

Using narrative therapy in an educational parenting group

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Abstract: Narrative therapy techniques have been used extensively in family therapy, individual therapy, and social work. Surprisingly, these techniques have seen limited application to therapeutic and support groups and almost no application to education groups. This paper reports on the use of narrative therapy with an education group, specifically a parent-education group. The central question addressed was: How do results compare with those of traditional parent-education groups? Case examples were reviewed to see if using narrative therapy was beneficial to parents. Written feedback was used to compare groups which did not use narrative therapy to groups which used narrative therapy. The review indicated that the narrative groups reported learning more specific 'helpful' skills (especially the skill of 'listening') compared to the non-narrative groups.

Key words: *narrative therapy, parenting groups, education groups, reflective teams, story repair, listening skills.*

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Introduction

Narrative therapy provides a clinical format where people tell narratives about their lives, their childhoods, and their families. The therapist then, after the initial narrative unfolds, uses reflection and discussion, to offer new insights and new views. These new insights encourage individual growth by changing the narrative story line of personal histories.

Narrative techniques have been used extensively in family therapy, individual therapy, and social work since the early 1990s (Coulehan, Friedlander, & Heatherington, 1998; Freedman & Combs, 1996; Merscham, 2000; O'Hanlon, 1994; Saleebey, 1994; Schwartz, 1999; White, 1986). But these techniques have seen limited application to therapeutic and support groups (Kelley & Clifford, 1997; Laube, 1998), and no application to education groups. The absence of narrative therapy in group settings is surprising because narrative therapy, with its emphasis on storytelling, reflection and discussion, would appear to harmonize with group processes.

This paper reports on the use of narrative therapy with an education group, specifically parent-education. The central question is how do results compare with those of a traditional parent-education group?

What is narrative therapy?

Narrative therapy was developed from postmodern philosophy, a belief that all reality is socially constructed-meaning, that we create our world-view through social interactions. These social interactions (or constructions) are intellectualized or realized through language. Consequently, a person's world-view is intimately connected with the words used to describe their experiences. Taking this process one step further, the postmodern view purports that reality is organized and maintained through the narrative.

These narratives contain no essential truths, because, obviously, what is one person's view might not be another's. For example, let's say John decides to stay in bed once a week because he 'doesn't feel like going to work.' A social worker, whose 'reality' is mental health, might view John's behavior as a 'depression.' John's mother, whose

reality differs from that of the social worker, might see him as 'lazy.' On the other hand, a different culture might see John's behavior as a 'privilege' – that is, a person who has the luxury of staying home once a week without getting fired. This example demonstrates how a person's life experience is seen through culture, upbringing, religion, and gender (Merscham, 2000). As another example of how a person's experience shapes a narrative; Alice might tell a therapist the following: 'You know, I can never do anything right; that's what my mother told me. She would say "we are Smiths, we never do anything right."' For Alice, her reality consists of viewing herself as always 'never doing anything right.' She constructs her world view using the language of her parent. Even when faced with successful ventures, she negates them because for her the only 'truth' is that she 'fails.'

Yet, a person's narrative is not consistent – it changes over time. As individuals journey through life, new insights and new views are added to the narrative, creating new interpretations and, consequently, new features come to dominate the narrative (Chen et al., 1998). Personal history is continually being re-created and constructed rather than remembered (Lax, 1992). The revisionist nature of memory was demonstrated in an interesting study with newlyweds. Researchers interviewed 373 newlyweds who were happy in their marriage. However, in a follow-up two years later, couples who now reported marriage problems claimed they knew the marriage was 'bad from the start.' The current marriage situation filtered out the good from the past and only the bad was remembered. The researchers concluded that 'such biases can lead to a dangerous downward spiral. The worse your current view of your partner, the worse your partner is in your memories., These filtered memories then further confirm your negative attitudes' (Holmberg & Holmes, 1994).

Narratives, however, can be changed for the positive. This is the crux of narrative therapy: people can learn new narratives to replace unhealthy ones. Howard (1991) calls this 'story repair.' He writes, 'part of the work between client and therapist can be seen as life-story elaboration, adjustment or repair' (p.194). In our fictitious example of Alice, the therapist might help her see that she has been successful in many areas: that she has not always 'done everything wrong' and that her personal story needs to be revised. 'Story repair' might help Alice build confidence so that she can be more successful in life and

take more risks.

Narrative therapy uses a three step method to repair stories: eliciting the narrative, reflecting on the narrative, and deconstructing and re-creating the new narrative. The role of the therapist is to follow these three steps.

