
Editorial

máire stedman

Welcome to this issue which originally started out as two separate topics, Refugees, and Race and Culture but it was decided to amalgamate them, and in doing so Shila Khan and I were anxious to embrace other elements of diversity in seeking articles. However, what we were aware of is that this is an enormous area and that we couldn't possibly hope to do justice to it in one edition of *Context*. In commissioning articles it became apparent that a number of individuals, who had promised contributions were struggling to balance writing with other work commitments and, in the case of one refugee young person, their university exams. We even had a journalist withdraw due to over-commitment! We would therefore very much like to thank authors, some of whom fulfilled their promises and others who took up the mantle at the last minute, for their very valued and stimulating contributions. We are aware there is scope for many more topics under the umbrella of our title and hope that further editions of *Context* can embrace these. I would also like to say a special thanks to Alex, who came to the UK in 2003 as an unaccompanied refugee young person, for the drawings depicting scenes from Uganda.

We were delighted to have the opportunity to reflect with Inga-Britt Krause on the MacPherson Report, ten years on, as well as on her thoughts about training and institutional racism in the current climate as she is someone who has been working in this area for some time. Woven into our conversation are comments from her own life journey as well as references to her personal and professional style in tackling these issues. In true systemic form she manages to disarm her interviewers and lures us into making some comments at the end!

The lyrics of Paul Brady's song in 1981 captures what was the reality of many Irish People 'living under suspicion' for a long time in Britain. He draws attention to the fact that, while jokes about other communities were challenged, the Irish community seemed to continue to be the butt of jokes long after it was unacceptable for others. In essence, it is also a song of many immigrants coming with hope but encountering racism and suspicion along the way. "*Putting up with the hatred and fear in their eyes. You can see that you're nothing but a murderer. In their eyes we are nothing but a bunch of murderers.....*" may resonate with members of Muslim communities who are the current group 'under suspicion'. Paul Brady illustrates how even acceptance can be within certain stereotypical limitations, of being an entertainer or liking one's 'turn of phrase'. While different from complete rejection, it nevertheless is acceptance within certain limited categorisation. There may be similarities to be drawn with many black communities' achievements in entertainment and sport, which can be seen as acceptable areas to succeed for these communities.

The photo of a sign prevalent until the 70s in many lodging houses, is a salutary reminder of the not too distant past. Communities who were head hunted for their labour from places such as the Caribbean, Ireland, India, Pakistan and other former commonwealth countries, were then subjected to blatant discrimination.

Gary Fereday reminds us that while the Irish are one of the earliest and largest ethnic minority groups in Britain, that recognising and meeting the specifics of their needs continues

to be a struggle. He highlights cultural differences and invisibility as significant contributors to mental ill-health as well as evidence of discrimination in many sectors. He points to the need for cultural competence and service provision. His remark, "Just how different North London in the swinging 60s must have felt to a young person coming from the West coast of Ireland is difficult to imagine today" may not be so inconceivable if you substitute coming nowadays from Afghanistan or Iraq, given the reliance these communities also place on family and community support. Ireland's history of subjection to colonialism and imperialism may no doubt be a further factor to be considered.

Chiara Santin's findings highlight the need in training and practice to "promote a culture of trust and openness within which personal and collective risk taking and self reflexivity" can occur. Referencing Celia Falicov's 'ecological niche' in her analysis of interviews with four family therapists, Chiara highlights the coming together of the many elements of the selfhood; the power of "language in constructing identities based on dominant discourses"; the varied approaches to issues of race and culture in training; and the ways in which individuals position themselves and are positioned in teams. The paper also picks up on Hardy & Lazsloffy's point about there being more emphasis on cultural awareness and less on culture sensitivity. It also beautifully illustrates how this research became an opportunity to engage in possibly more self-reflexivity than she had initially envisaged.

Renos Papadopoulos' paper reminds us of the importance of connecting with local cultural contexts in considering intervention and training overseas. He also highlights the need for information about local politics, a point Chris Evans later comments on in his paper. I would like to challenge Renos' questioning of the extent to which his observations may be relevant in this context, given the significant number of Somalians living in different parts of Britain. His political analysis and description of refugee camps, hosting relatives of many UK residents is, in my view, highly relevant. It is interesting that the US, as referenced in Paul Brady's lyrics, still remains one of the aspired to destinations of many hoping for a better life!

Derek Summerfield has challenged the relevance of Western Counselling models on many occasions⁽¹⁾ in involvement overseas, a point not lost on Renos and his team in their interventions! As Renos points out, connecting to local customs culture and beliefs, which then formed the basis of his training and interventions, is in fact systemic. As indeed is his identification of organisational dynamics and reciprocal interactional patterns between staff and those they were helping. Renos' paper also highlights the significance of having a non-pathologising stance, which acknowledges resilience as well as trauma, and provides opportunities to draw on life experiences in helping newcomers. The paper's addendum is many a refugee's dream. Although the exception rather than the rule, stories such as this tend to fuel intense longing for countless refugees over many years.

Andrew Keefe reminds us of how advocating on behalf of a client and dealing with some practical issues can be quite therapeutic and revealing. He comments critically that "the economic social and cultural conditions into which refugees

are placed in exile affect their psychological health, a view supported by our many clients' experiences". This is very much a position I would support from my own practice. He highlights the limitations of practice occurring in many agencies that separate "advocacy and support in dealings with practical issues" from therapy, illustrating this point with a pertinent case example. In line with developments proposed by the Just Therapy Group, and in true systemic style, the Refugee Council has a strong policy and remit about campaigning, which compliments the individual and family work undertaken.

Sigurd Reimers description of a "small" foreigner captures the complexity of the shifting attachments to country of origin and country of migration, factoring in the impact that this has on couple development and in particular with mixed cultural relationships. His article and interesting case examples, capture nicely the ways in which a sense of belonging and identity can shift depending on the context in which one finds oneself and the language being used. He provides a very interesting development to Goldner's gender difference perspective, factoring in language and nationality as significant domains to be considered in cross-cultural relationship therapy.

His paper leads nicely into the poem by Iman Mersal which also illustrates the push/pull influences of migration and takes up the theme of language and self expression, referencing accent as a strong marker of identity. Of the many powerful images evoked, one in particular caught my imagination and could be particularly poignant for many political refugees "Nothing is worthy of your rebellion. You are satisfied and dead!" This may also of course resonate for many migrants of all categories. The poem is in honour of our late colleague Dr Ali El Hadi with whom many conversations on these issues took place.

Barry Mason's paper brings to mind experiences of his handling of these issues on both the IFT Systemic Supervision course and a cross cultural discussion group which met at the Institute of Family Therapy post 11th September 2001. Barry has always been a strong advocate of equity and mutual respect in cultural exchange and this paper provides a lovely example of how he attempts to negotiate this with sensitivity and thoughtfulness.

Clare's experience as a trainee, remind us of the complexities of individual's narratives and of the dilemmas of negotiating these in various contexts, with their different levels of homophobia. She highlights the dilemmas faced by gay and lesbian trainees when a split can occur between training contexts and work environments and about when, how and whether to share issues to do with sexuality. Her question, "How do we position ourselves and clinical work in relation to homophobia?" is quite poignant.

Barry Sugg's article reminds us of how the self of the therapist can have a positive effect on engagement and sharing information, particularly where discrimination has taken place. He highlights the factors that might influence, lesbian and gay couples to seek therapy and the fears surrounding this process. He commented that while the sexual orientation of the therapist can be important, others such as personal experience of being in a couple relationship, as well as professional experience in couples work, played a significant role, as did gender, age, agency and context.

Chris Evans reminds us of all the obstacles such as language, culture barriers, poverty and social exclusion as well as political/administrative systems which asylum-seekers encounter on arrival in the UK. He goes on to highlight points, with which I would concur completely from my experience in this area⁽²⁾ – the centrality of the relationship

between the service-user and professional, and the fact that some of the challenges and living circumstances/contexts can have almost as traumatic an effect as the events in people's homeland, which led them to seek asylum in the first place.

Chris also reminds us of the importance of spelling out the purpose of our agencies and where they sit in relation to the home office as well as considering their views about the perceived impact on the asylum process of expressing mental health difficulties.

Chris references colonialism and 'corporate interests' – not insignificant when one considers the invasions of Iraq and Afghanistan as well as sales of arms and oil. Like many of the other groups in this issue, Chris reminds us that the individual needs, histories and countries of origin of refugees, *ought to be considered* when thinking about current needs but that it is critical not to lose sight of the individual in front of us. We must facilitate the telling of their unique story however familiar we might have become with the conflict in their country. Chris also reminds us that CAMHS are uniquely positioned to co-ordinate some of this work with unaccompanied refugee children but also need to consider potential differences between them and other groups of young people coming to CAMHS.

Attending the House of Commons All Party Parliamentary Committee Meetings on refugee children and young people, it is clear that lobbying needs to be an integral part of the range of services carried out by professionals. It was after all, only via the judicial review in the Hillingdon case that unaccompanied refugee children gained some ground in relation to the rights, which children in care in the UK are entitled to under the legislation, for the duration and at the point of leaving care. Took Chambers are currently challenging the selective implementation of the 1989 UN Convention on the Rights of the Child ratified by the Government who maintain that articles 2, 3, 9, 10 and 22 create new immigration rights or prevent effective immigration control. The UK is expected to report to the UN committee between mid-September and the beginning of October. There has been some effective collaboration with the legal profession in the whole area of the rights and conditions of unaccompanied refugee children, mainly from within the voluntary sector it has to be said.

Kevin Ball's review of Cecchin, Lane and Ray's book, *The Cybernetics of Prejudice in the Practice of Psychotherapy*, reminds us that prejudices of both client and therapist lie at the heart of psychotherapy. This is clear when we look at the definition of prejudice as "Any pre-existing thought, feeling, fantasy, hunch etc. that contributes to one's view of the therapeutic encounter". In sufficiently highlighting key elements of the book, the review entices the reader into considering how this could be a very useful text, particularly in this area of work and a valuable companion to their *Irreverence – a Strategy for Therapists' Survival*.

Christine Senediak comments on a number of therapeutic tools which can be employed to enable families to engage with tracking trans-generational patterns and 'externalise' issues. Her table No. 1 poses many thought-provoking questions, which could be borne in mind in working with families, as indeed does her appendix on immigration and acculturation. She very usefully highlights the importance of the therapist needing to "identify and access their own biases, knowledge and experience in working therapeutically". Coupled with this she points us in the direction of improving cultural knowledge, points echoed in many papers in this issue. She ponders the opportunities and challenges of being from the same and a different culture from the family.



Máire Stedman and Shila Khan at the UKCP conference in Torquay March 2007. © Máire Stedman

Disjuncture between family member's thoughts and views as well as between the family and their adopted country is of critical importance, as indeed may be the different journeys with different time frames. Referencing Imber Black (1997), she sums up cultural competence as incorporating models that cut across cultures; culture-specific content that avoids stereotypes; sufficient knowledge of one's own culture; and a therapeutic attitude marked by openness and lack of imposition.

Guantanamo has come to be a global representation of a response to 'terrorism' but Anna-Margrete Flâm's poem, from *Innovations in the Reflecting Process*, manages to peel a way through layers of objectification and dehumanisation to begin to 'see' the individuals beneath such objectification and to be in the presence of the 'other' – to sense, see, feel and hear what might be going on for them. This volume was written in honour of Tom Andersen's 70th Birthday and Anna-Margrete Flam very movingly utilises his reflective style in her poem

Michael Winterbottom's film *The Road to Guantanamo* was an attempt to also challenge that objectification. Special thanks to Louise Norris who managed to locate a very interesting commentary on the poster created to promote the film.

While challenging issues on the wider political arena has always and continues to be critically important, perhaps one of the challenges as practitioners is to continue to balance this with on-going challenges to our own assumptions that can lead to 'othering'.

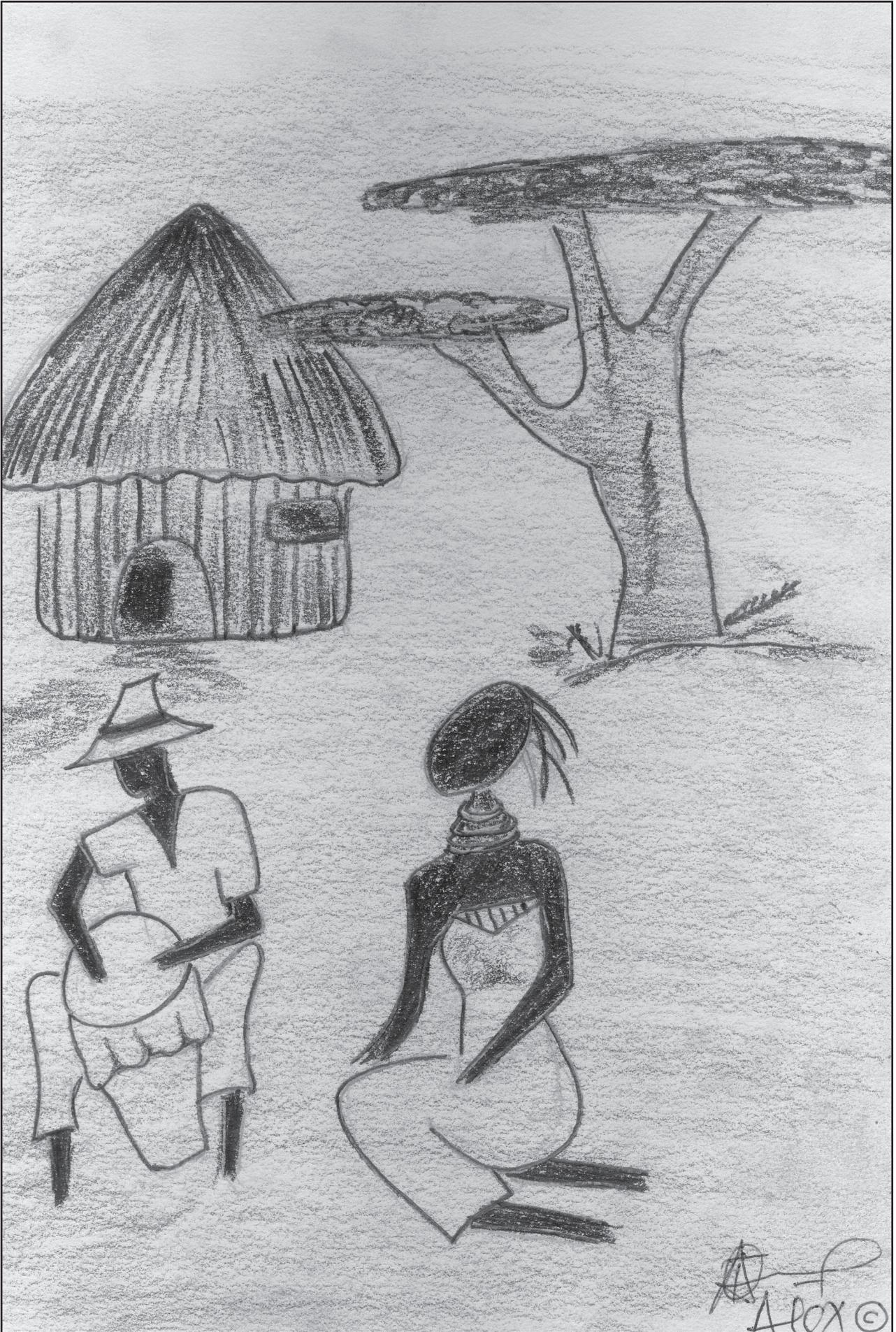
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Máire Stedman works part time as a consultant family and systemic psychotherapist at the West London Mental Health Trust, and independently, undertaking consultation, teaching, training and supervision. She also provides expert witness reports, particularly for unaccompanied refugees. She worked for three years at the Medical Foundation for the Care of Victims of Torture and a further three years at the Refugee Council in London. She represents AFT at the All Party Parliamentary Committee on Refugees and as a member organisation representative with UKCP.

Máire would welcome comments and is happy to be contacted about anything relating to this issue at E-mail: mairestedman@yahoo.co.uk

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Ugandan Scene © Alex

Inga-Britt Krause has challenged thinking and practice around issues of race, ethnicity and culture in systemic psychotherapy and has persistently, passionately supported their development. We were delighted to meet with her to share ideas, experiences and hopes

Shila Khan and Máire Stedman in conversation with Inga-Britt Krause

MS: Britt, would you like to tell us something about your own migration story to the UK? We were wondering how this experience might have impacted on your personal and professional interest in issues of race, culture and ethnicity.

BK: That's a big question I can't really answer without going even further back. I am from Denmark, but being a Dane is a recent affiliation because my family has come from many places in Europe. My last name is Krause, from my German grandfather who left Germany just before world war one to avoid being a soldier. As I was growing up in Denmark in the 50s, I remember lots of German pictures and books in my grandparents' home. I was often told the story of how my grandfather was very torn when the Germans occupied Denmark in world war two, and how he resolved that by helping Communists and Jews to flee to Sweden. When I was five or six, I remember sitting at my grandparents' table as they played bridge with two Polish communists from a concentration camp. So that kind of multiple European identity was a vivid experience from an early age. On the other side of my family are Swedes and also Slavs. There is really only one generation that's Danish, so this idea that one has one identity that is solid and enduring is not the case for me. I think it's not the case for a lot of people.

There is something about this that's important to me. I have always been interested in hearing people's stories about kinship, where you belong and who doesn't belong. I remember as a child sitting on my grandfather's knee and hearing about his youth as a carpenter and how he came to Denmark. I remember my grandmother telling stories about the past, stories about families.

I feel Danish. I love the language and I love the physical aspects of the country, but I am also aware I'm a mixture of many things.

My father and grandfather died when I was 14 and I had a difficult relationship with my mother. I think the mixture of my hearing stories as a young child and my conflict with my mother probably made me leave Denmark as a kind of solution. I was studying and planned to write a thesis on Polish folklore and peasant art. I was travelling by train from Copenhagen to Warsaw

and I met someone and fell in love. This person was a postdoctoral fellow in physiological psychology and was working in Prague and, eventually, he came to the UK to take up a scholarship at University College London. That was how I arrived in the UK. I wrote my thesis and started at the London School of Economics as a student in the Department of Anthropology.

MS: So the personal and professional are very entwined (shared laughter)...

BK: ... So, what was the question?

MS: Well it was about the impact of personal and professional interests in race, culture and ethnicity and how they have come together.

BK: As a child growing up in Denmark there was little talk of migration or immigration. Denmark didn't see much immigration until perhaps the seventies, although we had Greenland as our terrible, shameful colonisation. People from Greenland were treated as second-class citizens and experienced much discrimination. My awareness of difference and diversity was rooted in the more personal circumstances and experiences I described, of belonging and not belonging. Issues of race didn't really figure for me until I came to the UK.

SK: I'm interested in your comment about you not being a real Dane and talking about the multiplicity of your identity. I was just wondering if you could say a bit about more about this?

BK: But the funny thing is I do feel like a Dane, I absolutely feel like a Dane.

SK: So when you say that, what do you mean? What aspects are you referring to?

BK: I think I mean I recognise characteristics in me that are very Danish, particularly having been in England for a long time, I recognise certain things that I do, the way I speak ... I also have a love for the language, the literature, the country and its traditions. So when I say that I am not a real Dane, it is almost as if one part of me is talking to another part of me.

MS: I wonder if it is something to do with the context in which you grew up, Danish but with these other cultural influences?

BK: Yeah, I went to a Danish school and Danish is my mother tongue. That is always there. There is some sort

of continuity in all that. It is when I recount my family history and its complexity that “I’m not a real Dane” comes in. I suppose I fall into that trap that we all fall into when we think about ethnicity and race, that there should be something essential about it. There is not. And it is quite hard for us to always keep in perspective those bits of our identity that are changing and those that are continuing. I think that’s something fundamental about my identity and my ethnicity, and probably all ethnicities.

MS: That brings up something for me about second generation issues – that’s what resonates for me when I hear you speaking. Sometimes there is a pull between “am I British” or “am I originally Asian or African, African Caribbean or Irish” – who am I in all of this? I’m sure this awareness must bring a richness to any multiple identity work you might do.

BK: We speak about ethnicity as if it is an essence or an identity, but it is a person’s boundary, recreated. It can be more essentialised sometimes and less essentialised at others. I think I feel more Danish here than I do in Denmark. If I were being persecuted for being a Dane I might feel more Danish in some ways.

SK: The other connection for me is to do with how people engage in conversation about who they are, and how it can shift according to context. You’re drawing attention to how personal that journey is in some aspects and also how it is affected by contexts. I think that is certainly one of the strengths you have contributed to discussions of these issues. You have been a real pioneer. I don’t know what you think about that word in relation to your work, but you’ve been talking about race, culture and ethnicity in the UK, along with others, since the Eighties and early Nineties and you have continued these conversations through your different publications. What of your professional experiences contribute to your continued thinking about these issues?

BK: I came to family therapy as an anthropologist. I already had an interest in race and culture because anthropology is a discipline organised around these ideas. It caught my interest that anthropology and family therapy had a connection before. I remember thinking in the beginning, how odd! I actually wrote to Gregory Bateson when he was in Hawaii to ask if I could become his graduate student, but then I moved on and became more interested in caste and inequality in India. But I do remember thinking when I came to family therapy, how odd it is that family therapy dropped all that early anthropological stuff and how incredibly long it took for interest in these issues to reappear.

SK: What ideas do you have about how that happened in family therapy?

BK: I am only now beginning to understand. Family therapy is a funny field because sometimes it seems to have offered such an obvious, useful shift (the shift from individuals to systems or relationships) in comparison to other psychotherapies. But we tend to forget that this is a very, very complex shift and that without looking through the lens of race and culture, you can’t see its full complexity. These ideas are not even central yet. I think it is a great loss. If any discipline can handle the integration of race and culture, it should be family and systemic psychotherapy.

I’d read Bateson and Minuchin in studying anthropology and bumped into family therapy. It seemed

to make such practical sense to the ethnographer or medical anthropologist. But I hadn’t really made intellectual or emotional sense of that until very recently. So you are right when you say I have been on a journey. And I have not let go. Somehow there is so much to be fitted together if we place race and culture in the centre of our discipline, and we haven’t done it yet.

MS: I’m really curious when you mention anthropology because it seems to have had varying influences at different times. To what extent do you think it may have become more integral in the systemic field? There are people like Michael White who have used it in many ways, and occasionally you hear different anthropologists being referenced. I’m just wondering about your views on this.

BK: Anthropology is a complex and difficult discipline with many different positive and negative connections to our society. You could never negate or deny the connection to colonialism, but then anthropology also offers a window into our identities. I was drawn to Michael White’s work because he was someone who referenced people that I didn’t see referenced anywhere else in family therapy. But I have also become irritated with that, because often I have seen him only half use anthropological ideas. I think that is part of the problem and we have to go back to the question – “what is the hardest thing about taking on board race and ethnicity?” For an answer, I think we have to go back to the beginning, to our definition of “a system”.

Right now in systemic psychotherapy we are steeped in narrative and social constructionism and the hardest thing for us to grasp is continuity without stereotyping. It is easy to stereotype. It is also not that difficult to say we are always creating things together and making something new, that’s social constructionism and narrative. What is hard is getting a grasp of continuity when that is also being reshaped and changed constantly.

Culture is about expectations. That’s where the continuity lies, about the ways all kinds of events are taking shape in processes in particular sites and at a particularly time. And that’s all it is. This then includes history and development and process as well as what those involved might expect. Without expecting something it makes no sense to take part in any event and this is where meaning comes in.

SK: It is interesting to hear you talk about your journey and that you’re re-examining and developing some ideas from the past and present. I was reminding myself that you have been involved in a lot of important places where there has been fruitful thinking, talking and doing around race and culture, for instance the Marlborough Family Centre ...

SK, MS & BK: *which of course is where we all met.*

... and now the Tavistock Clinic in London.

Can you say more about the risks and points of creativity in what you described as ‘not being able to let these things go’.

BK: Well, risk is one thing and creativity another. I think we couldn’t let them go because they are politically important, in terms of our ideals and our thinking about how we exist together. That is a commitment that has to be stated. From that sprang the need to work out where race, culture and ethnicity fits with our other models and paradigms. There is great richness in that because it seems that is the place where the discipline will grow

when all the other avenues have been explored. In terms of big conceptual shifts, we have to concentrate on the area where we engage with diversity in all its aspects. That is why we have kept going. That is where the creativity is to be found.

In the Eighties when Anne Miller and I began to think about the Marlborough project, with requests from policy makers and ideas about how the NHS should develop with more diversity, it seemed obvious to put our efforts into getting money to do that. That is how the Marlborough project started. It also started because Alan Cooklin and others accommodated it and had a visionary view of what we should do. There was a feeling of “here is a place where we can recharge and find some energy and we will do that”. We were also naive because we really did not think much about the wider implications. Once you have put something like that together and you are successful, that’s the time when you start to think more about it. It became very complicated.

MS: I suppose that brings us to the next bit of what we were thinking about. What are some of the challenges institutions – not just the Marlborough Family Centre or the Tavistock; but what become the challenges... And that is a very fluid thing and it is a journey as well, but what in general are some of the challenges that you think institutions might pose once you have such a creative project?

BK: People have asked what we might have done differently, and I think it is difficult to know how much you can prepare an institution for something like this. Probably at some point we might have said we didn’t prepare the institution enough for the influx of six multicultural therapists and the programme. As we know about institutional dynamics, introducing a project like that into an institution can produce problems in other areas. I think that’s the same for the Tavistock. You need to think how much to prepare an institution, and it is an enormous challenge. We want to do it, but we can’t actually see the implications and ramifications and how these will affect our theoretical models, our ideas, the management hierarchy and so on. It is going to be a constant challenge because you are asking people to think differently.

