

Chapter 2

Community-Minded Family Therapy

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Introduction

Family therapy often focuses on the intra-family space as the locus of change to help families improve their lives. This may unfortunately convey to the family that the troubles they are facing are caused by what they are doing with one another and therefore it is they, and they alone, who need to make adjustments. We believe that living conditions and societal beliefs within which families live and work contribute in direct and indirect ways to the troubles they experience within their family interactions. When clients find ways to successfully adjust themselves to the conditions and societal discourses of their life worlds, those conditions and discourses remain unexamined as contributors to family troubles and may inadvertently be further re-inscribed as legitimate and “the way it is.” In our view, those extra-familial influences should be recognized for the potentially deleterious impacts they may have and in addition, should become our focus to (a) better understand the ways families’ lives and decision-making are influenced by the discourses they make their own, and (b) how the discourses might be altered by the families we see in therapy (Waldegrave 2009). Considering this level of mutual influence between families and the larger conditions and scripts they live by is a way of bringing the community (the extra-familial, the societal discourses) into the therapy room, a practice we call *Community-Minded Family Therapy*. By practicing *Community-Minded Family Therapy*, we approach change on two fronts: first, in the service of helping families live more harmoniously and second, launching

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initiatives by families and therapists to challenge the contextual factors and discourses that plague us within our communities.

Our Context

We are White, upper middle class, aged 60+ Americans living in an upwardly mobile city in Alberta, Canada, and a married couple working in the same academic setting, the University of Calgary. For the majority of our higher education academic careers, we have directed a marriage and family therapy (MFT) program within a school of social work. We have taught research and practice classes, as well as having our own caseloads of client families. As a result of these diverse activities in two different fields (social work and MFT), we found ourselves feeling quite divided, split, and emotionally harried; we recognized that the discourses surrounding professional specialties created a separateness (as demonstrated in most curricula) that was prominent in the ways that these areas were conceptualized, taught, and practiced. Students and academicians were choosing “camps” of what to believe! While we had heard some encouraging talk of integrating or bridging disciplines, we were not seeing this operationalized and we decided that focusing on “walking the talk” of bridging social work with MFT and research with practice would help us manage all our work. Therefore, we began experimenting with ways in which we could integrate across the curriculum (see Wulff and St. George, *Researcher as Practitioner*, 2016), our own research programs, and our clinical practices (Wulff and St. George 2014). We constantly asked ourselves, “How is each activity that we are investing in serving our other tasks/goals?” For example, how is the research we are doing and teaching serving practice and vice versa, and especially how can social work and MFT practices come together into an integrated whole? From this desire to connect our work into a coherent whole, we developed *Community-Minded Family Therapy* as a way to bring the extra-familial influences into the focus of therapeutic conversations.

Assumptions Grounding *Community-Minded Family Therapy*

We begin with our guiding assumptions that ground our thinking in this form of practice:

1. Practice decisions and actions impact many other systems beyond the family. Bateson (1972) reminds us of the interconnectedness of all systems (the ripple effect). As members of a common community, the efforts we put forward to change/improve a condition, policy, or practice impact everyone in that community, including us. Therapy is considered to be a part of the community in

which it arises, serving clients *and* the larger community by helping remediate troubles experienced by some. Therapy could be understood as a community initiative to reduce/resolve conflict and to increase harmony (Margolin 1997). This larger macrofunction of therapy is often upstaged by the emphasis on serving the family's wants and needs. Recognition of both functions of therapy broadens our understanding of how therapy works in society, revealing multiple levels of expectations. In *Community-Minded Family Therapy*, there is an overt recognition of how macro- and micro-concerns are inter-related.

2. Persons who directly experience problematic conditions in their daily lives are in the ideal position to understand those conditions and to form actions to change them. Persons a "step away" from the pain or frustration of a problematic situation (e.g., therapists) can offer insights from their perspectives, but the direct frontline experience of a problem is a position like no other. Person(s) who have the most to gain (or lose) rightfully should become the principal actors in what happens.
3. Broad-based understandings derived from multiple stakeholders equip actors with an appreciation of complex understandings that serve to guide designing and executing deliberate actions to alter societal conditions that negatively impact persons in that community/society. Respecting the client's centrality to the trouble, the inclusion of other viewpoints-of-concern can provide a breadth of ideas that clients can benefit from in deciding how to go forward. This broad and inclusionary approach validates the sense of relationality and community that we inhabit, supporting community initiatives in situations that we usually consider to be individual.
4. Family therapists are in a unique position to witness people struggling with dilemmas that are complex and which derive from decisions and practices emanating from systems, people, and ideologies. Therefore, we are obligated to uphold, honor, address, challenge, and extend the complexities by including and working with contradictions, multiplicities, and diversities. Problems that families face are neither simple nor singular so our work with families on change initiatives needs to hold those complexities rather than trying to chop up the ecology (Bateson 1972) by focusing only on parts/fragments, which tends to have the undesirable effect of blaming and pathologizing individuals.

