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Just Therapy

by

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Therapy can be a vehicle for addressing some of the injustices that occur in a society. It could be argued that in choosing not to address these issues in therapy, therapists may be inadvertently replicating, maintaining, and even furthering, existing injustices. A 'Just Therapy' is one that takes into account the gender, cultural, social and economic context of the persons seeking help. It is our view that therapists have a responsibility to find appropriate ways of addressing these issues, and developing approaches that are centrally concerned with the often forgotten issues of fairness and equity. Such therapy reflects themes of liberation that lead to self-determining outcomes of resolution and hope.

Introduction: The New Zealand and agency context

In all our therapeutic work we have endeavoured to relate to, and incorporate, the current issues that make up the New Zealand social and economic context. These include: the struggles to address the injustices to the indigenous Maori of New Zealand, and initiate an equitable partnership based on the Treaty of Waitangi (see page 59); the emerging consciousness and implications of New Zealand colonisation and consequent responsibilities to Pacific people; the marginalisation and increasing poverty of people and families on low incomes, as a result of deregulated economic and labour markets; and the attempts to address the inequities that persist between men and women as the rigidities of patriarchal webs of meaning are loosened.

Our agency structure has developed over the years to reflect our response to these issues. There are Maori, Samoan, and European (white) therapists who work, each from their own self-determining sections. The workers in these sections carry out family therapy and community development work in the fields of poverty, unemployment, housing, sexism, and racism.

This approach emerged ten years ago after we realised, during one of our six monthly reflective retreats, that many families were approaching our agency for therapy with problems which were not intrinsic to the family, but imposed by broader social structures. These included: families where members were unemployed; those living in inadequate housing conditions; the victim survivors of abuse; or cultures that were marginalised by the dominant culture.

Our retreats involve five days together in a large house beside a beautiful lake. We analyse and reflect on our work over the past six months, and set our goals for the following six months. At this particular retreat, about ten years ago, we realised that the problems these families were bringing to us were not the symptoms of family dysfunction, but the symptoms of broader structural issues like poverty, patriarchy, and racism. We, like most other therapists, were treating their symptomatic behaviour as though it were a family problem, and then sending them back into the structures that created their problems in the first place. We recognised that we were unwittingly adjusting people to poverty or the other forms of injustice by addressing their symptoms, without affecting the broader social and structural causes.

This realisation led us to set aside resources and initiate a community development base to our work. Over time we slowly and sensitively became involved with Maori and Pacific Island communities in our area. We then employed members of these communities in our agency who focussed on the issues facing their own people, adopting welfare thought to social policy initiatives. They also worked with the family therapists, and developed culturally appropriate ways of bringing the resources of therapy to their own people.

The co-operative work between the cultural sections has led to a number of interesting organisational processes. For example, all the workers in the agency, including those who type and receive people, take home the same salary. All work that involves someone from the Maori or Pacific Island communities is accountable directly to that cultural section. Likewise, gender work including that carried out in men's groups is directly accountable to the women in the agency. This is to ensure that a therapy is judged as just, primarily by the group that has been treated unjustly. Various ways of doing things that are uncommon to European culture, but central to Maori or Pacific Island cultures, are adopted. For example, we eat communally, make decisions consensually, receive and farewell guests formally and traditionally, and we share and express different forms of spirituality.

We are a small agency with eleven staff. Each cultural section has male and female workers so that we can appropriately address cultural and gender issues in ways that do justice to both. Because staff work in both the community development and family therapy fields, experiences from one inform the other. A family therapist may, for example, work on emergency housing, community

organising, and housing policy projects in their community development work. This experience broadens their understanding and responses to people coming for therapy who are inadequately housed. Likewise, the feelings of self-blame and helplessness often expressed by unemployed people when a community worker is involved in a project with unemployed people, are able to be addressed by a worker who is experienced and knowledgeable in therapeutic work.

As a group, a number of underlying assumptions to our work have emerged over the years. They are reflected in all the work that we do and are, therefore, worthy of note in this introduction. They can be summarised under three headings:

Spirituality, Justice and Simplicity

Since spirituality informs every aspect of life in Maori and Pacific Island cultures, it naturally plays an important role in a great deal of our work. Instead of the traditional European dualistic world view that separates physical and spiritual values, we have learned to respect the sacredness of all life. Spirituality for us is not centred on organised religion, but on the essential quality of relationships, and refers to the relationship between people and their environment, people and other people, people and their heritage, and people and the numinous.

We view the process of therapy as sacred. People come, often in a very vulnerable state, and share some of their deepest and most painful experiences. For us, these stories are gifts that are worthy of honour. The therapists honour them by listening respectfully for their meaning, and offering new meanings which enable resolution, hope and self-determination. This process necessitates a high view of humanity and relationships, and as such is sacred.

Justice highlights equity in relationships between people: it involves naming the structures, and the actions that oppress and destroy equality in relationships. This is reflected in families at the micro level, and beyond that to the social structures at the macro level. Just therapy must always take both into account. Unfortunately, the resources of therapy have been largely utilised by one group of people. In most Western societies, it is the middle-class groups, and they get most of the other resources as well. A just therapy ensures that those

most in need, like those on low incomes and those cultures that are oppressed, receive the resources of therapy in a manner that addresses their daily experiences of inequity.

Effective therapy, in our view, should reflect simplicity! It does not of necessity involve complex knowledges or processes, otherwise most societies before the advent of modern science would not have been able to resolve their families' problems. In essence, the therapy we offer finds its expression in the movement in meaning from problem-centred patterns, to new possibilities of resolution and hope. Therapists listen for the meanings as people articulate their problems and the way they understand them. Therapists then offer alternative and liberating meanings of those same events.

It is this essentially simple exchange that determines the nature and gives quality to the therapy. It follows from this that people from particular cultures have expertise in the meanings associated with their culture, just as women have particular expertise to understand women's stories. This expert knowledge is at least as important as expertise in the body of Western psychological knowledge.

What is Just Therapy?

'Just Therapy' is a reflective approach to therapy developed with colleagues over eleven years at The Family Centre in New Zealand. It is termed 'Just' for a number of reasons: firstly it indicates a 'just' approach within the therapy to the client group, one which takes into account their gender as well as the cultural, social, and economic context. Secondly, the approach attempts to demystify therapy (and therapists) so that it can be practised by a wider range of people including those with skills and community experience or cultural knowledge. These people may lack an academic background, but nevertheless have an essential ability to effect significant change. It is just (or simply) therapy, devoid of the commonly accepted excesses and limitations of some professional approaches and Western cultural bias.

The term 'Just Therapy' could suggest a dilution of therapeutic knowledge and competence, and could imply a general counselling framework for non-specialised therapeutic work – a sort of social therapy that may improve our ability to address racism and poverty, rather than psychotic illnesses and the

more serious psychosomatics, for example. We believe that this 'professional' reflex, not uncommon in clinical circles, may have helped create mythical boundaries around therapy, which have restricted its practice, clientele and effectiveness.

Far from being a dilution, 'Just Therapy' attempts a distillation of therapeutic practices. Though it encourages novel and more effective ways of working with poor families for example, its techniques also offer improved approaches to working with those who are socio-economically comfortable. Likewise the significance given to cultural processes and patterns of communication not only enables therapy to be more accessible and effective with Black, Hispanic, or Polynesian groups, for example, but also highlights, by contrast, the significance of socio-cultural experience in therapy for white middle-class groups.

'Just Therapy' attempts to extract the essence of therapy, which relates to the manner in which people give meaning to experience and create their 'reality'. Both therapists and clients weave webs of meaning (Bateson 1972, 1980; Maturana & Varela 1980, 1987; White & Epston 1989; Waldegrave 1989) around the problems presented in therapy. This therapy, in essence, concerns the movement from problem-centred stories of pain, to stories of resolution and hope; new meaning is given to experience, by the skilful weaving of new patterns.

This therapy is equally valuable for people who have psychotic problems, for example, as it is for those people broken as a result of being unemployed. In both examples the meaning ascribed to the problem has to be addressed, and new meanings that encourage creative change responses developed. However, the focus for the psychotic case will probably be more on intra-psychic and family communication than for the unemployed case. While these emphases would certainly have their place with the unemployed, the social, community, and political meanings would also be very significant: high levels of unemployment trace their origins to economic and political policies rather than individual motivation.

Thus 'Just Therapy' rejects the commonly accepted boundaries around therapy whereby practice is limited to intra-psychic, individual, couple, family or group work. As we have noted, broader contextual approaches to therapy are absolutely essential. Take, for example, a seriously depressed adult whose work

and general expectations of happiness have been truncated as a result of restructuring and subsequent redundancy in the workplace. The significance given to work in the society, and the implications of increasing free market policies in Western economies are as important to healing as the intra-psychic work. This does not suggest that one is more important than the other. 'Just Therapy' simply complements modern approaches to therapy with information and method that is usually considered outside the parameters of clinical practice. These include social, gender, cultural, and political data as it is appropriate. Thus any work with a family where the problem centres around a father's violent abuse will, of necessity, include qualitative information on the nature and development of patriarchy. The abuse will be addressed in relation to its immediate effects on family members, but also its association with the control men exercise over so many aspects of society and the violence implicated within sexist structures.

'Just Therapy' is essentially concerned with the often forgotten issues of justice in therapy, but it also attempts to effect the change in people's lives which characterises therapy. These two aspects complement each other. In our view, broader social and political change, like therapeutic change, is essentially about giving new meaning to the world of experience.

Weaving threads of meaning

In essence then, therapy is concerned with the manner in which people give meaning to experience and, in so doing, define 'their realities'. People seek therapy when 'their problem' has become so central to their perceptions and experience that they tend to interpret other experience in the light of it, either directly or indirectly.

People who have been sexually abused during childhood, for example, often consider themselves less worthy, less competent, or less valuable than other people. This belief in their unworthiness frequently develops into a meaning system revolving around failure. As a result, often experiences which others receive as marks of competence and success, they may view as confirmations of their failure. They may define a stable relationship with periods of conflict that are usually resolved, for example, as being unhappy, too

dependent, unloving, or in some way inadequate. Although their partner and close friends experience it as authentic and loving, their belief system filters out meanings associated with their competence, pleasure, and capacity to be loved. Furthermore, they may attain a high level of recognition at work or in some creative artistic arena, but pass this off as the result of someone else's action, unsatisfying, or of low value. Over time, this continuous assigning of information about their experience to categories of failure or inadequacy can become seriously depressing and self destructive.

When such a story emerges which dominates the experience of the person and their family, leading them in turn to therapy, then essentially the task of the therapist, in our view, is to facilitate new meanings which encourage the development of new stories of resolution and hope. We believe that to facilitate new meaning, 'political' as well as 'clinical' responses are required. Using the example of abuse again, in political terms (in the sense of decision-making power and judgement), sexual abuse perpetrated on a child is a brutal act, regardless of whether or not the child had other good experiences with that person. Politically speaking, the child is innocent of fault. S/he is a surviving victim of imposed actions.

Clinical work that addresses suicidal feelings, periods of depression, or unhappy sexual experience, but does not address the underlying political agendas, will merely be incorporated into the old meaning filter. This raises important ethical issues. Such symptoms may be contained for a while but new information eventually penetrates and acts upon the old filter. It is the political (ethical) work in association with the clinical work (in the narrow sense of the term) that will transform the meaning system which we have called the filter. The new meaning enables new stories of resolution and hope. The block to feelings of self-worth and confidence is transformed to attract them.

When describing therapy, we use the analogy of weaving. Although the symbolism of weaving is international, it is particularly appropriate in this context because it evokes the activity of many women in the South Pacific Ocean. People come with problem-centred patterns, and the therapist's task is to weave new threads of meaning and possibility that give new colour and new textures. For example, we consider the inability of many psychiatric hospitals and much clinical work to heal patients relates to the patterns of meaning they ascribe to the problem which serve to perpetuate the problem. A web of meaning

that defines people as 'sick patients' with 'such and such' a psychiatric illness denies the presence of competence and self-determination. This is further compounded by the institutionalising practices that occur in many psychiatric hospitals or units. This type of structure can perpetuate a malignant meaning pattern, while it combats symptoms with drug therapy and narrow symptom-focussed clinical work.

