

EXPLORATIONS:  
Challenges, Speculations, Risks

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# Family Therapy is Just One Option

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*I trace my development as a family therapist from being a single model worker in systemic family therapy to a more eclectic approach. The context of my work is children's services and private practice. Failure to appreciate when one method of therapy is more suitable than another can lead to family therapy being applied when it is not indicated. The dangers in such mistakes and a lack of careful assessment that includes the 'feeling state' of the therapist are illustrated by case vignettes. A possible effect of some therapy techniques is to create a 'distance' from clients and to shield the therapist from their emotional distress. I outline situations where I would not use family therapy.*

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## PURIST BEGINNINGS

This paper has been evolving over a number of years. I was in the middle of a one year Family Therapy course when in 1986 I moved to a position in a multi disciplinary child health centre. I had finished a Social Work Degree in 1982, and worked for three years in an Adult Mental Health team and then for eighteen months at the Child Abuse Team at the Children's Hospital. I first became aware of a nagging inconsistency, or problem that I could not properly articulate, in this workplace. Incoming referrals were assigned between social workers, psychologists and the child psychiatrist. We differed in the interventions we were able to offer clients: psychometric assessment, individual play therapy, and behaviour modification adapted to children's needs. Instead of the allocation of cases being a process that might throw open discussion about what problems were best suited to what methods and personalities, it was often reduced to the question of who was seen to 'own' various categories of referral (e.g. the referring person, the particular problem, the age of the child), who had the space for a client and so forth. What remains memorable from that time is the question—unspoken perhaps because it was potentially divisive—how to judge which approach was best for which client.

There are four reasons I can think of for my own views on originally preferring family therapy to indi-

vidual child work. By 'family therapy' I mean the systemic therapies that usually involve the therapist taking a strategic position in order to bring about change within the family.

1. I had seen and experienced great changes when using family therapy and was enthusiastic about its possibilities.
2. I had been taught about the shortcomings of individual psychotherapy for children, namely that it separated the parent from the child and could set the worker up as an 'expert' to fix the child, instead of the parent and child owning their success in changing things themselves.
3. There was no interchange about the respective merits of one form of therapy over another, an interchange that could have been useful in our professional education and would have benefited our clients enormously.
4. The alternative method I had been taught in my undergraduate degree (casework) I tended to disregard as not being 'clinical' enough.

While doing my family therapy training, and for some time after, I took the view that family therapy was almost always the preferable form of intervention for individual and family problems. The excitement of hypothesising, testing the hypotheses, reframing, formulating a message from the team and so on, was intoxicating and challenging. I see more clearly now that family therapy gave me overarching principles of theory and practice that built on my social work skills, and that it complements rather than replaces other approaches.

Family therapy gave me substantial 'tools of the trade', many techniques which I memorised and practised: tracking problems, feed forward questions (Penn, 1985), reflexive questions, readiness questions (Tomm, 1985), a

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theoretical framework with lots of recursive loops, and so on. One could feel insecure about the difficulty of remembering all of these and when to use them, or, if one did remember, one could feel happy that every conceivable eventuality was covered. This sort of emphasis on the ‘technology’ of therapy, and on the therapist to provide the right stimulus to enable change to occur, buoys up the therapist, but creates a distance between the therapist and client. For the feminist who pursues a relationship which minimises the power differential between client and therapist, such technology can be problematic (Sturdivant, 1980). It emphasises not what both client and therapist have in common, but their different roles.

After additional study in systemic family therapy, feminist therapy and casework, it is ironic that I am now faced much more often than when I began with the decision of how to proceed, what approach should be used and with whom. This progression from being a single model worker to being eclectic has not been by choice. It has been forced on me by my clients, by their unwillingness to fit within my purist systemic therapy model! Let me tell you more.

## The Case of Mandy

It began with Mandy, a young teenage girl I started working with when I was doing my training in family therapy. She, like most of my clients, had been sexually abused. At fourteen years she had endured the following: a mother who had rung ‘the welfare’ to take her away because she was uncontrollable, a grandmother in failing health who could not any longer take Mandy in, and a father who was now in gaol for trafficking and who had also assaulted Mandy. She had an expulsion record from two schools. What stood out behind her tough exterior was her thinly-disguised fragility and desperation. Trying to get a grip on her was like trying to get a grip on melting jelly. Engaging her felt impossible. She wouldn’t look me in the eye, didn’t want to talk about herself, and was scared to acknowledge that there was a problem at all. I could feel her slipping away from me each time I saw her, which turned out to be only four times. Those of us involved could pretty much see Mandy’s future as predestined, and mapped out. She felt she had no control, nor did the district officers, who could find no real place of safety or containment for her. She was running scared. Her father had sent a ‘friend’ from gaol to warn her off giving evidence against him in the court hearing that was only two weeks away. After walking out of several refuges, and being discharged from the remand centre where she was placed for her own safety, Mandy was found dead in the back seat of a stolen car after her last joy ride came to a swift end in a head to head collision.