First, the therapist must elicit the narrative. Frequently, narratives are elicited by use of a technique called therapeutic listening (Dean, 1998). During therapeutic listening, the therapist acts not as an 'expert with a privileged story or view, but as a facilitator of a therapeutic conversation' (Lax, 1992, p.74). Using Alice's example, the therapist would not ask questions about possible depression or past childhood abuses (the expert view of why she has poor confidence) but would ask questions to draw out the story. 'Tell me more about what your mother's view of life is.' 'When did you first think of yourself as a failure?' The therapist would not direct the narrative to where he or she believes the 'problem' lies (such as an underlying depression or lack of self-confidence), but would let the story unfold. When the therapist asks questions from the position of 'not knowing' (Laube, 1998), the therapist is free to 'listen' to all elements of the story; culture, upbringing, norms, gender, and so on (Freedman & Combs, 1996; Keily & Piercy, 1999; Weingarten, 1998).

Once the story is told, the therapist reflects (Freedman & Combs, 1996) on the narrative. In reflection, the therapist thinks out loud. The therapist points out aspects of interest. There is no analysis of the narrative (no expert views) but various aspects are commented on, such as; 'I noticed that you have not been fired from any jobs for the past five years.'

Sometimes, reflective teams are used to think about and discuss narratives. Reflective teams (Andersen, 1987), developed for use with family therapy, typically involve additional therapists observing a therapeutic or family session from behind a one-way mirror or sometimes in the same room (Freedman & Combs, 1996). After the session ends, the observing therapists are invited to reflect on their thoughts with the individual or family to allow the individual or family to hear multiple reflections, not just the reflections of their therapist.

Deconstruction is when narratives are disassembled, broken apart and examined using the feedback from reflections (Chen et al., 1998). The hope is to create a new dominant story (Merscham, 2000, p.282)

within the therapeutic session. One way to deconstruct a story is to provide alternative explanations. Retuning to Alice, the reflection showed that she had been successful in her work career. She could begin to re-create her narrative as 'the Smiths can hold jobs!' The deconstructed narrative and the new interpretation help the client change views and realize that some narratives are unhealthy and new narratives can help create new positive views.

Another technique of deconstruction is 'externalization' of the problem (White, 1986). Through externalization, problems become the product of a narrative rather than the creation of the individual (Schwartz, 1999). For example, the narrative therapist might ask a depressed client: 'What do you do when the depression comes walking in through the door.' Shifting the narrative from a personal problem (your depression) to an external problem (the depression) unburdens the individual of fault (depression is only a word, a social construct) (Suddaby & Landau, 1998).

Narrative therapy and group work: Literature review

Ruth Grossman Dean (1998) was one of the first to suggest that narrative therapy might be applicable to group work. She observed that 'when people come together they tell stories' (p. 27), thus making it logical that narrative therapy would work well in a group setting. The role of the group leader could be to elicit stories and encourage conversations about them. She suggested that through group conversations new ideas could be expressed, multiple perspectives seen, meanings changed, and alternative stories generated.

Similarly, Laube (1998) used narrative therapy to create group cohesion. Unlike individual therapy where the therapist works with an individual or family to create a narrative, Laube had group members commit to a common group story. He noticed that a communally created story promoted intimacy among group members.

Narrative therapy has also been used in support groups. An AIDS support group transformed 'separate experiences of suffering into shared insights, intense connections and comfort' through individual narratives (Dean, 1995, p. 287). In a support group for people suffering from fibromyalgia, a chronic-pain disease, narrative therapy

was used to co-create and share stories to help the group become unstuck 'in repeating the story of helplessness, and to harness their own resources' (Kelley & Clifford, 1997, p. 276). In another use, group members developed a therapeutic letter, helping the group think about themselves and others through alternative views (Chen et al., 1998)

Narrative in a parenting education program

Parenting education provides new information for parents (Fashimpar, 2000). This information is usually presented in a didactic manner, that is, parenting groups are classified (Hepworth, Rooney & Larsen, 1997) as educational – the purpose of the group is to teach new skills. Could parenting information be presented using narrative groupwork?

It was decided by the author and members of a parenting center to use narrative therapy to present educational material in a group for parents of adolescents. It was agreed that the content of the group would not be modified (as the curriculum provided information that parents would need: physical and behavioral development of teens; how to get teens to do chores, how to solve problems, and parent-child communication), only the leader's presentation style would be changed to use a narrative therapy approach.

