

RESEARCH INTO PRACTICE/PRACTICE INTO RESEARCH

One compelling reason that family therapy has failed to gain as much recognition as it deserves in academic settings is the widespread perception that its efficacy has yet to be convincingly demonstrated by research. Family therapy literature has itself acknowledged the lack of good empirical studies (while also acknowledging that a systemic view does not lend itself easily to testing via 'hard' methodological paradigms). Paradoxically, however, the practice of family therapy has increasingly gained acceptance at institutional level. Specialist family therapy agencies, specialist training programs, and the creation of 'dedicated' positions in mental health services are all indications of this acceptance. While the early evangelical zeal may have gone, family therapy has established itself among other treatment modalities, and claimed a significant place in programs set up to train counsellors and therapists.

Simultaneously, as a result of unrelated developments in higher education, there has been a rapid increase in research-oriented post-graduate programs open to family therapists or those in related fields. Established professional disciplines like psychology and social work have been joined by health studies, youth studies, and others. As universities compete for graduate student dollars, new programs such as professional doctorates are being set up which, though coursework-based, still require substantial dissertations. The result is that an increasing number of family therapists are in a position where they must conduct empirical research projects as part of gaining a higher qualification.

Many criticisms might be levelled at this state of affairs. Experienced clinicians may be disinclined to undertake research, yet required to do so, leading to lacklustre performance. Other clinicians may be enthusiastic to undertake research, yet find themselves unable to focus their work on the areas of greatest pragmatic usefulness to them and to others in the field, because their intended topics do not lend themselves to the interests or competencies of their supervisors.

Moreover, the requirements of academic writing often lead students to be socialised into a painfully obsessive, impersonal, reference-cluttered style which tends to obscure rather than highlight the relevance and usefulness of their findings. Pressure to turn theses into publications (particularly with supervisors as ancillary authors) in turn leads to a proliferation of stiffly formal material submitted to professional journals, where the novice authors (who may be excellent practitioners) fail to realise the difference between what is required in a thesis (where every t must be crossed and every i dotted) and what is more suited to an article, which needs to develop a single main line of thought, supported thoroughly (but not exhaustively) by references and good quality empirical data.

Despite these problems, the proliferation of research projects potentially offers real benefits to the

theory and practice of family therapy. Here, surely, is a chance to test out, albeit often on a limited scale, some of the practices and beliefs which have guided family therapy for many years now. Here is a chance to devise innovative research projects which, while acceptable to academic supervisors, nevertheless produce results of real relevance to those in the field. But the possibilities can reach even further than this.

Why shouldn't *practitioners* actually suggest topics and issues for research? Why shouldn't existing clinical innovations be rigorously tested by research students? Jeff Young and his colleagues' study of reflecting teams in Vol. 18 No. 1 points the way towards the kind of evaluative study that could be done, ranging all the way from small scale qualitative investigations to larger scale quantitative studies (which, if well done, need not be either boring or irrelevant to practice).

Our hope is that this page will act as a clearing house, showing practitioners what some research students are currently working on, while simultaneously showing potential researchers some clinical practices and innovations that might be worth researching. We will supply the material for the first couple of issues ourselves, purely on the basis of projects already known to us. We trust that readers will supply brief notices for inclusion in future issues. Projects and reports should be of some relevance to family therapy, should be kept to around 100 words, and should clearly indicate a contact name and details for enquiries. Use your report to highlight what you believe to be the most interesting features of your research/clinical innovation, the features that others would most want to know about. If your research is well advanced, you may want to indicate tentative conclusions. Should we be overwhelmed with contributions, we shall select for publication those with the broadest clinical relevance and interest to our readership. Two examples follow:

A Laughter Room in a Rural Hospital

Ilene Castle and Christine May presented a paper at the International Humour Conference held at UNSW last year, describing how a 'laughter room' was set up at Moruya District Hospital. 'The establishment of a laughter facility in a small rural hospital does not happen in the time span of a normal pregnancy. As the personnel involved in our exercise have found, it takes time and strong persuasion to shift attitudes and gain support for innovations in health'. A full evaluation report on the trial of the Laughter Room is available from Health Promotions Officer, Moruya District Hospital, PO Box 108, Moruya 2537 2 \$10 (incl postage).