Community-Minded Family Therapy

Community-Minded Family Therapy is not a brand new approach. Throughout the history of family therapy, practitioners have developed therapeutic practices that included extended families, significant others, and other families facing similar troubles (Laqueur 1976; Seikkula and Arnkil 2006; Seikkula and Olson 2003; Speck and Attneave 1973; Speck and Speck 1979; Waldegrave 1990, 2000, 2009). Narrative therapy (Denborough 2008; C. White 2007; M. White 2007) explores the

myriad ways that dominant discourses shape peoples' lives, oftentimes leading them into distress without the awareness of the influence of those discourses. *Community-Minded Family Therapy* is a term we use to remind ourselves, and to teach our students, to keep the wider social context of the families we serve in the forefront of our minds. This may involve physically including other persons in the therapy, but short of that, the awareness of systemic interconnectedness of all those persons involved in the lives of our clients should be front-and-center. There are many influences and influencers in the lives of our families who come for therapy and we should be perpetually curious about how they play out in the lives of our families, their difficulties, and their happiness.

One way we do this is by listening for and considering the discourses that we see as part of the daily rules of living or scripts that our clients have "taken up" and taken on as their own ways of living for achieving success. Someone once said, "Fish are the last to understand water," and we imagine the societal discourses or scripts we enact every day to be such a significant part of our daily existence that we do not notice them—they are assumed. Fish exist in a world of water that is necessary for their survival and we humans live within material worlds and discourses that guide our every move to such a degree that we think those aspects of our lives are "givens" or our own ideas. But when we suddenly have trouble breathing, or do not have the musculature to walk, or have our cherished beliefs or values challenged, we have the opportunity to see and experience how life might be with their absence. Societal discourses that we use to tell us what to perceive and how to move in the world are not hard-wired into us—we grow into them gradually and embrace them into the fabric of our lives (C. White 2007; M. White 2007).

As with all assumptions, the more we recognize that our understandings and worlds are shaped in relation to discourses (we literally "see through them"), the more we can embrace the possibilities that are present. When we began seeing the possibilities of the assumptions of *Community-Minded Family Therapy* for family therapy practice, we noticed how oftentimes helpers inadvertently encourage people to adjust to or accept their life conditions and circumstances rather than finding ways to challenge what was stifling them. For example, many practitioners still speak of commonsense solutions, coping, managing, and waiting. Perhaps these words and what they imply can lead to effective actions to improve people's lives, but in most contexts in which families are working hard to come together and live in their preferred ways, these actions could just as easily be referred to "maintaining the status quo"—encouraging people to become satisfied or content with conditions that are not favorable. For example, how many times have we, as therapists, helped people to cope with living in inadequate housing and dangerous living conditions, with trying to budget on insufficient funds to feed a family with healthy foods, or deal silently with discriminations at school or the workplace? How many times have those conversations occurred without a careful reflection on how they may not be in the client's overall or long-term best interest? Can we see that our actions to promote coping might be implicated in actually maintaining the problem or distress? Could we imagine other therapeutic options that not only benefit the families who come to

us, but have the potential to challenge those unhealthful conditions or circumstances that hold a role in the troubles for which our client families seek help?

Another factor that has contributed to adding *community-mindedness* to our family therapy practice was watching clients being accused of sabotaging their own success. Frequently, families are trying to address the troubles from the inside only while the problem at least, in part, stems from extra-familial influences. In many of these situations, the families experience failure in changing their lives and this often leads to self-blaming or criticism from others for lacking sufficient will or ability to improve the circumstances of their lives; we think this is an injustice. It is bad enough to misplace accountability for a problem, but to compound that by blaming the person(s) suffering seems particularly cruel.

