

NETWORK NEWS

Commentary, News and Reports from Regional and International Correspondents

Dropouts in Family Therapy

Roslyn Phillips, Glenn Munt*, Jan Drury, Margaret Stoklosa** and Janet Spink*, edited by Jane Chapman

The factors that are raised under this heading are varied and difficult to summarise, ranging as they do from reflections on the dropout of family therapists themselves, to the dropout of clients, the reasons for which have been variously construed. However, there is one issue, emphasised by both Roslyn Phillips and Glenn Munt, that would seem important to head this section, because often the obvious needs reiteration!

Engagement

The dropout rate in family therapy is a product of many factors and is closely related to the issue of engagement. The many factors are: the nature of the crisis which precipitated the referral; the identity of the customer; matching of service provision to need; the skill level of the therapist; his/her personal qualities; and the various practical issues to do with money, time accessibility and stability of agency personnel. The real customer, that is, the one who is concerned about the identified problem and wants to be involved in the process of change, may be the non-custodial parent, the teacher whose class is disrupted, a concerned grandparent, or the partner of someone behaving in self destructive ways.

One strategy to counter dropout is to pay closer attention to the beginning phase of engagement. Don Coles has written in this *Journal* (1995, 16, 4), about the letters he writes to new clients. These letters introduce the writer, outline expectations about the initial interview, and suggest possible lines of questioning. In a limited survey, he has found these letters helpful in engaging and maintaining clients. Coles also cites several articles on the same subject that have appeared in the *ANZJFT*. In this same article, he discusses the question of engagement—integral to this subject. The importance of the first couple of sessions in establishing a connection with a family, thus increasing the likelihood of their continuing, as well as the importance of the first session in setting the parameters for what will follow, predict the success of the therapy, whatever its duration.

In this topic, then, much credibility should be given to the therapist's own capacity to engage clients who

are variously motivated and committed. In turn, this capacity depends on many things, including the therapist's ability to 'hold' (in the psychological sense) the range of feelings expressed by individual family members, as well as the therapist's capacity for warmth, empathy and humour. Glenn Munt balances stories of clients who dropped out for reasons like difficulty in finding a parking spot, with the memory of clients who travelled from Indonesia last year and stayed in Brisbane for several weeks until their work was completed.

Expectations

A related issue is that of differing expectations between clients and therapists. Postmodern thinking has drawn our attention to the whole question of who owns the definitions and the theories, and as therapists, we may be prone to assume a need for therapy, because of our 'diagnosis', while clients themselves may have a quite different notion of what they require from the therapeutic process. This mismatch of expectations could be seen to be relevant to much of the so-called dropout rate.

Several correspondents have actively sought information when clients do not return for sessions, one of them by doing a survey of her colleagues. In this latter case, Jan Drury sent out fourteen survey forms to therapists in private practice, non-government and private agencies, and the public sector. Where people fitted more than one of these categories, they were asked to complete separate forms for each. Ten survey forms were returned, which was a pleasing result. Four of these came from private practitioners, four from public sector agencies, and two from non-government and private agencies.

Preliminary speculations about dropout rates included an interest in what would be the difference between the private and public sectors, where issues of cost on the one hand, and waiting times on the other, might compete for prominence of place as contributing factors in dropout rates. Also of interest was the interpretation therapists might place on clients' unexplained and perhaps unexpected discontinuation of therapeutic contact.

Respondents to the survey in the Hunter were asked to specify the percentage of their work which they would describe as family therapy, and to compare dropout rates with those in other treatment modalities

* Glenn Munt is Queensland's Guest Correspondent, and Janet Spink is Victoria's Guest Correspondent for this topic.

** We welcome Margaret as the new Tasmanian Correspondent, replacing Stephen Pinkus, now Treasurer for the Board.

offered by their service, where applicable. For three respondents, this was irrelevant, since most, if not all, of their work was family therapy. Of these, one reported a very low overall dropout rate, with high levels of consumer satisfaction expressed for their narrative/restoring experience. Two other private practitioners with mixed practices reported minimal dropout rates once a satisfactory negotiation of terms had occurred. Only two surveyed considered that dropout rates were lower for family therapy than for other services offered, with the other three respondents finding little difference. Two public sector agencies noted higher dropout rates for family therapy, which constitutes 75% of their work. They commented that within any family there may be different levels of interest in, and commitment to, the therapeutic process, which can influence whether or not a family continues; by contrast, in individual therapy there is just one person to engage.

