

## Family therapy and the public sector

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Volume 16 · No. 1 · February 1994

### DEVELOPMENTS IN FAMILY THERAPY IN THE USA

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### Introduction

Historically, family therapy emerged as a model for changing the dysfunctional and growth-limiting aspects of intimate systems. As this model evolved, attempts were made to apply its theory and practices to both increasingly larger and more complex systems. In the public sector, enthusiasm and expectations for what family therapy could do often exceeded its grasp, leaving therapists, social service workers, and administrators discouraged and demoralized.

Several years ago, state government in Delaware undertook an ambitious multi-year effort to transform its mode of operation across all types and levels of service, from a traditional medical model to one which is family-focused and systems-based.

Against the backdrop of larger trends in the conduct of family therapy in the public sector in the US, this paper chronicles successes and setbacks the authors have experienced in their role as consultants and trainers in Delaware. Important lessons about the usefulness of a family therapy paradigm and general implications for public sector application are explored.

### Defining the terrain

'Public sector' is a deceptively simple cover term for a large array of governance systems, large and small, in the political geography of the United States. At the last count, the several branches of federal government employed 3,115,056 persons. To this must be added fifty state governments and several territories, and 3,142 county systems, each with multiple municipalities and school districts (Rand McNally, 1993).

American government exerts a complex and all too often stressful

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impact on the lives of families. Therapists who enter the political domain soon learn that the structure and dynamics of this system differ markedly from those of family systems. Ironically, the underlying pattern of American government is in fact quite simple. Three basic functions – legislative, executive, and judicial – have been organized into discrete branches so as to promulgate careful checks and balances between the creation, implementation, and testing of public laws. Over time, advocacy has emerged as a less visible ‘fourth arm’ of the government. Unlike the three formal branches, advocates play an informal role, via a host of often competing special-interest ‘watchdog’ and lobby groups who exist to influence the operation of government. The National Alliance for the Mentally Ill, a family support group angered by their perception of family therapists as ‘parent blaming’, for example, successfully lobbied against federal financial support of family therapy research (Nichols and Schwartz, 1991).

The ‘check and balance’ quality of this structure makes it extremely difficult for any one agent, either inside or outside the system, to get all parties aligned and moving in the same direction. Legislators work reluctantly with the executive branch, while judicial leaders attempt to maintain as much distance as possible from both. As a result, one can never fully predict what kinds of response will arise, or from where, to impede one’s work in this domain.

In various forms, the same pattern of separate legislative, executive, and judicial powers (and its inherent checks and balances) appears at every level of the American political system: federal, state, county, municipal, and so on. The average citizen is therefore a ‘stakeholder’ in at least four or five separate government entities, each with numerous divisions concerned with health, education, welfare, safety, environment, etc. By even the roughest of estimates, any client who enters therapy in an agency context is in some way connected to over twenty different public sector systems.

### An evolving relationship

In the United States, the history of family therapy, while distinct in its own right, is inextricably tied to these many systems. As early as the turn of the century, changes in the legal status of children, compulsory education, child labor laws, and other social reforms heralded a new concern for the welfare of children and families (Nichols and Schwartz, 1991). These reforms spawned the Child Guidance

movement in America, and the earliest efforts to work directly with families. While in practice the child guidance orientation segregated psychiatric services for the child from social work with the mother, it did serve as a precursor to more systemic collaborations to follow.

A crucial advance occurred in the early 1950s, as Gregory Bateson engaged what was to become a seminal group of researchers in Palo Alto to study communication in families of hospitalized war veterans. Soon after, the Kennedy and Johnson administrations’ emphasis on community-based mental health services and the elimination of poverty engendered substantial support for new therapeutic approaches (Bowen, 1960; Minuchin *et al.*, 1967) and training of new careers (Haley, 1977; Pearl, 1981).

During the 1970s, having begun to prove its mettle through research with families with psychosomatic children (Minuchin *et al.*, 1978), the field of family therapy was ready to take on new social challenges. Studies of addiction (Stanton *et al.*, 1982), issues of refugee resettlement (Lappin and Scott, 1982), post-traumatic stress disorder (Figley, 1986), and law enforcement (Alexander *et al.*, 1977; VanDeusen *et al.*, 1985) reflected an intense optimism for what family therapy could do. Developmentally, the discipline seemed to be entering its adolescence, brazenly taking on traditional models, declaring itself an innovator.