Individual Perceptions of Being Human

Contributed by Carole Kirwood, Department of Health Studies, University of New England, email: ckirwood@metz.une.edu.au

How do culture, politics and past experience affect perceptions and experiences of health care? The experiences of Aboriginal women during midlife have provided a case study for understanding how health professionals and clients define Aboriginality; how 'cultural identity' determines that which is supposed to be 'culturally sensitive' care; how Aboriginal-specific services articulate with mainstream services in a 'culturally appropriate' manner; and how decision making is affected by socioeconomic disadvantages and levels of knowledge. Preliminary findings suggest that what is considered good health care by an individual from a minority group is by no means congruent with the political ideal, either Aboriginal or governmental. It appears that good communication, being taken seriously and treated with respect far outweigh any other considerations.

On Supervising your Supervisor

It is true that many experienced clinicians are ill prepared for research, and thus play directly into the hands of rigid, patronising supervisors. However, it is not so simple. Universities themselves are much to blame for the situation. There is a massive hiatus between undergraduate and post graduate studies, in standards, in level of conceptual challenge, and in requirements for original thinking. The Labor push to accept a far broader range of students into university has been seriously compromised by the amalgamations and forced 'competition' which began under the Hawke-Keating government and by the cuts and squeezes now endemic under a conservative administration. Faced with the imperative, 'do more with less—but don't dare fail anyone because the university needs the dollars', university staff have lowered standards, cut tutorial instruction, reinstated examinations, and offered less feedback on assignments. Faced with the imperative, 'accept—and graduate—more fee paying postgraduates at all costs', the same staff have taken into Masters programs students who would once have had difficulty getting into a final honours year, giving them credit for up to half their degree for 'prior learning' (very broadly defined) and then shaken their heads over their lack of understanding of basic research and writing principles. When such students come to dissertation work, they may not even have been adequately trained in how to write an acceptable level of lucid, formal English, let alone how to conduct a reasoned argument, survey existing literature in a meaningful way, or develop a researchable hypothesis. The coursework that is supposed to develop and support such competencies has either been skipped or skimmed. Even worse, students entering research-oriented programs may not even be driven by genuine curiosity: they may not, in other words, be researchers by temperament. No wonder such students have trouble 'formulating a research question', and deciding on an appropriate methodology!

Let us assume, however, that our hypothetical dissertation students are in fact experienced, competent

clinicians who have a genuine desire to explore beyond the limits of practice wisdom and to rethink what they learned as young social workers, psychologists, nurses, or whatever, five, ten or fifteen years before. How can they *assist their supervisors* to supervise them in a manner that is intellectually challenging, yet also respectful of practice wisdom? To begin with, our budding research students should invite their supervisors to view their own clinical work, and that of colleagues. Some supervisors of family therapists have only the most basic understanding of what counselling is, let alone what family therapy entails. Tactfully developing an appropriate level of understanding and respect for it in a supervisor is the student's first responsibility! Put it to a supervisor that viewing a relevant series of sessions (with client permission, of course) is the clinical equivalent of 'basic reading'.

Secondly, students should come to their research project understanding not only the intellectual justification for pursuing a particular topic, but also why they are personally drawn to that topic—something that few supervisors will realise the importance of, but which can make a great deal of difference to success or failure in research. It is a truism that we often do not realise fully why we are driven to know about something until after our study is completed, but at least for those of us whose business is self-knowledge, it ought to be possible to have at least an inkling. Supervisors talk of the need to be 'passionate about one's topic', and rightly so, for only passion will keep us going through the years of hard work and tedium that are often involved in research; but passion can be a double-edged thing, and if doing research on something is simply a substitute for resolving real conflicts in our own work or personal lives, then we may do better to acknowledge that therapy is what we need, not research. Our supervisors may not want to know about that part of it, but they do need to know that all intellectual projects have dimensions of personal meaning for the individuals who undertake them, or they will fail to offer us the full understanding to which we are entitled.

