Community Family Therapy and Narrative Approaches to Working with Parents

Struggling with Their Mental Health: A Review of the Literature

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Abstract

This paper focuses on family therapy and support for parents experiencing mental health struggles, with an emphasis both on supporting parents individually to increase their well-being and on ensuring that children are not at-risk of neglect or maltreatment. An overview of the current research on parental mental health is reviewed, as well as the importance of de-pathologizing mental health in clinical practice. Collaborative intervention models are explored from a community family therapy perspective, as well as from a narrative therapy orientation. Within these models, themes of alternative stories and positive action, inclusion of broader support systems, and leadership and advocacy are examined with implications for therapists and child protection workers.

1 Acknowledgements

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Rationale for Topic

To date, there is significant research on individual and relational therapeutic approaches to working with adults and children experiencing mental health difficulties. There is far less research on how children are affected by their parents’ mental health experiences, especially on the assessment of when those effects may include risk of maltreatment or neglect. Furthermore, there has been little focus upon how parents can proactively mitigate such safety concerns.

Community family therapy incorporates developmental and motivational theories, community mental health, economic development, and community mobilization strategies into traditional family therapy techniques (Rojano, 2004). This model differs from the norm of therapy models, as Rojano (2004) encouraged therapists to step outside of what is traditionally seen as their role, including moving the family income above the poverty line, increasing availability and access to necessary community resources, forming an individualized plan for personal and professional growth, fostering personal responsibility and self-sufficiency, and developing leadership skills and capacity for civic engagement.

Narrative therapy takes a collaborative and respectful approach, sees clients as the experts in their own lives, and views problems as separate from people (Morgan, 2000, White, 2006). This therapy model also assumes that people have many competencies, values, ideas, and skills that can assist them in changing the relationship they have with the problem in their lives (Morgan, 2000). Narrative therapy can additionally explore the ways in which something that is commonly seen as pathological has worked or been helpful for the clients (Tilsen, Russell, & Michael, 2005).

Community family therapy adds a focus on clients accessing community resources, furthering leadership skills, and increasing civic action participation (Rojano, 2004). Combining community family therapy ideas with narrative therapy could contribute to a multi-level focus for family therapy interventions that support children and parents who are at-risk of child welfare involvement.

Theoretical Orientation

This paper takes a critical, post-modern theoretical orientation to family therapy interventions with parents who are experiencing difficulty with their mental health. Research around parenting and mental health, particularly when child welfare is a consideration, has traditionally been from a modernist perspective, which can reinforce pathologizing narratives of these parents.

Narrative therapy and community family therapy ideas were selected to review in working with parents experiencing mental health struggles as they encourage therapists to challenge dominant discourses in Western Society and invite a broader systemic and community focus with clients. While this paper will be more focused on intervention strategies for family therapists, each of the intervention themes will include practice implications for child protection workers.

Research Findings on Parents with Mental Health Struggles

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Approximately 25% of child protection investigations in Ontario are surrounding parental mental health (Fallon et al., 2008; Public Health Agency of Canada, 2010; Westad & McConnell, 2012). Westad and McConnell (2012) found that mothers with a mental health diagnosis were almost three times as likely to have child welfare involvement than were mothers without mental health issues. Mental health can also occur concurrently with other struggles that can lead to child welfare involvement, including addiction and intimate partner violence.

Research suggests that 15-20% of people who are accessing supports for their mental health are also struggling with an addiction and that more than 50% of people receiving services around addiction also have a mental illness (Canada Centre for Substance Abuse, 2009). People who have experienced intimate partner violence are also at a higher risk for mental health struggles, including post-traumatic stress disorder, depression, anxiety, suicidal ideation, bipolar disorder, substance abuse, and generalized anxiety disorder (Coker et al., 2002; Okuda, 2011). Intimate partner violence is the primary concern in 34-39% of child protection investigations (Fallon et al., 2008; Public Health Agency of Canada, 2010) and addictions is a concern in up to 80% of child protection involvements (Walsh, MacMillian, & Jamieson, 2003). Given the intersections that addictions and intimate partner violence have with the mental health of parents, mental health may actually be a factor in many more than 25% of child welfare cases.

