

NETWORK NEWS

Commentary, News and Reports from Regional and International Correspondents

INTRODUCTION

Contributors this issue: Adrienne Wills, WA; Janine Mahoney, ACT; Maria McCarthy, Victoria; Akivra Bouris, NSW; Janet Roth, Queensland. Guest contributor: Kanthi Perera (WA).

This Journal welcomes a new Victorian correspondent, namely Maria McCarthy, who has a background of working in the Royal Children's Hospital in Melbourne. She has also lived in the USA, where she undertook further study into childhood stuttering, which was the topic of her thesis while she was studying at Bouverie–La Trobe University. Welcome to Maria, and farewell to Sarah Jones, who is already hard at work preparing something for the *ANZJFT*! Thank you, Sarah, for your long history with, and commitment to, the Journal.

JANE CHAPMAN

Local News

AUSTRALIAN CAPITAL TERRITORY

Learning to Relate without Abuse

ACT therapists are excited about a new local program being conducted to address violence in our community. The program began in August 1998 and is the first court-mandated program to be conducted in Australia. Similar programs are about to begin in Queensland and the Northern Territory. David Jones, the co-ordinator of the Domestic Abuse Intervention Program at Relationships Australia, Canberra and Region, manages the program and was happy to report on its early progress. (David and his colleagues at RA have also been conducting a voluntary program for men over the past eighteen months.)

The new program is funded by the National Committee on violence and had its foundations in the Community Law Reform Enquiry of 1992. The resulting report, which was released in 1995, advocated an integrated, community approach to domestic violence, and included the involvement of the police, Department of Corrective Services, Victims' Advocacy groups, the Domestic Violence Service, Legal Aid, ACT courts, the Department of Public Prosecutions and perpetrator program providers. A Domestic Violence Prevention Council was also established as an advisory body for the government and a criminal justice pilot project of which the perpetrator program is a part.

Participants enter the program via a mandate of the court or a directive of the Department of Corrective Services. In order for the men to participate, they must acknowledge that their violent behaviour is problematic. Participants are also required to sign a contract whereby they agree to the following: permission for the group

leaders to contact their partners and ex-partners regarding ongoing violence and safety issues; cessation of violence; confidentiality; abstinence from drugs and alcohol; and agreement for group leaders to contact Family Services in the case of child abuse. If men breach their contracts, they are managed on a case-by-case basis. This could mean consequences such as a return to court, living separately from their partners and the involvement of Family Services.

The program is based on the Duluth Minnesota Curriculum, which is widely known throughout the world. The Canberra program also incorporates narrative therapy and the work of Alan Jenkins and Rob Hall in Adelaide. The themes of fairness/unfairness, integrity, pride, accountability, justice/injustice, power and control are considered as they manifest themselves in relationships. Family-of-origin themes and domestic violence in participants' personal history are elicited in the process of addressing parenting skills. The program provides a frame for dealing with issues such as resentment and anger regarding relationships; child maintenance, residence and contact; social institutions; and legal matters. The men are expected to be accountable, to face up to their abuse and to discover alternative ways to manage their lives. Strategies such as 'Time Out', constructive self-talk and non-intimidatory body language are practised. Similarly, men are encouraged to develop skills in co-parenting and in respecting difference in their partners. According to David Jones, participants are encouraged to develop emotional independence by 'standing up to their insecurities', 'being in the driver's seat' of their own independence by demonstration of an 'equitable' relationship. The program has a pool of eighteen leaders who are qualified family therapists, experi-

enced in domestic violence issues. Most have completed the two-day Duluth training and receive weekly supervision for the two hours they spend each week on the program. Due to the intensity of the program, leaders do no more than twelve weeks at a time.