During the Reagan administration, Americans experienced a tragic juxtaposition of an economic shift from an industrial to a service-based economy, a widening economic gap between rich and poor, and sharply reduced governmental support for social programs. As the ‘Me’ decade unfolded, the threat of disintegration became very real for many families, businesses, and even whole communities (Layton and Lappin, 1982; Barlett and Steele, 1992).\*

The growth in influence of the religious right, in tandem with the prevailing conservative political and social climate, would point to these ‘failures’ as resting with the individual – a deficiency of character. While some might argue that this was merely racism and classism thinly disguised as ‘New Federalism’, family therapy was handed a sobering realization that it held no power in this domain. Family researchers were shocked to find the advances they had made

\* ‘In 1981, the ratio of foster care expenditures to child welfare services appropriations was about 2 to 1: by 1992, this ratio was 8 to 1. Moreover, declining state revenues, compounded by burgeoning foster care caseloads and costs, have largely exhausted state monies . . .’ (General Accounting Office, 1993: 4).

in treatment approaches and 'manpower' development consigned to bureaucrats' file cabinets. Family planning became a taboo topic.

The conservative agenda, to get government out of the lives of its citizens and re-empower families, ironically coincided with family therapy's tenet that the family is a basic source of solutions to behavioral and social problems. This alignment of interests helped one promising reform to survive and flourish through the 1980s. With the passage in 1980 of Public Law 96-272, the Adoption Assistance and Child Welfare Act, Child Welfare services throughout the country were forced for the first time to adopt a 'whole-family' philosophy and resolve family problems without placing children out of the home. This legislation fostered the rise of what has become known as 'home-based services', that is, the provision of brief, intensive therapy and supportive services in the home (Wells and Biegel, 1991; Berg, 1992). It also promulgated a challenge to foster parents and other providers of out-of-home care, to view themselves as 'partners' with biological parents in an effort to quickly return children back home (Minuchin *et al.*, 1990).

Over the course of the past decade, over 400 family preservation programs were instituted, including thirty statewide initiatives (Allen and Friedman, 1992). While these projects helped to build interest and trust in family systems approaches among public agencies, family therapists and public workers often lacked sufficient grounding in each other's fields to collaborate in a truly effective manner. Family therapists' enthusiasm and expectation often exceeded their grasp of public administration, leaving therapists, social service workers, and administrators discouraged and demoralized.

Hopes for family preservation have been further diminished by dramatic changes in the 'landscape' of American family life over the past decade. Public caseloads grew heavy with the converging impact of a number of critical trends: family members afflicted by loss of livelihood and home; drug and alcohol dependence; HIV; de-institutionalization of juvenile justice and mental health populations; school attrition; early pregnancy; and domestic violence. Caseloads continued to rise as greater numbers of human service professionals carried out their obligation to report child abuse and neglect. This expansion has driven public agencies to narrow the focus of their services to clients' most immediate needs – for food, shelter, and safety (Kamerman and Kahn, 1990). Currently, the number of children who are being placed out of their own homes is rising, while the percentage who have intact, functional families to return to is falling. The

Children's Defense Fund recently reported that in 1991, only one in eight families managed to escape poverty with government assistance, as compared with one family in five, twelve years earlier (Children's Defense Fund, 1992; 27).\*

### **A case study: family-centered services in the state of Delaware**

Inside a classroom of a children's in-patient hospital, a parent tutors her child. The rest of the class, engaged with the teacher on another lesson, pays them no mind, they have seen this before. Later, during a family therapy session in the Family Studies Center at that same hospital, the family therapist and a child protective worker meet with the family in front of a one-way mirror while being observed by an interdisciplinary team of hospital staff.

Downstate, in a converted lunchroom, a child protective worker videotapes a session with a sexually abusing father, his wife, and his probation officer. They are meeting to discuss the father's non-compliance with treatment. Instead of the probation officer performing the usual threatening legal harangue, something different happens. The mother, with the worker's help, is empowered to take a stand with her husband and insists that he move out and seek care.

Later that month, the same worker, along with a group of fellow workers, supervisors, and colleagues from different divisions and outside agencies watch the tape as part of their regular case consultation site meeting.

Five years ago, in the state of Delaware, these scenes did not exist. Today, for many public agencies in the United States, they still do not exist. What follows is the story of how one small, determined eastern state changed its philosophy and practices – its cultures – to a family/system-based model. As family therapists and trainers, our involvement in these reforms has varied between a lead role and indirect, behind-the-scenes involvement (Lappin and VanDeusen, 1993; VanDeusen *et al.*, 1992). To help clarify the full range of constraints

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\* Economist Timothy Sneeding recently found that US government cash assistance only reduced the 1986 poverty rate from 58 to 54 percent for children living in single-parent families. During the same period, in the middle of Conservative Prime Minister Margaret Thatcher's tenure, government cash assistance in the United Kingdom dramatically reduced the child poverty rate among single-parent families from 71 percent to less than 9 percent (Children's Defense Fund, 1992: 26).

and opportunities the authors have encountered in their work with this agency over the past five years, it should be understood that family-centered services have evolved within the context of several types of institutional reform, within and across agencies.

