a protracted period of time before attending family therapy.

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[10] The interviews for this study were completed prior to the changes to the child support legislation in 1992.

CHAPTER SIX

SEEKING HELP

If you're pushed into it and not ready to do it, you just don't. You might be there but you're not going to give it your best shot because you don't want to be there. (Jenny)

Just asking was hard, because I've always been totally in control of my life. (Denise)

INTRODUCTION

This chapter presents and discusses the information of the eight women interviewed about their experiences of making the decision to attend family therapy and seeking it out. Six of the women were referred by helping agencies who were already involved in their situation. Two referred themselves directly to the therapist who they were to see.

When thinking about the process of seeking help it seemed to me that the decision to either accept the offer of assistance or to seek it out is a significant one for anybody contemplating a therapeutic process. With this in mind, I asked each of the women to firstly, tell me how it came about that they went to see a therapist, and secondly, how it felt to ask for help. I concluded this part of the interview with a question about what they thought the therapy would be like. In response to these questions, the women gave me, what I consider to be, a detailed and insightful picture of the process of intake and engagement. The reader will see the path to therapy varied considerably for each of the women; that they had to overcome significant obstacles in the decision to attend the therapy, and that they each had expectations of what the therapy would be like, which for most of them caused some feelings of anxiety prior to the first interview.

This process can be described as the period of intake (Siporin, 1975:193) or as the contact phase (Compton and Galaway, 1984:345). The essential characteristics of this stage of the process involve the assessment by both clients and therapists as to whether they will work together (Compton and Galaway, 1984:345).

The focus of my discussion will be on the women's decision to present to a therapist rather than the decision of the therapist whether or not to accept the referral. It can be seen

from the comments of the women about the process that they were largely unaware of the selection process which takes place at intake. They became aware only when they experienced considerable difficulty in obtaining the assistance they thought that they needed as in Brenda's situation. This will be discussed more fully later in the chapter.

Included in the discussion about the women's experience of seeking help is a presentation of data pertaining to how the participants found asking for help, their expectations of the therapy, and the length of time between referral and the first interview. As all of the women had attended several sessions of therapy, it is reasonable to assume that their experiences at this stage encouraged them to pursue the therapy. The project does not include interviews with women who considered therapy and then changed their minds before attending the first interview or who withdrew from the therapy at any stage.

THE REFERRAL PROCESS

All eight women had initiated the process themselves. For two it was through self referral directly to the therapist. The six other women had initiated the contact with the agency which then referred them to the therapist.

Self-Referrals

Self-referral takes place when the client goes directly to the agency or therapist providing the service. In this project two of the participants fall into this category. They had each learned of the service provided by their particular therapists from different sources. Both Jenny and Barbara had each struggled with the problem they sought assistance for on their own for some time and then acted on information they had received, in Jenny's case through a friend and for Barbara from the local Citizens Advice Bureau.

Jenny heard about the therapist she saw through a friend who was having similar problems and who had commented that seeing the therapist had proven to be helpful:

> A friend of mine was taking her son there - he was being a real sod and Sam is quite good at being like that too and she said how good it had been for her kids, so I thought I might give that a go. So I did.

Jenny's comments indicate that her friend's recommendation of the therapist and the agency she worked for had been the deciding factor in seeking assistance for her son.

Jenny has received counselling assistance from another agency previously, which she did not find satisfactory, and she was consequently more cautious about seeking assistance for the problems she was having with her son. The recommendation of her friend encouraged her to put her past experience aside, in this instance.

Barbara contacted Citizens Advice who gave her information about where to contact a therapist. Barbara was looking for a solution to the arguing between her two children, and to gain an understanding about the problem:

> I probably went because of the arguing - I felt I needed someone to say, to help the children with why they were doing this, why they were constantly at each other.

It is clear from the comments of both Barbara and Jenny that their respective decisions to contact a therapist derived from their desire to find solutions to the problems they were experiencing with their children.

Agency Referrals

The remaining six women were referred to their family therapist through other agencies. These included: Birthright; NZCYPS; a General Practitioner; and the Family Court.

Birthright referrals

Judith and Linda were each referred to the same therapist through Birthright. In both cases they had sought assistance and support as solo parents through Birthright (which is an organisation which aims to support sole parent families). The idea of family therapy was proposed by the Birthright worker and then discussed with each of the women who agreed to try family therapy as a possible solution to the problems they were facing.

Judith described the process in the following way:

> It was her suggestion because Max had quite a bit of trouble with attitude and coping with all the changes over the last three years. He won't talk to me because I'm his Mum, and it's not cool anyway for an 11 year old to talk to his Mum! She [the Birthright worker] was doing a fee for service contract with me which meant all of us doing something to help the family because we had a lot of problems last year and the year before and they had just got on top of everything. So they'd built up and built up, and all of us had got too tired to deal with them.

Although the therapy was suggested by the Birthright worker Judith saw it as an opportunity to address problems which were beginning to overwhelm her and her children. For both Judith and Linda the referral arose from a suggestion by the Birthright worker who along with the women had identified problems which were not resolving with the support of the Birthright worker or the attempts of the women themselves.

New Zealand Children And Young Person's Service (NZCYPS) referral

The NZCYPS is a government agency with statutory responsibilities for the care and protection of children. Brenda had sought their assistance for her son Corey. Brenda had previously experienced considerable difficulty in obtaining the assistance which she believed she and her son required. She had tried for a number of years to obtain assistance from a variety of agencies in the region. She wasreferred to a family therapist, together with her son Corey, as part of the follow up to a child abuse investigation. Brenda thought that the referral was automatic for clients of the NZCYPS and she welcomed it as part of the service provided:

> They arranged it. It's all part of what they do once the child has made a disclosure, they automatically put them into therapy. It wasn't just Oh, well, you've been abused you can go home now. I think I would have phoned Parliament if they had done that to me.

So, although the referral was made by a statutory agency which in fact has the authority to insist on the client attending the therapy Brenda was pleased about the referral and indicated strongly that she would have been very dissatisfied if the referral had not taken place.

General practitioner referrals

Denise took her son Richard to the family doctor because of behavioral problems. The doctor arranged referral to a health agency which provided family therapy as part of its service. Denise discovered later that she could have referred directly to that particular agency herself:

> I found out later I could have just gone there because Richard has been under their care before, since he was about three years old, because he'd always had hearing problems. He'd had developmental problems and behavioral problems so he was going up there quite a bit. Although he hasn't been for some time. You don't find these things out until it's too late.

If Denise had been advised by the agency when she had originally attended their clinic with Richard that she could contact them directly about any concerns she had about him she would have been able to save both the cost of attending the GP and the time involved in arranging the referral through her GP.

Family court referrals[11]

Rose and Joanne were each referred as a result of attending the Family Court. Rose had gone to her solicitor to seek advice about separation from her husband and was referred to the Counselling Coordinator at the Family Court. She was taken by surprise at the referral initially and her comments indicate that she felt that she was to some extent caught in the process of the system. She had not realised that a referral to counselling is usual practice within the Family Court when it appears that a couple may be about to separate. Rose concluded that the referral was beneficial:

> I just got so fed up in here that I actually went to a lawyer and he put me on to the Counselling Coordinator at the Family Court. It snowballed from there, once I'd made contact with her it was almost like I was on a rollercoaster and I was being pushed from one slot to the other. I hadn't really intended to take it that far, I was only going to the lawyer for information.

Rose's use of the description of a rollercoaster indicates that in part she felt, once having initiated the process that there was no stopping it. She qualifies this as suiting her in that it provided her with the impetus to begin to work towards changes. Rose felt that she could have withdrawn from the therapy but we did not discuss what she thought the impact of doing so would have been on her intention to separate from her husband:

> I could have backed out as soon as I got in the Family Court, once I'd seen the Counselling Coordinator. I think it was that first step going to see the Coordinator and then being given forms to sign, I'm glad it happened but it wasn't what I set out to do at the beginning of that day.

So it would seem that although at the time Rose had felt like she was on a rollercoaster and events were taking her over, she had reached the conclusion by the time I met her that

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[11]The women who were referred to a family therapist through the Family Court tended to use the word counsellor, to refer to their therapist. In discussion with the Family Court counselling coordinator I was advised that the court does not fund therapy. For the purpose of clarity, and to avoid any conflation of counselling and therapy, it is necessary to point out that when contacting the therapists I asked them to invite those clients to take part with whom they had utilised family therapy methods. Therefore, despite the confusion of the terminology, I have assumed that the work the therapist undertook with them was based on family therapy.

she was glad that it had happened. However, it seems to me that it is important that at any stage of the process that a client have the power to withdraw if she so desires, and while it may have suited Rose to have been carried along by the process other clients of that system may not find it so beneficial.

Siporin (1975) argues that it is important during the intake process that the client realise that they can leave the system if they so wish:

> During each major step of intake, the applicant needs to be given a clear choice about accepting or rejecting the client role and taking the next step to become one. This is necessary to enable him [her] to make the continuing inner decisions and sequence commitments that are required to move the action process.

It seems to me that it is possible that the experience of being on a rollercoaster will have influenced Rose's approach to the first session. This will be discussed further in the next chapter.

Joanne was referred her therapist because of a dispute between her former husband and herself over maintenance. She found the therapy very helpful and wished that she had found out about the Family Court counselling service sooner as she felt that she had spent money unnecessarily on lawyers fees in the process of trying to have maintenance paid to her for one of her children:

> I didn't realise it was a service that was available to us, the general public, to go and get maintenance. Had I known that, I wouldn't even have gone to my lawyer. That's what the counselling coordinator said to me when I phoned. I said I wish I'd known this before I'd gone to my lawyer, because this is costing money that we haven't got to pay the lawyer when that service [the therapy] is absolutely free. I actually had him [her lawyer] up about that because he should've known about that service.

It seems to me that Joanne did not have adequate access to information about the counselling service, the responsibility for disseminating the information rests both with the Family Court and Joanne's lawyer. So rather than it being a matter of her own ignorance it is a matter of the responsibility of the both the agency and the lawyer to provide the necessary information. It seems to me that the lawyers actions may have been less than ethical in withholding the information from his client.

The experience of these two participants were very different at this stage of the process despite their referrals to a therapist being actioned through the same system. Rose was

advised immediately by her lawyer of the counselling service available through the Family Court whereas Joanne appears to have stumbled on to it almost by accident, after having spent money on legal fees.

Discussion

The referral path which each of the women experienced appears to have been influenced by several factors. These included: the identification of a problem and the realisation that therapy may be helpful; the women's knowledge of what was available; the knowledge of those professionals they had contact with in the referring agencies and possibly their willingness to share it; and the clarity of the information provided to them by the agencies they had contact with.

Once they had identified that there was a problem with which they wanted assistance the path to the therapist was not necessarily direct at all. For most of the women gaining access to the therapist was a process which involved contact with other agencies in the first instance. Usually the referral was the result of discussing their situation with professionals in the referring agency and that professional then suggesting the therapy and making the referral. The exceptions to this were Jenny and Barbara who sought assistance themselves through information available to them from a friend or the Citizens Advice Bureau.

For the other participants the therapy was suggested to them by other agencies or helping professionals. This raises the issue of whether the women perceived themselves as being able to say 'no' once the therapy had been suggested. While none of them indicated that they did not want to attend the therapy it is clear from their comments that it was not their idea but proposed by the person that they had gone to in order to seek help. This leads me to wonder how much persuasion was used in gaining the women's co-operation, by the referrer. It is possible that the participants may have felt compelled to attend if they wished to demonstrate that they were serious about wanting to change their circumstances. The participants themselves were vulnerable at this stage of the process to pressure from the referrer that it would be helpful for them to attend, they were also dependent on the willingness of the referrer to share information with them, as Denise and Joanne commented. There appears to have been an assumption that the referrer had the power and control over the referral which then disempowered the women and had the effect that the responsibility for the decision to make the referral was removed from the women themselves.

ASKING FOR HELP

The issues of power and persuasion in the referral process, identified above, led me to ask the participants what it was like asking for help. It seemed to me that making a request for help potentially implies a vulnerability and powerlessness that exposes the women to the aspects of motherblaming mentioned in chapter three (Caplan and Hall-McCorquodale, 1985; Hourigan-Johnston, 1989; Bograd, 1990).

Most participants found asking for help difficult although one, Joanne, once she realised that there was counselling help available through the Family Court system was relieved: "It was good to know that, that kind of help was available - I just didn't know that it was".

Common themes in the comments made by the other participants included: fears about what other people might think; and the belief that attending therapy was a sign of failure.

Two participants who expressed concern about what others might think of them for seeking assistance also indicated that they perceived themselves as stigmatised by the community due to their status as sole parents. They each stated that they felt that as sole parents they were being judged by other members of the community. Linda said:

> It's not something I like to do because I like to be in control.I don't like to think that the other parents think that I need it or I'm not capable.

Linda managed to overcome these feelings and made a deliberate decision to accept as much help as she could in order for things to be better but she still struggled with feelings of guilt about the assistance she was getting. This was tied to the fact that payment for the assistance she was receiving did not come from herself. As she says:

> The fact that it was being paid for by the Social Welfare Department and even with the Birthright worker coming to see me, she was sort of counselling me. The Social Welfare Department was paying her to counsel me and I would say to her: "Well you must have more needy people," and things like that which I stopped doing because she said everybody gets their turn.

Eventually Linda decided that by accepting the help she would be able to move on more quickly and achieve the goals she had set herself. She finally concluded that:

> There is no stigma, or anything like that. In actual fact it's something that more people could do. I don't think we've quite realised what we get out of it and it's one of those things that can't do any harm.

As will be seen later Linda found the therapy to be very helpful and this may well have been a factor in her eventual conclusion that there is no stigma attached to attending the therapy.

Judith also worried about what others might think. She felt that this fear caused her to delay going to family therapy. She had a very clear idea about what others might say, which she imagined might be: "oh she can't cope on her own very well. She must be silly, daft, she must be so weak."

Judith felt that because of the stigmatisation of sole parents she had to be seen to be doing a better job than anybody else:

> Well, for me as a person it always is hard to ask anybody for any help. You're trying to cope as a woman on your own in a society that dictates you shouldn't. Society dictates that you should have a male role model. So trying to cope on my own as a woman for three and a half years was, is difficult. Trying to be the strong one. Trying to be the comforter, provider and answer to all questions. And when you don't know, they wonder why. You're not human, you're Mum!

This comment reflects the enormous pressure which Judith felt as a sole-parent to meet all the needs of her children. It suggests that not only had she internalised the expectation to meet all her children's needs but that she perceived that they expected her to be able to do so. This takes on more significance with the knowledge that she also commented to me that she received little support from her family of origin or the children's father. As she says she was left to do all the parenting on her own.

Judith's comments further indicate that she felt that in asking for help she had not managed to demonstrate that she could do it on her own:

> It is difficult to ask for help personally, anyway, but to ask for extra help - it was a pride thing I think which is stupid because I teach the kids not to have too much pride to ask for help but I do it myself.

Whereas for Linda and Judith the comments of stigmatisation arose from their status as sole parents. For Rose those feelings appear to have developed from her ideas of what is expected of professional people. She talked about a sense of failure over the necessity to

go to therapy developing from the idea that as a professional person she should have been able to resolve her difficulties on her own. However, she had not been able to do so and she began to wonder if there was something wrong with her:

> I was going to have to overcome the whole stigma of seeking therapy. It's not that it's like you shouldn't have these problems but you do feel I shouldn't be like this, I'm a professional person, we're married, we're old enough not to have problems.

Jenny made the distinction between being referred for assistance and seeking help of her own volition. She has had experience of both eventualities and she found that in the former situation she had feelings of guilt and failure, whereas when she sought help of her own volition she did not:

> About a year ago my doctor suggested I put Sam in day-care just for a day a week. Then I said: "No, he's at kindy three afternoons a week, he's all right". When it came to me knowing that this is really getting up my nose, I realised it and I asked for the help. But before I was really hacked off that he'd suggested - I felt like I'd been a failure.

Jenny found that when she later sought help of her own accord that it was more beneficial. She felt in control of the situation.

Denise felt that asking for help was a sign that she did not have the amount of control over her life that she was accustomed to.

Brenda had attempted to get the help she needed for her son Corey over a number of years. This left Brenda angry and cynical about the whole process of asking for assistance and at the time of her last approach to NZCYPS she says that she was doubtful about the chances of receiving the help she thought she needed:

> As far as asking for help from them it was sceptical or cynical. The hardest thing was being believed. I truly have this child who can perform the exorcist and nobody believes me and really they didn't.

However once the service became involved on this occasion Brenda found that she was believed and as a consequence she and Corey were referred to a family therapist. Brenda did not ask for this, it was offered to her.

Discussion

For most of the participants asking for help was something which was done after considerable thought about the problem and effort to address the problem themselves. Most had to overcome anxieties about what others might think of them as well as anxieties about what taking such a step represented to themselves. It is clear that for all the participants seeking therapy involved an acknowledgement to themselves and to others that they were having problems. This was a considerable hurdle as they also demonstrated very high expectations of themselves. This manifested itself in different forms according to their particular situations. Those who were sole-parents said that they wanted to prove to themselves and to others that they could manage on their own. Whereas Rose, who had a professional career, felt that she ought to be able to sort her problems out herself because as a professional person she should know how to. It appears that these factors for some of the women caused them to put off seeking assistance. So it would seem that while the women were all very sensitive to being judged by others about their need for assistance they also had high expectations of themselves and when they did not meet these expectations felt a sense of failure. It seems to me that these reactions and comments on the part of the participants demonstrate the power of the ideals in society about the role of mothers and the extent to which this is internalised by mothers themselves as discussed in chapter three. Moreover in their comments about their sensitivity to judgements by others, the women are describing the influence of 'the normalizing gaze' as observed by Foucault (1980) and discussed earlier. It is through the internalisation of the gaze that the power is maintained and control effected. So, it would seem that the high expectations these women had of themselves is a manifestation of the control of women through ideas about the performance of mothering which permeate our society and inform the ideas which women internalise about the way in which they need to do the job.

EXPECTATIONS OF THE THERAPEUTIC PROCESS

Once they had made the decision to accept the referral the expectations of the participants were varied, ranging from an eagerness to attend to a fearfulness. This range seemed to be most affected by the method in which the participant had been referred to family therapy. The two women who had self-referred were the most positive in their expectations of the therapy. Of those participants who were referred to family therapy through another agency, those who asked for assistance from the referring agency, that

is, Birthright, General Practitioner,and the NZCYPS were prepared to attempt family therapy as a possible solution.

The two participants who were referred through the Family Court system, where referral may not have been seen as optional, were the most anxious about the referral.

Self-Referrals

The two participants who had self-referred to their therapists, Barbara and Jenny commented favourably about their expectations of the therapy. They commented that they looked forward to the therapy as a possible source of solutions to the problems which they were experiencing. Barbara saw the therapy as an opportunity to increase the understanding in the family. She said:

> I was looking forward to attending. I suppose I was thinking, well at least the children will understand how I feel and they could understand why I got upset.

Jenny also commented that she was looking forward to the seeing the therapist and she said:

> I wasn't nervous about seeing the therapist because I really wanted to see her. I think what I was expecting to come out of it was all the magical answers that were going to work overnight and turn him into a little angel. But it wasn't like that it was just.... that was what I was hoping for. I suppose I expected it to be just what it was like -*just the therapist asking questions and giving a bit of advice.*

So, it can be seen that Jenny was hopeful about the therapy. She hoped for a rapid and complete solution, but she also tempered that hope with a certain amount of realism that maybe if change was to come it would not all be brought about by the therapist.

Birthright Referrals

Although Linda had found counselling that she had received previously less than satisfactory she had decided to accept every offer for help that she could in order to resolve some of the issues that she had been facing. She described herself as going along to the therapy with an open mind. She said:

> Because we had so many years of counselling I thought we'll go along and try. The Birthright worker had said what a neat person he was and: "if

> for any reason you don't like him or don't get on with him all you've got to do is say, and you can go and see somebody else".

Linda seems to have found the knowledge that she could change therapist reassuring whereas Rose (as discussed later) thought this would be hard to do.

Judith had expected difficulty in encouraging her son to talk to the therapist: `I thought Max would shut his lips and not talk. I thought he would clam up on me'. The reluctance of Max to communicate was part of the problem which had led Judith to seek the therapy.

NZCYPS Referrals

Brenda also commented that her therapist came well recommended: "I'd heard nothing but good things about him anyway, so that helped."