The point we are making is that the sickness/patient analogy is also a pattern, full of meaning. It is as much a political statement as it is a clinical one. Ironically, it ascribes a particular status, ability, and set of expectations. Furthermore, it is a creation of the therapist. Another therapist may describe the same experiences that person or family has as 'loving' or 'competent' or 'normal under the circumstances'; this therapist weaves a very different pattern with other colours and textures which lead to different status, ability, and expectations.

For example, we worked with a family where the father and husband had spent the best part of a year in two psychiatric hospitals. He had been severely depressed and manifested psychotic symptoms. He would spend large periods of the day staring ahead and saying nothing. Instead of joining with the various mental health professionals who searched for causes, created sickness labels, used drug therapy, and tried to persuade him to participate with his family again, we:

> *… congratulated him on how loving and caring we thought he was. 'We don't meet many people who do the things you do, Rick.' When he couldn't protect, care, or breadwin for his family, his loving response was to do everything to find out the cause of his depression, and to get it out of himself. We said we saw him as a person who wanted to get to a hospital and find out how to get this problem 'fixed up'. He was not prepared to accept second best. He'd been willing 'to give up his home, give up his work, give up everything' to get this 'fixed up'. We thought this was a sign of someone who really cared for his family.*

This approach offered a totally new meaning to his experience. The diagnosis sent to us from the psychiatrist referred to his state as: major depressive episode (severe with catatonic features); alcohol abuse; premorbid schizoid and obsessional personality traits.

He considered he was seriously sick to the point of being crazy and in

need of ongoing psychiatric care. He also believed he had failed his family. The new meaning offered suggested that he had taken two deliberate and responsible decisions. Firstly, he had sacrificed his home, work, and everything that was familiar to him; and, secondly, he had done so in order to be admitted to hospital where he would receive the treatment necessary to restore his health.

Alongside the pathological meaning he ascribed to his sickness, we offered in a tone similar to his mechanical speech, this more responsible self-determining perspective. He was a bulldozer driver who spoke of depression having 'got into him' and his needing to get 'fixed up'.

Subsequently we spoke with Sharon, his wife, explaining that we noted:

> *... that she had sacrificed his contribution to the home and had 'stood with him through all of this'. We said that although she gives her love to him she realises it's not enough to get this depression out of him. She feels defeated by this. So she releases him and, in fact, 'discharges him to the hospital where they can nurture and look after him'. This gives her a break, so she can give him her best when he comes home next time. Like him, she doesn't want second best in this relationship either.*

As with the approach to Rick, this totally new meaning impacted on the old system. She believed she had failed him because she could not keep him well; she also believed she had a crazy and irresponsible husband. Our new meaning suggested that she had assessed the situation and had committed herself to sacrifice his roles in the family and arranged for him to go to hospital and get help. She loved him and had been very responsible. Furthermore, she gives her best to him when he comes home. Playing on the word 'discharge', we recognised her status in a medical sense. Again, we offered a responsible and self-determining perspective to the events she described.

Finally, we thanked the children for their memory and help. We also assured them that nothing they had done had caused their father's sickness.

The message at the end of the second interview was paradoxical, illustrating another way in which meaning can be changed. Rick had degenerated over the year in hospital, despite psychotherapy, anti-depressant, and anti-psychotic drug therapy, and even electro-convulsive therapy. We decided to affirm their story and 'prescribe more of it' since all previous work to oppose the symptoms had failed:

We said we thought Rick had a very serious depression, and we noticed that this sort of depression sometimes happened to people who lived in rural areas where hard work was highly regarded. Rick had worked very hard. In fact, he was an equal to his wife in work who had also worked very hard. (Rick worked all week for a company and ran his own business all weekend. Sharon was still doing housework most evenings after 1 am.) He had been a good provider, protector, husband, and father. We had realised that he had worked harder than us because we had at least taken time off during some weekends over the years. He now had decided to take a rest. He stopped work and has been catching up on the rest which normal people have had throughout their life. To ensure he was rested properly, he got really depressed so no-one would get him back to work. This type of depression really requires a long rest.

We went on to say that Sharon really understands this; after all she is his partner. She had said that 'half of her was missing' with him in hospital. We were impressed with the way she had taken over many functions from him. She received phone calls 8-11 times a day from him asking her advice on what he should do next. She got everything for him when he was home, and even decided when he should cuddle her. 'She works for him, thinks for him, and feels for him.' We thought it was very helpful that she had taken over all these things because that enabled him to get some proper rest.

He could concentrate on staring and 'you can't get more rest than that'. We noted that the children were getting their mother to do all sorts of things for them that other kids their age would do themselves. In this way they were like their father.

Finally we said we thought everyone was being very sensible, but that they could try a bit harder. We encouraged Rick to stare more and to telephone for advice whenever he was about to change activities. We also suggested Sharon have more contact with Rick so she could direct him more. By taking over more she could help him rest through staring. Finally we suggested it was not advisable to get better quickly, and we cautioned them against any activity that would get in the way of Rick's rest.

Between the third and fourth interviews, Sharon concluded that carrying everything for Rick and the family was absurd. She decided to leave her children

with her sister while she took the unusual step of going on holiday. She rang Rick and told him. He was disturbed by the change in Sharon and decided that he desperately needed to get out of hospital to look after the children. Unfortunately for him, there was a committal order on his stay in hospital so he had to prove to the medical staff that he was well enough to leave. Rick's staring stopped, he became very concerned with his family responsibilities and eventually was discharged after 10 days. Within two weeks he had found a local bulldozing job and a month later the family was reporting life as 'back to normal again'. Rick was even joking with me in the fifth interview.

We consider that it was the sickness definition that restricted Rick's progress. That definition assigned him a dismal status and expectations and destroyed his motivation and hope. It also affected Sharon, suggesting to her that she needed to be a totally self-sufficient adult in the house, thus leaving no room for the unconfident Rick. When he believed he was needed, that there was a gap that he should fill in the family, his beliefs and expectations of himself changed dramatically. This enabled a change in his motivation; he took hold of himself and became self-determining once again.

This is not to suggest that we should never categorise people's problems and close all our psychiatric institutions. Furthermore, this is not a 'cheap shot' at psychiatry or drug therapy, all of which have their place and even successes. Rather, it is intended to emphasise that central to practically all therapeutic problems is meaning, whose created pattern determines the manner in which the problem is responded to.

As a therapist engages with a person, or family, they soon offer their strands of interpretation, bringing different colours and textures to the meaning. It is the interaction of these strands with the existing meaning patterns that, we contend, determines successful or unsuccessful therapy. Every time therapists respond during interviews, and particularly when they speak, they are adding to the meaning pattern of their client, and this is the essence of therapy. We consider it the essence because it has the potential to change the person's, or family's, meaning web, and thus the way they view the problem.

Therefore, when therapists use a physical science model to seek the 'correct diagnosis' with the 'right interpretation or explanation' in order to 'treat' the 'pathology', they frequently further entrench the problem-centred web of meaning by further defining it. Those seeking help incorporate these threads of

advice and definition into their problem-centred web. Thus the meaning created in therapy can actually strengthen their problem's influence over them, offering scientific explanations for its onset and persistent domination.

As we said before, problem-centred webs of meaning persist by acting as the filter through which people interpret their experience. The meaning given to those experiences reflects the pattern created around the problem. This web of meaning remains quite intact by many (though not all) traditional therapeutic techniques including: sickness labels; symptom-focussed work; listening that simply understands the problem; and simple information concerning possible causes and explanations of the problem.

Furthermore, therapeutic work that does not reflect the underlying and surrounding socio-cultural threads of meaning will, in all probability, be rejected or incorporated in such an ill-fitting manner that the pattern will be full of tension. People's culture, their living conditions, and their gender, are crucial determinants of the meaning patterns they create.

The teaching of therapy in practically all academic institutions, however, has been mono-cultural. Concepts deeply imbedded in modern North American and Western European societies have been presented as the international and intercultural ways of therapy. Further, the social context of those most in need of health and welfare resources, such as housing, employment and an adequate income, seldom affects the therapeutic task. It is neatly confined to some other worker or institution, leaving the therapist free to get on with the 'real' therapeutic task. It is the culture of the particular person, however, which probably determines more than any other factor, the underlying structure of their meaning system. Inevitably, people's ability to access resources like food and housing significantly influences their construction of reality. It is little wonder that therapeutic work with the poor, and those from non-Western cultures has been so ineffective.

Feminist therapists and writers, on the other hand, have not been slow to point to the politics inherent in therapy. They have raised the issues of power in families and the preservation, through therapy, of patriarchal patterns of inequity. By addressing the gender context of women politically, they have revealed that much therapy has created ill-health among women because the underlying patriarchal-meaning web was not addressed. The cure of family symptoms has often been approached in a clinical vacuum, bereft of significance and meaning.

Inevitably new symptoms appear, because the same meaning web continues to interpret the experience.

When describing therapy we have previously said:

> *Instead of addressing a known pathology, therapists engage in conversation, listening respectfully for the articulation of meaning by the person or family. The conversation enables the generation of new meaning by the therapist. The threads that the family have woven into a problem-focussed pattern are joined by new threads of new colour with different meanings that encourage new possibilities, or ways of resolution and hope*. (Waldegrave 1989)

Culture

The preoccupation in clinical circles with scientific and medical meaning systems has sent therapists scurrying after 'the real causes', 'the real explanations' and 'the real cures', as though they were addressing events in the physical world, like earthquakes or the spread of AIDS. These meaning systems have required them to be rigorously 'scientific', 'neutral', and 'professional'. It was as though people's therapeutic problems were entities in themselves, and the humanity and meaning from which those problems spring are disregarded. This is not to suggest the therapists and researchers were necessarily inhumane or cold, but that the meaning system that underpins their therapeutic pursuit was understood best as physical, scientific, biological, and medical analogies.

This search for objective diagnoses, causes, explanations, and cures, has separated therapeutic problems from the social and cultural contexts out of which they develop. It is little wonder therefore that our psychiatric and psychological knowledge is, in fact, very restricted and tentative. It has been the analogies of 'construction', 'story', and 'weaving' that have removed the restrictions of physical scientific investigation from therapeutic discussion and relocated it within this arena of meaning.

The 'constructivist approach' (Maturana & Varela 1980, 1987) to therapy requires the search and pursuit of meaning. Furthermore, it requires therapists to become acutely aware of the meaning construction they create in therapy. This awareness must inevitably lead to the cultural determinants of people's meaning webs.

Cultures carry within them history, beliefs, ways of doing things, and processes of communication. Experience of the most intimate events and the most public are interpreted to people, to some considerable extent, by their

culture: culture, by its very nature, gives meaning to events and experience. This, in our view, requires of the therapist a qualitative appreciation and informed knowledge of a particular culture if therapy is to be successful in an ongoing sense. A family's story, their woven pattern, is significantly shaped by their culture, and the new threads of meaning have to sit comfortably with that culture.

This may seem obvious, but very little attention has been paid to it in therapeutic conferences, writing and teachings. With the exception of a few creative attempts, such as those of family therapists, Boyd-Franklin (1989), and McGoldrick, Pearce & Giordano (1982), 'tourist therapy', the term we coined in 1985 (Waldegrave 1986), is unfortunately much more common:

> *There now exists a method of working that has become all too common, which I wish to term 'tourist therapy'. This is therapy that operates with about as much cultural understanding and sensitivity as your average package tourist en route. It moves, as if from hotel to jetplane, and flies over all that is indigenous. Brief and unconvincing attempts are made by the therapist to appreciate the client family's perspective, during a long process of cross-cultural collisions, most of which the therapist is totally unaware of. These serve to close rather than open the family's involvement and confidence in therapy. At the same time they add weight to the therapist's growing list of evidence of the family's dysfunction. Stereotypic conclusions are often reached, and eventually the therapist retires without initiating any real change in the family system. S/he then returns to the more predictable Anglo-Saxon systems somewhat bemused, like a tourist arriving home having seen the world but having learnt little about it.*

As we have already noted, successful approaches in therapy are often presented as being somehow international and intercultural. Psychological knowledge is, by implication, considered simply sufficient in itself to address the problems of people, regardless of culture and background. Our work in a New Zealand agency, with staff and clients from three cultures – Maori, Samoan, and European (white) – strongly suggests this is a false conclusion.

