

[In Lightburn, A. & Sessions, P. (Editors). (in press). The handbook of community-based clinical practice. New York: Oxford University Press.]

Family and Network Therapy Training for a System of Care: “A Pedagogy of Hope:”

Mary E. Olson, Ph.D., LICSW

There is a growing consensus that American graduate and professional schools have failed to keep pace with the changes in community mental health. For more than a decade, there has been a national reform of public services based on the concept of a system of care. Yet, according to a research study by Meyers, Kaufman, and Goldman (1999) new graduates of professional schools are entering the workforce without the knowledge, skills, and attitudes that reflect the values and principles of the reform. These researchers say there is an absence of knowledge among educators about the community care movement and an adherence to traditional office models. This situation also reflects the fact that the system-of-care proponents have just begun to suggest the linkages between their philosophy and clinical models. Postmodern, dialogic and narrative approaches from the family therapy tradition represent parallel and congruent clinical advances. These therapeutic models are inspired by the same values and principles as the system-of-care framework.

This chapter will present a training curriculum that was developed by the author. It has been taught as an advanced master's-level course at a graduate school of social work. Parts of this curriculum have been the basis of presentations to community agencies and hospitals and of postgraduate workshops and courses. Some of the material was developed originally in collaboration with Carlos Sluzki, M.D. and other senior faculty at the Family Center of the Berkshires, during the years 1990-1995 when the author directed the Clinical

Externship in Systemic Family Therapy. This curriculum has been used successfully in a variety of settings and with trainees from a variety of clinical disciplines including social work, psychology, psychiatry, nursing, and family medicine.

The collaborative frameworks for family therapy prepare future mental health clinicians for network-oriented therapy, also called “communal practice”. The relevance of this training for working in a system of care has been reinforced by recent research suggesting that community practitioners are beginning to use postmodern ideas eclectically in therapy and case management (Collaborative for Community & Family-based Practice, 2001). This way of working is consistent with the four areas of competence that Meyers et al. (1998) specify for therapists operating in a system of care: systems thinking, family-professional relationships, cultural competence, and interprofessional education and training.

<1>A System Of Care

In the US, the concept of “a system of care” has gained strong credibility among researchers at the Center for Mental Health Services, the Child and Adolescent System Program (CASSP), public health policymakers, and many clinical administrators. It is a response to the widespread and alarming absence of effective mental health services for severely disturbed children and teenagers and their families (Stroul & Friedman, 1986; Coffey, Olson & Sessions, 2001). A recent study of nine, new community-based programs in Massachusetts examines the paradigmatic initiatives that are occurring throughout the US (Lightburn, Olson, Sessions, & Coffey, 2002).

A system of care is a service delivery system that seeks to provide a broad, comprehensive, and integrated continuum of care, in contrast to the traditional spectrum of

clinic-based child and family therapy, medication; and if these fail, hospitalization or other out-of-home placements. The hope of the new system is to help troubled children stay with their families and recover in their communities where they will continue to live and grow. A system of care ideally comprises an integrated array of services in the areas of mental health, education, medical care, child protection, substance abuse treatment, juvenile justice, vocational training, recreational activities, and case management. It goes beyond traditional therapy by expanding the definition of mental health care and including a range of supports to the family in a variety of life domains.

Further, there are strong emphases on coordinating the responses and resources of the various helpers and giving the family a voice in the treatment process. Therefore, the network of providers meets with the family regularly to develop the care plan and discuss progress toward common goals. This approach adapts the services to fit the child and family, rather than inserting people into a pre-existing menu of services (Burchard, Bruns & Burchard, 2002). Within the system of care, the term “wraparound” is used to describe this process of tailoring the services to the particular “needs, strengths, and culture” of a family.

The system of care is not only a network of services; it is a philosophy (Stroul, 2002). The values and principles that guide this reform are known as CASSP principles. They include (1) a non-pathologizing, or “strength-based,” orientation; (2) partnership with families; (3) inter-agency collaboration and coordination with the family; (4) the inclusion of social networks; (5) cultural competence; and (6) individualized plans with flexibility to change as families change. This philosophy is the scaffolding of the system. While it is easy to see

that there are therapeutic implications of this philosophy, its developers propose a definite distinction between service delivery and treatment. Seen this way, a system of care is a proposed framework for delivering treatment; it does not constitute treatment itself.

In light of recent, renewed calls for reform of youth services, (U.S. Public Health Service, 2000), Beth Stroul (2002), who originally formulated the system of care concept, has re-examined the philosophy. She makes the point that there are confusing myths that have grown up around systems of care: namely, that clinical interventions are not a primary focus and nonprofessional service providers have greater value than professional clinicians. Stroul challenges these misconceptions and states that mental health treatment is still the primary service provided by the system of care. In this way, there is a clear mandate for community-based therapists to be able to operate effectively within this framework and do treatment that draws on the naturally occurring resources of the family and social network. Traditional, expert, deficit-oriented, individual or family models are in deep tension with this reform. The following curriculum not only provides training in clinical models that share the premises of a system of care but also introduces language practices that potentially can generate therapeutic dialogue in any part of the treatment system (Seikkula & Olson, 2003; White & Epston, 1990).

<1>The Case For Postmodern Therapy

In the past decade, the field of family therapy has witnessed the emergence of a new template for practice based on reflection and narrative, instead of strategy and intervention. There also are broader social and cultural frameworks, especially regarding gender and issues of social justice. The style of practice has evolved from a hierarchical one to

therapeutic conversation based on collaboration. The intellectual movements of postmodernism and feminism challenged traditional cybernetic and systems models and provided the seeds for new forms of therapy. This evolving tradition as a whole can be traced back to the communication research of Gregory Bateson and his colleagues in Palo Alto.

One of the distinguishing features of postmodern therapy is the stance of treating the patient and family as members of a partnership within a network that includes the professionals and anyone else connected to the situation (Seikkula et al., 1995). This approach thus enacts the collaborative stance advocated by the system of care philosophy. From the postmodern perspective, the family is understood as a group of people who all have been through similar, difficult experiences and share the need for reconstruing these experiences in language. This kind of therapy highlights processes of communication and strives to create a language in which everyone has a voice.

The postmodern philosophical framework says language and communication are primarily constitutive of human realities (Gergen, 1999). In this way, the therapeutic conversation can be a loom on which to weave or reweave the language for a problem or symptom. This process can either dissolve the situation or reduce its larger negative effects on a person's identity and future and those of the caregivers. Creating language that gives voice and agency in relation to difficult experiences has been shown based on case studies to ameliorate many different kinds of human problems and symptoms. Included are eating disorders, psychosis, depression, non-organic somatic symptoms, chronic illness, and the effects of abuse, violence, and trauma. (Anderson & Goolishian; 1986; 1991; Goldner,

Penn, Sheinberg, & Walker, 1990; Griffith & Griffith, 1994; Herman, 1992; Olson, 1995a; 1995b; 2000b; Penn, 2001; Seikkula, 2002a; 2002b; Seikkula et al. 1995; Seikkula & Olson, 2003; Sheinberg & Fraenkel, 2001; White, 1995; White & Epston, 1990)

There are four, basic clinical applications of postmodernism that are covered by the curriculum under discussion. Other material included in the course is beyond the scope of the chapter, and there is a burgeoning literature on postmodern approaches to which students are referred (Anderson, 1997; Hoffman, 2002; Olson, 2000a). The essentials of this training are the reflecting process of Tom Andersen of Norway (Andersen, 1987; 1991; 1995), the open dialogue approach developed by the Finnish team of Jaakko Seikkula, Birgitta Alakare, and Jukka Aaltonen (Seikkula et al., 1995; Seikkula & Olson, 2003), the narrative therapy of Michael White (1995; White & Epston, 1990), and the linguistic turn in feminist, multicultural, and social justice models (McGoldrick, 1998). While there are important differences among these approaches, all strive to transform social worlds by fostering new language and meanings. For discussion of the differences, see Hoffman (2002), Smith (1997) and White (1995).