When Brenda's therapist had to cancel their first appointment unexpectedly Brenda felt let down. She describes a process in which she had built her self up for the visit and when it did not eventuate, due to circumstances outside the therapist's control she felt very let down:

> I got myself so worked up to see him that when he rang I felt like saying well you can forget it. I was depressed for days after that, I'd built myself up for it and knew what I was going to say and also for me because there were a lot of sensitive things, you build your barrier. I felt let down again, I had to look past that and say well it wasn't his fault. I did feel let down.

General Practitioner Referrals

Denise had a good deal of nervousness about the first visit. She had an understanding that the process would involve sitting and talking. She also expected censure from the therapist about her ambivalent feelings towards her son. Denise had expected that she would be judged about those feelings because she is a sole-parent:

> I'm in solo parent mode and I think if I say that, [how she feels about her son] people might think that oh, what else can you expect she's only a solo parent.

Family Court Referrals

Rose and Joanne had both been referred to the therapist as part of the process when presenting to the Family Court system. Neither of them had realised that family therapy

would be involved and they each expressed a reasonable degree of anxiety about what that would mean. They both expected to be blamed in some way for the fact that their relationship had either broken down or was in the process of doing so.

When Rose had gone to her lawyer for legal advice she was considering leaving the relationship and was worried that counselling would be used to try and influence her to do otherwise. As she said: "I thought I'll just be so angry if I get a counsellor who says you should try to reconcile."

Rose goes on to describe how she expected the therapist to work with her:

> I really think that I expected to be able to walk in there and say what the problem was, lay all the blame at my husband's door and for him to say you're perfectly right and it shouldn't be happening like that.

Rose was able to stipulate some selection criteria for the therapist that she was to see. She wanted a therapist who had children and she also wanted a male:

> It was important that they have experiences of what it's like to be a parent. I know that not every parent enjoys every single minute of parenthood. There are ups and downs and I knew that if the therapist had children he would be able to relate to problems that occur in a marriage because of children.

Furthermore, Rose wanted somebody who was skilled in working with children in case her son was involved in the process. She wanted someone who would be able to help her with telling her son that she was leaving the marriage and also possibly him:

> I remember talking to the Coordinator about it and saying that I definitely needed someone who was good with children in case it involved Ben because of the feeling that I was going to leave him behind. I was going to get ideas from this person about how I could then tell Ben that we weren't going to live together anymore and that I was going to be on my own.

Rose also asked for a male therapist for specific reasons:

> I would have preferred to have a woman, but at the same time I knew I couldn't have a woman because if I did then my husband would see that as very biased so I decided to have a man. I asked actually about having a male and a female and I think she said it was possible but they don't normally have the two sitting there together, I can't remember, she said something about someone having a partner that could be involved if I thought it was necessary. But I remember I decided that I couldn't have a woman because it wouldn't be right as far as my husband was concerned. I felt that had been a big concession on my part.

It is clear that Rose, despite the unexpectedness of the referral carefully considered her requirements of a therapist. She made specific requests, which were met in part. That is she was referred to a male therapist who had children. Rose seems to have undertaken a complex assessment of both the needs of her son and husband when selecting the therapist. Her own preferences came last in this process. She did suggest conjoint therapy but when it became apparent from the coordinator's response that this was outside the usual way in which Family Court counsellors in that area worked she did not pursue the matter. So, in the interests of maximising the chances of engaging her husband in the process Rose made a decision to overlook her own preferences for a woman therapist.

Rose was also advised that should she have any reservations about her therapist that she could change to a therapist who suited her more. Rose felt that it would have been hard for her to do:

> I thought if I went back to the coordinator and said, "Look I'm not getting on with the therapist, I need to change," I would be saying to him, [the therapist] "we're not getting on, I don't like you." Which was actually hard for me. I wouldn't like to be in his position and have a client say I'm not getting on with you so lets change, so I was very relieved that he was really very approachable.

Rose's reaction to the information that she could change her therapist indicates that despite the effort of the referrer to empower her she felt daunted by the impact such a decision would have on the therapist, which is in contrast to Linda who was told the same thing but felt reassured by the information.

Joanne had been pleased to learn that the therapy was available to her as she could see the potential benefits to her, in terms of the Family Court system. However, when thinking about attending and what it might be like, she was fearful and anxious about what would be involved:

> It was such a bitter battle going on, I thought these people are going to take it all out on me and it's all my fault. It was just such a bitter battle from the beginning and this is just some more of it.

It is possible that these two women felt that they had to comply with the referral in order to obtain the separation or the maintenance that they wanted.

Discussion

The theme which runs through the response of the women to my questions about what they thought the therapy would be like, is that they expected the therapy to involve talking. They also wanted somebody to understand their situation and to support them. But probably the most important feature of their expectations of the therapy and the factor which had led to them deciding to seek help, was that they wanted to find solutions to their problems. Hence, although Rose would have preferred a woman therapist she opted for a man because she thought this would facilitate the best chance of a solution, although part of her clearly wanted sympathy from the therapist.

TIME BETWEEN REFERRAL AND THE FIRST SESSION

The length of time between the referral and the family therapy commencing varied from a couple of weeks to three months. Four of the women commented on the difficulty in dealing with the wait and described struggling on with the problems they were facing. Of these four the two referred to the health agency had substantial waits before being seen; Denise three months and Jenny a few weeks. Denise did not find the wait easy:

> It was quite hard, I tried to deal with it as best I could, cos sometimes with Richard [son] he just wont listen so I just had to separate him and me.

Jenny said that once she took the step of asking for help she wanted assistance immediately:

> Anyway when I rung I felt like I wanted it right there and then. Like, desperation. I thought, oh well I'll wait, but she said if I was really desperate I could talk to her on the phone - this was some other woman as [the person she was to see] was away. I thought, no I'll be right, I've put up with it this long.

Judith and Brenda were both referred to a private practitioner. Judith waited eight weeks which was exceptionally long. She found the wait frustrating because, having decided to accept the advice of her Birthright worker and get family therapy, she wanted to get on with it as soon as possible. However, a series of miscommunications led to the delay. Judith decided not to tell her son Max about the referral until she had confirmation that the referral was actioned because she thought that doing so would have raised his anxiety about the matter and made any therapy more difficult.

Brenda had an especially difficult task in getting the assistance for her son which she had been seeking for almost five years. By the time Brenda was referred to a therapist she had begun to find some of her answers and she said that the waiting "wasn't so intense because now we had an answer."

Discussion

The women did not know what contributed to the waiting time. The person who had to wait the longest was Denise (three months), and she was seen by a therapist in the health sector. This is a very long wait, particularly given the situation of Denise, whose husband had died suddenly, and she was left on her own to support four children, one of whom had behavioral and learning difficulties. Judith also had a lengthy wait of eight weeks, although she saw a private practitioner who was contracted by NZCYPS.

The women were left to struggle on with the problems they were facing with no extra support during this period, only the hope that when they got to see the therapist that the situation would improve.

DISCUSSION AND SUMMARY

Several factors influenced the women's approach to the therapy. These included the referral path which led to them seeing the therapist, their views of what seeking help represented to others and to themselves, and their previous experiences of counsellors and therapists.

The referral path impacted on the expectations the women had of the therapy. The two who self-referred were looking forward to their first meeting as a chance to tell their story and to get some answers to the problems they were facing. Their comments indicated a lower level of anxiety about the referral.

Those who had the therapy suggested to them were more ambivalent with Linda summing up their attitude with her comment that she decided to go with an open mind. Several of the women in this group commented that their therapist had been highly recommended to them and that this helped.

Seven of the eight women expressed anxiety about asking for help. They included a fear of what others might think, and a sense of failure. Jenny who self-referred pointed out that when she asked for help herself she did not have a sense that she had failed. This was in contrast to her reaction when her GP had suggested some months earlier that she get assistance for her son. The difficulties in asking for help discussed by the participants in this study were related to the suggestion from others that the woman and her family might benefit from family therapy and what this suggestion actually represented about the way that they were viewed. Three of the women were worried that they would be blamed in the therapy for their situation. This included the two women referred through the Family Court.

The anxiety which most of the women experienced about what others might think and the concern of three of the women that they would be blamed for their situation reflect to me that each of these women were only too well aware of the predominant attitude in society towards mothering. They had imbued the belief that it was their responsibility to ensure that the emotional needs of their family members were being met and that if there was evidence that someone was needy then that reflected on them. When faced with evidence that they were not meeting their needs they struggled with overwhelming feelings of guilt and failure. This can be readily connected to the 'powerless responsibility' (Rich, 1976) and motherblaming (Caplan and Hall-McCorquodale, 1985) discussed in Chapter Three. It can be seen that the women were particularly vulnerable to feelings of guilt and to the idea that they might be blamed for the problems they were experiencing.

This being the case it is then incumbent upon therapists to examine both their attitudes and practice in order to address this issue. It is clear that the women pursued the referral to therapy out of a concern about the problems which they were experiencing. It seems that this concern outweighed their fears about being judged for needing help.

Howe (1989:41) suggests that the tension between the fear of being judged and the effects of doing nothing is central to the process of intake or engagement. He says:

> A family with a problem experiences two kinds of anxiety, each pulling in the opposite direction. The first is the pain and stress the family members suffer and for which they seek relief and which we might term problem anxiety. It draws them to therapy. The second is the stress engendered when someone is faced with personal exposure, scrutiny and evaluation. To be examined and possibly judged by others is personally threatening. Normally such stress is avoided. It pulls people away from therapy. We might call this service anxiety. Depending on which is the stronger - the need to relieve pain or the discomfort of the examination -a family will either stay in therapy or withdraw.

The experiences the women outlined to me during this stage of the process lead me to conclude that it is a time of a high level of anxiety for the participants as they struggle with the issues of reviewing their concept of themselves, the anxiety about what other people might think and the very real fear that they may be blamed by the therapist for the situation they are in.

It can be seen that the mothers in this project actively evaluated their family situation and the need for a referral to family therapy. The experiences of the participants at this stage of the process influenced how they approached the next part of the process, namely meeting the therapist, which is discussed in the next chapter.

CHAPTER SEVEN

MEETING THE THERAPIST

Well, the first time I met him on my own and like I didn't stop talking from the time I went in to the time I went out. (Linda)

INTRODUCTION

This chapter describes the process of meeting the therapist and beginning the therapy, the stage of the process which Chaplin (1988:2) refers to it as 'setting the scene'. It is generally considered in most schools of therapy that establishing rapport at the commencement of contact with the client or family, and maintaining it, is essential if the therapist is to be able to assist the family to change (Siporin, 1975; Compton and Galaway, 1984; Chaplin, 1988; Barker, 1992).

Barker (1992:91) asserts that once established rapport must continue to be fostered:

> Establishing rapport starts with the initial contact. It should be a main objective of the first interview, perhaps the first several interviews, and rapport must be maintained throughout the treatment.

The weight which Barker gives to the establishment of rapport with clients is supported by the comments the women made about the beginning stages of the therapy and the significance they gave to the relationship with the therapist which is discussed in the next chapter.

In this chapter I discuss: the process of meeting the therapist, who attended, where the meetings were held, and what the women thought of the first meeting. It will be seen that most of them found the first meeting in particular to be very significant with some describing it as emotionally draining.

THE FIRST MEETING

All the participants made comments that indicated that the first session had an especial significance for them. It was usually anticipated with some nervousness or anxiety and

all the women described the session itself as emotionally charged. The meeting had a high emotional content for most of them and it was important in establishing the relationship between the women and the therapist. The women's expectations of the first session varied, with some describing themselves as looking forward to the session and others feeling nervous about it. Those who felt nervous beforehand described themselves as feeling relieved afterwards. This was connected to their discovery that in that session, at least, they had not been attacked or blamed for the situation they were in.

From Denise's comments it seems that the first few minutes in the first meeting were pivotal for her:

> I can usually tell within about five minutes of meeting a person if I'm going to be able to talk to them or going to be able to make an acquaintance out of them. I felt good when she introduced herself. Funny that isn't it, it must be something to do with chemistry or vibes or whatever.

Having established that her therapist was a suitable person to talk to Denise appears to have become completely involved in the therapy and she was surprised at the length of time the interview lasted:

> We just sat there and chatted, the time actually flew. My neighbour took me up there, we had an appointment for nine o'clock, and she and her daughter sat in the car. I didn't expect to be long and I said, "Look if you want to go away and do some shopping. I can't imagine being much more than an hour." I thought that would cover it all, and at half past eleven I walked out of there. Two and a half hours. There's my poor neighbour and her daughter and they're just about asleep, and it was a boiling hot day. It was incredible the way you just talk about things and time flies by.

This experience was echoed by Linda who said: "Well, the first time I met him on my own and like I didn't stop talking from the time I went in to the time I went out."

Barbara also found the first visit emotional: "We all ended up in tears at some stage or other."

Joanne considered that the first interview was significant in relieving her anxiety about the process:

> I found the atmosphere quite warm. I felt comfortable going there and coming home. So when the next appointment was set up, all the anxiety had gone. It was sort of something I looked forward to.

Jenny saw the therapy as an opportunity to thoroughly discuss her situation and in the first session, in particular, she describes herself as "unloading":

> I really went into detail because I think I just wanted to unload on someone and she seemed like someone I could unload on, so I did! And she probably got a real ear-bashing. I didn't want to go there and just give her half the story, then I'd just be deluding myself. I'd be cheating myself of why I went. I thought I might as well be truthful and honest and hopefully come out of it with something, because I wanted to.

Rose was anxious about the meeting and found it draining:

> I was as nervous as a cat, really, really nervous. I had no idea what he was going to ask me or how the session was going to go, I think on the first session I kept saying to myself, I hope I don't cry I will be embarrassed with myself if I cry. I think I did on the first session. I felt stupid afterwards, but then it's nothing to feel stupid about, it's what happens I suppose. I'm quite reserved really, I find those sorts of things difficult to deal with. You know, going and seeking counselling, telling him all about my problems and baring all and then bawling, all those three things in the one session I found hard and I felt absolutely exhausted at the end of it. Absolutely mentally exhausted.

Although Rose found the session emotionally draining she also commented that her therapist did certain things in that first session which helped to put her at ease. These included his statement about confidentiality, his quiet manner, the way he spoke, and the amount to which he let her speak:

> The therapist made an effort to describe his role and said that everything would be confidential, that he was required to write a report back to the court but there would be no content whatsoever in it, it would be like a summary on very broad terms .... and his quiet manner, he's an easy-going chap and the way he spoke was very relaxing and it wasn't like he was loud or straight into it and he let me do a lot of talking, those sorts of things. My first impression, he never got my back up which is great.

The points which Rose make illustrate what is generally considered within counselling and family therapy practice theory as good engagement skills. For example each of the features which Rose mentions are outlined by Siporin (1978:206-208) in his discussion about building a successful helping relationship or engaging, successfully, someone into the helping process. It is also consistent with the suggestions of Chaplin, (1988) that the counselling be 'demystified' and the client given as much information as possible about what will be involved. Chaplin suggests that from a feminist perspective this helps to equalise the power.

So, although Rose had been very nervous prior to the session and found it emotionally draining she and the therapist had established, by the end of that first session, the beginnings of a working relationship. The manner in which the therapist did this was also important to Rose, her description of him as having 'a quiet manner', being 'easy-going' reflects the findings of Howe (1989:58) who said that: "the families all wanted to be approached gently and sensitively, thoughtfully and slowly".

Rose went on to comment that she had been worried that the therapist would be able to influence her into taking actions that did not suit her and she checked this out at the beginning of the session to her satisfaction:

> He said I'm not here to push you one way. That was a big weight off my shoulders, that was very important to me ... I didn't want to be pushed into a reconciliation. Years ago I think that's probably what people tried to do.

Rose was able to assert to her satisfaction that the therapist was not likely to influence her in a direction she did not want to take. It is clear from her comment that this had been a source of anxiety for her prior to commencing the therapy, and she was relieved that the therapist she saw did not practice in this way. In fact as a result of her experience with that therapist she concluded that such practice was now a thing of the past.

OTHER FACTORS INFLUENCING THE BEGINNING OF THERAPY

The comments of the women about the beginning stages of the therapy also highlighted the issue of the power relations between themselves and the therapist. These seemed to be centred around decisions about the location of the therapy and who attended the therapy.

Choosing the Venue

The venue for the therapy varied for each participant. Some were always seen at their own home, others were seen at both their own home and at the rooms of the therapist, some only at the therapist's rooms, and one, Rose, was seen at two different sets of rooms retained by her therapist. The location of the therapy tended to be determined by the therapist and usually involved the woman attending the therapist's rooms.

Two of the participants, Linda and Rose, commented in detail about the significance of the venue describing particular venues as having an impact on the therapy itself. Linda said that sessions were held either at home or at her therapists rooms. She preferred using the therapist's rooms as her children were usually involved in the therapy and she found that if the therapist visited them at home it was difficult to retain the children's interest. She commented:

> Well, sometimes we had them here [her home] but I kept away from that because there are too many distractions around here.

Rose found the venue for her first appointment reassuring and relaxing. She commented that a further appointment which included her husband was conducted at a different venue and Rose commented that: "it was a new place to deal with". While she did not comment in detail about the second venue her comment does appear to suggest that the change in venue presented a hurdle to overcome at the next appointment.

It is not clear from the women's comments how much choice they had about where they were seen, although Linda's comment that she kept away from having appointments at her home indicate the she was able to exert some influence on the venue of each session. It is not possible to determine this from Rose's response. However, her comment that the change in venue was a new place to deal with does indicate that she felt some discomfort about the change. She had obviously felt very comfortable at the first venue.

Power Dynamics of Inclusion

Although the participants had all been referred to a family therapist most sessions involved only certain family members. Family therapy texts such as Barker (1992) emphasise the importance of seeing the family together at least initially, however a brief review of the literature (Esler 1988; Epston, 1989; Hourigan-Johnston, 1989; Smith and Tiggeman, 1989; Jenkins, 1990; Wheeler, 1990) and case studies presented at workshops such as those run by Deborah Leupnitz (1992) and David Epston (1989) suggest that it is common practice to see individual family members, or the parents and children separately. Hare-Mustin (1980:935) suggests that it is not always in the best interests of the woman for the family to always be seen together. She sees such an approach as problematic because of the unequal distribution of power within the family. The women I interviewed in this project were often seen by themselves or only with certain members of the family. Four of the women were seen by themselves initially and

then their partners and/or children were included in the therapy. Where the issue of who would attend was raised the women were given a choice as with Jenny and Judith.

Judith commented that when given the choice of meeting as a family from the beginning or seeing the therapist on her own first she chose the latter because she felt that she would be able to provide information to the therapist which her son might not volunteer:

> I said I would rather meet him first to let him know a few things about my son that he wouldn't admit to and then go from there. Not that the therapist had to mention them, just be aware of them.

It seems from Judith's comments that she decided to meet with the therapist on her own first as she felt more comfortable talking to the therapist about her view of the situation without the presence of the children. Howe (1989) found in his research that several families felt compelled to bring the children and reacted by either withholding information from the therapist, because of their discomfort about talking in front of the children or talked when they would rather not and felt resentful about it. Judith, through the opportunity offered by the therapist was able to avoid this situation. Moreover, through meeting the therapist first Judith felt that she was able to give the therapist her interpretation of the situation. Furthermore this first meeting between Judith and the therapist provided Judith with the opportunity to establish whether or not the therapist met her expectations. She certainly had the potential between that appointment and the next, which involved the children, to withdraw from the therapy, if she felt so inclined.

Barbara and Brenda each commenced the counselling as a whole family, or rather with all the family members living in the same household attending. As the therapy progressed the composition of the sessions altered so that individual family members, or couples, or one or two of the children would attend. Brenda described this in the following way:

> We went along as a family. It was a family therapy type session. Occasionally I'd go on my own, or Corey would go on his own, or my husband and I would go together to talk about what was happening in the home.

Jenny commented that after her first session, which also involved her son, her therapist suggested that she attend on her own the next time:

> She said next time it might be an idea not to bring him and I said I think I will because it was good for him to know that he was being talked about because he was being naughty. Because he doesn't like to think I've told someone he's been naughty.

Without questioning the therapist it is difficult to determine why the therapist suggested to Jenny that she return on her own, when the reason for the involvement with the therapist was the behaviour of the son. However, Jenny's response was very clear, and when she attended the second session her son accompanied her. Jenny obviously felt that she had a say over who attended and was able to exert her influence.

