FAMILY THERAPY SELECTION
Compiled by Judith Lask

Australian and New Zealand Journal of Family Therapy (1996)
Reviewed by Judith Lask


In the current climate within the health service there is considerable preoccupation with waiting lists and throughput of patients; staff are even being appointed to deal specifically with the task of reducing waiting lists. This paper provides a useful discussion of the issues involved in offering a single session of family therapy to families who are on the waiting list. The author reports on the work of others and also on a study she carried out at the Bouverie Family Therapy Centre in Australia. She draws heavily on the work of Moshe Talmun in developing ‘single session therapy’. His findings are that families can find this approach very helpful, especially when it is combined with an open-door policy in which they are invited to contact and come back for further sessions when they so wish. The author investigated the experience of other clinics who had tried this approach and found a generally favourable response from clients and in addition a favourable response from staff, who felt much happier that families in crisis were not being left without help. Staff also felt greater confidence that more intense help was being offered to those who needed it most, as frequently the families had additional problems to those mentioned in the referral. In her own study families on the waiting list were offered the option of remaining on the list and being offered a single-session consultation. The first 50 families taking up the offer were studied and both quantitative and qualitative data were gathered. Clients appreciated the rapid response and, despite the limitations of a single session, generally reported that they felt listened to. It also appeared that in many families some changes and improvements had been made and some said that they felt empowered by this brief approach with its focus on problem solving and opening up of communication. Before the session families were sent a questionnaire in which they were asked to list things they would like to change and things that they would like to continue in their family so that the process of mobilising resources and thinking had already begun. It is no surprise that some families reported that the single-session consultation did not offer enough time and that issues could not be gone into deeply. Clearly many questions are raised by this approach. One important issue is whether changes are maintained over time. Furthermore, from an organisational point of view, if too many families responded to an open-door policy this would not be manageable. However, at a time when beliefs about therapy are being challenged and practicalities demand great attention, the experience reported in this paper is of great interest. One thing that comes through very strongly is that to do this work therapists have to be very experienced and be able to make skilled judgements about the suitability of families for the approach.


This paper offers what its title conveys. It provides a description of a comprehensive service offered in New South Wales. This service addresses the needs of all family members including perpetrators and grandparents, and is based on some of the thinking from the Ackerman Clinic in New York. The paper reminds us that much marital violence occurs in front of children and it is very important to address their needs. The approach uses a range of interventions based on groupwork, family work, and individual work. The value of the paper lies in its discussion of all the ethical issues involved in work in this area and also in the detailed outline presented of the principles the authors have developed. These principles include the provision of information, and a focus on women taking responsibility for their own and their children’s safety, as well as a clear recognition of the responsibility of the perpetrator. The authors’ emphasis on using a variety of methods and levels of help is central, and I could not help reflecting on the differences between this approach and the rather narrow approach that is often found in available services in this country.


Disenfranchised grief is grief that is not socially sanctioned. It has been discussed in relation to AIDS and adolescent love among other areas. This paper focuses on the experience of incest from the point of view of the daughter and nonabusing mother and discusses some of the areas of loss that are frequently significant. It highlights the confusing feelings of anger with the abuser, coupled with a sense of loss of that relationship and of family life in general. It proposes that therapy must incorporate all of these feelings and give some ‘social sanction’ to both experiencing and discussing the range of these emotions. In some ways this appears obvious, but the authors’ focus on the way in which social attitudes shape what it is possible to talk about has important implications for the conversations we have with clients.

Journal of Systemic Therapies (1996)
Reviewed by Damian McCann


‘When we talked together with our colleagues about creating this special section on narrative, it was our intention to bring forth what we think is really significant about this approach.’ The authors point out, however, that this special issue does not provide a general overview of the basics of the narrative approach. Instead, they wanted to bring forth aspects of narrative that have been less well attended to. With that in mind, all of the articles place a significant emphasis on the cultural and sociopolitical context of problems/problem stories.

All of the authors in this special edition were asked the following two questions: 1. What makes your work narrative? 2. How is narrative a political stance? At the end of each article, the authors attempt to address what they see as the critical aspects of narrative, i.e. the fact that therapists using this approach utilise a radically different notion of problem and self. For instance, they say ‘if problems exist in external stories of discourse, then we can begin to develop a view of the self as being shaped
and created by these discourses’. In other words, the immanent self is being challenged by these new ideas and as a result new practices are beginning to emerge. In addition, these new narratives are further contextualised in terms of power, both within the therapeutic setting and within society generally.

The decision to devote this journal to the narrative approach testifies to the continued importance of this school of thought and practice (derived mainly from the work of Michael White and David Epston) on the field of family therapy.