I had tried my best to create a sense of choice for Mandy, by dramatically outlining her ‘career options’ and pointing out the effects of the decisions she might make. The first meeting with her mother proved to be the only time the latter would agree to be involved and

when Mandy came she made herself as emotionally ‘absent’ as it was possible to be. I distinctly remember the feeling of panic that I experienced when I saw her and the conviction that what I could offer her would never be able to stem the tide that was about to drown her.

Needless to say, she has made an indelible mark on my thinking about therapeutic and lifesaving aspects of *containment*, both physical and therapeutic forms of containment. The limitations of therapy in this situation are fairly evident—it can be likened to sticking a finger in a leaking dyke. There was clearly a need for different levels of intervention. This was a situation where I believed that the state had to intervene to keep Mandy safe, perhaps by placing her in a temporary institution which could provide security, but there was no way this could be done at the time.

Three issues flow from my experience with Mandy. The first is that her situation needed responses at a number of levels:

1. Structural (child welfare and legal intervention to provide safety from risk-taking behaviour—her own and others’).
2. Familial (so that she could rekindle a meaningful connection with someone in her biological family or attach herself to another one).
3. Individual (she had to hold on to the desire to live long enough to get out of the danger period she was in).

The need for change on all these levels made therapy only one part of what Mandy needed, and in her case, her safety was a priority. It was precisely because no one could effect change on the other levels that Mandy was seeing me, rather than because therapy was especially desirable. She as an individual was the one accessible part of this mess, but perhaps she was the least powerful. It was in a sense unfair to expect that she might be able to effect change that would go against fourteen years of the accumulated experience which had resulted in her precarious hold on life.

The need for integrated approaches to child sexual assault work with legal, policing, welfare and other agencies is one example where therapy is only a part of the picture, and perhaps one of the less influential parts of the child’s life at different times. This view, which does not assume that therapy is central, is more likely to offer a more realistic and sensitive service to our clients. We don’t just short change our clients by thinking that a clever and enlightening exercise might change their life for good by overriding all other contrary experiences, but we effectively write out the most effective tool in helping people: ourselves.

The second issue that arises from my experience with Mandy is that some therapists believe that family therapy (or indeed, some aspect of their style of therapy) is always the most appropriate to proceed with, in working with almost any client. When confronted with Mandy, I picked up the only tools I knew I had. I made a cognitive, rational plea, using some of the techniques that

were at the time considered new and powerful. I 'collapsed time'; I used the metaphor of 'being at the crossroads' to try to get over her 'threshold' and I put to her that she had to make a decision to 'take control of her life'. It was the time when 'the boiling frog' analogy was being used to illustrate the concept of 'double description' that had originated from Bateson's work, and was being explored by Michael White (1986) in team workshops (one of which I attended in Sydney). The analogy fitted Mandy perfectly. Her life circumstances could be seen as a series of events that led to an inevitable 'career' in self destruction. I could see that the temperature was rising in Mandy's beaker and the bubbles were beginning to form, but I could not get her to see the same thing. While this approach may be worthy in itself, it was not sensitive to Mandy's situation. What had not been accounted for was the amount of internal and external strength someone needs to participate in such decision-making and personal change. Mandy really had no control over her environment and had almost no connection with her internal world. She was not in a position to save herself and I was doing her a disservice by pretending that she was.

### THE DANGERS OF ZEALOTRY; OR, PRACTISING CLONE THERAPY

I was not the only new family therapist making similar strategic miscalculations when reusing metaphors that had originally been applied successfully in particular circumstances, with particular families. Around the same time, a family was referred to me who had been previously seen by a psychologist at another hospital. He too, was training in family therapy, and had used with this 'warring' family the then popular analogy of the US-USSR cold war of the 1980s. The parents presented as locked into defending themselves against claims of incest by their adopted teenage daughter. They were a conservative middle class family who were furious about the language used. They felt they had been treated flippantly, or were being 'played with'. This metaphor clearly didn't fit for this family. It increased their defensive position and destroyed the tentative engagement that had been achieved. Why indeed should it fit? The individual nature of each family and situation must dictate tools the therapist uses. Pulling a preformulated therapeutic metaphor off the shelf and using it with every similar presenting problem should be anathema to us all. In this case, the therapist had not allowed himself sufficient time to get a better feel for what would allow the parents, and particularly the mother, to back out of their corners and consider a protective stance toward their daughter.