Concepts of self and individual assertiveness, for example, are products of individualistic Western living. They owe much to the 'Protestant ethic' and the need of modern economic systems to isolate and entrap as many individual consumer units as possible. Destiny, responsibility, legitimacy, and even human

rights, are viewed by Western European and North American people as being essentially individualistic qualities.

Because so much modern social science has been developed within these cultures, individual self-worth is usually seen as a primary goal of therapy. However, people from communal and extended family cultures do not relate easily to concepts of 'self'. For them, questioning that refers directly to self-exposure, or self-assertion, is often very confusing. To make sense of such questioning, the person has to reflect on a total family consensus.

Questioning relating to self alienates people because it crudely crashes through the developed sensitivities prevalent in communal-based cultures, where identity is expressed in extended family, rather than individual terms. The questioning is experienced by these people as intrusive and rude. Furthermore, such questioning ruptures the co-operative sensitivity among people in such cultures, sensitivity which provides the framework of essential meaning required for resolution of their problems.

Maori and Samoan people in New Zealand, for example, usually prefer to address problems they may have together with their families, rather than on an individual basis. Sometimes one person will be accorded spokesperson's rights for the family on a particularly sensitive issue, like sexual abuse for example. That person's pattern of meaning comes from the family as a whole and requires the same sort of attention as the many individual voices in a European family. Attempts to draw other family members into the discussion will be met with embarrassment and resistance. Other members of the family can be addressed when that story has been fully told.

When other members are addressed, however, there are cultural sensitivities that require attention. It is not acceptable for a young person to disagree openly with his/her parents. A question that invites an evaluative judgement of an adult relative's analysis of events will simply lead to silence and the lowering of eyes on the part of the young person. If a therapist wants to find out that person's opinions on a particular matter that has already been discussed, the question needs to be asked later in the interview in such a way that it won't involve disagreement with, or evaluation of, the older person's statement. Communication in these cultures is very sophisticated and often requires subtlety and indirect processes that are less common and more complex than in most European and North American cultures.

Therapists in Western countries have deluded themselves for long enough by dismissing this sort of information as irrelevant in their society. A closer look at most Western societies, however, reveals that there are numbers of indigenous, non-white, and/or communally-based cultures in all our countries and most of our cities. Furthermore, social deprivation statistics usually feature people from these cultures in disproportionately large numbers in areas such as unemployment, poor housing, low educational attainment, poor health, high crime rates, and so on. In other words, these people are more in need of the health and welfare resources of our countries than most other groups.

The sad conclusion we have reached is that therapists, generally speaking, have added to the problems these people experience by imposing Western meaning structures on them regardless of their own culture's meaning webs. The education systems, economic systems, the media systems, and all the other structures that create meaning in society have forced an alien meaning structure onto them. It is this primary difference, when cultural experience is far removed from, and often contradicts, the systems of control in a society, that is usually identified as the prime cause of 'failure to achieve'.

Therapy that does not address cultural meaning webs in informal ways simply continues the process of alienation. A symptom may be resolved but, in the process, people's primary meaning webs are devalued and they are subsequently distanced from their closest relations. Although it may be unintentional, such therapy should be seen as 'racist'.

This is because racism is not simply about individual prejudice and bigotry. Most cultures have their share of that. Racism exists when that prejudice is exercised by the culture whose values and beliefs dominate the institutions and structures of a given society. In other words, when the prejudice is coming from the group whose cultural experience and the systems of control in society are essentially in harmony. This is usually referred to as institutional racism. It directly affects Blacks, Indians, and Hispanics in the United States, for example, just as it affects Maori and Pacific Island people in New Zealand, or the Aboriginal people of Australia.

Many white people say they are not racist because they do not think black people are inferior, and they believe they should have an equal chance of 'success' along with everyone else. According to this view, everybody in Western democracies has essentially the same opportunities: therefore their

society is not racist. This argument is both very common and very ill-informed. It is preoccupied with individual intentions and beliefs, and totally ignores the social and institutional realities.

> *The disregard that many therapists have of the integral part spirituality plays in the life of people from non-Western cultures offers another example of this process. Nancy Boyd-Franklin (1989) states: Training in the mental health fields largely ignores the role of spirituality and religious beliefs in the development of the psyche and its impact on family life. In the treatment of Black families, this oversight is a serious one.*

In our experience, dreams, feelings, prayers, and 'other-worldly' experiences are an essential aspect of therapeutic conversation experienced with most Maori and Samoan families. This is often disregarded, considered irrelevant, or, worse still, treated as evidence of naivety and ignorance by therapists. In an attempt to be 'scientific', such activity is often viewed suspiciously and neatly side-stepped to make way for the 'real stuff'. In our work with Maori people we have found it quite impossible to carry out successful therapy without acknowledging the *wairua* (spiritual) side. It is not uncommon for the realisation of the significance of a dream to change the whole family system. This is because spirituality in many cultures is an integral and essential part of their meaning patterns.

There are many other ways cultures determine meaning for people and should be taken into account when they present for therapy. We have noted, for example, significant differences between cultures as a result of their history, for example, immigration or war trauma; their language and the manner in which it promotes certain concepts but reduces others; their definitions of acceptable and unacceptable behaviour; the associated concepts of respect and shame; patterns of thinking and communication – circular or linear patterns; family structures – boundaries and decision-making; and the degree of affirmation or subjugation of their culture; and ways of doing things in the society they live in.

All of these influence the meaning people attribute to events and experience. And it is out of these meanings that problems emerge and resolutions and healing can be affected. Good therapy engages authentically with people's woven pattern of meaning, and then in appropriate ways weaves new threads of

resolution and hope that blend with, but nevertheless change, the problem-centred design.

As we have stated, culture is probably the most influential determinant of meaning in people's lives. Cultures express the development of humanity and co-operation of groups of people over long periods of time. As such they are sacred and worthy of the greatest respect.

Cultures are not learned or understood by scientific observation, but experienced by living. People who are from a particular culture can articulate the processes and finer nuances of that culture. As a way of respecting the two Polynesian cultures we have worked with in New Zealand, we have not controlled the therapeutic work with people from those communities. This is a very important principle, because of the domination of European values and social structures in New Zealand society.

We had been working as a family therapy agency for a number of years in New Zealand, when it became obvious to us that Maori and Pacific Island people had no real access to the resources and skills of family therapy. This was because the therapists were part of the white community and had been practising with people of their own background. Maori and Pacific Island people are discriminated against in New Zealand and therefore have the highest rates of unemployment, highest sickness rates, lower educational achievement, and so on. It became important for us to address this problem.

Our organisation decided to take time to develop close links with the Maori and Pacific Island communities. We also set aside resources to provide employment for workers from those communities. Then over a period of time we shared with them the sorts of things we were doing in family therapy. Later we discussed the possibilities of a family therapy approach with families from these communities.

The Maori and Pacific Island workers indicated that there would need to be quite a number of changes in process if it were to be effective. They also pointed out that within their own cultures there are therapeutic processes that have existed for many centuries. They wanted to affirm these, and to ensure that the project would be informed by them as well as from the Western body of knowledge. In other words, there was to be an exchange of knowledge. Having established these conditions, we decided to embark on the project together.

Our organisation agreed to make all work associated with a particular culture accountable to the members of staff from that particular community. No work with members of the Samoan community, for example, would be carried out without support and direction from the Samoan consultant. The same was true for the Maori community.

This has resulted in Maori and Samoan workers choosing family therapy approaches which they found helpful for their communities, and applying those aspects in their particular cultural manner, a practice which is acceptable to their people. Their work has moved the resources and skills of family therapy to those communities in need and who were previously denied them. Their cultural patterns of meaning are now embraced in an informed and sensitive manner, such that new threads of resolution and hope are woven successfully with families every day.

Because of these agreements, a 'Just Therapy' has developed, a therapy that is essentially (or simply, or just) about meaning. Because it is about meaning, professional therapists, when working with people from cultures significantly different from their own, are required to defer to key people from those cultures. It is these people who have been tutored in the cultural meaning patterns through their life experience; this knowledge cannot be taught in an academic institution.

The control which key community workers/therapists exert over work with their communities ensures the preservation of their meaning patterns in therapy. It also reverses the institutional imposition of the dominant culture and its meaning patterns, which is at the core of the inequities perpetrated on these people. Furthermore, it is just because therapeutic resources are moved to those groups which are so often denied them.

Finally, the accentuation of cultural meaning and cultural difference also inspires reflection on Western meaning systems and processes. It offers a critical contrast to assess major issues like: co-operation as against individualistic competitive, self-determination; subtle indirect and circular processes of interviewing as opposed to direct and linear ones; traditional spiritual and ecological responses as opposed to a dualistic world view with a separation of physical and spiritual values; and so on. We found that, as a result of this work, we have both identified much more clearly key aspects of Western meaning systems, and received alternative concepts and processes that have informed and

improved our therapy with European families.

Socio-economic context

Just as therapy has been presented as intercultural, so it has also been presented as interclass and non-political. Because therapists have pursued sickness in patients rather than the meaning people give to events, their day-to-day living standards, access to housing, employment, income, and so on, have been of little consequence to the 'serious therapeutic task'. This has enabled therapists to side-step all the issues associated with inequity and injustice.

Yet in most modern Western countries those on the lowest 30% of income levels usually experience some of a number of forms of serious deprivation. They may be badly housed, unemployed, or have an inadequate access to money for food, clothing and/or health care. Certain groups of people usually appear in this 30% in disproportionately high numbers when compared with their percentage of the total population. These include women, cultural groups different from the dominant group, and those who are either without jobs or in the lowest paid and most precarious work.

There is ample evidence that the societal health consequences of being part of this group are significant indeed. For example, Harvey Brenner's large scale studies (1973) on the effects of economic recession in the USA, suggested that a 1% rise in unemployment is followed by 6% more first admissions in psychiatric hospitals, a 4% rise in suicides, a 4% increase in state prison admissions, and 6% more homicides. Further research by Brenner (1979) in England and Wales confirmed the American findings.

Abraham Maslow's famous 'hierarchy of needs' (1970) placed shelter, along with food, as one of the basic and fundamental needs which must be met, before any higher needs can be fulfilled. Many people seeking health and welfare resources in our societies have serious housing problems. In an important article entitled 'Housing Poverty in Japan' (1983), Kazuo Hayakawa, a Japanese professor of environmental planning, says:

> *It is not too much to say that housing is of the greatest importance because it affects the whole of our life in every way; for instance health, security and culture. Children grow up there, family life goes on there, and the greatest part of human life is spent there. Housing is related to human life day in and day out, and is the most important basis for the development of the total human personality in society.* (p.298)

In a previous publication we have set out in detail the effects of growing urban poverty in Western countries, and the groups of people that primarily bear the burden (Waldegrave & Coventry 1987). The psychological and physical ill-health that so often accompanies those on low incomes, and those who have only partial access to societies' resources, have been known for years. It is extraordinary that therapy with people whose problems are actually 'the symptoms of poverty' rather than the symptoms of internal family functioning, have been largely carried out using clinical sickness models that do not, of course, address the political meanings of inequity and deprivation.

Those who are employed in a society, for example, are able to participate in the production and services of that society. They have the benefit of earning their money, and the freedom to spend it. As long as they are paid adequately they are able to be, to some considerable extent, self-determining. There is dignity in that.

When a company 'restructures' and lays off a third of its workforce in a city where there is already high unemployment because of the national free market economic policies of their government, then many people are denied participation in the production and services of their society. At the same time they lose a self-determining income, and become the recipients of welfare payments and the associated lowly status. They cease to experience the social contacts they had in the workplace, and their days can become long and pointless as they lose the daily structure the workplace imposed upon their lives.