Delaware began its shift toward family-centered reform several years before the authors' involvement with the state. Delaware is a good example of how the 'fourth arm' of government can effect change. In response to pressure from advocates both in and outside of the system, the state instigated a major reorganization of the children's department. In 1982, all children's services in the state were consolidated. The threefold mission of this agency is 'to promote family stability and to preserve the family as a unit whenever feasible; to provide a family-focused continuum of care and treatment for abused, neglected, dependent, delinquent, and mentally ill or emotionally disturbed children and youth; and to avoid fragmentation and unnecessary duplication through a coordinated, unified and accountable service delivery system' (McCarthy, 1992).

This newly formed Department of Services for Children, Youth, and Their Families (DSCYF) served to create an umbrella organization encompassing child protective services (CPS), child mental health (CMH), and juvenile corrections (youth rehabilitation services (YRS)). In a politically astute move, the state also elevated the Department's head position to the level of Secretary on the Governor's cabinet. This move ensured greater political clout, a higher profile for children and family issues, and increased accountability to the public.

In 1986, Delaware capitalized on a joint private and publicly funded Family Preservation Project.\* The Project's goals were broad-based and were synchronous with an emerging family-based culture. Aware of the need for differences system-wide, the planners decided to channel project funds toward organizational change. Traditionally, when states undertake reform, they institute 'pilot projects'. These projects tend to be isolated from the mainstream, but none the less are pointed to as evidence of system-wide reform. The hope is that if they survive, they will painlessly 'spread' to the rest of the system. Without a 'sympathetic context' (McCarthy, 1992), however, many of these reforms die on the vine like a forgotten fruit.

\* State and federal funds were matched by a philanthropic grant from the Edna McConnell Clark Foundation, a major supporter of family preservation efforts throughout the United States.

This move to treating organizational 'symptoms' with second-order change had distinct family therapy thumbprints. In this case, they belonged to Patrick McCarthy, one of the principal architects of the Family Preservation Project.

Patrick McCarthy, Ph.D. is a social worker who was trained as a family therapist by Salvador Minuchin, MD at the Philadelphia Child Guidance Clinic (PCGC). Hired by the state because of his family therapy and organizational background, McCarthy and his reform-minded colleagues were well positioned to steer the planning and implementation of the Family Preservation Project. They realized that change needed to occur from the 'bottom up' as well as from the 'top down'.

When working in organizations, completing the feedback loop between all levels of the system is critical to the success of any system-wide change. It sends the message of co-responsibility to the workers *and* administrators and begins to equalize the bureaucracy's inherent power differences. This 'flattened' approach creates an isomorph of listening, empowerment, and collaboration that frontline workers – CPS, YRS, CMH – in their direct dealings with families, as child protective investigators, juvenile probation officers, and therapists, will hopefully model in their own practice. 'In short, the sum total of their many day-to-day case decisions are the real policies of the public agency' (McCarthy, 1992; p. 148).

Training therefore included opportunities for 'bottom-up' input through the institution of steering committees and ongoing evaluation. Later, consultation sites, which developed as an outgrowth of the training, would provide a regular forum for sharing difficult cases with fellow workers, supervisors, and administrative personnel. Examples of 'top-down' changes included fiscal reform; 'family-focused' contracting, i.e. shaping contracts with outside provider agencies to be sure their practices 'fit' with the Department's; guaranteeing the continuity of training by including it as an annual 'line item' in the budget; and making attendance at the introductory 'Family Focus Overview' mandatory for every one of the Department's 700-plus employees.\*

\* In 1988 the senior author, then working at the Philadelphia Child Guidance Clinic, wrote the initial successful proposal and was the principal trainer for the DSCYF training project.

### *Training the system*

'Immersing' the entire staff in the Department's new approach meant that the overview had to: (1) explain 'family-focus'; (2) account for an audience size that varied at any given presentation from 10 to over 200; (3) accommodate a varying mixture of MSW social workers, Ph.D. psychologists, custodial staff, secretaries, MDs, and administrators; (4) not use any clinical material; (5) counter the sting of making the training mandatory; and (6) be fun.

We decided that everybody likes a 'show'. To that end, videotaped segments of popular TV shows from the 1950s to the 1980s were used to document changes in the American family. The audience was encouraged to sing along to the opening theme songs, speculate on family dynamics, and got to 'see' the old characters in a new light. Examples of 'triangles', 'boundaries', and 'hierarchy' were in this way grounded to their own lives. We thought the next step, training the more 'clinical' workers, would be a short one. We were wrong.