While parental mental health does have associations to child welfare involvement, the presence of mental health struggles is not a strong indicator of parenting capacity; rather, there is significant variation in parenting capacity depending on factors such as the type and severity of the illness, as well as individual, social, and environmental contexts (Westad & McConnell, 2012). Parental mental health struggles are often experienced in conjunction with other life stressors, including poverty and social isolation, which certainly adds to the complexity of how therapists can work with clients around mental health.

Parents who are experiencing depression face unique challenges that can sometimes lead to their children being at-risk of neglect or maltreatment. The effects of the depression can lead to feelings of apathy and difficulty in getting up in the morning and doing practical day-to-day activities (Pluznick & Kis-Sines, 2010). This can lead to interactions, or lack thereof, with their children that can be hurtful and potentially neglectful. Younger children are particularly vulnerable when a parent experiences depression because they rely completely on their caregivers to meet their physical and emotional needs (Mustillo, Dorsey, Conover, & Burns, 2011). Depression can also contribute to parents demonstrating lower levels of warmth, and being less likely to engage in reading and playing with their children (Mustillo et al., 2011).

Children of parents with mental health struggles are at higher risk of experiencing emotional and behavioural issues, including depression, anxiety, and disruptive behavioural disorders (Mustillo et al., 2011; Westad & McConnell, 2012). This can be particularly difficult for parents experiencing depression, as the depression can sometimes interfere with parents in accessing mental health supports for their children, although there may be additional contextual factors that create barriers (Timmer et al., 2011). The depression can also influence parents to be easily irritated with children’s behaviour and more likely to criticize children (Mustillo et al., 2011; Timmer et al., 2011). While physical abuse can also be a risk for children when parents are experiencing mental health struggles, this is not necessarily more likely; instead, child
neglect is a more likely risk in homes where parents are struggling with their mental health (Mustillo et al., 2011). Children can also be quite vulnerable to mood changes in their parents, which can be unpredictable and confusing for them (Pluznick & Kis-Sines, 2008).

Parents who are experiencing mental health struggles sometimes use alcohol and/or drugs to cope with feelings of depression and anxiety (Pluznick & Kis-Sines, 2010). Appleyard, Berlin, Rosanbalm, and Dodge (2011) noted that intergenerational child maltreatment in families is connected with parental mental health struggles, and subsequently family social isolation and substance abuse. More specifically, they found that maternal experiences of physical and/or sexual abuse had a strong correlation to substance abuse and maltreatment of their own children (Appleyard, Berlin, Rosanbalm, and Dodge, 2011). This study points to the importance of supporting parents through a variety of life experiences that may be affecting their ability to parent their children in ways that fit with their preferred identities as parents.

Parents struggling with mental health difficulties also often experience financial instability and stress. It is not uncommon for these parents to encounter times of unemployment and/or underemployment (Pluznick and Kis-Sines, 2010). Westad and McConnell (2012) additionally highlighted that many parents, specifically mothers, may not have the financial means to continue to use effective interventions, such as medications and possibly therapy services. If parents are struggling with their finances due in part to mental health issues, their children may also be exposed to living in poverty, which can increase the likelihood that they may experience health problems and poor housing conditions (Rojano, 2004).

In a review of outcome research regarding therapy approaches with parents experiencing depression, Beach and Whisman (2012) pointed to parent training as an effective approach, particularly when combined with cognitive interventions. Gelfand, Teti, Seiner, and Jameson found that parenting training intervention to assess skills, strengthen mother’s self-confidence, and reinforce their existing parenting strategies led to improvement in depressive symptoms (as cited in Beach & Whisman, 2012, p. 211). Sanders and McFarland alternatively found that cognitively enhanced behaviour family intervention was successful in decreasing symptoms of depression (as cited in Beach & Whisman, 2012, p. 211).

