The Calgary Participator

A Family Therapy Newsletter
Volume 1 Number 3

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Samson Beaver and his family of the Stoney Nation (1906) *Photo Mary Schaffer*

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Editorially Speaking...

Carol Liske
Editor

Welcome back! The lengthy interlude since the publication of the last *Participator* is the result of busy lives and this publication being on a volunteer basis. Apparently, a new form of magazine being published on an ad hoc basis has been given the name *'Zine*. So it seems we have a *'Zine* here in *The Participator*. We might surprise you soon, however, as another issue is already under way and so your wait to the next issue, hopefully, won't be a long one.

During the last *Participator Conference* (1991), some dialogue was held regarding future directions for *The Participator*. One thing that seemed apparent was that *The Participator* has been a valued publication but family therapists are very busy people. Thus, therapists are willing, in spirit, to support this publication, yet they find making time to write articles and to help with actual production, difficult. Therefore, the Family Therapy Program (FTP)-based editorial committee has decided that as all costs of publishing *The Participator* will be assumed by FTP and as FTP staff produce the newsletter, that for the present time *The Participator* will be distributed without charge whenever it is produced. At sometime in the future, it may be that another contingency could occur which would mean the *The Participator* may become more self-sufficient and then subscription fees would be charged.

In order to provide a broader base in editorial perspective, an Associate Editorial Committee has been established to work jointly with the FTP Committee. The associate editors can provide a non-partisan involvement regarding the refereeing of submitted articles. Thus, the quality of articles can be appropriately monitored.

This issue contains a wide variety of articles relating different areas of focus. There has been an increase of articles written from personal experience, although more of this kind of material has been written by therapists, than had been the case in the last issue. An important potential in the representation of personal experience is that a wholistic picture of experience is available and this contrasts clearly with the more theoretical presentations regarding intervention, even if these latter expressions include therapy transcripts. Reminding ourselves about the "wholeness" in experiences can perhaps nourish our intuitive capacities to integrate the wide range of influences a person(s) computes in order to act. This reminder could help us with our humility as practitioners and can also serve to prevent our trivialization of human experience.

The Eastside Family Centre: A Walk-In Clinic for Parents and Youth has been featured here as *The Participator Profile*. This clinic is fashioned after a walk-in clinic for sexually abused women located in Minnesota and is, otherwise , thought to be unique. Karl Tomm represents some of his new thinking about *The Ethics of Dual Relationships*. Frank Young discusses *Being in a Men's Group, Lucid Dreaming, and Other Influences in My Development as a Therapist*; Jon Amundson speaks out about *Diagnosis in Another Light*; and Alan Parry has continued to elaborate his thoughts about *Shared Stories: The Tie That Binds*.

Our regular features *Sexplay* by Gary Sanders and *Parry Looks at the Books* by Alan Parry are also included in this issue. Enjoy!

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Family Therapy Program,
The University of Calgary Medical Clinic,
3350 Hospital Drive North West
Calgary, Alberta
Canada, T2N 4N1
(403) 220-3300 (voice)
(403) 270-7446 (fax)

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The opinions expressed within *The Calgary Participator* may or may not be in agreement with those of the Editorial Committee.

The Eastside Family Centre

Walk-In Support for Parents and Youth

A Participator Profile Interview with Dr. Arnie Slive*

Carol Liske

Arnie: Maybe I should go back to the beginning and how the East Side Family Centre came into existence. I'll tell the story. Part of what happened was that over the last five to six years we've noticed that a lot of our clientele are coming from this part of the city. Secondly, that when we tried to serve these people with a more traditional kind of outpatient service, like weekly family therapy or some kind of ongoing therapy service, that it hasn't gone well. Typically, what would happen, depending on the length of the waiting list, people might wait to be seen and when their name comes up either they're not interested anymore or they make an appointment and don't come, or they come one time and in the end nobody is satisfied. We're not satisfied; they're not satisfied. This situation led us into thinking about what should we be doing, because our mandate is to serve those people. Because Wood's [an in- and outpatient adolescent treatment care facility] has been expected by the community to be a last resort agency, and to serve a lot of people that are multiply challenged (i.e., economically, facing issues of family violence, abandonment, etc.). We were struggling to try to find the right way to connect. During that time, just by chance, I had a conversation with a friend of mine who's an orthopedic surgeon who was talking about this idea that he has of starting a walk-in clinic for people with back pain, or it might be a wheel-in clinic. The idea was that it might be both a better service and more efficient to have a kind of service that people can just go to when they're in pain to provide immediate pain relief. Some people might benefit from having a way of dealing with their pain from time to time rather than facing painful unwanted long-term treatments. The kind of clientele that Wood's works with are often people that are chronically in pain. The pain activates from time to time. The issues are there. The struggles are there. The struggles might be life-long. The primary issue is how to help them to hang together as a family so that they can continue to give support to their children.

The primary issue is how to help them to hang together as a family so that they can continue to support their children.

Carol: Regardless of the amount of pain?

Arnie: Yes.

Carol: It's almost like you are suggesting the intermittent provision of *pain-management* skills.

Arnie: So, we had thought about that kind of idea. At the same time, we started talking with people in the community, people that provide services in the community, like medical people, Alberta Mental Health Services, and people that live in the community, people that work in the community, getting their point of view. About one-and-a-half years ago we organized a community forum that we held out at the leisure centre (in this area) just inviting anybody that we heard about (people from the school board, school trustees, politicians, people from community associations, and "grass roots" community leaders. We told them that we had some resources that we could re-deploy and what we needed was advice about was first of all, if we should do that and second, what should we be doing? And the feedback that we got from them included a whole lot of different responses, but I'll put them in three categories. First, they wanted a facility that people could access immediately. They also wanted some kind of resource for the young people in this part of the city that are disconnected from families, school or

*Dr. Arnold Slive is the Director of Clinical Services for Woods Homes, Parkdale Centre, 805 - 37th Street N.W. Calgary AB, T2N 4N8

Patricia Jones, M. S. W. is the Coordinator of the Eastside Family Centre Northgate Village Mall Suite 255, 495 - 36 Street N.E. Calgary, AB,T2A 6K3

whatever. There are homeless youth in this part of the city, or young people that "hang out" all day long. They don't do it downtown so much, they might do it in this area, but there were concerns about that. And also the idea of being able to access a more ongoing or long-term kind of service. So with that, we took those comments and put those ideas on paper and then organized a task force, very task-oriented task force that met three times. They advised us on the location, they named the service, and they decided on its hours of operation. That was interesting as well actually. We assumed that we would have hours that were convenient and basically like Monday to Friday operation, but we're actually open six days a week, we're open Saturday as well. So what they decided was that during the week, that what would make sense would be afternoon and evening hours and that's when it's open, 4-9pm. But one of the people on the task force was a representative of the police service and he said that traditionally for police services across North America, the busiest time is Friday night and what would be most useful to a police constable on a Friday night dealing with a family dispute, for example, would be to be able to say to a family member, here's a place you can go tomorrow morning. And so we decided to be open Saturdays as well.

Carol: You open early?

Arnie: Yes, 9am-5pm on Saturday. And that's an interesting thing too because when we first opened that was the least used time, because people aren't used to it. So, we just started a *walk-in* counselling service where people can get a fifty-minute session with a professional therapist. The person can come in without an appointment, at no personal cost, and have an opportunity to express themselves and to look at possibilities. Of course, like with any other kind of therapy, different people come in for different reasons. What I notice, because I work here sometimes too, is that I love the clinical work here. In a lot of ways, it's the most interesting clinical work I've done in years because people come in just at a moment in time when they really want to talk to somebody. There's no coercion, no

Dr. Arnie Slive

pressure. They've made a decision that they want to come in and they want to talk with somebody. But they may come in for different reasons. Some people might come in just because they want another chance to be heard. Sometimes people might come in because they're looking for a referral. Sometimes people come in

We organized a task force...

because they're looking for ideas or a different way of looking at something. And those kinds of things need to be addressed, like why are they really here, as in any other kind of therapy, but they're really interested in being here and often will express gratitude that this is even possible. So they come in and usually what I do is sit down right at the beginning and take 30 seconds to explain the service because it's unusual. I usually make an analogy with a walk-in medical clinic. "You can come in without an appointment, see a professional, you can come back again too. You may or may not see the same person because there is a group of people who work here at different times of the week. So it's just like a walk-in medical clinic in that way." And I also say, "We usually try to keep the meeting to not more than 50 minutes so as not to keep other people waiting too long." They accept that with no problem at all and they leave readily when the time comes to end the session.

Carol: After the task force gave you their ideas, what did you do after that to actually open the clinic?

Arnie: The next step was actually finding the space.

Carol: The funds were already in place?

Arnie: That's a good question! Wood's has two large contracts with the government, one with Alberta Social Services and one with Alberta Mental Health Services. Some of our professional staff that provides service here, have their salary paid from our contract with Alberta Mental Health Services. But all the costs, like the cost of renting this space, secretary, furniture, all that kind of stuff, comes from fund-raising.

Carol: How do you do that?

Arnie: Wood's is a non-profit society with a Board of Directors and that's our Board's responsibility, to raise money in different ways. So we get money from foundations, from donations, from individuals in different ways, and that takes a lot of time and energy. One of our goals is to stimulate an interest in the community out here to take responsibility for raising funds for this service because it's really serving them. My long-term goal is for this community out here to own this. We have now, after that task force ended, organized a community advisory counsel. Some of the members of this counsel were people that were on the task force and some of

them were not. They meet monthly and advise us on the development of this centre. And believe me we listen to them. The issue here is that this service will be most valuable to the community to the extent that the community really knows what's going on here.

Carol: So, keeping close communication with the community was one of your objectives?

Arnie: The Eastside Clinic is to be really a community-owned service. It's a way of bringing services and communities together. There's a list of organizations that are all part of this, like Alberta Mental Health, they pay for some of it but they also have a staff member who works here part-time in the walk-in. Calgary Family Service Bureau has staff that work in the walk-in clinic and we're now partnering with them in developing a brief therapy service.

Carol: You mentioned brief therapy service a few times and I'm not quite sure how you distinguish that from walk-in clinic?

Arnie: One thing that we're doing that we just started actually in August and piloting with is to offer a brief therapy we're defining it as a *brief ongoing-therapy service.* We've defined that as treatment with the same therapist for up to five sessions. We're doing that in a partnership way with Calgary Family Service Bureau, so we'll be jointly staffed. Calgary Women's Emergency Shelter started a service as an offshoot of their program, which is a service for the male perpetrators of violence towards the women and children that they serve in their shelter and they heard that we were developing this centre and asked about the idea of locating that service here, which it has. It's a crisis-oriented service offered by Frank McGrath that's designed to provide a kind of crisis support and beginning work for the men who are interested in taking a look at resolving their participation in battering relationships.

Carol: How do you reach these men?

Arnie: The primary referral source are the shelters for women and children, both the Women's Emergency Shelter and the Sheriff King Home, and as well, he'll take referrals that come through the Eastside Family Centre. I've worked here when I've had a man come in within a week after his wife kicked him out and had told him "Get help or else," basically. He was really quite devastated by that and was taking it seriously. In addition, he was also taking some responsibility for what was going on. So I referred him to Frank.

Anybody can come to the walk-in...

Carol: Can anybody come into the walk-in clinic?

Arnie: Yes, anybody can come to the walk-in. Anybody, in any which way. I should mention some other things about it. The full name of the centre is the *Eastside Family Centre Walk-In Support For Parents and Youth.* It was really conceived for people that have issues with young people or children up to the age of 18. What we found actually, what surprised us—we thought that our primary clientele would be adolescents and families with adolescents—is that we're getting many more younger children and adults with adult issues than we expected. We're getting lots of people coming in with marital issues, much more than we expected. One of the most recent times I was here I had a man who was 60 years old complaining about his girlfriend. So, there's more of that than I thought there would be.

Carol: I know we started talking about *outreach* awhile ago but I was hopeful that we could maybe look more comprehensively at how you do that.

Mayor Al Duerr and Dr. Philip Perry

Arnie: What we're interested in, is supporting families and communities to hang in with their troubled young people. It's not like we're after cures because we know that we can't do that. So this service, while on the one hand the primary clientele are parents and young people, we have some young people who come in on their own. It's also a service to other people who serve young people. For example, we've had a school counselor come in to say, "I've got this young person who's driving me crazy and I've run out

of ideas, can I consult with you?" We're open to the police doing that or anybody in the community doing that. I've had some discussion, for example, with the Red Cross who have a volunteer service for people who are survivors of torture. It's primarily Spanish-speaking people that they serve, and we talked about the idea of their volunteers and their coordinator using this as a way of consulting when there is a crisis. They can come in with the client or they can come in on their own and say I've got this person who's talking suicide, or something, and I'm not sure what to do. So it's really designed around providing support so that people can hang in there.

Carol: How are you *actively* reaching these people? I think that it is one thing to have ideals about goals, but what have you actually done to reach these people in the community?

Arnie: Well, we've done a lot of advertising and talks. Our major referral source at this point, and I think will continue to be, is community schools in this part of the city. To a large extent, they are very, very familiar with what we're doing and what we're about.

Carol: How did the community schools get familiar with the Eastside Family Centre?

Arnie: We've gone and talked to them. We've sent them posters. We've talked with different groups of their staff and different resource people on the Board of Education about it. So I think that the chances are if you went to a community school, particularly in this part of the city, and asked them if they knew about it, they'd say "Yes!" We talk with the communities themselves through their community associations. We put advertisements in their newsletters. We've worked with the police around informing the police constables through informing their various sergeants. Actually one of the area-sergeants, from this area, is on our Advisory Committee. So the word gets out that way. The use of the clinic is, in some segments of the community, is more than in others.

We've done a lot of advertising and talks.

Schools are the primary users right now. The police use it to some extent but not nearly as much as they could at this point. It's an issue of getting used to it. Used to the concept. It's an unusual concept. It's unusual for the clientele as well. It's like something that you can go to right now. I've got an issue and I can go right now. People aren't used to that. Right after we opened I happened to be here one day and received a phone call from a woman who said she'd just been to her family doctor—we advertise to family doctors in a variety of ways and we get referrals from them—about some problems she was having with her 14-year-old daughter. The doctor advised her that she could just come over here and talk to somebody. She said"Is that true? Can I just come over and talk?" And I said, "Yes, you can." And then she proceeded in 30 seconds to give me a capsule explanation of issues with her daughter. I said, "Well it sounds like this is the place." And she said, "I can just come there now?" And I said, "Yes." Well, then she said, "I'm not sure if my daughter will come." And I said, "It would probably be ideal if your daughter would come, but your daughter doesn't have to come. You could come and talk about ideas that have to do with your daughter." And she said, "So I can just come?" I hung up the phone with a strong feeling that she wasn't going to come. The sense that I

Ribbon cutting

had of it was that she wanted to tell somebody that she was in pain. It's not that she wanted to do something about it right then. There's something about this kind of service that alters people's framework around the timing of things. Its availability. It's different. It's unusual. And it takes time for people to get used to it—to just walk over someplace and talk about an issue. Most people aren't used to that.

Carol: It's as though people are being offered an instant or immediate transition from intensity to relief. I wonder if people experience an implicit invalidation of their intensity by the fact that relief could be so easy. That's just not a concept in our society. I mean in general. In a way it's just a moment to moment decision whether you suffer or not, but a lot of people don't realize that.

Arnie: In a sense, there is a level where suffering is an important part of all of us. We wouldn't want to necessarily give all of that away.

Carol: No. We get pretty wedded to it. It would be kind of empty if you simply could take that away quickly.

Arnie: Can we talk about another part of this actually that interests me a lot? I think that in Calgary, Canada, and North America that there's a kind of funny thing going on with professionals and that is that professionals are coming under criticism. Not necessarily all for good reasons, but they are. A lot of what I think you hear is that we're largely seen as irrelevant, to people's lives. Some of it is that we're seen as inaccessible and I think to some degree this is a fair criticism. Some of it is entirely our responsibility. As services get cut back, waiting lists get longer, and irrelevance becomes almost self-perpetuating—that's an issue. I think that there is a need for us to look at that issue and to think about ways in which we could be more relevant.