Seven of the ten respondents keep some sort of statistics, which reflect dropout rates, amongst other things. Seven (not necessarily the same seven), had taken measures to attempt to ascertain the circumstances of client discontinuation. Allowing for the notoriously poor return rate of surveys, therapists have been able to draw certain conclusions. Some families (and this is well supported in the Brief Therapy literature) stop coming because they no longer feel the need. These families are likely to report feeling satisfied with the service received, and to have found it helpful. A direct relationship has been found in some public sector agencies between waiting times for first and subsequent appointments and client non-attendance (although one private practitioner considers that a waiting list helps weed out those ambivalent about the idea of therapy, thus reducing the rate of dropout). The complexity and multifactorial nature of many of the referrals to public sector services is also cited as a contributing factor to clients' ability to stay in treatment.

Respondents were asked to rank in order of frequency the following possible interpretations by therapists regarding families who have dropped out:

- Sufficient progress was seen to have been made
- The contact was not seen as helpful
- The time was not right for change to occur
- Cost was a problem.

Only two respondents in the Hunter placed first the fact that the contact had not been seen as helpful, and nobody ranked cost as number one. This left the majority of therapists considering principally that either sufficient progress was seen to have been made (for some therapists, this conclusion has been borne out by consumer satisfaction surveys), or that the time was not right for change.

Informal Follow-up

Information at a more anecdotal level can be sought directly from clients themselves as to why they discon-

tinued therapy. Taking into account the possibilities of clients trying to protect our feelings, and not admitting outright that they thought that the whole process of therapy was quite pointless, some of the following feedback was obtained by Margaret Stoklosa, who routinely rings clients after they cancel a session.

Each summer, Margaret takes holidays of approximately six weeks over Christmas to be with her family. This February, as she telephoned continuing clients she had not heard from, she kept this topic in mind. As always, her calls brought surprises. One family she contacted was a single mother who had been struggling with her sixteen year old son. The therapist has worked with the mother individually and with the mother and son together off and on for approximately three years. Last year had probably been the most disturbing, since the son had finally eliminated all options of schooling for himself by his rebellious and aggressive behaviour. The mother had eventually asked him to leave home. When Margaret telephoned, she had been prepared for the worst. She was relieved and delighted to hear that things had improved dramatically.

After the mother set limits and asked him to leave home, her son at last finally realised that, in order to stay with his mother, he needed to change his behaviour. He has been back in the home for approximately a month, and has been considerably more helpful and responsible. He had re-enrolled himself in school, and had apologised to her live-in boyfriend. These changes may be short lived, but the mother has certainly learned a great deal, and is growing in her own confidence about setting limits in her life. For the present, the therapist's help is not needed, and hopefully, will not be for some time.

Another phone call revealed that a fifteen year old with an obsessive compulsive disorder, who had also had a very disrupted school year, was feeling remarkably better, more settled, and looking forward to school. Her paediatrician had prescribed Prozac in the last weeks of school, and her response to this medication has been very good. The family had thought that since things were going so much better, they would see 'how things went'. Margaret suggested that, although progress had been made, they were in the very beginning stages of the year, and that it might be good insurance to establish some 'check up' sessions perhaps on a monthly basis: it was better to prevent problems rather than to react to them at a later date. The family was more than happy to accept these suggestions, having not thought in those terms.

A third follow up revealed that since they were last seen in December, one family was having as many difficulties, if not more. They were settling into routines at school before they contacted their therapist again for an appointment. They definitely felt the need to return to therapy. 'Dropping out' of treatment, therefore, may mean many different things and, without follow up, we have no way of knowing what the 'dropping out' actually means. The follow ups are usually greeted with

appreciation and often surprise that the therapist has taken the time to find out how things are going.

Not 'Dropouts' but Satisfied Customers!

Certainly, clients' circumstances change, or the felt intensity of the problems facing the family lessens, and the need for therapy lapses. There are also issues alluded to above in terms of the hypothetical difference between clients and therapists about problem resolution. This was demonstrated in Moshe Talmon's *Single Session Therapy*. Talmon tested his assumption that clients had attended only one session because they had not been satisfied with the therapeutic process. He found that in a great number of cases, they had not returned because they had got what they needed from that one session, lending a great deal of support for our belief in the need for clear problem delineation in the first session.

Talmon also states that if clients 'drop out', or 'if clients return to see us later on (especially if there has been help previously), that does not mean that we failed to cure them; it means that they used our services properly and in a timely fashion' (Talmon, 1990: 124). Again, we cannot determine what is 'right' for the client. Cummins (1986: 430) suggests that the therapist should offer clients the following bargain: 'I will never abandon you as long as you need me. In return for that, I want you to join me in a partnership to make me obsolete as soon as possible.' Clients may 'drop out' of therapy because we have become obsolete. We are service providers and clients are not obligated to explain why they do not continue to use us. It may be wise to shed our omnipotence and, instead of assuming that 'dropouts' are failures, accept that perhaps our families have rediscovered their resources and resolved their issues.