Recent research on caregivers' accounts of psychiatric illness in their families underscores the need for this kind of work (Stern, Dollar, Staples, Szmukler, & Eisler, 1999). According to this study, two types of caregivers' narratives tend to emerge in response to a severe psychiatric crisis: stories of "restitution or reparation," and "chaotic and frozen" narratives. The former makes meaning out of the experience, whereas the latter tends to see the episode as a series of random events, suggesting a "narrative wreckage" or "narrative chaos." Stories that bring some narrative coherence enlarge people's coping

strategies, ability to find solutions, and sense of the future. As Stern et al. (1999) write, “...Befriending the incomprehensible in the psychotic experience was seen to be an important aspect of coping in restitutive accounts, placing the bizarre within a continuum of understandable human responses. Seeing the illness as an opportunity to give and receive was another significant element in these stories.”

Both the patient and the caregivers need to participate in a therapeutic dialogue that creates positive meaning and thus, hope. Michael White’s recent work (2003, August) shows that this can be achieved even with young children in foster care and adoptive families who have come from situations of extreme abuse and neglect.

Alternatively, it is difficult to reconcile traditional approaches that tend to view the caregivers principally as the locus of pathology with the aim of community care, which is to support parents in learning how to become competent partners in the recovery process of their child (Seikkula & Olson, 2003). A pathologizing discourse may weaken or disrupt the family’s ability to respond to the situation. Lukens and McFarlane (McFarlane, 2002) suggest this point when they describe how the concept of the “schizophrenogenic mother” was popular among professionals at a time when the movement toward deinstitutionalization was emptying state psychiatric hospitals of chronic patients. Many of these patients received little or no further treatment and were forced to return to their families for care. The families suffered under the conflicting injunctions that required them to take responsibility for the care of their ill member and to accept the stigmatizing blame that they were also the cause of the person’s condition. The newer postmodern therapies strive to reduce blame and guilt and increase the sense of agency, thus paradoxically,

maximizing the resources and “response-ability” of the patient, family, and helping network.

In this way, postmodern therapy has clear differences from the earlier family therapy models that consumer advocacy groups have widely distrusted because of the seeming implicit and automatic blame assigned to the family for their situation. Indeed, it is true that two of the older, classic models—the structural approach of Salvador Minuchin (1974) and his colleagues and the systemic approach of the Milan Associates (Selvini, Boscolo, Ceechin & Prata, 1978)--propose that the problem or symptom is a product of the family system or the family-professional suprasystem. These models reconfigure the process of therapy as a deliberate intervention into the underlying organization or logic, respectively, of the network of relations. Yet, this move to the social ecology has been critical to understanding people in contexts, rather than as “containers” of pathology.

In fairness, there are points of congruence between structural and systemic ideas and the system-of-care philosophy. Structural therapists were the first to bring in cultural awareness and a concern for marginalized group. Many ideas from structural therapy have been included in multi-systemic therapy that fits the system of care concept and has been quite successful in treating juvenile offenders with an emerging evidence base for other populations (Henggeler, Schoenwald, Bordiun, Rowland, Cunningham, 1998). Moreover, the Milan group’s idea of logical connotation is integral to postmodern approaches and congruent with a “strength-based” orientation. Logical connotation describes how a problematic behavior or symptom makes sense in a particular context of action and meaning (Boscolo, Ceechin, Hoffman & Penn, 1987). Nonlinear, contextual thinking tends to be

affirming rather than pathologizing and thus, consistent with the values of community care.

While these older approaches have contributed such enduring, brilliant ideas to the field, the influence of the actual treatment models has diminished for the same reason that these models tend to be incompatible with CASSP principles. The idea of an “out-there” system that can be changed by an expert makes the family the object of therapeutic action, rather than a partner in the therapeutic process (Seikkula & Olson, 2003). As Hoffman (2000) writes:

At first, mothers were to blame. Then therapists zeroed in on parents, who were seen as triangling the child into their own conflicts. The collateral kin group was next focused on, then the other helpers who might be entangled in a case. As time went by, the lens steadily widened, but the blame remained (p. 7).

In their original forms, it is the highly expert and authoritative nature of these earlier models and their view of the family as the source of pathology that make them dissonant with a stance of giving voice and agency and at odds with the new thinking in community practice.

<1>Teaching Methods For Postmodern Therapy

Education and training have distinct meanings within the clinical fields (Reich, 1998; Meyers, Kaufman & Goldman, 1998). Education refers to learning broader theoretical frameworks for practice and reflecting on values and principles. Although related, training tends to emphasize the development of specific skills within a particular model and the developing the capacity for knowledge in action (Pakman, 2000). Since the various frameworks are often new to students, these must be taught along with forms of

practice. In this curriculum, there is a combination of lecture material (education) and an interactive exercise (training), with each aspect recursively reinforcing the other. This is way of structuring training is widely used in the family field.

For instance, an opening ritual accompanies the first lecture and communicates the value placed on the experiential and interactive. The author typically asks participants to share a metaphor or image of transformation in the first class. This process generates symbolic language and fosters personal connections that contribute to the overall emotional atmosphere, while directing attention to a consideration of what creates positive change. In the following description of the various frameworks of the course, the first part of each section is a distillation of a lecture and the second part describes teaching methods, other than lecture, that use film clips, role plays, cases, and experiential exercises. Thus, students can see the complex and abstract theories brought down to earth and applied to actual examples.

The optimal length of this training in terms of producing a genuine shift in perspective and transferable skills is an intensive course or externship with a minimum of 40 hours of seminar or classroom time. In an agency-based externship, the teaching seminar can be enhanced by a clinical practicum where trainees see actual families. At the same time, the author has distilled these principles into 2-hour consultations resulting in an effective shift in a case. Without a much more in-depth experience of this curriculum, however, it is unlikely that trainees will be able to sustain these ideas from relatively brief

workshops. In the longer curriculum, each model identifies and develops particular clinical skills. The work of Andersen is an excursion into the principles of conducting a therapeutic conversation and how to use these language and communication practices to generate new possibilities within the family and network. Open Dialogue shows how this way of working can be adapted to acute psychiatric care, when supported by fundamental changes in the organization of the treatment system. Narrative therapy is a perspective and set of skills useful for stuck, chronic, “problem-saturated” situations. The social justice therapies are crucial in applying these same clinical methods to doing therapy in a multicultural and rapidly changing society.

<2> Bateson’s Ecology Of Mind

The starting point of this curriculum is the work of the anthropologist and biologist Gregory Bateson (1972, 1979) who produced the communication perspective that became the foundation for the field. Arguably an early postmodernist, Bateson’s thinking prefigured many contemporary trends and directly influenced many of the people who went on to embrace postmodern approaches to therapy (Hoffman, 2002). Even though Bateson draws on traditional systems thinking, his work anticipated the shift from the notion of an objective system to a dialogic system made and remade by words and stories.

Bateson argued that events in living systems require a different model from the scientific paradigm of linear and mechanistic causality that is appropriate for explaining the inanimate, physical world. He proposed instead to think of the living world as “mind:” that

is, as communicational processes constituted in the integrated network of the individual plus environment. For Bateson, this concept of mind as a communicational system is evident in all aspects of the organic universe: DNA is an informational script; the brain and nervous system operate on signals; and social processes are governed by patterns of language and communication. Bateson's analyses of social life hinges on the concept of an evolutionary ecology of communicative and recursive relationships. Communication and interaction are crucial, because it is the history of joint action of organisms and environments over time that creates natural and human worlds.

Bateson's thinking addresses both structure and communication, but the early family therapists interpreted the features of a system as an objective entity –a triangle or game-- that can be changed from outside (Watzlawick, Weakland & Fisch, 1974). This form of interventionism repelled Bateson and led to a split with his early followers (Bateson, Weakland & Haley, 1976). The publication of Bateson's articles in an anthology, Steps to an Ecology of Mind (1972), and of his final book, Mind and Nature (1979) made his ideas much more available to a broader audience who received them differently than the early pioneers (Olson, 1984). The new generation of family therapists responded to Bateson's notion of "an ecology of mind" and his profound distrust of an instrumental epistemology based on power and control (Hoffman, 1986).