SK: I was just thinking of the different contexts that you and others have worked within and really grappled with these very complex issues and I wondered what enables that preparedness to talk and develop these ideas? What enables these conversations to happen more readily in some contexts than in others?

BK: It will be a challenge in whatever context you are in. But I do think that if you have very strict hierarchies and a very managerial culture it is more difficult than if you don’t. On the other hand, I also think that if you have a culture where you don’t necessarily think about internal worlds, that could also make things more difficult. So it’s not easy to say. What is clear is that if you introduce it at the very bottom there may not be much chance of change. The Marlborough was successful because these ideas were taken on board across the institution, supported by Alan Cooklin and Eia Asen, so we had that kind of legitimacy. Here at the Tavistock, the post of Training and Development Consultant was conceived of at a relatively high institutional level. Without that backing it would not be happening, but still that does not ensure success. Some people say you

have achieved an enormous amount, but do they say that because they don’t want to change any more or do they really mean it? I don’t have any illusion about working in this field and not having a struggle. It is going to be a struggle, all my working life.

SK: What would you say is the essence of the preparedness to struggle with these issues?

BK: You just don’t give up. One can try to make things more palatable without compromise and put points in certain ways so that they seem more relevant than others, and I think that’s maybe where we have a lot of work to do. What are we doing with these differences as clinicians? Working with race and culture in systemic psychotherapy hasn’t really moved far over the last thirty years yet we can’t deny the change in our society, its multicultural character.

SK: That’s interesting. When there are conferences or seminars around these issues, the people who are already prepared to think or have been thinking are the ones who tend to be there. I’m quite curious about the people who are not there but might need to be if we are to make these issues the responsibility of everyone and not just a few. What are your thoughts about what makes it difficult for some people to enter these dialogues and discussions? I still come across people who say, “we don’t really deal with many people from different cultures”, or “we come from this part of England where there isn’t a very mixed community so it’s not for us”.

BK: We have all got an inbuilt tendency to ‘other’ and to project onto others those bits we don’t want. That is part of our human ontology and it gets played out in a big way when we talk about racism and diversity. It is a developmental necessity that we experience this phase of being near our carers and then separated from them. That’s of course what psychoanalysts talk about, but I do think it is useful to bear in mind. Some people for various circumstances – psychological, political, social, emotional – are more inclined to shut down or pull out. I think you cannot be a mental health professional without having gone some way in a developmental sense of how open you can be to others. The danger for us as professionals is that we may say that we have ‘the answer’, but it doesn’t apply to us. Maybe that is about what we have been and not been exposed to and don’t know? Or maybe we don’t want to know? Or maybe we are racist?

We are not always going to conferences where people are asking how do we integrate these issues into clinical process and thinking? Maybe it is naïve and optimistic but I have this idea that if we can work on this, everyone would be better therapists, even those who haven’t experienced a great deal of diversity personally or professionally. It is essential. We are cutting ourselves off by keeping it on the margins.

MS: That brings us to an area which was another of your passions, in terms of thinking about the Macpherson Report ⁽⁹⁾ and how collective coming together, and the context, can bring about particular ways of thinking. You have talked at a personal and professional level about our role as trainers in helping the next generation to think more creatively and broadly about these issues. To what extent do you think there has been a shift in institutions as a result of the Macpherson Report and the Race Relations Amendment Act 2000? I suppose it’s

an ongoing process, but do you think there have been changes within the NHS prompted by that look at institutions?

BK: It is a difficult to give a simple answer to this question. To some extent it does help to have a law. It moves things onto another level. But there is also the danger that after a while we are back to ticking boxes. That's where we are, and I think it is because of a pervasive fear that we cannot bring these issues into questions of therapists, into therapy; that it cannot be part of the way I think about a person's family structure or how they use symbols, or what might they mean, or how I might find out.

The Macpherson Report was so far sighted that in society we have lost its important points about institutional racism. Its most innovative idea was that you can have discrimination in ideas. The ideas we hold collectively can be discriminating and indeed often are. That is the continuity I was talking about earlier. We can't live without it but we also have to recognise that it isn't the only way to think about something. We have to question.

There have been so many obstacles along the way. Take, for example, the Delivering Race Equality report, developed for adult services. The recent push has been to take it from adult services into CAMHS. Everyone knows that CAMHS are not adult services and that children are not the same as adults. So does it make sense just to adopt an approach from one part of the NHS into the other? We have to develop different approaches because children are much more embedded in kinship and can't always decide for themselves. I have been encouraged by the forward step of the Tavistock in creating my current post, but I do recognise we have not achieved as much as I had hoped.

MS: One of the fascinating things for me, in hearing you talk about this, is the personal and collective and the interaction between the two. It brings to mind for me conversations that often take place in clinics around ethnic monitoring forms. The statements therapists make are often quite revealing at these points. The question is often posed: "Are the secretaries going to do this or is it us?" Comments may come up about the impact that ethnic monitoring might have on our model or our professional way of being. I was also fascinated by your interplay between the personal and professional and the institution. I think about it as a triangle. It is like an eternal triangle where people are progressing and spiralling – the question is do they spiral up or down? (shared laughter)

BK: Ethnic monitoring forms are very much a census State kind of tool for us to count and counting can be used in very positive ways but also in very bad ways. As clinicians we have to think about ethnicity much more as a process, about boundaries being pushed in terms of what people choose for themselves and what others choose for them. I see these as dynamic concepts. But of course as soon as they come from the State they are not dynamic anymore.

MS: For some it can feel frightening, for others it is to be ticked and eliminated, so "now we will get on with therapy", and for others, while it has limitations, it poses an opportunity to get into a conversation which can lead to some of the issues the family have come about. It can

be interesting what can emerge around this whole process.

BK: I would say it is better to keep the two aspects of that separate because you can see how people would be frightened. I would be frightened for my identity, multiple as it is, to be pushed into one or the other direction. The monitors and audit people would be worried that the therapeutic process would pollute their statistics and I would be worried that the State's approach, the monitoring one, pollutes my client's understanding of the way I see these issues. These are the things we in systemic psychotherapy have to grapple with all the time. Something like evidence-based practice is hardly ever based on multicultural samples, samples from different ethnic groups. Even when it is, ethnicity is used in this 'State' way as if it were the same kind of variable as age or gender. We still have to bridge the gap between one kind of evidence-based practice and another which doesn't talk about categories but which nevertheless reports on what is happening in our therapy as another kind of evidence.

MS: I was wondering how we begin to integrate these issues into our thinking and practice. Is there a risk of evoking fear and paralysis, a sense of "oh we have got to do it", if the 'shoulds' come down as injunctions or with law or through training or ethical requirements? There is a sense that people can get paralysed around these constructs as ways of engaging. What are the rays of hope that keep you engaged with these 'issues to grapple with'?

BK: Well, I'm stubborn! (laughter) Apart from that, anthropology and systemic psychotherapy have had a big influence and I have a vision about how these issues might be integrated. I have written about some of this, maybe a bit clumsily, because the integration is in the making. I do have visions about what an integrated framework might look like. That keeps me going. I also think about my own therapeutic work as being a bit like ethnography so I think back to my ethnographic studies. I continue to discover other anthropologists thinking like therapists. To me it has been a kind of journey of discovery about where they fit together. There is something family therapists could learn from ethnography.

SK: Thinking about the field of family therapy, are there some developments or particular people or practices that make you hopeful?

BK: I have always liked the "Just Therapy" project in New Zealand (www.justtherapy.org), and I still very much like their political stance but I think maybe the most inspiration has come from people who have not necessarily focused on issues of race and culture. For example, I think Carmel Flaskas's work is important and the reality she writes about is also the reality of race and culture. I have been influenced by Bateson, of course, by the Milan approach and by structural family therapy. We need to be eclectic. I am not keen on saying I am this or that kind of family therapist. There is something about putting things together from different traditions. I am not keen on the division between narrative and systemic, for example. That's a great loss for our discipline if we carve ourselves up like that.

SK: As a trainer and a pioneer in the field, I wanted to ask you how you think training needs to develop to help people engage with these issues and their intricacies?

BK: It feels like a very difficult area. As a basic point our trainers need to be much more exposed to different systems, different ways of doing things at all kinds of levels. I just cannot understand that there is no basic teaching about kinship, about personhood, about medical systems, different ways of thinking about bodies, because it seems to fit in with the curriculum as it is taught. It does give this impression that when you talk about the system you are just talking about something that is always the same. That of course is our dilemma, we talk about relationships but surely none of us can really think about relationships without them being embedded in some kind of system of meaning. On training courses there should be much more exposure to diversity, not as an isolated issue on the margin addressed by a visiting lecturer.

MS: It goes back to your earlier point, about how do we train people to think in ways that connect to different people or that can facilitate that connection.

BK: Yeah, yeah, I think so. There are many opportunities. There is a wealth of ethnographic films to set exercises around; there are field work and observation exercises. You could extend those. You could make much more material available simply to free up people's thinking.

MS: I am just thinking as you were talking about the time a Race and Culture group came together, meeting at the Marlborough, under the umbrella of CONFETTI (Confederation of family therapy training institutions), to look at training materials. The group's report was later published as an edition of *Context* ⁽ⁱⁱ⁾. We began to think about different films and pictures, different ways of being, ways that if you didn't have that direct experience you could still be exposed somehow through media, through literature, through a variety of other ways. I am wondering if we have lost some of that. The opportunities were there, somehow...

BK: I don't think people were ready....were they?

MS: Maybe not but it is often a publication I come back to when I start thinking about training and when people say "Well how do we start tackling these things".

BK: There is a point in there, because you are not talking about dismissing a whole group of trainers. To some extent you have to try to facilitate trainers themselves to work through something they can manage. That is not very likely to happen unless there are economic reasons for doing so. So if for some reason your training course is not doing very well and you need to make some changes, that's perhaps when you can do it.

As a development consultant, I know I have had to put the brakes on myself because my vision may be much further advanced than trainers can manage, so it is about trying to find some institutional mechanism through which trainers might be encouraged to do some work with each other to see what's possible. It would be a great leap forward if every time trainers teach standard texts they say to themselves and to their students, "What does this tell us about race and equality?" Even if race and equality are not mentioned.

SK: As you were saying earlier, certain practices have progressed slightly but not gone far enough. There is always a sense that more can be done. You mentioned economic reasons for doing so. What kind of arguments could we make economically?

BK: It is about attracting students. To some extent the Race Relations Amendment Act is responsible for introducing clauses about race and equality into many different areas, including requirements of training and treatment. Therein lies a dilemma, of course, because if you are a reputable organisation you can attract students and there might not be much pressure on the quality of teaching. How are we to evaluate that? Is it good that people from different ethnic backgrounds are coming, but not getting good teaching connecting with their own backgrounds? The ideal would be to have a multicultural group of students taught in such a way that speaks to everyone's personal background in some way. So nobody is alienated. It is a very hard thing to achieve.

MS: You mentioned earlier that the Macpherson Report was far sighted and probably before its time. You also mentioned that some training initiatives and the CONFETTI publication were maybe too challenging, or people weren't ready for it. Macpherson opened up an opportunity, and it feels like people can now see more clearly the value of this kind of work and are saying "Oh yes, we're interested in these ideas", yet they are saying there is a limit to the ways it might be developed given the economic climate. I don't want to be too pessimistic, I think there have been changes and it has opened up thinking. But it also feels like there is almost a shutdown in many ways ...

BK: Of course when things are hard economically, you expect a shutdown which will impact on those who have least power. As a development person, I've learned the importance of taking the opportunities you have. The difficulty is to keep ideals, but still be opportunistic, otherwise you just don't go anywhere. I have been involved enthusiastically with many smaller projects from the beginning and given everything that I have and then we end up with a tenth of what we could have ended up with and I am left feeling disappointed and sometimes compromised. The movement from ideals to reality is complex and sometimes emotionally difficult...

MS: Speaking of which we have probably had more than our time...

SK: As part of our conversation with you, we also want to give you an open space to say anything that we have not enabled you to discuss today.

BK: I want to ask you both what keeps you going? Because you are sticking to these issues in some way or another, and you have also taken knocks. In a sense I have been lucky, that is another part of my story. I came into family therapy when it was not difficult for someone from an academic background to train, and I am very aware that both of you have had your careers compromised in different ways and that has been the cost of sticking to these issues. So what keeps you going?

SK: There are costs and there are risks in persevering. I think there has been a personal and professional dovetailing of not letting go, an awareness that these are really important for all of us, not just for me an Asian person or as an ethnic minority in Britain. These are issues about difference about 'othering', how being the other affects all of us. They are difficult, powerful issues for us, but I feel it is important for me to continue to grapple with these issues in conversation with others in an attempt

to understand our differences whilst finding connections across our areas of commonality. The challenge is to keep that conversation going with others.

Also I've noticed that I do not feel as easily bruised or angered if people are not readily engaging, as I might have been before. I have become slightly less than fundamentalist about it (*laughter*) if I can use that as a word without the association it now has! A sense that everyone has their own personal journey into these issues and that if I begin to judge people or expect things from people, that is a no-goer. People and organisations are at different parts of the journey and you have to acknowledge that without giving up the ideals you talked of. That is really what keeps me going.

MS: Yes, there are elements that are similar in a way and others that are different. It is the coming together of the personal and professional. But I think the people for whom it is then important are our clients as they come into organisations. You may feel personally bruised by some of the endeavours you have tried to set up in organisations and which have not gone as far as you would have wanted them to. But I think the thing that grounds me is the actual work with clients....

BK: Yeah, I agree...

MS: Because you think... "No I cannot give up on this, this is important and it is important that there is a facilitative context for people to be enabled to tell their story". And to tell their story in a way that they are not going to be judged. It's quite complicated because there are often three sets of contexts at play here. There are the clients' own cultural norms, which we have acknowledged are fluid; there are the lenses that we have as therapists, drawing on our own life experiences, cultural background and training. And as we acknowledged, trainings are often hierarchical in the value given to certain models. So the third factor is the institutional context with its policies and ways of operating, which may be more facilitative of some cultural ways of being and behaving than others.

Another area I know you feel passionately about as well, is the way in which Western trainings limit us. I have been fortunate with a number of people that I have worked with in having some psychiatrists, psychologists and family therapists who have been interested in anthropology or who were themselves from different cultures, so there was a meeting of minds and you can feel that strength and that unity. Also the creativity that comes with co-working with interpreters. This is what enables us all in many institutions to carry on, when there are one or two like-minded people with whom you can have conversations about your development, self-reflexivity and therapy because you know they understand where you're coming from. Together you can have conversations that challenge each other from a position of understanding rather than a critical, totalising or silencing challenge, while at the same time not being afraid to introduce difference or question a perspective. These opportunities in

organisations, with individuals, and with people from the wider contexts, rejuvenate you.

We keep coming back to referencing our conversations together at The Marlborough. They were quite pioneering in many ways, and remain resources to draw on. My personal experience, too, being an Irish person in this country, is something that brought with it 'otherness' when I first came here. I think I can see a connection now for me with say young Muslims I have worked with and unaccompanied refugee children. In a sense, I can see how totalising of the other, how denigrating of the other, it was. It has shifted over time and you can see how certain groups are perceived as posing less of a threat and others occupy that position. It is interesting the shift that has taken place where former 'terrorists' are occupying positions as accepted leaders, for example Nelson Mandela and Gerry Adams.

BK: There was a very good article recently in the *London Review of Books* with a title of something like "what have we learned from the Irish" directly relevant to young Muslims.

That is very serious, society making the same mistakes again.

MS: On a number of levels, you were referencing the "Just Therapy" Group which has also been an inspiration for me in thinking about work with unaccompanied refugee children, and in having set up the Refugee Skills Exchange Project ⁽ⁱⁱⁱ⁾. So you dip into these experiences, and they also enrich you to carry on.

- i. *The Macpherson Report into the Metropolitan Police's handling of investigations into the death of black teenager Stephen Lawrence*, 1999.
- ii. *Context* 44 August 1999 Sowing the Seeds of Cultural Competence: Family therapy training for a Multi-Ethnic Society.
- iii. *Context* 53 February 2001



Inga-Britt Krause

Nothing but the same old story

paul brady

I was just about nineteen
When I landed on their shore
With my eyes big as headlights
Like the thousands and thousands who came before
I was going to be something
...
Smiled at the man scrutinising my face
As I stepped down off the gangway

Came down to their city
Where I worked for many's the year
Built a hundred houses
Must've pulled half a million pints of beer
Living under suspicion
Putting up with the hatred and fear in their eyes
You can see that you're nothing but a murderer
In their eyes, we're nothing but a bunch of murderers

Hey, Johnny, can't wait till Saturday night!
Got a thirst that's raging . . .
Know a place where we can put that right
Wash away the confusion
Hose down this fire inside
But look out!
'Cause I'll tear you into pieces if you cross me.

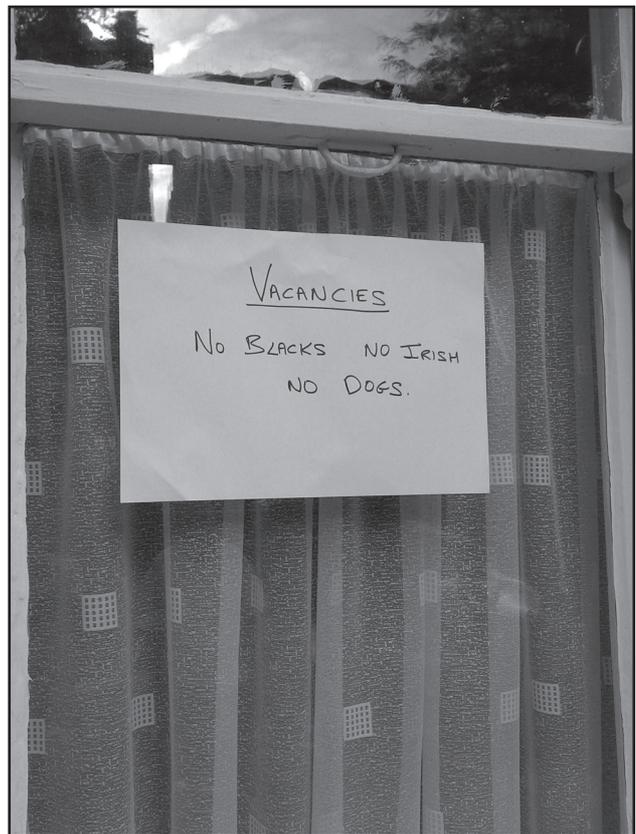
I'm sick of watching them break up
Every time some bird brain puts us down
Making jokes on the radio . . .
Guess it helps them all drown out the sound
Of the crumbling foundations
Any fool can see the writing on the wall
But they just don't believe that it's happening.
There's a crowd says I'm alright
Say they like my turn of phrase
Take me round to their parties
Like some dressed up monkey in a cage.
And I play my accordion
Oh! but when the wine seeps through the facade
It's nothing but the same old story
Nothing but the same old story

Got a brother in Boston
Says he'll send me on the fare
Just wrote me a letter
Making out that he's cleaning up out there
Two cars in the driveway

Summer house way down on the Cape
And I know he'd fix me up in the morning

I've been thinking about it
But it seems so far to go
People say in the winter
you'd get lost underneath the snow
And there's this girl from my home place
We've been planning to move back and give it a try
So I never got around to going
That's why I never got around to going

'Nothing But the Same Old Story', composed by Paul Brady.
Reproduced by kind permission of Hornall Brothers Music
Ltd. For more information about Paul, see www.paulbrady.com



Signs such as this were prevalent until the 70s in many lodging houses.

When immigrants from the 'New Commonwealth' arrived to join them, landlords added 'No Coloureds' signs in their windows to those which read 'Irish not Required'. This was the price of identity preserved.

Fernandez-Armesto, F. (1997) *Millennium*. London: Black Swan. (p. 542)

Culturally sensitive talking therapies; the Irish and other communities

gary fereday

With some 850,000 Irish born and over 5.5 million second and third generation Irish people, the Irish are one of the largest ethnic minorities in Britain today. However, Irish people are usually seen as no different to the white British majority; their differences often invisible, with the majority white and English-speaking.

This invisibility has meant their mental health is often overlooked. Yet Irish born people in England have rates of mental distress well above those for any other migrant group (except for psychosis rates in the African-Caribbean population), and suicide and undetermined deaths among Irishmen and women are up to 40% higher than the population average.

Reasons for these high rates of mental distress are complex. Irish people migrated to Britain as young single adults rather than as part of a family unit. Coming from a country where family and community support are important parts of life, this removed them from support structures that were provided by their families when they were living in Ireland.

Irish immigration from the Republic of Ireland was particularly high in the 1950s and early 1960s. It's hard now, given the economic boom of the last decade, to recall just how impoverished Ireland was: a poor, rural country, deeply conservative with a complex relationship with the Catholic Church. Just how different North London in the swinging sixties must have felt to a young person coming from the West coast of Ireland is difficult to imagine today. The Irish also left Northern Ireland too, and it's important to remember both the Protestant and Catholic experiences of migration. "The Troubles" in Northern Ireland add yet another layer of complexity to this history of migration: for many years some Irish people living in Britain hid their "Irishness".

For older Irish people their experience of immigration is likely to play a large part in their mental wellbeing: both the feeling of loss (of family and community) and anxiety about hostility in the host country. Many of the men worked in manual labour trades with little or no employment protection, and are now facing an impoverished old age further adding to their distress. For young Irish people coming to Britain today, loss is still a key factor. Ireland, despite its new found affluence, is still a country where family and local ties are very strong.

Add to this the considerable evidence that Irish people have faced discrimination in Britain for many years in employment, health, housing and education and it starts to become easier to understand the reasons for the levels of mental distress. Recent research found that 45% of users of mental health services of Irish origin felt they had experienced discrimination. Discrimination, uncertainty about where to get help and the Irish reluctance to turn

to statutory providers mean some end up self medicating with drugs and alcohol.

Cultural competence in service provision is increasingly being regarded as important in the work of providing health services. The Irish, like other communities, value and benefit from services which recognise, understand and respect their cultural difference in the provision of care.

icap (Immigrant Counselling and Psychotherapy) is a provider of culturally sensitive counselling and psychotherapy, serving the Irish and other migrant communities: providing over 1300 sessions every month of psychotherapy, operating nationwide, with centres in London and Birmingham, and a network of therapists throughout Britain who see our clients in their own consulting rooms, our services are accessible to the most vulnerable in the community and our clients make a financial contribution according to their means. We have built particular expertise in providing therapy for survivors of institutional abuse in the Industrial Schools and other institutions whilst children in Ireland.

But it's not just the Irish community that we serve, and we are increasingly attracting clients from many other communities. Currently around 65% of our clients are Irish or of Irish origin, the other 35% reflecting the cultural diversity of London and Birmingham. Increasingly, we are approached by groups working with new migrants from Central and Eastern Europe. It's interesting to reflect on some of the cultural similarities – Poland for example being a predominantly conservative Catholic country with high numbers of young, single migrants coming to Britain, often working in the same trades the Irish did in previous generations.

icap is now a recognised and respected part of the Irish community in Britain. Mary McAleese, the President of Ireland, has stated "icap and its existence has added a new and important dimension to the rich fabric of Irish community organisations throughout Britain". Yet the work we do and the mental health issues facing the Irish are not always widely recognised.

icap hopes to have a conference in the future. It's intention is to examine whether there is an 'Irish Psyche' and explore the complex clinical and cultural issues surrounding the concept.

icap is keen to ensure our understanding of some of those issues, and our expertise in working in a culturally sensitive way can be transferred and used to support newer arrivals to Britain.

Gary Fereday is Chief Executive of icap. For further information about icap telephone 020 7272 7906 or see www.icap.org.uk

Muddles and struggles of a trainee researching race and culture: implications for family therapy training

chiara santin

As part of my MSc in Systemic and Family Psychotherapy I undertook a small research project which reflects my specific interest in exploring the experiences of minority ethnic family therapists. Being a family therapy trainee in the UK, born and brought up in Italy, from where I moved nine years ago, I have been on a personal journey to try to understand how I can use my cultural self in therapeutic encounters. The culturally specific responses and multiple layers of meanings that I have experienced in the therapeutic process have intrigued me.

Given the increasing interest in cross-cultural issues and the emerging centrality of therapists' use of self in family therapy, my research study focused on gaining an understanding of the experiences of minority ethnic therapists and how they make sense of the ways they use their cultural self in therapy.

Although I have used cultural lenses e.g. focusing primarily on cultural difference, I have adopted a definition of culture which highlights the fluid and complex nature of simultaneous memberships of different cultural contexts. According to Falicov (1995) the "ecological niche" is the combination of multiple contexts and partial cultural locations to which people belong as a rich and endless possible combination of age, gender, family configuration, education, language, race, ethnicity, religion, socio-economic status, and sexual orientation.

Amongst qualitative methods, I chose Interpretative Phenomenological Analysis (IPA) as it seemed to offer the possibility of a more detailed and rich exploration of meanings attached to the experiences of minority ethnic therapists, enhancing their own self-reflexivity and validating their self-interpreting accounts. I have interviewed four family therapists from various cultural backgrounds. They were all female, maybe reflecting the gender imbalance amongst ethnic minority family therapists. Let us hear their voices through their own self-definition of cultural identity (Names have been changed to ensure anonymity):

Jenny is a family therapist/supervisor, working in a CAMHS (Child and Adolescent Mental Health Service) clinic.

"I describe myself as being of dual heritage....maybe the best term would be 'mixed heritage'.....Nigerian father, English mother, brought up in England by my mother and step-father who is from Trinidad...."