Another event reminded me of my work with Mandy. I was participating in a workshop where a clever externalising exercise was promoted as suitable for teenagers in situations like hers. Like other family therapy ideas I have come across that are freely promoted as having a wide applicability, it was presented without reference to any context beyond the mid 1980s. The intellectual and

historical context of the therapeutic idea were absent (as if the particular type of therapy was a new invention developed in a vacuum); there was no critique. Deborah Luepnitz (1988) analysed this trend as the ahistorical and apolitical nature of family therapy. The absence of context can reinforce the dangerous notion (which perhaps new therapists may be more liable to take up) that family therapy can save the world, or at least solve every problem that is referred to them personally. Perhaps even more dangerous was the absence of the fundamental principles of interpersonal work, which is the need for a thorough and ongoing assessment, and an engagement process where 'fit' is worked out between client and therapist before the decision is made about how to proceed. In fact, those initial phases of therapy are often the most crucial part of the work, determining the relevance of interventions that will be later tried. It's the phase of therapy where work agreements and goals are set, and what is *not* possible is established too. These skills are those which are taught in undergraduate social work degrees, in psychotherapy and counselling, but which are curiously not given high status in the family therapy world. 'Engagement' is what we have inherited from the family therapy tradition, and it has not been developed adequately or given much attention (Jackson and Chable, 1985). What amounted to a dismissal of the skills that I brought to family therapy from my own professional background occurred because those skills were not named as belonging to the family therapy, or higher level status, discourse. Being a 'therapist' and not (as it would have been in my case) a 'social worker' was the goal I was pursuing. Those 'social work' skills were however, precisely what I needed to keep hold of.

### 'HOLDING' AND OTHER DYNAMIC IDEAS

In the years following my brief therapeutic relationship with Mandy, I learned the value and potency of 'holding' (Winnicott, 1986), where your very presence is of significance, where you as the therapist can be used like an anchor. This brings me to tell you about Ann.

Ann began work with me to help her develop a positive image of herself. She told me she had conquered anorexia recently but was having problems talking to people at college. At first I worked from a short term model of intervention, setting tasks and mapping sequences of behaviour and anticipated that we might work for six months. Ann's main problem turned out to be crippling self doubt and depression, which led to her daily considering suicide. She continually experienced a deep sense of desertion and had had a childhood full of abandonment. Her chronically mentally ill mother was from Ann's birth subject to psychotic episodes and severe depression. Her mother's frequent hospitalisations left the little Ann full of fear, because she was left with the 'devil' of her mother's delusions: her father. Unfortunately, her father's requirements of her were unrealistic, and she anxiously aimed for high achievements to secure his praise. At sixteen years old, she was dangerously ill from anorexia, but survived and by twenty four she had

migrated to Australia on the basis of what proved to be a short-lived affair. When she came to see me in my private practice, she was experiencing a range of problems that had left her isolated, desperate, depressed and unable to work or study. She was at the time dependent on strict daily rituals of exercising and fasting.

After three months of proceeding in my usual systemic way, it was evident that I would have to do something different. Ann deteriorated into deep depression and in response, I found another model, one that could deal with this level of depression. This model was psychodynamic. The most therapeutic thing I could offer, in a safe predictable environment, was an experience of someone who would not desert her no matter how ugly or fat she was, no matter how desperate she felt, no matter how hopeless her life was. She had in effect isolated herself from all the supports she had had, and the next step would have been an admission to hospital, or suicide. The daily experience she had of helplessly falling, falling into a black void eventually became much less frequent. After two years of psychotherapy, she did substantial work on her relationships with peers. Her ability to hold onto life markedly improved when I was able to use the projective identification I experienced in the sessions: the feelings and thoughts that would fill me from time to time whose origins I attributed to my client (Malan, 1979). I believe that this was both a validating and empathic experience for her.

My experience in these and other cases where there has been severe childhood disruption and abuse has in a very real sense pushed me to take on other models where the importance of the therapeutic relationship, and the containment it can offer, becomes central. What can be equally important to the 'holding' in therapy which we individuals provide is the agency setting itself.

## DEVELOPING FLEXIBILITY

I then worked for some time at the Barnardo's Children's Centre in Auburn, one of the most impoverished areas in Sydney. This is an integrated family support agency, consisting of seven child care and welfare programmes, including weekend respite, domestic violence groups, a family support service, and medium term accommodation for homeless families. While as a therapist I was able to insist on initial family assessments, so that I could locate the child within the family, the work often proceeded from there in individually determined ways. I had learned to be flexible! In my mind, it is always important to build more secure relationships for the child's future with the person best placed to protect him/her in the family. Additionally, there is the need to leave the family more able than before to deal with future problems, and to normalise their reaction to trauma.