Because upper management's involvement in the training process was so crucial to the success of the project, the Department began with an 'enactment' of what all these changes would mean. Salvador Minuchin (Director, Family Studies Inc.) was invited to a management retreat to conduct live interviews with a family that had extensive Department involvement. These sessions grounded administrators experientially and made the concepts real in a way that no salvo of memos could ever hope to. Ironically, this strong clinical performance, by setting the tone and the expectations for what the training would do, initially influenced the system toward the 'magic' of family therapy and away from the more protracted and painful work of organizational transformation: i.e., if a few experts could achieve so much so quickly – why not just leave the whole thing in their hands and those of a few disciples and let the rest of the agency carry on business as usual? There are some things, like administrative presence, however, which cannot be delegated.

At the beginning of the training, the Secretary of the Department opened the Level I sessions. It was a powerful statement of commitment when workers could look over to see their supervisors and divisional leaders sitting in on the training. Over time, however, fewer and fewer upper level staff attended the trainings. Although the absence of a real administrative presence was benign – and even motivated by trust of the trainers – their not attending the mandated

training created resentment in the workers. Since the workers have less power than those above them, these feelings about having to learn the new 'culture' found their way into the training sessions.

Despite massive injunctions to the contrary, the fact that family therapy tapes were used to illustrate generic systems points only confirmed the workers' worst fears that they were being 'made' to do yet one more thing in an already over-burdened job – i.e., become family therapists. (We later went back to using movie and TV clips and found people far more receptive – a bit more 'neutral', perhaps.) The net effect of these combined forces was to create a formidable presence that, like Frankenstein's creature, took shape, breathed life, and sat next to its fellow mandated workers, menacing and large. We are not sure, but we also think it ate most of the donuts.

After the initial Family Focus Overview, which everyone received, the amount of subsequent training varied by job function. 'Frontline workers', who saw families as part of their job, received the fullest package. These 'upper' levels of training went from Level II, a two-day didactic workshop which used the presentation of clinical tapes and introduced family therapy concepts and methods, to Level III, which focused on specific clinical populations; Level IV, a three-day workshop meant to deal with difficult cross-divisional cases; and finally Level V, a case-based practicum modeled after the PGC Extrem Program, where participants could bring families for live supervision or could bring videotapes of their work.

But because 'family-focused thinking' was so new and the time constraints of implementing the grant were so limited (seven months to finish the orientations and all five levels of training), a kind of developmental technological lag existed throughout the state facilities. At one training, for example, the family was in one room while we observed the session from a TV monitor set up in the staff lounge. Supervision occurred in an atmosphere of a live performance art piece – staff traipsing into the room to get their lunch out of the refrigerator, a group huddled around the TV, the steady 'kathunking' sound of sodas dropping into the vending machine, and a constant flow of unsolicited commentary, 'Whatcha watchin', soap operas?' Fortunately, these experiences helped us to appreciate what the workers were up against. And, in the silliness of this and many moments like it, we joined in the mutuality of struggle and the humanity of being able to laugh.

*Thoughts on the first year*

As Bellman (1990) points out, playing to one's strengths can dull one's attention to unintended consequences. As a seasoned family therapist/trainer, accustomed to family therapy audiences, the senior author thought that the jump from 'classic' family therapy lessons for frontline CPS, YRS, and CMH staff should be not only short, but also pleasant. After all, they liked Minuchin. It seems the first lesson of family therapy and social work – joining where the client is at – had been lost in an over-reliance on strengths and the need to 'get the job done'. Fortunately, systems by nature are teaching organisms – they provide feedback with their resistance and forgive those who persist and listen. What evolved was a crash course on the Do's and Don'ts of implementing large-scale public agency change. While a family therapy lens was just one necessary component of this training, it was insufficient to the task of engendering the desired cultural shifts at the organizational level. The need to bring additional lenses – chiefly that of organizational development – into the training led to the eventual collaboration of the second author and a third colleague, Jamshed Morenas, both of whom were seasoned family therapists who had recently completed an evaluation of family-based services in Nebraska.

*Consultations: the next level*

While the initial consultation sites resembled the case-based design of the Level V practica, they also went beyond them in important ways. First, they were intentionally non-interdivisional. This acknowledged the then strong interdivisional conflicts that existed between CPS, YRS, and CMH. Presenting to 'your own' made it easier to share difficult cases and utilized the natural supports in the unit, thus helping to cushion the awkwardness of using new 'tools', such as genograms, ecomaps, and structural maps. Our hope was that once trust in the new thinking – and in the trainers – was established, the consultation sites could be expanded to include other parts of the system. Second, the consultation sites were not a close-ended training experience, but rather an ongoing, administratively sanctioned, 'safe' place where workers, supervisors, and families could meet. It was a commitment to keep the feedback loop intact and a vehicle to create a more flexible, family-friendly organization.