Geeta is 49, a family therapist since 1998 with a social work background; working in a CAMHS clinic.

"I am mixed race background, my mother is English, my father was from Guyana in South America but originally his family would have been from India through the indentured labour process."

Maxine is in her 40s, a family therapist since 1993, working as a therapist and trainer in her private practice.

"It depends where I am but if I am asked to, I start with African and Guyana to locate me in the country I come from, so African Guyanese."

Rahila is a family therapist with a social work background, currently working in a CAMHS setting. (To protect her anonymity and ensure confidentiality her ethnic background has not been disclosed.)

key findings

The key findings of the study can be summarised as follows:

1. The multiple and fluid nature of cultural identities highlights tension between an internal and external sense of identity which is reflected in the complexity of aspects of difference intersecting with one another and being activated in therapy.
2. Visible and invisible differences may become the embodiment of power inequality in the wider society and play a crucial role in cross-cultural therapy and the way ethnic minority therapists are positioned in teams.
3. The pervasive and covert nature of racism and the power of language in constructing identities based on dominant discourses is reflected in therapy and professional contexts.
4. Race and culture can be silenced or marginalised in professional contexts and family therapy training, hence the need to promote a culture of trust and openness, the importance of personal and collective risk taking and self-reflexivity.

For the purpose of this paper, I would like to focus on the participants' experience of these issues in relation to their personal and professional development, in particular drawing attention to their experiences of cultural difference in family therapy training and their workplace.

family therapy training: "mixed experiences of difference"

All participants acknowledged the importance given to 'race and culture' in their family therapy training, crucially complemented by the presence in the group of trainees from various cultural backgrounds which they felt helped to validate their own cultural identity. Rahila stated:

"I found some of the teaching on race and culture really interesting...we had an incredibly mixed group of students which makes all the difference..."

Geeta talked about how issues of culture and race were addressed in her family therapy training compared to her social work training:

“I remember thinking I was quite impressed...I thought they handled it very well.”

A different view was clearly expressed by Jenny: *“...my experience of difference in the training was not very well handled and it wasn't only my experience...I don't think it's sufficiently embedded in training, in trainers, to be able to discuss these things....so when it comes up, it comes up in terms of being quite an intense difficulty or intense issue that they then struggle to resolve...”*

Less positive views of training experiences seemed less explicit or more difficult to express for other participants. For example Maxine, being a trainer, compared how these issues have been addressed during her training and now:

“I don't think there is anything different to the way it is nowadays, we are still grappling with these ideas...” She added: *“It was much more personalised and individualised...and the emotions of it polarised people and I think it still happens...”*

“raising the issue” and being an “expert of difference” in professional contexts

All participants highlighted the challenges they face in their work context in relation to their cultural difference. Maxine stated:

“That is such a big question and I am thinking ‘where do I start?’ because it's something... it's difficult not just for me, it's difficult for the people around me.”

The participants' experiences of cultural difference seem to highlight the contradiction of their position within teams. On the one hand, working in a predominantly white environment creates the need to raise cultural awareness as an outsider, i.e. raising cultural awareness with colleagues; on the other hand, minority ethnic therapists may become constructed as “experts of difference” as an insider, when their expertise is used to promote a more culturally sensitive service. Geeta, who works in an overwhelmingly white area and service, stated:

“God...here we go again...it's my responsibility.”

Geeta also recalled when she was asked to redraw a form in relation to ethnic categories. She said:

“I remember noticing you know, ‘this is hundred years old, this is rubbish’ and mentioning it to my manager and ‘oh this is very exciting’ kind of ‘can you redraft it all?’ or whatever...but it's like suddenly I'm an expert...[laugh].”

The dilemma whether or not “raising the issue” can be associated with concerns about how participants were perceived by colleagues and their fear of not being heard or understood, was highlighted by Jenny:

“...sometimes I do, sometimes I don't and...I think about why I don't...I always think about these moments when I don't...I also think about...Well...how would it be perceived if somebody's always doing it and why do I have to? All of that sort of stuff...and...I say things but I don't know whether it's understood or heard...”

race and culture as marginalised voices in family therapy: implications for training and clinical practice

The findings highlight how the constructions of cultural identities in professional contexts and wider society are based on dominant discourses and power dynamics which are mirrored in therapy. The idea of therapy as a meeting of cultures (Pare, 1996) and the need for culturally sensitive practice bring dilemmas and challenges to be addressed both at training and professional levels which are receiving increasing attention.

Findings suggest mixed views about experiences of cultural difference within the training context, so that whilst race and culture are included as subjects, discussions about these issues are still difficult and cause intensity of feelings. Singh (2004) argues that in family therapy training there is not enough focus on issues of race and culture, whilst others have suggested that they can still be seen as an “add on” (Nolte, 2007).

Falicov (1995) advocates that issues of culture should become part of mainstream thinking and family therapy training. Hardy and Lazsloffy (1995) argue that there has been more emphasis on cultural awareness, e.g. learning about various cultural groups, than cultural sensitivity, which emerges from personal experiences of culture. They also suggest using cultural genograms as a training tool to highlight issues of pride and shame related to one's own cultural origins, cultural biases and their impact on oneself as a therapist.

Nolte (2007) rightly points out the importance of cultural awareness for white therapists too as Whiteness can hide issues of privilege and power, hence the need to deconstruct Whiteness. However, this is a personally challenging process, which typically brings anxiety and discomfort. In fact, Karamat Ali (2007, p. 371) claims: *“Respect and trust are vitally important since trainees tend to take a very cautious stance which can result in an avoidance of thinking about these issues”* [race and culture]. Mason (2005) advocates personal risk taking to promote trust and openness in talking about issues of race and culture. Similarly, collective risk taking in professional contexts can promote sharing prejudices, personal dilemmas and challenges of working cross-culturally with colleagues (Khan, 2002).

The marginalisation of race and culture within family therapy training is also evident in clinical practice. Some have highlighted the powerful influence of dominant discourses on power relations in society, including race relations and how these are reflected in the therapeutic process. Hare-Mustin, (1994) in particular, claims that family therapy may serve the dominant culture's agenda and perpetuate inequality in the ‘mirrored room’ if dominant discourses are not unveiled and challenged in therapy. Sinclair (2007), in reviewing the effects of her radical claim in the last decade, advocates discursive practice and therapist's self-reflexivity to name hidden patterns of oppression, and acknowledge the powerful influence of dominant discourses and elicit alternative discourses in therapy.

some reflections

I am enormously grateful to my participants for sharing their stories, at times infused with painful memories and experiences of difference; the richness of their accounts and depth of their reflections have greatly inspired my personal and professional journey.

The marginalisation of issues of race and culture in professional and training contexts emerged as a clear finding in this study. My aim, in fact, was to make a small contribution by letting some marginalised voices be heard in a family therapy training context. However, this journey was more ‘bumpy’ than expected and I found myself working through muddles which I could not anticipate. In fact, as I became increasingly aware of my influence on the research process, given my interest in the topic, I realised that researching ethnicity and race is “messy work” with its specific dilemmas, ambiguities, and the challenges of “a treacherous bind” i.e. working

“against”, yet inevitably “with” existing research categories (Gunaratnam, 2003).

I also became increasingly aware of the dangers of perpetuating social and racial discrimination, for example taking for granted, socially constructed ethnic categories like Black and White, which participants described as “pigeon holes”. Furthermore, choosing “minority ethnic therapists” as a research category led me to question my initial assumptions of being a minority. In fact, whilst I started situating myself alongside minority ethnic therapists as if I was one, towards the end, I became aware that my own Whiteness plays a part in constructing cultural identities as dominant and marginalised, hence revealing my own blindness to the disturbing effects of covert racism in my own thinking, analysis and interpretation.

Gorrell Barnes (2002) states: “Racism is multi-layered, multi-positioned, and liable to hit you from any angle when you least expect it”. When I was “hit”, I tried to “listen differently”, allowing myself to be included in the category of oppressor rather than defending myself (McGoldrick, 1998).

Cross-cultural therapy is an emotional and intellectual minefield for both therapist and clients (Khan, 2002) and can lead to a challenging and painful process for everybody concerned. Following Nolte’s argument that “White is a colour too” (2003), I would argue that White therapists should turn the mirror towards themselves to make White more visible and challenge its embedded and embodied privilege and sense of superiority and dominance. This may go some way to challenging the often secretive and unspeakable nature of racism, unveiling the effects of dominant discourses and promoting a safer conversational space where negative constructions of racial identities can be deconstructed in the hope of promoting more equal racial relationships across personal, professional and socio-political domains.

acknowledgment

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Chiara Santin is a family resource worker at a family centre within the Children’s Service Department of East Sussex County Council. She can be contacted by e-mail: chiara.santin@btinternet.com

Systemic challenges in a refugee camp

renos k papadopoulos

Systemic therapists work in many different settings and face varied challenges. What I will try to outline here are some of my experiences in working in a large refugee camp in Africa and some of the challenges I face there. Although not many situations encountered there would be of direct relevance to therapists working in more traditional settings, nevertheless, I believe that many of the issues that I will address below can be related to most of the challenges we face, whatever our work setting may be. Moreover, I would argue that working in different settings may help us to sharpen and deepen our understanding of systemic principles which tend to become imprecise within the context of too familiar and predictable work settings.

background and the setting

In January 1991 the government of Mohammed Siyad Barre in Somalia was overthrown by what is referred to as a 'popular uprising' and ever since there has been no stable government in the country. The chaotic instability that ensued has been characterised by unending violence that often peaks to catastrophic levels. Consequently, huge sections of the Somali population had to flee their homes either within their own country (as internally displaced persons) or outside the Somali borders (as refugees, abroad). Seventeen years on, the situation has not improved; if anything, it has deteriorated. On 26 March 2008 (while, in fact, I was working in the refugee camp) 40 aid agencies issued an appeal warning that there is a 'catastrophic humanitarian crisis in Somalia' due to the worsening of the situation which makes them 'unable to respond adequately to the needs'. They emphasised that 'there are now more than one million internally displaced people in Somalia' and that 'intense conflict in Mogadishu [the capital city] continues to force an average of 20,000 people from their homes each month' and 'two million Somalis [are] in need of basic humanitarian assistance' on a daily basis.

Back in 1991, the combination of civil war plus droughts, overgrazing and desertification caused 300,000 deaths and forced 900,000 to flee as refugees. As a result, the United Nations (UN) set up three temporary refugee camps for 800,000 Somalis around the small village of Dadaab in eastern Kenya near the Somali border. Now, the population of these camps (still considered 'temporary') is about 200,000 with the Somalis being the overwhelming majority (97.5%) and the rest from other neighbouring countries. Over the years, the population had gone down to 150,000 as some of the refugees were resettled in a third country or repatriated themselves. However, due to the recent upsurge of violence in Somalia the camp authorities predict that by the end of 2008 the population will double.

The refugees in the camps still live in huts that they make themselves out of twigs and mud using plastic sheets for roofing and they survive on meagre rations that they collect once a fortnight. According to the UN's own assessment, the living conditions in the camps (since their inception) remained 'substandard' in terms of essential

services, sanitation, food and water supplies. Nearly half of the population are women and young people. Only very basic education is offered and the resources available both in terms of materials and staffing are minimal. The camps are administrated by the UN agencies (United High Commissioner for Refugees – UNHCR) and its implementing partners, mainly CARE International.

Living in the camps is fairly difficult. They are situated in a sub-desert terrain, an endless flat surface of red sand with some scattered shrubs which are used as cooking fuel. The poor quality of the soil and the scarcity of water make it impossible to cultivate the land; a few inches under the thin sand the ground is hard almost like cement, baked by the scorching sun. The camps lie exactly on the Equator where it is constantly hot without much seasonal variation. The refugees have virtually nothing to do on a daily basis and almost all are unemployed. Some of them keep domestic animals such as chickens, goats and camels for their eggs, milk and meat. Remarkably, they succeed in maintaining some minimal trade with Somalia. A few refugees are involved in small trading and each camp has its own market with extremely modest stores selling very basic items of clothing, kitchen utensils and foodstuffs. Their movement is restricted and they are not allowed to leave the camps without a special permit. Geographically, the camps are extremely isolated and the nearest town is about hundred miles away. The survival of the great majority of refugees is ensured by remittances from relatives from abroad (Horst, 2004; Horst & Van Hear, 2002). Most of them (especially those who were born in the camps) never saw a city or a mountain or a lake or the sea. The majority of young people have nothing to do on a daily basis but are avid supporters of European football teams which they watch on TV sets in communal spaces. All refugees in the camps live with the hope or dream that one day they will be resettled in another country. Every year about one thousand refugees are resettled abroad, mainly in the USA.

Given the difficult living conditions and without an obvious viable political solution in sight that would enable their repatriation, the refugees have been living in a state of limbo. Inevitably, rivalries and conflicts along clan and regional lines are rife occasionally reaching violent expressions. However, the camps are virtually free of crime and have remained safe places. The only serious danger comes from roaming bandits who, rarely, attack and rob camp refugees; also, occasionally, women who venture out of the camps to collect firewood are attacked and raped.

remit and work

The initial invitation was for me to consult to the camp authorities focusing on reviewing the psychological assistance that is offered to refugees, provide suitable training to staff, and then submit a report with recommendations.

In 2004 the camp authorities established a Counselling Unit (CU) staffed by four counsellors (Kenyan nationals who do not speak Somali). Despite the severe limitations, the CU developed a remarkable range of activities providing

counselling services at individual, group, family and community levels, psychosocial support to the community, and training in basic counselling skills for various community resource persons. More importantly, the CU trained a group of young refugees as ‘para-counsellors’ who assist them as interpreters, offering basic counselling in their own communities in the camps and acting, in effect, as community mental health assistants.

To begin with, the logical question arises as to what a handful of counsellors can possibly do in a camp of 200,000 refugees who live under sub-standard conditions for seventeen years, without any clear future ahead of them? Are counselling interventions the best possible approach to address the situation? The inevitable conclusion would have to be that any psychological input should be interwoven within the fabric of the realities of the camps, i.e. both the external living conditions as well as the cluster of socio-economic, political, cultural and religious contexts. In a sense, these thoughts formed my main hypothetical ideas before I went there.

In addition to many communications (by e-mail and telephone), and studying documents and reports, two visits were made to the camps (last year and this year) after official invitations to the Centre for Trauma, Asylum and Refugees (CTAR) of the University of Essex. On both occasions I led the CTAR team; in the first visit I was accompanied by Ana Ljubinkovic and Simone Warner and in the second by Ana Ljubinkovic, Stefano Carta and Elisa Morellini.

During the first visit, we reviewed the work of the CU and it became apparent that there was a disjunction between the Western counselling models that the counsellors were trying to apply and the actual refugee realities (living conditions, cultural context, values and belief systems) in the camps. On closer examination, a central paradox emerged: on the one hand, being sensitive professionals, the counsellors (and para-counsellors) were, in fact, working appropriately and in tune with the cultural context of their clients but, on the other hand, their accounts of their work were formulated according to the only theoretical framework they had, which mainly was Rogerian counselling theory. For example, when they talked about their work with a raped young girl, the counsellors talked in Rogerian language about what they did with her during their individual counselling sessions, yet, when I asked to hear the exact sequence of all their interventions, they told me that, indeed, they did contact an Imam (who duly read the prescribed Koranic verses to her) and they did search and find a suitable elder person whom they used to assist her family in their plight. In other words, whereas their counselling models were Western and geared at individual interventions, their solid grasp of the complexities of the situations in the camps made them act appropriately in an apt psychosocial way based on systemic considerations. Following discussion with them of this paradox, I offered them (counsellors and para-counsellors) a brief and focused training on systemic principles so that they could have more appropriate conceptual tools to account more accurately for the various overlapping contexts of each facet of their work. In effect, this training validated (explicitly and implicitly) their own insights and the actual way they practised.

In addition to the work with the CU, we studied the overall organisational structures and relationships between staff and refugees in the camps and identified a cluster of four interrelated recurring patterns. Refugees tend to perceive staff as being ‘detached’ and staff tend to perceive refugees as being ‘greedy’. In a pattern of systemic communication, familiar to systemic practitioners, each side (following, implicitly, a linear epistemology) tended to blame the other side for their own stance which they saw

as a justified response to the primary ‘cause’ - the ‘original’ stance of the other. In other words, staff tend to respond with detachment because they feel that they cannot cope with the endless ‘greediness’ of the refugees, and the refugees tend to keep demanding more from staff because they blame them for being ‘detached’ and not caring sufficiently for them, i.e. the more ‘greedy’ the refugees, the more ‘detached’ become the staff, and the more ‘detached’ are the staff, the more ‘greedy’ become the refugees. In this way, both are caught up in a circular pattern of mutual blame by co-constructing each other’s position and thus maintaining this vicious circle. I explained this circular pattern to them and immediately they recognised its reality; this was followed by assistance to develop alternative ways of interacting (between staff and refugees) so that this pattern of destructive responses would be broken.

Another recurring and related pattern was the refugees’ insistence on maintaining a ‘victim identity’. Refugees have virtually no possessions; often they are seen clutching the only things they have – pieces of paper that describe officially the misfortune that had befallen them, e.g. that they were raped, that they suffer from a certain war injury, etc. These pieces of paper seem to confirm and maintain their only ‘official’ identity. Staff feel frustrated that refugees want to relate to them only through their specific victim identity and not in any direct way. In discussing this phenomenon with staff, I encouraged them to relate it to the wider system of power relationships within the camps where refugees are indeed powerless and helpless and completely dependent on staff for their basic means to survive. For example, it is indicative that their ration cards (the single most important means of ensuring refugees’ survival) have no name or photograph but only a number. The helplessness and anonymity of refugees is sharply contrasted to the perceived omnipotence and identity of staff. Within this context, it made sense that refugees would want (consciously or unconsciously) to confirm their own victim position so as to activate (consciously or unconsciously) the ‘rescuer’ position in staff in order to obtain maximum possible benefits from them.

The other two typical patterns we identified were the ‘dependency syndrome’ and the ‘resettlement syndrome’. The first is closely related to the ‘victim identity’ syndrome and it refers to staff’s impatience with refugees, perceiving them to be too passive and too dependent on them. The second refers to the refugees’ obsessive preoccupation with the magical solution of resettlement which often has detrimental consequences, especially when their lives are disrupted by the tyrannical obsession of the dream of a paradisaical life in some North American city. Somali refugees use the term ‘buufis’ to refer to this hope, dream and yearning for resettlement (Horst, 2006). This syndrome is also an understandable response to the unbearable helplessness of their situation as well as it is imbedded in the Somali tradition of migration (Horst, 2006), and staff, following our meetings, came to appreciate this phenomenon with compassion rather than dismissal.

This cluster was identified during the first visit and was clearly elaborated in the *CTAR report* (Papadopoulos, Ljubinkovic & Warner, 2007) which was well received by all. The report (which is a substantial document of about 16,000 words) started with a sincere expression of admiration of the camp authorities in general and of the CU in particular for their ‘remarkable achievements despite numerous and serious adverse conditions’ and went on to recommend that a new conceptual framework be adopted that interconnected the various structures, activities and roles of both staff and refugees as ‘expressing the inter-systemic relationship between refugees and staff’ (Papadopoulos, Ljubinkovic & Warner, 2007, p.8).

This framework was, in fact, the formalisation of the actual insights we had developed together with staff and refugees by working closely with them during our first visit. Some of the main characteristics of the proposed new framework included the appreciation:

- a. that certain negative roles and even identities of both staff and refugees were reciprocally and circularly co-constructed (as illustrated by the examples above).
- b. that refugees display characteristics of ‘nostalgic disorientation’ (Papadopoulos, 2002) which is the sense of pervasive and intangible uneasiness and discomfort that people experience as a result of their involuntary loss of home; therefore, some of their demands (especially some of those that staff deem to be irrational) could be understood as an attempt to give concrete form to the ungraspable pain from their ‘nostalgic disorientation’ which has an elusive nature but very clearly and painfully felt effects.
- c. that the way that both staff and refugees understood the refugees’ own experiences of being exposed to devastating events tended to focus exclusively on the negative consequences. This means that resilience and adversity-activated development (AAD) were ignored.

This led to specific training about the ‘Trauma Grid’ (Papadopoulos, 2004, 2005, 2006, 2007) which offers a systematic framework to identify the wide spectrum of all possible responses to adversity ranging from negative (such as post traumatic stress disorder and other distressful psychological reactions) to positive (such as resilience and AAD). Resilience, in the context of this approach, refers to the ability of a person to retain certain positive qualities after being subjected to adversity. The various positive characteristics of a person can be called resilient as long as they existed before the exposure to adversity and were retained despite the person experiencing adversity (e.g. their ability to look after themselves). AAD, however, refers to new positive qualities and characteristics that were developed as a result of a person being exposed to adversity e.g. compassion for other persons’ pain or valuing now every moment of living having come close to death. These qualities can be called AAD as long as they did not exist before the person’s experience of adversity. The advantages of the trauma grid are, *inter alia*, that they assist workers to move away from global and definitive categorisations (e.g. ‘this person is resilient or that person is traumatised’) to a more precise and differentiated way of identifying in a more reliable and discriminating way the various functions and characteristics of a person; moreover, the grid does not operate according to the all or nothing principle but accepts that the same person even at the same time may display different responses to trauma in relation to different contexts.

Finally, the report gave specific recommendations for the overall systemic functioning of the camps as well as for the CU, proposing to change their name to ‘Psychosocial Services Unit’ and function accordingly. It is important to note with gratitude that our work was made possible due to the welcoming and collaborative attitude of the management of the camps.

last visit

During the last visit (March – April 2008), our input was divided into work with refugees, with staff (mainly counsellors and para-counsellors), and consultation to the management team of the camps.

work with the refugees

Individually and in groups, we saw refugees from identified vulnerable groups, e.g. raped women and war injured. One of the important outcomes was the impact of

working with the Trauma Grid. Having established good therapeutic contact with them and after listening carefully and responding appropriately to their accounts of their plight (that emphasised all the negative effects), then we enquired in a sensitive manner about:

- a. the good qualities/functions/characteristics that they had before they were exposed to the devastating events and which survived the trauma and are still active in them, and
- b. the various ways that their experience of their trauma helped them in other facets of their lives, especially in helping others. Their responses were not only extremely moving but also contributed to changing radically the overall atmosphere of our meetings by providing a more holistic and representative picture of their reality now, of their current totality.

work with staff

The main work with staff counsellors (mainly counsellors and para-counsellors) was to hear from them how they were able to implement the recommendations of the report and discussed their difficulties and shared their excitement and disappointments, as well as to offer specific training in order to address identified gaps, e.g. how to work more systemically in a psychosocial way with families and how to collaborate better with other services and resources in the camps.

consultation to the management team

As always, the inter-agency management team of the camps was particularly receptive to our input and worked actively with us to re-think ways to keep improving the overall climate in the camps. One specific issue that is worth mentioning here is our alerting them to the implications of the huge influx of new refugees. We emphasised that in effect within the space of few months they are likely to face a completely new phenomenon in the camps, i.e. having two large groups of refugees (about 200,000 each) – the old and the new. In terms of group dynamics the possible outcomes could be that the two groups get on very well together (unlikely), become antagonistic (to various degrees) to each other, or join forces against a third ‘other’ (most likely to be the staff group). In considering various ways of addressing this anticipated situation, we suggested that they approach the existing group of refugees and ask for their help emphasising that they (the refugees) have a unique expertise which the staff do not have – the experience of being and surviving in the camps for so long. In a spirit of genuine (not artificial or strategic) collaboration, the refugees would be encouraged and supported to develop ways to share with the new group of refugees their positive and negative experiences of living in the camps and to welcome them. It is important that the refugees themselves would choose the best method of conveying these experiences in a medium and manner that they would feel to be the most appropriate, e.g. by enacted narrative stories, dance events, or whatever. In this way, the management would make a proper use of the refugees’ unique contribution in a genuinely empowering way.

final thoughts

This brief account cannot possibly do justice to the complexities of issues we encountered, the powerful feelings that were evoked in us by working there (despite many similar experiences in comparable situations) and the excitement we felt from being able to assist with the co-development of activate collaboration with staff and refugees. Nevertheless, I hope it will give the reader a taste of the challenges one faces in such unusual settings and also of the possible contributions

professionals with a systemic background can make. Ultimately, it is impossible to describe the enormous benefit one can derive from working with refugees who have endured so many adversities and still maintain their spirit in a most admirable way: a truly humbling experience.

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Renos K Papadopoulos, PhD, is professor and director of the 'Centre for Trauma, Asylum and Refugees' of the University of Essex, consultant clinical psychologist and

consultant systemic psychotherapist at the Tavistock Clinic, as well as training and supervising Jungian psychoanalyst. He is the founder and director of the MA/PhD in Refugee Care offered jointly by the Tavistock Clinic and the University of Essex. As consultant to the UN and other organisations, he has worked with refugees and other survivors of political violence in many countries. The latest book he has edited on the subject is '*Therapeutic Care for Refugees. No Place Like Home*' (2002). He is the editor of '*The International Series of Psychosocial Perspectives on Trauma, Displaced People and Political Violence*', published by Karnac Books. Renos K Papadopoulos can be contacted by e-mail: renos@essex.ac.uk



Subsequent to receiving the above paper from Renos, he sent us this piece and we decided to include it as a fitting supplement to his paper. When you read it, you will realise why.
Máire Stedman.