Evaluation of the program involves the administration of an abuse inventory scale, self-evaluation and interview with partners. Perceptions of change and safety are paramount. David reports that only 10% of participants have dropped out of the group so far. This is encouraging given the 50% to 60% dropout rate of similar programs in the US. David notes that participants often say that the program is helping them to make changes in their lives. However, he emphasises that it is 'gruelling' at times and that some of the participants in the US have chosen to go to gaol rather than to continue.

Despite its demands, David says that there is a 'sense of working with real life and death issues and you feel like you're dealing with problems of substance'. He added: 'It's scary, but you feel like you're making a difference. The spirit of domestic violence intervention means collaborative and cooperative approaches.' We all look forward to hearing about more formal evaluations of the program.

JANINE MAHONEY
State Correspondent

NEW SOUTH WALES

The 1998 Annual General Meeting of the NSW Family Therapy Association took place at the University of Sydney last October. Despite the fact that the association had had difficulty establishing a suitable permanent venue, bimonthly clinical meetings were exceptionally well attended, reflecting the high standard of presentation by 1998 guest speakers (namely Lea Crisante, Maxine Davey, Eric Lyleson, Prof. Valerie Walkerdine, Carmel Flaskas and Glenn Lerner). The Association also managed to reduce a \$4573 deficit in 1997 to \$184 in 1998 (the Federal Treasurer would be proud). This was accomplished by a slight increase in membership fees (and a slight increase in memberships), more economical production of the newsletter, and better financial investment.

As 1998 progressed, the Committee concerned itself more and more with preparations for the 1999 Conference. It was announced that keynote speakers addressing the theme of 'Alternative Voices' would include Barry Mason from the London Institute of Family Therapy, Carmel Flaskas of UNSW, Leslie Schwartz, the South African sociologist and speaker on social justice and Dr Laurie MacKinnon, author of *Trust and Betrayal in the Treatment of Child Abuse* (1998). By year's end there had been a very good response to the call for papers, which should mean a high standard at the Conference.

David Horner, Lea Crisante and the rest of the Committee have worked expertly to maintain a high level of interest in the Association in 1998 and in the forthcoming Sydney conference and deserve much praise.

At the October clinical meeting Glenn Lerner presented in a thoughtful and considered manner a paper

entitled 'Not-Knowing Knowing in Psychoanalysis and Family Therapy'. Reflecting his own journey which combined early child psychoanalytic training with family therapy, Glenn Lerner dismissed the idea of a hegemony of theory.

What he saw as the common ground was the idea that he is developing (to which he asked the audience to contribute) which holds that in both psychoanalysis and family therapy we have to be both 'knowing' and 'not knowing'. The problem with 'knowing' is that it closes things in therapy; the strength of 'not knowing' (reminiscent of Anderson and Goolishian) is that it opens things up. Lerner argued that for some clients, too much not knowing is 'diagnostic' and that we in fact need to live day to day with stories that we consider to be truth. The implication of this I took to be that the therapist cannot simply 'not know' and leave it at that if she/he is to be of help. The issue for therapists—currently topical—is how can we be collaborative and still impart some knowledge? This is the problem of power.

Glenn Lerner argued that the creation of a 'not knowing' space is the crucible for the family's 'knowing' to grow. He quoted Pocock in discussing this in terms of a space between knowing and not knowing, a space where a different kind of collaborative understanding is possible. Within this space can be included questioning, and a non-judgemental stance and, interestingly, expertise. In response Pam Lewis named the product of this collaboration as the 'aha' that you and your client experience periodically. Glenn Lerner informed the group that psychoanalysis was undergoing an analogous narrative revolution—a 'not knowing' approach. He also quoted John Macleod who argues that there is no one narrative therapy, that all therapy is narrative. I felt that Glenn Lerner's paper was an important contribution to the debate about knowledge and power in therapy.