Bateson (1979) says that human beings think in terms of "stories" or "little knots of relevance" (p. 13) that shape behavior (stories projected into action). In the tradition of

George Herbert Mead, Bateson anticipated postmodern, social construction theory by maintaining, that the mind is social; and therefore, the way we communicate with each other becomes an essential feature of the way we think. In this way, Bateson's theory of the double bind came from a theoretical attempt to imagine the kind of interpersonal and communicational context in which psychotic ideas and symptoms would seem adaptive (Bateson, Jackson, Haley & Weakland, 1956). It originally referred to a repeated pattern of communication within a life-important relationship where there were two different and mutually disqualifying levels of meaning about which one was forbidden to comment. (Nor could one leave the field without risking punishment.)

Subsequent writings by Bateson and his colleagues (1962) revised the original, dyadic formulation of the theory, and it is this later version that is one of the central organizing ideas of this curriculum:

The most useful way to phrase double bind description is not in terms of binder and a victim but in terms of people caught up in an ongoing system which produces conflicting definitions of the relationship and consequent subjective distress (p. 42).

While looking initially at patterns of message exchange, Bateson's followers like the Milan group (Selvini-Palazzoli, Boscolo, Ceechin, & Prata, 1978.) shifted to emphasizing the larger system of relations and conflicting patterns of meaning within a social group as a whole that generate these paradoxes. To some extent, everyone in a system may be affected, although the consequences are experienced most visibly and acutely by the person (s) who develop symptom(s). From a postmodern perspective, the double-bind situation

constitutes the kind of context that silences and disempowers people, resulting in loss of voice and onset of symptoms.

<3>Illustrating Bateson's Ideas

Film clips from the movie Shine (Scott & Hicks, 1996) have been used effectively to illustrate the double-bind theory. It is the story of David Helfgott, a gifted pianist who had a psychotic break in late adolescence. The scenes of David's childhood and adolescence portray the intense and conflicting injunctions tied to gaining outside recognition and leaving home in a Jewish family with parents who view the outside world as dangerous, having lost close family members in the Holocaust. Sketching this legacy of trauma and loss humanizes the parents' by placing their behavior in context, while showing the dilemmas emanating from their tragic experiences. Analyzing this film teaches implicitly the principle of logical connotation: the story of David renders his experience meaningful and supports the significance of narrative in making sense of his deterioration. Appreciating the entire context, including the cultural position of the parents, can foster an understanding of everyone involved and reduces the blame assigned to David or his family. Finally, David's recovery, although idealized in the film, shows how he builds an adult life despite its painful opening chapters, thus conveying a sense of personal agency in the face of enormous difficulty.

Another useful classroom exercise is reading transcript interviews as scripts. Excerpts from the clinical work of James Griffith and Melissa Elliott (Griffith & Griffith, 1994) form a useful bridge between Bateson's double-bind theory and postmodern therapy. Participants play the different parts and can learn how an experienced therapist conducts a

therapeutic conversation. Griffith and Elliott draw on a variety of important formats and ideas: the reflecting team, collaboration, a network orientation, techniques from narrative therapy, and an awareness of how culture, gender, race, and ethnicity can influence the problems people bring to therapy. Their emphasis is on life stories, rather than diagnostic categories or pathogenic systems, with special attention to double-bind communication, or what they call "unspeakable dilemmas." A gender premise, a family myth, or a religious system can produce an unspeakable dilemma, while silencing the kind of conversation needed to resolve it. The heart of this therapy is the telling of a person's story and giving expression to what was felt to be unspeakable in the presence of others.

Published interviews of this work read in class have included "When Patients Somatize and Clinicians Stigmatize: Opening Dialogue Between Clinicians and the Medically Marginalized" (Friedman, 1995). This example focuses on an isolated, homebound 12-year old girl and her depressed, divorced mother who participated in a joint meeting conducted by Griffith, Eliot and other medical colleagues. The girl had been evaluated for a sleep disorder, rheumatoid arthritis, and a variety of other health problems that the mother kept bringing to doctors but were not found to be present. This sensitive, interview, however, opened up a conversation about the daughter's unvoiced feelings of emotional paralysis. After listening to a reflecting team, both mother and daughter were able to see their situation differently, dissolve the medical focus, and express their concern for each other in a new and more constructive way that supported the daughter's desire for more independence.

It is important to teach the ideas and their applications, while simultaneously

encouraging trainees to develop their own perspectives and creativity. In an academic setting, one way of doing this is to ask students to keep journals on the readings and classes. Students are encouraged to write about how they would apply the ideas to cases from their field placements. The author also invites students to imagine applications outside the therapy office, e.g., in schools or a case management situation. Critiques of the ideas are also encouraged. The journals can serve as a set of written assignments for the course that helps students find their voices. Freire's (1971) concept of the midwife-teacher is one who engages the potential, creativity, and imagination of students. The author strives to incorporate this model both in the journal assignments and by encouraging collaborative dialogue in the classroom.

<2>The Reflecting Process

The work of the Griffiths introduces the reflecting process of Tom Andersen (Andersen, 1987; 1991; 1995). Originally using a format inspired by Bateson's ideas and advanced by the Milan Associates, (Boscolo, Ceechin, Hoffman, & Penn, 1987), Andersen moved from a hierarchical structure to a more horizontal one. The reflecting team is a simple and extremely important idea in the contemporary family field and has been adapted, in creative ways, to work with children and adolescents (Friedman, 1993). In its original formulation, a three-person reflecting team made up of professionals, sitting with the family or behind a one-way screen, listens to the conversation between the therapist and the family. The therapist then asks the family if they are interested in hearing from the team. If so, the team members reflect on what they have heard and have this conversation in the presence of the family. After the reflections, the interviewer asks the family to comment on

what the team has said. The family responds to the ideas that fit, and thus, gains a voice in their own evolution. The reflections of the team are speculative and nonprejudicial and tend to be comments that address, for instance, the family's dilemmas, emotional atmosphere, or future possibilities.

The reflecting team also draws on the contribution of the late psychologist, Harry Goolishian, who, with Harlene Anderson, argued that, above all, human systems are language based, created in and through dialogue (Anderson & Goolishian, 1988). Thus, therapy is a conversation, where new stories arise from the exchange. Alternating conversations foster "depth perception," an atmosphere of learning that allows the family to consider other perspectives. The reflecting process provides a format where the family can stand outside its situation and listen to different ideas about it. A new picture can develop with a new sense of alternatives (Andersen, 1987). Videos illustrating Andersen's approach include Dialogue and Dialogue About Dialogue (Andrew & Clark Explorations/Masterwork, 1992), Respecting Elders (Andrew & Clark Explorations/Masterwork, 1999), and Dialogues and Postmodern Connections: 3 Part Series, with Harlene Anderson (Andrew & Clark Explorations/Masterwork, 1999). The reflecting process is an important feature of both the open dialogue approach and narrative therapy, thus becoming a thread throughout the curriculum (Seikkula et al., 1995; Seikkula & Olson, 2003; White, 1995).

One way to teach the basic mechanics of a reflecting team is to do a role play based on a family invented by the participants. One group plays the family, and another group forms a reflecting team. The remaining students listen "as-if" they are family members who provide comments at the end (Anderson, 1997). It can be useful for the instructor to be the

therapist in the first interview, so students can learn from an experienced person. An alternative is to have a trainee rotate through the position of therapist with the instructor, it is hoped, as “an angel on their shoulder.” That is, the “therapist” can stop the interview at any time and consult with the instructor about what to say next.

In his recent work, Andersen (in press) has come to emphasize “open reflecting talks” in a variety of contexts. This kind of open-ended and participatory dialogue can be adapted easily to a classroom, workshop, research evaluation (Andersen, 1997), or other settings relevant to community care. Throughout this curriculum, we use the reflecting process with case presentations and the cultural genogram described below. The most effective experiences with the reflecting process seem to be when a trainee presents an actual clinical dilemma and other members of the class or workshop reflect on this real situation. There is an example of this kind of reflecting consultation at the end of this chapter. What has been impressive about this process is the way it changes the nature of our conversations about families. The collaborative format seems to energize participants, make them conscious of the effects of their language, respectful of families and of each other, and capable of hearing and sustaining multiple perspectives, thus inhabiting what Gregory Bateson (1972) called an expanded “ecology of ideas.”