The following story illustrates how dominant societal discourses (like entitlement, meaning some persons are automatically privileged through birth or being a member of a dominant cultural group, while others are not) intrude into persons' daily lives and decisions. Women in a transitional housing project failed to complete their secondary studies or take their driving tests, but organized and advocated for themselves when the local markets discontinued giving out free holiday food baskets. It appeared to us that in order to understand this in a way that did not blame or view the women as making poor choices and decisions (others before had viewed them this way), we would need to look for an explanation that would open ways to reveal how these behaviors "make sense." One of these alternative understandings could be to look at the social expectations held by people regarding what they are entitled to or could reasonably expect, rather than just focus on the missed opportunities for services or the complaining about something seemingly trivial like free holiday food. If one looked at the discourses-in-motion, the women in this example may have been rallying around their perceived "right" to have holiday food while they were less convinced that they were entitled to education. Conceptualizing families in pain as solely responsible for their own trouble flows out of a belief that we are all free-standing individuals who make our own ways in life. This individualistic perspective fuels accountability and responsibility, but it also shields us from understanding how influential others and other ideas are in our lives (Wulff et al. 2011).

We are not only talking about serving those deemed poor and/or disenfranchised. Our goal was to bring attention to societal discourses within our therapeutic work (Chenfeng and Galick 2015) with all families as well as attending to the levels of solutions or locations of emphasis and potential that we create and develop with our families. Introducing the idea of societal discourses as implicated in the lives of families in trouble requires a careful practical presentation of the use of everyday language to link societal discourses with trouble. Examining societal discourses is not just an intellectual argument; we believe there are ways to discuss these influences that anyone could appreciate.

We begin with families by explaining what we see discourses to be and how we see them as influential and implicated in family troubles. For example, if we detect a discourse that tends to valorize defending traditional practices (e.g., "this is the way our families have always done this," "we need to stay true to the ways we

learned,” “I learned this way and I am okay”), we might ask, “Is this way of relating something that you have seen before in other families or in your families-of-origin?” Or if we hear talk of wanting to do things in order to be accepted (e.g., “all the cool kids have phones,” “I will be the laughing stock if I can’t go,” “I really do not want to have the other parents in the car pool to know we have this trouble”) as an overarching theme, we could ask, “How does the trouble you describe show your desire to belong and to be accepted?” (Questions adapted from St. George et al. 2015b). We acknowledge that including this talk in therapy sessions may appear a bit unconventional as compared to traditional psychotherapy, but based upon our supporting premises, we are looking for ways to raise alternative explanations about the troubles families face. To do this may require stepping out of customary therapeutic conversation and questions and into new conversations that specifically discuss the larger systems and discourses.

Considering that client families in trouble are experiencing difficulties that other families not in therapy could more readily understand suggests that external forces/pressures are pervasive in our social worlds. This raises the possibility that families might very productively join together in therapy (or outside of therapy) with other families. Their collective understanding of their lives and their experiences may add new ideas to their ways of going forward. Our point here is that keeping families apart in their own individual therapy sessions when they have a great deal in common with each other may be limiting the progress that could be made; if we made it possible for these families to connect in joint therapeutic sessions (while still honoring families’ preferences for confidentiality/privacy and individual family therapy if they wished), we would open new avenues for therapy to make a difference.

Another point we would like to emphasize is that trying to produce change at a family level only without examining how community or societal levels are involved in the family’s trouble is not only likely to be ineffective, it is unfair and socially unjust (Almeida 2013; Parker and McDowell, in press; Richardson and Wade 2013; Waldegrave 2009). Repeating an earlier message, it seems to place blame or responsibility (perhaps inadvertently) on the family as if they were the source of the problem and its continuance. Alternatively, if we can examine those societal ideas that they have taken on as their rules for living and as their measures for success, we can develop a variety of possibilities for new conversations and paths toward change inside and outside of families that fit with a contextual understanding of the troubles that the family is experiencing. The larger systems and discourses now go under the therapeutic gaze.

We would also like to emphasize that *Community-Minded Family Therapy* is bi-directional, that is, not only do we assist families in their efforts to improve their lives, but we also bring the community into therapy by examining how the societal discourses work their way into family behaviors and by inviting others into therapy as supportive partners to the family. The potential exists that what happens in therapy can ripple out into the community by the involvement of significant others as well as by how family members take the learnings they develop through therapy into their “other” lives as students, employees, neighbors, or community members.

The boundary between “inside” therapy and “outside” therapy becomes more permeable—therapy becomes more overtly integrated and available within the community. This may lessen the stigma associated with therapy that may come from the secrecy surrounding it.