In November Dr Michael Yapko presented in Sydney on the topic of Depression on which he is regarded as a world authority. His visit to Australia drew a great deal of interest from the media and the general public. I was able to attend his two day workshop for professionals entitled 'Breaking the patterns of Depression: Solution-Oriented Approaches to Treatment', based largely on his recent book of the same name. My impression was that there were few family therapists in the audience, which I felt was a shame, because this was a first class workshop—bread and butter stuff. We all work all the time with people who are depressed. One in ten men and one in four women (close to one in two female psychologists) will suffer depression in their lives. The incidence in a clinical population is obviously higher. Dr Yapko told the audience what was known about depression and he very generously gave us nineteen treatment techniques which could be easily adapted by family therapists. As an injection of knowledge into our process oriented lives, this was it.

As a family therapist, I felt a bit of an interloper. Michael Yapko who, I gather, is a cognitive behavioural therapist, was absolutely positive about family therapy, although he did seem to hold that rather passé idea that family

therapy has something to do with seeing actual families. (Apart from a reference to de Shazer's miracle question, Yapko didn't much refer to family therapy during the two days). As I understood them, some facts (and some theory) of interest to us were the following:

Drug companies try to promote the idea that the newest drugs can provide the entire answer. However, psychotherapy is indispensable; there is a 50% higher relapse rate without psychotherapy. During the first month, medication is more effective; after two months, medication and psychotherapy are equal; after three months, psychotherapy is ahead. Psychotherapy, too, affects a rise in brain serotonin levels. People report a higher level of global functioning after psychotherapy, which teaches them skills to deal with depression. Cognitive, interpersonal and behaviour therapies have been proved to be the most effective therapies. Therapy should be time limited and aimed at symptom resolution. Psychodynamic psychotherapy is by far the least effective and used alone would in fact constitute malpractice. Cross national epidemiological studies show that insomnia, loss of energy, feelings of worthlessness (guilt), poor concentration, slowed thinking and suicidal thoughts correlate significantly with Major Depressive Disorder. Across nations at least, what are not significant are poor appetite and weight loss, hypersomnia, psychomotor retardation, agitation and decreased interest in sex. Sixty to 70% of people who are depressed suffer from an anxiety disorder. Certain cognitive factors are prognostically related to depression—specifically an internal, stable and global attributional style for negative events: perfectionism and rumination are also important here.

You often do need to deal with the depression before you deal with the marriage. Why the gender difference? Women ruminate more over negative events ('analysis paralysis'), whereas men cut off from the negative events by taking some action. To quote Dr Yapko: 'The same characteristic that makes men jerks insulates them from depression'. The implication for therapy is obvious.

I loved his intervention entitled 'A Poll at the Mall' (I think it rhymes if you're American). A man that Dr Yapko had been seeing had for many years avoided intimate relationships with women because he believed that women wouldn't marry anyone who had been hospitalised for depression. Clearly this is an example of the internal, stable and global attributional style. The man was in despair. Dr Yapko suggested that he find out if his fear were true without having to suffer the anxiety of self disclosure to a woman. Armed with clip board and dressed in a white lab coat, the man was sent to the Mall to conduct a survey of women shoppers. He was to ask them ten questions, one of which was: 'Would you marry anyone who'd been hospitalised for depression?' Nine out of ten women said they would. Surely a technique of wide applicability!

AKIVRA BOURIS

State Correspondent

See Tony Vassallo's combined review of Yapko's book and workshop in this issue. *Eds.*

QUEENSLAND

Family therapy has been criticised at times for lack of outcome research. Recently, Professor Barry Nurcombe of the University of Queensland Child and Adolescent Psychiatry Unit received NHMRC funding for conducting innovative research into the therapeutic treatment of childhood sexual abuse. Clinical trials will contrast Cognitive Behavioural Therapy (directed by Sally Wooding) with Family Therapy (directed by Peter Marrington) over 18 weeks. The project will include most of the child and youth mental health clinics in and around Brisbane, from the Sunshine to the Gold Coast and west to Toowoomba, as well as other government and non-government agencies. Training is provided for therapists who will be involved with over 300 cases across three years. The participants are children and adolescents, aged six to seventeen years, who have been sexually abused (but are not expected to go before the courts), and their non-perpetrator parents and siblings. Comprehensive assessments of children, young people, and parents will occur at pre-, post-, and follow-up times.