During my last visit to Dadaab we came across a Somali man whose daughter had been missing for the last 15 years. He is one of the many thousands of persons who had lost contact with relatives as a result of the war and fleeing their country. However, we felt that we could assist in this case because of his specific circumstances: during the outbreak of fighting this man took his daughter to an Italian military hospital that was at the time in Somalia and he even had photographs of her with two Italian hospital doctors. The father wanted to stay with his daughter at the hospital until she got better and discharged but he was not allowed to do so; he was told by the hospital authorities that he had to go home and that they would return his daughter (who, at the time, was 13 years old) on her discharge. Shortly after he returned home, the father had to flee due to the intensification of fighting and then was taken to the Dadaab refugee camps and never heard from his daughter again. In vain he tried for all these years to find her or obtain any information about her. On hearing this story, an Italian member of our CTAR team had the idea of seeking assistance from a popular TV show in Italy that searches for missing persons, so we videotaped the father telling his story and also showing the photo of his daughter with the Italian doctors. We sent the video with a detailed account of everything we knew about this story and the TV producer accepted to take this case on. They sent a reporter and a TV crew to Dadaab who investigated further the case and last week they showed the story on their programme. The miracle happened and the missing daughter was found! She had been adopted in South Italy and now she will be reunited with her father! We are delirious from joy!

Renos K Papadopoulos

The Refugee Council therapeutic casework model: addressing asylum seekers' external and internal issues within a helping relationship

andrew keefe

The Refugee Council Specialist Team in Brixton, South London, operates an assessment, referral and casework service for asylum seekers with mental health and mental well-being needs. The team has assessed and helped over 3,000 clients in the past eight years, the majority either newly arrived asylum seekers or those at the end of the process, who are destitute due to being refused asylum. We call our work Therapeutic Casework, which comprises emotional support and advocacy around the client's practical, external issues. The model has been developed by the Specialist Team over the past four years. This paper explores the thinking behind this approach and the clinical issues and dilemmas it creates and reflects upon how using this model has led us to think more systemically and to include *the family and living context* in our attempts to understand our clients' presentation.

Clients are referred to the Specialist Team by colleagues in the Day Centre, Access & Advice and Children's Section teams in our Brixton One Stop Service. They often present with highly complex sets of needs including the after-effects of violent incidents, loss of family members, home, culture and position in society; anxiety about loved ones left at home or missing or anxiety about the asylum process in the UK and worries about accommodation, money, education, access to legal advice or destitution. Many clients have histories of detention and torture in their countries of origin and of immigration detention in the UK. 34% of the women assessed by the team in 2007 had been raped or sexually abused, for example. Porter & Haslam (2005) conclude from a meta-analysis of over 100 studies of refugee mental health that the economic, social and cultural conditions into which refugees are placed in exile do affect their psychological health, a view supported by our clients' experiences. Such experiences obviously impact massively on family life and on relationships within families (Blackwell, 1989, pp 9-10).

understanding distress in asylum-seeking clients

Papadopoulos (2002, p16) describes the overwhelming psychological impact of the loss of home experienced by all refugees and notes that:

Under the painful influence of this kind of loss, refugees tend to single out specific complaints as the sole source of their unhappiness.

These complaints can assume "...extraordinary and excessive significance..." and are often practical in nature. We believe therefore that to understand fully a client's distress (and hence to begin to alleviate it) requires us to think about the concrete issues they bring on each of these three levels:

- The Practical
- The Emotional
- The Symbolic

If a homeless client presented to an advice worker, they may just help the client find somewhere to live, or refer them to a housing provider without attempting to process or hold the client's distress about *being* homeless. A psychotherapist or counsellor may offer empathy for the client's plight but suggest they return once they have found somewhere to live as they are currently "too concerned with their social issues to make use of therapy".

We suggest an alternative approach whereby the caseworker assists the client to find somewhere to live (perhaps through advocacy with the National Asylum Support Service, NASS) but also, through offering the client regular weekly or fortnightly appointments, provides a space to express the anxiety, anger and shame they may be feeling through sleeping rough. As the helping relationship develops, the caseworker begins to think about and discuss with the client, the deeper meanings of being homeless: whether the bringing of this issue in this way is communicating something about an earlier conflict or loss for instance.

This combining of the practical and the therapeutic is not unique: the Medical Foundation have offered practical support to asylum seeking clients for many years and the Women's Therapy Centre and the Mapesbury Clinic in London both now employ highly qualified advice workers as well. STARTTS in New South Wales, Australia also employ systemic thinking to address both psychological and social stresses on torture survivors (Aroche & Coello; 1994). What is less usual though is the offering of these three approaches by the same caseworker. We do not view the resolving of practical issues as merely a precursor to interventions of a more therapeutic nature – practical interventions build trust between caseworker and client and hence develop the helping alliance and thinking about the issues themselves can aid understanding of what the client needs to communicate.

"Dolly" is a Colombian woman in her early fifties. She is an asylum seeker and lives in NASS accommodation. She has been coming to casework for several months and feels that her life is empty. She describes herself as anxious and isolated. Dolly is separated from her husband and her daughters have grown up and left home. All Dolly will talk about is a broken window in her front room and her repeated failures to find anyone to fix it. The caseworker spends several sessions attempting to get the window fixed and listening to the client's frustration about the whole process



The Refugee Council Specialist Team. Back row, left to right: Anne Akaki, Ahmed Salim , Hermela Chassme , Marcia Thomas, Alan Javid. Front row, left to right: Elena Hage, Alanna Maycock, Andy Keefe

(including the caseworker) and sharing a mutual feeling of powerlessness. The caseworker begins to feel his own frustration with Dolly, who, unlike his other clients, does have somewhere to live. Dolly begins to attack the work, stating the sessions give her headaches and do nothing for her. Thinking about the significance of the broken window in supervision gradually allows space for this thinking in the casework sessions and Dolly begins to relate her fears the broken window is a sign the house is falling apart and will eventually crumble around her, leaving her street homeless as she was on arrival in the UK six years before. She had come here because paramilitaries threatened to kill her due to her husband's trade union activities. He had been on the run for eighteen months, leaving Dolly to face threats and intimidation while trying to protect her children. The husband later informed her he had met someone else and wanted a divorce and Dolly's daughters have now also left her.

The caseworker's failed attempt to help Dolly by fixing the window mirrored her ex-husband's failed attempt to help her by going on the run, to try to lead the paramilitaries away from her. The caseworker's sensitivity and ability to survive Dolly's subsequent attacks strengthened the development of the helping relationship to the point where Dolly could disclose the whole painful story which ultimately helped her to begin to grieve.

clinical dilemmas

In this example, if the caseworker had referred the client to a colleague for help with the broken window, the eventual unfolding of the true meaning of the issue may have been lost. It was only by holding in mind the three levels of the

reality of the issue that the complete communication could emerge. Introducing the practical brings dangers with it however: caseworker can collude with client in using the practical issue to avoid thinking about the true, often more disturbing material by concentrating on *resolving* rather than allowing deeper meanings to come to the surface. A caseworker who is too successful an advocate risks being seen as a rescuer or saviour in the therapeutic relationship and hence someone who cannot be criticised. Such a relationship carries with it the potential for the abuse of power, particularly in an organisation such as the Refugee Council, viewed by clients as a gateway to services such as accommodation and financial support: how open can a client be about their feelings towards the caseworker where there is a belief the caseworker could prevent them from getting accommodation? The expression of anger or negative emotion, which could be otherwise helpful could become suppressed. Supervision of this form of casework needs to be rigorous therefore to prevent potential problems of this sort developing.

the asylum seeker, the asylum system and the family

Engagement with the external leads us to think about the variety of factors affecting an asylum seeker's life and well-being and how we might engage with them. It is helpful to think systemically to incorporate the different areas of the client's experience. The client clearly has an internal world which can carry a history of trauma or loss but they also have a social life (culture and community), are part of a society, part of the Borders and Immigration Agency asylum

system in the UK and are affected by governmental laws and policies at the state level. While the Specialist Team engages with the *client* at the centre of this system and with their internal world, the organisation engages with many of the other aspects of the client's existence through our welfare advice, community development, policy and campaigning activities. We respond to the effects of the system on the client, but also try to change the system. What our clients tell us of their experiences is fed into our policy and campaigning work through case-studies.

Reflecting on this process we note that the *family* is missing although even individual clients bring family issues into the room in many different ways: deaths of family members would be part of the *trauma*, separation from family could be causing loss and anxiety. Young women raped in prison who are staying with relatives in London report being unable to tell them of their experiences for fear of rejection or blame. The stress of being an asylum seeker, cramped living conditions or lack of money can cause tensions in relationships. One father's personal and unacknowledged need for help for himself was presented via his son, whom he claimed no-one was helping, where in fact many services were in place.

future developments

To meet this need, we took a seven day course at the Institute of Family Therapy last year on "Working Systemically with Refugee Families" and are in the process of engaging a systemic practitioner as clinical supervisor for the team. We are also waiting for the results of a three year external evaluation of our work by the Centre for Migration & Social Care at the University of Kent. The evaluators

carried out a series of in-depth, semi-structured interviews with clients of the service about their experiences of being helped by us and this information will be of immense use in shaping the future direction of our work.

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Andrew Keefe is operations manager of Specialist Support Services at the Refugee Council, responsible for day centre and health and mental well-being services in London. He is also the organisation's national lead on refugee health and mental health. Andrew is a psychodynamic counsellor and member of the Foundation for Psychotherapy & Counselling (FPC). He works clinically at the Refugee Council and in private practice in East London. Andrew can be contacted by e-mail: Andrew.Keefe@RefugeeCouncil.org.uk



Ugandan Scene © Alex

Coming back as a “small” foreigner

sigurd reimers

introduction

Tom Andersen’s article on reflecting teams became a classic not only because it introduced many of us to new ways of working in teams, but also because it suggested to us practical ways in which we could apply the notion of difference as a tool for bringing about change. Rather, as with Goldilocks and the three bears, we could now try and introduce a difference that, if not always ‘just right’, was at least not too big or too small to be of use to families. Andersen suggested that there are three ways of fostering difference and change:

“One is through love. Another is to become a “foreigner” who, because of a different background, can add a new and exciting version of the world to the one the system had before. The third possibility is that one can pull back into loneliness for a while, which we in the North of Norway do when we disappear into the mountains and come back as a “small” foreigner.” (Andersen, 1987, p. 416).

When he wrote this, I imagine Andersen will have had the therapist in mind, but I have often imagined that migrants look back at their lives in their countries of origin with a similar sense of strangeness. The image of the “small” foreigner has a rather charming ring to it, with images of lonely people returning from the dark Arctic tundra to the comforts of a warm log cabin. However, in the brief exploration of mixed-nationality, mixed-language partnerships that follows, I think it will become clear that there can be uncomfortable, even frightening, moments as well, and these can sometimes come up in therapeutic encounters.

But let me start with a brief example of “foreignness” I came across recently, and then move onto three case scenarios from my own practice. The latter have all been substantially changed in order to ensure anonymity.

A few months ago, while I was standing in the check-in queue at Stansted airport, London, waiting for my plane to Oslo, I overheard a white man, who had been listening to a conversation between a black little girl and another child in front of him say to her in Norwegian: “Are you Norwegian, then?” She beamed back “Yes, I am”. Clearly perplexed, he asked: “But are you *completely* Norwegian?” She now seemed uncertain, looked down and didn’t answer. Within this brief exchange between two strangers I sensed feelings (probably for both parties) of threat, shame and confusion, and began to think that the mixed-nationality mixed-language families I am currently working with often have to handle similar moments of intense strangeness. At times like this they probably experience themselves as big foreigners. Far too big.

I work as a locum in a couples therapy outpatients’ clinic attached to a district general hospital in Norway’s fifth biggest town near the southern tip of the country. Although by British standards a town of 77,000 people is relatively small, over here such a town is a regional centre of some importance. A long seafaring tradition along this coast has always encouraged contact with other nations, for both commercial and cultural reasons, but it is only in the last thirty years that a sizeable number of people have migrated here, mostly to take up work within a booming economy. Although most ethnic or lingual minorities have their own communities, the clients I will be describing either are not able, or do not wish, to be part of these. They act

as a reminder that the common assumption in host communities that “these people look after their own” does not always fit.

the fifty-fifty feeling

Ali is in his mid thirties, and came to Norway from the Middle East at the time of civil war in his own country. He was clear that he had left his own background behind, and did not wish to talk about this in the therapy sessions. However, after a while he mentioned what he called his fifty-fifty feeling of being attached equally well to his adopted country as well as to his country of origin. On the one hand he tended to avoid what he described as his lazy compatriots in town, and spent time either with his Norwegian wife and their young daughter or running his small dry-cleaning business. On the other hand he spoke of having grown up in a Muslim family where the man was the undisputed head of the family. His wife Kari-Anne, however, had grown up in Norway, where the idea of gender equality has become very strong, extending to improved provisions of child care, paternity leave and a legal requirement that leadership positions in government and industry must be allocated so that at least 40% of one gender is represented.

Although Ali accepted, or perhaps tolerated, his wife’s insistence on a right to work on an equal basis to him, his fifty-fifty feeling did not seem to be giving him the best of both worlds as I, who also have a mixed nationality background, had assumed. Rather, he seemed to be drawn at times of crisis, rather as in a tug-of-war, between the isolation of having to adjust to a social change in his host community which he did not understand and a feeling of shame about being a “proper man” which would re-emerge from his past. The result of this unbearable fifty-fifty tug (or was it a feeling of paralysis?) was that Ali seemed at times to feel at home with neither identity, and sometimes became violent towards Kari-Anne.

Virginia Goldner and colleagues (1990) write compellingly about the “dread of collapse of gender difference which operates silently and powerfully in all relations between men and women,” and go on to say: *“Indeed we have come to think about battering as a man’s attempt to reassert gender difference and gender dominance, when his terror of not being different enough from “his” woman threatens to overtake him”* (Goldner et al. 1990, p.348, authors’ italics). This sense of a collapse of difference makes good sense when we are only talking about gender. When it comes to nationality and language, however, I wonder whether there is often already too much, rather than too little, difference at play during those fifty-fifty moments, as the couple, in their search for more similarity, actually find themselves drawn dangerously apart and as individuals feel profoundly uncertain as to where they belong. If this is so, then we as therapists may need to think of excessive similarity *and* difference as applying simultaneously, but at different levels.

the disappearing language

Salim came from what is now Bosnia to Norway twenty years ago, and had married Mona, a local white woman, initially against her parents’ advice. Mona had a professional job, which involved some entertaining, and Salim had become increasingly jealous of her, which resulted in his constantly

checking her mobile telephone for messages. I picked up on his use of the word “party” in relation to professional entertainment. Like Ali, he used the phrase “fifty-fifty” to describe his sense of belonging equally well in Bosnia and Norway, and, again, he too avoided local compatriots, preferring to be at home with his wife and daughters in the evening. Sensing that the notion of “party” might create a destabilising effect for the couple, I asked him what the word for “party” was in his language. He blushed as he stammered, “I can’t remember”. I had accidentally intensified his sense of shame, and felt in my gut the sense of shame in not being able to find the word in your “own” language. Here was a man who had left behind, not only his family of origin, but also, increasingly, his language. Added to this, his country of origin, Yugoslavia, no longer even existed. As Dubravka Ugresic’s recent novel *Ministry of Pain* illustrates, feelings of shame and confusion can easily lead to a profound threat to a person’s identity. Her novel describes the feelings of a group of young Yugoslav ex-pats studying in Holland at the time when their own country was falling apart during the 1990s, and I wondered whether Salim had some similar feelings.

And we are talking about strong feelings here. Although there did not appear to have been any actual violence, Mona was clearly uncomfortable with Salim’s controlling behaviour.

In trying to understand this, I find Karl Tomm’s (1988) interpretation of Cronen, Johnson, and Lannamann’s (1982) idea of “strange loops” helpful. Many of us are familiar with Cronen and Pearce’s five levels of context (culture, family script, relationship, episode and speech act), which are described as being linked in a descending order by a contextual force and upwards by a less powerful implicative force. What is perhaps less familiar is the idea of the “strange loop”. Such a loop can act as a complication, as when a speech act, such as “party” in this case, links directly with an example of a higher level context, for instance family script (in this case Salim’s memory of his mother leaving home many years earlier with a new partner), and both jointly form a powerful downward contextual force on beliefs about the current relationship (“In order to trust my wife I have to control her”). The geneogram formed a useful way of tracking how the couple had come to struggle with the issue of too little difference in the domain of gender, and too much difference in the domain of nationality and language. This in turn allowed a richer discussion than our earlier repetitive discussion about the latest argument.

the english patient

This sense of too little and too great a difference also seemed to apply to John and Torunn. A few years ago John had come to Norway from the West of England, an area I have lived in for half my life, in order to marry Torunn. Norway is a country where the English language is not only understood and widely spoken, but also deeply appreciated. John and Torunn had two children and spoke mostly English at home. The power of English is described well in Charlotte Burck’s (2005) research and writing, from which it appears that in mixed-language partnerships where there are children, the non-English language usually disappears within a generation, and even sooner if the non-English speaker is the father. But that is in Britain. As a British ex-pat, John seemed to me to be struggling. His Norwegian was reasonably good and he always insisted on conducting his arguments with Torunn in Norwegian, reserving English for gentler conversations. He seemed to appreciate the team’s suggestion that I reflect in English whilst the therapy session itself was conducted in Norwegian (all the participants had an understanding of both languages). The team’s intention was to reduce the profound sense of difference he seemed to experience in what he saw as a rather hostile environment. We thought

that the couple’s “fifty-fifty moment” occurred when the topic of her engulfing local family came into a tug of war with his glorification of his (actually highly neglectful) family in England, resulting in regular mutual violence. Again excessive strangeness and excessive familiarity were in conflict with each other.

the therapist as a small foreigner: a personal coda

Since recently coming to/returning to Norway from the UK, after over thirty years at home/abroad, I have twice come close to booking flights between the two countries on the correct dates, but in the wrong direction on the Internet because of a lapse of concentration around what constitutes an ‘outward’ and a ‘return’ journey on the booking forms. As a temporary visitor/returnee, sitting in front of and behind one-way screens, I have become fascinated by the accounts of other migrants about the process of looking forward and looking back, a feature that may be the lot of most migrants. This process is not always evident behind the chameleon-like behaviour of adjustment which successful migration often requires. However, there is also another side. When working with mixed-nationality mixed-language families, we may also run the risk of assuming that this is necessarily a problem. Some migrants are happy about the decisions they have made. They wish to look to the future, and do not feel a need to constantly be reminded of their country or language of origin. Secondly, in trying to be fair to migrants, there is always a risk that we become too interested in the “exotic” partner, leaving the “local” partner feeling rather featureless and undervalued. Going back to the first example, I now think that behind the official rhetoric of gender equality Kari-Anne actually felt very comfortable with the idea of staying at home with their young child full time, but we offered her no opportunity to discuss this unfashionable idea.

I think I have also brought a returnee’s curiosity with me in working with uni-national, same-language couples. It comes with being a “small foreigner”. I constantly find myself struck by taken-for-granted national pastimes, and ask couples about these. I ask a wife whether her husband actually appreciates the waffles with cloudberry jam and coffee (equivalent to British tea and scones), which she has served up every Sunday for the past thirty years. To a different couple, who spend all their efforts planning the purchase of their log cabin in the mountains (they already have one by the fjord), I reflect on what sort of people they would like to put in them. I suggest that a couple discuss in the session whether their so-far failed walks would work better in the forest than in the mountains. I express amazement at an ex-couple’s assumption that the national norm of an equal residence split for children is necessarily the best for their child. At its best, this affords clients an opportunity for raising their level of curiosity, at worst it can encourage in me a sense of the grass always being greener on the other side.

George Butunoi and Brian Dimmock (2008) have examined the challenges overseas social workers experience in coming to England to work. Their study concludes:

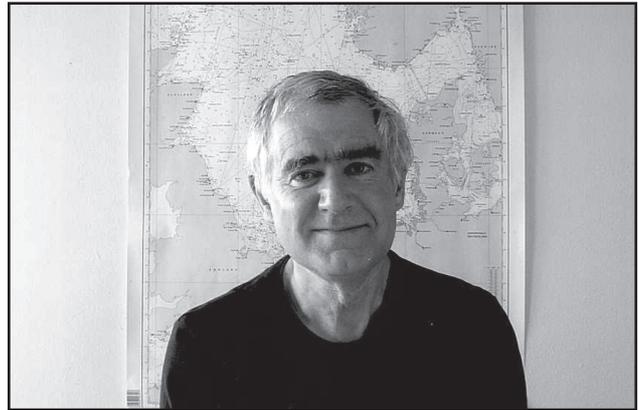
“The most challenging experience for overseas staff is ending up where they feel their country of origin is home when they are in England, but when visiting ‘home’ they then wish they were back in England; in other words, ending up with not really feeling ‘at home’ in either country.” Perhaps we should draw a general lesson from this. Those who work in the caring professions need to beware if they don’t know whether they are coming or going.

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Sigurd Reimers is a family therapist at Sørlandet Hospital, Kristiansand, Norway. He can be contacted by e-mail: sigurd.reimers@virgin.net



Nationality and language are common coathangers for a person's identity. The author somewhere near the Dogger Bank

Ali El Hadi – a tribute

Alternative Geography

Why did she come to the New World? This mummy, subject of spectacle,
 lying in her finery and grey linen: imagined life in a museum case.
 Embalming is an issue against immortality
 for the body will never be part of a rose.

The mummy didn't choose to emigrate, while those who waited
 at length in embassy lines,
 and built houses in other lands, dream of returning when they
 become corpses.

"You must take us there." That is how their wills weigh on the
 shoulders of their children.

As if death is an unfinished identity
 to be completed only in the family tomb.

.....

Why can't they forget where they are from? Futile strangers.
 They train their jaw muscles to escape the accent – the
 transparent hereditary disease that exposes them. It leaps out
 when they're angry, as they forget how to place their sorrows in a
 foreign tongue.

The accent doesn't die, though the strangers are qualified
 gravediggers.

They stick the names of dead relatives on the fridge so as not to
 call them up by mistake,
 and pay a quarter of their wages to phone companies, to
 convince themselves they're in a place definable by its distance
 from childhood.

Why can't they forget?

....

On another continent you left miserable enemies,
 you can only feel ashamed of yourself when you remember them.
 Nothing angers you now. It's difficult to meet a classical
 communist here,

They even put a clock up in government offices instead of the
 president's picture.

It may be a nightmare for you to spend a day like this under the
 influence of sedatives,

Nothing is worthy of your rebellion. You are satisfied and dead.
 And life around you appears as a hand of mercy,

that lights the room for an old blind man
 so that he might read the past.

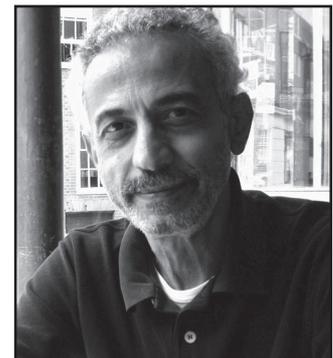
Iman Mersal (translated by Tarek Sherif)

Iman Mersal is an Egyptian poet and professor of Arabic in Canada. This is a translation of selected verses from *Alternative Geography*. More of Iman Mersal's work can be viewed at www.jehat.com/Jehaat/en/Poets/ImanMersal.htm

Alternative Geography is a poem given to me for this edition by Nadine, Dr Ali El Hadi's daughter. Dr Ali El Hadi was a valued colleague and friend with whom both Shila and I had many conversations about refugees, race and culture, particularly when we all worked in East London. We wanted to honour him in this edition and acknowledge the conversations that we had about Islam and the different world religions and the impact of cultural and religious beliefs on our work. All three of us were acutely aware of the impact of the 'terrorist' label on both the Irish and Muslim communities and the various ways that it got applied.

The poem is a very moving tribute and captures some of the many themes that we often, quite playfully, took positions around. Debates included whether the pain of staying connected to one's homeland was worth the effort and what choices people did or did not have if one was to remain psychologically healthy. We also quite often became rather animated in considering non-British ways of expression which allowed people to remain true to their identity but which could also lead to misperceptions. In addition both Ali and I had several conversations about cross-cultural relationships, which we were both part of. Ali had a wonderfully provocative sense of humour and he was very adept at using this to initiate what often went on to become very interesting and stimulating conversations freeing people in the process to take different positions.

Máire



Dr. Ali El Hadi, 1948-2004

The bridging card: connecting across difference

barry mason

It was graduation day. Graduates and their families, among them some of my trainees from the Institute of Family Therapy, were rightly proud of their achievements. They smiled, laughed, hugged, kissed, took photographs, celebrated; they were from many backgrounds, many ethnicities and cultures. They came up to the platform, waited for their names to be announced, walked across the stage, and shook hands with the Master of the College and the President, both male. For some time I had been re-visiting my thinking about how I greet female clients who do not shake hands with men, and at one point in the ceremony found myself wondering – will everyone shake hands with the two men or will some of the women feel, from a religious and/or cultural perspective, that shaking hands with men will not be acceptable to them. Towards the end of the ceremony, one woman did take such a position and rather hurriedly crossed the stage without pausing. While her actions were clearly important for her, I sat there thinking whether there could be a bridge across the difference that divided her and the two Birkbeck College representatives so that there could be a ‘meeting’ without disqualification of either’s beliefs and practices. In effect, could we find a both/and position rather than one of either/or.