Carol: That's interesting. You seem to be suggesting that the Eastside Family Centre has become an experiment in learning about what really is relevant to people, what would be helpful to their lives. Do you feel that the experiment has been carried on long enough to make any conclusions?

Arnie: Well, yes and no. You can make some conclusions. One is that universally,when people hear about this concept, they say "What a great idea!". This statement is interesting in of itself. Or, they say, "Why haven't I thought of that?" or, "Somebody should have done that before." or, "Are you going to do more of them?"—sort of like *MacTherapy*.

...there is a level where suffering is an important part of all of us.

Carol: Well, actually that's interesting you said that because it's been on the tip of my tongue to ask if you are advocating *MacTherapy*?

Arnie: That's one kind of feedback. When we introduced the idea of a brief therapy component to the Eastside Family Centre, to the Advisory Committee, and their first comment was "How is this going to affect the walk-in service? We don't want anything to get in the way of that." And to me that's really interesting feedback.

Carol: When you're talking about relevance, are you talking about just having the walk-in clinic or are you talking about some ways of approach to these people.

Arnie: What I'm optimistic about is that our clientele are going to be helping us to learn about ideas and approaches just by virtue of doing it over time. It's a little bit early but the objective really is to learn from them.

Carol: How do you put into a higher profile a vision of client change or therapeutic possibilities in a fifty-minute hour and thus not focus so heavily on the aspect of tension release?

Arnie: I think the issue there is, *yes* you can do both, and it really depends on where the client is at. One of the earliest learnings I think for somebody doing this work, certainly for me, was getting the feel for what the client really wants in coming here as fast as possible in that meeting. It's different than, for example, finding out early in the meeting what the problem is. If you don't find that out fast then you can wind up in a lot of trouble with only five minutes to go in the session. One of my first mistakes occurred when a family composed of two parents and their daughter who was about 8 or 9 years old, came into the clinic. They had just been to a meeting at the school and the school counsellor and the teacher were saying they were concerned about the daughter, and suggested that the family come here. The daughter seemed depressed. I heard that and there were some issues around who sees this as a problem. So we got that clarified. We went through the session and there were some things that were being talked about that gave me some ideas and I started suggesting some things. I thought they were really good ideas but they were going nowhere. When we had only 10 minutes left, I thought of saying to them, "What would tell you that this meeting was useful?". They said "Well, the counsellor told us we could come here to get a referral for individual therapy for our daughter and so if we got that, then this would be useful." That's really why they were coming. I'm coming up with all these great ideas and that's not why they were there. So one of the

things I've learned is that I've got to find out what the client wants really fast. So some people come because they're really looking for ideas, they're really looking to try something different. On the other hand, some people come just because they want to talk to somebody. Two or three different times now (again it's one of the surprises to me) that I've been here, I've had men come in on their own within days of a marital separation. On one or two of those occasions it was like they were crumbling and just wanted to talk to somebody. And they really weren't looking for anything beyond that. There was another incident where a man was really looking for help—he felt some pressure but he was also starting to think about himself and what he'd been doing to his wife. And so he was really wanting ideas or wanting to know about resources. So yes, I think there are times when you can really look at possibilities for change and that's why they're there. I think what it does though, to a therapist, is to make them very, very consumer-conscious. You don't have a lot of time to make mistakes, you better find out what the customer wants.

Carol: Can you open *Pandora's Box* and leave people in a bad place?

Arnie: My response to that is that one of the advantages of this kind of service is that there is a level at which it's as empowering as a service can be. It's like the less involved we are in people's lives, the better. As a general rule, to say that we can somehow do something that's going to devastate somebody's life, I think is to not have a real sense of respect for the people we serve. I think it's important to be sensitive. I can give you an example of this. Some parents came in with their daughter who was 15 and who had taken an overdose the night before. They had taken her to the Peter Lougheed Centre and they treated her medically and were told there to take her to the Calgary General because the Peter Lougheed doesn't have psychiatric services. So they did that and then it was suggested after saying that she wasn't suicidal, that the Eastside Family Centre could be a place to go. Later that day, the three of them came in and the story they told was that there have been problems and the parents had been concerned about their daughter for the last month. The reason they were concerned was that a month earlier they had learned that she had been raped. It was a date rape kind of situation and the story itself is an interesting one in that the rape had taken place 3 or 4 months earlier. It was some guy that she'd gone out with a couple of times and then he raped her. With the end of that relationship—they were going to the same school—she told nobody about it. But she got involved with another boy and it sounds like he was a sensitive young man who started to sense that something was going on with her and started to push her to talk about it and she finally did. He took her by the hand to the police where she reported what happened, which actually led to charges. But, of course, the police were dealing with this 15-year-old adolescent woman. They drove her home which is how the parents found out about it a month before her overdose. What were they hoping that they could get here? They said, "Well, in the context of what's happened in the last 24 hours, our daughter has said that she wants to talk to somebody about what happened to her. She wants the chance just to tell somebody what happened to her. And she doesn't feel comfortable telling us." I turned to her and asked if that was what she wanted to do, and would she be more comfortable if her parents were there or not and she preferred that they weren't there, so the parents left. Then I said to her, "Do you understand what this service is about? Do you understand that we're meeting here this one time? And you can come back again. It sounds like you want to talk to me about something that's very personal and very painful and that's fine, but I want you to understand what this context is." And then I asked her some other questions around that. I think you need to keep the context in mind and I think if you do that and are being professional about it—people can make their choices. She made her choices about how much to say.

I think what it does though, to a therapist, is to make them very, very consumer conscious. You don't have a lot of time to make mistakes, you better find out what the customer wants.

Carol: You have the questionnaire, so I was just wondering what the feedback is showing you? What mainly the people themselves are saying happen for them in coming here?

Arnie: They range from anything like three or four words saying,

"It's great that something like this is here!" Period. They don't necessarily comment on the session, or they say, "It's great to have an opportunity just to talk to somebody! The therapist really gave me an idea that I hadn't thought of before."

Carol: I don't know if there's anything else you think might be important.

Arnie: There is one other thing to comment on. I was talking about how the work here at the clinic gives you a sense of what's going on right *here and now* and so I think what this centre is going to do is give us a window on the community. Over the years, the kinds of issues people bring will change as the issues in communities change. But right now, I think we're really at a kind of an interesting place around certain kinds of issues that we hear lots about. One of the main ones is family violence, family community violence. So one of the things about this place is that it's an interesting opportunity to get involved with families around an issue like violence at a point that's a little bit earlier then when other professionals usually get involved. So there's a real opportunity for a preventative kind of work. It's also an opportunity because of the potential when people come here to volunteer and learn, for professionals to learn more.

Carol: It's almost a teaching resource for *grass roots* understandings.

Arnie: The other area I think that we'll wind up getting more and more involved in is the cross-cultural area because we have to learn about that. When you have it located in this community, you know that it's there and it's what Canada is becoming. So in the end, we're all going to have to learn about it. We'll start learning about it in a resource like this a little bit more quickly because of where it is located in the city and the kind of service that it is.

Carol: Are you planning to have therapists working at the clinic who are knowledgeable about particular cultural or ethnic groups?

Arnie: That's real useful and it's already starting to happen and it's going to continue to happen. And it's perking people's interest! It's perking therapists' interests! So we'll have somebody come in from another culture and know that starts raising questions. We want to create a service where there is a sense in the community that this is a place that people can go to be heard where somebody's going to listen and not be judgmental.

Carol: A place where people could feel very safe about telling their story to a listener who is wiling and able to comprehend the speaker's language.

Arnie: Yes.

Dignitaries at the opening of the Eastside Family Centre

Why Was I Defensive?

Sandra Dame
Family Therapy Program
The University of Calgary

Most of us have had work experiences that were less than satisfying. In fact, for many people the work experience consistently falls into this realm. They do not expect it to change, they simply persevere because the job provides the basic necessities of life.

As therapists and helping professionals, we too can find our work environment unrewarding, but should we settle for that? Recently, I have spent some time reviewing my own professional development and looking at what has been helpful and what has not been helpful, along the way. One experience stands out in such a pivotal way that I feel the need to share it with others

When I was first learning about the helping profession and doing rudimentary exploration and decision-making about the path I wished to take, I spent some time working in an agency devoted to the needs of women in our community. Initially, I was very caught up in what I was doing. There was a feeling of excitement and gratification in helping others and making a contribution to society. As time went on, however, it was pointed out to me that I had a problem with taking criticism; that I was defensive. Being young and inexperienced, I dutifully promised to work on this flaw that I had. This became my self-development project over the next months. I sincerely believed that the person who relayed this information to me must be right, because she was already a practicing professional with several years of experience and I was only a student.

An incident occurred, however, that encouraged me to question, not only her opinion, but the organization of professional services in general. Finding some satisfactory answers to these questions has continued to be part of my personal journey over the last few years. This incident, and some of the thoughts that have accompanied me on my journey, are what I would like to share. My duties at this agency included taking crisis calls on the telephone. One very busy evening, I had several calls at the same time and was directing them to other staff members as quickly as I could, so that no one would be left on hold. The choice of who took what call was arbitrary unless I was otherwise directed by the staff. One staff member indicated that he would talk to Mary, so I transferred Mary to him and then took the remaining line myself. As it turned out, this caller was also named Mary. I had no way of knowing that I had transferred the wrong Mary to the staff member and I proceeded to work with the caller I had on the line. The first indication I had of the mistake I had made was when the staff member appeared at my side looking displeased. I continued to talk to my caller while he waited, becoming visibly more distressed as the minutes passed. When I had finished, he made it very clear what had happened. I apologized and explained the situation to him, but he responded by telling me that the person I had been talking to was suicidal and at risk. Up to this point, I had been satisfied with the work that I had done with this woman, but now I began to doubt myself. The staff member and I discussed what had occurred and he seemed to relax. I thought the incident was over. I was wrong. The next day my supervisor called me in to talk to me. She informed me that I was still very defensive; that I had made the error and I should not have responded in the way I did. I told my supervisor that I was under the impression that the staff member had understood what had happened and that he and I had settled the matter ourselves. She informed me that this was not the case and that in future I should be more careful. I should just accept what people say to me and not be defensive about it. I asked her if it was not also important for others to be conscious of how they said what they said? Was it not important for us, as staff members, to treat each other with as much respect as we treated the clients? She replied that being careful of the feelings of other staff members was not part of the work that was done at this agency.

This incident has remained with me over the last few years. At first, I believed that once again I was wrong, but as time passed, I became certain that my question was a valuable one. The more I learned about people and about systemic work, the more convinced I was that how I spoke to others was vitally important. If I perceived someone as defensive, then I must have said something to make them believe that they needed to defend themselves. Defensiveness was not a flaw that resided in me, it was a component of the interaction.

This discovery had healing properties in it. I could now act as an observer to these interactions and could choose to respond differently; I was no longer bound only by the observations of others. I could also interact with people differently and not invite them to respond defensively to me.

This discovery appeared to be the end of the journey, but it was not. In fact, this discovery only presented new questions to me about the relationship between how we treat each other as colleagues and how we respond to clients. I would like to share with you where my journey is taking me right now.

There are four questions that I am pondering at this point in my development. They are as follows: Is it not important to foster an atmosphere of openness in our relationships with our fellow therapists? How can we present healing interventions to our clients, if we ourselves do not practice them in our professional interactions? If we believe that clients see us as behavioural models, can we model wellness in an environment that does not foster it? Finally, should we not treat our colleagues with the same care, compassion and empathy that we give our clients?

My tenure at this agency was relatively short and I left there feeling that I had been treated unjustly. In retrospect, however, I see it was an opportunity for personal and professional growth which is continuing to challenge me.

The Ethics of Dual Relationships

by Karl Tomm M.D.
Family Therapy Program
The University of Calgary

In my opinion, the AAMFT Ethics Committee and the AAMFT Board are attending to the wrong issue in actively discouraging dual relationships in the field of family therapy. The focus in the *AAMFT Code of Ethics* should remain centered on the avoidance of exploitation and not be shifted onto the avoidance of dual relationships. I acknowledge the importance of finding ways to protect the dependency and trust of clients. However, a more specific means of doing so is required than simply avoiding dual relationships. An ethical injunction to avoid duality not only fails to address the exploitation that occurs within professional relationships, it introduces some of its own problems.

Exploitation and dual relationships are very different phenomena. To exploit is "to use selfishly for one's own ends" (Webster 1989). In the context of a professional discipline it refers to taking advantage of one's professional relationship to use, or abuse, another person. Exploitation in relationships is always exploitation, regardless of whether it occurs in a dual relationship, a therapy relationship, a supervisory relationship, or a research relationship. A dual relationship is one in which there are two (or more) distinct kinds of relationship with the same person. For instance, a therapist who has a relationship with someone as a client and who also has another relationship with that person, such as, an employer, an employee, a business associate, a customer, a colleague, a supervisee, a research subject, a neighbor, a friend, or a relative, is involved in a dual relationship. While dual relationships always introduce greater complexity, they are not inherently exploitative. Indeed, the additional human connectedness through a dual relationship is far more likely to be affirming, reassuring, and enriching, than exploitative. To discourage all dual relationships in the field is to promote an artificial professional cleavage in the natural *patterns that connect* us as human beings. It is a stance that is far more impoverishing than it is protective.

The concern about dual relationships has been evident in the *AAMFT Code of Ethics* for some time. However, it has emerged even more strongly in the latest version of the *Code* which was approved by the AAMFT Board in March 1991 and came into effect on August 1, 1991. This version explicitly urges the avoidance of dual relationships in three areas: a) with clients, b) with students, supervisees, and employees, and c) with research participants. As such, the present *Code* imposes a pervasive restraint upon the nature and complexity of interpersonal relationships that are acceptable in the field. I regard this broad restrictive stance as counterproductive and believe the relevant issues need to be explored more rigorously and discussed more widely so that the statements in the *Code* can be reconsidered, and hopefully will be rewritten. In the reflections that follow, I will cite the pertinent sections of the current *Code*, raise concerns about the restrictions, draw attention to the potential benefits of dual relationships, and suggest that the issue be re-examined and the *Code* be revised.

Relevant Sections of the 1991 AAMFT Code of Ethics

Under the first principle, ***Responsibility to Clients***, Subprinciple 1.2 states:

> *Marriage and family therapists are aware of their influential position with respect to clients, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid dual relationships with clients that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with clients. Sexual intimacy with clients is prohibited. Sexual intimacy with former clients for two years following the termination of therapy is prohibited.*

Exploitation and dual relationships are very different phenomena

On the surface this seems like a reasonable statement and I certainly agree that exploitation of clients and sexual intimacy with clients are unethical. However, I find the logical implication (introduced with "Therapists, therefore,...") that dual relationships are the source of exploitation extremely misleading. Even if one denies such a causal interpretation, one is still left with "guilt by association." The overall statement begins by encouraging an avoidance of exploitation; suggests this could be achieved by avoiding dual relationships; and concludes by prohibiting sexual intimacy with clients. By inserting the issue of dual relationships in the text between the general issue of exploitation and the specific issue of sexual exploitation, any relationship with a client outside the therapeutic relationship is given a very strong negative connotation. Indeed, there is no acknowledgment whatsoever of any potential benefits of dual relationships. The Committee has turned a blind eye to the personal affirmation, improved reality testing, and mutual enrichment that often emerges through such relationships.

In my view, it is not duality that constitutes the ethical problem; it is a therapist's personal propensity and readiness to exploit clients (and occasionally a client's readiness to exploit therapists) that is central. Having a second relationship with the client only provides another avenue for exploitation to take place, if a therapist (or client) already happens to be

so inclined. Duality *per se* does not create, nor encourage, exploitation. Yet, it appears that the AAMFT Ethics Committee would have us believe it does. In promulgating this view, the Committee is obfuscating the core ethical issue. It is shifting the focus from exploitation to duality and is promoting a treacherous illusion that exploitation can be prevented by simply avoiding dual relationships. Therapists could become complacent about their power and influence if they believed that they could not exploit clients by virtue of not having dual relationships with them. A therapist who is inclined to exploit clients does not need a dual relationship to do so. Various forms of exploitation and abuse, including sexual abuse, can take place within the therapeutic relationship and in the therapy room itself. Fortunately, the statement in the *Code* prohibiting sexual exploitation is clear and to the point and is not confused with duality.