Before incorporating narrative therapy, the group leader would start the group by introducing a skill such as getting a teen to do a chore, or active listening. The skill was then discussed and parents were encouraged to ask questions. The group concluded with role-plays to give the parents a chance to practise the new skill (group leaders played various roles with the parents).

Narrative therapy was incorporated into the group following the three-step procedure described earlier. Narratives were elicited after the skill introduction. The group leader used therapeutic listening to ask questions such as: 'Do you have difficulty getting your kids to do chores, tell me what happens?' 'Was there a time when you felt that your kids did not listen to you?'

It was critical that the group leader did not approach the group as the 'expert.' This was especially difficult in parenting groups because parents generally ask the leader for advice. 'My son does not do his chores; I have to yell at him all the time, what do I do?' Usually the

group leader provides a solution (reduce the use of yelling, set up natural and logical consequences) to help the parent. In the narrative group, the leaders did not provide the solution directly but encouraged more details of the narrative through questioning: 'What happens when your son does not do his chores?' 'Is there any time that he does his chores without your asking?' 'What could be some of the reasons?' 'What are you feeling about this situation?'

Once the therapeutic questions were answered, the group leader began to reflect on the narrative. The leader commented. 'I notice that your son sometimes does the chores, as you said, but never when you yell at him.' Or, 'I wonder if you notice that you sometimes get upset with your son for not doing the chores and other times you don't.' By reflecting on the narrative, the parent might begin to see new insights into his/her view of events (story), and become involved with solving the problem.

In a unique twist, the parenting group members, themselves, were encouraged to become the reflecting team. When problems were presented (such as chores) the group leader would ask; 'Does anyone have a similar problem?' Group members were encouraged to reflect and comment on each parent's narrative: 'What do you think about what Ms. G. just said?' 'Does the group see this differently?' Using the group as the reflecting team, the leader encouraged group members to provide multiple reflections of the presented narrative to demonstrate that recollections/interpretations (narratives) are not objective, but based in the individuals' vocabulary of interpretation learned through social interaction. The leader encouraged exploration of alternatives (multiple reflective views) by joining in on the conversation and suggesting new insights as part of the group, again, not as the expert.

At the end of the group session, narratives were deconstructed and re-created (story repair). As the group members (acting as the reflecting team) gave new insights into the narrative, the group leader collected and repeated these reflections to build a new story. For example, the group might have observed that the parent was inconsistent in the way he/she asked his/her child to do chores. A skill that was presented at the start of the group (natural and logical consequences) could be brought in as a new language of parenting, to help create a new narrative. 'What would the story look like if your teen did not do his chores, and you told him that he could not

go to the mall?’ Parents were also encouraged to role-play the new story, thus reinforcing the new narrative. In the new story, the parent incorporates the skill; hopefully feeling that the group members and the group leaders provided new insight into how to address parenting issues.

The setting, members and leaders of the group

The Parent Resource Center (PRC) provides education groups for families in an inner city area through funding by the state’s Department of Child Protection Services (CPS). The PRC is managed by a nonprofit organization. PRC groups are conducted by master-level therapists. Approximately 250 parents a year attend education groups for parents of infants, toddlers, school-age children, and adolescents. Groups are limited to ten members and the average group size is five. Parents are referred through CPS, and only a small percentage (5%) is court ordered. Most parents have limited education.

A typical parenting group lasts ninety minutes and consists of skill introduction, (thirty minutes), a discussion of the material presented (thirty minutes) and role-plays (thirty minutes.) To provide consistency among the groups, leaders follow the curriculum guidelines designed by the PRC therapists.

The narrative approach was tested on two groups for parents of adolescents. The first took place from November to the end of December 2000 and was led by the author and a Master’s level student. The second extended from February to April 2001 and was conducted by the author.

Feedback from two groups conducted using a traditional educational format was compared with the groups in which narrative therapy techniques were employed. The groups employing ‘traditional’ methods were conducted during the summer and fall previous to the winter groups using narrative therapy. Specifically, the groups met July to August 2000 and September to October 2000. These previous groups were led by a PRC facilitator and by the author.

Both the non-narrative groups and the narrative groups were similar in gender, ethnic composition and referral source. The first non-narrative group consisted of two African-American females and

one Caucasian male, the second non-narrative group included two Hispanic females and one male and one African American male. The first narrative group had a Hispanic female and male, one African American female and one Caucasian female. The second narrative group had two African-American females, and a Caucasian male and two females.

Each group member was administered as an individual intake, during which it was explained that the group was educational rather than therapeutic. If parents felt a need for psychotherapy, they were offered a referral within the agency or within the CPS. Only one couple from the narrative therapy group requested a referral following the eight-week session, for marital issues rather than parenting issues.