<2>Open Dialogue

Drawing further on Bateson’s legacy and, in particular, Andersen’s idea of reflecting process, Open Dialogue is a network-based, language approach for severe, acute psychiatric crises. Pioneered in Finland, it is close to the idea of wraparound used in the US (Seikkula, 1995; Seikkula, Alakare & Aaltonen, 2001a; 2001b). While Vandenberg

(Vandenberg & Grealish, 1996), the originator of the wraparound, does not define his process as therapy, there are therapeutic ideas, such as “reframing” and “the strengths assessment,” incorporated into its design. Open Dialogue explicitly merges the distinction between planning and therapy and makes the “treatment meeting” the main therapeutic forum. There is a blending of dialogue and disposition in acute care. The implications of this model for a system of care are wide ranging. Open Dialogue shows that “transformative dialogue” may be possible in various kinds of settings not traditionally defined as hosting clinical interventions (Gergen, 2000). In the US, there is growing interest in Open Dialogue as the equivalent of a “wraparound” crisis intervention model within a system of care.

Open Dialogue was developed at Keropudas Hospital, a traditional, combined psychiatric inpatient and outpatient setting in Western Lapland. Following Alanen (1997), the Keropudas group began to have a treatment meeting in advance of any kind of therapy when earlier attempts to do family therapy failed in the hospital system. Its basic format is to bring together the person in acute distress with the team and all other important relations - relatives, friends, and other professionals - connected to the crisis. Dedicated to giving immediate help, the meeting occurs within twenty-four hours of the initial contact. It is organized by a mobile crisis team composed of outpatient and inpatient staff and takes place, if possible, at home.

The treatment meeting was conceptualized initially by the Keropudas group as a way to minimize the occurrence of double-binding transactions in acute settings (Seikkula

& Sutela, 1990.) A brief excursion into a separate, ethnographic study of the experience of head-injury patients (Krefting, 1990) will make this point clearer. Krefting's research illuminates the kind of communication difficulties that the Finnish team independently noticed occur in the treatment system of youth with psychiatric problems. There tend to be repeated patterns of conflicting messages from different sources: the family, the social network, the professional health care system, and the vocational rehabilitation system. There also tend to be pervasive social directives for independence and the contradictory messages of dependence. In what we can see as an analogue to psychiatric care, Krefting writes: "[many] of the double binds experienced by the head injured are created by pressures from community norms and expectations, rather than specific people" (p. 864). Even so, professionals can be powerful generators of conflicting meanings. With the organic impairment of the head injured, they often have little chance of accommodating, cognitively, their complex set of contexts. As a result, "common behavioral problems noted... include concrete thinking, angry outbursts, paranoia, and loss of trust of caregivers" (p.861). The double-binding transactions appear to exacerbate emotional difficulties and preclude the occurrence of more positive alternatives. In contrast, the team operating in Open Dialogue coordinates and integrates the participating systems formed by a severe psychiatric crisis. It serves to maintain psychological continuity (e.g., a coherent and consistent treatment team and plan) until there is a resolution of symptoms, thus reducing the iatrogenic effects of the patient's involvement with multiple systems.

As the work of the Finnish team has evolved, the idea of "dialogism" by Bakhtin (1984) became central. The aim of the treatment meeting explicitly became defined as that of

dialogue, in which the patient can find voice, thus reducing the person's sense of isolation. This approach emphasizes the process of finding language for psychotic experience that previously was inexpressible and creating a shared understanding of the crisis within a network. The use of ordinary words and creation of joint meanings tends to generate a collaborative set of relationships and to open up an avenue to people's own knowledge, skills, and capabilities.

The two other, key principles tied to dialogism are "tolerance of uncertainty" and "polyphony" (Seikkula & Olson, 2003). Tolerating uncertainty means establishing a climate of safety and intense support, with daily meetings, if needed, so that the solutions can emerge from the dialogue itself, rather than be imposed prematurely by experts. Polyphony, an interplay of multiple voices, allows for the process of exchange by which new words and new stories enter the common discourse and give voice to the previously incomprehensible suffering of the patient. The reflecting process among the helpers is a crucial part of this polyphonic conversation.

One of the effects of these language practices in the treatment meeting is to create a transparency in psychiatric care—indeed, the "openness" of Open Dialogue. The deleterious effects of contradictory injunctions originating from different contexts can be countered by making the confusing messages open for discussion during the meeting. There are no separate staff meetings to talk about the "case," so all "case management" issues, including medication, hospitalization, and psychotherapeutic options, must be addressed in the meeting with everyone in the network present.

In teaching Open Dialogue, there is a combination of lectures describing the

principles, the impressive outcome research (Seikkula et al., 2003), and readings. The author describes her own experience doing an ethnographic study of Keropudas Hospital and the acute team in Tromso, Norway where, under the guidance of Tom Andersen and Magnus Hald, this way of working has become well established, with some slight differences from the Finnish approach. Students practice learning to conduct “a dialogical dialogue” in small groups by discussing an ordinary problem that they feel comfortable disclosing (Seikkula, personal communication). Observers within the groups are invited to give reflections on the dialogue. Role plays of severe psychiatric crises are not performed. Alternately, transcripts of published sessions can be read aloud. The story of Pekka and Maja, an interview conducted by the Finnish team at Keropudas Hospital (Seikkula & Olson, 2003), shows the resolution of a psychosis in Open Dialogue. This transcript has been read and analyzed in class discussion.

<2>Externalizing Conversation

While the open dialogue approach was developed in the context of acute care, the narrative therapy of Michael White and David Epston (1990; White, 1995) was invented for “problem-saturated” situations with difficulties of longer duration and chronicity, in which people have experienced more “identity damage” as a consequence. Drawing on Bateson and poststructuralist Michel Foucault, Michael White shows how to “reauthor” the problem-saturated stories that clinicians often encounter in public agencies and outpatient community-based settings. In contrast to Open Dialogue, narrative therapy is not designed for the acute crisis phase of severe psychiatric problems.

White argues that one of the most oppressive effects of the dominant mental-health discourse is the identification of the person with the problem, rather than identifying the social contexts and discursive practices in which problems are embedded. The technique White invented, called "externalizing," creates a linguistic separation of the problem from the person. Externalizing the problem helps locate "unique outcomes;" or exceptions to the problem. Those experiences that fall outside a dominant, negative script provide the stuff for creating alternative, more hopeful stories. The idea is to find and develop a new story based on unique outcomes that have not been given significance, because they do not fit in with the person's self-narrative of inadequacy or failure that has become the "receiving context. " A self-critical narrative often has roots in the larger, oppressive normalizing "truths," or socially constructed cultural narratives about personhood, sexual orientation, class, gender, or racial identity. Narrative therapy attempts to counteract the effects of these demoralizing "truths" in people's lives.

White and Epston have created a rich and imaginative repertoire of questions, rituals, letters, archives, and other written documents, and much of this work has been developed for children and adolescents. These techniques and skills make visible the effects of problems and bring forward the skills, knowledge, and agency of the person in counteracting them. Narrative therapy represents one of the most compassionate therapies for chronic, long-term problems. The early critics of narrative therapy raised concerns that the therapists do not listen enough to people's suffering or respond to their desire to find meaning in it. In the last decade, by incorporating the influence of the reflecting process, narrative therapy has become more collaborative, participatory, and flexible. Videos for

teaching narrative therapy include Escape from Bickering (American Association of Marriage and Family Therapy, 1989), Re-authoring a Life in the Face of Lost Dreams (Andrew & Clark Explorations/Masterwork, 1994), The Best of Friends (Andrew & Clark Explorations/Masterwork, 1994), and the Interview with Harrassment (Educational Media Centre, 1999).

In teaching narrative therapy in an academic setting, one option for the final assignment is to ask advanced students to construct a narrative of professional development based on “sparkling facts” (White, 1989/90). “Sparkling facts” are the unique outcomes, or successful learning experiences and effective negotiations of difficulties within their professional education. The students first do this exercise in small groups of 4-5 people. There is the interviewer, the interviewee, and the other students who reflect on the person’s experience as “outsider witnesses.” An outsider witness is a person whose words can enrich the preferred story and help give it weight. Not all students will be able to be interviewed in class, so they are encouraged to form pairs and meet outside of class to have the same dialogue.