Barbara had attended each session along with her two children. Her son had missed the previous two sessions due to a holiday and ill-health and at the time of our interview he was refusing to go back. Barbara attributed this to her son having difficulty saying what he wanted to in the sessions:

> He can't really say what he wants to say for one thing and I really don't see the true Luke at all in counselling.

This comment reflected Barbara's own feelings about the therapy as well as her views about her son's experience of the therapy, in that she, at the time of the interview was seriously questioning its usefulness both for her and her family. Furthermore, Barbara also said that she thought she would have to explain to the therapists why he did not want to attend.

Summary

It seems that where there were variations in who attended this suited most of the women. When they were seen on their own they were able to discuss information with the therapist which they felt may not otherwise be raised. It also gave the women, where they felt hindered by the presence of other family members, the opportunity to discuss fully with the therapist their view of the problems they were facing. Barbara, on the other hand, felt accountable for her son's decision not to attend further sessions.

SUMMARY AND CONCLUSION

Two key issues emerge from the women's experience of this stage of the process: the significance of the first meeting; and the empowerment of the women.

It can be seen that the first contact with the therapist, particularly the first meeting was pivotal for the women I interviewed. Most of the women reported that they had entered

that meeting feeling anxious about the therapy and left the session feeling considerably less anxious. They linked this to successfully establishing a relationship with the therapist.

Although all participants had been referred to a family therapist the actual sessions usually involved only certain family members. The degree of anxiety reported by the women before the session does not appear, in this group of women, to have been an influential factor on whether or not they were likely to feel anxious after the first session. Those who were referred through the Family Court system and the NZCYPS described themselves as very anxious prior to the beginning of the first session. This had dissipated at the end of the session and is reflected in Joanne's comment that the therapy became something she looked forward to.

I expected that those who self-referred, Barbara and Jenny, would report less anxiety than those who were referred through an agency as they had the greater degree of control over whether or not they entered into the therapy. However, while Jenny did so, Barbara's anxiety remained high. This appears to have been connected to the poor relationship Barbara perceived with the therapists. It would seem that the level of anxiety felt by the participants, once the therapeutic process has commenced, reduced if they perceived themselves as having a good relationship with the therapist.

It would have been interesting to talk to a group of women who had not returned for a second interview, in order to determine what they had thought of the process at this point. Howe (1989), in his research found that families in this category remained highly anxious about the process of seeking help and came to the conclusion that they were unlikely to receive help through family therapy.

The second issue which emerged was the power which the mothers were able to use to influence the development of the therapy. At this stage of the therapy this emerged in decisions about where the therapy would be conducted and who would attend. The women's participation in these decisions appears to have been dependent on both the therapists' approach to including the women in the decisions and the women's perception of themselves as being able to influence the process.

It seems that most of the women in conjunction with the therapist decided who would attend the first session. This enabled the women to influence the direction of the therapy. In contrast to the view of Barker, discussed above. I see this as usually beneficial to the

process as it represented a more equitable sharing of the power between the woman and the therapist which has been argued for by feminist therapists (Goldner, 1985; Hare-Mustin, 1986; Hoffman, 1992).

CHAPTER EIGHT

EVENTS DURING THE SESSIONS

I felt like I was understood, that I wasn't making it up, it wasn't all in my head. (Brenda)

He may have it all on paper, but he hasn't got it, not for my situation anyway. (Barbara)

INTRODUCTION

This chapter presents and discusses the thoughts and activities which the women identified as taking place during the sessions. This stage of the therapeutic process is commonly referred to as 'intervention'. The focus, however, is not on the interventions of the therapist but on what the participants thought about this part of the process, including their relationship with the therapist. This is influenced by the critique of family therapy research contained in the introduction. A further justification for this from a theoretical perspective is outlined below.

In order to understand how the participants experienced the process of attending the therapy I asked them what they did during the sessions, what ideas and feelings were they able to discuss during the sessions, and what was their relationship like with the therapist. These questions generated a lot of information from the women.

On the whole they expressed strong feelings about the process. Their comments were generally positive about the experience, although for all of them the process was emotionally charged. The comments the women made about the process illustrate the significance of attending therapy, the impact on them of the way that the therapist worked, and the types of relationships they had with the therapists.

Their comments are separated into the following sections partly for ease of presentation, but more importantly because of the elements which are important in the therapeutic process namely: the relationship with the therapist, the effectiveness of the therapist, what, if anything they learnt from the therapist, their observations of the therapist's interactions with the children, and their comments about the interaction between the therapist and themselves. The chapter concludes with a brief discussion of the aids which

the women noticed the therapist using during the sessions. The material covered here is significant as it explores the women's view of the therapy and the therapist. Their comments provide some understanding about how they experienced the process of being 'in therapy'.

It is apparent that the establishment of a relationship with the therapist was pivotal in the therapy process. Strean (1983:266) suggests that:

> Most social work practitioners and theoreticians have considered the worker-client relationship to be a salient feature of treatment.

Such a relationship is typically referred to as the "helping relationship" (Compton and Galaway, 1984:219). As has already been established, my focus is on how the women themselves found the relationship. However, an analysis of the power in the relationship is also important. Wearing (1986a:34) discusses power in interpersonal relationships. She points out that:

> Power, then, refers to the relationship between dominant and subordinant groups such that the dominant group can define the situation, needs, wants, and desires of the subordinant group which accepts and internalises the definition, so that conflict is averted and the interests of the dominant group are met.

Given that a power imbalance exists, then it is likely that the power will impact on the therapy. The manner in which it does so and to what extent is, by and large, determined by the therapist rather than the client as the client, being relatively powerless, is usually required to conform to the definition of the therapist about the meaning of the process. The degree to which the power impacts beneficially, or otherwise, depends on whether it is openly acknowledged and discussed by therapist and client. Fook (1986:61) suggests that: "simply acknowledging and discussing unavoidable power imbalances may be an easy starting place".

Chaplin (1988:7) suggests that feminist counselling precludes an imposition by the therapist of the meaning of the counselling process. She states:

> The counsellor is not there to dominate or have power over the client... Feminist counselling aims instead to empower people and help them develop more self-confidence and control over their own lives. The counsellor is not seen as an expert or the doctor; the client is not a patient. Rather, they are two different people using 'clues' to explore the life of one of them. The focus is on one of them. The focus is on the client.

Inherent in such an approach is a helping relationship in which the client is likely to feel accepted, and where there is a degree of reciprocity between client and therapist. It will be seen in this chapter that these features of the helping relationship were important to the participants in this project. Moreover, where they were missing the participants felt that the therapy was limited as a result. It will be apparent to the reader that the women all viewed the relationship with the therapist as central to the therapy.

Other researchers of the therapeutic process, Bennun (1989) and Howe (1989), have found that a favourable perception of the therapist by the client is related to a favourable outcome of the therapy. At first this may seem obvious but as I have previously commented much of the research in family therapy has concentrated on the intervention's of the therapist rather than on the family member's experience of the process. Bennun (1989) found that where the family members perceived the therapist favourably there was a correlation with an improvement to the presenting problem. Bennun (1989:249-250) states:

> The results suggest that good and poor treatment outcomes can be statistically differentiated in terms of perceptions that some members of the family hold about the therapists. Specifically, if fathers experience a therapist as competent and active in providing direct guidance, then the likelihood of a good outcome is better than chance.

Bennun did not include families where there were sole parents. Despite the limitations, which derive from examining only traditionally structured families, I found his results interesting in that he links the outcome of family therapy to the perceptions of the therapist by family members. He relates his findings to research within individual therapy which has also suggested that the relationship between the therapist and client are important in effecting changes to the presenting problem.

Howe (1989) found that where families felt that they were understood by the therapist there was a greater degree of satisfaction with the therapy and with the outcome. He found that most of the families he interviewed did not feel understood. This correlated with the high percentage of participants who felt that the therapy was not useful to them.

Thus, it can be seen from the work of Bennun and Howe that the perceptions and feelings of the clients appear to influence both the approach of family members to therapy and the outcome of the therapy itself.

Some of the women viewed the therapist with a very high regard, considering that the therapist had a special gift for his or her work. When this happened, while seeing the therapy as very satisfactory, it seemed to me that the women were also inclined to question their own skills.

Some of the participants disagreed with the therapist about particular suggestions. Where they were able to talk about these disagreements with the therapist the relationship was enhanced and the women felt more accepted for themselves. Where they were not able to do so the disagreements interfered with the progress of the therapy.

In order to provide clarity to the reader, before proceeding I will briefly outline the interventions the women reported to me. They included: simple behavioral modification advice, such as rewarding good behaviour and ignoring the undesired behaviour, techniques for building self-esteem, (one therapist described these as problem-busting to one of the women), relationship building, talking about the problem and what they wanted to change, mediating between the opposing parties as in the situation with Joanne. This list does not convey information about the therapeutic models which the therapist used, as the theoretical perspective of the therapist was using was not readily available to the mothers.

RELATIONSHIP WITH THE THERAPIST

Seven of the eight participants described their relationship with their therapist as relaxed, easy going, and one in which they felt the therapist was genuinely interested in their situation. Of these seven, five saw a man and two saw a woman. All seven described the relationship in highly favourable terms and perceived themselves as understood by the therapist. They comment on several activities of the therapist which conveyed to them that the therapist understood them and was interested in what they had to say. These included: the humour of the therapist, taking notes about important parts of the conversation, and the interested manner of the therapist. I have included here examples from people seeing different therapists.

Jenny felt that she was able to establish a good relationship with the therapist concerned, describing it as a 'two way street':

> It wasn't just her dictating to me do this or that. She was suggesting things to me I could do. And also was open to suggestions she could probably use in the future. So it was good.

Judith described her relationship with her therapist as relaxed and friendly. She attributed this to the easy going manner of the therapist she saw and her own approach to relationships which she describes as a boots and all approach:

> He was really friendly - we laughed and joked and carried on. Really good ... after a while I'd be saying: "What's your problem and how are you!". Really easy going.

Judith also commented about the personal circumstances of the therapist which the therapist had disclosed to her. This further indicated a degree of reciprocity between the therapist and herself.

Denise found her relationship with the therapist to be good:

> We had quite a good rapport, even though we only met twice. I probably would have carried on if she hadn't had to leave.

Rose perceived her relationship with her therapist as beneficial. She described him as 'very nice' and went on to comment on the sense of relief that she experienced when on meeting her therapist she realised that she felt comfortable with that person: "I was very relieved that he was really very approachable and put me at ease straight away. I don't know how, he just did".

Linda felt comfortable in her relationship with her therapist:

> I got on so well with him, there's nothing I wouldn't say and like my language can be quite descriptive and he's a particularly good counsellor for me because of the encouragement he gives me.

Brenda also described her relationship favourably:

> He's done more for us than anybody has done for us. I don't know whether we were just ready for it or what it was. If it had been anybody else I don't know... but he was the best thing for us. I felt like I was understood, that I wasn't making it up, it wasn't all in my head. Somebody I could actually have faith in, it was amazing.

As discussed previously Barbara was seen conjointly and felt differently about the two therapists she saw. She felt that the lack of shared life experiences interfered in her relationship with one therapist (this will be addressed in the next section). However, she had this to say about the woman therapist in the team:

> I can feel that she's got an understanding way about her and you could confide in her and that she's got good knowledge of life skills that he does not appear to have.

EFFECTIVENESS OF THE THERAPIST

Each of the participants formed opinions about the effectiveness of the therapist they saw. Comments ranged from considering that the therapist had a special gift and was able to offer just what they needed, to those who appreciated the way in which the therapist worked with them, but were a little less enthusiastic to those who felt that their therapist's effectiveness was limited because they did not share similar life experiences.

Special Gifts

Brenda and Linda each belonged to the group who considered that their therapist had special gifts which enabled him to provide just what they needed. Interestingly, they each saw a male therapist, and I found myself wondering if this in some way influenced their enthusiastic response to his assistance. Linda comments: "I think he has a special talent of bringing out a lot of good things in people and I'm just so lucky to have got to see him".

Brenda was cautious about her therapist at the first meeting but this was replaced by a feeling that the therapist had something special to offer both her and her family:

> When I met him, I found him to be thoroughly nice. I thought, 'Maybe he's too nice for the job he's doing, what has this guy got?' It was only after being with him as long as we were and I found out that he's just got something. It's how he puts things to you, how he has answers there for you. It's amazing: he's got a good personality there for that.

In addition to feeling that the therapist had the answers there for her Brenda described the method that the therapist used when working with them. It included the therapist identifying which tactics were effective in altering the problem and bringing that to her attention:

> He wrote down all the positives and some other stuff in relation to what was happening and he would go back through it and he would say this is positive and make us go back through what we had said. All of a sudden you'd snap and think, 'Hey did I say that?'

Appreciation of the Way the Therapist Worked

Joanne said that she liked the way in which the therapist left her to do the talking:

> After being in the room five minutes they didn't say anything, they let us say it all. I thought that's really good, somebody's listening and not being biased. They're not interested in what happened, in who was the bad person - they were just interested in the issue which happened to be our son. It was good - I enjoyed the focus he put onto our son, away from us.

Usual family therapy practice would not consist of focusing on the child. However, in this particular situation, the parents were separated, with Joanne having remarried. Joanne described in detail to me a situation where she and her former partner were locked in a pattern of arguing over the custody and access arrangements for their son and her description of the therapist's response appears to indicate that this was addressed by encouraging Joanne and her former partner to consider their responsibilities as parents. Furthermore, Joanne is clear in her comment that this focus in fact suited her. She commented earlier that prior to the first session she was nervous about attending because of the bitterness between herself and her former husband and it seems from her comments that she felt reassured during the session due to the focus being repeatedly pulled back to the issue of what was best for their son. Thus the focus remained on solving the problem rather than laying blame.

Denise felt accepted by the therapist and appreciated that there was no judgement about the comments she made or her feelings towards her son:

> The therapy was pretty good, I found out quite a few things and it was more in depth than what I thought it was going to be. I had quite good feelings about it, there was no feeling of, 'OH I shouldn't have said that, oh gosh what will they think of me'. I admitted that I didn't get on particularly well with Richard and there was no censure, there was no, 'He's your son, you should get on with him'. There was nothing like that and I was quite relieved to find that.

The key features which the women in these two categories have commented on about the usefulness of the therapy include: a realisation that the therapist had answers for them; the therapist consistently brought out the good in the people attending the therapy, keeping

the focus on problem-solving rather than apportioning blame, and learning ways of dealing with the problem. Denise's comments about not being blamed for the way that she was feeling about her son are important as this was her major anxiety when she was considering attending the therapy.

Therapist Did Not Share Similar Life Experiences

Two women in the research group, Barbara and Jenny, both felt that the effectiveness of the therapist they saw was limited because they had not experienced similar life situations.

Barbara was seen by therapists working conjointly and these comments apply to only one of the therapists:

> His children are a lot younger and perhaps dealing with children the age of mine, he was really interested in the respect thing - what I meant by respect because he hadn't really yet come across that. He often uses words that the children can't understand or phrases too way above them. But then in some other aspects he treats them quite young, see. But I think a lot of that is life experience. He may have it all on paper, but he hasn't got it, not for my situation anyway.

Jenny said that she found the advice offered by her therapist helpful but she felt that it would have been more useful if the therapist had children, or was in a similar situation to herself:

> Some of the suggestions were good but I just felt that coming from someone that didn't have any kids, giving advice to me that I am stuck here on my own with one kid 24 hours a day, sometimes they can be a bit unrealistic. She was good - the advice she gave - but I don't know I kept thinking: "Wait till you have yours!". Easy to give advice when you haven't been through something.

Discussion

It appears, from the comments of Barbara and Jenny, that when the therapy proved unsatisfactory then the differences in life experience between the therapist and client began to be perceived as limitations. They did not think that the therapist appreciated their experience.

When comparing the comments of Barbara and Jenny to those of the other participants it is clear that they felt that the difference in life experiences between themselves and the

therapist limited the effectiveness of the therapy. The limitations varied between them with Jenny still finding the therapy useful, but perhaps not as satisfactory as it might have been. Whereas Barbara consistently expressed dissatisfaction with the therapy. As mentioned earlier Jenny had commented that she had a good relationship with the therapist. However, Barbara felt that one therapist had not established a satisfactory relationship with either her or her children. Jenny and Barbara's comments indicate that as a result of the dissatisfaction with the therapy and the perceived differences in life experiences they were less likely to accept the guidance or suggestions offered by the therapist.

INTERACTION BETWEEN THERAPIST AND MOTHER

The interaction between the therapist and the participant gives some indication of the extent to which the relationship between the two was reciprocal. The level of reciprocity the women reported ranged from: accepting what the therapist introduced; accepting what the therapist introduced but feeling discomfort over some points; open debate and disagreement over some matters; making a contribution to the therapists knowledge base; and finally, attendance at the sessions but dissatisfaction with the usefulness of the therapy. It can be seen that the range in reciprocity was wide, from accepting what the therapist had to say, to not accepting it, but remaining in the therapy. There may well have been others who were not included in this research who exited from the therapeutic relationship because of disagreements with the therapist. However, these women were unable to be captured in the research pool due to issues around the design of the research outlined in the methodology chapter.

Adding To The Therapist's Knowledge Base

Linda felt that she was able to contribute to her therapist's knowledge:

> He pointed out that for all the years that he's been at university and things like that I actually said something which he didn't know, and he in turn learnt something from me and he's made some changes and he never learnt that through all his years.

Other participants, including Jenny, Denise, and Brenda, also commented that the therapist noted ideas which they had thought of and found made a difference to their situation.

Acceptance Of What The Therapist Introduced

Joanne seems to have accepted the intervention of her therapist. She commented that she occasionally asked his opinion. Furthermore, the therapist commented favourably about some actions of her former husband and this caused her to review her own opinions:

> He listened to everything we were saying. Sometimes I'd ask him for his opinion. It was a very unbiased opinion. Some things he saw that my ex-husband was doing as really good and it was really good for me to see that too. I thought: "OK, if this guy thinks its pretty good then it must be good and I don't need to look hard at it again".

Joanne also commented that the therapist, who was acting as a mediator effectively controlled the therapy when she and her husband revisited old arguments:

> My ex-husband would bring up that my son needs a new bike and that would take us right away from the issue, X would bring us back. We'd start fighting over the silly bike... and while we were getting stuck into each other he would bring us gently back to the issue: "Let's talk about your son". Ever so nice.

Judith said that she found the first session distressing as mentioned in the previous chapter but for the remainder of the sessions she just listened to what her therapist was saying, especially to her son:

> The other sessions for me were just waiting and listening. Just trying to listen to what my son was saying and to the way the therapist brought it out of him.

Judith commented that she thought that the interaction between herself and the therapist helped to make the therapy more comfortable for both of them.

Discomfort Over Some Points

Brenda describes two factors which are significant in the interaction between her and the therapist. Firstly as with Rose and Joanne she was satisfied with most of the interventions undertaken by the therapist, including a shift in focus from her son to herself which surprised her but which she accepted believing the two to be interconnected. Secondly, Brenda observed several steps which the therapist took to keep her informed of what was happening in the process. However, she was uncomfortable with one of those steps:

> In fact he encouraged me to talk about me. I think that by doing that he was able to introduce ways where I'd changed and by doing that Corey improved. I guess in some ways it's a bit like reverse psychology.

Brenda considered that her therapist actively took steps to make sure that she was aware of how he was working and his thoughts about any changes that were taking place:

> He took notes and said that we could look through them when we had finished, he made sure that we were aware of what he was doing. He asked us what we expected him to do for us. He always made sure that we could read the notes if we wanted to and we would go back over some really positive points.

Although Brenda did feel comfortable with the direction of the therapy and most of the efforts of the therapist to inform her of how he was working she was uncomfortable about his questions about her expectations of the therapy:

> That throws me every time somebody says that, I hate that. You're going in there thinking, well you can change everything for us. Don't say: "what are you expecting?". I want you to say well: "I'm here to help you and make it all better".

Brenda's reaction to this indicates that she felt uncomfortable about sharing the power with the therapist. In fact her preferred comment of 'I am here to make it all better for you' suggests that she wanted the therapist to take the responsibility away from her. This is not surprising when considered in the light of the long and difficult path Brenda experienced when she was trying to get the help she knew both she and her son needed. Moreover, as was discussed earlier, she felt that the therapist had special gifts, and she had heard only good things about him before she commenced seeing him. Therefore, both her difficulties in getting help and the reputation of the therapist, made it difficult for her to share the power with the therapist on that occasion. Furthermore as Chaplin (1988:25-26) points out it is up to the therapist to inform the client what the counselling involves. So, while Brenda was looking for a cure, it was also appropriate for the therapist to be asking her what she expected as this informs the client that she will be sharing the process.