**Importance of De-pathologizing Mental Health**

Mental health issues are primarily understood in the context of the medical model, specifically through the DSM-5 (Strong & Busch, 2013). While this traditional medical model understanding of mental health can be useful in recognizing the importance of talking about parents’ mental health and in helping people to organize and see themes in mental health, it can also be pathologizing, with a focus on what is “wrong” with people and may neglect to address issues of power and oppression. The current trends in using the DSM and in the mental health system often focus on individual deficits and tend to neglect an examination of the systemic, social, environmental, and cultural influences around mental health and parental struggles (Drewery & Winslade, 1997; Marecek & Hare-Mustin, 2009). This can be problematic, as it risks further pathologizing, shaming, and blaming parents struggling with their mental health.

In recognizing that any system of understanding and treating mental health is influenced by
the values and beliefs of its originators, it’s important to consider questions about how and by whom the “knowledge” about mental health is being currently created and shared. This includes asking questions about who determines what constitutes mental health issues, who benefits from these determinations, whose voices are heard and whose are silenced, and who are considered the authorities on mental health (Marecek & Hare-Mustin, 2009). In the dominant ways of understanding mental health currently, the voices and experiences of people with mental health struggles are not often honoured and people are frequently not considered to be authorities on their own mental health (Marecek & Hare-Mustin, 2009).

Marecek and Hare-Mustin (2009) also described that this knowledge of mental health is shaped by the social location, politics, and life circumstances of people in positions of power and privilege in Western society. They also critiqued the DSM for reflecting white, middle-class ideas of health and wellbeing (Marecek & Hare-Mustin, 2009). These claims highlight the post-modern assumption that “truth” is relative and that the mental health system is not neutral.

This pathologizing trend in mental health systems is often reflected in the language used to describe people with mental health struggles. For example, the language used in Beach and Whisman’s 2012 article, Affective Disorders, which described “depressed patients” (p. 204), can been interpreted as a reflection of a mental health struggle being a descriptor of a person. This can be problematic, as descriptive language such as this can suggest that the person is depression, which can been stigmatizing and labeling of the person.

Given the pathologizing nature of Western society’s conceptualization of mental health struggles, it is unsurprising that families wherein a parent experiences mental health issues face stigma and isolation. Many parents struggling with their mental health encounter poverty, social exclusion, and sometimes have limited supports available to help them in parenting (Westad & McConnell, 2012). Parents can face further stigmatization by an assumption that they are unwilling to earn a living (Pluznick & Kis-Sines, 2010). Kis-Sines et al. (2008) also reported that other adults often blame parents for their mental health struggles. These assumptions and difficulties faced by parents with mental health issues reflects a dominant discourse that mental health is a defect of people and is often treated with much less compassion and understanding than other struggles parents might encounter, such as a physical illness.

This stigma and isolation can extend to children’s experiences as well. Pluznick and Kis-Sines (2010) noted that teachers, other parents, and children sometimes treat children of parents with mental health struggles differently than their peers. Children also sometimes feel unsure of what might happen next with their parents, which can lead them to be embarrassed or even fearful of bringing their friends over to their home (Kis-Sines et al., 2008). This can lead to children feeling shameful of their families.

Children and parents’ experiences of stigmatization can be especially difficult when coupled with crisis events that require hospitalization or intensive supports for parents. The act of forced hospitalization can be quite traumatizing for both parents and children (Kis-Sines et al., 2008). It is also important for other adults to consider how they will approach conversations with children when a parent has engaged in a suicide attempt; children may quickly infer that their parent’s mental health is not a topic for discussion, which can add to the silence and stigma.
Parents’ experiences of medications may also contribute to the pathologization of mental health. Many people who take medications for mental health report struggles with the negative side effects (Pluznick & Kis-Sines, 2010). Parents sometimes experience diminished feelings of personal agency, especially when the power to make their own decisions about medications is restricted or absent (Pluznick & Kis-Sines, 2010). This can be especially true when parents are recommended/required to take their prescribed medications by a third party, such as a child protection agency.