In my view, it is not duality that constitutes the ethical problem; it is a therapist's personal propensity and readiness to exploit clients ...that is central.

But why would the Ethics Committee shift the focus from exploitation to duality? Do the members of the Committee believe that dual relationships are, in fact, inherently problematic and therefore wrong? If so, this needs to be fully explained. Is it because there is a concern that the dependency and trust in the professional relationship will be transferred to and exploited in the dual relationship? This is a legitimate concern, but why give priority to exploitation in a dual relationship over exploitation in the professional relationship? Exploitation needs to be challenged wherever it occurs. Or is it simply because so many of the complaints that come to the attention of the Committee entail dual relationships? The possibility that many complaints about therapists first arise through dual relationships does not mean that the dual relationship is the primary source of the problem. It usually is easier for clients to recognize exploitation in a non-therapeutic relationship than in a therapeutic relationship. This obtains because a therapeutic relationship tends to be unique in the client's experience, while the dual relationship can be compared with other similar (business or personal) relationships that the client has or has had. The availability of these comparisons is one reason why dual relationships actually may be protective. They serve as a potential means for identifying subtle forms of exploitation so that appropriate restraints can be initiated. I suspect that if there is exploitation in a dual relationship, there is also exploitation in the therapeutic relationship. The dual relationship route for client recognition of exploitation may have contributed to the Ethics Committee's erroneous conclusion that a major source of exploitation is duality itself. Another possible reason for the Committee's focus on duality may be administrative expediency. It is relatively easy for an ethics panel to determine whether or not a dual relationship has existed while it is sometimes quite difficult to determine whether or not exploitation has taken place. However, such expediency alone would not justify an ethical principle to avoid such relationships.

Under the fourth principle, ***Responsibility to Students, Employees, and Supervisees,*** Subprinciple 4.1 states:

> *Marriage and family therapists are aware of their influential position with respect to students, employees, and supervisees, and they avoid exploiting the trust and dependency of such persons. Therapists, therefore, make every effort to avoid dual relationships that could impair professional judgment or increase the risk of exploitation. When a dual relationship cannot be avoided, therapists take appropriate professional precautions to ensure judgment is not impaired and no exploitation occurs. Examples of such dual relationships include, but are not limited to, business or close personal relationships with students, employees, or supervisees. Provision of therapy to students, employees, or supervisees is prohibited. Sexual intimacy with students, employees, or supervisees is prohibited.*

Besides perpetrating further obfuscation of duality as a source of exploitation, this statement again shifts the focus away from the more important issue, namely the increased interpersonal power available to the person in the dual positions of, for instance, supervisor and therapist. There is a significant power differential in all of the relationships referred to: between therapist and client, between teacher and student, between supervisor and supervisee, and between employer and employee. The core ethical concern should be whether the power differential (in any one or combination of these relationships) is used to empower the personal and professional development of the other, or is used to exploit him or her. Obviously, the more power one holds, the more devastating the possibilities for destructiveness. However, the converse is also true. The more power one holds, the greater the possibilities for constructive initiatives as well. It is not the power itself that corrupts, it is the disposition to corruption (or lack of personal responsibility) that is amplified by the power. If a training supervisor cum therapist is genuinely disposed to be helpful (an orientation which is presupposed for these social roles), the increased power will empower his or her helpfulness. Thus, the ethical focus in this principle should be on whether the increase in interpersonal power is exercised responsibly and on how one can build in more accountability when dual relationships do happen to emerge.

If the Ethics Committee was less preoccupied with duality and, instead, was more concerned about the imbalance of power in professional relations (which is intensified when a supervisor also

becomes a therapist), it would have proposed a different means of taking "precautions." For instance, it would have proposed a means of increasing the power of the supervisee/client as a counterbalance. This could be done by proposing that the therapist/supervisor empower the client/supervisee to select the third party to review or monitor any disturbing complexities in the relationship. The commentary on the new *Code* which appeared in the April 1991 issue of Family Therapy News (p. 20) proposed virtually the opposite. It advised that the therapist obtain supervision of a dual relationship with a client (cf. Subprinciple 1.2) and the supervisor obtain supervision of supervision of a dual relationship with a supervisee (cf. Subprinciple 4.1). To give the therapist or supervisor the authority to select the additional resource (whom the client or supervisee may never know about) is to give even more covert power to the therapist or supervisor. It would be far more ethical for the Committee to give responsibility to the therapist or supervisor to openly discuss with clients and supervisees the increased potential for both enrichment and exploitation through dual relationships and to invite clients and supervisees to bring in third parties of their choice at any time to clarify any concerns that might arise. The therapist or supervisor could be given the additional responsibility to assist in making such arrangements but would be expected to respect the client's and supervisee's priority in choosing which additional resources would be brought in.

I believe that any student, supervisee, or employee as well as any teacher, supervisor, or employer should retain a personal entitlement to turn down any invitation from the other for therapeutic involvement if they prefer to avoid the complexities entailed. But for AAMFT to categorically prohibit the provision of therapy to students, employees, or supervisees is unnecessarily restrictive in patterns of interprofessional relationships. Furthermore, such a prohibition implies that there is no continuity or overlap between supervision and therapy. It fosters the idea that the conduct of therapy can be separated from the person of the therapist. This reflects a reductionistic perspective. In keeping with the systemic view, I prefer a more holistic perspective which allows for the synergistic and integrative possibilities that arise when supervision is supported with therapy and vice versa. I have had several experiences of providing brief therapy for trainees where each process has enabled and enriched the other.

Under the fifth principle, ***Responsibility to Research Participants***, Subprinciple 5.3 states:

> *Investigators respect participants' freedom to decline participation in or to withdraw from a research study at any time. This obligation requires special thought and consideration when investigators or other members of the research team are in positions of authority or influence over participants. Marriage and family therapists, therefore, make every effort to avoid dual relationships with research participants that could impair professional judgment or increase the risk of exploitation.*

Once again, dual relationships are brought forth as problematic and their constructive possibilities are ignored. There are some advantages to the presence of dual relationships in research. For instance, an investigator is far less likely to carry out questionable studies or to conduct potentially harmful experiments when he or she has another meaningful relationship with some of the research participants. This effect arises because there is a more direct and personal basis from which to become mindful about and to care about the possible negative effects of the study. Furthermore, the investigator may be able to interpret a participant's responses more coherently if collateral knowledge about the research participant is available through the other relationship. Dual relationships also provide a valuable conduit for feedback about unexpected effects of the study. Research participants often can offer a richer and more comprehensive description of their experience in the study (and its subsequent effects upon them) through the dual relationship because such reporting is not structured by the research. To discourage such feedback, during and/or after a study by discouraging dual relationships, is to diminish the possibility that investigators would become aware of some totally unanticipated effects of their investigations. In other words, by discouraging dual relationships in research, not only are participants less protected, the potential richness of the new knowledge generated, also is liable to suffer.

In pointing out these potential positive influences of dual relationships in research, I am not saying that investigators should be actively encouraged to have dual relationships with their research participants. Appropriate decisions would depend on the specific nature of the study and on the particular individuals involved. Seriously problematic biases could be introduced in some studies by both researchers and participants through dual relationships. However, this is an issue for research design and methodology and the ethics of any particular study should be left to the local research ethics committee to adjudicate. With respect to the *AAMFT Code of Ethics*, the relevant focus should remain squarely on the avoidance of coercion and exploitation, and not be displaced onto duality.

The need to reconsider dual relationships as currently written, the *AAMFT Code of Ethics* does not acknowledge any possibility that a dual relationship can be constructive. Dual relationships are seen only as potentially exploitative and, hence, should be avoided. Indeed, the repeated use of the phrase, "could impair professional judgment," gives me the impression that the Ethics Committee has come close to regarding duality as something analogous to a *toxic substance*, so that having a dual relationship is rather like being intoxicated by alcohol or being impaired with drugs. An alternative perspective could be that the members of the Committee are so *intoxicated* with the idea that dual relationships are hazardous that they can no longer see anything positive in them.

In my experience, involvement in dual relationships actually can and often does contribute towards improved, rather than *impaired,* professional judgment. The *improved* judgment can be manifest in the specific case and/or it can be incorporated in one's overall patterns of decision making. Interestingly, this mode of professional development usually takes place after one has graduated and established a practice. This makes the value of dual relationships even more significant.

Any process of improving one's professional judgment after one's *official* training is complete, is extremely important in any profession.

Just how do dual relationships contribute to improved professional judgment? Duality provides an important pathway for corrective feedback; a means to improve understanding and consensuality which enables greater wellness in human social systems in general. Dual relationships serve to *open space* for increased connectedness, more sharing, greater honesty, more personal integrity, more responsibility, more social integration, more complete healing, and more egalitarian human interaction. Furthermore, dual relationships tend to *reduce space* for exclusion practices, for covert manipulation, for deception, and for special privilege. When persons relate to each other in multiple contexts there is greater opportunity to recognize each other as ordinary human beings. There is less probability of either party persisting in distorted perceptions of the other, such as attributions of exaggerated insight and wisdom in therapists (by their clients), or attributions of pervasive personal limitations and deficits in clients (by their therapists). It is through a dual relationship that one's "reality testing" about another person has a whole new domain in which to operate. Through the integration of collateral experiences in the two relationships one benefits from the "depth perception of double description" (Bateson, 1972) and can form impressions that are better grounded. In other words, duality generally creates improved conditions for greater sanity and health all around.

Should these constructive possibilities be curtailed in our field simply because there is also the possibility of exploitation in dual relationships? I think not. Has the Ethics Committee "thrown out the duality baby along with the exploitation bath water"? I think so. Given the current *Code*, the positive aspects of dual relationships cannot even be explored without the risk of ethical censure.

But the present AAMFT position against duality is more serious than a simple injunction against relationship complexities that have the potential to be constructive. Not only is the "baby" being thrown out; a pathologizing social process is being introduced to take its place. It is a process that gives priority to professionalism over personal connectedness. This priority is pathologizing because it fosters human alienation and promotes an increase in interpersonal hierarchy. In the name of professionalism, we, as marriage and family therapists, are being encouraged to avoid becoming involved in the personal lives of our clients, students, trainees, employees, or research participants. In effect, we are being told to maintain our "professional distance." The active maintenance of this interpersonal distance draws attention to and emphasizes the power differential between the persons involved. This distancing promotes a process of objectification and disposes us towards more of a vertical hierarchy in human relations. When social systems are structured in this way, it is the professionals whose status is raised. Consequently, the status of those being "served" is lowered in a reciprocal manner. This is one of the more sinister aspects of professionalism. Thus, while the policy of avoiding dual relationships ostensibly is in the service of protecting the vulnerability of clients, trainees, employees, and research participants, it actually privileges professionals instead. I question the ethics of such a policy.

I am clearly opposed to a general prohibition of dual relationships, I also am opposed to a general prescription of such relationships.

The alienating effect of professionalism is intensified when we begin to respond to others as occupants of a position or role rather than as unique persons. In other words, when the person of the other is rendered irrelevant or unethical to relate to, we tend to relate to the role or position he or she occupies instead. The professional relationship becomes a process of interacting roles rather than interacting persons. Being treated as a mere occupant of a position (e.g. as "the patient" or as "the student") rather than as a unique individual is a profoundly dehumanizing experience. A professional disposition or attitude of avoiding the possibility of dual relationships inadvertently supports such alienating practices. This kind of professionalism enstructures a significant break in "the *patterns that connect*" us with one another as human beings. It separates and alienates us instead. Ironically, the professional who turns down invitations to be involved in a dual relationship can now cite the *AAMFT Code of Ethics* self-righteously as the basis for his or her action. Anyone who has used such grounds to turn down a friend's request for therapy can attest to the uncomfortable alienating effects of such a response.

Experience in dual relationships

I, personally, have experienced dual relationships both as a client/trainee and as a professional. In the most significant experience that I have had as a client (i.e. 2 years of personal analysis during psychiatric residency training), I had concurrent advisory and preceptor relationships with my therapist. Each relationship seemed to augment the other. For instance, the advisary relationship enabled the initiation of therapy. My learning as a student of my therapist's theoretical work in clinical skills was enhanced and energized by my therapeutic relationship with him. While in the therapeutic relationship I felt more valued as a whole person because of the other relationships I had with him. Without these additional relationships I suspect that I would have struggled much more with feelings of being a "defective" human being simply by virtue of being in the "demeaning" client role. The dual relationships helped me preserve a better sense of personal worth. The long term effects were also positive. An egalitarian colleagueship and friendship subsequently emerged between us and has continued over the years to be a significant source of ongoing validation for me, both personally and professionally.

As a professional, I have had predom-

inantly positive experiences in dual relationships as well. I have found that participation in such relationships constitutes a strong covert invitation for me to strive towards greater personal integrity, in both the personal and professional aspects. The dual involvement seems to activate a non-conscious process in me towards becoming more honest and authentic with the other. It is much more difficult to "hide behind the cloak of professionalism" when I allow a dual relationship to emerge. My mindfulness grows as I automatically become more aware of the potential significance of a wider scope of my behaviors in the experiences of the other. For instance, when I see a friend as a client, I become mindful of the potential consequences of my behavior as a therapist for the friendship. I also become more mindful of the relevance of my behavior as a friend for the therapeutic relationship. I find myself naturally seeking more congruence in these relationships and am stretched in the direction of more consistency, coherence, integrity, and authenticity. As a result, I seem to be evolving towards becoming both a more friendly therapist and a more therapeutic friend. This has been a welcome development, and, in my opinion, has enhanced the clarity and humaneness of my professional judgment.

The majority of the feedback that I have received from clients, students, and supervisees about the dual relationships that I have had with them has been positive. Indeed, one trainee whom I saw briefly with his wife in therapy felt that it would have been unethical for me to turn down his request for therapy, given the importance of the training relationship I had with him at the time. In my view, the therapy enabled his training and the training enabled the therapy. This is not to say that my involvement in dual relationships always has been a simple, or an easy process. In a rather complicated situation of long-term therapy, one client felt she had lost me as a clinical resource when personal friendships emerged between our respective families. I supported her decision to find another therapist, but could understand her experience of loss in choosing to no longer see me as a therapist. Thus, complications do occur but they are not necessarily exploitative. Whenever I invest the time and energy to sort out such complications, I usually find that they enrich my personal and professional development to a significant degree. Thus, I concur with Ryder and Hepworth (1990) that we should not simply avoid the complexities involved in dual relationships, but regard them as a means to facilitate our continued learning about and understanding of human relationships.

Concluding Comments

It is my opinion that the AAMFT is doing our field and our communities a major disservice by imposing such pervasive restraints on dual relationships through the *Code of Ethics*. Far more research and exploration into the nature, complexities, and consequences of a wide range of dual relationships is needed before such a broad restriction on duality is allowed to become entrenched in our professional attitudes. Not only is the issue of exploitation being confused, human enrichment possibilities are being restrained, professional hierarchy is being privileged, and social alienation is being enhanced. In view of these effects, I propose that the existing statements on dual relationships in the *Code* be rescinded and the issue of exploitation be addressed more directly and explicitly. The Ethics Committee should redirect its focus to differentiating and clarifying the various forms of exploitation that commonly occur within primary and/or dual relationships and articulate additional principles like the statement prohibiting sexual intimacy. Clear statements about the specific kinds of exploitation (egoistic, emotional, voyeuristic, financial, authoritarian, ideological, etc) that can occur would help professionals and clients alike know what complications to look out for. The past experience of the Ethics Committee in responding to actual complaints from clients, trainees, and research participants would be one major resource in developing such statements.

I believe the complexities of dual relationships should be addressed somewhere in the *Code* as well; preferably in a separate section to curtail any continuing identity with exploitation. Opportunities for possible enrichment should be noted as well as risks for possible exploitation. One important example of the latter is the non-conscious transfer of the power differential (including dependency and trust) from one relationship to the other. This implicit process enhances the vulnerability to exploitation and should be disclosed explicitly and brought into the conscious awareness of professionals as well as those with whom they work. Whether a separate section on dual relationships is introduced into the *Code* or not, any future restatement of the issue needs to be far more differentiated and balanced than what currently exists.