A successful example of this learning exercise comes from Samantha Smith (2003), a graduate student in social work, who discussed in class and then wrote about doing therapy with Javier, an 8 year-old Puerto Rican boy, whom she saw in an urban school-based mental health program called “Partners for Success.” The boy was referred for significant obesity, depression, poor social skills, academic struggles, absenteeism, and concerns over his history of broken bones. He had had several prior therapists and was on his way to becoming a chronic case. Samantha was already familiar with narrative therapy

from this field placement and creatively wove the idea of “unique outcomes” together with other ideas and techniques from different approaches.

While it is beyond the scope of the chapter to describe all that went into this therapy, one ingenious idea was that Samantha facilitated a non-competitive basketball team that provided Javier with his first tangible experience of being an athlete. When Javier first met Samantha, he expressed a huge interest in basketball and told her about the 75 trophies he had already won for outstanding competitive play. Samantha did not challenge this make-believe, but was inspired to give him an experience of actual basketball, thinking it might help this boy initiate a new narrative about his identity. This activity was combined with play therapy in which the therapist created a sensitive connection that allowed Javier to give expression to the many painful things in his life. Soon this boy began to change and started to laugh and smile on a regular basis. Teachers further saw dramatic improvement in his schoolwork and attendance. He began making friends and started losing weight. Samantha worked actively with his mother and teachers to reinforce this new identity as the “real Javier,” who before had been eclipsed by his problems.

Finally, another student, Lynne Anderson, who interviewed Samantha in class during the small-group exercise, suggested the parallel process between Javier and Samantha where both emerged feeling like “the real thing.” Samantha wrote:

We both entered the therapy feeling somewhat like “frauds:” he having to lie about his relationships and athletic abilities and me identifying as a completely inexperienced therapist who was not likely to make a difference in this kid’s life. [By the end], Javier now had genuine friendships and basketball skills and I now had some pride in my work and could

feel justified in being paid for such services in the future!

Samantha's account of this "sparkling fact" in her professional development helped to solidify a confident identity as a child therapist and gave her a direct experience of a narrative technique that increased her understanding of its therapeutic effect.

<2>Unspeakable Dilemmas of Social Identity

Narrative therapy is among various, distinct strands of family therapy that have attempted to address the political and social contexts of people's lives. From the outset of the curriculum, there is an emphasis on these contexts not only as they shape human life but also in terms of the social and political ingredients of theory building itself. Starting in the mid-eighties, the impact of the feminist critique altered American family therapy by showing that there were gender biases built into the traditional models that privilege autonomy and power. Once the objectivity and neutrality of the dominant theories were thus challenged, the use of a postmodern, collaborative stance assumed a compelling logic. That is, basing therapy on a collaborative process of inquiry, rather than a theory of structural reality, makes sense in a rapidly changing world where as Judith Stacey (1996) states, "... contemporary Western family arrangements are diverse, fluid, and unresolved." The convergence and tension between postmodernism and the critical implications of feminism and other social justice movements—or two kinds of thought, deconstructive and political—is an important sub-dimension of the course.

The clinical work of the Gender and Violence Project at Ackerman shows the relevance of a language-based approach to gender dilemmas of various kinds, including

violence and abuse (Goldner et al., 1990). Unlike prior family models, this group includes the moral and ethical considerations about safety and responsibility of the persons caught up in these situations. Gender prescriptions are addressed in clinical practice through the use of specific techniques like “deconstructing violence,” developed for work with couples where the man wants to stop being violent. Deconstructing violence is a slow-motion analysis of a violent episode that takes place between the therapist and the male partner. It surfaces the gender premises, feelings, memories, and images that converged in the violence, thus finding words and making a narrative for the person’s otherwise fragmented experience. These clinical discussions can be supplemented with Sut Jhally’s educational video, Tough Guise (1999) examining the rise of hypermasculinity in America and its effects on different racial groups. Jhally’s work deciphers the stories told by the larger culture about masculinity as evident in the media and media imagery.

The author uses her clinical work and research on anorexia to explore the idea of gender-linked unspeakable dilemmas and how these are built into the social experience of girls growing up in our culture. Introducing Grimm’s’ (Hunt & Stern, 1944/1972) fairy tales is useful in looking at a traditional Western gender discourse. Students read aloud “The Beam” and “The Shepherd Boy” and contrast the representations of female and male knowledge. There is a convergence among this gender discourse, the double-bind theory, and Gilligan’s “relational paradox” where young adolescent girls learn to silence voice and body to gain acceptance and protect relationships ((Brown & Gilligan, 1992; Olson, 2000b). The story of a young woman with bulimia shows how collaborative formats of therapeutic conversation and writing can give voice to, and thus address, the unspeakable

dilemmas tied to gender prescriptions (Olson, 1995a). These ideas converge with Mahmoud's (1998) excellent article on the double binds of racism. It becomes clear that the double-bind situation goes beyond the family and can be an artifact of cultural narratives about social identity. In tandem, the film The Joyluck Club (Stone & Wang, 1993) shows the intergenerational transmission of double-binding premises rooted in culture, gender, and race as refracted through mother and daughters confronting the tragic circumstances and legacies of immigration (Tan, 1989).

As Charles Waldegrave (1998) observes, the influence of postmodernism opened space for and legitimated other, diverse voices. In the 1990s, more presentations at conferences and more articles began to appear from wider social and cultural perspectives. The multicultural movement became the recognition of difference and how differences are socially constructed and politically inflected. Even the phrase "multicultural" became critiqued for obscuring the link in the US between "different" and "less" (Akamatsu, 1998). A cultural thread had developed in the 1960s in family therapy, but these earlier models lacked the explicit political analysis of difference that emerged in the late 1990s. By now, class, culture, gender, race, and sexual orientation can define all families, not just marginalized ones.

As the gender critique challenged theories of therapy as biased, a cultural perspective has shown that these same theories are culture bound. According to the anthropologist Clifford Geertz (1983) the concept of a separate, autonomous self is a rather peculiar notion in most parts of the world where self is conceived as embedded in relationship and community. Conceptions of emotion, identity, communication, and

cognition are all shaped by culture. The concept of family itself is culturally determined. Cross-cultural comparisons of legal marriage afforded to gay and lesbian couples and access to reproductive options and adoption illustrate this point. This awareness is imperative for American therapists operating in a diverse, multicultural society.

The cultural genogram developed by Ken Hardy and Tracy Laszloffy (1995) is one way of learning how to enter a therapeutic conversation about difference. Trainees are invited to do a cultural genogram, following Hardy and Laszloffy's guidelines of identifying the "organizing principles" and "pride/shame issues" of the family's particular cultural group. The group is asked to join in by reflecting on the cultural question about the family posed by the trainee presenting the genogram. Here the emphasis is both on multicultural knowledge and the ability to conduct an inquiry that does not impose stereotypes. The aim is to facilitate a context for self-definition and agency.

Voice and authorship are political shifts that emerge from methods of collaboration. The curriculum examines many examples of giving voice. There is special attention in this section to social justice therapy, a model where families participate in the organization of the treatment context itself (Waldegrave, 1990). The same principle is upheld by the system of care framework that, in order to create a socially just framework, there must be a commitment to partnership with families in the building of services themselves.

<1>An Example of a Postmodern Education in Action

The following account provides an example of a consultation using dialogic, reflecting and narrative ideas in a mental health agency that serves a poor community in the outskirts of

Boston. It is an illustration of how postmodern clinical practices can be hand in glove with the system of care philosophy. While this consultation occurred in a mental health agency, the exact same format can be used in classroom settings and postgraduate workshops to teach community-based mental health practice.

Chris O'Rourke, M.S.W., who had been trained in the above curriculum and worked at this agency, asked the author to provide training to the staff. The consultant organized the consultation around an actual case where the clinicians were feeling stuck. The consultation began with a 30-minute introduction sketching the idea of dialogue, the format of the reflecting process and the narrative technique of finding exceptions, or unique outcomes, to shift away from problem-saturated stories. These therapeutic principles produced both a process and outcome compatible with the system of care movement. Specifically, this clinical consultation promoted a non-pathologizing framework, a partnership with the family, interdisciplinary collaboration, cultural awareness, and the inclusion of natural supports from the person's own relatives to stabilize the crisis, rather than turning to an institution.