I have worked cross-culturally for many years. In particular, since 2001, I have paid much more attention to people’s religious beliefs. I am a humanist and an atheist who is fascinated by religion and enjoys working with people who hold religion as an important part of their identity, perhaps the most important. I work/have worked with Sunni and Shia Muslims, Buddhists, different kinds of Christians, Hindus and Sikhs. In the last few years I have worked increasingly with ultra-orthodox Jews, where invariably women do not shake hands with me. If I am perfectly honest, not shaking hands with me because I am a man who is not a close family member, has felt at times discriminatory. However, I accept that this is a reality I need to engage with and it would be therapeutically unhelpful, if not abusive, if I did not accept this reality. Nevertheless, it does not stop me from exploring whether this matter can be addressed in a different way. Indeed, is this not one of the bedrocks of systems theory (Bertalanffy 1968; Weiner, 1975), that there are different ways of seeing? The challenge for us is to find ways of respectfully engaging with difference.

an idea emerges

I have been a visiting teacher to Singapore for the last twelve years. I have very much been taken by the elegance and dignity by which people present you with their business card as part of usual professional interaction. They present it to you with both hands, the card held between the forefingers and the thumbs. As you present it you bow slightly and the receiver accepts the card in a mirror image of the person presenting. The fingers do not touch. I started to think that I could adapt this to the issue of greeting Muslim and orthodox Jewish women who do not shake hands.

the card

I am a great admirer of Art Deco and last year went to one of its jewels in the crown, the small city of Napier on the



Figure 1

North Island of New Zealand. In 1931 Napier was struck by a major earthquake and nearly every building in the city was destroyed. They quickly set about the task of re-building, completing most of it within two years, and did so in the main architectural style of the day – what became known as Art Deco. The photograph in figure 1 is a side view of one of the buildings in the city. The buildings seemed to represent the forging of a new beginning, new hope, that people can always find new ways forward. Art Deco expressed all the vigour and optimism of its time. In choosing a design for one side of a card that I would use therapeutically I wanted something that represented similar themes. Developing new ways forward in cross-cultural work is one of our biggest and most important challenges.

I added the word welcome to the card. While I give this card to all my clients, the main driving force was to find something that would offer a different way of greeting certain female clients and trainees, one that would respect their position about not shaking my hand but would also respect my position of normally connecting with people through hand contact. Further, before starting out to use the card, I discussed the idea with some female Muslim colleagues as well as an orthodox rabbi who is also a therapist. They were enthusiastic about the idea and indicated that from their knowledge there were no religious reasons mitigating against its adoption.

I first used it with Muslim family therapy trainees, Sharifah Fairuz Syed Abu Bakar (figures 2 and 3), and Maimunah Mosli (figure 4) at the Counselling and Care Centre in Singapore. They were trainees on a Masters programme in family therapy in collaboration with the Institute of Family Therapy and Middlesex University, London. I explained to them that I appreciated that from their cultural and religious perspective they did not shake hands with men who were not from their family, whereas, from my cultural perspective, I would normally shake hands with women. I told them that I had thought of an idea that would bridge our difference in a way that I hoped they would find acceptable. I offered the card to each of them. In their context, of course, presenting a business card in the way shown was not new, just its adaptation. They both found the use of the card acceptable. When I presented it to Maimunah and explained the reasoning she looked a little



Figure 2

tearful and at first I wondered whether I had upset her. When she had accepted the card she said she was very touched by the fact that I had thought of the idea. She wrote the following to me when I was back in England. She called the card – the bridging card - and I now use the same term.

I am utterly moved by the effort taken to even produce this card. Personally, your action makes me feel so understood without having to go into the position of having to explain myself. Not that I have a problem with it. At times, having to explain about our beliefs and values can be misconstrued as being too “ON” about our religion. Thank you for acknowledging my position, as this position is salient to me and my beliefs.

She added:

The Bridging-Card is indeed a step towards acknowledging difference and it will remain for me a most memorable and impactful one.

using the bridging card with clients

When I mentioned the idea of using the card to an ultra orthodox Jewish woman who I was seeing with her husband for couple therapy, I explained the reasoning for using it (as above). At first she wasn't quite sure. She had never come across such an idea before, but then said, “If it is important to you, that's fine”. I thought for a moment and then said something I had never said before. “Yes, I suppose it is important to me, thank you, but please feel free not to agree.” “It's ok”, she replied. I presented the card and she took it without us touching. In subsequent sessions this greeting became more natural between us. I should add that while the card is taken by the client at our first meeting (the other side of the card has my details), on subsequent greetings the card is just touched. The last thing a clients needs is ten or fifteen of my cards. This became a joke with one couple; the use of limited space in the house was an issue between them and the husband said (laughing) to me when we had met a few times and they were both engaged in the therapy, that he had



Figure 3



Figure 4

this image that if they had to come to therapy for a long time he would have to build an extension for the cards. His wife thought this was hilarious, which prompted him to repeat the same joke at a number of sessions that followed. She always laughed. I played the straight man. If the bridging card contributed to the establishment of a connection between them at my expense, so to speak, that was fine. I could cope!

Another client just said to me after I explained the idea behind the card – “isn't that sweet!”

There is only one client who has actually said no to the idea in the nine months since I have been using it and she said she would like to get advice from her rabbi first. The following session she said her rabbi had advised against it and, of course, I accepted this. I didn't ask her what the rabbi had said as I thought this may put her in a difficult position.

in conclusion

In developing cross cultural relationships, professionally and personally, it is incumbent on us to find bridges across difference. Bridges allow connection between familiarity and difference. Both are important. I know of no bridge across a divide which only loops back on itself. Such a bridge, if it did exist, would be a structure for exclusion rather than inclusion.

The idea put forward in this paper is a small contribution to finding new ways forward, an idea for use in clinical work, training and maybe ... graduation ceremonies. It doesn't have to be a card, of course. It could be some other connector agreed between people.

acknowledgment

I would like to express my appreciation to Sharifah Fairuz Syed Abu Bakar and Maimunah Mosli for allowing me to use the photographs and comments for publication and teaching.

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Barry Mason is a family and systemic psychotherapist in private practice, chair of the advanced training programme in supervision at the Institute of Family Therapy, and co-director of the doctoral programme in collaboration with Birkbeck College, University of London. E-mail: b.mason@clara.co.uk

My experience of training

clare

I had two thoughts immediately on being asked to write something about my experience of issues around sexual identity on my training course. One was that I couldn't possibly represent a "lesbian" experience of training and the other that I would welcome the opportunity to consider this for myself as it was not something I had done in a coherent way so far.

Thinking about culture during revision for the exam I realised the myth of a representative "lesbian experience". My own narrative is made up of many different narratives so that unpicking the different strands is complicated and full of possibilities. There is no part of me that can be identified as the lesbian bit, just as culture is part of many different aspects and is embedded and embodied in ways unique to each family and its members. It is impossible for me to speak on behalf of all lesbians or to know which part of my context is influencing different parts of my experience. However, given this, it seems important to have a go at thinking about how this difference is thought about in the training and whether my experience can contribute to this.

I think it is worthwhile thinking about visibility as a significant aspect of sexual identity. Coming out is a complicated ongoing process. There are times when life seems to be an endless series of decisions about who to tell what.

There is an idea that "lesbian families" are families of choice. I think this is confusing. My civil partnership photos show the same mixture of parents, children, other relatives and friends as heterosexual weddings. The power of putting my relationship centrally in my genogram however reminds me of the years of not doing so while my children were young adolescents at school. And how visible are "gay" therapists allowed to be with their clients? And how does the context affect this? Is it allowed at IFT but not at CAMHS? One occasion stands out: I shared something of my experience of being part of a "step-family" with a family at CAMHS where I have a placement. The team I am part of later reported wondering whether I would use "she". I did not but when I started talking I wondered if I could monitor myself sufficiently to be able to use gender-neutral language. I assume mostly that my gayness is something I have a choice about revealing but a young person saying to a colleague (about me) "she has VERY short hair" indicates something different. This is different from other differences which may have a more obviously visible aspect such as my whiteness and femaleness and age.

I often choose to use other aspects of myself such as gender and motherhood explicitly in clinical work but have never used a lesbian identity. Experiences of homophobia outside the course are reminders of dominant discourses of normal families and the invisibility of homosexual parenting. My identity of lesbian mother is supported amongst friends and family without wider public acknowledgement. I use this aspect of my own experience to hear and understand marginalised experience in clinical work but never use this explicitly. In keeping ourselves hidden do we contribute to dominant discourses of normative relationships and what implications does this have in training?

How do we position ourselves in clinical work in relation to homophobia? It was useful to hear in a plenary about the therapist taking a stand against parental homophobia but it is one thing to have that as a theoretical position and another to attempt this with families in other work contexts.

In other aspects of the course I have been more open. There have been some open and useful conversations around sexuality and difference and coming out in the more intimate

supervision group. Part of my experience of feeling "safe enough" has been the presence of a gay (male) trainee in my supervision group. Issues of same and different emerge and are part of a historical context where lesbians are less visible than gay men and their experience has been assumed to be the same. Shared understanding enabled me to explore issues around my genogram. We have used experiences of coming out as part of the reflecting team which was useful in relation to another experience a family was bringing about who to tell when. On a different training course some years ago where I had been openly exploring my dilemmas at that time, another trainee said that I had helped her have a more positive view of lesbian mothering. I had not realised she had had a negative one and it was a reminder that different people have different perspectives about our differences which cannot be predicted and are often hidden. It is easy to feel stuck between the fear of making something out of nothing and keeping experiences of difference private or only to be shared amongst those who share a particular difference!

There is the added dimension of how revealing a lesbian or gay identity can imply ownership of sexuality. I had thought that age and "partnership status" made that safer for me but realised in a discussion about attraction in the therapy room that I had left those aspects of myself which are to do with being a sexual being firmly at home! I wondered if that was a consequence of my own personal reaction to being watched and evaluated which I have discovered is a particularly painful experience. What I am not sure about is how internalised homophobia has contributed to this and how this relates to ideas about menopausal women.

The power and diversity group has sometimes been a place where experiences of difference can be explored but this is more useful when we have been in smaller groups. The focus on client work and the large group make exploration of these issues in ways that relate to our own positions almost impossible. I am sad that there was not enough time to explore dilemmas in relation to culture and sexuality which I am aware of when working cross culturally and are about my own assumptions and fear of judgement. There are times when this seems particularly pertinent for me as a lesbian.

The danger I think is that there is too easy an assumption of shared understanding on the course and too great a fear of being judged or assessed negatively if we express anything outside an acceptable position. Yet if this training is about anything it is about how this is unreal and the importance of enabling therapist and families to reveal assumptions and examine alternatives. Many have experiences of oppression and prejudice but somehow there is never quite the right place or time to engage in discussions around this. I feel frustrated that opportunities have been lost.

Clare works for a youth inclusion project, working with young people aged 9-16 and their families.
E-mail: clareworonicka@hotmail.com



Looking after ourselves: lesbian and gay couples talk about family therapy

barry sugg

Recently, as part of an MSc at the Institute of Family Therapy, I had the chance to talk to some lesbian and gay (LG) couples about family and couples therapy (FCT). My study sought to address a perceived lack of information on this subject by examining the perceptions of LG couples who had not previously used this type of service. Using in-depth interviewing with a small sample, combined with a methodology that enabled a rich exploration of respondents' experiences, it looked at couples' specific ideas about therapy, whether or not they might consider using it and factors that might influence choice of therapist. It explored an idea that LG couples' readiness to use family and couples therapy might be influenced by how much they thought society in general supports LG couple relationships.

British society is arguably moving towards greater acceptance of LG lifestyles, and certainly recent policy changes have given LG couples stronger rights – e.g. civil partnerships and anti-discrimination legislation. Yet LG families may be at an 'invisible' disadvantage if the support mechanisms available for heterosexual counterparts at times of difficulty are perceived as not available to them or not equipped to meet their particular needs.

Psychotherapy has been seen as slow to address issues of working with LG clients (Ussher, 1991) and criticised for the way such issues are dealt with in the training of therapists. LG therapists have felt that therapy has not fully thrown off its historical attitude towards homosexuality as pathological (Davies and Neal, 1996). There seemed little information on to what extent these views are shared by the wider LG community and the degree to which they might make LG couples and families reluctant to seek psychotherapeutic help at times of difficulty.

There is now a growing literature (King *et al.*, 2007) suggesting there are specific issues for LG people, of which therapists (gay and straight) need to be aware in order to function competently with this client group. These include awareness of the pressures arising from continuing homophobia and heterosexist attitudes within the wider society, the need to avoid stereotypical gender norms when dealing with LG clients, the significance and complexity of the 'coming out' process and the importance for LG couples of 'families of choice' as their main source of support, rather than biological 'families of origin' (Bepko & Johnson, 2000). The importance of these issues to LG couples is generally confirmed in the present study.

I interviewed four same-sex couples, where both partners identified as lesbian or gay – three male and one female. All had been together for over eight years and none had previously used family and couples therapy. All were white and broadly middle-class. The couples were interviewed in their own homes and the interviews were then transcribed and analysed using a recognised

qualitative research methodology – Grounded Theory (Glaser & Strauss, 1967).

I approached this piece of research as a gay, white, older, middle-class, male psychotherapist. Some of these qualities would have been obvious to the respondents and others (like being gay) would have been known to them because of my recruitment method. Interestingly, my 'profile' broadly fitted what the respondents described as desirable in a therapist, and I wonder what different stories I might have heard had I, for example, been heterosexual or female or black. I suspect that being gay was an asset in making participants feel more comfortable and I wonder if the strength of their stories of discrimination would have been told less forcefully had I been heterosexual. They were also aware I was a therapist and could theoretically therefore have 'edited' some of their negative comments about therapy or have had added concerns about confidentiality. In the event these latter factors did not seem to have a significant influence, judging by the variety of views expressed and the degree of candour.

All the couples thought it unlikely they would turn to others for help if they experienced difficulties in their relationships or family lives. In the (unlikely) event they would do so, it would be to friends first. Families were seen as unlikely to be helpful. However, a problem talking to friends would be that you would have to 'blow your cover'. Talking to a therapist was well down people's lists of who they might talk to. Participants tended to have a poor opinion about therapy as a process, sometimes based on the experience of other people they knew and sometimes on more general beliefs about therapy's function in society. One couple saw it as a fashionable consumer-desirable, mostly accessed by the affluent.

People expressed fears of 'what might come out' in therapy, the implication being that it might make matters worse rather than better. One couple questioned what a 'stranger' could 'add to the argument'. Another had concerns about a therapist's ability to maintain confidentiality, especially in a 'tight' local gay community and was also concerned about ending up as 'practice material' for a therapist who had little experience with gay couples.

Despite their scepticism, participants were able to describe things they thought might help make therapy useful and effective as a process and were interested in four main aspects of anyone that they might talk to. Although the sexual orientation of the person was not considered the most important issue, there was a feeling that a gay counsellor would understand LG issues better and that, on balance, it might be easier to feel comfortable with somebody of the same orientation. There were qualifications to this. One female respondent wondered if she might feel intimidated by a lesbian counsellor who had a view of what a 'good lesbian' should be like. People

also felt that a personal recommendation from somebody they trusted would override the issue of whether or not a counsellor was gay.

People wanted to be sure any therapist was suitably experienced. This partly referred to knowing they had experience working with LG couples but also a desire to know the therapist personally had experience of living in a couple relationship, whether gay or straight.

There was concern about a therapist's age, with participants preferring to talk to somebody of their own age or a bit older and with a disinclination to talk to somebody much younger.

There were mixed views about a therapist's gender. Interestingly, the lesbian couple had no preference about gender but the male couples expressed reservations about straight male therapists. They generally preferred the idea of a gay male therapist, but thought they might be okay with a heterosexual female.

When they thought about how to go about finding a therapist, all participants thought the best way would be to ask around for a recommendation. They might ask people they knew and respected who were therapists themselves or who had had a positive experience of therapy. A good recommendation was thought to override some of the other considerations about sexual orientation and gender. The only problem with this was that some couples were troubled by the fact that asking somebody you knew for a recommendation would reveal to that person that you had relationship problems.

I asked people whether they preferred the idea of seeing a private counsellor or one who worked for an agency. Again, respondents thought a personal recommendation would override this consideration. Without that, some felt it might be easier to check out a private counsellor and make sure they were right for you, whereas with an agency you might have to 'take pot luck' whom you saw. Others thought an agency had a reputation to consider and this might improve their standard of service – also that there would be 'more back-up'. One couple had a strong mistrust of any kind of organisation. It was wary of any organisation that advertised itself as 'gay friendly', feeling that "If you have to tell us, it's not going to work".

Everyone commented on the impact of where they lived in relation to all the issues we discussed. Two couples who lived in a 'gay-friendly' city felt positive about the availability of gay or gay-friendly services locally. This helped them feel supported, even though they might make no use of the services. They assumed that if they needed to find a gay counsellor that would be easy locally, although one of them also wondered if there could be a threat to its confidentiality/anonymity. Both couples felt they were fortunate to live where they did, even though there were still anti-gay attitudes abroad in such a supposedly gay-friendly environment. The lesbian couple, which lived in a more suburban setting, felt more isolated and was aware of the strong 'heterosexual biases' in its local community. It thought it would be hard to find a therapist with gay experience locally, let alone a gay therapist. The male couple which lived in South London felt it was 'living on the front line' and had to face actively hostile attitudes from those around it.

The findings confirm that a major and continuing influence on LG people is their awareness of the pressures arising from homophobia and heterosexist attitudes within the wider society (Bepko & Johnson, 2000). They suggest people build an 'internal', defensive position and a desire to

'sort things out ourselves', perhaps serving to make the daily experience of difference and hostility easier to cope with – one that has possibly become so habitual that people have ceased to notice it in themselves.

The effects of discrimination/stigmatisation have a strong influence on what people do and say. Clearly, going to consult a therapist is a process that involves self-disclosure as a LG couple, both by the words you need to use and the action itself. To the extent that you are sensitive about such exposure, you may also be sensitive and reluctant to 'take the risk' of going to therapy. Respondents' concern with the term 'family' and, to some extent, 'couple' confirm earlier research (Ussher, 1991; MacKinnon & Miller, 1984) and suggest a need for therapists and organisations to consider their terminology in marketing their services to LG people. The importance to LG people of 'families of choice', as opposed to 'families of origin', accords with the findings of Bepko & Johnson (2000).

These findings suggest a complex set of influences on couples. At one level, they did feel supported and that this support was increasing. The recent establishment of civil partnerships was seen as an important example. However, a contradictory set of influences was linked to experiences of homophobic behaviour or awareness of wider societal disapproval. This became internalised and led all the couples, to different degrees, becoming self-reliant and wary of talking to 'outsiders' about personal problems. This dual set of influences was like 'living in two worlds'.

I think the study provides important information for therapists and therapy organisations which offer FCT to LG people:

- There is considerable sensitivity to the term 'family' and some to the term 'couple'. Agencies need to be careful in their use of such terms in the way they publicise and describe their services;
- Some LG people will want to see a therapist who identifies him or herself as gay. This lends support to the need for more trained and experienced LG therapists;
- LG people may often be happy to see a heterosexual therapist, particularly if that person has been recommended to them by somebody they trust. However, they will want to be sure that the therapist has experience of working with LG couples and has positive attitudes to LG lifestyles;
- Feelings of inhibition and restriction by virtue of being gay may be affecting couples who in all obvious respects seem well-adjusted to their sexual identity. Therapists will need to take account of this possible 'hidden' dimension to their LG clients;
- LG couples who present for therapy may be as influenced or more influenced by other factors in their lives (such as living with a disability), than the fact of their sexual orientation;
- Therapists and therapy organisations need to pay particular consideration to the local context in trying to offer their services to LG clients and there may be particular issues for those working in more suburban and rural areas;
- Therapy organisations cannot rely on equal opportunity statements and 'gay-friendly' publicity to make their services attractive to LG clients. Indeed, such measures could have a deterrent effect, by raising fears about 'political correctness'. Policies and statements are no substitute for suitably trained and experienced therapists.

The study articulates useful information about how LG couples might go about finding a therapist and what qualities they would be looking for:

- They would be likely to rely on personal recommendation as a means of finding a therapist;
- Although the sexual orientation of the person was not considered the most important issue, there was generally a feeling that a gay counsellor would understand LG issues better and that, on balance, it might be easier to feel comfortable with somebody of the same orientation;
- People wanted to make sure any counsellor was suitably experienced. This partly referred to knowing that any counsellor had experience of working with LG couples but also a desire to know that the therapist personally had experience of living in a couple relationship, whether gay or straight;
- People preferred the idea of talking to somebody of their own age or a bit older and with a disinclination to talk to somebody much younger;
- The gay male couples expressed reservations about straight male therapists. They generally preferred the idea of a gay male therapist, but thought they might be okay with a heterosexual female therapist;
- The lesbian couple had no preference about therapist gender.

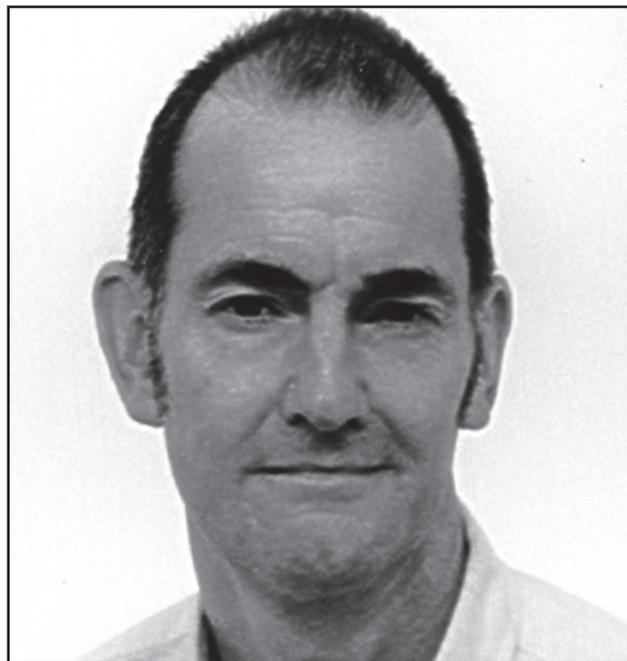
This study was unusual in that it looked at therapy through the eyes of people who had never used it. It revealed a wealth of information about how participants felt about living in contemporary British society, some of it (to me at least) surprising and disturbing. This provides a context or 'lens' through which they contemplate life in general, with FCT but a small part of that, and it cannot therefore fully explain their reluctance to consider using it. Further work with other groups who have not used FCT might afford useful comparisons and allow us, as therapists, to view the world through the eyes of those who choose not to come near us.

Undertaking the study has influenced my understanding of myself as a gay man, re-connecting me with feelings of difference that I had experienced many years ago and reminding me there remains a struggle for acceptance and equality, despite the progress of recent years. As a gay therapist I am used to working with LG clients who are accepting of therapy as a process, so it was hard to hear how unwelcome therapy was for these participants. However, I have been led to listen more carefully for, and to take more seriously the stories of difference and alienation that might underlie my LG clients' apparent adjustment. Were a heterosexual therapist to listen to these stories, I imagine he or she might have a similar response. Discrimination is often a subtle and non-deliberate process. We rely on such stories to open our eyes. I had the impression that the stories told by these participants were not ones they regularly told, even to themselves.

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Barry Sugg has a background in social work and social work management. He has worked for several years as a couples counsellor with Relate, helping to develop a therapy project aimed specifically at the LGBT community. He also works as a therapist in private practice and is currently completing a training in systemic psychotherapy at IFT. Barry can be contacted by email: barry.sugg@btopenworld.com



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Developing a conversation about empowerment

chris evans

For anyone coming to the UK as a refugee or to seek asylum there will be a series of complex challenges to face. Language, the political/administrative system, cultural barriers, poverty and social exclusion all represent challenges, which compound those they have already faced. For Child and Adolescent Mental Health Service (CAMHS) professionals working with refugees and asylum seekers, the challenges of language and intricacies of culture will also need to be navigated. In addition to which, many of those referred to CAMHS will have experienced trauma, loss, and some inhumane treatment, even torture. Acute practical needs resulting from poverty, housing insecurity, and the difficulties of adapting to life in the UK further compound their situation, along with the ever-present uncertainty about their status in the UK. These factors taken together represent significant barriers for clients and can leave professionals feeling de-skilled, powerless, and not knowing how to help. However, I believe that there are ways in which CAMHS professionals can respond, and play a pivotal role. By thinking about these groups of service users we may consider how these responses could be employed with other marginalised groups in the community.

In this article I will be considering some of the ways in which the needs of asylum seekers, refugees and forced migrants can be responded to within CAMHS. In order to do this I will be drawing on the experiences of CAMHS professionals, social workers and those working for voluntary or community sector organisations in North East London. There will also be an attempt to consider some of the stresses and dilemmas inherent in this work and to identify possible ways forward.

I first started working with young people seeking asylum and refugees in the late 1990s, initially as a Children's Rights Officer and later as an Independent Reviewing Officer. This was a period which coincided with the wars in the Balkans, and in particular Kosova, and local authorities in the South East were faced by a rapid increase in the numbers of young people and families referred to them. In my role I was acutely aware of the challenges this presented to the capacity of local authorities to cope and of reconciling liberal children's legislation with that governing asylum and immigration. In 2003 I decided to take on this challenge directly and became the manager of a Children's Services Asylum Team. These experiences have given me the opportunity to consider and reflect on the issues concerned from different perspectives. They have also given me a strong commitment to enabling refugees and asylum seekers to begin to cope with the challenges they face, in particular with regard to their daily lives in the UK.