Bergin and Garfield (1971) reviewed analyses of the length of treatment offered at several American clinics. The median number of treatment interviews was most often reported as from five to seven. They noted that in nearly all of these clinics, the dropout pattern was seen as a problem, as abnormal, not the result of deliberate planning. 'It can be stated with some degree of confidence, therefore, that the finding of an unplanned and premature termination from psychotherapy on the part of a large number of clients is a reasonably reliable one' (Bergin and Garfield, 1971: 71). We do not have any reason to insist that family therapy's results are any different. Clinical experience concurs with these results and brief therapies are predicated on the assumption that this approximate number of sessions will be enough.

So, when therapists refer to dropouts, are they really describing difference of opinion about whether treatment has ended, or should end? Or should they examine their practices about engagement, their skills, practical arrangements about times, location, matching of expectations?

Dropout of Family Therapists

In another vein entirely, the guest correspondent from Victoria reflects on the dropout of family therapists, and reflects on her own choice to have done so:

I had come to family therapy in 1983. Family therapy theory and practice gave me a model of understanding, strategies and ways of thinking about what was happening in families. I learnt what questions to ask, and it didn't seem to matter what the family's answers were, it was how cleverly the question was asked. I felt secure and confident in my technique, while a little worried that it didn't always work. I could always blame the family. I had an arrogance which helped me to work with very distressed families.

She continues by posing the following questions: who is dropping out, us or the families? And why? Is the pressure of postmodernist thinking and liberal economics too much for families and family therapists?

Lyotard, a theorist of postmodernity, suggests that during the enlightenment, reason and progress were applied to science to give an objective account of nature and the laws governing physical reality. There was a belief that universal social theories could be uncovered to offer a certainty about predicting relationships that underlie human affairs. Maybe family therapy was about those universal theories and grand narratives. But the universal theories didn't really work for those who most needed them. Now we have particular theories for particular groups like eating disorders, or ADHD. Do they work any better?

Have we been hoodwinked by the theories of particular solutions to particular problems? Have we been ignored yet again by the context, the influence of the international political economy, which leads to increasing inequality in living standards, privatisation of the welfare state and stricter regulation of the poor? Meanwhile on a local level, trust in professional opinion is in decline, there is a focus on the consumer as expert, and a shift away from the community to the individual (Taylor-Gooby, 1994). As family therapists, are we addressing these gendered, political, social and economic problems in our therapeutic work? Have we abandoned the ship, or were we never on the ship in the first place?

In like vein, a recent article by Hair et al. (1996) outlines how over the last two decades, a number of family therapists have chosen to entertain the themes of poverty, sexism, racism, environmental crisis, political oppression, and the shifting alignments of world power. Their writings extend the boundaries of therapy 'to include the world of poverty, the significance of culture, the power inequities of gender, social accountability and justice, the horrors of political oppression and torture, and the ongoing threat of international nuclear war' (Hair et al., 1996: 296).

These factors form the backdrop of our own and our clients' lives, and our willingness to broaden our domains of enquiry into the wider contexts that impact on clients may have some bearing on the dropout rates of clients and therapists alike.

References

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Local News

SINGLE SESSION WORK USING A REFLECTING TEAM IN CENTACARE, ACT

Looking back, I would say it really started in 1995 when our Director went to a conference in Canada on Narrative Therapy. There were some big names there, Michael White, David Epston, Tom Andersen and many others. He came back full of it all, and fell upon our Wednesday afternoon professional development meeting with an almost messianic fervour, eager to share with us the ideas and sounds and flavour of what he had experienced. Now, we twenty or so counsellors comprising the Student and Family Counselling Unit are a seasoned lot. We've seen it all and we're not easily impressed. I have to admit, we were not as receptive as we might have been. Our attitude was perhaps: Reflecting Teams? Yes, yes, we know about those, what else is new? Yet I do think it was at that meeting that the seed was sown for some ongoing work which is proving to be exhilarating and worthwhile. I am interested in the way that good ideas somehow propagate themselves, and grow. Perhaps something about our Director's enthusiasm was the professional 'Multigro'. I shall try to describe the process by which we began to learn and experiment with single session reflecting team work.