The authors say that ‘adults molested as children often present for therapy describing difficulties in their relationships... For many young people, the experience of sexual exploitation by a stranger or trusted adult is one of profound helplessness and powerlessness’. The authors contend that the assumptions made by traditional models about gender, power, intimacy, and sexuality can inadvertently perpetuate these difficulties. An alternative approach based on narrative ideas is presented that will, it suggests, ‘help people challenge the sociopolitical conditions that contribute to violence and victimisation’. It is argued that traditional models, by focusing on deficits and psychopathology, are seen as reinforcing the person’s view of self. As a ‘patient’ or ‘client’, the person who experiences abuse may rely too heavily on the professional knowledge of the therapist rather than on developing his or her own self-knowledge.

Narrative approaches, on the other hand, are influenced by social constructionist conceptualisations that argue that what we call the ‘self’ is a socially generated phenomenon. Self, it is argued, emerges when interpersonal conversations are internalised and organised into stories that we use to understand our experiences with regard to the abuse. The narrative therapist is interested in the meaning the young person ascribes to the experience of the abuse and how this meaning influences the story he or she develops about the self. For instance, they may have a tendency to notice only information that reinforces a view of self as powerless and disqualifies information that is not consistent with this view. The authors say ‘they either fail to recognise or explain away experiences where they behaved in a competent manner or where other people treated them as a person of worth’. In addition to considering the personal narratives that people develop about themselves, the approach also examines the sociopolitical conditions that can contribute to the development and maintenance of problems. To that end, psychotherapy is seen as being part of the larger culture and, as such, therapists are challenged to constantly re-evaluate their assumptions and practices to minimise the potential for their work to be experienced as disempowering by their clients.

Interventions are designed to help people escape oppressive stories and to evaluate ‘normative’ expectations about how they should be as men and women in relationships. Interventions are also designed to challenge those specifications that are experienced as constraining. This particular narrative constitutes what the authors describe as the political dimension of their work. The model assumes that people present for therapy when their lived experiences contradict the dominant story about themselves and their relationships. Symptoms and crisis are considered as evidence of progress and indicate that the person has already begun separating from a story that is no longer viable. The separation process is facilitated by externalising conversations that locate the problem or problematic beliefs, behaviours and stories outside of the person. The authors suggest that these conversations help adults molested as children begin to understand their experiences within a context of oppression. The narrative therapist helps the person identify unique outcomes since these provide the platform for clients experimenting with more preferred stories about themselves and their relationships.

The main content of the article concerns a description of a group that the authors have developed for couples where one partner has a history of child sexual abuse. They say that they have experimented with a variety of formats and, wherever possible, female and male therapists working together have facilitated group sessions. Conversations, they say, were maximised in groups that included four or five couples. The main content of the article lies in the way the authors contextualise the abuse, gender, intimacy, and sexuality within a framework that allows a couple to reflect and transform their beliefs and behaviour with one another and with the outside world.

Families, Systems and Health (1997) Reviewed by Jenny Altschuler


Despite increased attention to the psychological implications of childhood illness on families, little attention has as yet been paid to adult or parental illness. Therefore, these papers provide much-needed insight into the implications of adult illness for a woman’s sense of self, increasing our understanding of the experience of parental illness for families. The first paper provides a personal account of the threat of cancer to the author’s well-being at many levels, with insights and information aimed at facilitating healing for patients and their families. The commentary, written by a family researcher, highlights how this account offers health-care professionals, family members, and friends of breast cancer patients the opportunity of reflecting on the meaning breast cancer may have for a woman’s life and feminine identity. Becvar challenges the stigma of having cancer with an acknowledgement of her personal growth through her cancer ex-
perience. In so doing, she communicates openly her fear and uncertainty, and the effect this may have on her relationships with those dear to her. Drawing on the work of Gilligan and Belensky (1982), Weihs emphasises how, having been socialised to care for others, women’s sense of self may be challenged by illness needs to prioritise self-care. How this is resolved will impact not only on women’s experience of illness, but the meaning of the illness for their children as well.

References


This paper evolved out of research aimed at understanding the meaning of the patient and family’s terminal illness experience. It also addresses the meaning of parental illness for families, providing a dialogue between the voice of ‘insiders’ and a group of professionals. As such it is aimed at extending our views on health care and training. The family’s accounts highlight how a tradition of faith and family commitment were central to the way they coped with the mother’s death. Each of the professionals’ accounts focuses on slightly different aspects of health care: on how, despite the reality of death for every patient, physicians are taught that death represents failure; on the burden placed on medical interns to be certain in a context in which the struggle with terminal illness embodies so much that it is uncertain; and on how the meanings of the stories the family chose to share were influenced by the context of the listener. The paper provides a useful appendix of the questions used in exploring the family’s experience of illness, and ends with a plea to recognise that the most valuable lesson we have to learn as health care professionals is from the families themselves.