I am clearly opposed to a general prohibition of dual relationships. However, I also am opposed to a general prescription of such relationships for the enrichment that is possible through them. Dual relationships often are very taxing in personal time and energy. Hence, each individual therapist and client, teacher and student, supervisor and supervisee, employer and employee, or research investigator and participant should be entitled to exercise free choice about whether or not he or she is ready and/or willing to enter into a particular dual relationship or not. Any such person also should be free to enter into a dual relationship with some persons, without being obliged to do so with others. In addition, if after having entered into a dual relationship, the persons involved wish to change their minds and would like to discontinue such involvements, they should be entitled to do so. What does seem reasonable to expect, however, is that any desires or decisions to avoid, initiate, and/or relinquish dual relationships be openly discussed, so that the parties involved can expand their awareness of the potential consequences, and, hence, become more responsible.

References

AAMFT Code of Ethics. (1991) Washington D.C., American Association for Marriage and Therapy,

Bateson, G. (1972) Steps to an Ecology of Mind, New York: Ballantine.

Preister, S. (1991) *AAMFT Code of Ethics* changes, Family Therapy News, p. 20.

Ryder, R., and Hepworth, J. (1990) AAMFT Ethical Code: Dual relationships. Journal of Marital and Family Therapy, 16, pp.127-132.

Webster's Unabridged Dictionary of the English Language. (1989) New York: Portland Press.

Parry Looks at the Books

Rejoyce

by Alan Parry

James Joyce is surely the most influential and important literary stylist of the twentieth century. Perhaps because of this, however, his daring experiments have made reading him for many an intimidating obstacle rather than an invitation to fresh ways, not only of reading, but of experiencing life itself. His three great works are *Portrait of the Artist as a Young Man, Ulysses,* and *Finnegans Wake*. Yet even his first published work, Dubliners, a book of short stories, introduces his challenge to ways of experiencing a world that must be perceived in ways both new and very old, if indeed we are, it now appears, to survive it much less understand it.

Joyce might be described as, at one and the same time, the quintessential modernist and the first post-modernist. By modernism I refer to a movement that challenges conventional assumptions about what constitutes good middle-class living by exposing its complacency and superficiality in the name of humanity's enduring mythic or archetypal experiences. As such, more perhaps than any of his peers, he suffers that troublesome symptom of the modernists, a recondite elitism that requires that the reader either bring along an expert in Joyce, through the medium of a university course, for instance, or, more likely, a companion volume such as Stuart Gilbert's *James Joyce's Ulysses*, or Joseph Campbell's and Henry Morton Robinson's *A Skeleton Key to Finnegans Wake*. Only then will the undertaking become one of clarification and illumination rather than of confusion and irritation.

In spite of the latter necessity, indeed because such guides are readily available, a modernist reading of any of Joyce's three masterpieces repays richly. *Portrait,* (for short), is a dazzling, relatively short novel that is, in fact, sufficiently accessible that it requires no such guide. What one might look for in it is Joyce's first great experiment with the portrayal of personality as a river rather than as a statue (Ellmann, P.). At each stage of the protagonist's life his world is described according to his capacity to experience it at that time. Thus, the famous opening lines, of Stephen Dedalus's experience at around age three:

> *Once upon a time and a very good time it was there was a moocow coming down along the road and this moocow that came down the road met a nicens little boy named baby tuckoo.....(p.7)*

Portrait is also inviting for its wondrous example of one of Joyce's key themes, that of epiphany, regarded, not as a visitation of a god, but of those profane moments which bring moments of illumination into the very *reality of experience.* Thus, there is a scene that serves as Stephen's calling to the life of an artist, a calling experienced by him as no less holy than that to the priesthood itself (which he had, in fact, once considered).

While walking along the beach one early evening he sees a young woman wading in the water, her skirts held thigh-high. Anything but a pornographic experience expressing lustful desire, it is, by virtue of its sensual and even sexual beauty, a glimpse less into the beauty of holiness than into the holiness of beauty:

> *She was alone and still, gazing out to sea; and when she felt his presence and the worship of his eyes her eyes turned to him in quiet sufferance of his gaze, without shame or wantonness. Long, long she suffered his gaze and then quietly withdrew her eyes from his and bent them towards the stream, gently stirring her foot hither and thither. The first faint noise of gently moving water broke the silence, low and faint and whispering, faint as the bells of sleep; hither and thither, hither and thither; and a faint flame trembled on her cheek.*
>
> *—Heavenly God! cried Stephen's soul in an outburst of profane joy.*
>
> *He turned away from her suddenly and set off across the strand. His cheeks were aflame; his body was aglow; his limbs were trembling. On and on and on and on he strode, far out over the sands, singing wildly to the sea, crying to greet the advent of the life that had cried to him.*
>
> *Her image had passed into his soul for ever and no word had broken the holy silence of his ecstasy. Her eyes had called him and his soul had leaped at the call. To live, to err, to triumph, to recreate life out of life! A wild angel had appeared to him, the angel of mortal youth and beauty, an envoy from the fair courts of life, to throw open before him in an instant of ecstasy the gates of all the ways of error and glory. On and on and on and on. (pp. 171-72)*

Here we find the heart and soul of modernist gift to reawaken both meaning and enchantment in a world that had become thoroughly disenchanted. The hitherto colonized sacred once again escapes to reveal itself in the very midst of the profane, as an act of grace that sanctified human experience with a gift from the "wild heart of life itself" not in some spiritual idea of perfection but in "all the ways of error and glory."

For those of us that have responded to the calling of therapy, the healing of the wounded souls, there can be no sounder credo, that out of error may come the capacity *to recreate life out of life*. There is this and more in this book of profane holiness. Joyce's definitive statement of the nature of tragedy and its operative emotions of pity and terror and, in their heartfelt contemplation, the healing power of art. Joyce, in the *Portrait,* begins a process that would remind us that the crown of human capacity lies in the imagination, the capacity it offers us to experience life in all its error, terror and pity and to transform it from the tragedy to comedy.

(To be continued...)

Shared Stories: The Tie That Binds

by Alan Parry
Family Therapy Program
The University of Calgary

A story is a narrative that says something happens—not all stories are myths but all myths are stories. Myths are a particular kind of story, not just a one person story, but a story which many people understand and share and use to define themselves as the people who have that story. It is our story.

Wendy Doniger O'Flaherty

George and Phyllis were a couple in their early 50s who came to see me because they no longer had much feeling for each other. Phyllis wanted to leave to make a new life for herself; George was reluctant for the marriage to end. They had become distant from one another and their few conversations had become forced. They said that they no longer shared common interests or values. They had lived in a suburb of the City which had meant that George was away from home from early in the morning until into the evening. This went on for several years and it took the couple further and further apart as Phyllis developed interests of her own and George immersed himself in his work. He would stay in the City if there were staff social functions and often remained overnight. His staff came to think of him as unattached, though all knew of course that he was married. Phyllis felt shut out of his life and resented it, and he had lost all sense of her's. George had had one affair that she knew of and she took for granted there had been more.

Gradually, however, Phyllis became, in her necessary self-sufficiency, increasingly confident in herself and decided to leave what was left of the marriage to make a new life that was entirely her own. To her surprise, George was devastated and begged her to reconsider. He said he could not imagine not being married to her, that his marriage and home were the mainstays of his life. Though reluctant to delay things any longer, Phyllis agreed to come for marriage therapy, much more out of a sense of duty that she owed her marriage vows at least this much, than out of any feeling for George for whom she now professed indifference. Each one told of the marriage from their own perspective: George of his growing sense of feeling unimportant, of being reduced exclusively to the role of breadwinner as his wife devoted herself to their two children and their activities; Phyllis of being abandoned to the status of de-facto single parent while her husband threw himself into his career.

At the end of the second session I asked the couple to experiment with the almost standard marital therapy exercise of one talking while the other did nothing but listen, thirty minutes for each. The couple agreed with little comment. They returned one month later and reported that much had changed and they now thought they could make it, this time together. When there was nothing to do but talk and listen respectfully, each was able to listen for the first time to the other's story, of how it had been for that person while oneself was immersed not only in each one's own life but nursing feelings of hurt and resentment toward the neglect that each felt from the other. Both said that they realized that the other had not acted in the way they had out of meanness or indifference, but unintentionally out of hurt and that all both wanted from the other was love and attention. They agreed they were each very willing to offer these to the other. Since rediscovering each other in this entirely unanticipated way they had been spending the last month talking, appreciating and enjoying each other all over again.

There is a sense in which the healing power of shared stories has always been known and acted upon in human affairs.

What most impressed me about what this couple had done with this exercise was that they not only used the blame-free atmosphere that it provided and the information that this facilitated to understand where each had been coming from in their actions., they had also taken their two separate stories and made them into a shared story of compassion, overcoming years of misunderstanding. As I have reflected on the way that this couple healed themselves so quickly of many years of estrangement, it has led me to consider the possibility that shared stories are intrinsically binding and bonding.

There is a sense in which the healing power of shared stories has always been known and acted upon in human affairs. Nations are created and maintained in a sense of continuing unity and patriotism by shared stories of those great ones whose exploits brought them together. When the security, or even the survival, of a nation is threatened its people draw sustenance from stories that they share about their standing together on these occasions against their common threat. Probably no nation on earth illustrates the binding and bonding power of shared stories in these ways better than the United States.

A nation of unparalleled power and influence was, in fact, created which succeeded in establishing a sense of unprecedented loyalty from amongst the most disparate collection of immigrants imag-

inable. People gathered from all over Europe and eventually Asia and South America, including even enslaved, enforced migrants from Africa and cheated and defeated indigenous peoples of the land itself. Eventually, a single nation emerged, all I would argue, on the basis of the collective genius to disseminate stories to be shared about tumultuous beginnings, heroes and villains, and even the very war that almost tore the country apart.

Meanwhile, the more insecure and introverted neighbour to the north, Canada, has always wanted, not for the ingredients of great stories, but for the will and confidence to tell them and to make sure they were shared proudly. Thus, Canada still struggles to find a sense of national identity and even wrestles all these years after its formation with the imminent possibility of its dismemberment. Perhaps, in fact, the source of that possibility is that Quebec has too little sense of being part of a shared story with the rest of Canada. It is not, surely,constitutions or legal agreements that keep countries together. It is the sharing of a story about a common struggle and the willingness to continue that story together because it has become and remains our story. In the Soviet Union today, on the other hand, the story that had bound the vast company of nationalities together was a story that has become discredited—that of the Communist Revolution. Ergo, the country falls apart.

Religion: The Ultimate in Shared Stories

Amongst the religions of the world we find even more powerful and enduring examples of the binding power of shared stories. *Religion,* in fact, might be defined as a story or collection of stories, the continuing truth of which is periodically confirmed by the performance of certain specified practices that are shared by a community of people who believe both the story and the practice to reveal or exemplify the meaning of life. Wendy Doniger O'Flaherty, perhaps the foremost living mythologist (succeeding her teacher—Mircea Eliade and also Joseph Campbell) defines myth (of which she says, tellingly, that it is "impossible to define...but cowardly not to try") as

> *a story that is sacred to and shared by a group of people who find their most important meanings in it; it is a story believed to have been composed in the past, or more rarely in the future, an event that continues to have meaning in the present because it is remembered; it is a story that is a part of a larger group of stories. (1988, p.27)*

Following O'Flaherty (1988) in her definition, then, it seems safe to say that myths are the stories upon which religions establish their central beliefs and practices. I will go on to suggest that myths are not the exclusive domain of religion, that any shared story that gives meaning to particular relationships thereby bonded, constitutes *myth.* As such, myth, at whatever level of relationship it is used, may be said to constitute the story which connects, a metastory, or story of stories (*cf.*, Bateson, 1979, p.11).

...any shared story that gives meaning to particular relationships thereby bonded, constitutes myth.

The word myth, unfortunately, has become so interchangeable with the word lie that every attempt to use it in a deeper and more encompassing sense, requires an explanation. Moreover, even such efforts often stumble over this historic equation. In my own efforts to understand properly the role of myth in people's lives, I have previously suggested that it refers to the domain of the taken-for-granted or no-longer-questioned horizon of meaning (Parry, 1991a, p.52).

This use of myth goes all the way back, as O'Flaherty points out, to Plato. The unfortunate equation has been perpetuated by the religions of the West, Judaism, Christianity and Islam, all of which have insisted dogmatically upon the historical and inalterably factual nature of their founding stories. Thus, when these stories have been referred to as myths, in their capacity as shared stories that give life meaning, the response of the faithful has generally been outrage. Indeed, when Salman Rushdie attempted to deconstruct one such story, that of Muhammed, in an imaginative way in order to breathe new life into its accepted meaning, the outrage that followed led to a sentence of death being placed on his head (1988).

Rushdie's plight, in fact, illustrates two very crucial features of shared stories, especially those deemed sacred. In the first place, unless a myth is periodically deconstructed it does tend to become, as I previously argued, the justification for a taken-for-granted limit placed upon important life choices and possibilities. Secondly, however. so vital to the very existence of the community is its shared sacred story, its myth, that when someone who is expected to be sharing the story instead challenges it, the community's wrath is far greater than it would ever be to an outsider who overtly attacked it, however irreverently. It is as though any slight to the story from one who is assumed to share it is regarded as a threat to the community in a way that is not felt even by the most furious challenge from those who do not. Rushdie's personal tragedy was not only that he did not, nor apparently ever had, considered himself a member of the sacred community of Islam, only of its culture. As a postmodern artist, writing with the irony so typical of that position, he assumed that these factors gave him both the freedom and the distance necessary to challenge a myth. To his great surprise and consternation he was treated instead as an apostate from a way of believing that he never had nor probably ever could share—his recent undoubtedly sincere submission to Islam notwithstanding (1991).

The religions of the East, by contrast, have never locked themselves into factuality or history, indeed the very notion of priority being attributed to phenomenal events that are subject to change and decay is regarded as the source of life's sorrow in the first place. Even the story of the undoubtedly historical Buddha is regarded as incidental to the possibility of enlightenment. Nor do the religions of aboriginal peoples rest any claim to the validity of their shared stories on the insistence that what was said to have hap-

pened in the beginning times, had to have taken place. Indeed, this kind of critical thinking was undoubtedly foreign to them. In any event, the truth of the story was the shared sense of meaning provided by the attempt to address, if not altogether answer the everlasting question of why—why things are the way they are.

Something that all religious, and probably most national myths, have in common is not just the sharing of the story in the telling but its sharing through ritual enactment. Thus the Christian story of the life, death and resurrection of Jesus has been told and retold , but what separates the Christian community, the Church, from many other people who have heard and gained pleasure and even inspiration from the story is its ritual enactment through participation in the Eucharist. The story is often used, to be sure, to attract people to the community, but the Eucharist is most commonly restricted to those who have been accepted into it. In that sense, it could be said that where the story includes, its ritual enactment excludes—a vital distinction for revisioning centers of value in a decentered world, as I shall attempt to show below.

"But Can We Tell the Story... ?"

These postmodern times in which we live today, characterized as even the daily headlines remind us, by the absence of any secure sense of an unchanging truth or universally shared perspective, may be precisely what is foretold in the old Hasidic tale of that generation that only had the story, for it had forgotten all else:

> *When the Baal Shem-Tov had a difficult task before him, he would go to a certain place in the woods, light a fire and meditate in prayer—and what he had set out to perform was done. When a generation later the "Maggid" of Mezeritz was faced with the same task he would go to the same place in the woods and say: We can no longer light the fire, but we can still speak the prayers—and what he wanted done became reality. Again a generation later Rabbi Moshe Leib of Sasov had to perform the task. And he too went into the woods and said: We can no longer light a fire, nor do we know the secret meditations belonging to the prayer, but we do know the place in the woods to which it all belongs—and that must be sufficient: and sufficient it was. But when another generation had passed and Rabbi Israel of Rishin was called upon to perform the task, he sat down on his golden chair in his castle and said: We cannot light the fire, we cannot speak the prayers, we do not know the place, but we can tell the story of how it was done. And, the story-teller adds, the story which he told had the same effect as the actions of the other three. (quoted in O'Flaherty, 1988, p.127).*

The religious crisis that is virtually synonymous with modernity (Cf., Parry, 1991b) was worsened in the West precisely to the degree that representatives of the religious structures insisted upon the historical and singular truth of its shared stories in the face of challenges implicitly and explicitly brought against them by the discoveries of science. It was, however, these challenges that led the scholars of the major Protestant communities to adopt many of the methods of science to engage in an activity that was unprecedented in the history of religion: a systematic and critical study of its own sacred stories as contained in its scriptures. The actual upshot of more than two centuries of such examination has been the liberation of these stories from the dogmatic and destructive hand of literalism, the insistence on their invariant truth. In the main the stories were not denied as having a basic historical foundation, after all they described events that took place in the written memory of historic humanity. At the same time, however, as the literalistic claims of the communities of the devout concerning their stories were being challenged, the efficacy of their ritual enactments was also being questioned as vestiges of superstition and mindless formalities best left behind by the triumphant progress of science and rationality. All that remained intact were the stories themselves. Fortunately, as the Hasidic tale reminds us, a good story never loses its power to transform.