Peter Marrington, of Protect All Children Today (PACT), has developed a manual for the Family Therapy component of the project based upon the PACT family-systems model. Essentially, this model has three phases of six weeks each, and the parents and children are together for all phases. Phase 1: Reframing and Stress Management is a time to normalise the traumatic symptoms, establish goals, externalise the problem, highlight changes, and promote coping through relaxation skills training. Phase 2: Parenting Issues and Family Functioning, focuses on parent education, using structural theory as a basis to understand how families work or don't work. This phase incorporates ongoing therapy directed at individual and familial change. Phase 3: Application and Consolidation comprises six weeks of consolidating of the skills developed in Phase 1 and 2, and also is a time for the family to choose other issues they would like addressed. It provides space for the family to resolve problems that have developed such as extreme stress, anger, or developmentally inappropriate sexual behaviour. In this last phase, changes are highlighted.

To provide a context for this model, a bit of history may be useful. Peter Marrington originally trained in structural and strategic therapies, and then evolved into narrative therapy, especially utilising the concept of externalisation. Peter previously worked for the Abused Child Trust, and came to PACT to set up a model for traumatised families who wanted a service to alleviate their stress. At the time, no service was available. PACT is a community based, non-government organisation that advocates for the needs of children at a state and federal level. PACT operates a Child Witness Support Program aimed at reducing the trauma experienced by children aged three to seventeen years who are required to give evidence in the Criminal Courts, as either victims of, or witnesses to, a crime. An important legal consideration guiding PACT was not to 'contaminate the evidence', and therefore a therapy program focusing

on the effects of abuse was developed, which does not explore the detail of the abuse/crime while the child or young person is involved in the court process. In essence, PACT focuses on the symptoms, not the traumatic events. Although most trauma theories suggest that it is important to relieve the trauma associated with sexual abuse in order to move beyond it, Peter points out that this is not necessarily the case. At times, re-experiencing the trauma can be equivalent to retraumatising the individual, especially young children who may not have the cognitive abilities to cope with this type of therapy.

The project was launched in February with the training for therapists. One of the challenges of the program is that therapists, recruited from different agencies, draw from a range of different knowledge bases, experiences and orientations. Therefore, sessions are audiotaped to monitor the integrity of the treatment, and ongoing training and supervision are provided. The first few months were dedicated to piloting and refining the treatment program through feedback from clinicians. Then, in July, the study formally begins. If you are interested in knowing more about this project, Peter can be contacted at pact@medeserv.com.au; or fax: + 61 7 3290 0499.

JANET ROTH
State Correspondent

VICTORIA

After ten years of writing for Network News, Sarah Jones has decided to call it quits. Sarah has been a prolific writer, and whether addressing the mundane or the polemic, she has managed to captivate us with her analytic and thoughtful writing style. Vale Sarah! Those of us who know Sarah and her indefatigable nature know that we shall continue to hear from her in this Journal and other fora.

Family therapy courses now abound in Melbourne. I list some. Williams Road Family Therapy Centre in collaboration with Swinburne University and The Bouverie Centre in collaboration with La Trobe University both continue to offer their Graduate Diploma courses. In addition to its clinical Masters program, Bouverie has introduced a Doctor of Clinical Science (ClinScD) course, with the first two students commencing in 1999. The Bouverie Centre in collaboration with La Trobe University also offers research Masters and Doctoral degrees. Other options include the Specialist Course in Couple Therapy offered by Relationships Australia, and the Contemporary Therapy Centre is offering several 'Nothing but Narrative' courses.