The loss of dignity is compounded by the guilt of not having a job, and by the contempt of others and comments about 'lazy dole bludgers'. The pressures of family financial needs, and the lure of commercial advertising add to the problem. It is little wonder unemployed people often experience classic depression with feelings of sadness, hopelessness and self-blame. Thus many people in these situations present problems to therapists that in fact are the 'symptoms of poverty'. These may include psychosomatic illnesses, violence, depression, delinquency, psychotic problems, marital stress, truanting, parenting problems, and so on. However, the meaning placed on their experience of events often does not include a political analysis of poverty. On the contrary, they, and many others, consider them to be failures, individually failed. Their feelings of sadness, hopelessness, and self-blame, stem from this problem-centred web of meaning.

If the 'clinical problem' is dealt with in isolation, regardless of the employment context, then the fundamental meaning web will not be addressed. The clinical problem which could be presented as a pervading sense of depression and an accompanying psychosomatic condition, for example, might recede for a time. The meaning that gave rise to the persistent feelings of sadness, hopelessness and self-blame, however, still remains. In a sense, this type of therapy adjusts people to poverty by treating clinical symptoms as though they were simply internal, individual or family problems. The same old web of meaning, together with the political context of unemployment, will soon give rise to the previous manifestation which will provide the fertile environment for new clinical problems. These, of course, will be the new set of symptoms of poverty.

This type of therapy is unjust because it perpetuates the destructive and false myth that unemployed people are the architects of their own destiny. It fails to address the victim nature of unemployment where the economies of today are deregulating, and businesses are restructuring. In most Western countries, regardless of whether all unemployed were highly motivated, well groomed, and relevantly skilled, there just wouldn't be the jobs available for those wanting them. High levels of unemployment have been structured into the economy.

Michele Ritterman (1985) addressed this problem of social context in her work with torture victims and people forced into exile as a result of political decisions in their home country. She says: *The symptom inductive events e.g. the social sequences emanating from a repressive political system – are the opposite of the therapeutic context and the reverse of sequences of healing.* She goes on to say: *We lack a means of assessing the nature of the connection between social context and individual symptoms, a means of assessing the extent to which our social reality builds and develops us or robs us of freedom.* Referring to her therapy with these people, she says: *It seeks to move what has gone inward, becoming a private personal self-absorbed process into a public event of shared social concern. In this way the spell of 'you are damaged' can begin to be broken.*

In many countries, economic planners have sacrificed full employment goals as a trade-off for low inflation. The thousands, and in larger countries millions, who become unemployed as a result of that process, pay a substantial price for the reasonable prosperity of the rest of society. They did not choose this

course – they are the casualties thrown up in the big economic game plan; it could be different. These policies are not necessary, as some market economies choose full employment as a central goal of social policy and address inflation in other ways.

The essential political and ethical point is that self-blame and feelings of guilt among unemployed people in such circumstances are as misplaced as those in women who experience the same feelings after they have been beaten up by their partners. A meaning pattern that identifies the generation of the problem internally is ill-informed, and blocks any chance of resolving it. Unemployment and domestic violence require information and understanding of the social context out of which the problems arise. These meanings have to be addressed.

The new threads of meaning remove blame by introducing a more informed analysis of why a person is unemployed. Meanings of self-failure recede, and praise and recognition for the survival strength of the victims are encouraged. The economic and political structures that choose policies that lead to the current lack of employment are identified. So too are organisations of unemployed people and advocacy groups who are working to change those policies. This information strengthens the new pattern of meaning and allows people to choose to work against their economic plight with others if they wish.

Political concepts and clinical concepts are thus drawn together. The problems and 'sicknesses' become identified as the symptoms of unemployment, poverty, and injustice. New meanings that address the clinical factors in a political context emerge. The new understanding strengthens feelings of self-worth and subdues the failure-centred meaning pattern. As the unemployed people have further experiences of 'unsuccessful job interviews', financial constraints, and so on, there is a new meaning context capable of addressing those problems. Instead of experiencing overwhelming feelings of failure, they are able to locate significant aspects of the problems beyond themselves. Their new web of meaning strengthens as they see themselves in context along with thousands and even millions of others in the same situation. Furthermore, they are able to work with others against their experience of injustice if they choose.

In this way, therapists are not making people 'happy in poverty'. On the contrary, the political and economic context is addressed in relation to the problem. Feelings of sadness, hopelessness, and self-blame, transform appropriately to feelings of anger, new possibilities of hope, and self-worth. The

loss of motivation, a prime symptom of unemployment, gives way to new energy and adaptability. Those experiencing these problems are then free to direct that energy, having faced their problem openly and in an informed manner.

The onset of many clinically-identified problems for people on low incomes is often associated with socio-economic events. If these problems are isolated from that context and its related meaning, then the therapist has acted politically to silence the voice and understanding of the main victims of inequitable economic policies. Although this may not be what the therapist intended, it is nonetheless usually the effect of their actions.

We believe that therapists in such cases are used (however naively) by the state to mop up the malign consequences of government policies. Making people happy in poverty by treating their clinical problems without reference to their political and economic context ensures that they identify themselves as the problem, thus leaving the state free of blame. It is bewildering that there are still people who consider this sort of therapy is a non-political activity.

We have chosen the structural effects of unemployment to illustrate the significance of socio-economic context to the therapeutic task. We could have chosen bad housing, inadequate incomes, inadequate access to health resources, and so on. The same list of therapeutic problems can be observed as a result of any of these economic situations.

When two or three families are living in a house built for one family, then social, psychological, and physical problems are likely to emerge. Kitchens, hallways, and living rooms double as bedrooms. Insufficient space encourages conflict. It becomes almost impossible for children to study at home after school, and so the problems multiply. Housing is often integrally linked to the therapeutic problems these people present.

The meaning therapists assign to the problem will determine whether or not the problem will continue to be located internally or be defined in terms of its socio-economic context. Either way, therapists act politically. They either address the meanings associated with the society's resource allocation as expressed through their housing and income policies; or, they further entrench feelings of self-blame and internal location of the problem by avoiding it.

Therapists can convey significant political and socio-economic information and meaning: for example, people can be commended for surviving a housing crisis with their family still intact. Their ability to survive a crisis, not

of their making but of the housing planners, can be recognised as courageous, committed, or extraordinarily competent. Their failure meanings are challenged as they recognise another authentic way to view the same events. Given the failure of governments to stem the housing crisis among low income families in most Western cities, many people in these situations are directly affected. Furthermore, they can be told they have experienced a gross injustice and survived. We are not sure we would have had the same courage as them had we found ourselves in the same circumstances.

It is our view that good therapy should always be just. The measure of its commitment to justice can be assessed by the commitment to the themes of liberation and self-determination at the heart of the therapeutic process. Denying or simply not addressing the lack of access to survival resources for 20%, and often 30%, of people in Western societies is to deny the influence of these factors on the problems presented in therapy. Such an approach ensures ongoing self-depreciation and dependency.

In order to address the themes of liberation and self-determination, the therapist cannot continue to categorise clinical knowledge separately from cultural, socio-economic, or gender knowledge. The therapist must be informed in all of these areas and ensure that they are included in the therapeutic conversation. They need to be as informed about these as they are about clinical problems and symptoms. In other words, they take a broader, ecological approach to the therapeutic task.

It is also very important that therapists honour the stories of people, particularly those who have been alienated and under-resourced. It is precisely because of the educational, cultural, and other forms of alienation, that relevant therapeutic resources should be available to help reverse the injustice and deal with the cause of many of their problems. Instead of colluding with the system that has mistreated socio-economically deprived people, therapists should facilitate transformation in meanings that will encourage new stories. To this end, family therapists in our organisation are also involved in local community development projects as part of their work.

Two consequences present themselves when therapists choose to work using these beliefs. Firstly, the therapist's conversation involves cultural, socio-economic, and gender-perspective reflections as they relate to the problem. The themes of liberation and self-determination provide the underlying pattern of the

therapist's meaning web. The threads they weave convey these implications, while restricting those that convey the internal location of the problem – self-depreciation and dependency. Put another way by White & Epston (1989), clinical problems often refer to 'oppressive or dominant stories and knowledge' which they address by encouraging 're-authoring alternative stories' that by implication are liberating.

Secondly, this ecological approach ensures that therapists become aware of the lack of therapeutic help available for those most in need of health and welfare resources. Therapeutic practice, generally speaking, is concentrated in areas that can be accessed by those who are economically comfortable. In other words, more resources are given to environments of less need. This raises a basic issue of justice itself. Not only has much clinical practice fostered (however unintentionally) the internal location of the problem and dependency among poor people, it has also reduced their access to therapy by the choice of clientele.

Themes of liberation and self-determination in therapy help unmask social myths that condemn the victims of political and economic policies. They encourage openness and the spread of information concerning all the factors that have helped create the problem. They do not protect systems of oppression or deny injustice. They are deeply sensitive to people's most fundamental fears and concerns: for example, the fear parents express when they are not able to provide an adequate home for their children; the fear of increasing debt payments; or the fear of ongoing joblessness. They approach this information with an informed context which facilitates reflection and understanding.

Finally, it may not always be obvious when the socio-economic context is essentially linked to the problem. Levels of poverty and the effects of deprivation are not always easy to define. Furthermore, the problems of the poor are not only products of their socio-economic position. There can be a range of factors that make up their problem-centred pattern. Most importantly, and that which has been the emphasis in this section, is the need for therapists to search for the broader context of the pattern, and where appropriate address it in significant ways.

Gender

The patriarchal structure of modern Western societies has been deeply influenced by the development and persistence of market capitalism. As these

societies abandoned subsistent and semi-subsistent local economies, large numbers of people moved from 'the land' to 'the factory' and city. Money became the currency of survival. Now virtually every basic resource, including food, shelter, clothing, medical care, and so on, requires the exchange of money.

As people were increasingly alienated from the land, so also were the families they lived in severed from many of their previous functions as a social institution. These included economic production, responsibility for education, religion, health care, entertainment, and so on. All that was left to the family after the nineteenth and early twentieth century social and economic upheaval was domestic privacy and close interpersonal relationships.

Men, almost entirely, have developed and controlled our modern market-orientated economies. For over two centuries they negotiated a path through scientific research, industrial invention, colonial enterprise (including the slave trade), industrial development, capital expansion, and post-industrial technology. They took control of public life, defining it for themselves, and assigned the private family sphere to women. This division of labour, driven by pervasive economic forces and patriarchal logic, soon became institutionalised. Exceptions to it arose during times of short labour supply, as for example in wartime.

Today the inequities of these developments have been glaringly exposed by feminist critique, and challenged in every aspect of life they have previously influenced. Despite this and the self-determination of many women, Western societies are still largely patriarchal in structure. We have described elsewhere (Waldegrave & Coventry 1987) studies that show men in these societies still capturing and controlling the vast majority of wealth and decision-making, from the boardroom to the local city council. Women earn significantly less than men, and are often economically dependent on them, while the majority of women who live with men and are employed still carry out most of the household domestic responsibilities. The poorest people in Western societies are single parent women. Furthermore, therapists continually see the persistent theme of mothers presiding over private things and fathers presiding over public things, fulfilling the nineteenth century inspired patriarchal division of labour.

Virginia Goldner (1985) notes: *The effect of this dichotomous social arrangement was not only to place women in the home but to virtually equate women with the home, so that women were not simply members of families, they*

were embodiments of 'The Family'. To use the nineteenth century phrase, the family had become 'women's sphere'. What this means is that family life became female-dominated, a social fact that family therapists mistake for a clinical disturbance. Seen from this perspective, the over-involved mother and peripheral father of the archetypal 'family case' emerge as products of a historical process two hundred years in the making.