Open Disagreement Over Some Points

Denise and Jenny openly disagreed with their therapist on particular issues. They both stated that they said that they did not feel compelled to comply with the therapist's point of view. It is interesting to note here, that both Denise and Jenny saw a woman therapist.

Denise differed with the therapist on whether or not to tell her son about the circumstances surrounding his father's death. Denise thought that the therapist believed that it would be a good idea to tell him whereas Denise considered that he did not have the maturity to understand it:

> That's the only thing we disagreed on, not violently or anything like that but she did want me to tell them and tell them how and all that sort of thing. I didn't agree with that. She wasn't pushy about it but she said: "Well you're their mother, it's up to you". Knowing Richard quite well I know what he can absorb. Before [husband's death] I would have put myself in the therapist/patient mode and because she was the therapist, automatically she was right. I don't say she thought that, she wasn't lording it over me, nothing like that at all. She was just putting her point of view across and I felt it's alright to put my point of view.

The interchange Denise describes illustrates the self-confidence with which she approached the issue. Earlier I have outlined how Denise felt that she was accepted and understood by the therapist, and it seems to me that these two factors combined with the personal development Denise had accomplished since her husband's death may have influenced the outcome of this difference of opinion. It is clear from Denise's comments that she felt very comfortable asserting her opinion whereas previously she may have deferred to that of the therapist.

Like Denise, Jenny also disagreed with some of the advice given to her by her therapist. In Jenny's case, the disagreement was about the issue of physical punishment and although the Jenny felt that it was what her son required she did modify the way in which she used the punishment:

> She doesn't agree with smacks. I said I was given plenty when I was brought up and I'm not any the worse off for it. When you're giving advice you've really got to take account of the kids.

Jenny had previously mentioned that she felt that the therapist did not understand what it was like to be in her situation. I felt that her comment about needing to know the kid was a further indication that she felt that the therapist had not fully appreciated her situation.

Consequently, I asked Jenny how the issue of the smacking was resolved between her and the therapist. Jenny replied:

> Well, I just said to her: "I used to get smacked when I was a kid and it didn't do me any harm and as far as I'm concerned I don't think it will do Sam any harm". Especially Sam. If I didn't give him smacks he would probably walk all over me. I use the strap on him. But I was starting to use it too much and it didn't have any effect. So I stopped using it for a while.

Jenny describes how the therapist suggested a strategy for handling her son's behaviour. Jenny did modify her discipline of her son from using the strap to smacking, but not as much as the therapist originally suggested:

> And she said: "Try to just smack him". She said: "Think of what he is doing and does that matter". So if he was in here making a helluva mess, I'd think do I really care, does it matter? And I'd realise, no it doesn't matter.

Jenny also commented that during the first session her therapist recommended trying a range of approaches which she had already tried and felt that they hadn't worked. When Jenny said this the response her therapist gave was to try harder.

> The first time I saw her, a lot of the things she told me or suggested to me I'd already done or was doing and she just said: "You've got to try harder. It's going to come through for you in the end."

> I said to her: "God, I feel like I've tried everything and failed with it all". She made a couple of other suggestions that I'd done and were probably right but hadn't carried them on but I'd just felt it was like bashing my head against a brick wall because he is so determined.

The comments of the therapist to try harder frustrated Jenny as she felt like she had already been trying as hard as she could with her son. It may have been this comment which lead Jenny to the conclusion that the therapist did not really appreciate what it was like in her situation as a mother on her own. Jenny was in a situation where she was isolated from the community, and the therapists suggestion to 'try harder' led Jenny to the conclusion that the problems were her fault, and that she was doing something wrong. However, Jenny also described how the therapist pointed out to her the impact of motherblaming on solo-mothers in particular. It may have been this comment which gave Jenny the confidence to try what the therapist was suggesting despite the reticence that the therapist didn't really know what it was like because she hadn't been through it herself.

> I said to her: "I feel there are pressures coming from other people about what to do when Sam is at school". And she agreed there were pressures out there. She was the one who said that about pressures on mums, especially solo parents. She knew about it. She was onto that. But she just isn't there.

Discussion

So, it seems that while the comments discussed above were frustrating for Jenny and confirmed her isolation it seems that there were other components to the therapist's interventions, especially the discussion around motherblaming which mitigated the effect of the limitations Jenny raised. As a result of this discussion Jenny felt more inclined to follow the therapist's advice and did so with reasonable success. The discussions which Denise and Jenny have outlined indicate a process which was more reciprocal than those the other women described. They both saw a woman therapist, and it is interesting to observe that they were each very comfortable about stating their opinions when differences occurred. They listened to what the therapist had to say, but did not feel compelled to implement it. It seemed to me when listening to their descriptions of what took place that the therapy was richer for it. They were less overawed by the therapist, particularly in comparison to the group of women who accepted what the therapist introduced. (The women in this group all saw a male therapist). They each responded to the disagreements differently. While Denise felt that she was able to discuss her situation with the therapist and come to her own conclusions about the best course of action to follow Jenny felt that inherent within the discussion was a lack of understanding by the therapist about her particular situation. This confirms the results of Bennun discussed earlier, in which he found that there was a correlation between the satisfactory relationship between the therapist and client, as perceived by the client, and the outcome of the therapy. Therefore, while Jenny felt that the therapist's ability to understand was limited because she had not had relevant life experiences, the impact on the overall therapy was lessened due to the quality of the relationship which they shared. It can been seen from Jenny's comments that they were able to discuss the viability of possible solutions. When these outcomes are compared with those discussed below it suggests that a satisfactory relationship between therapist and client is necessary to the usefulness of the therapy. The outcome was most severely affected when significant differences were not able to be discussed within the therapy as with Barbara.

It appears that the gender of the therapist may have influenced how the mothers viewed the interventions of the therapist. The male therapist was the therapist who was perceived as having special abilities by some of the participants. Moreover, the suggestions and

interventions of the female therapist were challenged by some of the mothers. Whereas, none of the participants who saw the male therapist openly challenged his suggestions.

Dissatisfaction and Limited Interaction

The interaction between Barbara and her therapists seems to have been limited. At the time of the interview she was feeling that the therapy had been unhelpful. However, as she had not used up all the allotted sessions she thought that she would continue to attend. Barbara felt that a significant factor in this situation was that appointments were too far apart, some of them being up to one month apart. She would have preferred weekly sessions. Barbara did not discuss her ambivalent feelings about the therapy with the therapists involved.

Howe (1989:43) encountered several people who reacted to the therapy in a similar manner to Barbara. He described this group as ambivalent attenders: "They remained in therapy, but were not engaged yet they still held the prospect of help". It can be seen from Barbara's responses that she intended to keep going to the sessions because she was aware that there was still time available, and she was hopeful that she might be able to find the solutions that she was looking for, although by the end of the interview it was also becoming clear that she was looking outside the therapy for solutions, as evidenced by her enquiry to me about the type of assistance provided by Toughlove.

INTERACTION WITH CHILDREN

Several of the women commented on the interaction between the therapist and their child or children. The level of interaction ranged from the child playing quietly on the floor, with the occasional question addressed to him or her, to being seen by the therapist on their own for either a part or whole session.

Two of the women, Linda and Judith, commented on the ability of the therapist to communicate with children, perceiving the therapist to have greater skills than themselves in communicating with children.

Linda felt that her therapist was particularly good at relating to children:

> He's very good at bringing children out, like praises them and finds things in them that perhaps I even wouldn't be aware of and I think he [son] wouldn't even have been aware of them.

Judith had expected her son not to communicate with the therapist as she herself had been experiencing considerable difficulty in getting him to talk to her:

> I actually cried because my son was talking like a river to this man I'd never seen in my life before. But he's got the skills - he's been trained to get things out of people. Whereas I don't have, I've skills in my way but it's not obvious not the way that's adequate for my son. He couldn't get my other son to talk, so it's different again for him. He needs a different approach.

It appears that when Judith observed her son talking to the therapist that this undermined her confidence in her ability to communicate with her children. She went on to comment that: "I started to cry because I felt inadequate". The success of the therapist in talking to her son led Judith to try the techniques she had observed the therapist using when communicating with her other son, although she had not previously identified a communication problem with him. Moreover, the therapist had in fact been unsuccessful in establishing a rapport with that particular child.

Judith goes on to comment that her son began to look forward to the visits of the therapist. However, when he began to resist further visits she placed the responsibility for addressing the issue directly with the son and made no attempt to rescue him:

> On the third I think it was, he said: "I don't want to talk to him any more". I asked why not. "I've got no more to say and he gives me a headache". "Why does he give you a headache?". Max said: "Because I have to think so much. Because I HAVE to talk and I've got nothing to say and I don't know what to say". I said: "OK, that's your first problem to sort out - you're going to tell him, not me".

Barbara faced a similar problem but she responded differently. Barbara found that her children disliked attending the family therapy and at the time of our interview, her son Luke was refusing to attend. Barbara felt that this was because he did not feel understood by the therapists:

> Luke says to me they think Abby is just a little goody-goody two shoes. If only they knew really what she was like! He does come across quite differently at therapy than what he's really like at home. He just seems to put up this front. I think he's going to be one of these children, or men who doesn't show emotion.

Barbara said that at their appointment later that day she would have to tell the therapists that her son was unhappy about attending:

> When we go today I've got to say Luke is not particularly happy about coming today. They're going to say why? The repercussion of that will be: "Why did you say that Mum?".

It seems from this that Barbara felt pushed into a situation where she was taking responsibility for the relationship between the children and the therapists. There is a marked difference between Barbara's response to the issue of a child not wanting to participate in the therapy any further and Judith's. It appears that Barbara felt pushed into taking responsibility for the relationship between child and therapist, whereas Judith put that responsibility back to her son. It is interesting to observe here, that Judith had a much more satisfactory relationship with her therapist, and has consistently commented favourably about the usefulness of her involvement with the therapist. Moreover, she has also been able to take more control of the therapy as evidenced by her early decision to meet the therapist before he met her children. Barbara, however, was able to effect little control of the therapy following her initial contact with the local Citizen's Advice Bureau who put her in touch with the agency. So, it can be seen that while Judith questioned her own knowledge base she remained relatively more powerful in the therapeutic system than Barbara.

Denise commented that her son, Richard, seemed to respond very well to their therapist. She did not attribute this directly to the expertise of the therapist but rather to a combination of the questioning and to Richard's response:

> I was quite impressed with the way she talked to Richard, you know kept throwing things back to him, she made it very definite what she was trying to get from him. She'd ask him a question and ask about his feelings about it and not many people have done that with Richard and I think he was quite impressed. He was at a bit of a loss for a while but once he got tuned in to her, he got on very well with her and I could see him just blossoming under the questioning. He didn't have a problem at all, our whole life history was sort of there you know. He's obviously felt the vibes too, it made him feel quite important I think.

Jenny's son accompanied her to both appointments with the therapist:

> I took James with me [a preschooler] - he just played and listened and she just asked me questions about his behaviour. Taking James there was good because he listened and he loves to get praise from people.

Jenny said that the therapist interacted to a limited extent with her son:

> She spoke to him a little bit but not actually to talk to him. He was drawing lots of pictures and she said to him they were really nice.

While Brenda and her family were referred to the therapist because of the behavioral problems with her son she found that the emphasis quickly shifted to herself. Brenda thought that this was useful and believed that through this approach the behavioral problems of her son were able to be resolved:

> Not so much deal with the child although by dealing with my problems he was able to bring the change about with the child.

Joanne and her former husband were disputing custody and access arrangements and Joanne found that the therapist included their son in order to determine what Jonathan regarded would be a satisfactory outcome:

> The therapist gave him the choice and that was the bit he would come into the interview to and be part of it. The therapist had to call in Jonathan and say: "We're not here for mum and dad, we're here for you, you know, is this what you want?".

Although Rose had stipulated that she wanted a therapist who had children her son was not included in the counselling.

Summary

The interaction between the therapist and the children varied considerably. The participant's reactions to the interaction also varied. None commented that they would have liked the therapist to spend more time in talking to the children, although one, Jenny, did decide to continue bringing her child to the sessions even when the therapist suggested that the child not come to the follow up session.

Two of the participants, Linda and Judith, when observing the skills of the therapist in relating to children perceived them as special in some way. They considered that the therapist had skills which they did not have. This raises the issue of how much the expertise of the therapist in this situation served to disempower the particular participants. Judith commented that she was upset when she witnessed how readily her son talked with the therapist, which would indicate that she felt disempowered to some degree. This

will be examined further when discussing how she felt about the outcome of the therapy. Each of these participants saw a male therapist.

The participants' observations of the interaction between the children and the therapist seemed to reflect their general observations about the therapist. If they saw the therapist as having special skills in the therapy and/or were confident about their relationship with the therapist they viewed the interaction between therapist and children favourably. Whereas, Barbara, who was dissatisfied with the overall progress of the therapy, was also dissatisfied with the interaction between the therapist and children, believed that her son was also dissatisfied, and assumed responsibility for advising the therapists that he did not want to attend.

SKILLS LEARNT FROM THE THERAPIST

Several participants commented that they learnt particular skills and techniques from their therapist. This was usually in relation to managing their children's behaviour. Rose and Joanne, who were referred to the therapist through the Family Court do not feature in this discussion which focuses on particular skills learnt in the course of the therapy, although they both commented during the interviews about gaining a better understanding of their situation through the therapy.

Denise identified several skills which she said were developed through attending the therapy. These were: planning when to intervene in the children's arguments, being consistent, being open with the children about her own feelings. She said that she developed these skills from observing the therapist and that therapist's attitude to the problems:

> I think because of what she said and the way she said things made me think, 'cos sometimes I'm a person who does things on the spur of the moment without thinking. The questions she asked and the way she asked them and the way she treated your answers made me think, well ,perhaps I could do that as well. I mean not put myself up as a trained therapist but because she obviously listened and took in and really thought about what she was hearing I thought well perhaps I could try that too without going off half cocked at the kids all the time.

Denise recalled in detail the therapist's advice about managing the children's behaviour and in the following excerpt describes the process which she followed when implementing that advice:

> She said that it doesn't matter what you're consistent about, even if you just take one thing like when they get up in the morning the first thing they've got to do is get dressed, so she said if you just keep doing that so that he knows that he's not allowed out to have his breakfast til he gets dressed she said or you might like to try something else. But I started with that and then I went on to right no television until you've had your breakfast and all that sort of thing and I found that worked really well and he seemed to appreciate that and you hear a lot how children appreciate limit lines and that you don't really believe it but I really saw it working with him.

In addition to following the therapist's advice about consistency, Denise was also influenced in her perception of the family dynamics. She noticed more fully the interactions between the children. It seems that this was a new skill which she developed from observing the way in which the therapist approached the family problem:

> The visit with the therapist put me in a more receptive state of mind to what's going on around me and I thought well, Richard doesn't have to put up with that, no wonder he's going off half the time.

Judith said that she learnt skills about prioritising tasks, how to encourage her son to talk and the importance of making reasonable requests. She says that:

> He really taught me about getting the nasty stuff over first, then the routine stuff, establishing ground rules and then carrying on with life. So for me I learnt a lot. And I learnt a lot from my kids actually. I learnt, if you like, how to manipulate them, but in a positive way.

Judith also gained an understanding of the contextual perspective of problems which she explained in the following way:

> I learnt how to, as X said, bust problems; that the problems be controlled by us, not problems control us. If the problems occur, not to let the results lead onto more problems. Then you're only going in a circle. Take each individual problem as it comes and work with it and away from it. And get rid of it eventually hopefully.

Denise and Judith have each referred to gaining an insight into how their children view the situation. This heightened empathetic understanding of their children was coupled with an increase in their parenting abilities. They have both reported becoming firmer about some things as well as learning to assess more accurately what is going on for their children. It seems that through discussing the situation with the therapist they were able to see the problem more accurately and effect changes.

Brenda said that she and her husband developed their own guidelines to managing their son's behaviour. Brenda believed that they developed these ideas after learning from the therapist about the impact of control issues in the family:

> It was in relation to what the therapist had been telling us in relation to certain patterns and how to break them because it was a real power struggle because we had no control, absolutely no control. That was how he made me feel [her son] but after working that out I eventually got my power back.

It can be seen that all three of these women were able to take key elements of the therapist's approach and apply them to their own situation. They each had an assumption that the therapist's knowledge about how to relate to children and how to perceive family interaction patterns was greater than their own. However, they were able to take that knowledge and adjust it to their own situations. This is illustrated by the experience of Brenda who describes developing her own guidelines to managing her son's behaviour after attending the family therapy.

TECHNOLOGICAL AIDS

I asked all the participants if the therapist used technological aids such as a one way screen or video camera in the therapy. This question was derived from my own experience as a family therapist some years earlier. At that time I had available to me both a one way screen and a video camera for observing and recording family therapy sessions. I noticed that many families were uncomfortable with their use. Furthermore, Howe (1989) suggested that many families found the use of technological aides at least off-putting and in some situations intrusive.

In response to my question on this issue the mothers all reported that the therapist had not used such aids during their sessions. Barbara said that her therapist had suggested the idea of using a screen with some colleagues behind it but this had not taken place at the time of the interview. She said that she would have been prepared to cooperate with this suggestion. Linda and Rose said that their therapist drew on the whiteboard to illustrate a point. This was the only aid that they were aware of.

Jenny commented that if her therapist had asked her to consider the use of a video or one way screen she would have refused. She said:

> I wouldn't have felt comfortable with that. Unless they were wanting to interview Sam, and Sam didn't want me to be away from him.

The use of one-way screens and other technological aids such as video cameras does occur within family therapy practice. It is possible that their absence from this particular group of participants reflects the provincial setting of the research. However, at least two of the therapists whose clients I interviewed had ready access to one-way screens. The fact that they were not used raises questions about whether this reflects a move away from perceiving such aids as helpful or the time involved in using a reflecting team and one way screen precludes their use in the economic and political environment of the nineties.

DISCUSSION AND SUMMARY

The women at this stage of the process continued to assess the suitability of the therapist as someone to trust. The women identified the following key characteristics about the therapist and the way the therapist worked which made a difference to them, and which they considered had a beneficial effect on their relationship with the therapist: a genuine interest in the situation of the woman, understanding their situation, friendliness, an openness to new ideas, especially the ideas of the women, and an acceptance of the women. Each of these factors helped in establishing a more equitable relationship between the therapist and woman.

It is interesting to note from the descriptions provided by the women, that they observed the therapists taking actions which were designed to share the power such as making their notes available to the women, seeking advice from the women, and asking them what they were wanting from the therapy. However, none of the women referred to a discussion between themselves and the therapist about the power issues affecting the therapy. Although the women were, by and large, aware of the impact of the power relationship between the therapist and themselves. While the impact of the power of the therapist may be more keenly felt at the beginning stages of the therapy, it was also present in this stage of the therapy for instance in the reaction of Linda and Judith to the therapist's perceived greater ability at communicating with the children. They thought that the therapist was more adept than they at this and they felt that they had to be more like the therapist in their interaction with the children in order to be effective as parents. Their response indicated to me that the therapist's ability in this respect caused them to doubt of their own skills, which I think is undesirable in the long term.

The level of reciprocity in the relationships with the therapist appears to have varied considerably. Two participants, Joanne and Judith, accepted the information and content of the therapy as provided by the therapist. Although, Judith, by seeing the therapist on her own first did give herself the opportunity to withdraw from the therapy before he saw the children. Once the therapy commenced, however, Judith and Joanne each appear to have demonstrated little questioning of the therapeutic content of the sessions. Brenda accepted the majority of what the therapist offered during the sessions, including the therapist's analysis of the effects of their particular problem. However, she expressed reservations about one aspect of the therapist's attempts to inform her of his ways of working. Linda realised that she was able to contribute to the knowledge base of the therapist. Barbara seems to have had little real interaction with the therapists. She expressed dissatisfaction with the therapy to the researcher but indicated that she intended to continue attending. Some of the women, such as Judith and Brenda, came to regard the therapist with affection as well as respect.

Barbara and Jenny commented that the therapist had not managed to convey to them that she or he understood their life experiences. They concluded that the therapist's effectiveness was limited due to limited life experiences and suggested that this interfered with the progress of the therapy. Jenny made the distinction that this did not interfere with the relationship with the therapist although she thought it made a difference to the quality of the assistance the therapist was able to offer her. Nevertheless, Jenny also reported an improvement in the presenting problem between her first and second session when she put into place some of the suggestions of the therapist. By contrast, Barbara felt that the relationship with one member of her therapy team became problematic for both herself and her children and that the limitations of the therapist's life experiences impinged on the ability of that therapist to be of any real assistance to her.