Bringing the Community into Therapy

What has been done. Others have written about expanding the therapeutic system by inviting “outsiders” to therapy (Denborough 2008; Dulwich Centre 1999; Seikkula and Arnkil 2006; Wulff 1994). These practitioners have included extended family members, or used reflecting teams and witnessing practices, or brought in supportive networks either in person or by distance communications. Often families are reticent to bring in others because they see their problems as private and feel a sense of shame should others know of their distress. When using one-way mirrors, we demystify the situation by having observers or reflectors (often our supervisees) come into the room with the family to share their immediate reactions, ideas, solutions, doubts, and what they are noticing. When we see families’ problems as common to those that many families experience, other families and not just professionals can be effectively used as reflectors or contributors to assist fellow families respond to troubling life circumstances. This expansion of the therapeutic system encourages clients to reach out to others rather than becoming isolative in their distress (Wulff and St. George 2011).

Calling upon former clients. Another way of bringing the community into therapy is by asking families who have “graduated” from therapy to join us to offer support and stories of change (White 2007a, b). The inclusion of outsiders is not unlike what happens in group therapy except the conversations are between two families (rather than groups of individuals) as they recount their experiences, worries, fears, and hopes and listen to the others. We ask families as they are getting ready to end therapy if they would be interested in being called upon to help other families with similar dilemmas by joining in the conversation as a “consultant.” Many say yes because they would like to be of help to others and they feel validated by being invited to share their wisdom. If current families are amenable to expanding the system in this way, we bring the families together in the same room. They are interviewed together: we ask for their theories of the difficulties they face or have faced, we ask about the typical kind of advice they are given or have been given, we ask about small successes and glimmers of light, we ask about preferred futures, and we ask about being helped and being helpers at the same time. As you can see, the particulars about the troubled families’ lives that bring them to therapy are usually not the centerpiece of these meetings, though they may be revealed in the course of the conversation. Primarily we are looking for the conversation to focus on ways to go forward by using the commonalities between families and their experiences very similar to Almeida’s work (Almeida and Durkin 1999) through the Cultural Context Model.

We have written elsewhere about the possible unfortunate consequences of confidentiality policies and practices that create a sense of isolation around families which can prevent support from being offered and accepted (Wulff et al. 2011). While we are not advocating for the dismissal of confidentiality practices, we are taking a close look at the ways in which confidentiality and privacy cloister people in their pain seriously hindering their abilities to move on successfully. Confidentiality is a therapeutic practice that is typically unreflectively applied and deserves close scrutiny for its tendency to influence therapists to keep clients apart, and in a sense, encouraging isolation. Ironically, isolation may be the primary culprit in keeping clients from being able to move forward into new and improved patterns of interacting.

Collegial meetings to generate new ideas. Many of our workplaces are currently experiencing shortages in terms of funding, personnel, supervision, time for reflection, and peer consultation and support. “Accountability” practices have stressed fidelity to certain protocols/models and a concentration on reaching pre-set target goals for clients which often leave practitioners feeling tired, constrained, and pessimistic about producing viable and sustainable change with their clients. To counter this increasingly rapid closure of creative space, we have initiated bi-monthly meetings held in our home on Saturday mornings inviting practitioners across the helping professions, from all levels of expertise and types of service providers. We made the focus of these meetings talk about infusing social justice into our therapeutic work. We operate at two levels here. The first is learning how to listen for justice talk that our clients might offer, ways in which we take, decline, or miss the invitation along with instances in which our workplace contexts are implicated in injustices, and secondly, proposing smaller changes we might introduce. We have coffee and conversation; the conversation is generated by questions or stories that one participant may bring forward, usually coming from a recent experience or reflection on something observed. The value of these meetings is evidenced by the attendance—on the weekend, after hours, and unpaid. To use one’s time to do this is a testimony to the importance of these gatherings.