Family Stories

The anthropologist, Victor Turner (1969), maintains that societies, and certainly by implication families, cannot function adequately unless, within their inescapable, day-to-day operations—within the demands of certain hierarchical and rule-bound structures—they are able to find release in what he calls *Communitas.* Communitas is the experience of love and intimacy in a context free from demand and domination, where "the first shall be last and the last first". This indispensable renewing transition can only be navigated by experience within ritual space which exists in rites of passage between the one state and the other, between structure and Communitas.

Something that all religions have in common is not just the sharing of the story in the telling but its sharing through ritual enactment.

In family life story-telling can be the means for the experience of Communitas. In making this connection I am referring to stories told and retold about family members, family history and notable forebears, experiences, adventures, travels and travails, "remember when" exchanges—in all stories that include, embrace, celebrate and, when necessary, grieve for the family and its members as a body. I am not including stories told at the expense of certain family members, such as derogatory gossip, or stories that ridicule or scapegoat individuals within the family. While such stories go far to define a family, they do not, as the former kind do, create the experience of Communitas. I furthermore suggest, following Turner, that the frequent experience of Communitas is essential to a family's capacity to function adequately. It gives its members a sense that this is one place in an otherwise unpredictable and often unfeeling world where they do belong and where they are always some-

body. In this sense, I am suggesting that such shared family stories constitute the family mythology. As such, this further refines the definition of a myth: it is a story that, when told or enacted in ritual space, invites its listener into an experience of Communitas.

Family Myth and Ritual

I indicated above that stories tend to invite and include whereas ritual enactments of even the same story tend to exclude. Accordingly, postmodernism may be described as a time in which the loss of a sense of a universal truth calls for the great sacred myths to be freed from their excluding rituals that they might be shared by all, at the same time as the sharing of stories within today's rapidly fragmenting family be ritualized in order to build a feeling within families of inclusion and identity, of Communitas.

Indeed, I would go so far as to suggest that the simple act of creating a space for the sharing of its stories on a periodic basis would go far toward providing those experiences of Communitas—of warmth, togetherness, forgiveness and love—that would, by itself, spontaneously challenge the structural dysfunctions that give rise to pathologizing interactional patterns. My proposal, in other words, is that such patterns arise when there is an experienced insufficiency of *Communitas.* Children make what their parents experience as inordinate demands on their patience and attention; parents make what amount to moralistic judgments, labelling their children's behavior as good or bad and themselves as failures so that feelings of being excluded from the love and understanding of other family members runs rampant. The attempt to correct the problems that then emerge are inevitably insufficient because they rarely address the plea for *Communitas* that the offending behavior invariably represents, either as a test of family love or as resentment at its felt absence.

...the loss of...a universal truth calls for the great sacred myths to be freed...

Such painful developments are all but inevitable in a world in which the centering domain of the sacred and the imaginary has been either literalized or minimized and the real and the profane exalted (Parry, 1991b), so that there has been assumed to be a technical solution for every problem. Meanwhile, the healing power that lies within the imaginary domain of stories told inside a sacred space that is set aside for that purpose , perhaps humankind's oldest protection against estrangement, has been overlooked.

Interventions that sought to incorporate the healing power of the shared story and a space set aside for its ritual enactment would take the following form. After a discussion is held of the role thus far played by story-telling and sharing within the family at hand, its members are asked to schedule a time and a place about one week hence at which time all of them are to gather for the sole purpose of sharing family stories. The therapist will seek agreement from all members of the family household that they will attend these meetings and place them on a first priority basis. The week interval is suggested to be used by each member to think of some favorite happenings that he or she would like to share. Old photos, family albums and any other kinds of favorite items or memorabilia can be brought along to facilitate memories and accompany stories. The family is to obtain for itself a talking stick, makeshift at first but perhaps carved and shaped as a family project later. The one who has the stick is the only one with permission to talk. Everyone else is then to listen. When the one with the talking stick is finished, the stick is passed to the next person who wants to tell a story. A time should be set at the beginning of the story-time, of not exceeding one hour and not taking less than thirty minutes.

A second phase to story-sharing can, if wished or deemed necessary in the interests of family reconciliation, then be set aside for the sharing of experiences in which there is an embittering and excluding clash of perspectives, stories told at each other's expense, where blame has assumed dominance. At such times, again using the talking stick, each party to the difference speaks to the other(s) and the other(s) listen(s), as in the exercise described at the beginning of this paper. Then the roles are reversed. Each story is to be told as experienced by oneself rather than on what the other did or did not do. When completed there is to be no further discussion or comment on this matter. When the time of story-sharing ends, family members may then have an airing of any lingering resentments which, by prior agreement, are to be left at the door when the meeting ends; finally there is to be an exchange of expressions of appreciation and caring for each member, particularly any arising from the stories shared in the time now ending. At this time, the meeting is brought to a close and the talking stick placed in an agreed-upon place of significance until the next meeting, to be held not less than one and not more than two weeks hence.

How are such stories to be shared? M. Buber tells how to relate a good story:

> *A rabbi, whose grandfather had been a disciple of the Baal Shem, was asked to tell a story. "A story," he said, "must be told in such a way that it constitutes help in itself." And he told: "My grandfather was lame. Once they asked him to tell a story about his teacher. And he related how the holy Baal Shem used to hop and dance while he prayed. My grandfather rose as he spoke, and he was so swept away by his story that he himself began to hop and dance to show how the master had done. From that hour on he was cured of his lameness. That's the way to tell a story." (quoted in O'Flaherty, 1988, p.l)*

References

Bateson, G. (1979) *Mind and nature: A necessary unity.* New York: E.P. Dutton.

O'Flaherty, W.D. (1988) *Other people's myths: The cave of echoes.* New York: Macmillan.

Turner, V. (1969) T*he ritual process: Structure and anti-structure.* Itaca: Cornell University Press.

Parry, A. (1991a) A universe of stories. *Family Process* 30(2).

Parry, A. (1991b) If the doors of perception were cleansed. *The Calgary Participator* I(2) pp. 9-13.

On a Cold Stone

by Chris Kinman

At one time
I left my father
To travel with my mother
Whom I loved and love today
I suppose that I simply held more value for where she seemed to be travelling

But today there is a new journey

Not a voyage back to my father
But an excursion
Onward
Or more precisely
Downward
To a dark bristling strength

A strength of which I
And my mother
And my wife
Are afraid

I could stay and join them in this fear
A fear which for them is entirely justified
I could stay in the world they graciously permitted me to share
A world which they fought for valiantly
A world in which I was raised
And purposely joined in my teens

Or I could leave them for a while in the world which they are crafting
Leave them for a journey
That I take alone

A journey to a place I don't know

Some place feral
Some place dangerous
Some place obscure
Some place that speaks rarely
Yet is loudly resonant in a vacant sort of way

A journey to a destination of which I am uncertain

I journey on

•••

There's my father

He's alone
And he cries
Yes
There are tears in this dark and bristly place

Tears
That grieve

Tears
Because he understands that as a child
He was not planned or wanted

Tears
Because
With no mentor
He had to find his own path
And prepare his own trail

There's my father

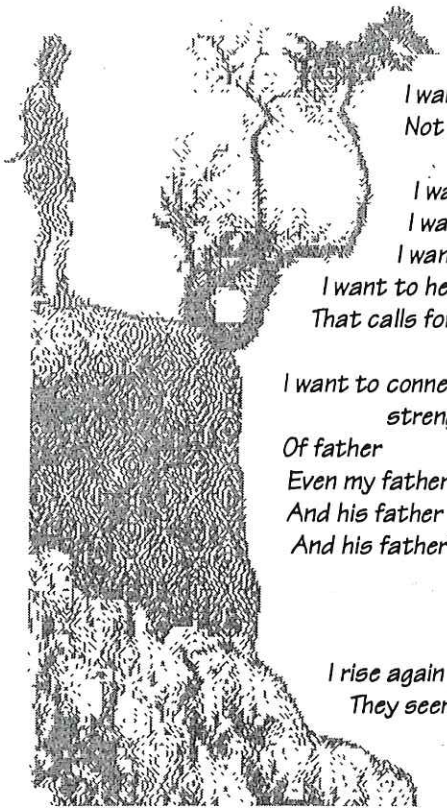
And he cries
Because the path that he struck often did appear to lead
Where others wanted to go

He cries
Because he lost
Or perhaps never had
The respect of his own sons

He cries
Because his misguided trail was often interfered with and redirected by others
Some of whom really did seem to have the edge on wisdom
Others who obviously did not

There's my father

He sits on a cold stone
By a cold river
Watching cold fish rise



I see him cry
And I want him to stand
I want him to walk over to me and hold me
Not like my mother did
But as a father would
I want to feel his beard on my cheek
I want to recognize the grief in his eyes
I want to touch his despair and loss
I want to hear clearly the unclear sigh
That calls for the face of his father

I want to connect to the grief and the wisdom and the strength
Of father
Even my father
And his father
And his father's father's father

•••

I rise again to the world where women live
They seem curious and skeptical and nervous

I believe that they are wise and know that this place must be visited
Yet it seems that they do not want me to go
Perhaps they fear that I'll enter and return with some scar that is ugly
Perhaps they fear that it is down below that men become beasts who war and kill and cut

But I don't find blood below
I find emptiness

And my father

Sitting on a cold stone
By a cold river
Watching cold fish rise

•••

I go back downward
Where my father's grief flows

I go

So that my father and I

May cry
Together

Being in a Men's Group: Lucid Dreaming and Other Influences in My Development as a Therapist

Frank D. Young Ph.D. C. Psych.*
Calgary, Alberta

Working full-time in private practice has been a wonderful learning experience. Although I am enjoying networking and occasional creative collaboration with other community colleague, I have been on my own, working by choice out of the lower level of our family home. This idea came from the desire to transform my life from institutional overload to a more frequent and less stressed contact with family, friends, and a home environment closer to nature. Rarely in the last three years has there been a slack period in an otherwise strong and steady flow of referrals so I feel quite grateful and gratified that this community is supporting me with the opportunities I enjoy.

The Posture of Expert Opinion.

However, I have learned an important distinction between the contexts of public and private practice in Canada, that were not as obvious before. I had always prided myself on the tenacity of client engagement and thoroughness of the therapy process evident on our team in the hospital clinic. Furthermore, with heavy demand and few resources, we had the luxury as well as curse of being quite selective, with a bias toward more severe or needy cases. This allowed us to operate more easily from positions of prestige and gave us the weight of "expert opinion," which well-suited the models favored at the time. These models had the common feature of bold and (at that time) unorthodox *Interventions* that required clients to depart radically from familiar patterns: i.e., the spatial repositioning of the Structural approach, the hierarchical realignments of the Haley-Madanes approach, the attempted solution pattern-breaking of the M.R.I. model, and the outrageous and often humorous interventions of the Ericksonian approach (Young, 1988), featured an action-orientation in therapy. But even with the Systemic interventions of the Milan Model, all approaches suited the status of expert opinion to allow the therapist to impact and help transform the system of ideas and patterns of the people seen in therapy. Even the style and pattern of the interviews were structured and orchestrated to a dramatic and summative Intervention towards the end of the session, with tactics of closure to minimize disqualification or dispute of it by family members (Blom. 1985). Those were the days of drama, excitement, cataclysmic change, thunder and lightning, strategies, tactics, second-ordercChange, and other phenomena that suited the historical era of the '70s and early '80s, the adolescence of the strategic/systemic therapies.

Gradually, strategic and systemic therapists shifted from the powerful-outsider role, to the influential-insider role, "inviting" the family to a new understanding of its dilemma ...

Post-Modernism: Deserters from the Expert Field.

Even then the experts began to tire of the performance demands and role requirements of their posturing. Anxiety mounted about the Strategic responsibility for change, especially in the face of overwhelming odds, against resistances that were all functions of interactions, but at times well beyond the therapist's ability to influence. Gradually, strategic and systemic therapists shifted from the powerful-outsider role, to the influential-insider role, "inviting" the family to a new understanding of its dilemma (Wardenburg. 1991). Reviews and follow-ups of difficult cases led the therapists to review the notions of salience in therapeutic interventions, adopting a more humble posture (Treadway, 1990). Over the years, *"BIG" Interventions of Change* became small interventions of transformation through recursions of language and co-creation of reality (White & Epston, 1989). With feminist influences and sensitivity to the plight of the people in the family system, power shifted to empowerment. Therapists began to divest themselves of a position outside the system observed. The Consulting Team Behind the Mirror was no longer unreachable and anonymous; the Reflecting Team allowed for recursions upon recursions of reflections, and "wondering about" the possibilities became the soft-gloved recommendations of the narrative and storying new therapy team.

By this time the strategic/systemic therapies had evolved into a general orthodoxy, with less radicalism and more refinement through elaboration under the commonly accepted rubric of a solution-focused brief-therapy approach. These therapies appeared to be on the threshold of maturity and integration.

If all of these models and popular trends in family therapy were equally valid and useful for most cases, we could perhaps be more content in this era. However, the contemporary trend towards narrative (White & Epston, 1988) and extremely respectful classes and styles of interventions can be an much of a misfit with client needs and

**107 Range Way N.W. Calgary, Alberta T3G lH6 (403) 241-0090*
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expectations as were often the case in the positive-connotation no-change prescriptions of the early Milan style interventions. Furthermore, while cloaked in polite language, the weight and bias in circular questioning or in the wonderings of a reflecting team, can be just as subtly oppressive as client-centered therapy empathic reflections were shown to be. The team or therapist's reluctance or refusal to take an expert position can be false modesty among the cunning, or a posture of benign non-interference by the self-deluded.

The Management of Expertise.

In summary, I think the position of excessive politeness of therapeutic storying can at times be a false abdication of the expert position on the part of therapists. On the other hand, I can genuinely appreciate the respect conveyed by understanding that the client is his/her unique authority on what has worked for them thus far. While celebrating this success, the therapist can assist in bridging ways to utilize and extrapolate skills from one context to another. Also, the therapist can cite research findings and previous case experience, while respectful of the meaning of these directions. recommendations, and findings as they apply to that individual case. In this way, the expert role is reestablished as proper to the domain of consultation, while due respect is accorded the applicability to the individual case, inviting client creativity to co-create a new therapeutic reality.

The role of consultant can be especially effective in the context of private practice. As your immediate employer is the client, your offering the client a therapeutic conversation within the metaphor of co-authoring a narrative may well mismatch the set of your client. For example, how many of you have engaged accountants, engineers, firefighters, or computer systems analysts with such an invitation? Your client is appropriately entitled to expert opinion in the very contract of the consultation. To offer less (unless you have definite evidence that such an approach is doomed to failure) is to limit a therapeutic resource. On the other hand, to be rushed into rendering a quick expert opinion, rather than guiding a person through a graduated process, can be quite uncomfortable, as all of us have experienced at some time.

In this decision, one pressuring factor in private practice arises from the context of the sometimes limited financial resources of your client. It is possible in these cases to have even more insistent demands for quick results than in public practice cases. Consistent with a brief therapy model, you may be lured into the challenge of working so hard toward the goal of efficiency, that you may be compromising the principle of effectiveness (what you are ultimately working for) and elegance (the quality that gives your life as a therapist aesthetic meaning). Your referral sources may appreciate your efforts to reduce ultimate cost (especially if they are EAP Human Resource Coordinators), but sometimes your clients will not. They want quality care, and proper attention to a congruent pacing of therapy, although they may have to drop out when they have to pay for the entirety of their fee. The pacing of change is especially cogent under these constraints, so that adequacy prevails sometimes at the expense of thoroughness in these cases.