Centacare ACT is an agency which, among other things, provides a school counselling service to 60 or so schools in the Archdiocese, covering an area from West Wyalong through Canberra, Goulburn and down to Eden on the coast near Victoria. Almost all the psychologists and social workers in the student counselling unit are sole workers, placed out in their schools and inundated with casework. Although there has been, for some years, a strong interest in family therapy team approaches, nothing much was done. How could such approaches possibly fit with the constraints of our case-loads and our geographical isolation from one another?

To begin with, we experimented with forming a family therapy team, Milan style, and having it operate as a training exercise during our precious (and only) time together, on Wednesday afternoons, using the somewhat antiquated one-way room and sound equipment which was the pride of our agency in the 1980s. It was

heady stuff, all this unaccustomed co-therapy, yet it was breathtakingly expensive in terms of our time. We simply could not afford, as an agency, to have an established, ongoing team in this style.

The next step in our learning process about team approaches probably owes more to equipment problems than to anything else. Having abandoned the one-way room and its geriatric sound system, the team had moved to another room and attempted to link therapists and team by video. Alas, we are not very technical, and the results were not altogether predictable. We were keen to continue with team work, and hoped to expand into country areas. But if we were to be able to take these ideas about working in teams out into our country schools, it would clearly have to be without the benefit of a whole lot of technical equipment. We began to think of ways to work, technology free.

A further step in our experimenting concerned how the team was constituted. We had accepted the prevailing view that a proper team must form and work together with the same members for some time in order to be effective. But one of our counsellors had been to Adelaide quite recently and trained with Gregory Smith. She recalled that he had assembled a reflecting team on the spot from the participants present, and some real work with a real family had been done. With this liberating idea, we began to wonder whether good work could be done after all, with a team assembled just for the day.

I suppose we can blame, or thank, economic rationalism for one other part of our learning process. The ACT, in its wisdom, had voted in a local Liberal government somewhat in advance of the rest of the country, and as a result, the local welfare sector had for some time been considering how to do more with less. Perhaps as part of this process, ACT Health's Child and Adolescent Service had begun to offer Open Days, during which families were offered single sessions with a team of workers, using a set protocol of problem exploration, followed by team consultation out of the room, followed by an intervention being offered, after which the family left. Some families returned for further work, but many were satisfied with this one-off session. We much admired this concept of single sessions, and the impact it might have

on one's waiting list. We began considering Open Days in country areas.

Our first experiment with using a family therapy team approach in a country area happened in Temora. We had a counsellor living locally, whose identification of and engagement with the families was a crucial factor. We worked in the technology free environment of the lounge room of the old presbytery, a homely, comfortable room with plenty of space for children to crawl about, and big old lounge chairs. Somehow we assembled a team of workers who, by swapping days, extricating themselves from other commitments, and starting at the crack of dawn, were able to get to Temora from Canberra, in time to start with the first family at 9.30 a.m. We had decided on an approach in which two workers would sit and work with the family, while the other three sat apart, observing. Then we left the family and all repaired to the kitchen to compare notes and come up with an observation. Then we rejoined the family and gave them the benefit of our ideas. The families seemed pleased and grateful, and we were happy about the experience too. I can remember thinking: We did it! We actually did it, and it worked! We had demonstrated to ourselves that it was possible to offer useful single therapy sessions, without special facilities, and with a team assembled just for the day. We had come quite a long way.

The next stage of our experimentation was informed by the writings of Tom Andersen, whose ideas about reflecting teams had by then filtered through to us. We liked the respectful and non-directive feel of this approach, the way that the family was invited to hear a conversation about themselves from people who never left the room, and to take from this conversation whatever was of value to themselves. None of us had ever done it before. Yet the ideas were so simple, so beautiful, so sensible that the country workers of our unit were once again inspired to have a go. A different team was assembled, and we set off for Batehaven. It was one of those exhausting but exciting days, at the end of which you know why you went into counselling in the first place. The difference between this approach and what we had done at Temora was palpable. I knew that I wanted to do more of this.

Since then, our agency has indeed done more of this sort of work. We have used these ideas in a newly funded program targeting the families of homeless and at-risk youth in country areas of NSW. We have co-worked with people from other agencies, assembling and preparing a team, then working with the family, and debriefing afterwards, all within the space of two hours.

I remember one family in particular, the mother struggling to live without alcohol, and having just left her most recent violent relationship, the three children all with different fathers they never saw, and problems of their own. The reflecting team commented on the love it saw, on the family's hope and efforts at change; it wondered respectfully how the mother and the elder son, who had been fighting violently, might jointly manage some practical financial matter; it noticed an opport-

unity for doing things together now that alcohol was not running the family. At the end, the mother was in tears. But she explained that these were tears of joy. The next week, at his school, the fourteen year old told his school counsellor the session was 'Excellent. Really rad.' He had never heard anything good about his family before; maybe they weren't hopeless after all.