In Delaware, as in all public agencies, there is no way to avoid

'bumping up against the system'. That is to say that, as with multi-problem families, the majority of tough cases typically have multiple division involvement. This caused the consultation sites to evolve into a forum where various alumni of the training could meet on informal, collateral terms to work on 'active' interdivisional cases that did not conform or respond well to existing procedures and practices. Presenters began to invite outside personnel, who had a direct stake in the case, to attend the consultations too. Thus, the usual boundaries between formal and 'shadow' faces – the 'informal' coffee machine, gossip network – of the organization were temporarily, strategically blurred in these sessions, fostering creative solutions.

The consultation sites in fact work best when cases are presented in a manner embodying as much of the real-life situation as possible, for example when the presenter hosts the meeting at her own worksite, or convenes family members and peers to work conjointly with the consultants. To feel equal ownership, supervisors and managers are encouraged to bring their cases too, and not be allowed to just react to the line workers' cases.

Just as consultation sites offer their different members a place to resolve differences, so too are the sites a place where the competing paradigms of family therapy and public agencies can meet and do friendly battle. And, as with the group members, unless these paradigms come to terms with one another, all the training can be for naught.

For many in America, the word 'bureaucracy' conjures up images akin to Terry Gilliam's movie *Brazil* – a vast, confusing wasteland where people argue over who has the biggest desk and where change is eschewed like a mole avoiding sunlight. In this regard, public agencies resemble small socialist countries – innovation and individual risk are exchanged for predictability and the security of a 'government job'. Conflict is to be avoided.

This paradigm contrasts sharply with family therapy's – a model that embraces change and values difference. Conflict, from a family therapy perspective, can lead to healthy solutions. In order to discover such solutions, actual cases are used to 'drive' the consultation site, and in this way a supportive, collaborative context is provided for reconciling paradigmatic differences. Because cases brought to the consultation sites are 'stuck' and attempted solutions have failed, anxiety and defensiveness could create a contextual gridlock. Fortunately, the family therapy tenet of 'searching for strength' provides a path out of the bogs.



By actively tapping the strengths and diversity of the staff, they need not relinquish what they know in order to accept the 'new'. Instead, they can discover alternative solutions that they co-create with one another, and many times with family members. It is important to avoid the message that family therapy is somehow 'better', otherwise, we inadvertently side with a kind of paradigmatic imperialism – when change is imposed from above or the outside, it merely reinforces the notion that no real partnership with decision-makers is possible.

Even though the basic structure of the consultation site meetings is planned – dates, location, agenda, etc. – we have learned that one cannot orchestrate what will happen at a specific session once it starts. Improvisation, for family therapists, is fundamental practice. Like a traditional *bricoleur*, the therapist must be able to incorporate any readily available resource – people, objects, furniture, ideas – into a form that will help to carry the system toward the desired goal. In organizations, being a *bricoleur* takes on system-wide proportions – one must be prepared to enact what one knows within the context of what one has at any moment (VanDeusen and Lappin, 1993). Many times, unplanned organizational enactments can go beyond the immediate situation and reap family-focused lessons for the entire system. One barometer of success with these kinds of interventions – if the organization is 'getting' systems ideas – is whether they become a part of the 'shadow' organization's lexicon: like 'the trumpet session'.

Shortly before Christmas one year at a consultation site downstate, a CMH therapist brought in a mother and her younger son, William, 12. The crisis for the family was that William's older brother Peter, 15, was about to be released from the YRS correctional facility. William, an Attention Deficit Disorder child, was formerly seen as the 'good' son in the family. He had been physically abused by his older brother and, with the brother's impending release, William was becoming increasingly anxious and exhibiting some of the same behaviors his older brother displayed before his arrest.

Peter had been incarcerated for fire-setting, stealing, and shop-lifting. The father was allegedly a serious drug abuser, whom the mother divorced. The mother initially had custody of both sons, but could not maintain a residence and, as a result, the boys went to live with their father. About a year later, the father sent the brothers to live with an aunt, where they remained for a few months. From there, the younger boy was sent to foster care through CPS. He remained in foster care for three months, returned to his father's home for a week,

and then went to live with his grandparents in another state. He stayed with his grandparents until two years ago, at which time he returned to live with his brother and mother who had established a home back in Delaware.

Rather than recreate a 'consultant as expert' phenomenon, the senior author stayed behind the one-way mirror while the CMH therapist interviewed the family. In this way, the therapist had greater ownership of the case. The consultant, back with the group, used their considerable experience and diversity as adults, parents, and agency workers to collaboratively formulate family-focused ideas and suggestions.