Rose, the person at the center of concern, and her family did not attend the consultation even though she and her children were invited to participate. The reason for this may have been that this way of working was new and unfamiliar, both to the professionals and the client. While this mother reportedly benefited significantly from this consultation, her presence in the actual conversation would have been highly valued. At the same time, it shows that working even with part of the therapeutic network can produce a significant shift that helps people unable to attend. Obviously, in an academic setting, it would be

highly unusual for families to attend, and as in this situation, the primary contact with the network would be the treating therapist.

The consultation took two hours. Chris presented, with insight and compassion, the case of a 32-year-old, African-American woman who was the mother of four children, ages 7-11. Rose originally came to the clinic after the death of her beloved grandmother and in the aftermath of her boyfriend's infidelity with a neighbor. She was depressed, poor, unemployed, and living in dangerous public housing. Rose also had a complicated history of childhood sexual abuse by an adult outside the family. Her marriage had been violent, and she left the children's father because he beat her. This mother also had a history of alcoholism, but stopped drinking, because she reckoned, "I can either be an alcoholic or a mother." It was evident that she loved her children and that these relationships had a positive stabilizing effect on her life. Her children had an array of difficulties for which Rose sought help at the clinic, including a concern for her eldest son who had once been suicidal.

Chris had been seeing Rose individually for over a year, and another therapist, Helen, had been working with Rose and her children. Both therapists were present at this meeting and described excellent work assisting Rose to handle repeated crises in her life. Their primary concern about Rose was a continued weight loss during the past year. She was not eating much; and at five feet, three inches tall, her weight had fallen to about 85 lbs. In order to help her eat, Chris had arranged for Rose to attend a psychiatric day treatment program that she attended sporadically the summer before. She also took medication with mixed results. For the therapist, the question looming over the consultation was whether

Rose had to be hospitalized on an inpatient unit, thus jeopardizing her ability to take care of her children. The hope of the consultation was to generate new possibilities for Rose to stay in the community. This proposal also protected her children, since they would not have to be separated from their mother.

The consultant started by thinking how we might together create a safety net around Rose and counteract the larger shared sense of being overwhelmed by her problems. Without minimizing or downplaying her difficulties and symptoms, the consultant's goal was to find alternate perspectives and possibilities that might help everyone feel safer and more hopeful. The consultant organized the staff into three groups. In the first group, there was Chris, Helen, the family therapist, and the consultant. Second was the reflecting team, which included the members of the staff who were the child and family specialists. Third was the larger group of other staff members, many of whom volunteered to listen "as-if" they were family members. The same structure can also be created in a classroom.

The consultant started by listening to the first group and drawing a genogram that included a question that brought forward exceptions to the story of Rose not eating. This part of the consultation began with the two questions posed to Chris, as the person requesting the consultation, and were first proposed by Andersen (1995): "what is the history of the idea to have the meeting" and "what would be a good outcome for the meeting." The consultant based her subsequent response on the answers provided to these questions, so the meeting became an evolving dialogue. Being respectful to all participants by acknowledging their responses was key.

The themes of this initial conversation emerged as concerns about Rose's safety and her

prior experiences of abuse and danger. The first thing the consultant did was to create a protective protocol around the weight loss. Chris agreed to ask the primary care physician to define the weight Rose needed to maintain to be medically safe. Should Rose decide to go below this weight, then a hospitalization would be pursued. This clarity brought a sense of safety and relief to everyone.

After Chris and the other therapists presented the case, the reflecting team commented. The team honored Rose's suffering and also highlighted aspects of her story that held new possibilities. After listening to the team, Chris said that he was filled with emotion because it was the first time that he did not feel alone with this frightening case. The family therapist Helen also felt the team's support and compassion.

After the initial set of reflections, we continued the conversation and developed the idea of building a network of care around Rose and her children that included, not only the professionals, but also her mother, her sister, and the other women in her life. From the genogram, we had learned that there were strong women in Rose's family who had been the only people capable of getting Rose to eat. In the past year, she had become separated from these family members when she had to move to a different neighborhood because of a change in her housing subsidy.

Following the consultation, Chris shared two ideas with Rose that seemed to help her to change. The first was to comment on her competence as a mother, the love she had for her children, and how much she wanted to keep them safe. The second was to share our appreciation for Rose's connection to the women in her family and to tell her how important these relationships were. Chris asked her how she could continue to draw on

these relationships to help her manage? Who else could she identify as support? The main clinical outcome of the consultation was to create a network around Rose by calling attention to the women in her family as life-important sources of nurturance and care. In this way, the staff found a natural way to help Rose diffuse the crisis.

As a postscript, Chris added that over the next months, Rose developed a stronger sense of personal agency and purpose, and was taking care of herself and eating more adequately. Rose responded deeply to the acknowledgement of her abilities as a mother. She was empowered by this recognition and in the months ahead she began looking for a new place to live. Chris was impressed by Rose's determination to move herself and her children out of where they had been living and into a safer apartment closer to her own family. Although he left the agency during Rose's search for housing, he felt strongly that he saw a different person emerging—a person capable of taking the action she needed to in order to get to a better place.

In a brief period this consultation accomplished several things on multiple levels. First, by sharing ideas, the team created a much richer description of this woman's life that led to new possibilities and ultimately kept Rose in the community, out of a hospital and out of a possible inpatient career. Second, the consultation built support and safety around the therapists who felt isolated and alone. Third, the consultant provided training to the staff and facilitated teamwork, rapport and supportive interactions among them. In this way, the reflecting process helped the staff to work together effectively in a crisis. The dialogic and narrative practices that come out of the family therapy tradition offer formats that can serve to generate creativity and connection. As this example shows, by introducing opportunities

for inquiry and reflection, this capable staff came up with a solution without recourse to more costly measures.

<1>Basic Guidelines For Doing Clinical Consultation In Community Care

Here is a summary of guidelines for doing clinical consultation with a community-based orientation that reinforces the principles of the system of care philosophy.

Present clear, brief guidelines for the reflecting process. The interested practitioner should consult this literature for a more extensive description (Andersen, 1991; 1995; Griffith & Griffith, 1994).

Focus on an actual clinical situation. In a world of limited time and resources, this will be experienced as real help.

Present two or three clinical ideas and keep it relatively brief (20-30 minutes in a 2 hours consultation). If this consultation is part of a longer course, it is still important to review for students the ideas in use.

Describe why these particular ideas are useful in this particular situation. For instance, in community agencies, reflecting conversation can help build clinical teams where people can share ideas and find solutions, in contrast to the isolation and fragmentation professionals often experience. Finding exceptions in problem-saturated stories can create an effective difference when this is extremely hard to do.

Begin with the following two questions: “what is the history of the idea to have the meeting” and “how would you like to use this meeting?.” The first question addresses the immediate context and the ideas people are bringing to it. The second question constructs agency and launches people in the direction of their hopes and best intentions. Please refer

to Andersen's (1995) own in-depth discussion of these questions as starting points.

In most agency contexts, professionals are not used to having clients present for staff training, so it is unlikely that they will have enough trust, at first, to bring them. It is possible to constitute the missing voices in the network and gain a more fully polyphonic conversation by doing a genogram and asking reflexive questions (Seikkula, personal communication). For instance, "If Rose were here, what would she say has been helpful to her?" "If Rose's sisters and mother were here, what would they say about her not eating?"

Hypothetical, future-oriented, or externalizing questions engage the imagination and introduce reflexivity, or the capacity to stand outside the situation and view it from a different experience. I.e., "What does Rose's ability to leave an abusive marriage and stop drinking tell us about the person she is becoming?"

Do not outlaw other points of view. Embrace differences. All ideas can be in the service of dialogue and reflection.

Listen for the emergence of a new sense of possibilities, exceptions, meanings, and naturally occurring resources. Let the solutions come from the dialogue itself.

Conduct the consultation with a spirit of improvisation, compassion, and hope.