So this is about where we are up to in our experimenting with single session reflecting team work. We are still learning by doing. From the seed of an idea, something has grown which has enriched our expertise, expanded our ideas, and, I believe, done some of our client families a power of good.

SUE GLENN-HUME

HUNTER REGION

Journal readers in the Hunter are watching with interest as the new format takes shape; however, there can be no complaints as to poor representation of our local perspective, if the last issue can be taken as a guide.

Family therapists in the region have been generous with their time and experiences in completing the brief survey which formed the basis of this issue's Network News topic. Thanks are extended to all who participated. The exercise was an interesting one, providing contact with therapists who do not necessarily come together with any regularity.

This raises an issue which has been noted before in the Hunter's contribution to *Network News* (The Changing Face of Family Therapy, 1994, 15, 1). It would seem that a relationship to some extent exists between increased experience and confidence in family therapy, and a decreased need/desire for contact with other family therapists through forums such as HAFST, Inc. This issue has not been surveyed to date, but would be interesting to follow up. Without feedback, one can only speculate as to how local therapists go about satisfying their perhaps variable need for a professional network (a potential future topic for Network News?) For myself, and probably for many therapists working as part of an agency, these needs are well met within the workplace.

One local group who are making their own arrangements to support each other in the development of their work are practitioners of the narrative approach, which has a strong following in the Hunter. Whilst most people have previously had to travel to Adelaide or Sydney for such training, 1997 brings some local opportunities for training in narrative practices.

JAN DRURY

NEW SOUTH WALES

The first of the Association's monthly meetings was held in April with past presidents exchanging anecdotes of past lives! The new committee, the largest ever, has because of its size occasioned a rewriting of the constitution. Meanwhile, President Cathy O'Brien

(coordinator of the St George Youth Service) and David Horner, Vice President, continue to ponder changes the association is facing, considering criteria of membership, purpose and function.

Family therapy is being given a more significant place in post graduate clinical education for social workers. The University of NSW is offering a graduate diploma in couple and family therapy. The diploma can be combined with a masters programme to gain a MSW (with additional subjects) or a Masters in Couple and Family Therapy. More information from Liz O'Brien, phone +61 2 9384 4745.

Some movements of personnel: Don Coles, who has worked at Merrylands Health and Teaching Centre for many years, is now the Director of Training and Education for Life Care—Counselling and Family Services (Baptist Counselling Service). His article, A Pilot Use of Letters to Clients before the Initial Session, *ANZJFT*, 16, 4: 209–213, was referred to in our collaborative essay on Dropouts in Family Therapy, above. Jacqui Tulloch and Sandra Martel, who were with Dalmar at Cranebrook are now at Unifam's Adolescent Family Therapy and Mediation Service at Parramatta. Dr John Brennan has been appointed Director at Redbank House, Department of Child, Family and Adolescent Psychiatry, Westmead Hospital.

There have been several educational seminars advertised. Brian Cade has on offer week long introductory and advanced courses in brief/solution focused therapy. He has also arranged one day and half day workshops on humour and the unpredictable in therapy, on working with adolescents, with reluctant clients, on substitute care with the child from multiple placements, and on the use of emotion in brief therapy. These events have been spread over the first half of the year.

Dr Toni Single, Senior Clinical Psychologist at the John Hunter Hospital spoke at Liverpool in March on the emotional abuse of children: clinical and legal issues. This day was organised by the energetic group at the Paediatric Mental Health Service. Richard Elms conducted a two day workshop in April at Penrith, on the application of narrative ideas to various presenting problems.

ROSLYN PHILLIPS

QUEENSLAND

QAFT was fortunate to have Hugh and Maureen Crago, editors of this *Journal*, as guest speakers at our AGM to discuss their ideas for the future of the *ANZJFT*, along with the trials and tribulations of editing. They were quick to agree that indeed, the 'Crago idiosyncrasies' for which they are affectionately known here in Australia, were likely to manifest themselves in the *Journal*. One of their key goals is to maintain the *Journal's* balance of rigorous academic writing with direct, personal writing. The audience was strongly encouraged to contribute stories, case studies, research projects, and innovative clinical projects.