Methods of evaluation

Two methods of evaluation were used. Case examples were recorded and presented to the PRC team members (the PRC director, the Clinical Director, and the four group leaders) for review. The second form of evaluation used data from the group's written final evaluation. Two open-ended questions were asked: 'I learned the following information or skill(s) from participating in the parenting group' and 'What was most helpful about participating in the parenting program?' The results were reviewed by the staff, and presented to a Ph.D. social work clinical seminar. As the nature of this project was exploratory, the staff and the class pointed out differences in the results without drawing conclusions.

Case examples from the narrative group

This case example illustrates the leader using reflection to show parents how they were viewing their adolescent's behavior.

During the second session the leader asked the group to describe what it was like 'when they were fourteen years old.' Members shared sad stories about their past; stories about running away from home, getting caught with contraband, or being wrongly accused of stealing. After the stories were shared, the leader (in reflection) said; 'Did you notice what the original question was?

I asked you to tell me about what it was like “when you were fourteen years old” and nothing more. I didn’t ask you about problems you had as a teen. Yet, everyone told me something bad. I would like you all to go around again and tell me something you liked about being a teen.’

Because group members were having problems with their teens, this view filtered their own recall of their adolescent years, blocking good memories and letting through only the negative. The leader, after reflecting on the story, helped the members repair their narrative and think about memories of teenage years which were not bad, hopefully applying this view to their own teenagers.

In this next case example the group itself became the reflecting team.

A mother and father complained bitterly for 15 minutes about their teenage daughter’s ‘attitude,’ how the teen would make faces, roll her eyes or pout when her parents tried to talk to her. They wanted the leaders to ‘tell us what to do.’ The leaders, not playing the ‘expert’ asked for more details of the ‘attitude’ and how the parents were interpreting the behavior. The leaders asked the group for their views. The members began to question the parents. Using narrative therapeutic questioning, the group guided the couple to new insights. Slowly, the parents revealed that the daughter was the father’s step-child. Custody was shared between the natural mother and father. At the end of the session it was clear that the daughter was apparently showing her allegiance to her biological father through her refusal to ‘listen to her step-dad.’ So when the stepfather asked the daughter to do a task, the daughter would make a ‘face.’

Through narrative questioning by the leaders and group members, the group as a whole began to help the parents see alternative explanations of their daughter’s ‘attitude.’ As a reflecting team, the group offered new insights to the parents: the daughter had issues of allegiance and was confused about how to express her feelings. The parents were helped to see that it was not an ‘attitude’ problem but something more profound which could be addressed in family therapy.

The final case example, while not specifically addressing a parenting issue, shows how a group became an effective reflecting team and used the skill of externalizing the problem.

In a fifth session a parent told the group how he was denied a supervised visit with his children because the CPS worker thought he was 'drunk' when he came to the office for his weekly visitation. Rather than challenge the accusation, Frank (name changed) stormed out of the CPS office. Once calm, he went to the rehabilitation center and took a urine test to prove that he was not intoxicated. Frank insisted that he was 'never going back' to supervised visitation 'ever again.' The group, as a reflective team, began to deconstruct Frank's narrative. They pointed out that storming out of the office was not the best idea. Realizing that, the members began to formulate alternative ways of handling the situation. One member suggested that Frank, by leaving, fulfilled the expectations of the CPS worker. He told his interpretation of the event, suggesting that the CPS worker, who knew that Frank had a history of alcohol abuse, may have been hyper-vigilant, which in turn may have caused the CPS worker to misinterpret cues, thus falsely accusing Frank. Frank, already feeling like a failure, reinforced the CPS worker's suspicion by leaving. Another group member suggested that Frank could have said to the CPS worker, 'What can I do to show you that I'm not drinking? Can I take a urine test now? What about my kids? What are you going to tell them? Can I get another appointment to see my kids?'

The group leaders' role in this case example was not to provide directions but to allow the group members to become the reflective team to comment on and deconstruct the story. When one member pointed out that CPS was doing its job by watching to see if Frank was maintaining his sobriety, the group externalized the problem – Frank's ability to stay sober was not the problem, how he behaves towards others was the concern. The problem became externalized; that is the problem was seen as 'what do you do when someone thinks that you have been drinking?' Reflective views of the story were presented: the CPS worker was being hyper-vigilant and Frank was feeling like a failure and acting out the part. From these reflective views, alternative

approaches were generated for what Frank could have done and what he could have said. These alternative approaches were followed up with likely consequences-in effect, alternative 'endings' to Frank's visitation story.