These results are not consistent with those of Howe (1989) who found that most of the people he interviewed did not feel understood by the therapist. This led him to conclude that being understood was an unlikely result in family therapy due to the requirements of the therapist to operate within family therapy models. Furthermore, the distancing which Howe describes as the modus operandi for the therapists involved in his research project, does not appear to have been a feature of the way in which the therapists who saw these women worked, or, if it was, it was not a feature in the work of the therapist's with the women in this study. Such distancing runs counter to the necessity, discussed by Strean, (1983); Compton and Galaway, (1984); Chaplin, (1988); and Barker, (1992) to establish

rapport with the client or family members. The results in this project suggest it is necessary for family members to perceive that their situation is understood by the therapist.

One characteristic of the helping relationship which Siporin defines (1974:202) is the application of resources by the helper, and the utilising of the resources by the client. The women, apart from Barbara, indicate that they felt that their therapist was able to offer them resources which they were able to use. These included the ability of the therapist to: provide answers, bring out the good in the family members, and to keep away from blame and focus on problem-solving. Through these actions they felt that they were able to learn something from the therapy.

The following chapter will present and discuss the women's experience outside the therapeutic session. It covers what took place between the sessions and following the termination of the therapy. It includes a discussion pertaining to whether the mothers feel that they have been able to maintain the gains that they reportedly made during the therapy.

CHAPTER NINE

OUTSIDE THE THERAPY ROOM

The only credit that can come to anybody, even though the counselling was really beneficial, is to me for making them do something. (Brenda)

INTRODUCTION

The title of this chapter refers to the events which occurred outside the therapeutic process itself. The chapter has two foci: the first being the experiences of the women between the sessions, and the second is the termination process. I have presented these two components of the results together because I think they each demonstrate the resources the women brought to bear on the problem. The results in this chapter show that there are marked differences and similarities to the experiences of the women at the previous stages of the process. Firstly, the impact of guilt and mother-blaming diminishes for those women who achieve some agency over the problem. Secondly, the relationship with the therapist for most of the women remains important to them, despite the end of the therapy. Thirdly, access to further therapy is constrained by a lack of material resources. The situation for Barbara is discussed separately at the end of the chapter as at the time of the interview she was still attending therapy.

My interest in the experience of the women between the sessions arose from my observations as a therapist that frequently people report to me changes which I would not have predicted as a result of the work conducted in an interview. This has led me to the observation discussed above that the therapy is part of a complex interplay of factors. Consequently I decided to ask the participants what it was like for them between sessions.

In asking this question I was aware that in my review of the literature pertaining to family therapy research I did not find any research which has investigated the process which takes place for clients between sessions. This limits the generalisation of my findings in this section to other groups of people. Furthermore, it points to a significant gap in the knowledge base of family therapy which in itself is not surprising given the preoccupation with events in the therapy room. At a recent workshop Virginia Goldner (1994) suggested that the therapeutic process involves the therapist 'floating' ideas and

interventions and that the family members 'float up' to particular aspects of those interventions. While, I see this metaphor as liberating for the therapist, I think as therapists we need to understand more about the process which takes place when women appear to respond to certain interventions. It is my intention that this research is a small step towards this. My aim is not to foster the role of the therapist as a member of the so called 'brain police' (Furlong, 1989:217) but to further demystify the therapeutic process for women and therapists.

BETWEEN SESSIONS

The following information is presented according to the changes the women noticed both in their response to the therapy and to the presenting problem. The women's comments indicated that their experience varied widely between the sessions. Some described an improvement in their problem while others felt anxious between sessions, especially the first two or three, one noticed no change at all to her situation, and one found that the situation actually deteriorated between the first and second session, and then subsequently improved.

An Improvement

The three participants, Jenny, Brenda and Linda, who noticed an improvement in the problem between sessions had each described themselves as having a good relationship with the therapist. Jenny saw a woman therapist while Brenda and Linda each saw a male therapist.

After her first interview Jenny noticed an immediate improvement in her son's behaviour which she attributed to his wanting the approval of the therapist:

> After the first time I felt quite confident. Taking Sam there was good because he listened and he loves to get praise from people. And I'd say: "Gee, [therapist's name] would be really pleased if you ate all your tea tonight because we've got to see her again soon".

Brenda commented that she 'couldn't wait between sessions'. She felt that was due to the actual sessions going well and to an improvement in their situation:

> It was just so good. Every time we finished one we'd go away feeling so good it was amazing, like the tension lifting. It was amazing the change that came about not just in Corey but in us too.

Linda found that after the sessions she felt very optimistic about her situation and her ability to change things. She described it in the following way:

> I would go out of there feeling so good about myself, like I was just on a total high. If I rang anybody; I had a particular person that I would ring and he would notice that I was just so high and it would take me hours to come back down.

The contact with her therapist became very important to Linda and when asked what it was like between the sessions she commented that: "We got through because I knew that we were going back again."[12]

Anxiety Between Sessions

Denise and Judith described themselves as anxious between sessions. This anxiety appears to have been connected to the idea that there was a correct way to do things. When discussing this issue both women referred to strategies that had been given to them by the therapist to effect a change in the family situation. They expressed anxiety about being able to put the strategy in place in the right way. I think that this is connected to the internalisation of the societal expectations of them as mothers, which I discussed in Chapter Three. Denise and Judith have earlier described how, as solo mothers, they were vulnerable to the judgements of others and their response was to prove to 'the others' and to themselves that they could manage. This was a hurdle to overcome in deciding to accept the referral for the therapy and it then manifested in their concern with ensuring that they did the therapy the right way.

Furthermore, while they shared a similar reaction between sessions their responses were different in one critical respect. Denise was preoccupied with being able to effect changes to the problem. However, once she had done so she also noticed her own abilities which had always been there and she was able to put the problem into context. By contrast, Judith appears to have adhered to the solutions suggested by the therapist. As mentioned in the previous chapter, when discussing the interaction between the therapist and the

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[12] I think that there is an important difference between the observations of Linda and Brenda and that of Jenny. Linda and Brenda left the sessions from the beginning with a greater sense of their control over the situation. Their comments reflect that they both had a greater amount of self-confidence in their ability to change the situation.

While Jenny also commented that the situation improved immediately, it seems that the improvement derived from her increased power over her son. It would seem that she was using the therapists authority to increase her own authority over her son.

children, Judith doubted her own abilities when she saw the therapist communicating easily with her son who had not talked to her. It is interesting to recall in relation to this, the differences in the way in which they saw their relationship with the therapist. Denise had a relationship in which she was able to clearly and firmly state her differing opinions and keep to them. Judith, on the other hand, saw her therapist as having special skills both in connection with his ability to do his job and in relating to children. The effect of this was that it took Judith longer to realise her own skills.

Denise saw her therapist on two occasions and described the period between sessions as a bit rocky to start with:

> The start was a bit rocky because I didn't really have much confidence that the things (that I'd learnt - that I'd be able) to put them into practice but I started first on consistency and I thought that if Richard can see that, *gosh it was hard*, I am going to be consistent maybe the rest of it would follow.

Denise overcame the self doubt about being able to apply the parenting techniques the therapist had suggested. Once she observed them working her confidence increased and she began to place the problems with Richard in the family context. She stopped seeing his behaviour as a reflection of a supposed lack of mothering skills on her part. In fact she started to notice those things which she was doing well:

> I saw it working with him and I was quite chuffed about that and I thought: "At last, I've got something right". Then I thought: "Well he's the only one I have problems with. I must be doing something right because the other three are okay". They have their squabbles, they're not perfect by any means but they get on together and I can leave them in the room with their colouring or whatever they happen to be doing and know that they won't strangle each other as soon as I set foot outside.

Judith had more sessions than Denise and she describes herself as being on edge at first between the sessions which was associated with a desire to do things the `right' way and to attempt the techniques suggested by the therapist:

> At first it was on edge, waiting for him to do something wrong so we could problem bust it, you know. For me, it was waiting to see if anything went wrong, to see if he could problem bust it himself. And if not to remind him how to. Worrying whether I'm doing it the right way.

As the therapy progressed and she had more sessions Judith began to relax:

> I had to leave him to try to sort out the best way for him to solve his problems, knowing that I shouldn't jump in and interrupt and bail him out

> of trouble every five minutes which I have a tendency to do. Because I had to be the thinker for the whole family, it's natural. It's off pat. Without even thinking, you think for them. Whereas before I'd say, you do this, you do that and he went away and did it and if it didn't work out it was my fault. But now it's learning to think for himself, giving him alternatives.

This comment reflects that as the therapy progressed Judith began to evaluate the impact of her own interactions more. It is also an excellent description of the vicious cycle which can develop for women, especially those parenting on their own. It derives from both the desire to prove to themselves and others that they can manage and from wanting to compensate for the absent parent. Interestingly, as Judith relaxed about the expectations that she had of herself, she gave her son more responsibility to solve his own problems and their overall situation began to improve.

No Change Between Sessions

Barbara was the only participant who found that there was no real change to the problem between the sessions. This reflected her general level of dissatisfaction with the therapy that she received. I will discuss this in more detail later in the chapter.

Problem Worse Initially

Rose found that there was little difference to the problem she sought assistance for between the first sessions, as she was seeing the therapist on her own. She did say, however, that she felt better herself because she had someone to talk to about it:

> It helped me personally because I was acknowledging that there was a problem and that if it was to be sorted out then both of us were going to have to make changes.

However, an external factor to do with the Family Court process contributed initially to a deterioration in the problem. This was not so much due to any interventions undertaken by the therapist, but to the promptness of the communication between the therapist, the Family Court and Rose's husband, which left Rose with little time to prepare her husband for the arrival of the letter advising him of the counselling requirement of the Family Court.

The tone of the letter also seemed offensive to Rose's husband and this, combined with its unexpectedness, severely jeopardised the prospects of Ray attending the counselling:

> The letter came the day after I said to [the therapist] that I was happy for Ray to be notified. I had intended to tell him that it was on its way. He was in here when the mail arrived and I had to say to him this letter has been instigated by me. He opened it and never said a word, he was extremely angry. The whole tone of the letter from the court, he took to be very threatening. They mentioned court action if you don't attend, which I had been told that if I was happy if Ray didn't want to go to counselling then that was fine.

It seems that the promptness of the court system in this situation both at the time that Rose initially saw the Counselling Coordinator and again at this point when she wanted to involve her husband came close to undermining the effectiveness of the process.

Furthermore, the state can and does compel people to attend counselling, either through the Family Proceedings Act (1980) in the Family Court or the Children and Young Persons and Their Families Act (1989). This compulsion, when either threatened as in the case of Rose and Ray or actioned, which did not occur to any of the women in this project, does impact on the nature of the counselling or therapy. As Furlong (1989:217) in his discussion of statutory family therapy practice points out:

> At the practice level if one or both actors have somehow been acculturated to expect an adversarial relationship, this will help establish a dynamic confirming this expectation.

It is clear that Ray took offence at the threatening tone and it was only through careful persuasion from Rose, and possibly the therapist who also talked to Ray, that he agreed to attend. Rose and Ray only had one session together, and they did not complete the exercise given to them by the therapist although Rose did remind Ray about it.

Furthermore, the nature of the letter which was a standard letter, sent to all clients of the Family Court in this situation, ignored Rose's wishes that Ray not be compelled to attend the therapy unless she decided that it was necessary. So, a second effect of the letter was to render Rose once again powerless in her efforts to get the system to operate in a way which suited her.

Summary

It can be seen that the experiences of the participants varied between the sessions. Some found that there was an immediate improvement to the situation, and that they looked forward to the appointments, others were anxious about their ability to perform as the

therapist suggested. This did tend to resolve once they saw that they were able to effect changes to the problems.

Many of the women made comments which showed the extent to which they reviewed their own actions between the sessions. They considered their thoughts, actions and responses to the problems they were dealing with in the light of what had taken place in the therapy. They were actively engaged in evaluating their own impact on the problem itself, whether it was behavioral or an argument about access and custody. This aspect of the women's experience and response to the therapy is discussed more fully in the section which discusses who they attribute the changes to.

Rose was the only participant who felt that the situation deteriorated between the sessions and this is attributable to the rather heavy handed intervention of the state in the therapeutic process, in the form of a letter to her husband threatening him with court action if he did not attend the therapy.

USE OF ALTERNATIVE RESOURCES

Six participants referred to other resources which they turned to in order to try to find a solution to the problems they were facing. The use of other resources demonstrates that the therapy is only one of a wide range of supports which the participants drew from in sorting out their difficulties. This is an area to which little attention is paid within family therapy literature, since the focus is on what takes place in the therapy room.[13] While I am particularly interested in the other resources which women bring to the problem I think that the argument of Karpel (1986:xiii) that therapists are likely to overlook the family resources can also be applied to women's resources:

> It is easy to lose sight of a family's resources in treatment. That is assuming that we recognise their presence in the first place. Family members, themselves, may be the last to point them out to us.

As mentioned earlier I do not adhere to a treatment model. However, Karpel's comments about family resources are interesting in the light of the comments made by the participants in this project.

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[13] The preoccupation of the literature on what takes place in the therapy room is based on the assumption that events there influence events outside of the room.

The women were more likely to use resources which they knew of themselves, which were already an established part of their network. Those they mentioned included books, friends and family, support groups, community groups, counsellors, the family general practitioner, and attending courses at the local Polytechnic.

Throughout this research, Barbara has been the most dissatisfied with the therapy which she and her family received. Interestingly, Barbara described utilising a wide range of other resources in trying to resolve her problems. These ranged from special friends who she identified as good to talk to, other parents in similar situations, family members and self-help books. Barbara felt that she could trust her friend implicitly:

> There is a woman at work who when I have a few problems I can talk to her and she is really good, and I know it won't go any further.

Barbara referred to a book which she read sometime previously which made a profound impact on her view of parenting. She was able to recall in detail the message of the book and she has used the book as a guide in her parenting of her children. She felts so enthusiastic about it that she had also lent it to friends:

> I've actually lent that copy to somebody and all the people who've read it have said what a brilliant book. I'd like to get another copy because there is so much brilliant information in it.

Linda also had a wide range of resources which she utilised to address the problems she was faced with. Some of them have been mentioned in the discussion in Chapter One about contact with other therapists. They included attending a support group, other counsellors, and support through community groups such as Birthright. Linda commented that on some days she would see her Birthright worker in the morning, attend her support group in the afternoon and see the therapist the same night. Clearly, she was able to link and integrate ideas from a range of sources.

In addition to the more formal supports she received Linda also commented on the importance of reading, attending courses and thinking:

> I think that while I was going to see them I was also doing a lot of reading and probably that influenced it too. I do a lot of thinking, I'm always thinking and I can see that what I read now is what I've actually been able to work out for myself.

Brenda had previously attended counselling which she felt was an important resource which she utilised when she first realised the nature of the problems she was having with her son. She also commented that she gathered a lot of information about the particular problem and read widely on the subject. Moreover, through her own counselling she had learnt information about her own coping techniques which she no longer viewed as helpful and she made a deliberate effort to change them while attending the therapy.

Jenny referred to the helpfulness of talking to people in similar situations, as opposed to well-meaning friends and acquaintances who had not had similar experiences:

> I find it better talking to other friends who are solo mothers and I get more helpful hints from them because they know, they've been there, they're doing it.

Denise had found that following the death of her husband that she had started to turn to her friends more for support and while she chose not to attend counselling for herself she did use the support of good friends who lived close by her:

> Now I find I do need the assistance of friends to cope with every day life and I have three or four extra special friends that I can just go to at any time and say: "I'm feeling a bit down". Before I had to have an excuse like borrowing a cup of sugar, then you would all sit down and have a cup of coffee and it would all come out about how you were feeling really horrible.

Friends also provided practical assistance to Denise, in helping her with transport to the therapy sessions.

As mentioned earlier, Rose found the first session emotionally draining and afterwards she visited her mother and shared with her the impact of the meeting:

> I felt like I'd been through the mill. In fact I remember going round to my mother who knows that we've sought counselling and I said to her I feel like a wrung out rag.

Denise's therapist suggested that she contact a local support group from which she thought Denise might benefit:

> She gave me the names of a couple of support groups. I didn't actually get around to going. I know that sounds awful after she was really kind, but a lot of their meetings are at night and I find it very hard to get out at night.

Denise does not say whether she wanted to go to the support group but her response does suggest that her supports which she referred to above were less available at night. As the solo-mother of several dependent children who did not drive or own a vehicle her ability to follow up the support group suggested by the therapist was severely restricted.

Discussion

It can be seen that although the therapy was important to all the women in this project it was not the only element they used to try to bring about changes, rather it was usually one of several factors which they applied to their situation. The other resources utilised were ones that the women often developed through their social and community networks and often ran in conjunction with the counselling. I think that the tendency to undervalue or ignore these resources within family therapy practice reflects assumptions about both the value of women's work and the way in which women tend to be regarded as passive. The resources to which the women in this project refer, accurately reflect the nurturing and caring women provide and receive from one another, but which also tends to be undervalued in analyses about the nature of work (Waring, 1988; Finch, 1984 and 1989).

Furthermore, much feminist literature describes how women are perceived as passive and expected to behave passively. Lerner (1983) discusses with this issue at length and suggests that women are not usually as passive as they are expected to be. This would certainly be supported by my findings which demonstrate that in addition to attending the therapy the women were also actively using other means with which to address their problems. Lerner (1983:699) points out:

> Women are rarely as dependent as they seem to appear; rather, women learn to display passive-dependent behaviour in order to protect others (including the therapist) and maintain the homeostatic balance of systems in which any move away from a dependent stance is responded to by important others as a hurtful and aggressive act.

Therefore, in view of the tendency to overlook women's work, the prevailing view of women as passive, the tendency of women to behave passively, and the pre-occupation within family therapy with that which takes place in the therapy room, it is unlikely that the therapist will be aware of the other resources the women are implementing, a factor which is further supported by the observation of Karpel referred to earlier. It seems to me that it is unlikely that the therapist asked about the supports and resources and that the information remained hidden to the therapist.

In my own practice, it was as a result of this research that I began to regularly ask clients what other resources they were currently using to either effect change or to support them while they were attempting to effect change. I had previously asked them what they had done in the past but not what they were currently doing. I think that this is an area which deserves more research attention both in terms of the influences between the sessions and the external resources which women apply to their situation. If other participants in family therapy use resources in the same way as this group of women have done it is important for therapists to realise that their advice and interventions are being constantly weighed against advice and information from other sources and that their involvement is likely to be only one of a range of resources available to the women. If these issues become a subject for discussion during the therapy then it provides the opportunity for the client to discuss the problem from the point of view of a wide range of resources, rather than the situation developing where it is possible that the therapist and other resources are contradictory.

TERMINATION OF THE THERAPY

The final section presents the women's experience during and following the termination of the therapy. Chaplin (1988) describes the termination period as a time of loss for both therapist and client. Chaplin (1988:113) suggests that from a feminist perspective:

> The time to end the counselling is when the client feels she has internalized those aspects of the counselling that she wants to keep.

This section of the chapter includes a discussion of changes in the presenting problem, where they occurred, who the women attributed the changes to, and the decision that the therapy was completed. It concludes with a discussion of the women's plans for future contact with the therapist. I have presented the information in this manner because it reflects three key aspects to the termination process which are identified in the literature. These are: firstly that termination progresses more smoothly when the client has developed an appreciation of their ability to deal with the problem (Barker, 1992), secondly that the termination of the therapy should be the result of a mutual decision between therapist and client and include a thorough evaluation of any progress (Siporin, 1974; Compton and Galaway, 1984; Chaplin, 1988), and thirdly it is important for the therapist to convey confidence in the client's ability to work on their own (Barker, 1992).

Changes to the Women's Problem-Solving Abilities

Barker (1992:251) suggests that termination is more satisfactory when families are able to see that they have made progress:

> Termination is often better accomplished when the family members are able to see the extent of the changes that have occurred, and when they realise that their problem-solving skills have improved.