While the field of child welfare is currently undergoing a shift in thinking and practices from a risk-based model to a solution and strengths-focused model, its history of paternalism with clients has continued to present challenges to working in partnership with families (Turnell & Edwards, 1999). These authors argued that a paternalistic approach to child welfare traditionally places workers as the holders of expertise in families, with full responsibility for assessing and solving families’ problems. Turnell and Edwards (1999) emphasized that partnership is central to child protection work, and that this requires workers to step out of the expert role and collaboratively partner with families to keep children safe. This does not mean that workers do not know anything, but rather that the knowledge that families have of themselves needs to be honoured.

Turnell and Edwards (1999) further suggested an approach to child protection work that is heavily influenced by Solution-Focused Therapy. This includes looking for exceptions to when the “problem” wasn’t there and capitalizing on what was done to keep the problem at bay (Turnell & Edwards, 1999). In considering times when the problem was avoided, the focus starts to shift from problems to solutions and on people’s strengths rather than on their deficits. Within this, there is an inherent assumption that people have strengths (Turnell & Edwards, 1999).

Community-based programs are intended to make supports more accessible for families and to strengthen partnerships with other organizations with which families may be already connected. Appleyard, Berlin, Rosanbalm, and Dodge (2011) concluded from a longitudinal, community-based study of 499 mothers and their infants that there is a high need for assessment and early interventions for mothers with mental health and addiction issues in community settings. These researchers also suggested that by reaching mothers at a community level for prevention and early intervention, the stigma for mothers reaching out for support might be reduced (Appleyard et al., 2011). Frensch, Cameron, and Hazineh (2005) further support the use of community-based child protection programs in their analysis of three community and school-based child protection programs in Ontario. They found that these programs encouraged service providers to have more knowledge of community and family strengths, as well as to relevantly meet the needs of families quickly.

It is also important for practitioners to consider how to work within other mental health systems with a collaborative and strengths focus with parents struggling with mental health. Madsen (2007) highlighted that how documents are structured can have a significant impact on how conversations with clients occur, which can be problematic if the documentation tends to be pathologizing of mental health. He further noted that assessment tools tend to focus on the
problem, a client’s history, functioning, risk factors, diagnoses, mental status, etc., which are not necessarily strengths-based (Madsen, 2007). Madsen (2007) noted that narrative questions that externalize the problem could help practitioners to assess problems rather than assess families. This is an important distinction, as it removes the problems from being inherent to the people and recognizes them as unique individuals with strengths, accomplishments, and stories.

**Narrative and Community Family Therapy Interventions**

Narrative therapy and community family therapy ideas for working with parents were chosen because these models not only suggest micro-level interventions in sessions with clients, but also take a broader perspective by advocating for involving clients’ community and family supports and encouraging clients to become civically engaged (White, 2007; Rojano, 2004). These therapy models acknowledge the systemic barriers that people encounter and aim to focus on enhancing clients’ views of their strengths.

In this literature search, peer-reviewed articles, government reports, and theory and practice books from the fields of couple and family therapy, psychology, and social work within the past 15 years were utilized, except where earlier books and/or articles provided key foundational information. Some evidenced-based articles were included, but the focus of many of the articles was theoretical, as the current research appears to be less empirically based. In reviewing this literature on narrative therapy and community family therapy, three themes emerged; creating an alternative story with clients that focuses on strengths/life of positive action and self-development, the inclusion of a broader community network of personal and supportive resources (including family members), and encouraging leadership development, civic engagement, advocacy. The literature of each of these three themes will be reviewed, combining narrative and community family therapy ideas throughout.

**Alternative Stories, Positive Action, and Self-Development**

Both community family therapy and narrative therapy emphasize that therapists should listen for strengths of clients and enhancing clients’ views of themselves from a strengths perspective (White, 2006; Rojano, 2004). Rojano (2004) suggested that therapists work with clients to strengthen their connection with their own histories, identities, and self-esteem. This can include reducing clients’ negative self-images through deconstructing their feelings of shame, blame, hopelessness, and anger (Rojano, 2004). The theory behind this deconstruction is to facilitate the construction of new paradigms (Rojano, 2004). Rojano (2004) also encouraged therapists to explore client strengths to enhance their self-esteem and implement a plan to take charge of their lives.