Sometimes I have found that play and projective techniques are the approach of choice. A great advantage of psychodynamic play therapy or Gestalt methods is that they don't rely heavily on verbal ability. Sandtrays, painting, modeling clay and drawing can all be used with

a focus on the symbolic and real meaning for child clients, and their own expression of their inner world. This internal focus does not exclude work with their family. Family work may run parallel to it, or be included within it.

Additionally to being very well suited to the child's developmental stage, these sorts of play therapy allow a space for the unconscious. An example of combining the two methods is when I was seeing a six year old boy who made a sandtray scene in which he represented himself as a 'lost and alone' chicken separated from his mother hen, who was hidden behind barricades in the corner. The use of the animal symbols allowed him to access a taboo and frightening subject (his mother's wish to leave the family). After talking about what the meaning of this was for him, we asked his mother to join in. John was able to tell her about his fear of losing her, which facilitated further work with the dyad and with each of them individually. Dreams and nightmares, a frequent presenting problem for sexually assaulted children and teenagers, can also be explored using projective techniques.

Family therapy methods assume some 'sense of self', or 'ego strength', to use psychodynamic terminology. A systemic description of 'ego strength' or 'sense of self' may be that the person or family members have 'developed a sense of personal boundaries'. Family therapy methods assume some inner strength that most clients have to some degree. They also assume some commitment and ability to participate in change on the part of the parents. There are times, however, when family therapy can be used by very angry or destructive parents to attack their children, or indeed vice versa. Therapy must not be used to abuse family members. If the balance of power cannot be kept fairly equal, or if therapy is not safe for everyone, then family work should not proceed (MacGregor, 1990).

Sexually assaulted children and adolescents often ask to be seen alone when we routinely discuss 'How do we proceed from here?' following the initial meetings. While individual work may proceed with the child, the parent is kept engaged, and may be given information about progress if the child is comfortable in doing this. At the completion stage, I aim to do joint work to ensure that the family, and especially the mother and child, have worked on all the issues that have been a problem for them concerning the abuse. This work relies on an ongoing assessment of individual and family strengths, where the most leverage can be brought to bear, and where the most support can be marshalled for the child.

## CONCLUSION

I have written about some of the ways that I have learned to be more flexible, to use family therapy and other modalities to serve me, rather than the other way around. The struggle to find 'space and guidance' for understanding and using the therapist's feelings in a family therapy model has been explored by Flaskas (1989). These days I feel confident to be myself much

more, to cry without embarrassment when told a moving story, to pay attention to the range of emotions that are activated within me by clients, and to use them in the session when it's appropriate. I no longer find it appropriate to keep these emotions at a distance. But this does not come from the family therapy tradition. Rather, it has been borrowed from psychodynamic, feminist and Gestalt practice.

The question of keeping a distance from the client was illustrated for me when I had a massage recently (this is not a comment in any way about whether therapists should physically touch their clients, but strictly an analogy). The masseur's tools of trade are his or her body—their hands and elbows and the weight of their body are all used for therapeutic effect. There is close contact with skin on skin. The physical touch remains safe and I know I could stop it at any time. As the massage progressed, the masseur asked me for directions about where to work, and how hard to press; we worked together. There was no plastic membrane thrown over me to create a distance that would interrupt the masseur's empathy with what I needed. Indeed, touch is considered vital for the diagnosis of tight muscles and to feel the muscles responding to treatment. Therapeutic skills can be like an invisible plastic membrane, ensuring that we don't feel the client's distress too much, or lose our ability to be meta to the 'situation'.

Techniques of therapy are useful, but cannot override the importance of the personal relationship that has been linked to good outcomes (Gurman and Kniskern, 1974). I don't think any evaluation study has held the 'technological bits'—the clever reframes, or the circular questioning—in equally high regard. I remember seeing my supervisor a number of years ago through a one-way screen doing something with a family who were 'stuck' in therapy. All of us watching were struck by the potency of what she was doing; the family were visibly blossoming. My supervisor was extremely interested in

theory and its application. She had drilled us in the stages of Milan therapy, but all that she was doing that seemed to make a difference in this session was *listening*—attentively listening and moving with the family's account. Listening and empathically being with them, being moved by them. This was an aspect of the relationship that can be part of family therapy and I suspect often is, despite the lack of validation of the use of the relationship in theoretical models. If I had felt it permissible to work this way when Mandy was my client, I would have been able to use the rising tension I felt in my gut to help me make a connection with her, instead of trying to push it away.

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