While the group was observing the session and speculating on why the young man was so recalcitrant, a paraprofessional casework aide who had driven the family to the session remembered that the young man had been plucked from school to attend the meeting and was missing an important band practice. She suggested that this might be why he was more intractable than usual. With this information, the therapist was able to create a dialogue between mother and son where she gently talked with him about expectations, disappointments, and hope. More importantly, she was also able to assure him that he would be safe from his older brother – that *she* would call the police if the older brother broke his pledge not to hurt William. The mother and son got beyond their impasse. To 'seal' the session, the group joined the family as the young man gave an impromptu concert of Christmas carols on his trumpet. In that moment, the abstract concepts of isomorphism, complementarity, reciprocity, appropriate use of hierarchy, nurturance, collaboration, and searching for strength, were enacted for everyone. Christmas had come early.

Unfortunately, administrators rarely have a first-hand opportunity to witness such an event and understand the day-to-day consequences of the changes they have just implemented. Typically, as administrators have bought 'pre-packaged' training and have entrusted the outcome to someone else, their 'stake' may be minimal. Far too often, staff bookshelves at public agencies are lined with 'innovative' training booklets, but like unused tools in the basement, they sit dusty and forgotten, dormant with good intentions.

Knowing this, the consultation sites instituted the regular practice of taking minutes and distributing them 'up and down' throughout the DSCYF system. After getting feedback through the 'shadow' side of the organization that 'everyone reads the minutes', one consultation site in the southern part of the state adopted a literary style that

loosely resembled Scheherazade's telling of *A Thousand and One Nights*. By year's end, even the Secretary of the Department had made the two and a half hour drive south to see what was happening.

*Whose family is it, anyway?*

Public agencies often resemble the impoverished families they serve. They can be massively over-involved at the formal level, with an over-reliance on 'rules and procedures', and similarly over-involved at the 'shadow' level, or disconnected and distant. In either event, the 'rule' governing these systems, including the families, is abdication. Family therapists understand this rule, but none the less fall prey to its power. The consultation sites also offer opportunities to correct this systemic tendency toward abdication of responsibility. This has led us to shape each site in distinct ways.

One setting that highlights the differences in consultation site practices is the hospital. While it shares the Department's overall goal of serving children and their families, its more medically based mission and staff composition form a unique constellation of people and place that distinguish it from its sister divisions. In the hospital, training must both account for and incorporate these distinctions in such a way as to promote family-focused practices within and across institutional, professional, and divisional boundaries.

At the children's in-patient hospital facility, for example, the staff comprises psychologists, social workers, psychiatrists, teachers, and mental health aides. Quite a few would identify themselves as family therapists and are conversant with its concepts. Differences between staff are either discipline based and/or paradigmatically based. In other words, while they agree that a family-focused approach is valuable, they might not agree on how to do it or who should be involved. Having family therapists on staff may be a necessary condition for a family-focused institution, but it is not sufficient.

One aspect of reconciling these differences is to ensure that the hospital does not use its 'higher' medical status or its familiarity with family therapy ideas to go 'one-up' to the rest of the system. For example, even the inadvertent use of medical terms or speaking in 'family therapyese' can distance the hospital from its non-medical, non-family therapy counterparts. Avoiding these kinds of practice contaminants helps to keep the walls of the hospital as permeable as possible, both for families and for staff.

The medical model is like an atmospheric condition in the

institutional ecology. Its accompanying reductionistic tendencies run counter to the collaborative goals of a family-focused approach. Case consultations and family therapists help to keep the institutional boundaries fluid and responsive to external as well as internal feedback. For many reasons, in public systems, this task is as constant as time.

When a child is hospitalized, a dependent, deficit-based 'set' is created in the perception of the family, DSCYF, and for other outside agencies. Since the family does not have enough of 'something', *ipso facto*, someone else becomes physically, if not emotionally, responsible for the child's welfare.\* If that 'set' is allowed to gel, a short-term hospitalization can evolve into a lifelong 'career' due to the multiple systems' inability to work in such a way that conflict is resolved and change occurs.

Yet another variation of the abdication process occurs when a family is referred 'outside' to a contracted agency for family therapy services. In contrast to in-house referrals, the system organizes its members so that once the family is referred out, case-managers can feel that 'The family is no longer "our" problem. I am just following *their* [the contracted agencies'] directions.' The cumulative effect of all this can be that virtually nobody, including the family, has to take responsibility for changing.

This leads to some of the core questions for any family therapist working in or with the public sector: Whose side do I take? My own/the family's/the agency's/the caseworker's? Ideally, one would like to think that decisions about families – should the father return home after he has beaten his children? is this alcoholic mother recovered enough to parent? etc. – are guided by professional standards that are objective, measurable, and protected from competing political agendas. All too often, family therapists find this is not the case. Instead, what they soon learn is that the playing field is not even – for all their schooling and skills, they have less power than the public agency case-manager.