Following on from their brief presentation at the

AGM, the Cragos conducted a one-day writers' workshop, which was extremely well attended and of notable worth to each participant. Often when reading the *Journal*, there is a sense of 'those who write for the *Journal*', and 'the rest of us'. An especially important outcome from this workshop was the dissolution of this division, which has the far-reaching potential to broaden both the topics and styles present in the *ANZJFT*. Although it would be difficult to summarise the day, on reflection it was an exercise in experiential learning—those 'new' strategies that trainers everywhere are expounding. Briefly, participants learned through their own experiences during the workshop (as opposed to being lectured), were led to draw meaningful, personally relevant conclusions (e.g. how to improve one's writing style) and then generalised their new insights, knowledge and skills to other relevant contexts (e.g. the *ANZJFT*). As a result of this workshop, participants saw themselves as 'writers' by the end of the day, with the realisation that there was no single 'right' way of writing, yet with an understanding of the qualities which make particular reports stand out.

At the AGM, Glenn Munt was re-elected President of QAFT for his second consecutive year. He commended the Committee of 1996 for their excellent work, particularly in policy development. As an example, a request for tenders is made prior to choosing a workshop leader/topic. The Video Outreach Program has been successfully established, especially for country members who wish to view and discuss the clinical meetings. Glenn stressed that preparation for the 1998 Family Therapy Conference in Queensland will be a central focus for the Committee in the coming year.

JANET ROTH

TASMANIA

The highlight of the year for the Tasmanian branch of the Family Therapy Association was our conference in Hobart last August. After many months of hard work, we were pleased that it all came together so well. We would like to thank all those who participated in the conference, both presenters and attendees, for helping to make it enjoyable and very worth while professionally.

There were other events in 1996 in Tasmania which we have not yet reported. The Tasmanian Family Therapy Association has continued to meet on a bi-monthly basis, usually with an invited speaker. We were addressed by Malcolm Cunningham, Director of Family Court Counselling, at our Christmas meeting and Annual General Meeting. Malcolm discussed the very important issues of what sort of image we create for our children at Christmas, about celebrations, and what myths and beliefs we pass on. He also discussed the issues of the family facing the first Christmas after separation. These are issues that face us each holiday season and are important to take into account in our work with families.

Towards the end of the 1996 year, the Family Court and the Tasmanian Family Therapy Association jointly sponsored a workshop on Family Group Conferencing, presented by Paul Ban. Paul is a social worker based in Melbourne, who has presented both nationally and internationally on this topic. Attendees found that Family Group Conferencing is a useful method of case management that allows families to participate actively in the management of their children, particularly around the issues of custody and access. It can also be useful with children who are out of the control of their parents.

In January 1997, the northern part of the state was offered a workshop on narrative therapy, presented by Michael White. This workshop was organised by the Department of Public Health, and was reported to be excellent.

Now that we have sorted out the issue of who will be the state correspondent, and how it all works, we look forward to networking with the *Journal* for the remainder of the year, and also to continue our local meetings and the sharing of expertise.

MARGARET STOKLOSA

VICTORIA

Dropout rates in family therapy! Who is dropping out and why? Well, in my neck of the woods, the locals all know we have lost the likes of Yvonne Hunter, Mark Furlong and Susie Costello from mainstream family therapy. These three people are all well known in the Melbourne family scene as therapists who write, teach and work diligently to promote good practice. They are, coincidentally, all social workers. One of them has spoken to me about the seductiveness of 'family therapy', with its more modern flavour of technique and privilege. That funny old term 'social work' associated with deprivation, was to be avoided. Then we remembered that social workers were seeing families at the turn of the last century, and have long had a mandate with multi-systems, the marginalised, and with women and children (Wood, 1996). Dropping out of family therapy might in fact be a sign for some people of reclaiming their professional knowledge base, rather than a refutation.

The above three all dropped out of family therapy, espousing different reasons. Mark has said he was always the social worker in a family therapy agency, rather than the other way round. He has moved to acad-

emia. Yvonne is writing, amongst doing other things, I am sure. Both have left Bouverie and its associated main stage status. Susie is a senior manager for one of our more recently emerged mega councils. So academia, writing and management are all places where people 'drop in'. So is motherhood/fatherhood, upgrading one's qualifications and burn out. One of the things we do not talk about is how hard this work can be, often done with very under-resourced families in under-resourced work contexts. Private practice is of course seductive, for those with the means and desire. Dropping out before burning out may be just the thing! Our guest correspondent, Janet Spink, has written a personal perspective on this theme, and her views are contained in the article edited by Jane Clapham.

Farewell to Max Cornwell from all the Victorians. Max is the retiring editor of this *Journal*, and it is with huge respect and admiration that we say goodbye to him. The VAFT AGM was in March, and in our June issue I shall write about Max's presence at the important event which kicked off our professional year, hosted by the 1996 VAFT President, Barbara Fraser.