Parents' final evaluation

Table 1 lists the results from the exit interview; 'I learned the following information or skill(s) from participating in the parenting group.' Table 2 lists the results for; 'What was most helpful about participating in the parenting program?'

Discussion

Communication skills were taught in both narrative and non-narrative groups, therefore it was the skill used as a comparison of parents' feedback. Both the staff and the Ph.D. seminar students in their review noted a difference between the two groups on what parents reported learning. Members of the traditional parenting groups reported that they learned 'to talk' to their children. They wrote: 'How to talk to my teens' 'To talk to my children', and 'How to express myself'

Parents from the groups that used narrative therapy reported they learned to 'listen.' They wrote: 'Importance of listening,' 'Reasoning, understanding, listening,' 'Listen to children more.' 'I learned how to listen.' 'Take time to listen.'

One explanation of the differences between the groups could be that the narrative leader did therapeutic listening. The parents could see the skill being demonstrated and used, thus improving the chance that listening would be learned. Another explanation could be that the emphasis on having members listen to each other (especially in reflective teams) reinforces listening. In the traditional group, the leader taught the skill, communication, hence the parents learned to talk (communicate) with their children, but not to listen.

Overall the narrative groups reported learning more specific helpful skills than the non-narrative groups. Feedback responses were longer and more detailed (See Table 2). This is surprising. It was assumed (by the staff and the author) that the narrative style, with its emphasis

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Table 1

I learned the following information or skill(s) from participating in the parenting group

Non-Narrative group	Narrative group
Reverse psychology	Importance of listening. The “Colombo method” The “broken record.” Emotional based remembering and recalling of events. Love and Logic, reality based consequences.
How to turn a bad situation into a good one	Reasoning, understanding, listening, respecting and most of all punishment if needed, but not to hit my child.
How to express myself a little better towards my children	How to deal better with my teen, without fighting a lot
How to talk to my teens without fights, positive and negative thoughts	Work on your problems together
To talk to my children, do not argue with them	Listen to children more To listen to my children when there is a problem with any situation at home, school. To deal with behavior that creates a power struggle. I learned how to listen more to my children and how to take correct action without any anger I learned to work with me, child and take time to listen

Table 2

What was most helpful about participating in the parenting program?

Non-Narrative group	Narrative group
Hearing other people's opinions	The role plays. Hearing experience of other parents. Hearing how being supportive and asking open ended questions promotes conversation. Realization on part of teen and provide an opportunity for parent to find out more from child's mouth.
The feedback that I received and me being able to speak and actually hear myself	Knowing that it doesn't take for you to beat on a child, to get some understanding and respect.
Giving feedback and hearing feedback	Learning to communicate better on a teen's level.
Being able to talk to other parents about concerns	Try to have your child participate in finding solutions Learning to help solve problems Learning to deal with a child who doesn't take no for an answer. Learned to deal with problems rather than a crisis. To put the problem reasons back on child to deal with it. Listening to others who have the experience dealing with children. Acting out role-plays. The helpful thing, to understand my child.

on leaders 'not being the expert,' would de-emphasize parenting skills and focus more on the narrative stories. It appears the opposite happened. Parents seem to have acquired more skills through a non-expert leadership style. It could be that skills were acquired through presentations of alternative viewpoints, such as when skills were brought in to develop new narrative endings. It could also be that the group members saw new ways to solve problems through listening to the reflective team, or as the narratives were reflected on, new learning took place through insight.

Yet parents from the non-narrative group found the 'expert' advice the most helpful. Comments such as; 'feedback and hearing feedback' and 'Being able to talk to other parents about concerns' demonstrated that getting their questions answered was perceived as most helpful. The debate about which method is more beneficial requires more systematic study.

Conclusion

The study was limited by a small sample, lack of randomization, and lack of concurrent control groups. The results, however, raise interesting questions for further study. Should narrative work be applied to education groups? Can the technique, originally designed for therapy, be used to help members learn better? Could narrative approaches be developed for other education groups, such as sex education or drug awareness groups where curricula are usually well defined? Would narrative approaches help with conflict management and anger management groups, which tend to walk the tightrope between therapy and education? This paper offers data that the narrative approach may be beneficial for parenting groups. Results indicate that narrative group members reported learning specific parenting skills, but more importantly they reported that they learned how to listen better. As communication skills are a major component of social-education groups, the narrative therapy approach might be of value.

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