<1>Conclusion

The postmodern curriculum trains clinicians to do therapy in a way that integrates the values and principles of a system of care approach. The new clinical practices in the service of the community movement look for ways to reduce suffering and foster recovery by drawing on the possibilities within the existing professional and social networks. In this endeavor, the use of language and the establishment of dialogue are living elements that can

be garnered in helping to reconstruct the terms on which the people live their lives. A genuine dialogue can create a different future by generating new meanings and new, more helpful relationships within a social network. Such practices lend themselves to being more culturally-, racially- and gender- sensitive because they steer clear of objectifying the other and attempt to provide the tools for claiming a sense of control over one's destiny.

In his book, "Pedagogy of Hope," Freire (2002) makes the point that "teaching is not a simple transmission" (p.80). Echoing Bateson, he goes on to say that "teaching someone to learn is only valid...when educands *learn to learn*..."(p. 81). And one of the mandates of his pedagogy is to learn to learn how to have "critical hope," rather than a naïve hopefulness (p. 8). In training clinicians in community-based practice, critical hope lies in teaching them how to embrace suffering without creating pathology, to listen and generate dialogue in the face of the incomprehensible, to ask questions that surface people's ideas, skills, capabilities, and prospects, and to understand the power of language as a world-making, identity-making activity. It is always difficult to say exactly what a particular consultant did to shift a desperate situation: there is no single intervention; but a collaborative process that happens between people--shaped by reflection, dialogue, and certain kinds of questions--that create a context where the new can emerge. It is in the magic of human interchange that we find freedom where we were stuck; that we are joined with others in shared responsibility, and that instead of the weight of pathology, we are lightened by solutions that make care a new experience of hope.

<1>References

Akamatsu, N. N. (1998). The talking oppression blues: Including the experience of power/powerlessness in the teaching of "cultural sensitivity." In M. McGoldrick (Ed.), Re-visioning family therapy: Race, culture, and gender in clinical practice, (pp.129-144). New York: Guilford.

Alanen, Y. (1997). Schizophrenia. Its origins and need-adapted treatment. London: Karnac Books.

Andersen, T. (1987). The reflecting team: Dialogue and meta-dialogue in clinical work. Family Process, 26, 415-428.

Andersen, T. (1991). The reflecting team: Dialogues and dialogues about dialogues. New York: Norton.

Andersen, T. (1995). Reflecting processes; Acts of informing and forming: You can borrow my eyes, but you must not take them away from me! In S. Friedman (Ed.), The reflecting team in action: Collaborative practice in family therapy (pp. 11-37) New York: Guilford.

Andersen, T. (1997). The client as the co-researcher. Canadian Journal of Counseling.

Andersen, T. (in press). The network context of network therapy: A story of the european nordic north. In A. Lightburn & P. Session, Community-based clinical practice. New York: Oxford University Press.

Anderson, H. (1997). Conversation, language, and possibilities: A postmodern approach to therapy. New York: Basic Books

Anderson, H. & Goolishian, H. (1988). Human systems as linguistic systems: Preliminary

and evolving ideas about the implications for clinical theory. Family Process, 27, 371-393.

Anderson, H. & Goolishian, H. (1986). Systems consultation to agencies dealing with domestic violence, In L. Wynne, S. McDaniel, & T. Weber (Eds.), The family therapist as systems consultant (pp. 284-299). New York: Guilford.

Anderson, H. & Goolishian, H. (1991). Thinking about multi-agency work with substance abusers and their families. Journal of Strategic and Systemic Therapies, 10, 20-35.

Andrew & Clark Explorations/Masterwork (Producer). (1992). Dialogue and dialogue about dialogue. (Available from the Andrew & Clark Explorations/Masterwork Web site, <http://www.masterswork.com>.)

Andrew & Clark Explorations/Masterwork (Producer). (1994). The best of friends. (Available from the Andrew & Clark Explorations/Masterwork Web site, <http://www.masterswork.com>)

Andrew & Clark Explorations/Masterwork (Producer). (1994). Reauthoring a life in the face of lost dreams. (Available from the Andrew & Clark Explorations/Masterwork Web site, <http://www.masterswork.com>)

Andrew & Clark Explorations/Masterwork (Producer). (1999). Reflecting elder stories. (Available from the Andrew & Clark Explorations/Masterwork Web site, <http://www.masterswork.com>)

Andrew & Clark Explorations/Masterwork (Producer). (1999). Dialogues and postmodern connections: 3 part series (Available from the Andrew & Clark Explorations/Masterwork Web site, <http://www.masterswork.com>)

Bakhtin, M. (1984). Problems of Dostojevskij's poetics. Theory and history of literature:

Vol. 8. Manchester: Manchester University Press.

Bateson, G. (1962). A note on the double bind. In C. Sluzki and D. Ransom (Eds.) (1976).

Double bind: The foundation of the communicational approach to the family. (pp. 39-42)

New York: Grune & Stratton.

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

Bateson, G. (1979) Mind and Nature. New York: Dutton

Bateson, G., Jackson, D., Haley, J., and Weakland, J. (1956). Toward a theory of schizophrenia.

Behavioral Science, 1, 251-254.

Bateson, G., Weakland, J. & Haley, J. (1976). Comments on Haley's "History." In C.

Sluzki and D. Ransom (Eds.), Double bind: The foundation of the communicational approach to the family (pp. 105-110) New York: Grune & Stratton

Boscolo, L, Cecchin, G., Hoffman, L., & Penn, P. (1987). Milan systemic family therapy: Conversations in theory and practice. New York: Basic Books.

Brown, L. & Gilligan, C. (1992). Meeting at the crossroads: Women's psychology and girls' development. Cambridge: Harvard University Press.

Burchard, J.D, Bruns, E. J. & Burchard, S. N. (2002). The wraparound approach. In B. J.

Burns & K. Hoagwood (Eds.), Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders (pp. 69-90). New York:

Oxford University Press.

Coffey, E. P., Olson, M.E. & Sessions, P. (2001). The heart of the matter: An essay about the effects of managed care on family therapy with children. Family Process, 40, 385-399.

Collaborative for Community and Family-Based Practice. (2001). Innovations/ Dilemmas/ Reflections/ Recommendations. Unpublished manuscript.

Educational Media Centre. (Producer) (1999). An interview with harassment [Motion picture]. (Available from Educational Media Centre, University of Auckland. Private Bag 92019, 23 Symond St., Auckland, New Zealand.)

Freire, P. (1971). Pedagogy of the Oppressed. New York: Seaview

Freire, P. (2002). Pedagogy of Hope: Reliving pedagogy of the oppressed. New York: Continuum.

Friedman, S. (1993). The new language of change: Constructive collaboration in psychotherapy. New York: Guilford.

Geertz, C. (1983). Local knowledge: Further essays in interpretive anthropology. New York; Basic Books.

Gergen, K. (1999). An invitation of social construction. London: Sage.

Gergen, K., & MacNamee, S. (2000). From disordering discourse to transformative dialogue. In R. Neimeyer & J. Raskin (Eds.), Constructions of disorders (pp. 333- 349). Washington DC: American Psychological Association.

Goldberg, C. (2001, July 9). Children trapped by mental illness. The New York Times, pp. A1, A11.

Goldner, V., Penn, P., Sheinberg, M., Walker, G. (1990). Love and violence: Gender paradoxes in volatile attachments. Family Process, 29(40), 343-364.

Griffith, J. L. & Griffith, M.E. (1994). The body speaks: Therapeutic dialogues for mind-body problems, New York: Basic Books.

Griffith, J. L. & Griffith, M.E. (1995). When patients somatize and clinicians stigmatize: Opening dialogue between clinicians and the medically marginalized. In S. Friedman (Ed.), The reflecting team in action: Collaborative practice in family therapy (pp. 81-99). New York: Guilford.

Hardy, K.V. & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. Journal of Marital and Family Therapy, 21, 227-237.

Henggeler, S.W., Schoenwald, S.K., Borduin, C. M., Rowland, M.D., & Cunningham, P. B. (1998). Multisystemic treatment of antisocial behavior in children and adolescents. New York: Guilford Press.

Herman, J. (1992). Trauma and recover: The aftermath of violence—from domestic abuse to political terror. New York: Basic Books.

Hoffman, L. (1986). Beyond power and control: Toward a “second-order” family systems therapy. Family Systems Medicine, 4, 381-396.

Hoffman, L. (2000). A communal perspective for relational therapies. Journal of Feminist Family Therapy, 11(4), 5-17.