On the other hand, the possibility of being part of a support system for non-change is also problematic. The client will tease you with pseudo-changes, but you will come to realize that second-order change is not forthcoming. The client may be aware of the impasse, but may not be able to handle your candor about your impotence to assist him(her) without some kind of collaborative movement on his(her) part, or a consultation on your part. All manner of glib reframings do not seem to suffice in situations where your client is a complainant rather than a customer, and in these situations other approaches may be helpful (DeShazer,1988).

...I became increasingly aware of my vulnerability due to the lack of locally available male friendships.

The Influence of the Men's Movement.

About two years ago, I became increasingly aware of my vulnerability due to the lack of locally available male friendships. I still believe that women make the best friends and lovers. This is partly because I am naturally biased that way, but also because I agree with feminist colleagues who assert that women are socialized to be better listeners and more attentive to the needs of others, more tending towards the principles of cooperation, holism, and conservation. Moreover, through working with an almost exclusively female staff and clientele for several years, I became aware of my timidity in defending traditional male values, although involved in a martial art (judo) that was far from passive. In supporting feminist and egalitarian agendas, I was still aware that I was a minority in my social circumstance, and only tentatively championed the values I knew to be valuable from the masculine tradition: duty, honour, courage, competitiveness, and resolute focus of attention. More to the point, I missed close and regular male friendships. Experimenting with individuals was encouraging, but still I lacked the collective voice of a reference group for my experience and development. A few compelling and pleasurable experiences made me aware of this strong need, so when a new group of male therapists from the community was forming, I decided to join them.

There were seven of us, promoting an atmosphere of mutual support as men hopefully beyond the traditions that had entrapped us and our fathers in the prison of emotional isolation. This meant promoting vulnerability, diminished competitiveness, and connection with our fathers, sons, colleagues, clients, and other men in our lives. Similarly, we would explore gender issues in relating to our mothers, spouses, daughters, colleagues, and other women in our lives. Insofar as helpful, we also intended to give witness and voice to our understandings as we experienced them. After the first year, we have now met one morning

every 2 weeks, as well as cross-country skiing and partaking in a very hot and interesting sweatlodge experience, in addition to other gatherings in social and professional connections in the community.

The effect of this group experience for most of us has been that of steady warmth and progressive evolution, rather than fireworks and cataclysmic change. Most of us had previous experience with several therapeutic and personal growth encounter groups in the past, both as participants and facilitators, so we were both blessed and cursed with process sophistication. Nevertheless, as in other solution-focused approaches, steady change, though mild and incremental, can eventually lead to major decisions and paradigm shifts in our values. Signs of these trends are beginning in several members.

As for me, perhaps the greatest changes are taking place in my use of self in therapy. I am now more inclined to engage with male members of couples and families, noting their overbalance of financial power and their corresponding lack of emotional power through connectedness and support in relationships. I am less reticent in modeling my responsiveness to tenderness, vulnerability, sadness, joy, and silliness. Sometimes I can admit that I am perplexed and I may not have the answers that my clients so desperately seek. On the other hand, I find it easier to be Frank and direct, less need for window dressing, less concern about the wrapping of the message. If the message is valid, it does not matter. In this way, I feel more powerful, and more respectful of my client, at the same time. In the Zen sense, I feel more actualized as a therapist and as a person than ever before.

At the same time, I feel more humble, inclined to join the thinking of Treadway (1991) and Wardenburg (1990), quietly stronger but less forceful at any given moment, more receptive to the field forces around me. Sometimes I wonder about opportunities to strongly push for change that I would have promoted in earlier days; I wonder if I am as effective as a therapist as I was then. At other times I am aware of my own potential to influence more strongly than ever, because I am less invested in the outcome.

Possibly more important than the foregoing, I am beginning to enjoy the principles of aesthetics that eluded me in the earlier, more ambitious years of therapy. Since I spend the majority of my working life working with these people, I might at least enjoy their company and stories in the brief period of time they are within my purview. I am reminded of Siddartha (Hesse, 1962) who, after several experiences with different lifestyles, opts to be a ferryman, enriching his life with those whom he transports. This is his karma, analogous to mine. I feel privileged to be audience and co-author in part of their drama of living, thereby enjoying a considerable part of my being.

...I was really amazed that the capabilities for endorphin-production were indeed quite real.

From Madness to Method: The Paths of Pioneers.

However, I am not dissolving into the pool of the mystic and magic of existentialism. The teacher and supervisor in me still honours the crucial distinctions between method and style. I read and watch the literature for news of a difference which makes a difference to therapists and their clients. I model and teach these distinctions insofar as I can.

Nevertheless, it is difficult nowadays to discover those aspects of strategic and systemic therapies that are truly pioneering. It seems that the ideas and interventions that were like wagon ruts two decades ago are like superhighways now. I teach in a Marital and Family Therapy program in which the formerly radical is now the orthodox, a strange irony indeed. While seeking over the horizon in the field, I am increasingly aware that the wheat itself is the crop, not the methods of seeding and harvesting, and I am captivated by a prevailing sense of awe about the process of life and growth, less about the tools that cultivate it.

The New Frontier of Inner Space

In the last three years I have come under the influence of a new realm of personal discovery. You might recall that I have always been interested in hypnosis, altered states of consciousness, state-dependent learning, parapsychology, and transpersonal psychology. (You also might not recall this, but perhaps that's why I mentioned it.) About three years ago, I became interested in a device that was supposed to replace the psychologist or therapist in terms of stress management. The device was called the Psycho-Energizer or something like that. It was based on the well-known effect of photic driving, or the frequency-following response of people exposed to strobe lights, rhythmic drum beating (as in aboriginal ceremonies), or rock concerts. I was understandably curious about the possibilities of Nirvana-in-a-machine, so I was really amazed that the capabilities for endorphin-production were indeed quite real. Of even greater note, some of these realms of ecstasy were available without sex, religion, or even running a marathon.

The realm of mind-machine experiences available through *Megabrain* (Hutchison, 1985) and other mind centers really turned me on to the possibilities for personal exploration of unconscious horizons through imagery produced in alpha and theta states of brain-waves. These machines can greatly assist the vast majority of people who are too undisciplined to meditate regularly, and perhaps too skeptical to allow for the suggestions of trance phenomena as realistic guides for our growth and development. They certainly assist in the development of pleasant and stress-relieving states, and additionally help develop imagery that can unlock unconscious creative problem-solving and paradigm shifts unavailable through usual channels of communication. During this time I have been using light and sound devices as useful adjuncts to the personal growth and exploration of therapy in some of those circumstances requiring an unusual or novel approach to symbolic or unconscious material. Moreover, I have used it upon occasion to help disparate couples or dyads "get on the same wavelength" with the common

point of juncture of a totally novel experience. These developments do not replace the advantage of a metaview provided by therapy, but allow for access to a novel and internally-valid "inner-view" supplied by the imagery of the unconscious, giving some empowerment to the intuition and internal vision present (but often invalidated) in all of us.

Lucid Dreaming.

Parallel with this interest in the somewhat occult field of the unconscious was my fascination with *Lucid Dreaming*. Actually, this represented a return to a favorite childhood pastime. I can vividly recall as a child awakening on a Saturday morning dissatisfied with how a dream had just ended. No problem. I would just go back to sleep, re-dream that dream, and bring it forward to another ending. Or, if I was in a dream, and knew I was dreaming, all I had to do was to run forwards rapidly beating my arms like a bird and I could fly like an eagle, doing aerobatics about 500 feet in the air. It was truly thrilling, at least until I told my friends and relatives about it. They all thought I was crazy, so I stopped telling them about it; after a while I had less and less of these weird but wonderful experiences. Then, many years later, I heard about a place where they train people to do what I used to do spontaneously. This is the spin off of the sleep disorder center at Stanford University.

The *Lucidity Institute*, as it is called, is an amazing institution of several people dedicated to the principle that dreaming is the best way to travel. They use highly effective seminars to train people to enhance dream recall, recognize signs of the dream state, test for reality conditions in this state, and then navigate and explore the dream environment (LaBerge & Rheingold, 1990). As you might guess, there are many interesting parallels between the literal but unchallenged realities of the worlds of trance and dreams. As such, the mystical world of dreams constituted for me the ultimate frontier of *Inner Space*. In this world, the creator-participant can transcend the laws of gravity, social convention, traditional relationships, and other contexts to assemble totally new creations. The unconscious mind can provide the raw material of intuition, to which the more conscious part can add realistic simulations and models as to how these inspirations would tumble and play in a reality in which factors could be varied or held constant.

I sure don't fully know where all this is leading, but I do know that the process is a skill and can be learned.

This is now the world in which I play whenever I can. Unfortunately, there are limitations imposed by time, energy, and lack of skill and discipline so that I still cannot quite *lucid dream* at will. Still, I am learning and acquiring these skills, assisting others on an individual and group basis in skill acquisition, and facilitating others in the interpretation of the dream world and the symbolism of theta reverie. I am helping them use and develop images derived from hypnogogia and dreams to form icons of personal growth and exploration.

Thus my new ideal profession is that of DreamMaster or DreamGuide, helping people incubate and truly create their own realities in an altered state, and integrate those realities in their living social environment. Implicit with such a discipline is the understanding that we are all dreaming most of the time, and are seldom lucid enough to see things for what they are. Increasingly, I am enticed to function in a land of illusion, but I at least accept it for what it is, and prefer to live in a realm of relaxed imperatives and intriguing possibilities.

Of course, I continue to do straight therapies with straight people seeking straight answers for straight questions, but these may become more and more the minority of my practice, as I continue to seek the absurd as a highly cherished commodity. While exploring some of the huge caverns of the unconscious, I am increasingly aware of irony as the driving force of the universe.

I sure don't fully know where all this is leading, but I do know that the process is a skill and can be learned, just like trance and meditation, and its possibilities seem to transcend all bounds. The Lucidity Institute is interested in the clinical application of this thought technology, and the possibility that I may have something to offer them. I still do not know, because it is all so overwhelmingly new. But I do know that I want to be one of the most skilled and informed about it in Canada, and perhaps even among the best in the world. (There goes that hubris again: teacher, leader, pathfinder, competitive cooperator. Oh well...).

Once again I have left the highway of surety for the pathway of curiosity. I certainly have less certainty, but it's amazing how you can learn to live with ambiguity. . .

References:

Blom, D. J. (1986) *Inside the Milan interview. London*, Ont.: Somersit Press.

DeShazer, S. (1988) *Clues: Investigating solutions in brief therapy.* New York: Norton.

Hesse, H . (1962) *Siddhartha* . New York: Bantam Books .

Hutchison, M. (1985) *Megabrain: New tools and techniques for brain growth and mind expansion.* New York: Ballantine.

LaBerge, S. & Rheingold H. (1985) *Exploring the world of lucid dreaming.* New York: Ballantine.

Treadway, D. (1991) From Arete to Crow. *J.S.S.T.* **10** (1), pp. 66-77.

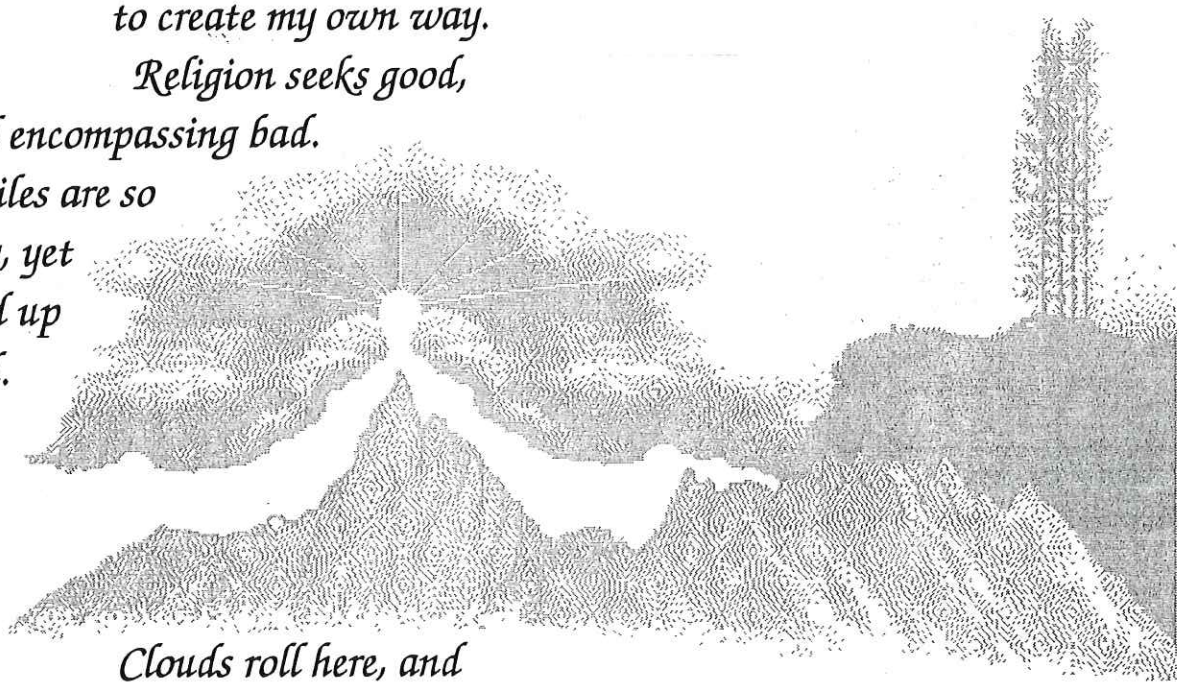
Wardenburg, F. (1991) The magic glasses. *The Family Therapy.* **15** (4) . pp . 61-64 .

White, M., & Epston, D. (1989) Literate means to therapeutic ends. Adelaide, South Australia: *Dulwich Centre Publications.*

Young, F. D. (1988) Three kinds of strategic humor: How to use and cultivate them. *Journal of Strategic and Systemic Therapies* **7** (2), pp. 21-34.

Always shall I travel

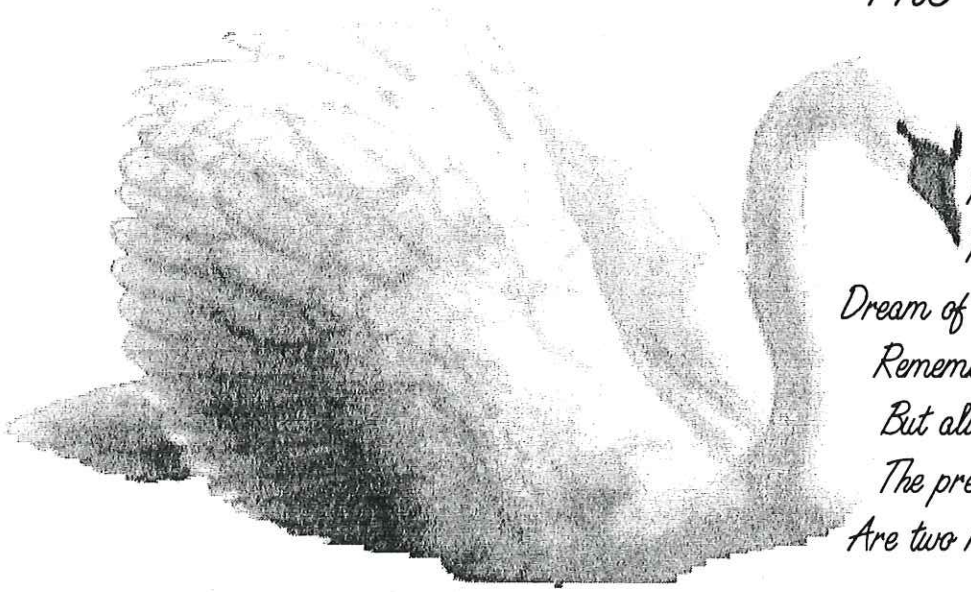
Always shall I travel,
day to day.
Seldom do I manage
to create my own way.
Religion seeks good,
still encompassing bad.
Smiles are so
happy, yet
wind up
sad.