It will be seen that most of the women felt that their problem-solving skills had improved. Many of them describe a growth in the sense to which they perceived themselves as having control over the situation at the end of the therapy. Seven reported an improvement in the problem for which they originally attended therapy. This is in contrast to the results which Howe (1989) obtained. The vast majority of his participants found the therapy to be unhelpful. This difference is at least in part due to the differences in research design mentioned earlier, in particular the research pool in this project consists only of those who had completed or in one case were about to complete the family therapy. The few participants in Howe's research who reported an improvement in the presenting problem referred to an observable improvement in the child's behaviour which led the parents to see the therapy as worthwhile. One woman commented that while there had been little overall improvement she coped better as a result of attending the therapy (Howe, 1989:76-78).

In this project seven of the eight participants reported an improvement to the problem for which they had sought assistance. Two of the women: Linda and Jenny, who had sought assistance for dealing with their children's behaviour commented that while there had been changes which they were pleased with they had found them difficult to maintain over time. In some cases the participants also noticed changes in a broader spectrum, particularly in the way they themselves were responding to their situation, such as listening to the advice of others and adapting it to their own situation.

Difficulty Maintaining the Changes Over Time

Linda commented that she thought that there had been changes to the presenting problem despite feeling a keen sense of loss when the counselling was completed. She thought that the regression she and her children experienced at the completion of the therapy was due to her own reaction to the resultant lack of positive feedback:

> Well, they gave me so much encouragement and they found a lot of good things in me that I don't see in me. They kept on telling me them [sic] and I didn't feel so much of a failure and it really kept me going. Then they weren't there and I didn't have enough of it in me to keep me right because when it's all boiled down, it's down to us.

At the same time as the therapy ended for Linda the contract she had with the Birthright worker also expired. This led to a greater degree of isolation for Linda which may well have contributed to her sense that the situation slipped back. Linda concluded this discussion with the comment that she was beginning to pick herself up now which indicated that she was beginning to change. As will be seen in the next section Linda attributed this to her own abilities.

Jenny commented that her son's behaviour changed for a while but that in the month immediately preceding our interview his behaviour had regressed:

> It was alright for a while. Just over the last month or so he's really deteriorated. He's ready for school and starting to get smart and cocky. I seemed to have everything under control for a while. But I've sort of lost it a wee bit lately.

The reader may recall that Jenny had effected the changes by using the therapist's power over her son to gain control of him, and that she relied on the support of the therapist either indirectly or directly to effect the behavioral change. It seems to me that as a result of this Jenny's own sense of agency over the problem was not developed as strongly as it was for some of the other women. While Linda also commented that she noticed a deterioration in the situation after the therapy, she had begun to effect changes herself indicating that despite the initial setback after the termination of the contract, that she was beginning to use the strategies she had learnt.

Changes in the Broader Spectrum

The following discussion highlights significant changes which the women observed, primarily in the way in which they responded to differing situations.

Brenda found that she herself began to have more power in the family system:

> Everything became less and less important and the main issue was to have a happy stable family life where there is no more of this out of controlness that Corey [her son] was in charge. So, I've got my power back. I'm a lot more self assertive than I used to be, more confident.

Judith commented that the therapy had led to changes in the way that she approached ongoing issues. She described herself as beginning to adapt other peoples ideas to her own situation:

> A lot of good things came out of the sessions, for me and for the children. Not necessarily what the therapist spoke about and how he said to solve the problems but other things that led from it. Right now I'm starting to listen to what other people say and adapting that to suit our selves.

This is a pivotal change in Judith's perception of her abilities and confidence in herself. Earlier I discussed how she had felt overawed by the therapists ability to communicate with her children. This comment shows that at the time of the interview with me she had the confidence to adapt the suggestions of others to her own situation when she perceives that they have potential to help her. It seems that she started to gain confidence in her ability to adapt the suggestions of others to her situation. This is reflected in Judith's comments in the next section which indicate that she felt that the changes were due to her approach to the therapy as well as to the abilities of the therapist.

Joanne was very satisfied with her experience of the counselling. She compared her experience with her therapist, who she was referred to through the Family Court to her experience with lawyers saying: "If counsellors are like him [the therapist] then lawyers should take a hike. Lawyers are a waste of time".

Joanne also commented that her relationship with her former husband had improved since seeing the therapist:

> We don't really talk but when we do like over the phone if he asks if Jack can come I just get him whereas another time I might have said, 'What are you doing ringing here?' Before, if I rang, he'd slam the phone down on me.

Not only did Joanne and her former husband negotiate a mutually agreeable arrangement for maintenance there was an improvement in their ability to communicate with each other.

Denise commented:

> I feel quite positive about it. I did learn things and I am putting them into practice and I feel that he has been a lot better.

Rose's comments indicate that while the problem had not been resolved she felt that the therapy had enabled both her and her partner to make some significant changes to the problem:

> So far as its gone I suppose I'm glad that it's happened. It's made us face a lot of things, and as I said I don't think that if we hadn't had the counselling we would have had that discussion on our own. At the same time I've got my eyes wide open, there's a hell of a lot of differences between us that I don't think can be solved so it might end up yet in a marriage breakdown. Whereas before, I felt sure that a breakdown would be extremely nasty, it might not be quite so bad now.

While Rose perceives the outcome as beneficial her comments of 'I suppose' and 'it made us face things' repeat the theme of powerlessness which has occurred from the beginning of her contact with the Family Court when she referred to the experience as 'like being on a rollercoaster'. Her comments here suggest that she continued to feel like the therapy was outside her control.

Discussion

Jenny and Linda, who each experienced a set back after the therapy was completed, attributed it to a failing of themselves. This attribution of the problem to shortcomings in themselves demonstrates the extent to which they have internalised the expectations of them as mothers. This reflects the arguments of Foucault (1980) concerning the interiorisation of power and the argument of Rich (1976) that guilt and self-blame experienced by women contribute to the success of patriarchy.

The overwhelming impression gained from the women I interviewed, however is that they found the therapy helpful and that its benefits continued after the therapy was completed. For the majority, they had established as Barker (1992) suggests is necessary, a view of the progress they had made and in some instances the changes they had effected were far reaching. As the women and I discussed these changes it became clear that for some of them the therapy had empowered them to take charge of their lives in a way that they had not been able to do beforehand. This is reflected in the following section which discusses to whom the women attributed the changes.

THE MOTHERS' VIEW OF WHO WAS RESPONSIBLE FOR THE CHANGES

I was interested in whom the women attributed the changes to. I expected that this would indicate the extent to which the women had achieved agency over the problem with which they were dealing, thereby reflecting whether or not their perception of themselves as holding some power had altered through the therapy.

In considering this issue, I expected that the participants would be likely to ascribe the reported changes in the problems to the therapy or to the therapist given that they entered the therapy in a relatively powerless position. I thought that this would be most likely with Linda and Brenda who had each referred to the therapist they saw as having special gifts. I found instead that while all seven who had experienced changes did attribute some of that change to the therapy, six of them, including Linda and Brenda considered that the change was, to a significant degree, a result of their own efforts outside the therapy. They believed that while they may have got ideas from the therapist it was their own efforts at following up those ideas which brought about the change.

Brenda attributed the improvement of her family situation to her own tenacity in seeking the help which she realised that the family needed:

> The only credit that can come to anybody, even though the counselling was really beneficial, is to me for making them do something and to make them listen. What I term as the clean-up job at the end [the therapy] is minimal to what you have to do yourself.

Jenny shared the view of Brenda that while it was helpful to talk to the therapist, she herself had to do most of the work to bring about the changes. Overall Jenny found the therapy beneficial although she also made it clear that she perceived some limitations because of her perception that the therapist she saw had limited life experiences. Nevertheless, when comparing her involvement with the therapist to her contact with other helping professionals, Jenny described the therapy as very beneficial. Jenny was also fully aware of the work she was required to do in order to bring about the changes:

> The counsellor stays back there in the office and you come home, you've still got to come home and deal with them and put in even more than what you've been putting in to make it work.

Linda credited her therapist with the changes she observed but she also observed that the changes came about because she was prepared to put the effort and energy in to making them work:

> Counselling and therapy work and a counsellor can carry you along but you have to be able to want to make it work. It's bloody hard work when you've got kids who are misbehaving and you know that the only way to stop that misbehaviour is to be stronger in yourself.

Judith shared this perspective saying:

> If you want something positive to come out of the sessions, there's got to be input, you've got to be aware of what's going on. Not just say: "Hey you sit there and you sit there and you talk and I'm going to do something else".

Rose attributed a pivotal discussion between herself and her husband, which took place outside the therapy room, to the impact of the therapy itself; while it had not been in a therapeutic context she thought that it would not have occurred if she and her husband had not attended the therapy, "I don't think that if we hadn't had the counselling we would have had that discussion on our own".

One participant, Joanne, felt that the change in her relationship was directly attributable to the actions of the therapist during the therapy. Joanne described her relationship with her former husband as now significantly more cordial. She attributed this to the approach of the counsellor when they had disagreements during the therapy:

> We're civil to one another which we haven't been before and that was because of the counsellor. He defused any ugly situation which could have arisen.

Discussion

Six of the participants attributed the changes which they experienced both to the counselling and their own actions subsequent to the counselling.

It would seem that while the counselling provided the initial impetus towards some sort of change its usefulness was related to actions that they took outside the therapy itself. Many of them referred to consciously using the ideas of the therapist, or to directly copying the way that the therapist approached a member of the family. These six participants all clearly indicated that in their view the therapy on its own had not been

sufficient to bring about the changes. They each felt that their own actions had been significant in altering their situation.

As discussed above, Joanne saw this slightly differently as she attributed all the changes to the actions of the therapist, although she did describe herself as now behaving differently towards her former husband.

It would seem from this that how the women each approached the therapy and their problem, was significant in altering the overall situation. This seems to be dependent upon the women's strength and resources which enabled them to put in place some of the suggestions of their particular therapist. It would seem here, that the therapist needs to be able to assess that ability and to adjust their practice accordingly.

The women have suggested that their experience of the process was one in which they were able to establish their own sense of authority and responsibility over the problem. While they had experienced doubts at the beginning of the process and were very fearful of being blamed for their problems, by the time the therapy was completed they had overcome these doubts and were feeling overall more confident about their abilities to deal with the problems. This was also the case for those women who had experienced some setbacks following the completion of the therapy.

The therapy seems to have empowered them in some sense to take control of the problem and to reduce its effects on their lives. This reflects the suggestion of Chaplin (1988:7) in her discussion of feminist counselling in which she says:

> Feminist counselling aims instead to empower people and help them develop more self-confidence and control over their own lives.

The seven women who reported this outcome had all previously commented favourably about the relationship they established with the therapist. This suggests that the process of talking to someone about their problem in some way validated their experience and mitigated the guilt and self-blame which many of them described as a significant obstacle at the beginning of the process.

THE DECISION TO END THE THERAPY

Siporin (1975:340) in his discussion about the termination process suggests that the:

> Termination should be based on a mutual decision by client and social worker and on a mutual assessment of the helping programme and situation at the time the decision is made.

This view is further supported by Compton and Galaway (1984:557) who suggest that:

> Whenever termination is being considered, a thorough review and evaluation of what has or has not been accomplished and of the processes by which these gains were made or failed to be made, is imperative.

In fact the decision to terminate the counselling met these criteria only for two of the women, Brenda and Rose. I found that other factors including the immediate availability of the therapist and the amount of funding available impacted on the decision to terminate the therapy.

Two women, Jenny and Denise, saw their therapist only twice. This was because the therapist was about to move out of the district. Denise was advised at the point of intake that her therapist would be available for a limited time period. She described herself as initially questioning the usefulness of seeing someone who was moving away but at the completion of the sessions was satisfied with the progress made:

> She said at that first meeting, or perhaps it was when she first rang me that she would only be able to have a couple of sessions because she was leaving and it sort of flicked through my mind then, well what's the point. What if when we get up there Richard needs in depth counselling, is there much point. It's not good to be swopping from one person to another. He's had that with his teachers and ended up quite confused.

Despite these reservations Denise said that by the end of the second session she felt confident about continuing on her own:

> I don't know if it was just the way she did things but I felt at the end of the second meeting that we were confident about going it alone.

Jenny, however, while accepting the therapist's suggestion that contact was no longer needed, has not followed up further therapy, although her son's behaviour has since deteriorated. Jenny had some reservations about not attending any further sessions but did not express them clearly to her therapist. Instead, it seems that she was swayed by the

therapist's positive encouragement about the progress that had been made between the first and the second session:

> She said: "Well, I don't think we need to see you again. You seem to be doing really well, so we might as well close the file on this one if you like". The therapist had seemed pleased with what I had done and when she said that I didn't need to see her again, I wondered if we could cope without another visit. I thought: "Yes, okay". And it went alright for a while.

While the therapist did not comment to Jenny directly about her imminent departure as a feature in the decision not to have further sessions, it will be seen in the following discussion about future plans for seeing the therapist that Jenny was aware that the therapist has left. It seems to me that it is likely that the therapist was so encouraging about the progress that Jenny has made at least in part due to the pressure brought about by her departure. Moreover, the therapist worked for a public agency which at that time was experiencing pressure on its services.

The remaining six participants had time-limited contracts with their therapist after which further funding had to be applied for. The time-limited nature of the funded therapy appears to have become an issue where the therapy was forced to a conclusion because the contract had expired, as will be seen in the next section when the women wanted to re-establish contact with the therapist.

Brenda and Rose completed the therapy within the allotted time and the decision to terminate appears to have been made in consultation with the therapist. Brenda described herself as deciding that no further appointments were needed:

> We actually didn't have that many visits with him but when things were starting to settle down at home a lot more, we said well we don't need to see you. But we will ring if we do.

Rose and the therapist appear to have discussed together the plans for the termination of the counselling and come to a mutually acceptable arrangement whereby Rose understands that there are three sessions remaining in the contract and that she or her partner can contact the therapist if they decide to use that time.

In Linda's situation the therapy was terminated because the contract had expired and as discussed earlier she found this difficult to deal with. Moreover, it led to a temporary

deterioration in the problems she was dealing with, in terms of managing her son's behaviour:

> When we stopped the counselling all the contracts came to an end at the same time. I really felt that I had lost an awful lot and I think I got quite down and I was angry that everybody had deserted me. [Linda also had a contract with a voluntary agency which provided additional support, and was concurrent with the counselling.] But then I realised that people can't be there for ever and I have to keep on going.

It seems that for at least three participants the external factors of the availability of the therapist and funding played a large part in determining when to cease the therapeutic relationship. This also affected how they approached the issue of seeking assistance from that therapist again in the future.

It seems that for the women in this project there were advantages and disadvantages to each of the settings in which the therapy took place. Those who were seen in the health setting had a lengthy wait before they gained access to the therapist and the number of sessions they received were limited due to that therapist moving away from the district. Those who were seen in the private sector, either as a result of referral through the Family Court system or the NZCYPS, were subjected to the potential for a greater amount of social control. This was evidenced by the letter which Rose's husband received from the Court instructing him to attend the counselling. In one instance (Judith) they also had a lengthy wait before the first session.

FUTURE PLANS FOR SEEING THE THERAPIST

Barker (1992:258) suggests that when terminating contact with clients that the therapist must convey confidence in the family's ability to manage on their own:

> The family should not leave feeling that the therapist expects it to fall apart again. After you have expressed a positive view of the family's competence, the message should not be weakened by any implication of doubt about the longer-term outcome.

Most of the women I spoke to wanted to know that if they encountered further difficulties they would be able to obtain further assistance. I think that this is related to two factors: firstly the importance women place on inter-relatedness and inter-connectedness (Perry, 1993:41) and secondly the difficulty in gaining access to the therapy if they did need to obtain assistance again in the future.

Once an adequate relationship was established with the therapist the women envisaged the possibility that they would see the therapist again. I do not see this as a problem in terminating the relationship but more of a reflection of the way women view therapy and the significance to them of the therapeutic relationship. This is a view supported by Chaplin, (1988). Furthermore, most of the women in this project had expressed considerable anxieties about what the therapy would involve before it commenced and it is reasonable to expect that if they needed further assistance they would want to obtain it from the therapist with whom they had established a satisfactory relationship.

Some of the women expressed concern at the difficulty of regaining access to the therapy due to financial restraints. This is of major significance as Rich (1976:52) points out women have the 'powerless responsibility' for meeting the needs of their children. As discussed in the social policy chapter Ungerson (1985) supports this argument. She suggests that it is both dangerous and stressful to the mothers and their children that at the time when women have dependents for whom they are responsible they are also likely to be dependent themselves, for most of the women in this study on the State, in order to meet those responsibilities.

It is, therefore, conceivable that the women in this project wanted to reduce that powerlessness by seeking out the same therapist should they need to, and by ensuring if possible that they would be able to re-establish contact if they needed to.

Therefore, when I asked the participants whether they would see that therapist again I was interested in determining firstly whether they would want to, secondly if they did want to what plans they had for doing so, and finally what they thought the obstacles would be in obtaining access. Most said that they would recontact if they needed to. However as I expected, for some of them access to further therapy was an issue, either due to the unavailability of the therapist or a lack of funding for further therapy with those therapists in private practice.

Funding for further therapy was an issue for Brenda and Linda. Brenda said that she understood from her therapist that she could recontact him if necessary. Her comment shows that she was holding on to this idea, particularly when she found the old problem reappearing:

> We haven't made another appointment because I think things are going OK but I know that if things don't go OK I can get back in touch with him

> and we can re do Corey's counselling. Still a long way to go so we'll hold on and see how things go.

Brenda was aware, however, that access in the future could be problematic due to the necessity to obtain funding through the NZCYPS:

> If we need to see him again we have to apply through Social Welfare for another contract of three months. Which is a bit of a pain in the neck. It's getting access which is the hardest thing. It's only because they pay for it.

Linda has stayed in contact with her therapist through participating in training programmes that he runs. She does not have any further therapy available to her from this therapist, unless a new contract is established through a funding agency. As discussed earlier this has been an issue for Linda as she found dealing with the withdrawal of supports at the termination of the contracts difficult.

Denise and Jenny were aware that they could get further therapy if they wanted it, but that it would be with a different therapist as the person they saw originally had left. As discussed earlier Jenny commented that her son's behaviour had deteriorated and she had thought about getting more assistance. However, she was restrained from taking that step as the therapist she saw originally, had left and she would have had to see someone else:

> Maybe I could have had another one [appointment]. I felt that I could have rung her if I was having trouble, though she's finished now. If she was still there I would still feel that I could go back and see her. I did get the feeling that if I wanted to I could go back. I wouldn't now because I think I'll just cope with it until he goes to school.

Denise commented that she realised that she can go back to the agency where the therapist worked, although she would have to see someone else. At the time of our interview she had not contemplated doing this as the initial changes had been maintained:

> I have got that thing that I can go back if I feel I have to. He's not nearly as violent. We still have screaming-matches sometimes, but I think that's Richard.

Rose commented that she had an open ended arrangement with the therapist that she can contact him in the future if she needs to. She feels that this could well be a useful arrangement, particularly if there are significant changes in her relationship with her partner over the months to come:

> He [the therapist] said that he would ring in a month's time and discuss where it was going from there. I told him that we'd had this discussion where we had solved a few things and he was happy about that and I've left it that he's going to write a written report to the Family Court. I've got about three sessions left up my sleeve.

Judith felt that although she had no immediate plans to see her therapist that her relationship with the therapist was ongoing. She described their last session as more of an overview of progress than a conclusion to the therapy:

> That was just a sum-up and round-off of what had been happening. But not an end to it. There wasn't an end to it because it's an ongoing thing. And if I need any help I know where to go.

This situation suited Judith because she felt that she could recontact her therapist if she needed to. She had the idea that she would be able to stay in contact with the therapist.

In Joanne's situation the counselling was terminated once she and her former partner had reached a mutually acceptable solution. She has no plans to stay in touch with the therapist.

It appears that for most of the women access to the therapist once the original counselling had stopped was difficult. This was either due to problems with funding to see those therapists in private practice or because the therapist in the public sector had left the agency.

The contracts in the private sector were of a time limited nature and had to be applied for. This placed constraints on the possibility of further contact with the therapist unless the woman was in a position to meet the costs herself.
It is clear that some of the women felt this limitation keenly, whereas others who had no plans to see the therapist again or who had further time available to them did not experience these constraints.

Those women who were seen through the health sector did not have the constraints of the financial costs. However, access to the preferred therapist was limited by that therapist's move away. Although it is likely that there were personal factors involved in this decision, staff turnover is a feature of the public sector therapy services, which affects the likelihood of the client recontacting the agency.

COUNSELLING PROCEEDING

Barbara described herself as still attending counselling although it was more than a month since she had last seen her counsellor.