In considering the ways in which refugees and asylum seekers can be helped within CAMHS I would not want to give the impression that it is a particular specialism, mystified or shrouded in a restricted knowledge base. As with other groups in the community, the most important element is the working relationship between service user and professional. However, when we work with young people from refugee and asylum seeking backgrounds we need to be cognisant of the

different factors which enter the room with us and can hinder any progress that could be made. It is also important for CAMHS professionals to note that these young people will be living in a variety of settings. In social services departments in recent years, the focus of this work has tended to be on unaccompanied asylum seeking children (UASCs) and those living in private fostering arrangements. CAMHS professionals may encounter young people living with their families and young people who have status as refugees or leave to remain, but whose needs arise from their experiences either before they arrived in the UK or as a result of the challenges of adjusting to the changes they have had to cope with. This wider focus is an important factor because it is less encumbered by the strictures which dictate statutory provision. This is because of the way in which cases are referred to CAMHS and because of its purpose and basis.

I have already mentioned some of the barriers and obstacles faced by refugees and asylum seekers in adjusting to life in the UK and in their encounters with professionals. However, a pertinent issue is that of power and the asymmetries which are particularly poignant when working with these groups of people. While thinking about this I have been reminded of a young woman who came to social services having been referred that same day from the Home Office. She sat clutching a bag, in complete silence with a look of fear and confusion on her face. An interpreter was called but still she remained silent. When a social worker explained to her that this was not the Home Office, and what the role of social services was, she visibly changed and started to talk about how she had come to the UK and to tell her story. Some time later she explained that there was no way for her to know the difference; as far as she could see this was another office with a man asking her questions. These uncertainties could be accompanied by preconceptions about mental health and fears that the client may have, such as that if they are seen as having a mental health problem this could adversely affect their asylum claim. There are of course stories of the opposite view being taken, that evidence of a mental health problem would help an asylum claim. However, those cases do not detract from the issue of the power asymmetry.

These issues of power are pertinent to a lot, if not most of the work we do as CAMHS professionals. Issues of gender, class and culture can never be ignored; however, given the vulnerability of this group of service users, they are graphically relevant. In some cases they will not only be informed by the factors I have already mentioned but also by historical factors such as the inheritance of colonialism and the role Europeans continue to have in many of the countries refugees and asylum seekers come from. In the modern world they no longer represent nation states but corporate interests and in some case Non Governmental Organisations (NGOs). As a social worker, considering issues of this kind was integral in my training, as it is to my role as a Practice Teacher. However, working with refugees and asylum seekers acts as a strong reminder that anti oppressive practice has to respond to the reality of the lives of service users.

Responding to that reality in a CAMHS setting means being aware that refugees and asylum seekers are not a homogeneous group. They have not all had the same experiences and their backgrounds are diverse. When we work with young people we may be aware of the context in which they live their lives; their family, maybe that of their carers, their community. For refugees and asylum seekers there will also be the family they have lost or left behind, the things with which they were familiar. In my experience this unseen element is not unconscious in the sense that a therapist might regard aspects of a client's personality because this unseen element is part of that person's everyday reality, something, which preoccupies his or her mind concerning things or people they have left behind.

There are common experiences for refugees and asylum seekers such as loss, isolation or trauma, but we cannot assume what these are. However tempting it might be to do so, we do not know the details of these lives. We may assume that their thoughts exist and that what they say and do is driven by those thoughts, but they are not easily apparent like the nose on their face. In the case of refugees and asylum seekers we may know something of their experiences and could fill in gaps from our knowledge gained from the news media, or knowledge of history. But we do not know the story of the person sitting opposite us. That is a version of events constructed from their experiences and their own perspective. For example, there has been a recent increase in referrals of young people from Afghanistan. We can read about the conflict in that country, or see it on television. We might assume when working with someone from a distinct group, for example Hazaras, that they are Shia Muslims. We might think of the destruction of the statues of the giant Buddhas or the massacres carried out on the Hazaras, but that does not mean that we know that person's story. To assume so would be as intrusive as claiming to know another person's thoughts.

What we can know is that there is a story, a narrative which connects the person in the room with the aspects of their life prior to coming to the UK. By allowing that narrative to develop, a second journey may be facilitated which allows and considers the young person's overall experience. Many CAMHS professionals will regard this as basic, but in my opinion it is particularly pertinent when working with refugees and asylum seekers because the context in which they are now living is likely to be so different to what they had left behind. I have discussed this with a range of professionals and a consensus of opinion tends to be that in order for an asylum seeker or refugee to undertake this kind of work they have to feel ready and able.

I mentioned earlier that refugees and asylum seekers face a variety of challenges and obstacles. These may also affect their ability and willingness to consider the hidden aspects of their lives, or even their ability to engage at all within a CAMHS on issues which include their experience prior to coming to the UK. My observation from these conversations with colleagues and from working with this group of young people, is that they can only fully engage once they have reached a position of relative strength and security. I say relative because insecurity is an ongoing feature of life for this group of young people but there are tasks which can be engaged in which can start to promote the ability of young people in these circumstances to cope. In my work, I also use the image of 'the journey' as part of this process because it is part of the young person's progress away from what has happened to them towards something new. This has to be done with care because the security of leave to remain is not within our gift, but we can help to facilitate progress in other ways. Refugees and asylum seekers may want to find out

about relatives and friends they have left behind and while there are agencies such as the Red Cross who can try to trace people, this is another thing which cannot be guaranteed.

CAMHS professionals have shared with me their views that this is affected by the "hierarchy of needs" which refugees and asylum seekers face. Housing, education (including learning English), money and legal representation will weigh heavily on refugees and asylum seekers and may need to be addressed prior to them fully engaging in CAMHS.

It could be argued that this falls under the remit of local authority social services. However, what I have found from other professionals both within local authorities and third sector organisations is that, while statutory services do provide significant support to those where there is a clear statutory duty, the young people referred to CAMHS may not clearly fit this criteria, or may live in circumstances such as private fostering where their basic needs are met and resource limitations constrain what local authority social workers can do. In these circumstances CAMHS professionals can provide an important co-ordinating role, utilising statutory and third sector organisations effectively and, in so doing, build up a supportive network or system for the young person. I mentioned earlier that refugees and asylum seekers could find it difficult to discern the difference between the Home Office and local authority social worker. This may also be the case where a variety of agencies become involved.

Within Children's Trusts there is the developing concept of the lead professional whose role is to co-ordinate support for young people and children in need. A similar concept has been put forward with regard to the idea of GP-style social work practices for looked after children. In essence I am arguing that CAMHS professionals can perform a similar task with asylum seekers and refugees or make a contribution where this role is fulfilled elsewhere. Within a CAMHS setting this has the added advantage of enabling young people to see their CAMHS worker as useful and so promote a working alliance. This in turn could facilitate circumstances in which asylum seekers and refugees can start to bring together aspects of their experience.

Many of the professionals I have spoken to mentioned the effect which working with asylum seekers and refugees has had on them. There seems to be a renewed awareness of the effect of working with vulnerable young people, which deserves more in depth consideration than I can give in this article. However, one of the feelings commonly mentioned is that of disempowerment. A common source for this is the legal situation and whether a young person will be given leave to remain in the UK. Many young people are left in a state of uncertainty for long periods of time while others have their claims refused. There are agencies and professionals, for example the Medical Foundation for the Victims of Torture, who can assist through the provision of medico/legal reports for Home Office Tribunals and appeals and in some cases this can be very valuable.

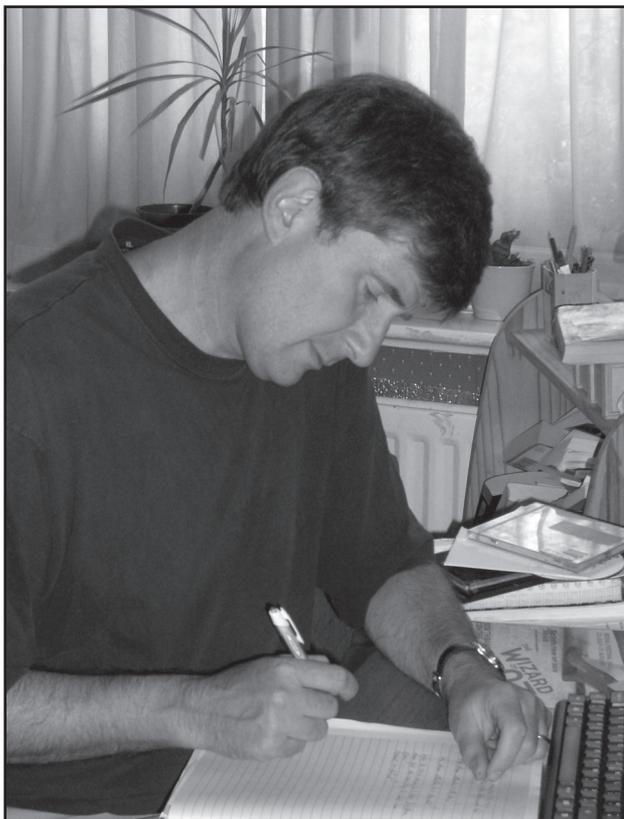
It is not the remit of CAMHS professionals to advise on aspects of law, but developing a supportive network of agencies who do provide advice and advocacy can be crucial in ensuring that a young person's rights are not denied and that they are able to challenge decisions. This is also a way of working which could be said to promote resilience. While I would agree with this, I am cautious of this term with regard to asylum seekers and refugees. This is because I have heard many social workers and professionals talk about this group of young people as if they are inherently resilient. A social work student who has made me re-evaluate this thinking has challenged me for thinking in this way. Perhaps this view had come about because of a crudely empirical observation

of asylum seekers and refugee young people who were noted for being willing to engage in education and were more co-operative than other groups of young people encountered by social workers. I question this because it is based on a generalisation of a group of people who are by no means homogeneous. It may be that there are factors for these young people which promote resilience, for example a family network or supportive community, but this might not be the case. Therefore to assume resilience is in my view at least a limited view and may cloud our judgement. But this is not to say that resilience cannot be promoted.

In conclusion, what I have argued is that when refugees and asylum seeking young people are referred to CAMHS, they bring with them the effects not only of their current challenges, but of their past experience. This is not unique for young people referred to CAMHS but the cultural, legal and linguistic challenges along with the scale of the challenges and in some cases the nature of the experiences these young people have had, makes them different from other young people. Questions have also been raised about the way in which this group of young people's needs are provided for and here again they have much in common with other marginalised groups referred to CAMHS. However, there are responses that can be made to the needs of refugees and asylum seekers with the development of supportive networks which may enable them to engage with CAMHS and empower them to develop the resilience to cope with the circumstances in which they find themselves.

Chris Evans has been working with young people since 1984 and qualified as a social worker in 1992. Throughout his career he has worked in North East London as a social worker, children's rights officer and

reviewing officer. Between 2003 and 2007 he managed a Social work team for young people seeking asylum and is currently a social work manager in a CAMHS service.



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A new book from David Epston
Down Under and Up Over
– Travels with Narrative Therapy
 Available from 12 September 2008

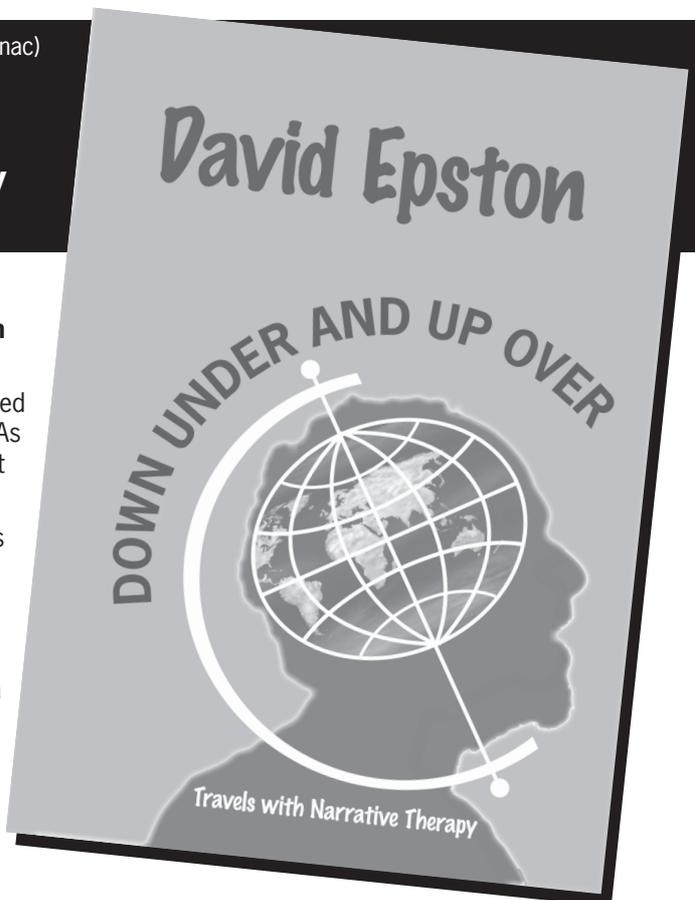
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David Epston's new book is in two parts, with an introduction by Barry Bowen.

Part One (Down Under) contains previously published work from different periods of David's writing career. As always, each chapter reflects David's creativity, and at times those of his co-writers.

Part Two (Up Over) contains six examples of David's current work, all of which are printed here for the first time, including inventive approaches to chronic bed-wetting, relationships between children and their estranged fathers, court reports, stealing, and sibling conflicts, as well as a long chapter on Anti-Anorexia, a subject close to David's heart.

David Epston continues to be a considerable influence on many UK family therapists/systemic psychotherapists, as well as being one of the two creators of Narrative Therapy, the other being the late Michael White.



The cybernetics of prejudices in the practice of psychotherapy

by G. Cecchin, G. Lane and W. Ray, 1994

reviewed by kevin ball

In the spirit of irreverence, one might say that *The Cybernetics of Prejudice in the Practice of Psychotherapy* is a book that outlines the manifesto for a post-ideological orientation in therapy. According to the authors, the essence of this approach is to 'deconstruct one's own mythologies of change', and the ability to do so will lead to being able to engage the client in a lively and irreverent improvisational interaction. This is a theme that has its origins in the authors' previous book entitled *Irreverence – A Strategy for Therapists' Survival* (Cecchin, et al., 1992). What is different about this book is the emphasis on the client's prejudices and not just the therapist's. However, the book does lay greater emphasis on the prejudices of the therapy world and calls provocatively for a 'deconstructing of the entire family therapy movement'.

The book is separated into three distinct sections. The first section explains the theory of a cybernetics of prejudices, the second part lists a number of typical psychotherapeutic prejudices that are held by therapists and the third part illustrates how a cybernetics of prejudices works in a clinical setting.

The theory of the cybernetics of prejudice observes that therapy occurs as the interplay of the prejudices of the therapist and the client. What Cecchin et al. are emphasising here is not just the uncovering of prejudices but the tension that arises through the interaction of the prejudices of the therapist and the client. It is this emphasis on the consequences of the families' and the therapists' prejudices for therapy that is the focus of the cybernetics of prejudices. As Cecchin et al. state: "the process is cybernetic in that it is outcomes that shape the behaviour of both therapist and client. Another way of saying this might be that it is not so much the content of any particular prejudice but the relationship between the prejudices of the therapist and client that is the heart of therapy. Therapy in fact is the interplay of prejudices."

What is meant by prejudices is any pre-existing thought, feeling, fantasy, hunch etc that contributes to one's view of the therapeutic encounter. These prejudices are embedded in the very language we use to communicate in therapy. As an example of prejudice, there is the Missionary therapist who believes he or she is there to give an expert opinion on what is normal, informed by their own childhood suffering. Cecchin et al. argue that the Missionary position provokes an escalation in which the client feels handicapped and needing constant reassurance from a 'wise professional'.

Cecchin et al. stress that one cannot not have prejudices but that the heart of therapy is to create a context where the interplay of prejudices can be examined in a non-threatening way. Therapeutic impasse occurs when two prejudices become locked. In the third part of the book, an example is given in which a therapist has a prejudice that good therapy is about a son being more independent and moving out of the family home. This clashed with a family whose belief is the opposite. Cecchin et al. warn of the pernicious consequences of the therapist pathologising the family or defining them as resistant. The therapy only starts again when the therapist abandons his or her prejudices.

The authors acknowledge that their approach can be dismissed as nihilistic scorn for any notion of truth. Any approach claiming to be post ideological deconstruction may leave itself open to this standard objection. However, Cecchin et al. want to say that it is more responsible to examine one's prejudices. As Cecchin et al. write: "we want to emphasise that we are talking about a strongly held ethical position here, and not merely describing some simple strategic tactic". This theme of taking up an ethical position follows from the authors' previous work on irreverence. In *Irreverence – a Strategy for Therapists' Survival* (1992), irreverence was the ability of the therapist to question his or her own theory. In *The Cybernetics of Prejudices*, it is both the therapist's and the client's prejudices. It is unfortunate that the authors do not draw out this ethical theme more explicitly given that it links so strongly with the ethical turn in Derrida's later work (1978) which was influenced by the ethical philosopher Emmanuel Levinas (1996). Without this ethical development in Derrida's work, it too is dismissed as nihilistic. At the heart of examining prejudices is the attempt to enable an ethical discourse in relation to the client. Consider this position alongside Levinas' notion of the ethical relation: "to be in relation to the other face to face is to be unable to kill. It is also the situation of discourse". That having been said, this book's appeal and importance is the tension it creates between maintaining a systemic 'prejudice' and the hermeneutic 'prejudice' at the same time rather than appealing for a discontinuity of metaphors as Freedman and Combs do (1996). This is comically illustrated in the metaphor of the 'last family therapist', who, despite being on his death bed, is still alive and kicking at the end. This is precisely the lesson of deconstruction that at the end of metaphysics there is something alive, something undeconstructible. There are many names Derrida gives to the undeconstructibles – justice is one of them. Perhaps another is Cecchin!

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Kevin ball qualified as a UKCP psychotherapist in 2008. He has worked in one of the Philadelphia Association's therapeutic communities set up by R.D. Laing, in Guy's and St Thomas's hospital in the Department of Palliative Medicine and as a psychotherapist at the Richard Dimblebey Cancer Centre. He is currently working in a CAMHS in Redbridge.

Competent cross cultural family assessment: a framework for clinicians

christine senediak

There is a growing need for clinicians to be culturally competent with our rapidly growing multicultural society (Ecklund & Johnson, 2007). When working with families from diverse cultures clinicians need to be mindful of the influences of ancestors, grandparents, significant 'spiritual beliefs' and in some cases, the tribe to which the family member belongs. In family therapy, the 'family group,' as defined by the client, should be the focus of treatment. The particular concerns that bring the family to therapy can be understood to be influenced by the way the family interacts given their life circumstances, beliefs, attitudes and resources from their cultural perspective (Sluzki, 1979). There are increasing demands for all clinicians to be culturally competent by developing a broad and open understanding to the wide array of differences, commonly grouped as *culture*. This paper presents a practical framework for guiding clinicians in competent cross cultural family assessment and interviewing (Whaley & Davis, 2007).

genograms

It is common practice when working with families that a genogram is used to conceptualise the history of the family across a number of generations. This is done to provide a visual focus for the family and the therapist in understanding the historical nature of the presenting problem (McGoldrick, Gerson & Shellenberger, 1999). By using a genogram and associated sociogram the therapist can develop a thorough understanding of the influences the client and their family have endured. Enquiring and being respectfully inquisitive about the client's past and present circumstances and family situation, allows the therapist to develop a starting point for therapy by knowing the client's strengths, resources and wider social supports (Shellenberger, Dent, Davis-Smith, Searl, Weintraut & Wright, 2007).

Genograms also help the family to objectify powerful family affects and help to get some distance from them. If the 'problem' is seen in the genogram picture (rather than with the presenting client), this helps the family begin to track trans-generational patterns and externalise the 'problem' to some extent. It can also help as a concrete way of bringing absent family members into the family sessions, or bringing the family into individual sessions, as in a sense it gives 'permission' to reflect on the part played in the problem by other family members or their beliefs. Table 1 provides a cultural genogram template to aid clinicians working with clients from diverse backgrounds.

table 1
cultural genogram

The following questions can be considered when conducting a cultural genogram to aid understanding of past, present and future influences on the family.

1. What was the migration pattern for this family?
2. Nature of immigration (political refugee, choice)?
3. Expression of oppression (do different family members internalise or externalise their feelings)
4. Relationship between group's identity and ancestry?
5. Significance of race, skill, colour etc.,
6. What is the role in this family for religion and spirituality?
7. Gender roles and how these are expressed implicitly and explicitly?
8. Prejudices/Stereotypes (within the family, outside of the family)
9. Role of names (do family members 'carry the family name'? What expectations does this place on the person?)
10. Occupational roles (valued/devalued). Have the occupational roles changed due to migration?
11. How is the family defined in their cultural group?
12. How are outsiders in general and mental health professionals defined?
13. How are the organising principles of this group shaped by the family?
14. What expectations do the family have of you?
15. Is there more than one culture of origin with this family?
16. What impact does all the above have on you as a therapist working with this family/couple?

principles of cross cultural family therapy

While family therapy has been practiced for years, it has only been the past 15 years or so that the issue of culture has become addressed with any real vigour. Now, of course, with the shift towards a multicultural and globalised society, many therapists have realised the importance of understanding and working with immigrant families (Constantine & Sue, 2005; Dana, 1998).

It is widely acknowledged that a therapist working with culturally diverse families first needs to identify and assess their own bias, knowledge and experience in working therapeutically (Hayes & Levine, 1997; LaRoche & Maxie, 2003; Gregory & Leslie, 1996). The more the therapist is aware and shows interest in understanding the client's experiences and situation, the better able they will be to understand the impact of these on the presenting problems faced by the client and their family. Improving the therapist's cultural knowledge also improves the accuracy of the therapist's hypotheses about the factors contributing to the

development of the client's problematic situation (Maxie, Arnold & Stephenson, 2006). Gregory & Leslie (1996) add to this by noting the strength of this approach to working with families is that it draws from an ecological approach, emphasising the impact of historical, cultural, political, social and economic factors on the family, and in turn, therapy.

tasks for competent cultural family therapists

McGill (1992) identified three critical tasks for therapists working cross culturally with families. The tasks for therapists are the need:

- to have some knowledge of the particular content of different cultures (including the contexts of gender, race, life cycle issues etc.)
- to be able to make the presence of difference within the family, between the family and therapist, and between the family and the larger societal system be seen as an opportunity rather than a problem
- to hear the complexity of the family's stories within the context of society's stories in a way that separates the story from ordinary, daily family life.

By the therapist helping the family retell its personal story both the family members and the therapist can appreciate it within the context of the larger societal story. McGill states that to do this successfully within the context of a therapeutic relationship with their client, the therapist must take time to learn about various cultures and be interested in the client's 'telling'. This is not to say that a therapist must be from the same culture as the client but rather they are prepared to broaden their cultural perspectives (La Roche & Maxie, 2003; Pare, 1995). Other writers have also emphasised the importance of awareness and acceptance of difference within and between families when working with families (e.g. Falicov, 1988, McGoldrick *et al.*, 1999). It is important to reflect on the meanings and adaptive behaviours that are attributed by family members to certain life events and situations (Sue & Sue, 1990). It is assumed that a multidimensional definition of culture is required by the therapist who can understand the client's stage of migration, acculturation and what cultural subgroups they belong to.

There are both advantages and disadvantages to working within the same cultural group as the family that is being seen in therapy. The advantage may be for possible greater understanding and empathy and that it may be easier to interact with the family, based on shared experience and language. However, the disadvantage may be that the therapist over-identifies with the family and thus limits their ability to help the family find new solutions (Downing Hansen, Randazzo, Schwartz, Marshall Kalis *et al.*, 2006). While a therapist from a different culture can offer the family new insights from an objective framework and is not limited by personal experience, they may inadvertently miss important factors for the family as the right questions are not asked to find out about the family's cultural story. This dilemma reflects the importance of clear guidelines for an integrated and culturally affirmative framework to guide clinicians working with diversity.

family therapy interventions: considerations

Imber-Black (1997) notes that to become culturally competent the therapist needs to be able to work with families by incorporating the following elements: theoretical models that cut across cultures; culture-specific content that avoids stereotypes; sufficient knowledge of one's own culture;

and a therapeutic attitude marked by openness and lack of imposition. Different cultural groups differ in their experience of pain; what they label as a symptom; how they communicate about pain and symptoms; what they believe regarding aetiology; what their attitude is towards professional helpers; and what treatment they desire or expect (Canino & Alegria, 2008; McGoldrick *et al.*, 1999). Depending on the cultural group the therapist may be working with, there can be a very different emphasis in the language used to describe symptoms or the importance of myth or spiritual interpretation attributed by the family to the problem in therapy (Groleau, Young & Kirmayer, 2006; Rolland, 2006).

issues to consider

1. Use of cultural story in therapy

"If family therapy is about meaning, then cultural stories offer a way to 'restory' and to reclaim meaning and to create an ecology of the family's mind" (McGill, 1992).

Some cultural groups have literal stories while others have myths. These stories offer multiple truths that can be applied in therapy. By looking at the similarities and idiosyncrasies in a family's cultural story, the therapist can find the perspective that provides the family access to their problem. This can often involve the interweaving of historical material with present day issues faced across the generations affected by the problem. Through discussion, this allows for changes in the family members' perceptions and beliefs which can in turn facilitate adaptive change in the here and now (Deveaux, 1995).

2. Consideration of Family Life Cycle

It is important that the therapist is aware how culture interacts with life cycle at each stage. Culture influences families in their definition of the nature, timing, tasks and rituals of life cycle phases and transitions. Families from different cultural groups vary in the significance attached to each life cycle transition. For example, a 'Western' perspective sees separateness as appropriate during the adolescent/young adult phase while for other cultures (e.g. Asian) this may not be so.