For example, a recent Saturday morning meeting conversation centered on agency meetings when typically all service providers come together to discuss a client’s progress and future plans. As we complained about the usual disciplinary hierarchies that are evident in these meetings and the type of languaging used, we imagined what it might be like if questions were posed to the group as a whole rather than focusing on individual therapeutic reports from individual practitioners (e.g., a psychologist’s report on testing, a physician’s report on medical conditions, a psychiatrist’s report on psychological makeup, a social worker’s report on community supports and services). While these are useful aspects to discuss, they are effectively mentioned in written reports—conjoint professional meetings could attend to the relationships between the workers and the family. Some of the alternative questions we generated included,

1. What ideas have been stimulated in you after reading the various professional reports about this client?

2. Is this client moving in a hopeful direction? Are we contributing to this success? If so, how (specifically)? If not, what are we doing that inhibits progress?
3. What questions linger or what new questions have emerged that you would like to discuss with the other professionals working with this client/family?
4. Which of our efforts hold the most promise in the short term? Which have the greatest chance to be durable/sustainable?

Another example that the group discussed has to do with the situation in which a client is making progress but not fast enough in the allotted time frame. This usually results in a discontinuation of services temporarily and then a new start-up in the agency or in another agency. In addition to lobbying for the client to continue needed services, the therapist could see this as an opportunity to research more thoroughly how services failed to reach the desired goal. This could be done by contacting other professionals and other agencies to see if this problem has some pattern to it (e.g., occurs with certain types of clients, at certain times of the year, in conjunction with some types of services) (St. George et al. 2015a; Wulff and St. George 2014). This project would look at a myriad of factors that could have been involved in the service failure—including systemic issues within the agency or the helping network as well as client factors. This illustrates how “failed” work with clients could launch efforts to more closely examine our practices and potentially improve them.

Working transdisciplinarily. Our first attempt at working transdisciplinarily occurred at the University of Louisville where our students were graduating with a Master’s degree in social work *and* a credential in MFT (see Wulff and St. George, *Researcher as Practitioner: Practitioner as Researcher*, 2016). We worked to create transdisciplinary professionals who would conceptualize their work with families through their chosen “micro-” approaches while simultaneously factoring in the larger context and social justice overlay they studied in their social work courses. We worked hard to have their program become a practical demonstration of how two helping disciplines can be strengthened through mutual influence. To accomplish this, we would constantly ask:

- “What are all the ways we can imagine how this family’s problems and unsatisfying dynamics make sense?”
- “Throughout everything, what is this family working to try to accomplish?”
- “What are the invisible forces blocking their movement toward what they are trying to accomplish?”

When the accrediting bodies from both social work and MFT came to interview our students, each group asked our students whether they saw themselves as social workers *or* MFTs. They answered: “We see that question as asking us to choose one set of skills over another, not appreciating how we have blended them into a set of practices that enhance both sets. We cannot *not* see the larger context of the family’s dynamics and the multiplicity of forces (macro and micro) that impact the troubles our client families face.” We think the idea of merging disciplines in the helping fields is a viable and important path to pursue. Our professional tendencies to specialize into discrete activities that are not integrated or only loosely

interconnected pose significant problems for clients who must manage the integration for these multiple services—they must create the sense of coherence of all these helping initiatives.

“As if.” One more way of bringing the community into therapy is through “as if” thinking and exercises (Anderson 1997; St. George 1996). “As if” thinking usually involves supervision or large group consultation regarding a therapeutic situation. A therapist presents a case situation to a listening group who has been divided into various listening positions to correspond with the different actors in the case situation (e.g., client, relative, spouse, co-worker, therapist, neighbor, teacher). In a given situation, one of the *as if* listeners might listen to the consultation conversation from the position of an exhausted mother, or a 13-year-old blind daughter, or a stepson who is engaging in reckless behaviors. Rather than listening from one’s home disciplinary position, each *as if* listener listens from a different specific position in the case situation, trying to fit into those “shoes” rather than from a professional posture.

When the story has been told, the therapist and supervisor listen to the reactions of the *as if* participants as they express what thoughts they had about the situation of interest, what they thought was perhaps a misunderstanding, or what could be thought about but not asked about. They offer some fresh unrehearsed and unscripted ideas for the therapist and supervisor to take into consideration for future conversations regarding this case. Of course, the *as if* reactions do not represent the “truth,” but they allow for much that is possible yet unspoken, to be spoken—a way of transforming one’s work and including social justice issues.