These ideas of Rojano’s first level of engagement with clients overlaps significantly with White’s narrative ideas of externalization and searching for and strengthening clients’ alternative narratives. White (2006) argued that externalizing conversations provide an alternative to people internalizing their problems as a reflection of their character, their relationships, or other people. In separating the person from the problem, the problem ceases to be a “truth” about their identity, which allows for new possibilities for solutions to emerge (White, 2006).
Knight and Koch (2009) further supported the use of externalizing conversations with clients as these conversations help to move away from the idea of being deficient and refocus on how clients can use their strengths to explore ways to deal with the problem. Externalizing conversations also help people to deconstruct some of the negative conclusions that they have often reached about themselves and their identity because of the problem (White, 2006). For example, a therapist could work with a family to externalize the effects of the depression. Note that from a narrative perspective, part of the externalization includes naming the problem, so that it is removed from the person: it is not a person’s depression, instead it is the Depression (White, 2006).

In working with clients to externalize the problem, therapists might ask, “What is the name you would give to your difficulties?”, “What effect does it have on your relationships with friends and family?”, “Does it ever have you saying or doing things you might not otherwise say or do?”, “Does it ever come between you and the people who love you?” (Pluznick and Kis-Sines, 2010, p. 43). Further externalizing questions might include asking for a rich description of the problem, such as asking about the colour, size, where you feel it, is it always there, when is it lighter/heavier, what does it tell you, do you talk back with it, etc. (White, 2006). Externalizing conversations can also help clients to explore their values and preferred identity, as well as their active resistance to the problem (Knight & Koch, 2009; Penwarden, 2006; White, 2006).

Therapists can use a variety of methods to explore clients’ strengths in externalizing the problem and enhancing their preferred narratives, including using art, drawings, photos, and therapeutic letters (Knight & Koch, 2009). Therapists can even write narrative letters with and/or to their clients to celebrate significant accomplishments and may describe how a person or family has reclaimed their lives from the problem (Morgan, 2000). These narrative approaches can also help family members to join together to stand up to the problem, which can strengthen feelings of unity and collaboration in families (Knight & Koch, 2009). This can be especially helpful with families where a parent is experiencing struggles with mental health because it can help them to be able to talk about the problem and warn one another when they notice the effects of it (Knight & Koch, 2009). This may also help to reduce the stigma of mental health in families as it firmly separates the person from the problem.

Therapists can continue to strengthen clients’ alternative narratives and paradigms by honouring their knowledge about themselves and the problem. More specifically, both community family therapy and narrative encourage clients to re-write their stories, coming to a different understanding of their history (Rojano, 2004; White, 2006). This includes the assumption that people’s lives are never totally dominated by problems (Pluznick & Kis-Sines, 2010). Therapists can look for openings to explore these unique outcomes by listening for times when the problem wasn’t such a problem, such as when a person was able to get out of bed despite the Depression (Pluznick & Kis-Sines, 2010).

This also goes hand-in-hand with White’s idea of the absent but implicit, which is the assumption that in any expression of a life experience, there are unstated signs or descriptions that imply possibilities for a multi-storied view of clients’ histories (White, 2000). This includes investigating clients’ preferred narratives by listening for what the problem is not, which may not
be stated directly by clients, but instead implied through their description of the problem (Carey, Walther, & Russell, 2009). Carey et al. (2009) recommend asking questions that highlight that which is absent but implicit in conversations with clients by asking questions such as, “What is it that you are refusing to go along with in raising this concern or in expressing your distress?” “It sounds as though you are not accepting of this situation. If you are not accepting of it, then how are you responding to it?” (p. 325). This idea of absent but implicit can also be connected with the narrative idea of double listening, which means that therapists are listening for not only clients’ stories of struggle and trauma, but also for what they value and see as important in their lives (Knight & Koch, 2009).