Feminist therapists and writers have actively addressed issues of gender context in therapy. Marianne Walters, Betty Carter, Peggy Papp, and Olga Silverstein (1988), for example, note: The prevailing patriarchal model of family is grounded in a number of assumptions we have long taken for granted. Basic to patriarchal family organisation is the concept of role complementarity, with instrumental tasks such as earning money through work the province of the male, and emotional tasks such as nurturing, building, and maintaining relationships, and child-rearing the province of the female. In this model, the organisation of power is based on male hierarchy. In contrast to this organisation is our feminist model of family, which is characterised by role symmetry, in which each sex engages in both instrumental and expressive tasks, in both work and nurturing. This model reflects an egalitarian approach to power between male and female, and a *more democratic and consensual approach to parental management of children.*

Referring to their therapeutic approach, they say: *The central operating principles of our revisions of family therapy derive from this feminist perspective. First, no systems formulation can be gender-free. Formulations that purport to be gender-free or 'neutral' are in fact sexist because they reproduce the social pretence that there is equality between men and women. Women, in fact, are disadvantaged in our society, and a failure to acknowledge this fact doubly disadvantages them. Second, all interventions need to take gender into account by recognising the different socialisation processes of women and men, with special attention to the way in which these socialisation processes disadvantage women. We need to recognise that each gender hears a different meaning in the same clinical intervention and accordingly feels either blamed or supported by an identical therapeutic stance.*

These writers articulate very clearly the political implications of gender in therapy, and the meanings therapists ascribe to people. For example, a woman who is seriously depressed and has been threatening physical harm to one of her

younger children may be referred to a therapist. The family may have noticed her loss of energy in recent months, her frequent crying, and her unpredictable outbursts. Her husband may have explained to the children that their mother is 'sick' but was receiving help and in time she would get 'better'.

Individual therapeutic work that does not seek out the gender context and meaning associated with it will often entrench the problem further. By defining the woman as 'sick' and treating her in isolation, the meaning passed on to the family and particularly her husband is that they are, by implication, 'well'.

An analysis of family process, however, may reveal the following common scenario, that after some happy and equitable years together, she gave birth to their first child. The father was then assigned the role of breadwinner and her the role of homemaker. Over a period of four years, two other children were born. He became increasingly absent from the home due to work and sporting interests on the weekend, leaving practically all the children's upbringing to her. She felt betrayed and resentful but whenever she wanted to speak about it he either avoided the subject, or listened and didn't do anything.

Over time she grew to expect little affection from her husband and turned to her children for nurturance. This led, on occasions, to her giving mixed messages. At times she would need to discipline but she realised that if she were angry with them she was 'cutting off the hand that was nurturing her'. The children sometimes took advantage of this by playing up and rendering her powerless in her own house. When her husband came home on such occasions he considered the house was in chaos and accused her of failure and loss of control.

In short, her experience in the family was one of failure in marriage and failure in parenthood, both of which she was considered responsible for. Her attempts to address the situation were avoided by her husband. She could not abandon the children so she was locked into a destructive structure which inevitably led to low feelings of depression and other symptomatic behaviour.

It is a travesty of therapy to treat a woman in such circumstances individually and clinically, and then send her back into the family structure that created the problem in the first place. Family members will see her as a 'failed sick mother' whom they have to 'support' on occasions. Her husband's 'strength' will be called upon to help carry the family until she's 'got over this'. He will receive much sympathy for this 'extra load' he's had to 'take on'. She, of

course, will become sick again because the underlying inequitable structure that caused the problem has not been addressed.

Therapists who adopt an individual clinical focus in such situations ascribe the symptomatic behaviour to inner personal processes. In doing so, they create a reality that explains to all family members the cause and cure. This profoundly affects the meaning families give to these events and their subsequent behaviour in the future.

Therapists, on the other hand, who are keenly aware of the way socialisation often disadvantages women, will understand the behaviour as a symptom of both the family relationships (as opposed to the individual), and of gender inequity. Therapeutic work with that family will require an analysis of the meaning web that encouraged the development of their family process, and the incorporation of new threads that facilitate new meanings of self-determination among family members through co-operation, sharing, and a liberating approach to gender roles. We are not just referring to a more equitable distribution of household and parenting tasks, but rather a movement from a patriarchal web of meaning to a shared or co-operative meaning structure. Although couples in these situations often stay together, it does not follow that they necessarily will.

This is not simply an argument for family therapy over individual therapy. Family therapy is very often carried out with no reference to gender equity at all. Indeed, the whole concept of 'a family system' with its 'homeostatic balance' and 'a function for every symptom' often 'depoliticises' inequities at the expense of girls and women.

The metaphor of a biological system employed in the majority of family therapy literature may appear appropriate and fitting when referring to school refusal, for example. A therapist might hypothesise that the systemic balancing function of the young person's refusal to go to school is the support of a parent at home who is perceived to be aggrieved and lonely. Therapeutic work might then focus on the resolution of the aggrieved parent and their partner in order to make redundant the balancing behaviour, leaving the young person free to attend school. This is a classical systemic formulation and is attractive because of its functional explanation of the interdependence of family members which removes blame from the person with the problem. The young person is perceived as sensitive and caring, rather than undisciplined and irresponsible.

However, when this same systemic metaphor is used to refer to a man who hits his partner, injustices are likely to occur in therapy. The systemic therapist asks, what is the function of this symptom for the system? In other words, what is the function of violence for this family? To even concede that violence can have a function in a relationship is unjust and outrageous. It suggests a woman is in some way responsible for her partner's violence to her.

The problem with the 'systems' metaphor is that it does not address the power differential between men and women. All behaviour is considered morally relative and all family members contribute to it. Furthermore, the family is often considered self-sufficient and separate from the patriarchal social context, which has spawned violence as a means of control. This can have the effect of removing responsibility from the 'perpetrator' and 'blaming the victim'.

Michelle Bograd (1984) illustrates this with the following sequence: *A wife reminds her husband to fix a broken window; he feels infantilized and withdraws; she impatiently reminds him; he feels inadequate; she demands that he do as he promised; he angrily lashes out and slaps her. In this 'neutral' description, the woman is described as demanding and aggressive, which are conventionally undesirable female qualities. Her behaviour is framed as provocation or nagging, and not as the legitimate right of a wife to voice dissatisfaction. The husband's role is downplayed through the more sympathic portrayal of his insecurity. His violence is almost normalised as an understandable attempt to regain his 'rightful' place in the marriage. Similar formulations are further biased against women because they: 1) imply that the battered woman could and should control her husband's feelings and actions; 2) attenuate (reduce) the man's responsibility for his violence; 3) ignore physical size differences between men and women; and 4) deny that violence may be linked to pre-existing personality characteristics of the abusive husband and not only to transactional variables that developed over the course of the relationship.*

If the patriarchal web of meaning that enabled and to some extent justified the violence is not addressed, then, even though the hitting may stop, new controlling behaviours are likely to emerge.

Patriarchy refers to a view of the right to power dominance by men over women at every level of society from government to the family. It is integrally

woven into the structures of modern Western societies (and most others as well) and all its institutions. It is inequitable and unjust, and any therapy which does not address that injustice consciously is by implication sexist.

Constructivist approaches to family therapy can fall into the same trap as the systemic approach. The realities created by both family members and therapists are viewed as interpretive observer descriptions, each carrying their own meaning. The denial of objective reality in these observer descriptions can lead therapists to treat the attributions of meaning given by different family members as being of equal value. The stories of abused children and women, however, are more likely to reflect what really happens in a household, than the reduced story a person who abuses often gives.

The moral relativism latent in the constructivist approach fails to identify the preferable or even the malign meaning webs intrinsic to such therapy situations. In other words, this approach de-politicises the broader social context and inequities. Issues of responsibility and blame are critical in abuse work. Abusive behaviour and the patriarchal meanings central to its creation need to be opposed, and abused people relieved of blame. A construction that acknowledges the gender context is an ethically preferable construction, as the political meanings are woven into the clinical process.

The manner in which therapists seek information concerning the problem in therapy will also convey meaning, and determine the sort of information they will receive from people. If a therapist considers the family to be a social institution that protects and encourages intimacy, for example, then they may well question the need for an adult member to stay in that family when, despite numerous attempts to address the problem, processes in the family destroy intimacy. If, on the other hand, a therapist considers that families should usually be helped to stay together, they will tend not to raise such questions.

The avoidance of key questions limits therapy to the existing family structures. Where inequities are occurring within the family, the total therapeutic process may only serve to enshrine patriarchal meanings and practices. However, questions concerning the choice people have to continue to live together, the economic possibilities of separation, the possibilities and fears of violence if a woman chooses to leave, and the shared issues of emotional and psychological dependence can open discussion enabling choice, change, and bargaining between them. Thus the process is enlarged and new possibilities of self-

determination, hope, and resolution are facilitated.

Other modes of questioning can help people reflect on patriarchal meaning webs in their family during the process of therapy. McKinnon & Miller suggest:

> *Such questions as: 'Who has been most influential in determining current beliefs? Who is most served by the current beliefs and social definitions of problems and relationships? What has been the socio-historical evolution of these beliefs?' (These questions can be simplified.) This, by necessity takes us beyond the family as a thing and forces us to examine the social construction of our own theories and of ideologies concerning the family, gender, heterosexuality, motherhood, childhood, and of problems we have hitherto located within the family such as child abuse, incest and wife battering.* (1987)

Questioning that broadens the therapeutic discussion to the webs of meaning underlying and surrounding behaviour admits the possibility of changes of meaning. Certain other questions, phrases, and themes in therapy can restrict that possibility. The use of phrases like a 'violent family', when referring to a family where a father is violent, confuses responsibility and meaning. The term 'sexual addict' instead of 'sexual abuser' changes a political metaphor into a medical one, and reduces responsibility. Likewise, the common practice of working for change in the family via the most responsive person, usually the mother, simply plays into the old patriarchal meaning web. She ends up having to do most of the work and take most of the responsibility.

Work against patriarchy requires continual monitoring, because therapists have grown up socially gendered like their clients. In our organisation, oversight of this work is carried out by the women therapists. Over time, appropriate gender roles have been allocated to the various therapists. When a woman has been abused, for example, she is seen by another woman, and the man who abused her is seen by a man. It is only after he has taken responsibility for his abuse that we will engage in a family interview. We ensure that our staff complement includes at least one man and one woman from each of the three cultures we work in partnership with. For men who are violent we also run culturally-based groups directed towards non-violence.

One recent example of this gender related approach was our attempt, after years of work with both the victim/survivors and perpetrators of violence, to articulate a further revised set of policy guidelines for therapists working with

men who abuse. We were trying to address the problem therapists experience as they work beside a person who abuses. On occasions they can advocate on his behalf and resist challenging directly his violent behaviour.

Early on in this project we agreed that men working with those who abuse should make their therapy accountable in a direct way to women workers in the agency. Various gatherings have been called over the years as our reflections on the work have matured. The most recent meeting articulated the following policy goals which were subsequently adopted by the whole agency.

When working with men who abuse

Men's stories should not be told in a vacuum. Reflective work with their stories should help them identify the growth and persistence of abuse.

– Work should primarily focus on the abuse and its consequences on the women and/or other victims and their liberation, and secondarily on the victim experience of the person who abuses, e.g. racism, problem childhood, etc.

The test of good work is a change of heart or second order change, that internalises the issues set out in (1) and (2) above. This is beyond simple intellectual or intentional change.

– When working together, male workers share the story as the person who abuses tells it. Female workers share the story as the abused person tells it. It should be recognised that the stories of people who abuse usually reduce the level of abuse, and male workers should not advocate against the story of the person who has been abused.
– Within the context of a warm, working relationship, male workers need to be direct, challenging, very clear on the issues of oppressive violence, and professional in their work with abusers.
– Confidentiality remains with the agency and the normal procedures that are in place for implementing this. Information from the female workers, in particular, is not to be shared with the person who abuses, without permission from that female worker. A similar procedure should also occur with information given by male workers.

This policy clarifies a preferential meaning web with regard to one therapeutic area. Therapists who agree to this set of guidelines have chosen a

pattern of values that are opposed to the continuation of patriarchal webs of meaning. Furthermore, the relationship between male and female therapists is woven into the policy.

This approach directly affects the therapeutic task. The meaning that is created by the therapist becomes apparent within the context of the policy guidelines. Furthermore, this offers a well-grounded structure for appropriate accountability between colleagues.

Gender equity is a just expectation of any therapist and their work. For it to be realised, the broader patriarchal structures of society should be addressed in our therapy, our organisations, and our practice. The structures of Western societies are not gender-free, nor is any therapeutic work. We contend that therapists should work for equality between men and women by recognising the current gender injustices, and consciously creating therapies that facilitate new meanings that will enable equality in relationships.