Hoffman, L. (2002). Family therapy: An intimate history. New York: Norton.

Hunt, M. & Stern, J. (Trans.) (1944/1972). The complete grimm’s fairy tales. New York: Pantheon.

Jhally, Sut (Director). (1999). Tough guise: Violence, media, and the crisis in masculinity [Motion picture]. (Available from the Media Education Foundation, 26 Center Street, Northampton, MA 01060).

Krefting, L. (1990). Double bind and disability: The case of traumatic head injury. Social

Science & Medicine, 30 (8), 859-865.

Lightburn, A., Olson, M., Session, R., Coffey, E. (2002). Practice innovations in mental health services to children and families: New directions for Massachusetts. Smith Studies in Social Work, 72(2), 279-301.

Lukens, E. P. & McFarlane, W. (2002). Families, social networks, and schizophrenia. In McFarlane (Ed.), Multifamily groups in the treatment of severe psychiatric disorders (pp. 18-35). New York: Guilford.

Mahmoud, V. M. (1998). The double binds of racism. In M. McGoldrick (Ed.), Re-visioning family therapy: Race, culture, and gender in clinical practice, (pp. 255-267). New York: Guilford.

McGoldrick, M. (Ed.) (1998). Re-visioning family therapy: Race, culture, and gender in clinical practice. New York: Guilford.

Meyers, J., Kaufman, M., & Goldman, S. (1999). Promising practices: Training strategies for serving children with serious emotional disturbance and their families in a system of care. Systems of Care: Promising Practices in Children's Mental Health, 1998 Series, Volume V. Washington, D.C.: Center for Effective Collaboration and Practice, American Institutes for Research.

Minuchin, S. (1974). Families and family therapy. Cambridge, MA: Harvard University Press.

Olson, M. E. (1984). Form, difference, and change: A study of Bateson, the Milan Associates, and second-generation family theory. Unpublished master's thesis. Smith College School for Social Work. Northampton, Massachusetts.

- Olson, M. E., (1995a). Conversation and writing: A collaborative approach to bulimia. Journal of Feminist Family Therapy, 6(4): 21-45.
- Olson, M. E. (1995b). The family-therapy perspective. In S. Donner and P. Sessions (Eds.), Garrett's Interviewing: Its Principles and Methods, Fourth Edition (pp. 113-119). Milwaukee: Families International Inc.
- Olson, M.E. (1999). Voices of anorexia: A study of voice, communication, and the body. University of Massachusetts, Amherst.
- Olson, M.E. (ed.). (2000a). Feminism, community, and communication. Binghamton NY: Haworth Press.
- Olson M.E. (2000b). Listening to the voices of anorexia: The researcher as an "outsider-witness." Journal of Feminist Family Therapy. 11(4): 25-46.
- Pakman, M. (1999). "Designing Constructive Therapies in Community Mental Health: Poetics and Micro-Politics in and Beyond the Consulting Room," Journal of Marital and Family Therapy, 25 (1) 83-98.
- Penn, P. (2001). Chronic illness: Trauma, language, and writing: Breaking the silence. Family Process, 40, 33-52.
- Reich, J. (1998). Do we know what students are getting from their education? American Psychological Association Monitor. June, 1998, 41.
- Scott, J. (Producer) and Hicks, S. (Director). (1996). Shine [Motion picture]. Australia: The South Australian Film and Film Victoria.
- Stacey, J. (1996). In the name of the family: Rethinking family values in the postmodern age. Boston: Beacon Press.

Seikkula, J. (2002a). Open dialogues with good and poor outcomes for psychotic crisis. Examples from families with violence. Journal of Marital and Family Therapy, 28, 263-274.

Seikkula, J. (2002b). Monologue is the crisis—dialogue becomes the aim of therapy. Journal of Marital and Family Therapy, 28, 275-277.

Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. & Sutela, M. (1995). Treating psychosis by means of open dialogue. In S. Friedman (ed.), The reflective team in action. New York: Guilford Press.

Seikkula, J., Alakare, B. & Aaltonen, J. (2001a). Open Dialogue in psychosis I: An introduction and case illustration. Journal of Constructivist Psychology, 14, 247-266.

Seikkula, J., Alakare, B. & Aaltonen, J. (2001b). Open dialogue in first-episode psychosis II: A comparison of good and poor outcome cases. Journal of Constructivist Psychology, 14, 267-284.

Seikkula J., Alakare, B., Aaltonen, J., Holma, J., Rasinkangas, A. & Lehtinen, V. (2003) Open dialogue approach: Treatment principles and preliminary results of a two-year follow-up on first episode schizophrenia. Ethical Human Sciences and Services, 5, 1-20.

Seikkula, J. & Olson, M. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. Family Process, 42, 403-418.

Seikkula, J. & Sutela, M. (1990). Co-evolution of the family and the hospital: The system of boundary. Journal of Strategic and Systemic Therapies, 9, 32-42.

Selvini Palazzoli, M., Boscolo, L., Ceechin, G., & Prata, G. (1978). Paradox and counterparadox. New York: Jason Aronson

Sheinberg, M. & Fraenkel, P. (2001). The relational trauma of incest. A family-based approach to treatment. New York: Guilford.

Smith, C. (1997). Introduction: Comparing traditional therapies with narrative approaches. In C. Smith & D. Nylund (Eds.), Narrative therapies with children and adolescents (pp. 1-52). New York: Guilford.

Smith, S. (2003). Sparkling facts in the case of Javier. Unpublished manuscript.

Stern, S., Doolan, M., Staples, E., Szmukler, G., & Eisler, I. (1999). Disruption and reconstruction: Narrative insights into the experience of family members caring for a relative diagnosed with serious mental illness. Family Process, 38, 353-369.

Stone, O. (Producer) and Wang, W. (Director). (1993). Joyluck Club [Motion picture]. United States: Hollywood Pictures.

Stroul, B.A. & Friedman, R. M. (1986) A system of care for severely emotionally disturbed children and youth. Washington DC: Georgetown University Development Center.

Stroul, B. A. (2002). A framework for system reform in children's mental health. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health, Child Development Center, U.S. Public Health Service, (2000) Report of the Surgeon General's Conference on Children's Mental Health: Developing a National Action Agenda. Washington, D.C.

VanDenBerg, J. E., & Grealish, E. M. (1996). Individualized services and supports through the wraparound process: Philosophy and procedures. Journal of Child and Family Studies. 5(1), 7-21.

Waldegrave, C. (1990). Social justice and family therapy: A discussion of the work of the family centre. Dulwich Centre Newsletter. No. 1.

Waldegrave, C. (1998). The challenges of culture to psychology and postmodern thinking. In M. McGoldrick (Ed.), Re-visioning family therapy: Race, culture, and gender in clinical practice, (pp.404-413), New York: Guilford.

Watzlawick, P., Weakland, J. & Fisch, R. (1974). Change: Principles of problem formation and problem resolution. New York: Norton.

Weakland, J. (1960). The "double bind" hypothesis of schizophrenia and three-party interaction. In C. Sluzki and D. Ransom (Eds.) (1976), Double bind: The foundation of the communicational approach to the family. (pp. 23-37). New York: Grune & Stratton

White, M. (1995). Re-authoring lives: Interviews & essays. Adelaide, South Australia: Dulwich Centre Publications.

White, M. (1989/90). Family therapy training and supervision in a world of experience and narrative. Dulwich Centre Newsletter, Summer.

White, M. (2003, August). Title. Paper presented at Smith College School for Social Work. Northampton, Massachusetts.

White, M. & Epston, D. (1990). Narrative means to therapeutic ends. New York: Norton.

Smith College School for Social Work

This term was coined by Ken Gergen, applied clinically by Tom Andersen, and appears in Hoffman (2000).

A postmodern conception of a system is a dialogic one, as will be explained further.

⁴There are, of course, obvious limits to this approach when parents commit crimes of assault or incest against their children.

Andersen (in press) also sketches the evolution of the “Northern Network” and the principles of the training program in the European Nordic North.

See Griffith & Griffith (1994), pages 160-162, for their succinct distillation of Andersen’s principles of the reflecting position

PAGE 37

PAGE 2