Vromans and Schweitzer (2011) conducted an outcome research study of 47 participants experiencing depressive symptoms and found that in using narrative therapy, including deconstructing problem narratives and externalizing the problem, almost 75% of the clients reported reliable decreases in their experiences of depressive symptoms. These researchers also found that while there were limitations to their study, the outcomes on depression using narrative therapy were comparable with cognitive-behavioural therapy, psychodynamic-interpersonal therapy, interpersonal therapy, and process-experiential therapy outcomes reported in other empirical research (Vromans & Schweitzer, 2011). Vromans and Schweitzer (2011) also noted that this study was conducted as a response to the limited empirical research conducted on narrative therapy, possibly due to its postmodern approach to knowledge and relativism that leads narrative approaches to be more difficult to operationalize in traditional research.

**Implications for child protection workers.** While these recommendations for practice are primarily in the context of therapists, many of these kinds of questions and approaches can be applied in home visits or meetings with families in a child welfare context. Using externalizing conversations can help to move away from a risk- and deficit-focused approach with parents and may also be useful in building trusting relationships with clients. Parents may feel more empowered and less criticized if workers use externalizing language about mental health, as it reinforces that they are valuable people and separate from the struggles they are encountering.

The use of unique outcome questions can also help workers to identify parents’ strengths and to highlight the safety that they are already creating for their children. These techniques would work well along side Turnell and Edward’s (1999) *Signs of Safety*, particularly in partnering more equally with families and optimizing on their strengths. Helping parents to re-author their stories may also be especially powerful when parents are experiencing feelings of hopelessness and defeat during involvement with child welfare services. As the history of the risk-focused model can often lead parents to feel shamed, demonized, and unacknowledged of their efforts (Turnell & Edwards, 1999), using these interventions may help workers to demonstrate respect for families and actively share the responsibility of protecting children them.

**Inclusion of Broader Community and Family Network and Supportive Resources**

Rojano (2004) advocated for therapists to support clients through case management, connecting clients with community resources, wraparound programs, engaging in community outreach, and networking with other helping professionals. Through doing this, therapists can help clients to build or re-build their relationships with special family members and close friends,
as well as encouraging the development and mobilization of clients’ social networks (Rojano, 2004). Within the community family therapy model, therapists are also encouraged to network extensively with other community professionals, which may be time-consuming for practitioners, but allows for more encompassing support for a variety of clients (Rojano, 2004).

Buckley and Decter (2006) also highlighted this idea of including important family and community members in working with clients through difficult times and having the clients dictate who they would like to be included. When a parent is experiencing a mental health struggle, therapists can extend an invitation to children and their parents to be consultants in therapy, which demonstrates value of their lives experiences and wisdom (Pluznick & Kis-Sines, 2010). This inclusion of additional people in the collaborative process can help to reduce the stigma experienced by parents with mental health struggles and to strengthen their preferred stories about themselves and their families.

Outsider witnessing can be one method for including more people into the sharing of people’s preferred narratives. Outsider witnessing is a therapeutic practice in which a third party is invited to listen to and acknowledge the preferred story of a client through witnessing a dialogue between the client and therapist (Carey & Russell, 2003). These witnesses can be family members, friends, community members, other professions connected with the client, or other therapists/practitioners who do not know the client (Carey & Russell, 2003). This experience can also help clients and witnesses to link what happens in therapy sessions to the rest of the person’s life (Carey & Russell, 2003; Knight & Koch, 2009).

In outsider witnessing sessions, therapists ask the witnesses part way through the session about what caught their attention in hearing the client(s) speak, what images or metaphors were evoked by this witnessing, what it is about the witness as a person that lead them to be drawn to those images, and where the witnesses were transported that they might not have been otherwise if they had not witnessed this session (Carey & Russell, 2003). These kinds of questions often lead to very meaningful and significant responses, particularly if witnesses listen and respond in ways that honour clients’ experiences (Carey & Russell, 2003).