In the life of public agencies, family therapy is but a recent acquaintance. And, as if to mask its own discomfort in this meeting, family therapy has made some bold claims as to what it can do for the public sector. This, along with the systems' inherent 'no conflict' set, ripens conditions for coalitions and 'dirty joining'. Dirty joining is a

\* The authors would like to thank Jorge Colapinto for his conceptualization of this idea.



way to connect with someone – individuals, families, agency personnel, new acquaintances, people you do not know, or people you do not like – without having to go through the work or anxiety of really getting to know them, or work through your differences (Buchanan and Lappin, n.d.). It is a kind of free-floating coalition: 'I think you're swell, it's the *case-manager* who thinks you're a bad parent.'

This fits hand in glove with the kind of 'bad restaurant' mentality that prevails in many public agencies. It is reported that if someone goes to a restaurant and has a good meal, they will tell three people. If they go to a restaurant and have a bad meal, they tell twenty. For the in-house public sector family therapist, this means that disagreement with the case-manager over what is 'best' for the family can result in the case management equivalent of a bad meal – an end to referrals.

It is easy to forget our 'systemic sensibilities' and become embittered if one is on the receiving end of this kind of treatment. One can either get angry, distance – abdicate, or 'take it like a family therapist'. By acknowledging our own dark side, we in effect collaborate internally with others. Inside we join with our disenfranchised and hurt clients, as well as our fellow workers, whose awesome responsibility for families can leave them awash in anxiety. In these moments we return to the larger community of imperfect beings and, through that connection, see our own place in it with greater clarity. Such a focus can help family therapists model self-empowerment and self-healing by accepting their piece of the interactional equation. In this way, we begin to help the system heal itself and in doing so create the possibility that the families it serves will be healed in kind.

### Summary

We have traced the evolution of family therapy in the public sector. Despite the hopes that the family therapy revolution would change the system as briefly and dramatically as it did families, its impact has been more modest and change has been slow. Perhaps, in our early days, we liked to think of family therapy as an 'irresistible force'. It did not occur to us that the public system would be an 'immovable object'. Yet, all is not lost. The Family Preservation movement, private and public family-focused initiatives, and the steady increase of family therapists in the marketplace at all levels in and outside of

the public system, may be coalescing into a kind of 'critical mass', whose energy will, in fact, transform the system.

The state of Delaware is one place where such a change is being attempted. After five years of intensive involvement, and the addition of an organizational development lens to our work, the authors and their partner, in conjunction with committed employees in the Delaware system, have seen some remarkable transformations. And while everyone does not 'speak' family therapy in the system, we have to be content that many practice its core values and methods.

What remains to be seen is whether it will be good enough to counter the constancies of abdication and conflict avoidance, and the uncertainty of changing faces in the larger political system.

### Acknowledgements

The authors wish to thank Jamshed Morenas, Patrick McCarthy, Theodora Ooms, and a host of colleagues at the Delaware Department of Services for Children, Youth and Their Families.

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*Journal of Family Therapy* (1994) 16: 97–101  
 0163-4445

## Family therapy and the public sector in the UK: comment on Lappin and VanDeusen

John Carpenter\*

In reflecting on Lappin and VanDeusen's fascinating account of the development of family therapy in the public sector in the USA, I was reminded first and foremost of what we here take for granted: family therapy in the UK is, almost without exception, public sector family therapy. Indeed, it is misleading to describe British practitioners as 'family therapists' since we are, virtually all of us, employed by the state to fulfil a variety of roles depending on our profession and the agency for which we work. The tasks we undertake range from committing people to mental hospitals to organizing 'packages of care' for people with disabilities; from investigating and supervising families in which child abuse is suspected to providing mediation for divorcing couples. We are psychiatrists, social workers, nurses, psychologists and probation officers first, and family therapists second.

If there is something distinctive about British family therapy, this is it. Family therapy in this country has had to find a place within our daily work. The challenge was, and remains, to adapt the theories and skills which had been developed mainly within clinical settings in the United States and the UK for use in the mainstream health and social service agencies (e.g. Treacher and Carpenter, 1984; Manor, 1984; Campbell and Draper, 1985; Carpenter and Treacher, 1993). In this brief comment I will indicate how this task has been attempted in Britain and draw some comparisons with Lappin and VanDeusen's American experience.

### Politics and family therapy

First a word about the political context. In contrast to the individualism highlighted by Lappin and VanDeusen (the 'Me

Generation') the political rhetoric in Britain regularly returns to 'The Family'. The Conservative Party, the party of government since 1979, calls itself the 'Party of the Family', although it is ironic that it, like the opposition Labour Party, has failed to develop a consistent family policy (Walker, 1988). Instead, what the Conservative politicians look back to is a golden age in which Mother looked after the home and taught the children right from wrong whilst Father went to work. Now, the ills of society in general, and the 'rise in crime' in particular, are blamed on the 'breakdown' of the family – with this year's targets for blame being young single mothers, who apparently have children only in order to qualify for state housing and welfare benefits, and, it seems, social workers and other professionals (including family therapists) who support such anti-social tendencies.