3. Use of Rituals

The use of rituals (e.g. grieving rituals), can be particularly helpful for families who have been subjected to torture, and for refugee families. The culture of the refugee family is a resource, which can help integrate experiences of atrocity and adapt to a new and safer life. Healing rituals can enhance the therapeutic process as it allows for time to deal with the grief and trauma. 'Storying again' can be useful as it offers respect and time to weave together survivors' memories and current experiences with their traditions and beliefs into an account that makes sense of their disrupted and confused inner and social world.

'Storying' can also promote the conscious and unconscious meanings of actions or beliefs for the family. For example, Woodcock (1995) describes how cultural and religious festivals can help motivate a family in their recovery by encouraging family members to participate in traditional forms of celebration offering renewal by way of linking family members to crucial elements of their cultural identity. This process also encourages links with their own community, affirming their position and present life circumstances.

This overview provides a framework for developing cultural sensitivity by considering issues such as the ecological /systemic context to which the family belongs. This also includes the family members' linguistic proficiency, expectations of treatment, 'definition' of family, and level of acculturation. For some families, especially those that are relatively recent migrants, it is necessary to assess pre-migratory family life and experiences, the actual migration experience and the impact of migration on the individual family members.

A number of therapists (e.g. McGill, 1992; Deveaux, 1995; Sue & Sue, 1990) emphasise that over-reliance on cultural conceptualisations and interpretations can lead to misguided expectations for the therapist working with a family. At the same time however, the therapist should be guided by common cultural themes and metaphors and should use these as reference points to further explore the family's cultural principles and standards. Appreciating the cultural and ethnic background, difference, and what this means to the family, will improve service delivery. Through the health professional's improved understanding and knowledge of the client within their ecological context, services can be tailored to meet their specific needs. The family's perspective is a good place to start.

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appendix: immigration and acculturation

While a number of these issues will be covered in the cultural genogram questioning under the heading 'migration history', these additional questions can aid understanding of the influences on the family's immigration and acculturation.

1. How relevant is the socio-cultural context for the members of the family? Does it differ between members of the family?
2. Are some of the family members more comfortable with their migration than other members? What are the influences that make this difference?
3. Was all the family involved in planning its immigration? Did any member make particular sacrifices in their move? Who was in favour? Who was against? Who was left behind? Whom did the family bring?
4. Are any members 'frozen in time' in a way which impacts on belief systems (of country of origin and those of the adoptive country)?
5. Does the host country meet their expectations?
6. How much did they know about the adoptive country?
7. How successful was the family in their country of origin? Any experienced economic loss?
8. Have all members of the family achieved all phases of acculturation?
9. Are there any 'polarisations' within the family: old country/new country? How does the family deal with these differences?
10. How have the family members been able to mourn the loss of country?
11. What is the ethnic allegiance of the members of the family? (Identity and loyalty)
12. How does the family discuss differences among them?
13. What can be seen as the strengths and constraints of immigration for the family?

Christine Senediak is a senior clinical psychologist with the NSW Institute of Psychiatry and the Transcultural Mental Health Centre, Sydney, Australia. She coordinates training in child and adolescent mental health, family therapy and clinical supervision, and consults widely in cross cultural mental health practice.

E-mail: Christine.Senediak@nswiop.nsw.edu.au



Guantanamo

anna margrete flåm

Guantanamo

If you look into that word,
what do you see?

If that word had a face,
how would it look like?

If many faces...

If those faces could speak,
what sounds could you hear?

Would there be any voices to be heard?

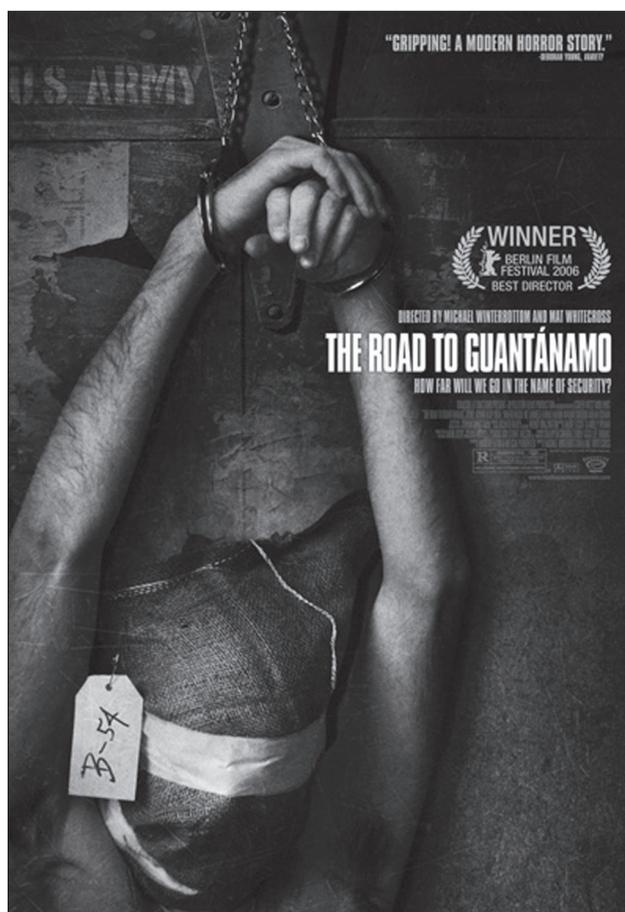
If your body sensed these voices,
what could it tell?

Would it tell any words that you know?

If you look into those words,
what do you see?

Do you see any ways to go on?

From *Innovations in the Reflecting Process* (2007),
Harlene Anderson and Per Jensen (Eds),
Karnac Books



The original poster made to promote the film *The Road to Guantanamo* (Michael Winterbottom, 2006) in the United States, which was refused by the Motion Picture Association of America. The reason given was that the burlap sack over the detainee's head was considered to be depicting torture, and therefore inappropriate for young children to see. (http://en.wikipedia.org/wiki/The_Road_to_Guantanamo)

The Road to Guantanamo

In film *The Road to Guantanamo* (2006), co-directors Michael Winterbottom and Mat Whitecross recount the true story of four British Muslim men who visit Afghanistan just as war is breaking out in late 2001, and end up in Guantanamo Bay, Cuba, as prisoners of the U.S. government. Winterbottom skillfully blends archival footage, real-life interviews, and dramatized scenes shot on location in Afghanistan, Pakistan, and Iran to give a visceral sense of the men's experience. Held by the Americans initially at Kandahar Airbase in Afghanistan, they face physical abuse and mistreatment. Transferred to Camp X-Ray, the holding block at the time for detainees on arrival at Guantanamo, the men are locked in open-air cells resembling dog kennels. Both there and at Guantanamo's Camp Delta, they are interrogated by CIA, FBI, and military personnel and held for nearly two years without charge before being released. The film delivers a powerful critique of the dangerous disregard of the Geneva Conventions by the United States and its allies. Winner of the Silver Bear for Best Director at the 2006 Berlin Film Festival.

Synopsis reproduced with permission by *Human Rights Watch International Film Festival*: www.hrw.org

Code of ethics and practice

Policy Document revised May 2008

All AFT members are required to read and abide by the AFT Code of Ethics. The Ethics committee have revised the policy document and it is printed below for your information.

introduction

The purpose of the AFT Code of Ethics and Practice is to define general principles and to establish standards of professional conduct for psychotherapists in their work and to inform and protect members of the public who seek their services.

- A. The Association for Family Therapy and Systemic Practice (AFT) is the only organisation for family therapy and systemic practice, which covers the whole of the United Kingdom. It has members from all the main helping professions, and seeks to improve the standards of professional practice with family and other systems, by promoting family therapy ideas in practice, teaching, supervision and research. A significant number of members of AFT are employed in designated posts as Family and Systemic Psychotherapists, to whom AFT provides the services of a professional body. AFT accredits family therapy training courses at various levels in the United Kingdom.
- B. AFT is a member of the United Kingdom Council for Psychotherapy (UKCP), and is responsible for the registration of individual members. In accordance with UKCP requirements, registered Family and Systemic Psychotherapists are subject to AFT's formal complaints and disciplinary procedures. There may be a range of sanctions including de-registration of the therapist. Non-registered members of AFT (either qualified Family and Systemic Psychotherapists who have not registered or other professionals using family therapy ideas, e.g. systemic practitioners) who bring the organisation into disrepute are subject to discipline by the AFT Board who may suspend or terminate membership of AFT.
- C. AFT is a member of the Family, Marital, Sexual and Systemic Therapy Section of the UKCP whose flag statement is: 'Organisations within this Section have in common an understanding that symptoms, problems and difficulties arise in the context of relationships, and are to be understood in terms of interactive and systemic processes. The main focus of intervention emerges from these patterns of interaction and the meanings given to them. Given this focus, the members may work with individuals, couples, families or parts of them, and other significant relationship networks.'
- D. Each member organisation is required to include and elaborate upon those principles in its own Code of Ethics.
- E. The terms 'family therapy' and 'systemic practice' are to be understood as referring not only to systemic work by therapists and practitioners with families, but also to activities such as consultation, publication, research, supervision, training and a variety of direct forms of work with clients other than as part of a family.
- F. The term Family and Systemic Psychotherapist refers to a person who has completed accredited qualifying-level training, and/or is registered with UKCP. The

term systemic practitioner refers to a person who has completed training to intermediate level. For the sake of clarity the generic term Member will be used throughout the Code to emphasise that the Code refers to all members of AFT whether they are Family and Systemic Psychotherapists, systemic practitioners or any other person who is a member of AFT. See also para. 19

- G. In addition to the ethical requirements of members in their relationships with families and individual clients, there are crucial contextual issues which they have to address in order to be effective in their work. These include:
 - i. Making satisfactory arrangements with their employing agencies, particularly when it comes to:
 - a. having a systemic approach accepted as a viable way of working,
 - b. receiving adequate support and supervision, and
 - c. being provided with at least the minimum facilities to practice as a Family and Systemic Psychotherapist.
 - ii. Promoting greater public awareness of issues to do with the emotional health of family life, and information about family therapy.
 - iii. Familiarising themselves with any local interagency procedures in relation to child protection and mental health.

general principles

1. The purpose of family therapy and systemic practice is to promote greater well-being and/or understanding in those with whom members are concerned.
2. Members must promote the welfare of families and individuals. Relationships with clients must be based on honesty and integrity.
3. When faced with an ethical dilemma members should adopt the course of action which 'maximises the good' and does the 'least harm'. They should attach particular weight to the rights of the vulnerable and those with least power.
4. Members are required to refrain from any behaviour that may be detrimental to the profession, to colleagues or to trainees.
5. Members must not exercise negative discrimination in the selection of clients on the basis of age, gender, disability, race, sexual orientation, religion, social class, national origin or political affiliation.
6. Members should be aware of the particular needs of children and vulnerable adults and attend to issues of safety.
7. Members should endeavour to adopt a culturally sensitive stance to clients from ethnic minorities and should do what they can to make therapy accessible to those constrained by disability, poverty or language barriers.

therapeutic contract

8. There must be a clear and unambiguous agreement between members and client(s) regarding the work to be undertaken.

9. Before therapy begins, members should provide an appropriate explanation of the nature of the therapy being offered.
10. Where relevant, members should be prepared to recommend alternative treatment to their clients and help them obtain such alternatives from appropriately qualified practitioners.
11. Members in private practice must discuss financial arrangements before therapy begins. Fee arrangements must be clear and explicit.
12. Members must not accept payment from referrers, nor pay anyone a fee for referrals made.

relationships with clients

13. Members should maintain appropriate boundaries with their clients. They must take care not to exploit current or former clients in any way, whether financially, emotionally or sexually.
14. Sexual intimacy with clients is always unethical and any possibility of attraction should be discussed with the appropriate superior/supervisor and alternative therapy arrangements made. Sexual intimacy with former clients is prohibited for three years following the termination of therapy.
15. Members should not use relationships with clients to further personal, religious, political or other non-professional interests.
16. Therapy should continue only so long as it is beneficial to the client(s).
17. Financial transactions between members and clients, other than those relating to fees, are forbidden.
18. The use of violence against a client is forbidden, though the use of restraint and/or reasonable force within the law may be justified if the safety of any person present is threatened.

qualifications

19. Members must disclose their qualifications if requested, and must not claim to possess qualifications which they do not have. Membership of AFT should not be presented as a qualification. The title of Family and Systemic Psychotherapist should not be used unless the practitioner has successfully completed accredited qualifying training and/or has UKCP registration.
20. Advertisements should not make false claims and should only describe training undertaken, qualifications held, and services offered by the therapist.

competence

21. Members should operate only within the limits of their competence, and must cease to practice if that competence becomes impaired for any reason.
22. Qualification as a Family and Systemic Psychotherapist affirms competence to practice independently. Family and Systemic Psychotherapists are required, however, to maintain their ability to perform competently through continuing personal and professional development.
23. Members must ensure that they have made appropriate arrangements for supervision of and/or consultation to their practice.

confidentiality

24. At the outset of therapy, members should clearly explain the confidential nature of their work to

clients. All material and information passing between clients and therapist is confidential.

25. Confidential material may be disclosed to colleagues without the client's consent where those colleagues are bound by rules of confidentiality. Examples would include case discussions, allocation meetings and supervision.
26. Members should inform clients that circumstances may arise when it is a matter of public or professional duty to break confidentiality. Situations involving self harm or actual or potential risk of harm to family members or others would constitute such circumstances.

notes, records, use of video and audio tape

27. Permission must always be obtained from clients before audio- or videotape recordings are made of a therapy session. The uses to which such recordings may be put must be fully specified. Specific consent must be obtained from clients to use tapes in research or teaching.
28. Specific consent forms must be signed by each client, including children where appropriate, and only in exceptional circumstances should parental permission overrule the wishes of a child. It is not sufficient to record consent on audio- or videotape.
29. Members should clarify with clients how long tapes can be held. Recordings must be erased after the time agreed with clients, unless further consent is obtained.
30. Clients' records, including notes and tapes, must be stored securely. Any personal data stored in any form, including electronically, must be completely safe and confidential, in accordance with current legislation. Members should familiarise themselves with these requirements and those maintaining electronic records will need to be registered under the Data Protection Act (1998). Records should be retained for a minimum of 7 years after the termination of therapy.

wider context of therapy

31. Members are advised to gain consent from clients before contacting general practitioners and other professional agencies in situations where this is appropriate.
32. Members must inform clients if their professional role also involves responsibility to take statutory action (e.g. under the mental health act or child protection legislation).
33. Some members have more than one professional qualification. These members should make it clear to clients in which professional role they are practising, in order to avoid any conflict of interests.
34. Members have a duty to recognise, protect and promote the particular rights and needs of all individuals in families. This may sometimes include responding to requests for individuals to be seen separately.

fitness to practise

35. Members are responsible for addressing any current limitations, such as factors in their personal background, and mental or physical ill-health, which affect their ability to practise competently.

36. Members should not practise when under the influence of alcohol, or drugs that are likely to affect their judgment, or when impaired by illness, psychological distress or infirmity.
37. Members should take appropriate action if they are concerned about a colleague's behaviour or fitness to practise. This could include initiating the relevant complaint and disciplinary procedures.

professional executors

38. Members should make provision for the appropriate care of their clients in the event of sudden illness or death by naming a colleague or colleagues who should be kept up to date with names and addresses of current clients. Such colleagues would also be responsible for administering the professional estate of a therapist who dies suddenly, in accordance with AFT's Guidelines for Professional Executors.

professional indemnity insurance

39. Members must ensure that their professional work is adequately covered by appropriate indemnity arrangements against possible claims for damages for negligence, malpractice or accidental injury, whether in private practice or in work undertaken for an employer. Members must never assume that someone else is holding this responsibility.

research and publication

40. Members who undertake clinical research must comply with the requirements of their Local Research Ethics Committee and their employer's Governance procedures, and must gain fully informed consent from clients who participate.
41. Members are advised to seek consent from clients before using clinical material in any publication. Care should be taken to ensure that any material used in publications or in lectures, seminars and workshops is presented in such a way as to protect a client's anonymity.

relationships with colleagues, trainees and junior staff

42. Members must address ethical issues in training and supervision and should ensure that all students, trainees and junior staff for whom they are responsible, maintain an appropriate ethical standard in their practice.
43. Members who engage in personal relationships with students, trainees or colleagues must ensure that such relationships do not compromise their effectiveness as therapist, consultant or trainer, or interfere with the standard of service offered to clients.
44. Sexual intimacy between supervisors/trainers and trainees should be actively discouraged for the duration of the course and any possibility of attraction should be discussed with the appropriate superior (e.g. head of department) and alternative training arrangements made.

working with the media

45. Members who work with the media, for instance in making TV programmes, are required to adhere to the same ethical guidelines that would apply to clients in other contexts. They should examine

their personal motivation for taking part and keep participants' needs at the centre of their concern with a particular focus on the needs of children and vulnerable individuals. They should also consider the impact on their current clients. They should not get involved if the topic is outside their area of expertise.

complaints and disciplinary procedures

46. Members must inform AFT if an employer or professional body upholds any complaint against them, if they are convicted of any criminal offence, or if successful civil proceedings are brought against them in relation to their work.
47. Anyone who has any concerns about the ethical conduct of an AFT member should bring this to the attention of the AFT's Ethics Committee, who will investigate the complaint.
48. The complaints procedure can be viewed at www.aft.org.uk or obtained from the AFT office.

AFT's Ethics Committee welcomes queries from members about any aspect of this Code as it relates to their practice. Please contact Sue Kennedy, AFT Executive Officer, 7 Executive Suite, St James Court, Wilderspool Causeway, Warrington WA4 6PS. Tel: 01925 444414 E-mail: s.kennedy@aft.org.uk

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Registered Charity No. 1063639. Registered office is the administrative office, as above.



Autumn meeting
**Friday November
 14th, 2008**
10am to 4 pm
**The Dorking Halls,
 Dorking**

Barry Bowen **'An Introduction to the Theory and Practice of Narrative Therapy'**

**Cost £45 (incl. coffee/tea at
 registration & mid-morning)**

To book send a cheque for £45 payable to
Surrey AFT, plus s.a.e. to:

**The Treasurer, Surrey AFT, Cotswold
 House, Sutton Hospital, Sutton, Surrey,
 SM2 5NF.**

(Telephone: 020 8652 7900)

Research update

The SCORE Project

peter stratton

"All artists are willing to suffer for their work, but why are so few prepared to learn to draw?" Banksy, 2006, p. 10.

A major commitment of AFT has been to the development of the SCORE outcome measure. This research page aims to inform AFT members about our progress and our hopes. But you might detect a subtle sub-text of concern that progress has been much slower than we had hoped. The more we have done with the pilot versions of SCORE the more excited we have become about the uses we could make of the definitive version in therapy and research. But this will only happen with active participation by many therapists so I want to start by briefly indicating why the work takes the form it does, and to speculate about possible obstacles to participation. After which Banksy's comment might look relevant.

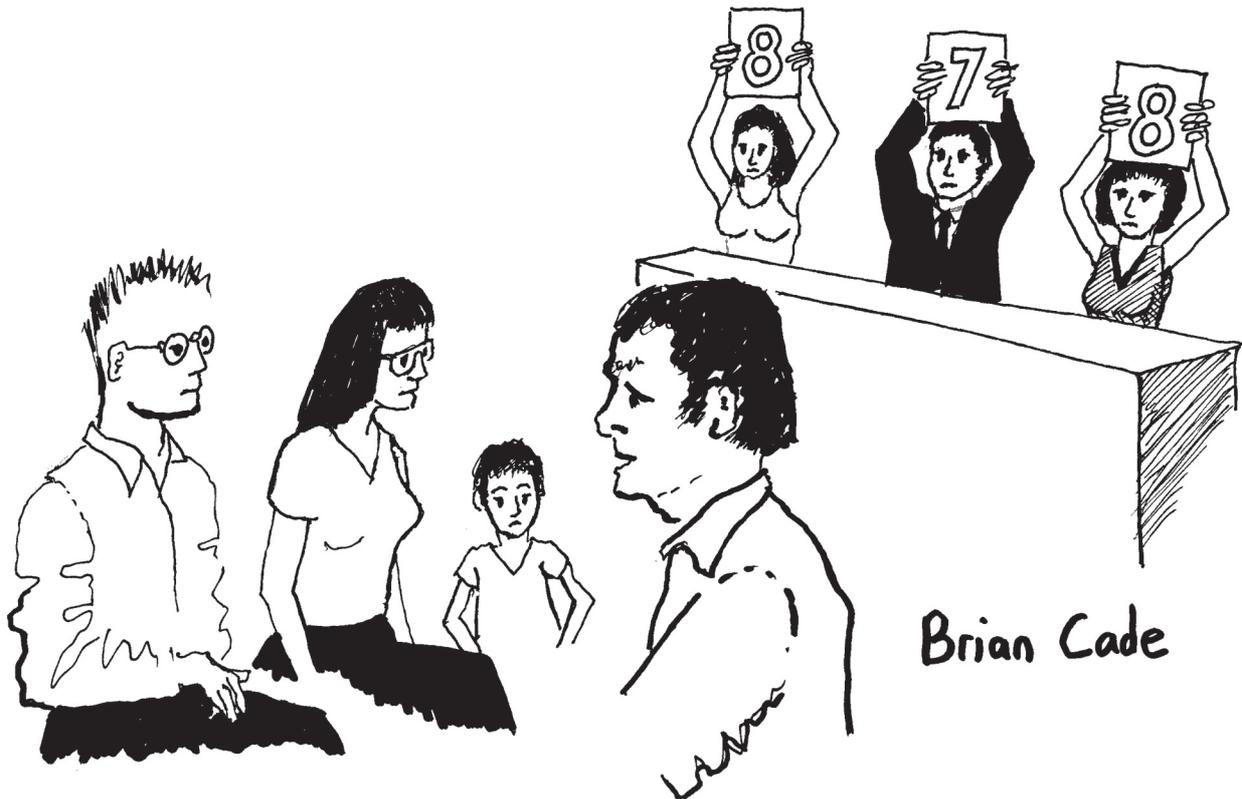
The work of the SCORE team started in 2005. The core team consists of Julia Bland (Chair), Emma Janes, Judith Lask and me. We also had valuable previous input from Chris Evans and Anne Ward, statistical consultation by Sabine Landau and were recently joined by Niki Kern. We see the need for a measure of change in families during therapy that reflects current concepts

of what family therapy is trying to achieve, that is geared to the needs of the range of family therapy provision, and is free. There are no such measures available for practical use. There are political reasons for Family Therapy and Systemic Practice to be (and to be seen to be) committed to evaluating our practice. But the fundamental motivation of those involved is the ethical responsibility of therapists to know whether what they do is effective; what makes it effective when it is; and what stops it being effective sometimes.

different perspectives

Many therapists are willing to allow research into processes of therapy but not into outcomes. If I were being excessively blunt I would say that even this permission is sometimes qualified by provisos such as 'so long as it only uses qualitative methods' and 'so long as I don't have to do the research myself'.

From a researcher's perspective, the order might be different. A small digression: Some time ago there was an interesting debate about why some children are obedient and other are not. A battle developed between behaviourists and psychoanalysts about which theory had the best explanation. Eventually researchers examined the issue and found that all children are



It's a pilot outcome measure we're using called SCORE.

obedient in some contexts and disobedient in others. There was no phenomenon of the obedient and the disobedient child that needed explanation. A researcher will try to remember that it is advisable to establish the existence and nature of a phenomenon before investing in explanations of why it happens.

But we are systemic, so we expect the two directions of travel to happen in conjunction with each other. A developing spiral in which we have theories about what should work that directs us to the most fruitful areas to find out about their effectiveness; that feeds back to refine our questions about which aspects are most worth building into practice; then investigating the newer practice and so on. Which is how the SCORE project is evolving.

what is SCORE?

It is not a measure of cure, nor is it a specification of the perfect family. It provides family members with a way of saying how satisfied they are with a variety of indicators of family functioning. We have chosen the indicators, in the form of simple descriptions, for those areas that therapists and the literature have indicated are important in enabling families to handle the difficulties they encounter. If therapy puts them in a better position to cope with the serious problems that bring people into therapy, then the SCORES they provide should indicate this effect.

So how far have we got? We researched existing measures of family functioning and therapy progress, identified five dimensions of family functioning that we wanted to cover, and created a 16 item version of SCORE to pilot. That version was circulated widely, researched in various ways and then we created a 55 item version to give us scope to discover how the scale functioned and which items work best. Early research included an intensive qualitative study with experienced family therapists which gave us valuable ideas about how it could be used clinically, as well as research issues to consider. Other therapists simulated responses by members of families they were seeing in therapy, which produced substantial differences in response between those that were doing well and those who were struggling. A 'users group' provided reactions about its usability and acceptability. It was administered to non-clinical families who almost invariably found it acceptable, often offering them interesting insights about their own families. Independent ratings of their level of family difficulty, that they provided on a more qualitative part of the questionnaire, correlated significantly with their SCORE average.

Encouraged and informed by these various trials we eliminated 15 of the less acceptable or uninformative items and are now in the process of a formal research project using the remaining items in the SCORE40. We have many colleagues collaborating to generate data but despite obtaining national ethical approval in 2006 many are still bogged down in getting local R&D and ethical approval. We need data from at least 200 families for this stage, and so far are only half way towards that total. HELP!

If you would be interested in participating in this stage, do please email directly to Emma Janes for more information Emma.Janes@slam.nhs.uk

the future

As soon as we have the definitive version, we will proceed to having it used in two ways. To see how the scores change during therapy, which will be part of the validation process; and to explore its clinical uses in collaboration with family members during therapy.