Clouds roll here, and
clouds will move there.
Waves forever carry on,
washing a blank stare.
From the beginning, you
will continue to see...
In the end, only to be....
Sweet nothing.

Richard Lennard – 29/04/91

The Past



The past is a part of life,
The part of life that's yesterday.
Dream of tomorrow,
Remember yesterday,
But always live today.
The present and the future
Are two more parts of life!

Rhonda Fabik

Sweet joy befall thee

Sweet joy befall thee
...as in your own Bosom you bear your heaven
And Earth & all you behold; Tho' it appears
without, it is within.
In your imagination, of which this would be of
Mortality is but a Shadow,

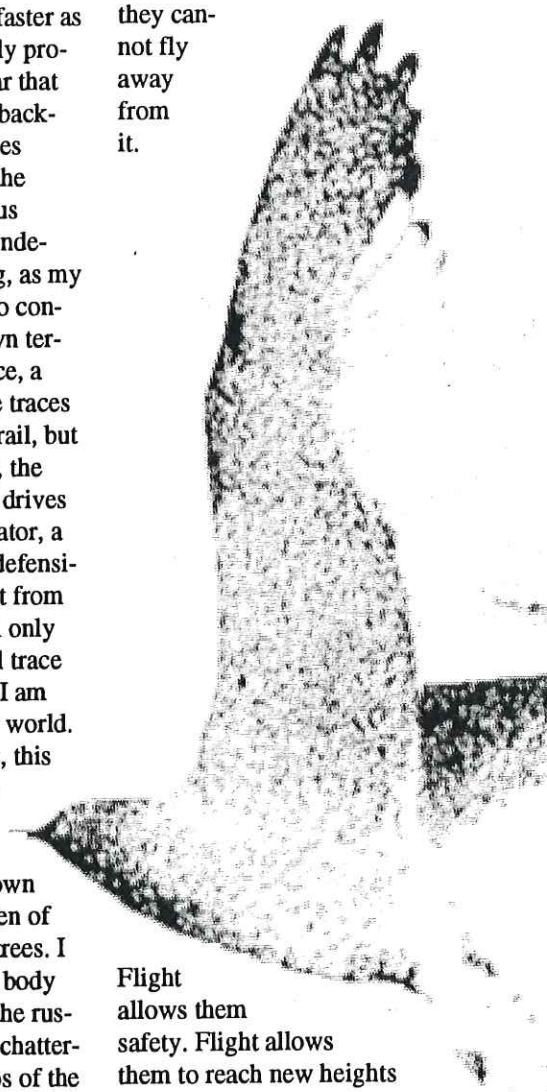
William Blake

Taking Flight

Anonymous

My legs pump faster and faster as I flee up the hill, the only propellant, an unknown fear that pursues me. With furtive glances backwards, sideways and cautious stares ahead, I continue advancing into the woodlands away from a mysterious predator, pursuing me invisibly, undetectable, yet ever present. Slowing, as my breath becomes labored, I pause to consider my location. I am in unknown terrain, yet, it is not a fear of the place, a verdant woodland, with no visible traces of humanity save this well worn trail, but the very thought of that humanity, the very thought of man himself, that drives my fear. Man is a dangerous predator, a controller, I the controlled, the indefensible female, and all I know is flight from the predator. Stepping off the trail only fifteen paces into the trees, and all trace of humanity disappears. It is as if I am the only being, this place the only world. I can feel safe in this great silence, this great aloneness. Flight into peace, away from that indescribable yet pervasive fear. The impulsion leading to this flight is unknown to me, but the landing is this garden of peace, tranquility of the tall dark trees. I can stop now, drop my exhausted body onto a soft bed of moss, listen to the rustle of leaves in the wind, hear the chattering of squirrels, the cheerful chirps of the birds away from sounds of man, who no longer exists in my free world.

I have always admired the freedom of birds, freedom to soar where they will, alone, or in company, to soar close to the edge of the waving water, to soar to unreachable clefts in the cliffs, to soar to the top of the highest tree atop the highest mountains, to be able to see the immensity of the world around them, to experience the perilous fall towards earth with the knowledge that they have the power to stop that perilous drop with a flapping of their wings, to be able to use the spirit of the wind and move where it wills them, but also the freedom to defy the wind and push against it and retreat to their own dark or open corner as they will. Birds, only fearing the predator if they cannot fly away from it.



Flight allows them safety. Flight allows them to reach new heights of wonder~ to observe new vistas only limited by their ability to soar. Birds can observe as silent sentinels hidden among the leaves in the tops of trees or they can boldly alight on the outreached arms of shrubs or the outreached arms of people, a freedom to choose their associations or to hide from them.

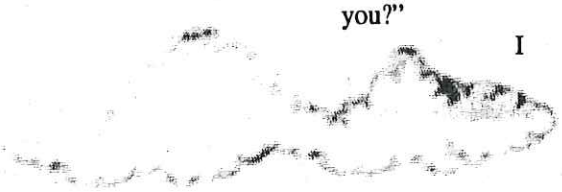
As I child I watched fledglings taking their first awkward steps towards taking flight, always worried that the parent birds, not wary enough, would not save them from the predatory neighborhood cats silently watching from the shrubs. Some of those abandoned little birds were buried in our backyard rose garden cemetery for lost little animals, buried in funeral services solemnly conducted by myself and my friends, always with a twinge of guilt that we had been unable to save the little ones from their fate. We were fledglings ourselves in a world that was not always safe.

His steel blue eyes pierce through me, burning a hole into my very soul,

The smile on his face slashes and tears at my fragile self, cutting me down to size.

I await his command. I am now under his control. I am his, to do with as he pleases.

He says, "What's the matter with you?"



I gaze downward. I submit. I don't know what I've done wrong, but now stand repentant, ready to sacrifice whatever is needed to atone for my unknown sin. I am ready for my punishment.

The mist,
a gentle, quiet predator,
creeps in,
and takes the fields and flowers
unaware;
as love sometimes attacks the lonely.

Steel blue eyes, piercing, cutting through to my very soul, a smiling face, probing, penetrating, digging into the core of my being. I cannot hide from him.

Diagnosis and Treatment in Another Light

Jon Amundson, Ph.D.*

A child has been discovered to be horribly burned - he alleges his step-father has set him upon a hot plate because

"I keep wetting my pants."

Removed to a care setting, the biological mother expresses shame, guilt and repentance, begging return of the child to her care. The court in its desire to appreciate narrative tradition for the mother asks for an expert to give voice to her story.

Family therapy in offering alternative epistomologies (i.e., cybernetic, constructivist or narrative), stands in stark juxtaposition to the more foundational concepts of traditional mental health practice. Specifically, in regards to diagnosis, there has been a schism emerging which is not only aesthetic but political in nature. Some of us don't believe that it's useful to use diagnostic or descriptive terms like "character disorder", "passive-aggressive" or "secondary gain." Our solution-focused principles rail against the potential abuses of classification and labelling. We realize that "truth" is often historical, that social practices evolve and that psychology and psychiatry ride on the back of, rather than stand apart from, culture. Further we see from our clinical experience that "non-traditional" perspectives are at least as valuable, if not more valuable, in serving our patients.

psychology and psychiatry ride on the back of, rather than stand apart from, culture

However, denunciation and denial when it comes to diagnosis seems a luxury which is most easily exercised from an established/secured position. It is, for example, easy to decry destruction of the rain forest from the security of post-industrial North America but undoubtedly harder to live out in Brazil. It is easier to avert our eyes than enter into the, at times, painful exercise of dialectic with realities with may not be ours. While many of us do feel inclined to "uncage the skylarks" (Rozak 1973) the air in which they take wing is populated by others' ideas; others' distinctions. While our philosophies fly freely in the protected atmosphere of our consulting rooms and self-defined institutions, their viability elsewhere is challenged.

Before proceeding I would ask the reader to ponder the brief case presented above. If we were a purely reductionist, non-discursive society, judgment would be quick and decisive. We have seen circumstance throughout history - regimes of terror are always based upon a certainty, and the power it engenders; quickly reducing the most complex issues of human affairs to facile disposition. Therefore, let us imagine that formal evaluation and diagnosis (especially for legal decision-making) is an invitation to narrative; to *ground* or to give meaning to events as they stand against the larger discourse of a life, a relationship to perhaps even society and the world at large.

Mental Health Opinion in the Context of the Narrative of Justice

Courts and our legal system as ultimate agents of social control regularly ask mental health practitioners to participate in the creation of legal narrative. A judge faced with the terrible decision to direct the lives of others calls for the intertwining of crime, justice and disposition with that of the story of individual(s) lives. Instead of addressing the "what" of the event, she may demand that the gaze also be directed to and through the "whys" of a matter. What is it we need to know, in the most complex and capable sense about humans, to guide the decisions we are required to make? It is not enough, as with the case above, that a child had been *injured,* a man violent and a mother passive. It is the desire to bring these features to light in as complete a fashion possible, for the benefit of the narrative of justice.

Diagnosis Under Fire

Psychological opinion - as information for legal or other forms of decision-making - however, has often been held suspect. Criticism comes from several directions. For one thing there is an apparent lack of specificity in psychological diagnosis. *Appendicitis* as medical diagnosis, for example, specifies a limited set of well-determined procedures as treatment. This precision supports the use of diagnosis as an inherent course of action. "Character disorder" or "depression" however, provide a basis of understanding between professionals but sponsor no small amount of debate regarding treatment. Because psychological opinion is frequently limited in an active or predictive sense, there is a tendency to dismiss it. A whole literature, in fact, has arisen to challenge psychological opinion (Ziskin and Faust in 1988) not only based upon lack of specificity between practitioners but that a) it is not scientific enough; b) therefore validity and reliability are suspect and c) then, prediction and control are not possible.

Defending the Indefensible: Nonetheless, there are reasons why it is too soon to turn our back upon diagnosis as formal opinion, at least as diagnosis applies to decision-making. It can be argued that if the realms of

Dr. Jon Amundson is in private practice and may be contacted at Amundson and Associates, 206, 2003 14 St. N.W., Calgary, AB, T2M 3N4 (403) 289-2511

objectivity/specification (i.e., courts, schools, institutions, etc.) invite psychological narrative in dealing with the complexities of human behaviour, can we decline? Neo-conserativism is a far more likely response than abandonment of empiricism in most decision-making situations (Parry 1990) and so, by protesting or declining invitation to dialectic, we invite the "scoundrels" to set the stage.

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But what of the pseudo-science and quasi-empiricism of clinical diagnosis and opinion? No less prestigious a journal than *Science* has published critique regarding the limitation of clinical diagnosis (Faust and Ziskin, 1988). Though psychological opinion has traditionally been weak, in fact, recent evidence does indicate that reliability of diagnostic procedure is increasing. Clinicians can and are seeing a similar reality when faced with demands for specification (Matarazzo 1990). While in some ways this may not be good news - for some akin to Nazi's developing a better transport system - this is set against other advances in developing diagnostic opinion.

Among psychologists there is increasing appreciation of the limits of diagnosis and the need for that appreciation in order for diagnosis to be helpful. In a recent review (Amundson 1990), I discovered the single common feature in a collection of articles on child abuse was the mandate for both clinician and policy-maker to attend to abuse not only as intra-personal event but as imbedded in an ecology encompassing inter-personal dynamics, social forces and larger systems perspectives. This larger accounting is not simply glib nor token subscription to liberal politic but rather, an acknowledgement that *simplistic diagnosis is a luxury* not offered ourselves nor the judicial system.

This "ecological" emphasis is at times maddening to the institutions seeking professional opinion. Though we damn ourselves regarding diagnosis, diagnosticians are not, in fact, praised by others. Edmund Muskie once bemoaned the fact there are no "one-handed psychologists". Mental health practitioners always tend to present information in an "on the one hand this/on the other, that" format. This, fortunately, is necessary, for to do justice to the truths we have to tell,

> *....(the) first concern must be the monitoring of expertise and the careful delineation of the limits of specialized knowledge. Psychologists who answer question ... are not violating ethical principles provided they are cognizant of the limits of their knowledge and take steps to insure that the trier of fact is aware of such limits (Melton and Limber 1989).*

Though it has been vigorously argued by others, that our opinion is flawed because of its limitation, this does not appear sufficient basis for rejecting, excluding or abandoning opinion. The exactness of our prognosis regarding dangerousness of individuals, parenting competency and personal conduct is often no less exact than that of "engineering, medicine and other professions" (Matarazzo 1985). In the incident of the Edgemont house explosion/death here in Calgary, forensic experts on gas flow, combustibility and structure varied in their estimates from between twenty minutes to three hours as to the time required for such an explosion. In a 1970 study, it was established that as much as seventy percent of the time "hard science" witnesses provide equivocal or erroneous data. Finally the cornerstone of the legal system - *eye witness* testimony - has, over the past ten years been demonstrated to be perhaps more fallible and less reliable than hundreds of years of jurisprudence would assume (Kassin et al. 1989). Absence of precision it seems is no excuse to give up our role in significant decision-making.

simplistic diagnosis is a luxury not offered ourselves nor the judicial system

The Failure of Positivism

Though it is perhaps possible to demonstrate increasing technical efficacy in casting formal opinion this may be beside the point. The most obvious criticism rests upon philosophical grounds, especially the ground philosophy travels in this age of post-modernism. Positivism and empiricism as belief in a *value free* truth or an enduring "centre" around which to form our lives has left much to be desired. It appears that this is not because empiricism is wrong but that it is just not right, nor big enough to cover all the terrain. As a result, we are tempted, as mentioned, to retreat to the neo-conservativism so characteristic of rightist politics, or to keynesian economics or to fundamental religion, or we simply go shopping for new ideas.

What we find in the market-place of ideas as antidote to *dead stick* empiricism has been variously called "anti-foundationalism" (Rorty 1979, Neilson 1985, 1987, 1988), "social constructivism" (Gergen 1985, Harre 1984), "contextualism", "constructivism" (Fisher 1988, Kelly 1963), "relativism" (Pfohl 1985), "coherentism" (Dancey 1985), and/or the "textual" metaphor (Potter and Wetherell 1987). Though subtlety and nuance divide these schools, there is a semblance of unity in that they all appear to,

> *...recognize the social world as consisting not of social facts, but the continual production and reproduction of social artifacts. (Stam, 1990 p. 248)*

Alas, we realize today in the afterglow of the novelty of clinical constructivism that some "artifacts" are more real than others. Social problems like inequality, injustice, power imbalance and role by gender, though not foundational *per se*, seem beliefs we cannot easily de-con-

struct. While we may be free of "facts" in the largest sense i.e. specification under global truths, we cannot trivialize our "artifacts" at local levels. While embracing a philosophy of indeterminance, randomness, incoherency, paradox and mutability clinically we must also accept certain "special status" beliefs (Wittgenstein 1958).

While, globally, we can accept that things are relative and contextual, "not everything is relative at once" (Stam 1990, p. 249). What we say betrays what we don't say: what's out front, suggests what's lurking behind, whether we know it or not. Watzlawick (1967) has said "one cannot not communicate." So too it seems one cannot not have some beliefs that are bigger than other beliefs.

Clinical "Artifacts" and the Pragmatic Criterion

The value however of a belief is not determined inherently but rather in relation to utility (Harre-Mustin and Maracek 1988). Diagnosis and evaluation are of value not in/of themselves (nor contrariwise of harm) outside of a given place, time, population, etc. Diagnosis can, at its least, represent a "hobby" indulged in by a group in order to self-define and nominate professional competence or constitute expanded understanding, say, in a court of law,

- as to why "failure of character" is not a big enough story to explain why an abused woman returns to an abusing husband.

- as to why "retarded" is an impoverished, cultural explanation for a Native child's failure to achieve in white society.

- as to why social factors which mitigate against women as perpetrators of child sexual abuse must also be used to account for such perpetration when it occurs (Amundson 1988).

Mental health practice does not live up to positivistic/empirical standards and though it is getting better we must not forget that it is more art than science. In a post-modern society it would appear the most we can hope for are ideas which bear some utility. "Accurate representation" is the compliment we pay those beliefs that are successful in helping us with what we want to do.