Barbara had difficulty during the therapy influencing either the period between appointments or the issues which were discussed. She had gone to the therapy, initially feeling powerless, and she continued to feel powerless during the therapy. This was not addressed by the therapists and she was unable to utilise any information or assistance contained in the therapy despite a demonstrated ability to utilise information from other resources. If these issues had been discussed during the therapy then it is likely that it would have been much more beneficial for both Barbara and the therapists. It was clear from her comments throughout the interview that Barbara felt that the therapists did not understand her situation, and that they had little to offer her.

Barbara persisted with the therapy as a result of the idea that the therapists may come up with some information or suggestions which she would find helpful:

> I'm still going because we've got eight sessions. I'm not saying that I'm not going to learn anything from it. We might get on to a different tack and they might be able to help me.

It seemed that the process had been affected by two factors. The first was the length of time between the interviews, and the second was the need for more suggestions about what to do. Barbara commented that often the interviews were a month or more apart and she thought that this meant that it was easier for things to deteriorate: "When the interviews are such a long way apart things slide back." Barbara also said that she wanted more ideas about what to do: "It may be that what I need is more ideas on what to do and ways of achieving what I want". This latter comment reflects the findings of Howe (1989:80) who said that most of the people he interviewed wanted advice about what to do.

When asked if she would contact the therapists again in the same situation, she said no. Barbara was the only woman in this project who said that she would not recontact the therapist in the future. It is important to note that despite this clear statement of intention she did not feel that she could stop attending the family therapy. This was related to the hope that the therapy might eventually prove to be helpful. I think that this arises from her powerlessness in the situation. Whereas, the other participants had become more

empowered as the therapy progressed, Barbara actually was disempowered by the therapy. She had initially been assertive enough to self-refer through the Citizens Advice Bureau. However, despite her dissatisfaction with the therapy she was unable to stop the process or to advise the therapists what she was thinking about the therapy. At the time of the interview Barbara had come to some conclusions about what it was that she was looking for:

> I think I need a group that if I'm having problems, that I'm stressing out that I could say: "Look I've done this, do you think it was right in doing that?". Not that I need someone to tell me what to do, but you sometimes need confirmation that, yes I am doing the right thing and no, they shouldn't make me feel guilty because I've said no or whatever.

It seems that despite the fact that she wanted advice, Barbara had decided that therapy was unlikely to provide her with the assistance she was looking for and had started thinking about other options. Barbara asked me how to contact Toughlove - a parent support group which she thought might meet the above criteria. I provided her with a possible contact. My decision to provide Barbara with the information requested was consistent with the approach outlined Oakley (1981:43). Oakley describes how, when faced with requests for advice from interviewees she responded by providing the information although aware that by doing so she was not maintaining the role of objective researcher. Oakley argues that objectivity and neutrality are inconsistent with the principles of feminist research.

When I telephoned Barbara some months later about her interview transcript she referred again to her frustration with the family therapy and said she was relieved that it was over.

There is a significant contrast in Barbara's position to that of the other seven women who all experienced some changes to the initial problem. While they had gone to the therapy relatively powerless, some had in fact been directed to counselling through the Family Court or NZCYPS, it would appear that their relative sense of power over the problem had increased during the period in which they were attending the therapy.

CONCLUSION

While most of the women had been referred to the therapist by another agency two had self-referred. I had expected that these two were more likely to experience a satisfactory outcome to the therapy. This did not prove to be the case. One, Barbara, despite having

self-referred now found herself locked into a therapeutic process which she found unhelpful yet which she felt committed to. This suggests that although people who self refer are likely to be the most relaxed in the initial stages of the therapeutic process, this will not continue if they are unable to establish a sense of rapport with the therapist, as discussed in the preceding chapters.

The other, Jenny, experienced a dramatic immediate improvement to her situation, and was encouraged by her therapist into not making a further appointment and then found that when the situation had deteriorated that the therapist had left.

Seven women noted some improvement to their overall situation. This was much higher than I had expected. Furthermore, I had also expected that if changes occurred they would be attributed to the therapy. In fact, only one woman saw the therapist as solely responsible for the changes she experienced, with the remainder considering them to be a result of their own efforts as well as a result of attending the therapy. This is related to the women's utilisation of resources they obtained outside the therapy and which ran concomitantly with the therapy. So, it is possible that as women were using these resources of their own initiative they were also able to realise the significance of their own role in bringing about any changes. Given the dearth of literature pertaining to events outside the therapy room, it is unlikely in my opinion that the therapist was fully aware of the extent of the supports or the way in which the women used them.

The particular agency which the women attended appears to have had an impact on their experience both of the therapy itself and its termination. Those who saw a private therapist were generally seen more quickly after the initial referral but were also constrained by the availability of funding for the counselling. So, it was clearly time limited, and contract based.

Those who saw the therapist in a public agency had a delay of between two weeks to three months before being seen. Once they gained access to the system they then had two sessions each with the therapist. They were not re-referred to another therapist at the time of this therapist's departure and although they each realised that they could make contact again they had not done so.

Barbara was seen in the voluntary sector and experienced considerable delays between appointments. Moreover, she expressed the most dissatisfaction with the assistance she was receiving. She also felt that she should continue attending despite her dissatisfaction.

Three factors emerge at the conclusion of the family therapy which have had an impact on the therapy at other stages in the process. They are: mother blaming, gaining access to the therapy service, and, finally, the importance of the relationship with the therapist to the women.

The fear of being blamed for the problems that they were experiencing and their sense of guilt about the problems was a significant issue for most of the mothers at the initial stages of the therapy, both when the decision was being made whether to attend, and at the beginning session. (See Chapters Six and Seven). It is clear that for all the participants, except Barbara, that this issue diminished as they gained control over the problem. This is not to say that the mother blaming no longer exists, rather that the women themselves are less vulnerable to it as their sense of agency over the problem has increased. It seems that they began to experience themselves as having some power and control as described most clearly by Brenda 'I've got my power back'. They began to see themselves as actors on the problem.

Brenda's comment illustrates that developing a sense of her power enabled her to take charge of the situation and assisted her to resist the constraints imposed by the societal expectations of her role which she had previously internalised. It seems that these women were in some measure able to reduce the impact of the guilt feelings, which Rich argues (1976) controls womens lives, and their view of themselves changed and they began to take charge of their lives. This is supported by the changes that have occurred in the lives of the women since the therapy. Since the original interview, three of the women have commenced training programmes with a view to improving their future employment and career opportunities.

Running parallel to this has been the importance of the relationship which the women established with the therapist. The usefulness of the therapy to the women was inextricably connected to whether or not they perceived the therapist as being able to understand them, and having sufficient skills to assist them. In this it was not sufficient for the therapist to be someone who was good to talk to, the therapist also needed to be able to demonstrate some expertise in dealing with the particular problems they were facing. The women valued the relationship with the therapist, expressing at times concern, for his or her well-being and asking me questions during the course of the interviews about where and what each of the therapists were involved in now. In

Barbara's situation where she felt that one of the conjoint therapists did not demonstrate an appreciation of her situation this had overridden her appreciation for his colleague.

The seven women who reported changes to the presenting problem all made comments indicating that they thought that the therapy had worked because they had done the work. As Jenny said she was the one who had to go home and do it, while the therapist stayed back in the office. Whilst I agree with their analysis of the process, I do not think that it provides a full explanation of what it is that makes therapy work. It is clear from Barbara's comments that she was doing a lot of work in the therapy, including mediating between the therapists and her children, as well as mediating between her two children. Perhaps the issue is not whether the client is prepared to work but rather whether the therapist is able to assist them to do that work which will be most helpful in addressing the problem. Barbara continued to experience a lot of guilt feelings about her situation and the problems she was experiencing with her children. When comparing her experiences with those of the other participants it is noticeable that she did not develop a sense of her own agency over the problem. In fact, her comments suggest that she perceives herself as continuing to be blamed for the problems which she is experiencing. It should be noted here that the women all realised that I was employed as a family therapist. It is possible that because of this the women reported more favourably about the outcome of the therapy than they might otherwise have done. Nonetheless, Barbara was able to tell me about her dissatisfactions and they all were able to discuss with me the other resources which they utilised in addition to the family therapy. Furthermore, the favourable outcome may have been influenced by research design factors which resulted in the research pool consisting of women who were firstly identified by their therapist as possible participants, and secondly, who had completed the therapy.

Finally, at the conclusion of the family therapy the question of access to the services of family therapy re-emerges as of fundamental concern to the women. This issue arose whether they had time-limited contracts through the statutory system or whether they were seen in the health sector. In the first instance, some of the women were faced with requesting new contracts from the appropriate agency with the concomitant intrusion into their lives and the possibility that they would be turned down. Jenny and Denise, if they wanted more assistance would have to see a new therapist as theirs had moved away. Associated with this are the risks involved in establishing a new relationship with another therapist.

The lack of access to material resources either in the form of the therapy or the means to pay for the therapy themselves continues to restrict the choices available to the women in this project. While the therapy had been very useful to the women and some of them had begun to effect long lasting changes in their lives the structural features which constrain women's access to assistance such as family therapy remain in place and limit the changes which they are able to effect on their lives and those of their children.

It could be argued that the women are addressing this issue as some have begun training programmes in order to equip themselves for employment. However, it will be a considerable length of time before they are able to purchase therapy themselves, if ever, given the demands that will be placed on their income and the restrictions on the level at which that income is likely to be at. This is discussed earlier, in Chapter Two and is supported by information drawn from the Statistics New Zealand publication, 'All About Women in New Zealand' (1993:104) which clearly states that when women do manage to obtain employment it is likely be part-time and at lower levels of remuneration than is the case for men.

PART FOUR

DISCUSSION AND CONCLUSION

This final part of the thesis presents the conclusions drawn from the results presented in Part Three. The conclusions are informed by the context within which family therapy takes place as discussed in part one of the thesis, namely the social policies which both provide for family therapy service delivery and inhibit it; the family therapy theories which inform the practice of family therapy; and the performance of mothering in contemporary society. Several areas requiring further research are identified.

CHAPTER TEN

DISCUSSION AND CONCLUSION: IMPLICATIONS FOR PRACTICE

INTRODUCTION

This final chapter identifies and highlights the main themes which emerged from the interviews with the mothers in this study, emphasising the implications for both practitioners and mothers seeking family therapy. The chapter begins with a discussion of the tension between my own private and public worlds which has underpinned the research. It then proceeds to a brief overview of the experience of the mothers as they progressed through the therapeutic process, and an analysis of the impact of the role of mother on the women who took part in the project. I then discuss the issues which have influenced the experience of the mothers who took part. These include: choosing family therapy; material resources and family therapy; the expert knowledge of the therapists; and the relationship between the therapist and the woman. The chapter concludes with a discussion of areas for further research.

AN UNDERLYING TENSION

This project, having emerged from my own experience as a mother and a therapist, reflects the tensions in my life between my private world as a mother and my public world as a family therapist. On the one hand as a mother I was, at the time I sought assistance for my children, suspicious of family therapy. That suspicion continues today and I often find myself commenting to people that if I need assistance I am very careful about who I would go to. On the other hand, as a family therapist I believe that therapy can be useful and I want it to work. The tension is reflected in the work presented here. For example, in the social policy chapter I have argued that women have a right to access to family therapy although later I have discussed in detail the prevalence of motherblaming both in wider society and in therapeutic practice and theory. I do not regard these two differing perspectives as mutually exclusive. In fact, that same tension holds the potential for more effective, and useful therapy through ongoing debate and discussion about what it is that constitutes effective therapy, from all participants, therapists and family members. That such debate is making a difference is apparent in this

research as it appears from the comments of the mothers I talked to that their therapists were trying to get away from motherblaming. The therapists themselves raised the subject in some situations. Furthermore, the mothers also demonstrated that they had room for manoeuvre through the extent to which they made maximum use of the resources available to them, of which family therapy was one. The mothers I spoke to were facing enormous problems, and demonstrated impressive courage in using whatever resources they could to overcome the problems. Throughout the interviews it was apparent that all they wanted was help to shoulder those problems more effectively.

An example of how the tension influences my approach to family therapy is situated in my reaction to the extent of alternative resources the mothers were using to effect change on the problem. It would be more accurate to say that it surprised me and that it didn't surprise me. The surprise comes from my position as a family therapist, and the extent to which I too become preoccupied with events in the family therapy room. However, when I stopped to consider the resources that I bring to bear on problems of my own, it makes sense to me that other mothers do the same. Consequently, the extent to which mothers use a wide range of resources is important information to therapists who are interested in enhancing the agency of the people who come to see them. Not only can the therapist encourage their utilisation but the therapist is reminded that the therapy is only one of a range of resources that mothers bring to bear on the problem. An acknowledgement of this on the part of therapists would contribute to the demystification of the therapy process and reduce the disparity between expert knowledge and the common knowledge of the mothers.

A BRIEF OVERVIEW OF THE PROCESS

The results section of the thesis presented and discussed the information from the interviews with the mothers in the light of the therapeutic process, taking account of the stages of the helping process in some detail. The following is a brief overview of the experiences of the women from the time therapy was first suggested to them until the conclusion of their involvement in the therapy process.

At the time these women were seeking help some of them encountered considerable difficulty in obtaining the assistance they required. While, as a result of social policy changes the range of choice may be greater, the women did not have access to information to assist them with making an effective choice, rather other people made that

choice for them. Only two of the eight women self-referred to the therapist they saw. Furthermore, it seems that once the 'choice' was made they received only limited assistance. Most of the women I spoke to received only between two and six sessions of family therapy.

The feelings and thoughts of the women about the therapy appear to have altered as they moved through the process. At the beginning when they were first considering seeking help most of them were feeling defeated by the problems they were facing and they were unsure about whether therapy would be useful.

When they accepted the referral and attended the first session most of them were worried that they would be blamed in some way for the problems they were experiencing. This anxiety appears to have dissipated for all of the women, except Barbara, as they established a relationship with the therapist. It seems that as they began to trust the therapist their anxieties about being blamed reduced. Barbara was one of two women who had self-referred and as a result her reported level of anxiety prior to the commencement of the therapy was one of the lowest. However, she was not able to establish an effective relationship with her therapist and this had an effect on the remainder of the therapeutic process. It seems that the mothers preferred a therapist whose life experience was similar to their own. In some cases choosing a therapist because they had children, or criticising a therapist because they did not, and therefore did not really understand what it was like.

As they progressed through the therapy some of the mothers made comments that indicated that they lost their sense of control over the problem. This was associated with the idea that the therapist had expert knowledge which they did not have. This is discussed in more detail later in this chapter. However, all the women except Barbara reported that at the conclusion of the therapy they felt more in charge of the problem, and in some cases this had led to their taking more charge over other aspects of their lives. However, many commented that if they needed further therapeutic assistance they thought gaining access would be problematic.

Given the level of anxiety most of the women reported prior to attending the first session it seems to me that it is very important for therapists to spend a considerable part of that session establishing rapport and outlining to the client what they can expect will happen in the therapeutic process. Rose described in Chapter Six, in some detail the extent to

which her therapist did this in the first session and it was clear that this helped to put her at her ease.

It can be seen that for most of the women in this study, the control they had over their situation moved from relatively little to relatively more by the end of the therapy, at least in relation to the problem.

THE EIGHT WOMEN AND MOTHERHOOD

Most of the mothers in this project sought assistance for problems associated with their children and even where the child was not the initial motivation for seeking assistance the woman was primarily concerned with the impact of any solutions on her child. The mothers were keenly aware of the expectations of them to meet the needs of their children despite factors whether structural or personal which might inhibit this. Each of the women struggled in their own way with the issues affecting mothers in general which I discussed in Chapter three. Namely, mothers and work, changes to family structure, mothering and motherblaming. This is related to the observation of Hare-Mustin (1986) that if it were not for women's pervasive unhappiness then therapy would be unlikely to be as popular as it is at present.

The concern of these women for their children emerges repeatedly in their comments as does their awareness of the way in which they are constrained by their responsibilities to their children. Although they saw themselves as constrained they did not indicate in any way that they wished to abandon those responsibilities. They wanted help to shoulder them.

Indeed the tension between their ability to meet the needs of their children and the expectations of others and themselves that they meet those needs was of ongoing concern to these women. An analysis of power and control in society using the ideas of Foucault (1980) suggests that normative concepts such as 'mothering' are a very effective and efficient method of ensuring that the accepted 'norm' remains in place, and are in fact a means of social control, thus ensuring the maintenance of a patriarchal system. Furthermore, the normalising includes self-judgement as to whether or not mothers are meeting the required standards so that the mothers I spoke to as well as being blamed also blamed themselves for the problems they encountered. This is part of the process which contributes to the subjugation of women's experience making it difficult for the mothers

to explain their experience in an alternative way and if they are able to do so, to speak out about it. When the issue of the blaming of mother's was brought up, it was done so by the therapist rather than the mother, herself. However, when the therapist was able to demonstrate that she or he was aware of this the women felt more positive about the therapy.

On the basis of this outcome and the work of feminist writers such as Rich (1976) and therapists such as Esler (1988) and Hourigan-Johnston (1989), the extent to which the women were assisted to deal with guilt which derives from motherblaming and internalised through the high expectations the mothers had of themselves, appears to be the key issue in determining whether the women were in a stronger position at the conclusion of the therapy.

This then suggests that therapists, if they are to assist women to make changes which are long lasting require an understanding of the process which women struggle with in the performance of the role of mother. They need to be aware of the extent to which women are inculturated into having impossibly high expectations of themselves; that if they do not meet these expectations they are failing their children; and that they will be blamed for their failure. A therapist working with women who are mothers requires an appreciation of the impact of mothering both on the individual woman and the social and political context which influences the way in which she is able to meet the role and an ability to utilise this analysis in her or his work with women.

CHOOSING FAMILY THERAPY

It seems to me that rather than family therapy being a deliberate choice of assistance sought out by the women concerned, they appeared to get family therapy because of a decision either by the referring agency or the therapist. This raises the issue of whether family therapy is really what family members want as discussed by Wyne (1988:255):

> Does anyone in the family actually want family therapy? Or, do they want therapy for the patient but something else, such as information, for the other family member's?

In this study the women made a decision to seek help or had help suggested to them and then the form of that help seems to have been determined by where they received the assistance from, rather than an informed choice on the part of the women. It seems to have had more to do with the preferred way of working of the therapist to whom they

were referred. It is clear that mothers would be able to make a more informed choice about the type of assistance they needed if they were provided information about a range of therapists and the methods of that therapist. Some of the women did tell me that during the first interview the therapist described his or her way of working to them. However, it seems to me that given the rather complicated referral process that some of the women experienced that an explanation at this stage of the process is too late to enable the women to make an informed choice, particularly when it is considered that most of them had between a two week and three month wait between referral and the first interview.

Moreover, at the time of referral to the therapist the women in this project were suffering high levels of stress and anxiety about the problems they were experiencing. Given the time lapse between referral and the first appointment I think that it is unlikely that they would have felt sufficiently in charge of the situation to shift their demand elsewhere, assuming that they knew where elsewhere is. This is evidenced by Barbara's experience. Despite feeling dissatisfied with the service she was receiving she continued to attend the sessions in the hope that the therapists would come up with something that would prove to be helpful to her.

MATERIAL RESOURCES AND FAMILY THERAPY

A lack of material resources contributes to the existence of many problems, as well as inhibiting the potential for the client to utilise alternative resources to overcome their situation. Some of the material issues which emerged during the conversations with participants in this study included: access to transport to the sessions; access to alternative care-givers in order to follow up suggestions of the therapists; access to resources in order to provide for their children. Bunkle (1994:17) suggests that:

> Therapists not taking account of material factors are quite likely to get cases wrong, leaving clients more confused, and less effective in recognising and dealing with their situations.

The therapist in his or her assessment of client situations must take into account material factors. For example when recommending support groups the therapist rather than leaving the woman to determine for herself how to resolve the issue of transport could also recommend people to contact about transport problems who are already attending the group.

The experiences of the mothers in this study suggest that if therapy is to be useful at all then the therapist requires a political analysis of the situation of mothers which she or he is able to introduce into the therapeutic conversation. That analysis must include, both an analysis of the material situation of women and the normative controls influencing the performance of mothering.

THE EXPERT KNOWLEDGE OF THERAPISTS

In the introductory chapter I pointed out that one of the underlying assumptions of this project is that women are 'knowers' and that, therefore, they have their own expert knowledge. The prevailing idea both in popular psychology, and referring agencies that the solution to problems lies in finding the correct therapist or therapy undervalues the knowledge which women hold (Illich, 1977; Bunkle, 1994). Illich (1977) argues that the professions rather than being enabling of their clients are in fact 'disabling'. This derives from the expert knowledge which the professions claim and which is largely unchallenged. He suggests:

> Religion finally becomes displaced, not by the state or the waning of faith, but by professional establishments and client confidence. The professionals appropriate the special knowledge to define public issues in terms of problems (Illich, 1977:27).