Current developments include an international dimension. Alan Carr in Dublin has a number of projects that will give us valuable information about how SCORE40 works in other clinical settings. At the recent EFTA meeting in Helsinki we set up a framework for a collaborative European project. We already have the SCORE translated into Greek, German, Spanish, Norwegian and Spanish. Also in June we presented the SCORE at the Society for Psychotherapy Research conference in Barcelona and laid the foundations for a wider international collaboration. Closer to home we are exploring collaboration with the CORE project, and setting up a non-clinical sample with demographics to match the clinical sample so that we can make a direct comparison.

We are hoping that, having read this far, you will have spotted ways that you might want to consider becoming involved, so do please email me with comments and offers. You might even have ideas about an objective not mentioned so far: of getting funding, which will be essential to get the validation stage completed to a high standard.

Further detail and updates about the SCORE project are on the AFT website www.aft.org.uk

Reference: Banksy (2006) *Banksy: Wall and Piece*, Century, London.

Peter Stratton, Academic and Research Development Officer. E-mail: p.m.stratton@ntlworld.com



Your chance to influence NICE about what matters to you

peter stratton

The National Institute of Health and Clinical Excellence, the body responsible for NHS clinical practice guidelines and health promotion, has a continual process of review. The process works by NICE first announcing consultations on the scope of what each set of guidelines will cover, then issuing draft guidelines for comment before announcing final recommendations. AFT has successfully influenced previous NICE activities to take more account of systemic and family concerns. Invitations to contribute often come with short notice. AFT wants to be better prepared to respond quickly, and is creating a register of members with relevant expertise who are willing to contribute to NICE consultations.

This is an invitation for you join the AFT register, and to provide brief details of your areas of particular experience and interest.

What would this let you in for? You would be contacted if there was NICE activity relevant to your area of interest. NICE is in danger of overlooking important issues without our input. For example their initial scoping of trauma made no mention refugees or asylum speakers; the draft guidelines on changing behaviour for better health did not mention families.

Sometimes NICE forgets to consider important research. They are willing to be reminded.

Please consider whether you could offer some help. Maybe in one of NICE's current topics for review? These include:

- Borderline personality disorder
- Looked after children
- Mental wellbeing in secondary education
- Alcohol use disorders in adults and young people
- Mental wellbeing and older people
- Management of long-term sickness and absence
- PSHE and promoting mental wellbeing at work

Or in an area of your choice that NICE might in future review or revisit?

Please help AFT increase its effectiveness by e-mailing your name, position, and area of interest and experience to the AFT office. E-mail: s.kennedy@aft.org.uk

When something relevant to family therapy and systemic practice is taken up by NICE or another government agency, we will invite those who have registered the relevant interest to join a small group. We will then provide support to coordinate their response.

THANK YOU

AFT news

AFT

The Association for Family Therapy & Systemic Practice in the UK

Notice of Annual General Meeting

The 33rd AGM will take place on Friday 12th September 2008 at the Midland Hotel, 16 Peter Street, Manchester, M60 2DS

from 5.30pm to 6.30pm.

The Agenda and Reports will be available on the members' area of our website from 15th August 2008 and at the AGM. If you require a paper copy in advance of the AGM, please request this by email to s.kennedy@aft.org.uk or by letter to AFT, 7 Executive Suite, St James Court, Wilderspool Causeway, Warrington, WA4 6PS, or telephone 01925 444414

A nomination paper to stand for the Management Committee and proxy form can be found on the inside back cover of this magazine. We have one vacancy for an ordinary member.

Branches Update

The Branches Committee met in London on the 15th May. Despite the fact that no trains were running into London Euston that day from the North, there was still a good turnout. Following the successful *Roots, Shoots & Branches* article on Branches in the April issue of *Context*, the Branches Committee felt that you might like to see the ballad overleaf prepared by one of the Branch Representatives to explain a little more about the Branches committee and the work of the Branches. If you would like to know where your local Branch is please see the Branches page of the website: <http://www.aft.org.uk/about/branchlist.asp>

roots, shoots & branches ballad of the branch reps meeting

Some of us are struggling from miniscule beginning,
Some well-established branches offer – ‘We can lend a hand’,
But whichever branch, this multiverse community is winning,
A mutually supportive group makes for a stronger stand.

Chorus

Coz roots, shoots and branches grow
And sap runs sweet,
Our far-flung colleagues we can know
When branch reps meet.

When branch reps meet Shan takes the chair and keeps
the conversation
Both structured so we reach decisions, loose enough to
see
If some alternate knowledge can impact upon an issue
And make a space for reps to show some creativity.

chorus

When it comes to training we’ve a smorgasbord on offer,
Cooklin went to Kent, and also Dorset in the West,
Hants had Gary Robinson and will be hosting Epston
As will Sussex, whose first meeting Stratton had
impressed.

chorus

And many other training days are held in all the branches,
Jenkins, ADHD, Context authors and much more,
Wherever you are in the country, something is on offer –
Just click AFT website – ‘Branches’ – and see what we
have in store.

chorus

Kate and Viv are stepping down as Branch Reps on the
Board,
Ian Lea takes Kate’s place now, Angela Markham, in the
Fall,
Will substitute for Viv; we hope this staggered changing
over
Will be good for continuity as they speak the views of all.

chorus

Mindful of our feedback loops, for good communication,
Shan informs and will inform on national/board news,
Freeing up for Ian and Angela bottom-up presentation,
To scroll the roots and shoots; express at Board the
Branches’ views.

Chorus

Coz roots, shoots and branches grow
And sap runs sweet,
Our far-flung colleagues we can know
When branch reps meet.

Margaret Henning

Sussex AFT

Registration Committee Update

2008 CPD Review

Thank you to all Registrants who have returned their CPD paperwork promptly and provided the relevant information. If you have not received a letter from me you can assume that all is well with your submission and we will not carry out another review until 2011. Please remember to ensure that you keep good records of training undertaken plus other aspects of CPD.

From this year’s review it has been noted that many CRB checks did not include a check for children and vulnerable adults. It was clear that some HR departments did not request this although as a family therapist this is necessary as children may be seen even in adult services. Please could you advise your HR accordingly. For those only in private practice there has been a change in the process of obtaining checks. The previous system is not available and we now ask for the Scottish Disclosure which can be done on line.

Most registrants had included a letter from their supervisor but a number were not signed. This is essential for obvious reasons.

From time to time the Registration Committee faces issues which require discussion and policy decisions. The committee is guided by three main principles

- Protection of the Public
- Supporting good provision through effective supervision and CPD
- Creating systems that are effective, achievable, inclusive and fair to all concerned.

There is also an additional incentive for robust registration procedures. That is to ensure that our register is fit for transfer to HPC (Health Professions Council).

Over the past two years a number of decisions have been made and although they have been communicated individually via *Context* we hope that it will be helpful to gather them together in the form of answers to frequently asked questions.

One big change has been the move to three-yearly review of CPD. Renewal of registration will depend on successful completion of the review. This will entail submitting evidence of CPD activities, insurance cover, supervision arrangements and appropriate Criminal Records Bureau checks. It is essential that our processes are robust. The plan is for psychotherapists to be regulated by HPC (probably within the next three years) and we hope that the current voluntary register will be seen as robust enough for those on it to be transferred as a group to the new system. In the process of our review any concerns about aspects of registration (e.g. an ongoing complaint) may lead to a request for a further review within the three year period and the committee reserves the right to ask for this.

frequently asked questions

What are the rules about the kind of supervisor acceptable to AFT?

There is no firm rule at present that supervisors need to be on the AFT Register of Supervisors although this is highly recommended. All supervisors should be registered with UKCP in the FCSST Section. However family and systemic psychotherapists who have been on the register for three years can have part of their supervision with psychotherapists registered in other sections of UKCP although the majority should still be systemic.

What happens if I think my supervisor is well qualified to offer supervision but is not on the UKCP Register?

A CV of the supervisor should be submitted to the Registration Committee and a decision will be made about the suitability of the supervisor.

Can I have peer supervision?

Anyone can have as much supervision and consultation as they want but there must be sufficient supervision to fulfil AFT requirements. Peer supervision can be counted if you have been on the register for three years but if this is used to fulfil the supervision/consultation requirements the group must be small enough and meet for long enough to ensure that each member has time to regularly present and the group should arrange an annual external consultation to the work of the group and the name of the external consultant should be submitted at the time of the three-yearly CPD review.

Can I have telephone or e-mail supervision?

It is recognised that this is sometimes necessary as a substitute for face to face supervision and consultation but at the moment and with current technology the committee do not see it as equivalent to face to face supervision. For other than occasional telephone and e-mail supervision a request and underlying rationale should be submitted to the Registration Committee. This request is only applicable if telephone/email supervision is to be used as part of required supervision hours for UKCP registration.

How soon after qualifying can I apply for registration and what is the limit?

Qualified family and systemic psychotherapists can apply for registration immediately following qualification and should apply within three years of receiving confirmation of their award by the qualifying route. If the application is made more than a year and up to three years following the end of the course a further reference is required to cover the time between the end of the course and application for registration. Evidence of CPD for that time is also required. If the three year limit is exceeded, applicants will have to apply through the APEL route, unless there are exceptional circumstances in which case a request can be made to the committee for registration through the course route.

Do I need Professional Indemnity Insurance?

Personal professional indemnity insurance is recommended for all those on the register. It is essential for any registrants undertaking private clinical practice, private supervision or teaching. For registrants who only practice within their employment roles it is advisable for them to have an extended insurance cover such as that provided by Unite (previously Amicus). This will provide some personal cover if a complaint is made to the professional association. It is a requirement that the HR department provide a letter to confirm basic insurance cover. If there is no personal professional indemnity cover registrants will be asked to sign an undertaking not to do any private practice. All insurance should cover the registrant for the practice of family and systemic psychotherapy

How do I obtain a CRB check?

For those in employment CRB checks are usually organised by the employer. It is essential that these include work with children and vulnerable adults as

potentially a systemic and family psychotherapist can meet with any aged client. At the moment it is not possible for those working only privately to get a CRB check and we require that they obtain a Scottish Disclosure. This can be done on-line. At the moment the various rules relating to CRB checks are being renewed. We ask all those practicing privately to ensure that they have a check every three years. For those in employment where employers have not renewed the CRB we require a letter from the HR department to say that they are satisfied with the current CRB situation.

What if I have to have a break from practice or from the register?

Registrants may have a gap of three years from practice or the register at the discretion of the registration committee. Registrants must advise the registration committee of this intention and thereafter annually confirm the situation. When registrants begin practice again within that three years they should let the committee know how they are planning to progress their CPD. If registration has lapsed for more than three years a full application for registration will have to be made.

What if I am unable to complete my CPD for a particular year?

CPD is assessed over a three year period so a shortfall in one year can be made up in subsequent years. Any special circumstances should be communicated to the committee for consideration.

Can I apply for UKCP registration if I work outside the UK or have trained outside the UK?

UKCP registration is primarily for those working in the UK and it is difficult to deal with complaints for those working outside the UK. However if someone has trained in the UK and intends to return to work in the UK or is working with UK clients in other countries, it may be appropriate to apply for registration via the overseas route or accredited course route (within three years of qualifying) please see above. For those who have trained outside the UK and wish for registration in order to work in the UK then an application should be made via the overseas route. There should be a clear statement of why this registration is required. For those who have trained in the UK and intend to practice in another country, the association can provide a letter to state that if the person remained in the UK they would be able to register. Up to three years following this a therapist could apply for registration if they moved to the UK but would have to demonstrate that they had completed all necessary CPD. After three years they would need to make a full application via the overseas route.

Can I continue to supervise if I give up clinical practice?

It is expected that most supervisors will continue to practice as well as supervise but if someone has supervised and done clinical practice for ten years they can apply to the committee to re-register whilst only doing supervision. This is in recognition that some therapists may give up clinical practice at retirement and beyond but still have a great deal to contribute as a supervisor.

We hope this clarifies some issues but for any exceptional circumstances please contact the committee. Not only are these rules a protection for the public but also they protect the therapist.

Judith Lask on behalf of the Registration Committee

Dear all,

I hope you are enjoying the Summer (and the Winter) for those readers on the other side of the World.

I went to Helsinki to attend a meeting of the National Family Therapy Organisations who are in EFTA (European Family Therapy Association) in June, which was a very interesting and enjoyable experience. I did not find anything equivalent to the delicious custard tarts that we had in Portugal at the IFTA (International Family Therapy Association) Conference, but the breads were delicious. I am wondering what we will find at the Manchester Conference, a slice of Manchester tart or Eccles cake I hope.

On a serious note, EFTA would like to work more closely with us and use our expertise to support developing countries by sharing our training and professional policies and procedures with them. EFTA is financially quite poor as the contributions of some countries are very low due to their financial economies. The NFTO chamber members were asked to encourage our own members to join EFTA as individual members. Details of how to join and the costs are given on the EFTA website www.eftacim.org Individual members receive a subsidy on the EFTA conference and the European family therapy passport which offers access to periods of training in centres that are participating in the programme. However, I feel that those who choose to join would see this as an altruistic gesture given that European families need as much help as our own and yet the expenses of running EFTA are greater because of the geography. I will leave this request with each reader.

Logically we can not draw the line under European children and

families, but need to look towards greater collaboration with IFTA (the International Family Therapy Association). All of this whilst not taking our eyes off our own AFT finances and developments in the UK.

The AFT National Conference is now fast approaching and delegate places are filling up fast, so do book soon. We will hold our annual general meeting (which is open to all members not just conference delegates) from 5.30pm to 6.30pm on Friday 12th September. A nomination paper to stand for election to the Management Committee is on the inside back cover of this issue and we have one vacancy for an ordinary member. We welcome new people onto the Management Committee (Board of Directors and Trustees as we usually refer to it) so do think about applying. The Board is crucial to the decisions that are made about your organisation and for the future of the profession. We normally meet four times per year and have lots of e-mail communications too. There are lots of changes happening with new Government Initiatives, the 'family' being very prominent in these initiatives and we feel that we should use our expertise with families to shape strategy for the future. We need to embrace the profession of psychotherapy, but also the whole range of service providers and people who work with families. Statutory regulation is another big issue we are facing and the relationship between UKCP and the HPC (Health Professions Council) is still uncertain. I do encourage you to read the annual reports from committee chairs and Board members to get a clear picture of the work that is being undertaken. There is a tension between doing lots of proactive work i.e. dealing with

the government's endless changes, safeguarding the systemic model against the runaway juggernaut of CBT, but keeping enough money in the bank to ensure there is an association when I end my term as Chair. There is a sense of cut down and cut back as we go through the financial upheaval, though this is the time we need to be developing. We are therefore putting the membership fees up slightly because we have come down on the side of being proactive. I hope members will agree with this action.

To reduce printing, postage and paper costs we are placing the annual reports and papers on the 'members' area of the AFT website www.aft.org.uk, but if you would like a paper copy posted to you please let us know.

I would also ask you to read the revised Code of Ethics that is printed in this issue. All members are asked to abide by the Code of Ethics and you may find some of the content helpful to your practice.

I look forward to seeing many of you in Manchester and for those who can't make Manchester this year, please note in your diary that the 2009 AFT National Conference will be held at Robinson College, Cambridge from the 11 – 13th September.

Best wishes,
Dorothy Ramsay
Chair AFT

John Casson and David Steare gratefully acknowledge the contribution of Drew Bird, Dramatherapist, to their recent article *Involving Children Playfully in Family Therapy* in Issue 97 of *Context*.

London AFT

London AFT are looking for facilitators for future events and would welcome interest from first time or experienced presenters.

London AFT invites you to get together with another systemic psychotherapist in order to present in the 'conversation format'. This is a format for events that tend to be approximately two hours long, in a central London venue for an intimate audience of 20-30 people. The chosen topic is usually an aspect of practice or a client group with which the facilitators have experience. A small fee is payable to the presenter. For more information or to send us your suggested topic in no more than 250 words please contact Victoria or Vasiliki at: victoria.georgopoulou@swlstg-tr.nhs.uk or vchryssikou@yahoo.com

We look forward to your ideas!

calling all AFT members in london

Do you have ideas that you would like to turn into action? Are you interested in shaping London AFT events? We are currently looking for people to join us on the LAFT (London AFT Branch) Committee.

If so, please contact Vasiliki Chryssikou at vchryssikou@yahoo.com



AFT

**AFT 33rd National Conference 2008
in association with Manchester AFT
12th and 13th September**

**“Linking the Old and the New: regeneration within
therapies and therapists”**

Day Delegate places still available

Friday £85 (students £60)

Saturday £85 (students £60)

Please Hurry: Last date for booking 28th August.

Visit the website for the full programme

<http://www.aft.org.uk/training/conferences.asp>



International Family
Therapy Association
Founded in 1987

XVII

**World IFTA Congress 2009
Slovenia, March 4-7, 2009**



Congress Theme: Reconciling Differences: Can Family Therapy Help Heal the World?

Topics

- | | |
|--|----------------------------------|
| <i>Abuse /Violence</i> | <i>Mental Illness/Health</i> |
| <i>Couples</i> | <i>Research</i> |
| <i>Death/Loss</i> | <i>Spirituality</i> |
| <i>Infidelity</i> | <i>Substance Abuse/Addiction</i> |
| <i>Legal/Courts</i> | <i>Training/Supervision</i> |
| <i>Medical/Physical/Collaborative Care</i> | <i>Trauma</i> |

**For further information visit our website:
www.paragon-conventions.com/ifta2009**



Paragon Conventions
18 Avenue Louis-Casai, 5th floor
1209 Geneva, Switzerland
Tel: +41 22 7477930
E-mail: ifta09@paragon-conventions.com



WHO'S THE EXPERT? SOLUTION FOCUSED FAMILY THERAPY -

Friday 3rd October 2008

Cost: £110.00

Chris Iveson: Co-founder of BRIEF, the UK's leading brief therapy clinic and training centre.

Solution focused family therapy focuses on future possibilities and the histories that support these. It requires an entirely different language to the language of problem definition and resolution.

This workshop will be a fast-paced lesson in the constructive application of language to the creation of new possibilities in family life. Participants will find the simplicity beguiling and the practice both professionally and culturally challenging.

SYSTEMIC INTERVIEWING, THE THERAPEUTIC RELATIONSHIP AND THE DEVELOPMENT OF THERAPEUTIC STYLE -

Friday 17th October 2008

Cost: £110.00

John Burnham: Consultant Family and Systemic Psychotherapist; Director of Systemic Training, Parkview Clinic, Birmingham.

Dr Barry Mason: Chair of the Supervision Programme; Co-Chair of the Doctoral programme, The Institute of Family Therapy.

This workshop will present the interviewing techniques that have been developed and written about by John Burnham and Barry Mason. They will place these ideas in the context of their thinking about the therapeutic relationship and explore how the self of the person influences the self of the practitioner and their therapeutic style.

ATTACHMENT NARRATIVE THERAPY -

Monday 20th & Tuesday 21st October, and Thursday 20th & Friday 21st November 2008

Cost: £340.00

Dr Rudi Dallos: Course Director, Clinical Psychology Doctorate, Plymouth University.

Dr Arlene Vetere: Deputy Course Director, Clinical Psychology Doctorate, University of Surrey, Guilford.

This four day workshop aims to provide participants with grounding in attachment theory across the lifespan, with reference to cultural universals and specifics. It will also provide an understanding of how attachment theories and systemic theories have been integrated in mainstream clinical practice with families and couples. Participants will be introduced to Attachment Narrative Therapy (ANT) and will be invited to consider their own clinical work within the ANT framework.



INSTITUTE OF FAMILY THERAPY

Preventing family breakdown, enhancing family strengths

THE QUESTION OF GOD IN THE MIND OF CHILDREN -

Friday 14th November 2008

Cost: £110.00

Organised by the Centre for Child Studies at the Institute of Family Therapy.

Archie Smith: Professor of Pastoral Psychology and Counselling, Pacific School of Religion; Graduate Theological Union, Berkeley, California; Ordained American Baptist Minister; California Lic. MFT.

This workshop will address questions of God, spirituality, faith and meaning-making in particular contexts. It will draw on CS Lewis and Freud amongst others as representing different ways to think about experience and root metaphors across cultural, age (or life stage), social-economic and gender difference.

The Training Department, Institute of Family Therapy, 24-32 Stephenson Way, London NW1 2HX

Tel: 020 7391 9150

Fax: 020 7391 9169

email: ift@psyc.bbk.ac.uk

or visit our website at:

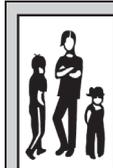
www.instituteoffamilytherapy.org.uk

Registered Charity no: 284858

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per annum FTE, according
to experience



THE ANNA FREUD CENTRE

We are looking for a creative and motivated Family Therapist to join The Anna Freud Centre's Court Assessment and Family Support Services. The Centre is a registered charity based in North West London, dedicated to the emotional well-being of children. It has an international reputation for the development of methods of assessing attachment relationships.

This is an exciting opportunity to contribute to two multi-disciplinary team services based at the Centre. The Court Assessment Service provides in-depth assessments of families in care proceedings. This specialized service focuses on complex cases where a parent has a potential diagnosis of personality disorder. The Centre's Family Support Service offers interventions for families with a child or young person experiencing difficulties due to emotional and behavioural problems. The approach (Mentalizing Based Family Therapy) integrates systemic, cognitive and psychodynamic therapies. Full training and ongoing supervision will be provided.

The post will give the holder the opportunity to offer in-depth assessments and brief clinical interventions and to work with highly experienced practitioners on developing innovative interventions with personality disordered parents and their children.

For an informal discussion please contact Minna Daum, CAS Co-Manager on 020 7794 2313 or minna.daum@annafreud.org

Application packs should be downloaded from www.annafreudcentre.org

Closing date for applications: 9.00 am Monday 15th September 2008

Interviews will be held on the afternoon of Tuesday 23rd September 2008

New Training Courses at the Anna Freud Centre Autumn/Winter 2008



The Tavistock and Portman
NHS Foundation Trust

Integrative Multimodal Practice with Troubled Adolescents

A 2 Day Introduction
9th-10th October AND 4th-5th December 2008

Provides an introduction to Integrative Multimodal Practice (IMP), which is an innovative manualized approach to outreach work with hard-to-reach multi-problem adolescents. IMP uses an attachment framework and proposes a practitioner specifically trained to work with multiple treatment modalities, bridging many of the 'dis-integrative' forces that these patients and their families face, supported by a robust supervisory framework. Theory and basic tools from this approach are introduced.

Trainers: Dr Peter Fuggle and Dr Dickon Bevington
Attendees: There will be 40 places on each course
Price: £400
Bookings: Will be allocated on a first come, first served basis.
To reserve a place on a course please email course.enquiries@annafreud.org stating which dates you prefer.

Interpersonal Psychotherapy Training 1 & 3 day course, 3rd-5th September 2008

The aim of the course is to provide experienced mental health professionals with an introduction to the IPT model, and how to apply the IPT approach to patients with depression. The 1 day course will cover the knowledge and research base of IPT with an introduction to some basic clinical skills whilst the 3 day course is an additional 2 days focusing on clinical practice of IPT.

Trainers: Dr Alessandra Lemma, Dr Roslyn Law and Professor Anthony Bateman

Attendees: There will be 50 places on the 1 day course, and 24 on the 3 day course
Price: £200 for 1 day course, £600 for 3 day course
Bookings: Will be allocated on a first come, first served basis. To reserve a place on the course, please email course.enquiries@annafreud.org

To find out more about these courses and all the training opportunities available at the Anna Freud Centre please visit www.annafreudcentre.org.

AFT advertising from £150

Reach family therapists and related professions

Members of AFT and subscribers to Context include teachers, social workers, child and adult psychiatrists, psychologists, psychotherapists, occupational therapists, community psychiatric nurses, mediators and family court welfare officers, guardians ad litem, health visitors, counsellors, students and those who train and manage these professions.

3 ways to advertise

- **Context** – published bimonthly in mid-April, June, August, October, December and February (Advertising deadlines one month before publication)
 - **www.aft.org.uk** – advertise at short notice*
 - **Mailshots** – direct to AFT members, timed to suit your advertising needs
- *Print adverts include a free listing on aft.org.uk

For further information or to discuss your advertising requirements please email Louise Norris: l.norris@aft.org.uk



UNIVERSITY
of DERBY

Derbyshire AFT

The 'for a tenner' series

ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD): THE GOALS OF MISBEHAVIOUR

Thursday 20th November 2008 9.30am - 4.30pm

A whole day event focusing upon systemic thinking and practice in relation to ADHD. We will explore ideas relevant to parents and to practitioners within Mental Health, Education, Social Services and the Voluntary Sector. The day will provide an introduction to ADHD and will explore medical and non medical narratives relating to prevalence causality, treatment and support.

Facilitators: Gary Robinson, Family Therapist, and Natalie Alleyne, Educational Psychologist plus the DAFT Committee.

Cost: A tenner! (£10) **Free** to parents who have a child with a diagnosis of ADHD.

Venue: Heap Lecture Theatre, University of Derby, Kedleston Road, Derby.

Booking: To book a place, please complete and return the slip below with your cheque. We are unable to send invoices, but can issue receipts if requested. Confirmation of booking will be sent via e-mail unless alternative address is specifically requested.

For more info e-mail Sue.Cousins@DerbysMHServices.nhs.uk or ring 01773 882505
Lunch and refreshments will **NOT** be provided, however, a range of facilities are available at the University.

Name:

E-mail:

Please reserve a place for me on the DAFT day workshop on 20th November 2008. I enclose a cheque to the value of £..... payable to Derbyshire Association of Family Therapy. Please send this slip with your payment to: Sue Cousins, Derbyshire Association of Family Therapy, c/o Rivermead, Goods Road, Belper, Derbyshire. DE56 1UU

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