State intervention in family life, especially in the interests of 'child protection' from suspected or actual abuse and in the case of mental health problems, is taken for granted here and large and costly services have been developed to do so. The British are, on the whole, remarkably deferential to doctors and other professionals – an aspect of the class system. However, there has been something of a backlash in relation to 'excessive' intervention in child abuse and the most recent legislation has emphasized 'partnership' between families and professionals and stressed both the continuing responsibility of parents and safeguarding the rights of children (Children Act, 1989). These principles are syntonous with those evident in family therapy, and there is evidence of the impact of family systems thinking on the delivery of public services: as Reimers and Street observe, '... the manner of operation of family systems is part of the received wisdom of services for children and adolescents' (1993; p. 32). The official government guide for social workers on the assessment of children at risk, for example, highlights the family life-cycle, the couple relationship, family interactions and networks (Department of Health, 1988).

Similarly, much of the philosophy of recent legislation on community care for people with disabilities, including older adults and people with severe mental health problems, is congruent with family therapy principles. The main goal of the policy, to enable people with disabilities to live as independent a life as possible in their own homes rather than being incarcerated in institutions, has been implicit in family therapy since the 1960s. The policy also stresses the importance of involving both the 'service user' and the natural system of carers surrounding the person in the assessment of needs and in the formulation of 'individualized packages of care'. This is entirely

consistent with a family therapy approach which can enable the assessment of the family's own needs and resources, help resolve conflicts of interest, clarify goals and agree care plans (Procter and Pieczora, 1993).

### Families and public service agencies

Yet, whilst family therapy ideas 'fit' with the official philosophy of state services, family therapy as a method of intervention has hardly swept the board – indeed, outside child and adolescent mental health services, evidence of its use in practice is distinctly limited. This is not simply because practitioners in state services are under pressure of large workloads (which they are – although not, I think, to the same extent as in the States), or even because of an increasing shift from therapeutic counselling to 'managing' cases. It is certainly, and particularly in the context of adult mental health services, a matter of power relationships, but also a function of the complexity of the task.

As Lappin and VanDeusen point out, the practice of family therapy in the public sector requires a sophisticated understanding of the relationship between families and agencies and between agencies themselves. British family therapists have devoted a considerable amount of attention to these matters (e.g. Skynner, 1967; Dimmock and Dungworth, 1985; Reder, 1986; Hardwick, 1991). Of particular importance is the relationship between the family as 'client' and the therapist as a practitioner exercising a legally prescribed role: who is the 'customer' for change (Carpenter and Treacher, 1989)? An understanding of these dynamics has been especially well developed in considering the child abuse system (Furniss, 1990; Bentovim, 1993; White *et al.*, 1993). What is also clear is that in such complex cases, as in family-based work in mental illness (Kuipers *et al.*, 1992; Falloon *et al.*, 1993), *multi-level* systems intervention is required: family therapy alone is not enough.

### Changing the system

Lappin and VanDeusen's description of their attempts to change the system of children's services in a whole state is an impressive example of a multi-level systems intervention of a kind with which it is difficult to find a parallel in this country. I suspect this does say something about the American 'can do' approach which we in Britain admire publicly, whilst muttering privately 'It could never happen here'.

Indeed, the nearest equivalent that I could think of was the development of a family-orientated community mental health service in Buckingham by Falloon and his colleagues (1993) – and Falloon worked for many years in the States! Furthermore, what is telling about this example is the minimal impact that Falloon's impressive demonstration of the efficacy of this service has had on the psychiatric establishment as a whole – yet another example of vested power relations.

Nevertheless, there are important reminders and lessons in Lappin and VanDeusen's report. In promoting organizational change, we must work with the whole system, involving commissioners and managers at all levels. We must be wary of the illusory power of 'clinical magic', especially now that advanced level family therapy training is developing within clinical settings where therapists work in teams, video cameras and screens are standard and families come voluntarily, rather than within 'hard-end' agencies where workers are on their own, technical resources are absent, families are reluctant, to say the least, and 'therapy' is often a dirty word. As far as public sector services are concerned, we need to train professionals to use family therapy thinking and skills rather than to be family therapists (Carpenter, 1984). We must be modest; as Lappin and VanDeusen put it, to 'return to the larger community of imperfect beings and . . . see our own place in it with greater clarity'. And, they might have added, we could start listening to our clients – disenfranchised and hurt as they may be – listening to their views on the kind of services we provide. For only then will we create public services which respond primarily to their needs rather than to our own (see Treacher and Carpenter, 1993).

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