'Get Together FaSt' sounds like a dating service for unattached singles. But it isn't! The FaSt project is a DHS service initiative designed to get more Mental Health clinicians better trained in good collaborative family work with clients. During 1998, The Bouverie Centre undertook a statewide venture exploring, with mental health institutions (including adult mental health facilities, aged-care and child and adolescent centres) the notion of family-sensitive practice. The project

involves the team visiting services all over the state and working with management and staff on policy, procedures and clinical work with families to reflect the ethos of family sensitive practice. Describing the response to the program as 'mixed', Dr Colin Reiss, Principal Consultant on the project, reported that there is a need for all public agencies to reflect upon families' experience of Mental Health Services and how this information may be used to influence changes in service delivery. The areas explored in the program ranged from the notion of having families involved as consumers in the development of services and 'democratising' services for families, to very simple, pragmatic ideas such as placing a bowl of fruit in the waiting room to convey a sense of warmth and generosity to families. The FaSt Times Newsletter has been produced to disseminate the work of the project team. They would be glad to hear from participants, other states, or anyone interested in the project. (Contact Jeff Young or Brendon O'Hanlon +61 3 9376 9844.)

I am delighted to be taking on the role of Victorian correspondent for the Journal. I welcome any contributions from Victorian readers and can be contacted on email: mmarks@clyde.its.unimelb.edu.au or by phone/fax +61 3 9500 2134.

MARIA McCARTHY
State Correspondent

WESTERN AUSTRALIA

In December, Perth was privileged to have Michael White present workshops to an eager audience. The following is a report prepared by Kanthi Perera (Social Worker and Community Liaison Officer, Early Intervention in Psychosis Programme, Fremantle Hospital and Health Service), describing her experience of the event. Thanks to Kanthi for her comments. I have heard from a number of people that they found the seminar to be very informative and enjoyable.

1999 saw a visit from another well-recognised therapist, when Alan Jenkins came to Perth in May. Centrecare arranged the Jenkins workshops, as well as 'Narrative in Action', which is a time for therapists interested in narrative ways of working to come together and share ideas around an allocated monthly topic. These meetings are held on the third Wednesday of each month. Further information is available from Centrecare.

ADRIENNE WILLS
State Correspondent

Michael White in Perth

I have read many of the articles and books written by Michael and attempted to use a narrative therapy approach in my work. However, this was the first seminar that I attended that was given by Michael himself. In the two days, he demonstrated through videos and storytelling that the primary focus of a narrative approach is people's expressions of their experiences of life.

He first explained how narrative analysis is located in post structuralist thought. I initially had some difficulty coming to grips with this idea, which to me was a good indication that a large part of my training in the mental health service has been embedded in structuralist thought. In structuralist analysis, *life is represented in terms of behaviour that are considered to be the surface manifestations of deeper elements or forces*. In narrative analysis, *expressions of lived experience are construed as actions that are constitutive of life—these experiences are what it is that is 'going on'* (White, 1998). Therefore, a non-structuralist approach to our work opens up space for 'new stories' and moves us away from an assumption that professionals are experts.

There were frequent changes in the styles of presentation of material. For example, soon after teaching us about structuralist and non-structuralist ideas, Michael showed a video done in the 1970s by Barbara Meyerhoff (a North-American anthropologist) on a shared identity project of an ageing Jewish community in Los Angeles. The participants told stories of their lives and the history of their culture. The audience then told stories of what they heard. The re-telling encapsulated the story and extended its boundaries. By this process of telling and re-telling (definitional ceremony), the stories became more richly described, and thus re-graded rather than de-graded.

Michael also used many videos. These demonstrated the importance of 'double listening'—reflecting back to the client his understanding of the trauma of an event, and also the survival skills that were used. The videos that were of most interest to me showed clients who had a diagnosis of schizophrenia. Michael worked with a young man and his sister who described their relationship as being 'stuck in cement'. This very description showed that they had an idea of other possibilities for themselves. Michael went on to explore the sister's part in the brother's survival and the brother's caring for the sister. This process validated the clients' story but at the same time gave them alternative descriptions of their relationship. Another video demonstrated his use of externalising conversations when working with schizophrenia to reverse the relationship the client had with the hostile voices that 'derailed' her and caused 'isolation'. So, instead of fighting the voices or running away from them, clients are able to disempower them.