The narrative therapy approach also recognizes the influence that significant figures and identities in a person’s life (past, present, and projected future) can have in how a person constructs their identity (White, 2006). Re-membering conversations with clients can facilitate highlighting the voices that have been most meaningful to them in their lives (Morgan, 2000). These conversations can also help clients to strengthen their alternative stories (White, 2006). Therapists can elicit this re-membering process by asking clients questions about people who have been influential in their lives (alive, dead, here, or not), what it was about those people that made them so influential, what those people value about the clients, and what would have lead them to know those things about the clients (Morgan, 2000).

While there has been some evidence-based research supporting the practice of building support networks and including other important people in clients’ lives, this area would benefit from further research. Suter and Bruns (2009) noted in their meta-analysis of the use of wraparound programs with children, youth, and their families that while the research findings are generally positive, the information is insufficient for reliably evaluating these programs.
Additionally, evidence-based research supporting the use of narrative therapy around these themes is limited, possibly because of how the values and ideas of narrative therapy can conflict with the practices of evidence-based research. For example, Speedy and Thompson (2004) challenged the current paradigm of evidence-based research through a narrative lens, arguing that the traditional methods of research do not fit with the narrative ideas of de-centring therapy, exploring re-presentations of people’s stories, and making marginalized voices more audible in society.

**Implications for child protection workers.** The child protection system in Ontario already advocates for collaboration with extended families and community supports to help ensure child and family safety and wellbeing. The community-based teams, which include having child protection workers in schools, health care settings, women’s shelters, etc., live out this value of involving the community in child protection. Child protection workers can continue to make these connections with community supports, both as supported structurally by their organizations, but also informally through community outreach.

Workers and families might also consider collaboratively inviting these family and community supports into more home visits and meetings. This could provide additional opportunities for these valued supports to be witnesses to families’ strengths and achievements. Workers might also elicit clients’ positive descriptions of themselves through asking re-membering questions.

**Leadership Development, Civic Engagement, and Advocacy**

Doherty and Carroll (2002) noted that there is often a gap between therapists’ expected role in dealing with personal problems and the social justice values that are inherent in the therapy profession. They invited practitioners to consider how family therapists can broaden their focus to engage with communities at a more macro level and challenged several assumptions traditionally held in this field that it is not therapists’ role to take on social issues in the therapy room (Doherty & Carroll, 2002). Rojano’s (2004) community family therapy model holds the principle that both therapists and clients should get involved in civic action beyond the therapy room.

By engaging in their communities, clients can move from isolated, stigmatized individuals towards feeling empowered as active citizens (Rojano, 2004). In this community family therapy model, clients are expected to take control of their own lives, get active in their own communities, and join civic or charitable organizations (Rojano, 2004). Therapists are likewise expected to have familiarity with community issues and to participate actively in at least one community project (Rojano, 2004). While many therapists and practitioners may feel concerned that community engagement is an additional expectation on them, Doherty, Mendenhall, and Berge (2009) suggested that this kind of community project engagement can require only 6-8 hours per month over an extended period of time.

Gowen and Parvicini (2005) provided an example of how narrative therapy helped a group of young women who had experienced sexual violence to create an initiative to speak out against sexual violence. This group of young women engaged in outsider witnessing practices
and began to tell and re-tell their stories to high school students in their area (Gowen & Parvicini, 2005). They further partnered with young men who had perpetrated sexual violence to educate other young people and encourage social change (Gowen & Parvicini, 2005). Gowen and Parvicini (2005) noted that this group of women wanted to open their dialogue up even further in the form of a school club that anyone could join, raised money for people in the local community who had experienced domestic violence, and created commercials for their campus TV station. These researchers also highlighted that this group of young women expressed their hopes for changing peer culture, their desires to be positive role models and to help people, and their commitment to contribute to living in a world that is free of violence and abuse through this process of telling their stories (Gowen & Parvicini, 2005).