The power differential is important in deciding what gets talked about in any process and whose view of the situation is accepted. In this study some of the women commented that the therapist they saw was very highly recommended to them and that this influenced their decision to agree to the referral. In some instances this led to the women questioning their own skills and regarding the therapist as having special gifts. While this was not an either or process and some of the same women commented that they thought that they were able to contribute to the knowledge base of the therapist even temporary disempowerment is undesirable in the therapeutic process given the little power that mothers are able to exert in our society.

Furthermore, the therapist, whether male or female, is considerably more powerful in the therapeutic relationship and the impact on the women is likely to be correspondingly greater. The investing of therapists with expert knowledge is likely to be encouraged and to continue to develop as therapists either in private practice or employed in the state sector contend with the introduction of the competition of the market place into their field of work. In order to be successful they must compete with colleagues to attract clients.

Success in attracting clients rests on their reputation which is likely to enhance the idea that therapists have expert knowledge which outweighs the knowledge of their clients. There are clearly advantages to this, in that those therapists who are incompetent may well be avoided by their potential client group, if their reputation becomes known. However, those therapists who manage to earn or develop a reputation for excellence are likely to come to be regarded as experts in their field with an associated potential for a greater gap between their expert knowledge and the knowledge of their client group. It seems to me that expert knowledge becomes problematic when it overrides the knowledge that mothers hold. This happened to Judith when she tried to utilise the communication skills she had learnt from the therapist in a relationship with which she had previously been satisfied. This was despite Judith noticing that the therapist had been unable to establish effective communication with that particular child.

The manner in which the therapist utilises the knowledge is important as is the extent to which the expert knowledge is open to scrutiny and challenge. However, as Goldner (1991) suggests, and I discussed in Chapter Four the danger can also lie in the therapist not assuming leadership and thereby failing to be of assistance to the people who seek help from her. The women in this study clearly wanted advice and suggestions from the therapists. Expert knowledge in family therapy is required but the knowledge of the mothers attending the therapy needs to be both acknowledged and incorporated into the therapeutic process. This demands three things of the therapist. Firstly, that they pay careful attention to what mothers have to say about the problem. Secondly, that they continually evaluate the effects of their own comments and interventions. Finally, that they expose their own thinking to the client. As Hoffman (1992:22) suggests it is not enough to stop blaming mothers. She argues that:

> Women as well as men must have access to the thinking of the persons they consult, in order to prevent 'professionals disguised as experts' from making their choices for them.

In applying this approach to therapy the result is one of participation rather than treatment. Recent writing in the family therapy field emphasises this approach, particularly that emerging from the narrative therapists such as Epston and White (1989).

THE RELATIONSHIP BETWEEN THERAPIST AND CLIENT

It is clear from the comments of the mothers that from their point of view the relationship with the therapist was pivotal in establishing the potential for them to work together towards change. Indeed where the relationship was not developed it is apparent that the therapy was of limited usefulness. However, the meaning of the relationship to the therapists and the mothers is likely to differ significantly, in that while therapists are trained to maintain a professional distance and to avoid over-involvement in their relationships with clients, the mothers in this study considered the relationship with the therapist to be vitally important.

Sue Wise (1990) points out the social worker is taught not to become over-involved with clients. Yet sufficient involvement is necessary to maintain an effective working relationship. Furthermore, the women in this study appeared to look for connections between themselves and the therapist. Moreover, where the contact had been more than one or two sessions they experienced a significant sense of loss at the conclusion of the therapy. It is likely that the therapist as well as paying attention to developing the relationship, was also giving careful consideration to the interventions and techniques they were utilising with the family. These were important to the mothers but if they had been offered without the associated relationship it is unlikely that they would have been accepted or even acceptable to the mothers concerned. While this is only a small study and further research is needed to establish how it is that the relationship makes a difference, this result has important implications for therapists in that it suggests that therapists need to pay careful attention to the relationship with their client. While I have not explored the effectiveness or otherwise of particular interventions, it is necessary to point out that it appears that there is a complex interplay between both the relationship and the interventions the therapist utilised. Interventions which have an ineffectual or unhelpful outcome may undermine the credibility of the therapist and influence the level of trust with which the women invests the therapist thereby hindering the development of a workable therapeutic relationship and a satisfactory outcome, from her point of view. Conversely, the utilisation of interventions without enough emphasis on the development of a satisfactory relationship may also be detrimental to the overall usefulness of the therapy in that the interventions are unlikely to be accepted.

Furthermore, the relationship with the therapist may well have taken on significance to the women as they were all experiencing considerable upheaval in their lives at the time they were seeing the therapist. This then, when considered in light of the isolation of

many mothers further increases the potentiality for a greater disparity in the power relationship between therapists and mothers.[14] However, some of the mothers openly disputed with the therapist about the suggestions that the therapist made to them. The women who discussed these with me both saw a women therapist which suggests that they may have felt more comfortable about challenging her than they would have a man.

When the issue of gender is added to the power difference which already exists between therapist and client it seems that this increases the power differential sufficiently to make it more difficult for the women to challenge the therapist. Moreover, interactions between men and women are characterised by men doing more of the talking and women offering comments and making affirming responses (Habgood, 1992). This impacts on both the interventions of the woman family therapist and the degree to which clients accept the authority of the woman family therapist (Ault-Riche, 1988). This has implications for male therapists working with women, in that it demands of them particular skills in both ensuring there is a space for women to speak in family therapy and that what they have to say is attended to. For women therapists it suggests that to be effective they need to be able to establish their authority and expertise without either becoming overbearing or disappearing in the therapeutic process and as a consequence then being unable to offer an effective service.

CONCLUSION

It could be argued that this research contains several limitations aside from the methodological constraints outlined in Chapters Five and Nine. These relate particularly to the decision to focus on the experience of mothers in family therapy. As discussed in Chapter One this decision derived from my own experiences as a mother and a family therapist. It could be suggested that the focus on mother's perpetuates the very situation which I have argued is problematic for mothers, in that it reinforces the role of women as the lynch-pin in the family. However, the decision to take such a focus was aimed at examining what mothers thought about their role in the family and in family therapy. Ignoring the experiences of mothers in the family and in family therapy is equally problematic as doing so has the potential to render their experiences invisible (Spender,1982).

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[14] This disparity can and does lead to the abuse of women by professionals (Epston,1993).

This focus has, necessarily, placed limits on the project in that the experiences of other family members and the therapists have not been examined. Moreover, the project does not include an analysis of the therapeutic process itself. This has resulted in a reliance solely on the perceptions of the mothers. However, the project has made some progress in exploring the experience of mothers in the therapeutic process.

The results suggest that most of the mothers found the therapy helpful as they did manage to effect some change on the problems for which they sought help. This contrasts with the argument that as it is the structures in our society that require change any attempt at therapy is merely perpetuating those structural inequalities and working against the change needed. So rather than advocating that therapy ought to be abandoned it is my position that we ought to be scrutinising more critically how and when therapy is used and with whom.

Sue Wise (1990) provides some useful guidelines for such an exploration in relation to feminist social work which I think can be readily transferable to family therapy. She suggests that social work is about social control in that it ensures minimum standards for the vulnerable in our society, some of whom are women but many of whom are children, who may need protection from their mothers. In the light of her argument it seems to me that family therapy, which enables mothers to better meet their responsibilities; empowers mothers to effect the changes which they desire; and which takes account of the material and patriarchal constraints on womens lives is one approach to resolving the dilemma between working towards structural change and family therapy.

It is not enough for the practitioner to have a feminist perspective, however, she also needs the support of others with a similar perspective otherwise she herself will be marginalized and rendered ineffective.[15] It is, therefore, important for women working in this way to meet together, to exchange ideas, to gain support from one another to pursue their preferred way of working. Without such support feminist therapists will be hindered in their attempts to address such issues as the normative view of the family, the social control of families through family therapy, and the difficulty for women in gaining access to an effective and accountable service.

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[15] Wearing (1985) found that the support of other mothers was one of the critical factors enabling women to explore alternative approaches to mothering. Her results emphasised to me the importance, for women who wish to address issues pertaining to the impact of patriarchy, of the support of other women struggling with similar issues.

In addition to the suggestion of further research about the nature of the relationship between therapist and client two further areas have emerged which in my opinion warrant further investigation. Firstly, this project has not considered in any detail the differences between the experiences of therapist and client in the process. As Howe (1989) points out there is likely to be some key differences in their experiences particularly the extent to which therapy is a familiar and well known process for the therapist and a strange and unfamiliar process for the client. Furthermore, the power differential between therapist and client is likely to add to the differences in the way in which they experience the process. It seems to me that investigation and discussion of this issue could usefully contribute to understandings amongst therapists and clients about what it is that makes therapy work.

Secondly, as mentioned earlier in the project I was unable to talk to mothers who had begun therapy and then withdrawn after only one or two sessions. I think that if it is possible to obtain access to this group of people that their experiences if available would inform potential therapy participants of what to beware of. It would also provide a wealth of information which may contribute to more effective and helpful practice, benefiting both therapists and clients.

To conclude, this project has shown that family therapy can contribute to the well-being of people and it can be helpful in assisting mothers to deal with the difficulties in their situation. However, it is not a panacea for the injustices of discrimination of any sort or the inadequate distribution of resources. Family therapy cannot change the economic and financial constraints which a woman is facing, however it can assist her to find ways to deal with her problems more effectively. All the women who took part in this project accepted the family therapy as a means of achieving that. It was clear to them that no one was likely to shoulder their problems for them. It is my opinion, that given the material constraints women, especially women with dependent children, experience that the combination of family therapy and material assistance has the greatest potential to enable women to effect change for themselves and their children.

APPENDIX I

INTERVIEW GUIDELINES FOR INDEPTH INTERVIEWS WITH SELECTED PARTICIPANTS

1 Please tell me about how it came about that you went to see a therapist?

2 How did it feel to ask for help from a therapist?

3 What did you think the therapy would be like?

4 What did you do during the sessions?
What were the sessions like for you?

5 What ideas and feelings were you able to express during the session?

6 What was it like for you between the sessions?

7 What was you relationship like with the therapist?

8 What was it like for you once you had stopped seeing the therapist? How did you feel about that?

9 What did you think about the way the therapy turned out?

10 Did the therapy involve the use of technological aides such as a one way screen, a video, or audio recorder? What did you think of this?

APPENDIX II

LETTER TO COLLEAGUES

142 Vigor Brown Street
Napier

24 June 1992

Dear Colleague

I am writing to you in your capacity as a member of the Hawkes Bay Family Therapy Practice Group.

As you may know I am planning a small scale research project about women's experience of family therapy as part of my Masters degree. It is my opinion that it is usually women who present to agencies seeking assistance for themselves or on behalf of their families and very little attention has been paid to their experience of the helping process. I am hoping to redress this in a very small way.

One of the problems in researching clients experience of family therapy is that it is a confidential process. In order to respect this I need your assistance. I would like you to invite your women clients, specifically those that you see during the months of June and July 1992, to take part in the research and for you to then provide me with the names and addresses of those who are interested.

The research will not include an analysis of the therapeutic methods used in the process or the particular school of family therapy in which you may work. If you consider that the methods you have used in working with a family are essentially family therapy derived then those women clients are candidates for the project should they wish to take part.

They will be asked to fill in a questionnaire that they will receive through the mail and return it to me. A few of them will then be invited to take part in a more in-depth interview with me.

If you are feeling a bit nervous about involving your clients I hope that you are reassured by knowing that the focus of the research is on the womens experience in general rather than a critical examination of a particular therapists practice.

I will be very happy to provide you with general feedback arising from the research, however in order to keep the process confidential I will not be able to provide you with information given to me by particular clients.

I hope that this research will help us all to develop in our practice and to learn more about what our clients find useful or otherwise.

In the hope that you will agree to assist me in contacting possible participants I have included several copies of an introductory letter which is to give to women who are considering taking part. I am working to a schedule and with this in mind

I will need to have the names and addresses of women who are prepared to take part no later than 31July.

If you have any questions about the project please feel free to contact me.

Daytime phone: Community Health 835 3139
Evening phone: Home 835 3827

I'm told that I am very difficult to contact so please leave a message if I'm not available and I will ring back.

Thank you for your assistance.

Yours sincerely

Jill Robinson

APPENDIX III

LETTER TO CLIENTS

142 Vigor Brown Street
Napier

24 June 1992

Hello

My name is Jill Robinson. Like your counsellor I am a family therapist working in Hawkes Bay. I am hoping to do some research about what women think of the help they get when they go to counselling about problems in the family. I am doing the research as part of an university course.

I have asked your counsellor to invite his/her clients to take part in the research. If you agree it will involve filling out a brief questionnaire that you will receive through the mail and returning it to me. A few women will also be invited to take part in an interview which I expect would last approximately one and a half hours.

I think this research is important because it is your chance to tell family therapists what you think about the way that they work.

If you take part, any information made public in reports or workshops will protect your identity, including feedback to therapists who have invited clients to take part.

Yours sincerely

Jill Robinson

APPENDIX IV

CONSENT FORM

WOMEN'S EXPERIENCE OF FAMILY THERAPY
IN A PROVINCIAL AREA OF NEW ZEALAND

CONSENT FORM

have read the information sheet for this study and have had the details of the study xplained to me. My questions about the study have been answered to my satisfaction, nd I understand that I may ask further questions at any time.

also understand that I am free to withdraw from the study at any time, or to decline to nswer any particular questions in the study. I agree to provide information to the :searchers on the understanding that it is completely confidential.

wish to participate in this study under the conditions set out on the information sheet.

Signed: .....
(Participant)

Name: .....

Date: .....

Signed: .....
(Researcher)

Name: .....

Date: .....

INFORMATION SHEET

The information contained in this information sheet was given to participants on the Massey University letterhead.

INFORMATION SHEET

Jill Robinson

The research is being conducted by Jill Robinson.

Jill is a Senior Social Worker employed by the .....[16]

Jill has a Bachelor of Social Work and seven years of experience as a social worker, during the last four years she has specialised in family therapy.

This research is about women's experience of family therapy; what changes, if any they noticed during or after family therapy; and what sort of relationship they had with the therapist.

Very little research has been done until now about what it is like for people seeking help from any type of counselling and it is hoped that this research will go some way to addressing this.

This project has been given approval by the Massey University human Ethics Committee and the Ethics Committee of the... Area Health Board under No.1992\29.

The research forms the basis of a thesis for the Master in Social Work at Massey University. As such it is being supervised by two lecturers in the Department of Social Policy and Social Work, Mark Tisdall and Celia Briar. If you have any concerns or complaints about the researcher they can be made to the supervisors at the above address and phone number.

If you decide to participate in the research it will involve one interview with the researcher Jill Robinson, of approximately one to one and a half hours long. With your permission I would like to tape the interview. The tapes will only be listened to by an assistant and myself. My assistant will be required to sign a statement declaring that she will treat the information as confidential
The material gathered may also be used in publications and workshops by Jill Robinson discussing the same or similar subject.

If you decide to take part in the study you have the right to:

- refuse to answer any particular question, and to withdraw from the study at any time
- ask any further questions that occur to you during your participation
- provide information on the understanding that it completely confidential to the researcher. All information is presented anonymously and it will not be possible

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16 While information regarding my employers was provided to participants I have deleted it here in order to protect the confidentiality of participants. As the research was undertaken in a small provincial area of the country I think that this step is required to preserve confidentiality.

to identify you in any reports that are prepared from the study. Further to this in inviting you to take part your therapist understands that this is a confidential process between the researcher and you.

- be given access to a summary of the findings from the study when it is completed if you so wish. The therapist who have invited their clients to take part in the research will also be given access to a summary of the findings if they are interested.

If you have any questions about the project at any stage please feel free to contact me.

Daytime phone: .....

Evening phone: .....

I'm told that I am very difficult to contact so please leave a message if I'm not available and I will ring back.

Thank-you for your assistance.

STATEMENT OF CONFIDENTIALITY SIGNED BY TYPIST

I, ... state that I will consider any material that I transcribe for Jill Robinson in the preparation of the MSW thesis "Women's Experience of Family Therapy" to be confidential. I understand that because of this that the only person that I may discuss the material with is Jill Robinson, herself.

Signed: .....
(Typist)

Name: .....

Date: .....

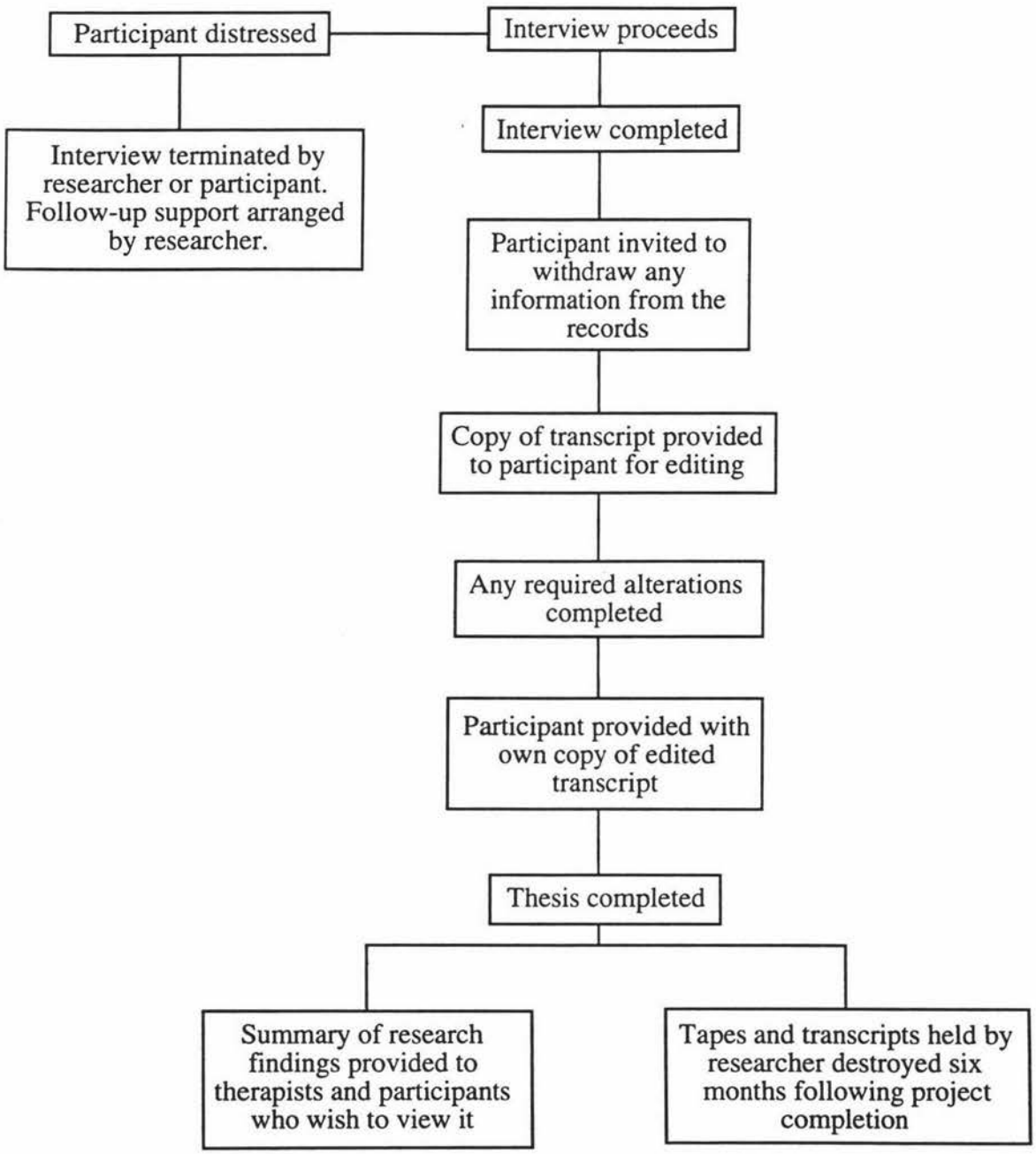
Signed: .....
(Researcher

Name: .....

Date: .....

APPENDIX V

STEPS TO ENSURE VOLUNTARY PARTICIPATION



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