The therapeutic exchange

Therapy, in our view, essentially involves an energised conversation, during which the therapist listens respectfully for the articulation of meaning by a person or a family. Professionalism, with this approach, is judged by the quality and skills of the conversation, rather than superior knowledge and training. The skilled therapist helps people to experience new ways of reflecting on, and organising, the significance they give events. The domination of the problem-focussed web of meaning becomes addressed by them as they weave new threads of possibilities.

This approach imparts to those coming for therapy a sense of prominence. Their story is the focus of therapy, and they are perceived by the therapist to be the experts in articulating its significance and meaning. The therapist's contribution is to honour the story presented in therapy, by encouraging its articulation, and respecting its significance for the people concerned. The therapist then offers new meanings and possibilities of resolution and hope from the same events.

From this perspective the so-called 'presenting problem' is not a pathology to be treated, but a sacred story given in trust. People come to

therapy and make themselves vulnerable by exposing the deepest and most personal events in their lives, along with their explanations of those events. They often feel defeated and even humiliated by the persistence of their problem. In these circumstances their exposing of their pain and the context out of which it springs, is like a gift, a very personal offering, to the therapist: it has a spiritual quality.

This offering is worthy of honour. It is not a scientific pathology that requires removal, nor is it an ill-informed understanding of the problem that requires correction. It is, rather, a person's articulation of events and the meaning given to those events which have become problematic. The story needs to be respected in a manner not dissimilar from that of a trusting friend exposing their own pain or sorrow. Help is often needed in describing it – to include parts forgotten or difficult to mention, and finally to reflect on it.

It follows from this approach that a therapist of the same culture as the client's will more easily understand the significance given in a story. They will also be more informed about possible new meanings ascribed to those same events, drawing significantly on the culture, rather than disturbing and alienating it. That expertise is at least as significant as professional clinical knowledge, and in some cases more so.

This approach offers the possibility of cultural partnerships in therapy, with Black, Hispanic or Indian cultures in the United States, for example, or Maori and Pacific Island in New Zealand. The cultural expert, whom we refer to as a 'cultural consultant', offers understanding concerning meaning, and the clinical expert offers understanding concerning the Western body of psychological knowledge. As long as the expertise of both is respected equally, the cultural consultant will, over time, learn clinical knowledge, and the clinical consultant will learn sensitivity and differences in cultural terms.

In this manner, cultural groups who have little access to therapeutic resources see members of their community respected and trained in therapy. Furthermore, the expertise of the cultural consultant appropriately deters the clinical consultant from intercultural ascriptions of meaning. The particular meaning systems of the particular cultural group then become increasingly differentiated from the dominant meaning systems. Eventually the cultural consultant becomes clinical and cultural consultant. As is sometimes said in New Zealand: *A Maori can always learn to be a psychologist, but a psychologist*

cannot learn to be Maori. And we could add, *but a psychologist can learn to respect and be sensitive to things Maori, or Samoan, or Black, or Hispanic, or Australian Aboriginal, and so on.*

Women therapists also have experiences and understanding in common that are differentiated from those of men. Their therapeutic attentiveness to women's story in therapy, and their analysis of appropriate new meaning, is transforming modern approaches. The field in the past has been dominated by male theorists whose meaning systems have grown largely out of patriarchal societies and scientific discipline. There are numerous therapeutic occasions where women are simply more capable, more appropriate and more expert than men. They can relate to, and listen for, the articulation of meaning more easily because it is closer to their own.

Therapists then, initiate conversation in the first interview. Their demeanour, their words, and their attitude communicate meaning immediately. Different cultures, for example, have ways of beginning conversations with those they haven't met before, and people from the same culture know at the outset if their processes are going to be understood and respected. A Maori family in New Zealand will feel much more comfortable, if each person is introduced and the therapist shakes hands individually, or hongi (press noses respectfully), or kisses the women on the side of the cheek. After this people will sit down and the conversation will focus on where they come from, who their family are related to, and connections that may exist between the therapist and any members of the extended family. It is only after this process, and other similar discussions, that it becomes appropriate to introduce the reasons for coming to therapy.

People struggling to survive economically soon know whether their daily pain is appreciated and understood. Therapists who usually experience much more comfortable economic circumstances express their reality by the way they talk and the significance they give to the struggles of poor people. Can they identify with the toughness that life in poverty requires of families? Can they link into the humour? Do their comments reflect establishment views that denigrate poor people, or do they respect their stories?

We begin the interview informally in a manner that attempts to relax the people while giving an underlying message of respect and genuine interest in them and what they care about. We then seek to draw out their story. It is very important that it is their story, without intrusion or contamination by the therapist. We elicit this with a very straightforward and open question, like:

- *Well, what's brought you along here today?* or
- *What is it that you would like from us?* or
- *Okay, perhaps you could tell me what the problem is?*

By asking this kind of question, the therapist throws the initiative over to the person/people to define the problem, explain the significance and set the goals of the therapeutic partnership. They tell their story and, regardless of what they say, it is taken very seriously. The therapist does not define the order of the speakers or direct the discussion. Instead s/he allows the process to shape itself.

When working with families, the spokespersons, the silent ones, the conflicts, the partnerships, and the articulations are all observed. Some families volunteer the story and articulate detail with very little prompting from the therapist. Others elaborate with the help of enquiring questions to give details, place events in sequence and, with encouragement, discuss those things they find difficult to say.

The therapist's task is to draw out the story and observe the meaning the family gives to the story. S/he should not advise, interpret, congratulate, or in any way interfere with the people's story. The therapist's task is to draw it out, take it seriously, and communicate respect, understanding, and concern.

By comparison with many other therapies, the therapist practising this approach is verbally inactive. Their speaking simply acts to facilitate and promote maximum relevant detail relating to the person/people's story. They usually contribute only about 10% to 20% of the therapeutic conversation. Every question is carefully phrased to encourage the articulation of events and the meaning the family ascribes to those events.

Although the questioning is open-ended in an attempt not to 'lead' the people, the information sought is deliberately chosen. We ask questions that bring out gender, cultural and socio-economic contexts and meanings. We are interested in how other members of the family, and extended family, reacted, who they went to for advice, what reason they give for such-and-such an event, what is their understanding of what happened, what significance they give these events, and so on. The answers to these types of questions convey the gender, socio-economic and cultural ascriptions of meaning conveyed by people.

It is very important that the questioner seeks to clarify and understand, while never on any occasion assuming or predicting people's responses. S/he

asks many 'what' questions and 'how' questions, for example:

- *How old were you at this time? What do you think of the teacher's explanation?*
- *What did you do when she said she was going to kill herself? So he hid in the cupboard, then what happened? How often does he hit you?*

'What' and 'how' questions invite raw information. The therapist is asked to avoid 'why' questions which invite a thinking interpretation of the raw material. The description of events are already usually organised by people into some primary-meaning web. Further interpretations tend to obscure its simplicity and energy. If the meaning of an event is not clear, we encourage a 'what framework' for a 'why' type question, e.g. *What explanation would you give for Johnny's disappearance?*

Other 'what' type questions can be used without the use of the words 'what' and 'how', e.g. *Where were you living at that time? Did you get on okay with your father then? Who was it that took you to hospital?*

The story being told can also be prompted by emphasising or repeating key phrases said by that person during therapy as an invitation to expand, for example: Jane: *My parents resented me.* Therapist: *They resented you?* Jane: *Yeah, they always ...*

The therapist persists with the family to enable their story to be recounted in full and an account of the meanings they attribute to it to be given. If there are connections that are not understood, further questions elicit the information. It is never assumed. If parts of the story are unclear, questions to clarify are asked. If other parts are difficult to speak about, support is given to encourage their articulation.

This process encourages people to own their stories and promote them as the focus of therapy. This not only provides the information the therapist requires to address the problem appropriately, it also gives a considerable measure of control of the therapeutic conversation over to the clients. Their stories and points-of-view are requested, and taken seriously.

For some clients this is not always easy, especially when the person is in a low functioning state. On these occasions the therapist needs to engage verbally more frequently. The following dialogue occurred in the first interview I had with the family I referred to earlier, where Rick, the father and husband, had spent a year in two psychiatric hospitals:

Therapist: *I need to know if there's anything you want from us.*

Rick: *Well, I want to try and get better.*

Therapist: (gently) *Better from what? I don't really know what is your problem.*

Rick: *I get depression.*

Therapist: *It's a pretty wide term. What do you mean by that?*

Rick: *Well, I just seem to have it in me all the time.*

Therapist: *You have it in you?*

Rick: *Mmmm.*

Therapist: *How do you know you've got it? What is it that's depressed?*

(silence)

Rick: *I don't know really.*

Therapist: *So, you've got depression in you but you don't know what's depressed. Do you have any feeling? Do you have any thoughts?*

Coming from an institution that both defined and acted for him, it was important to signal that he needed to clarify his own problem and that we would treat that very seriously. Later:

Therapist: *I'm not always sure the way other people describe it is the accurate way. Now, we've had some indication from the hospital of what they think, but for us it's much more important to get it from you because you're the one that lives with it.*

Rick: *Yeah.*

Therapist: *They don't. I don't. It's something you're living with, and your family lives with it.*

Rick: *Yeah.*

Therapist: *So, I'm really interested in the way you see it, your definition of it. I mean, how does it affect you? Can you just sort of put some words around it?*

Rick: *Well, it gives me no energy and that.*

Therapist: *No energy ... You just feel all tired or something. Is that something different from the way you used to feel?*

Rick: *Yeah.*

Therapist: *How did you used to feel?*

Rick: *Good as gold.*

Therapist: *Good as gold?*

Rick: *Yeah.*

Later, to the wife and mother in the family:

Therapist: *What do you observe happens to Rick when he gets depressed?*

Sharon: *Um, he finds it hard, difficult to talk. Um, and there is sort of no feeling, or no emotions. There hasn't been any of that for months.*

Therapist: *No feelings, no emotions?* (To Rick) *Is that the way you feel?*

Rick: *Yes.*

Therapist: *You don't have any feelings at all?*

Rick: *No.*

Therapist: *Gees, that's a bit rough, eh? Do you ever feel happy at all, or do you always feel bad?*

Rick: *I always feel down to it.*

Therapist: *Alright.* (To Sharon) *And there's not much talking?*

Sharon: *No.*

It was also important to know the children's experience. I later enquired of the ten-year-old son and brother:

Therapist: *Do you know what your dad is talking about when he says he gets depressed? Do you know what he means?*

Guy: *No, not really.*

Therapist: *No ... Do you notice anything different about your dad?*

Guy: *Yeah, it's hard to talk.*

Therapist: *Hard to talk?*

Guy: *Yeah, or make a conversation.*

Therapist: *Did you used to talk to him much more?*

Guy: *Yeah, we used to play with him. We miss that now.*

Therapist: *Oh, he doesn't play so much?*

Guy: *No he can't, really.*

In a sense, this dialogue is atypical because the therapist is much more involved than usual in the verbal interplay. In most circumstances one or two questions initiate a story from people. When that is not forthcoming, because of, as in this instance, the very low functioning state of the person, then the story is elicited with more verbal participation by the therapist. The focus remains on 'what' type questions, people's experience, and the meaning they give to that experience. The therapist often recycles phrases used by the family for further clarification and amplification. This indicates to the family both attentiveness and interest on the part of the therapist.

This process of storytelling and questioning usually takes us about 50 minutes to an hour. The therapist then leaves the people to reflect, either by themselves, or preferably with a colleague, who has been observing the interview through reflective glass. (The family, of course, met the observer before the interview began and were aware they were being 'screened'.)

An analysis of the problem-centred story then takes place. There are obvious advantages if the therapist has an observer to reflect with. Together they note the events referred to in the story and the meaning ascribed by different members to those events. They discuss the emergence and development of the problem into its central, dominating focus.

Because culture, gender and socio-economic context are at the heart of people's experience and the development of their meaning webs, therapists appropriate to the particular context are assigned to the persons or families coming for therapy. Male and female therapists, for example, have particular roles when gender issues are central to the problem. When the clients come from cultures that are significantly different from the majority culture, and are dominated in society, therapists belonging to those cultures take the leading role. These therapists more easily understand the meaning webs, and know better how to strengthen people by encouraging them within the context of their culture, rather than alienating them from it.