Michael explained: statement of position map; definitional ceremony; re-membering conversations; 'taking it back' practices.

This seminar has helped me in my work with young people who first present to our service with a diagnosis of psychosis. I am now more aware of the questions that I ask. I use questions differently; I try to generate experience for the client rather than just gather information for myself.

The seminar was very well organised. The venue (Churchlands campus of Edith Cowan University) was pleasant, except that the air-conditioning on the first day reminded me of winter in North America! I turned up on the second day, rugged up in my winter gear, only

to find the air-conditioning adjusted to reflect a beautiful spring day in Perth. The food was delicious, and I also had the opportunity to catch up with many colleagues. Many thanks to Ian Percy and Rob Andrews from Centrecare for organising the seminar.

KANTHI PERERA

Guest Correspondent

The Eating Disorders Conference, Melbourne, November 1998

As a family therapist and doctoral student who has spent an abundance of years in eating disorders research, I was astounded at the seeming disparity at this conference between clinical work and research findings. Chris Fairburn, Professor of Psychiatry at Oxford University, and perhaps the most notable personality in the field of the treatment and research of bulimia, presented a thorough summary of the research into eating disorders. This huge bulk of research was dominated by cognitive behavioural, psychodynamic and medical interventions with a small focus on systemic therapies. The main representative of family therapy at the Conference, Dr Chris Dare from Kings College in the UK, presented his research on a comparison of separated (the 'patient' seen separately from the family), and conjoint family therapy (the patient and her family seen together), in the treatment of anorexia. However, I was left somewhat unsatisfied with the way family therapy's treatment of eating disorders was represented.

What was conspicuously absent at this conference was the presentation of the extensive array of feminist, narrative and systemic ideas that impact on the work of a vast number of clinicians both in the private and public sector. I question how this occurred. Was it a function of those who actually presented at the conference? Or, was it a function of the lack of wider dissemination of systemic and narrative ideas in the field of eating disorders, compounded by a lack of high quality research projects to back up our work? It is obviously research that attracts money and notoriety, as indicated by a five million dollar grant received by Professor Fairburn and his international team to continue his research into a treatment called 'interpersonal psychotherapy'. I fear that the field of systemic and narrative therapies are missing out on a piece of the pie simply because we have been perhaps cynical or perhaps reluctant to engage in this form of rigorous evaluation.

What a shame! I was left feeling a little disappointed that we were not challenged to think in different ways about our work. In these times of economic anorexia, it is the evaluations that will prove our worth. But since we have faith in our own interventions, should we not be bold enough to put them to the test, and even risk shattering our own potentially idiosyncratic versions of what works and what doesn't?

KAREN WEISS

Springvale Community Health Centre

Susie Essex, 'Resolutions' Workshop. Perth, November 1998

Susie Essex believes Freud's heritage is alive and well in child protection; she says, 'The field is organised around the notion of denial'. Andy Lusk writes, 'Abusers who deny strike at the core of this (psychodynamic) tradition and at the objective of progress through insight' (Lusk, 1996: 15). Traditionally, families in which there is substantiated abuse but who deny responsibility, are viewed to be 'untreatable'. In these cases the option of removing the child looms large, but where the child remains in the home, the situation frequently degenerates into a stand-off between the family and increasingly frustrated professionals.