Wood, A., 1996. The Origins of Family Work: The Theory and Practice of Family Social Work since 1880, *ANZJFT*, 17, 1: 19-32.

SARAH JONES

WESTERN AUSTRALIA

The Moshe Lang Workshops that were anticipated in the last issue unfortunately had to be cancelled, but the good news is that they were rescheduled for Friday 2nd May, 1997 and Saturday 3rd May. To remind readers, the topics were to be: working with survivors of trauma and their families, and the therapist's resilience.

WAFTA continues to seek new members and to develop more opportunities for networking and workshopping. CentreCare's Brief Therapy Service has publicised its programme for 1997, which includes Narrative Therapy Training Programme (Levels 1 and 2), Solution Focused Brief Therapy Training, and Practitioners' Course (Intermediate and Advanced). There are a number of specific focus training workshops, including Yvonne Dolan workshops (life trauma and sexual abuse), working with chronic illness and pain, and Narrative Therapy Workshops with David Epston (April and May). Inquiries can be directed to CentreCare (+61 8 325 6644).

ADRIENNE WILLS

LOYAL CONTRIBUTORS

Grateful thanks are once again due to Jane and her team. In an attempt to meet the publisher's deadlines, state correspondents have now produced copy for two issues in the time they have normally had to prepare *one*.

They have had to seek out double the usual amount of local news at a time of the year when it is conventional to think that nothing much is happening. And on top of that, they are still accustoming themselves to their new format. After this, they will have a more reasonable length of time to do their work.

Letter from USA

Dusty Miller

I was delighted to receive an invitation from Maureen and Hugh Crago to be the US correspondent for the ANZJFT. The influences of Australia's Michael and Cheryl White, and New Zealand's David Epston and the Just Therapy group have had a profound effect on the way many of us in the US are training students, doing therapy, and generally thinking about the world. And for me personally, this is an opportunity to connect with the Cragos—alums of Antioch New England Graduate School where I teach—and to reconnect with old friend Laurie MacKinnon—my host and co-presenter in 1985 when I spent three weeks in Sydney—and Kerrie James, a long-admired Australian colleague with whom I had a memorable meeting during the same visit to Sydney.

I'll begin by introducing myself. I'm a clinical psychologist, specialising in families and individuals affected by interpersonal violence and addictions, as well as family/larger system consultations and professional training. Much of my professional writing has been concerned with the interface between the professional helping system and consumers who experience violations perpetrated by family members and the professional system as well. In 1994 I published a book, *Women Who Hurt Themselves: A Book of Hope and Understanding*, designed to offer consumers a new way to understand themselves and to advocate for themselves in getting help from their communities (including but not confined to the professional community). My work with the consumer community has continued, strongly influenced by the aforementioned theorists and professional activists from your part of the world.

I also train and supervise professionals in my full-time job in the Clinical Psychology Department at Antioch New England Graduate School. I think it is important for your readers to know how much your compatriots continue to influence many of our faculty. In my department, Bill Lax has done a great job creating and maintaining an awareness of Narrative and Just Therapy thinking along with another faculty member, Bill Madsen. Pat Wieland, the Associate Director of Antioch's Marriage and Family Master's Program, is also a brilliant teacher of Narrative and Just Therapy ideas and practices.

Although Antioch is quite a progressive institution, we are not the only teaching center to have been swept up in the Narrative and Just Therapy wave. Many other New England graduate schools, training sites, agencies, clinics, etc., have Narrative affiliations. A star student from our department was delighted to learn in her interview for internship training that one of the most prestigious hospitals (previously quite traditional—read 'dull

and constricted'), now has strong Narrative proponents who make this site highly desirable to students like her.

After this introduction, perhaps it will not surprise you to hear that in my opinion, one of the 'Big Ideas of the Moment' in US family therapy is the shift from Psychotherapist-in-the-office to Psychotherapist-in-the-community. Whether I see this as the influence of progressive thinking or of Managed Care, I am interested in how this new arena is being developed. I see evidence of the shift in my local community and on the national scene. From the position of 'local clinical scientist'—observing but also part of that which I observe—I cheerfully note the shift towards the community and away from the alleged Ivory Tower (our US metaphor—and perhaps yours?—for Academia). Our students increasingly want to be trained in skills and constructs that allow them more practical, direct, useful access to their clients. They are more likely these days to think of those they serve as 'consumers' rather than 'patients' or 'clients'. They are comfortable with the many family therapy approaches that encourage the family to view themselves as 'expert' and offer briefer models of intervention that fit with the demands of the current Managed Care, insurance-dominated market place.