Using the information gained, the therapists then create alternative meaning that will enable resolution and hope from the events previously described by the family. They prepare a message or reflection for the family or person which is designed to weave new threads of meaning that will undo the rigid problem-centred pattern.

The process takes about a quarter of an hour to twenty minutes.

Meanwhile, the family chatter, drink coffee, and relax. The therapist who has been visible throughout the story session then returns to the family with a reflective message, in note form or the full text. The earlier process of listening to, and drawing out the people's story is reversed. Instead, they listen to the message from the therapist, which is read twice, preferably in silence (though it's not always possible).

The interview finishes after the message. The message is not designed to be discussed at this point; instead it is designed to arrest the domination of the problem by the surprising appearance of an alternative creation of reality around the same events. The new reality loosens the threads of the old pattern and sensationally opens the design to new possibilities.

An illustration of the sort of message we give is taken from a Samoan family with whom we worked. The Department of Social Welfare referred the family because of their concern about James who, at the age of 14, had been assigned by the court to a Department children's home. The parents, Samu and Sieni, were charged by the police with not having James 'under proper care and control'. James had been living on the streets, truanting from school, and had been caught breaking and entering a number of local businesses during the evenings. James' father, Samu, believed in very strong physical punishment when disciplining his children. He was an ex-boxer and had punished his children severely in the past. He was also in the habit of drinking a lot and scaring Sieni and the children when he came home. There were two girls still living at home. The Departmental workers felt they were unable to communicate with the family at all. We were approached because of the Samoan workers in our organisation.

Two Samoan women and I were involved in the therapy. One of the women was in the room with the family and the other two of us were behind the one-way screen. At the end of the first interview the therapist read the following message twice:

> *The team has listened very closely to all the things that you have said. They were very moved by your honesty and your openness, and by your tears of pain. As a family you have had hard times but they know that you have already started to change these, and you want to find love and happiness again together.*
>
> *Samu, the team knows how important it is for you to have a good family*

name. They also know that some of your children have hurt you. You have thought about this a lot and have tried to make some changes to help all your family. Not only have you tried to get James to be good and to do what you want him to do, but you have also cut down a lot of your own drinking for the sake of your kids and your family. The team were really happy that you have made these changes.

Sieni, the team understood how much you care for all your children and your husband. They thought you were a hard-working good mother who prays for all her children. They know that you have reached the point of nearly giving up with James at times, but you are still here with your family because you wanted to know what to do best for them.

James, the team know that even though you want to be with your mates a lot, you have chosen 'to come home and belong to your family'. You have already begun to try to get things right and they know you will go on trying. The team thinks you love your father very much. They saw how afraid you got when he became drunk, in case he was mugged, the way some street kids mug other drunk people.

Winnie and Anne, the team could tell that you cared a lot for your family and want things to come right. Your tears, Winnie, showed us your love.

As a family, you still have some problems. The changes that have taken place will need to go on. And some of you in the family seem to be quite lonely. We think that you have enough alofa [a Samoan word that refers to very deep, committed, and sacrificial love] *and strength in your family to make these problems come right and be happy, with some help from all of us working together.*

The message was designed to present a different reality around the same events the family had experienced. Essentially, the family, which was proudly Samoan, had been humiliated by being taken to court and having their child assigned to a State Home, The court system categorised both the parents as being inadequate for the task. The Department viewed them as another failed family. The parents, who were poor immigrants, were bringing up their children as they would in Samoa, where housing is in extended family structures that are open to the whole village. The children had quickly adapted from the traditional processes in Samoa to the less defined ones in New Zealand, while their parents

were still struggling with speaking English. They were living in one of the poorest suburbs in the Wellington region. Their situation was not dissimilar to that of numbers of Pacific Island immigrant families in New Zealand.

The message (perhaps surprisingly) indicated that we considered the parents were both competent and committed to their children, and that the children loved their parents. Furthermore, there was enough alofa and strength in the family to see them through these difficult times. We recognised deep Samoan values, such as concern for a 'good family name', our description of 'a good mother who prays for all her children' and 'alofa'. We acknowledged the family's pain, and the gift of their openness to us, particularly after their distrust of the Department of Social Welfare.

Each person and their particular loneliness was addressed. The parents struggled with English which was their second language, so we used simple concepts like being 'happy' and being 'good', and so on. Nevertheless, all the information we gave back to the family was assembled from the story they had told us.

Because the message was an authentic creation that viewed the same events from a different perspective, it loosened the tightly woven pattern of failure, humiliation, and incompetence. While our meaning respected the family's efforts and acknowledged their pain, the new information imparted to them was surprising and stunning! Its impact was increased by reversing the interview structure from the family's articulation of their story, to our reflection on those same events. In this manner we began to weave the new threads of resolution and hope.

We consider that the real work of therapy takes place in people's lives between interviews. We don't give the message for debate; instead we offer a dynamic reflection, that is designed to impact on the problem-centred meaning web that organises people's creation of reality. Its significance unravels slowly in the days following, as people view their lives and relationships differently.

Each interview after the first simply pursues the development of meaning among the family. After pleasantries and any appropriate acknowledgements, we ask another open-ended question like:

- *How have things been since we last saw you?*
- *What's happened since we last saw you?*

Again the therapist persistently tracks events and the meaning given to

events with 'what' and 'how' type questions.

During the interview, all, or as many as possible, of the critical problem areas are tracked in the family's story. The therapist monitors the movement in these areas. The stories change over time as the threads of new meaning emerge. The therapist, generally speaking, continues to contribute only 10% to 20% of the verbal interplay as s/he draws experience and meaning from the family.

After the first interview it is very important to highlight the differences in meaning and behaviour which have emerged since earlier interviews. These changes are not congratulated or marvelled upon; they are simply noted as different from last time. Congratulations are offered later in the message to increase its impact. Underlining change simply involves a statement like:

- *Well, that's different from what was happening last time, isn't it? So you've decided to trust your parents now? Okay, what was it like when you did that?...*

and the therapist tracks the new information, or

- *Gee, that's a change, eh. And what happened after that?*

The messages given from the second interview onwards begin by noting the changes in behaviour and meaning since the previous interview. They go on to spell out the significance the therapists give to certain key behaviours that have occurred between interviews. The message has great flexibility: information can be presented in an encouraging manner, a directive educational manner, in paradoxical form, in dilemma form, or in whatever way the therapist thinks will loosen the old threads of meaning and encourage growth of the new ones.

The message at the end of the second interview with the family we have just referred to, for example, took the following form:

The team has been very impressed with all the changes that have occurred in your family since they last saw you.

Sieni, the team noted that you have decided to trust your children more. You are letting them take care of themselves more as they grow up. They know that you know that if you and Samu trust them then, they are more likely to be responsible for themselves. They heard you say how very proud about your kids you are. They also wanted you to know that they understood how you have been hurt in the past by Samu and still have to talk about that at times like this. Despite all these things, you still love him and your family very much and that is why you are still with them.

Samu, the team have heard today from you, and all the members of your family, about your changes. They know that you know just how dangerous your drinking has been to the family. Your family can smile again now that you don't come home drunk. Because you have succeeded in this, your children and your wife are not afraid of you like they used to be. They want to talk with you now. The team was very impressed with the way you did not interrupt Sieni to defend yourself when she wanted to talk about those bad times from the past. They think the most important thing you said today was near the end when you said 'Now I don't *want to give a hiding, I* want *to talk'. They thought that was wonderful. Winnie and James, we know it's been a long time for you here today, but we think you understand that these times help make things for your family better. The team thinks you must really love your parents very much, both mother and father, because you have begun to speak more freely with them very quickly. As they have trusted you and let you go out, you have stopped being afraid and got closer to them. You are beginning to trust each other. And the team knows that all of you know that this is the start of good and happy family life.*

The team understands that the court case next Monday is a worry for you. They want to say that they think that you are making the right preparations for a new beginning as a family together. They think you can begin to feel confident and sure about the future.

In a culturally appropriate way, this message respectfully placed the initiative with the parents, who had decided to trust their children in a more risky manner. As a result, the children had responded with closeness and trust themselves. In this way, the clear boundaries of respect and status between parents and children in Samoan families were not disturbed. Trust and responsibility were linked, enabling the parents to adapt to the more liberal pressures on their children in New Zealand, while at the same time encouraging them to understand that this placed some form of appropriate accountability upon the children.

The message also addressed key gender issues in the family. The therapist had drawn from Sieni during the interview, articulation of her deep hurt and distrust of Samu because of his drinking and violence. In the message she was spoken to first, and the legitimacy of her pain acknowledged. Samu was directly reminded how dangerous his behaviour was, and his determination to change his

ways was quoted. The word 'brave' that is often associated with male violence, was re-interpreted to refer to him humbly listening, without defending himself, to Sieni's talk about the bad tunes.

All of this was carefully expressed with hope and respect for the family.

Each paragraph attempted to strengthen the meanings that were encouraging the new behaviour. As with the first interview, all subsequent messages were read twice.

We only needed to see this family over four interviews. The Department of Social Welfare and the Judge then assessed the family home as being the most appropriate place for James to live. This was because parents and children were trusting each other and the violence and alcohol abuse had ceased. As the Department's report put it:

> *Overall, it would appear that movement has taken place and there is a far greater match in ideas and expectations of discipline and boundaries between parents and children in this family. Parents and children are also communicating more freely and discussion is being seen as a good method of problem solving. Furthermore, the family home was the place James now wanted to live in.*

By addressing the meaning web in this way, a poor, immigrant, broken family, enmeshed in police, judicial, and welfare systems, reassessed and liberated themselves from those systems, becoming self-determining after only four sessions.

Another example of this process is offered via the messages given at the end of the first and fourth interviews with a family in which life-threatening violence had occurred on numerous occasions. The mother, Mere, and her two sons, George and Raymond, were referred to our centre by the local women's refuge. Mere had been seriously beaten on many occasions and taken to hospital with head injuries and broken bones. It was considered too dangerous for her to stay in the local women's refuge in her town so she was moved to our area. She left behind her husband and elder son. In the refuge her younger 8 year old son, Raymond, was causing havoc for the other families. He was switching the channels on the only TV set while others were watching a program, hitting other children in the refuge, being very rude to his mother and continually making a lot of noise around the other families.

The family was Maori and a Maori woman therapist and I worked with them. She was the therapist in the room. At the end of the first interview we compiled the following message:

We'd like to congratulate you, Mere, for putting an end to the cycle of violence. It takes a lot of courage to leave your home town, and Jim and Pete. We can see you are determined to make a new life, and we think you are a very responsible mother. George and Raymond, we think you are very lucky to have a mother who loves *you the way she does; a mother who has got the courage to make a new start.*

George – we know that you support your mother a lot, but we are worried, Raymond, that you are acting more like a six-year-old than an eight-year-old. Eight-year-olds are usually smart enough to know that when they live with other people they should respect *them by being quiet and helpful. Young kids like six-year-olds make a lot of noise, show off, and like hitting small children. They like hitting their mothers and switching TV programs. Six-year-olds are too dumb to know how to respect people around them, especially adults.*

We want you to grow up to be an eight-year-old. You can learn from your brother how to quieten down, not show off, and respect *your mother like an older kid. We know that you can. You don't have to be six.*

The message was designed to recognise Mere's courage and strength, and to set that meaning alongside her very depressed and hopeless feelings of failure. Again, we acknowledged her self-determining steps 'to end the cycle of violence'. It is not always appropriate in Maori culture to praise someone directly: they can often feel very embarrassed. Instead we told George and Raymond how lucky they were to have a mother like her. This indirect message was both culturally appropriate and gender sensitive. The boys, particularly Raymond, were still confused as to the rights and wrongs of their mother's move.

The words to Raymond also illustrated ways of affecting meaning change in children. He thought all his antisocial behaviour was a sign of his maturity and future manhood. By redefining age and maturity in a manner that seduced him, we offered another perspective designed to stun and arrest his current behaviour and beliefs. By repeating the word 'respect', we were calling on a deep Maori

value which he would have heard many times.