Out of years of work with such families and knowing it *is* possible to work successfully with such cases, Susie Essex, John Gumbleton and Colin Luger from Bristol have developed 'Resolutions', a model for 'working with families where responsibility for abuse is denied' (Essex, Gumbleton and Luger, 1996; Essex and Gumbleton, 1999). Susie says this model developed from taking seriously the desires of abused children who consistently told her they wanted to remain in their family but also be certain of their safety. Susie believes that creating a partnership between the family and professionals regarding the child protection concerns, and focusing on safety for the child in the present and future, rather than arguing about responsibility for the maltreatment, are the crucial factors in protecting abused children.

Over two days, using a mix of lecture, video, small group exercise and role play, Susie presented the four main elements of Resolutions. The first phase of *engaging with the family and the professional system* is done with the family by exploring as many as possible explanations about the situation but with no attempt to establish responsibility. It is essential that the statutory worker observes the treatment process, as this keeps the family thinking about the statutory agency's requirements and keeps the worker directly informed of progress. The second phase, working in the hypothetical mode, asks the parents to consider the maltreatment in a *similar but different* family. This allows an open and rigorous discussion of the issues without trying to force a confession from the family. The third phase involves developing the *family safety guidelines*, where the non-abusing parent and children develop

comprehensive rules about future family life. The guidelines are subsequently presented to the alleged abuser. This encourages non-abusing parents to assert their solutions and places responsibility on the alleged abuser to ensure that the rules are adhered to. The final phase of *communication between family and its supportive network* is a crucial link in ensuring the ongoing safety of the children. As large a network as possible (supportive relatives, friends, work colleagues, school personnel, neighbours and significant others) is directly involved. This network is what Susie calls 'an alternative lighting system' to create light and safety in every corner of the child's life. Susie reported that the model has demonstrated encouraging results. Research has found that re-abuse rates in fifty families who had used the service were significantly lower than the norm (Gumbleton, 1997).

Over two unusually warm November days in Perth, Susie presented Resolutions to an audience of therapists, counsellors and child protection workers, who in the main appreciated the potential of the model to offer a way around denial. Striking video examples clearly showed Susie's skill at engaging very difficult families, though the strong West Country accents often required liberal translations for our Australian ears. Inspired by Susie and her colleagues, two small teams of therapists in both Perth and Melbourne have begun to develop similar services for families where maltreatment has been substantiated and responsibility is in dispute.

References

- Essex, S., Gumbleton, J. and Luger, C., 1996. Resolutions: Working with Families where Responsibility for Abuse is Denied, *Child Abuse Review*, 5: 191-201.
- Essex, S. and Gumbleton, J., 1999. 'Similar but Different' Conversations: Working with Denial in Cases of Severe Child Abuse, *ANZJFT* (forthcoming).
- Gumbleton, J., 1997. Untreatable Families? Working with Denial in Cases of Severe Child Abuse. Unpublished Dissertation for Master of Science Degree in Child Welfare, University of Bristol.
- Lusk, A., 1996. The Significance of Denial in Child Abuse Work: The Professional Construction of Risk. Unpublished Dissertation for Master of Science (Econ.), University of Wales.

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Letter from Argentina

The Value of 'Versus'

We have just read the letter sent to *ANZJFT* (Vol. 19, No. 4) by our colleague Jürgen Hargens from Germany. Here in Buenos Aires we cannot avoid thinking about the situation of Mental Health in the world. Though the Argentine situation is different from the German one, it is no more encouraging. Until a few years ago,

health services in Argentina were clearly offered by both the public and private sectors. The state was in charge of public health through hospitals, whose efficiency always depended on the economic interests of the governments in power to dedicate funds for the population's basic necessities: health, education, housing. In any case, there have always been some Psychopathology Services in

public hospitals that, being very prestigious, became not only important assistance centers but also well-known places for therapists' training, the cradle of psychotherapeutic schools of different epistemologies.