If what we want to do is protect children, reduce suffering, share and contain complaint, or constrain/qualify violence we shall from time to time be required to render opinion. This need is best served when diagnosis is not trivialized by over-use. To be compelled to be significant, even when clinically useless, is the basis for abuse of diagnosis. Fredrick Hersberg once said "principle is the lost refuse of the incompetent" and so, too, we might say of diagnosis when it simply privileges us and marginalizes others in harmful ways.

To be compelled to be significant, even when clinically useless, is the basis for abuse of diagnosis.

When, however, our de-constructivist clinical work has failed, when problems have exceeded all the skills which we can bring against them, our therapy is "incompetent." Not in the sense of malpractice nor professional culpability but rather in its adequacy as a practice to stand up to suffering/compliance. Certain terrible meaning does appear to transcend my efforts at de-construction; perhaps I fear even the efforts of ten like me and ten different. There do seem to be problems on a collision course with agents of social control. In that realm, it is *directive description* and attempt, to specify answers that hold value. Utility in this domain is explanation.

And so what? Just because we do not yet have a unifying language of mental health practice does not, it appears, give us license to stand about shouting in whatever dialect we choose. Until something more useful comes along, I fear we cannot but live with the creative tension which exists between the realms of treatment and diagnosis in clinical practice.

Just because we do not yet have a unifying language of mental health practice does not, it appears, give us license to stand about shouting in whatever dialect we choose.

To do this creatively means being true to the democratic principles we expose in contemporary brief, pragmatic and solution-focused approaches. We cannot marginalize the "rich", (not to mention "powerful") tradition diagnosis represents. We can learn its language, understand its practices, however, without succumbing to its imperialism. In the best circumstance we can speak this language with our own accents, fostering dialogue and the potential for mutual influence. Diagnosis must never be accepted as excuse for inadequate clinical practice but it will at times be necessary in order to keep the conversation going.

References

Amundson, Jon (1988) *Psycho-socialization issues in a case of child sexual abuse by a sole female perpetrator.* Unpublished manuscript.

Amundson, John (1990) Book Review Early prediction and preventing child abuse, Browne, Power and Stratums, (Eds.) Chichester, England: John Wiley and Sons 1988) in *Aggressive Behaviour* **16,** (1).

Dancy, J. (1985) *An introduction to contemporary epistemology.* Oxford: Basil Blackwell.

Faust, D. and Ziskin, D. (1988) The expert witness in psychology and psychiatry, *Science* **241,** p. 31-35.

Fisher, D.D.V. (1988) Experiential being and the inherent self; Towards a con-

structivist theory of self, *Journal for the Theory of Social Behaviour* **18,** pp. 149-168.

Gergen, K.J. (1985) *The Social Constructivist Movement in Modern Psychology American Psychologist,* **40,** pp. 266-275.

Harre, R. (1984) *Personal being: A theory for individual psychology.* Cambridge, MA Harvard University Press.

Harre-Mustin, R. and Mareck, J. 1988) The meaning of reference; Gender theory, post-modernism and psychology" *America Psychologist* **43**(6).

Kelly, G.A. (1963) *Theory of personality: The theory of personal constructs.* New York, Norton.

Matarazzo, J. (1990) "Psychological Assessment Versus Psychological Testing: Validation from Binet to the School, Clinic and Courtroom, *American Psychologist* **4**(9),pp. 999-1017.

Melton, G. and Limber, S. (1989) "Psychologist Involvement in Cases of Child Maltreatment: Limits of Role and Expertise" *American Psychologist* **44**, No. 9

Nelson, R.J. (1969) Behaviorism is False. *Journal of Philosophy* **66** p. 417-452

Nielson, K. (1985) *On finding One's Feet in Philosophy; From Wittenstein to Marx Metaphilosophy* **16** p. 1-11.

Nielson, K. (1987) Philosophy as Critical Theory. *Proceedings and Addresses of the American Philosophical Association Supplement* **61** (1) p. 89-108.

Nielson, K. (1988) On Transforming Philosophy. Paper presented at the symposium *A Celebration of Excellence,* University of Calgary, Calgary, Alberta.

Parry, A. (1990) A universe of stories *Family Process,* **30** (2).

Pfohl, S. (1985) *Toward a Sociological Deconstruction of Social Problems Social Problems,* **32,** p. 228-232.

Potter, J. & Wetherell, M. (1987) *Discourse and social psychology: Beyond attitudes and behaviour.* London Sage.

Rorty, R. (1979) *Philosophy and the Mirror of Nature,* Princeton: Princeton University Press.

Rosnow, R.L. & Georgoudi, M. (1986) (Eds.) *Contextualism and Understanding in Behavioural Science.* New York Prager.

Stam, H. (1990) "Re-building the ship at sea: The historical and theoretical problems of constructivist epistomologies in psychology, *Canadian Psychology* **31**(3).

Watzlawick, P., Beravin, Janet H., and Jackson, Don (1967) *Pragmatics of Human Communication: A Study of Interactional Patterns, Pathologies and Paradoxes* New York: W.W. Norton.

Wittgenstein. L. (1958) *Philosophical Investigations* (2 ed.) Oxford: Basil Blackwell.

Ziskin, J. and Faust, D. (1988) *Coping with Psychiatric and Psychological Testimony,* **1-3** Marina Del Rey, California Law and Psychology Press.

Sexplay

Five "Sexy Words"

Gary Sanders
Family Therapy Program
The University of Calgary

"Just a young couple", I thought of the Darrins. They seemed so young to have such wisdom - the wisdom that comes from a lifetime of struggles and joys, not from two years of marriage for two 23 year old people, both of whom had been virgins when married.

"What wisdom?" you ask. The conversation went something like this:

G.S.: "You say that you haven't been able to have sexual intercourse at all during your marriage and that both of you were virgins upon marrying?"

Dalia: "Yes, I have a spasm of the muscles around my vaginal opening which makes intercourse impossible. My doctor told me it's called vaginismus."

They seemed so young to have such wisdom...

Ruben: "We have tried, though - don't forget that. In fact on our honeymoon we tried on a number of occasions but Dalia always found it too painful and I found it too worrisome to try harder. Since then, we try a couple of times every month in hopes of succeeding so at least we can have a baby."

G.S.: "Would you say that you have a mutually pleasurable sexual life together despite not being able to have vaginal penetration, or do you find your sexuality to be lacking in some way?"

Dalia: "Well, when we are concentrating - you know, trying to have intercourse - the pleasure isn't there very much. However, we both seem to enjoy our sex life very much when

we actually make love. We both want to, we take our time, we can both be orgasmic if we want and afterwards we are both satisfied. I know, since Ruben and I have talked about it. In fact, sometimes I can't imagine anything more pleasurable than when we make love!"

What an unusual view of sex! This couple seemed to have an experiential understanding of the difference between intercourse and sexuality. It was couples such as these young people who began to orient me to understanding sexuality from what I have come to call The Five Words of Sex: Volition, Mutuality, Arousal, Vulnerability, and Trust.

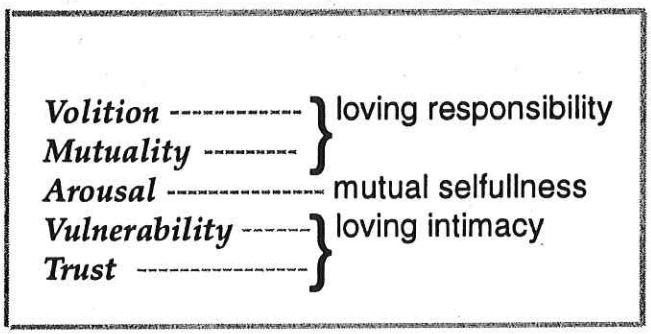

Figure 1. Sexuality as Experience

For generations, perhaps eons, in our culture we have defined sex from a hierarchical perspective - a patriarchal one where the sexual interests and experiences of men have been privileged *compared* to those of women. In doing so, the "IT" of sex is sexual intercourse (just ask any 13 year old!). But intercourse doesn't necessarily mean sex. It could be violence, as in assault mediated genitally. It could be business, as between a prostitute and her or his client. It could be duty, even loving duty, between a man and his woman friend. Any "sexual" behaviour could be seen at times to be something other than sexual if one uses what the Darrins had stumbled upon by being "disabled" from falling into the same centuries old definitional pitfall - an experiential definition of sexuality.

Such an understanding is deceptively simple, yet clinically and, yes, even personally liberating. Here, look for yourself: Close your eyes after reading this paragraph. Bring to mind (silently and without action, please!) one of the best sexual experiences you have known. Think not of just what actions you engaged in, or who you may have been with, but rather of the feelings, thoughts, enjoyments you knew. Once you have it in mind, open your eyes and continue reading.

Your best sex (even if anonymous, or for only one occasion) probably included the five words.

First, you and your partner recognized self and other as being involved together out of free choice.

Second, you both were involved mutually in sex - i.e., you were both on the "same side of the fence at the same time".

Third, both partners' experience was in the domain of arousal - the type of arousal that neither you nor your partner need worry about the other's - each seemed fully experiencing their own arousal. In fact, your partner's arousal probably fed his or hers and vice versa.

Fourth, these experiences and actions were occurring in a context of mutual personal vulnerability. Each could be open with her or his physical and emotional experience.

Finally, the vulnerability occurred within knowing trust; trust that one's partner would not take advantage of, or be abusive of one's own openness.

How well did I guess? Most people find that these five words do describe their best and their hoped for sexual experiences.

These five words together make the personal experiences sexual or "sexy"; but if you can't get even one of them, the sexiness is missed and the *genital* event becomes less than best or less than hoped for.They can be grouped (see figure 1) into *loving responsibility* - ensuring mutual free choice and that the activity, along with its intended experience, is mutual; that one takes personal responsibility for one's own arousal - what I have come to call *seflfullness* in order to distinguish it from *selfishness*; and finally loving intimacy - the emotional experience of coupled vulnerability with valid trust.

By thinking of people's intended sexuality from such an experiential frame, therapists can invite the clients into better being able to realize their intended lovemaking.If, on the other hand we simply continuing using that age-old, worn-out, and most importantly, non-mutual definition of sexuality as simply behavioural, we risk inviting the clients into simply trying yet again to perfect what thousands of generations of humans haven't managed - mutual sexuality based on an inherently non-mutual opportunity!

When I see a new client, I try to take what my clients have been saying for the last 15 years - that good sex is relational, mutual, and volitional. Most importantly, sex is based more on the experiences of the two involved and not so much simply on the behaviours that are engaged in. As a result, I often talk with clients about these five "sexy" words, helping them see how these words are descriptive of their hoped for experiences. I even suggest that they cut out the five words, put them on the refrigerator and reflect on them every time they open the door! Imagine if they reflected on them every time they went to be sexual!

I even suggest that they cut out the five words, put them on the refrigerator and reflect on them every time they open the door!

More to follow in the next issue on the clinical use of these five "sexy" words!

The "Just Therapy" Conference and Workshop

(November 4 - 6, 1991)
Family Therapy Program
The University of Calgary
Carol Liske

Have the psychotherapies, including Family therapy, been co-opted by the dominant culture (of men over women, of whites over non-whites, of rich over poor, etc.) to suppress the liberation of disadvantaged persons who often present to mental health professionals with personal problems?

Among the various therapeutic approaches being explored today, none address this question so directly as do the "Just Therapists" of New Zealand. Three representatives of the Family Centre in Lower Hutt, New Zealand, Flora Tuhaka (Samoan), Kiwi Tamasese (Maori), and Charles Waldegrave (Caucasian) were in Calgary, November 4 - 6, 1991, to present their work described as follows:

Charles Waldegrave

Therapy can be a vehicle for addressing some of the injustices that occur in a society. It could be argued that in choosing not to address these issues in therapy, therapists may be inadvertently replicating, maintaining, and even furthering existing injustices. A "Just Therapy" is one that takes into account the gender, cultural, social, and economic context of the persons seeking help. It is our view that therapists have a responsibility to find appropriate ways of addressing these issues, and developing approaches that are centrally concerned with the often forgotten issues of fairness and equity. Such therapy reflects themes of liberation that lead to self-determining outcomes of resolution and hope. (Waldegrave, 1990)

From this perspective, Waldegrave explains, therapy is judged as just, primarily by the group that has been treated unjustly. Therefore, the *Family Centre* members have recruited indigenous therapists to provide culturally-accountable treatment. These therapists then have the responsibility for client care and healing but they are held accountable to the elders of the clients' culture. An important aspect of the work is that to facilitate new meaning in the lives of oppressed persons, *political* as well as *clinical,* responses are believed to be necessary. Thus, the Family Centre is mandated toward an *activist* posture, and families cared for there can receive help with regards to meeting their instrumental needs as well as their needs for spiritual, cultural, and emotional well-being, in an atmosphere of caring, respectful concern. To be congruent with the principles of *Just Therapy* the Family Centre in New Zealand has been organized on a highly egalitarian basis. *Regardless of the 'role' undertaken within the agency, all staff members receive the same pay.* In addition, as is a traditional South Pacific custom, staff meals are frequently prepared and eaten collectively. The value of community spirit is privileged highly.

In essence, *Just Therapy* is concerned with the manner in which people give meaning to experience. For instance, persons who have been sexually abused during childhood often consider themselves less valuable than other people. This belief can act as a filter to the meanings ascribed within their experience. Over time, the continuous interpretation of information into categories of failure or inadequacy can become severely debilitating. *Culturally-appropriate therapy* addresses *cultural and spiritual meaning webs* to prevent and work against the process of alienation

The *Just Therapy Conference* was attended by a wide range of professionals including Native and Metis persons who were invited to come as guests of the Family Therapy Program. These professionals were particularly welcomed as they represented a group of individuals traditionally disempowered in our culture and it was thought that the *Just Therapy* work could be *relevant* to the journey of Native re-empowerment.

A fundamental posture within *Just Therapy* toward empowerment is to acknowledge the presence and spirituality of "the other." Throughout the presentation, expression in the language of spirituality prevailed. This languaging was clear in how greetings and prayers (giving thanks for being brought together, seeking help in sharing the pain, and asking for guidance in choosing wise decisions and solutions) began and ended the conference days. These spiritual words set the direction to humility and wisdom and seemed essential to the palpable attentiveness among the conference participants. Spirituality was also honored in the profound receptivity

Regardless of the 'role' undertaken within the agency, all staff members receive the same pay.

The Just Therapy Team and visitor: Front row - Flora Tuhaka, Diane Sollee (AAMFT), Kiwi Tamasese, Hally Campbell Back row - Betsam Martin, CHarles Waldegrave, & Jan McDowell

given to clients to tell their stories with minimum interference and with an emphasis on constructive positive re-connotation.

Although in *culturally-appropriate therapy*, a balance between the cultures and the genders of the therapists must be maintained, due to restraints imposed by the conference format, Charles Waldegrave conducted two live interviews involving families with single-parent mothers. He did, however, ensure that an appropriate *consultation team* was formulated and then situated behind the one-way mirror. Initially, the opportunity was given to the clients to tell their stories in the context of a respectful audience and occasional positive connotation, by the therapist. During an intermission to the treatment, Charles met with the team and a highly-detailed statement was formulated, collaboratively, to be read to the clients and then read again a second time. This statement took into account the political features of the situation, and in addition, positively connoted a large number of the life events that had been previously revealed in the relatively long narrative discussion with the clients. The statement then, re-connoted how the forces of oppression had been active, in terms of the family's experience, and the valiant (heroic) efforts that had been made, by family members, in relation to these forces. These *re-connotations* provided a secure base from which to suggest and invite promising healing directions that the family members could take which did not involve silencing the "voices of their oppression".

We at the Family Therapy Program have found many of the *Just Therapy* ideas valuable and we are planning to encourage dialogue about how we could incorporate some aspects of this philosophy into the functioning of our program. In a future edition of the *The Calgary Participator*, we hope to share some of our *journey* toward this implementation in our work—a journey toward *social justice*.

10th Anniversary of the
Calgary Participants Conference

Dates: **April 30 - May 1, 1992**
Location: **Family Therapy Program**
The U. of C. Medical Clinic
3350 Hospital Dr. N.W.
Calgary, AB, Canada
T2N 4N1

For information contact:
Myrna Fraser
Family Therapy Program
Phone (403) 220-3300
Fax: (403) 270-7446

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