Raymond's response was immediate and dramatic. Mere soon moved into her own house. The message at the end of the fourth and last interview tells the story, and continues our appreciation of Mere's ability and courage. By this time we had got to know her a lot better, and we thought she should receive our praise both directly and indirectly without embarrassment:

> *Mere, we are very impressed with the way you have been able to take charge of your family and make your boys and yourself safe. You now have an independent life and your boys look good.*
>
> *George and Raymond, you have a wonderful mother who has made big changes in her life so that you can all be happy. She has courage, strength, and a lot of aroha* (a Maori word that refers to very deep, committed, and sacrificial love). *We are also very impressed with you kids. We could hardly believe, Raymond, that you are the same boy that came here three months ago, who is now getting achievement awards at school. You've done very well indeed, and George, you've also been very good and we wish you a lot of luck on your rugby trip to Australia.*
>
> *Mere, you've done very well. You are now communicating with your kids. You sit down and talk, and you have a peaceful house to live in. They look so much better.*
>
> *You must be very careful in the future never to get involved where there is violence. Do not let a lot of people you are not sure about into your house. Set the controls yourself. You are independent now and you must be very careful not to get into a relationship where there is violence again.*

Central to this approach to therapy is a radical juxtaposition of the lengthy and detailed focus on the people's story with the trance-like, brief and positive reflection of the therapists. The new and contrasting meaning will only be adopted, of course, if it springs authentically from the detailed information given by them. Because the person or family has been carefully listened to, they tend to be very responsive to the therapist's reflection. They often lean forward when the therapist comes in with the message and are usually exceedingly attentive.

In some clinical circles, messages have been used in an ill-considered manner – as authoritative interventions. It should be clear from the explanations and examples given here that we prepare sensitive messages only after prolonged

attentive reflection on people's stories of pain. They are designed to free them from the rigidity of problem-focussed meaning, and lead them to liberating and self-determining possibilities. The new meanings are profoundly ethical because, as we have explained, the context is based upon just principles.

The therapist in the room is not interrupted by the observing therapist, unless the need is felt to change direction or seek further information. Often there is no interruption at all. Too many disrupt the story and its flow.

The real work is carried out rapidly after the story focus, and before the message is given. The observing therapist can be very helpful here. It is the colloquial but cleverly devised response of the therapists that creates surprise and initiates change. Practice speeds this process up. We usually take about 15 minutes to compile the message, but it can vary from between 10 and 20 minutes.

The language used both in questioning and in the message is colloquial, rather than literary. It is designed to re-echo phrases used by those people in therapy. The linguistic precision increases with experience, and its use is essential when creating new and positive patterns out of the old problem-centred ones. Key words provide the bridge from the old concept to the new ones.

Visitors often refer to our reflective messages as 'interventions' and 'reframes'. We don't like those metaphors, for the same reason (as we noted earlier) we disliked use of the term 'constructivism'. These controlling and mechanical metaphors don't indicate the sensitivity of the therapeutic exchange. Furthermore, these messages are not simple reframes, but rather changes in total patterns of meaning.

Our approach enables a thorough exploration of these patterns and their changes through therapy. The apparent simplicity of the approach should not be confused with a lack of professionalism or reduction of clinical expertise. On the contrary, the messages require creative and lateral thinking skills that are developed over years. We believe that people's webs of meaning lie at the heart of the change that occurs in the process of therapy. The messages endeavour to capture the essence of that.

It should also be noted that variations on the message can be made, especially during later interviews. For example, it can come halfway through an interview, if it seems an appropriate time for discussion; instead of the usual reflection, a metaphorical story can be very effectively told. In addition, a team

split can take place to emphasise a dilemma where the person in front predicts or recommends one set of actions and while the one behind offers the opposite, thus leaving the person or family with both viewpoints to reflect on – and so on. As we have already noted, messages can also carry significant political, cultural, or social information and meaning.

People with cultural knowledge or community skills can be trained in this approach. The continual experience of analysing, reflecting with an experienced therapist as the message is prepared is a rich learning opportunity. If the person is also reading and discussing a breadth of clinical knowledge, he or she can soon become an effective therapist. Those who are normally denied access to therapeutic training, because of a lack of academic requirements, can become good therapists, working in particular with people from their own community. We have trained numbers of people like this.

The therapy, we think, is just. It is just because it requires the gender, cultural, and socio-economic contexts to be taken seriously. These issues are integral to the therapy. It is also just because it gets to the simple heart of therapeutic change, and enables a broader range of people to become therapists, particularly those from groups who have previously been denied that opportunity. It does so without compromising skill, knowledge, or effective change. Finally, it is just therapy – a seemingly straightforward approach to complex problems.

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(All names of families mentioned in this paper have been changed.)

Colonisation and its effects[1]

In the nineteenth century, the British believed it was their destiny to expand and rule the Pacific region, dreaming of a British Empire of the South Pacific centering on New Zealand, In the 1850s Bishop Selwyn launched the Melanesian mission from New Zealand, which created spiritual claims to responsibility among the islands of the South West Pacific, among them Samoa. The Christian missionaries were the precursors of the colonising settlers, and it is from the first contact of indigenous people with the missionaries that the story of colonisation begins.

Contact with missionaries led to profound changes in traditional life. The culture, values and practices of the colonising nation become the dominant ones, those that the indigenous people should aspire to in every area of life – religious, economic, social. Success and acceptance in that dominant culture is measured by how closely people can conform to the values and lifestyle of the dominant culture. In the process, traditional values, practices and structures were devalued or destroyed. Even more destructive is the belief that it is only the colonising nation which is capable of making judgements about what is valuable or otherwise in the indigenous culture.

The missionaries altered the balance of life in Samoa, and this is particularly apparent in the redistribution of power between men and women. Because the Church was hierarchical, and its patriarchal missionaries contributed to the institutionalising of the oppression of women.

In 1918 New Zealand was granted a League of Nations mandate to govern Western Samoa. As in most colonial governments, economic policies were designed more for the benefit of New Zealand than Samoa. While Samoa gained independence in 1962, economic and personal links with New Zealand have remained close. The Samoan people have been treated as something of a human 'commodity' within the New Zealand economy, being brought into the country when unskilled labour is in demand, and expelled during times of heightened unemployment, with overstayers sometimes hunted ruthlessly. Upon migration to New Zealand, extended family and village structures broke down or were weakened, and the checks and balances which had always existed to regulate Samoan life and relationships were threatened.

For the Maori people, colonisation has led ultimately to their status as an alien in their own land. The Treaty of Waitangi has not been honoured, for the

lands, forests, fisheries and chieftainship of the Maori people have not been protected. Statistics on all important social indicators show that the Maori people are seriously disadvantaged in gaining access to the resources of the country, and thus have never truly enjoyed the rights and privileges of British subjects as promised in the Treaty. Unemployment rates among Maori are more than double those of the non-Maori labour force, and there is evidence of widespread preference on the part of employers for European workers. The Maori and Pacific Island people are therefore the first to feel the effects of economic hardship and unemployment and are disproportionately represented in the poverty statistics, and hence victims of all the family and social upheaval and health problems which accompany poverty.

But even more significant is that the only criteria of success and worth are judged by white cultural standards, and Maoris have received powerful messages for decades that they do not measure up. Maori values and cultural practices and those of the Pakeha are often mutually exclusive. To succeed on Pakeha terms can mean having to abandon Maori values. Warihi Campbell gives this example: *In a Pakeha schoolroom the teacher may ask the children a question. A Pakeha child, knowing the answer, will keep it a secret and raise his hand. The teacher will praise him and he will earn status. A Maori child, if he knows the answer, will share it with his cousin and then be punished for cheating.*

It is not surprising therefore that after so many decades of colonisation, many Maori and Pacific Island people now perceive themselves as damaged and devalued. In recent years the Maori and Pacific Island people have become determined to throw off the effects of colonisation and embark on the painful process of resurrecting the values of their culture, and share its relevance and richness with the wider society.

Note

1. This piece was written by Carmel Tapping to provide some background material that is relevant to understanding the work of the Just Therapy Team.

The Treaty of Waitangi[1]

Central to an understanding of the cultural partnership which characterises The Family Centre is an appreciation of the terms of the Treaty of Waitangi. This Treaty was negotiated in 1840 between the British Crown and over 500 Maori Chiefs. The Preamble of the Treaty contains the rationale for the Treaty itself – a desire on the part of the British Crown to bring the white settlers under a formal system of law, to secure peace and good order, and to protect the Native Chiefs and Tribes of New Zealand and their rights and property.

The treaty itself contains three articles. In the first, the chiefs gave up governorship, (Kawanatanga), to the Queen of England. In the second, the Queen gives to the chiefs and 'all the people of New Zealand' the full chieftainship (Rangatiratanga) of their lands, villages and possessions ('taonga', everything that is held precious), with the restriction only that the Crown be given exclusive right of purchase of Maori lands should they be offered for sale. The Third Article imparts to the Maori people all the rights and privileges of British subjects.

On the surface then, the terms and conditions of the Treaty seem quite straightforward, providing little scope for ambiguity. However, it must he remembered that several forms of the Treaty exist. There is an English language version (which bears a total of only 30 signatures) and a Maori language version (signed by 482 of the 512 signatories), and translations of each.

Ambiguity is generated by the meanings some of the English terms held for the Maori people, and in the translation of these terms from one language to another.

In Article 1 of the English version, the Maori people cede 'sovereignty' to the Crown. However in the Maori version, this term is translated as 'kawanatanga', which means 'governorship', a term the Maori understood as describing a relationship of lesser status in a partnership. In effect, their belief was that only the shadow of the land would go to the Queen, the substance of the land remaining always with the Maori.

Further confusion arises from Article 2, in which the full, exclusive and undisturbed 'possession' of their lands is guaranteed to the Maori. The Maori version however contains the term 'rangatiratanga', which means 'leadership', 'chieftainship' or 'dominion'. But in addition, the Maori claim that if the British had intended the Maori to give up their sovereignty and chieftainship, then the

word 'mana' (meaning influence, prestige or status) should have been used. Indeed, if 'mana' is what the Crown intended the Maori to surrender, then the Treaty would never have been signed, it being inconceivable that a Chief would surrender the mana of his people.

In any event, International Law requires that in any ambiguity in agreements between a colonising nation and the indigenous people, the condition of *contra proferentem* applies. This means that interpretations should be made against the party who drafts the agreement, and that further, the text written in the indigenous language must take precedence.

The Pakeha (Europeans) regarded the Treaty as a legal document, and over the decades have acted in relation to it as Europeans tend to do towards most legal documents – scrutinising it closely to determine how minimally they could comply to its conditions, and searching for 'loopholes' which would enable them to by-pass their duties and responsibilities under the Treaty. To the Maori however, the Treaty was a covenant, a testament, awesome in its sacredness and significance.

The Pakeha failure to honour the terms of the Treaty has resulted in the alienation of Maori from their lands, loss of self-determination, subjugation to a colonising power with its culture and values, and their relegation to second-class citizenship in their own land.

Recently the Ministerial Advisory Committee on a Maori perspective for the Department of Social Welfare advocated a policy of bicultural development (Puao-Te-Ata-Tu, or Day Break) as the appropriate direction for New Zealand. Among its recommendations were a commitment to attack all forms of cultural racism in New Zealand which result in the values and lifestyle of the dominant group being regarded as superior to those of other groups. The values, cultures and beliefs of the Maori people are to be incorporated in all policies, and there should be a sharing of power and authority over the use of resources, with these resources being allocated equitably.

It is this commitment to honouring the terms of the Treaty of Waitangi which guides The Family Centre in its day-to-day work with families and the larger social system, and in its staffing policies and structure. According to the Treaty, the relationship between Maori and Pakeha must be one of a just and equitable partnership, with the Maori people being recognised as the first people of the land of Aotearoa (New Zealand). They see their work with families, and

their community development work in the larger community as based on concepts of social justice, accountable to their clients of Maori, Pacific Island or European cultures for meeting their needs in culturally appropriate ways. Alongside equity for the Maori people, the Centre is committed to justice for Pacific Island people in New Zealand. There is a recognition of the injustice they have suffered as a result of the colonisation of their lands by New Zealand.

Note

1. This piece was written by Carmel Tapping to provide some background material that is relevant to understanding the work of the Just Therapy Team.