Speaking of Managed Care, I must admit that I don't know if this phenomenon has affected your world yet as it has mine. If it has, you need no explanation. If not, in brief, the world of managed care has moved health care out of the public sector and private practice domain into a world where the insurance company reigns as Director, Supervisor, Boss, Supreme Being ... So it is impossible to practise family therapy, train practitioners, or develop new theories and practice models without being influenced by this radical shift. What this means in more concrete terms is the privileging of brief interventions, outcome research, measurable change, and viewing the client/consumer as the expert in defining and fixing the presenting problem. This is both good news and bad news, from my point of view.

The good news is that the client is less likely to be pathologized by the professional system and is more likely to be given useful skills to address a broad spectrum of problems. The therapist is dethroned from his/her expert position and held accountable for implementing concrete, measurable changes in the client's current life. The not-so-good news is that therapy tends to be very symptom-based and often overlooks deeper issues that pertain to long-standing pain, power imbalances, and larger cultural constraints such as sexism, racism and poverty. As a practitioner and teacher devoted to serving victims of violence, the conditions of sexism, power abuses, and deep-seated pain seem to me like pretty big areas to ignore.

In shifting the therapist out of the office and the Ivory Tower and into more direct alliances with consumers, the values of the more progressive Narrative Therapy and Just Therapy practitioners and of the Managed Care legions seem, curiously, to combine. To give you some examples of this strange confluence, let me review some of the workshops and articles featured in several recent journals, flyers and pamphlets.

In the most recent issue of the *Family Therapy Networker*, a very widely-circulated bimonthly magazine read by a broad spectrum of helping professionals, there were a cluster of articles suggesting that we need to look beyond Managed Care and pharmaceutical solutions if we want to relieve the suffering of families and individuals suffering from depression. One article in this group titled 'The Smiling Thief', by Mark Collins, offers the headline 'managed care can make being depressed even more depressing'. Collins says:

Thanks to the advances in the diagnosis and treatment of mental illness, depression sufferers no longer have to worry about spending years in an insane asylum. Instead, they can worry about a new insanity called 'managed care', an insurance practice that reduces both the cost and your chances of being cured.

The feature article, an interview with clinical psychologist Mary Pipher, author of *Reviving Ophelia*, urges therapists to reconsider the moral and social implications of their work. She suggests that we work to create community in the battle against privatisation and alienation. These articles seem to be moving in the same direction as the ideas many of us North Americans have applauded when voiced by Michael and Cheryl White and the Just Therapy team: building community, honouring the resources of the consumer, challenging the position of the power-wielding professional.

Yet there is an equal weight given to the voices of the 'quick fix' allies of Managed Care, if you look at the ads in this same issue of the magazine. Page after page features ads for recipe-style treatment programs, manuals and business-focused invitations to frightened therapists. Here's an example:

Meet the demands of today's market with brief, effective therapy ... *TFT can bypass all that tedious therapeutic business of joining, empathy, history-taking, reprocessing and the like*, [emphasis mine] and zero in on the problem immediately at hand. With 10 minute treatments not at all unusual ...

'From couch to corporation ... Becoming a successful corporate therapist,' promises another ad for a two-day seminar. And there are a host of other examples. Brief, technique-centred treatment models are clearly the trend among the advertisers. Even the most recent catalogue from a usually progressive press with a strong commitment to issues of social justice features books on its cover page that offer 'four programs that work and why' or 'thirty guides for imperfect parents ... good, commonsense practical guidelines.'

In today's mail I receive an ad for an 'indispensable resource ... over 1,000 carefully crafted prewritten treatment plan components ... a handy workbook format for recording custom treatment planning options'. And in a newsletter I receive regularly (certainly not through any choice of mine) I read the advice of one allegedly successful practitioner who hands out three business cards to each client: 'one is for their appointment, one to keep at their office or their pocketbook, and one to give to a friend'. So it seems clear that while some family therapists are envisioning a return to community activism and empowerment of the client, others are scrambling to market themselves, reduce treatment to custom designed steps and manuals, and recreate themselves in a corporate image.

Where these two seemingly divergent paths overlap, it seems, is at the place honouring the relative good health and resources of the client/consumer. Both camps would probably agree that most people have the potential to heal from their pain by drawing more on the resources of their natural communities and relying less on the expertise of the professional helper. The differences between the motives, philosophies, and values, are of course myriad—as are the means to the end. Perhaps that would be the place to begin in my next column.