Finally, we can help our supervisors, and ourselves, by doing some preliminary thinking and writing of our own on the topic or topics that we are drawn to, so as to explore our own thinking, and our own experience, *before* plunging into a lengthy literature review. This way of proceeding is, of course, contrary to what many supervisors counsel, but it has much to recommend it. Students who reflect critically on their clinical experience in relation to a given issue or problem are tapping their own creativity before stifling it under a daunting blanket of received opinion and 'expert' knowledge. Much of this preliminary writing may later need to be abandoned, but it will not have been wasted, even if the research ultimately develops in a different direction. 'Trust the process' is a principle that supervisors ought to understand better, and students who are secure in their awareness of their own intellectual and emotional process can help them. A literature review that arises out of a student's own ability to identify gaps in personal

knowledge, and hence (surprisingly often) collective knowledge, is likely to be a far better and more meaningful literature review than one that arises out of a dogged slog through everything the CD-ROM search can turn up on 'reflecting teams', 'gender and power in therapy', or 'counselling and cancer patients'.

Discourse Analysis

Sometimes it is stimulating to look outside family therapy, to see what research is being done on us by others! An example is work by Karin Aronsson and Ann-Christin Cederborg, 1996, *Coming of Age in Family Therapy Talk: Perspective Setting in Multiparty Problem Formulations*, *Discourse Processes*, 21: 191–212. Apparently unimpeded by any belief system about the *purposes* for which family therapists intervene in the way they do, these discourse analysts study what they see actually happening in sessions. They observe (193) that 'the therapist could be seen as an important agent in perspective setting' ['ways of making people see the viewpoints of other actors']. They find, e.g.:

part of the role of the therapist seems to be to identify underlying divergencies in perspective taking without aligning too much with any of the opposing parties. A joking mode seems to be one of the therapist's ways of facilitating such a perspective setting (208).

The authors briefly outline the discourse analysis method, and from their list of references, it is clear that there are others like them, studying the discourse of therapy and family therapy without themselves being therapists.

Birth Order Rules, OK?

By now, readers of this *Journal* will have become aware of the existence of Frank Sulloway's *Born to Rebel*:

Birth Order, Family Dynamics and Creative Lives (New York, Pantheon Books, London, Little, Brown, 1996), as a result of a long article in *The New Yorker* last year, and recent TV interviews. Sulloway has spent the better part of two decades since his last book (*Freud, Biologist of the Mind*) collecting and analysing a massive body of data on the relationship between birth order and openness to innovation (as manifested especially in scientific innovation). His conclusion, bound to be controversial, is to confirm that birth order does matter, although not quite in the highly specific ways that some earlier writers have claimed. For Sulloway, the key distinction is between firstborns and laterborns, although towards the end of his book he does begin to distinguish a specific profile for youngests. Drawing on a large biographical database, he concludes that laterborns are significantly more likely to innovate (both scientifically and in other related ways) than firstborns, and that laterborns will also tend to support radical movements and ideologies to a significantly greater extent. Sulloway's analysis of the birth-order positions of the members of the French Revolutionary Convention of 1793 is particularly striking: a far higher proportion of the deputies were laterborns than would have been expected, and yet of the twelve who comprised the executive Committee of Public Safety (responsible for the Terror), no less than seven were *firstborns*. Sulloway's analysis of this, and many other historical phenomena, is distinguished by extreme care in winnowing out the influence of possible confounding variables, by statistical tables that are easy to read and well explained, and above all, by a writing style that makes 600 pages of text and supporting material a pleasure to read. Here is clear proof that psychology can, if it chooses, address 'big' issues, and, deprived of 'clean', laboratory data, still produce work that is rigorous, readable and provocative. The *ANZJFT* will review *Born to Rebel* in more detail in due course.