Creating and using teams. We like the idea and experience of using teams. However, this can be an expensive and time-consuming proposition. Therefore, we have developed an alternative if we cannot gather a team in the same room. The idea is based on the notion that we are all made up of multiple selves and hold many different ideas about those selves. We bring together the “multiple selves team” without cost or extra time. We have only begun this kind of thinking and are trying it with our students: We ask them to provide explanations of what is happening with a given client or client situation from their “inner” geographer, public policy analyst, accountant, manager, therapist, public citizen, investor, neighbor, dietician, medical provider, or educator. We have them role play sessions making observations and suggestions from these different *as if* positions. It works well when any of us find ourselves stuck with a family’s situation and need to find a way to think from some new vantage points. This is a good exercise to stretch our thinking and help us to avoid narrowing our approaches to families that can come from influential disciplinary training or repetitive professional experiences.

Bringing Therapy into the Community

We have some lovely examples from some international colleagues of moving therapy into the community that we have adapted to our context.

The Just Therapy Team. The Just Therapy Team from New Zealand has been an inspiration for us. The Just Therapy Team looks for patterns across their client families similar to our Research As Daily Practice strategy (St. George et al. 2015a; Wulff and St. George 2014). For example, they might notice that an increase in domestic violence is not solely part of an intra-family dynamic; that across these families there were common denominators such as job loss or insufficient housing. Their strategy for change is to work on multiple levels, including going to the community or government for assistance or modifications of policies. If there are not receptive ears at that level, they would consider going to the media to reach the public in order to reveal the conditions that are oppressing families in their communities. The point is not to expose their clients to scrutiny but rather the conditions of their lives that are implicated in their distress. The situations and circumstances revealed in the family's distress are the focus; the distress points us toward the conditions of concern that need addressing. It is similar to the "canary in the coal mine" idea—the toxic conditions in the coal mine are noticed and revealed through the canary's sensitivity to those conditions. The canaries (and our troubled families) serve as an early-warning system that something is amiss. To treat the canary (or the family) without addressing the conditions that led to the distress is doomed to failure, the canary (and the family) will simply be re-traumatized by those persistent conditions. This idea is a significant turn from seeing the client family as the locus of the trouble and the persons who need to change. Our attention is directed to work for change in the *conditions* that led to the families' suffering, not only the sufferers of those conditions—they deserve support but the toxic conditions need the reformation.

We all could do that, too, by studying the patterns across our client caseloads. We have done similar things in our own ways—not by going to the media, but by presenting findings from our Research As Daily Practice to other professionals, students, parent groups, and corporations. An illustration is that we have found that adolescents, especially those from financially stable families, may seem lazy, rebellious, apathetic, or selfish. However, upon a closer look we were able to see these adolescents from another vantage point. We noticed another common pattern—they were tired of (and distrustful of) being evaluated (positively *and* negatively) and were withdrawing from the constant pressure of being scrutinized by others, especially the adults in their lives. These messages about being evaluated alerted us to the many ways in which evaluative talk is frequently used in our therapy sessions and we actively wondered about how evaluative language was used in our questions about intended meanings, unintended consequences, accuracies and inaccuracies of the messages, and examination for what was desired.

By looking for the larger patterns in the lives of our client families, we can see how parents and children living together includes bringing in certain practices and patterns that we adopt from our peers and neighbors and how bringing these all together in our family living may increase the difficulties we have with one another. Looking for the sense that our interactions make allows us to stay in contact with each other and to wonder about how our intentions with one another can be

understood. These efforts are strikingly different from approaches that focus on pathological behaviors and intentions.

Community Therapy. We have learned about a second very impressive example of taking therapy to the community from our Brazilian colleague, Marilene Grandesso. She and her colleagues literally bring together community members to serve as helpers to one another. They do this in a community setting of any number of people, often hundreds and thousands at a time. They describe their work as responding “to various forms of social suffering and ‘psychic misery’” (Barreto and Grandesso 2010, p. 33) by honoring the people’s local knowledge alongside professional knowledge. Using a stage-like process in this large community meeting, small groups of people discuss the issue brought forward by sharing how they, too, are affected by the problem up for discussion (e.g., discriminations, isolation, fears) and ways to alleviate the problem. They describe this as a “shared space of suffering...a process of offering and sharing strategies of dealing with suffering...a public space approach which enable participants to become the doctors of their own experience” (p. 37).

We love this idea, but, in North America where privacy prevails, this becomes a challenging proposition. Perhaps we could do this on a smaller scale or by tailoring other ways of bringing the community into therapy. For example, maybe we could bring back some of the ideas of multiple family therapy, especially when we see our families suffering in similar ways. Instead of seeing one family in therapy, we could see several in one session (Wulff 1994). We could use mirrors or just have cross-family conversations, much the way that some of the domestic violence programs have multiple couples groups (Stith et al. 2011). To proceed down this path, we would emphasize building skills of group facilitation and diminish behaviors that uphold expert authority. These practices could drastically alter how we see therapy today.