However, psychotherapy developed mainly in private clinics and institutes. Unlike other Latin American countries, Argentina has always been a society with a strong, numerous and well-off middle class. This middle class has been able to afford to live according to fashion. Especially in Buenos Aires, the capital city, psychotherapy has been in fashion; at the beginning only the psychoanalytical school was in favour. But later, despite some resistance to other therapies, acceptance extended to other trends, especially to systemic psychotherapies. Being basically privately developed, their cost was always regulated by 'the laws of the market'. On the one hand, there were prestigious psychotherapists who charged very high fees as well as younger or not so prestigious ones who got paid less. On the other hand, there were patients that chose therapists according to their economic capacity. This meant that the state did not interfere either with the regulation of the economic aspect or the professional practice.

Although our situation is different from that of other Latin American countries, we still basically live in a developing country where 20% of the population has gotten rich in the last 20 years and the remaining 80% has become poor in a notorious way. As a result, the old strong middle class is beginning to disappear and the lower classes are becoming increasingly impoverished. It is not that we have 'poor' legislation for the regulation of mental health administration, but that we simply do not have any laws to regulate it at all.

The implication is that the individuals who need therapeutic assistance have the following options:

- 1) Going to the public hospitals where assistance will depend on the theoretical and clinical preferences of the Service Chief as well as the good will of the psychologist attending the patient. It is a paradox that when patients do not get good service it is more often due to external problems such as the scarcity of available consulting-rooms, specialised personnel, etc. than to the good will of the psychotherapists, who more often than not, work for free in order to get experience.
- 2) Consulting those psychologists who are included in the health insurance plans. Since this insurance coverage has never been provided by the Government, it is automatically regulated only by the laws of the market and, therefore, strongly conditioned by economic factors.
- 3) Having private counselling, for which neither the patients nor the psychotherapists get any refunds.

In spite of all the difficulties generated by either Government action or omission of action, the social pressure to achieve the inclusion of psychotherapeutic service covered by health insurance has been successful,

leading to the recent passing of the law called PMO (Obligatory Medical Benefit). This pressure has been exerted by the population in general, but more particularly by the psychologists who have directly or indirectly fought to get greater professional recognition.

Let us now consider the situation of the systemic therapists. In spite of difficulties, the School of Psychology in the University of Buenos Aires boasts one of the highest enrolments; also, the Systemic Graduate Degree (Program for the Update of Clinical Psychology with Systemic Orientation) was created three years ago; besides, the number of university and private courses is enormous. International Congresses attended by around 1000 participants from all over the country and Latin America take place every two years; we have ongoing theoretical-clinical debates about gender, violence and epistemological topics (systemic-constructionist), their conceptual level and bibliographical comprehensiveness being of a very high academic standard. There are two widely read systemic publications, *Sistemas Familiares* being one of them, which presents all these theoretical questions in print, and is popular among a considerable number of Spanish American subscribers who want to keep up to date with the work of our colleagues in the country and abroad. There is also an association, ASIBA (Association of Systemic Psychotherapy of Buenos Aires), which, although relatively small, has brought us together for sixteen years and through which we have achieved greater recognition for systemic therapy. Not long ago, everything that was not related to the psychoanalytical or psychiatric fields was discriminated against in the professional academic sphere.

As it has often been said, it is possible that the challenge imposed by lack of resources makes specialists, in this case, mental health professionals, double their efforts to achieve (better) personal, professional and social developments. Systemic therapists are beginning to participate in other areas of society, such as in interdisciplinary work in companies, and in the judicial and educational fields.

In our setting, we usually complain about the number of *versus* that exists among psychologists: DSM IV diagnosis *versus* relational diagnosis; relational diagnosis *versus* individual diagnosis; constructionism *versus* orthodox systemic approaches; private service *versus* public service; state regulation *versus* free market, and so on and so forth.

Our own opinion is that the *versus* help us keep up with theoretical-clinical knowledge and master bibliographical content as well as the application and research aspects of our theories. Maybe thanks to this particular situation of extreme pressure, we should celebrate and highlight the benefits of those *versus*.

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