Other practitioners from a narrative perspective have also engaged at the community level to share stories and empower people. The ACT Mental Health Consumers Network & Dulwich Centre (2003) organized a gathering of more than 50 community members to share their stories of living with mental health struggles. The report on this gathering was made available to each of the participants and highlighted the inclusion, honouring of people’s stories, solidarity, and safety offered to others as a result of this unique community experience (ACT Mental Health Consumers Network & Dulwich Centre, 2003). This article also quoted several individuals’ comments about the process of coming together as a group with shared and unique experiences of mental health. One participant expressed:

“It was significant to hear the recognition of our knowledge and expertise. I have had a difficult time recently, and I realised that I had to come to this weekend to replenish myself. It makes me think about what it would be like if this was a more common experience.” (ACT Mental Health Consumers Network & Dulwich Centre, 2003, p. 45)

Another individual shared that:

“I hope that in the future there may be more opportunities for workers on psychiatric wards to meet us when we are well, so that they can hear more about our lives and the sorts of stories we have told today. Those who work in acute mental health services only ever see people in crisis. They see us when we are at our worse, when we are most ill. I would love the opportunity to invite these workers to a meeting like this one, to invite them into our world. I know that some of these workers would really appreciate this as they have told me this themselves.” (ACT Mental Health Consumers Network & Dulwich Centre, 2003, pp. 45-46)

**Implications for child protection workers.** Child protection workers can extend their practice into the realm of the community by supporting the families with whom they work in getting involved in their own communities. Workers can also explore getting involved in community projects in small way, including gaining knowledge of community issues. Child protection workers can also advocate for continued change within the child welfare system that promotes a strength- and solution-focus with families, the involvement of extended families and communities, and the de-pathologization of mental health struggles. This could include talking about these issues with professional associations, in trainings and conferences, with politicians, and within child protection organizations.
Implications of the Review for Future Research in Couple and Family Therapy

While Rojano’s (2004) article on community family therapy provides significant insight into some new ideas of moving beyond the therapy room, this article is the primary information base about the community family therapy model. Doherty, Mendenhall, and Berge (2010) articulated that community family therapy ideas have been included in some participatory action research. However, more research would be beneficial on how therapists can move outside of their traditional roles and into the community realm, including very specific recommendations and how those recommendations could be applied with busy therapists. This could be particularly helpful for therapists who want to live out their values of social justice and anti-oppression on a variety of levels. It could also provide therapists with additional skills in partnering with clients to create meaningful change in their lives.

While much has been written on challenging traditional how practitioners understand mental health, particularly from a post-modern perspective (Drewery & Winslade, 1997; Marecek & Hare-Mustin, 2009), there has been less evidence-based research on this topic. The couple and family therapy field might benefit from further research on diversity within defining mental health, including how cultural differences and power relations may play into our understandings of mental health. Jeste, Twamley, Cardenas, Lebowitz, and Reynolds (2009) also highlighted that while there is a lot of research on mental health of people from diverse backgrounds, there is a shortage of researchers from minority backgrounds. They further suggest that in order for research to be more reliable and culturally appropriate, there is a need for more researchers from a diversity of backgrounds and experiences (Jeste et al., 2009).

Conclusion

As mental health is a factor in significant amount of child protection investigations and is a frequent presenting concern in therapy, it is important for therapists and child protection workers to consider how they engage in supporting parents with mental health struggles. These parents are often seen as having deficits as parents and shamed and blamed for the challenges they experience. These pathologizing trends in mental health work are problematic in Western society and are worthy of examination in order to explore alternatives that support parents’ strengths and accomplishments.

In reviewing some of the research on narrative and community family therapies, these models seemed to both move away from a pathologizing outlook on mental health. They also encourage therapists to work with clients on a variety of levels; at a micro level to engage in re-storying clients’ understandings of their strengths and abilities, at a mezzo level that recommends involving clients’ families and communities, and at a macro level that involves therapists and clients becoming active citizens and advocates for social change. These themes are significant, as they challenge therapists and child protection workers to move beyond the traditional expectations and limitations of their roles to live out values of social justice, community engagement, and the de-pathologization of mental health. While these therapy models provide useful information, further research is required to fill a gap in specific recommendations for how therapists can get more involved at a community level and on the community family therapy model in general.
References


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