Conversations about discourses. When we use the idea of discourses in therapeutic conversations (without specifically calling them “discourses”), we have found that our clients have routinely taken them beyond the therapy room and even outside of their families. We are often finding that talk about unfairnesses such as certain people in the family and the workplace having voice or taking up shared space disproportionately has filtered into their workplaces, circles of friends, and schools. They are becoming quiet activists for changing language and practices in their communities. To illustrate, in a therapy session, parents talked about the use, and effects, of “smart remarks” and sarcasm for “teaching” their children and began to see the connection of those behaviors to language practices in the media (e.g., television sitcoms, popular music, cartoons, and videogames). They became uncomfortable as they saw those behaviors as hurtful and not at all what they intended. This issue was no longer “funny”; they sensed that they had been duped into thinking that these smart remarks were harmless and perhaps even desirable. They also realized that everyone in their family was using this language convention with each other and even in their relationships outside of the home. Without fanfare or telling anyone else, they began to change their own language with their peers and noticed how their change could impact their relationships at school and work.

They were pleased with the development of more appreciative interactions and an understanding of how they could be influential in their relationships.

Working transdisciplinarily. We are advocates for taking therapy into the community in small daily ways—no initiatives, money, or strategic planning is necessary. We favor recruiting our fellow professionals into a different kind of talk, joining with community groups (Doherty et al. 2010). We often talk with groups in large corporations, small teams of cross-disciplinary therapists, staff who work at residential treatment centers, parent groups, and researchers who are planning qualitative inquiries. Our process follows the pattern of examining the language that is being used, the hopes people have for using such languaging, the success rate of accomplishing the hoped-for results, the effects of using that languaging, and then helping to refine the language to help achieve greater success. For example, a single, unemployed mother of eight children who was struggling with serious behavioral issues of some of her children, grinding poverty, and racial discord in her neighborhood was receiving social and mental health services that were organized around the goal of helping her become independent from services. Examining the multiple stressors in her life seemed to render the goal of helping her achieve independence a bit far-fetched. Another perspective might have approached this client from a position of locating ways to support her in coordinated and effective ways now and in the future. Using these alternative approaches challenges the preferred institutional patterns that oftentimes are designed mainly to benefit the institution. To coax an institution into seriously examining alternatives would require a presentation that demonstrates how the agency or institution would benefit by a new approach (this may be no small task).

A great deal of this alternative work is conducted outside of the bounds of regular service providers (e.g., established and funded agencies and programs). For example, we created a “public” practice on a pro bono basis inviting agency practitioners to allow us to work with those families who have seemed to exhaust or have become exhausted by the system. In our current setting, we are planning to pilot an “Impossible” Cases Clinic staffed by interdisciplinary teams of students and professional supervisors to act as consultants to pervasive and non-changing situations. The challenge posed by so-called impossible or intractable cases points toward the helping system to re-evaluate its approach, rather than criticize or demonize the client that it does not seem to be able to help (Duncan et al. 1997).

We have found that “opening up” therapy in the ways we have outlined in this chapter raises interesting questions about the designation and role of “expert.” Professional helpers have training in certain areas of understanding but without abiding connections within their community, professionals can become isolated (just as clients can) and miss out on the possibilities of collaboration. When communities of people (of all backgrounds) work together on projects, important actions can occur. We know this from experiences of seeing persons facing calamitous situations who are helped immediately and profoundly by their neighbors. Traditional therapy is also amenable to such processes and can be a part of a collective of resources of both professional and non-professional natures. Rather

than hide distress and make it a private affair, perhaps we need to think more seriously about the healing powers of communities and enlist them when families struggle.

Conclusion

Therapy is an activity that occurs within communities. It helps members of those communities to manage stress and trouble in their lives. It is not separated from communities—it becomes a service that occurs within communities. Seeing therapy as apart from communities and indeed a private affair misses the intimate connection that exists. Persons who go to therapy are seeking to live more successfully within their communities and communities are hoping that therapy works.

The relationship only begins there in our view. The possibilities of communities to support therapy and for therapy to influence community life are rich and varied. In this chapter, we have tried to direct our professional viewpoints toward greater acknowledgement of our role in community living and some potential avenues for more explicit connection.

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